The meaning of nurses' caring for clinically deteriorating patients

Kate Hinvest

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School of Nursing

Faculty of Health and Environmental Sciences

Auckland University of Technology

Abstract

Over recent years, the care of deteriorating patients has improved with technological advances. The global ageing population means patients are often presenting with more complex co-morbidities and therefore are deteriorating from an increasingly complicated baseline. Nurses comprise the largest sector of the health care work force and often have frequent patient contact therefore are most likely to be in a position to detect deterioration and act on it. Much is known about many aspects of clinical deterioration, especially regarding detection and management, however little is known about how nurses experience the clinical deterioration of their patients. This study reveals and explores the stories of ten Registered Nurses working in Acute Assessment Units caring for clinically deteriorating patients.

This research uses the perspectives of hermeneutic phenomenology, drawing on the works of Heidegger and van Manen to explore the meaning of nurses' caring for clinically deteriorating patients. The 10 participants recruited were Registered Nurses working in Acute Assessment Units across the Auckland region and who self-identified as having cared for a deteriorating patient. Semi-structured interviews were conducted with participants and transcribed verbatim by the researcher. Coherent stories were recrafted from the transcripts and returned to the participants for verification. Common notions were identified through hermeneutic interpretation.

The findings of this research uncovered three main themes; Being connected, Being there as nurse, and Being with. The nurses' stories revealed that their experiences of caring for deteriorating patients were deeply human and at times strongly linked to their own identities. The findings show that the way nurses experience patient deterioration cannot be separated from who they are as people, and the complex parts of themselves that they bring to their role in their connectedness and sharing of situations with patients.

The results of this research provide an insight into the realities faced by nurses in their everyday experiences of caring for deteriorating patients and highlights the complexity of the emotional work and caring that takes place in their work. Recommendations have been made to support nurses in their care of deteriorating patients through

increased education and practice changes to encourage reflection and acknowledgement of the emotionality faced in their nursing care.

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Attestation of Authorship

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning."

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Chapter 1 - Introduction

> *"My first thoughts when I realise a patient is deteriorating are always*
> *'oh shit'. I think it's because I'm aware of my responsibilities and what*
> *might happen if I fail to act, but it's also concerns for the patient. I*
> *always think of the worst-case scenario and do everything in my*
> *power to try and stop it. It's not a situation I ever want a patient to*
> *get into if I can prevent it." (Ben)*

This study explores the meaning of nurses' experiences caring for clinically deteriorating patients in Acute Assessment Units from two District Health Boards (DHBs) in New Zealand. The stories of ten Registered Nurses are interpreted using hermeneutic phenomenology to explore what it means to care for these patients. Extracts from participants' stories are presented at the beginning of each chapter as a way of illustrating the content.

This chapter provides a background for this study and will outline my own interest in this topic. A brief outline of the methodology and how it influenced the formation of the research question will be presented. The purpose and focus of this study will be outlined and key terms defined. A summary of the entire thesis will conclude this chapter.

1.1   What is the purpose of this study?

This study is concerned with understanding the experiences of nurses caring for clinically deteriorating patients in Acute Assessment Units. Caring for clinically deteriorating patients is a complex phenomenon, with many contributing factors and influences. It is a phenomenon that most nurses will face in their career, bringing with it a range of emotional responses. This multifaceted issue requires knowledge and skills to recognise deterioration, communicate concerns, and react in a way that ensures the patient receives appropriate care. Further to this, with an aging population (Howdon & Rice, 2018) and progressively high acuity workload (Needleman, 2013; Winters & Neville, 2012), it is likely that nurses will be increasingly caring for deteriorating patients.

In New Zealand, patient deterioration is a health issue of key importance to be addressed and is one of the safety improvement foci for the Health Quality and Safety

Commission of New Zealand (HQSC). An investigation by Moore and Poynton (2015) identified that clinical deterioration was not detected or responded to consistently in New Zealand DHBs, and that preventable harm or inappropriate care was occurring. An investment case was put forward to address these issues which led to a patient safety improvement programme being developed by the HQSC. This five year national programme has three main workstreams; recognition and response systems, patient, family or whānau escalation and shared goals of care (Health Quality Safety New Zealand, 2018). Additionally to this programme, a current focus in healthcare is improving patient experience, described as the cornerstone of optimal health care delivery (Kreimer, 2018). Enhancing patient experience has benefits such as improved partnership with health care consumers and improved health outcomes (Health Quality Safety New Zealand, 2018).This leaves me questioning whether similar improvements could be made by exploring the nursing experience of patient deterioration, and if having an understanding of these experiences may help to ensure that these HQSC workstreams are being implemented and utilised in a way which works for nurses. This is particularly so as nurses are the largest workforce in the health care sector (New Zealand Nurses Organisation, 2018) therefore understanding and improving nurses' experience will benefit health care in general.

Caring for deteriorating patients is complex in any setting, and perhaps more so in acute care areas such as the Acute Assessment Unit (AAU) where there is pressure to not only give high quality treatment and care to patients with acute presentations but to simultaneously facilitate patient flow and bed availability. Although this is an important consideration in most inpatient areas, the AAUs were implemented specifically to expedite patient flow and there is often a higher ratio of acute patients due to patients who are more stable being moved to the wards or discharged. A literature search showed that there was a paucity of research about the experience of nursing in these units, which further reinforces the possibility that it may be different to other areas. Therefore, nurses must consider what can be learnt from exploring these experiences and how this may contribute to improving outcomes and management of patients who are clinically deteriorating.

In my own experience, caring for a deteriorating patient is a highly emotional situation, but the emotions are not often voiced, expressed or discussed. As nurses, we spend

significant time learning how to prevent, detect and manage patient deterioration but there is little space created for nurses to openly discuss their experiences, emotions and feelings, or even acknowledge that an event may have been distressing. Registered nurses working in the public health system in New Zealand do not usually have formal 'clinical supervision' sessions where practice issues can be discussed, as other disciplines do.

For nurses working in AAUs, caring for deteriorating patients alongside the pressures of the fast paced and acute nature of the ward is often a daily occurrence. The phenomenon is so frequent that it is taken for granted, expected and often normalised. This leads me to investigate what meaning lies hidden within these everyday experiences.

1.2   My background

I was born in New Zealand, the eldest of four children. Although I have felt like I have been in the role of care giver almost all of my life, the decision to be a nurse was a surprising one, coming seemingly out of nowhere. In retrospect, it now seems like a natural progression of things that I was drawn to throughout my childhood and youth. I loved books and stories about people, often with a medical basis. When I think back on my nursing career so far, it is the interaction with people, the human experience and finding joy and meaning in everyday situations that I remember. It is the patient stories, and the nursing stories that have stuck with me. I have learnt more from these stories than any courses or books, and these are undoubtedly what have shaped me the most as a nurse. Hermeneutic phenomenology has enabled my love of stories and words to merge with my love of nursing and people. I was drawn to phenomenology, much like I was drawn to nursing, finding myself unintentionally immersed in each and feeling like I belonged.

I have been a Registered Nurse since 2000. I have worked in the Assessment & Diagnostic Unit at Waitakere hospital since 2011, and I hold two roles in the department. I work part time as the Clinical Nurse Educator, and part time as a senior Registered Nurse. I have had years of experience working clinically caring for patients, as well as having operational and managerial experience. I have an understanding of nursing in an acute area from both sides, knowing what it is like to work in this fast-

paced environment, as well as knowledge of how things work in a management sense and the underlying reasoning for operational decisions. My work as a nurse educator means that I am often in a position to help nurses caring for their deteriorating patients or offer guidance and support. I draw on stories from my own past experience and use these in my teaching.

1.3   Why this topic?

I recently experienced a situation which sparked my thinking and guided me towards this research. I was working with a new graduate nurse, assisting her in the care of a gentleman who was coming to the end of his life. During our busy shift, a decision was made by the medical team and the family to stop active treatment, and to make the patient comfortable. Our new graduate nurse came rushing out of the patient's room not long after this decision was made, panicking and looking for help. Her patient was distressed, and she was asking, 'what should I do?' When I walked back into the room it was clear to me that this patient was in the final minutes of his life. I had seen patients like this many times before, I knew the signs and was familiar with the particular look he had. I remember looking at the new graduate nurse and observing how unnerved she was and realised that although we were seeing the same scene, we were not seeing the same thing at all. I was seeing something quite familiar to me and remembering dying patients I have cared for before. Over my years as a nurse, I have experienced the phenomenon of caring for a deteriorating patient many times. I have cared for patients who suddenly deteriorate, and for patients who slowly decline over days or weeks. I have been the terrified new graduate nurse watching my patient die. I have also been the family member watching, waiting and saying goodbye. I bring all of these experiences to my practice as a nurse and as an educator, and each time I experience it, it adds to the layers of knowledge. In contrast, our new graduate nurse was seeing a situation that was completely new to her and feeling out of her depth.

As I stood in the room, I was also struck by the realisation that the patient and his family were also experiencing this same moment but in a way that was different from me, with their own experiential influences, beliefs, feelings and past events playing into their interpretation and experience. This was the moment when I became aware that I was fascinated by this concept.

The insight from this encounter encouraged my interest in studying this phenomenon and made me aware that I can only know what the experience is like for me with my own pre-understandings. It made me stop and wonder what the experience is like for others. Therefore, this study asks: 'What is the meaning of nurses' caring for clinically deteriorating patients?'

1.4   My approach

As the research purpose was concerned with studying and describing lived experience a phenomenological approach was best suited. I have used a hermeneutic phenomenological approach, drawing on the work of Heidegger and Max van Manen to interpret the nurses' stories and uncover what is hidden within their everyday experiences of caring for deteriorating patients.

Phenomenology focuses on individuals' experiences and the meanings that may be attributed to these experiences, with hermeneutic phenomenology having a greater focus on interpretation of text. McWilliam (2010) suggests phenomenology allows researchers to gain understanding which can add to what is known about a phenomenon and be used to inform practice. van Manen (1984) says, "In drawing up personal descriptions of lived experiences, the phenomenologist knows that one's own experiences are also the possible experience of others" p.51. This rang true for me as I knew the nurses possibly experienced patient deterioration the way I did, but I was fascinated to explore deeper and understand others' experiences too.

Ten Registered Nurses agreed to be the research participants, and were interviewed by me, to explore their experiences of caring for clinically deteriorating patients in Acute Assessment Units. These interviews were transcribed verbatim, with coherent stories drawn from the transcripts and then interpreted phenomenologically. An emergent design was used, as data collection and interpretation were refined as the study progressed and my understanding of phenomenology grew.

1.5   The terminology used in this thesis

Nurse - The term 'nurse' in this thesis will refer to Registered Nurses. Nurses in New Zealand are able to practise in a range of clinical environments, depending on their education and scope of practice experience. Although not relevant to this study it

needs to be noted that in the context of New Zealand nursing, a nurse does not deliver babies. New Zealand nurses are expected to uphold standards of behaviour within their professional practice, as outlined by the Nursing Council of New Zealand (2012). Nurses apply annually to renew their practising certificate, and are assessed regularly to ensure they have adequate hours of practice and education. This also includes maintaining proof of competence, which helps to ensure protection for the public that nurses are caring for.

Caring for - In relation to this study, 'nurse caring for' refers to the Registered Nurse who is actively involved in the patient's clinical care. Usually, this would be the nurse who is allocated to care for this particular patient, however in some circumstances other nurses are also involved in the care of deteriorating patients. In some units, a support nurse or senior nurse does not take a patient load but helps with clinical tasks and facilitating patient flow through the unit, usually helping the nurse with the most acute workload first. In many cases, participants discussed situations where they were helping their colleagues with deteriorating patients and although the patient wasn't considered 'theirs', they were actively involved in the care. Therefore, it is reasonable to expect that the nurse who is 'caring for' the deteriorating patient, may not necessarily be the allocated nurse.

Clinical deterioration - For the purpose of this study, I have chosen to focus on patients who are worsening physiologically, rather than deterioration in other aspects such as mental health. The term 'clinical deterioration' is used widely internationally, as well as in New Zealand. During the research interviews, nurses were asked about caring for deteriorating patients, and were reminded that this did not necessarily mean a resuscitation scenario, or a dying patient, as some thought, but a patient who was in a state of change, moving from one clinical state to a worse clinical condition (Jones, Mitchell, Hillman, & Story, 2013). The literature on patient deterioration will be critiqued in more detail in chapter two.

Acute Assessment Unit - Acute Assessment units (AAU) are a relatively new occurrence having been implemented in New Zealand and throughout many other countries (Reid et al., 2016) to try to take some of the pressure off the emergency departments (Ardagh, 2015). In my experience, it is a unique place to work, with

unique pressures. AAU nurses are expected to give high quality care to multiple acute patients, as well as being ready to move patients to the ward and accept new admissions at any time. The acuity of the patients in an AAU means that caring for a deteriorating patient is an everyday experience, and is complicated by the pressures associated with the purpose of the unit.

For the purpose of this research, an umbrella term of 'Acute Assessment Unit' will be used to cover the different units that nurses were recruited from for this study. Acute Assessment units go by many different names around the world such as: 'Admissions and Planning Unit', 'Assessment and Diagnostic Unit', 'Clinical Decision-making Unit', 'Medical Assessment Unit' and 'Acute Admissions Unit'. Using an umbrella term will aid understanding but will also help with confidentiality as naming the unit where the participant works, would potentially reveal which hospital they work at.

Both of the Acute Assessment areas where the participants were recruited from accept patients from 14-15 years of age and upwards. The units work similarly, admitting patients via General Practitioner referral, specialist referral or Emergency Department (ED) referral. The patients are assessed by nurses, and then admitting Doctors who decide if the patient needs to be admitted for further assessment, diagnostics or treatment, or whether they can be discharged. The aim of these units is to help facilitate 'Shorter Stays in Emergency Departments', a six hour target introduced by the Ministry of Health in 2009 to address overcrowding in Emergency Departments with the intention of improving patient outcomes (Ardagh, 2017). This six hour target means patients are moved from the Emergency Department within this timeframe, if stable enough, and wait in the AAU until a ward bed is available, usually staying in AAU less than 24-48 hours. At times, when bed availability allows, patients are moved directly from the ED to a specialised ward, bypassing AAU.

If admission to a ward is not required, the patient has a short stay in the AAU before being discharged. This means that the turnover of patients in the AAU is often rapid, depending on bed availability in the hospital, and patients are most often in their acute phase of illness, thus are more susceptible to deterioration (Beaumont, Luettel, & Thomson, 2008).

Observations - Patient observations, also known as vital signs, include measures such as: blood pressure, respiration rate, heart rate, temperature, level of consciousness. Nurses in AAU generally assess and record patients' observations at a minimum of four hourly intervals, often more frequently in their acute presentation phase before they have been assessed by a doctor.

Early Warning Score - An Early Warning Score (EWS) system was introduced in many hospitals worldwide, as a supportive tool for nurses and physicians (Spångfors, Molt, Samuelson, & Bunkenborg, 2019). Early Warning Scores provide a systematic and objective measure to define parameters and set the frequency of vital sign recordings. Each observation measure has a score assigned and depending on the result a specific response may be triggered (Alam et al., 2014). Both of the DHBs where nurses were recruited from use an Early Warning Score.

Patient at risk team - Many hospitals globally have specialised teams of clinicians who respond to calls for assistance with patients who are deteriorating, which are known by different names depending on which hospital they are employed in (Pirret, Takerei, & Kazula, 2015). Both of the District health boards that participants were recruited from have such teams, which are nurse led. Their involvement extends to assessment, advice, hands on support, support with escalation of concerns and at times modifying the Early Warning Score (EWS). These nurses often have a background of critical care experience and work closely with the medical teams to manage deterioration of patients throughout the hospital (Milliken, Goodwin-Esola, & Seeley, 2018). Within Waitematā District Health Board, this team is called the Critical Care Outreach team, and within Auckland District Health Board the team is known as the Patient at Risk team. For the purpose of this research, the term 'patient at risk team' will be used to refer to either team, for ease of reference or to maintain confidentiality.

Codes - When a patient deteriorates to an extent where they need resuscitation or advanced supportive measures to maintain their vital signs, clinicians are able to call a specialised team of rapid responders to assist (DeVita, Hillman, & Bellomo, 2017). These are often referred to as resuscitation calls, Medical Emergency Team (MET) calls, Rapid Response team calls or Codes, depending on which hospital or District Health Board they occur in. The nurses participating in this research used these terms

interchangeably, but most frequently they referred to them as codes, therefore this is the term which will be used in this thesis.

Task / Tasking - As nurses, we are taught as undergraduates that nursing is not about achieving tasks, it is about providing holistic care to people. The contemporary reality is that for most Registered Nurses, their everyday work is reduced to tasks/ jobs that need to be done, interspersed with increasingly infrequent episodes of care and holism (Kessler, Heron, & Dopson, 2015). The controversial word 'task' is used frequently by nurses. If a nurse has a lower workload or is sent to another ward to assist with acuity, they are literally asked 'can you please task?', meaning they will go around helping their colleagues achieve nursing tasks such as administering medications, or toileting a patient. Despite the attempt to move nursing away from tasks and towards holistic care, the term 'task' was used by every participant in this study during their interviews.

1.6   Significance of this study

The phenomenon of patient deterioration is a current focus of healthcare across the world, and the aim of this research is to bring to light the experiences nurses have with this occurrence. Little research has been conducted about nurses' experiences of caring for deteriorating patients, and in particular relating to the AAU setting.

Patient deterioration is a current and important issue in New Zealand, as demonstrated by the HQSC patient deterioration programme, which aims to improve the management of deterioration in New Zealand hospitals, as discussed earlier in the chapter. Improving the management of patient deterioration is imperative to enhancing health outcomes and reducing patient mortality. Exploring how nurses experience the care of deteriorating patients is important to deepen understanding of the phenomenon. It is anticipated that understanding nurses' experiences will bring to light potential issues that may arise in the care of deteriorating patients and assist in developing education and strategies which may help to support nurses in these situations.

1.7   Structure of my thesis

Chapter one: Introduction to the study. In this chapter I provided the reasoning for my interest in the topic and my own background. I outlined the relevance of this

research to the New Zealand context, as well as the aims of the research. I also provided an outline of key terminology used in this thesis.

Chapter two: Literature review. Literature is reviewed regarding nurses' experiences of caring for deteriorating patients. Firstly, patient deterioration will be explored, including what is known about prevention, detection and management of deterioration. Secondly, literature relating to Acute Assessment Units will be considered. The literature encompassing nurses' experiences will be examined and discussed. Gaps in the literature will also be identified.

Chapter three: Methodology and Methods. This chapter describes the methodology and use of hermeneutic phenomenology, guided by van Manen and Heidegger, to explore participants' stories. The chapter will then also describe the methods used to generate this study, and how the research was conducted.

Chapter four: Being Connected. This chapter is the first of the findings chapters describing nurses' experiences of connecting with others and how this influences their care of deteriorating patients. This includes sub themes regarding building relationships, recognising subtle signs of deterioration, and feeling disconnected. Also discussed are the sub themes of the connection shifting to the family, nurses feeling like they have shared part of themselves with their patient and subsequently carry the patient in their heart.

Chapter five: Being there as nurse. This chapter, the second findings chapter, explores participant's stories about what it is like to be there in the moment as a nurse, clearly outlining how nursing in an AAU is different. Sub themes regarding wearing a mask, being a witness and being part of a team are also explored.

Chapter six: Being with. This final findings chapter explores what it is like being there in the moment with the patient as they deteriorate, presenting interpretations from the data leading to the sub themes of recognising deterioration, nursing intuition, asking for help, normalising deterioration and feeling stuck.

Chapter seven: Discussion of findings. This chapter summarises the key findings in the thesis, critiques these findings relating these to the philosophical underpinnings,

and the notions which spanned across the research, which were *Being more than nurse*, *Caring with courage* and *Knowing as a nurse*. This discussion chapter also summarises the strengths and limitations of the research, as well as the implications for nurses caring for deteriorating patients, and answers the research question, 'What is the meaning of nurses' caring for clinically deteriorating patients?'

1.8   Conclusion

This chapter has introduced the study, along with relevant issues and has outlined how I came to this research and why I am interested in exploring it further. Caring for clinically deteriorating patients is complex. Nurses working in AAUs must juggle their acute workload with the demand for inpatient beds, therefore when a patient is deteriorating the nurse is often pulled in several directions with their different responsibilities. The experiences of nurses working in AAUs has not yet been explored and this research aims to breach that gap.

Chapter 2 - Literature Review

2.1 Introduction

This chapter will include literature relevant to the phenomenon of nurses caring for clinically deteriorating patients. Firstly, the search terms and search process will be outlined, followed by aspects of patient deterioration, such as detection and management, including the recent developments of patient deterioration management in New Zealand. The literature regarding Acute Assessment Units will be examined, as well as nurses' experiences of caring for deteriorating patients. Current gaps in the literature will be identified and discussed.

2.2 The search

The main databases that were used to conduct the search were Scopus and CINAHL complete. Other databases that were used included ClinicalKey and ScienceDirect. Reference lists of articles that were particularly important to the study were also useful to source additional publications. The initial search terms included variations of; 'patient deterioration', 'clinical deterioration', 'nurse experience', 'New Zealand', 'Acute assessment unit', and 'caring for deteriorating patients'. Alternative terms were also included such as 'unwell patient', 'sick patient', as well as possible alternative names for acute assessment units for example 'acute admission unit', 'clinical decisions unit' and 'medical admission unit'. The literature was searched from the year 2000 to present time to ensure relevance of articles. Articles were excluded which were concerning children or were in languages other than English.

The search found many articles pertaining to aspects of patient deterioration, including detection, response and management, the majority of which were quantitative studies. The search was narrowed to only include publications regarding patients in hospital and acute clinical deterioration rather than deterioration of other aspects of health such as mental health or decline in overall function.

In respect to the population surveyed, some qualitative studies were found regarding specific aspects of clinical deterioration, such as patient's perceptions of deterioration (Guinane, Hutchinson, & Bucknall, 2018; Strickland, Pirret, & Takerei, 2019), nurse perceptions of barriers to using rapid response services (Padilla, Urden, & Stacy, 2018)

and clinician's perceptions of factors leading to patient deterioration (Padilla et al., 2018). Despite many publications about clinical deterioration, there were only few articles found regarding nurses' experiences of caring for deteriorating patients. The majority of the studies found were focused on student nurses (Fowler, 2015), enrolled nurses (Chua, Mackey, Ng, & Liaw, 2013) or new graduate nurses (Della Ratta, 2016). Articles were found internationally about the effectiveness of acute assessment units and the impact on patient care and flow (Knarr & MacArthur, 2012; van der Linden, Lucas, van der Linden, & Lindeboom, 2013) as well as New Zealand (Ardagh, 2017) however, no articles were found that to date have focused on the nurse experience in these settings.

2.3 Patient deterioration – international developments

Over the years, developments have been made leading to improved management of clinical deterioration (Pain et al., 2017). The patients who deteriorate in hospital currently are often presenting with more comorbidities than in the past. The medical profession is now able to keep people alive for longer with research and technological advances. In turn, the patients who deteriorate and now often deteriorating with a more complex baseline as they age and develop more age-related illness according to the World Health Organisation (2018).

2.4 Patient deterioration – New Zealand developments

In 2014, an investment case (Moore & Poynton, 2015) was presented with the aim to reduce harm caused by clinical deterioration in New Zealand hospitals. This case led to the development of the Patient Deterioration programme, run by the Health Quality and Safety Commission New Zealand (2018). This five year national programme aims to diminish harm to all adult inpatients from failure to detect or respond to acute physical deterioration. The Patient Deterioration programme has three main workstreams; National Early Warning Score, Kōrero Mai, and Shared goals of care, each contributing to the improvement of the care of deteriorating patients in New Zealand Hospitals.

2.5 Clinical deterioration

Clinical deterioration is experienced frequently by nurses and other clinicians working in acute care areas. It is a complex phenomenon requiring knowledge and skills to

detect abnormal signs in a patient which may indicate deterioration and respond to these in a timely and appropriate way. Many human elements determine the patient outcome in clinical deterioration events, and if the deterioration is not detected or managed appropriately, it may lead to cardiac arrest and or death. Jones, Mitchell, Hillman and Story (2013) characterise a deteriorating patient as one who is moving from one clinical status to a worse clinical status, increasing their risk of further dysfunction or death. Other terms are frequently used in healthcare to describe patient deterioration, such as 'unwell', or 'sick', as well as colloquial terms like 'going downhill' or 'crashing'.

Nurses are more likely than other healthcare staff to be with the patient when they deteriorate, meaning nurses have a professional responsibility to detect deterioration and act promptly (Orique & Phillips, 2018). For this reason, much of the literature regarding patient deterioration is focused on nurses.

Why and when patients deteriorate

Clinical deterioration can occur at any point during a patient's hospitalisation, but it is most likely during their acute phase or soon after presenting to the hospital (Cullinane, Findlay, Hargraves, & Lucas, 2005). Patients are more likely to deteriorate due to pre-existing medical conditions, medication changes, age, post-surgery or acute infectious illnesses (Johnstone, Rattray, & Myers, 2007), and can also occur or be exacerbated due to human error (Beaver, 2017). As the population is aging across the world, the patients presenting to hospitals are often more acute, and frequently have multiple co-morbidities or medications which make deterioration more likely and at times more severe (Jones, 2018; van Galen et al., 2017).

It is difficult to pinpoint how frequently patients deteriorate during their hospital admission as the factors are complex and varied. A study of 13 hospitals in New Zealand found that 12.9% of patients suffered an adverse event related to their hospital stay (Davis et al., 2003). Worldwide studies indicate that adverse events occur in approximately 10% of admissions according to Jones and Subbe (2018). The reasons for these adverse events are varied but often attributed to staff failure to recognise deterioration or respond appropriately.

A common issue discussed when a patient deteriorates is whether it is appropriate for the patient's life to be prolonged, because of existing diagnoses, co-morbidities and concerns for their quality of life. Psirides (2018) suggests it can be hard to distinguish between a dying person with an irreversible process and a sick person with a reversible process who needs aggressive treatment. Many clinicians raise concerns that patients may be treated or admitted to intensive care units when this may prolong their lives in unwanted ways and lead to poorer quality of life (Huynh et al., 2013; Jones et al., 2012). The Patient Deterioration Programme (Health Quality Safety New Zealand, 2016) aims to address this with their shared goals of care workstream, which focuses on ensuring the care given is warranted and wanted, and that these decisions are made before a patient deteriorates, in partnership with the patient and their family.

2.6   Recognising clinical deterioration

A patient's clinical deterioration is often reflected by a change in the regular observations charted by nurses such as heart rate, blood pressure, respiratory rate or level of consciousness (Lavoie, Pepin, & Alderson, 2016). It is a nurse's role to record, interpret and relay the observations to the medical team if any of the vital signs are outside of the normal range (Andrews & Waterman, 2005). Nurses play a critical role in detecting clinical deterioration by providing surveillance and monitoring observations (Dalton, Harrison, Malin, & Leavey, 2018; Purling & King, 2012). Furthermore, effective observation and assessment is one of the first steps in identifying and managing a deteriorating patient (Odell, Victor, & Oliver, 2009).

Over 80% of patients show measurable signs of clinical deterioration in the hours before cardiac arrest or life threatening deterioration (Jones et al., 2013; Matthew, 2010). These preceding signs may be changes in physiological parameters such as blood pressure, pulse and respiration rate (Alam et al., 2014). Early identification of deterioration is vital to reduce mortality (Beaumont et al., 2008). Many hospitals throughout the world use track and trigger systems, like an Early Warning Score (EWS), designed to identify patient deterioration and provide a standardised pathway to escalate concerns. EWS will be discussed in more detail later in the chapter.

Adverse event reports have frequently shown that patients or whānau (families) are often able to identify unusual clinical signs or markers of deterioration before clinicians

because the patient is so well known to them (Health Quality Safety New Zealand, 2019). Minick and Harvey (2003) suggest that family members often perceive subtle signs of deterioration such as a change in level of consciousness before clinicians have noticed. It can sometimes be difficult for these concerns to be relayed to clinicians and for the worries to be actioned, especially when they are not seen as typical red flags to clinicians. In many services, patient or family concern has been added to the EWS, which triggers a high score, prompting escalation in an attempt to address this. Furthermore, family-led escalation processes called 'Kōrero Mai', translated to 'talk to me', have been introduced to hospitals throughout New Zealand as part of the Patient Deterioration Programme (Health Quality Safety New Zealand, 2016), enabling families to call for help if they are concerned about their family member's condition, and feel they are not getting adequate help or interest from the care team. The introduction of the Kōrero Mai programmes has also increased awareness in staff of the clinical significance of family concern. Similar programmes have been introduced throughout the world and have been found to be used infrequently, but when they have been used it has been clinically relevant (Gill, Leslie, & Marshall, 2016).

Nurses rely not only on objective signs of deterioration and empirical knowledge, but also on their past experiences as well as a sense of nursing intuition (Fasolino & Verdin, 2015; Robert, Tilley, & Petersen, 2014). Nursing intuition is a contested issue with some literature suggesting that intuition has no place in an objective situation as the decision making is based on someone's emotions rather than scientific evidence (Hams, 2000). However, other literature supports the concept of intuition (Odell et al., 2009), saying that when a nurse experiences a 'gut feeling', it is often strongly linked to subtle cues that they are picking up on yet unable to name (Cioffi, Conway, Everist, Scott, & Senior, 2010; Melin-Johansson, Palmqvist, & Ronnberg, 2017). Interestingly, several studies cite nurses who said although the patient's vital signs were normal, they had a 'feeling' about a patient who later did deteriorate (Hassani, Abdi, Jalali, & Salari, 2016). In clinical settings where there is a high patient turnover, nurses often have contact with the patients more frequently and this often leads to heightened awareness of potential deterioration (Orique, Despins, Wakefield, Erdelez, & Vogelsmeier, 2019). A systematic review by Gao et al. (2007) indicated that seven out of 25 early warning systems included 'concern' as a prompt for involving the response

team, but that nurses found it difficult to articulate their concern to medical staff. However, a study by Douw, Huisman-de Waal, van Zanten, van der Hoeven, and Schoonhoven (2016) indicated that adding a 'nurse worry' score, combined with an early warning score improved the prediction of patient deterioration.

It is not enough to just record the vital signs; staff must understand the significance of variations in the measurements. Failure to identify deterioration is a significant factor in the care of hospitalised patients. To be able to respond to patient deterioration, nurses must be able to identify cues of deterioration despite the distracting background noise of workload and environment (Orique et al., 2019). Nurse workload as well as time constraints are a known barrier to nurses identifying patient deterioration (Mok, Wang, Cooper, Ang, & Liaw, 2015). Further to this, situational awareness is said it be a major factor in nurses identifying deteriorating patients (McKenna et al., 2014). Situational awareness and identification of deteriorating patients is said to improve with increased nursing experience (Hill, 2010; Purling & King, 2012).

2.6.1 Early Warning Score

The Early Warning Score (EWS) is a simple tool which is easy to use at the patient's bedside, and may help to recognise and prompt treatment for patients who are either deteriorating or have the potential to (Alam et al., 2014). Vital signs are measured, and a weighted score is applied to each measured value. These scores correspond to an algorithm, where higher scores are related to sicker patients and predict poorer outcomes. The score triggers a clinician's response proportional to the level of deterioration (G. B. Smith, Prytherch, Meredith, & Schmidt, 2015; Spångfors et al., 2019). Early warning scores ensure all patients in an organisation are receiving the same vital sign assessments and standardises the clinical decisions. Recognition and response systems "provide objective criteria for escalating care, a clinical safety net for detecting acute deterioration, and agreed processes for escalating care to appropriately skilled responding clinicians."(Health Quality Safety New Zealand, 2017, p. 5). The use of recognition and response systems, such as EWS, can help to prevent harm from inpatient deterioration (Drower, McKeany, Jogia, & Jull, 2013).

Some of the key benefits to adopting these early warning systems are that they provide objective, evidence-based decision making which is supportive to junior staff, however, early warning systems have been criticised for the notion that nurses will rely on the scores instead of using critical thinking or assessment skills (Burns et al., 2018; Grant & Crimmons, 2018). Burns et al. (2018) found that nurses felt that the use of the EWS system increased communication as well as proactive reactions to clinical deterioration. Some of the factors of why nurses don't escalate concerns for patients who are scoring on the EWS system are culture, confidence and past experience (Wood, Chaboyer, & Carr, 2019). Interestingly, several studies have found that nurses use EWS to quantify or prove a patient's deterioration after they have already detected it (Donohue & Endacott, 2010).

2.6.2 New Zealand Early Warning Score

In 2011, as part of a Ministry of Health directive, all of the 20 District Health Boards in New Zealand implemented systems which identified deterioration (Psirides, Hill, & Hurford, 2013). Although all of the DHBs had some kind of early warning system in place, when investigating serious or sentinel events it was found that despite the patient triggering a response on the early warning system, the suggested escalation was not followed. This lead to the recommendation from the HQSC to further standardise the EWS in New Zealand and bring all DHBS in line with each other by using the same system, as part of the Patient Deterioration programme . The National Early Warning Score, known as NZEWS was introduced into all New Zealand hospitals, with the final DHB implementing the change in early 2019. This means that as junior medical staff rotate throughout different hospitals across the county, the process for detecting and managing a deteriorating patient should be essentially the same. Early warning systems have also been adopted for use in paediatrics, and are currently in the process of being implemented for use in maternity throughout New Zealand hospitals.

Failure to recognise

Despite the detection of deterioration being standardised and being made easier, it is widely evident in the literature that patient deterioration is still going unrecognised or unreported, leading to adverse events and poor outcomes for patients. A number of

studies and systematic reviews were found which addressed the reasons why nurses failed to recognise patient deterioration.

A descriptive case study by Foley and Dowling (2019) indicated that nurses may choose not to escalate an elevated EWS, if they are able to justify the abnormal vital signs by using their own judgement about a patient. However, the study did reveal that nurses would escalate concerns about their patients if they thought they were at risk, regardless of what the EWS was. This study also raised the issue of the difficulties nurses face in getting medical staff to alter the EWS parameters, meaning patients with chronic conditions, such as lung disease, will always score highly on the EWS despite having lower oxygen requirements than other patients. A mixed methods inquiry by Lydon, O'Connor, Byrne, Gleeson, and Offiah (2016) found similar results in the barriers to escalating higher EWS scores, with staff reporting difficulties in getting parameters altered, or staff relying on their own judgement instead of escalating higher scores. Al-Moteri, Plummer, Cooper, and Symmons (2019) suggest that delays in recognising and responding to clinical deterioration are associated with human factors, like ward culture. When the EWS is elevated, part of the algorithm is to increase the frequency of observations to be able to monitor a patient's condition. Although this can be a protective factor and determine the path of deterioration, it can also become a barrier to escalation as it increases the nurse's workload and increases interruptions (Odell et al., 2009).

2.7   Response and management of clinical deterioration

There are several important aspects of responding and management of clinical patient deterioration which include communication, and response protocols such as rapid response teams.

Communication

Effective communication skills are a hugely important aspect of caring for a deteriorating patient, allowing nurses to relay their concerns appropriately and encourage team work (Brier et al., 2015; Liaw, Scherpbier, Klainin-Yobas, & Rethans, 2011; Martland, Chamberlain, Hutton, & Smigielski, 2016; Mok, Wang, & Liaw, 2015). Poor nurse to physician communication is commonly cited as a contributing factor in adverse events in patients (De Meester, Verspuy, Monsieurs, & Van Bogaert, 2013).

Nurses often use more casual language (Andrews & Waterman, 2005) which does not always communicate the urgency or severity of the patient's deterioration, which is where a communication tool such as ISBAR may be helpful. ISBAR is also known as SBAR and stands for Introduction, Situation, Background, Assessment, and Recommendation. This tool is used to refine hand over communication or to ensure appropriate relaying of information during escalation conversations, and has been shown to improve communication between health care staff (De Meester et al., 2013; Müller et al., 2018). Foley and Dowling (2019) showed in their study that nurses knew about ISBAR and its importance however, using the communication tool was not second nature and thus in times of stress they often forgot to use it.

