

Manuscript version: Author's Accepted Manuscript

The version presented in WRAP is the author's accepted manuscript and may differ from the published version or Version of Record.

Persistent WRAP URL:

<http://wrap.warwick.ac.uk/111372>

How to cite:

Please refer to published version for the most recent bibliographic citation information. If a published version is known of, the repository item page linked to above, will contain details on accessing it.

Copyright and reuse:

The Warwick Research Archive Portal (WRAP) makes this work by researchers of the University of Warwick available open access under the following conditions.

Copyright © and all moral rights to the version of the paper presented here belong to the individual author(s) and/or other copyright owners. To the extent reasonable and practicable the material made available in WRAP has been checked for eligibility before being made available.

Copies of full items can be used for personal research or study, educational, or not-for-profit purposes without prior permission or charge. Provided that the authors, title and full bibliographic details are credited, a hyperlink and/or URL is given for the original metadata page and the content is not changed in any way.

Publisher's statement:

Please refer to the repository item page, publisher's statement section, for further information.

For more information, please contact the WRAP Team at: wrap@warwick.ac.uk.

TITLE

Understanding assessment on a hospital ward for older people: a qualitative study.

ABSTRACT

Aim: To explore assessment on a hospital ward for older people from the perspectives of patients and healthcare professionals.

Design: A qualitative study drawing on grounded theory was undertaken between February 2015 and January 2016.

Methods: Interviews with 15 patients and 22 healthcare professionals, a focus group with six healthcare professionals, 45 hours of observation, and review of 18 sets of patient notes. Analysis was conducted using initial and focused coding, continuously comparing data, emerging codes and themes.

Findings: The core category was navigating, constructed through three themes: containing complexity, networking, and situating the process. Navigating assessment was a complex, flexible, context dependent and social process in which healthcare professionals used a combination of formal, informal, visible and invisible ways of working. Registered nurses were at the centre of networking and focused on gathering and sharing information within the multi-disciplinary team, whilst patients had a passive role despite a variety of preferences about their involvement.

Conclusions: Navigating the assessment of older people is contextually situated, includes networking and a professional focus on containing complexity. This process may be enhanced by: 1) making informal assessment visible to others; 2) developing the nurses' role beyond chasing information towards coordinating care; 3) asking patients and acting on how they would like to be involved in decision making.

Impact: Acknowledging that navigating assessment is a social, flexible and complex process, including different ways of working to meet patient needs, may enhance the usability of current assessment guidelines and their development.

KEYWORDS

Aged; Geriatric assessment; Grounded Theory; Interdisciplinary communication; Multi-disciplinary Team; Needs assessment; Nursing; Older People; Qualitative Research.

SUMMARY STATEMENT

Why is this research needed?

- International and national guidelines advocate using Comprehensive Geriatric Assessments when assessing older people in hospital, which is a formal, standardised and structured approach to assessment.
- Comprehensive Geriatric Assessments are not always used in practice.
- It is unclear how assessments are currently undertaken on a hospital ward for older people.

What are the key findings?

- Navigating assessment is a complex, flexible and social process. It is underpinned by three main themes: containing complexity, networking and situating the process, which means each assessment can be undertaken differently depending on its context.
- Patients are constantly informally assessed and this is often invisible to patients and other healthcare professionals.
- Within navigation patients and healthcare professionals are part of a complex networking process with nurses at the centre. Patients have a passive role despite various preferences regarding involvement in decision-making.

How should the findings be used to influence policy/practice/research/education?

- To utilise and develop all aspects of assessment practice within the care of older people, a raised awareness of the social process of navigating is required, including formal, informal, visible and invisible approaches to assessment.
- Nurses need resources and support to find a balance between their duties at the centre of multi-disciplinary networking and providing direct patient care to allow informal assessment to flourish.
- Individual patient's preferences regarding their involvement in decision making needs to be incorporated into assessment practice and healthcare professionals need to review and act on these preferences throughout the patient's admission.

INTRODUCTION

With 524 million people aged 65 and older in 2010, and an expected rise to 1.5 billion in 2050 according to the World Health Organisation (WHO, 2011), the global population is ageing. In the United Kingdom (UK) at least 18% of the population is 65 years or older and this number is expected to increase to a quarter of the population by 2045 (Office for National Statistics, 2017). Healthcare organisations such as the National Health Service (NHS) must meet an increasing demand for care (WHO, 2012a). Assessment of older people is required in order to understand their care needs (NMC, 2014). This study has focused on how these assessments are undertaken on a hospital ward for older people.

