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Transfers to residential aged care: Health professionals' lived experience of decision making in hospital.

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Dedication

I dedicate this thesis to my husband Karl, and children Jack and Luke for their support and encouragement, I am eternally grateful to you all. I also wish to thank my parents for always believing in me and encouraging me to set my own path. To my sister Cassie, our family and my wonderful friends, I thank you for all your support and sometimes much needed laughs. I also want to include my love and respect to those we lost during this thesis journey.

Finally, I dedicate this thesis to all the health professionals, older people, family and carers who make transfer decisions from hospital to residential aged care.

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Statement of Authentication

This thesis is submitted to the Western Sydney University in fulfilment of the requirement of Doctor of Philosophy.

The work presented in this thesis is, to the best of my knowledge and belief, original, except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

Signature:

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Date: 28th September 2020

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Abbreviations

Abbreviation	Full term
ACAT	Aged Care Assessment Team
CNC	Clinical Nurse Consultant
DP	Discharge Planner
Dr	Doctor
NUM	Nurse Unit Manager
OT	Occupational Therapist
PT	Physiotherapist
RN	Registered Nurse
SW	Social Worker

Abstract

Understanding how health professionals make transfer decisions with older people from hospital to residential aged care is important as it sheds light on a previously unexplored phenomenon as well as identifies the barriers and enablers in making these decisions. The literature review revealed a dearth of studies that focused on this particular aspect of transfer decision making in hospitals, which indicated that further research was needed to better understand this complex phenomenon.

My study explored the lived experience of doctors, occupational therapists, physiotherapists, registered nurses and social workers in making transfer decisions with older people from hospital to residential aged care. The significance of my study is that it is the first that has examined health professionals' transfer decision making from a phenomenological perspective. The application of a phenomenological approach informed by Husserl supported an understanding of health professionals' experiences in making transfer decisions. This included the use of two data collection methods of interviews and observations to explore not only the descriptions of their lived experience in making transfer decisions but also in observing how they made these decisions. My study was conducted in five hospitals in New South Wales, Australia. Interviews were conducted with 16 health professionals that had two or more years' experience making transfer decisions with older people from hospital to residential aged care. Observations of four multidisciplinary transfer review meetings in three different hospital settings were also conducted.

Data were analysed using Colaizzi's phenomenological approach. The interview data were analysed using Colaizzi's seven-step approach, while the observation data were analysed using Colaizzi's perceptual description approach. The findings developed through the application of these strategies then needed to be validated. This was achieved through the alteration of Step 7 in Colaizzi's approach and included within methods triangulation of the interview and observations findings, phenomenological reduction, and a clear audit trail. Adapting these steps supported the development of trustworthy findings.

The findings revealed that health professionals made transfer decisions by exploring options through assessments as well as collaborating with the older patient, family, carers, and the multidisciplinary team. However, this sometimes led to conflict. Overall, the health professionals gathered information and tried to make collaborative, safe transfer decisions, with limited options, under significant time pressures. The implications that arose from these findings for policy makers, hospital administrators and clinicians include the lack of transfer decision assessment tools and education on how to make these decisions along with the difficulties of accessing alternatives to transfer to residential aged care.

The recommendations for future practice, research and education that arose from this research include strategies that support older patients' choice as well as registered nurses' participation in the transfer decision. Making quality transfer decisions requires both education and the development of comprehensive multidisciplinary transfer assessments which include access to supports.

Chapter 1
Introduction

This study focuses on multidisciplinary health professionals' transfer decision making with older people from hospital to residential aged care through a phenomenological perspective. The impetus for this study came from my previous experience as a discharge planner making transfer decisions in hospital and the lack of understanding about how these decisions are made. Other factors that contributed to the exploration of this topic include the global ageing phenomenon which is likely to lead to an increased number of older people who may require being transferred from hospital to a residential care setting as well as the prevalence of disease and disability, that is associated with age, which can lead to a hospital admission. The resultant factors are that more older people are likely to require transferral to residential care directly from hospital, yet how health professionals make this decision is largely unknown.

Health professionals, who work in hospitals, conduct assessments and plan interventions or treatments with the aim of supporting people to resume the activities of daily living and ideally to return home. Yet for some older people returning home is not possible, this may be due to poor health, mobility issues, alterations in cognition, unsuitable living conditions, lack of access to support, carer stress or a variety of other reasons. In these situations, transfer to residential care may be considered. Transferring to a residential care setting can be a significant, life-changing event for an older person, especially when the decision is made in hospital. The unfamiliar environment, combined with recovering from an acute health event that led to their admission, can make this decision more challenging for older

patients, family, carers and health professionals. This has become an important issue in the current climate due to a global increase in the older population.

The population is ageing both in Australia and internationally, and is expected to be a significant alteration to the makeup of society (United Nations,Department of Economic and Social Affairs, 2019). While this brings opportunities, there are also challenges, as now, and in the future, we are expected to experience an increased number of older people presenting to hospital. Due to the increased incidence of disease and disability associated with age, older people are more likely to require assistance to perform the activities of daily living. For some, this assistance will be provided in a residential care setting. For health professionals, the decision to recommend an older person transfer direct from hospital to residential aged care is not well understood. Therefore, in light of the global ageing phenomenon it is expected that more people may transition from hospital to residential care which increases the need to understand this process. It is important to understand this decision as people rely on the information they receive from health professionals to guide them on what to do, yet how they make the decision to recommend that an older patient transfer to residential care from hospital is largely unknown.

In order to enter a residential care facility an older person in Australia needs to be comprehensively assessed by the aged care assessment team referred to as ACAT (Department of Health, 2018a). The aged care assessment team conducts an assessment to determine whether the person meets the criteria to receive government funded community services, which include transitional care, a home care package, respite at home or in residential care, short-term restorative care or that they require a higher level of support that can only be provided in a residential aged-care facility (Department of Health, 2018a).

Once these assessments have taken place and they have been approved to enter an aged-care facility then the older person, their family and carers can begin to look for a facility (Australian Government, n.d.). Prior to this assessment all those concerned may have already been considering this move in one way or another for a period of time. This phase can be difficult and encounters a range of emotions and logistics that need to be considered. Ideally, this process occurs through a naturally evolving situation where the older person, family and carers come to a mutual decision to make the transfer into residential care when it is right for them. However, in some cases a sudden change in medical or functional health can mean that the decision of where and how to live occurs in a hospital setting. Multidisciplinary health professionals working in hospitals play an important role in transfer decision making from hospital to residential care prior to the aged-care assessment. Yet, it is not known how they make these decisions.

This chapter proceeds by explaining the global ageing population and the impact ageing has on people's health, which contributes to the need for some people to transfer to a residential aged-care facility. Following this, a discussion of hospital policies and processes related to the length of stay and the impact it has on the older patient transferring to residential care is presented. As this thesis focuses on transfer decision making, section 1.2 defines this process from an individual discipline perspective. The methodological and theoretical approaches are then explained in the context of my study and are followed by the research question. An overview of the thesis is then provided. The chapter ends with a summary of this chapter and introduces the next chapter.

1.1 Background

Globally, the population is ageing. Projections from the United Nations Department of Economic and Social Affairs (2019) show that in 2019 one in 11 people in parts of Asia and Africa were over 65 years old. This is projected to increase to one in six people by 2050. In Europe and Northern America one in four people will be over the age of 65 by 2050, while globally the number of people aged over 80 is expected to triple by 2050. The increase in an older population is in response to a variety of factors which include a lower incidence of child mortality as well as an increase in life expectancy (World Health Organisation, 2015) and is something to be celebrated on a global scale. However, there are challenges that come with a growing older population.

Many older people experience good health, while others require medical intervention and support which is often provided in hospitals. In the United States of America between 2001 and 2010 older people accounted for 175 million presentations to hospital with 38% of them resulting in admission (Lo et al., 2016). In the United Kingdom people aged between 70-74 made up the highest number of hospital consultations and the largest number of critical care records in hospital (National Health Service, 2018). In Australia people aged 65 and over made up 15% of the population, yet they accounted for 49% of the total patient bed days in 2017-18 (Australian Institute of Health and Welfare, 2019), and one in four presentations to the Emergency Department (Australian Institute of Health and Welfare, 2018). Whereas in the European Union older patients admitted to hospital were more likely to have a longer length of stay than younger patients (Organisation for Economic Cooperation and Development (OECD), 2019).

Internationally, and in Australia, length of stay in hospitals is used as a way to measure efficiency and is connected to cost, yet there is a precarious balance between discharging a patient too quickly, as it may reduce their overall recovery and lead to a re-admission (Organisation for Economic Cooperation and Development (OECD), 2019). Globally, readmission rates are a way to measure hospital performance. In Australia, readmission rates add to the overall cost of healthcare and are often seen as a failure to adequately provide quality care to patients (Considine, et al 2019), while in Denmark, England, Germany and the United States, hospitals are financially penalised for readmissions within 30 days of discharge (Kristensen, Bech, & Quentin, 2015). However, older people with complex medical conditions are likely to experience a longer length of stay and multiple hospitalisations, which significantly increases the risk of being readmitted to hospital (Pedersen, Meyer, & Uhrenfeldt, 2017).

Diagnosis related groups are used in many countries such as the United States, Australia as well as Eastern and Western Europe to reimburse hospitals for the costs of providing care. Patients with the same diagnosis related groups are expected to follow a certain trajectory which should incur the same costs (Mihailovic, Kocic, & Jakovljevic, 2016). One problem is that hospitals may gain financial benefit if people are discharged quickly. Hospitals try to manage admissions, discharges and average length of stay while also trying to reduce costs. This is hampered by an ageing population that has a higher demand for hospital services (Ní Chróinín et al., 2018) and extended length of stays (Yin, Lurås, Hagen, & Dahl, 2013).

A flow on effect from an extended length of stay is access block or bed block. Access block is when a patient in the emergency department has been admitted and requires a hospital bed but is unable to access one as the beds are full. The lack of access to a hospital bed can lead

to overcrowding in emergency departments (Metcalfe, McNally, & Smith, 2017). This problem raises concerns in relation to quality health care, as there is less capacity to care for critically unwell patients (Innes et al., 2019). It can also flow onto hospital wards, as the lack of vacant hospital beds is the largest contributing factor to access block (Innes et al., 2019).

In the Australian context National Emergency Access Targets (NEAT) were introduced to address timely care in emergency departments. This was in response to a similar initiative from the United Kingdom which required a proportion of patients to be admitted, discharged or transferred from the emergency department within four hours of presenting at hospital (Sullivan et al., 2016). Older patient presentations to the emergency department are not included in this four-hour deadline (Sullivan et al., 2016), yet they can be targeted at a ward level for discharge or transfer in order to ensure that there are beds for patients in the emergency department. This is a consideration for older people who often take longer to recover from changes in health and are unlikely to fit the quick fix, high turnover needs of hospitals. The four hours 'treat and street' expectation is unlikely to work for older people who are often seen as 'bed blockers' in a cure-focused system that has limited resources and options.

Despite older people having an increased need for hospital services, most of them are discharged to their place of usual residence, yet some older people may no longer be able to live at home and may transfer to institutionalised care. In the United States of America 1.3 million people live in residential care (National Center for Health Statistics, 2015), and in the United Kingdom 3.2% of the population live in a residential care setting (Office for National Statisitcs, 2014). In contrast, in Australia, 4.6% of people who are 65 years and over live in residential care (Australian Bureau of Statistics, 2018), although less than 2% of older people

were transferred to a residential aged-care facility directly from hospital (Australian Institute of Health and Welfare, 2018). The impact on the older patient of transferring directly to residential care from hospital is significant and can trigger relocation stress. Relocation stress can develop as a result of transferring from a familiar setting to an unfamiliar one (Melrose, 2004) and is likely to impact on the older patient's quality of life (Melrose, 2013).

Older patients who are not involved in making the transfer decision are more likely to experience relocation stress (Walker, Curry, & Hogstel, 2007). This is because relocating to a residential aged care setting is associated with multiple losses which include the loss of autonomy, familiar objects and places as well as the loss of independence (O'Connor & Durack, 2017). While relocation stress is questioned by some, the general view of residential care may negatively influence older peoples' perceptions (Walker et al., 2007). It is possible that pre-existing depression is exacerbated by relocating to a residential care setting (Walker et al., 2007). Yet, whether it is relocation stress or an exacerbation of exogenous depression, older patients transferring to residential care are likely to experience stress responses, especially if they were not the main decision maker, which may impact on their quality of life.

Older people who transferred to residential care directly from hospital rated their quality of life as death-like, or worse than death, and were more likely to die within four months of admission (Giles, Hawthorne, & Crotty, 2009), while those who transferred through other channels were at risk of experiencing very poor health related quality of life (Giles et al., 2009). While there is a connection that transfer to a residential care setting can reduce quality of life, those who transferred directly from hospital experienced a poorer quality of life than those who transferred from other places (Giles et al., 2009). It was not the focus of

the Giles study to examine why this was the case. Yet, it is possible that the potential lack of choice and participation in transfer decision making may contribute to older patients who were admitted to residential care from hospital, having a poorer quality of life than those that were transferred from other places. Despite this, there continues to be a need for these services due to alterations in health that are associated with ageing.

The increased incidence of disease and disability associated with ageing can mean that older people require a level of support that can only be provided in an aged-care facility. People in hospital often rely on the information they receive from health professionals to guide their decisions. However, how they make decisions in the transfer of older people from hospital to a residential care facility is not well understood (Rhynas, Garrido, Burton, Logan, & MacArthur, 2018). It is widely considered that the continual pressure to discharge patients from hospital does not provide enough time for health professionals to make effective transfer decisions (Pellett, 2016). In view of the projected increase in the older adult population and the impact of this transfer on the older person, combined with the demand for hospital beds, it is important that transfer decision making is better understood.

There is an urgent need for research into new admissions to residential aged care from hospital, predominately due to the costs involved and the increased number of older people (Yoo, Nakagawa, & Kim, 2013). Thus far this has not yet occurred at the expected level. My study aims to address this matter by developing an initial understanding of health professionals' experiences in making these decisions which has the potential to inform further research in this area as well as improving service delivery for older people their families, carers, health professionals and the wider community.

1.2 Transfer Decision Making

My study focuses on health professionals' transfer decision making and it is important to define what this means as well as the difference between discharge planning and transfer decision making. Discharge planning aims to support the continuity of care through an interdisciplinary approach which includes assessment, planning, implementing, coordinating and evaluating (Lin, Myall, & Jarrett, 2017). It is a holistic process that encompasses all aspects related to discharge such as medications, transport and equipment. In a health context, the term 'transfer' refers to moving a patient from one setting to another, which can include a variety of settings such as another ward, unit, community setting or a residential aged-care facility. Alternatively, transfer decision making refers to the processes and information that health professionals use to reach a transfer decision. Transfer decision making is an integral part of discharge planning, yet it is only one part of the discharge planning process.

While health professionals often develop their own decision-making style, the underlying foundation is embedded in their training and discipline. Doctors' decision-making includes deductive reasoning that involves collecting information, considering a hypothesis, testing the hypothesis and reviewing the results (Trimble & Hamilton, 2016). Occupational therapists make decisions through intuition, discussion and validating information by using clinical evidence (Lee & Miller, 2003). Physiotherapists use reliable research to reach decisions based on their own practical experience and the patient's wishes (Herbert & Elsevier, 2011). Registered nurses make decisions using systematic processes, reflection, pattern recognition and synthesized information (Jacobs, Wilkes, Taylor, & Dixon, 2016).

Social workers make collaborative decisions by utilising their intuition, critical thinking, and judgement (Leonard & O'Connor, 2018).

This brief discipline specific description of decision making is provided to highlight how their decisional approaches may differ or intersect. When making transfer decisions it is possible that health professionals will remain connected to the approaches that are fundamental to their profession. However, it is not known if that is the case. Gaining an understanding of their transfer decision making has the potential to shed light on this previously unexplored phenomenon as well as increasing discussion and research into the way older people enter residential aged care. This is particularly relevant for older people, families and carers who are an integral part of transfer decision making. To ensure that my study remained focused on the topic under investigation, a research question was developed.

1.3 Research Question

The research question in my study is:

> *What is the lived experience of health professionals making transfer decisions with older patients from hospital to residential aged care?*

To address the research question, it was important to utilise a methodological and theoretical perspective that supported the exploration and understanding of health professionals' experiences when making transfer decisions with older people from hospital to residential aged care. These experiences are always *lived* in phenomenology, which seeks to explore the depths of human experience in the attainment of knowledge.

1.4 Methodological and Theoretical Perspectives

The methodological frameworks used to examine this topic were informed by Husserlian phenomenology and Colaizzi's approach. I selected Husserlian phenomenology as it provided a way to examine the phenomenon of health professionals' transfer decision making from hospital to residential care through their lived experience. In order to gain an understanding of people's experiences, Husserl encourages us to move beyond our natural way of thinking of the world and all that we know about it, and transcend to a point where all preconceived ideas are suspended, if only for a short time, to see things as they really are (Husserl, 1970). This is a crucial and difficult endeavour to achieve, yet is important to ensure that the experiences of people are viewed through a clear lens. To achieve the setting aside of beliefs, Husserl provides the epochē (Husserl, 1982), also referred to as bracketing. In the epochē, Husserl asks us to suspend our knowledge of the world, to ensure that the data tells the story unaltered by the researcher's prior beliefs or assumptions. This is a difficult process and requires reflective practice which as described by Dahlberg (2006), involves adopting a bridled naivety about the world and what we know about it. These concepts are woven throughout the thesis and are more explicitly explained in sections 2.1 and 3.3.

Husserlian phenomenology informed the methodological perspective. Yet to disclose health professionals' lived experience in making transfer decisions with older people from hospital to residential care, a data analysis approach was needed that would fit with the methodological and philosophical perspective in my study. Colaizzi's phenomenological approach was selected as it offered a way to analyse data and understand lived experience. My study explored health professionals' lived experience in making transfer decisions from hospital to residential aged care by observation as well as hearing descriptions of their

experiences when making transfer decisions. This meant that two methods of data analysis were required, one to analyse interviews and another for observations.

Colaizzi's 7 step approach provided a way to analyse interview data from a Husserlian phenomenological perspective, while his perceptual descriptive approach was utilised to explore the observations of health professionals' making transfer decisions. The findings from both the interview and observation analyses were combined into a comprehensive description of the phenomenon. This is explained in sections 3.8 and 3.9. Once the data is analysed and findings are considered it is important to have a theoretical framework to support an explanation of the findings (Collins & Stockton, 2018). A theoretical framework supports the researcher to remain connected to the research focus and enhances the ultimate understanding of the phenomenon in question (Lynch, Ramjan, Glew, & Salamonson, 2020).

My study examined transfer decision making from a multidisciplinary perspective, which meant that a theoretical framework was needed that focused on decision making, in a range of settings, and was not specific to any one health discipline. I selected cognitive continuum theory as a theoretical framework in this study as it provided a way to understand decision making across a range of poorly defined to well-defined problems in a health care setting. Originally conceptualised by Kenneth Hammond, this theory offers an adaptive approach to judgement which connects intuitive and analytical decision making (Dunwoody, Haarbauer, Mahan, Marino, & Tang, 2000). Importantly, it does not require specific training or skills for people to apply (Cader, Campbell, & Watson, 2005). Therefore, it can be used to explain decision making across a range of different disciplines such as medicine (Custers, 2013),

health (Parker-Tomlin, Boschen, Morrissey, & Glendon, 2017), nursing (Standing, 2008) and risk identification (Dunwoody et al., 2000).

In cognitive continuum theory, the type of decision making applied is defined by the type of problem. At the intuitive end of the continuum, decisions are often made quickly based on pattern recognition, which are person dependent (Hammond, Hamm, Grassia, & Pearson, 1987). At the other end of the continuum is analytical decision making which is utilised for structured, clear-cut decisions that are supported by rigorous evidence. In between analytics and intuition is the middle of the continuum. Referred to as quasi-rationality, this is where the most reliable type of decision-making occurs as there is a balance between intuition and analytics (Hammond, 2010). The nature of the task determines the decision-making mode utilised although issues can arise if the decision maker selects an approach that does not suit the type of problem (Custers, 2013).

In a health context, decision making is a key part of health professionals' clinical judgement, which is developed through experience, education, practice and ongoing critical review (Kienle & Kiene, 2011). In cognitive continuum theory, poorly defined problems are more likely to utilise intuitive decision making whereas well-defined problems use analytical decision making. An example provided by Custers (2013) explains this in the context of health care. In terms of interpreting pathology results, which have clearly defined parameters, a health professional is more likely to rely on analytical processes, while tasks that are more intuitive and time sensitive will move towards the intuitive part of the continuum (Custers, 2013). This fits the nature of transfer decision making, which can be clear cut and require analytical decision-making skills, yet can at other times be complex, and requires more intuitive decision-making skills. However, due to a lack of reliable peer-

reviewed evidence of transfer decision making, the use of analytical decision making on the continuum could be based on standardised assessment outcomes, while intuitive transfer-decision making may rely on experience and practice.

Ideally, health professionals' transfer decision making should sit in the quasi-rationality phase which holds the balance between analytical and intuitive decision-making skills. The combination of intuition and analytics may support the processing of information quickly (Dhami & Mumpower, 2018). However, as explained by Benner, Tanner and Chesla (2009), new graduate health practitioners predominately use analytical decisional skills, although as their experience increases they are more able to use a range of approaches that include intuition, common sense and analytics. It is possible that those professionals who have limited experience in making transfer decisions will use more rule-based, analytical decision-making skills, while those with more experience utilise a mix of analytical and intuitive decision-making skills. Transfer decision making is an important part of this study and cognitive continuum theory provides a way to understand the commonalities and differences in transfer decision making. This theory is explained more fully in section 2.5 and discussed in the context of the health professionals' experiences in making transfer decisions throughout the discussion chapter.

1.5 Organisation of Thesis

This thesis follows a conventional pattern which is summarised in this section. Chapter 1 provides the scaffolding for the thesis. This chapter offers an overview of the thesis which includes background information on the global ageing phenomenon and health professionals' transfer decision making with older people from hospital to residential aged care. A theoretical framework of cognitive continuum theory and the phenomenological

perspective applied in my study are also introduced along with the research question this study aims to address.

Chapter 2 presents a critical review of the literature on health professionals' transfer decision making from a global perspective. It explains the processes undertaken to conduct the literature review, which includes a discussion of the phenomenological perspective. A detailed explanation of the literature on transfer decision making in hospital is provided. The literature was organised into two main sections that outlined the assessments that informed transfer decisions and broader factors that influenced their transfer decisions. The literature on time pressure, risk and collaborative practices added to the understanding of what was known about transfer decision making. The review of the literature revealed a lack of studies and evidence on health professionals' transfer decision making from hospital to residential aged care. The literature review was an important part of this thesis, as it situated the study in the context of what is known about this topic.

Chapter 3 explains the methods and methodology used in this study. The chapter begins by discussing the research design and the phenomenological perspective that underpins this study. The phenomenological methodology and philosophy used in this study provides the lens through which I viewed the health professionals' lived experience in making transfer decisions. Using a phenomenological perspective helped me to explore the experiences of making transfer decisions with older people from hospital to residential aged care. Two types of data collection—interviews and observations—were used in this study. These two approaches supported a deeper understanding of the phenomenon.

Following the description of the data collection methods, the application of Paul Colaizzi's 7 Step approach to the interview data is explained. This is followed by a description of the analysis of the observations using Colaizzi's perceptual description approach. A discussion of the synthesis of the interview and observation findings into a 'comprehensive description' of the phenomenon is then presented. This last part of the chapter describes the validating steps of methodological triangulation, supervisor's review as well as an audit trail and the phenomenological reduction.

Chapter 4 presents the findings derived from the application of the phenomenological approach explained in Chapter 3. The findings are presented through the comprehensive description developed by the adaptation of Step 7 of Colaizzi's approach. Excerpts from the interviews and observations are used to highlight the findings so as to ensure that the phenomenon is heard through the participants' voices and experiences.

Chapter 5 presents a discussion of the findings in the context of the literature and identifies what is known about this phenomenon and what is new knowledge. This is where the outcome of the previous four chapters comes together and recommendations are made to improve the experiences of health professionals and older people.

Chapter 6 presents the concluding remarks of this thesis. This includes an explanation of what I learnt through this study and ideas for the future.

1.6 Chapter Summary

In this chapter I introduced the study by providing background information that explained the global increase in the ageing population, the increased incidence of disease and disability associated with ageing and the subsequent need for some older people to transfer from hospital to residential care. Entering residential aged care can be a significant life event, especially when it is precipitated by a change in health that has led to a hospital admission. I showed that this can lead to relocation stress, depression and lower quality of life, especially if the older patient is not included in the decision. The global increase in the older population means that it is likely that more people will require a level of assistance that can be provided in a residential aged care setting. Typically, people in hospital rely on information from health professionals to help them to decide what to do. While health professionals have a key role in transfer decision making from hospital to residential care, it is not known how they make these decisions.

The focus of my study is to explore health professionals' lived experience in making transfer decisions, prior to the aged-care assessment in hospital, through Colaizzi's approach as informed by Husserlian phenomenology. It is important to understand their experience of making transfer decisions from hospital to residential care so as to shed light on this previously unexamined phenomenon.

In Chapter 2, which follows, I present a critical review of the literature from an international and Australian perspective. Discussion of the literature and available research includes identification of the gaps in the literature and highlights the significance of this study. The literature review situates this study in the context of other literature.

Chapter 2
Literature Review

In the previous chapter I explained the background to my study and transfer decision making. In this chapter I will present a review of the literature that informed my study which aimed to describe health professionals' lived experience in making transfer decisions with older patients from hospital to residential care. The chapter begins by explaining the phenomenological perspective that underpins the literature review. Following this, the review of the literature is explained in the context of my study, and the search strategy used to access the literature is presented. This then leads into a review of the literature on health professionals' transfer decisions from hospital to residential care and identifies the gaps in knowledge that my study aims to address. The literature review is presented in two main sections. The first section explains the assessments they may use and the impact on transfer decisions. The second section explains the broader factors that influence transfer decisions. This includes sub-sections of time pressure, risk safety and ethics, as well as collaboration in transfer decisions. Following this a summary of the literature review is provided. Finally, I explain the theoretical framework that informs the study.

2.1 Phenomenological Approach Underpinning the Literature Review

Typically, in a phenomenological approach, a full review of the literature is undertaken after data analysis is completed. Leaving the full review of the literature until the end in a phenomenological study supports the development of a pure description by minimising the preconceived ideas the researcher may have about the phenomenon being explored (Speziale & Carpenter, 2011). However, despite leaving the full literature review until after

the data analysis has been completed researchers may hold prior knowledge of the topic being explored. In this study I originally undertook a literature review to prepare for confirmation of candidature, interview questions and conference presentations. The confirmation of candidature process is conducted in the first year of Doctor of Philosophy studies and involves the preparation of a document that outlines the significance of the study and the methodological strategies that are planned to be utilised in the study. Conducting a literature review during this process is an important step, as it ensures that the study's findings do not replicate existing knowledge but are likely to add to what is known about the topic.

In addition, I have significant knowledge and expertise in transfer decision making and discharge planning through my previous work as a clinical nurse specialist in a dedicated position that included making transfer decisions with older people in hospital. As such, I held some prior knowledge of the literature surrounding health professionals' transfer decisions in hospital. Due to this knowledge the application of the phenomenological epochē (bracketing) was particularly important in phases of the research process. As explained by Holloway and Galvin (2016, p. 222)

> *"For the purposes of using phenomenology as qualitative research in health, bracketing can be characterised as a kind of disciplines practice that involves remaining open to what and how the meaning of a phenomenon appraisal, and to a 'slowing down' so as not to add one's interpretation too readily, but rather to set aside, pre-existing ideas and/or to hold back any leap towards theoretical enframing or 'going beyond the data'."*

The setting aside of subjective knowledge in the data analysis phase of the study through the epochē, supported me in understanding things objectively and to search for the "true heart of the experiences of the participant" (Butler, 2016, p. 2034). This is a challenging yet vital

step in establishing methodological rigor, as it helps ensure that the researcher's knowledge is set aside to let the participants' experiences be heard. Once the findings had been developed, I returned to the literature to examine more comprehensively what is known and not known about health professionals' transfer decisions with older people from hospital.

By rigorously applying the epochē during the data analysis phase of the study through deep reflective practices, keeping a reflective journal and in-depth discussions with the research supervisors, the impact of my prior knowledge of the literature and pre-existing knowledge surrounding transfer decisions in hospital was minimised. Revisiting this pre-existing knowledge was important during the formulation of the findings. This crucial element of the phenomenological endeavour is more fully outlined in the methodology chapter. However, it is important to state it here, as the literature review in phenomenology is intimately connected to the entire research focus.

2.2 Reviewing the Literature

This section presents the literature search strategy and the review of the literature related to health professionals' transfer decisions with older people from hospital to residential aged care. The literature review presented in this chapter is a more comprehensive review of the literature that was conducted following the data analysis. As explained by Merriam and Tisdell (2016) a preliminary review of the literature in qualitative research is usually done prior to the study to inform the study design and purpose as well as identify whether the topic has already been explored. Holloway and Galvin (2016) further discuss that while a preliminary review of the literature is conducted prior to the study commencing, reviewing the literature continues throughout the study to situate the findings within the literature and critically analyse findings already reported. In my study the literature review presented

here was conducted once data analysis was completed to support the discussion of the findings. This enabled me to develop an understanding of the gaps in the literature on health professionals' transfer decision making from hospital to residential aged care as well as identifying the issues associated with the topic.

2.2.1 Search Strategy

To ensure that papers were included that explored health professionals' transfer decisions with older people from hospital to a residential care setting a variety of databases were used. They included ProQuest, Nursing & Allied Health Database, social science premium, Ovid MEDLINE ALL, CINaHL, PsycINFO and SCOPUS. Search terms used included *residential facilities, nursing homes, long term care, secondary care, admission, discharge, decision making, discharge planning, transfer, hospital (general, private, public), secondary care centers, tertiary care centers, doctors, geriatrician, occupational therapy, physiotherapy, physical therapist, registered nurse and social work*. Boolean operators were used as well as subject headings: MeSH headings and suggested subject terms were also used. This included a review of the grey literature and other relevant documents. Literature was included that was published in English from 1982 onwards. This date was selected as discharge planning became a formally recognised part of care in 1983 (Preyde, Macaulay, & Dingwall, 2009). Selecting a year prior to 1983 supported the inclusion of literature that covered the emergence of discharge planning as a formal process.

While the focus of this study is health professionals' transfer decisions from hospital to residential aged care, transfer decision making is one part of a comprehensive discharge planning process. As defined by Gonçalves-Bradley et al. (2016, p. 7) discharge planning is:

"the development of an individualised discharge plan for a patient prior to them leaving hospital for home".