Adaptions to technological tools specifically designed to improve communication have been shown to be useful in health care settings. The systems nurses use to contact doctors makes a difference to how deterioration is managed. Waitematā District Health Board has recently introduced technology which enables nurses to more easily page doctors with concerns about their patients (Pearce, 2018). This technology also has the ISBAR headings as part of the paging template to prompt nurses or other clinicians to utilise this communication tool, as well as standardise communication.

Rapid Response Teams

Rapid Response Teams are made up of non-ward based clinical teams and are either nurse or physician led. They aim to provide a preventative process where health professionals can access increased support and management before a patient becomes critically ill (Pain et al., 2017). Jones, Gillon, and Ramsdale (2018) say "An RRT call may be initiated when the requirements of a patient exceed the capability of the staff currently caring for them" p.40. Hospitals in New Zealand have variations of these teams which go by different names, such as Resus team, Medical Emergency team (MET) or Patient at Risk (PAR) team, which were adopted following the increased implementation of Rapid Response systems in Australia and the United Kingdom (Psirides et al., 2013). The development of the national Patient Deterioration Programme has addressed these variations by standardising the EWS and providing guidance on appropriate escalation protocols (Health Quality Safety New Zealand, 2017).

Different hospitals and DHBs have different response teams in place as part of their rapid response system. These may be Patient at Risk teams, or Critical Care outreach teams, which are usually staffed by nurses with intensive care backgrounds. These teams attend ward patients who have triggered a high EWS, providing assessment, support and have contact with ICU physicians, facilitating review or referral if necessary. Hospitals also usually have a MET team or Resuscitation team who are called to episodes of severe deterioration or cardiac / respiratory arrest to provide an ICU level of support at the patient's bedside.

There is conflicting evidence to support the use of rapid response teams (Al-Qahtani et al., 2013) however they are generally associated with decreased mortality and lower intensive care admissions (Shah, Cardenas Jr, Sharma, & Kuo, 2011). A New Zealand study indicated that the introduction of a PAR team reduced cardiac arrests, intensive care admissions as well as length of hospital stay, but did not reduce the number of MET calls (Pirret et al., 2015). Despite patients meeting the criteria in the early warning system, the rapid response systems are often not activated (DeVita et al., 2017) which can lead to an increased risk of adverse events (Massey, Chaboyer, & Aitken, 2014). A study by Shearer et al. (2012) indicated that the majority of staff recognised that a patient met the escalation criteria, despite the rapid response system not being activated, and that this was most likely due to hierarchical issues rather than a lack of knowledge. Hierarchy is still seen as a barrier, with staff feeling hesitant to escalate to seniors, fearing reprimand if they are seen to have called without good reason (Andrews & Waterman, 2005; Kitto et al., 2015). However, once a rapid response is activated it is intended to eliminate hierarchical issues (Jones, DeVita, & Bellomo, 2011). Another barrier noted by Shearer et al. (2012) was staff feeling that they already had the necessary skills and knowledge with the existing team present, or in other cases it was because escalation had occurred previously and the responsibility or plan for the patient was now unclear. This can be a barrier to escalation, as well as helpful, as a supportive team is a significant factor in facilitating effective responses to patient deterioration (Cioffi, 2000; Cox, James, & Hunt, 2006; Massey et al., 2014).

2.8 Nurse Experience of deterioration

Very few articles about nurses' experience of patient deterioration were found. The majority of those located were focused on student or new graduate nurses in general

wards. Several articles were found concerning aspects of nursing deteriorating patients, such as a cross sectional explorative study relating to the nurses' perceptions of clinical deterioration cues (Orique et al., 2019) and a generic qualitative study concerning factors affecting assessment and response to acute deterioration (Dalton et al., 2018). Three articles in particular concerning the nurse experience of caring for a deteriorating patient stood out during my literature search. The study by Della Ratta (2016) used an interpretive phenomenological design with a sample of new graduate nurses from a variety of wards, research by Cox et al. (2006) used an exploratory descriptive design and experienced nurses from one ward, and a study by Chua et al. (2013) also used an exploratory description design, but focused on enrolled nurses. Although these studies were conducted years apart with different samples, it was interesting to see the similarities in the emerging themes, and that the landscape of caring for a deteriorating patient was largely unchanged during this time. All studies cited a lack of previous exploration of the nurse experience of patient deterioration in their literature review, and both used a similar sample size. Della Ratta (2016) gave detailed information about the demographics of the participants, and clearly outlined her inclusion criteria. She also included her interview questions within the article which added to a rich understanding of the results. Her analysis using the method of Diekelmann (1992) gave an overall impression of rigorously analysed data, which was clearly related back to the methodology. Della Ratta (2016) also clearly outlined the different ways that trustworthiness was ensured throughout the study. It was clear throughout the article that Della Ratta kept true to the phenomenological methodology and identified that the use of this hermeneutic perspective contributed to a greater understanding of novice nurses. The results of both studies were presented as themes, supported by use of verbatim quotes from the transcripts. The study by Cox et al. (2006) resulted in themes such as *clinical environment*, *professional relationships* and *patient assessment*, and the research by Chua et al. (2013) presented similar themes: *recognising deterioration* and *taking responsibility*. The study by Della Ratta (2016) however, presented themes that were phenomenological in nature, *Dwelling with uncertainty*, *Building me up* and *A new lifeline: salient being*. Although these studies had many similarities, the strength of the data reported in the Della Ratta (2016) study was evident and appeared to uncover the experience of caring for

deteriorating patients in a robust and relatable way, compared with the exploratory descriptive studies by Cox et al. (2006) and Chua et al. (2013).

2.9   Acute Assessment nursing

As introduced in chapter one, for the purpose of this research, the units where the participants were recruited from were collectively known as Acute Assessment Units (AAU) for ease of reference and to protect privacy. It was difficult to find literature pertaining to AAUs due to varying labels or definition criteria being used throughout the world. Literature was found which refers to Medical Assessment Units (Rushton et al., 2017) or Acute Medical Units (Byrne & Silke, 2011). The majority of the research found regarding AAUs were quantitative studies which looked at the effectiveness of implementing the units to reduce length of stays in the Emergency Departments (ED) in line with health targets.

As more AAUs have been implemented internationally since the late 1990s and early 2000s (Reid et al., 2016), they have continued to gain popularity as the patient population and needs continue to change. Acute Assessment units were designed with the purpose of receiving inpatients from ED, or the community for a designated amount of time, often 24-72 hours before being discharged home or transferred to wards for further care (Bokhorst & van der Vaart, 2018; van Galen et al., 2017). This is said to also improve the flow of patients throughout the hospital and avoid extended stays in the ED (Buckley, Castillo, Killeen, Guss, & Chan, 2010; van der Linden et al., 2013). Decreased patient safety and increased mortality is associated with ED overcrowding caused by lack of bed capacity within the hospital (Ardagh, 2015). Longer stays in ED are linked with poorer patient outcomes, as well as reduced privacy and dignity for patients (Hawkins, 2014).

Improving the patient flow in hospitals appears to lead to greater access to care, lower costs and wait times, as well as improved patient outcome (Knarr & MacArthur, 2012). Several studies have also shown a decrease in mortality rates in EDs after the implementation of an AAU (Ardagh, 2017; Rooney, O'Riordan, Silke, Moloney, & Bennett, 2008). However, the literature did raise some staffing concerns about the increased workload and stress in AAUs because of the acute nature of the patient population (Scott, Vaughan, & Bell, 2009). Clinical deterioration can occur at any point

but patients are most susceptible to deterioration immediately following admission to hospital, post-surgical procedure or while recovering from a critical illness (Adam & Odell, 2005). Increased complexity of nursing care and dynamic work environments are factors which are associated with errors, missed nursing care which can lead to failure to rescue (Bower, Jackson, & Manning, 2015). Unfamiliarity with a patient is linked to decreased awareness of subtle cues of deterioration and can be a barrier to detecting deterioration, which is potentially an issue for nurses working in acute areas (Gazarian, Henneman, & Chandler, 2010).

To date, no qualitative articles were found regarding nurses' experiences or perceptions of working in an AAU, as outlined in chapter one. Synonyms for Acute Assessment units were also searched, as well as changing the search criteria to include other clinicians and health care workers.

2.10 Gap in the literature

It is clear from the review of the literature that there is a lack of research about how nurses experience patient deterioration, and how these experiences affect the detection and response to deterioration. There is also a lack of qualitative literature regarding nursing in Acute Assessment areas, in particular a lack of phenomenological research. The experiences and perceptions of nurses and clinicians working in these units does not yet appear to have been explored which raises questions about what could be learnt from further investigating Acute Assessment areas in a qualitative or phenomenological way.

2.11 Conclusion

The literature has shown that caring for clinically deteriorating patients is a complex experience for nurses and presents unique challenges in the Acute Assessment Unit context. Much is known about many aspects of patient deterioration such as detection and responding to deterioration, however the literature lacks an acknowledgement of the connection of nurses' emotional experiences of patient deterioration and how the nurses' experiences influence the way they manage a clinically deteriorating patient.

The chapter which follows, chapter three, will outline the methodology used to guide this research and describe how the study was conducted.

Chapter 3 – Methodology and Method

3.1 Introduction

Phenomenology was chosen as the methodology for this study and influenced how the research was conducted. The development of this research study was guided by the writings and philosophical underpinnings of Heidegger and van Manen with an aim to shed light on the meaning of the experiences of nurses caring for clinically deteriorating patients. I chose phenomenology as I had an awareness that my own experience was merely my interpretation based on my past, my experiences and my 'self'. I thought of my nursing colleagues and wondered if we experienced things differently to each other despite working in the same setting. Our experiences caring for patients were rarely talked about, they just 'were'. I was intrigued by uncovering what was hidden in other nurses' experiences. An overview of hermeneutic phenomenology will be presented in this chapter, followed by a description of how this methodology was used to guide the research methods. The methods used to conduct this study will be outlined.

3.2 Hermeneutic phenomenology

Phenomenology guides a philosophic method for questioning, rather than a method for answering questions or finding specific results. van Manen (1990) expands this further by saying that in this questioning there is the possibility for insights and understandings which give us ideas about the meaning of the phenomenon. "Phenomenology aims at gaining a deeper understanding of the nature or meaning of our everyday experiences. Phenomenology asks, "What is this or that kind of experience like?"" (van Manen, 1990, p. 9). Smythe, Ironside, Sims, Swenson, and Spence (2008) suggest that the purpose of Heideggerian phenomenology is not to provide answers, but to invite readers to listen to and provoke their own thinking.

Heidegger's philosophy is considered hermeneutic or interpretive (De Chesnay, 2014). The hermeneutic approach is interpretive rather than descriptive, providing a way to interpret the participants stories, their words and language, and is used to uncover meaning behind the text (van Manen, 2014). Phenomenology enables researchers to uncover what is hidden in every day experiences. Inwood (1999) suggests things are hidden not because we have forgotten them or they are undiscovered, but because we

are too accustomed or close to notice them. Interpretive phenomenology is about bringing something that is ordinarily covered over into the light (Heidegger, 2010).

Phenomenology delves into the human aspects of a situation, searching for what it means to an individual to experience something, and what the implications of that experience may be for the person (Wilson, 2015).

3.2.1 Philosophical underpinnings

Phenomenology has philosophical origins as far back as ancient Greece and has evolved through the years with many philosophers such as Husserl [1859–1938] and Heidegger [1889–1976], questioning and contributing to what is believed about lived experience. Phenomenology is based on the idea that human knowledge is not founded upon a solid truth or reality, but rather upon the meaning and beliefs that humans assign to phenomena or experiences. This relates to Heidegger's notion of Dasein, or 'being-there' (Harman, 2007). Heidegger believed that our understanding and experience is always influenced by our existing knowledge and pre-understandings and the way we are in the world (Neubauer, Witkop, & Varpio, 2019).

3.2.2 Heideggerian notions

There are many notions which Heidegger has contributed to philosophy. For the purpose of this study's context, the concepts of Dasein and Being will be briefly outlined.

Dasein

The concept of Dasein loosely translates to 'being-there'. "For Heidegger, Dasein is where Being reveals itself, - a 'clearing', he likes to say, as in the midst of a dense, dark forest, where Being is lit up and becomes unconcealed." (Crotty, 1996, p. 78). Heidegger believed that humans are the only beings who are concerned with or aware about their existence, and said Dasein is therefore, human existence (Heidegger, 2010). We all individually have our own Dasein because we all exist in the world in our distinct and separate ways. Dasein is "thoroughly immersed and embedded in a world of things and relationships" (J. A. Smith, Flowers, & Larkin, 2009, p. 29).

Being

The most generalised concept of Heidegger's' hermeneutic phenomenology is Being. To uncover meaning in the experience of a phenomenon is to ask for the 'being' of an object or individual. To question the Being of anything is to enquire into the very nature or meaning of that phenomenon (van Manen, 2014).

The idea that experiences are always interpreted in relation to something, and to us, ourselves, is what Heidegger calls 'Being-in-the-world'. Being-in-the-world refers to the way humans exist or are involved in the world (van Manen, 1990). In this research study the nurses demonstrated a particular way of Being and Being-in-the-world which was evident in their stories.

3.3 Methods

The remainder of this chapter describes the ethics and research methods that were informed by hermeneutic phenomenology and used to gather and interpret the data from nurses' stories to find meaning about caring for clinically deteriorating patients.

3.3.1 Ethics

Approval was sought from Auckland University of Technology Ethics Committee (AUTEC) and was granted on the 12th March 2018, with the number 18/52 (Appendix A). The process of applying for ethical approval helped me consider how to protect my participants and their patient's privacy throughout the research. Locality approval was granted by Waitematā District Health Board (Appendix B) in March 2018 after discussion with the Director of Nursing. As the research progressed and recruitment was expanded, locality approval was also granted by Auckland District Health Board Research Centre (Appendix C). For both DHBs, the Charge Nurse Managers were contacted, and the research was discussed with them, in each unit, giving their own approval for their staff members to be approached. In time it became clear that the recruitment of participants was difficult. An amendment application to AUTEC was submitted and approved on this date (Appendix D), which enabled the researcher to expand the recruitment criteria.

3.3.2 Informed Consent

The participants were free to choose to participate in the research. In most cases, the participants were the ones to make first contact, unless they were referred by a colleague or a friend, in which case, consent was sought to make contact. Upon initial contact, the participants were sent a copy of the Participant information sheet (Appendix E), which outlined the purpose of the study as well as the risks and benefits of participating. Carr (1994) states that informed consent is one of the most important ways that researchers keep participants safe and ensure their human rights are maintained. The researcher needs to be certain that participants agree to partake with a clear understanding of potential risks or benefits, how the data will be collected, stored and their privacy protected (Doody & Noonan, 2016; Munhall, 2012; "Privacy Act," 1993). At the beginning of each interview informed consent was discussed with the participants and a consent form was signed (Appendix F).

3.3.3 Privacy

A number of steps were taken to ensure privacy for participants, as well the information they shared. Pseudonyms were offered to each participant after the interview. Some participants wanted to choose their own pseudonym, and others were happy to have one chosen for them. Two of the participants preferred to use their own name.

Generalised labels; 'Acute Assessment Unit' and 'Patient at Risk team' were assigned to the different units and response teams at the two district health boards for ease of reference and to ensure that the answers are not identifiable to one particular unit. Any information that could potentially identify a patient or specific nurse was reworded or altered to ensure confidentiality.

Transcripts, consent forms and demographic forms were stored in supervisor office once analysis was completed to protect the participant's privacy.

3.3.4 Treaty of Waitangi

The Treaty of Waitangi principles of protection, partnership and participation offer a starting point for identifying Māori ethical issues in terms of rights, roles and responsibilities of researchers. It was important that these principles were honoured

regardless of whether there were any participants of Māori descent. I contacted the managers of both of the units to see if there were any potential participants who identify as being of Māori descent, but both managers informed me that at that time there were not. I felt that it was important that if there were any Māori nurses, that they would have an opportunity to participate without being disadvantaged in any way. A Māori research review was completed by He Kamaka Waiora who works with Auckland and Waitematā District Health boards, who subsequently approved this research (Appendix G). Although there were unlikely to be any Māori participants, He Kamaka Waiora asked that a question be added to the indicative questions regarding nurses' experiences caring for deteriorating patients from another culture, saying that showing diversity of experiences may still benefit Māori.

It was important to me to be respectful of the Māori ethics framework, (Hudson, Milne, Reynolds, Russell, & Smith, 2010), which includes "four tikanga based principles (whakapapa (relationships), tika (research design), manaakitanga (cultural and social responsibility) and mana (justice and equity)", knowing that if the research was respectful of these tikanga (protocols) for Māori, then it would be ethically respectful for all participants.

I attended a patient deterioration conference run by the Health Quality Safety Commission of New Zealand in 2018 where the Māori perspective of patient deterioration was explored. I found this very useful in increasing my understanding. The take home message was that as health professionals, we need to be providing excellent care to Māori patients who deteriorate, carefully considering the principles of the Treaty of Waitangi. This should set the standard of care for every New Zealander. The same principle was applied to my own research.

3.3.5   Sampling and recruitment

A total sample of all registered nurses who were currently working in an Acute Assessment Unit within the two Auckland district health boards were invited to participate in this research. The nurses were eligible for inclusion in the study if they had worked in their unit for at least 6 months and identified as having cared for a deteriorating patient in this time. I aimed to recruit nurses from a range of ages and ethnic backgrounds, and with varied nursing experience, however this was determined

by which nurses were interested in participating. The exclusion criterion was any nurses who I had seniority over in my position as Clinical Nurse Educator, including current colleagues.

Initially, I had hoped to be able to recruit participants from the DHB that I am employed in, but it became clear that this limited the research and recruitment opportunities. Recruitment was slow, but I also became aware that by broadening the recruitment to include other DHBs in the Auckland area, I was likely to get a wider range of experiences, ethnicities and either find commonalities or differences. With AUTEC approval (Appendix D), the inclusion criteria were to be extended during the recruitment phase to include nurses working in all the DHBs in the Auckland area, as well as former colleagues.

Initially, purposive sampling was used, where the researcher consciously selects certain participants, elements, events or incidents to include in the study (Marshall & Rossman, 2011; Richards & Morse, 2013) and is commonly used in phenomenological research (Smith, Flowers & Larkin, 2009). This was chosen as the most appropriate sampling strategy for this study because participants with experiences of the phenomenon of interest were needed in order to answer the research question, however this proved too slow for time frames. The ethics application was amended (Appendix D) to include snowball recruiting, which enabled participants to approach and invite their colleagues to participate in the research as well (S. Kelly, 2010). Altering the sampling strategy had an immediate positive effect on recruitment.

Five nurses consented to being contacted who were invited to participate in the research but chose not to take part. Three of these nurses did not reply to the invitation, one was interested but was unavailable due to moving overseas, and the last did not provide a reason.

To recruit the participants, advertisement posters (Appendix H) were placed in staff areas of the Acute Assessment Units. A message was also posted on one of the AAU's Facebook group inviting participants using the same advertisement poster. The advertisement was emailed to staff members by the unit manager, inviting their participation. Participants and colleagues discussed the research with their contacts in these areas, and invited them to either contact me or be contacted directly by me.

I had initially aimed to recruit 10-15 nurses as participants, however as the research progressed, I found that I was reaching data saturation (De Chesnay, 2014). Many of the participants were answering the questions with similar stories and clear themes were beginning to emerge. I decided that the tenth participant would be the final interview.

3.3.6 The participants

The participants were registered nurses employed by either Waitematā or Auckland District Health Boards. One nurse was trained overseas, and all other participants were trained in New Zealand. There were two male participants and eight females. Their cultural backgrounds included Pākehā, Indian and Other. The participant ages ranged from 20 to 55, with the majority of participants falling in the 26 to 30 years age category. Most of the nurses had some postgraduate education, and the range of experience of working in the Acute Assessment Unit ranged from six months to 10 years. There were no nurses who worked longer than 10 years in this unit, due in part to the fact that the unit had not been open longer than this. The following tables outline the participants' demographic information.

Table 1. Participants' nursing experience

Pseudonym	Nursing experience	Where first qualified?	AAU experience	Highest qualification	Level of Practice
Jessie	1-5 years	NZ	3-5 years	Postgrad cert	2
Ben	5-10 years	NZ	1-2 years	Masters HS	Senior
Tricia	20+ years	Overseas	5-10 years	Postgrad dip	3
Taylor	1-5 years	NZ	1-2 years	Postgrad cert	2
Annie	1-5 years	NZ	1-2 years	Postgrad cert	2
Sally	1-5 years	NZ	1-2 years	Postgrad cert	2
Lily	5-10 years	NZ	0.5 – 1 year	Postgrad dip	3
John	1-5 years	NZ	1-2 years	Postgrad cert	2
Nina	1-5 years	NZ	3-5 years	Bachelor HS	3
Rose	1-5 years	NZ	3-5 years	Postgrad dip	3

3.3.7 Data gathering

Pre-understandings

The data collection began with a pre-understandings interview with my supervisors, in keeping with the phenomenological methodology (Wright-St Clair, 2015). Pre-suppositions interviews are a useful tool to explore one's own prejudices for how they enable and limit understanding (Spence, 2017). This enabled my own thoughts and understandings about caring for deteriorating patients to be explored and helped me become aware of any biases. Lincoln and Guba (1985) suggest identifying one's own perspectives and assumptions improves the trustworthiness of the data. This interview was also very useful in helping me understand how asking particular questions elicited a 'story' or rich description.

This interview enabled me to view the ideas I already had around caring for deteriorating patients and reflect for the first time on how my previous personal and professional experiences shaped and influenced the way I came to this topic. It made me realise that I came to this research well before it began. The love of stories and caring and wanting to understand the essence of experience was in me before I came to nursing. It made me realise that I could not put aside my own experiences of patient deterioration and hear others' stories without thinking of my own.

Husserl proposed that researchers must practice the concept of bracketing, putting aside one's own ideas and experiences in order to understand the phenomenon in question to avoid distortion (Bourgeault et al., 2010), however I agree with Heidegger who argued that this was not possible (Blattner, 2006). For me it is impossible to set aside my past and my experiences. In hearing other's stories, I am reminded of our differences and similarities, and cannot help but call on my own knowledge and experience. This reflection also enabled me to stay open to what might be uncovered in revealing experiences that differed to my own.

Working in an AAU, I often observe nurses caring for deteriorating patients and see reactions ranging from indifference to panic, which makes me wonder what this experience is like for other nurses, and how these experiences influence and shape their practice. In my own experience, caring for a patient who deteriorates can be an emotional experience which lingers with me. I carry these previous experiences with

me and call on them when I am faced with the same situation again. I remember how I felt, or how the room smelt, or the sounds I could hear. I remember the look on the patient's face. When I see the same signs in a different patient, something is triggered in me – a reminder that I have seen this before and know what to do. Thinking about my own experiences raised questions for me about the lived experience of other nurses – what does care mean to them and how does caring for a deteriorating patient affect them?

Interviews

Individual in-depth semi structured interviews were chosen as the best fit for the methodology as phenomenology is concerned with lived experience. Interviews allow the researcher to "capture the deep meaning of experience in the participants' own words" (Marshall & Rossman, 2011, p. 93). This is also supported by van Manen (1990) who says deeply exploring participants' experiences through their stories is possible in these one on one conversations.

Participants were invited to take part in a one on one interview, with a mutually convenient location agreed upon. In some cases, this was a meeting room at North Shore or Waitakere hospital, and in others this involved meeting at a café to conduct the interview over a hot drink. Each participant received a supermarket voucher and handwritten card as Koha (a gift) for their time. The participant interviews were conducted between May and December of 2018.

The interviews began with discussing the study and seeking consent. Once the participants had signed the consent form (Appendix F), the audio recorder was started. Indicative questions (Appendix I) were used to guide the interviews and questions were asked in a similar order each time. Open ended questions were used to evoke stories about particular moments and events when caring for a deteriorating patient (Kelly, 2010). At times, probing questions were used to draw out an anecdote, and at other times the interview flowed like a conversation and the questions were answered naturally during the course of the discussion. At the end of the first interview a new question emerged about what the term 'caring' meant to the participant. This question was added to the list of indicative questions for each subsequent interview because of the richness and depth of the answers gained, as well as an insight to how each

participant viewed themselves as a nurse. Each participant completed a demographic form (Appendix J) after the interview, the results of which are summarised earlier in the chapter.

Interviews were conducted over an hour, with some extra time for filling in forms and discussion. Each interview was audio-recorded, and then transcribed verbatim in the days following the interview. I decided to transcribe the interviews myself to stay immersed in the data and found it very valuable to listen to the interviews again a few days after the interview, hearing something new with each listen. "Listening and re-listening, to the stories while typing up the transcripts is a way of dwelling with the interview data and of beginning to fully engage in it. It assists a deep familiarity with the text." (Wright-St Clair, 2015, p. 60). Listening closely to the interviews again and again helped me to understand my own interviewing style and helped me to refine my questions and questioning technique.

3.3.8 Data analysis

Analysis began with the pre-suppositions interview, as previously described, because this was where I first started to consider the meaning behind my own caring and my own experiences. I started to be open to possibilities and started to question what was underlying my own thoughts and feelings, and what was being revealed to me about my own everyday practice.

In phenomenology, there is no prescribed 'right way' to do analysis (Smythe, 2011; Wright-St Clair, 2015). van Manen (2014) agrees that the phenomenological method cannot be constrained to rules, or a set of steps or procedures. "To choose to do hermeneutic interpretive phenomenology one needs to understand and demonstrate skills of interpretation" (Smythe, 2011, p. 45). Smythe also suggests that phenomenological researchers need to approach analysis slowly, returning to it over and over again, knowing that there is still much meaning which remains hidden and unsaid.

The analysis of the findings continued concurrently as the interviews ensued. I transcribed the interviews myself and found that as I listened to the stories repeatedly, meaning was starting to be revealed. "Hermeneutic analysis requires that the researcher dwell within the data, awaiting glimpses of the phenomenon."(Crowther,

Ironside, Spence, & Smythe, 2017, p. 827). This is exactly what was occurring for me as I listened, typed, and re-listened. Often, I would need to pause to take note of a particular phrase or feeling as it jumped out at me, and this continued as I crafted stories from the transcripts.

3.3.9 Recrafted stories

Shaping stories from the verbatim data was one of the initial steps of analysis (Zambas, 2016). Coherent stories were drawn from the transcripts and then returned to each participant to offer them the chance to express whether their words were captured as they had intended. The transcripts were read and re-read, with superfluous details removed. Sentences were kept that appeared to hold meaning and then ordered in such a way that the story flowed. When I read these stories back, I wanted to make sure that the nurse's experience was captured in the story. Hence, each participant's stories were returned to them. In all instances, participants agreed that the essence of their meaning was represented in the stories, in one case saying 'I can hear my own voice, as if I am speaking it'. Others told me it was cathartic to talk these situations through. Many participants said this was the first time they had told anyone these stories, or the first time they had realised how much of an impact they had had on their nursing career. Caelli (2001) suggests recrafting the transcripts into stories or narratives enables central ideas to shine through. Crowther et al. (2017) agree that in hermeneutic phenomenology, data are used to highlight the different meanings within phenomena, and to provoke thinking and understanding in the reader. Crafting the data into stories allows meanings to be brought to the surface of the data, it is a way "that 'shows' what the researcher is noticing and interpreting while working with the data." (Crowther et al., 2017, p. 832).

As stories or anecdotes emerge from the transcriptions, the analysis moved forward, uncovering meaning in what was hidden in the experiences of caring for a deteriorating patient. The ideas of van Manen (1990, 2014) were drawn upon here to guide the interpretation and thematic analysis of these stories. "Grasping and formulating a thematic understanding is not a rule-bound process but a free act of "seeing" meaning." (van Manen, 1990, p. 79). van Manen goes on to describe phenomenological themes as the structures of experience, and therefore in unearthing the themes we are discovering the structures which make up that experience. In the

process of writing, thinking, listening and reading, themes are uncovered, and meaning is 'seen'. This process is not linear, the text is returned to repeatedly, with new thoughts and insights occurring with each reading and re-writing, in-line with Heidegger's concept of the hermeneutic circle (Gadamer, 2013). Being deeply immersed in the findings, stories and anecdotes, allows for interpretation of the meaning to unfold.

The participants shared stories about their caring for deteriorating patients in AAU, each one painting a picture of chaotic shifts where they felt pulled in many different situations. As the analysis moved along, at times I found that the stories were merging into one, in a way, with the stories painting an overall picture of the reality of working in an AAU. I decided to draw a picture (Appendix K) to help to illustrate the busy and chaotic workplace. I showed the drawing to several people who have never worked as a health professional, and each person instantly seemed to grasp a sense of what a typical shift is like in AAU. The drawing assisted my analysis as it enabled me to more clearly see how each story stood on its own, while at the same time contributed to a greater whole. When I look back on the drawing, I feel that each nurse is represented in some way, each sharing their own experience, yet being part of a collective group.

3.3.10 Reflective journal

A reflective journal was kept from the very beginning of this research. Events were reflected upon, such as participant interviews, and at other times the journal was used to capture thoughts that came in the middle of the night, or in the midst of hanging out washing. It has been a place where I recorded my thoughts, explored ideas, and can now, in retrospect, see how this research has evolved from the beginning. This is in keeping with the notion of the hermeneutic circle – a constant process of reading, thinking, discussing, reflecting and writing to allow meaning to be revealed (J. A. Smith et al., 2009). A reflective journal is shown to encourage learning and interpretation, and add validity to results by acting as an audit trail (Vicary, Young, & Hicks, 2017).

3.4 Trustworthiness

Qualitative research is said to be credible "when it presents such faithful descriptions or interpretations of a human experience that the people having that experience would immediately recognise it from those descriptions or interpretations as their

own." (Sandelowski, 1986, p. 30). Conversations with participants after they have confirmed their re-crafted stories, as well as conversations with colleagues has revealed that the nurses recognise themselves in these stories and anecdotes. The human experience in the writing, is evident to other nurses.

A main consideration towards trustworthiness in research is choosing an appropriate methodology to address what is being studied, Phenomenology was a clear choice for me because it enabled me to uncover meaning which is hidden in the phenomenon of nurses caring for clinically deteriorating patients, with the intention of providing valuable insight to further understand this experience (Howell, 2013; van Manen, 1990).

I was guided by the four criteria for evaluating trustworthiness in phenomenological research suggested by Annells (1999). The four criteria are as follows: an understandable and appreciable product, an understandable process of inquiry, a useful product and an appropriate inquiry approach.

It is evident that there is a literature gap regarding the experience of nursing in an AAU, which this research will contribute to bridging. The findings of the study will be presented in such a way that they are readily understandable by nurses or other readers in the form of journal articles, conference presentations or education delivery. In this way, the first criterion will be addressed.

To address the second criterion; having an understandable process, it is important that the phenomenological methodology is referred back to and drawn on in the research process, and that the methods, data collection and analysis used is congruent with phenomenology (Munhall, 2012; Richards & Morse, 2013). These processes have been outlined in this chapter. Another way this was addressed was by keeping a reflective journal, noting important or thought-provoking conversations, ideas, notes from supervision sessions, themes, revelations as they occurred to show my thinking as it unfolded. This is to ensure the process of decision making is clear to the reader. "If you cannot readily understand the process, or the decisions made, then not enough information has been presented for you to evaluate the worth of the project" (Annells, 1999, p. 11).

The third criterion from Annells (1999) is 'a useful product'. The information gained from this research will be used to inform nursing practice and the development of strategies to support nurses as they care for these patients, increase awareness of the possibility of unspoken thinking and experiences of caring for clinically deteriorating patients.

Annells (1999) fourth criterion is 'An appropriate inquiry approach'. I believe there is meaning in the nurse experience of caring and this exploration may provide valuable insights making phenomenology an appropriate approach for this research. van Manen (1990) says phenomenology is not used to create a theory which lets us explain reality, but rather offers "plausible insights that bring us in more direct contact with the world" p.9. The intention of this research has not been to provide definitive answers, but to offer and provoke thinking, questioning and conversations.

3.5   Challenges faced

The challenges that I have come across in conducting this research all relate to recruitment. Recruitment was slower than I had anticipated, with only three participants in the first six months agreeing to take part in the research. I had a conversation with each participant about why they thought recruitment was slow. I wanted to know if the advertisement was off-putting or if the topic was not interesting or relevant to nurses. Each participant told me that they thought it was due to the heavy winter workload that nurses were experiencing, as well as a general feeling of unrest and angst amongst the nursing community in relation to the pay negotiations that were taking place. This unrest was evident as nurses across New Zealand took to social media to vent their frustrations about the safety of their workloads and deciding to reject five separate pay offers (Nursing Review, 2018). DHB nurses went on strike for the first time in over thirty years in July 2018 (Fraser, 2018), which was right in the middle of an incredibly busy winter season with many emergency departments seeing record numbers of presentations (Lawrence, 2018).

I had also hoped to recruit nurses from Counties Manukau District Health Board as they also have an AAU but found that there were several barriers to recruiting participants. I gained approval from the research centre to go ahead with recruitment, however the Acute Assessment Unit was undergoing restructure, and I was unable to

gain access to staff. This is a potential limitation as this would have expanded the recruitment possibilities and may have attracted participants from different ethnicities or with different experiences.

3.6 Conclusion

This chapter has outlined the use of hermeneutic phenomenology in this study and the appropriateness of choosing this methodology. The notions of Heidegger and van Manen have been summarised, together with an outline of how hermeneutic phenomenology has guided the research process. The research methods for ethical considerations, recruitment, data gathering, and analysis have been summarised and described. The following three chapters: *Being connected*, *Being there as nurse* and *Being with* will introduce the findings from this research and discuss the notions that emerged from the participants stories.

Chapter 4 – Being Connected

"Caring is a feeling that I don't think you can ever really explain as a nurse. I think every nurse has the ability to care, and it is where and who you use it with that is quite rare and only comes out once in a while. With time, you gain connection and you share part of yourself with them. You give a little bit of yourself to them, and they give a little of themselves back." (Taylor)

4.1 Introduction

This chapter offers findings describing nurses' experiences of connecting with others. Throughout the findings chapters, the participants will be referred to as nurses, to ground the stories in their nursing roles. Connecting, in the context of this study, means bridging the gap between the nurse and patient and relating to each other on a human level. It is about the nurse seeing the person behind the label of 'patient' and thereby attempting to establish a bond which supports the nurse being able to ascertain the patient's needs. The nurses spoke of wondering about what it must be like to be that patient, experiencing this reality. They also spoke of feeling a sense of responsibility as part of their role. It seems that this connection often led the nurse back to themselves, their identities as nurses and as people, nudging them to think 'this could be me'.

In some cases, the nurses actively tried to build a relationship with the patient, and in others they revealed that they could not form a rapport because of the demanding workload in the Acute Assessment Unit (AAU). Sometimes it was because the patient presented in a different way which sparked interest, sometimes it was because the patient reminded the nurse of a patient they have cared for before, or their own family member. In other cases the connection seemed to occur because the nurse felt responsible for the patient or had a sense of guilt as they deteriorated. In situations where the nurse felt a connection, the nurses said they really cared and felt as if they had shared part of themselves with the patient.

The act of connecting recurred in the nurses stories and seemed to enable the nurses to more easily identify signs of deterioration. In many cases the nurses revealed that having a connection with a patient meant that they felt they would carry the memory of that patient forever. These stories recount moments when the nurses were

connected in some way with a deteriorating patient. Consistent with the phenomenological methodology, each story is followed by my interpretation of the text.

4.2   Seeing the person

Several nurses shared that finding out who the patient really is, and seeing the person behind the label of 'patient' is how they ensured they were meeting the patient's needs and making them feel cared for. When the patient felt well cared for, the nurses felt that they had done their job well. It seemed to go beyond that though to social reciprocity and human expectations, with the nurses demonstrating, 'I see you as a person and I want you to see me as a person sharing this experience together'. This led nurses to moments in their care of the patient where they were brought to the realisation 'this could be me'. When they saw the patient as a person, the nurses started to recognise that one day it could be their turn.