Background

Assessing patients' needs is an important aspect of care provided by the multi-disciplinary team (NMC, 2014). Assessment has been defined as the first step in the care process where information about the patient is gathered (American Nursing Association, 2016). However, gathering information needs to be seen in conjunction with taking action (RCN, 2004). Therefore, assessment is:

'The evaluation of a person ... during which time information is collected to identify the patient's needs and formulate a treatment plan.' (Segen's Dictionary, 2012)

This definition includes the gathering of information and the development of a plan of action. Both of these activities are present in Comprehensive Geriatric Assessments (CGAs) which are recommended nationally and internationally (Department of Health, 2001; Vize, 2001; European Parliament, 2006; NHS England South, 2014; WHO, 2015; 2016). CGAs are defined as a diagnostic process where an interdisciplinary team addresses multiple areas of need. The aim is to provide integrated care and treatment with long-term follow-up (Wieland & Hirth, 2003). Despite extensive research regarding the effects of CGAs on patient outcomes (Ellis et al., 2017; Ekdahl et al., 2015), it remains unclear which characteristics are most beneficial for patients and professionals (Bakker & Olde Rikkert, 2015). An NHS benchmarking project (2017) stated that 89% of frailty units incorporate CGAs. However, they did not meet the CGA standards suggested by Wieland and Hirth's (2003) as a care plan or input from nurses or therapists was not always included. Greater clarity is therefore required regarding current assessment in hospital wards for older people. This study aimed to further our understanding of older people are currently assessed during their hospital admission.

THE STUDY

Aim

This study aimed to explore the assessment process on a hospital ward for older people from the perspectives of patients and healthcare professionals.

Design

This study was conducted using a constructivist Grounded Theory (Charmaz, 2014). The philosophical underpinning included the acknowledgement of coexisting multiple subjective truths rather than a search for the absolute truth (Potrac, Jones & Nelson, 2014). It included the importance of context (Bate, 2014), the notion of constructing reality and the researcher's position as part of the construction (Walker & Dewar, 2000). Charmaz (2014, p.17) aims for an *'interpretative portrayal of the studied world'*. Sampling, data collection and analysis were undertaken simultaneously with data informing the direction of the research leading to a conceptual understanding of assessment (Charmaz, 2014).

In the interpretation of the data the researcher's perspective is crucial (Charmaz, 2014). The lead author (HW) had nine years of nursing experience in acute, sub-acute and community care for older people in England and the Netherlands. Interest in the topic arose due to different experiences of assessment, ranging from CGA approaches to less structured ways of working. At the start of this study the researcher believed that all assessment should be in line with a CGA approach due to positive personal experiences in practice, however as the study evolved these beliefs changed towards valuing less formal assessment alongside structured assessment of older people.

Sample/Participants

The study took place on one hospital ward at a UK NHS University Hospital Trust, with 42 beds for older people. Twelve beds were assigned to patients who needed close attention, such as those who had a high risk of falling. Activity coordinators organised daily activities for all patients. All Healthcare Professionals (HCPs) working on this hospital ward and all admitted patients were potential participants. Agency staff, and patients if they were dying or if they lacked capacity, as stipulated by the ethics committee, were excluded. The HCP's identified eligible patients and with their permission contacted the researcher who explained the study and took consent. On six occasions, on the following day, the patient did not remember the purpose of the visit and participation was not pursued. HCPs were approached by the researcher. All participants were given an information sheet, and had at least 24 hours to consider participation before providing written informed consent. All data was anonymised by using participant numbers.

Data was collected through interviews with patients and HCPs, observation of care, review of medical and nursing notes and a focus group with HCPs. These methods will be further explained in the next section. For HCP's a purposive sample was used (Coyne, 1997) followed by theoretical sampling as coding developed. Theoretical sampling is when participants are recruited based on the evolving themes (Charmaz, 2014). For example, data showed Healthcare Assistants (HCAs), unqualified nursing care providers, conducted initial informal assessments and so further HCAs were recruited. Overall, 57 multi-disciplinary HCPs consented to either an interview, being observed, participation in the focus group, or two or three of these options. Further details are presented in table 1.

Insert Table 1

Data collection finished when theoretical saturation was achieved. Theoretical saturation occurs when no new ideas arise within the categories and themes (Charmaz, 2014). Themes were saturated after 18 HCP interviews and another four were conducted to ensure lack of new insights (Marshall, 2013; Charmaz, 2014). Thirty hours of observation were required and a further session was undertaken at the nurses' station and at the patient's bedside to confirm saturation. The place and duration of observation undertaken and time required to review the 18 sets of medical notes is presented in table 2. A focus group with HCPs was conducted during analysis to share the findings which supported the authors' views that saturation was achieved.

Insert Table 2

A convenience sample (Suri, 2011) of relatively healthy older people was obtained due to the exclusion of patients with cognitive impairment and frailer patients declining participation. Of 54 patients who were invited to participate, three gave written informed consent to observation, and 15 to an interview. All 18 patients agreed to a review of their medical and nursing notes. Of the 54 patients, six were excluded during recruitment due to compromised cognition. Reasons given for declining participation were feeling poorly, tired or unable to cope (N=9), unable to read or understand the documentation and unhappy to sign a form (N=9), lack of interest (N=7), family unhappy with participation (N=4), and no reason given (N=1). After twelve patient interviews saturation was reached, three further interviews confirmed saturation of the themes.

Data collection

Interviews

The 22 HCP interviews and 13 of the 15 patient interviews were digitally audio recorded and transcribed verbatim. Two patient interviews were not recorded due to logistic issues, notes were taken and included in the analysis. Interviews took 45-75 minutes, with an average length of 60

minutes. Open questions (see figure 1) guided the conversation and these were amended as analysis progressed. All professionals were happy to be interviewed in a lounge area just outside the hospital ward, whereas all patients requested to remain in bed or at their bedside.