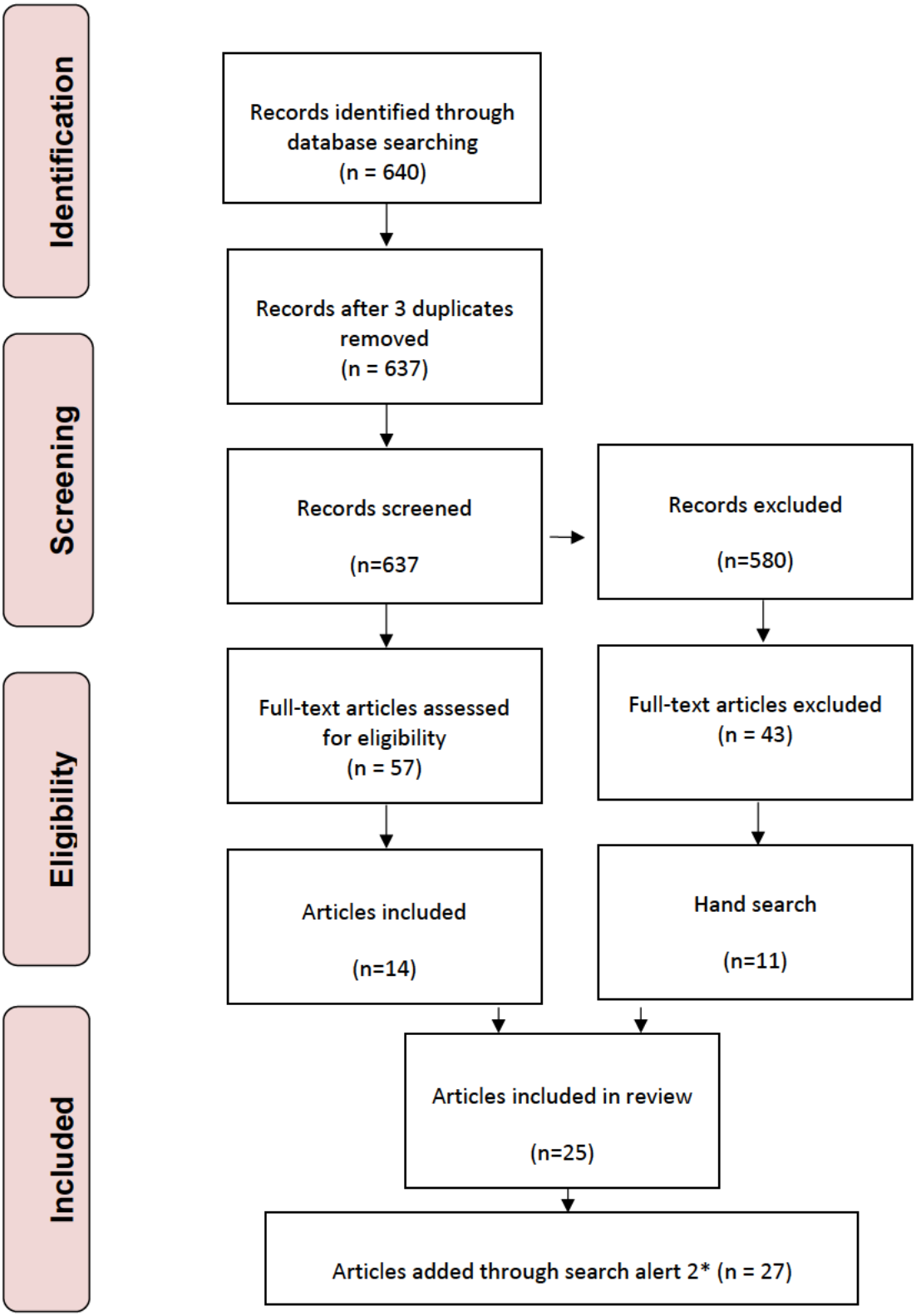
Transfer decision making is part of discharge planning and it was considered that there may be different terms used for transfer decision making. For this reason, the search term 'discharge planning' was used. This inclusive approach to the literature search was aimed at providing access to a wider variety of papers, although papers were only included in the literature review that specifically focused on health professionals' transfer decision making from hospital to a residential aged-care facility.

The search strategy produced 640 papers. Figure 2.1 depicts the screening processes undertaken in this literature review. The first step in reviewing the literature involved removing any duplicates. In total three duplicate papers were removed. The next step involved screening the papers through a title and abstract search to determine whether they related to health professionals' transfer decisions with older patients from hospital to residential care. Papers were excluded if they did not fulfil this requirement. There were a high number of papers excluded as they focused on the transfer of older patients from residential care to hospital. This meant that 580 papers were excluded through the title and abstract search. Following this step, the remaining 57 papers were reviewed in more detail, including the reference lists.

This was a significant process which involved careful reading and consideration of the papers and their connection to the topic. As a result of the in-depth review, 43 articles were excluded which left 14 papers that met the search criteria. In addition, I conducted a hand search of grey literature and screened the reference lists of papers that met the search criteria. This resulted in a further 11 papers being included in the literature review. To

ensure the literature presented in this chapter is as up to date as possible, search alerts from the search strategy were set up so that papers published after the review of the literature were identified. This led to two further papers that directly related to the topic being included. This left a total of 27 papers being included in the literature review.

Figure 2.1 ***PRISMA 2009 Flow Diagram adapted from Moher, Liberati, Tetzlaff, Altman, & The PRISMA Group (2009)***



2.2.2 Synthesising the literature

Using the above search strategy, the literature related to health professionals' transfer decisions with older patients from hospital to residential care was reviewed and categorised. This process involved careful reading of each paper and making summary notes. Once the 27 articles were critically reviewed and summarised, I then re-read them to identify the strengths, limitations, and gaps in the literature that my study aimed to address. Following this the literature was then organised into two main sections. The first section discusses the assessments that inform health professionals' transfer decisions with older patients from hospital to residential aged care. The second section examines the broader factors that influence health professionals' transfer decisions with older patients from hospital to residential care. By separating the sections in this way there is no suggestion that one is more important than the other. However, gathering information through assessments is a key component of health professionals' decision making (Hausmann, Zulian, Battegay, & Zimmerli, 2016; Standing, 2010). In addition, assessments are usually the first step of their interactions with a person, therefore, it was decided to present assessments first.

2.3 Assessments Informing Transfer Decisions

In the clinical environment health professionals use assessments to inform their transfer decisions. The assessment information can be gathered through formal or informal processes. In relation to discharge planning in hospital Rhudy, Holland, and Bowles (2010) explain that the process often starts with the registered nurse conducting assessments to decide whether they will coordinate the discharge process or refer to multidisciplinary discharge planning services. The qualitative descriptive exploratory study conducted by

Rhudy et al. (2010) involved 14 registered nurses who worked in medical or surgical wards at one of two hospitals in America.

The registered nurses in the study provided direct patient care and were also responsible for discharge planning tasks which were shared with a specialised discharge planning nurse and social worker. The registered nurses used informal assessments to gain a sense that a patient was not following the standard recovery pattern. They also tried to identify if there was a significant alteration in the planned trajectory which required more complex discharge support services. Although, if a patient was recovering as expected the registered nurses saw themselves as coordinating the discharge as they conducted preliminary assessments, usually on the day of admission, to begin the development of a discharge plan. Yet they were unlikely to fully participate in the transfer decision process due to high patient care requirements. Unfortunately, the specific assessments the registered nurses used to inform the discharge plan were not a focus of the study. Including a description of the assessments may have led to a better understanding of the initial processes that supported their transfer decisions. Despite this, the study provides insight into the discharge planning role of registered nurses in hospital, who provide direct patient care as well as the information they used to identify when more complex discharge planning services were needed.

Similarly a study conducted by Potthoff, Kane, and Franco (1997) found that assessments were used by health professionals to develop potential discharge destination options which were then evaluated until one option was selected. This is a complicated process as the older person, families and health professionals often evaluate the assessment information differently. Through the application of a qualitative approach, informed by a decision sciences framework, open ended phone interviews were used to explore discharge plans in

10 hospitals across seven cities in America. As a result Potthoff et al. (1997) developed a systems analysis of the discharge planning process. The authors found that during the process of transfer decisions, assessments were conducted by a range of health professionals who used formal and informal processes. They used the information gained from patient records, collaboration with care providers and conversations with the older patient, family, and carers to inform their transfer decisions. Many assessment processes were informal and there was a lack of empirical evidence to support their assessments and transfer decisions.

While the study conducted by Potthoff et al. (1997) is older and only provides a brief explanation of the strategies used to analyse the data, the findings highlight that there was a lack of consistent assessment processes when making transfer decisions with older patients in hospital. Interestingly Potthoff et al. (1997) explains that conducting discharge planning assessments involves art as much as science. This may be due to a complex mix of informal assessments, which can be difficult for other clinicians to follow, along with more structured assessments which lack empirical evidence. It is possible that this is still the case, as despite an increase in research related to discharge planning, evidenced-based assessments that support transfer decision making are still lacking.

In contrast, Unsworth (2001) conducted a quantitative study which aimed to develop predictive models, using evidenced-based assessments, to support health professionals to make discharge destination decisions for people who had experienced a stroke or had lower limb orthopaedic problems. The study followed 223 patients and their discharge destinations in two Australian hospitals. Using stepwise discriminant function analysis, the study found that four functional assessment tools could predict the discharge destination for people with

lower limb orthopaedic problems. Yet only one of the assessment tools was able to predict the discharge destination for people who had experienced a stroke. This may be due to the longer recovery time associated with a stroke, compared to lower limb orthopaedic issues which are more likely to lead to a faster full recovery. However, for those patients who had experienced a stroke, the inclusion of their 'living situation' and 'premorbid cognition' led to a slight increase in accurate predictions. Not surprisingly, the most significant factor that increased the accuracy of discharge destination predictions was the person's ability to access supports on discharge. The ability to access supports is likely to minimise the risk that the older patient is injured as there is someone who can assist them if needed.

While the transfer decision-making process was not the focus of this study, it does highlight that standardised assessment tools in conjunction with assessments that include living situations and access to supports may be useful to inform health professionals' transfer destination decisions. Unsworth (2001) also explains that ethical transfer decision making should involve patients, families, carers, and health professionals. However, this may not fit with a standardised assessment approach, which might focus more on the assessment than what the patient, family or carer wants.

The combination of standardised assessments that includes the wishes of older patients, families and carers is an important component of supporting older patients to make empowered, informed choices. In a critical review of the literature on person centred care in the transfer of older patients in Australia from hospital to residential care, Kendall and Reid (2017) explained that standardised assessments of function and ability do not include the older person's unique identity and wishes or support them to be in control of the process. In addition, the limited time health professionals have to conduct assessments and collaborate

with the multidisciplinary team, minimises the holistic quality of their transfer decision making. While the discussion paper presents a targeted review of the literature it is not a comprehensive review of all literature. This may limit the impact of the discussion as it presents one aspect of the literature and does not consider alternative views. Despite this, the potential for the person to be lost in standardised assessments is an important consideration as moving to residential aged care can be a significant event in a person's life.

Similarly, a discussion of the literature by Hoare (2004) explained that while comprehensive assessments are needed to inform transfer decisions with older patients from hospital to residential care they only represent a person's abilities at that point in time. Ideally, assessments need to be ongoing and used to monitor potential improvements or deterioration, rather than a final determination of abilities. In addition, older patients often take time to recover and restrengthen, although the time required for this to occur does not work in the fast-paced hospital environment, which is focused on treatment and discharge. Hoare (2004) goes on to state that because of these factors, admitting a person to a residential aged-care facility directly from hospital should not occur, as the older person requires more time to rehabilitate and recover and health professionals need more time to complete comprehensive assessments.

Hoare (2004) raises interesting points in the discussion paper and presents factors that may influence health professionals' transfer decisions. However, the recommendations of the paper indicate that assessment information can inform health professionals transfer decisions, yet it does not explain how this information is processed or how decisions are reached, other than recommending that the older person, family and carers are included. The paper also provides a targeted view of the literature and does not specifically include

transfer decision making from hospital to residential aged care. This limits the depth of discussion on the assessments that health professionals may use to inform transfer decision making with older people from hospital to residential aged care.

A qualitative study conducted by Jette, Grover, and Keck (2003) used a grounded theory approach to explore seven physical therapist and three occupational therapists' decision-making processes with patients in a 550-bed hospital in America. The study found that the physical therapists and occupational therapists assessed four constructs to inform their discharge decisions. These constructs were: the person's function and level of disability; their wishes; the ability to actively participate in care and outcomes; and the living situation which included access to support networks (Jette et al., 2003). While Jette et al. (2003) did not specifically explore multidisciplinary health professionals' transfer decisions with older patients from hospital to residential aged care, the authors developed a model of discharge decision making that began with the four constructs which focused on the patients wishes, function and living situation. Interestingly, they also found that the experience level of the therapist, their initial impression of the discharge destination, the impact of policies and regulations as well as collaborative processes impacted the occupational and physical therapists decisions. This is in contrast to Unsworth (2001) who found that standardised functional assessment tools can predict discharge destinations for physiotherapists and occupational therapists.

The occupational therapists and physiotherapists in the Jette et al. (2003) study did not use formalised assessments to determine a person's function and abilities. Instead, they considered a range of unstructured assessments to reach a transfer decision. This highlights the different assessments health professionals may use to inform their transfer decisions as

well as the importance of appropriate experience, policy, and collaborative practices. The lack of streamlined comprehensive assessments and approaches to transfer decision making is a problem, particularly for those health professionals who have less experience of working with older people who may require being transferred to residential aged care.

A quantitative study conducted by Hickam, Hendrick, and Gorton (1991), used receiver operator curves to measure health professionals' predictions of an older patient's possible transfer to residential care from hospital. The authors found that the physicians, nurses and social workers in the study predominately agreed that the older patient would transfer to a residential care setting, which may be attributed to them using the same criteria to inform their prediction. Hickam et al. (1991) used a quantitative approach to explore physicians', registered nurses', and social workers' discharge destination predictions through case reviews of 342 patients admitted to two hospitals in America. A limitation of this study is that the results were difficult to interpret due to multiple predictions and options being presented. Despite this, the results showed a high level of agreement between the health professionals for patients who could potentially be transferred to residential aged care. However, it was not clear how the health professionals reached their decision.

The health professionals were given specific data on which to base their transfer predictions and were asked to consider the probability of being discharged to a residential care setting using a numerical percentage. This may have limited the accuracy of their predictions, as they did not have the opportunity to independently assess the older patient. Talking to a patient and observing their interactions and abilities is an important part of any assessment and using an 11 point category scale to determine a transfer destination may have

minimised the informal information health professionals gain through their interactions with older patients, family, and carers.

Alternatively, Wright, Cooper, Nairn, and Telford (2001) found that occupational therapists, physiotherapists and registered nurses using a standardised assessment tool reached different decisions in relation to a person's capabilities and did not focus on strategies to address limitations or the possibility of improvement. The retrospective survey examined all nursing and residential care placements in Cheshire in the United Kingdom for a four-week period in 2000. The findings showed that the decision-making process was not clear and tended to focus on disability rather than ability, as well as the identification of risk factors, despite no standardised risk assessment having been carried out. Interestingly, a nursing assessment was completed when transfer to residential care was being considered but the inclusion of other health professionals in the transfer decision was arbitrary and unplanned. The assessments themselves also caused problems, as they often contradicted other health professionals' assessments and were used to confirm the decision to transfer to a residential care setting rather than inform it (Wright et al., 2001). Unfortunately, the study did not describe how they reached a transfer decision, yet it provides insight into the somewhat haphazard use of standardised assessment processes to inform their transfer decisions.

Conducting assessments and making transfer decisions can become more complex when the older person is experiencing a crisis. In a qualitative grounded theory study Taylor and Donnelly (2006) interviewed health and social services staff in the community and hospitals in Northern Ireland. Using focus groups and interviews the authors explored the views of social workers, home care managers, community nurses, occupational therapists, consultant geriatricians and general medical practitioners on risk and decision making in relation to long

term care of older patients. While the findings were not consistently separated into health professionals working in the community and those working in hospital, they do indicate that falls, a sudden onset of illness, disability, disease, and carer exhaustion could precipitate a crisis admission to hospital, which increased the complexity of assessment processes and limited the options on discharge. Similar to the study by Wright et al. (2001), the health professional's in the Taylor and Donnelly (2006) study inherently determined the risk of some situations such as falls, which often overrode objective risk assessments. The crisis that initiated the admission also made it challenging for health professionals to explore suitable options, as they needed time to conduct in-depth assessments and establish discharge options, especially when the older person was not previously known to them. Assessments that focus on risk may be an important component that influence health professionals transfer decision making. This requires further exploration to ensure that risks can be identified and minimised where possible.

Using a qualitative descriptive approach, Phillips and Waterson (2002) interviewed 12 older people who had recently transferred from hospital to residential care as well as seven relatives and 11 social workers who had been responsible for assessing the older patient in a hospital in the United Kingdom. From the social workers' perspectives, the transfer decision process was driven by assessment forms that focused on functional abilities and did not include the spiritual and emotional needs of the older person. This is supported by Kendall and Reid (2017) who conducted a critical literature review on person-centred care for older patients moving from hospital to residential care and found that aged-care assessments were geared towards the assessment of cognition and function, which did not take into consideration cultural, linguistic and social factors.

Despite an assessment focus, the social workers felt that they had an important role in the transfer decision-making process as an intermediary between the family, carers, hospital and residential care to support the interests of the older patient (Phillips & Waterson, 2002). The social workers reported that once they had a referral to see an older patient, the nurse or doctor had usually already discussed with the older patient the need to transfer to residential care. Interestingly few social workers questioned this decision due to concerns about legal issues if they supported the older patient to go against the doctor's advice (Phillips & Waterson, 2002). The findings revealed that there is a clear role for social workers to act as a barrier against pressure from consultants to transfer quickly to clear beds and residential aged care facilities who are trying to fill beds. This small study highlighted the use of assessment forms and the role of social work in the transfer of an older patient from hospital, but did not explore their transfer decision processes. Further exploration of multidisciplinary transfer decision making from hospital to residential aged care is needed, particularly from a social work perspective. As social workers have an important advocacy role in care transitions, it is important to gain an understanding of their transfer decision processes in hospital.

Assessments form a key part of the information that informs transfer decisions, yet it is only one part of a complex decisional process. A real life case study of an older couple and their family's experience of deciding to transfer to a residential care setting, initiated a three part literature review conducted by Kane (2011) to explore the range of post-hospital options in America and the implications of each option. The literature review found there was limited evidence to support a discharge recommendation of one setting over another. The discharge destination selected was more likely due to the health professionals' discipline and clinical

experiences rather than an evaluation of options based on assessments. The results showed that the key roles for physicians in transfer decisions were to support the coordinated delivery of primary health care as well as advocate for effective decision making, which required some knowledge of organisations that the older person could be referred to for assistance. While the literature review conducted by Kane (2011) explored some aspects of physicians' transfer decision making, the findings highlighted an oversight and delegation role which may not reflect the level of medical involvement in different settings. Even though the literature review on physicians' transfer decision making is interesting, it is also important to observe how physicians and other health professionals make transfer decisions to understand the process they use and the factors that influence them. This is a key aspect of my study which is explored in the findings chapter.

A qualitative, observational study explored hospital discharge functions and variabilities in discharge practices in two Norwegian hospitals by observing the process for 20 older patients who were required to either transfer to a residential aged care setting or other community support services (Laugaland, Aase, & Waring, 2014). Through a detailed process of observation, which included 173 conversations with patients, families, carers and health care professionals (doctors, nurses, health care providers and patient coordinators), the study found that hospital discharge functions involved a complex process of coordination between the patient, family, carers and the multidisciplinary team.

The assessment process involved multiple activities that were geared towards making an appropriate transfer decision, which included addressing issues that could cause a delay, as well as preparing the older patient and next of kin for discharge. However, the health professionals who were responsible for making transfer destination decisions to a residential

aged-care facility reported that: the recommendations from the hospital; having prior knowledge of the older patient's living situation and support; availability of residential care beds; and pressure from family, informed their transfer destination decisions (Laugaland et al., 2014). A limitation of this study is that data collection did not begin until the morning of the expected discharge, which therefore did not include the transfer decision-making process. Despite this, the study provides insight into the factors that may influence a transfer decision, yet it is concerning that the patient's wishes were not noted as a factor that influenced transfer decisions. This is an essential component of patient-centred care which will be explored in this thesis.

2.4 Broader Factors Influencing Health Professionals' Transfer Decisions

From a review of the literature, several broader factors emerged that influenced health care professionals' transfer decisions with older patients from hospital to a residential aged care setting. In this section, the literature is arranged into subsections to explore the reported factors that impact on health professionals' transfer decisions. The first subsection is time pressure which is followed by risk and ethics. The final subsection reviews the literature on processes to support team collaboration.

2.4.1 Time pressure

Health professionals working in hospitals are often under pressure to do things quickly. Through a review of the literature it became apparent that pressure to do things quickly was studied and discussed in the context of transfer decision making to residential care. This section examines the literature on the impact of time pressure on health professionals' transfer decisions from hospital to residential aged care. Using a literature review supported

by a case study, Kane (2011) examined physicians' transfer decisions to long term care from hospital in America. Through the review of the literature Kane (2011) recommended that physicians should ensure that the patients' goals, family situation, access to resources and capacity to improve should be considered when making transfer decisions, even though doing this under significant time pressure in hospital was challenging. Not surprisingly, these factors were often assessed by multidisciplinary health professionals such as physiotherapists, nurses, and occupational therapists.

The information these health professionals gather through their assessments can trigger the older patient, family, and carers to reach a transfer decision. However, as Kane (2011) explains the recommendations from the health care team should be considered as advice not as an imperative. Interestingly, Kane (2011) goes on to report that hospital discharge planners were possibly not suited for this role as they were often expected, by their employers, to discharge patients quickly. One reason for this may be that policies that focus on discharge at admission may unintentionally emphasise discharge. A discussion paper by Johns et al. (2011) explained that in the United Kingdom an estimated date of discharge needed to be established within 24-48 hours of admission to hospital and should be regularly reviewed throughout the admission with action taken as needed. This is also the case in Australia (Department of Health NSW, 2011), although as Ou et al. (2011) reported the estimated date of discharge is not consistently developed, especially for older patients and those with chronic conditions.

While Johns et al. (2011) do not explore the transfer decisions of the multidisciplinary team, the clinical practice paper explains the principles of transfer processes from hospitals and highlights the almost immediate focus on discharge either on or shortly after admission. The

development of an estimated date of discharge so soon after admission is aimed at limiting access block by ensuring that people spend the shortest amount of time in hospital as possible. One factor that contributes to access block is the lack of vacant hospital beds to move patients into (Innes et al., 2019). However, older people often take more time to recover from alterations in health and may need comprehensive multidisciplinary assessment and support (Johns et al., 2011), which may be challenging for health professionals who are required to begin planning for discharge on admission. This may influence health professionals transfer decision making, yet it was not included in the Johns et.al. (2011) study. Nevertheless, it is possible that the immediate emphasis on discharge may subtly or even overtly emphasise discharge and impact on their decision making.

Ekdahl, Linderholm, Hellström, Andersson, and Friedrichsen (2012) also found that time pressure was a significant factor that impacted on health care professionals' transfer decisions from hospital. The qualitative observation and interview study that examined discharge practices with older people in hospital was undertaken in three hospitals in Sweden. Participants included nine patients who were over 75 and had complex diseases, as well as three doctors and six nurses. The findings revealed that the doctors and nurses believed they were meeting the needs of the hospital when they discharged patients quickly. In some cases the time pressure meant there was not enough time to consider their transfer decisions in more depth or discuss options with other health staff, the older patient, family, and carers (Ekdahl et al., 2012).

This is supported by Wright et al. (2001) who reported that health care professionals were more likely to recommend transfer to a residential care facility due to the time taken to arrange services in the community as well as the possible risks associated with an older

patient returning home. Unfortunately, the study conducted by Ekdahl et al. (2012) did not include the broader multidisciplinary team or specifically focus on the transfer decisions to residential aged care. Including these aspects may have provided a more multidisciplinary perspective in transfer decision making to residential care. However, the paper does highlight the pressure that doctors and nurses experienced to make transfer decisions quickly with older patients in hospital.

A Canadian qualitative study examined factors that influenced 10 occupational therapists discharge decision making from hospital to rehabilitation and geriatric facilities. The occupational therapists worked in a variety of settings and made transfer decisions with older patients that included residential care. Using an interpretive approach, Moats (2006) found that transfer decision making for the occupational therapists that worked in hospital, was strongly influenced by time pressure and fast decision making (Moats, 2006). The pressure to make transfer decisions quickly often meant that there was not enough time to perform tasks properly or complete assessments, which meant that decisions were based on incomplete information. This is also supported by Laugaland et al. (2014) and Jette et al. (2003), who reported that time pressure significantly impacted on the quality of health professionals' transfer decision making. As Moats (2006) found, the transfer decisions were often made before the older person had the opportunity to fully recover and reach their full potential. The study by Moats (2006) did not solely focus on transfer decisions from hospital to residential care, yet it showed that for the occupational therapists who worked in hospitals, time pressure was a factor that impacted on their transfer decision making, which challenged their ability to provide person centred care.

A review of the literature conducted by Morgan, Reed, and Palmer (1997) also reported that recommending an older person transfer from hospital to residential aged care was faster and less complicated than arranging appropriate support services in the community. In addition, the pressure to ensure that people are discharged quickly meant that they were more likely to recommend transfer to a residential care facility, as it involved less risk and reduced the health professionals' concern that the older person would struggle to cope at home or have a fall. The literature review presented by Morgan et al. (1997) did not describe the process used to undertake the review, which may mean this was a targeted review rather than a comprehensive one. This may limit the depth of the findings, as all literature may not have been considered. In addition, the literature review focused on occupational therapists' discharge decision making with older people and did not include the multidisciplinary team. Despite this, the findings support the concern that pressure to discharge quickly influenced health professionals' transfer decisions with older patients moving from hospital to residential care.

2.4.2 Impact of risk, safety, and ethics on transfer decisions

Health professionals often make decisions that are associated with risk, especially in a hospital setting, which can impact on their decisions. A literature review conducted by Moats and Doble (2006) examined avoiding risk while supporting autonomy in occupational therapy discharge decision making with older people. Unfortunately, that paper did not provide the search strategy used which may limit the impact of the findings, since the search terms and decisions of what papers to include or exclude were not evident. Despite this, the findings from the literature review showed that a discharge decision-making model that connects risk avoidance and autonomy was not discovered.

Instead, Moats and Doble (2006) recommended that a negotiated approach should be developed for transfer decision making, which supports clients to have decisional control and respects both autonomy and beneficence. To develop this approach Moats and Doble (2006) recommended that a range of strategies should be adopted. The strategies included reviewing team transfer decisions to understand how decisions are made, especially in terms of the patient's wishes, other health professionals, the hospital environment, and social factors. This would involve a time-consuming process, which may be onerous and not prioritised in a hospital environment that is structured towards rapid decision-making practices.

Using a qualitative approach and thematic analysis, Atwal, McIntyre, and Wiggett (2012) also found that occupational therapists and physiotherapists perceptions of risk influenced transfer decisions with older patients. This study, conducted in the United Kingdom, used a vignette to facilitate semi structured interviews that focused on discharge decisions associated with risk and found that the health professionals identified risky situations but were less able to describe what the risks were. These professionals conducted assessments to identify functional abilities as well as risk of accident or injury. Identifying risk is helpful and significantly impacts on health professionals' transfer decision making with older people (Rhynas et al., 2018), possibly because they often associate risk with blame which can make them risk averse (Atwal et al., 2012).

Based on a vignette, the health professionals identified the discharge risks which included: function problems; limited mobility; isolation; neglecting self-care; cognitive problems; and potential for pressure sores (Atwal et al., 2012). In addition, the attitude of the daughter and the patient in the vignette was identified as a risk because the patient was considered

uncooperative and the daughter did not want to follow the discharge plan. This is an interesting and concerning finding, as older people, family and carers can be viewed as uncooperative if they do not agree with health professionals' plans. This raises questions related to patient-centred care and autonomy for older people, family and carers when making transfer decisions from hospital to residential care. However, some health professionals were willing to support an older person to make decisions that were associated with risk while others used negative terms to describe patients who chose risky discharge options. Not surprisingly, having access to a carer reduced the perceived level of risk when considering transferring an older person home.

In situations where risk was identified, the therapists reported that they discussed the case with other health professionals and shared the risk with the multidisciplinary team. While the study highlighted that the occupational therapists and physiotherapists perceptions of risk impacted on their transfer decisions, there was limited discussion of the process when there was disagreement about risk and how it was assessed. In addition, the study included occupational therapists and physiotherapists and did not explore the collaborative multidisciplinary aspects of transfer decision making, especially in situations that were associated with risk.

It is concerning that the emphasis on risk minimisation limited the transfer options that health professionals were able to present to older people. It could be argued that transfer decisions are necessarily complex and that they are informed by multiple factors aside from risk. However, trust is an important part of risk acceptance. The Better Care Fund (2017) conducted wide ranging research into delayed transfers in hospitals in the United Kingdom and reported that fear as well as lack of trust reduced the risks that health professionals

would accept when making transfer decisions. A lack of trust meant health professionals were more likely to take the position that risk minimisation was the main priority. They were also less willing to adopt new ideas and alter the original decision due to fear of litigation or poor outcomes.

Minimising risk is an important part of transfer decision making. This was also discussed by Popejoy (2008) who used a qualitative descriptive design to conduct a study in a 375 bed hospital in America. The study used semi-structured interviews with five nurses and two social workers, who worked as discharge planners, on their use of adult protective services to minimise risk in transfer decisions (Popejoy, 2008). The findings revealed that safety was a significant factor that impacted on their transfer decisions. Notably Popejoy (2008) found that each health professional viewed safety differently but all included factors associated with risk such as, falls and mobility issues that made it impossible for the person to escape the home if there was an emergency, lack of access to food and water, lack of ability to correctly take medications and lack of support. In situations where it was not possible to address safety concerns and the older person refused to transfer to a residential care setting, the health professionals referred the person for follow up in the community by adult protective services as a way to quickly access community support.

However, Popejoy (2008) explains that the use of adult protective services as a way to fill the gap caused by a lack of community services is not appropriate nor does it solve the problem of readmission or poor outcomes for the older person. While the study was conducted in a smaller community hospital and did not explain the transfer decision process or function of the health care teams, the findings highlight that there is no single definition of safety for older patients wanting to return home. In addition, the study reveals the strategies the

health professionals were prepared to use to ensure that transfer decisions with older patients were safe, quick, and minimised the risk of readmission to hospital. While safety should be determined on a case-by-case basis, the lack of clarity for health professionals on what constitutes a safe transfer decision may limit the risks they are prepared to take when making transfer decisions. This factor is a feature of my study, as safety and the lengths health professionals may go to, so as to minimise risk are crucial elements in transfer decisions.

