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Authors	Lane, Aoife;Landers, Margaret;Andrews, Tom
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UCC
University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

Abstract

Aim: To explore the influences on nursing practice in acute hospital care.

Design: A Classic Grounded Theory study

Methods: Data collection (2013 – 2015) was through interviews and non-participant observations. Analysis was undertaken using constant comparative data analysis and theoretical sampling. Memo writing was used as an aid to understanding and conceptualising data during analysis. Theoretical coding served to integrate emerging concepts.

Results: This theory explains core nursing as a nebulous intention, an idea which acute care nurses retain throughout each shift, that they will nurse their patients fully when they have the opportunity. It reveals this as the resolution of their main problem which is the constant deferral of core nursing care. This paper explains its two sub-core categories, accommodating and integrity eroding.

Conclusion: The theory highlights nurses' attitudes towards their role, demonstrated by deferring it to accommodate the work of others, but offers a new perspective on the significant contribution nurses make to the safe and cohesive transition of patients through the acute healthcare system.

Impact: The theory adds a new understanding of the unique contribution nurses make to patient health and safety in acute care environments. It also provides insight into nurses' attitudes towards their own professional work. It explains the consequences of attitudes which undermine core nursing when it competes for priority with accommodating. Accommodating indicates a greater workload for nurses than has been previously understood in explaining the activities, additional to core nursing care, which nurses undertake to contribute safety and cohesion to the patient's acute care journey. These new insights suggest a role for managers in recognising accommodating in decisions about staffing and resources and for educators in improving the profession's regard for its theoretical underpinnings and for its self-image.

Key words: Accommodating, conforming, connecting, coordinating, intuiting, nursing, prioritising, vigilance

Introduction

This study arose from a concern that the nursing needs of patients may not always be the focus of acute care nursing activity. The study's exploration of influences on nursing revealed the main concern among nurses to be an inability to consistently reach their patients to perform holistic nursing care.

Realisation that patients do not routinely receive good quality nursing has been growing in recent years as international cohorts of researchers repeatedly demonstrate missed and rationed nursing with corresponding potential damage to patients' health outcomes (Kalisch, Tschannen & Lee, 2011; Schubert et al. 2013; Winsett, Rottet, Schmitt, Wathen & Wilson 2016). Studies to determine the exact elements of nursing that are missed or rationed suggest common trends to do with patients' hygiene and mobility needs (Papastavrou, Andreou & Vryonides, 2014; Papastavrou, Charalambous, Vryonides, Eleftheriou, & Merkouris, 2016; Winsett et al. 2016,) and failure to individualise patients' nursing care (Vryonides Papastavrou, Charalambous, Andreou, & Merkouris, 2015). Ward environmental factors (Kirwan, Mathews & Scott, 2013) and nurse patient ratios (Aiken et al. 2014, Ball et al. 2018) are demonstrably linked with patient outcomes and attempts are underway to determine safe nurse staffing levels (Drennan et al. 2018; Griffiths et al. 2016).

The addition of this study is clarification of the patterns of behaviour among nurses which cause nursing care to be missed. The theory explains nurses' continuous struggle to achieve nursing against the competing demands of hospital systems and how the negative value nurses place on their own profession's status compounds this. Nurses meet organisational demands through accommodating at the expense of core nursing which often remains a nebulous intention.

Background

According to the International Council of Nurses (2012) '*Nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health and to alleviate suffering.'*

In acute care, the actions towards improvement of health outcomes are largely time sensitive and frequently require rapid intervention (Hirshon et

al., 2013). The large tertiary referral hospital within which this study was undertaken included all specialties and all levels of inpatient care.

Previous studies have investigated specific potential influences on nursing work. Poor work environments and scarce resources have been identified as negative influences on practice and there is evidence that nurses attribute this to budget restrictions (Harvey, Thompson, Pearson, Willis & Toffoli, 2017). Tang and Idris (2016) found nurse staffing and resources to be poorly rated by nurses and Ducharme, Bernhardt, Padula, & Adams (2017) identified resource procurement as the area where nurse leaders had the least influence.