In the Acute Assessment Unit the nurses work with an awareness that the patients may be required to move to the ward or be discharged at any time. Some said that they actively worked on building a nurse/patient relationship in a short space of time so they could identify the patient's needs and then go about meeting them. The nurses revealed a realisation that they could not always presume what the patient's needs were, because each patient was uniquely different and expected different things from them. There was a sense that in AAU the nurses were in the dark as to what the patient was like and who the patient was, in terms of physical condition as well as personality. The nurse also needed to be on guard or wary because these intangible qualities meant that the patient was both unknown and unpredictable, and at times seemed to hold back from building a rapport as a type of self-protection because they knew the patient would not be in AAU for long.

Rose, a nurse with five years' experience, said that to be able to connect with the patient, she tried to see the person behind the label of 'patient', and respect that first and foremost, they were a person.

> "It's about respect. Respect for the patient and recognising that they aren't just a patient, they are a person, and they may be more than what you see in front of you. There are so many stories and ups and downs in people's lives. It's about treating them like you would want

to be treated. If there is no respect then whatever you do after that is meaningless. I could go in and give medications, but anyone off the street could do that, a robot could do that. What changes you is the way you treat the other person, respectfully, for who they are and not judging them." (Rose)

Rose recognised that although the people in her care were identified as 'patients', before they come to be in her care, they were firstly 'people'. It was easy for nurses to get caught up in their workload and see their patient care as intervening tasks that need to be completed, but sometimes they were unexpectedly reminded there was an actual person that they were caring for, rather than a 'to-do list'. Rose shared a story about an older gentleman who she had been caring for and how she was reminded of the person behind the label of patient.

> *"Yesterday I had a 100 year old who lives by himself, totally independently. He was so lovely. I got chatting to him and until then he was just a patient who had come in with a fall. He was so friendly and talking about his life, and I was like 'oh my gosh, you've been to all these amazing places and you were somebody really important, and I wouldn't have known that!'." (Rose)*

Rose said, '*until then he was just a patient*'. By starting to see him as a person, she was able to form a bond with him and relate to him on a human level. Rose's words suggested that this doesn't happen with every patient, but when it does it shifts her perspective and reminds her, this could be her or her family members. It starts to make the person behind the patient a reality.

Tricia outlined her connecting in a similar way to Rose about seeing the patient as a person, and said that connection starts with rapport. She said that when you build rapport you start to hear from the family what that patient was like before they came into your care and that it helps the nurse to see them as a person, rather than just a patient. Tricia revealed that she made sure to introduce herself to every patient at the beginning of each shift, helping to build an attachment.

> *"One of the things I try and do every shift is to start with rapport. You have to make time to fit the interpersonal stuff into your day, no matter how busy it is. I always go into the room and introduce myself to all my patients so they know who I am, and so that I can put a face to the name and it's not just 'the appendix' in bed one." (Tricia)*

Tricia said that building rapport helped her patients to develop a sense of trust in her. Tricia believes *'if you don't start with that then they don't have much faith in you'*. It is important to her that her patients have faith in her and trust her. Her words suggest that this is a strong part of her nursing identity – 'I am here to help you, you can trust me.' Tricia considered what it must be like to be that patient, and how it would be to arrive in a strange place in the dark. As she works predominantly night shifts this is a common occurrence.

> *'These patients are going into a dark room, they don't know where the toilet is, they might have been given the call bell, but they don't know what's happening, they don't know what's going on. If you follow that person in and they know who you are, well that's how you build rapport with your patients'. (Tricia)*

Tricia knew that part of her role was to help the patients through their journey and wanted them to have a good experience. She had a sense of responsibility for their overall well-being. She established a connection early in the relationship, considered what the experience was like for the patient and then tried to improve it.

Tricia pointed out that when caring for someone who is sick or deteriorating, the patient's priority is often different to the nurse's, and that having a rapport is helpful because it supports the nurse to best know how to show care to their patient. It seems that Tricia saw beyond the list of tasks that need to be done and thought about what may be important to the patient in that moment, what would make them actually feel better as a person. *"You try and put yourself in their place and think about what it must be like to be that patient and what you would want if you were the patient"*. She doesn't just consider how the patient is feeling, but thinks of what she can do to improve their situation and what will make them feel cared for. When she has built a rapport, she feels like she knows how to best care for the patient.

Tricia also shared a story about caring for a patient who was the same age as her. She was shocked at how much he had deteriorated and said *'he was my age for goodness sakes'*. This suggests that in realising the patient was the same age as her, Tricia was reminded that she too could be the one in the bed who was so sick, this could be her. It was also a reminder, a motivator, that if she was well and healthy at this age, then he could be too.

"I remember a man I looked after recently who had come in with bilateral pneumonia. He was really sick. When I came onto shift he was pyrexical and tachycardic, and he had been started on IV antibiotics and oxygen. He was just laying slumped down in the bed, covered in a stack of blankets and when I walked in and saw him I was like 'are you serious?'. The shift previous had done everything from a task point of view, but from a nursing point of view they hadn't done anything. They hadn't sat him up properly, or done any cooling cares, or got him a fan. They hadn't even started him doing deep breathing or coughing exercises. He was my age for goodness sake, I think if he had been left in that position he would have ended up in critical care. So, I went in with all guns blazing, got him sat upright, got the pillows behind him, got the blankets off him, got a fan in there, got him coughing and expectorating, got everything sorted and he improved. It was wicked. By the time morning rolled round his observations were back to normal and to see that improvement in him was just amazing. I know that it wasn't just the antibiotics that had kicked in, it was also that my nursing care had kicked in. He had been very sick and heading towards Critical Care, but I'd pushed with him all night, and that was really good for me as a nurse and as a person." (Tricia)

Caring on a level that deeply connected with her personally, motivated her to do more for this patient. She says *'I pushed with him all night'* and by the time morning came, he had improved. Tricia had formed a bond with the patient which reminded her that it could easily be her in that bed. She seemed to lend or share her energy with the patient and gain satisfaction from this encounter, which comes back to her nursing identity and the feeling she has of 'I am here, you can trust me'.

Tricia seemed to able to develop trusting relationships with her patients easily. She told me that when she goes to the shops close to where she works, she often walks past a group of people who live on the street, several of whom she has cared for frequently in hospital. *"When I go walking in town some of them recognise me and call out 'that's my nurse!' How many people can say that? They wave to me and I wave back".* Tricia seemed to feel pride that her patients recognised her in the street, as if she had left an impression. When a patient feels well cared for, Tricia feels she has a done a good job as a nurse. Even in the street, she is recognised as 'the nurse', which reiterates the fact her nursing identity is important to her, and is linked to the human interactions and connections she makes with her patients.

Nina, a nurse with five years' experience, also likes to create a rapport with her patients, but prefers to ask her patients what they need from her.

> *"You don't necessarily have to know what they are going through, but just to be able to be like 'oh hey, I hear you man. I'm here for you. Tell me what you need'. Or be like 'I can see what you need, but what do you really want? What can I do for you? Let's be a team.'" (Nina)*

Nina uses the bond that is created to work in partnership with her patient, so they are working towards the same goal. She said she could see what they needed, meaning she could see what tasks she needed to do but she asked the patient *'what do you really want?'* Nina had an awareness that what was needed and what the patient may have wanted were not necessarily the same thing. She demonstrated that she knew that even if she did everything right from a nurse's perspective, it might not be what made the patient feel cared for. It suggests that although she may have felt she was doing a good job as a nurse, it lacks meaning and value if the patient doesn't feel cared for, listened to or acknowledged for who they are. To make them feel well cared for she looked beyond what she thought they needed as a patient and worked on providing what they needed to have a human connection and feel seen as a person.

John has worked in an AAU for three years and also works on creating a connection with his patients to help them feel well cared for. He had considered how coming to hospital can be frightening for patients, especially when they were in the acute phase of their illness, without a clear diagnosis or plan of care. He had an awareness that they may deteriorate, and he knew this was not a pleasant occurrence.

> *"Patients often deteriorate more quickly in AAU just from the nature of the patient being early on in their hospital journey, things are still often quite uncertain. They might not have a proper diagnosis yet, they might not have the proper treatment initiated yet. You can make it a good experience for them because coming to hospital often isn't a good experience. Caring is about making people comfortable. It means using my sense of humour. That's just my personality. I like to make all of my patients smile or laugh each shift, that's part of who I am as a person." (John)*

This suggests he has wondered how it is for the patient, he has put himself in their shoes and considered what he would want in the same situation. *"The nurses are the ones that will often see the patients first, so you're the first contact point in hospital"*.

John identified strongly as an AAU nurse, and saw part of his role as ensuring patients were put at ease during their admission. He assumed it may not be a nice experience, and he gained satisfaction from making patients feel cared for. For John, his job satisfaction did not seem to come from achieving his task list or workload, instead it seemed that if John had made a patient smile or laugh, made them feel cared for, then he had done a good job as a nurse.

When the nurse had connected with the patient in some way and had wondered about them as a person or what their life may be like outside of the hospital, it seemed that they were thus more open to identifying subtle signs of deterioration.

4.3   Recognising subtle signs of deterioration

Nurses are taught to recognise deterioration by detecting key clinical indicators such as increased pain or vital sign deviations, but there are often more subtle signs present in patients that a connection enables the nurse to notice.

Ben, a senior nurse, shared a story of a time he walked past a young woman crying in the corridor. His professional responsibility and ability to empathise with people drew him to ask her what was wrong and if he could help, even though he was not caring for patients on the floor that day. She responded by saying "Poppa doesn't look right". Ben was instantly alarmed. He had not a been made aware of a patient who was deteriorating on the ward but he said *"I've always believed that relatives know the patients better than we do, so I went to see Poppa with her."* Ben had picked up on a sign of deterioration which is often overlooked. He understood by seeing through the family lens, the significance of a family member recognising an important change in the patient's condition. Ben seemed to be immediately transported to thinking about his own family, and he knew that if he was in this woman's position, he would know better than any medical professional what was normal for his own family member. Before he even got to the room, he *knew* that this man was deteriorating from his baseline, he *knew* this was significant. The ability to empathise and connect with this young woman, enabled him to pick up on something clinically important, that perhaps had not even been picked up on by nurse who was actively caring for the patient.

> *"When I walked into the room I could see he was leaning over the table, he was a shade of blue and working really hard with his*

breathing. When I got closer I could see he had intercostal indrawing and purple nail beds. I approached him with a smile, which is just my way, because if I start showing on my face 'oh shit', then it has an impact on how the patient might respond to that situation. So, I approached him with a smile and I said, 'Good morning sir, how are you feeling?'. It took him about five breaths to actually get out a sentence which was another sign that he wasn't well. I put my fingers on his wrist and I checked his pulse, and immediately I could feel that he was tachycardic. His nail beds were purple, he was diaphoretic, and his pulse felt very thready, and in my head I'm adding up all the numbers, and I didn't need an Early Warning Score, I didn't need anything empirical to tell me I was dealing with a very, very sick man." (Ben)

Through his words, I interpret that Ben used his personality as a tool to relate with the patient, and to put him and his granddaughter at ease. At the same time Ben was running through several quiet and observational assessments on the patient, all in the space of a few minutes since meeting the granddaughter crying in the hallway. This suggests that Ben is able to form a rapport quickly with a person, and doesn't need to spend time with them for long for this to happen. He put this down to being just his personality which allows him to relate to people and put them at ease. He didn't just connect with the granddaughter, but came in to the room and instantly started trying to put the patient at ease too, at the same time as recognising the significance of this patient's deterioration.

Sally shared a story about a patient she was caring for who deteriorated throughout her shift, and how as she spent more time with him, she detected that he was deteriorating. She saw him at the beginning of the shift, and described him as 'fine'.

"He came back from x-ray and was fine at this point. I gave his meds, he had breakfast, he would get up and go to the toilet and I would unplug his monitor, and then plug it back in when he came back. He was fine. He was probably my easiest patient that day." (Sally)

As the shift progressed, he started to show signs of deterioration. His observations were still within normal limits so Sally had difficulty escalating her concerns, but there were signs that he was clinically going downhill, and these signs niggled at Sally, becoming a quiet worry, building as her shift progressed.

"He was lying down and coughing really oddly and I said 'that's not going to help you, you have to sit up and cough', and he was like, 'I

feel really tired, I can't sit up', and this is a man who was
independent, he had been walking around and was fully with it."
(Sally)

Sally pointed out, this man had been completely independent at the beginning of her shift, but was now too tired to sit up. Sally was concerned. She went about her shift and not long after this, while she was seeing other patients in another room, her colleague came and told her that the same man had wet the bed. Sally was alarmed, and told her senior colleagues that this was not right. Her concerns were dismissed because his observations were fine. Sally was not convinced, and her worry grew.

"I was like, 'an independent man will not pee himself'. He would have
been so embarrassed, but he didn't have the energy to be
embarrassed, he didn't even have the energy to move. The fact that I
had to get people to help me move an independent patient kind of
freaked me out." (Sally)

These symptoms in a patient are not unusual for nurses to come across, these are every day occurrences and easily dismissed, but what Sally had picked up on because of the relationship she had formed with the patient throughout her shift, was that these were abnormal signs for *this* patient and that something had changed. She had noted seemingly subtle signs that her patient had deteriorated from his baseline, which were significant, and proved to be correct as her patient continued to deteriorate despite Sally escalating her concerns time and time again to various medical and nursing colleagues. This suggests nurses may miss subtle cues of deterioration in the AAU if they have not had time to get to know the patient's baseline, or when they haven't had a chance to interact with the patient and form a connection. Without having time with the patients, they may not notice little signs that point to impending deterioration until they are reflected in more obvious or clinical signs.

Rose suggested that patients who are deteriorating often look unwell but it is more than this, it is about how they are behaving and how this relates to what condition they presented with.

"It's other things as well, like their vital signs, but it's how they look
and what they are doing at the time, and what they came in with.
Sometimes they tell you that there's something happening, and they

look fine but you do an assessment to find out what they mean. A deteriorating patient to me is someone who doesn't look or feel the way they were feeling when you first saw them. They often look sweaty, scared, short of breath, not settled, uneasy. Sometimes it's that they generally aren't as perky as they were, or they aren't communicating with you. They are lethargic, slow to respond, or can't be bothered to respond." (Rose)

Rose said when the patient looks *'scared'* or *'uneasy'* that is something she notices as a sign of deterioration. Often the patient will feel something unusual in themselves that they can't express. Sometimes, as Rose pointed out, the patient may tell the nurse that something is happening. Rose has enough experience to recognise that these are sometimes subtle pointers that something is going on for the patient. When Rose picked up on these signs it was alarming to her, just as much as a low blood pressure would be. Rose used her connection with the patient to provide context for the signs she was seeing. When she saw these signs, or heard her patient say 'I don't feel right', she heard a call for help and was summoned to act as a nurse.

A connection with a patient can enable nurses to discern subtle signs of deterioration, but often times when the nurse is feeling overwhelmed by their workload, it can lead to a feeling of disconnection instead.

4.4   Feeling disconnected

The nurses described times when they felt distracted by their workload, which made them feel disconnected from their patients. This seemed to lead the nurses to reduce the patient to a 'task', instead of being able to see them as a whole person.

Sally often felt she was unable to connect with patients in the way that she would like because of the nature of the AAU. She shared a story about having a new patient arrive in her cubicles and how a colleague had seen her new patient before Sally had been able to get there.

"If you have a sick patient, you don't get to reduce your patient load, they just keep coming. I was getting new patients, and one of them was a young man. We have ENs [1] who assist, so they come in and do a set of observations, do a set of bloods, but you have to assess the patient.. When I got to see him, I was so shocked that nobody had done anything about him, but I guess I was that someone who was

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[1] Enrolled Nurses

expected to do something. The EN had done the bloods and done a set of observations, and he was scoring a seven. With someone scoring that highly off the bat, you'd be like 'whoa'. She must have come and told me, but I don't remember, that's the thing. She probably came to me and told me to go and see that patient and I would have been like 'yep, yep, it's on my list, I'll get to it'. When I saw him, he wasn't well at all. He was a 23 year old coming in with an exacerbation of asthma, and I felt so bad when I finally got to him. He should have been seen first, but no one had flagged the doctors because I hadn't been able to see him." (Sally)

Sally had been so caught up with a sick patient, that she couldn't get to see the new patient who needed her just as much. Sally was disengaged from the new patient, distracted and busy with another unwell patient. She was shocked at the new patient's condition when she finally got a chance to go and see him and assess him for herself.

In a similar vein, Lily told a story about caring for a patient who was extremely unwell who she hadn't been able to form a bond with.

"You don't really know the patients that you are caring for in AAU, they are there for such a short time. There was a patient who had an exacerbation of COPD[2], and he was so sick. Once we got him nebulised[3] and gave him steroids, he started being able to talk and I was like, 'oh my gosh, you've got an accent!' I'd been caring for him but I had no idea, because I didn't know him or what he was like before." (Lily)

Lily was 'tasking', doing the things that needed to be done but it wasn't until she learnt something about him that was not visually obvious that she really noticed him as a person. She had not felt connected with him on a personal level at all, all she knew was that he was unwell and needed help. Something seemed to shift when she was reminded he was a person and not just a patient. It suggests that the nurses don't need the connection to *provide* care, but perhaps when the connection is there, they *feel* care.

Sometimes the nurses felt a connection with the patient and wanted to show care for them, but their workload prevented it. Annie told a story about a man with Down

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[2] Chronic Obstructive Pulmonary Disease
[3] When a medication is converted from a liquid to a fine mist, enabling a patient to inhale it more easily

Syndrome who was deteriorating throughout her shift. She was able to do the tasks that needed to be done, like giving him antibiotics, but he kept calling for his caregiver.

> *"It was hard when he was calling out for his care giver. I couldn't really understand what he was saying, and he just seemed really distressed and sad, and I felt so bad that I couldn't just sit with him. I would have loved to sit with him and let him know it's all ok and that we were looking after him, but I couldn't. I physically couldn't. For his sake I had to find his team, and I couldn't neglect my other patients. There were antibiotics due and other cares that I couldn't delay. I felt like even though he was so distressed he couldn't be my priority, though I wanted him to be. That definitely stuck with me." (Annie)*

She felt like she knew what would make him feel cared for, but was pulled away by the rest of her workload. Annie's words suggest that she felt like she had let her patient down, even though it was beyond her control. She performed the physical cares he needed, but she felt like she was blocked from being able to really show him care. She couldn't uphold her part of the relationship or perform her role as nurse. There was an affinity with this patient that she couldn't utilise. In one sense he was well cared for because his deterioration was managed, but Annie was left feeling she hadn't been able to make him feel cared for at all.

Jessie shared about how she works on not being attached or being too connected to the patient, in order to cope with what she experiences.

> *"Sometimes I feel like I've become numb to the feeling of caring for a deteriorating patient and I kind of actively work on not being too attached. The first few years of nursing mentally took a lot out of me. I'd go home feeling anxious about what was happening after I left, and I'd have panic attacks thinking about what I was going to walk into the next day." (Jessie)*

In the past, Jessie had been consumed by the emotions of caring for a deteriorating patient. She spoke of patients who she had cared for who had died, who she had stayed behind after her shift to give a little bit more care to, and shared how this took a lot out of her. She said that she tried to distance herself emotionally now as a protective measure. This hints at a lack of bond with the patient impacting the care that is given, and could be a potential barrier to identifying deterioration. Jessie shared other stories which suggest that although she may try to keep an emotional distance

from her patients to protect herself, her nursing identity means she can't help but show care.

> *"I think caring is about compassion. It means showing patients love. Showing them tenderness and doing the little things that make them feel safe and looked after. Making them feel safe, so that they're not scared or alone and trying to make them feel as if someone wants them to be okay, because sometimes the family is not there to do that." (Jessie)*

Jessie wanted to keep her distance emotionally, to protect herself, but her instinct was to show compassion to her patients, and make them feel safe and cared for.

In all the stories there was a feeling that the nurses wanted to be able to bond with their patients, recognising that this made their patients feel well cared for and in turn makes the nurse feel that they have done a good job. There was frustration when the nurses were prevented from doing this because of their workload or the nature of AAU because they felt unable to show that they really cared. At times the pressure of the workload meant that if an unexpected deterioration occurred, the nurses had a feeling of being unable to respond in the way they felt they should.

4.5   Losing my head

When a patient suddenly deteriorated and the nurse found themselves in an emergency situation or 'code', there was often a described period of being frozen, unable to think clearly or act appropriately. The connection with the patient in this instance was about the nurse / patient relationship, a sense of responsibility and a heightened need for action. Interestingly, the same nurses also said that if it was not their patient they could jump into the situation quickly and know what do, their professional role as a nurse kicked in.

Annie revealed an experience where she administered an antibiotic to a patient in the clinic area, who had an unexpected reaction to it and deteriorated. She had followed all the usual procedures, explained the chance of a reaction and what this might look like, and then administered the medication carefully. She was shocked when not long after the antibiotic was given, one of her colleagues was yelling for her to come quickly.

> *"The patient was saying she was dizzy and said 'I can't see.' I was like, 'what the heck?' We got her onto a bed, which was miraculous because she was a dead weight, she couldn't carry herself. I was like a stunned possum. The ABCs[4] literally went out of my head completely and all I could think was 'this isn't happening. What is going on?' I think I was more focused on what I had done to cause the patient harm, and it fully paralysed me in a sense. I felt like I wasn't responding as professionally as I should do. I feel like I was so close to the patient in that interaction, but I also think I was just stuck on 'what did I do wrong?'" (Annie)*

In this situation, Annie felt responsible for her patient and the patient's deterioration. She even said *'I was so close to the patient in that interaction'* as if she was unable to take a step back and see the situation objectively. Annie was fixated on feeling like she caused harm to her patient and was unable to respond in the way she would have expected or liked of herself. She knew how she was supposed to react, but she felt paralysed by her sense of guilt.

Nina described similar feelings to Annie when she faced a clinical deterioration in her own patient, but in contrast felt she could be more objective if she was stepping in to help with a colleague's patients.

> *"When I go into an emergency situation when it's not my patient, people are frantically doing tasks and I'm like 'hold up a minute, what is going on and who is leading this?' It's definitely easier to step back and be objective in that situation. If it's my patient, it's definitely helpful for me to be doing something, but you're always emotionally involved and thinking 'oh shit, what's happening, what have I done?' It's really hard. I think nurses always blame themselves." (Nina)*

Nina disclosed that she worried that she had done something or missed something which led to her patient's deterioration. She found it helpful to be occupied in this situation, to be hands on with a task to distract her mind, suggesting that this prevented her from feeling paralysed as Annie described earlier.

Importantly, Taylor described a feeling of guilt akin to Annie and Nina, when a patient she was caring for suddenly deteriorated, yet she too said that if it was someone else's patient it was easier to know what to do and to be objective.

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[4] Airway, Breathing, Circulation

> *"If one of my patients is seriously sick and I'm the one that has to push that red button, I end up shutting down and stepping back a bit. If it's someone else's patient, it's easier to come in, get my hands dirty and know what to do. When it's my patient, it's like a cloud comes over me and I'm thinking 'What have I done? What's happening?' I think I feel responsible straight away and there's a flush of guilt, even if I know I didn't do anything wrong. It takes a good 30 seconds to a minute, to realise everyone is just getting it sorted, and then I can get back into it."* (Taylor)

It is interesting that Taylor, similarly to other nurses, felt overwhelmed by a sense of guilt, even when she knew she hasn't done anything wrong. This suggests that nurses take their responsibilities very seriously, feeling that if the patient is unwell, there is a possibility that they have not done their job adequately, and they have let their patient down. It also hints at the nurse doubting themselves, wondering if they have made a mistake and what the consequences may be firstly for themselves, but more importantly for the patient who they are caring for.

Ben described a similar experience of panic when a patient is unexpectedly deteriorated. It seemed that despite the fact he is a senior nurse he too found it difficult to order his thoughts when he was faced with a patient who was deteriorating, suggesting an overwhelming sense of responsibility to make sure the patient gets what they need in a timely way.

> *"In these situations, I'm thinking 'What could this be? What could this result in?' and 'What am I going to do?' When I'm panicking I like to make myself a mental list of the next few steps I absolutely need to do. It just helps me order my thoughts. That does change from situation to situation though. If it's a cardiac arrest then I go into auto pilot, I know what to do before I even think about it. I go straight back to basics. Hit the emergency bell, airway, breathing, circulation, reassure the patient. There's been times when I'm caring for a deteriorating patient, when I've lost my head. I get scatter-brained and what I verbalise comes out fragmented. It's all over the place. I call it a verbal seizure. It's like I can't make sense. I know everything that needs to be done but it all blurs into one sentence, without structure."* (Ben)

There is an impression from Ben's inability to verbalise himself that if he did not get himself and the situation under control then the patient was at risk. There was so much at stake that he needed to find the right words. He knew that if he did not do his job well, the patient who was already in danger faced an increased risk of further

deterioration or even death. It suggests that Ben was not only flustered trying to ensure he was communicating appropriately to save the patient, but also that in this moment he was being looked to as a senior nurse by his colleagues, as if he should know what to do. He felt that everyone was relying on him, the patient most of all, and he needed to act quickly. It is interesting however, that Ben said that if it is a cardiac arrest he goes into 'auto pilot' mode. I wonder if this is because this scenario is practiced frequently, with annual updates for all nurses. Although it is clear that Ben would still be contemplating all the different variables of what has gone wrong and what needs to be done, the very basics, maintaining the patient's airway, breathing and circulation is automatic – he does not need to think to do it.

Further to the feeling of having difficulty ordering their thoughts, the nurse's stories highlight that when a patient is deteriorating there is often another priority that the nurses need to shift their focus to: the patient's family or loved ones at the bedside.

4.6   Shifting the connection

When the patient is advanced in their deterioration, perhaps close to death, the nurse often seems to stop relating to them and instead, shift their emotional connection to the family. When a nurse is caring for a patient, they sometimes experience a feeling of 'this could be me'. If a patient becomes very unwell, it seems harder for the nurse to put themselves in those shoes, but can more easily relate to any family members who are present. It is easier to imagine what it must be like to be that family member, to be reminded of their own family, and the nurses start to shift their emotional care to the patient's relatives, without seemingly being consciously aware of it.

Nina told a story about a woman who was admitted with advanced gastrointestinal bleeding. She continued to deteriorate and died during Nina's shift. Nina said "*I hadn't even really had time to bond with her but for some reason she has just stuck with me*". It seems that she was busy doing tasks, taking observations, cleaning up blood, administering treatments, but her words suggest that she was actually disengaged from the patient. There is a sense that Nina has taken a step back from the patient themselves. The patient had deteriorated too far, almost as if she was not there to form a rapport with. Instead, Nina looks to the family. She wonders what it is like to be

them, she imagines 'what if this was my family member?' This is where she feels able to show care now.

> *"Both ends were going, just pouring out blood. She just kept bleeding and bleeding. It was the most horrific thing I've ever seen in my life. The worst part was that her father and brother went out to move their car, and she died within a few minutes of them being off the ward. I think she waited for them to leave. The hardest part was having to call them and say 'I'm really sorry, but you need to come back right now'. And then having them come back to that." (Nina)*

Nina appreciated that this was an appalling scene for the father to come back to. She described the experience as horrific and was concerned that the woman's father had to come back to the ward and witness this, knowing that if it was horrifying for her, it would be even more horrifying for the family members. Even after the woman died, Nina was still trying to find a way to make it better in some way for the family. She said, *"A few of us stayed back after our shift and cleaned her up and made her look pretty for her family"*, as if she knew the image of the patient bleeding so profusely would be imprinted in her memory, and she didn't want the father to remember her this way. She wanted to give the family members a different image to remember. Nina said this patient has stuck with her although she also said she never really bonded with the patient, suggesting it was the family that she was able to show and feel care for.

Taylor too, shared a story about a patient who deteriorated and died during her shift. She had not known the patient or the family long, but it is clear from her re-telling of the story, that the patient was not who Taylor had a rapport with, as in Nina's story. I get the sense that Taylor started her shift by bonding with the patient, but as they got sicker and became unconscious, it was harder for her to relate. Instead, she could imagine what it might be like to be a family member watching someone you love die despite never experiencing this herself. Instinctively, her bond shifts to the family who were surrounding the patient, and making the experience better for them.

> *"I've never dealt with any deaths in my own family. I'm very lucky, but I remember thinking I would want to be told, instead of guessing that my family member was dying. I remember kneeling down so that I was at the same level as the family and speaking to them about what was happening, what was changing. They were crying, and I started crying too. It was witnessing the family that was the hardest. I didn't know the patient very well so it wasn't that, it was seeing loved ones*

lose a loved one. When I got to my car after that shift, I called my Mum and just cried. It wasn't a distressed cry, it was just those emotions of seeing my first patient die, and the sadness of seeing loved ones lose their loved one." (Taylor)

Taylor's narrative hinted at how she was reminded of her own family during this patient encounter, and how she was prompted to think about how she would feel. It was her first patient death, and the first time being very aware that when a patient is dying, the family need to be nursed too. I am struck by her bravery in this situation when she felt out of her depth, offering herself as support, crying with the family, kneeling down and being present with them. Her story illustrates the essence of nursing, how we can be profoundly connected with strangers through a shared experience, and show care.

Rose shared an account of caring for a man who was deteriorating and at the end of his life, and how she came to realise his family needed to be cared for just as much as the him.

"On this day, he suddenly deteriorated more and more. We were quite shocked, and the family were too. It was the reaction of the family and the helplessness that I was feeling, that I couldn't fix this for them. During the day we moved from active cares, to comfort cares. It was a big decision for the family to make, and watching this process was a bit hard for me. You put yourself in that situation and you think, 'my gosh, how would I make that decision?' Watching that process unfold in front of me with the family was really hard to watch. It made me think of my own family and I know that if I had to go through that situation it would just be heart breaking. It's important to have a bit of rapport with the family. We are often so focused on the patient and making sure they are okay, it can be easy to forget the family. I try to keep talking to them while I am doing cares, like talking about what is happening, that the doctors are aware of what is going on, and what they should expect next. I think it was one of the first times I realised it wasn't just about me giving medications or following the plans, it's also about family and whānau cares as well."(Rose)

It is clear that Rose had thought about what this situation was like for this family, and she said that it made her think of her own family, like Taylor's story. In the moment with this patient and their family members, she was reminded of her own family, and seemed to almost invite their presence into the room with her to be guided at how best to 'be' with these people as they navigated this journey. Rose said it was hard to

watch and she knew it must be heart-breaking for the family. This tells me she has taken on board some of these emotions and feelings, as if it really was one of her family members in the room. Rose disclosed that it was one of the first times she became really aware that her nursing care was not just about tasks, instead it was about caring for the patient and the family, being guided in her care by their needs.

Jessie too, commented that when she is caring for a deteriorating patient, a lot of the time the care is more for the family. She shows concern that the family members aren't prepared for some of the unpleasant things they may witness while a patient is deteriorating.

> *"We don't really have visiting hours in AAU so often the family is there. The families end up seeing things like seizures or codes. No one is really prepared for seeing their family member go through that, and it's scary for them. It's about caring for the patient and their family at the same time." (Jessie)*

Not all of the nurses seem to feel this care towards the family members in these situations. Lily shares her thoughts about a time when a patient was deteriorating and they were surrounding by a large family.

> *"We had a code the other day… and all of a sudden there were 12 people in the room. We were trying to work around them and I was like 'someone needs to talk to them, there needs to be no one in here right now'. The patient was really unwell. When you've got a patient that's deteriorating, as much as you want to have cultural consideration, the focus is on the deterioration." (Lily)*

Lily seems to view the family's presence as a distraction and doesn't seem to have the need or desire to connect with the family to show care. Lily's stories suggest that she shows her care for patients and families in a different way. She often spoke of 'jumping in to codes' to assist and helping other nurses with their unwell patients. It seems that Lily shows care by being practical, doing what needs to be done and by advocating for patients to get good care. When Lily expressed frustration at the family being present, it hints at her showing care to the patient by being concerned that they are deteriorating and that the family being 'in the way' is a barrier to them receiving appropriate care.

The nurse's stories, with the exception of Lily's, suggest that the nurse is always looking for a connection in their patient interactions. When the patient cannot respond or the family's needs are greater, the nurse instinctively turns their attention and care to the other people surrounding the patient.

4.7   Giving part of myself

When patients are deteriorating, the nurses often gave the impression that they felt that they could not fix the situation for the patient as they would have liked to, yet they still had something to offer. They could share the experience, acknowledge what the patient was going through and could be a witness to something significant in their life. For some of the nurses there was a sense of reciprocity in their relationship with their patients, even though the nurse was not always consciously aware that in their giving something to the patient they were in turn receiving something back. Even in the most acute situations there was a perception of give and receive; I look after you well and in return you survive. This gave the nurse satisfaction and helped validate that they were a good nurse. In the situations where patients did not survive, the nurse still seemed to gain satisfaction in providing good care, or making it a better experience for the patient and their family, often sharing thoughts such as 'at least they were comfortable'.

For many of the nurses, there was a feeling of responsibility and an understanding that part of their role is to give time and energy to their patients. This was often how the nurse showed that they cared. In some instances, the nurse seemed to feel a vulnerability, that they couldn't improve a patient's situation and outcome, instead they could give only themselves, and their time.

Tricia suggested that nursing is 'giving part of yourself' to the patient or the situation. Tricia does not seem to be being altruistic in saying this, she appears to simply believe this is what nursing is. She is the nurse, therefore she gives part of herself in each nursing interaction, it is a taken for granted part of her role.

> "It's giving of yourself. That's why nursing is so exhaustive. It doesn't
> matter if you are just sitting with that patient and doing nothing
> while they are dying, it's giving of yourself." (Tricia)

Tricia said, *'just sitting'*, which hints at other tasks and patients waiting in the background for attention, but for Tricia and her patient it was more than that. It may look to an outsider like she was *'just sitting'*, but in that quiet stillness she was offering to her patient her presence and her comfort. It makes me imagine the chaos in the unit with all the things that need to be done and the list of tasks building, and yet in the middle of that, she was sitting quietly giving her presence to a deteriorating patient she cannot save. There seemed a sense of, 'I can't fix this, but I can give you myself'.

> *"I remember a patient once who I sat with most of the night. She was elderly and confused and was in a six bedded room. She was in bed A and there was a lady in bed C who heard me talk to this patient all night, and she sent me a bouquet of flowers and a card to say thank you, and to thank me for the nursing care I'd given to the elderly woman. To me it's just doing my job but when you sit back and think of it, you give so much of yourself without realising it. If you analyse it, then you realise why you go home so exhausted in the morning and look forward to your days off. It's second nature, caring, and until you really analyse it, you don't realise you are doing it. Caring is about breaking down those barriers that come between you as a person and you as a professional. You can't always stay professional as you give yourself personally to this job." (Tricia)*

Tricia pointed out that as a nurse you can't always stay professional, keeping an emotional distance from your patient because sometimes barriers are broken down without realising it. She said it is second nature, and this is reflected in the way she talked about her patient interactions. For Tricia, caring in this way comes naturally, and in return she felt like she had performed her role well. In the account Tricia shared, another patient witnessed how she cared for her older patient who was confused, and showed her appreciation and acknowledged this. I get the sense that although this patient bought her flowers, for Tricia, the validation came from someone recognising her effort and care, rather than the gift itself.

Taylor said she knows when she has really cared for someone because she feels like they have shared something together. She remembered a patient she cared for who she felt she had a strong relationship with.

> *"I was getting handover, and I recognised the names of one of the patients that I was about to take over. It was an elderly lady who had been in a few weeks earlier with a chest infection. I went in to see her,*

and she looked at me and smiled. I asked her if she remembered me and she said, 'Yeah, I do'. We chatted away throughout the shift, and I had remembered things she had told me last time, about her son. We ended up gaining quite a strong, therapeutic relationship. We were joking and laughing together. You don't get that very often. I think there are certain patients that you end up really caring for, and I knew she was one of them." (Taylor)

Taylor cared for this patient all day, and said she was fine. She was walking around, talking and laughing with Taylor. She got a bed in the unit next door and Taylor helped move her. Not long afterwards, Taylor overheard the charge nurse talking about a patient who had suddenly deteriorated. Taylor recognised with alarm that it was her patient that they were talking about.