Similarly, in an Australian context Denson, Winefield, and Beilby (2013) found that transfer decision making with older people was influenced by safety and the minimisation of risk. Using a case study approach Denson et al. (2013) recruited 18 experienced health professionals which included, doctors, occupational therapists, psychologists, social workers and nurses as well as eight younger relatives and 10 older people to evaluate a case study. Participants were asked to review the case study and make a recommendation of who should be the principal decision maker as well as make a transfer destination recommendation.

The need to support safety was considered, by most of the participants, as more important than ensuring that the ethical issues of beneficence, autonomy and duty of care were attended to. This was potentially due to the health professionals being more concerned about being blamed if the older person was injured on returning home. Unfortunately, the strategies health professionals used to resolve ethical conflict were not a focus of the study. Such a focus would have provided a better understanding of how health professionals address ethical conflicts, for example in relation to the issue of blame, as mentioned earlier. In addition, the study did not include observation or discussion of how they made a transfer

decision, managed ethical dilemmas or collaborative practices within the multidisciplinary team. However, the findings revealed that balancing safety and autonomy when making transfer decisions was a complex process which required further exploration.

Interestingly, as found by Denson et al. (2013), supporting the older patient's right to make autonomous self-determined choices was challenging. This was because the older people in the study by Denson et al. (2013) reported that they wanted the next of kin, guardian or health professionals to make the transfer decision, while health professionals and relatives wanted the older patient to decide. Supporting an older patient to make a transfer decision is ideal but may be difficult to achieve due to the alterations in health that led to the admission to hospital and a concern about safety and risk. A level of safety and risk was viewed as acceptable by the older people who participated in the study as they described strategies such as access to community services to mitigate the risk. Based on the case study, older people, who participated in the study by Denson et al. (2013), considered what would be better for the patient and were more likely to recommend that the older patient returned home. This may be due to older people being acutely aware that they too may need to decide whether to transfer to a residential setting and were more cognizant of what risks were acceptable.

This was also considered by Cox (1996), who conducted a qualitative study that explored the main factors that influenced the discharge decisions of 172 carers of older patients with dementia in five hospitals in America. The study had several data collection methods which included: interviews; sociodemographic details; awareness of support systems available; the level of satisfaction carers had in support services; and the supports they accessed. The findings showed that the strongest influence on carers' transfer decisions from hospital to a

residential care setting was the condition of the older patient, while the second strongest influence was the opinion of the physician, followed by the opinion of the social worker.

A further finding from the study conducted by Cox (1996) was that carers rarely discussed the transfer decision with the older person. This is particularly concerning as the carers also commented that the older person was satisfied with their involvement in the transfer decision. As it is important to include the older person in transfer decisions, it is concerning that they can be left out of the decision and still be satisfied. This may be because they are too unwell or fatigued to participate in the process. While Cox (1996) highlights the impact of the transfer decisions of physicians and social workers, it did not explore how they reached a transfer destination decision. Despite this, the findings indicate the emphasis carers place on the discharge destination recommendation of physicians and social workers. This is important in my study as carers may well rely on the recommendation of health professionals when making transfer decisions, yet it is not clear how the health professionals make these decisions.

In a similar way Devnani, et al. (2017) conducted a qualitative study to understand the decision making of surrogate decision makers with older patients in hospital. The study involved 362 surrogates who had made at least one decision related to either of the three factors of; prolonging life; informed consent; and discharge placement. While Devnani et al. (2017) focused on three aspects of surrogate decision making, my study specifically relates to the aspect of transfer destination decisions. The surrogates were asked to rate the decision-making principles in order of preference. Unexpectedly, the researchers found that 77.8% of surrogate decision makers reported that the main principle that impacted their

decision making was to support the well-being of the patient, with 21.1% supporting the patient's preferences.

This challenges the ethical principle of autonomy which is usually connected to surrogate decision making (Devnani et al., 2017). It is concerning that surrogate decision-makers appear to be more focused on supporting the older persons wellbeing than following their wishes. Well-being includes the physical, social, psychological and emotional aspects we experience in our lives (McColl-Kennedy et al., 2017). These emotions shape our experiences and can have long-term implications, especially if those experiences are negative. It is difficult to see how well-being can be supported when the older person's wishes were less likely to impact a surrogate's choice. It can be challenging for older people to participate in medical decision making when they are unwell and surrogate decision-makers provide decision support, although they should aim to uphold the older person's wishes as much as possible. This is relevant in my study, since carers as well as substitute decision makers may influence transfer decisions from hospital to residential care and it is important to explore the effect this may have on health professionals' experience in making transfer decisions.

Interestingly, Ekdahl et al. (2012), found that health professionals did not always include the older patient in discussions about discharge. This was done to support rapid decision making. The health professionals reported feeling guilty in relation to this, yet believed that by minimising delays they were appropriately fulfilling the important task of freeing up hospital beds. Somewhat surprisingly, the older patients reported that they were not overly concerned that they were not involved in the transfer decision as they did not feel that they had any ability to influence the decision. This raises ethical considerations of person-centred care, equity, and autonomy as deciding where and how to live is central to our wellbeing. As

explained by Morgan et al. (1997), making a decision to transfer to a residential care setting can significantly affect the older patient's perceptions of control, identity and security, especially when the decision is made as a result of an admission to hospital. This could reduce their ability to actively engage with the decision-making process and may require targeted strategies to ensure older patients are included in the transfer decision process.

A study conducted by Clemens (1995) also found that the wishes of older people were not included in transfer decisions making. Using a questionnaire in a 450-bed hospital in America Clemens (1995) examined people's ability to exercise choice in the discharge planning process. The questionnaire was given to 40 hospital discharge planners comprising of nurses and social workers and 40 family caregivers. The study did not report the methodology used, yet provided a description of the study methods which included a somewhat complicated process of triads and dyads. The caregiver triad comprised of the older patient, a family carer, and a discharge planner, while the caregiver dyad was made up of a carer or older patient and discharge planner. All participants were asked the same questions about their perceptions of choice in the discharge planning process. The findings revealed that most patients and carers reported that they had little influence on transfer decision making.

The carers in Clemens (1995) study reported feeling bullied by health workers to transfer the older patient from hospital to a residential care setting. They also described that they felt the decision to transfer the older patient was forced on them by: a lack of time to consider options and plan for discharge; perceptions that the hospital planners had the power in the decisional process; and limited information provided on community services. It is notable that the social workers viewed transfer to a residential setting as a faster and safer discharge

option that would also protect the hospital from any potential liability if the older patient were discharged home and became injured.

This is supported by Morgan et al. (1997), who found that transferring the older person from hospital to residential care was quicker and easier as it reduced the need to arrange community services, which can be challenging and time consuming. However, as explained by Giles et al. (2009), 81% of older patients, who were new admissions to residential care from hospital, reported their quality of life as a state similar to death. Therefore, the impact of this decision on the older person is significant and raises ethical concerns if the older patient was not included in the decision, or alternative options were not explored due to pressure to make fast, safe decisions. It is concerning that time pressure may minimise an older patient's participation in such an important life event, and developing an understanding of this process may help to identify areas that could be improved.

The study conducted by Clemens (1995) provides insight into the factors that influence health professionals' transfer decisions with older patients in hospital and includes the perspective of the carers. Unfortunately, the study did not include the broader multidisciplinary team, which limits a fuller understanding of the factors from a multidisciplinary perspective, yet did reveal the ethical challenges health professionals faced when making transfer decisions with older patients. Of some concern was the health professionals' emphasis on processes and safety over autonomy and consent, which limited the older person's ability to exercise dignity of risk. Dignity of risk connects quality of life to peoples' ability to take risks (Ibrahim & Davis, 2013). Therefore, reducing peoples' ability to make an informed choice that is risky can directly impact on their quality of life and dignity.

This can have lifelong implications for the older patient in terms of the grief and loss associated with transfers to a residential aged care setting.

It is noteworthy that Clemens (1995), Cox (1996) and Morgan et al. (1997) reported that the decision to transfer to residential care did not consistently include the older person. More recently a qualitative narrative study conducted by Rhynas et al. (2018) also found that the voice of the older person was not included in health professionals' transfer decision making in hospital. The study conducted by Rhynas et al. (2018) reviewed the medical records of 10 older patients who were admitted to a Scottish teaching hospital from home and discharged to a residential aged-care facility. The findings revealed that there was minimal documentation on the older persons' thoughts and wishes in relation to transfer decisions, this was especially true for nurses' documentation. It is noted that the findings were developed through a review of medical records which may not include all aspects of the transfer decision making processes. This is mainly due to the nature of hospital documentation, which is usually objective and concise (Mathioudakis, Rousalova, Gagnat, Saad, & Hardavella, 2016) and may minimise the effectiveness of their use to explore transfer decision making where situations are complex and evolving. In addition, the legal nature of medical records may mean that some conversations between health professionals, patients and carers were not documented, which may reduce the strength of the findings. Despite this, the study provides an interesting insight into the transfer decision-making process from hospital to residential aged care.

Using health professionals' documentation provides an insight into transfer decision making. However, a deeper understanding of their transfer decision making with older patients from hospital to residential care may have been supported by including a description of their

decision making. Since not participating in decisions about where to live can negatively impact an older person's physical and psychological health (Carpenito-Moyet, 2013), it is important to gain more of an understanding of the impact of risk and safety on health professionals' decision-making processes from hospital to residential care in order to better understand this complex phenomenon.

2.4.3 Collaboration in transfer decisions

Team collaboration emerged from the review of the literature as an important factor that influenced health professionals' transfer decisions with older patients from hospital to residential aged care. A clinical practice paper by Johns et al. (2011) explained that ensuring safe and prompt discharges is a challenging process, especially in light of a growing ageing population who often have complex care needs. Johns et al. (2011) discussed the roles and functions of members of the multidisciplinary team, which included a discharge coordinator (who is usually an experienced nurse), occupational therapist, physiotherapist and physician, who have a vital role in ensuring safe, quick discharges.

To support effective transfer decisions, multidisciplinary meetings provide an opportunity for health professionals to come together to develop discharge plans. As Rhynas et al. (2018) explained these meetings are often used to support health professionals transfer decision making from hospital to residential aged care. In these meetings physicians provide an overview of significant medical issues and advise the team of an expected date that the patient will be medically ready for discharge. Johns et al. (2011) provide a clear overview of the transfer decisional process but does not explain whether the patient, family or carers were included in these meetings or how the information from the meetings was communicated to the patient and other health professionals. In addition Johns et al. (2011)

did not explore the transfer decision-making processes after the meeting or what happened if the older patient was not able to be discharged due to poor mobility or social needs.

Despite this, the clinical practice paper provides insight into the processes of collaborative transfer decision making in hospital, which were supported through multidisciplinary meetings. In these meetings doctors discuss a patient's medical concerns and develop a potential time that the patient will be medically ready for discharge planning. Johns et al. (2011) also concluded that to establish effective transfer processes health professionals should ensure that physicians are key members of the multidisciplinary discharge team and should establish good communication systems. Communication between the multidisciplinary team, older patient, family and carers are an integral part of transfer decision making and may be a significant factor in the process.

The importance of communication is also explained by Jette et al. (2003) who found that occupational therapists and physiotherapists often shared information with each other to determine if their discharge plans were in agreement before going to the multidisciplinary team. In addition Ekdahl et al. (2012) found that the doctors and nurses in Sweden communicated with each other before seeing the patient to identify those that were likely to be discharged. Using qualitative interviews and observations, Ekdahl et al. (2012) studied older patients and health professionals' participation in discharge from hospital. A finding of that study was that nurses attempted to discuss with the doctor their concerns that an older patient was being discharged before they had been able to work through the issues, although this was not successful.

Interestingly, the senior doctor felt that as the older patient had refused community supports the discharge would still go ahead as the doctor imagined an unknown person or

service would look after the older patient at home. While the nurse and junior doctor raised concerns about this, their input was overridden. The lack of collaborative decision making led more senior nurses to counsel junior nurses not to think about what may happen to frail older patients when they were discharged home. This indicates that the nurses were aware that older patients may struggle at home without access to supports and that they had limited power to alter the doctors decision.

Similarly, Moats (2006) reported that the occupational therapists who worked in hospital teams found there was ongoing tension between a medical decisional approach and a patient focused approach. The hierarchy in hospitals holds doctors as the predominate decision-makers, which may limit health professionals collaboration and a patient-centred approach. This may be due to transfer decision discussions being unstructured, sporadic, and only occurring if instigated by the older patient. However, this was not the only barrier to collaborative transfer decision making. The lack of support and formal decision-making processes limited their ability to collaborate with older patients, families, carers, and health professionals; this impacts on health professionals' transfer decisions.

This is supported by Reed and Morgan (1999) who reported that there was no formalised approach to making transfer decisions with older patients from hospital to residential care. The qualitative action research study conducted by Reed and Morgan (1999) in the United Kingdom examined the experiences of older patients and health professionals in the transfer from hospital to residential care. While the study did not explore how the health professionals reached transfer decisions it provided insight into the process of making transfer decisions in hospital. The registered nurses in the study reported that there was no formalised approach to making transfer decisions with older patients from hospital to

residential care. Transfer decision discussions were unstructured, sporadic, and usually only occurred if instigated by the older patient.

Interestingly, the registered nurses did not encourage these conversations with the older patients as it may upset them. The registered nurses had minimal knowledge of the process for transferring people to residential aged care, including the differences between facilities and how to arrange entry, as they saw this as more a social work role than a nursing one. It was interesting that registered nurses did not want to participate in these decisions as they did not feel that this was their job. Registered nurses are more likely to know more about the patient as they spend the most time with them, so it is concerning that they are not involved in the process. While the study conducted by Reed and Morgan (1999) is older and this may no longer be the case, it is an important aspect to consider, particularly in light of the multidisciplinary nature of transfer decision making.

Social workers are an important part of the multidisciplinary team in transfer decision making from hospital to residential aged care. As explained by Reed and Morgan (1999) social workers understood the processes of accessing a residential aged care bed, they also felt that their decisions were strongly influenced by pressure to arrange the transfer, which minimised the time they had to talk through options with the older person. This, combined with a lack of decisional supports, left them dissatisfied with the process. The medical staff saw their role as one of making the transfer decision and ensuring the transfer happened quickly as they were conscious that other people needed the hospital bed. The medical staff held the belief that the nurses and social workers would support older patients during this process. Even though due to time constraints and role assumptions it appears that this was not the case. The lack of established decisional support systems and role clarification may

minimise the ability to utilise collaborative processes. The study highlights a lack of collaboration between health professionals, older patients, family and carers. In addition, it provides insight into the potential intrinsic boundaries between health disciplines that can impact on the effectiveness of collaborative transfer decisions from hospital to residential aged care.

Importantly, using an anonymous vignette of an unrepresented older patient's journey through hospital, Abdool et al. (2016) explained that as nurses spend the most time with the patient, they are in a unique position to know the patient's abilities and wishes. This is in contrast to, Morgan et al. (1997) who found that while the multidisciplinary team met to discuss transfer decisions, the nurses who provided direct patient care were not always included in those meetings. Missing the input from nurses who spent the most time with the older person has the potential to limit the effectiveness of multidisciplinary transfer decisions. Interestingly, Phillips and Waterson (2002) found that nurses became less engaged with the logistics of the process once the decision was made to transfer to residential aged care. This is supported by Reed and Morgan (1999), who found that nurses did not have a strong understanding of the process of transfer decisions. The inclusion of the nurse may increase the collaborative nature of transfer decision making as well as provide the multidisciplinary team with information gained through prolonged contact with the patient. The time spent with the older patient gives the nurse the opportunity to assess whether the patient is able to consistently attend the activities of daily living. Yet, nurses have a limited understanding of transfer decision making from hospital to residential aged care.

This was also supported by Leahy and Lording (2005) who found that nurses had minimal understanding of transfer decision making. However, when nurses were included in transfer decision making their job satisfaction increased and they developed a stronger understanding of the process. This finding was part of a project conducted in an Australian hospital that established a social work residential care team which specifically focused on older patients in hospital who may transfer to a residential care setting (Leahy & Lording, 2005). Including social workers in this process is supported by Cox (1996), who reported that social workers have a key role in the transfer decision process from hospital to residential aged care.

The use of a residential care team made up of experienced social workers was aimed at increasing discharges and reducing length of stay in hospital. While the study by Leahy and Lording (2005) highlighted increased engagement and an emerging understanding of the transfer decision process for nurses, it did not explore the transfer decisions made by the social work residential care team. Yet, it did highlight that a lack of understanding for nurses concerning the transfer decision process may impact on their ability to participate. This indicates that nurses may have less understanding of transfer decision making which reduces their ability to participate. Strategies to address this could be considered in order to support nurses to actively participate in multidisciplinary transfer decision-making practices.

To support collaborative person-centred decision-making practices in hospitals and health care the World Health Organisation prepared eight priority statements that focused on coordinating care. The second priority statement relates to collaborative care planning and shared decision making (World Health Organisation, 2018). The aim of this priority statement is to ensure that patients, family and carers are involved in the planning of care.

The benefits of this collaborative care planning approach were reported by Scotland, the Netherlands, South Africa and Tanzania (World Health Organisation, 2018). However, only South Africa and Tanzania applied this approach in an aged care context. South Africa applied a patient-centred focus that supported each resident's right to make autonomous choices. While in Tanzania, the development of individual holistic care plans by consulting with the older person, family and carers was found to improve the quality of patient-centred care and emotional support (World Health Organisation, 2018) Interestingly both approaches increased person-centred care and autonomy for the older person.

While not specifically related to transfer to residential aged care, the foundation of patient-centred care and autonomy are important parts of collaborative care planning and shared decision making. Including these approaches to transfer decision making with older patients from hospital to residential aged care may enhance a collaborative approach.

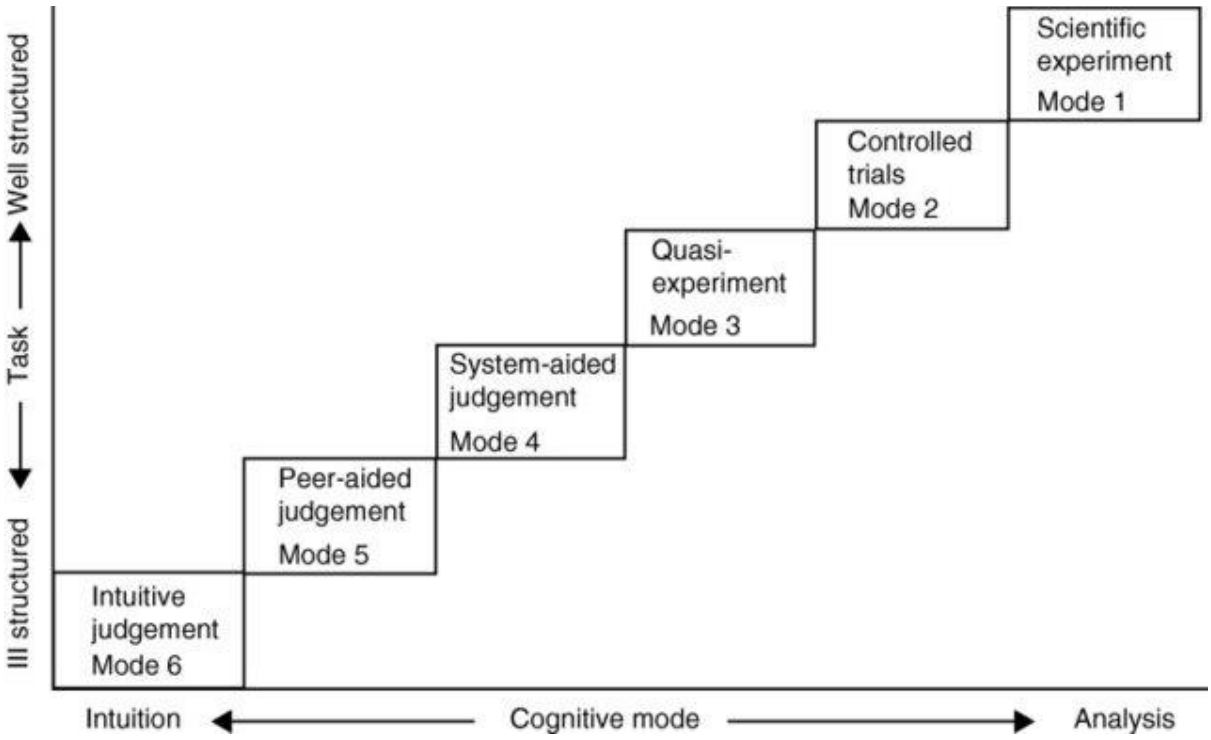
2.5 The Theoretical Framework of Decision making

In the context of the literature review a theoretical framework was identified as a way of comprehending decision making. In my study the theoretical framework of cognitive continuum theory was selected to understand and explain health professionals' decision making from hospital to residential aged care. A theoretical framework in qualitative studies is used as a lens to explain how the findings are understood in the context of new knowledge (Collins & Stockton, 2018). An explanation of this theory is provided here.

2.5.1 Cognitive continuum theory

In response to the idea that intuition and analysis are two separate forms of decision making Hammond (1996) posed that making decisions could involve both intuition and analysis. This inclusive theory challenged the dichotomous view of using either analytical or intuitive cognition to make decisions. Instead, Hammond (1996) suggested that decision making should move from being analytical to intuitive, depending on the type of problem. In the intuitive mode, decisions are made using rapid unconscious processing that combines information to reach a decision which is reasonably accurate, but inconsistent (Hamm, 1988), while the opposite end of the continuum holds analytical decision making. This type of decision making involves careful consideration of information and has a high degree of accuracy, but is a slow process. In the middle of the continuum intuition and analytical cognition meet and common sense comes into play. Referred to by Hammond (1996) as quasi-rationality this important aspect of decision making makes use of "our most frequently used cognitive activity" (p.148) common sense. Figure 2.2 provides a diagram of cognitive continuum theory by Hamm (1988).

Figure* 2.2 *Cognitive Continuum Theory



Hamm (1988, p. 87)

An important component of this theory is the impact of the task, expertise, and context of the decision. The task can determine what mode of decision making to consider but the expertise of the decision maker is also important. In a health care setting if the decision-maker does not know the standard accepted procedure for a task then they cannot think about the problem analytically, instead they will need to work intuitively which has a higher chance of being unsuccessful (Hamm, 1988). Cognitive continuum theory decision making is more effective in situations where the decision-making approach is aligned to the task attributes. Hammond et al. (1987) explained that when the decision-maker's thinking matches the task properties the decision is more likely to be accurate.

The type of decision making applied is defined by the type of problem. At the intuitive end of the continuum decisions are often made quickly based on pattern recognition which are person dependent (Hammond et al., 1987). However, at the far end of the continuum (mode 6) decisions are made based on opinion which is informed by experience, while modes 1 through 3 are usually applied in medical diagnostic situations (Hamm, 1988). At this end of the continuum analytical decision making is utilised for structured clear-cut decisions that are supported by rigorous evidence. In between analytics and intuition is the middle of the continuum. Referred to as quasi-rationality this is the most reliable and utilised type of decision making where there is a mix between intuition and analytics (Hammond, 2010). Hammond (1996) explains that this type of decision making uses common sense which is:

> *"cognition that is as analytical as it can be and as intuitive as it must be, or the converse, depending on the inducement from the task situation"* (p.150).

The nature of the task determines the decision-making mode utilised, although issues can arise if the decision maker selects an approach that does not suit the type of problem (Custers, 2013).

An example provided by Hammond highlights how decision making often uses a mixture of intuition and analytics. As Hammond (2000) explained, when a decision is made about employing a person, it may be based on their previous work history, which is analytical. However, they may also decide that the person seems collegial and astute which is intuitive decision making. In the example provided by Hammond (2000) the decision-making mode was more towards the intuitive end of the continuum. This was a result of there being more intuitive data that informed the decision, rather than analytical. Viewing decision making as a continuum rather than a binary action supports the ability to utilise all the information to make effective decisions. However, at the far end of the continuum, intuition and analysis

are rarely, if ever, utilised on their own. This may be due to the significantly different properties of analytical and intuitive decision making which are shown by Hammond et al. (1987) and presented in Table 2.1.

Table 2.1 Properties of intuition and analysis

	Intuition	Analysis
Cognitive control	low	high
Rate of data processing	rapid	slow
Conscious awareness	low	high
Organizing principle	weighted average	task specific
Errors	normally distributed	few, but large
Confidence	high confidence in answer: low confidence in method	low confidence in answer: high confidence in method

(Hammond et al., 1987, p. 755)

This theory provides a framework that explains aspects of health professionals' transfer decision making. The ability to apply both intuitive and analytical approaches is relevant in my study, as health professionals are often required to make a range of complex decisions. The theory is applied in Chapter 5 in the context of the health professionals' transfer decision making.

2.6 Chapter Summary

Through a review of the literature it became apparent that there was a lack of validated assessment tools that triggered a transfer decision. For the most part, the literature revealed that assessments often focused on function, but did not lead to a transfer decision or include the older patients wishes. This was interesting, as despite the considerable pressure to make decisions quickly, there was a lack of development of transfer decisional tools to support health professionals to make these decisions in a timely manner. It was also concerning that the registered nurse carried out assessments of function yet predominately stayed out of the transfer decision-making process. This was possibly due to the high care needs of the patients in their care and a lack of knowledge of the transfer to residential aged care process. Multidisciplinary decision making may support communication but the lack of inclusion of the registered nurse and the hierarchy in hospitals, where doctors are the main decision-makers, may limit collaborative decision making.

The participation of families and carers in the transfer decision was evident in the literature. Interestingly, carers felt that the transfer decision was forced on them and the older patient was not included. The literature also revealed that in some cases health professionals wanted to make sure that older patients were safe and could view those who did not agree with their plan as uncooperative. It was unsurprising to find in the literature that in the

absence of standardised assessment tools the ultimate discharge decisions could be based on the health professional's discipline and clinical experiences, rather than peer reviewed decisional support.

There were significant gaps in the literature to explain health professionals' transfer decision making from the hospital to residential aged care. While there was some discussion around aspects of transfer decision making from the hospital to residential aged care, there were none that explored doctors, occupational therapists, physiotherapists, registered nurses and social workers transfer decision making individually and collectively. Exploring multidisciplinary health professionals' transfer decision making in the hospital environment can contribute to what is known about their transfer decisions. In addition, exploring this topic may reveal aspects of transfer decision making not yet uncovered in existing studies.

From a review of the literature it appears that no studies have been done that observed collaborative multidisciplinary (doctors, occupational therapists, physiotherapists, social workers and registered nurses) transfer decision processes as well as interviewed multidisciplinary health professionals about their experiences making transfer decisions. In addition, no studies were identified that explored health professionals' transfer decision making from a phenomenological perspective. Exploring this topic through a phenomenological lens can lead to further understanding health professionals' experiences of transfer decision making. This can provide a deeper understanding of older patients, families and carer involvement in transfer decision making and potentially contribute to policy and practice development to ensure that older patients are encouraged to actively participate in decisions about where and how they live.

In this chapter I critically examined the literature on health professionals' transfer decision making from hospital to residential aged care. Through the review of the literature gaps were identified that this study aims to address. The following chapter explains the methodology that was used in the study to examine health professionals' lived experience in making transfer decisions with older patients from hospital to residential aged care.

Chapter 3
Methodology

This chapter presents the methods and methodology applied to this study that explores multidisciplinary health professionals' lived experience in making decisions in the transfer of older patients from hospital to residential aged care. This chapter begins by presenting the research question and objectives which are connected to the methodology. They are provided here to centre the study topic within the methodological approach. This is followed by the research design and a discussion of the phenomenological perspective that underpins my study. A phenomenological perspective was used in this study as it supports in-depth exploration of peoples' lived experience. Following this is a discussion of the application of phenomenological methods to collect and analyse data in my study. The final section of the chapter explains the strategies used to ensure rigor in my study.

3.1 Research Question

What is the lived experience of health professionals making transfer decisions with older patients from hospital to residential aged care?

3.1.1 Objectives

This study sought to:

1. Explore how health professionals perceived their role in the overall decision-making process prior to an aged-care assessment team referral.
2. Examine what informs health professionals' decision making when assessing an older patient prior to the aged-care assessment team's referral.
3. Explore the assessment tools health professionals use to inform their decision making.

4. Describe the enablers and impediments health professionals identify which affect their decision making.
5. Describe the satisfaction health professionals' experiences when participating in the decision-making process in relation to the transfer of older people from hospital to residential care.

3.2 Research Design

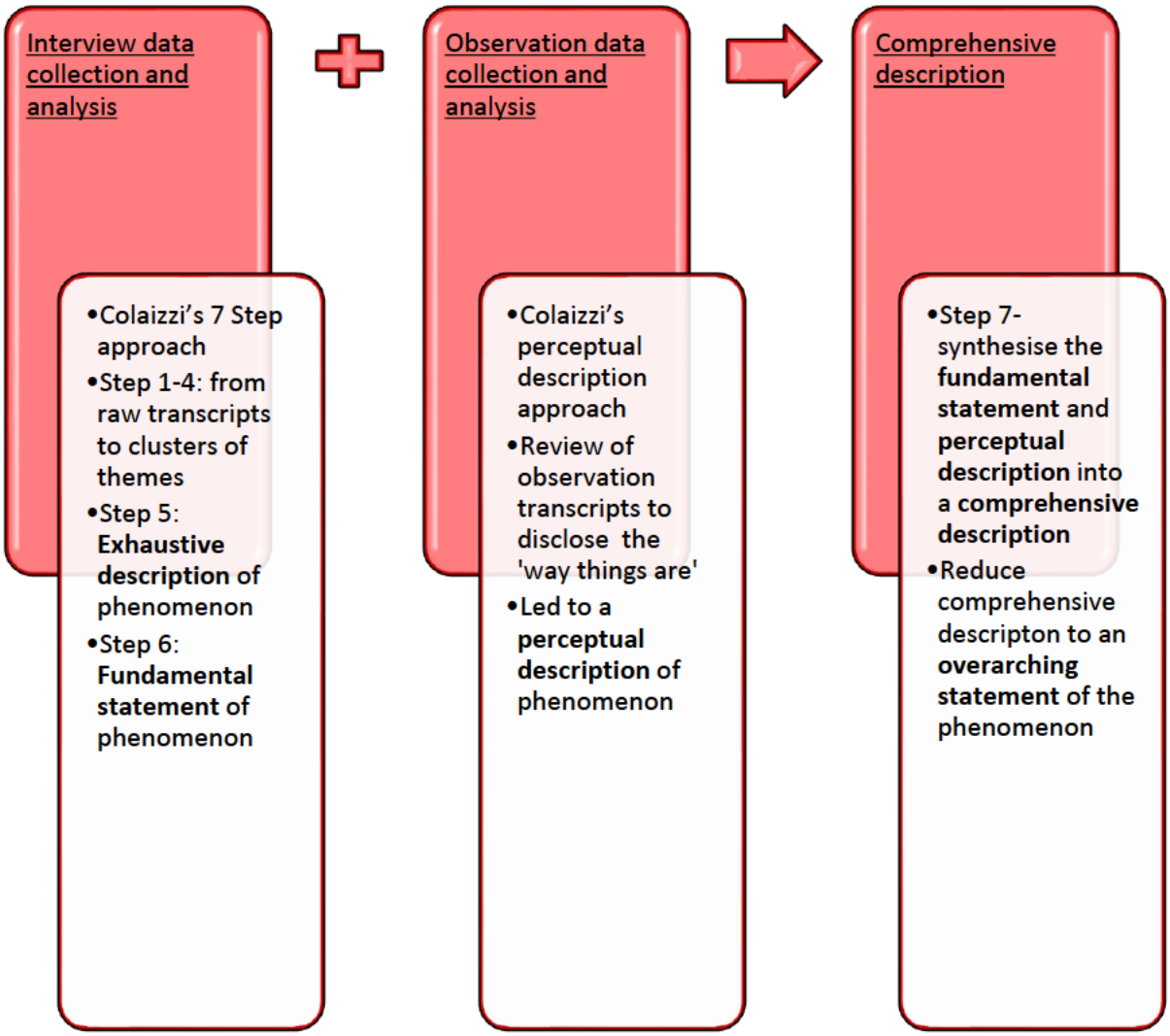
A qualitative descriptive design informed by Husserl's phenomenology and Colaizzi's approach to analyse the data was selected as the framework for this study. Health professionals' decision making is a multifaceted experience that is impacted by a myriad of factors (Jette et al., 2003). Describing the factors involved in the decision-making process provides an understanding of a previously unexplored phenomenon: health professionals' lived experience in making transfer decisions in hospital. To achieve this understanding, a methodological approach that supported a descriptive exploration of health professional decision making was required.