A further influence arises from the fact that priorities for nurses include ward management and, often, multidisciplinary team (MDT) coordination. This work is additional to the discreet professional role championed by nurse theorists and it impacts negatively on the quality of nursing practice (Kirwan et al. 2013; Locke, Leach, Kitsell & Griffith, 2011; Orvik, Vagen, Axelsson, & Axelsson, 2015; Scott and Timmons 2017).

Variance in degrees of professionalism related to attitudes and experience among nurses was found by Bunkenborg, Samuelson, Akeson, & Poulsen (2013) to influence their decision making and patient surveillance. A related influence has been found to be the addition of healthcare assistants to the nursing staff compliment with an increase in poor patient outcomes identified by Twigg et al. (2016) and no patient care improvement identifiable in a study by Duffield et al. (2018).

The addition of non-nursing tasks to nursing workload is also connected with failure to complete nursing work (Bekker, Coetzee, Klopper, & Ellis, 2015; Bludau 2017; Furaker, 2008; Rheaume et al. 2015; Roche, Friedman, Duffield, Twigg, & Cook, 2017) and there is some concern with the focus on technical skills (Foth and Holmes 2016, McKenzie and Brown 2014) rather than holism and nursing theory.

If nursing is to be based on the recognised body of nursing science, then the work of nursing theorists such as Boykin and Schoenhofer (2001), Watson (2012) and Parse (2016) who focus the attention of the nurse singularly on the patient, or of King (2007), Kolcaba (Kolcaba and Steiner 2000), Orem (1956), Roy (2011), Newman (1999), Ray (1994) and Neuman & Young (1972) who also recognise the influence of the dynamic environment within which

the patient exists, needs to be recognised in practice and this requires time and presence with the patients. Interruptions to nursing care negatively impact this, however, according to Winters and Neville (2012).

Nurses are frequently unhappy with their work environments (Barlem et al., 2013; Lewis and Cunningham, 2016; van Bogaert et al., 2014) and a factor in this is dissatisfaction with the nursing they are providing for patients (Barlem et al., 2013; Kalisch, Landstrom, & Williams, 2009; Papastavrou et al. 2014). Evidence of job dissatisfaction and reduced ability to provide comprehensive care suggested further examination of nursing influences.

The choice of Classic GT methodology was in the interests of achieving understanding of the influences most relevant to nurses, from their perspective.

"Grounded theory allows the relevant social organisation and social psychological organisation of the people studied to be discovered, to emerge – in their perspective!"

(Glaser 1992)

It allowed better understanding of acute hospital dynamics which most affect nurses which, in turn, led to a better understanding of nurses' behaviours within that environment.

Aims: The aim of this study was to discover, from nurses' perspectives, influences on nursing practice in acute hospital settings.

Methods

Design

The classic grounded theory (GT) methodology was used. In Classic GT, initial data is generated from inquiry into the field rather than through focus on a preconceived problem (Glaser 1992). The aim of this study was to explore, with minimal bias, what influences nursing practice in acute hospitals. GT methodology was therefore appropriate.

Sample/Participants

Sampling was purposive; participants were clinical nurses, in acute hospital wards, who were more than three years qualified. Requests to volunteer for interview were issued through ward Clinical Nurse Managers. Sampling continued until data saturation was reached (n=24), in other words, until no

new indicators of categories were emerging. Study information, consent, researcher interest and rationale for study were given prior to interview commencement. Before each interview was commenced, participants were reminded of the nature of the study and reassured of the voluntary nature of participation and their freedom to withdraw from the interview. None chose to do so.