Insert Figure 1

Observation

Observation took place at the patient's bedside, during nurse handovers, around the nurses' stations and during board rounds. Board rounds were daily multi-disciplinary meetings where patients' treatment and discharge progress were addressed. The focus was on assessment, including communication between HCPs and between patients and HCPs. This related to gaining knowledge about the patient and using knowledge to provide care. Field notes were taken during observation sessions and in-depth memos written immediately afterwards. The researcher was an observer participant (Gold, 1958) and direct participation happened on a few occasions to ensure patient safety.

Review of medical and nursing notes

A template of questions was used to review the medical and nursing notes (see Figure 1). Extensive memos were written for each question. Additionally, a general reflection drawn from all data sources was written to reflect the developing findings, challenges and areas to pursue further. Eighteen patients agreed to a review of their nursing and medical notes which took up to 60 minutes each, depending on the complexity of their care. The memos and reflections were uploaded into NVIVO and coded.

Focus group

The focus group of 90 minutes was undertaken at a later stage during the analysis to present the preliminary findings and discuss the emerging themes with HCPs. Open questions (see figure 1) based on the preliminary findings were used to focus the interview (Charmaz, 2014). It was digitally audio recorded, transcribed verbatim and coded.

Ethical considerations

The study was approved by the local Research Ethics Committee (14/WM/1229), with the requirement that patients with cognitive impairment were excluded, and by the NHS Trust's Research and Development department.

Data analysis

NVIVO 10 was used for data management. Research team meetings were held regularly to plan and prepare for each stage of the research and enhance theoretical sensitivity (Charmaz, 2014). The research team consisted of Grounded Theory and content experts. The lead researcher had extensive expertise in the care of older people. Memos were written throughout the research process to include analytical thoughts, methodological developments, and self-reflection. Initial and focused coding (Charmaz, 2014) took place with continuous comparison of data and emerging codes and themes. The core category was identified including three main themes, presented in a conceptual framework to show their connection.

Rigour

To ensure trustworthiness and authenticity, the study drew on criteria presented by Guba and Lincoln (1989) and Charmaz (2014). Charmaz (2014) overlaps with and extends the criteria identified by Guba and Lincoln (1989) by adding “originality” and “usefulness”. To enhance credibility (Guba & Lincoln, 1989) data were collected over twelve months using a variety of data collection methods. A focus group with HCPs confirmed that the findings resonated with their experience. To ensure transferability and dependability a detailed description of the context, participants, methods, research process, and findings have been provided (Guba & Lincoln, 1989). Confirmability was facilitated by using participants’ quotations, researcher memos and field notes to aid the evolving analysis (Charmaz, 2014). Authenticity (Guba & Lincoln, 1989) was demonstrated through written and verbal reflection to enhance awareness of personal interpretations of constructed reality. The originality of the study (Charmaz, 2014) is addressed in the discussion and the usefulness of the study (Charmaz, 2014) in the study recommendations.

FINDINGS

A sample of 57 HCPs included specialist, senior and junior nurses, physicians, HCAs and allied care professionals including occupational therapists, physiotherapists and discharge coordinators. The sample consisted of 16 men and 41 women and experience ranged from a few weeks to over twenty years. The patients, fourteen women and four men, had an average age of 83.5 years, ranging from 67 to 100. Their average length of stay on the hospital ward was 15.2 days, ranging from two to 60 days.

Core category: Navigating

The analysis identified the core category of navigating as the key social process used in assessing older people. It incorporated three themes, which are containing complexity, networking, and situating the process. The core category, themes and codes are presented in table 3. Navigating was defined as a

context dependent, social process in which each assessment can be conducted in a different way. It encompasses extensive networking involving HCPs and patients, and HCPs contain complexity through using formal and informal, visible and invisible ways of working, as they prioritise aspects of care with the aim of meeting competing demands. Situating the process identified the context in which the assessment takes place which included daily hospital ward life and tailoring assessment to individual patient needs. Nurses were at the centre of communication, gathering and sharing information with HCPs whereas patients had a passive role. The focus group participants felt navigating reflected their perspective of practice and supported the emerged core category.

Insert Table 3

A conceptual framework of navigating is presented in figure 2, showing the centrality of containing complexity. This is surrounded by and interlinked with networking. These two aspects of navigation are surrounded by and interlinked with the context in which the assessment occurs. These themes are further explained below.

Insert Figure 2

Theme: Containing complexity

HCPs aimed to meet competing demands by incorporating different elements of assessment, which were embedded in different ways of working.

Elements of assessment

The data revealed three steps of assessment, knowing, understanding and if needed, acting. These were undertaken using a range of different elements, see figure 3.