"I dropped everything and ran over there. I felt so responsible. I kept wondering what was going on because she had been fine with me all day. I think the connection I had with this lady, made me care more. It made me care in a different way than I would for other patients. It made me worry. I worried about her as a person but also I kept thinking 'what have I done?'" (Taylor)

Taylor talked about how she felt she really cared for this patient and recognised that the connection she had with her was different to normal, it was special. She said the patient had shown no signs of being unwell while she was caring for her, but she *'dropped everything'* to go and find out what had happened. It suggests that if she had not had this bond with the patient, she would have more easily been able to rationalise the unexpected deterioration. Instead, Taylor felt responsible, as if it was her fault. She spoke of feeling vulnerable because she cared for this patient.

"There's a difference between really caring for a patient and carrying out cares. I can tell which patients I have really cared for, the ones I got emotionally invested in. I think that's okay. You're allowed to be vulnerable and feel emotions. Caring is a feeling that I don't think you can ever really explain as a nurse. I think every nurse has the ability to care, and it's where and who you use it with that is quite rare and only comes out once in a while. With time, you gain connection and you share part of yourself with them. You don't connect with everyone, but when you do, you've shared time and humour, and it's a two way street. You give a little bit of yourself to them, and they give a little of themselves back." (Taylor)

Taylor felt that she shared something special with this patient, saying she gave a little bit of herself, and the patient gave a little bit back. This story fosters the idea that in the nurse/patient relationship there is always subtle reciprocity.

John also talked about a time when a patient deteriorated during his shift and died, and how helpless he felt that he couldn't make things better for his patient.

> *"We couldn't get on top of her pain and it really affected me because I felt so sad for her. We were giving regular pain relief, but her pain was never really under control. I remember feeling so helpless, it was pretty upsetting. They decided to make her palliative, and there was a family meeting with some of the doctors right at the end of my shift. I stayed about an hour late to help the family. I talked to them, explained things and helped them understand" (John)*

In John's telling of this story, he considered what it was like to be this patient and how much he wanted to take away her pain for her. He shared that it was upsetting to him, to watch this patient suffer and know that although he had done everything he could, it was not enough to alleviate her pain. He also recognised that the family members who were witnessing her suffering, needed something from him too. John stayed behind after his shift, giving his own unpaid time to the patient's family, almost as an apology, 'I'm sorry I couldn't save her. I'm sorry I couldn't take away her pain.' In this situation, John felt that his responsibility extended beyond the patient care, he needed to show care to the family members too. He not only imagined what it was like to be the patient and tried to do everything he could to improve her experience, but he also thought about what it must be like to be the family, witnessing that, and he tried to improve their experience too. He gave part of himself to the patient that day, when he had nothing else to offer.

Similarly, Jessie told a story about a patient who was deteriorating throughout her shift. She had formed an attachment with the patient and his family, which led to her giving 'extra' care to them.

> *"I felt like I had a good rapport with them. Towards the end of my shift he got moved to a different area of the unit, so I was no longer his nurse, but the family kept finding me and asking 'are we checking for this, or that?' and 'what is happening?'. I already had a different patient load and I didn't really know what was happening for him which was hard." (Jessie)*

Even though he was moved to a different area in the unit, the family felt a bond with Jessie and they trusted her. They kept finding her and drawing her back into the situation, asking for her help. I hear that the rapport and the bond grew because of their sense of trust in Jessie. She felt responsible because they trusted her and needed her. The patient continued to deteriorate and died right before the end of her shift.

> *"His family didn't want anyone else to help care for him after he died,*
> *or transfer him to the mortuary, so I stayed. I went home at least two*
> *hours late that day." (Jessie)*

Jessie gave her own time out of her shift, to give to this patient's family. Instead of going home to her own family after her shift, she stayed late, unpaid, and helped them. There is a sense that Jessie felt they needed her, and she was motivated by this need and trust in a vulnerable moment. Jessie knew she couldn't bring their loved one back, or make it better, so she did the only thing she felt she could do was giving herself and her time in this situation.

The nurses expressed that when they cared for a patient in a way that felt noticeably different to everyday caring, they shared part of themselves and in turn, left the patient encounter feeling that they were now carrying the patient in their heart.

4.8   Carrying them in my heart

Many of the nurses talked about patients who they remember after having formed a bond with in some way, saying that they carry these patients in their hearts. They shared moments with these patients that shaped their practice and that have become part of who they are as nurses. They use these memories to guide them in their patient encounters, thinking 'this reminds me of that' and often when the nurse is caring for a deteriorating patient, they are often calling on the memories of the patients who have come before them who they are carrying in their heart.

Jessie recounted a situation with a man who died during her care. The family had a difficult relationship, and Jessie built a rapport with them.

> *"I often think of him and his family and how he held on for so long. I*
> *think about how they finally came together as a whole family,*
> *forgiving each other, right before he died. I think about him when I go*
> *near the room where he was, even years later. I'm reminded of him*
> *when I see another family dealing with a similar situation and they*

are so angry, and think 'oh, they just didn't realise this was going to be the end'." (Jessie)

Jessie revealed that even years later she still thinks of this man when she goes near the room where he died. The memory of this patient lingers. Jessie shared that she is often brought back to that memory by witnessing a patient's family dealing with a death. She remembers how it was with him and how his family hadn't realised he was so close to the end. She uses these memories as reminders of how these people may need to be cared for, and how they may need to be guided through this situation. When she experiences a patient's deterioration, in some way she is also re-experiencing this man's deterioration.

Ben described a similar feeling after he was involved in a deteriorating patients' care, saying he carried the patient with him that day.

"Sometimes I'm not sure how to deal with all my own emotions during these events. It made my day more challenging because that took two unscheduled hours, and I'm not saying that's a bad thing because that's my job, that's what I'm here for but it meant I went to commitments later that day without a break, and feeling depleted. I felt like I was in a constant flap. I carried it with me that day. I kept wondering how he was and if I had done the right thing." (Ben)

For Ben, even though this is an everyday part of his job, sometimes the emotions were close to the surface, and his mind drifted back to the patient throughout the day, not only at work, as the connection was always present. He questioned whether he gave good care or made the right decisions, and wondered how the patient was faring. Even as his day moved on to other engagements, he still felt the presence of the patient with him. Ben felt depleted, he missed his break because he was helping this patient, which suggests he needed time to rest and process what had happened, so he could go about his day. There was no time for this, instead, thoughts of the patient lingered.

Similarly, John talked about a patient whom he cared for at the end of her life and said, *"I generally have a terrible memory but I have never forgotten that lady so I think it affected me in some way."* John was aware that this was somehow different to other patient interactions, which suggests there was something that he learnt, or something noteworthy which he now carries with him. *"I still remember past patients and bring those memories with me to my interactions with new patients."* He has a perception

that he collects these remembrances and they build his knowledge and experience, and contribute to who he is as a nurse. These memories prompt him in the care of his new patients and remind him of how the situation may unfold, guiding his actions. Because of these past experiences, John had an awareness of how he could best care for his patients.

Nina spoke about a patient who deteriorated and died during her shift. It was quite a memorable situation, a traumatic death, and Nina felt she crossed a boundary in her caring.

> *"It's different to caring for somebody outside of work, because you don't have that emotional attachment for the most part. Occasionally you cross a boundary which you shouldn't have crossed, and that's how people become those patients that you carry with you forever. Like my GI[5] bleed lady, she's in my heart. There was just something about her, she's in my heart forever now. I know the other nurses who were working with me still remember her too, we talk about her sometimes." (Nina)*

As in John's case, Nina had an awareness that this was different from other patient interactions. She realised that by being involved and being a witness to this patient's deterioration, some part of that will stay with her, and become part of who she is as a nurse. She knew that if she cares for a patient presenting the same way in the future, she will look back and remember this woman. Nina has a clear sense that she now carries this patient in her heart.

> *"Whenever I think about leaving nursing, I think about her and that's what keeps me here. It was such a privilege to be able to care for her." (Nina)*

The memory of this woman, and the care that was given to her and her family, is linked to Nina's nursing identity now. When she thinks about leaving nursing, she remembers in her heart why nursing is so important to her.

4.9 Conclusion

Throughout the nurses' stories is a thread of being connected, which at its essence, is how the nurses make sense of caring for the deteriorating patient, well beyond clinical

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[5] Gastrointestinal

task engagement. When patients feel cared for, the nurses feel that they are doing their jobs well, and their identity as nurses is validated as well as their sense of self. In this chapter, nurses' stories were explored relating to seeing the person behind the label of patient, being more open to subtle signs of deterioration, shifting the connection to family members and also about carrying patients in their hearts. At times the nurses work on not being connected as a self-protective measure to stop themselves caring too much. These bonds or links with the patients are often long lasting and the memory or learning that comes from these episodes of deterioration, often stay with the nurse long after the patient has left their care. The nurses have a way of knowing that connecting with patients and their families often brings meaning to their work.

Chapter 5 - Being there as nurse

"When I realise a patient is sick, my first thought it that they need help and I'm the one to give it. If I don't get my act together then this patient is either going to deteriorate or they will die, and I don't want that on my conscience. I want to give the best care I can." Tricia

5.1   Introduction

This chapter present findings describing the nurses' experiences of being present with the patient in moments of deterioration. When the nurses are caring for a deteriorating patient, they know that there are certain things that are expected of them as a nurse, both professionally and personally. There is a responsibility to respond appropriately, which is clearly outlined in the competencies for expected practice by Nursing Council of New Zealand (2012). Additionally, a sense of accountability to be an advocate and ensure that the patient is getting the care that they need, as well as a duty to act professionally, even in the face of distressing events. When faced with a patient who is deteriorating, the nurse is already prepared with a clear feeling that they are the one who will help.

The nurses described moments when they were responding professionally to a deteriorating patient, yet simultaneously experiencing the situation in their own personal way too. At times the nurse has their own sense of distress, and a feeling that this must be hidden from the patient and their family, to protect them, as well as to be seen as a professional. The nurses shared that although they tried to hide their emotions from their patients, talking about difficult situations with their colleagues was beneficial, but was rarely done in a formal way.

In these circumstances, caring for deteriorating patients, the nurse is aware that they cannot do this alone. There is a feeling of being part of a team and drawing strength from their colleagues, bonding or forming a relationship. The nurses suggested that sometimes because of staffing levels or unit acuity it is difficult to find support. The nurses who were interviewed shared similar stories about caring for deteriorating patients, but all agreed that caring for patients in the Acute Assessment Unit (AAU) was different to other areas where they had worked previously.

5.2   Nursing is different here

The nurses said that working in the AAU is different to nursing in other areas. There are unique pressures and concerns that are not found to the same extent in other areas of the hospital because of the nature of the department. This is additionally complicated by the fact that patients admitted to the AAU are usually in the acute phase of their hospital journey, often unwell or unstable. Further to this, when the nurse is caring for a deteriorating patient, it is not uncommon for there to be more than one patient that they are concerned about at the same time. If the baseline workload is different to the wards, it stands to reason that when a patient deteriorates, this experience is different too.

In telling their stories, the nurses painted a picture of busy shifts where they were pulled in multiple directions by their different responsibilities. They described a flurry of movement and at times an overwhelming feeling of pressure to not only provide good care to their patients, but also to be a 'good AAU nurse', by ensuring patient flow through the unit was maintained. There was a sense that the nurses had a lack of control of how their shifts progressed, often working reactively, rather than being able to plan the care they gave. The nurses compared AAU to other wards where they have worked and said that in the wards, they may have had time at the beginning of the shift to plan their patient's care, or a higher ratio of stable patients. Interestingly, many of the nurses said that although they found working in AAU stressful and challenging, it was also enjoyable.

Jessie told a story about a shift in the Acute Assessment Unit that she found particularly challenging, yet at the same time she describes it as if it is an everyday occurrence.

> *"I remember one shift I had a turnover of 18 different patients. I had maybe half an hour for each patient, to do their full work up and bloods and as soon as I was finished it was like 'right, next patient'. We had ambulances waiting, and patients in the corridors. Each time there was patient movement to the ward, the patient was barely out of the bed space before another one was there taking their place. That can be frustrating. We get to see so many different kinds of patients and different presentations, you never know what's coming in next. We never keep the patients for long either. As soon as we stabilise them, they get moved to the ward or discharged. Everyday*

there is something different, so we don't really see the same thing over and over. It's interesting and fun but sometimes pretty challenging. Often I leave my shift feeling like I've forgotten something. It feels incomplete, which is hard for me because I've always liked having a shift plan and being able to tick things off. That's what we were taught as a student, you know? When I have a deteriorating patient that shift plan just goes right out the window. It makes me feel a bit helpless." (Jessie)

Jessie described that there were many patients in the department that day. She spoke of patients in corridors and ambulances waiting, and the beds barely being vacated before they were filled by another patient. This suggests that Jessie felt under pressure to move people quickly because she could see the backlog building. She knew it was part of her role to facilitate flow, yet it was also part of her role to provide good care to each patient who was assigned to her. She seemed to be torn between her responsibilities as a nurse to the patient, and her responsibility as an AAU nurse. She said it was if she was having to say *'right, next patient'* as soon as she had ticked off the necessary tasks for that patient, Jessie was only able to do the bare minimum. It makes me wonder if she was able to show care in these brief interactions when it seemed to be more about achieving tasks on a checklist? Jessie went on to say that she liked to plan out her care, as she was taught as a student, and liked to tick things off her list – but this situation, was different for her. She usually experienced a sense of satisfaction from achieving things for her patients, but when there were so many patients that it was only possible to do the bare minimum for each one, the satisfaction did not seem to be there. Jessie explained that when she had a deteriorating patient, her plan went *'right out the window',* as she was unable to provide planned care in this situation, instead she needed to work reactively. This means that when she went home at the end of a shift, she felt incomplete – without her shift planner she was unsure if she had accomplished what she needed to do for each patient in her care.

Ben appeared to experience working in AAU in a similar way to Jessie, and shared his thoughts about changing priorities and the difficulties of managing all the nursing tasks when a patient deteriorates in AAU.

"Patients in AAU when they deteriorate, they deteriorate more rapidly. When it's a patient in a general medical ward they already

have a fixed plan and we usually know what is going on with them and what might have led to that. We don't have that in AAU. They might deteriorate before a doctor has seen them. We also have new patients constantly coming in, so the patient load is not always stable. The patients are moving through the department all the time and we have multiple balls in the air that we are juggling, and it can be hard to manage that when someone suddenly deteriorates. You have to keep reprioritising. A priority can change in AAU for one patient in a very short space of time and you might have six patients at once whose needs are all changing, so you're constantly reorganising and reshuffling priorities." (Ben)

Ben, like Jessie, had difficulty juggling everything that needed to be done for all of the patients as well as managing a sudden deterioration. He seemed to view it differently to Jessie though, and said that it is about reprioritising. He shows an awareness that a nurse's priority for one particular patient can change quickly, and it might be that the priority is constantly changing for all of the patients that the nurse is caring for. Ben said that he was reorganising and reshuffling priorities all the time. As a senior nurse he has grown to be flexible, recognising that a shift plan is not something you can organise at the start of your shift in this setting and expect to be able to follow it. For Ben, as the patient situation evolved, so did his plan of care.

Ben also said that the patient may deteriorate before they have been seen by a doctor. He clearly felt an extra sense of responsibility for the patients before they were seen by a doctor. Once the doctor has seen the patient, there is an idea of a diagnosis, and an idea of the plan of care, but it is more than that; there is now a shared responsibility for that patient. Now the nurse knows that they are not the only one who has performed an assessment, they are no longer carrying the burden of responsibility alone and having to wonder things like 'Did I assess this patient appropriately? Did I take the right blood samples?' There was a reassurance that someone else was now watching out for this patient too.

Sally is relatively new to working in AAU and explained how this compared to her ward experience. Similarly to Ben and Jessie, she described how her nursing priorities shift and changed as the patients moved through the department.

"Before I came to AAU, I worked for around a year and a half on a general medical / general surgical ward. It's different in AAU. There are different priorities and it shows that nursing is not really straight

> *forward. On the ward it's a lot about maintaining a person's dignity and kind of trying to keep a routine for them, like keep their life going and encourage forward planning, whereas in AAU it's a lot of what is happening right now. We don't focus a lot on what is going to happen, it is very task orientated. It's about getting the bloods done, getting them up to x-ray, getting them here, getting them there. On the ward you look at the person more as a whole I think. The turnover in AAU is so fast. I had one shift where I easily had 30 people come through my cubicles. It was a really bad day. I got into this mode of 'do this, do that'. I don't think I remembered half of their names, it was horrible. I was referring to them by room numbers and 'that one'. You can't keep up. It's different in the ward because you have people stay for weeks. They stay so long that you get to know them and their families. You know how to approach them, whereas in AAU you have to be on your feet, on your guard a bit more because you're not quite sure about the person. They can present one way one minute, and then change so quickly." (Sally)*

Sally suggested that the overall priority in AAU is different to working on the ward. In AAU, she said, the focus is on right now and what is happening for the patient in the immediate future. This is compared to the ward where the focus is more on seeing the patient as a whole, and making sure they maintain their independence, and plan for the future. In AAU, it is not about what is going to happen, it is about getting through the tasks that need to be done for this patient. Nurses in AAU are often having to put aside what they have always been told is an important part of nursing – caring holistically and planning towards successful discharge, to work in a reactive way – responding only to what is needed right now. I get the sense from Sally that she could not relax into really caring for her patients, and that she kept her patients at an emotional distance, as she knew they may move at any time and a new patient would appear in their place with their own needs. AAU seems to be an 'in between place', where just enough care is given, not because the nurses don't want to care, but because that is all that can be managed in this environment.

Like Sally, John had recent experience working on a medical ward and agrees that AAU is very different.

> *"I find I'm able to be a lot more independent. With our standing orders[6] we can provide more immediate care for people than previously when I worked on the wards. It's definitely a lot quicker*

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[6] A prewritten medication order and specific instructions to administer the medication in clearly defined circumstances.

paced, you certainly have to have pretty good time management. It's often very sort of task focused at times when there are those really busy periods. It's quite difficult to be super forward thinking. You have to focus on getting the important things done, prioritising and then moving on. You don't get that time at the beginning of the shift to sit down and plan out what you are going to do for the day because the patient might be gone in two hours, either home or off to the ward."
(John)

John has reiterated that there was a quicker pace in AAU than elsewhere, and that time management was important. He says that the focus was on prioritising, getting tasks done and then moving on to the next thing that needed to be done. Interestingly he felt that in AAU he was able to be more independent. He said he could provide immediate care using standing orders. I perceive an awareness in John that he has grown during his time in AAU. He can now use his knowledge and assessment skills and provide a better experience for the patient by responding to their immediate needs without having to wait for a doctor's assessment. This tends to suggest that there was satisfaction for John in being able to make the patient feel better more quickly, and this was linked to his identity of being a good nurse.

Taylor described working in AAU in a similar way to John, confirming that nurses in the AAU work autonomously and need to think critically about their patients and what they are presenting with.

"Nurses in the acute area are quite autonomous and because we are the first interaction with the patients we often do a lot. There's a lot of independence and critical thinking. There is a high turnover and time management is definitely one of the key characteristics of being a nurse in the acute setting. We have most of our patients coming from GP referral, and the rest are referrals from ED. There's a good connection between the nurses and the doctors because you're working with them so closely, you work as colleagues. I think sometimes that is missing in other areas." (Taylor)

Taylor pointed out that in AAU the nurses and doctors worked closely together, which in her experience was different to working in other areas. Taylor described it as a good connection, suggesting she felt well supported by having the doctors present and available in the AAU so that the patients got the treatment they needed. This was particularly important to Taylor because of the high turnover of patients, and the need to shift her priorities to accommodate her workload.

Likewise, Rose explained how the focus on patient flow means she needed to shift her priorities frequently which made her nursing work more difficult when she was caring for a deteriorating patient.

> *"The focus on patient flow makes things really difficult in AAU when you are caring for a deteriorating patient. I don't think it's something we can help or change really. You tend to focus all your energies into the deteriorating patient, but you've got other patients coming in and going out, and there is pressure from the coordinator and duty manager to move patients or bring in more patients, and then suddenly you might have another patient who is deteriorating too. You have to divide your attention to make sure they are both safe as well as moving patients in and out of the department in a timely way." (Rose)*

Rose said she concentrated her energy on the patient who was deteriorating, but she was distracted constantly by new patients arriving, or pressure from management to move other patients out of the department. She felt that she was pulled away from what was most important, to focus on things that she knew were also worthy, but in this moment were of less priority to her. While she was grappling with this, Rose said she may suddenly have had another deteriorating patient to care for at the same time. Rose was torn between responsibilities. What sort of nurse would she be if she did not help her patients? But what would her seniors think if she did not help to maintain adequate patient flow? Rose's solution, she said, was to divide her attention and give a little bit to each priority, suggesting that in giving a little bit to everything that was taking her attention, she was 'doing enough', but perhaps was not performing as well as she would prefer.

Nina shared a story about having to prioritise her care for two deteriorating patients in AAU and ended up feeling like she had not done a good job for any of her patients that day.

> *"I've had lots of patients die, and I don't remember all of them. Two I remember in particular because they died at the same time! I didn't know what to do, it was the worst shift. I was quite busy going between the palliative patients, as well as trying to care for the rest of my patient load. I decided to go for a break because I felt like I might collapse. I had just started my bowl of cereal, when I heard the emergency bell go. Everyone was like 'who's patient is that?', and I looked up at the panel and I was like 'Oh shit! That's mine!' I had to run back to the room, but he had already died. It was so sad. The*

*family were there, and I told them to take their time with him and
that I would be back. I thought I would just check on my other dying
patient before I went back to finish my break and I went into his room
and he was dead. I was just like 'oh my god!' I went out and kind of
cry-laughed because that's just my luck. They were both expected
deaths, but it was still hard. I had to get our Charge Nurse, and I said
to her 'I can't do this, they've died together!' She was really good. She
stayed with me and rubbed my back while I had to ring the second
man's wife. I felt really bad after that shift, I felt like I hadn't given
them enough, but what can you do right? That's AAU."* (Nina)

There is the sense from Nina's story that she had to constantly prioritise her care during this shift and felt like no matter how much she gave to each of her patients, it wasn't enough. Because of the workload in AAU she was unable to give the care she wanted to give and physically incapable of being there with both patients and they died simultaneously. Nina said, *'That's AAU'*, as if this sort of situation was expected and unsurprising. It hints at her colleagues also being under pressure with a heavy workload so the care of the unwell patients could not be divided further. It suggests that Nina was not the only nurse dealing with deteriorating patients during that shift, and Nina seemed philosophical about it, saying 'that's just how it is here'.

Annie, like many of the other nurses interviewed, had a clear sense of what it was like to work in AAU and the position of AAU in the rest of the hospital. Annie's words also suggest that she believes 'that's just how it is here'.

*"Compared to the ward, AAU is just so different. Even when I
handover to the ward, I see it. When they have roster gaps they say
'no, we're not staffed, we can't take that patient', whereas
downstairs we are getting patients in corridors, overflowing the clinic
area and we can't say no. We have to take them, and they just keep
coming. We just have to deal with it. We don't have any protection in
that sense. I feel like my practice is at risk in these sorts of situations
and I can't do anything about it."* (Annie)

Annie said that in AAU there was no ability to decline to take a patient, they just kept arriving. The nurses did not have a choice to say, 'we are too busy' or 'we are short staffed', it was just something they knew they had to deal with. It suggests a feeling of helplessness amongst the nurses, and Annie even pointed out that she felt like her practice was at risk. Essentially, Annie was saying the workload and focus on patient flow meant she felt unsafe, but also felt that she had no power to be able to change it.

The nurses talked about being pulled in different directions, having to shift their priorities constantly, knowing that each patient, and management, needed something different from them suggesting that at times they were having to hide how they were feeling in order to meet the needs of that moment in time.

5.3   Putting on a mask

When the nurses were sharing moments with their patients, they seemed to be putting on their professional masks to be able to cope with their own feelings of distress. They told stories of situations where they had to pretend to be fine, when they wanted to go home or take time to process what they have experienced. At times the nurses felt they had put on a professional front when they experienced frustration or were overwhelmed and talked about how they had to just keep going.

Annie spoke about caring for a patient who deteriorated suddenly, and how she felt she had to hide her emotions from the patient and her colleagues.

> *"I was so shaky afterward, but I just had to get on with the job. I found that really hard actually, like I've just witnessed someone close to dying and now I have to go back to work and act like nothing happened and see the next ten patients who need to be seen. I actually just wanted to go home." (Annie)*

Annie felt that she had had a significant patient encounter, witnessing someone close to dying and then had to pretend nothing had happened. She said she needed to go and see the next ten patients that needed care and felt that she needed to pretend for them. If she followed how she was feeling, she would have gone straight home to process what she had seen, but she was stuck. She had to wear her professional mask and hide her feelings from her patients, because they needed something from her. She put aside her own needs, because her professional identity required that. It was her job to make the patients feel safe and cared for, and she could not do that if she showed on her face that she had just witnessed a patient close to death. She could not let the patients feel like they too may be close to death. This was not the only time when Annie felt that she had to put aside her own needs because of her responsibilities to her workload in AAU.

> *"Overall, it's great, and I do love the style of nursing but it's just that I feel unsafe a lot of the time in my practice. As I've progressed in the*

department I have become more senior, which is bizarre because I'm in my second year of nursing. It's so overwhelming with the pressures of getting patients to the ward, new admissions arriving and sometimes I feel like I am almost having to guess or take chances. It's like, I can't see this patient because I'm so busy with that one, but here comes a new one, and I need to go on a break because I haven't had a break for more than six hours." (Annie)

She said she felt like she needed a break, but she could not take one, because she was still needed on the ward. Annie was putting aside what she needed to give something to her patients, not because she necessarily wanted to be altruistic, but because that is what it meant to be a nurse in AAU.

Annie had worked in AAU for close to two years, and said she often felt unsafe in her practice. She needed to wear a facade of competence when she felt out of her depth. She spoke of being seen as more senior, even though she herself felt like a junior, suggesting that perhaps she was seen as more senior because she was so good at covering how she was feeling. Even when Annie felt out of her depth and like she was having to guess or take chances, she was able to hide this and behave 'like a nurse should'.

Annie also talked about the experience of watching her Grandpa die, and how it had taught her how to be a nurse around the family of a patient who is dying, and also gave her an awareness of the mask she wore in this situation.

"The experience of watching my Grandpa die from pneumonia definitely influences my practice, especially when I am caring for a deteriorating patient. I think the biggest thing it taught me was to acknowledge the family, and to acknowledge their role if they are present. Acknowledge that they love this person, and to show attentiveness and not appear too busy. It's one of the hardest things, to seem attentive when you can't really be." (Annie)

Annie has experienced being the family member watching the nurse hurry around completing tasks. She was keenly aware of how it felt to be sitting there and watching as if her family member was a task on a list. Annie said that she tried to seem attentive, even when she could not be. As she went into the patient's bedspace, she readied her mask, making sure the patient and family felt as if they had her time and

attention, even when Annie knew her mind may have been on other patients that had more pressing needs at the time.

In a similar vein, Tricia spoke about the feeling of being with one patient while thinking about the needs of other patients. She told a story about caring for a deteriorating patient in one room, with a patient being held down by the police in the next room. She spoke about the difficulty of switching between the emotions in each room, concealing her own feelings and hiding what was happening elsewhere in the department.

> *"Sometimes it's just a tough shift. Not just from a physical task orientated perspective, but from an emotional perspective. Some nights you just get hammered with patients, and some of those patients are verbally or physically aggressive even though they're not very sick, and that can take its toll on you. Sometimes it's hard to emotionally switch between being really angry because you've just come out of a room where the patient is being verbally aggressive, and they've got the police or security basically sat on top of them, to a room where the patient is deteriorating and not complaining. You have to switch all your emotions within a 12-hour period, changing every few minutes. It's hard sometimes, especially if you're tired and you've got stuff going on in your own life. It does get to you." (Tricia)*

Tricia felt protective of the sicker patients, as if she felt that they had more of a right to being there, as well as more of a right to good care, than a patient who was being verbally aggressive. She said she had to switch her emotions every few minutes, depending on which patient she was with. With the deteriorating patient who was not complaining, Tricia took care to hide how the aggressive patient in the other room made her feel, instead focusing on what this patient needed from her.

The nurses spoke of having to shift or hide their emotions from their patients, in order to remain professional and complete their work because it was their role as a nurse. The same can also be said when nurses were witnessing their patients suffer, there was a feeling that they could not always show their emotions, or fix the situation, instead, they were a bystander.

5.4 Being a witness

The nurses, in their everyday work in AAU, observe scenes of human suffering, loss and pain. It is not just the patient experiencing this moment, the nurse is also there

alongside the patient, having their own experience of the same moment. Sometimes there is a sense of disbelief at what they have just witnessed, a feeling like life should stop and pay its respects to this moment, to this occurrence. At times, there is also an awareness of privilege, feeling a sense of honour to be allowed to observe this special moment. The nurses talked about the lack of space created for them to deal with these situations, and how they were often expected to get back to work straight away. For some nurses, the interviews were the first time they had opened up and admitted or realised that what they had seen had affected them.

The nurses were being a witness, not just to awful things, but to love and tender moments. In these moments, nurses gained some further understanding of what it means to be a daughter, a father, a sister. The nurses viewed moments of generosity of spirit, for instance when a patient has died, yet the family take the time to say thank you for what the nurse has done.

Ben shared a story about a woman who was dying, and the special moment he was able to share with the patient and her family.

> *"I can still remember the doctor having the conversation with her family about all the things we could try and do. I was right next to her, holding her hand. She turned to me and said 'I just want to go to sleep, I don't want any heroics'. I knew I needed to stand up for her in that moment. She had accepted that she was deteriorating, and she had accepted that enough was enough. She just wanted it over. I stepped out of the room and told the doctor and the family, 'She's just told me that's enough, she doesn't want any more heroics'. Her sister was there as her next of kin, and she just said, 'Okay then, well that's it'. I think the family had already resigned themselves to what was going to happen, but no one wanted to be the one to say it. She passed away shortly after this conversation. The reason I think she stays with me is that by having this conversation we turned the page from thinking about how to keep fighting, to thinking about how we could make this good for her. She ended up passing away with her daughter holding one hand, her granddaughter holding the other, and her sister stroking her forehead. That image stays with me."*
> *(Ben)*

Ben was actively involved in this situation, he was there alongside the patient, and helped her through a difficult time. He was her voice when she needed it and an onlooker during a significant moment for this woman and her family, witnessing a special and tender moment. Not only was he present when the woman divulged that

she had had enough, but he was also observed the family accepting her decision. Finally, he was also a witness when she died, surrounded by her family.

For the nurses, there were profound moments of being reminded of the fragility of human life and a sense of wonder at what was unfolding in front of them. Ben spoke of the image of his patient being surrounded by love staying with him. Jessie too, shared how she felt when she was caring for a man who deteriorated and died.

> *"I was trying to explain things to her [the daughter] as best I could, and a few minutes later the emergency bell went, and he passed away. It was so strange, seeing him alive and then a few minutes later, dead… and life just kept going, you know?" (Jessie)*

Jessie had a sense of disbelief that one minute this patient was alive and she was part of trying to help maintain his life, and the next minute, he ceased to be. She said, *'life just kept going'*, as if she was suddenly aware that outsider's lives and thoughts were not revolving around this patient, as the family and hers were. An awareness of a patient being there, and then suddenly not being there, is a harsh reminder of mortality for a nurse, often leaving them thinking, 'This will be me one day. This will be my loved ones one day'. There is a profound return to one's own self-awareness of mortality – and the everyday-ness of death, the fact it happened so easily, so naturally, is sometimes shocking for nurses to experience. The circle of people who are shocked and upset by this death is relatively small but can include families and nurses alike. For others, it can be that life just goes on, and it doesn't seem right. In the midst of the busy AAU, this juxtaposition is hard to understand and process, especially as the nurses must carry on caring for their next high priority patient.

Rose also discussed a time when she witnessed a patient's deterioration and needed to hide the shock that she felt. Rose's patient was admitted due to suffering a miscarriage and during Rose's shift, her patient's condition worsened.

> *"She was okay, like her blood pressure was good and everything, but she just didn't look right. She was young, and really pale, sweaty and her eyes were funny, like she wasn't quite there. You were talking to her but she wasn't really there. It made me quite worried. I went and got some fluids and talked to the doctor. When I came back, she was suddenly looking kind of blueish and I knew she needed help right away. We rushed her to Resus. Everything was done right in front of us. The gynae doctors came and they had to manually remove what*

> *was left of the foetus. She was going into shock. I was fine during the situation but afterwards I was really shaking and I had to tell myself to calm down." (Rose)*

The language Rose used here is important. She said, *"Everything was done right in front of us"*. This speaks of a sense of disbelief that she was present for this moment, that she was even 'allowed' to be there for it. This was a monumental but very private moment for the patient, and Rose was alongside her, watching the occurrence unfold in front of her. This patient's story, now becomes part of Rose's story. She is changed because of being there and sharing this experience with the patient. Rose said *"I was fine during the situation but afterwards I was really shaking and had to tell myself to calm down."* There is a lag to starting to process what she had seen. Rose needed to remain professional and not let on to the patient that she was shaken by what she had observed, until she had some personal space to start to process the situation.

Tricia, like Rose, witnessed a horrific scene which left her shaken. It was the little details that Tricia remembered about this situation, what she saw was etched in her mind. She shared a story about helping with a young woman's resuscitation.

> *"I can still picture her. She was a tiny little thing, just sat there rubbing her knee. She had presented with pain in her knee, but she was known to oncology. The department was full that night, and she had sat out the front waiting for a bed for about 45 minutes. They were getting her into a bed, when I happened to hear my colleague call for a code because she was so hypotensive. I went in to help, and in between getting her into her bed and into a gown, she crashed, and she died. She was just so young. I can still picture her, sat out the front, rubbing her knee, and then as soon as she got on the bed, bang. How weird was that? The team was amazing. The anaesthetist came and took control and there were so many people in the room because she was so young. Everyone played their part. It was so calm and quiet. No one was shouting. It was all controlled. It was like something really surreal was happening. She was just so unbelievably sick. When we took blood samples off her tunnelled line[7], her blood was black. It was the quietest, most controlled crash I've ever experienced." (Tricia).*

Tricia had a profound memory of her visual observations, the patient rubbing her knee, her 'black' blood. She also remembered what the feeling in the room was like. Tricia

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[7] A tunnelled central line is a thin tube that is placed in a vein for long term use.

described the feeling in the room as being calm, quiet, controlled, as if it was an everyday occurrence, though the situation she talked about was out of the ordinary. It suggests that everyone in the room was sharing the same feeling of disbelief, a reverence at such a young life ebbing away before them. Tricia remembers little details: she was so young, so tiny, so sick. She was sitting in the waiting room, just rubbing her knee but looking well, right before she died. Tricia revealed that although the situation was calm, it was upsetting.

> *"It was horrendous but kind of good at the same time, in terms of how the team worked together and how hard we tried for her. But it was bizarre. The whole scenario was bizarre. It was amazing to be part of it but I felt upset afterwards. It stayed with me for quite a while." (Tricia)*

Tricia talked of experiencing the bizarreness of what happened, suggesting that AAU nurses are not used to young patients dying in this manner. It was a shock, but even while the scene was unfolding in front of her, Tricia acknowledged that the team work was amazing, everyone was working together to try and save this young woman. There seemed to be a sense that no one had to face it alone, and everyone was hoping for the same outcome. For Tricia, as nurse, it was a comfort to be part of the team and experience this resuscitation alongside her colleagues. Although she witnessed something horrific, it was made easier by feeling part of the team, and feeling the support they offered by sharing this experience. Formal debriefing is not always offered to nurses, however, at times the nurses shared how they felt when they had been given space to talk about their experience with other staff members.