The sample comprised nurses of three nationalities and included male and female nurses. All were acute care nurses in permanent employment in Ireland. The majority of participants were experienced nurses, educated to degree, post graduate diploma level or above. Glaser (2011) advises to avoid participant details as they risk blocking conceptualisation through the introduction of researcher bias. Details provided here (Table 1) are in the interest of informing the reader.

Data collection

Data were collected through open interviews and non-participant observations of general nursing activity in the medical and surgical wards of the hospital. Interviews were typically between 30 minutes and an hour in duration. They took place in private spaces within each ward so that the interview could be private, but the participant was immediately accessible should the ward need them. Reassurance was given of the researcher's understanding of patient priority.

Interviews were tape recorded, and later transcribed for analysis, to guard against selective hearing and to allow the researcher to engage fully in the interview. Participants consented to audio recording and the device used was un-intrusive. Field notes were taken separately and concurrently in the wards and data analysed using the same method as with interview data.

Ethical considerations

Approval for the study was obtained from the appropriate social research ethics committee. Participation was voluntary, consent was informed, and data were anonymised and stored in accordance with university policy. Recordings did not include participant or ward identifiers and were labelled numerically.

Data Analysis

In keeping with classic GT methodology an open question, “What influences your nursing care?” was asked of participants. This was augmented in instances where participants found it difficult to start, by prompts such as “What are you drawing from when you think about your daily work”, or “Everything you can think of that informs what you do”. Question guides, though used with alternative GT methodologies, are not appropriate for Classic GT (Glaser 2002) since they risk directing the participants’ responses.

Constant comparative analysis was undertaken. This is the classic GT method of simultaneously collecting and analysing data which allows for the process of theoretical sampling. In Classic GT, the researcher codes and categorises data alongside data collection by comparing it to that which has already been collected until patterns begin to emerge. As the process continues, these patterns generate further open questions exploring whether the participants’ perspectives include them. Alternative data sources may also be indicated. Concurrent memoing, which can take any form, aids the researcher to theorize, making connections between codes and categories, and retain ideas as they occur (Glaser 1978). With the continuous use of constant comparative analysis and theoretical memoing, behavioural patterns come to be understood at increasingly higher conceptual levels if they are sufficiently present. If initial findings are found to be anomalous or associated with only a limited number of interview sources, theoretical sampling will expose this, and they will not contribute to the theory (Glaser 1998). This also serves to minimise researcher bias. In Classic GT, Glaser (2002) advises that the researcher carefully avoids intruding their own views, but that researcher bias is minimised by its addition to the constant comparative analysis process and the abstract nature of the emergent categories.

Rigour

Rigour in classic GT is ensured by researcher adherence to its methodological principles (Glaser 1998). It is demonstrated through the emergent theory’s fit, relevance, modifiability and because it works (Glaser 1978). The current theory has fit because, as a result of the researcher’s adherence to classic GT methodological principles of data collection and analysis, it is grounded in the substantive area of data collection. Its relevance was achieved by stringent precautions against researcher bias so that it was minimised as far as possible. Concepts, not upheld by further data collection and analysis,

were excluded. The theory is open to a higher level of conceptualisation by the addition of new data collected from a greater substantive area, for example other acute care hospitals. Modification in significance of individual concepts within the growth of larger theory is part of this process. Finally, findings from literature comparative to the theory's individual concepts, and subsequent sharing of study findings with acute hospital nurses, demonstrated that the theory of nebulous intentioning is a fitting explanation of nurses' patterns of behaviour in acute hospitals.