The two methods of data collection used in this qualitative descriptive study are semi-structured interviews and observations. Both methods were underpinned by a phenomenological perspective. Using two methods of data collection supports the richness of data and validity of findings (Bolster & Manias, 2010). Collection of the interview and observation data occurred concurrently. The semi-structured interviews provided a first-hand account of a health professional's experiences in making decisions in the transfer of an older person from hospital to residential care. The interviews were analysed using Colaizzi's seven-step approach which moves beyond individual descriptions and supports an

understanding of the essence of the phenomenon. A deeper explanation of the analysis of the interview data is provided in section 3.6.2.

The observational component of the study allowed me to witness the multidisciplinary team meetings and their transfer decision-making process as it unfolded in real time. The semi structured interviews provided the opportunity to explore health professionals' stories of their experiences while the observations provided the opportunity to witness them making decisions in the transfer of older patients from hospital to residential aged care. The observation data were analysed using Colaizzi's perceptual description method, which is explained in more depth in section 3.7. The interview and observation data were validated through the adapted Step 7 of Colaizzi's approach, which is explained in section 3.9. The perceptual description derived from the observational data and the fundamental structure developed through Steps 1-6 of Colaizzi's approach were synthesized to provide a comprehensive description of health professionals' transfer decisions with older patients in hospital. A more detailed explanation of the application of this process is provided in section 3.8. Figure 3.1 depicts the processes used to develop the comprehensive description in this study. It is noted that there are three kinds of description outlined in this chapter, so it is important to distinguish these.

Figure 3.1 Process to develop comprehensive description



3.3 Phenomenological Perspective Underpinning the Study

A descriptive phenomenological approach informed by Husserl was selected as the most appropriate methodology for this study. Phenomenology is the study of the essence of humans lived experience (Abalos, Rivera, Locsin, & Scoenhofer, 2016). It is both a methodology and a philosophy which was refined by Husserl although it did not become significant until the 20th century (Abalos et al., 2016; Giorgi, 2005). While there were several major philosophers who contributed to the development of phenomenology, it was formalised by Edmund Husserl (Giorgi, 2005). The philosophy of phenomenology is grounded in the experiences of people, their intentionality and the meaning of their experiences (Giorgi, 2005). Husserl proposed that people live in the "natural attitude" where we understand the world exists with all its real and potential actualities (Husserl, 1970).

It is important to note that there are differing views and understandings of meaning within phenomenology. In Husserlian phenomenology the approach is to disclose the phenomenon, while in Heideggerian phenomenology the phenomenon is uncovered through interpretation (Heidegger,1988). Martin Heidegger proposes that objects and experiences take on meaning because of the interactions people have with them. In effect, meaning presents itself through a relationship between people and things. Colaizzi, following Husserl, sees meaning as something which emerges on the way to knowledge: any relationship is suspended in Husserl, whereas in Heidegger this cannot occur. While both approaches seem reasonable, in light of my pervious experience in transfer decision making I decided that Colaizzi provided a more manageable way of getting close to the phenomenon, as I was able to engage in the epochē.

To conduct a phenomenological enquiry informed by Husserl the researcher is asked to 'transcend' their natural attitude by suspending all judgements about the external world (Husserl, 1970; Paley, 1997). The aim is that by suspending all judgement the external world is disclosed. In my study it is the experiences that are of interest. Accessing these experiences through Husserl's descriptive phenomenology provides the opportunity to see things through the eyes and voices of the people who experience it. Husserl uses the epochē as a process of putting aside, through deep reflection, our natural attitude in order to understand the phenomenon in its purest form (Husserl, 1970). Husserl (1982) writes:

> *This universal depriving of acceptance, this "inhibiting "or "putting out of play" of all the positions taken toward the already-given Objective world and, in the first place, all existential positions (those concerning being, illusion, possible being, being likely, probable, etc.),—or, as it is called, this "phenomenological epochē " and "parenthesizing" of the Objective world—therefore does not leave us confronting nothing. On the contrary we gain possession of something by it; and what we (or, to speak more precisely, what I, the one who is meditating) acquire by it is my pure living, with all the pure subjective processes making this up, and everything meaning in them, purely as meant in them: the universe of "phenomena*"…. (page 20)

To achieve this the phenomenological onlooker (researcher) in the epochē transcends to one who is no longer bound to human beliefs, which Fink (1984) describes as being "freed of the shrouding cover of human being" (p.40). By applying the epochē our attitude is transformed to one where we set aside our knowing of the world in order to discover the true essence of the phenomenon (Bradbury-Jones, Irvine, & Sambrook, 2010; Husserl, 1970). although this setting aside of our natural attitude is not intended to be a permanent state. Husserl refers to a zigzag strategy where one can move between a reflective to a non-reflective state with the goal of seeking the phenomenological reduction (Cai, 2013). The development of the phenomenological reduction is made possible through the epochē (Husserl, 1970) as well as rigorous self-reflective practices, in order to develop an understanding of the phenomenon that is transparent (Fink, 1984; Husserl, 1970).

As Giorgi (1994) explains, this concept can be challenging for researchers and he offers a clearer way to access the epochē and phenomenological reduction in a research context. By setting aside our pre-existing knowledge and understanding of the phenomenon the researcher accepts the phenomenon as it appears, while also being aware that it may not be as it originally appears. It is a process of 'bridling', in effect, a tethering of prior understandings, theories and thoughts that might impact on the understanding of the phenomenon (Dahlberg, 2006). This bridling helps support the development of the epochē which in turn leads to the phenomenological reduction. In this space the researcher can see the phenomenon as it appears with clear thoughts and disconnected from the research focus, essentially accepting the phenomenon as it presents itself. The strategies provided by Giorgi were applied in this study to develop the phenomenological reduction and are explained in section 3.9.3.

The phenomenological reduction supports the development of an understanding of the phenomenon as well as making it possible to clearly present the reduction (Fink, 1984). While this helps, Overgaard (2015) also recommends using direct quotations from the participants in order to ensure that their unaltered voices are heard. This strategy ensures participants' descriptions of their experiences are presented impartially (Overgaard, 2015). While Overgaard applies this strictly, the use of direct unedited quotes to evidence participants' descriptions of their experiences in making transfer decisions with older patients in hospital was applied to this study.

3.3.1 Ethical considerations

Prior to collecting data an ethics application was prepared and submitted to the health district's research and ethics office. As this research aimed to be conducted in six hospitals it was necessary to apply for overarching approval to the local health district. The approval was sought and granted (Appendix 1). Reciprocal ethics approval was also gained from the Western Sydney University research office, approval number H10791 (Appendix 2). This process was necessarily rigorous to ensure that the study was conducted under the guidelines of the National Statement on Ethical Conduct in Research Involving Humans (1999). The following section contains an explanation of the ethical principles and methods applied to this study.

3.3.2 Autonomy

The study involved direct contact with participants through interviews and observations, therefore the autonomy of the participants needed to be maintained. Autonomy was achieved by ensuring that participants were informed about the study and were able to give consent free from coercion (Lund & Ekman, 2010). Any potential participant who contacted me was sent a participant information sheet (Appendix 3) and consent form (Appendix 4). They were also provided with an opportunity to ask questions. The participant information sheet and consent form clarified the voluntary status of participation as well as the ability to withdraw at any time without prejudice. Participants were advised that they could return the consent form by email, mail, or hand delivery. One participant contacted me and was sent a consent form which was not returned. To ensure participants were not coerced, the participant was not followed up. By not returning the participant information sheet or consent form I took this to indicate that they did not wish to participate.

The practices used to support autonomy in the observational component of data collection, were different to the interview participants. Following discussions with the multidisciplinary team meeting's convenors, I attended a multidisciplinary team meeting and explained the study to potential participants. Participant information sheets and consent forms were provided to potential participants at this meeting. I then returned to the next meeting to answer any questions and to check if the participants had consented to being observed. Some participants had given their signed consent forms to the nurse unit manager and others handed them to me before the meeting began. At the four meetings attended all 26 participants consented to be observed and recorded. A fuller description of the participants is provided in Chapter 4.

3.3.3 Privacy

Maintaining privacy was important in this study as participants provided their demographics as well as interview or observed information. Privacy was achieved through several methods. The research was conducted within a local health district that included regional and metropolitan hospitals. The mix of regional, rural and metropolitan facilities meant that by naming the specific health district it was possible that individual participants may be identifiable. Therefore, in consultation with the research supervisors, I decided not to identify the local health district where this research occurred to ensure individual participant's privacy was maintained. Furthermore, audio recordings and transcripts for the interviews are kept in a locked filing cabinet in a locked office at Western Sydney University for five years after publication of the study. This is in line with the data storage and retention guidelines of the National Health and Medical Research Council at the time, and remains the current standard (National Health and Medical Research Council, 2019).

In accordance with the ethics approval, the recordings of the observations were erased once they had been transcribed, as they contained patient information. I listened to the recordings and only transcribed the discussions that were related to transfer decision-making from hospital to residential care. The de-identified transcriptions of the observed meetings are kept in the locked filing cabinet in a locked office. Similar to the interview data, the de-identified observation transcripts will be shredded, and computer files deleted five years after the publication of the study. Pseudonyms were used in all transcripts to protect privacy. While the supervisory panel also reviewed the de-identified transcripts, I was the only one aware of the identity of the participants.

3.3.3 Justice and beneficence

Participants were recruited based on their experience in making transfer decisions with older patients from hospital to residential aged care. Selecting people based on predetermined criteria supports justice as it ensures people are not recruited based solely on their ability to be exploited (Schneider et al., 2013). Providing participant information sheets and consent forms that clearly explain what was involved in participating in this study meets the principle of justice.

It was possible that participants could become distressed when retelling their experiences of making decisions in the transfer of an older patient from hospital to residential aged care. Therefore, a strategy was developed to ensure that participants would not suffer harm due to their participation in the study. If a participant became distressed the interview would be stopped and the participants would be provided with contact information for the employee assistance program counsellors and lifeline (Appendix 5). By stopping the interview and providing counselling options I could take action to prevent harm and support the principle

of beneficence. During the data collection for this study no participants became distressed or indicated that they wanted to stop the interview due to distress.

3.4 Interview Data Collection Methods

Two methods of data collection were applied in this study. The first method involved semi-structured phenomenological interviews. The second method was undertaken through observations. While the two methods were initially planned to be undertaken concurrently, the interviews began before the observations. This was not an intentional way of proceeding but occurred because participants expressed interest in the interviews. The positive outcome of the interviews occurring earlier was that connections were made which assisted me in attending the multidisciplinary team meetings to observe transfer decision making. Interview participants were recruited until data saturation was achieved. In total 16 participants (Table 4.1) were recruited for interview in this study and 26 participants in four multidisciplinary team meetings were observed. Of the 26 participants (Table 4.2) in the observations, two health professionals had also participated in the interviews. This is explained in section 4.1.2.

3.4.1 The research setting

My study explored health professionals' transfer decisions with older patients in hospital. Therefore, the research was conducted with participants who were employed in a hospital. Six acute hospitals were selected as the sites for the study, although health professionals in five hospitals participated in the study. The hospitals were part of a large health district in Australia that comprised metropolitan, regional, and rural hospitals. The first hospital was a tertiary hospital in a regional area that provided a range of acute, palliative, and aged care services. This hospital had three staff (one clinical nurse consultant, one registered nurse

and one enrolled nurse) who were in dedicated discharge planning roles. The second hospital was a smaller regional hospital that worked in conjunction with the first hospital. The regional hospital accepted patients from the tertiary hospital who had been approved for residential aged care placement and were waiting for a bed to become available. While this hospital was included in the participant recruitment, no health professionals contacted me. This may have been due to a higher number of patients who had been transferred to this hospital while they waited for a bed in a residential facility. This meant that health professionals had fewer opportunities to make transfer decisions.

The third hospital was a principal referral hospital that provided a range of acute and sub-specialty services which included rehabilitation and aged care. The fourth hospital was a major metropolitan hospital that provided a range of acute and community services. This hospital had a specific focus on orthopaedic services and rehabilitation. The fifth hospital was a large principal referral hospital that provided a wide range of services including aged care and dementia. The sixth hospital was a rural hospital that provided a range of acute services for the community.

3.4.2 Participant sampling

A purposive sampling method was selected for the interviews in this study. This ensured that participants had experience with the phenomenon being explored (Thorne, 2016). All 16 participants recruited had experience with transfer decision making with older patients from hospital to residential care. Recruiting participants that, as a result of their experience, can provide rich descriptions of the topic under investigation, and allows the researcher the opportunity to understand and describe the phenomenon (Sousa, 2014).

Originally, three doctors, three occupational therapists, three social workers and five registered nurses were included in the study. These groups were initially selected as these were the professions identified by Dainty and Elizabeth (2009) as being the most involved in transfer decisions. However, while conducting the interviews it became apparent from the participants' stories that physiotherapists had an active role in transfer decisions. Therefore, an amendment was submitted to the research and ethics office to include the recruitment of physiotherapists (Appendix 6). Once the amendment was approved two physiotherapists were recruited to the study.

3.4.3 Inclusion criteria

Participants were included in the semi-structured interviews for this study based on the following criteria:

- Be a registered: doctor, occupational therapist, physiotherapist, registered nurse, or social worker.
- Have a minimum of 12 months experience assessing older patients for potential transfer from hospital to residential aged care. Experience must have been gained within the last two years to ensure that it reflects current practice.
- Have at least two years' experience working with older patients in an acute hospital setting. After two years of practice, clinicians are more likely to have developed a global view of patient management rather than focusing on developing technical skill (Benner et al., 2009).

3.4.4 Participant recruitment

Health professionals in hospital often work on a rotating roster which ensures adequate staff coverage seven days a week, 24 hours a day. This means that staff may not be available for information sessions at regular times. To combat this and the fast-paced nature of a hospital, a variety of techniques to enable successful recruitment of participants who met

the criteria are necessary (Shue, 2011). Identifying potential participants was difficult, particularly in the two larger hospitals, as there were many staff and wards. To address this, I decided to first meet with the Directors of Allied Health, Medicine and Nursing in each of the hospitals to explain the study and request permission to recruit in the facility as well as identify wards that more commonly made transfer decisions to residential aged care. In addition, permission to place the recruitment flyer (Appendix 7) in staff areas was requested. The Directors assisted by providing contact details for three Nurse Unit Managers who oversaw wards that were more likely to transfer older patients from hospital to residential aged care. The staff members were then approached, and permission was sought to place recruitment flyers up in ward areas. In the three ward areas approached this permission was granted.

The Directors also emailed the recruitment flyer to heads of the department of Medicine, Nursing, Occupational Therapy, Physiotherapy and Social Work asking them to place the flyers in common areas. This significantly increased participant responses as it provided access to staff that may not otherwise see the recruitment flyer. The flyer encouraged potential participants to contact me and ask any questions they may have about the research. This safeguarded against information being given to participants that may not reflect the sampling plan or method (Minichiello, Sullivan, Grennwood, & Axform, 2004)

Potential participants who contacted me were screened to ensure they met the inclusion criteria, and all participants that contacted me met the inclusion criteria. Potential participants were provided with the participant information sheet and were given the opportunity to discuss the study and ask any questions. In total 16 health professionals were interviewed in this study. A more detailed description of the participants is presented in

section 4.1.1. It was decided to include a description of the participants in Chapter 4, as their experiences in making transfer decisions are connected to the findings.

3.4.5 Semi-structured interviews

Health professionals were invited to participate in semi structured interviews if they met the inclusion criteria. Semi-structured interviews were used as they supported the opportunity to access descriptive information about people's lived experience and understandings of events (Taylor & Francis, 2013). As described by Colaizzi (1978), eliciting descriptive data that identifies a specific phenomenon requires appropriate questions. Colaizzi (1978) also recommends using the researcher's reflections as the foundation for the interview questions. This phenomenological process described by Colaizzi (1978) informed the development of the five interview questions (Appendix 8). The process was also reviewed by the research supervisors and changes were made to ensure the questions were relevant to the research topic, were open-ended and clear, and did not lead participant responses.

However, the interview questions were not intended to be prescriptive. In keeping with a phenomenological approach, questions needed to focus on the phenomenon being explored. Therefore, as needed, questions were adapted and added to better understand their experiences. Following the first interview and transcription, I met with the supervisory panel to review the interview questions. Minor changes were made to the first interview question. This involved rewording the question to ensure it was clear to the participants. Throughout the data collection phase I met with the research supervisors and reviewed the transcripts to ensure that the interview questions remained connected to the aims and objectives of the study.

3.4.6 Interview process

Interviews were conducted over a one-year period in the hospitals where the participants worked. Interviews were supported by the use of a semi-structured interview guide and were conducted in a conversational style, which encouraged the participants to explain and describe their experiences. Adopting this method provided the opportunity to collect rich data to inform the findings of the study.

The interview questions (Appendix 8) were developed collaboratively with the research supervisors as well as referring to the reflective journal and a preliminary review of the literature. An initial search of the literature was undertaken before the study commenced to determine whether this topic had been explored. This is explained in section 2.2. The preliminary search also informed the interview questions. According to Colaizzi (1978), using the reflective process to develop the interview questions has a similar effect to conducting a pilot study. Through a preliminary search of the literature and in using the reflective journal it became apparent that there was a lack of knowledge of health professionals' experiences when making transfer decisions and the factors that influenced their decisions. In addition, there appeared to be limited literature on the potential barriers or enablers to transfer decision making. To understand the health professionals' experiences, I also wanted to uncover how they felt about the decisions they made. This was due to some evidence that health professionals could have difficult experiences when deciding to recommend an older patient transfer to residential aged care and I wanted to explore whether this was still the case.

As the study was being conceived I began documenting my thoughts, feelings and ideas in the reflective journal, based on Ahern's ten tips to bracketing. This included: use of the reflective journal to document interests or issues that may influence the research; identification of personal values; exploring areas or role conflict; identifying external interests; acknowledging feelings that are not neutral; identifying any data that is new or unexpected; reframing any blocks to the research; re-looking at the analysis once complete; critical review of the literature; and monitoring for any bias in the findings and rechecking (Ahern, 1999). By applying this process, the interview questions that were developed aimed at disclosing their lived experience of making transfer decisions in hospital. The reflective process continued throughout the development of the study design through to the completion of my study. The reflective journal was a crucial tool to the development of the phenomenological epochē and was referred to continually throughout Colaizzi's seven-step approach.

Once the interview questions had been developed and approved by the research supervisors, the first interview was conducted. While this interview was not specifically a pilot interview, after the initial interview, and in conjunction with the supervisors, I reviewed the transcript to ensure that the interview questions were gaining access to a description of their experience of the phenomenon. From the review it was decided that further changes to the interview questions were not required. Interviews were audio recorded in this study so that the focus could be on the flow of conversation rather than record keeping. Potential participants were informed in the participant information sheet that the interview would be recorded. They were also asked verbally at the start of the interview if they consented to having the interview recorded.

All interviews were conducted at the workplace of the participants at their request. One interview was conducted in a quiet area of the hospital cafeteria, all other interviews were conducted in the offices or meeting rooms allocated to the individual staff member. At the start of the interview the participant information sheet and consent form (Appendices 3 and 4) were again given to the participants. In addition, participants were provided with a demographic form to complete (Appendix 9). Participants were reminded that they could withdraw from the study at any time. Interview duration ranged from 20- 60 minutes. No participants withdrew from the study or expressed any concerns with the data collection process.

3.5 Observation Data Collection Methods

In my study four multidisciplinary team meetings were observed to gain a deeper understanding of how health professionals make transfer decisions with older patients from hospital to residential aged care. Including the observations provided the opportunity to triangulate the interview and observation data so as to identify the similarities and differences in health professionals' descriptions of their experiences as well as observing the practice of making transfer decisions in the multidisciplinary team meetings.

A multidisciplinary team meeting is defined as:

> *A structured round where key clinicians involved in the patient's care meet together to discuss the patient's care and the coordination of that care. The round is a place where dialogue and feedback occurs in relation to the needs of the patient and provides the multidisciplinary team an opportunity to plan and evaluate the patient's treatment and transfer of care together.* (Department of Health NSW, 2011, p. 8).

Phenomenological observation provides the opportunity to disclose the essence of the phenomenon by gaining access to data derived directly from the experience (Pfadenhauer & Grenz, 2015) and provides a real life context of the situation being explored (Bolster & Manias, 2010). Observing the participants making transfer decisions also supports the ability to discover parts of the phenomenon that the participants are either not able to articulate, or as Colaizzi (1978) states are "beyond human experiential awareness" (p. 65). The use of observational data allowed me to access experiences that participants may have found difficult to describe as the actions may not be clearly known by the individual.

3.5.1 Observation recruitment

Participants were included in the observations based on their attendance at the multidisciplinary team meeting. In total, four meetings were observed, two meetings were in the same ward, two days apart. The meetings were identified by the meeting convenors seeing the recruitment flyer. All four meetings involved wards where it was identified that decisions to transfer to residential aged care occurred.

Prior to attending the multidisciplinary team meetings, I discussed the study with the three meeting convenors and requested permission to attend the beginning of a meeting and explain the study as well as answer any questions. The meeting convenors gave me permission to attend the meeting and explain the study. Three of these meetings were convened by the Nurse Unit Managers and one by the Discharge Planner (Registered Nurse). At each meeting I gave a brief explanation of the study and provided the attendees with a participant information sheet and consent form (Appendix 10 and 11). The participants were given a week to review the documents which had my contact details on them in case they

had any questions or concerns. The following week I again attended the meeting. At the four meetings attended the 26 participants agreed to be observed and recorded.

Doctors attended three of the meetings, and at the fourth meeting doctors had a standing invitation to attend, although none were present on the day of the observation. At the three meetings doctors attended, they stepped in and out of the meetings as they finished their ward rounds. However, the other health professionals remained for the duration of the meeting and participated when patients, whose care they were involved in, were discussed. The observations were conducted using an observer as participant role. This involved observing the phenomenon with minimal involvement, although all ethical considerations such as consent, needed to be met before the observations could occur (Holloway & Galvin, 2016). The advantages of the observer as participant approach include being able to access an understanding of experiences without also being required to take an active role in what was being observed. However, it can also be challenging, as the observer may find it difficult to step back and not become involved in the process (Holloway & Galvin, 2016). The observer as participant role and the strategies to address risk are presented in section 3.5.2.

Preparing for the observations was supported by the epochē and reflective journal. Through the adoption of an observer as participant role and phenomenological practices it was possible to access a unique insight into the way the health professionals made transfer decisions, as it demonstrated how agreed plans from the prior meeting were implemented, how barriers were managed and negotiations about the next steps of transfer decisions were undertaken. A detailed description of the observation environment and participants is provided in sections 4.1.2 and 4.1.3. The description is provided in the findings chapter as the people and the environment are central to the findings.

3.5.2 Observational process

To effectively develop rich understandings of decision making in the multidisciplinary team meetings, data were collected by audio recording the meetings and keeping field notes. Organised field notes include: a description of the setting and participants; a chronological order of events; descriptions of behaviours and social interactions; and an audio tape of events which provide the researcher with standardised, systematic data (Angrosino, 2007). The field notes organised in this way provided a useful tool when it came to analysing the observations.

During the meetings I sought out a position that was unobtrusive, yet enabled a clear view of the recording equipment and the meeting. I also adopted an observer as participant role. This role helped me to be collegial with other meeting attendees, as they were aware that I was a registered nurse, yet also remained an outsider who did not interact with participants during the meetings. As I had previous experience of attending multidisciplinary team meetings, I was comfortable in this situation which helped me to be unobtrusive. I feel this enabled me to blend into the group and while I did not say anything throughout the meeting, I adopted an interested yet calm demeanour. In this way I was able to perceive their experience in making transfer decisions with older patients from hospital to residential aged care as an observer without any distractions. However, as Bloomer, Cross, Endacott, O'Conner and Moss (2012) explained, a dual identity can exist in situations where the researcher is also a clinician. This has the advantage of supporting collegial connections, but comes with the risk that the researcher may be put in a position where they need to choose whether they were a nurse or a researcher. It was possible that during the observations issues could have been raised that compromised patient safety.

As a registered nurse I and other qualified health professionals are required to act. Prior to the data collection I considered this possibility and reflected on possible scenarios to explore potential strategies in the event this occurred. Throughout the interviews and observations no issues occurred, although I had developed strategies to address potential issues during the observations.

Conducting observational research in a hospital setting requires acknowledgement and adjustment of the unpredictability of the environment (Bloomer et al., 2012). Therefore, in the event of a clinical emergency or any kind of emergency that ceased the meeting, I planned to turn off the audio recorder and leave the ward area. In the meetings I attended there were no emergencies or adverse events. Following the meeting the observation recordings were transcribed. This occurred within 3 hours after the meetings as it was important to be familiar with the participants' voices so as to accurately identify the health professional's contribution. Any identifying information was removed in the transcripts to protect privacy.

3.6 Methods to Analyse the Data

Data analysis of the interviews and observation transcripts were attended to through Colaizzi's approach. The interview data were analysed using Colaizzi's 7 step analysis approach and the observation data were analysed using Colaizzi's perceptual description method. The following section explains the application of these methods to the interview and observational data.

3.6.1 Interview analysis

The analysis of the interviews is an important aspect of the methodology in this study. The interview analysis was based upon Colaizzi's (1978) seven-step framework, which is a rigorous approach to qualitative data analysis (Edward & Welch, 2011; Wojnar & Swanson, 2007) that conveys the findings and shows how they were developed (Saunders, 2003). This is supported through Husserl's phenomenological approach, which requires a time where prior experience and beliefs are put aside to allow the participants' experiences to tell the story. This is referred to by Husserl as the phenomenological epochē (Husserl, 1982).

The concept of epochē, however, is complex and has been interpreted by readers to mean different things (Paley, 1997). My understanding of this, in the context of my study, is that in order to describe how health professionals made decisions in the transfer of older patients from hospital to residential aged care I would need to examine the participants' descriptions of their experiences in detail. To aim for this, I attempted, as much as possible, to suspend my subjective self and look at the participants' descriptions from every angle and perspective until what was left was the essential structure of the phenomenon. This process was supported by keeping a reflective journal which is based on the steps to bracketing developed by Ahern (1999).

In the context of this qualitative descriptive study, Husserl's phenomenological approach was applied through Colaizzi's framework. This framework provides a structure to operationalise Husserl's approach and explore health professionals' decision making in the transfer of older patients from hospital to residential aged care. However, in this study, Colaizzi's framework was adapted to better fit the study. Colaizzi's framework is not intended to be prescriptive and, as he explains:

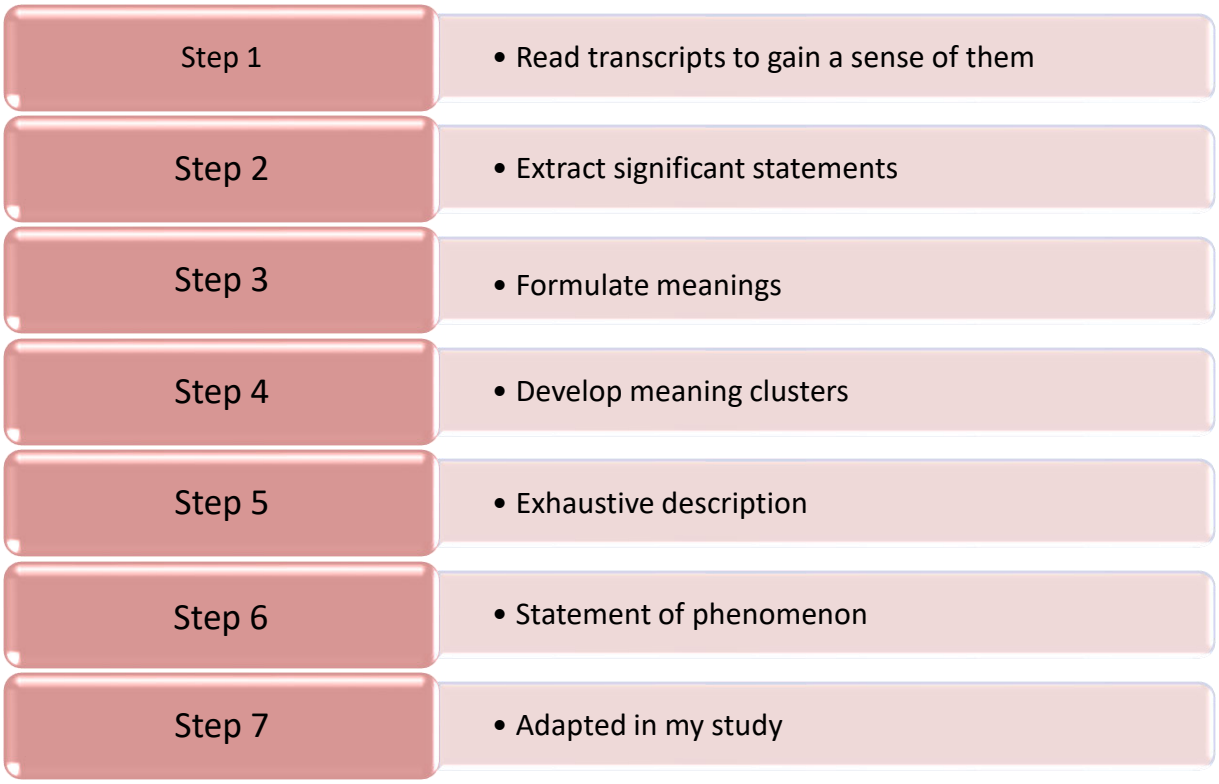
> *"It must be emphasized that these research procedures of analysis that I employed should be viewed only as typical, and are by no means definitive; furthermore, they usually develop with much overlapping among them, so that both the listed procedures and their sequences should be viewed flexibly and freely by each researcher, so that, depending upon his approach and his phenomenon, he can modify them in whatever ways seem appropriate"* (Colaizzi, 1978, p. 59*).*

Gender schema aside, Colaizzi encourages the researcher to adapt the framework to fit the study. In my study Colaizzi's seventh step was adapted to support the development of trustworthy findings. The adaptation is described in section 3.9.