5.5   Talking about it

The nurses shared stories about times when they had cared for a deteriorating patient and it had affected them emotionally. Several nurses admitted during the interviews that they had not ever shared their feelings about a particular patient story with anyone, and others spoke of times when they had been able to open up and share their thoughts at feelings.

Annie shared a story about a patient who unexpectedly deteriorated and Annie had felt shocked and guilty as if it had been her fault.

*"I debriefed with one of the other nurses involved afterwards who
had been quite hands on during the code. I was telling them, 'I feel
like the worst person ever' and telling them how paralysed I felt in
that situation. They were saying, 'oh it's fine, it's your first code, it will
be okay next time'. I just hadn't known what to do. Reflecting on it, I
was really glad to have experienced it, not for the patient, but for me
in that environment around supportive people, who picked up the
pieces when I felt like I dropped the ball. When I went home, I called
my brother. He's a nurse too. I called him and talked to him about
what happened. It was good to have that debrief. I actually talked
about it and debriefed with a few different people. I think I was just
so shocked about what had happened and what I was exposed to. I
like talking about it actually, I'm not an internaliser." (Annie)*

Annie's anecdote highlighted that in many cases, the nurses wanted to have an
opportunity to talk about what they had seen and experienced. Annie said she doesn't
usually keep her feelings inside, demonstrating that she felt a need to discuss things to
help her process their meaning. She said that she talked about the situation with
several different people but was not offered a formal debriefing session. Through her
reflection with colleagues and her brother, she found that she was able to appreciate
the experience she gained in this situation.

Similarly, Nina talked about a patient who died unexpectedly during her shift, and how
upset she felt afterwards. Like Annie, there was no formal debriefing but she did
discuss her thoughts and feelings with several colleagues.

*"I didn't have any formal debriefing, but I have talked to a lot of
people about this situation and everyone has said the same thing,
charge nurses, doctors, ICU doctors, everyone. They have all said that
there was nothing else I could have done. Even if he had stayed in ED,
it wouldn't have changed what happened. It's nice to have that
reassurance but I still feel like shit about it." (Nina)*

Talking about this patient's death helped Nina to feel reassured that it was not her
fault that the patient died, and helped her to logically process what had actually
happened, understanding that because of his comorbidities and how unwell he was,
the outcome was likely to be unchanged no matter what action she had taken. Despite
this, Nina says she still felt awful about the situation. It makes me wonder if a formal
debriefing would have been able to deal more specifically with how she was feeling,
and may have helped support her as she processed her emotions around what she saw
and experienced.

Sally too, talked about a traumatic situation with a deteriorating patient, which left the unit nurses feeling shocked. Unlike Annie and Nina, in this situation the nurses were offered formal debriefing. Sally talked about how much it helped her process it.

> *"A few days ago, we had a young patient who passed away. There are often people dying, but when it's somebody so young and somebody who is usually well, it's really traumatic. It's shocking. It wasn't my patient, but I was able to appreciate the way the debrief was run. Everyone had a chance to voice their take on the situation, and then they took the time to really talk to the nurses who were directly involved. The charge nurse really validated the shock of it and their feelings. He's been around for more than 30 years, but he was saying 'oh my god, I've never seen something like this'. That validates that we are not over-reacting, that this is crazy and tense. That goes a long way towards processing it. I don't think you become immune to it. There are some nurses who have been around for years who say 'nope, you never get used to it'." (Sally)*

Sally had a different experience to Annie because there was a formal debrief held in the unit, which was run by one of the charge nurses. She talked about how it validated the nurse's feelings of shock and helped them understand that it was okay to feel upset, and that even nurses with many years of experience were shocked and upset too. Sally said that *'it goes a long way towards processing it'*, reiterating the reassurance it gave to the nurses who were involved in caring for the patient who passed away.

The stories the nurses shared about being able to talk about the traumatic experience they had encountered, highlighted the importance of nurses knowing that they are not alone in their thoughts and feelings, that their colleagues are likely feeling it too. When a team debriefing was held, it seemed to be of the most benefit to the nurses, because they felt supported and listened to, and like they were part of the team.

5.6 Being part of something

The nurses shared about times when they felt that they were part of a team or partnership, and gained a sense of belonging and a sense of identity that came from this. At times it was related to being a nurse in AAU, at other times there was a strong feeling of working in partnership with the doctors. In some cases, the feeling of belonging came from experiencing a situation together with a patient or their family.

Tricia remembered a situation that where she felt profoundly moved by the experience of being involved with the whānau as a patient was taken home to die. Although she was an outsider in this situation, she felt like she shared the experience with the patient's family and the ambulance drivers. She was profoundly moved by being involved in this situation with them.

> *"The family was lovely. There were road works happening on the way to her house so instead of a 20 minute journey, it took an hour. She Cheyne-Stoked[8] all the way. I was thinking 'Please don't die. What do I do if she dies in the ambulance? What do I do then?' I'm not from New Zealand so I didn't know what would happen if she died on the way. The daughter was okay, she knew what to do. The daughter just talked to me all the way home, just a normal conversation. I've come all the way from the other side of the world, and this is just so different. We got her home and got her into the bedroom and the family had invited lots more of their whānau to come, so they were arriving too. We were about to transfer her from the trolley to the bed, when the woman's little white dog jumped up on the bed. The dog put his two front paws across the woman and put his head down between its paws, as if he was praying. Everyone went really quiet, and I couldn't speak. The ambulance men were choked up too, and I don't think any of us spoke until we got back on the motorway heading back to the hospital. It was quite a traumatic experience, in a way. As a nurse, this is not a regular event, thank goodness, but even so to experience that and to be part of that woman's journey was amazing. It was something that will stay with me." (Tricia)*

For Tricia, this feeling of belonging and sharing in the experience was enhanced by a realisation of how different this was to anything she had experienced before. Tricia was humbled to experience something unique, and something that was personal to the family, yet they welcomed her being there. She felt nervous that the patient may die on the journey home but she was reassured by the daughter being there and knowing what to do. It suggests that in this situation, Tricia was taken out of her comfort zone of her identity as being a hospital nurse and instead was experiencing a feeling of being unsure and uncomfortable, while at the same time feeling a sense of privilege that she was able to experience this with the patient and her family, knowing that nurses do not usually get to do this. Tricia felt that she was part of something special and unique.

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[8] Irregular breathing which is often present at the end of life

Unlike Tricia who felt like she was part of something by sharing an experience with a patient and their family, Taylor talked about a sense of belonging and being part of the AAU team.

> *"It's always helpful knowing that you are well supported, even if you are not getting actual help. I like to communicate with my colleagues, the charge nurse and the doctors, updating them on what I've done, what I'm doing and what is happening. Sometimes I feel like there is so much responsibility, I need to verbalise what I'm feeling or doing. It's a sense of reassurance. I think in the acute setting, nurses' kind of thrive off caring for deteriorating patients. I'm quite happy to do it as long as I know that people are aware of what's going on. I'd hate to be busy as anything and people not acknowledge it or ask, 'are you alright?' or 'do you need a hand?'. When the unit is really busy, everyone is in that head down mode, and it almost turns into a delirium. We are just in life preservation mode. You're only able to do what absolutely needs to be done. There's this euphoric feel and we laugh, 'ha-ha, another day in winter'. If I'm working with colleagues that I get along with then I know that even if my shift is going to be shit, it's still going to be a fun day because I will be able to cry with them, yell with them, ask questions and know we will all support each other. It's great having all the doctors in the unit. I think it's a confidence thing, being able to ask them questions about what to assess for or say 'hey, I'm really worried about this patient, can you see them next?' It's something I pride myself on, knowing the doctors and talking to them. It's a good way to learn and it's nice to be able to walk into work and say hi and know that you can trust them and that they trust you." (Taylor)*

Taylor spoke of a sense of closeness and alliance with her colleagues, and a feeling that the support and friendship she got from these relationships was pivotal in helping her cope with the workload in AAU. She described a sense of euphoria when the unit was so busy and laughing with her colleagues as a way of dealing with the feeling of being overwhelmed. She also spoke of the importance of having a close, trusting relationships with the doctors and how helpful it was to be able to get help for patients who needed it.

Rose, in accord with Taylor's experience, described that having a good relationship with the medical team and being able to work as partners was so important when caring for a deteriorating patient.

> *"I had a patient come in with symptoms of a urinary tract infection and a background of intravenous drug use. She started to deteriorate*

during my shift. She was febrile, and her blood pressure was dropping, her heart rate was going up. They thought she might be septic but with her history of drug use they were also considering endocarditis and things like that. We started the treatment really fast. The registrar gave us verbal orders, so we could get things ready by the time he had charted it, like antibiotics and fluid. I was able to anticipate things that would need to be done and also make recommendations, like 'let's put in an IDC[9] so we can keep an eye on her urine output'. It was great having those good conversations with the registrar because everything that needed to be done, we were able to prepare quickly and get them started, rather than waiting for him to write up the plan. It was like an evolving plan, and it felt like more of a partnership with the doctor. It was great teamwork, not just from me and the doctor, but other people who were helping too, like colleagues saying, 'I can see you're busy, can I help you with anything?"

For many of the nurses, a feeling of being part of the team and not feeling alone with the overwhelming workload in AAU was very important and helped them cope with the demands of the unit. When patients were deteriorating, it was helpful to the nurses to find support and be able to ask for help, as well as feeling like there was mutual trust with the doctors as they worked together to care for deteriorating patients.

5.7   Finding strength in numbers

Several nurses spoke about their concerns regarding the staffing levels in AAU and how there often was not enough staff members for the nurses to feel they could give safe and adequate care. The ratio of nurses to patients was deemed to be safe by management, however the nurses felt that the ratios were skewed by acuity and this was not accounted for. When patients deteriorate in AAU, there was no capacity for nurses to hand some of their workload to a colleague, because their colleagues were caring for patients who were similarly unwell. Overwhelmingly, the nurses agreed that having a higher ratio of nurses to patients would improve the care that was given to deteriorating patients.

Sally explained the staffing ratios and how unsafe she felt when the unit was short staffed.

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[9] Indwelling catheter

"Sometimes staffing is just at the line where safe is deemed, like just safe. You're not necessarily comfortable, you're still run off your feet and you're still freaking out, but it's safe because the numbers are there. They look at the overall ratio and say that technically every nurse is getting four patients. No, I'm getting six. One nurse is getting two because she's in monitored. It's not the same. I'm still having to do all this work, but the staffing roster percentages come out to 'it's safe'. So that's not helpful, and you can't convince management otherwise." (Sally)

Sally expressed frustration that the nurse to patient ratio was technically safe according to management, but in practice reality, it did not feel safe at all. She described being run off her feet, feeling unsafe and not being able to get help because according to the rules the staffing levels were considered safe. Annie agreed with Sally and shared how she often felt unsafe at work because of the staffing levels.

"The staffing issue hasn't changed since I started, in fact I think it's even getting worse at the moment. That is a constant pressure that I wish I didn't have to face at work I can't remember the last time I turned up to a shift and we were actually staffed appropriately. There are always sick calls that aren't covered. It's meant to be a one to five ratio, but it's often one to seven or eight, and it's just so unsafe." (Annie)

Annie agreed with Sally that the staffing ratios were not safe, and described it as a constant pressure, with nurses having to take a higher ratio of patients because of sick calls not being covered, or because of staffing issues in the unit. Overwhelmingly throughout the interviews, the nurses agreed that they often felt unsafe in their practice because of the staffing levels, and frequently felt that they were unable to give the care that patients needed because of it.

5.8 Conclusion

This chapter has outlined the findings from the research describing the nurses' experiences of being present with the patient in moments of deterioration. The stories have highlighted how the nurses are present with their patients in a professional and personal capacity, and how being a nurse in an Acute Assessment Unit is different to working on other wards. The nurses shared their experiences of witnessing significant moments in their patient's lives, and also how being part of a team and talking about what they had thought and felt was helpful to them. The subsequent chapter follows

on from these ideas, exploring what it was like for the nurses to be present with a patient as they deteriorated.

Chapter 6 - Being with

"When you have got something happening right in front of you with a deteriorating patient, other things kind of fade to the background and in the middle of doing something you might remember, 'oh, I need to do this for my other patient, can someone help me?'" (Rose)

6.1   Introduction

Being present with a patient as they deteriorate can be a profound experience for a nurse as they navigate their thoughts and feelings around the situation, often leading the nurses to question their own nursing skills and knowledge. The nurse and the patient are often already engaged in a nurse/patient relationship, relating to each other in their own roles as the clinical deterioration occurs. When the nurse realises the patient is deteriorating, there is a shift in that nurses' thinking. The clinical change in the patient seems to ignite a reciprocal change in the nurse, as they move from being with the person in a caring role to a being with them in a responder role, now concentrating on managing or correcting the patient's deterioration. For some nurses this leads them back to protocols and procedures to guide their response and management, while other nurses are fearful and worry that they have missed something which they may have caused or worsened. The nurse seems to pay closer attention when it is apparent that the patient is deteriorating, enabling the nurse to tune in to more subtle signs or symptoms and take note of things they may not have detected before. Most often, the nurse feels a sense of professional responsibility to help the patient but sometimes finds that asking for help from their colleagues or the doctors is not easy.

For most of the nurses the signs of clinical deterioration were clearly identifiable. At other times there were no objective signs but despite this the nurses said they 'just knew' that something was not right with their patient. The nurses frequently seemed to be guided by feelings of intuition about their patient's clinical condition, at times even being able to rationalise signs of deterioration, saying their patient was 'fine'. The stories suggested that recognising clinical deterioration was complex, and the nurses relied on their own feelings, judgement and knowledge to interpret signs of deterioration. Several nurses also spoke of a sense of being stuck between the

deteriorating patient and other responsibilities such as the rest of their workload, or cultural considerations.

The stories that follow delve into such moments with deteriorating patients, where the nurse is recognising the deterioration, asking for help, feeling stuck or rationalising the symptoms, while having a sense of the importance of being present in the moment alongside the patient.

6.2   Recognising the change

In sharing their stories, the nurses indicated that in the Acute Assessment Unit, they are 'always' preparing themselves to care for a deteriorating patient. They don't know who will come through the door and be assigned to them to care for, but the nurses anticipate the fast turnover and that their priorities are likely to change throughout their shift. The nurses have learnt from their training, work education and experience how to recognise a deteriorating patient, and what clinical signs point to a patient being unwell.

By being present with a patient, the nurse is able to utilise their senses, assessment skills and underlying knowledge, enabling them to recognise when a patient's condition changes and what this could mean in the patient's clinical context. Being engaged with the patient enables the nurse to see the full picture and may explain why sometimes the nurse is more concerned than their colleagues who are more removed from the situation, as Lily described in the story that follows. She shared her thoughts about helping a junior colleague manage their patient who was deteriorating.

> *"The senior nurse had previously told her not to call a code because the rhythm was okay. I'm not cardiac trained, and neither was the nurse that I was helping, but we could both see that this patient was not okay. I pushed the emergency bell and went out to call a code. While I was walking out, the bell got turned off, so I turned around and went back in… At that time, they were still trying to get a set of obs[10] and the saturations were like 86%, 87%, and I was like 'that's a true reading. That is exactly what we are seeing.' And I put the emergency bell back on." (Lily)*

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[10] Observations or vital signs

Lily was firm in her knowledge that the patient's clinical observations were matching their physical presentation, and although she was not the most senior nurse in the room, her past experience and knowledge spoke to her and she was clear in her thinking that this patient needed more help than the nurses alone could give him. The senior nurse appeared less worried about the patient, because she was focused on the cardiac rhythm, however Lily was fully present, seeing the whole patient and recognised that despite the cardiac rhythm, this patient was still deteriorating. Lily spoke with authority, suggesting a sense of knowing in herself that she trusted implicitly. In this situation she decided to override a senior colleague's decision not to call for help, because to Lily it was obvious that this patient was very unwell and her trust in her own knowledge and experience is not swayed by other's opinions. She was able to justify her concerns by saying that the patient's observations backed up the patient's clinical presentation. This trust in her own knowledge was further illustrated in a different story she told.

> *"It was a patient with an exacerbation of COPD[11], who was using all of his accessory muscles to breathe, and the Registrar was just standing there. So, I pushed the button, right in front of her and she was like 'what are you doing?', and I was like 'his respirations are nearly 50! He needs a plan!'" (Lily)*

Again, Lily felt that the patient was clearly deteriorating. She pointed out the clinical signs that made this obvious and seemed to feel that the situation had gone too far and was concerned about the patient getting adequate help. There was a Registrar attending the patient but Lily said she *'was just standing there'*. It is clear that Lily was frustrated in this situation. She felt that things were not moving fast enough, and the patient needed help immediately. If the Registrar was engaged with the patient, assessing and formulating a plan, or even recognising the deterioration, it was not obvious to Lily. Lily knew this patient needed immediate help. She seemed to be drawing on past experience, letting her nursing judgement be guided by these experiences.

In a similar vein, John told a story about using his nursing judgement to determine from the clinical signs before him that his patient was deteriorating. John returned

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[11] Chronic Obstructive Pulmonary Disease

from his break to discover four new patients had been allocated to him to care for. John had no handover for these patients, but he knew that they were now his responsibility.

> *"I was working yesterday, and I got back from my lunch break to find four new patients in my rooms. I knew they were my patients because we are allocated specific spaces at the beginning of our shift. It's not unusual to find that many new patients. I think I had a turnover of about 15 patients in my shift. I quickly walked through the rooms to do a brief visual assessment. One of the new patients didn't look well at all. She was pale, sweaty and covered in vomit. I quickly checked her blood pressure and obs, and her GCS[12] was sitting around 13 or 14 but fluctuating. She was very drowsy, and her blood pressure was low. I knew straight away she was seriously unwell". (John)*

John was aware that there were four new patients that he needed to care for, and with this awareness came a perception of a growing list of tasks that would now need to be done. He was unsure where to start, but knew that because they had just arrived in the hospital, the new patients were likely to be acutely unwell. He was already expecting that they may be deteriorating, and so when he introduced himself to each patient he performed a quick assessment of all four, and was not surprised to discover that one of them was clearly unwell. John says, *'I knew straight away'*. There was no uncertainty, John knew in that moment that this patient was now his priority, and the list of tasks would need to wait. It seemed that John had noticed that this patient was unwell from the moment he was in the room with her by observing distinct clinical signs that the patient was deteriorating, showing knowledge and understanding that these signs meant she needed help. Although he identified the patient's deterioration by being in the bed space with the patient, his further assessments backed this up objectively.

Annie had a similar experience to John where she was quickly able to detect a patient's deterioration by being present with the patient. She shared a story where she had just taken over the care of an older woman who had been admitted for bilateral lower lobe pneumonia.

> *"When I came onto my shift, I found her naked in the bathroom. The nurse who was giving the handover didn't realise she was in there, so*

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[12] Glasgow Coma Scale

when we did the bedside handover we were like 'oh my gosh!',
neither of us were expecting that. I knew straight away that she
wasn't well, and I could tell that she was delirious. I got her back to
bed and started monitoring her. Her breathing was deteriorating. Her
respiration rate was increasing but her saturations were decreasing,
and she was using accessory muscles. She was a standard picture of
pneumonia, not doing too well."

Like John, Annie also said, *'I knew straight away that she wasn't well'*. On the one hand, Annie said the patient was a standard picture of pneumonia, but on the other hand she recognised that something was different this time – the patient was not doing well. There was something unusual about this patient's presentation that Annie had detected as she stood in the bathroom with her. Annie quickly listed all the clinical signs that revealed that her patient was more unwell than expected, like that she was delirious and using accessory muscles to breathe. Like Lily and John, Annie too, seemed to call on her knowledge and past experiences which helped her to notice the clinical signs of deterioration, and identify that they were significant in this patient's context of pneumonia. A nurse caring for a patient with pneumonia expects some abnormal vital signs in an acute presentation, but these clinical signs in this patient indicated to Annie that this was more than the usual signs of pneumonia. This patient was deteriorating.

Although these stories shared moments of recognising deterioration from clear clinical signs, the nurses also shared stories of times when there were no such signs, instead they described an intuitive feeling while being with the patient which informed them something was not right.

6.3 Knowing something is not right

While the nurses are trained to detect signs of deterioration and respond accordingly, at times the nurses were caring for patients who were not showing clinical signs of deterioration, and instead the nurses identified a feeling that 'something' was not right. The nurses revealed that it was often hard to articulate what it was about the patient that they were worried about, but they *'just knew'*. Several nurses suggested that their past experiences were what builds their sense of intuition and knowing, although some nurses seemed to be more attuned to this way of thinking than others.

The stories that follow describe moments when the nurses were guided by their instinct in the recognition and care of deteriorating patients.

Many of the nurses frequently used the word 'something', to convey a quality that they had picked up on, which made them suspect their patient was deteriorating, saying "something is not right". The Collins English dictionary defines 'something' as a thing that is specified or unknown (*Something*, 2019). The language the nurses use suggest this quality – they don't have the words to articulate this feeling, it cannot be specified or expressed further than this.

Ben shared a story about a time he was helping a junior nurse with a deteriorating patient, and he started to wonder if the patient was more unwell than was first thought. As he stood in the room with the patient, Ben realised *'something is not right'*.

> *"The junior nurse asked me why I looked like I was starting to panic. I guess I was actually. I think it was subtle signs that I was picking up that made me think 'hang on, something's not right here'. What I was seeing in the patient did not match up with the vital signs. On paper she looked fine, but in person there was just something not right. It was hard to articulate to the doctors and to that junior nurse. It was hard to put into words, but it was a combination of the physiological changes, the assessment and asking the patient how she was feeling. I think I was drawing on subconscious past experience too, things that I'd seen in the past that perhaps the junior nurse hadn't." (Ben)*

He said *'on paper she looked fine, but in person there was just something not right'*. If someone had described this patient to Ben, he would not have identified that she was deteriorating, however, in being with the patient, Ben saw or felt something that worried him. He had a feeling that something wasn't right, and he was reminded of situations he had been in before. This subtlety was too difficult to articulate to someone else because his colleagues were not drawing on the same memories and knowledge. Ben tried to explain what he was sensing to the junior nurse, but he did not have the words, or perhaps did not want to say 'it's a feeling I have', since he didn't have any proof to back it up because *'on paper she looked fine.'* Ben was right though, this patient was much more unwell that she seemed on the surface.

> *"I remember feeling terrified. The junior nurse thought I looked panicked but that was nothing compared to how I was feeling on the*

inside. I just kept thinking 'shit, shit, shit, shit'. I kept worrying that we had missed something. I realised that this patient was far more unwell than we had initially thought, and I knew we needed help… I knew there was no room to wriggle, they needed to see her now. We got her reviewed urgently, and half an hour after I first set eyes on her she was in theatre with a ruptured appendix." (Ben)

Ben seemed to carry past patients with him in his nursing practice, calling on these memories and trusting the intuition that comes with that experience. Even though Ben may not have more authority than a doctor, he may have more experience in seeing this particular presentation, so trusting his instinct was vital. The nurse may feel that the patient needs help, but in describing the patient to a colleague or other clinician, it seems they are not always able to convey their concern clearly, especially if objective or empirical signs do not paint the same picture that the nurse obtains by being with the patient in the moment.

Jessie also discussed how she often had a feeling about a patient and agreed with Ben that it can be hard to articulate to others. Jessie named her feeling as a *'gut instinct'*, a sense that something was not right. She said that at times she became aware that she was being drawn to a particular patient and she was not sure why, and it was only later that she realised there was a reason.

"I don't think it's always a conscious thing and I don't know if I always recognise it as a sign, but I feel that gut instinct quite often when a patient is unwell. I think I've always had this instinct, but I trust it now. I know to listen. When a nurse tells me in handover 'I think something's going on here', then I take notice. Often, I find myself drawn to a particular patient. I keep finding myself back in their room, or it seems to be hard to leave them, and then it becomes clear that there was a reason. I had sensed something. It can be a really helpful thing; I feel like it helps me be prepared and think ahead to what might need to be done. I've learnt to recognise when patients are really sick. Sometimes I think it's a gut instinct. I had a patient who presented with a PR[13] bleed and even though he seemed to have stopped bleeding, I just felt like something was wrong. I could smell something. No one else could see it or smell it, and I just couldn't explain what it was. It just felt inevitable, like something was coming. I kept telling people 'don't stand him up, don't stand him up!', and then they did stand him up and he suddenly had a massive bleed." (Jessie)

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[13] Per Rectum

Jessie has learnt to trust her instincts and now takes notice when she 'senses something'. If she found herself drawn to a particular patient, she knew that there was something she needed to pay attention to. A memory nudged at her in this moment, even if she could not remember the exact situation, there was something familiar that triggered her alarm. When Jessie said she knows to trust it now, I expect that there have been situations in the past where she has brushed this feeling aside, only to realise later that it was trying to tell her something important about her patient. For Jessie, this sense of something not being right meant she was at times in tune with her patient in a different way to others around her. In the situation Jessie described there was a particular smell in the room which disquieted her, yet no one else could smell it. Jessie shared her concern with her colleagues saying 'don't stand him up', however the patient was helped to stand and subsequently had a further bleed. Jessie trusted her sense of smell, and her quiet worry, suspecting something may happen. This was how Jessie's trust in her own gut instinct continued to grow, and encouraged colleagues to start to trust Jessie's insight, and perhaps their own insights too.

Tricia described a similar feeling she experienced with a patient, noticing that something was not right, but not being able to ascertain exactly what she was picking up on in that moment.

> *"Sometimes you see a patient that just looks sick. You don't know why, they just look abnormal in some way. You do their observations and think 'yeah ,there's something going on here', and you don't exactly know what. You go back five minutes later, and your sense of urgency is even more urgent, but again, you don't know why'. Sometimes their observations are normal, or unchanged, but you still pick up on something you're not happy with. I think nursing instinct is something that partially comes from your own personal experience of people or relatives that you have nurses over the years. When it's really busy and you're admitting a patient, it's sometimes not what they say, it's what you read in between the lines. You use your interpersonal skills of how they say things and how they look." (Tricia)*

Tricia has shared that although her patient had normal vital signs, she detected that the patient was not actually as well as they seem. She sensed that there was something else going on, that had not yet been brought to light. Tricia described an urgency that she felt at times which drew her back to her patient, a niggling uneasiness that all was not well, yet she could not articulate what it was that made her think that.

As other nurses have said, Tricia agreed that this intuition came from her past nursing experience, and she trusted that it was telling her something important about her patient.

Sally, described having similar 'something is not right' feelings as the other nurses, however she doesn't believe that it's 'intuition'.

> *"People call it intuition, but it's not. You're in a situation so many times that you can draw parallels without even thinking about it. You're drawing on past experience. You're thinking things like, the last patient that died was this pale, this clammy. The last time I had this, oh, this looks like that. You're able to kind of draw lines and pick up on ideas and thoughts and the more you panic, the more stressed you feel about it and then I start thinking 'oh yeah, maybe something is going on', and I start to try and listen to myself. You might not be able to pinpoint it. You might not be able to put your finger on it, but it's something. It might not be reflected in the vitals, it might not be reflected in their history even. They might be young, it might be counter-intuitive but you know there's something that's not right."* (Sally)

Sally said that it's not intuition that nurses are feeling when they are worried about a patient, it is more that they are remembering past experiences and comparing the patients to what they have seen before. Interestingly, the way she described this feeling, was the same way other nurses described their feelings of intuition. Sally agreed that the feeling was not able to be clearly conveyed to others, but it was *'something'*. She said she sometimes started to panic or started to feel more stressed, and there didn't seem to be a clear reason. In these cases she listened to what her 'feelings' were telling her. It suggests that Sally experienced nursing intuition just as her colleagues did, but perhaps didn't recognise it or acknowledge it in the same way.

The nurses shared stories about how they were guided by intuitive feelings and knowledge as they cared for deteriorating patients, often revealing that it was difficult to articulate their concerns when it was not backed by objective clinical signs. When it had been hard for the nurses to express exactly what it is that they were worried about, it had also made it difficult for them to ask for help, despite current literature and knowledge in health care which supports clinician concerns as being a predictor of deterioration.

6.4   Asking for help

The nurses discussed situations where a patient was deteriorating and they needed to ask for help, but that there were barriers they faced in calling for help. They also disclosed stories about times where they felt they should be able to manage the deterioration on their own, some putting this down to a culture that has developed the unit, where patient deterioration is managed without asking for help. The nurses spoke of an internal struggle to manage on their own, which contradicts what they are taught and also interferes with their nursing identity. There seems to be a sense from the nurses that they were sometimes made to feel that if they were good nurses, they should be able to cope.

Taylor revealed a story about how she struggled on her own to care for an older gentleman who was deteriorating, which suggested she felt that she should have been able to cope.

> *"I tried to contact the patient at risk nurses, but they were very busy. They didn't decline him, but they put him on their list to see when time allowed. It probably got to around four hours of me trying to manage this patient and I just put my hands up and said, 'I can't do this anymore'. I knew I couldn't keep giving him one to one care, it was becoming unsafe for him and I knew he needed more. I hadn't seen my other patients for hours. I got the charge nurse to call a code, and he ended up being taken to ICU[14] where he was ventilated. My charge nurse knew that I was doing this one to one care for this patient, and I did feel supported because I was working so closely with the doctor. It wasn't until I was talking about it afterwards that I realised I should have called the code earlier. I think my inexperience, and being swayed not to call the code, jeopardised that patient and also my practice. I had been confident in my care and I wasn't out of my scope, but in hindsight, the lack of improvement and the fact he had been scoring so highly on the EWS[15] for so long, I should have just called it. I think in the unit, or other acute settings, we tend to feel that we have the doctors there and all the resources, so we try and fix them ourselves. Sometimes I think if we had called a code an hour earlier, maybe he wouldn't have been so acutely ill. Sometimes the patient deteriorates almost too far, like we only call if they are actually needing resuscitation. It's like an attitude that has kind of developed. I've spoken to my colleagues about it recently and we've come to an agreement that we just need to call codes earlier, and not to be afraid, it's not embarrassing. As nurses we like to fix it and be*

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[14] Intensive Care Unit
[15] Early Warning Score

hands on, we have the skills and resources, but it's actually safer and more effective if the patient gets those further assessments more quickly." (Taylor)

It is interesting that Taylor says *'it's not embarrassing'* to ask for help. This suggests that there was an unspoken feeling of embarrassment for nurses if they needed to ask for help, as though it undermined their competency as nurses. It seems that at times, the nurses have learnt from their colleagues that they should be able to manage an unwell patient if they are a 'good' nurse. It suggests the nurses feel that they don't want to ask for help from their support systems because it may make them look like they don't know what they are doing, or they feel that they may be a nuisance if they need assistance. Nurses also appear to not want to call for help and then have their decision questioned by the support teams who arrive, or are hesitant to ask for help because someone more senior may come in and pick up on things that should have been done but were not, or mistakes that had been made. Taylor felt that she could not manage this alone, but that she should have been able to. In the moment with the patient, Taylor was overwhelmed by her responsibility. The patient was looking to her and trusting her to give good care, but Taylor seemed to be hesitating, trying to manage on her own when she knew she felt out of her depth and that the patient needed assistance that she was not able or authorised to give. In the moment with the patient, she felt that she was managing, but it was afterwards that she realised the extent of the risk her patient was at, and was able to reflect on how she thought she should have managed the situation.

Sally agreed with Taylor, and seems to attribute this feeling to a culture that has developed in AAU because of the doctors being more available than they are in the wards.

"Downstairs they are so used to ED doctors and registrars being right there, they don't escalate concerns about their patients as they should. I think there's a right time to escalate and a wrong time. If a patient has had everything done for them and they are not quite meeting code criteria, then don't escalate, if there's a doctor right there and they are being reviewed, and things are happening for them, and a code is not going to add anything to that, then don't code them. If you're thin on the ground though, and there's no doctors around, or the doctor is quite junior, and they need support, it's not fair to expect them to work at a higher level than they are

supposed to, then we should ring a code. It's the culture, I think.
Downstairs they are cowboys. They think they can handle anything,
and yes, they can handle it, but is that in the patient's best interests?
Is it in your best interests? It's not fair on our patients, or our other
colleagues. It's showing that you do know you're in above your head,
and I think that's more intelligent, it's showing better clinical
judgement than handling it by yourself." (Sally)

Sally suggested that nurses are less likely to call for help while working in the AAU because of the doctors being present on the unit, and that a general understanding that has developed amongst staff, that they should escalate concerns to the doctors who are already there, rather than ringing the wider supports such as the patient at risk team. Taylor hinted that the nurses were hesitant to ask for help because it may call their competency to question, but Sally said the opposite, indicating that nurses were showing more competence, and *'better clinical judgement'* by calling for help when they were out of their depth.

When caring for a deteriorating patient, the nurses were not only having to think about whether asking for help was justified, as Sally stated, they also needed to consider when to call for help, and why, as well as who they should ask. Jessie talked about how helpful it was when it was made easy for the nurse to ask for help.

"Something that really helps in AAU is having a clear plan, especially
if it's clearly the most up to date plan. Sometimes there's pages and
pages of notes, and when someone's deteriorating, you have to sift
through them all and see which plan is the most recent one to follow.
I love it when it's a forward thinking plan, when the Doctor has
written what to do if a) b) or c) happens and who to escalate to. That
is so helpful. I've noticed that patients that have this kind of plan in
place improve so much quicker than ones we have to chase the teams
for. It's also great when there's a supportive charge nurse or leader
and there's a good rapport with the medical team. Then you can have
good conversations back and forth and work together." (Jessie)

Jessie pointed out that when there was a clearly documented plan, it was easy to know who and when to ask for help, and that the patients improved much more quickly. There was a feeling that in these cases the whole team was working towards the same goal, and there was mutual respect and appreciation for the different skills each team member brought. It also suggested that by having a clear plan documented for a patient, it gave permission for the nurse to ask for help, without having to consider

whether his or her practice was being called to question. Jessie suggested that these kind of plans facilitate good team work, and in her experience are more beneficial in helping a deteriorating patient improve. It indicates that having clinical guidelines in place, as well as a plan of who to escalate concerns to, helps the nurse feel that they are giving the best care to their patient.

Unlike the other nurses who seemed to question when to call for help, Nina had a situation where she felt like she couldn't ask for help at all. She described a shift where she was caring for a man who had recently arrived on the ward and had not yet been assessed by a doctor. Nina helped him to the toilet and then settled him into his bed, and took his observations. She noted that his observations were abnormal, but put this down to the fact that he had just mobilised.

> *"I took his observations, and his EWS was high, but I had to take into account that he'd just walked to the toilet. I told him I'd be back in half an hour to recheck his observations. I left to go and see my other patients, when the daughter came out and said to me, 'he's not breathing very well', and I was like, 'What?!', and ran back to the room. They were thinking he may have had TB[16], so I had to stop and get my mask on, and I was putting on and just watching him and calling out, 'Sir, are you okay?', and then I literally saw him stop breathing. I put the bed down, started compressions and hit the emergency bell. Everyone came in, and it was a VT[17]/VF[18] arrest, but we ended up stabilising him. He was okay for a while, and the doctors decided to do a CT scan on him because we didn't know what was going on. He died before he got his scan. It was horrific. It was so bad. To this day I'm still wondering, 'what if I had alerted people earlier?'. I've talked to so many people about it and everyone has said the same thing. Even if I had got someone earlier, it was horrendously busy, and they wouldn't have been able to come. They wouldn't have seen him in time. I feel like even though I've had four and a half years-experience I should have been able to see this coming. I just remember when we were having the code, straight away I had that guilt about whether I missed something, It was the most horrible feeling I've ever had. If I could do it differently, I would go and get a doctor straight away, but really, he wasn't much different to other patients we had at the time." (Nina)*

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[16] Tuberculosis
[17] Ventricular Tachycardia
[18] Ventricular Fibrillation

It is not uncommon for patient's vital signs to be elevated after mobilisation, therefore Nina was initially able to justify why this patient's observations were abnormal when she first assessed him. It was easy to brush aside her concerns and make a note to herself to come back and repeat them soon afterwards. She did not get a chance to repeat them because he suddenly deteriorated and collapsed. Nina said *'to this day I'm still wondering'*. Nina carries the weight of this guilt even now, wondering if things would have been different if she had escalated her concerns at the time. Interestingly, Nina pointed out *'he wasn't much different to other patients we had at the time'*. In retrospect, his deteriorating state was still able to be normalised, because the only difference between this sick man and other sick patients in the unit that day, was that he collapsed and subsequently died. Nina was not alone in her assessment of this situation as she pointed out, *'I've talked to so many people about it and everyone has said the same thing'*. Until he collapsed, there were no clinical signs alarming enough to warrant immediate medical attention. Nina spoke of her frustration that the unit was so busy that even if she had escalated her concerns, the patient was unlikely to have been seen by a Doctor immediately, due to the acuity in the unit that day. Nina's story demonstrated how the nurses often felt that because of the acuity and workload, the care a patient gets was sometimes down to luck. When a patient has first arrived in the AAU and they are not yet known to any nurse, it was difficult for the nurse to know whether they need help, or whether their clinical presentation was warranted or able to be normalised.