Insert Figure 3

In the first step knowledge about the patients was gained through hearing, reading or observing. Often these were combined, for instance observing and hearing:

'I notice it straight away if they are not right. ... Then ... I ask the patient how she is' (Allied HCP 23)

In the second step knowledge was understood through combining and comparing knowledge and experience with the current event. For instance, the observed pale skin linking to knowledge about anaemia. HCP's also compared knowledge about the patient in two different ways. Firstly, they compared current with previous knowledge:

'We can compare what they are like now to what they are normally like' (Junior nurse 22)

Secondly, HCPs compared different knowledge about the same event:

'I am trying to match what they are saying with ... the clinical picture, the drugs ... blood results, the blood pressure ... what they look like' (Senior nurse 27)

In step three of the assessment process action was taken if needed, for instance by administering pain relief, making a treatment plan, communicating verbally, documenting or aiming to coordinate or monitor the assessment process. These last three actions were also linked to the theme networking, which is addressed later.

Ways of working

The data showed how the elements of assessment were embedded in different ways of working. These included formal and informal approaches to assessment with different levels of visibility and a task based, prioritised approach to care. The informal approach was explained as an internal process based on instincts and feelings. It does not follow a standardised pattern and is developed through experience. For instance:

'I would walk around all the patients ... just seeing like how they are, just see if they are talking to you, if they are confused or just having a look at their skin. If they are sitting up straight and things like that' (Junior nurse 7)

An informal process does not necessarily result in verbalisation or documentation. It appeared as an embedded way of working, seemingly natural to HCPs who incorporated this process almost continuously.

The formal approach was closely linked to standardised documentation and was a structured and formalised approach using risk assessments and specifically designed assessment documents. HCPs spoke about the formal and informal ways of working as an interlinked approach, both perceived as relevant.

'Sometimes you have the informal thought first ... but then you look for evidence to back up what your instincts are revealing' (Allied HCP 44)

Where the informal approach seemed more natural to HCPs, the formal process appeared to have gained importance from outside the profession:

'In today's society and the culture ... it just proves the point that if it is not written down it hasn't happened' (Junior nurse 30)

Care processes were separated into isolated tasks to manage workloads and meet competing demands.

'Time is something everybody lacks. ... We try to do what is most important' (Physician 39)

Acute medical issues were prioritised above social or chronic issues:

'If an ECG is needed urgently then ... it just overrides ... leg dressings' (Junior nurse 30)

Separating care is potentially due to specialisation and hierarchy as different people hold different information. This caused confusion with some patients:

'Everything seems to be in a separate little box' (Patient 13)

Both informal and formal ways of working had different levels of visibility to patients and HCPs. The informal ways, which had an internal nature, may even be invisible to HCPs themselves:

'Then also, probably not even consciously, you pick up whether someone is very ... frail' (Physician 15)

It was also invisible to colleagues and patients when processes remained internal. The formal ways of working were normally visible to HCPs as they involved formal documentation and communication. To patients, however, the formal assessment may be as invisible as informal assessment, as it was often undertaken out of their sight or earshot:

'You can hear them [HCPs], but you can't see them [HCPs]' (Patient 11)

In summary, containing complexity encompassed the different ways of working when navigating assessment processes through the three steps of knowing, understanding and acting. This included formal, informal, visible and less visible ways of working and incorporated a prioritising approach to manage workloads.

Theme: Networking

Networking between HCPs/ the role of the nurse

The multi-disciplinary team included different disciplines focusing on their area of expertise. HCPs updated one another on the progress made regarding the patient treatment and care, rather than discussing the patients. Multi-disciplinary board rounds to discuss patient progress, hospital ward rounds, nurses' hand overs and documentation were part of formal communication. Informal communication, which was more ad-hoc, ongoing and without a format was particularly valued by HCPs to keep up with the changing environment and patient conditions:

'If I had to work on [a different] hospital ward this afternoon I would feel as if I knew nothing, because ... I am missing all the auditory information' (Allied HCP 44)

Both senior and junior nurses were found at the centre of networking. Senior nurses were overseeing all 42 patients, focusing mainly on admissions, discharges, "poorly" patients and problems. Junior

nurses were responsible for up to twelve patients. All nurses gathered and shared information from and with other disciplines:

'You are in the middle ... like the centre point' (Junior nurse 29)

Nurses described the amount of information as *'overwhelming'* (Junior nurses 22 and 30) and they disliked the time spent on documentation:

'There are days where I just feel all I do is paperwork' (Junior nurse 24)

Other aspects of nursing care, such as personal care, seemed to be perceived with less priority and was often delegated to HCAs:

'They [trained nurses] have to write their assessment ... they rely on us then to give them the feedback' (HCA 1)

'You are ... relying on your HCAs. ... I would like to do more patient care' (Junior nurse 24)

Nurses summarised their networking activities as *'chasing people.'* (Junior nurse 7). This suggested that nurses check whether a range of activities have taken place, which differs from coordinating care in which activities are steered. Additionally, other HCPs did not always listen to the information nurses were able to share:

'Hospital ward nurses are the ones who seem to have the most comprehensive information, but they are not always listened to' (Field notes 13)

Networking between patients and HCPs

The data revealed a difference between updating and actively involving the patient in decision making. HCPs used updating to provide information to the patient and/or their relatives. Different views were shared regarding the extent to which patients felt they had been updated:

'The doctor took very much time in explaining and telling me what was going to go on' (Patient 9)

'I was told after the scan I could go home. ... I am still lying here and I haven't got a clue' (Patient 12)

Networking with patients mostly did not move beyond updating, with limited examples of patient involvement in the data. Patients presented different preferences regarding their level of involvement in decision making, with some of them preferring a more active role than others. One patient, who was more involved in decision-making explained how this led to disagreement:

'I want to go home. ... [The physician] ... didn't want to hear it... I don't think he thought that was a possibility' (Patient 10)

Overall, the role of the patient within networking appeared to be a passive one:

'This isn't my body ... for a few days now, because it is theirs' (Patient 9)

'If you are a patient ... you grin and bear it' (Patient 11)

In summary, networking was a key professional activity within navigating assessment and patients had a largely passive role. Nurses were found at the centre of networking as they focused on chasing others to gain and share information about the patient with the multi-disciplinary team.