3.6.2 Colaizzi's approach to analysing the data

The first step of Colaizzi's (1978) framework involves acquiring a sense of the participant's descriptions. The second step involves extracting significant statements. Following this step the significant statements are reviewed and formulated meanings developed (Colaizzi, 1978). Step 4 involves organising the formulated meanings into theme clusters (Colaizzi, 1978). The next step includes developing an exhaustive description of the phenomenon (Colaizzi, 1978). In Step 6 of Colaizzi's (1978) framework the exhaustive description is formulated into the fundamental structure of the phenomenon being explored. The final step involves returning to the participants to validate the fundamental structure of the phenomenon (Colaizzi, 1978). The process to develop this from Step 1 to Step 7 is illustrated in Figure 3.2 and a description of these steps, as applied in my study, is provided in section 3.6.2.1 to section 3.6.2.7.

Figure 3.2 Step 1-7 of Colaizzi's approach



3.6.2.1 Step 1

In the first step of the analysis of the data Colaizzi (1978) asks the researcher to read the transcripts, referred to as protocols by Colaizzi, and gain a sense of them. In my study this was achieved by transcribing, then reading and re-reading the 16 transcribed interviews. This was a continual process throughout the data collection and analysis. Following each interview, the recording was transcribed, and the transcript read and re-read whilst listening to the recorded interview. This was to ensure that it was transcribed accurately, as well as to listen with no other distractions to what the participants were saying. Once data collection was completed the interviews were re-read in conjunction with re-listening to the recorded interviews. Field notes and the reflective journal were also concurrently reviewed as the interviews were read to ensure that any initial thoughts of the interview were considered.

This process assisted me to become immersed in the data and to begin to make sense of the descriptions.

3.6.2.2 Step 2

Following this, Step 2 was undertaken. Colaizzi (1978) refers to this step as "extracting significant statements" (p.59), which involves analysing each description and drawing out any phrases that directly relate to the study focus. To achieve this the transcripts were read and re-read while considering phrases that directly related to health professionals' lived experience in making transfer decisions with older patients. Following multiple readings and re-readings of the transcripts, significant statements that directly related to my study focus were identified. Throughout the analysis of the data, this step was continually revisited to check that the statements related to the phenomenon being explored.

3.6.2.3 Step 3

The third step in Colaizzi's (1978) seven-step framework is to formulate meanings based on the significant statements. The significant statements should be studied carefully to establish the essence of their meaning (Saunders, 2003). This involves reviewing the significant statements and repeatedly asking "what does this tell me about the decision to transfer an older person from hospital to residential care?" and "what is the meaning of this statement?" Alternatives to the formulated meanings should be explored, which help in identifying the parts that are, or are not, central to the concept (Paley, 1997). Table 3.1 provides an example of the application of Steps 1-3 of the interview data to demonstrate how Step 3 was arrived at.

Table 3.1 Steps 1-3 of Colaizzi's approach

Step 1 — gaining a sense of the description HP_RN_interview1 T1.P10 L.298-307	Step 2 — extracting significant statements HP_RN_interview1 T1.P10 L.298-307	Step 3 — formulating meanings HP_RN_interview1 T1.P10 L.298-307
Interviewee — I just wonder if the time frame that people are given from the presentation to hospital and the decision making of having to make a decision to change your life completely leave your home that you have known for many years. Is that appropriate? Facilitator — So, in terms of the time frame, people are given by? Interviewee — Their length of stay, from , you know, your given a length of stay for you're illness then the assessments are that you can't go home, that you're unsafe to go home and it all happens so quickly and it would be hard to get your mind around it Facilitator — Yes Interviewee — and if you've got a cognitive impairment or a disability trying to work through those processes	I just wonder if the time frame that people are given from the presentation to hospital and the decision making of having to make a decision to change your life completely leave your home that you have known for many years. Is that appropriate? Their length of stay, from, you know, you're given a length of stay from your illness — then the assessments are that you can't go home, that you're unsafe to go home and it all happens so quickly and it would be hard to get your mind around it and if you've got a cognitive impairment or a disability trying to work through those processes	Working with older people who have complex medical issues takes time. Policies and processes focus on quick decisions and ensuring safety which makes it hard for the older person and health professionals to have time to process the options.

3.6.2.4 Step 4

Step 4 requires the researcher to formulate the meanings into clusters (Colaizzi, 1978). Clustering the meanings is a cyclical process of reviewing meanings which aims at identifying commonalities and differences. This was achieved by reviewing the formulated meanings and considering whether they were similar, contradictory, or unrelated. Clustering the meanings into themes was a challenging process which involved grouping together similar meanings and including those that covered the same topic from different perspectives. This led to the development of three clusters and eight threads. As the clusters and threads developed, the meanings were checked against the transcripts and the significant statements, to ensure that they accurately reflected the original meaning.

3.6.2.5 Step 5

Once meanings are formulated in Step 4, the fifth step is to develop an exhaustive description. As Colaizzi, (1978) states:

> *"*The results of everything so far are integrated into an *exhaustive description* of the investigated topic*"* (p.61)

Developing an exhaustive description involved a challenging process of reviewing Steps 1-4 and generating an integrated account of health professionals' transfer decision- making with older patients in hospital. This was a difficult step which involved many iterations to ensure that the description included everything about the topic. This led to the development of an exhaustive description that contained a description of health professionals' decision making in the transfer of older patients from hospital to residential aged care. This was checked by the research supervisors to ensure that it contained the significant statements, formulated meanings and meaning clusters. The exhaustive description is just one aspect of the

development of the findings and as such is not presented in its entirety in this thesis. For the same reason my journal entries are not presented.

In Step 5 Colaizzi uses the term 'results'. While it is not intended to be a descriptor for the final statement of the phenomenon developed through Colaizzi's seven-step approach, the term results has quantitative connections. The term 'findings' is more commonly used to describe the synthesis of information that is developed by researchers as a result of qualitative data analysis (Sandelowski & Leeman, 2012). Therefore, in my study, the term 'findings' is used to describe the outcome of the data analysis of health professionals' transfer decisions with older patients in hospital.

3.6.2.6 Step 6

Once the exhaustive description is developed in Step 5, the sixth step involves rigorously analysing the description to reduce it to an overall statement of the phenomenon. In other words, the goal of this step is to reduce the exhaustive description to an essential configuration (Saunders, 2003). As Colaizzi (1978) outlined:

> *"An effort is made to formulate the exhaustive description of the investigated phenomenon in as unequivocal statement of identification of its fundamental structure as possible"* (p.61)

In this study this was achieved by reviewing the aims and objectives of the study and re-reading all the analysis steps thus far, including the exhaustive description developed in Step 5. Developing the fundamental statement of health professionals' transfer decision making in Step 6 was a cyclical process that involved returning to the previous steps in Colaizzi's approach and considering the aspects that were central to the participants' descriptions. Through this process the exhaustive description (Step 5) was reduced to a fundamental statement (Step 6) of the phenomena. The overarching statement that comprehensively

describes the phenomenon is provided in section 4.2.1.1. However, the fundamental statement is only one part of the overarching statement. It was in the next step that the overarching statement of the phenomenon was synthesized with the findings from the observations to provide a fuller description of health professionals' experiences in making transfer decisions with older people in hospital. This is explained below in section 3.6.2.7.

3.6.2.7 Step 7

In my study, Step 7 was adapted to support trustworthy findings and to synthesize the findings from the interviews and observations. This was achieved by synthesizing the fundamental structure (Step 6) of health professionals' experiences making transfer decisions with the perceptual description derived from the observational analysis (described in section 3.7). This led to the development of a comprehensive description of health professionals' transfer decision making and is explained more fully in section 3.8. The comprehensive description differs from the interview analysis in Steps 5 and 6 of Colaizzi's approach as it synthesizes the perceptual description derived from the observations of health professionals' transfer decision making. This provided a new way to access the phenomenon and supported a more profound view of how health professionals' experiences transfer decision making with older people from hospital to residential aged care.

The result of synthesizing the six steps of Colaizzi's framework and the perceptual description is the development of an overarching statement of the phenomenon which needs to be validated. In my study, the fundamental structure of the phenomenon derived from the interview data (Step 6) was considered in the context of the observational findings in order to gain a deeper understanding of health professionals' experiences making transfer

decisions with older patients from hospital to residential care. This also supported the validation strategies of the observation findings which are explained in section 3.9.

In the seventh step Colaizzi (1978) suggests that the findings be returned to the participants to ask whether the results relate to their experiences. Colaizzi (1978) refers to achieving Step 7 by "asking the subject about the findings thus far" (p.61). It appears that this means that the findings from Step 6 are returned to the participants as a process to support validity. Returning the findings to participants for validation is known as member checking. Member checking is a validated method of establishing trustworthy findings (Lincoln & Guba, 1985). However, member checking can pose methodological challenges in phenomenology (Giorgi, 2006; Giorgi, 2008; Maggs-Rapport, 2001; McConnell-Henry, Chapman, & Francis, 2011; Morse, Barrett, Mayan, Olson, & Spiers, 2002; Sousa, 2014; Thomas & Magilvy, 2011).

A grounding belief in phenomenology is that people view the world from the natural attitude. In the natural attitude people understand that the world exists as a "constant actuality" (Husserl, 1970, p. 145). The world and all that is associated with it is accepted, as it is, in an unreflected state (Dahlberg & Dahlberg, 2003). From this viewpoint people describe their experiences with the belief that things are what they perceive them to be (Churchill, Lowery, McNally, & Rao, 1978). However, phenomenological analysis requires viewing their experiences through a different lens. In phenomenology, the researcher is trying to explore participants' experiences in order to understand the essence of their lived experience (Flynn & Korcuska, 2018). This is fundamental in phenomenology where we are encouraged to look at things from every angle and every perspective, leaving nothing unexplored, to reach an understanding of the phenomenon. To reach this understanding requires viewing the phenomenon as it presents itself with all its "indefinite definiteness" (Dahlberg & Dahlberg,

2003, p. 44). This means that the researcher and the participant look at things from different viewpoints (Sousa, 2014). In the natural attitude people describe their experiences in an unreflected state, while the researcher adopts a phenomenological and discipline-specific stance (Sousa, 2014). The different perspectives mean the same outcomes may not be reached, since the researcher is seeking the essence of the experience from a phenomenological stance and the participant from the natural attitude (Churchill et al., 1978). The contrasting perspective of the participants and the researcher can lead to validity problems during member checking (Maggs-Rapport, 2001; Sousa, 2014).

As Giorgi (2008) explains, using member checking in Colaizzi's approach has theoretical and practical concerns. Theoretically, using member checking in phenomenology is not considered a reliable strategy as the participants are describing their experiences in the natural attitude, while the researcher is considering individual and collective experiences. This could place more emphasis on the individual rather than the phenomenon (Giorgi, 2008; McConnell-Henry et al., 2011). Furthermore, the researcher is looking at things from a phenomenological and discipline perspective. This involves a level of expertise by the researcher who is likely to have a greater understanding of phenomenological practices than participants, who may look for their own experience rather than a broader explanation of the meaning of the experience (Giorgi, 2008).

A further consideration presented by Morse et al. (2002) highlights that researchers may hold back during analysis in order to minimise any potential participant concerns when they member check. This may reduce the validity of the findings, since the researcher tries to keep the findings so close to the participants descriptions that the work may end up being descriptive (Morse et al., 2002). This is not the intention of the phenomenological

endeavour, as the researcher is encouraged to go beyond individual descriptions to disclose the essence of the phenomenon.

To gain an understanding of the meaning of the phenomenon the researcher may, during member checking, ask questions to clarify aspects of their descriptions. This may lead the participant to overemphasise it, which is referred to by McConnell-Henry et al. (2011), as the 'halo effect'. The halo effect is the tendency for people to make inferences about the positive qualities of something, often without evidence (Forgas, 2011). In a research context, it is possible that participants view the researcher as having a greater understanding of the topic. The result can be that it is less likely that the participant will challenge or question the researcher's analysis due to the inherent power imbalance between researcher and participant. This can mean that, unknowingly, a researcher may influence participants when member checking to respond how the researcher wants them to (McConnell-Henry et al., 2011).

A further consideration is that participants may become distressed when reviewing the transcripts or some of the analysis. Strategies exist during data collection to ensure participants are supported if they become distressed, but this may not be the case when member checking. In addition, Birt, Scott, Cavers, Campbell, and Walter (2016) explain that there could be a significant passage of time before transcripts, preliminary findings or the complete report are ready to be sent to participants who may no longer recognise their descriptions or feel that their input was left out. It is also possible that participants may become upset when reviewing the product of their descriptions, as they may relive the experience or no longer feel the same way that they did when the interviews were conducted (Birt et al., 2016).

Ideally, member checking involves participants reviewing part or all of their descriptions at any stage of the analysis or a draft of the final report (Thomas & Magilvy, 2011), although it is not clear what form the findings are in when they are presented to participants for member checking. Colaizzi refers to a fundamental statement developed in Step 6 which indicates that this is what is returned to participants. Yet it is not clear if individual participants' accounts are provided or a collective description of the fundamental structure of the phenomenon is presented to participants for review. Colaizzi (1978) does encourage the researcher to alter or adapt any of the steps so it is possible that the researcher can decide what form the findings are in when they are returned to the participants, or as in my study, alter Step 7 entirely.

In Step 7 of Colaizzi's approach, the researcher is asked to include any information that stems from member checking into the final description (Colaizzi, 1978). This is concerning as the analysis, undertaken from a phenomenological perspective, is fragile and may be undone by the requirement to include any participants' requests for additions (Giorgi, 2008). Giorgi (2008) goes on to state that if the researcher is asked to alter the research outcome to address individual participants' accounts then the need for the researcher to analyse information is no longer required. Instead, participants can describe what their experiences mean to them with no further need for analysis. While this is a slightly simplistic way of looking at the understanding of experiences it does highlight that the researcher is expected to hold knowledge of the phenomenon and as explained by Maggs-Rapport (2001), be an expert in phenomenological practices. The researchers understanding of the research methodology means that individual and collective experiences can be described. This

requires considerable training, skill, and time to adopt phenomenological practices which may not be in the purview of participants.

For the reasons described in this section it was decided to utilise rigorous methodological strategies, other than member checking, to validate the findings developed through Colaizzi's approach. Therefore, to validate the comprehensive description, Colaizzi's seventh step was tailored to provide a better methodological fit in this study. Validating the comprehensive description of the interview and observation findings in my study was achieved through: methodological triangulation of the interview data and observational data; supervisor's review and audit trail; and phenomenological reduction (Northall, Chang, Hatcher, & Nicholls, 2020). These methods are reliable strategies used to establish trustworthy findings in qualitative research (Lincoln & Guba, 1985). As the validating step involves both the interview and observational data, the observational processes used in this study will first be explained. This is followed by the application of the tailored Step 7 in Colaizzi's approach to the observation and interview analysis (section 3.9).

3.7. Observation Analysis

The observational data in this study were analysed using Colaizzi's (1978) perceptual description approach. Perceptual description aims to "faithfully express what we see." (Colaizzi, 1978, p. 67). Theoretically, phenomenological perceptual description is grounded in the philosophy of Merleau-Ponty (2012). Merleau-Ponty (2012) explained that we know what we see, hear, smell and do because it has been learned through our perception of the world over time. Yet when we analyse what we see, hear, smell and do we move from what is seen to what we think we see, which creates the "experience error" (Merleau-Ponty,

2012, p. 5). However, prior to Merleau-Ponty's discussion of perception Husserl had also considered that things are exactly as they appear to us. As explained by Husserl (1970)

> *"That which is self evidently given is, in perception, experienced as "the thing itself," in immediate presence, or, in memory, remembered as the thing itself; and every other manner of intuition is a presentification of the thing itself."* (p.128)

Similar to Husserl, Colaizzi (1978) posed that when observing events the focus should be on what is seen rather than forcing our comprehension on what we think we see. To achieve this, Colaizzi (1978) asks that the researcher sets aside any contaminating thoughts, and only then can the researcher come back to what is observed. The result is intended to be more than a summary of perceptions, instead the researcher is asked to aim for a perception of worlds (Beck, 2019). As Merleau-Ponty (2012) explains, the world does not relate to a set object, it is more the field of phenomenon which includes our individual perceptions.

This is where the phenomenological reduction comes into play, as it supports the disclosing of the world of the phenomenon so it can be seen clearly, as it is, through the researcher's perceptions (Merleau-Ponty, 2012). Applying the perceptual description approach to the observation data supports the development of a deeper understanding of the phenomenon. In this study the perceptual description provides a statement that expresses the observed experiences of health professionals making transfer decisions in hospital. The following section explains the strategies used in this study to develop the perceptual description.

3.7.1 Perceptual description

To aim to achieve Colaizzi's perceptual description of the observational data, several strategies were used. Initially I transcribed the recordings of the observations directly after each meeting. The transcripts were then read while listening to the recordings. Discussions that did not include transfer decisions with older patients who were being considered for

transfer to residential aged care were deleted as they were not the focus of the study. Once this was done what remained were the discussions that involved multidisciplinary transfer decisions in relation to older patients' potential transfers to residential care from hospital. I then reviewed the recordings, transcripts, and field notes with the reflective journal. This helped to identify and set aside any preconceived ideas, and as Paley (1997) states, come to the things as they are.

While continuing to reflect and practice the phenomenological epochē, I began to develop a perceptual description of each of the four observed events. The aim was to develop a description that was an expression of the observed events rather than a summary. This was achieved through a rigorous process of reviewing the transcripts, field notes and reflective practices to ensure that the description remained connected to the observed phenomenon. The epochē assisted in this process to ensure that I had developed a perceptual description of what was observed. I practised the epochē by using the reflective journal to document any preconceived ideas. This helped me to identify my thoughts and ideas so that I could, for a moment, suspend my ideas and see things as they were. However, this does not mean that my thoughts were permanently suspended, as in phenomenology the researcher is a crucial part of the process.

I revisited my thoughts through phenomenological reduction, which helped me to develop the perceptual description of health professionals' lived experience in making transfer decisions with older people from hospital to residential aged care. In this study, the perceptual description includes the observation of health professionals making collaborative transfer decisions as well as a description of the environment. The environment where these

meetings were held are an important component of health professionals' decision making. Therefore, the environment was considered as a crucial part of the observations.

Once the perceptual description of each observation were developed, I compared the descriptions to identify any commonalities or differences. I also reviewed any unique situations and events. I decided to combine the four perceptual descriptions into one description to develop a fuller perceptual description of health professionals' transfer decision making. This was a complex task and involved ensuring that the description was inclusive, clear, and comprehensive. Throughout the analysis process I kept an audit trail and documented any thoughts in the reflective journal. This provided the opportunity to identify any potential preconceptions in the analysis process. The perceptual description was reviewed by the research supervisors to ensure that the description was more than a summary of observed events, but was a clear expression of what was observed. This was also supported by the within-method triangulation strategy, reflective practices and the phenomenological reduction discussed in section 3.9.

The perceptual description of health professionals making transfer decisions in hospital provides a unique insight into what they do rather than what they think they do. This perspective combined with the health professional's individual accounts of making transfer decisions provides a deeper insight into their experiences of making transfer decisions with older patients from hospital to residential aged care. To achieve this the perceptual description developed from the observation data was viewed in the context of the interview data. Combining the outcomes of the observation and interview analysis was aimed at supporting a deeper understanding of the phenomenon. This led to the development of a

comprehensive description of health professionals transfer decisions with older patients in hospital.

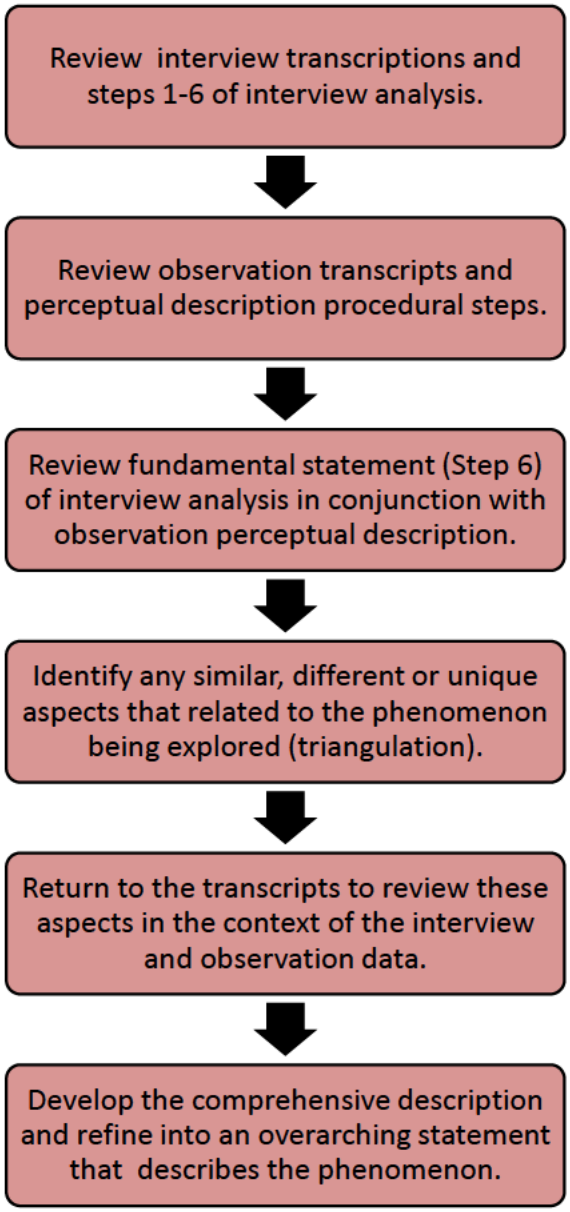
3.8 Comprehensive Description

The analysis of the interview and observation data provided a deeper insight into health professionals' transfer decisions with older patients in hospital. To more effectively understand the essence of the phenomenon the outcome of the interview and observation analysis needed to be synthesized. This was achieved through the synthesis of the perceptual description of the observations and the fundamental statement (Step 6) of the interviews and is referred to as the 'comprehensive description'. Developing the comprehensive description was a rigorous process of triangulating the interview and observations transcripts and data analysis to identify any similarities or differences. Once the comprehensive description was developed, it was then reduced to a statement that provides a clear and inclusive description of the phenomenon. As there was no name for this full, rich understanding I reflected on what this could be called. For the purposes of clarity, and to differentiate the comprehensive description from other terms used, I have named this description as an 'overarching statement' that describes the phenomenon. The term 'overarching statement' is intended to reflect the attempted inclusivity of health professionals' transfer decision making, as it involves participants' stories of making their experiences as well as the observations.

Developing the overarching statement that comprehensively describes the phenomenon involved reviewing Steps 1-6 of Colaizzi's approach, as applied to the interview data, while also considering the observation transcripts and perceptual description (see Figure 3.3). This was an iterative and somewhat exhausting process of reading and re-reading transcripts and

analysed data. I continually moved back and forth in the process to develop the comprehensive description to ensure that I was being inclusive, accurate and staying connected to their experiences. The procedures used to develop the comprehensive description and overarching statement are shown in Figure 3.3. Step 4 and Step 7 of Colaizzi's approach were particularly important in developing and presenting the comprehensive description.

Figure 3.3 ***Development of comprehensive description of phenomenon***



Validating the interview and observation analysis of the data through methodological triangulation (explained in section 3.9.1) also helped develop the comprehensive description. As the comprehensive description was being developed it became apparent that the theme clusters developed in Step 4 of Colaizzi's approach to the interview data also reflected the perceptual description of the observational data. While not all findings supported each other, the concepts were similar and added more depth to the overall findings. Therefore, it was decided to present the findings in the clusters developed in Step 4. The aim was to develop a description that included similar, different, and unique aspects of the phenomenon. Reviewing the data and using the reflective journal as a guide supported me to remain connected to the topic and the phenomenological epochē.

The overarching statement derived from the interview and observational data provides an understanding of health professionals' transfer decisions with older patients in hospital. Once this was developed the steps taken to reach this description needed to be validated. The comprehensive description of the phenomenon is explained in section 4.2.1 and the overarching statement is presented. The following section explains the steps used to validate the overarching statement of the phenomenon.

3.9 Adaptation of Step 7

As discussed in section 3.6.2.7 Colaizzi's seventh step was tailored in this study to include validating the interview and observational data through the three steps of methodological triangulation; the supervisor's review of data collection as well as analysis; the keeping of an audit trail and the phenomenological reduction practices through the epochē (Northall et al., 2020). This section explains the application of these processes to validate the findings.

3.9.1 Methodological triangulation

Triangulation involves reviewing the phenomenon from different perspectives and is a reliable strategy to establish trustworthy findings (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014; Sousa, 2014). As explained by Lincoln and Guba (1985), information must be triangulated with another source, such as an interview or observation, before it can be considered reliable. Methodological triangulation involves the use of more than one method to answer a research question, which can be either between or within methods (Holloway & Galvin, 2016). Between-methods triangulation involves using qualitative and quantitative data to confirm findings (Holloway & Galvin, 2016). In qualitative research triangulating with different methodological approaches such as interviews, observations or focus groups is known as within-methods triangulation (Flick, 2007).

Within-methods triangulation can be used to uncover more perspectives than using a single method (Flick, 2007) as well as establishing trustworthiness (Lincoln & Guba, 1985). In qualitative research, within-methods triangulation is more commonly used to check interview and observation data and is considered to support the development of more reliable conclusions and enhances trustworthy findings (Holloway & Galvin, 2016). The seventh step in the approach of Colaizzi (1978) involves checking the fundamental structure of the phenomenon developed in Step 6 with the participants. However, in this study, within-methods triangulation was undertaken through a process of checking the interview findings and the observation findings with each other (Northall et al., 2020). This involved reviewing the interview and observation findings concurrently in order to identify any concepts that were similar or different (Northall et al., 2020).

3.9.1.1 Application of within methods triangulation

Applying within-methods triangulation involved a process of reviewing the interview and observation data to identify any similarities, differences, or new information. This was achieved by reviewing the highlighted statements that were identified as significant in Steps 2 and 3 of Colaizzi's seven-step approach and the perceptual description. Highlighted concepts were then traced back to the original transcripts to ensure that key points were identified. The perceptual description and observation transcripts were also reviewed to explore any potential connections that may lead to a deeper understanding of the phenomenon. As this is a complex process, it is important to provide an exemplar in this chapter before the fuller findings are presented. In this example a doctor explained the relationship between a person's functional health and ability to access supports and the impact it has on transfer decisions. To validate this all steps of the analysis were reviewed to ensure that the 'comprehensive description' remained connected to the participants' stories and observations.

> *… I always say well nobody needs to go to nursing home care if they've got adequate supports. Then again, everyone needs to go to nursing home care if they've got no support…It's a sliding scale, if you like, depending on (a) their functional state and (b) the amount of supports that are available or able to be put in place.* Henry Dr

Triangulating this with the observational analysis showed that the doctors were aware that functional health and access supports were important factors that could determine whether an older patient was likely to return home. Yet the doctors relied on the multidisciplinary team to explore these issues.

> *Dr —…she lives by herself so if we can get OT. Physio - she is walking OK, just make sure she's good to go home…* Observation 1

In this situation the findings from the interviews supported the findings from the observation, in that the doctor was aware that functional health impacted on the transfer destination. While the doctor did not specifically assess the functional health or supports in place, the information presented informed their transfer decisions.

While some interview and observational data supported each other, there were also situations where they were divergent. One participant described the way the team made transfer decisions. This participant was also involved in the observational component of the study.

> *The discharge planning processes are very good. If we say somebody can't go home, they don't go home. If we say we have to work through all these processes, we work through the processes.* Katie SW

However, during the observed multidisciplinary team meeting the doctor discharged the person before social work had finished their interventions and cleared them for discharge.

> *…we didn't clear her for discharge and we're very concerned but she was discharged by the medical team on the Friday. So, we put (service provider name) in and (patient name) was readmitted on Sunday.* Observation 4 SW

In this situation triangulation revealed that the interview and observation findings did not support each other. The differences between the findings does not mean that they are inaccurate. Accepting experiences that contradict each other can help to explore alternative descriptions of the phenomenon. This adds to the richness of the final description of the phenomenon. Using this approach as one of the steps to establish trustworthiness in this study provided the opportunity to validate the findings as well as supported the development of a richer comprehensive description of health professionals' decision making in the transfer of older patients from hospital.

3.9.2 Supervisor review and audit trail

Reviewing the steps taken during the analysis of the data involved my supervisors independently screening all aspects of the analysis, including the comprehensive description to ensure that it reflected the original statements. The review is intended to provide the researcher with different views that reduce the potential that the findings are biased (Morse, 2015). In this study, the research supervisors reviewed the analysis and findings as they were developed to ensure that the research process remained rigorous. The application of Colaizzi's approaches provided a framework for analysis of the data that supported the development of a clear audit trail. Developing a clear audit trail is important, as it allows the reader to make their own decision about the trustworthiness of the study and the findings (Lincoln & Guba, 1985).

Review of the analysis decisions through the audit trail, and the resultant findings is a rigorous but necessary process that aims to ensure that trustworthy findings are developed. Throughout each step of the analysis, decisions, thoughts, and ideas were documented in the reflective journal. As the steps were reviewed by the research supervisors the researcher, through the reflective journal, was able to identify why decisions were made. The review of the analysis decisions and the resultant findings by the research supervisors was a rigorous process. This is necessary to ensure that trustworthy findings are developed that reflect the participants' experiences (Northall et al., 2020). Throughout these steps I continually used the reflective journal to document any ideas or thoughts. The reflective journal was also used as a cross check to ensure that the impact of any pre-existing ideas was minimised.