Findings

'Nebulous intentioning' conceptualises how nurses resolve their frequent deferral of core nursing such as preventing patient deterioration and discomfort, ensuring rehabilitation and nutrition and providing support and comfort to patients. Nurses find themselves prevented from fully engaging in this type of nursing because of the many conflicting demands placed on them in the acute care environment. Whilst accommodating the influences which pull their attention from core nursing, nurses retain a general intention to return to the patient and complete their nursing when time permits (nebulous intentioning) but this is rarely satisfactorily achieved. Explanations of the influences which detract from nursing care fall into two sub-core categories: accommodating and integrity eroding. Accommodating conceptualises the work nurses do which prevents them from reaching the patient to provide core nursing. The categories out of which accommodating evolves are coordinating, connecting, facilitating and proactive vigilance. These concepts relate to behaviours which enable cohesion of the disparate contributions of other professions and services. Their consequences for nurses are perennial jobbing, priority recalculating, skimping and struggling. Integrity eroding conceptualises the mind-set which allows nurses to defer nursing in favour of accommodating. Its contributing concepts are conforming, intuiting and reality-facing (Figure 1)

Accommodating

Accommodating relates to the perception that nurses should be constantly available to undertake work which facilitates the smooth running of the services in acute hospital care. Nurses engage in accommodating to facilitate efficient and timely patient progress through the service and timely resolution of organisational deficits, to smooth the pathway for others' work and patients' recovery.

I think the place would fall down without us, we are doing this and not able to do our own work, and there is a new thing where people say, "It's not my job" and then nurses do it because we have no boundaries and take on everybody's work and ours doesn't get done.

(Participant 7)

Coordinating

Coordinating the activities of patients, service employees and health professionals impacts heavily on the daily work of the nurse. The coordinating role becomes more complex as patient turnover and condition complexity increases. Consequently, coordinating impacts enormously on nursing in acute care where the throughput is fast, and the health profiles of patients include multiple co-morbidities. Coordinating requires being available to allow for surveillance and openness to others' requests to ensure that help is at hand when needed.

This morning I was an hour on the phone trying to sort out something about blood results, an hour, and that was like before I even got in to see either of them, you know, before I even get…so something like that. I think we are expected to be everything. Answer the phone, the macerator sluice was broken yesterday, our problem, we have to get it fixed.

(Participant 10)

Connecting

Connecting enables staff and patients to relate to each other through the nurse, ensuring that where a patient requires attendance by multiple professionals, the various activities and communications necessary are negotiated and facilitated by the nurse.

They could be very sick and you have the medical crowd coming over and we have people going out for dialysis in the middle of it all and then people coming in with social problems so you have the social workers involved and psychiatrists a lot of the time as well with the plastics patients and that sort of thing, and they just tend to write notes to each other – the doctors – and even the physiotherapists and that, whereas we talk to all of them.

(Participant 6)

Facilitating

Facilitating maximises opportunities for the practical work of others to combine to promote a good outcome for the patient or the successful attainment of the various treatment plans for that patient.

The role of the nurse isn't very clear, yes you have your nursing and your basic nursing but outside of that, yes, we kind of spill into other bits such as secretaries and doctor's aids

(Participant 16)

It is undertaken so that essential elements of work will not be missed, and that elements of the service which are required for work to continue are all present. Facilitating prepares the ground for the work of others providing for a seamless and safe journey for the patient.

Proactive Vigilance

Facilitating necessitates proactive vigilance, that is, remaining alert to anticipate others' omissions or mistakes and resolve them or to undertake work that does not easily fit into the remit of any other group. Proactive vigilance is perceived by nurses as a duty to protect the patient from potential errors or underperformance by other members of the organisation. It is used to identify and resolve gaps in the overall service for the patient to circumvent adverse incidences and promote better outcomes for patients.

I think the patient is the centre so if they need something done you will do it, chasing up doctors for medicines and x-rays. No matter who makes the mistake, everyone rings the nurse.

(Participant 7)

The many ways in which the various activities of accommodating occur are neither known nor understood by the organisation and therefore the extra work which they generate for nurses is not formally identified. The extra work must, therefore, be assimilated into the nursing role and this results in a perennial list of jobs for the nurse to complete.