Theme: Situating the process

Navigating an assessment emerged as context-dependent, influenced by the individual patient needs and the hospital ward environment.

Individual patient needs

Individual patient needs underpinned all three steps of assessment and in particular the third step of acting.

'Acting ... is contextual It will be slightly different from patient A, from patient B, on the same assessment' (Physician 39)

The timing and content of information that was required from or about the patient was based on patient's needs.

'If ... they are from their own home ... I can ask them a little bit about how are they coping. ... If they are in a nursing home ... I might not ask them so many questions about that' (Physician 13)

Cognition was mentioned as an important influence on navigating assessments. For instance, to diagnose pain a HCA mentioned:

'I think facial expressions say a lot when people can't express other ways' (HCA 1)

Additionally, information was gathered via family or care home professionals when patients were unable to do this. Therefore, each assessment process was navigated to meet the patient's needs.

Daily hospital ward life

Daily hospital ward life focused on practical resources and ward processes, including time, staff availability and guidelines:

'It depends ... how busy the hospital ward is and where the nurses are. ... I would try and ask them if there is any nursing concern for that patient, but ... that doesn't always happen' (Physician 15)

'At the end of the day, this is the hospital guidelines, this is how you are supposed to [carry out your work]' (HCA 1)

Guidelines influenced assessment practice, such as existing predesigned assessment documentation. Additionally, risk assessments add up to actions dictated on the basis of scores, rather than on clinical judgement. Therefore, following the guidelines influenced the navigating process. In summary, the third theme focused on how assessments are embedded in and influenced by their context.

DISCUSSION

Although guidelines and literature advocate a standardised and formalised approach, this study presented navigating as the key social process in assessing older people. Navigating is a complex, flexible, context dependent, and social process in which HCPs constantly network and use different ways of working to meet competing demands. They use a variety of formal and informal processes to navigate assessment and provide care which may be invisible to others. Additionally, nurses were found at the centre of networking as they chased other members of the multi-disciplinary team. Their role in direct patient care was limited, despite the informal assessment requiring close contact between nurses and patients. Lastly, the patient's role was passive despite different preferences regarding their role within the networking process. In this section these points will be further discussed.

Originality is demonstrated in the identification of navigating as the central process of assessment (Wiltjer, 2017). Navigating has been used to describe the process in which nurses signpost patients through the healthcare system for treatment and disease management (Cantril & Haylock, 2013; Cathro, 2016; McMurray & Cooper, 2016). In these studies, assessment is the first step of navigating, whereas in the current study navigating is the core process of assessment. This is a new finding.

The literature on assessing older people mainly focuses on CGAs (NHS England South, 2014; NMC, 2014; WHO, 2016; Ellis et al., 2017) which is a linear and standardised process where information is gained and care is planned and provided in a structured manner. This neglects the social process of navigating where HCPs constantly network, contain complexity by using different ways of working and tailor each assessment to its context. This suggests that lack of use of CGAs in practice is not merely an implementation failure (Gladman et al., 2016) but a failure to consider the social process in which assessment occurs.

To maintain the complexity of the navigated assessment within its context, HCPs used different ways of working including diverse levels of formality and visibility and a task based approach to care, supporting the work by Penney et al. (2016). Informal ways of working were identified as using tacit knowledge (Polyani, 1966; Schön, 1995; Gabbay & Le May, 2004; Bate et al., 2012) where experience of practice is valued (Benner, 2001; Rycroft-Malone et al., 2010). HCPs used the informal and formal approach in combination, for instance formal information could support initial informal assessment.

Therefore, both approaches were valued and used in assessment processes and HCPs need to have the skills to incorporate both in daily practice.

Some aspects of navigating assessment were invisible to HCPs, patients, or both, due to internal processing of information. Invisible care may hide the complexity of care processes and consequently HCPs may not be acknowledged for this advanced skill (Allen, 2015). HCPs were also prioritising their work by separating care processes into tasks. These findings resonate with current literature which highlights working within resource limitations which may lead to potential omissions in care (Maben et al., 2012; Jones, 2016; Griffiths et al., 2018).