3.9.3 Phenomenological reduction

Husserl considered the phenomenological reduction as a way to explore phenomena objectively and see things from a new perspective (Christensen, Welch, & Barr, 2017). Phenomenological reduction can be achieved through reflective practices and the epochē. This is a crucial part of conducting a Husserlian phenomenological study, as it supports an understanding of things as they are. Reflection aids in the development of the epochē as well as the phenomenological reduction (Cai, 2013), and is woven through all aspects of the study from conception to completion. During analysis of the data, reflective practices can assist the researcher to identify and set aside any preconceived ideas to ensure that participants voices are heard (Tufford & Newman, 2012). To achieve this, I followed the description provided by Giorgi (2012) to develop the phenomenological reduction attitude. Achieving this requires looking at the phenomenon in question and taking it as it presents itself, without posing or voicing ideas about what it is. Importantly, this includes putting aside any previous knowledge that may explain what is being presented. Giorgi (2012) explains that only then can the phenomenon be comprehensively examined, as it has been presented.

The researcher in the phenomenological reduction attitude can now focus on the phenomenon being investigated through a clear lens. The keeping of a reflective journal was particularly useful when developing the epochē and phenomenological reduction, as I had experience making transfer decisions with older patients in hospital. As a result of this experience it was important to ensure that any preconceived ideas and assumptions were identified so that they could, as much as possible, be put aside. Using reflective practices

provided by Giorgi (2012) and the tips to bracketing provided by Ahern (1999), I was able to develop, as much as possible, the phenomenological reduction attitude.

Throughout this process I questioned whether the self can really be suspended. Gallagher (2010) explains that our existence in the world means we cannot completely separate ourselves from our experiences. In all steps of Colaizzi's framework I reviewed the transcripts of interviews where participants described their experiences and I interpreted these descriptions. In effect, what is provided is a carefully considered description of a phenomenon as described by a participant and interpreted by a researcher. In this study I adopted reflective practices to achieve Husserl's epochē. The bracketing process that is part of the epochē, however, is not a constant state of being. Throughout the study the researcher steps in and out of the epochē to develop the research and acknowledge any preconceived ideas. This was supported by the reflective journal and reviewed by the research supervisors. It is through the reflective process that objectivity can be achieved (Colaizzi, 1978). This helped me to view the transcripts and analysis as a fresh concept, unexplored and unknown.

3.10 Trustworthiness in this Study

There are multiple perspectives on how to establish trustworthiness in qualitative research (Sousa, 2014). In this study trustworthiness was supported by developing credibility, transferability, dependability, and confirmability. The strategies used to establish trustworthy findings have been discussed in this chapter. The following section provides an overview of what has been discussed as well as additional methods to establish trustworthiness in this study.

3.10.1 Credibility

Credibility can be achieved in a qualitative study by using methods that ensure the participants voices are heard and that the findings developed by the researcher are plausible (Holloway & Galvin, 2016). In this study, credibility is supported through the application of Husserl's phenomenological approach and Colaizzi's framework. Husserlian phenomenology aided the development of credibility, though the application of a philosophical approach that ensures that peoples' descriptions of lived events are presented, unaltered by the researcher's assumptions. Through the application of the phenomenological reduction the researcher attempts to put aside any preconceptions or ideas (discussed in more detail in section 3.9.3). Applying Husserl's phenomenological approach, the epochē and phenomenological reduction helped ensure that participants' experiences of making transfer decisions with older patients in hospital were credible. In addition, the application of Colaizzi's approach provides a clear, methodical decision trail that supports the development of trustworthy findings (Edward & Welch, 2011; Saunders, 2003). The combination of Husserl's phenomenological approach and Colaizzi's approach further supported the credibility of the findings in this study.

3.10.2 Transferability

Transferability of qualitative research is ultimately the responsibility of the reader, as it is dependent on whether the findings can be interpreted to fit another context (Erlandson, Harris, Skipper, & Allen, 1993; Sousa, 2014). Colaizzi's approach provides strategies to support the development transferability through the application of reliable processes. Colaizzi's strategies were applied to the interview and observation data using rigorous processes. This supports transferability.

3.10.3 Dependability

Dependability in a qualitative study refers to the findings being accurate and consistent (Holloway & Galvin, 2016). Lincoln and Guba (1985) explain there are several approaches to address dependability. One of these approaches is achieved through triangulation. In this study, within method triangulation was consistently applied throughout the analysis to support rich descriptions and trustworthy findings. Colaizzi's 7 step framework was used to analyse the interview data. This framework had been widely used in nursing research (Abu-Shosha, 2012; Edward & Welch, 2011; Saunders, 2003) and supports the development of findings that are relevant (Abalos et al., 2016). To support methodological consistency and dependability Colaizzi's perceptual description approach was used to analyse the observation data. Using two types of data collection and analysis provided the opportunity to apply methodological triangulation. A description of this is provided in section 3.9.1. The comprehensive description was developed by synthesizing the analysed interview and observation findings. This description was reviewed in the context of the interview and observation analysis to ensure that it consistently and accurately reflected the participants' lived experience in making transfer decisions. Using these methods supported the development of dependable findings.

3.10.4 Confirmability

According to Lincoln and Guba (1985), the main strategy used to establish confirmability is triangulation and the use of a confirmability audit which is comprised of a clear audit trail. The audit trail includes raw data, analysis processes, data synthesis, audit notes, personal notes and instrument development documents (Lincoln & Guba, 1985). Other techniques for establishing confirmability include triangulation and reflective practices (Lincoln & Guba, 1985). Through the application of Husserlian phenomenology and Colaizzi's approach

confirmability was addressed. Colaizzi's seven-step framework guides the researcher through the analysis process. Through the application of Colaizzi's framework the researcher moves through the steps of analysis, recording decisions and thoughts along the way. These records make up the audit trail.

Furthermore, Colaizzi's perceptual description framework provided a way to access the phenomenon through a different lens and enabled methodological triangulation. The keeping of a clear audit trail and reflective practices also supported confirmability of the observational findings. These findings, once combined with the interview findings, led to a comprehensive description of the phenomenon. The comprehensive description was developed through within-methods triangulation practices and the keeping of a clear audit trail. These practices helped support confirmable findings.

3.11 Chapter Summary

In this chapter I explained the qualitative descriptive methodology informed by Husserlian phenomenology used in this study. The application of a phenomenological approach is central to my study. This approach provides the philosophical lens that health professionals' experiences can be viewed through. Using Colaizzi's approach to explore the interview and observation data supported an understanding of their experiences of making transfer decisions. A particularly important aspect of the methodology in my study is the adaptation of Step 7 of Colaizzi's approach. Adapting this step to include methodological triangulation, supervisors' reviews and an audit trail as well as phenomenological reduction supported a better understanding of the health professionals' lived experience in making transfer decisions in hospital. This also provides a way for qualitative researchers to utilise strategies

other than member checking to validate qualitative findings using a phenomenological approach.

In the following chapter I describe the participants and present the findings developed through the application of the methodology to explore the phenomenon. This description of the participants is required as their experiences are connected to who they are.

Chapter 4
Findings

In the previous chapter I outlined the methodology and methods used to collect and analyse data gathered through interviews and observations of health professionals' decision making in the transfer of older patients from hospital to residential aged care. As Colaizzi (1978) explains, people's experience of an event is individual; it is not an entity that can be separated from the person. Therefore, this chapter begins by providing an overview of the interview participants to fully introduce them and provide context to their experiences of making transfer decisions in hospital. A complete description of the observation participants is also provided. This includes a detailed description of the setting where the four multidisciplinary team meetings were observed. This description is important, as the environment where the meetings were held was an integral part of their transfer decisions.

The multidisciplinary team meetings and individual health professionals' experiences making transfer decisions are intricately connected, therefore the findings needed to be presented as one description. However, Colaizzi did not discuss combining two separate sources of data, which meant that there was no term to describe the combined findings. Therefore, in this study, the 'overarching statement' is used to identify the synthesized findings derived from the interview and observation data. A discussion of the strategies to analyse and validate the findings are described in Chapter 3.

4.1 Description of Participants

This section provides a detailed description of the interview and observation participants. The description is provided in the findings chapter as who the participants are is intricately connected to their experiences. A detailed description of the observation environment is presented for the same reason.

4.1.1 Interview participants

This section focuses on the interview participants. A total of 16 health professionals participated in the interviews. Three of the 16 participants in this study were male, two were doctors and one a social worker; the remaining 13 participants were female (one doctor, three occupational therapists, two physiotherapists, five registered nurses and two social workers). Details of participant demographics are presented in Table 4.1. First name pseudonyms were assigned to the participants to uphold their privacy and maintain confidentiality. Three doctors, Ruth, Henry, and Peter participated in this study. The first, Ruth, was a rehabilitation specialist and was one of two participants who held a master's degree. As a rehabilitation specialist, Ruth assessed whether people were suitable for rehabilitation. For an older patient, the option of rehabilitation increased the likelihood of returning home. The second, Henry, was a geriatrician who had worked in hospitals for 22 years. During that time Henry had spent many years making transfer decisions with older patients in hospital. The third, Peter, was a staff specialist consultant geriatrician, who believed that the responsibility of transfer decisions was part of the senior consultant role.

Table 4.1 Interview participants

Profession	Highest level of qualification	Years of clinical experience	Years' experience making transfer decisions from hospital to residential care	Pseudonym
Doctor	Masters	12	2	Ruth
Doctor	Bachelor	22	18	Henry
Doctor	Bachelor	15	5	Peter
Occupational Therapist	Bachelor	12	5	Jane
Occupational Therapist	Bachelor	15	15	Lucy
Occupational Therapist	Bachelor	14	4	Katrina
Physiotherapist	Bachelor	27	8	Cath
Physiotherapist	Bachelor	9	7	Linda
Registered Nurse (NUM)	Bachelor	9	7	Phoebe
Registered Nurse (NUM)	Bachelor	25	3	Chloe
Registered Nurse (RN)	Certificate	40	5	Sarah
Registered Nurse (CNC)	Masters	34	5	Lily
Registered Nurse (DP)	Certificate	50	38	Ellen
Social Worker	Bachelor	34	20	Katie
Social Worker	Bachelor	7	2	John
Social Worker	Bachelor	10	10	Grace

There were three occupational therapists, Jane, Lucy, and Katrina, who participated in this study. Jane worked in hospital wards; her role included supporting people to function independently. Lucy and Katrina worked in the emergency department as part of an aged services emergency team to assess older people.

The two physiotherapists, Cath, and Linda, who participated in the study had vastly different levels of clinical experience. Cath worked on the wards and managed the physiotherapy department, which included an outpatient clinic. Similar to Cath, Linda also worked on the wards and provided care to patients who required physiotherapy as well as rehabilitation. Both Linda and Cath worked with older patients who had functional problems that impacted on their ability to manage the activities of daily living.

The five registered nurses who participated in this study had different levels of qualifications, experience, and positions. The first two registered nurses, Phoebe and Chloe, were Nurse Unit Managers (NUM). Phoebe and Chloe coordinated and oversaw transfer decision processes and ensured there was a plan developed for each patient admitted. The third was Sarah, an experienced clinician, who was the only registered nurse who worked in a medical ward and provided direct clinical care. The fourth registered nurse, Lily, was a clinical nurse consultant (CNC) who specialised in aged care and complex discharges. The fifth registered nurse, Ellen, was someone who worked solely as a discharge planner (DP). Both Lily and Ellen did not take a direct patient load, they worked across the hospital, supporting patients who were likely to need complex discharge support. These patients were often identified at the multidisciplinary ward review meetings. Sarah was the only registered nurse (RN) who worked on the ward and was responsible for providing direct

patient care. Sarah was an experienced clinician who worked on a medical ward. Both Sarah and Ellen had over 40 years of clinical experience working in hospital.

The three social workers also held a range of positions and had diverse work experience. Katie was a manager of a social work department who also worked clinically with people who were admitted to hospital. The two other social workers John, and Grace, worked on the wards and often received referrals to see patients with complex discharge planning needs.

4.1.2 Observation participants

The inclusion criterion for the observational component of the data collection was the health professionals' attendance at the multidisciplinary team meetings. Health professionals attended the meetings based on their involvement in the planning and care of patients admitted to that ward. They also attended to identify patients who might require assessment or intervention. Meetings 1 and 2 were held in the same ward two days apart, which meant that some of the participants attended both meetings. Table 4.2 provides a description of the observation participants at the four observed meetings. The total number of participants in the observational component was 26. Interestingly, two participants in the interviews also attended two multidisciplinary team meetings. Both participants worked in different hospitals. I was aware that as I was interviewing health professionals who had experience making transfer decisions that they may also, in the course of their work, attend multidisciplinary team meetings. In this situation I did not make any reference or acknowledge their involvement in the interviews. This was to ensure I protected their right to confidentiality and privacy.

Table 4.2 Observation participants

Meeting 1 Same hospital same ward	Meeting 2 Same hospital same ward	Meeting 3 Different hospital unspecified ward	Meeting 4 Different hospital unspecified ward
5 doctors (*2 of these attended meetings 1 and 2)	3 Doctors (including 1 additional doctor who did not attend meeting 1)	2 doctors	
Nurse Unit Manager*	Nurse Unit Manager	Nurse Unit Manager	Deputy Director of Nursing
	Enrolled Nurse		Registered Nurse (Discharge planner)
Occupational Therapist *	Occupational Therapist	Occupational Therapist	Occupational Therapist
Physiotherapist *	Physiotherapist	Physiotherapist	Physiotherapist
Social Worker *	Social Worker	Social Worker	2 Social Workers
	Dietitian		
	Pharmacist		
	Speech Pathologist		
Total 9 Attendees	Total 11 Attendees	Total 6 Attendees	Total 6 Attendees

*Participants who attended both meeting 1 and meeting 2 have been marked with an asterix to emphasise their repeat participation.

Doctors attended meetings 1, 2 and 3. The doctors stepped into the meeting as they finished their rounds and talked about the plan of care for the patients who they were responsible for and then stepped out of the meeting. In meeting 4, doctors were invited, however, no doctors attended the observed meeting. This was the only meeting that was conducted away from the ward in a conference room. It was decided to not use pseudonyms for the observation participants as some participants were involved in more than one meeting, which made the description confusing and difficult to follow. Instead of using pseudonyms, participants in the observations are presented through the data collection method followed by the meeting they attended as well as their health discipline, for example, Meeting 1 Dr.

4.1.3 Observation environment

A total of four multidisciplinary team meetings were observed at three hospitals in Australia. Meetings 1 and 2 were observed at the same hospital, two days apart. In meetings 1, 2 and 3 team members grouped around the white board in the middle of the wards. Written on the white board was the patient's name, admitting doctor and estimated date of discharge. There were columns for allied health team members to record when they had completed their interaction with the patient before discharging them from their service. There was also a space to document the planned daily medical intervention for the multidisciplinary team. The nurse unit manager in the three meetings updated the estimated date of discharge, allied health and medical intervention as each patient was discussed.

As these meetings were held in the nurses' station, which is a high traffic area, the meeting environment was noisy and chaotic. Ward phones rang regularly and there were multiple interruptions from other medical teams, staff, patients, and relatives. Due to the setup of the wards it was difficult to maintain privacy or confidentiality and there was a strong sense

of things happening quickly, with the fast pace of the meetings being dictated by the medical team. The sequence of patients discussed was based on whichever medical team arrived at the meeting. Hence, the nurse unit manager needed to continually scan the whiteboard to identify the patients who were under the care of the doctor, update the plan and find the next patient. At these three meetings the nurse unit managers often struggled to keep up with which patient was being discussed, as the doctors were not cognizant of having to keep pace with the nurse unit manager as they updated the plan on the whiteboard. Nevertheless, there was a level of focus and determination from the health professionals to cover the key issues and develop a plan. This usually involved an allocation of tasks rather than a resolution of issues.

While three multidisciplinary team meetings occurred on the ward, meeting 4 occurred in a conference room in another building. At this meeting, an overview of each admitted patient was provided by the discharge planner. Following the overview, the health professionals who were involved in the care of that patient discussed their plan and explained where they were up to with assessments and interventions. If there was no intervention required and the patient was expected to progress from admission to discharge, then they moved onto the next patient. In cases where complex issues were identified the team discussed the issues and developed a plan. They collectively developed a discharge plan that was written down and later added to the patient's medical record. The health professionals took turns to document each plan. Overall, this meeting was calm and organised, although it is important to note that no doctors attended this meeting. Their absence may have impacted on the effectiveness of the plans as doctors are crucial team members, yet they were not involved

in developing the plans and the expectation was that they and others would read the information in the patients' notes.

4.2 Synthesising the Interview and Observation Findings

The following section presents the findings that comprehensively describe health professionals' experiences making transfer decisions with older patients from hospital to residential aged care. In keeping with Colaizzi's (1978) approach, the comprehensive description of the phenomenon was developed by combining the interview and observation analyses to arrive at a more complete picture of the phenomenon.

The comprehensive description is elaborated through the theme clusters and threads developed in Step 4 and is supported by relevant excerpts from the 16 participants' descriptions of their experiences of making transfer decisions identified in Steps 1 and 2 of Colaizzi's approach, as well as excerpts from the 26 observation participants' transcripts. The clusters identified in Step 4 of Colaizzi's approach also aligned with the perceptual description. Therefore, it was decided to elaborate on the comprehensive description through the clusters and threads developed in Step 4. This was done to present the comprehensive description of the health professionals' experiences making transfer decisions more clearly. Validating the interview and observation findings, through the adaptation of Step 7 of Colaizzi's approach, assisted in the development of a rich description of health professionals' transfer decision making with older patients from hospital to residential aged care.

4.2.1 Comprehensive description of the investigated phenomenon

Throughout the analysis of the data, it became apparent that health professionals' transfer decisions with older patients in hospital were complex and evolving. The comprehensive description of the phenomenon intends to provide an understanding of the lived experience of making transfer decisions to residential aged care from hospital. Colaizzi (1978) presents his statement in three paragraphs. In this chapter the overarching statement, developed through a reduction of the comprehensive description from Step 6 and the perceptual description, to its essential elements is presented. There are many elements that have gone together in this statement, so differently from the exhaustive description (Step 5) and the perceptual description, the overarching statement needs to be something that is discrete. In this chapter I will outline the elements of this statement which will be further elucidated in the discussion chapter. The synthesized statement is referred to as an overarching statement that comprehensively describes the phenomenon and is provided below.

4.2.1.1 Overarching statement of the phenomenon

Experience is everything. Learning by doing is the main way of building transfer decision-making skills. The health professional's world becomes narrowed down to assessments and processes that intrinsically focus on speed and safety. Time is currency and is traded between professional groups as they search for transfer options. Inherent and external factors inform decision-makers' options, often without knowing why. They find their own way of doing transfer assessments by using cues and triggers learnt on the job. They see things through a different lens where the cues and triggers inform their decisions, therefore it is both specific and general with all aspects being considered. Individually, and as a team, the main goal is to have the right person in the right place at the right time. Although in the transfer decision making world the right place is anywhere but hospital.

Collaboration, through group decisions and experience is key and gives them a sense of security that the decision is not their sole responsibility. They share the burden in case their decision fails. Ensuring older people are safe is a constant focus and underlies the foundation of their transfer decision making. Concerns about safety and risk are prevalent. They see risk as having two sides, one is accepting that people live with a level of risk, the other is protecting people from risk. Collaboration and experience alter their perspective as they share the risk which gives them security and means that balancing the two sides of risk is challenging but possible. Their security is fragile as conflict is ever present. The world of transfer decision making in hospital involves conflict. Hierarchy and different views, laden with individual and discipline specific values, contribute to the conflict. Strategies to minimise conflict do not always work and they accept that conflict is part of the process. The resilience to try again another day helps them to see things as they are, an evolving process that is fluid, adaptable and at times combative.

The difficult process of making transfer decisions is heightened by a lack of options. Accessing alternatives to transferring to residential aged care is difficult and time consuming. For want of a better option they look for ways to go around barriers in an attempt to give people some extra time at home. Delaying the inevitable transfer to residential care gives them a sense of patient-centred altruism, as accessing services is complex and takes valuable time to arrange.

Through their experience they reset the way they see things. Their decisions are personal and professional, factors which ultimately become part of how they practise. They are advocates who are prepared to argue for people who they feel are being marginalised and overridden in the transfer decision-making process, although they are also torn between

allegiances to the older patient, families, carers and the hospital. They want everyone to get the care they need when they need it and feel a heightened sense of responsibility to help ensure this happens.

4.2.1.2 Applying the phenomenological reduction

Applying the epochē throughout the analysis was vital in order to ensure the participants voices were heard. This involved what I refer to as a stepping-in and stepping-out process where I attempted as much as possible to set aside my preconceptions in order to disclose health professional's lived experience of making transfer decisions with older people from hospital to residential aged care. While the epochē was practised throughout the analysis, it is particularly important in Step 4, as this is where the experiences that are given in Step 3 becomes what Colaizzi (1978) refers to as the themes given within their experiences, although, in this study, I refer to the themes as clusters and threads.

To gain access to the clusters and threads within the experiences I needed to ensure that I set aside any of my previous knowledge on this topic. This was achieved through phenomenological reduction and epochē. A discussion of the phenomenological reduction and the strategies I used to develop the epochē are explained in section 3.9.3. This section presents a deeper discussion of the application of the phenomenological reduction that supported the development of the clusters and threads.

Prior to commencing the study I was aware that I held pre-existing knowledge of the phenomenon. Using the reflective approach as explained by Giorgi (2012), I considered health professionals' descriptions of their experiences, as they were, without any ideas about what the thing was. The reflective journal based on the tips provided by Ahern (1999) formed the basis of the epochē where experiences are, at times, set aside. The epochē is not

intended to be a permanent state of being. It is more a process where at times my knowledge of the phenomenon needed to be set aside and at times was included. This was not easy to do, as it can be hard to know when to include pre-existing knowledge and when not to. Throughout the analysis I practised the epochē by using the reflective journal to ensure that the analysis was connected to the participants' descriptions and observations, unaltered by my previous experience. Even though the epochē is not a continuous process, at certain points I needed to step in and step out of the epochē in order to understand their experiences and gain a deeper understanding of the phenomenon.

4.3 Clusters and Themes

The comprehensive description describes, as much as possible, the experience of health professionals' transfer decision making through interviews and observations. However, providing a more detailed description of their experience of making transfer decisions from hospital to residential aged care is required in order to highlight the intricacies of the phenomenon. In Step 4, Colaizzi asks the researcher to combine the formulated meanings developed in Step 3 into "clusters of themes" (Colaizzi, 1978, p. 59). The theme clusters describe the health professionals' experiences of making transfer decisions with older patients from hospital to residential aged care. The perceptual description of health professionals' experiences of making transfer decisions was considered in light of the fundamental statement of the phenomenon developed in Step 6 and the themes in Step 4. Through this process I found that the theme clusters developed in Step 4 were similar to the characteristics of the perceptual description, therefore, I decided to present the synthesised fundamental statement and the perceptual description through the themes identified in Step 4 of Colaizzi's approach.

The first cluster by which the comprehensive description can be elaborated is 'exploring options'. This cluster explains the strategies the health professionals used to explore discharge options with older patients in hospital. Within this cluster are two threads: 'identifying cues and triggers' and 'drawing on clinical judgement and experience'. The second cluster is 'collaboration and conflict'. This cluster and its threads reflect the participants' lived experience of making collaborative transfer decisions. The threads include 'working with older patients, family and carers' as well as 'individual and team decisions.' The third cluster involves 'making difficult decisions'. This cluster reflects the participants' descriptions of making difficult transfer decisions and the factors that influence them. The threads in this cluster are: 'seeking safety'; 'accessing support'; 'questioning capacity'; and 'time pressure'.

To help illustrate the comprehensive description and to ensure that the participants' voices are heard in their pure form, direct quotations identified in Step 1 of Colaizzi's approach have been used as well as excerpts from the observations. Quotations were selected that represented a participant's experiences of the phenomenon. The following section seeks to elaborate the comprehensive description by way of these clusters and threads.

The clusters and threads are shown in Figure 4.1. The threads within the clusters are explained and quotations from the participants are included to further illustrate their experiences. A circle was used as the scaffolding for the diagram as this reflects the cyclical nature of transfer decision making as described by the participants. As already outlined, a comprehensive description of the phenomenon was developed through the adaptation of Step 7 of Colaizzi's approach, which triangulated the findings derived from Colaizzi's seven-step approach and the perceptual description. Applying the phenomenological reduction in

the interview and observation analysis was important to ensure participants voices were heard.

Figure 4.1 Clusters and threads

4.4 Exploring Options

In order to reach a transfer decision, the health professionals used a variety of strategies to develop a suitable discharge option. The health professionals in my study often recognised factors that triggered a transfer decision. These factors are explored in the thread 'identifying cues and triggers'. The identified cues and triggers for possible transfer to residential aged care, combined with their clinical judgement and experience, assisted them to reach a transfer decision. This is discussed within the thread 'drawing on clinical judgement and experience'.

4.4.1. Identifying cues and triggers

To prepare to reach a transfer decision the health professionals usually conducted assessments to gather information. The assessments helped them identify cues which often triggered further assessments or a transfer decision. The cues included: limited or no access to a reliable carer or support services; inability to independently complete the activities of living; cognition problems; deteriorating functional health; inability to mobilise short distances independently; frequent representations to hospital for non-acute reasons; and unable to manage at home with existing supports.

In some cases, the assessment triggered decisions that were clear cut and could be made quickly. These cases were rare and usually involved the older patient having access to pre-existing supports or situations where the health professional could quickly see that returning home was not likely to be an option. Interestingly, decisions could be initiated based on reading the patient's medical history. They could identify triggers from reading a patient's notes, as they seemed to inherently know what they were looking for, without necessarily being able to vocalise it. This is shown by Lily (CNC) and Peter (Dr) who explained:

> *There is another third group whereby you've got the same conditions, nothings different, other that they've got good caring supportive families or carers that can provide the care that is required other than going into nursing home but they're slim on number…*Lily CNC

> *I mean, there are people that I think even just looking at the emergency room notes…you know at least they need the question raised, does this patient need consideration for placement?* Peter Dr

The quick decisional process was witnessed during the observational component of the study. In Meeting 1 an older patient was discussed; the team rapidly decided that this patient was all right at home and did not require assessment in preparation for discharge. This was based on his functional status and access to supports. They shared the decision and did not need to go into further detail as the team understood that a person who is independent and has support does not need their input. The speed in which they determined this appeared to be based on their experience, which gave them confidence to make decisions with minimal information, as shown in the excerpt below.

> *NUM — He doesn't need anyone does he?*
>
> *Dr — He's quite independent, he's got a supportive family, daughter and wife.*
>
> *NUM — Alright.* (Meeting 1)

They seemed to know that the older patient was able to go home, as they appeared to have an inherent and shared understanding that people who are independent and have support can return home. However, health professionals' transfer decision making was not always so clear cut. In the interviews and observations, the health professionals described conducting targeted assessments to gain a sense of what was happening for the older patient, family, and carers. This helped them identify factors that could trigger a transfer decision. The older patient's functional ability and access to support were common triggers that impacted their transfer decisions. Transfer decisions were based on a sliding scale between functional

ability, the older patient and family wishes as well as access to support. They balanced these factors using an internal scale that they were less able to describe as it appeared to be intuitive rather than evidenced based. An example is Henry (Dr) who, like the other health professionals, held the belief that the more dependent the older person was the more supports were needed, although if supports were not available or the dependency was too high the older patient was more likely to require transfer to residential aged care.

> *…everyone needs to go to nursing home care if they've got no support… It's a sliding scale, if you like, depending on (a) their functional state and (b) the amount of supports that are available or able to be put in place* Henry Dr

This was a common theme and was noted in the observations of the multidisciplinary team meetings. In these meetings doctors were aware of the need to look at both medical and functional health in preparation for discharge. Typically, a doctor stated that the older patient was close to being medically ready for discharge and wanted to ensure that the multidisciplinary team had a discharge plan in place. For the most part the doctors were not overly interested in the specifics of what needed to be done to ensure the older patient had the supports they needed to be discharged. They expected that this was the job of other members of the multidisciplinary team and they trusted them to do their jobs as quickly and as efficiently as possible. This is highlighted through an excerpt from Meeting 1 where a doctor stated:

> *Dr — She lives by herself so if we can get OT. Physio she is walking OK, just make sure she's good to go home…* Meeting 1 Dr.

Doctors were aware of the role allied health had in transfer decision making and trusted that they would do what was needed to get the patient home. Occupational therapists, as part of the multidisciplinary team, conducted comprehensive functional assessments which often

triggered a transfer decision. Their transfer decision was not based on one assessment as they often used cues such as: assessing the older patient's physical needs; cognition; input from family or carers; as well as access to support and equipment. The ability to access support was a significant trigger that impacted on the health professionals' transfer decisions. The more support a patient had at home the more likely the health professionals were to decide to recommend transfer home. While a patient's functional ability influenced physiotherapists' and social workers' transfer decisions, they also looked at the older patient, family, and carers' ability to manage the activities of daily living prior to admission. This was particularly relevant if the older patient was not coping at home with supports before admission and had now deteriorated.

These health professionals understood that the difficulty accessing or increasing community services in combination with an exhausted carer meant that discharge options were limited. Linda (PT) explained that if the supports available at home no longer met the needs of the older person and it was not possible to get more help other options needed to be considered, this included considering transfer to residential care. Linda (PT) like other health professionals had developed a set of cues and triggers that were used to inform transfer decisions. The cues, developed through experience, were often intuitive and connected to their specific discipline. They used the cues as a checklist to make sure that they had covered all the bases. There was a level of confidence that came from using the cues and triggers that they had learnt through experience, which helped them to map out a transfer decision. As an example of this Linda (PT) said:

> *…how much assistance they were getting before and how much support they can get at home, if that wasn't meeting their needs before and now their needs are higher than that, then clinically you assume that if they can't get more support at home then we're going to have to look at alternative arrangements.* Linda PT

As care requirements increased, the need for supports increased. For health professionals this was a trigger to transfer to residential aged care as getting more support was a significant barrier that left them with minimal options other than transfer to residential aged care. While there are similar cues that can trigger health professionals' transfer decisions, there are also factors that are discipline dependent. The physiotherapists looked at mobility and function objectively. A person's mobility and function were at the centre of their decision, they remained connected to their discipline and possibly trusted other members of the multidisciplinary team to explore what the older patient wanted. It was a system-based approach which focused on measurable outcomes, rather than unique patient characteristics. Cath (PT), for example, felt that if a patient could consistently get out of a chair, transfer to a bed or the toilet and mobilise 5-10 metres with a suitable aid then they were potentially able to return home. Cath (PT) said

> *So, whether somebody can consistently and confidently, and competently, manage to get out of the chair, transfer into bed, to the toilet, walk-mobilise five or 10 metres with a suitable walking aid. That's sort of a bare minimum that you need to be able to do at home.* Cath PT

The internal and self-developed cues for what level of function is needed to return home may well represent safety, yet excludes the wishes of the older patient.