Perennial Jobbing and Priority Recalculating

Accommodating adds multiple activities to the nurse's daily workload. As the requirement to facilitate or intervene occurs, work becomes task orientated (perennial jobbing), and priority recalculating occurs to enable nurses to manage each task in accordance with its perceived urgency. The planned approach to individual patient care is removed so that jobs can be undertaken as they arise to enable the next action in the sequence of business. These may be part of core nursing or may be tasks which are not nursing per se, but which enable the functioning of the ward or organisation as a whole. Decisions regarding priority are made against a time deficit contributed to by the added competing demands of professional colleagues.

To actually be with the patient like sometimes you feel you're trying to sort out so many jobs and doing so many bits and pieces that sometimes it's hard to give your patient the time… just simple things like did they get enough fluids into them, they aren't eating, like the basic things you know.

(Participant 13)

While nursing provides a safety net for the omissions of other health professionals, there is no similar safety net for the omissions of nurses.

You know the person who's not going to be able to eat, if you don't give them their breakfast then they're not going to get it, as simple as that sounds.

(Participant 20)

Thus, the intention to return to the patient to complete care remains but is often unrealised.

Skimping and Struggling

This is a consequence of perennial jobbing and priority recalculating. The greater the engagement in perennial jobbing, the higher the risk of skimping; the cursory execution of nursing activities to make room for non-nursing activities or nursing activities of a higher priority. Skimping relates to individual nursing care.

Nearly basic patient care would be, yes, would be the areas... I think it's probably the personal care that gets overlooked rather than the jobs that need to be done and the investigations that need to be done.

(Participant 16)

Core nursing at this level, is administered as tasks, often performed with the minimum of presence and communication with the individual necessary to complete the task. Skimping includes suppression of personal interaction beyond that necessary to complete the task in hand because of the lack of time available to properly engage with the patient or the risk of being called away from an important therapeutic conversion with a patient, thus causing them further distress.

And even, you hear people, "Oh they kept me in ages because they were chatting" and like that's so normal but you haven't time to be chatting with them.

(Participant 23)

Struggling is the result of the conflict which skimping creates with the expectation nurses have of wholly tending to each of their patients at the time of being with them.

Its time orientated now yes, well, usually, it's sad to say it is the patients that it's being taken away from. You're trying to get the jobs done first and foremost and, you know, you're ticking off the boxes.

(Participant 24)

Nurses are satisfied that they do the best they can in difficult circumstances but are not satisfied with the nursing care which patients receive. The persistent albeit nebulous intention to fully attend to the patients after the jobs are completed is accompanied by a persistent sense of struggling.

Integrity Eroding

This sub-core category explains why nurses allow their core professional work to take a secondary position to the accommodating activities explained above.

Conforming

Conforming is demonstrated by nurses' obedience to managers and professions outside nursing and acceptance that control over their core professional work is not held within the profession. There is an assumption within the profession that part of nursing is to undertake medical tasks and that nurses are responsible to consultant doctors. Conforming includes a

reluctance to relinquish medical aspects of non-nursing work and this is partly due to a perceived power imbalance which exists between nursing and medicine, partly to maintain good relationships and partly due to an inability to definitively distinguish nursing from medical activities.

I know, it should be a doctor (chasing up medical results) or whoever ordered, I don't know is it a hierarchy thing kind of engrained? I don't know what it is exactly.

(Participant 24)

The use of the term basic indicates bedside nursing care and this is perceived to be as important but less intellectual work.

Intuiting

Intuiting conceptualises the inability of nurses to coherently articulate their professional work.

It's just a massive list of care for that one person, its endless and it's from the ADLs to saying that I rang your mother and she said that your cat was OK.

(Participant 23)

Intuiting is the process used by nurses to form an understanding of their central nursing role. It includes notions of holism, reaching potential and avoidance of complications. Attempts to articulate nursing are couched in lay rather than professional terms. Nurses intuitively associate nursing with soft personal characteristics which lend themselves to relating to patients but are innate rather than the result of education and do not hold the kudos that medicine does. Intuiting results in a weak notion of what nursing is but a strong reaction to not being able to engage properly in it. Associated with it is a strong impression of impotence within the profession in terms of taking control of their work.