Nurses gathered and shared information as direct patient care was delegated to HCAs, supporting Allen (2015) and Kessler, Heron and Dopson (2015). Although nurses valued their networking role, time spent undertaking direct patient care allowed for close observation of and communication with the patient as part of informal assessment practice. Allen (2015) advocates a move away from direct patient care towards more tasks related to care organisation and planning. However, the current findings suggested expertise is required for informal assessment, incorporating knowledge and experience, and thus nurses should remain active in direct patient care. This suggests registered nurses require a balance between direct patient care and their role at the centre of multi-disciplinary networking. Additionally, as HCAs undertake informal assessment they need appropriate training to enhance their skills. The current study points to a continued conflict between the nurses' aim to coordinate care and the reality of chasing others. The nurses' role within the team has been linked to a potentially lower status than, for instance, physicians and senior therapists (Allen, 2015; Liberati, Gorli & Scaratti, 2016). Historically nurses are largely female and a supporting profession (Goodman, 2015) and the chasing role may be part of this legacy.

Most patients in this study had a relatively passive role and limited involvement within the assessment process. These findings differ from guidelines (NHS England South, 2014; NMC, 2015; WHO, 2015) and literature highlighting Person-Centred Care (McCormack et al., 2010; Ekman et al., 2011). Patients had differing preferences regarding their level of involvement in decision-making, supporting findings by Tobiano et al. (2015). The findings from the current study pointed to the importance of assessing, reviewing and facilitating individually preferred levels of involvement.

Limitations

Strengths of the study include the use of a constructivist Grounded Theory and qualitative methods, providing a philosophical underpinning and 'tools' to explore patients' and HCPs' perspectives on the assessment process. HCPs from a range of disciplines took part, allowing for multi-disciplinary perspectives.

A limitation of the study is that it was conducted on one hospital ward, therefore the findings are not necessarily transferrable. A clear description of the findings and context provides an opportunity for readers to decide how the study could relate to their situation (Charmaz, 2014).

Due to the ethics committee's advice, patients with cognitive impairment were excluded. The prevalence of dementia amongst patients of 70 years and older in hospital ranges between a third (Briggs et al., 2016), 25-29% (Timmons et al., 2015), and 42.4% (Sampson et al., 2009). In addition, in this study 30 of 54 patients declined participation for reasons mentioned earlier. Therefore, the researcher recruited patients based on availability, resulting in a convenience sample. Although this resulted in saturation of the available data, this was not theoretical saturation as suggested in Grounded Theory (Charmaz, 2014).

CONCLUSION

To utilise and develop all aspects of assessment practice within the care of older people, a raised awareness of the social process of navigating assessment is required. This includes formal, informal, visible and invisible approaches to assessment. Education and practice settings should provide the opportunity to reflect on, explain, purposefully use and develop skills in relation to navigating assessment processes. Additionally, nurses need resources and support to find a balance between their networking duties which they aim to develop from chasing others to coordinating the team effort alongside providing direct patient care to undertake informal assessment. HCAs require appropriate training to enhance their role within informal assessment. Further research is needed to understand the way HCPs incorporate informal and invisible assessment, and how this can be developed further while HCAs are undertaking most direct patient care. Patient engagement should be incorporated with involvement preferences accommodated throughout assessment. Further research is required to explore how to facilitate individual involvement preferences within navigation of assessment.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet the following criteria (recommended by the ICMJE [<http://www.icmje.org/recommendations/>]):

- Substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
- Drafting the article or revising it critically for important intellectual content.

ACKNOWLEDGEMENTS

We are very grateful to the study participants. This PhD was a self-funded project. Some funding towards university fees was secured from the Nightingale Fund, the Reid Trust, and the Barber's Company Clinical Nursing Scholarship.

CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

ORCHID

Hanneke Wiltjer: 0000-0001-9765-9765

REFERENCES

Allen, D. (2015). *The invisible work of nurses: Hospitals, organisations and healthcare*. London: Routledge.

American Nursing Association. (2016). *The nursing process*. Retrieved from <http://www.nursingworld.org/EspeciallyForYou/What-is-Nursing/Tools-You-Need/Thenursingprocess.html> [Accessed 27 January 2017 Accessed 7 July 2018].

Bakker, F. C., & Olde Rikkert, M. G. M. (2015). Hospital care for frail elderly adults: From specialized geriatric units to hospital-wide interventions. *Interdisciplinary Topics in Gerontology and Geriatrics*, 41, 95-106.

Bate, L., Hutchinson, A., Underhill, J., & Maskrey N. (2012). How clinical decisions are made. *British Journal of Pharmacology*, 74(4), 614-620.

Benner, P. (2001). *From novice to expert: Excellence and power in clinical nursing practice. Commemorative Edition*. New Jersey: Prentice Hall Health.

Briggs, R., Dyer, A., Nabeel, S., Collins, R., Doherty, J., Coughlan, T., O'Neill, D., & Kennelly, S. P. (2016). Dementia in acute hospital: the prevalence and clinical outcomes of acutely unwell patients with dementia. *QJM and International Journal of Medicine*, 110(1), 33-37.

Challis, D., Abendstern, M., Clarkson, P., Hughes, J., & Sutcliff C. (2010). Comprehensive assessment of older people with complex care needs: the multi-disciplinarity of the Single Assessment Process in England. *Ageing & Society*, 30, 1115-1134.

Cantril, C., & Haylock, P.J. (2013). Patient navigation in the oncology care setting. *Seminars in Oncology Nursing*, 29(2), 76-90.

Cathro, H. (2016). Navigating through chaos. Charge nurses and patient safety. *The Journal of Nursing Administration*, 46(4), 208-214.