On the other hand, nurses described getting cues from the multidisciplinary team, older patient, family, and carers to inform their transfer decisions. Like the social workers, they looked at the situation holistically to determine where the patient's care needs could be met. However, in contrast to social workers, the nurses described a more triage-like process to find factors that would trigger a transfer decision. Phoebe (NUM) described her set of cues and triggers that informed the decision to recommend transfer decision to residential aged care. The cues included recurring representations and admissions to hospital for

illnesses that did not usually require hospitalisation, especially if the older person returned to hospital quickly. Exhaustion was another cue, as the effort involved in attending the activities of daily living was more than the older person was able to manage, even with assistance. These cues indicated the patient was not coping at home and may require transfer to residential aged care.

> *Sometimes it's based on the fact of patient re-presentation and what they are re-presenting with non-acute illnesses or conditions or quick, very quick returns…some of the elderly patients you see are tired out and exhausted from living you know surviving on their own.* Phoebe NUM

In summary, the health professionals conducted assessments to help them identify cues and triggers that informed their transfer decisions. These health professionals described assessments of mobility, function, and access to supports as being significant factors that influenced their transfer decisions. Through their descriptions of conducting assessments it was apparent that the wishes of the older patient were not a central focus as they explored potential transfer options. While it is concerning that the cues and triggers they used to inform their transfer decisions did not include the older patient's wishes, the health professionals had developed their own unique set of triggers which they had learnt through their experience to inform their transfer decisions.

4.4.2 Drawing on clinical judgement and experience

The health professionals in my study drew on their clinical judgement and experience to identify and explore discharge options. They described their experience and clinical judgement as valuable decision tools, which helped them to understand family dynamics and risk as well as identify if the patient was not improving as expected and was unlikely to return home. Experience meant they were more prepared for difficult situations. They tried

to work out a solution which sometimes worked and sometimes did not. They used experience to perceive how people were progressing and clinical judgement to make a decision. Their experience was personal, professional, and unique to them. It was their most valuable decisional tool which they considered as intuitive as well as clinical. Intuition for them was multifaceted and tended to be around empathy as well as clinical judgement. They trusted their experience and judgement to help them reach a transfer decision and also relied upon emotional connections with older patients and carers.

Henry (Dr) relied on his experience as a valuable decisional tool as did Jane (OT). Linda (PT) used clinical judgement and Sarah (RN) described using her intuition to develop a transfer decision. While Katie (SW) explained that through her experience she had developed a level of intuition which helped her to see what was really happening for the older person and carers. The excerpts below act as examples of the diverse ways health professionals made transfer decisions.

> *Well my own experience I rely on. So, it's like once you - when you've looked after 5000 patients in the same sort of situation it's - my - I think that is more valuable than anything else.* Henry Dr
>
> *I think it just comes from experience…* Jane OT
>
> *So basically, it's clinical judgment is what informs us.* Linda PT
>
> *Well some you may have the gut feeling that this person is not progressing.* Sarah RN
>
> *It's about being able to perceive how people are really feeling, how carers are feeling and how patients are feeling. So, it's an intuitive thing. That's how I work.* Katie SW

Having experience making transfer decisions helped the health professionals, as they were able to recognise patterns and identify when things were not going as expected. When making these decisions the health professionals rarely used decisional tools. This was mainly because they did not find decisional tools useful, as they do not take the older patients'

preferences into account. Instead, the health professionals combined their clinical judgement, often learned through experience, with their understanding of cues and triggers to make transfer decisions. While information gathered from assessments informed their transfer decisions, they represented one part of the overall picture of the situation for an older patient, family, and carers. Lily (CNC) showed this when she explained that even though there were no specific tools to inform or guide transfer decision making, she would not use them anyway as she felt they did not allow for the individuality and complexity of these decisions.

> *I don't think there's a specific tool that we just tick a box… I don't think we fit into a tick a box system for this, it's just our years of experience and training*. Lily CNC

Experience working with a patient supported the health professionals transfer decision. They drew on their clinical judgement and experience of knowing the patient from previous admissions to determine the potential rate of deterioration, which meant they could develop a plan that slowly prepared the older person for transfer to residential care. This was done by accessing respite admissions in residential care, which could include several separate respite admissions. This was shown by John (SW) who felt that giving the older person time to settle into residential aged care temporarily, would soften the blow for the older person when they needed to move in permanently. This was because he felt the older person had been given time to adjust to living in residential aged care.

> *…some of the patients that keep presenting into hospital… we have to have an intelligent guess of where things will sit. So, experiencing respite, making a smart prediction can help them adjust to those changes… when the time comes to go on a permanent basis it's not such a huge step.* John SW

What John (SW) describes as an 'intelligent guess' might be more correctly framed as clinical judgement based on knowledge and experience. Clinical judgement gave John (SW) the confidence to have a long-term plan which gave the older patient time to make this decision. Using a long-term plan helped the health professionals to feel they were supporting the older patient to make the transition with the time and preparation that was needed. Making these decisions over several months made the decision easier for the older patient, families and carers. As an example of this Ruth (Dr) said:

> *I guess it is easier if the decline and the decision making has been ongoing for a few months, then it's easier for the families and for the person themselves.* (Ruth Dr)

To sum up, it appears that there was an overall lack of validated assessments that health professionals used to support their transfer decisions and it seems that even if there were, they would not use them. Instead, they relied on their clinical judgement which they developed through their experience of making transfer decisions with older people. As their clinical judgement developed the health professionals became more intuitive and patient focused. This may be because they have learnt by doing and had developed their own internal processes of assessments. The assessments when combined with their clinical judgement and experience become more patient centric.

4.5 Collaboration and Conflict

The health professionals utilised collaborative processes in order to reach a transfer decision. They tried to 'work with the older patient, families and carers' and other health professionals to make 'individual and team decisions'. However, this could lead to conflict between the older patient, family, carers, and the multidisciplinary team.

4.5.1 Working with older patients, families, and carers

The health professionals tried to collaborate with the older patients, families, carers, and the multidisciplinary team to reach a transfer decision. Making collaborative transfer decisions was important, as they tried to ensure that the older patient was able to participate in transfer decisions. For instance, Peter (Dr) and Chloe (NUM) explained that transfer decisions were easier when there was support from the older patient, family, carers, the multidisciplinary team, and the general practitioner.

> *Having a supportive GP and a supportive family, and a family that knows or is fairly involved with care, it makes the process a lot easier.* Peter Dr

> *So, it's a collaborative approach. It is the actual getting the expert advice from the physio and the OT that helps to make the decision. The social worker, depending on the social circumstances…*Chloe NUM

Collaboration supported the health professionals transfer decisions, yet they also wanted to support the older patient's choice, however, sometimes the needs of the older patient were outweighed by the needs of the family or carer. Ultimately, health professionals wanted what was best for the older patient, but it was not always evident what this was. Ideally, the older patient should decide where and how to live, although as the older patient's care needs increased, their wishes were no longer the primary consideration, instead, the ability of the family and carers to meet the needs of the older patient became the main focus. This was a prevalent experience for the health professionals and is demonstrated by Grace (SW) and Chloe (NUM) who explained this by saying:

> *…the right for people to decide how to live is eroded as their increased care needs, in an acute ward.* Grace SW

> *Sometimes, if a person does need placement, it's because the carer can't manage.* Chloe NUM

This was a commonly held view which goes against the principles of autonomy that health professionals aim to uphold and highlights the underlying focus on safety. It was important for health professionals to support an older patient's choice. However, if the carer was not able to manage and increasing services at home was not an option, predominately due to the time taken to arrange and access support, then transfer to residential care was the only choice.

Carers provide significant support to older people living in the community and it is reasonable that at some point the care needs may be such that they are no longer able to safely and properly care for the older person, even with the highest level of community services. It is reasonable to consider the wishes of the carer in these situations, but it appeared that the input of the carer may be overemphasised, particularly in situations where the carer has minimal involvement in the older person's life. Cath (PT) explained:

> *They were not caring as such other than making the odd phone call from a distance, but they needed to know that this patient was going to be safe. It was not anything about her needs.* Cath PT

It is understandable that carers may not be able to continue in the caring role for a variety of reasons, yet there were also situations where carers were reluctant to give up the caring role. This may be due to the role becoming part of their life and they believe they are doing the right thing. The challenges arising from these situations were considerable, especially when there were concerns for the older person's health and wellbeing, which were difficult to investigate and hard to recognise. This is demonstrated by Chloe (NUM) who explained:

> *They're not coping or the patient keeps coming back multiple times. You can see that the patient's dehydrated, malnourished…there is DoCS for the kids but there's nothing for the elder abuse.* Chloe NUM

The health professionals in this study held the desire to protect older patients and while they applied this in their own unique way there was an awareness of the need to ensure that they made transfer decisions that were safe. However, this was not always possible as they were likely to follow the wishes of the carer, even if that was not what the health professionals wanted. The lack of supports for vulnerable older people contribute to the challenges and left health professionals feeling frustrated that there was nowhere to take these concerns. However, working together as a team helped them share the burden of difficult decisions.

Ideally the transfer decision was made in collaboration with the patient, family, carers and health professionals once opportunities for the patient's health and function to improve had been explored. Social workers work with the older patient, family, and carers to try to develop a clear picture of family dynamics. They look at the whole picture from the beginning and try to develop a plan that meets the needs of the older patient, family, or carers. They work collaboratively and act as detectives to try to find out why some older patients are reluctant to agree to transfer to residential aged care. Ideally, older people should be able to make their own decisions, however, an older patient with no advocate was more likely to be placed in residential aged care than those who had an advocate.

Social workers often advocate for patients in hospital and it is concerning that they hold the belief that they are doing the right thing when supporting an older patient to transfer to residential aged care, even if this may not be what the person wants. This could possibly be due to competing allegiances, as they want to ensure that people can decide where and how to live but also want to ensure that they are safe. If the older patient does not have an advocate, they were more likely to transfer to residential care, possibly because the health professionals considered this the safest, quickest, and best option. Out of their comfort zone

and with little power, the older patient, without an advocate, was unlikely to be able to alter the decision.

> *I think if people didn't have someone to advocate for them it seems to me it's more likely they will be placed than people that do.* Grace SW

In some situations, case conferences, also referred to as family conferences, were used to help support the transfer decision process. A case conference was usually held when there were barriers to developing an effective transfer plan. Typically, the case conference included the health professionals that were involved with the older patient's care as well as the older patient, family, and carers, where possible. The case conference provided the opportunity for everyone to come together to decide. Lucy (OT) explained the importance of case conferences to support transfer decision making, as they provided an opportunity for everyone to agree on a transfer plan.

> *I think the process with doing the family conference is so everyone can discuss and come to an agreement. I think it's harder if you don't have a family conference*. Lucy OT

While case conferences in some cases supported transfer decision making, in other situations where there were barriers or challenges associated with the transfer decisions, case conferences provided a way to get all parties together. In contrast to the multidisciplinary team meetings, case conferences usually occur in a private room and include multidisciplinary team members as well as the older patient, family, and carers. Interestingly, some health professionals in this study found case conferences difficult, especially when the older patient wanted to go home but this was not the recommendation of the team. The health professionals found this challenging as the older patient was outnumbered and often not able to advocate for themselves. Grace (SW) described her experience in a case conference where an older patient was threatened that she would not

be admitted to the hospital again unless she agreed to transfer to residential aged care. Grace (SW), like other health professionals, found this challenging but did not feel able to do anything about it.

> *I remember the one case conference in particular where the deputy director of nursing attended and told her that he would bar her admission to ED if she insisted on returning home and that she would not be admitted anymore...* Grace SW

Similarly, Katrina (OT) described difficult case conferences where they tried to convince an older patient, who wanted to return home, that he needed to transfer to a residential care setting. Despite having cognitive capacity, Katrina (OT) felt that the older patient was outnumbered and coerced into agreeing to transfer to residential care. Ideally, a patient in hospital with capacity can make their own decisions about where or how to live, yet in this situation, it appears this was not the case. This was a difficult experience for Katrina (OT), as the wishes of the older person were not considered.

> *I guess sometimes it's hard, especially when we have the case conference. Especially if the patient still has insight, and they're saying they don't want to go to a facility...* Katrina OT

Cath (PT) also described the trauma of case conferences and felt that the older patient was voiceless, as communication from the health professionals was technical and the needs of the older patient were ignored. As a result of this experience Cath (PT) had decided not to participate in case conferences.

> *I think my experience is that patients are left without a voice so very often in those situations…I try and keep away from case conferences now, because I find them incredibly distressing to myself and disempowering to patients. Cath PT*

The use of case conferences as an opportunity to convince an older patient to agree to transfer to residential aged care did not sit well with health professionals, who questioned whether patient-centred care was being provided. While case conferences could be

challenging for health professionals, they supported transfer decision making since everyone came together to decide, even if the decision was not what everyone wanted.

Overall, the health professionals aimed to work with older patients, family, and carers to reach a transfer decision together. They worked with the older person to come up with a plan, but the input of the carer often held more weight than the wishes of the older person. Strategies such as case conferences helped but it appears the older person's choice was not always included and instead of a collaborative process it was sometimes a place where older patients were voiceless.

4.5.2 Individual and team decisions

The health professionals used individual as well as team processes to make transfer decisions. They often conducted their own discipline specific assessments and then collaborated with the multidisciplinary team to make transfer decisions. Good communication between the doctor, older patient and the team helped the transfer decision process, although this may not consistently happen, possibly due to time pressure. Grace (SW) showed this when she said:

> *…it's made easier if the doctor involved is very good at communicating... In my experience, that doesn't happen necessarily with as much time, thought, and effort as it should.* Grace SW

The pace of these decisions may be a factor that limits communication between health professionals as well as the older patient, family, and carers. Communication between the multidisciplinary team can make decisions difficult and conflict can occur. A common cause for conflict was disagreement amongst the team about what was best for the older patient. Doctors have admission and discharge power, and if they disagree with the multidisciplinary teams transfer decision, they will discharge the patient. In situations such as this the team

waited to see if the patient would ‘bounce back’ to hospital. This is developed through John (SW) and Chloe (NUM), who described their experience when doctors used their decisional power to override the recommendations of the team.

> *Well, doctors have admission and discharge powers, so sometimes they can disagree and decide to discharge a patient if they feel that they've spent as much time as needed in hospital.* John SW

> *...ultimately it's the actual medical team that will decide whether or not the patient goes home. That's happened multiple times that the team, the doctors have said, no, they are going home, even though that's against what the physio and OT, social worker recommend….* Chloe NUM

Ideally transfer decision making is collaborative, although it is evident that doctors have authority to determine who is admitted under their care and when to discharge them. They acknowledge this, as they seem to inherently recognise situations they are prepared to fight for and those it is better to accept. When there is disagreement between the team and doctors about discharge destinations, doctors have the final say. This can lead to collaborative conflict when the health professionals need to adjust their plans and do the best they can to put in supports at home for the older patient. This contributes to the health professionals stress and was observed in the multidisciplinary team meetings as well as heard from the participants in the interviews.

Observing the multidisciplinary team meetings provided the opportunity to witness collaborative transfer decisions as well as hierarchical decisions. There was occasional frustration in these meetings, especially when there were delays to the older patient being discharged. An example of this was witnessed in a multidisciplinary team meeting when the doctor had cleared the patient for discharge, however, allied health team members had not completed their assessments and interventions. This doctor became annoyed about the delay in discharge and commented that:

This guy has been here for like 600 years…Meeting 2 Dr

Despite this frustration, the patient was not discharged until the whole team was ready to do so. Delays in discharge often led to frustration but the doctor appeared to be aware that the care older patients needed involved social and functional support as well as medical. However, this was not always the case. A lack of collaborative transfer decisions can cause problems which can lead to premature discharges that do not allow for all members of the multidisciplinary team to have a plan in place. Ideally, transfers occurred when all members of the multidisciplinary team were ready and plans were in place to support the older person. However, in some situations, transfers occurred before the team had competed their assessments and established a plan. This caused problems yet they showed their patient-centred focus and resilience as they adapted and did what they could to support the older patient, family, and carers at home.

An example came from the interviews and observations where an older patient was discharged despite allied health not clearing the older patient due to concerns about their ability to manage at home. The older patient was readmitted two days after discharge and the team resumed their efforts to develop a discharge plan. This situation was particularly noteworthy as the observed meeting involved a health professional who had also participated in the interview component of this study. In the interview Katie (SW) said:

> *The discharge planning processes are very good. If we say somebody can't go home, they don't go home. If we say we have to work through all these processes, we work through the processes.* Katie SW.

Yet in the observation of the multidisciplinary team meeting the doctor discharged a patient before social work had cleared them. This contradiction may be due to the nature of the transfer decisions where things do not always go to plan.

> *We didn't clear her for discharge and we're very concerned, but she was discharged by the medical team on the Friday. So we put a (name of service) in and (pt name) was a readmitted on Sunday...* Meeting 4 SW

The resilience of health professionals when making transfer decisions was significant. They aimed to do what was needed to make sure older patients were safe and adapted quickly when things did not go to plan. Despite situations where the team may not collaborate or negotiate as effectively as it should, they worked together to ensure the older patient, family and carers, were supported.

Negotiation amongst the multidisciplinary team as well as older patients, family, and carers was particularly important when making transfer decisions, although this did not always occur, possibly due to hierarchy and time factors. A considerable issue was negotiation with doctors when there was disagreement about the transfer destination. Doctors have admission and discharge power and it is important that they hold this, yet the negotiation to ensure that the patient is not just medically ready for discharge, but also socially and functionally ready is vital. Although this does not always occur, as Grace (SW) explained:

> *…You're going to end up in a nursing home, by doctors… So I think it's raised sometimes straight up by them. Then the rest of the team catches up to whether that's actually a warranted thing to be throwing out there or not*. Grace SW

This goes against the collaborative nature of transfer decision making and possibly highlights a siloed hierarchical approach. Collaborating and working as a team supported health professionals to make decisions, yet the transfer decisional process was challenging for all health professionals, in particular for social workers. Social workers have an advocacy role and in the context of transfer decision making they aim to ensure that the older patient has an advocate if needed and can participate in the decision. This is a difficult position as the

social workers were often at odds with other health professionals. Peter (Dr) showed this when he said:

> *But I think the whole process has become almost adversarial like in the way that the social workers sometimes just throw their hands up in frustration and very, very dissatisfied with the process.* Peter Dr

Social workers try to support the voice of the older patient, family and carers which can put them at odds with the rest of the team who may have a different focus, although social workers were not the only advocates, as other members of the multidisciplinary team also took on this role. However, it appears that this was only when a situation particularly concerned them. They seemed to pick and choose the cases that they advocated for and did not appear to know why. There was a possible build-up of pressure that at a certain point triggered them to step in and recalibrate their decisions. As they continued making transfer decisions, they incrementally altered their internal criteria for transfer decision-making until they had reached a point where they had stepped over the line and were making decisions that did not meet their internal ethics. They seemed, possibly unknowingly, to rectify this imbalance by taking a stand in cases where they recognised the line had been crossed.

This was shown by Ellen (DP), who felt that older patients had been convinced that they had to transfer to residential care by health professionals and family. Ellen (DP) wanted to advocate for these patients, which caused problems within the team, as she was not convinced that all the alternatives had been explored. Ellen (DP) also felt the older person had not consented to transition to residential care. Despite her attempts to support the older persons wishes the team decision prevailed. This left Ellen (DP) with trauma and frustration and there was nowhere else to go with her concerns. Ellen (DP) described her experience:

> *I will never get over him, how he was convinced,, so it took them three weeks to do though, three weeks, he was adamant… I fought with the geriatrician and I fought with the social worker and I fought with the executives and I said, you know what their wishes are, and you know the wife has been badgered, and they all badgered, they badgered and badgered and badgered and I went to elder abuse about it, I just felt like we did the wrong thing.* Ellen DP

The frustration described by Ellen (DP) was shared by other health professionals who found these situations difficult. Despite this they showed resilience by continuing to make transfer decisions and fight for cases where the belief was that the patient had not consented to the transfer.

Strategies, such as whiteboard meetings, encourage collaborative transfer decision making, as it helps to share the decision. Differently from case conferences, whiteboard meetings, also known as multidisciplinary team meetings, are opportunities for the whole health care team to discuss the plan of care. The multidisciplinary team meetings occur daily, or several times a week, depending on the hospital. The patient, family or carers are not included in this meeting. These meetings are brief and focused with the aim of determining a plan of care and a plan for discharge. Chloe (NUM) explained:

> *Every morning we have a multidisciplinary meeting at the whiteboard…it's quite a succinct meeting. It takes about 15 to 20 minutes. We talk about all the patients. We start the discharge process from the admission.* Chloe NUM

Chloe (NUM) described this meeting as 'succinct' which is appropriate considering that the meeting takes around 20 minutes with all patients in the ward considered and discharge planning discussions are instigated. The meetings are targeted and organised albeit in a slightly haphazard way. There is minimal opportunity to have a fuller discussion as there is a constant feeling of needing to move onto the next patient. In some cases, the team decision could be made quickly based on the older patient's age and medical conditions. This usually

involved collaborating with members of the multidisciplinary team to gauge their discharge destination recommendation.

Like all the health professionals, Ellen (DP) had developed her own set of risk factors which indicated that the older patient may require additional supports at home or a transfer to residential aged care. These risk factors included long length of stay, poor health, and age.

> *If they've been any long stays, is there a reason, is it because they're not coping… if it's medical problems, we look at their ages and at the white board meetings, if there's any concerns we talk to the NUMs…*Ellen DP

Using their set of risk factors, they were able to determine suitable options that came together to make a team decision. The multidisciplinary team meetings supported their decision making in a way, but fuller conversations happened outside the meeting where the health professionals independently and collectively made transfer decisions that they then presented at the meetings.

While the multidisciplinary team meetings supported collaborative decisions, not all team members attended. A notable absence from this meeting and the transfer decision-making process was the registered nurse that looked after the older patient. Attendance at these meetings involved members of the multidisciplinary team which did not appear to include the registered nurse. Ideally, the nurse who spends the most amount of time with the older patient should be involved in the transfer decision as a source of information and an advocate.

> *Therapists come in they'll spend their allocated time whether it be 10 minutes, ½ hour or an hour with that person, whereas the nurse is there. Sarah (RN)*

Sarah (RN), who provided direct patient care, commented that they spend the most time with the older patient. This indicates that they are more likely to develop a deeper level of

understanding of the older patients' ability and wishes developed over time, rather than through targeted assessments and intervention. This was also reported by Grace (SW) who described that not having the input of the nurse who looks after the patient at the meetings may limit the effectiveness of the teams decisions as information may be missing.

> *I don't think nurses ever really get involved other than the discharge planner we were talking about or maybe the NUM… I think the nurse should be very involved in advocating or disseminating information about the patient. Grace SW*

In the four observed multidisciplinary team meetings, the nurses who provide direct patient care did not attend. The nurse unit manager in three of the meetings talked about the general care of each patient. A similar situation occurred in the meeting that was run by the discharge planner. There was a notable absence of the registered nurse at the meetings I attended, who provided direct care to patients. The doctors talked about the medical health of the older patient and the members of the multidisciplinary team talked about their assessments and recommendations. While it is possible that the registered nurses may have passed on information to the nurse unit manager, the lack of time in these meetings could have minimised the ability to include it. The nurse unit manager was also responsible for running the meeting and documenting the plan on the board. This meant they were often caught up in the processes of the meeting which left little time to provide further information. This is seen as a considerable gap as registered nurses who provide direct patient care are likely to have unique knowledge about the people in their care, yet it appears that they have less opportunities to share it with the multidisciplinary team.

Despite the registered nurses who look after the patient not being involved in the transfer decision, the collaborative nature of the transfer decisions was evident. The multidisciplinary team meetings gave the health professionals an opportunity to share their assessments and recommend a transfer destination. However, the brief time spent on each patient meant that complex situations and collaborative discussions were kept to a minimum and there was a lack of a clear plan. There was often confusion as the pace of the meeting was so fast that it was difficult to keep up and it was often unclear which patient was being spoken about. This is demonstrated through the excerpt below.

> *NUM- Are you guys involved? We're talking about (patient name).*
>
> *Dr- We're talking about (different patient name), wait no were not talking about…(Meeting 1)*

Despite this, the nurse unit manager, who for the most part runs these meetings did their best to keep on track. Dots were used on the white board as an indicator of when allied health team members were involved with a patient. In most hospitals, whenever a team member had completed their interaction with a patient and discharged them from their service, they documented this on the white board. However, in some cases this added to the confusion and there was limited time to seek clarification. The excerpt below highlights the underlying confusion of these meetings.

The nurse unit manager, in an attempt to determine whether the patient was cleared for discharge by allied health, asked the team to clarify their involvement with the patient. Different coloured magnetic dots were added to the white board next to a patients name to indicate the allied health disciplines involvement with the patient. There was a square for dots that indicated that the health professionals had a referral and were providing treatment to the patient. Once they had completed their interventions, they moved the dot to another

square which reflected that they had completed their interventions. It seemed that the dots were not consistently updated and the nurse unit manager attempted to determine if referrals had been made for allied health and assessments undertaken. However, the response from the team members was brief and possibly due to time pressure the nurse unit manager moved on to the next doctor's patient.

> *NUM — Where's the dots along here guys, who's in, do we know? Are these right or wrong or?*
>
> *Team member — Don't know.*
>
> *NUM — Your turn.*
>
> *Dr 3 — Hello.*
>
> *NUM — Hello, your turn. (Meeting 2)*

There was no time to clarify or get held up by other factors. The meeting was focused and organised yet still chaotic. There was a system to it, and everyone seemed to know what to do. I could see as the observations unfolded that there was an organised chaos about these meetings. It appeared that everyone knew their role and acted accordingly. Overall, the health professionals attempted to work collaboratively to make transfer decisions. They carried out individual assessments and tried to develop a plan together. While the multidisciplinary team meetings supported this, there was often conflict amongst the team about the transfer decision and a lack of time to make collaborative decisions. The absence of the registered nurse looking after the older patient as well as the fast pace of the meeting and the noisy environment impacted on their ability to collaborate and make effective transfer decisions.

4.6 Making Difficult Decisions

The health professionals described that making transfer decisions was often difficult, as they tried to seek the safest option when making these decisions. This is explored in the thread 'seeking safety'. The thread following that describes the challenges of 'accessing supports'. This was an important factor that impacted on their transfer decision, especially in cases where there was concern about the older patient's cognition, a factor which is explored under the thread 'questioning capacity'. The transfer decisions were difficult as they were often made under time pressure. The 'limited time' meant that they were not always able to fully consider their decisions.

4.6.1 Seeking safety

Health professionals talked about the need to assess a patient's risk factors when making transfer decisions. They aimed to make safe transfer decisions that minimised or addressed any actual or potential risks. The risk factors included an older patient living alone, exhausted carers, risk of falling, cognitive impairment, and concerns about the older patient's safety. In a situation where risk was identified that could not be managed, transfer options were altered. It was important to them that older people were safe, and they internally decided what this meant. Ellen (DP) said:

> … *you can't not have people safe* Ellen DP

The health professionals talked about safety as an important aspect, and they each held their own view of what a safe decision was. There was no singular definition of a safe transfer decision, as it was personal and discipline specific. They developed their own criteria for what a safe decision looked like, possibly because there were no set standards to support these decisions. Selecting an option that mitigated risk was a factor that the health

professionals described as impacting on their transfer decisions. They aimed to ensure that they assessed the older person's risk, which took time, but was important to help them get an idea of the older persons capabilities. They were prepared to use valuable time to determine whether the older patient was at risk. This was explained by the health professionals in my study. They described:

> *… probably it needs about a week, a good week to sort of observe the patient in hospital, how they do things, how they mobilise, are they going to be at risk?* Peter Dr
>
> *We'll do the best we can to get them home as safely as possible. But they're the ones who we feel are at highest risk*. Jane OT
>
> *It's like separating out all the risk factors and starting to identify why they make it unsustainable or unsafe for somebody to return home.* Katie SW

Ideally the health professionals want older patients to be able to return to their own homes yet they also need to ensure that the older patient is safe, and that risk is minimised. They were caught in the middle, trying to balance the older patients wishes to return home and the need to ensure that they would be safe. There was a lack of guidelines to follow that showed what a safe decision was, so they developed their own way of doing things and accepted that the older patient may well be at risk once home. This is illustrated by Jane (OT) who said:

> *We'll do the best we can to get them home as safely as possible.* Jane OT

As there were no set criteria for what a safe transfer decision was, there could be conflict amongst the team when there were different views in relation to risk. The more experienced a health professional was the more likely they were to accept a level of risk, while less experienced health professionals often made risk averse decisions. A safe decision was recommending transfer to residential aged care, but the more experienced health professionals were cognizant of the significant harm of sending someone prematurely to

residential aged care. This meant that they learnt to accept that transfer decision making involved accepting the inherent risk associated with older patients returning home. Lucy (CNC) and Phoebe (NUM) explained:

> *I think the selection as in their age and life experiences…I don't know if the barrier is in relation to the responsibilities they might feel if patients return, say after having a fall at home and they're trying to prevent that, or is it more the liability…* Lily CNC

> *People sometimes make decisions that aren't always in their better interests or necessarily without risk but some people, some of the different team members might view that risk in different ways…* Phoebe NUM

The health professionals attempted to mitigate risk, but the decisional process was fraught with barriers that made it difficult to decide if an older patient was able to manage safely at home. They questioned whether a transfer decision should be made in hospital, as older patients were deskilled and less able to improve. They felt there was a better way but did not know what this was, just that the process, as it was, was wrong. Ellen (DP) explained:

> …we deskill them, we take all their medications from them, we toilet them, we don't walk them, they don't get their meals, we do everything wrong. The worst thing we ever do is take that Webster pack off them… Ellen DP

This was not what the health professionals were aiming for. These situations were difficult, as they wanted the older patient to return home but practices that 'do to' rather than 'do with' can reduce an older patient's capabilities and make them more dependent rather than less. The need to have older patients safe overrode the need for them to continue to do the activities that they could manage. This could mean that they could no longer safely or independently manage the activities of daily living.