6.5   Normalising the deterioration

At times it seemed easy for the nurses to rationalise any concerns about deterioration, saying the patient was 'fine', and at other times the nurse could be swayed by their colleagues' opinions, even when they had a niggling feeling that something was not right. What seemed normal to a nurse in that moment with the patient, might not have seemed normal or 'fine' to that patient and their family. When the nurse did not know the patient or had not had time to get to know them, it seemed to be easier for clinical concerns to be attributed to other causes, rather than deterioration.

Taylor described a situation with an older man who was unwell when he arrived and continued to deteriorate. Her initial assessment suggested that he was unwell, but she was able to brush her concerns aside because his wife was a nurse and said he was

okay. The wife's opinion reassured Taylor and helped her think this patient was presenting in a normal way for him, but it was only as she spent more time with the patient that she realised her first impression was warranted.

> *"He seemed fine, but as my assessment went on, I started to wonder. His wife said he wasn't confused but she was doing a lot of the talking for him which I think swayed me. She had told me that she was a nurse, so I put a lot of trust in what she was saying. When she left about an hour later, the doctor and I realised that he was delirious. He was a very sick man." (Taylor)*

Taylor felt worried as she recognised that there was something not right about this patient, yet she doubted herself because she trusted the wife's judgement, *especially* because she knew she was a nurse. It was easy for Taylor to believe that this was normal for this man because she didn't know him, and easy to justify other symptoms. As the situation developed, Taylor became increasingly aware that he was deteriorating and sought help.

Rose shared her thoughts about how her nursing experience in AAU has developed and how these experiences increased her knowledge and understanding of patients who were deteriorating, and how she has learnt which patients may present with abnormal vital signs that are actually 'normal'.

> *"As a new nurse in AAU, the Early Warning Score was really helpful. There's a pathway, and it keeps you and your patients safe. As a new nurse learning about diseases and how people can deteriorate and what the signs and symptoms are that you are looking for was so helpful. It prompts you to immediately go and get somebody to help. As you develop, you can of course start to think critically about what is happening. Like if you have a patient coming in with CHF[19] and low blood pressure, you start to understand that it's probably not a bad thing. You have to think critically but in the beginning the EWS was a great tool and pathway to helping me understand. Working with so many patients in AAU and seeing the variety, you get to know when a patient is deteriorating. When I first started, I was a very new nurse in terms of experience but seeing those deteriorating patients, taking care of them and knowing what to do, you start seeing those patterns. That's really helpful." (Rose)*

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[19] Congestive Heart Failure

Rose talked about how when she first started in AAU as a new graduate, she relied on the Early Warning Score to help her know when her patients were deteriorating. By getting to know which observations trigger a score, she started to understand which vital signs would mean the patient was improving and which would mean they were worsening. It helped her understand what was happening for patients and therefore, Rose felt that it had also given her the experience to know when she could safely normalise abnormal observations.

It's not always evident for nurses to know when they can rationalise abnormal vital signs, as it seems to be for Rose. Sally expressed concern that the Early Warning Score was not always working to detect deterioration, as it was meant to.

> *"It's good in a way because it makes you pay attention a bit more, and we should be able to recognise people that are deteriorating more quickly, I think that's the idea behind it. It's not quite working, because people are becoming very blasé, 'oh they are probably scoring a one for everything' is kind of what is said. I don't know, it's really weird, it's supposed to be an extra safety measure but it's becoming something that's almost not taken seriously in some situations. The person could be a six very easily and they are like 'oh they are fine, it's not that bad', and the clinical judgement is important I believe, but so is not cutting corners." (Sally)*

Sally suggested that patients score easily on the Early Warning Score, and this makes people complacent. Nurses care for patients who are triggering a high early warning score every shift, so it becomes less alarming and more common. Sally feels that sometimes people cut corners and don't follow the escalation protocols because they no longer see someone with a high score as being unusual. The patients don't seem unwell, because having unwell patients in AAU is normal.

On the other hand, Lily, as a more senior nurse, said she gets frustrated by people being so caught up in the early warning score.

> *"It drives me nuts when people get so stuck on the EWS. Some of the new grads get flustered over a saturation of 95%. I'm like, 'they have smoked for 25 years, 95% is bloody good for them, chill out.' Or a young female patient having a blood pressure of 105, and they are freaking out. I guess you have to have experience to understand that." (Lily)*

Lily pointed out that without experience it was hard to differentiate between patients who were scoring highly because they were deteriorating and patients for whom these signs were normal. It was a fine line, and Lily has enough experience to feel like she knows when she needs to worry, and when it was normal, but other nurses may not have learnt this yet. Lily told a different story about when she came onto her shift to care for a patient who she had been told in handover was unwell.

> *"I came on to shift one day and my patient was scoring between an eight and a nine on the EWS. The end-of-the-bed-o-gram looked worse than an eight or a nine, so I did the obs again. The patient was grey and clammy, you know, just not the right colour. I pushed the emergency bell pretty much straight on handover and got the patient assessed straight away. The handover had been clear that the patient was sick, … but the patient just looked like they weren't getting enough oxygen requirements and they needed a plan that the nurses could follow." (Lily)*

Lily called on her experience as she assessed her patient. She realised he looked worse than his observations were saying, and she was concerned that he had been unwell for the previous shift too. She knew that something needed to change for this patient, it was not okay to say, 'this patient is just sick', to make it normal as perhaps had happened for the previous shift. Lily seemed to be attuned to the patient's deterioration and felt a sense of responsibility, because she had felt she could not ignore or make normal the fact that this patient was so unwell.

Lily seemed to recall past experiences that guided her decision making when she was with the deteriorating patient, suggesting she knew what may happen next if she didn't act, as if she had seen this so many times before, she could appreciate how unwell the patient actually was. Interestingly, Nina seemed to feel the opposite way, saying that seeing the same patient presentations frequently, made it easy for the nurse to normalise what they were seeing.

> *"I was caring for an elderly lady who had come in with COPD. Her heart rate was up, and she was short of breath. You know, your usual COPD presentation. I did all the things that I usually do, inform the team leader, follow the EWS algorithm, and gave the Patient at Risk nurses a ring. I asked them if there was anything else that I should do for this lady, and they said nah, just give her some high flow oxygen, which I had already put in place. So, the patient was just waiting to be seen by the doctors. I think it becomes like a pattern. You know*

> *what to do. It becomes like a factory. See this one, fix them, next*
> *patient. Try to make the patient feel better, and then move on to the*
> *next one."(Nina)*

Nina explained, *'it becomes a pattern'*. This suggested that Nina had seen the same presentations over and over, and perhaps something that alarmed her in the past, was just normal now. There may be a point where nurses see so many sick patients, that sick becomes the new normal. Ben agreed with Nina and said that as nurses we constantly compare our patients to ones we have seen previously and because most of the patients are sick, it is easy for it to become normal.

> *"I think back to deteriorating patients I've cared for before. I think as*
> *nurses we become immune to what we consider normal and what*
> *others consider normal. We compare our patients to ones we saw five*
> *minutes ago and think, well they aren't that unwell. I think in the*
> *acute care setting actually every patient is unwell, and we can forget*
> *that." (Ben)*

Ben seemed to feel that working in an AAU and seeing unwell patients repeatedly, may make the nurse immune to what is abnormal. It suggests that patient deterioration may be camouflaged and harder to detect because so many of the patients present the same way. This hints at the possibility that patient deterioration may be going undetected in acute care areas, not because of the nursing skill or knowledge, but because it has become so normal for the nurses. Taylor agrees with Ben in this sense, also suggesting that instead of focusing on what was normal for a particular patient, it was easy to compare them to the rest of the patients as a benchmark for their wellness.

> *"Often as nurses we say a patient is fine, and it's true, they are fine.*
> *Well, we consider them fine. They are not baseline fine, but they are*
> *fine. At that moment, they are okay, they are stable. Sometimes the*
> *charge nurse asks if you have any patients you are concerned about*
> *and you have a whole room full of scoring patients but you're like*
> *'nah, they are fine', because they are. They have the potential to*
> *deteriorate, but you probably compare them to the rest of your load*
> *and they are fine." (Taylor)*

Taylor's story indicated that because there were so many patients who were deteriorating or who had the potential to deteriorate in AAU, the patients were at more risk from the nurses normalising their unwellness by comparing it to other

patients instead of comparing the patient's current condition to their own baseline state.

It was difficult for nurses who see deteriorating patients as part of their everyday work to distinguish when the abnormal was extra abnormal and it was easy for nurses to forget that compared to the patient's normal, they were unwell. Unless nurses in the AAU have patients who return frequently to the department, there is no way of knowing what was normal for this particular patient. There was a danger of normalising deterioration so much that concerns were ignored or downplayed.

At times, the nurses' experience allowed them to think critically about the patient's presentation and signs of deterioration, often enabling them to correctly justify abnormal vital signs because of understanding the patient's usual baseline state. At other times, seeing the same presentations frequently and being accustomed to caring for deteriorating patients, seemed to make nurses less likely to feel concerned about patients who were unwell. For some of the nurses, they seemed to be caught between knowing when abnormal signs can be normalised and when they must not.

6.6   Being stuck

Some of the nurses revealed a feeling of being stuck between different responsibilities when they were 'being with' deteriorating patients. In the moment with the patient, they described feeling torn between what they wanted to do and what they had to do.

Annie shared a story about when she was caring for a patient whom she knew was dying. The patient's son wanted information, and Annie was trying to get a doctor to come and talk to him.

> *"It looked like she was going to die, she was so unwell and not responding to the Airvo[20] very well. She was sitting around 88% with no other underlying lung conditions. She was febrile. It was really bad. We were continuing with antibiotics and treatment, and the son came in and was wanting to know what was happening. I told the Registrar and asked him to come and talk to the son. He was just like 'I'll talk to him when I can'. I was telling him, 'she's so unwell, he needs to know what is going on'. There wasn't even a resus plan in place. I think the Registrar was overwhelmed. I ended up calling the consultant and saying 'this is not okay, she needs to be reviewed'. The*

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[20] Respiratory Support equipment

son was in the hallway asking 'what is going on with my Mum?'. I
tried the Registrar again and he was like, 'I will talk to him when I
can'. I couldn't believe it. I couldn't advocate for my patient. We were
meant to be a team and I wasn't able to advocate, I couldn't do my
role." (Annie)

Annie felt that she was prevented from performing her role, which was advocating for
the patient and her family because the doctor was not supporting her. Annie clearly
felt alone in this situation, and out of her depth with the patient's son asking her
questions she was not equipped to answer. The son looked to her for answers as she
was the one who was present. She *knew* the answer – his mother was dying, but she
didn't feel she had the authority to tell him, or didn't feel prepared to answer the
inevitable questions that would come from this conversation. She looked to the senior
doctor for help, but did not find it. She felt trapped and as though she couldn't be a
nurse in the way she would have liked to in this situation.

Annie was left feeling helpless that she was trying to work with the doctor and
advocate for the patient, but she was unable to perform her role in the way she would
have liked. Similarly, John and Jessie shared stories where they were also trying to
advocate for their patient in a different way, but were left feeling helpless too. They
shared their frustration of AAU being an in-between place, where patients are often
waiting to be assessed by the Intensive Care unit (ICU) or taken to the ward. The
patient stayed in AAU to be stabilised and assessed, but often weren't accepted to ICU
because of comorbidities, however, they were too sick to move to a ward. This was
further complicated by the reality that the sick patient cannot stay in AAU indefinitely
because of the need to focus on patient flow through the hospital. Jessie remembered
one of the first times she cared for a deteriorating patient in AAU.

"My patient's condition fluctuated throughout the shift. He was de-
saturating and his blood pressure was all over the place. He was
EWs[21] scoring a five, then a three, then an eight, then a ten. He was
having blood transfusions, albumin, and everything. He was going
through these peaks and waves, getting a little better and then
crashing. He was so unsettled, like there was something happening
inside that he couldn't explain. We all thought he needed to go to
ICU[22], but he had so many comorbidities that he was declined. I felt so
frustrated and overwhelmed, and almost like there was no support

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[21] Early Warning Score
[22] Intensive Care Unit

because I knew that he needed one on one ICU level of care, but he wasn't going to get it." (Jessie)

Jessie said she felt like there was no support, but what this suggests was a feeling of helplessness. She wanted the patient to get help and to improve, but because of his medical conditions it was unlikely that he would improve to the point of having a good quality of life. The ICU referral process often happens as conversations and assessments between doctors which are not documented in full. It can be hard for the nurses to understand the reasons for the declined referral, especially when they are the one at the bedside with the patient and family. Jessie felt like the patient had been let down, and she felt stuck between what she knew was possible, and what was appropriate. Jessie felt helpless, but she had no control over changing the outcome.

John shared a similar view to Jessie about feeling that patients were stuck in AAU, not being well enough to move to the ward, but not being unwell enough to be accepted to the Intensive Care Unit.

> *"If you have empty beds in your allocated space, the patients keep coming, no matter what else you are dealing with and you just have to prioritise according to what you think is the most important thing to do for the patient at that time. Also, we often have patients that are really unwell, waiting to be assessed by ICU or taken to the ward. They stay with us to be stabilised and assessed. Sometimes the patient won't be accepted to any different area, so you are stuck with a really sick patient. They can't go to the ward because they are too sick, but they aren't appropriate for ICU for whatever reason, but really, they can't stay in AAU either because we need the bed. That can be really difficult and makes the workload quite challenging."*
> *(John)*

John's story suggests that he feels the same feeling of helplessness as Jessie, wanting to help the patient improve from their deterioration but feeling like there was nothing he could do. His story also alludes to a sense of being stuck between the deteriorating patient who was not going anywhere but needed an increased level of care, and managing the rest of his workload, including other deteriorating patients.

Ben seemed to feel stuck when he was caring for a deteriorating patient, but in a different way to the other nurses, perhaps because of his role in the department as a senior nurse. His nursing responsibilities often overlap when there was a deteriorating

patient. He felt he wanted to help junior colleagues learn but then he also recognised when he needed to step in and rescue a deteriorating patient. His experience was one of being torn between his responsibilities to his junior colleague's needs, and his responsibility to the patient and their needs.

Ben illustrated this with a story about a time he was asked to help a new graduate nurse *'just hang a bag of blood'*. When he arrived, the situation was not as simple as had been suggested.

> *"We had a patient who had GI [23]bleed, with a haemoglobin that was still falling, and who had already had three units of red blood cells. So, immediately I realised that these stories aren't matching up and there's two things going on here. One, we have a patient who is significantly unwell, and two, we have a staff member who hasn't picked up on that or what that means. So while I normally like to give people an opportunity to learn, I knew I was going to have to step up and show some leadership here because if we carried on at this pace, the patient was not going to make it." (Ben)*

In this situation, Ben felt stuck between his responsibility to the junior staff member and his responsibility to give the patient the help they needed. This often happened because he was torn between two roles – his professional role as a senior nurse but also his nurse identity which was always there in the background – he could not separate these roles when it came to an unwell patient. The nurse identity took over.

Ben told an additional story where he was stuck in a different way, but which he described as being a common occurrence in AAU. The nature of the Acute Assessment Unit means that patients do not always belong to a particular speciality or team or doctors because they are early on in their hospital journey. Sometimes there can be a period of ambiguity before the teams are allocated, where it is not easy to tell which team of doctors is responsible for the patient's care.

> *"I think of a situation recently where a senior nurse in the department had noticed that a patient's ECG had changed. They asked me to get a doctor while they worked with the patient. I took all the core details that I needed and I walked into the room where the doctors were and asked if I could get someone to come with me. I explained the situation, and there were a few blank looks. I could tell that some of the doctors were close to the end of their night shift and about to*

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[23] Gastrointestinal

*hand over. I understood that they were worried about starting
something they didn't have time to finish, but the patient needed
help. It happens so often. You walk in and say, 'I need someone now',
and everyone has a reason why they can't come. Sometimes it's like
the doctors think their speciality is more important than others. It's so
frustrating when there's no ownership about what's going on. When
you hear 'I'm not the this, I'm not the that', I always want to say 'I
don't care! You are a doctor and the patient needs a doctor NOW'. I
repeated my concerns about this patient, and then someone spoke
up, 'I will come'. This particular doctor hadn't even started their shift.
I don't know what it was that had made it obvious that they needed
to come now, but they did come and see the patient. It was brilliant!
20 minutes later the patient was in the Cath lab getting three stents."
(Ben).*

Ben shared the frustration he often faced in his work, trying to get an unwell patient
seen by a doctor when it was not clear who 'should' be seeing the patient. When the
doctor in Ben's story said she would come and help, Ben clearly felt relieved and
grateful, he said *'it was brilliant!',* His words suggest that his reaction was not only
about the fact that someone answered his call for help, but because it enabled the
patient to have a good outcome. In this situation, Ben was caught between his nursing
responsibility to seek help for a deteriorating patient, and the difficulty of finding a
doctor who was willing to take accountability for attending to the patient.

Rose too, told a story about a time that she felt stuck when she was caring for a
patient who was deteriorating. Unlike with Ben's story, in this situation Rose felt stuck
between her nursing responsibilities and being sensitive to her patient's cultural
needs.

*"One of the things I really struggled with when I began nursing was
caring for Māori and Pacific patients. They usually have such a close-
knit family and anything that happens to the patient affects them
quite a bit. Sometimes they react in a negative way, and I remember
a patient who was like that. No matter what I said or did, it wasn't
good enough. There were so many people in the family that I had to
answer to. They were obviously all very protective and worried for
their family member, but it just didn't come out in a good way. It's
different to my own culture. Usually in my culture we have one person
who speaks up and talks with the medical staff, and then relates it to
everyone else. It was a bit hard in the beginning to tell this person,
then the next person, and then the first person isn't there, so you
have to tell somebody else. It's hard to know who we actually tell
what to. I have had to learn to speak up and ask if we can have one*

spokesperson. It sometimes works, and it sometimes doesn't, and you have to remember that their reaction is not a reaction towards you, but their protectiveness of their family member. It can be a bit of a barrier to giving care because it takes up a lot of time." (Rose)

Rose was caught between trying to care for the patient and do what was needed to help them in their time of deterioration, as well as ensuring that they were taken care of culturally. Rose was stuck in a different way too, she was reminded of her own culture and had to step aside from what she had grown up believing to be normal and react the way this patient and their family needed. She felt that fulfilling the cultural needs in this situation was taking her away from the care she needed to give to the patient, in order to ensure their safety. Rose felt the family's frustration was directed at her, but she knew that despite this, it was not about her. This situation highlighted to Rose the cultural differences she brings to her job because of her own background. She was prompted by this realisation to reflect on her own family and how things would be done, she was able to have empathy with this patient's family and be reminded of what it means to love someone.

Nina had a similar experience when she was caring for a patient from a different culture who was very unwell. As with Rose, Nina felt caught between attending to the physiological signs she was concerned about with her patient and the cultural considerations she knew she needed to be mindful of. She felt conflicted as a nurse, knowing she had a duty to provide safe and appropriate care, but that this also extended to a duty to provide culturally appropriate care. Nina was stuck, not knowing which one to prioritise. She knew which one was more important to her as a nurse in this moment, but she also realised that this was not necessarily the same for the patient.

"I was caring for a Māori patient who had come in with diabetic acidosis. I knew I needed to be so careful and respectful and I knew I needed to follow what her and her whānau [24] were wanting; culturally, spiritually, physically, emotionally, just all the four corners of the house. Sometimes it can be really tricky to be able to do that because are you so concerned about them culturally, that you forget what actually needs to be done? How do you incorporate it all together? I found that although those things were really important to the patient and her whānau, I also had to bear in mind what was

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[24] Family

important to me, which was to make sure she was comfortable, safe and getting the care that she needed to improve or at least be stable. The whānau were quite spiritual and wanted to get a Kaumatua [25]involved, and they were reminding me to make sure her head wasn't touched, and that we had the correct colour pillows and things like that. It was hard to remember everything, but I made sure I was respectful. I appreciate that everyone has their own needs, and everyone is an individual, but I asked the whānau if I could fix the physical aspects first and then call the Kaumatua and get everything else sorted. They were really good about it." (Nina)

Being with the patient in this situation meant that Nina felt torn between different nursing responsibilities. She felt that she needed to address the physiological concerns for this patient, but at the same time felt a pull to fulfil the patient's cultural needs. 'Being with' the patient meant Nina was caught in the nexus of meeting the physical needs of her patient as her nursing identity required but also relating to her patient on a human level, seeing the person behind the label of patient, and realising the person had needs that were separate, but parallel to the physical requirements.

6.7   Conclusion

As the nurses responded to the clinical change in the patient, it seemed to bring a change in the nurses' thoughts and actions too, as they moved from a caring role to a responder role. The nurses shared stories about having a sense of responsibility to help patients, but not always being able to fulfil their role due to the barriers they faced, such as asking for help but not receiving it. In most cases, the signs of clinical deterioration were easily distinguished, but in other situations there did not seem to be clear signs, and yet the nurses had an intuitive feeling that something was not right. The nurses revealed that the nature of working in AAU with multiple deteriorating patients and patients who are in their acute phase of illness means patient deterioration can tend to be normalised.

Being with the patient in moments of deterioration was a meaningful experience for most of the nurses, often bringing an awareness that caring for these patients was contributing to their nursing knowledge and enabling them to better care for future patients. 'Being with' was revealed in the nurses stories as times when the nurse was

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[25] A Māori elder

not only alongside the patient in their state of deterioration, working to manage the deterioration, but provoked to think critically about their own nursing response.

Chapter 7 - Discussion

*"Caring is about compassion. It means showing patients love.
Showing them tenderness and doing the little things that make them
feel safe and looked after. Making them feel safe, so that they are not
scared or alone and trying to make them feel as if someone wants
them to be okay." (Jessie)*

7.1 Introduction

The primary question of this research study aimed to explore 'the meaning of nurses'
caring for clinically deteriorating patients'. Ten nurses working in Acute Assessment
Units (AAU) across the Auckland region were the study participants, who shared their
experiences caring for clinically deteriorating patients. Three main themes emerged
during the research, which were: *Being connected*, *Being there as nurse*, and *Being
with*. These themes were explored in the findings chapters and a summary of each will
be provided in this chapter. Several common notions became evident which ran
through each of these themes and spanned all of the nurses' experiences, which were
Being more than nurse, Caring with courage, and *Knowing as a nurse*, and will be
examined in more depth in this chapter. These overarching notions add to what is
already known about caring for deteriorating patients, as well as provide a deeper
understanding of the experience, especially as it pertains to nursing in an AAU
environment. This chapter discusses and critiques the core findings and provides a
critical contrast with the local and international literature. The strengths and
limitations will be outlined, as well as the implications for nursing practice.
Recommendations for practice, education and further research will also be discussed.

7.2 Summary of findings

The three main themes that emerged from the findings were grouped as *Being
connected*, *Being there as nurse* and *Being with*. The nurses shared stories which
indicated that these were the essence of what caring for clinically deteriorating
patients was like for them.

Being connected suggested that a connectedness between the nurse and the patient
mattered to both the nurse and the patient. It also revealed that connectedness
affects the way nurses detect and respond to patient deterioration, as well as the way

nurses relate to the patient and the sense of responsibility they felt for their patients. The nurses also revealed that although feeling a connection with a patient had a positive impact on patient deterioration, the workload and operational expectations of AAU was frequently a barrier to connectedness.

Being there as nurse concerned the way the nurses responded to deterioration professionally, within their identity as a nurse. The nurses indicated that being a nurse in AAU was different to other places they have worked, and those differences meant that caring for a deteriorating patient here was different too. Being there as a nurse also seemed to mean that the nurses were thrown into situations because of their role as nurse where they were suddenly a witness to scenes of suffering, moments fraught with tension and emotion, but also moments of tenderness and love.

Being with described moments where nurses felt more attuned to what was happening for a patient, than they did in general episodes of care. This awareness with a deteriorating patient changed the situation from something that was happening to the patient, to something that the nurse and the patient were now experiencing together. The nurses described knowing a patient was deteriorating by recognising specific clues such as a change in vital signs, but many of the nurses also described knowing in an embodied way that 'something' was not right, even with an absence of typical signs of deterioration. The nurses' stories revealed that being with a patient in moments of deterioration was more than just performing cares as a nurse, it was a deeper and more involved experience, relating to the patient on a human level.

7.3   Interpreting across the findings

The findings suggest that at the heart of the nurse caring for deteriorating patients was a person, who brought with them all their knowledge, past experiences, culture, beliefs and emotionality. Interpreting across these findings found that this phenomenon could be further grouped into the following notions; *Being more than nurse*, *Caring with courage* and *Knowing as a nurse.*

7.3.1   Being more than nurse

Across all the findings it emerged that the nurses responded in a professional capacity to patient deterioration yet they could not help but bring their humanness with them

to each interaction. The nurses talked about themselves as 'nurses', yet their stories revealed how much of themselves outside of their nursing identity they brought to their work. Their stories showed that they were often unaware of how integral their personality, culture, beliefs and past experiences were in shaping the way that they were as nurses. The dimension of 'humanness' in the provision of nursing care seemed to need to be hidden and was often taken for granted. In telling stories about times when they cared for deteriorating patients the nurses frequently referred to things outside of nursing, such as their own family members or cultural beliefs. What came to light through interpreting the findings was, that although they identified strongly as nurses, the 'nurse' was only a part of what they brought to each patient encounter. The label of nurse is how the nurses knew to relate with the patients, and the mask they used to keep themselves separate from the patient and maintain professional boundaries.

Part of the nurse identity seems to be related to the idea that there are clearly defined professional and societal expectations and boundaries of what a nurse is and what a patient is. What seemed to surprise the nurses was the fact the lines were easily blurred when caring for a deteriorating patient. As the nurses formed connections with patients, they were reminded that they could themselves be a patient at any time. Similarly, at times the nurses were reminded of a family member and started to realise that although they felt separate and protected by their nurse identity, they were not far removed from the patient at all. Tricia spoke of her shock at caring for a deteriorating patient when she realised they were the same age, *"he was my age for goodness sakes".* When she realised they were the same age, she could see herself in the patient, which seemed to prompt her to care more. "*By the time morning rolled round his observations were back to normal and to see that improvement in him was just amazing… I'd pushed with him all night."*

Seeing past the labels of 'patient' and 'nurse' allows the nurses to see the ways in which they are the same as the patient, and how they are both people, both capable of being well or unwell. The idea of a common humanity in the care context has been articulated recently in the literature. "Indeed the caring relationship creates the opportunity for the nurse to recognise her common humanity and dignity in the mirror of the patient." (Manookian, Cheraghi, & Nikbakht-Nasrabadi, 2017, p. 113).

As nurses who care for patients who are deteriorating, their professional side is expected and visible to others, but their humanness remains largely hidden and taken for granted. The nurses seemed surprised when telling their stories at times, as if they hadn't realised their own human response to a patient's deterioration, as if this situation happened to the patient therefore it should not have affected them too.

To an outsider, and even the nurses themselves, it may seem that 'responding as a nurse' is what is occurring, but in the retelling of their experiences and the language they used, revealed that the phenomenon of 'being a nurse' was disguising the humanness in their actions. When they responded to deterioration it seemed that their humanness was disguised behind the identity of nurse. This is a notion which Heidegger called semblance, where the appearance of something "does not mean that something shows itself; rather, it means that something which does not show itself announces itself through something that does show itself" (Heidegger, 2010, p. 29). To the nurses and others around them, they see a nurse, going about their job. This becomes the focus, when what is hidden is the phenomenon of being intrinsically human. What we see instead is 'Nurse'. This was evident in Annie's care of a patient who suddenly deteriorated. *"I've just witnessed someone close to dying and now I have to go back to work and act like nothing happened."* Everything that makes up the nurse as a person, is actually what they bring to their work and what shapes their practice.

The language relating to nurses' work is often concerned with ratios, numbers, or tasks, almost as if nurses are only here to perform tasks, but the stories illustrated that nursing is more than that. Rose said showing respect and treating a patient as a person was the heart of connecting with a patient. *"I could go in and give medications, but anyone off the street could do that, a robot could do that. What changes you is the way you treat the other person, respectfully, for who they are and not judging them."* The human connection, and the parts of themselves that they bring to their work as nurses are what makes their work meaningful. In a similar way, Manookian et al. (2017) suggest that nurses and patients relate in a human to human way, with the potential to both affect and be affected. Jessie describes caring as *"Showing patients love. Showing them tenderness and doing the little things that make them feel safe and looked after"*, which infers that Jessie had thought about what would make her feel cared for as a patient, and brought this human perspective to her caring. Feeling cared

for and comforted as a patient has been reported as an integral part of the healing process (R. Kelly, Wright-St Clair, & Holroyd, 2018), and Jessie seemed to know this intuitively.

The stories of the nurses', male nurses' in particular, showed parts of their personalities which became part of the way they were as nurses. For instance, John said he used humour as part of his caring, *"Caring is about making people comfortable. It means using my sense of humour. That's just my personality. I like to make all of my patients smile or laugh each shift, that's part of who I am as a person."* The use of humour is said to improve patient experience, increase trust and encourage the patient to participate in their care, as long as it is sensitive and appropriate (Mota Sousa et al., 2019). Ben too, used his personality to put patients at ease *"I approached him with a smile, which is just my way, because if I start showing on my face 'oh shit', then it has an impact on how the patient might respond to that situation."* The nurses used more than their knowledge and skills to provide care for patients, they used their personalities and humanness to connect and make patients feel seen and cared for. In a similar way, Lindemann (2014) discusses the concept of 'personhood', the practice of expressing one's personality as an act or performance which becomes so customary we no longer notice we are doing it. How we see others in their identities has some kind of effect on our own, like in the nurse-patient relationship. The nurse and the patient both bring their own personal capacities and social agency to professionally perform as is expected for the situation.

Through the analysis of the nurses' stories it became clear that what could not be separated from the nurse was the way they are in the world. Heidegger believed that seeing our existence in relation to others is a unique characteristic of being human, and this gives us an insight into human existence (Blattner, 2006). The nurses in this study talked about seeing themselves as separate to the patients, but at times were caught unaware, by realising how similar they are and how the line between being a nurse and being a patient can be blurred. Their culture, beliefs, past experiences and personality affected the way they experienced and responded to patient deterioration. In being a 'nurse', they are actually being much more than what this label suggests.

7.3.2 Caring with courage

Courage was a common notion evident in the nurses stories, although the nurses never explicitly spoke of themselves as being courageous. Courage is defined in the Collins English Dictionary (*Courage*, 2019) as "a quality shown by someone who chooses to do something risky or hard, despite being afraid". The nurses seemed to be unaware of how much of themselves they brought to their nursing care and what their humanness meant when going about their work they frequently showed courage in their caring. Aristotle's notions of what makes a good man, or in this case, nurse, are based on human virtues, one of which is courage (Rachels & Rachels, 2015). Courage, in Aristotle's notion, is situated between cowardice and foolhardiness. Too little courage shows cowardice, but too much is fool hardy. The nurses in this research shared stories which seem to be situated in this same notion of courage, where they are showing bravery to care for their patients, but not so much that they are in personal danger. One could argue that nurses have a moral and professional obligation to show courage for their patients, however their stories demonstrate courage which seems to go beyond a sense of duty, to a more human connection of what is the right thing to do as a person, for this person.

At times the nurses recounted situations that they described as 'horrific', 'horrendous', 'surreal', 'bizarre' or 'terrifying'. They spoke of viewing suffering, not only by the patients but also by the family members who were witnessing someone they loved go through these horrific and horrendous things. Jessie said "*The families end up seeing things like seizures or codes. No one is really prepared for seeing their family member go through that, and it's scary for them. It's about caring for the patient and their family at the same time.*" Despite these feelings, the stories revealed that nurses faced these situations with courage. Courage in caring moments, was often shown in subtle ways. The nurses were being present with patients and their families, witnessing alongside them and doing whatever they could to alleviate distress and make it easier. This interpretation is consistent with research which identifying that nurses need courage to help patients face suffering, and to be able to bear witness to this suffering (Thorup, Rundqvist, Roberts, & Delmar, 2012).

Annie shared how she felt after seeing a patient close to dying. *"I was so shaky afterward, but I just had to get on with the job… I've just witnessed someone close to*

dying and now I have to go back to work and act like nothing happened and see the next ten patients who need to be seen. I actually just wanted to go home." Annie's instinct was to *go home* to a safe place and process what she has experienced, instead she had to be resolute within herself to work the rest of her shift and *act like nothing happened.* She was suppressing her emotions to continue her caring role, which is reflected in current literature. Badolamenti, Sili, Caruso, and FidaFida (2017) suggest that at times nurses need to suppress their emotions to follow rules and regulations, while ensuring patients feel cared for. This sentiment is shared by Van Zyl and Noonan's (2018) contention that nurses often witness suffering and have to appear professional by censoring their feelings and emotions. The study by Della Ratta (2016) also touches on this aspect of caring for deteriorating patients with the nurses expressing shock at their own emotional reaction to seeing patients deteriorate, needing to put their feelings on hold to be seen as professional in their nursing practice.

Courage in nursing practice

The nurses stories about the daily reality of working in AAU suggested that they frequently felt that their practice – meaning their ability to do their jobs within their scope, or adhere to policies as a protective measure, was compromised due to staffing and workload. In some ways they felt there were set up to fail. Annie revealed that on a daily basis she felt like her practice was at risk. *"We are getting patients in corridors, overflowing the clinic area and we can't say no. We have to take them, and they just keep coming. We just have to deal with it. We don't have any protection in that sense. I feel like my practice is at risk in these sorts of situations and I can't do anything about it."* Her words reveal her frustration and feelings of unease, but also speak of a quiet courage to turn up to work and care for patients in spite of knowing she will likely feel overwhelmed during her shift.

Taylor shared a story about caring for a very unwell patient. She had escalated her concerns but had been encouraged to keep going with the care, as it was busy with several other unwell patients in the unit. *"It probably got to around four hours of me trying to manage this patient and I just put my hands up and said, 'I can't do this anymore'. I knew I couldn't keep giving him one to one care, it was becoming unsafe for him and I knew he needed more. I hadn't seen my other patients for hours"* Taylor's

story shows courage in two ways. Firstly, she showed strength in continuing to put all of her energy into caring for this patient. She revealed later that she wished she had pushed for more help for this patient earlier, but in the moment she was showing bravery by facing a situation which made her uncomfortable. This is supported by literature which indicates a sign of courage in nursing in remaining in situations where the nurse does not feel comfortable (Edmonson, 2010; Gallagher, 2011). Taylor also showed bravery in the moment where she admitted defeat and had to get help for the patient. Cummings and Bennett (2012) indicate that being brave and speaking up when things are not right is a courageous attribute in nurses. Lindh, Barbosa da Silva, Berg, and Severinsson (2010) agree that speaking up is a sign of courage but warn that it can put nurses at risk professionally.