A property of intuiting is characterising which confers an innate set of traits on good nurses. Its central tenet is that nurses are born rather than educated and that education cannot change these traits or give them to someone who has not already got them.

No amount of education is going to teach you that. I think communication is something you either have or you don't.

(Participant 22)

Reality facing

Reality facing is the result of a lost battle between what nurses intuit to be their core role and what they perceive they have to do. A consequence of this is that nurses favour education which prepares them for the reality of medically and skills driven activities which facilitate accommodating.

Definitely the refresher courses we're always doing like your CPR and your manual handling and anaphylaxis, all those things, we do lot of dialysis here, so we keep them up to speed

(Participant 16)

This is strongly preferred to nursing theory or education aimed at reflecting philosophy and facilitating holism and depth of relationship. Ultimately, preparation for the reality of nursing is thought to be best achieved by learning from more experienced nurses.

Discussion

This classic grounded theory explains how influences within the acute care organisation impact nurses' performance of what they consider to be their core role. It identifies, as their main problem, the struggle between achieving core nursing and accommodating the deficits of the organisation for the benefit of the patient. The study was limited to one large acute care organisation and the theory would benefit from expanding the study to a wider substantive area.

Implications for Practice

Accommodating is not formally recognised as a core nursing role, but its activities are evident in comparative literature as indirect findings from a variety of studies. Furaker (2008), investigating nurses' views on their professional role found them to be committed to a wide range of activities similar to those identified as accommodating in the present study. Further studies reveal reliance upon nurses for communication and coordination within the multidisciplinary team (Begley et al., 2010; Higgins et al., 2017; Kilpatrick, 2013; Papastavrau et al., 2014,).

The notion of connecting arises under the concept of boundary spanning in sociological literature. Long, Cunningham & Braithwaite's (2013) theoretical literature review examining boundary spanners or ways of brokering the

boundaries between different collaborative networks, reveals concepts which resonate with the connecting position held by nursing in acute care. According to Long et al. (2013) brokers can facilitate information or resource access and coordination of work across networks but may be overloaded and stressed by others' reliance on them. The present theory suggests connecting as a form of boundary spanning undertaken by acute hospital nurses; an under-recognised and therefore hidden form of brokerage which is often fleeting or incidental and, as such, difficult to measure. Recognising its occurrence in nursing practice may be important for staffing and workflow planning.

In terms of facilitating and proactive vigilance, a sense of ultimate responsibility undertaken by nurses, for care given by all services under assumptions of advocacy or safeguarding, is shared at various levels in nursing literature (Bu and Jezewski, 2007; Choi, Cheung & Pang, 2014; Churchman and Doherty 2010). Because they also carry out interventions prescribed by other providers and are gatekeepers of healthcare (Jones, Hamilton & Murry, 2015) nurses have a unique understanding of the nuances of the work of others. A direct link between nurses and patient safety is, nevertheless, difficult to identify, even in terms of focused links such as patient surveillance and failure to rescue (Fasolino and Verdin, 2015; Griffiths, Jones & Bottle, 2013; Shever 2011,). Proactive vigilance, often incidental or confined to a private interaction between two people, is less easily quantifiable but potentially as important to patient safety. If it is to be effectively utilised, it needs to be properly understood and formally recognised within the nursing role.

Previous studies in the areas of perennial jobbing and priority recalculating highlight the detrimental effects of non-nursing tasks and tasks left undone on staff satisfaction and retention (Bekker et al., 2015; Roche, Duffield, Friedman, Dimitrelis, & Rowbotham, 2016) and on skill mix and division of work (Kessler, Heron, & Dobson, 2015; Roche et al. 2017). Connections are made in the literature between the numerous tasks which fall under the nurse's remit and uncompleted nursing work (Bekker et al., 2015; Bludau, 2017; Furaker, 2008; Rheaume et al. 2015, Roche et al. 2017). The present study suggests that the origin of these tasks includes accommodating while perennial jobbing and priority recalculating conceptualise the manner in which they detract from nursing activities.