Charmaz, K. (2014). *Constructing Grounded Theory* (2nd ed.). Thousand Oaks, CA: SAGE Publishing.

Coyne, I. (1997). Sampling in qualitative research. Purposeful and theoretical sampling: merging or clear boundaries? *Journal of Advanced Nursing Practice*, 26(3), 623-630.

Department of Health. (2001). *Modern Standards and Service Models, Older People, National Service Framework for Older People*. Retrieved from

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198033/National_Service_Framework_for_Older_People.pdf Accessed 1 February 2017.

Ekdahl, A. W., Sjöstrand, F., Ehrenberg, A., Oredsson, S., Stavenow, L., Wisten, A., Wårdh, A., & Ivanoff, S. D. (2015). Frailty and comprehensive geriatric assessment organized as CGA-hospital ward or CGA-consult for older adult patients in the acute care setting: A systematic review and meta-analysis. *European Geriatric Medicine*, 6(6), 523-540.

Ekman, I., Swedberg, K., Taft, C., Lindseth, A., Norberg, A., Brink, E., Carlsson, J., Dahlin-Ivanoff, S., Johansson, I., Kjellgren, K., Lidén, E., Öhlén, J., Olsson, L., Rosén, H., Rydmark, M., & Sunnerhagen, K. S. (2011). Person-centred care- ready for prime time. *European Journal of Cardiovascular Nursing*, 10(4), 248-251.

Ellis, G., Gardner, M., Tsiachristas, A., Langhorne, P., Burke, O., Harwood, R. H., Conroy, S. P., Kircher, T., Somme, D., Saltvedt, I., Wald, H., O'Neill, D., Robinson, D., & Shepperd, S. (2017). Comprehensive geriatric assessment for older adults admitted to hospital. *Cochrane Database of Systematic Reviews* 2017, Issue 9. Art. No.: CD006211. DOI: 10.1002/14651858.CD006211.pub3.

European Parliament. (2006). *Decision No 1982/2006/EC of the European Parliament and of the Council of 18 December 2006 concerning the Seventh Framework Programme of the European Community for research, technological development and demonstration activities (2007-2013)*.

Statements by the Commission. Retrieved from <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32006D1982:EN:NOT> Accessed 4 February 2017.

Fried, L. P., Tangen, C. M., Walston, J., Newman, A. B., Hirsch, C., Gottdiener, J., Seeman, T., Tracy, R., Kop, W.J., Burke, G., McBurnie, M. A., & Group, C.H.S.C.R. (2001). Frailty in older adults: evidence for a phenotype. *The Journals of Gerontology. Series A, Biological Sciences and Medical Sciences*, 56(3), M146-156.

Fried, L. P., Ferrucci, L., Darer, J., Williamson, J. D., & Anderson, G. (2004). Untangling the concepts of disability, frailty, and comorbidity: implications for improved targeting and care. *The Journals of Gerontology. Series A, Biological Sciences and Medical Sciences*, 59(3), 255-263.

Gabbay, J., & Le May A. (2004). Evidence based guidelines or collectively constructed “mindlines?” Ethnographic study of knowledge management in primary care. *British Medical Journal*, 329(7473), pp.1013, doi: <https://doi.org/10.1136/bmj.329.7473.1013>.

Gladman, J. R. F., Conroy, S. P., Ranhoff, A. H., & Gordon, A. L. (2016). New horizons in the implementation and research of comprehensive geriatric assessment: knowing, doing and the ‘know-do’ gap. *Age and Ageing*, 45(2), 194-200.

Gold, R. L. (1958). Roles in sociological field observations. *Social Forces*, 36(3), 217-223.

Goodman, B. (2015). Why do nurses behave as they do? Retrieved from <http://www.bennygoodman.co.uk/why-do-nurses-behave-as-they-do/> Accessed 13 January 2017.

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. Thousand Oaks, CA: SAGE Publishing.

Griffiths, P., Recio-Saucedo, A., Dall’Ora, C., Briggs, J., Maruotti, A., Meredith, P., Smith, G. B., Ball, J. & Missed Care Study Group. (2018). The association between nurse staffing and omission in nursing care; a systematic review. *Journal of Advanced Nursing, ahead of print*, doi: 10.1111/jan.13564.

Imison, C., Poteliakhoff, E., & Thompson J. (2012). *Older people and emergency bed use. Exploring variation*. Retrieved from https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/older-people-and-emergency-bed-use-aug-2012.pdf Accessed 9 March 2018.

Jones, T. L. (2016). What nurses do during time scarcity- and why. *The Journal of Nursing Administration*, 46(9), 449-454.

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.

Liberati, E. G., Gorli, M., & Scaratti, G. (2016). Invisible walls within multidisciplinary teams: Disciplinary boundaries and their effects on integrated care. *Social Science & Medicine*, 150, 31-39.

Maben, J., Adams, M., Peccei, R., Murrells, T., & Robert, G. (2012). ‘Poppets and parcels’: the links between staff experience of work and acutely ill older peoples’ experience of hospital care. *International Journal of Older People Nursing*, 7(2), 83-94.