Tricia remembered a situation where she was helping to take a patient home to die. She was travelling in the ambulance with the patient and her daughter, and spoke of uncertainty and fear as they drove along. *"There were road works happening on the way to her house so instead of a 20 minute journey, it took an hour. She Cheyne-Stoked all the way. I was thinking 'Please don't die. What do I do if she dies in the ambulance? What do I do then?"* Even though this was an experience Tricia had never had before, she nursed with courage, facing her own fears and concerns to be there as a nurse for this patient and her daughter.

Being in between

The nurses revealed that a large part of their role when caring for a deteriorating patient was needing to facilitate moments between the patient and something else. At times this was the space between a patient and doctor, the space between patient and 'help' or the feeling that they were standing between the patient and the help they needed. The nurses felt that if they didn't get help for the patient when they needed it, they had let them down. This seemed to occur even when the decision was taken out of their hands, when a nurse had asked for help, but had been blocked from receiving it because of the workload. The stories indicated that it was not always easy to navigate the spaces in between, but the nurses showed courage in having difficult conversations, risking being disliked at work, risking being wrong because they wanted to help the patient get what they needed.

Annie shared about a time when she felt stuck in between a patient's son and the registrar. *"I ended up calling the consultant and saying 'this is not okay, she needs to be reviewed'. The son was in the hallway asking 'what is going on with my Mum?'. I tried the Registrar again and he was like, 'I will talk to him when I can'. I couldn't believe it. I couldn't advocate for my patient. We were meant to be a team and I wasn't able to advocate, I couldn't do my role."* Here Annie felt that she was being held back from doing her job and advocating for her patient. The son wanted information about his mother who was dying, and Annie was unable to give it to him. She needed help from the registrar to explain what was happening, but every time she tried to get help, she felt hindered. For Annie, there was a sense of being there, facilitating that space with the son, but feeling out of her depth. Her story revealed courage in having to keep returning to the son, facing his reactions, as well as the courage to keep asking for help when she had been turned down. In the end she was so concerned the patient would die that she escalated her concerns to the team consultant, which took bravery in itself to ignore hierarchical norms. In this situation Annie was experiencing moral courage (Brown, 2015), speaking up because ethically she felt she must. Annie sensed time slipping away from her patient, knowing the son needed answers as soon as possible. Literature suggests that finding the courage to challenge colleagues to be able to care for a patient (Thorup et al., 2012) sometimes can be difficult because of organisational cultures, no matter how much courage a nurse possesses (Gallagher, 2011).

At times it seemed the patient or family member was looking to the nurse, relying on them to take action. When the nurse experienced an inability to fulfil the need, it led to a lack of satisfaction and a feeling that the nurse was not doing their job well, even though it was out of their hands. Throughout the stories of caring for deteriorating patients was an underlying thread of courage in facing emotionally taxing situations, having difficult conversations, and the courage to show up and do it all again in the next shift.

7.3.3   Knowing as a nurse

Through the nurses' stories, a sense of nursing knowledge emerged. Every nurse carried knowledge with them from different sources, and collectively they seemed to have an awareness of this knowledge growing and changing with each experience. The

nurses often talked about how their knowledge evolved as they developed professionally as nurses.

Nursing knowledge and experience

The nurses spoke of knowledge gained through their undergraduate education and then the knowledge that continues to grow with each patient encounter and practice setting, as time goes on. Knowing from 'nursing knowledge' – the knowing we get from nursing training and understanding how to apply this information to practice. Schub and Karakashian (2018) suggest critical thinking is part of the nursing process and to be a critical thinker requires nurses to use knowledge and previous experience to guide their problem solving and to analyse situations. Della Ratta (2016) described findings which also talked about graduate nurses having a sense of developing a tool box after repeated encounters of patient deterioration added to what they knew and helped them know what to expect.

Evidence suggests that as knowledge and skills increase, the ability to detect deterioration increases (Orique et al., 2019). The memory or learning that comes from these episodes of deterioration often stay with the nurse long after the patient has left their care and become part of the nurses' tool box. This thinking aligns with a finding in this study when John revealed that this was certainly true for him, *"I still remember past patients and bring those memories with me to my interactions with new patients."*

Rose too, had an awareness of her knowledge and ability to think critically when managing deteriorating patients growing and developing over time. *"Working with so many patients in AAU and seeing the variety, you get to know when a patient is deteriorating. When I first started, I was a very new nurse in terms of experience but seeing those deteriorating patients, taking care of them and knowing what to do, you start seeing those patterns."* For the nurses in AAU, caring for deteriorating patients is always calling on past experiences and underlying knowledge to guide them in their care and decision making. This concept of pattern recognition and evolving knowledge in the detection and management of deteriorating patients was also evident in literature from Butler (2018), whose study suggested that specific education around patient deterioration was beneficial to nurses, but that the knowledge was acquired in more ways than formal education alone.

Holding nursing intuition

The stories from the nurses revealed that they were very knowledgeable about what a deteriorating patient might look like, and the signs that showed they were in a state of deterioration. What also came to light was that most of the nurses did not just rely on empirical evidence to know a patient was unwell, they also assigned importance to feelings of intuition that arose. For example, Jessie explained how she often experienced 'knowing'. *"I find myself drawn to a particular patient. I keep finding myself back in their room, or it seems to be hard to leave them, and then it becomes clear there was a reason. I had sensed something."* Intuition is defined as feeling "that something is true even when you have no evidence or proof of it" (*Intuition*, 2019). The concept of intuition in nursing has been debated and explored over the years (Melin-Johansson et al., 2017) but is widely evidenced in literature as being valid and important (Carper, 1978; Robert et al., 2014). Intuition is often based on experience and knowledge, rather than just a 'gut feeling' (Melin-Johansson et al., 2017), and is one of the factors nurses consider when recognising deterioration and seeking help (Odell et al., 2009).

Intuition is frequently used in clinical decision making although it is often seen as less scientific than other decision making methods (Pearson, 2013). Intuition is described as comprehending without logic, "knowing without knowing how" (Pearson, 2013, p. 213). In Ben's experience, his experience in the moment seemed to defy logic. *"It was subtle signs that I was picking up that made me think 'hang on, something's not right here'. What I was seeing in the patient did not match up with the vital signs. On paper she looked fine, but in person there was just something not right."* Ben described knowing something wasn't right with his patient, even though her vital signs were normal. His story went on to reveal that he was correct to trust his feelings, as the patient deteriorated significantly shortly afterwards, '*We got her reviewed urgently, and half an hour after I first set eyes on her she was in theatre with a ruptured appendix.*'

Harrison, Kinsella, and DeLuca (2019) suggest through examining the work of philosopher Merleau-Ponty, that knowing can occur from an awareness of one's own body and how it relates to the world, which can lead nurses to be more attuned to changes in their patients, as Ben seemed to be. In this situation, Ben was able to

understand that something was not right, through his own physical awareness. He trusted his own understanding, and utilised this knowing to take action for his patient.

Normalising deterioration

For the nurses working in AAU, caring for deteriorating patients was an everyday experience and had become normal. The nurses were quick to describe what a deteriorating patient looked like, the signs they might present with and what this might mean for the patient. For some of the nurses, deterioration had become so normal it made me wonder what then made the nurses cross over from thinking it was normal, to being concerned. For Taylor, it was partly about comparing the patient to other patients to determine who was the most unwell, '*they have the potential to deteriorate, but you probably compare them to the rest of your load and they are fine.*' Similarly, Grant and Crimmons (2018) argue that patients with comorbidities or complex medical histories are unlikely to have vital signs which fit the blanket idea of normal, which is one of the concerns of relying on Early Warning Scores. Lily questioned the value of the Early Warning Score, saying nurses need to have experience to understand abnormal observations. '*It drives me nuts when people get so stuck on the EWS. Some of the new grads get flustered over a saturation of 95%. I'm like, 'they have smoked for 25 years, 95% is bloody good for them, chill out.'.* This is an example of how a vital sign, which perhaps is abnormal in the text book sense was able to be safely normalised, if there was underlying knowledge and experience to enable the nurse to think critically about the patient and their medical history.

Taylor shared an experience she had in the unit with a patient who was being managed by the AAU team of doctors, who didn't feel that the situation needed to be escalated to the code team, '*Sometimes I think if we had called a code an hour earlier, maybe he wouldn't have been so acutely ill. Sometimes the patient deteriorates almost gets too far, like we only call if they are actually needing resuscitation. It's like an attitude that has kind of developed*'. One of the dangers faced in AAU was that there were so many patients who were acute or deteriorating and the medical teams or local support were already available in the unit, which at times prevented nurses from escalating higher (Kitto et al., 2015). In some ways, having the medical teams so accessible was protective but in other situations it seemed to actually prevent the patient from getting the help they need. The nurses revealed that sometimes they would not feel a

need to escalate their concerns further than the doctors who were present in the unit, even if the EWS pathway indicated they should, because they were able to get the patient seen quickly. The nurses felt supported by the doctors because their concerns were already being actioned, and treatment was commencing, however this led to the urgency for call for a code being toned down. Professional hierarchy is a known barrier to accessing rapid response teams, with medical staff not wanted to inappropriately escalate concerns, or cross hierarchical obstacles (Chua et al., 2019; Chua et al., 2017). Another well-known barrier to following escalation protocols is local cultural rules, such as managing the deterioration within the unit. These cultural rules are usually informal and not well understood (Shearer et al., 2012), which was reflected in the nurses stories within this study.

Knowing from reflection

The nurses shared stories about how they were personally affected by caring for deteriorating patients, and how these experiences lingered with them often long after they occurred. Tricia shared a harrowing story about a young woman dying and said *'I went in to help, and in between getting her into her bed and into a gown, she crashed, and she died. She was just so young. I can still picture her'.* Tricia could still see this young girl in her mind, and the memory of that experience was something she now carries with her. Other nurses told similar stories, about situations that they found hard to deal with. Sally revealed that there was a death in the unit which shook the staff, and said, *'it's really traumatic. It's shocking'.* In this case, Sally shared that although it was unusual, a debriefing session was held in the unit to encourage staff to talk about what happened. Sally revealed how valuable the staff found this. *'That validates that we are not over-reacting, that this is crazy and tense. That goes a long way towards processing it.'* The nurses stories showed that they often had strong emotional reactions to things they had witnessed. A recent study of physicians' experiences of caring for patients during critical events revealed that the encounters were fraught with personal emotional responses, which in many cases had long lasting effects on job satisfaction and burnout (Antinienė & Kaklauskaitė, 2018). The emotional effects of caring for such unwell patients is not limited to the patients or the nurses, but extends to the whole team involved.

The nurses in my study revealed that formal debriefing was rare and there didn't seem to be protocols around conducting these sessions for staff even though they felt they would have found it useful. The lack of formal debriefing was mirrored in the literature from Theophilos, Magyar, and Babl (2009). Debriefing is found to improve performance and self-awareness in clinicians (Tannenbaum & Cerasoli, 2013) as well as promote reflective thinking (Decker et al., 2013). Debriefing can be useful to support the development recommendations for practice, however a barrier to conducting debriefing is a lack of trained facilitators (Decker et al., 2013; Rose & Cheng, 2018). Further to this, reflection has been found to help nurses develop self-awareness and improve clinical skills by gaining new perspectives on situations (Tashiro, Shimpuku, Naruse, Maftuhah, & Matsutani, 2013). The nurses in my study discussed how helpful debriefing would have been in situations that were hard to process, and their stories suggested debriefing would have helped them feel less alone and responsible for what had happened. The research interviews served as an informal debriefing session for some of the nurses, with several nurses revealing that this had been the first time they had talked about what had happened with anyone.

The stories illustrated that 'knowing as a nurse' was complex and strongly influenced by nurses' past experiences and could not be constrained to formal knowledge learnt in a classroom.

7.4   Strengths and limitations

There were a number of clear strengths in this study, including the gaining of an in-depth emic perspective, enabling rich data, the crafting of experiential stories and bridging an important gap in the literature. The stories and meaning of these experiences of the participants were gathered from nurses working in AAUs across Auckland who encountered the phenomenon almost every working day. These participant stories resonated with many other nurses I talked to when discussing my study who agreed that these were similar to their experiences too, adding to the rigour of my analysis.

The sample size of 10 Registered Nurses is both a strength and a limitation. It is a strength in that data saturation was occurring during the interviews, with many nurses telling stories that were similar in nature, pointing to a collective experience.

The small sample size also constituted a limitation, potentially limiting a broader distribution of demographics such as Maori or Pacific. Only one participant was trained overseas, which made me question if the experiences of nurses who were not trained in New Zealand was different. There were two male participants and eight female, therefore gender distribution could be a potential limitation. Although, this is fairly representative of the actual male / female nurse ratio in most practice settings, there were not any clear findings that suggested the experience was inherently different for different genders. Culturally, no participants self-identified as Māori or Pacific, which would have offered a valuable point of view which could be used in a meaningful way to improve the experience of Māori patients who deteriorate in AAUs.

My recruitment was limited to Waitematā and Auckland District Health Boards, whereas I had hoped to recruit additional participants from Counties Manukau District Health Board, who also have an Acute Assessment Unit. This was a potential limitation of this study as Counties Manukau has a diverse cultural and socio-economic patient population which could indicate a wider cultural range of nurses working there.

7.5   Implications for practice

This study's findings have implications for nurses working in Acute Assessment Areas, as well as other acute areas such as Emergency Departments and the wider nursing population in general, bringing to light the emotionality required by nurses in the care of deteriorating patients.

The research findings may be used to develop guidelines for practice for use in AAUs, regarding clinical supervision, debriefing or reflection pathways. This may be valuable for nurses working in DHBs for their own development and learning, as well as providing support for emotionally difficult experiences. The nursing workforce is large, and this is a potential barrier to offering clinical supervision to all staff, however if this was offered to managers and senior nurses, with a particular focus on improving the management of staff who are experiencing traumatic situations, this could have a positive flow on effect to staff.

Encouraging nurses to add reflection and discussion about difficult situations into their shift handover time could be a simple but valuable implementation. In some AAUs the nurses gather as a group with a clinical manager at the beginning of a shift awaiting

assignment of their workload which could be a good opportunity to encourage discussion about recent difficult situations.

This research also highlights the need for nurses to feel able to ask for help and escalate concerns higher without fear of repercussions. Staff must be encouraged to call for help if they have any doubts or concerns. This has partially been addressed by the implementation of the New Zealand Early Warning System, however a campaign to promote this culture would be useful at an organisational level, and help to normalise asking for help.

7.6   Implications for education

My study has revealed that although much is known about detecting and managing patient deterioration, there are several barriers for nurses in the care of these patients, which could potentially be addressed by adjusting the education that nurses receive, at undergraduate, postgraduate and organisational levels.

Nurses working in AAUs or similar areas are more exposed to patient deterioration than in other clinical areas, for this reason education at the organisational level should focus on advanced assessment skills, recognising deterioration as well as response and management of the deteriorating patient. A development of a service specific study day would be beneficial to all nurses working in an AAU, and could be tailored to suit all level of nurses from junior to senior.

This study has highlighted that often the nurses had a 'feeling' about a patient, and could not articulate what was worrying them, but were often proven right as their patient deteriorated. Nurses need to be taught and encouraged to trust their knowing and instincts and get help earlier if they feel something may not be right with their patient. The feelings of intuition seem to occur most often for nurses when they could relate it back to past experiences, therefore this education would be particularly useful at the postgraduate level as well as being offered at an organisational level.

Further to nursing intuition, it is important that the validity of patient or whānau concern is also addressed educationally. Most DHB nurses will be aware of the Kōrero Mai programme, but an understanding around the significance of patient and whānau concern, and how this is a red flag in patient deterioration would be beneficial. This

could be supported with case studies to clearly demonstrate how patients can present with signs and symptoms that appear normal to healthcare professionals, but to a patient's family member are obvious unusual signs for that patient. Including this in organisational education such as simulation, scenarios and in-services would be most beneficial.

Improving the use of language to describe patient deterioration, and to convey urgency when escalating concerns is an important aspect of the care of deteriorating patient. The use of the ISBAR tool provides a well-known structure to communicate concerns (De Meester et al., 2013; Müller et al., 2018). This is already used in one of the DHBs where participants were recruited from, but having this standardised across healthcare in general would be a positive introduction to daily practice through education at the organisational level.

Nurses need emphasis in their undergraduate education regarding the subtle cues that may be present in patients, and how clinical observations are just one facet of detecting deterioration. Clues that a patient may be deteriorating are often present for hours before acute deterioration or arrest occurs (Jones et al., 2013). Increased emphasis on early recognition would be valuable at an organisational level too, which could be provided in the form of practice simulation sessions. There is evidence to suggest that simulation of patient deterioration gives nurses a safe space to practice and improve skills (Bliss & Aitken, 2018; Orique & Phillips, 2018).

7.7   Recommendations for further research

There is a need for continued research regarding nurses' experiences as practice settings and patient populations vary greatly in healthcare and it is evident that nurses experiences are largely missing in literature. There is much to be gained by uncovering nurses experiences and unique perspectives, and this research has further highlighted this by the reminder that so much of nursing is invisible and covered over by performing tasks.

It seems that doctors and other health care professions experiences are missing from the literature also. Exploring these experiences would add depth and richness to what is known about caring for deteriorating patients in general.

Given that New Zealand is culturally diverse, it would be valuable to explore patient deterioration from the unique lens that different cultures such as Indian, Chinese, Filipino, may bring for nurses, patients and their families. The stories of the nurses in this study hinted at this experience being different depending on the nurse or patient's cultural background. Exploring these experiences could shed light on important aspects of patient deterioration which are currently being overlooked.

7.8   Conclusion

The meaning of nurses caring for clinically deteriorating patients is a reflection of what it means to be human, while at the same time being a nurse. So much of what is known about patient deterioration relates to numbers, statistics, vital signs, and technical words. When the nurses were asked 'What does a deteriorating patient look like?' their answers consistently showed a clear awareness of the empirical signs and management of deterioration, but delving deeper into their experiences revealed the human connection hidden behind this technical language. Much like the label of 'nurse' hides the humanness of nursing work, the label of 'patient' hides the true human cost of clinical deterioration.

The findings of this study revealed three main themes; *Being connected*, *Being there as nurse*, and *Being with.* These findings indicated that connectedness affected how clinical deterioration was detected and managed and that the nurses' professional identity meant they were often present for significant moments in patients' lives which then had meaning for them as nurses. The findings also suggested that when nurses were attuned with patients during episodes of deterioration, despite the professional identity, they could not help but relate to the patient on a human level.

Across these findings, the overarching notions of *Being more than nurse, Caring with courage,* and *Knowing as nurse* were evident, and showed that at its essence, although caring for clinically deteriorating patients is a complex and demanding experience for nurses, it is inherently a human to human experience. As the nurses care for deteriorating patients they are often brought into a realisation that they are face to face with human mortality. This lived reality seems to facilitate a transcendence across the boundaries of the nurse / patient relationship, creating an intersection where the nurse and patient meet at a human level. In caring for a deteriorating patient, the

nurse's humanity is called upon. The nurse's humanity is now mirrored in the humanity of the patient in front of them. Nurses' caring for clinically deteriorating patients means, in the moment, the labels and role boundaries start to fall away; it is now more than patient and nurse, it is human to human.

References

Adam, S., & Odell, M. (2005). An acute problem? A report of the National Confidential Enquiry into Patient Outcome and Death. *Nursing in Critical Care*(5), 225. doi:10.1111/j.1362-1017.2005.0135b.x

Al-Moteri, M., Plummer, V., Cooper, S., & Symmons, M. (2019). Clinical deterioration of ward patients in the presence of antecedents: A systematic review and narrative synthesis. *Australian Critical Care, 32*(5), 411-420. doi:10.1016/j.aucc.2018.06.004

Al-Qahtani, S., Al-Dorzi, H. M., Hussain, S., Fong, L., Arabi, Y., Tamim, H. M., . . . Al-Knawy, B. A. (2013). Impact of an intensivist-led multidisciplinary extended rapid response team on hospital-wide cardiopulmonary arrests and mortality. *Critical Care Medicine, 41*(2), 506-517. doi:10.1097/CCM.0b013e318271440b

Alam, N., Hobbelink, E. L., van Tienhoven, A. J., van de Ven, P. M., Jansma, E. P., & Nanayakkara, P. W. B. (2014). The impact of the use of the Early Warning Score (EWS) on patient outcomes: A systematic review. *Resuscitation, 85*(5), 587-594. doi:10.1016/j.resuscitation.2014.01.013

Andrews, T., & Waterman, H. (2005). Packaging: A grounded theory of how to report physiological deterioration effectively. *Journal of Advanced Nursing, 52*(5), 473-481. doi:10.1111/j.1365-2648.2005.03615.x

Annells, M. (1999). Evaluating phenomenology: usefulness, quality and philosophical foundations. *Nurse Researcher*(3), 5.

Antinienė, D., & Kaklauskaitė, Ž. (2018). "What Is Worse Than Death?": Experience Of Critical Events Among Physicians. *Baltic Journal of Sport & Health Sciences, 111*(4), 2-11. Retrieved from http://www.lsu.lt/en/scientific-journals_BJSHS website: http://www.lsu.lt/en/scientific-journals_BJSHS

Ardagh, M. (2015). A comprehensive approach to improving patient flow in our hospitals - the 'left to right, over and under' concept. *New Zealand medical journal (Online), 128*(1420), 55-64. Retrieved from http://www.nzma.org.nz/journal

Ardagh, M. (2017). The 'six hour target' in New Zealand is associated with reduced mortality and greater efficiency. *New Zealand Medical Journal, 130*(1455), 12. Retrieved from http://www.nzma.org.nz/journal

Badolamenti, S., Sili, A., Caruso, R., & FidaFida, R. (2017). What do we know about emotional labour in nursing? A narrative review. *British Journal of Nursing, 26*(1), 48. doi:10.12968/bjon.2017.26.1.48

Beaumont, K., Luettel, D., & Thomson, R. (2008). Deterioration in hospital patients: early signs and appropriate actions. *Nursing Standard, 23*(1), 43-48. Retrieved from https://journals.rcni.com/nursing-standard

Beaver, P. (2017). The challenges of risk control in New Zealand public hospitals. *New Zealand Sociology, 32*(2), 55-80. Retrieved from https://www.nzsociology.nz/index.php/nzs

Blattner, W. (2006). *Heidegger's Being and Time*. London: Bloomsbury Academic.

Bliss, M., & Aitken, L. M. (2018). Does simulation enhance nurses' ability to assess deteriorating patients? *Nurse Education in Practice, 28*, 20-26. doi:10.1016/j.nepr.2017.09.009

Bokhorst, J. A. C., & van der Vaart, T. (2018). Acute medical unit design – The impact of rearranged patient flows. *Socio-Economic Planning Sciences, 62*, 75-83. doi:10.1016/j.seps.2017.08.003

Bourgeault, I. L., Dingwall, R., & De Vries, R. G. (2010). *The SAGE handbook of qualitative methods in health research*. Los Angeles: SAGE.

Bower, R., Jackson, C., & Manning, J. C. (2015). Interruptions and medication administration in critical care. *Nursing in Critical Care, 20*(4), 183-195. doi:10.1111/nicc.12185

Brier, J., Haverly, M., Januario, M. E., Padula, C., Carolyn, M., Tal, A., & Triosh, H. (2015). Knowing 'something is not right' is beyond intuition: Development of a clinical algorithm to enhance surveillance and assist nurses to organise and communicate clinical findings. *Journal of Clinical Nursing, 24*(5-6), 832-843. doi:10.1111/jocn.12670

Brown, G. (2015). Ethical and Moral Courage is Distress among Professional Nurses: A Workplace Issue. *ABNF Journal, 26*(3), 63-64. Retrieved from https://abnf.net/publications

Buckley, B. J., Castillo, E. M., Killeen, J. P., Guss, D. A., & Chan, T. C. (2010). Administration of emergency medicine: Impact of an Express Admit Unit on Emergency Department Length of Stay. *Journal of Emergency Medicine, 39*, 669-673. doi:10.1016/j.jemermed.2008.11.022

Burns, K. A., Reber, T., Theodore, K., Welch, B., Roy, D., & Siedlecki, S. L. (2018). Enhanced early warning system impact on nursing practice: A phenomenological study. *Journal of Advanced Nursing, 74*(5), 1150-1156. doi:10.1111/jan.13517

Butler, C. (2018). Nurses' experiences of managing patient deterioration following a post-registration education programme: A critical incident analysis study. *Nurse Education in Practice, 28*, 96-102. doi:10.1016/j.nepr.2017.10.014

Byrne, D., & Silke, B. (2011). Acute medical units: Review of evidence. *European Journal of Internal Medicine, 22*, 344-347. doi:10.1016/j.ejim.2011.05.016

Caelli, K. (2001). Engaging with phenomenology: Is it more of a challenge than it needs to be? *Qualitative Health Research, 11*(2), 273-281. doi:10.1177/104973201129118993

Carper, B. A. (1978). Fundamental Patterns of Knowing in Nursing. *Advances in Nursing Science*(1), 13.

Carr, L. T. (1994). The strengths and weaknesses of quantitative and qualitative research: what method for nursing? *Journal of Advanced Nursing, 20*(4), 716-721. doi:10.1046/j.1365-2648.1994.20040716.x

Chua, W. L., Legido-Quigley, H., Jones, D. A., Hassan, N. B., Tee, A., & Liaw, S. Y. (2019). A call for better doctor-nurse collaboration: A qualitative study of the experiences of junior doctors and nurses in escalating care for deteriorating ward patients. *Australian Critical Care: Official Journal Of The Confederation Of Australian Critical Care Nurses*. doi:10.1016/j.aucc.2019.01.006

Chua, W. L., Mackey, S., Ng, E. K. C., & Liaw, S. Y. (2013). Front line nurses' experiences with deteriorating ward patients: a qualitative study. *International Nursing Review, 60*(4), 501-509. doi:10.1111/inr.12061

Chua, W. L., See, M. T. A., Legio-Quigley, H., Jones, D. A., Tee, A., & Liaw, S. Y. (2017). Factors influencing the activation of the rapid response system for clinically deteriorating patients by frontline ward clinicians: a systematic review.

International Journal for Quality in Health Care, 29(8), 981. doi:10.1093/intqhc/mzx149

Cioffi, J. (2000). Nurses' experiences of making decisions to call emergency assistance to their patients. *Journal of Advanced Nursing, 32*(1), 108-114. doi:10.1046/j.1365-2648.2000.01414.x

Cioffi, J., Conway, R., Everist, L., Scott, J., & Senior, J. (2010). Changes of concern for detecting potential early clinical deterioration: A validation study. *Australian Critical Care, 23*(4), 188-196. doi:10.1016/j.aucc.2010.04.002

Courage. (2019). In *Collins English Dictionary*. Retrieved from https://www.collinsdictionary.com/dictionary/english/courage

Cox, H., James, J., & Hunt, J. (2006). The experiences of trained nurses caring for critically ill patients within a general ward setting. *Intensive & Critical Care Nursing, 22*, 283-293. doi:10.1016/j.iccn.2006.02.003

Crotty, M. (1996). *Phenomenology and nursing research*. Melbourne: Churchill Livingstone.

Crowther, S., Ironside, P., Spence, D., & Smythe, L. (2017). Crafting Stories in Hermeneutic Phenomenology Research: A Methodological Device. *Qualitative Health Research, 27*(6), 826. doi:10.1177/1049732316656161

Cullinane, M., Findlay, G., Hargraves, C., & Lucas, S. (2005). *National Confidential Enquiry into Patient Outcome and Death. An acute problem?* Retrieved from https://tinyurl.com/y89dtcp7

Cummings, J., & Bennett, V. (2012). *Compassion in Practice. Nursing, Midwifery and Care Staff: Our Vision and Strategy.* Retrieved from https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

Dalton, M., Harrison, J., Malin, A., & Leavey, C. (2018). Factors that influence nurses' assessment of patient acuity and response to acute deterioration. *British Journal of Nursing, 27*(4), 212-218. doi:10.12968/bjon.2018.27.4.212

Davis, P., Ali, W., Lay-Yee, R., Briant, R., Scott, A., & Schug, S. (2003). Adverse events in New Zealand public hospitals II: Preventability and clinical context. *New Zealand Medical Journal, 116*(1183). Retrieved from https://www.nzma.org.nz/

De Chesnay, M. (2014). *Nursing Research Using Phenomenology : Qualitative Designs and Methods in Nursing*. New York: Springer Publishing Company.

De Meester, K., Verspuy, M., Monsieurs, K. G., & Van Bogaert, P. (2013). SBAR improves nurse-physician communication and reduces unexpected death: A pre and post intervention study. *Resuscitation, 84*(9), 1192-1196. doi:10.1016/j.resuscitation.2013.03.016

Decker, S., Fey, M., Sideras, S., Caballero, S., Rockstraw, L., Boese, T., . . . Borum, J. C. (2013). Standards of Best Practice: Simulation Standard VI: The Debriefing Process. *Clinical Simulation in Nursing, 9*(6), S26-S29. doi:10.1016/j.ecns.2013.04.008

Della Ratta, C. (2016). Challenging graduate nurses' transition: Care of the deteriorating patient. *Journal of Clinical Nursing, 25*(19-20), 3036-3048. doi:10.1111/jocn.13358

DeVita, M. A., Hillman, K., & Bellomo, R. (2017). *Textbook of rapid response systems : concept and implementation* (2nd ed.). Switzerland: Springer.

Diekelmann, N. L. (1992). Learning-as-testing: a Heideggerian hermeneutical analysis of the lived experiences of students and teachers in nursing. *ANS. Advances in nursing science, 14*(3), 72-83.

Donohue, L. A., & Endacott, R. (2010). Track, trigger and teamwork: Communication of deterioration in acute medical and surgical wards. *Intensive and Critical Care Nursing, 26*(1), 10-17. doi:10.1016/j.iccn.2009.10.006

Doody, O., & Noonan, M. (2016). Nursing research ethics, guidance and application in practice. *British Journal of Nursing, 25*(14), 803-807. doi:10.12968/bjon.2016.25.14.803

Douw, G., Huisman-de Waal, G., van Zanten, A. R. H., van der Hoeven, J. G., & Schoonhoven, L. (2016). Nurses' 'worry' as predictor of deteriorating surgical ward patients: A prospective cohort study of the Dutch-Early-Nurse-Worry-Indicator-Score. *International Journal of Nursing Studies, 59*, 134-140. doi:10.1016/j.ijnurstu.2016.04.006

Drower, D., McKeany, R., Jogia, P., & Jull, A. (2013). Evaluating the impact of implementing an early warning score system on incidence of in-hospital cardiac arrest. *New Zealand Medical Journal, 126*(1385), 26-34. Retrieved from https://www.nzma.org.nz

Edmonson, C. (2010). Moral courage and the nurse leader. *Online Journal of Issues in Nursing, 15*(3). doi:10.3912/OJIN.Vol15No03Man05

Fasolino, T., & Verdin, T. (2015). Nursing Surveillance and Physiological Signs of Deterioration. *MEDSURG Nursing, 24*(6), 397-402. Retrieved from http://www.medsurgnursing.net/cgi-bin/WebObjects/MSNJournal.woa

Foley, C., & Dowling, M. (2019). How do nurses use the early warning score in their practice? A case study from an acute medical unit. *Journal of Clinical Nursing, 28*(7/8), 1183-1192. doi:10.1111/jocn.14713

Fowler, T. (2015). Starting out: student experiences in the real world of nursing. Caring for a deteriorating patient underlined the importance of 6Cs. *Nursing Standard, 30*(7), 27-27. Retrieved from https://rcni.com/nursing-standard

Fraser, R. (2018). 24-hour nurses strike underway. *Nursing Review*. Retrieved from http://nursingreview.co.nz/24-hour-nurses-strike-underway

Gadamer, H.-G. (2013). *Truth and method* (J. Weinsheimer & D. G. Marshall, Trans. 2nd ed.): London : Bloomsbury.

Gallagher, A. (2011). Moral Distress and Moral Courage in Everyday Nursing Practice. *Online Journal of Issues in Nursing, 16*(2), 1-1. doi:10.3912/OJIN.Vol16No02PPT03

Gao, H., McDonnell, A., Harrison, D. A., Moore, T., Adam, S., Daly, K., . . . Harvey, S. (2007). Systematic review and evaluation of physiological track and trigger warning systems for identifying at-risk patients on the ward. *Intensive Care Medicine, 33*, 667-679. doi:10.1007/s00134-007-0532-3

Gazarian, P. K., Henneman, E. A., & Chandler, G. E. (2010). Nurse decision making in the prearrest period. *Clinical Nursing Research, 19*(1), 21-37. doi:10.1177/1054773809353161

Gill, F. J., Leslie, G. D., & Marshall, A. P. (2016). The Impact of Implementation of Family-Initiated Escalation of Care for the Deteriorating Patient in Hospital: A Systematic Review. *Worldviews on evidence-based nursing, 13*(4), 303-313. doi:10.1111/wvn.12168

Grant, S., & Crimmons, K. (2018). Limitations of track and trigger systems and the National Early Warning Score. Part 2: sensitivity versus specificity. *British Journal of Nursing, 27*(12), 705. doi:10.12968/bjon.2018.27.12.705

Guinane, J., Hutchinson, A. M., & Bucknall, T. K. (2018). Patient perceptions of deterioration and patient and family activated escalation systems—A

qualitative study. *Journal of Clinical Nursing, 27*(7-8), 1621-1631. doi:10.1111/jocn.14202

Hams, S. P. (2000). A gut feeling? Intuition and critical care nursing. *Intensive & Critical Care Nursing, 16*(5), 310-318. doi:10.1054/iccn.2000.1500

Harman, G. (2007). *Heidegger explained : from phenomenon to thing*: Chicago : Open Court.

Harrison, H. F., Kinsella, E. A., & DeLuca, S. (2019). Locating the lived body in client-nurse interactions: Embodiment, intersubjectivity and intercorporeality. *Nursing Philosophy: An International Journal For Healthcare Professionals, 20*(2), e12241-e12241. doi:10.1111/nup.12241

Hassani, P., Abdi, A., Jalali, R., & Salari, N. (2016). The perception of intuition in clinical practice by Iranian critical care nurses: a phenomenological study. *Psychology Research and Behavior Management*(1), 31. doi:10.2147/PRBM.S101040

Hawkins, C. (2014). The transfer of patient care from the Emergency Department to inpatient areas within the intra hospital setting. *Emergency Nurse New Zealand*, 6-10. Retrieved from https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/journal

Health Quality Safety New Zealand. (2016). *Patient deterioration programme: Recognising and responding together*. Retrieved from https://www.hqsc.govt.nz/assets/Deteriorating-Patient/PR/Patient-deterioration-programme-charter-Sep-2016.pdf

Health Quality Safety New Zealand. (2017). *Recognition and response systems: A summary*. Retrieved from https://www.hqsc.govt.nz/our-programmes/patient-deterioration/workstreams/recognition-and-response-systems/

Health Quality Safety New Zealand. (2018). Patient Deterioration - About us. Retrieved from https://www.hqsc.govt.nz/our-programmes/patient-deterioration/about-us/

Health Quality Safety New Zealand. (2019). *Patient, family and whanau escalation process case for change*. Retrieved from https://www.hqsc.govt.nz/our-programmes/patient-deterioration/workstreams/patient-family-and-whanau-escalation/

Heidegger, M. (2010). *Being and Time* (J. Stambaugh, Trans.). Albany: State University of New York Press.

Hill, K. S. (2010). Improving quality and patient safety by retaining nursing expertise. *Online Journal of Issues in Nursing, 15*(3). doi:10.3912/OJIN.Vol15No03PPT03

Howdon, D., & Rice, N. (2018). Health care expenditures, age, proximity to death and morbidity: Implications for an ageing population. *Journal of Health Economics, 57*, 60-74. doi:https://doi.org/10.1016/j.jhealeco.2017.11.001

Howell, K. E. (2013). *An introduction to the philosophy of methodology*. Los Angeles: SAGE.