Nurses' concern that accommodating activities prevent them from holistically nursing the patient and their assumption of nursing's secondary position to medical and administrative work is important for practice if rationed nursing is an independent predictor of poorer patient outcomes (Ausserhofer et al., 2013; Schubert, Clarke, Glass, Schaffert-Witvliet, & De Geest, 2009,). Connections between poor nurse-patient ratios and increased morbidity and mortality rates (Ball et al., 2018; Liu, Lee, Chia, Chi, & Yin, 2012) are complicated by poor resources and poor communication (Kalisch et al., 2009) and role unpredictability (Blackman et al., 2015). Accommodating helps to explain role unpredictability and highlights deficits in resources and communication. It also, however, exposes the safety net which nursing provides for the acute hospital. Nurses' role in safety warrants formal recognition to enable understanding that reduced nursing numbers may incidentally reduce patient safety levels.

Implications for Education

Accommodating is augmented by nurses' tendency to conform. Both intuiting and reality facing comprise a rejection of nursing theory but the discreet body of knowledge which belongs to nursing may be important to its professional boundaries. Lamont and Molnar (2002) explain that professional education and credentialing are important in closing the symbolic and social boundaries of each profession and that this in turn is important in the division of resources. If education plays a part in the formation of professional boundaries (Lamont and Molnar 2002), the rejection of nursing theory is risky. Without its theory, nursing may lose the boundaries created by its discreet body of knowledge. Educators, as they develop and revise nursing curricula, may consider how to redirect the profession towards its theoretical underpinnings and enable reconsideration of nursing as a distinct profession with the intention of contributing nursing expertise to the work of the MDT as a priority over assisting with the professional work of their colleagues.

Implications for Research

Vryonides et al. (2015) contend that nursing ideals, which Ten Hoeve, Castelein, Jansen, & Roodbol (2016) found to be the desire to care for others, are not matched by the reality of nursing. Benne and Bennis (1959) finding nurses' professed role to be different than their practice, suggested that nurses needed to change their ideal. Sixty years later, this study suggests that

neither ideals nor reality have changed but there is evidence of increased attrition rates among nurses associated with job dissatisfaction (Liu et al. 2016). Nursing theory and nurses' professed ideals of holistic caring match; an indication that practice may need to change. This study's findings suggest closer examination of the activities of accommodating to determine their prevalence and to distinguish between accommodating activities which require the expertise of a nurse and might therefore be incorporated into the nursing role, and those which are suitable for non-nurses and could therefore be delegated to the appropriate services.

Nursing care should not exist as an unrealised intention. The intention to nurse holistically should be realisable and staffing levels and resources which recognise accommodating could facilitate this. Nurses themselves, however, may need to address the value they attach to their own professional work.

Limitations

This study is limited to a single institution in the substantive area. Extension to a wider sample of the acute hospital sector would further develop this substantive theory.

The study is also limited to the nursing profession. A fuller understanding of issues which influence the care of other healthcare professionals has the potential to uncover unrecognised barriers to their core work too. This study is potentially, therefore, a starting point in a greater investigation.

Conclusion

This theory identifies core nursing as a frequently unrealised intention; a consequence of accommodating and integrity eroding. Nurses should identify aspects of accommodating which require nursing knowledge and include them in their core role so that such activities are undertaken with forethought as part of the nursing plan. Recognition of this additional work may impact the negotiation of safe staffing levels and skill mix and influence nurse education.

The malleable nature of nursing and its tenuous link with the established body of nursing theory indicates a need for deeper exploration of attitudes to the profession. Undermining nursing's central contribution to acute care may risk patients' health outcomes.

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