Maguire, D., Dunn, P., & McKenna, H. (2016). *How hospital activity in the NHS in England has changed over time*. Retrieved from <https://www.kingsfund.org.uk/publications/hospital-activity-funding-changes> Accessed 29 January 2018.

Marshall, B., Cardon, P., Poddar, A. & Fontenot, R. (2013). Does sample size matter in qualitative research?: A review of qualitative interviews in IS research. *Journal of Computer Information Systems*, 54(1), 11-22.

McCormack, B., Karlsson, B., Lerdal, A., & Dewing J. (2010). Exploring person-centredness: a qualitative meta-synthesis of four studies. *Scandinavian Journal of Caring Sciences*, 24(3), 620-634.

McMurray, A., & Cooper, H. (2016). The nurse navigator: An evolving model of care. *Collegian: The Australian Journal of Nursing Practice, Scholarship & Research*, 24(2), 205-212.

National Health Service Benchmarking Network. (2017). *Older people's care in acute settings national report*. Retrieved from http://www.bgs.org.uk/pdf/cms/event_downloads/0318_benchmarking_network.pdf Accessed 21 March 2018.

National Health Service England South. (2014). *Safe, compassionate care for frail older people using an integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders*. Retrieved from <https://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf> Accessed 5 February 2018.

Nursing & Midwifery Council. (2014). *Standards for competence for registered nurses*. Retrieved from <https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-competence-for-registered-nurses.pdf> Accessed 20 March 2018.

Nursing & Midwifery Council. (2015). *The code, standards of conduct, performance and ethics for nurses and midwives*. Retrieved from <https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf> Accessed 5 February 2018.

Office for National Statistics. (2017). *Overview of the UK population: July 2017*. Retrieved from <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/overviewoftheukpopulation/july2017> Accessed 26 January 2018.

Penney, W., Poulter, N., Cole, C., & Wellard, S. (2016). Nursing assessment of older people who are in hospital: exploring registered nurses' understanding of their assessment skills. *Contemporary Nurse*, 52(2-3), 313-325.

Polanyi, M. (1966). *The tacit dimension*. London: Routledge and Kegan Paul Ltd.

- Rycroft-Malone, J., Fontenla, M., Bick, D., & Seers, K. (2010). A realistic evaluation: the case of protocol based care. *Implementation Science*, 5(38), doi: 10.1186/1748-5908-5-38.
- Sampson, E. L., Blanchard, M. R., Jones, L., Tookman, A., & King, M. (2009). Dementia in the acute hospital: prospective cohort study of prevalence and mortality. *The British Journal of Psychiatry*, 195(1), 61-66.
- Schön, D.A. (1995). *The reflective practitioner: how professionals think in action*. Farnham: Ashgate Publishing.
- Segen's Dictionary. (2012). *Assessment*. Retrieved from <https://medical-dictionary.thefreedictionary.com/assessment> Accessed 30 Oct 2017.
- Suri, H. (2011). Purposeful sampling in qualitative research synthesis. *Qualitative Research Journal*, 11(2), 63-75.
- Timmons, S., Manning, E., Barrett, A., Brady, N. M., Browne, V., O'Shea, E., Molloy, D. W., O'Regan, N. A., Trawley, S., Cahil, S., O'Sullivan, K., Woods, N., Maegher, D., Ni Chorcair, A. M., & Linehan, J. G. (2015). Dementia in older people admitted to hospital: a regional multi-hospital observational study of prevalence, associations and case recognition. *Age and Ageing*, 44(6), 993-999.
- Tobiano, G., Marshall, A., Bucknall, T., & Chaboyer, W. (2015). Patient participation in nursing care on medical hospital wards: An integrative review. *International Journal of Nursing Studies*, 52(6), 1107-1120.
- Vize, R. (2012). *Delivering dignity*. Retrieved from <http://www.ageuk.org.uk/Global/Delivering%20Dignity%20Report.pdf?dtrk=true> Accessed 10 February 2018.
- Walker, E., & Dewar, B. J. (2000). Moving on from interpretivism: an argument for constructivist evaluation. *Journal of Advanced Nursing*, 32(3), 713-720.
- Wieland, D., & Hirth V. (2003). Comprehensive geriatric assessment. *Cancer Control*, 10(6), 454-462.
- Wiltjer, H. (2017). Exploring the assessment process on a hospital ward for older people: A Constructivist Grounded Theory. PhD thesis. University of Warwick.
- World Health Organisation. (2011). *Global Health and Ageing*. Retrieved from http://www.who.int/ageing/publications/global_health.pdf Accessed 10 February 2018.
- World Health Organisation. (2012). *About ageing and life-course*. Retrieved from http://www.who.int/ageing/about/ageing_life_course/en/index.html Accessed 10 February 2018.

World Health Organisation. (2015). *World Report on Ageing and Health*. Retrieved from http://apps.who.int/iris/bitstream/10665/186463/1/9789240694811_eng.pdf?ua=1 Accessed 10 February 2018.

World Health Organisation. (2016). *Global strategy and action plan on ageing and health (2016-2020)*. Retrieved from <http://www.who.int/ageing/GSAP-Summary-EN.pdf?ua=1> Accessed 10 February 2018.