Hudson, M., Milne, M., Reynolds, P., Russell, K., & Smith, B. (2010). *Te ara tika : guidelines for Māori research ethics : a framework for researchers and ethics committee members*: Health Research Council of New Zealand on behalf of the Pūtaiora Writing Group.

Huynh, T., Kleerup, E., Wiley, J., Savitsky, T., Guse, D., Garber, B., & Wenger, N. (2013). The Frequency and Cost of Treatment Perceived to Be Futile in Critical Care. *JAMA Internal Medicine*(20), 1887. doi:10.1001/jamainternmed.2013.10261

Intuition. (2019). In *Collins English Dictionary*. Retrieved from
https://www.collinsdictionary.com/dictionary/english/intuition

Inwood, M. J. (1999). *A Heidegger dictionary*. Oxford: Blackwell Publishers.

Johnstone, C., Rattray, J., & Myers, L. (2007). Physiological risk factors, early warning
scoring systems and organizational changes. *Nursing in Critical Care*(5), 219.
doi:10.1111/j.1478-5153.2007.00238.x

Jones, D. A. (2018). Introduction. In R. Chalwin, D. A. Jones, A. Psirides, & S. Radford
(Eds.), Managing Deteriorating Patients : A quick bedside guide for rapid
response team members. (1st ed.). Retrieved from https://rrthandbook.org.

Jones, D. A., Bagshaw, S. M., Barrett, J., Bellomo, R., Bhatia, G., Bucknall, T. K., . . . Parr,
M. J. (2012). The role of the medical emergency team in end-of-life care: A
multicenter, prospective, observational study. *Critical Care Medicine, 40*(1), 98-
103. doi:10.1097/CCM.0b013e31822e9d50

Jones, D. A., DeVita, M. A., & Bellomo, R. (2011). Rapid-response teams. *New England
Journal of Medicine, 365*(2), 139-146. doi:10.1056/NEJMra0910926

Jones, D. A., Gillon, S., & Ramsdale, J. (2018). The roles and goals approach to rapid
response team management. In R. Chalwin, D. A. Jones, A. Psirides, & S.
Radford (Eds.), Managing Deteriorating Patients: A quick bedside guide for
rapid response team members. Retrieved from https://rrthandbook.org.

Jones, D. A., Mitchell, I., Hillman, K., & Story, D. (2013). Clinical paper: Defining clinical
deterioration. *Resuscitation, 84*, 1029-1034.
doi:10.1016/j.resuscitation.2013.01.013

Jones, D. A., & Subbe, C. P. (2018). What is known about deteriorating patients? In R.
Chalwin, D. A. Jones, A. Psirides, & S. Radford (Eds.), Managing Deteriorating
Patients: A quick bedside guide for rapid response team members. Retrieved
from https://rrthandbook.org.

Kelly, R., Wright-St Clair, V., & Holroyd, E. (2018). Patients' experiences of nurses'
heartfelt hospitality as caring: A qualitative approach. *Journal of Clinical
Nursing*. doi:10.1111/jocn.14701

Kelly, S. (2010). Qualitative interviewing techniques and styles. In I. L. Bourgeault, R.
Dingwall, & R. G. De Vries (Eds.), *The SAGE handbook or qualitative methods in
health research* (pp. 307-326). Los Angeles: SAGE.

Kessler, I., Heron, P., & Dopson, S. (2015). Professionalization and Expertise In Care
Work: The Hoarding and Discarding of Tasks in Nursing. *Human Resource
Management, 54*(5), 737-752. doi:10.1002/hrm.21695

Kitto, S., Marshall, S. D., McMillan, S. E., Shearer, B., Buist, M., Grant, R., . . . Wilson, S.
(2015). Rapid response systems and collective (in)competence: An exploratory
analysis of intraprofessional and interprofessional activation factors. *Journal of
Interprofessional Care, 29*(4), 340-346. doi:10.3109/13561820.2014.984021

Knarr, L. L., & MacArthur, B. G. (2012). An Admission Unit: A Vital Link to Patient Flow.
Nurse Leader, 10, 45-48. doi:10.1016/j.mnl.2012.03.003

Kreimer, S. (2018). Patient experience takes a front seat. *Physician Leadership Journal,
5*(6), 20-23. Retrieved from
https://www.physicianleaders.org/publications/journal

Lavoie, P., Pepin, J., & Alderson, M. (2016). Defining patient deterioration through
acute care and intensive care nurses' perspectives. *Nursing in Critical Care,
21*(2), 68-77. doi:10.1111/nicc.12114

Lawrence, M. (2018). High winter demand continues to plague hospital emergency departments. *NZ Herald*. Retrieved from https://www.nzherald.co.nz/nz/news/article.cfm?c-id=1eobjectid=121143421

Liaw, S. Y., Scherpbier, A., Klainin-Yobas, P., & Rethans, J. J. (2011). A review of educational strategies to improve nurses' roles in recognizing and responding to deteriorating patients. *International Nursing Review, 58*(3), 296-303. doi:10.1111/j.1466-7657.2011.00915.x

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Newbury Park, California: Sage Publications.

Lindemann, H. (2014). *Holding and letting go : the social practice of personal identities*. New York: Oxford University Press.

Lindh, I. B., Barbosa da Silva, A., Berg, A., & Severinsson, E. (2010). Courage and nursing practice: A theoretical analysis. *Nursing Ethics, 17*(5), 551-565. doi:10.1177/0969733010369475

Lydon, S., O'Connor, P., Byrne, D., Gleeson, L., & Offiah, G. (2016). A mixed-methods investigation of health professionals' perceptions of a physiological track and trigger system. *BMJ Quality and Safety, 25*(9), 688-695. doi:10.1136/bmjqs-2015-004261

Manookian, A., Cheraghi, M. A., & Nikbakht-Nasrabadi, A. (2017). The mirror of humanity: A hermeneutical perspective in nursing. *Nursing Practice Today, 4*(3), 112-114. Retrieved from http://npt.tums.ac.ir/index.php/npt

Marshall, C., & Rossman, G. B. (2011). *Designing qualitative research* (5th ed.). Los Angeles: Sage.

Martland, J., Chamberlain, D., Hutton, A., & Smigielski, M. (2016). Communication and general concern criterion prior to activation of the rapid response team: A grounded theory. *Australian Health Review, 40*(5), 477-483. doi:10.1071/AH15123

Massey, D., Chaboyer, W., & Aitken, L. (2014). Nurses' perceptions of accessing a Medical Emergency Team: A qualitative study. *Australian Critical Care, 27*, 133-138. doi:10.1016/j.aucc.2013.11.001

Matthew, E. (2010). Rescuing the deteriorating patient. *Australian Nursing Journal, 17*(9), 31-33.

McKenna, L., Missen, K., Cooper, S., Cant, R., Bogossian, F., & Bucknall, T. (2014). Situation awareness in undergraduate nursing students managing simulated patient deterioration. *Nurse Education Today, 34*(6), e27-e31. doi:10.1016/j.nedt.2013.12.013

McWilliam, C. (2010). Phenomenology. In I. L. Bourgeault, R. Dingwall, & R. G. De Vries (Eds.), *The SAGE Handbook of Qualitative Methods in Health Research*. London: SAGE Publications Ltd.

Melin-Johansson, C., Palmqvist, R., & Ronnberg, L. (2017). Clinical intuition in the nursing process and decision-making: A mixed-studies review. *Journal of Clinical Nursing, 26*, 3936-3949. doi:10.1111/jocn.13814

Milliken, C. L., Goodwin-Esola, M., & Seeley, S. (2018). Implementation of a Pre-Rapid Response Nurse: A Success Story. *Nurse Leader, 16*(5), 326-330. doi:10.1016/j.mnl.2018.06.003

Minick, P., & Harvey, S. (2003). The early recognition of patient problems among medical-surgical nurses. *MEDSURG Nursing, 12*(5), 291-297. Retrieved from http://www.medsurgnursing.net/cgi-bin/WebObjects/MSNJournal.woa

Mok, W., Wang, W., Cooper, S., Ang, E. N. K., & Liaw, S. Y. (2015). Attitudes towards vital signs monitoring in the detection of clinical deterioration: scale development and survey of ward nurses. *International Journal for Quality in Health Care, 27*, 207-213. doi:10.1093/intqhc/mzv019

Mok, W., Wang, W., & Liaw, S. Y. (2015). Vital signs monitoring to detect patient deterioration: An integrative literature review. *International Journal of Nursing Practice, 21*(S2), 91-98. doi:10.1111/ijn.12329

Moore, D., & Poynton, M. (2015). *Business care for investing in a quality improvement programme to reduce harm caused by clinical deterioration*. Retrieved from https://www.hqsc.govt.nz/assets/Deteriorating-Patient/PR/Deteriorating-patient-investment-case-Sapere-report-Oct-2015.pdf

Mota Sousa, L. M., Alves Marques-Vieira, C. M., Antunes, A. V., Graça Frade, M. d. F., Silva Severino, S. P., & Sousa Valentim, O. (2019). Humor intervention in the nurse-patient interaction. *Revista Brasileira de Enfermagem, 72*(4), 1136-1143. doi:10.1590/0034-7167-2018-0609

Müller, M., Jürgens, J., Redaèlli, M., Klingberg, K., Hautz, W. E., & Stock, S. (2018). Impact of the communication and patient hand-off tool SBAR on patient safety: a systematic review. *BMJ Open, 8*(8), 1. doi:10.1136/bmjopen-2018-022202

Munhall, P. L. (2012). *Nursing research : a qualitative perspective* (5th ed.). Massachusets: Jones & Bartlett Learning.

Needleman, J. (2013). Increasing Acuity, Increasing Technology, and the Changing Demands on Nurses. *Nursing Economics, 31*, 200-202. Retrieved from http://www.nursingeconomics.net/cgi-bin/WebObjects/NECJournal.woa

Neubauer, B. E., Witkop, C. T., & Varpio, L. (2019). How phenomenology can help us learn from the experiences of others. *Perspectives on Medical Education, 8*(2), 90. doi:10.1007/s40037-019-0509-2

New Zealand Nurses Organisation. (2018). Nursing workforce. *NZNO Strategy for Nursing 2018 – 2023.* Retrieved from https://www.nurses.org.nz/nursing_workforce

Nursing Council of New Zealand. (2012). *Code of Conduct*. Retrieved from https://www.nursingcouncil.org.nz/Public/Nursing/Code_of_Conduct/NCNZ/nursing-section/Code_of_Conduct.aspx?hkey=7fe9d496-9c08-4004-8397-d98bd774ef1b

Nursing Review. (2018). Historic 'accept or strike' decision expected Tuesday [Press release]. Retrieved from http://nursingreview.co.nz/historic-accept-or-strike-decision-expected-tuesday

Odell, M., Victor, C., & Oliver, D. (2009). Nurses' role in detecting deterioration in ward patients: systematic literature review. *Journal of Advanced Nursing, 65*, 1992-2006. doi:10.1111/j.1365-2648.2009.05109.x

Orique, S. B., Despins, L., Wakefield, B. J., Erdelez, S., & Vogelsmeier, A. (2019). Perception of clinical deterioration cues among medical-surgical nurses. *Journal of Advanced Nursing*. doi:10.1111/jan.14038

Orique, S. B., & Phillips, L. J. (2018). The Effectiveness of Simulation on Recognizing and Managing Clinical Deterioration: Meta-Analyses. *Western Journal Of Nursing Research, 40*(4), 582-609. Retrieved from doi:10.1177/0193945917697224

Padilla, R. M., Urden, L. D., & Stacy, K. M. (2018). Nurses' Perceptions of Barriers to Rapid Response System Activation: A Systematic Review. *Dimensions Of Critical Care Nursing: DCCN, 37*(5), 259-271. doi:10.1097/DCC.0000000000000318

Pain, C., Green, M., Duff, C., Hyland, D., Pantle, A., Fitzpatrick, K., & Hughes, C. (2017). Between the flags: Implementing a safety-net system at scale to recognise and manage deteriorating patients in the New South Wales public health system. *International Journal for Quality in Health Care, 29*(1), 130-136. doi:10.1093/intqhc/mzw132

Pearce, R. (2018). Hospitals roll out NZ-developed clinical messaging system: North Shore Hospital and Waitakere Hospital have rolled out a smartphone messaging service developed by Auckland-based Oncall Systems Limited. *ComputerWorld (0813295X)*, 1-1.

Pearson, H. (2013). Science and intuition: do both have a place in clinical decision making? *British Journal of Nursing, 22*(4), 212-215. doi:10.12968/bjon.2013.22.4.212

Pirret, A. M., Takerei, S. F., & Kazula, L. M. (2015). The effectiveness of a patient at risk team comprised of predominantly ward experienced nurses: A before and after study. *Intensive & Critical Care Nursing, 31*(3), 133-140. doi:10.1016/j.iccn.2014.10.005

Privacy Act, (1993).

Psirides, A. (2018, November 2018). *State of the Nation: Rapid Response Systems and Patient Deterioration.* Paper presented at the Patient Deterioration Conference, Auckland.

Psirides, A., Hill, J., & Hurford, S. (2013). A review of rapid response team activation parameters in New Zealand hospitals. *Resuscitation*. doi:10.1016/j.resuscitation.2013.01.022

Purling, A., & King, L. (2012). A literature review: graduate nurses' preparedness for recognising and responding to the deteriorating patient. *Journal of Clinical Nursing, 21*(23/24), 3451-3465. doi:10.1111/j.1365-2702.2012.04348.x

Rachels, J., & Rachels, S. (2015). *The elements of moral philosophy*. In. Retrieved from http://ebookcentral.proquest.com/lib/AUT/detail.action?docID=5471292

Reid, L. E. M., Jones, M. C., Weir, C. J., Lone, N. I., Dinesen, L. C., & Morrison, Z. J. (2016). The effectiveness and variation of acute medical units: A systematic review. *International Journal for Quality in Health Care, 28*(4), 433-446. doi:10.1093/intqhc/mzw056

Richards, L., & Morse, J. M. (2013). *Readme first for a user's guide to qualitative methods* (3rd ed.). Los Angeles: Sage.

Robert, R. R., Tilley, D. S., & Petersen, S. (2014). A Power in Clinical Nursing Practice: Concept Analysis on Nursing Intuition. *MEDSURG Nursing, 23*(5), 343-349. Retrieved from http://www.medsurgnursing.net/cgi-bin/WebObjects/MSNJournal.woa

Rooney, T., O'Riordan, D., Silke, B., Moloney, E. D., & Bennett, K. (2008). Impact of an acute medical admission unit on hospital mortality: A 5-year prospective study. *QJM, 101*(6), 457-465. doi:10.1093/qjmed/hcn025

Rose, S., & Cheng, A. (2018). Charge nurse facilitated clinical debriefing in the emergency department. *CJEM: Canadian Journal of Emergency Medicine, 20*(5), 781-785. doi:10.1017/cem.2018.369

Rushton, C., Crilly, J., Adeleye, A., Grealish, L., Beylacq, M., & Forbes, M. (2017). Scoping review of medical assessment units and older people with complex health needs. *Australasian Journal on Ageing, 36*(1), 19-25. doi:10.1111/ajag.12353

Sandelowski, M. (1986). The problem of rigor in qualitative research. *ANS. Advances in nursing science, 8*(3), 27-37.

Schub, E., & Karakashian, A. (2018). *Critical thinking: the nursing process and competent patient care*. Ipswich, Massachusetts: EBSCO publishing.

Scott, I., Vaughan, L., & Bell, D. (2009). Effectiveness of acute medical units in hospitals: A systematic review. *International Journal for Quality in Health Care, 21*(6), 397 407. doi:10.1093/intqhc/mzp045

Shah, S. K., Cardenas Jr, V. J., Sharma, G., & Kuo, Y. F. (2011). Rapid response team in an academic institution: Does it make a difference? *Chest, 139*(6), 1361-1367. doi:10.1378/chest.10-0556

Shearer, B., Marshall, S., Buist, M., Finnigan, M., Kitto, S., Hore, T., . . . Ramsay, W. (2012). What stops hospital clinical staff from following protocols? An analysis of the incidence and factors behind the failure of bedside clinical staff to activate the rapid response system in a multi-campus Australian metropolitan healthcare service. *Quality and Safety in Health Care*(7), 569. doi:10.1136/bmjqs-2011-000692

Smith, G. B., Prytherch, D. R., Meredith, P., & Schmidt, P. E. (2015). Early warning scores: unravelling detection and escalation. *International Journal of Health Care Quality Assurance (09526862), 28*(8), 872-875. doi:10.1108/IJHCQA-07-2015-0086

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis : theory, method and research*: Los Angeles : SAGE, 2009.

Smythe, E. A. (2011). From beginning to end: How to do hermeneutic interpretive phenomenology. In G. Thomson, F. Dykes, & S. Downe (Eds.), *Qualitative research in midwifery and childbirth* (pp. 35-54). London: Routledge.

Smythe, E. A., Ironside, P. M., Sims, S. L., Swenson, M. M., & Spence, D. G. (2008). Doing Heideggerian hermeneutic research: A discussion paper. *International Journal of Nursing Studies, 45*, 1389-1397. doi:10.1016/j.ijnurstu.2007.09.005

Something. (2019). In *Collins English Dictionary*. Retrieved from https://www.collinsdictionary.com/dictionary/english/something_1

Spångfors, M., Molt, M., Samuelson, K., & Bunkenborg, G. (2019). The National Early Warning Score predicts mortality in hospital ward patients with deviating vital signs: A retrospective medical record review study. *Journal of Clinical Nursing*. doi:10.1111/jocn.14728

Spence, D. G. (2017). Supervising for Robust Hermeneutic Phenomenology: Reflexive Engagement Within Horizons of Understanding. *Qualitative Health Research, 27*(6), 836-842. doi:10.1177/1049732316637824

Strickland, W., Pirret, A., & Takerei, S. (2019). Patient and/or family activated rapid response service: Patients' perceptions of deterioration and need for a service. *Intensive & Critical Care Nursing, 51*, 20. doi:10.1016/j.iccn.2018.11.007

Tannenbaum, S. I., & Cerasoli, C. P. (2013). Do Team and Individual Debriefs Enhance Performance? A Meta-Analysis. *Human Factors, 55*, 231-245. doi:10.1177/0018720812448394

Tashiro, J., Shimpuku, Y., Naruse, K., Maftuhah, & Matsutani, M. (2013). Concept analysis of reflection in nursing professional development. *Japan Journal of Nursing Science, 10*(2), 170-179. doi:10.1111/j.1742-7924.2012.00222.x

Theophilos, T., Magyar, J., & Babl, F. (2009). Debriefing critical incidents in the paediatric emergency department: Current practice and perceived needs in

Australia and New Zealand. *Emergency Medicine Australasia*(6), 479.
doi:10.1111/j.1742-6723.2009.01231.x

Thorup, C. B., Rundqvist, E., Roberts, C., & Delmar, C. (2012). Care as a matter of
courage: vulnerability, suffering and ethical formation in nursing care.
Scandinavian Journal of Caring Sciences, 26(3), 427-435. doi:10.1111/j.1471-
6712.2011.00944.x

van der Linden, C., Lucas, C., van der Linden, N., & Lindeboom, R. (2013). Clinical:
Evaluation of a Flexible Acute Admission Unit: Effects on Transfers to Other
Hospitals and Patient Throughput Times. *Journal of Emergency Nursing, 39*,
340-345. doi:10.1016/j.jen.2011.09.024

van Galen, L. S., Lammers, E. M. J., Schoonmade, L. J., Alam, N., Kramer, M. H. H., &
Nanayakkara, P. W. B. (2017). Acute medical units: The way to go? A literature
review. *European Journal of Internal Medicine, 39*, 24-31.
doi:10.1016/j.ejim.2016.11.001

van Manen, M. (1984). Practising phenomenological writing. *Phenomenology &
Pedagogy, 2*(1), 36-69.

van Manen, M. (1990). *Researching lived experience : human science for an action
sensitive pedagogy*. New York: State University of New York Press.

van Manen, M. (2014). *Phenomenology of practice : meaning-giving methods in
phenomenological research and writing*. Walnut Creek, California: Left Coast
Press.

van Zyl, A. B., & Noonan, I. (2018). The Trojan War inside nursing: an exploration of
compassion, emotional labour, coping and reflection. *British Journal of Nursing,
27*(20), 1192-1196. doi:10.12968/bjon.2018.27.20.1192

Vicary, S., Young, A., & Hicks, S. (2017). A reflective journal as learning process and
contribution to quality and validity in interpretative phenomenological analysis.
Qualitative Social Work, 16(4), 550-565. doi:10.1177/1473325016635244

Wilson, A. (2015). A guide to phenomenological research. *Nursing Standard, 29*(34),
38-43. doi:10.7748/ns.29.34.38.e8821

Winters, R., & Neville, S. (2012). Registered Nurse Perspectives On Delayed Or Missed
Nursing Cares In A New Zealand Hospital. *Nursing Praxis in New Zealand, 28*(1),
19-28. Retrieved from http://www.nursingpraxis.org

Wood, C., Chaboyer, W., & Carr, P. (2019). How do nurses use early warning scoring
systems to detect and act on patient deterioration to ensure patient safety? A
scoping review. *International Journal of Nursing Studies, 94*, 166-178.
doi:10.1016/j.ijnurstu.2019.03.012

World Health Organisation. (2018). Ageing. Retrieved from
https://www.who.int/ageing/en/

Wright-St Clair, V. (2015). Doing (interpretive) phenomenology. In S. Nayar & M. D.
Stanley (Eds.), *Qualitative research methodologies for occupational science and
therapy*. Abingdon, Oxon: Routledge.

Zambas, S. (2016). *Data analysis within an interpretive inquiry : meaning as
consequence*: [Los Angeles, California] : SAGE, 2016.

Appendix A - AUTEC Approval

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

12 March 2018

Eleanor Holroyd
Faculty of Health and Environmental Sciences

Dear Eleanor

Re Ethics Application: **18/52 The meaning of nurses' caring for clinically deteriorating patients**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 9 March 2021.

Standard Conditions of Approval

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/researchethics.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/researchethics.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. You are reminded that it is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

For any enquiries, please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: katehinvest@gmail.com; Valerie Wright-St Clair

Appendix B - Locality Approval Waitematā District Health Board

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From: **Kate Hinvest (WDHB)** Kate.Hinvest@waitematadhb.govt.nz
Subject: FW: RM13998 Locality Authorisation
Date: 20 May 2019 at 12:09 PM
To: katehinvest@gmail.com

From: Research & Knowledge Centre [research@waitematadhb.govt.nz]
Sent: Wednesday, 14 March 2018 11:02 a.m.
To: Kate Hinvest (WDHB)
Subject: RM13998 Locality Authorisation

Dear Kate

The Research & Knowledge Centre has now received the relevant approvals for the following study:

Title: The meaning of nurses' caring for clinically deteriorating patients

Registration #: RM13998

This study now has Waitemata DHB Locality Authorisation. Please continue to forward to us copies of all correspondence regarding ongoing ethics approval for this study (if any). All amendments to your study must be submitted to the Research & Knowledge Centre for review.

Note that all research, audit and related activity must meet ethical standards in relation to the safe storage, retention and destruction of research data.

At the conclusion of this study a copy of any outputs, reports or publications should be forwarded to research@waitematadhb.govt.nz

Good luck with your study.

Regards
Research & Knowledge Centre
Level 1, Kahui Manaaki (Building 5)
North Shore Hospital Campus
Waitemata DHB

research@waitematadhb.govt.nz
ph. (09) 486 8920 ext 43740

Legal Disclaimer : www.waitematadhb.govt.nz/Disclaimer.aspx

Appendix C - Locality Approval Auckland District Health Board

AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Auckland DHB
Research Office
Level 14, Support Bldg
Auckland City Hospital
PB 92024, Grafton, Auckland
Phone: 64 9 307 4949 Extn. 23854
Fax: 64 9 307 8913
Email: mwoodnorth@adhb.govt.nz
Website:
http://www.adhb.health.nz/health-professionals/research/

Institutional Approval

22ⁿᵈ June 2018

Kate Hinvest
Assessment and Diagnostic Unit
Waitakere Hospital

Dear Kate,

Re: Research project A+8128 (AUTEC 18/52) Nurses' experiences caring for clinically deteriorating patients

The Auckland DHB Research Review Committee (ADHB-RRC) would like to thank you for the opportunity to review your study and has given approval for your research project. The term of this approval is one calendar year from the date of this letter. If you wish to extend the approval after that date contact the Research Office.

Your Institutional approval is dependent on the Research Office having up-to-date information and documentation relating to your research and being kept informed of any changes to your study. It is your responsibility to ensure you have kept Ethics and the Research Office up to date and have the appropriate approvals. ADHB approval may be withdrawn for your study if you do not keep the Research Office informed of the following:

- Any communication from Ethics Committees, including confirmation of annual ethics renewal
- Any amendment to study documentation
- Study completion, suspension or cancellation

More detailed information is included on the following page. If you have any questions please do not hesitate to contact the Research Office.

Yours sincerely

On behalf of the ADHB Research Review Committee Dr Mary-Anne Woodnorth
Manager, Research Office
ADHB
c.c.   Karen Schiamanski, Anne-Marie Pickering

Welcome *Haere Mai* **|** **Respect** *Manaaki* **|** Together *Tūhono* **|** **Aim High** *Angamua*

Appendix D - AUTEC Approval Amendment

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

2 May 2018

Eleanor Holroyd
Faculty of Health and Environmental Sciences

Dear Eleanor

Re: Ethics Application: **18/52 The meaning of nurses' caring for clinically deteriorating patients**

Thank you for your request for approval of amendments to your ethics application.

The amendment to the Inclusion Criteria (nurses from other DHBs) and data collection protocols (location of interviews) is approved.

I remind you of the Standard Conditions of Approval.

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/researchethics.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/researchethics.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Non-Standard Conditions of Approval

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. If the research is undertaken outside New Zealand, you need to meet all locality legal and ethical obligations and requirements.

For any enquiries please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: katehinvest@gmail.com; Valerie Wright-St Clair

Appendix E - Participant Information Sheet
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Participant Information Sheet

Date Information Sheet Produced: 18th June 2018

Project Title: *The meaning of nurses caring for clinically deteriorating patients*

An Invitation: My name is Kate Hinvest. I am a Registered Nurse and Clinical Nurse Educator working in the Assessment & Diagnostic Unit (ADU) at Waitakere hospital. I would like to invite you to take part in a study about nurses' experiences of caring for clinically deteriorating patients in the Acute Assessment Unit (otherwise known as ADU, SSI, CDU, APU or MAU). Completing this research will allow me to fulfil the requirements of a Master of Health Science at Auckland University of Technology.

What is the purpose of this research?

The purpose of this research is to explore nurses' stories about their experiences in caring for clinically deteriorating patients in the Acute Assessment Unit. Information gained from this study will be used to develop strategies to support nurses and improve patient care.
There are very few studies published so far regarding nursing in an Acute Assessment Unit, and this study aims to offer a unique look at caring for deteriorating patients.

How was I identified and why am I being invited to participate in this research?

You responded to an advertisement about this study, indicating that you are interested in taking part in this research and you fit the criteria needed to participate. As a nurse working in Acute Assessment Unit your stories about caring for deteriorating patients are valuable and important. Ideally, a wide range of ethnicities and levels of nursing experience will allow for a range of different perspectives and ideas to be explored.

What are the inclusion and exclusion criteria?

Registered nurses who currently work in an Acute Assessment Unit (or equivalent unit) will be considered. You must have worked in the unit for more than 6 months, to ensure adequate experience of nursing deteriorating patients.
Nurses who I have worked with previously including current or former colleagues will be excluded. This will include any nurses whose portfolio I have assessed as part of my nurse educator role. I will request that no portfolios from ADU WDHB be assigned to me for assessment to ensure that ADU staff are not disadvantaged by taking part in this research.

How do I agree to participate in this research?

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

You will be asked to sign a consent form if you choose to participate in this research, which you will be given a copy of to keep. You will have two weeks after receiving this information sheet to let me know if you would like to take part.

What will happen in this research?

You will be asked to complete a demographic profile form about you and your Acute Assessment practice experience. You will be interviewed by me, where we will discuss your experiences of caring for deteriorating patients. The interview will take place in a private meeting room at North Shore hospital, outside of your usual work hours. The interview is expected to take 1-1.5 hours, including time for discussion and to sign the consent form. The interview will be audio recorded and then typed into a document. Stories will be extracted from the transcripts and will be returned to you to confirm your words were captured as you intended.

An example of a question you may be asked is: "Tell me about a time when you cared for a deteriorating patient"

What are the discomforts and risks?

It is not anticipated that there are any risks involved in taking part in this research. Some participants may find it uncomfortable to discuss their experiences of caring for deteriorating patients if the situation was upsetting or traumatic.

How will these discomforts and risks be alleviated?

The interview will be a private discussion and you will be able to stop the discussion at any time should it become uncomfortable for you.

AUT Health Counselling and Wellbeing is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992

- let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet

You can find out more information about AUT counsellors and counselling on http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling.

What are the benefits?

Your participation will potentially benefit Acute Assessment Unit nursing staff as a whole. Exploring these nurse experiences will highlight the reality of nursing in an Acute Assessment Unit and will be used to help develop strategies to support nurses and improve the care of deteriorating patients.
I will benefit, as the researcher, by using the research and findings to write a thesis, which will contribute to completing the requirements for a Masters' degree qualification.

How will my privacy be protected?

All reasonable steps will be taken to ensure your privacy and confidentiality. You will be invited to use an assigned pseudonym (false name), unless you prefer to use your own name. Every effort will be made to keep the information confidential, however due to the nature of the experiences being discussed, and the reality of working in a small unit, some details may limit this.

What are the costs of participating in this research?

There are no direct costs to you for participating. Participation will take up to two hours of your time.

What opportunity do I have to consider this invitation?

You will have two weeks from time of first contact to consider this invitation and respond.

Will I receive feedback on the results of this research?

Yes. You will receive a summary of the research findings.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor:

Professor Eleanor Holroyd

Eleanor.holroyd@aut.ac.nz

09 921 9999 ext. 5298

If you require Māori cultural support talk to your whānau in the first instance. Alternatively, you may contact the administrator for He Kamaka Waiora (Māori Health Team) by telephoning 09 486 8324 ext 2324.
If you have any questions or complaints about the study you may contact the Auckland and Waitematā District Health Boards Maori Research Committee or Maori Research Advisor by phoning 09 4868920 ext 3204.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext. 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Kate Hinvest

Kate.hinvest@waitematadhb.govt.nz

027 632 2470

Project Supervisor Contact Details:

Professor Eleanor Holroyd

Eleanor.holroyd@aut.ac.nz

 09 921 9999 ext. 5298

Approved by the Auckland University of Technology Ethics Committee on *12.3.18*, **AUTEC Reference number** *18/52 WDHB* **Reference number:** RM13998 **ADHB Reference number :** A+8128

Appendix F - Consent Form

.

Consent Form

Project title: The meaning of nurses' caring for clinically deteriorating patients

Project Supervisors: Professor Eleanor Holroyd, Dr. Valerie Wright-St Clair

Researcher: Kate Hinvest

○ I have read and understood the information provided about this research project in the Information Sheet dated 4th March 2018

○ I have had an opportunity to ask questions and to have them answered.

○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.

○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.

○ I understand that although I will be allocated a pseudonym (false name), due to the nature of the study some of my answers may unintentionally identify me.

○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.

○ I agree to take part in this research.

○ I wish to receive a summary of the research findings (please tick one): Yes○   No○

Participant's signature: ....………

Participant's name: ....………

Participant's Contact Details (if appropriate):

………………………………………………………………………………………….

………………………………………………………………………………………….

………………………………………………………………………………………….

………………………………………………………………………………………….

Date:

Approved by the Auckland University of Technology Ethics Committee on 12.3.18 AUTEC Reference number 18/52

Note: The Participant should retain a copy of this form.

Appendix G - Māori Research Review Approval

He Kamaka Waiora
Waitematā and Auckland DHB
Level 2, 15 Shea Terrace,
Auckland 0740,
New Zealand
Private Bag: 93-503

20/06/2018

Kate Hinvest
Clinical Nurse Educator
Assessment & Diagnostic Unit
Waitakere Hospital

Re: Nurses' experiences caring for clinically deteriorating patients.

Thank you for providing the following documents the:
- ☐ RRC application
- ☐ Study protocol
- ☐ PIS/CF
- ☐ HDEC application

The study is a regional investigation of nurses' experiences caring for clinically deteriorating patients. There will be up to 10 – 15 participants recruited from within the Auckland region. It is estimated that the number of Māori participating in the study may be approximately 2.

Māori responsiveness:

The study has not been designed to purposively identify and discuss nurses' experiences of caring for clinically deteriorating patients from diverse cultures. Any aspects of care that relate to cultural responsiveness may not be captured. It is recommended that the researchers consider including a question in the interview schedule that relates to nurses' experiences of working with patients of different ethnicities.

It is possible for research to benefit the Maori population even when the research includes all ethnicities. Research can be designed based on a methodology that generates data to provide insights into diverse experiences.

On behalf of the Waitematā and Auckland District Health Boards Māori Research Committee, the study has been approved.

Heoi ano

Kim Southey
Kaupapa Māori Analyst
Waitematā and Auckland DHB
Level 2, 15 Shea Terrace, Auckland 0740,
New Zealand
Private Bag: 93-503
p: +64 021 828 651
email kim.southey@waitematadhb.govt.nz

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Appendix H - Advertisement

DO YOU WORK IN ADU?

ARE YOU A REGISTERED NURSE?

HAVE YOU CARED FOR A DETERIORATING PATIENT?

You may be eligible to take part in research about caring for clinically deteriorating patients in ADU by sharing your stories and experiences. I would love to hear from a wide range of ethnicities or levels of experience – every nurse has a valuable story to tell.

Please contact Kate Hinvest for more information
kate.hinvest@waitematadhb.govt.nz

Approved by the Auckland University of Technology Ethics Committee on 12.3.18 AUTEC Reference number 18/52

Appendix I - Indicative Questions

Indicative Questions

Project title: The meaning of nurses' caring for clinically deteriorating patients.

Project Supervisors: Professor Eleanor Holroyd, Dr. Valerie Wright-St Clair

Researcher: Kate Hinvest

Specifically, the study will aim to answer the research question: What are nurses' experiences of caring for clinically deteriorating patients in the Acute Assessment Unit?

Indicative questions for the interview are:

1. Tell me about being a nurse in the Acute Assessment Unit
2. Tell me about the first time when you cared for a patient who deteriorated
   a) What happened?
3. What did you do? How did you feel?
4. Tell me about the last time you cared for a patient who deteriorated
5. Tell me about a time that caring for deteriorating patients affected you in some way?
   a) What about personally? Or professionally?
6. What has helped you?
7. What was not helpful?
8. What does the term 'deteriorating patient' mean to you?
9. What does caring for a deteriorating patient mean to you?
10. What does caring mean?

Appendix J – Participant Demographic Information
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Demographic Information

Project title: The meaning of nurses' caring for clinically deteriorating patients.

Project Supervisors: Eleanor Holroyd, Valerie Wright-St Clair

Researcher: Kate Hinvest

Please answer the questions below

Are you?
Male □   Female □   Other □   Prefer not to answer □

What age range are you in?
20-25 □   26-30 □   31-35 □   36-40 □   41-45 □   46-50 □   51-55 □   56-60 □   61-65 □

What is your ethnicity?
NZ European/ Pākehā □ Māori □ Pasifika □   Asian □ Other □
MELAA (Middle Eastern, Latin American, African) □

How long have you been a Registered Nurse?
1-5 years □   5-10 years □   10-15 □   15-20 □   20+ □

Where did you first qualify as a Registered Nurse?
New Zealand □   Internationally Qualified □

How long have you worked in ADU?
6 months – 1 year □ 1-2 years □ 3-5 years □ 5-10 years □

What level of practice are you?
RN1 □ RN2 □ RN3 □ RN4 □ Senior Nurse □

What qualifications do you hold? Please specify:

………………………………………………………………………………………………………..

Appendix K – Drawing for Analysis