4.6.2 Accessing supports

While some health professionals were more able to accept transfer decisions that held a level of risk, they still utilised strategies to minimise that risk. The health professionals wanted older patients to be able to return home if possible. However, they also wanted to ensure that they had strategies in place to ensure the older patient was protected from risk of injury. The ability to access supports for the older patient in the community helped the health professionals to accept the risk associated with returning home and gave them the chance to remain at home. However, if it was not possible to access supports then transfer to a residential care setting was the only alternative. The health professionals preferred to make transfer decisions that gave the older patient the opportunity to return home with services and see if they could manage. They appeared proud of these actions when they were able to get the services they needed, to support older patients to return home. It was how they wanted to practise, and they gained a sense of patient-centred care when they spent valuable time arranging services which they could incrementally increase as time went on. Similar to the other health professionals Lucy (OT) and Lily (CNC) said:

> *…for patients if they haven't had services at home it's a big step to go from home to a nursing home but if you can send patients back home with services then you actually – you're at least trialling it a little bit each time.* Lucy OT

> *We just don't have the community resources to support that for everybody…we can't facilitate the time to be able to get to their peak before sometimes they're transferred into a residential care facility.* Lily CNC

The ability to access rehabilitative programs, such as transitional aged care, provided an alternative to recommending transfer to residential aged care. However, some health professionals found accessing the program difficult, mostly due to the need to get a member of the Aged Care Assessment Team to conduct an assessment to determine the older patient's eligibility for transitional aged care. This caused frustration and stress as they

wanted to give older patients the opportunity to return home, yet were reluctant to use services that were associated with delays. Cath (PT) described her frustration when trying to access transitional aged care support.

> *…we've had issue with ACAT assessing them as not suitable for TAC… You have to go through and make this big paper trail of almost excuses so that they can get services so that they don't go into placement.* Cath PT

The delay in accessing transitional aged care and the resulting team frustration was also witnessed during Meeting 3 of the multidisciplinary team meetings. In this situation the team was discussing their plan for an older patient to go home with transitional aged care support. To access transitional aged care requires an assessment by the aged care assessment team as well as approval by the transitional aged care team. This can cause delays.

> *Dr — When's the ACAT coming, not today?*
>
> *NUM — Wednesday, Thursday, Friday?*
>
> *Physio — Well I put the referral in yesterday, they'll give me a call and let me know when they can do it.*
>
> *NUM — So we are looking at maybe Thursday.*
>
> *Physio — No.*
>
> *OT — Friday at best.*
>
> *SW — But that's crazy (Meeting 3)*

The frustration for health professionals to have to wait three days for an assessment was obvious. They were aware of the process, that older patients needed to be approved by the aged care assessment team as eligible for transitional aged care, but were concerned about the delay. The health professionals knew that the older patient would benefit from transitional aged care but also knew that there were other people who may need the

hospital bed. This led to them being frustrated but resigned to wait for the assessment so that the older patient could get the support they needed to return home. This experience was not unique to them, overall using services that were not able to start quickly caused delays and frustration. Health professionals preferred to seek alternatives to services that were associated with delays. They weighed this up and while they were often frustrated with the delay, they were prepared to wait for services that provided comprehensive, restorative care that gave the older patient the support they needed to stay at home.

4.6.3 Questioning capacity

The health professionals were aware that older patients may have alterations in cognition which affected their decision-making capacity. This was an important factor that impacted on their transfer decisions as they wanted to ensure older patients had cognitive capacity to participate in transfer decisions. In cases where the older patient was cognitively able to make decisions and wanted to return home, even if that was not the team's recommendation, they explained the risks and supported their right to self-determination. John (SW) explained:

> *So when we're 100 per cent clear that in terms of their cognitive function they can make decisions for themselves, we do our assessment. We say this is our recommendation. If they agree with it, we run with that. If they disagree, we then tell them, okay, these are the risks.* John SW

This is the ideal, where an older patient is cognitively able to make decisions even if they were risky. However, for older people who had cognitive impairment to a level when they were no longer able to make complex decisions the health professionals often in conjunction with the carers were aware that they needed to ensure that the older patient was safe. This was a difficult process as they wanted to consider the older patients wishes, yet when there was a concern about the cognitive capacity of the older patient the health professionals felt

the need for safety outweighed the wishes of the older patient. Having access to a reliable carer often increased the transfer decision options that the health processionals could choose from and is discussed later in this section. Health professionals wanted to protect older people with diminished capacity which they felt was the right thing but were also aware that it was difficult to do. This was a common experience and is shown by Peter (Dr) who said:

> *If they don't have capacity then safety is your overriding concern. That takes precedence over the patient's wishes... In practical life it's not that easy.* Peter Dr

When the older patient had, or may have a cognitive impairment the transfer decision became increasingly difficult. There were a range of issues that contributed to this complexity. Capacity fluctuates and can be difficult to assess, and just because a person has altered cognition does not mean they cannot make their own decisions. Cognition can be situationally specific; this means a person with a cognitive impairment may be able to make simple decisions but may not be able to make high functioning complex decisions such as weighing up the risk of going home. The health professionals were aware of this and had their own measure of capacity, which was unique to them. This could be difficult, as members of the multidisciplinary team held vastly different views on capacity. The potential risks for an older patient with diminished cognition are significant and health professionals held strong, yet diverse, beliefs about the capacity and level of risk for an older patient. These decisions were difficult and complex. Lily (CNC) explained:

> *I think that the most difficult case that we have or cases that we have are people with cognitive impairment.* Lily CNC

Health professionals were often involved in cases where the older patient had a cognitive impairment. These situations were difficult as the health professionals did not always reach consensus when making transfer decisions with cognitively impaired older patients. This was because the health professionals had their own way of determining what an accepted level of capacity was and they stood their ground when their decision was not supported. Interestingly, they did this with minimal decisional tools, instead they appeared to have an internal threshold of the level of cognition needed to return home, which could be altered depending on the level of supports available. The different perspectives within the multidisciplinary team caused conflict. Lucy (OT) described:

> *I think that doctors are sometimes a barrier and other staff because obviously sometimes - a patient who is extremely unsafe and we know has cognitive issues and we feel from a safety point of view isn't right to go home the doctors might say well they've still got capacity to make their own decision.* Lucy OT

They staunchly stood by their decision even if the doctor did not agree and were concerned for the safety of older patients with a cognitive impairment who went home. The challenges associated with determining capacity meant that there was often disagreement about the capacity of an older patient to make decisions. Working in a multidisciplinary team brings a comprehensive perspective but can also be a somewhat siloed process, as each professional discipline has its own unique focus. This focus could be comprehensive or narrow depending on the situation. However, problems arise when health professionals focus on a discipline-specific issue. This was demonstrated through Linda's (PT) experience as she explained:

> *So you'll often have people coming from a different perspective, in that, they're not safe from whatever perspective. Say it might be cognitive, but they're not deemed as not having enough capacity...and the patient really wants to go home. Mobility wise they're safe but there'll be other team members driving from a different direction of they're not safe* Linda PT

Ideally, as part of a collaborative team each health professional does their assessments and then shares the information with the multidisciplinary team. In some cases, different disciplines do their assessments together, but health disciplines have their own perspective which often represents one part of the whole picture of what is happening for the older patient. The individual perspectives combine to make a multidisciplinary transfer decision, which intends to ensure that an older patient with a cognitive impairment is safe. Although this was not always the case, as there could be disagreement about whether the older patient was able to return home. Lucy (OT) said:

> *I think that doctors are sometimes a barrier and other staff because obviously sometimes - a patient who is extremely unsafe and we know has cognitive issues and we feel from a safety point of view isn't right to go home the doctors might say well they've still got capacity to make their own decision.* Lucy OT

In these situations, the health professionals argued for their decision but ultimately the doctor, using all the information from the multidisciplinary team and their own assessment makes the decision. While there can be disagreement about the transfer decision amongst the multidisciplinary team, the cognitively impaired older patient, family, and carers may also not agree with the transfer destination recommendation. This increased the complexity of the transfer decisions. Interestingly, from the health professionals' descriptions of their experiences, families and carers were more likely to recommend that an older patient with cognition problems should transfer to residential care. In situations like this the health professionals often placed more weight on the carer's decision than the older patient. The health professionals understood that if the carer could not support the older patient, who had a cognition problem, at home, they were more likely to recommend transfer to residential aged care. It was apparent that the wishes of the family and carers were focused on more than the older patients, even if the health professionals did not think the older

patient needed to transfer to residential aged care. The health professionals were aware that when an older patient had alterations in cognition it was only natural that the carers have more input. Grace (SW) explained her experience which was similar to the health professionals. Grace (SW) said:

> *If there are cognitive issues, I think people naturally listen to the carer or the person responsible, far more than the patient...I think those families tend to be more reactive and they seem to want to look at placement far earlier than I think is necessary.*
> Grace SW

An older person with cognition problems that lived alone was more likely to be transferred to residential care. Having access to a carer minimised the risk as there was someone there who could support the older patient to stay at home, as long as the carer was able to maintain support. However, the health professionals were concerned about the vulnerability of older people, especially those with cognition problems. In situations where the older patient, family, or carers insisted the older person return home, despite a lack of ability to provide care, the health professionals considered applying for guardianship. This usually arose from situations where they had concerns about elder abuse, neglect, safety, or significant cognition problems.

This was an onerous process and took extended periods of time. In some cases the older patient could wait for the guardianship process at home. However, if that was not possible the health professionals needed to argue for the older patient to remain in hospital, even though this could be difficult as the guardianship process could take several months and until a hearing was held the older patient cannot be transferred. The health professionals described the reasons why guardianship may be needed, and the problems associated with the length of time this could take. As Peter (Dr) and Grace (SW) said:

> *The other main thing that we are seeing a worrying trend of is patients waiting for guardianship who require placement. It takes about roughly six weeks for even the tribunal to receive the application and set a date...* Peter Dr

> *So it could be elder abuse: if the person they're living with is physically abusive or psychologically abusive, or maybe financially abusing them, any kind of abuse….Usually, we're all in agreeance on that; but because of this length of stay thing and because guardianship takes three months, sometimes you do need to argue the case a little harder than other things.* Grace SW

The length of time it took to go through the guardianship process as well as the associated stress and exhaustion meant that the health professionals viewed the guardianship process as challenging. They tried to do what was necessary to ensure the older patient with cognition problems was safe and they also wanted to avoid a long length of stay while the older patient waited for guardianship in hospital. It appeared that the need to reduce long lengths of stay seemed to override ethical considerations. Katie (SW) acknowledged that the situation was manipulated in order to avoid waiting for a guardianship application to be processed. Interestingly, Katie (SW) felt that this was the right thing to have done in order to avoid the lengthy guardianship process.

> *So even though she's got poor short-term memory loss and she does have a dementia, the geriatrician has had a conversation with her about power of attorney and what that means and who she might appoint. She's identified this family as being her friend. So, it's going that way. It's had to be manipulated a bit to go that way. But it's the right decision... it's the right decision for a short-term decision that was urgently needed, because guardianship would have taken such a long time…* Katie SW

There was considerable confusion surrounding guardianship, along with a shared understanding that guardianship was often necessary but if possible was to be avoided. The health professionals questioned this and tried to advocate for the older patient, but they were often overridden. During Meeting 1 of a multidisciplinary team meeting the team discussed the plan for a cognitively impaired older patient who was recommended for transfer to residential aged care. The team discussed that this patient was significantly

cognitively impaired and said “yes” to everything that was asked. While the team felt that this response did not consistently reflect what the patient felt or wanted, as long as the patient was not objecting to the transfer, the health professionals were able to transfer to residential aged care without requiring further assessment for guardianship. While concerns were raised about this, they were prepared to do things that did not sound or feel right when making transfer decisions, possibly due to the underlying pressure to make decisions quickly.

> *NUM — Yeah the family want her to go but it doesn’t matter if she agrees or doesn’t agree if she doesn’t have capacity.*
>
> *OT — Have they got power of attorney or?*
>
> *Dr 1 — No if she doesn’t have capacity but she agrees and the family agrees then we can skip the RUDAS the neuropsych part isn’t it?*
>
> *NUM — OK so if they’ve got dementia and they don’t really know what they are saying they say “no” then we have to get neuropsych but if they have dementia and they don’t know what they’re saying and they say “yes” we don’t have to?*
>
> *SW — Yes.*
>
> *Dr 1 — Yes.*
>
> *NUM — It’s not right, something’s not right in that sentence (Meeting 1).*

This example highlights what was a significant issue for health professionals that impacted on their transfer decisions. The need to ensure people transitioned through the hospital was challenged when the older patient had cognition problems to the point where guardianship was needed. They talked about these situations as the most difficult. There were limited guidelines and questionable strategies that were adopted to ensure the older patient was safe. They were prepared to stretch ethical boundaries and justified their actions as they felt they were doing the right thing for the older patient, family, carers, and the wider community.

4.6.4 Time pressure

The lack of time was a major factor that impacted health professionals' transfer decisions. They talked about time pressure as a constant focus which impacted on their transfer decisions. Like their discussion of the guardianship process, the health professionals in this study were constantly aware of the time it took to make transfer decisions. They described feeling pressured due to a variety of factors to make decisions quickly. Grace (SW) commented:

> *So it does feel like, at times, decisions are made too quickly. That's about the pressure of the ward and the number of referrals and the inability to have private conversations in busy rooms with people.* Grace SW

The health professionals described a difficult balance between ensuring the older patient had time to make appropriate transfer decisions and that people had access to a hospital bed. They described being constantly aware that there were multiple people in the emergency department awaiting a hospital bed. They attempted to balance the needs of a person who was waiting for a hospital bed and the need to make appropriate transfer decisions. The pressure was compounded by policies and processes in relation to the estimated date of discharge as well as length of stay and were concerned that an older patient may have been able to return home if they had had more time. This was a significant issue for the health professionals which is demonstrated by Peter (Dr), Linda (PT) and Lily (CNC) who said:

> *…we really have to come to a decision where this patient goes. It is hard to sort of tell families that you are a little bit on the clock …I think it's not a great argument to them that you're trying to free up beds in an already packed public system...* Peter Dr

> *We always feel that pressure here because people would benefit, and maybe have greater options around returning home if we had more time.* Linda PT

> *Here is an acute hospital so it's about average length of stays, there's benchmarks that the hospital through to the ministry are accountable to... In the past our greatest length of stay has been patients waiting for placement.* Lily CNC

This became evident when the decision had been made that the older patient was going to transfer to residential aged care. However, while waiting for the aged care assessment team to carry out an assessment to determine the older patient's eligibility to enter residential care the patient had time to recover sufficiently so they no longer needed it and were able to return home. This caused concern for the social worker who viewed the situation as evidence that the transfer decision had been made prematurely.

> *…if they're looking at placement and that decision's made. Sometimes you can see it's been made too quickly because then by the time ACAT have gone in and whatever, people have picked up enough that - no, now you can go home actually. That's a concern...* Grace SW

Health professionals were aware of the impact and were concerned that older people in hospital were not given enough time to process what was happening before being asked to make such life changing decisions. The impact of leaving your home to enter hospital and be told that you cannot return home can be life changing for the older patient and the health professionals questioned whether this decision should be made in hospital. They knew that older patients were in an unfamiliar environment and still recovering from a change in health when they make these decisions but were also aware that hospital may not be the best place for the decision to me made. As Sarah (RN) explained:

> *I just wonder if the time frame that people are given from the presentation to hospital and the decision making of having to change your life completely, leave your home that you have known for many years. Is that appropriate?* Sarah RN

The health professionals described wanting to work with older patients who were unwell and give them time to improve but this was difficult in the hospital environment. Social workers, in particular, found that the therapeutic perspective they used to work through

peoples' grief and loss, related to transferring to residential aged care, took time and put them at odds with the quick fix, discharge-focused process in hospital. Katie (SW) said:

> *… so you can see why the ward, who's only interested in discharge, want a quick fix. But it isn't a quick fix...So we've seen that before with doctors and other people who will just say you're going to a nursing home, and the person saying, no, I'm not. Oh, yes you are... Katie SW*

The pressure to discharge quickly was felt mostly by social workers, as they were an important part of transfer decision making. They felt that the process was often adversarial, mainly when there were delays which seemed to be placed on the social workers. The social workers were held responsible when there were delays and while they wanted to give the older patient more time to make decisions, they were pressured to do things quickly. The pressure to make decisions quickly often came from discharge planners, nurse unit managers and senior nursing management. Grace (SW) explained:

> *Always the medical treating team and the discharge planner...sometimes even more senior nursing management. There was a time when the deputy director or even the director of nursing would come to our allied health team meetings. With the aim of moving people through the hospital system faster, it seemed, the pressure would come from there...Grace SW*

Similarly, the delays in getting the aged care assessment team's approval for a transitional aged care service in the community, the health professionals also experienced pressure to get them to assess people for entry into residential aged care. This was compounded by staff shortages as well as waiting for families and carers to make the decision. This caused considerable frustration as system delays, which the health professionals had minimal control over, slowed down the process. They felt responsible for anything that caused delays

but had limited opportunity to do anything about it. This is highlighted by Henry (Dr) and Chloe (NUM) who said:

> *Well it can be the slowness of getting the ACAT assessment done. Occasionally it's families perhaps not able to come to the difficult decision of agreeing with our assessment that the person needs care...* Henry Dr

> *Then ACAT have to come and see the patient. They have to formalise the process. That can take a couple of days. It's very annoying… the Ministry of Health, the KPIs for getting patients out of hospital - the pressure's on.* Chloe NUM

Similarly, in the observation component, health professionals followed up referrals and assessments to ensure they had been received and were acted on. This was done because they did not trust referral pathways. To address their concerns, they followed up referrals to ensure that the older patient's family and carers would be seen as soon as possible. They felt they needed to be on top of what was happening to avoid delays.

Overall, the health professionals described feeling the pressure of a lack of time. They described a jumping through hoops process of team decisions and working with the older patient, family, and carers. Once there is agreement to transfer to residential aged care they referred to the aged care assessment team for an assessment which could take precious time. This process takes time, which makes it difficult to meet the expected discharge date and increased the frustration and pressure.

4.7 Summary of Clusters and Themes

The three clusters and eight threads presented in this chapter provide a phenomenological description of health professionals' lived experience in making transfer decisions with older patients in hospital. The clusters were developed through the application of Colaizzi's phenomenological approach to the interview and observation data. The first cluster 'exploring options' explored the processes the participants used to reach a transfer decision.

The threads of ‘identifying cues and triggers’ and ‘drawing on clinical judgement and experience’ reflected the decisional strategies they used.

The second cluster ‘collaboration and conflict’ explained the collaborative nature of health professionals’ transfer decisions with older patients in hospital. The thread ‘working with older patients, families and carers’ described the collaborative strategies health professionals used to inform their transfer decisions. The second thread of making ‘individual and team decisions’ examined the strategies the health professionals used to make collaborative decisions.

The third cluster of ‘making difficult decisions’ showed the significant challenges that were an inherent part of the health professionals’ experiences of making transfer decisions with older patients in hospital. The thread of ‘seeking safety’ illustrated the precarious balance the health professionals aim for between ensuring an older patient is safe while also accepting a level of risk that can arise when making these decisions. The thread ‘accessing supports’ presented how health professionals’ transfer decisions are influenced by the ability to access alternatives to transfer to residential aged care. The third thread of ‘questioning capacity’ examined the unique decisional challenges for health professionals making transfer decisions with cognitively impaired older patients in hospital. The fourth thread of ‘limited time’ showed the significant pressure health professionals experienced when making quick decisions about transfer in hospital and the impact this had on their transfer decisions.

The phenomenological description intended to create a shared understanding of health professionals' experiences making transfer decisions in hospital. To support this, examples were used to highlight the clusters and threads. This helped to generate a shared understanding of the phenomenon. Through the shared understanding the previously unexplored experiences of health professionals' transfer decision making with older patients in hospital have been uncovered. These findings can be used to inform practice, future policy development as well as initiate the development of training and education in transfer decision making.

4.8 Chapter Summary

In this chapter I presented the findings which emanated from the interviews and observations of health professionals' transfer decisions with older patients from hospital. The findings were developed through the application of Colaizzi's seven-step phenomenological approach and the perceptual description which led to the comprehensive description. The findings were presented through the comprehensive description with an emphasis on the clusters, developed in Step 4, as these brought out the finer aspects of the health professionals' experiences. I also presented the overarching statement about the phenomenon which emanated from the synthesis of the interview and observation findings. Examples taken from the transcripts were used to illustrate the comprehensive description of the investigated phenomenon.

The findings showed that health professionals considered transfer options for older patients. They did this by looking for cues and triggers to inform their decisions. The health professionals had developed their clinical judgement over time and relied on this to help them make sometimes difficult decisions. In an attempt to reach a transfer decision the

health professionals collaborated with older patients, families, carers, and the multidisciplinary team. However, they tended to focus on the needs of the carer rather than the older patient. It was apparent that if a carer was no longer able to continue supporting the older patient there were limited alternatives other than transfer to residential aged care, even if this was not what the older patient wanted.

Communication amongst the older patient, family, carers, and the multidisciplinary team was an important part of transfer decision making. Communication was supported through multidisciplinary team meetings, case conferences, and team collaboration. The multidisciplinary team meetings in some ways supported team decision making but the fast pace and noisy environment minimised the depth of the discussions. I was particularly aware of their resilience as they continued to negotiate and collaborate within the multidisciplinary team as well as with older patients, families, and carers when they considered that the transfer decision was not going to plan. However, the registered nurse who looked after the patient was not usually involved in the process, which may have reduced the effectiveness of their transfer decision. Case conferences were also used as a way to collaborate, yet the ability of the older patient to utilise autonomy was diminished and in some cases the older patient was not the principal decision-maker.

Overall, the health professionals attempted to make safe decisions which were limited by difficulties accessing supports. Accessing supports meant that the older patient had an opportunity to try to manage at home, although the delays associated with accessing services caused frustration. Health professionals' lived experience in making transfer decisions with older patients who had altered cognition were challenging. They staunchly stood by their individual decision, which could be different for each health professional. It

was unclear ground for them, as there were no guidelines to support these decisions. This became even more problematic when guardianship was being considered. It appeared that anything that was associated with a delay, caused problems for the health professionals who were constantly aware of the need to move people through the hospital quickly. Time pressure was a part of the transfer decision process, which they had learnt to accept even though they would have preferred to have more time. Making decisions quickly was inbuilt in their processes, which they accepted, although they were increasingly frustrated by anything that caused delays.

The health professionals used cues and triggers as well as their experience to make transfer decisions. Their clinical judgement was vital and was developed through their experience. The experience of making transfer decisions involved some level of conflict but also collaboration. They aimed to work with older patients, families, carers, and health professionals to reach a decision which was often informed by the needs of the carer. Strategies such as multidisciplinary team meetings and case conferences could support transfer decision making yet it appears that there were barriers to effective communication, which minimised the effectiveness of these strategies in some cases. The emphasis on making safe, timely transfer decisions was significant and they attempted to balance this which sometimes worked and sometimes did not.

In the next chapter I discuss the findings in detail. This discussion is presented within the broader context of the literature on health professionals' transfer decisions in hospital. The discussion chapter concludes by presenting the strengths and limitations of the study.

Chapter 5
Discussion

In the previous chapter I presented the findings that emerged through the application of phenomenological methods to the interview and observational data on health professionals' transfer decisions with older people in hospital. This chapter presents a discussion of the findings in the context of the literature and explains the strengths and limitations of the study. A theoretical framework of Cognitive Continuum Theory is also considered in the context of transfer decision making. The catalyst for my study came from a combination of: professional experience I gained when working as a discharge planner in hospital; an increasingly ageing population; a higher incidence of disease and disability associated with age; the proportion of older people admitted to hospital; the impacts on the older person of transferring to residential aged care; and the lack of knowledge and understanding of health professionals' decision-making processes when recommending that an older patient should transfer to residential aged care direct from hospital.

In an attempt to address this lack of knowledge, in conjunction with the research supervisors I developed and conducted this phenomenological study in an effort to gain an understanding of how health professionals make transfer decisions with older patients from hospital to residential aged care. In this study automatic objectivity was not the focus, rather I attempted to achieve objectivity by becoming acutely aware of my own position as a researcher and nurse discharge planner through phenomenological reflection. This helped me to bracket my own experience as I analysed the data and listened to, as well as observed health professionals. As every attempt to achieve the epochē was practised, the findings were still developed by me. This meant that I needed to remain, at times, connected and at

other times disconnected to my experience. To achieve this, I practised stepping in and out of the epochē to gain a deeper understanding of the participants' transfer decision making with older patients in hospital. This understanding is presented in this chapter in the context of the literature and developed from the findings.

The significance of this research is that, to my knowledge, it is the first phenomenological study that has examined multidisciplinary health professionals' transfer decisions with older patients from hospital to residential aged care by using observations and interviews. Understanding how they make these decisions is important as studies have shown that the older person is not always included in the transfer decision-making process (Cox, 1996; Ekdahl et al., 2012; Rhynas et al., 2018). Participating in decisions of where and how we live is central to our ability to live autonomous, self-determined lives, therefore understanding how these decisions are made is important for older people, families, carers, health professionals, hospital administrators, policy developers and the wider community in Australia and internationally.

This chapter begins by re-presenting the research aims and objectives, followed by a discussion of the four major aspects of the findings in the context of the literature. This is followed by an explanation of the contribution to knowledge that arose from the study as well as my recommendations for future research, education, and practice. The last section presents the strengths and limitations of the study.

5.1 Discussion of Findings

The focus of my study was to address the research question which aimed to gain an understanding of the lived experience of health professionals making transfer decisions with older people from hospital to residential aged care. The way to address the research question through a phenomenological perspective was to explore the health professionals' experiences of transfer decision making with older patients in hospital through their descriptions of their experiences and observations of them making these decisions. The aim was to explore and describe the factors that influenced their decision making as well as come to an understanding of their experiences. To develop this understanding, a phenomenological approach informed by Husserl was used. As described in Chapter 3, interviews were conducted with 16 health professionals who had two or more years' experience making transfer decisions with older patients from hospital to residential aged care. Additionally, I observed four multidisciplinary team meetings where transfer decisions were made, with the objective of gaining an added perspective to the interview transcripts. Interview transcripts were analysed through Colaizzi's seven-step approach. The observation transcripts were analysed utilising Colaizzi's perceptual description method combined with my descriptions of the environment. The analyses of the interviews and observations were then synthesized into an overarching statement that comprehensively describes health professionals' experiences of transfer decision making with older patients in hospital. The methods and methodology to achieve this are explained in more depth in Chapter 3.

The five objectives were to:

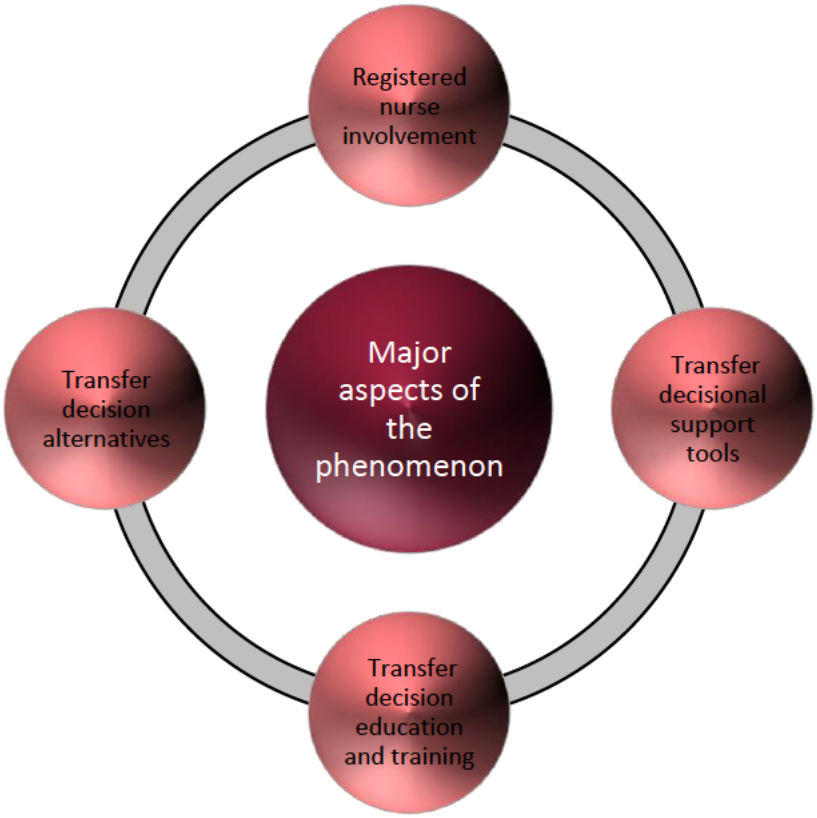
1. Explore how health professionals perceived their role in the overall decision-making process prior to aged care assessment team referral.
2. Examine what informs health professionals' decision making when assessing an older person prior to the aged-care assessment team's referral.
3. Explore the assessment tools health professionals use to inform their decision making.
4. Describe the enablers and impediments health professionals identify which affect their decision making.
5. Describe the satisfaction health professionals experience when participating in the decision-making process related to the transfer of older patients from hospital to residential care.

Initially, these objectives provided a way to organise the analysis. However, further iterations led to clusters and threads being developed that more effectively presented the essence of the health professionals' experiences in making transfer decisions. This aided the elucidation of the more complex descriptions involved in the study, which are presented in Chapter 4. The current chapter aims to address the research question which drove this study. What is the lived experience of health professionals making transfer decisions with older people from hospital to residential aged care? Through the research objectives the response to this question is provided in the context of the literature as well as the theoretical framework, and is presented under two main headings of:

- Role and assessments (Objectives 1, 2 and 3)
- Informing decisions, enablers, barriers, and satisfaction with the process (Objectives 2, 4 and 5)

This chapter also presents the four major aspects of the phenomenon that were disclosed through the application of Colaizzi's approach and informed by Husserlian phenomenology. Through the findings chapter, four aspects were identified as factors that significantly impacted health professionals' experiences of making transfer decisions with older people from hospital to residential aged care. The four aspects of the findings are outlined in Figure 5.1 and are discussed in this chapter. The essence of the phenomenon cannot be articulated in a few words. Instead, as has become apparent with the overarching statement, the essence of the phenomenon presents itself in a complex fashion. Figure 5.1 is an attempt to capture the interconnections that make up the four major aspects of the phenomenon.

Figure 5.1 Four major aspects of the phenomenon



5.1.1 Role and assessments

This section explains two aspects of the findings in this study. Section 5.1.1.1 addresses objective 1 in my study by discussing the health professionals' role in making transfer decisions and identifies the first aspect. The second section (5.1.1.2) addresses objectives two and three and three by discussing the assessments health professionals used to inform their decisions, and outlines a gap in transfer decision making that forms the second aspect in this study. The combination of interviews and multidisciplinary transfer meeting observations enabled a deeper insight into their experience and acted as an adaptive response to Step 7 of Colaizzi's approach.

5.1.1.1 Health professionals' role

Health professionals had a significant role in providing quality health care to older patients, especially during transitions of care. The specific role of the health professional impacted on their assessments and, in turn, their decision making. Doctors understood that older patients' functional ability, access to supports as well as the wishes of the patient, family and carers needed to be considered when making transfer decisions. Yet the doctors focused on assessing and addressing issues with overall health and identified when a patient was medically ready for discharge. They took a global view of the medical, physical, and social health of the older patient and ensured that the multidisciplinary team was preparing an appropriate plan for discharge. This is consistent with the findings of an American qualitative study on physicians' roles in care transitions conducted by Kane (2011), who reported that doctors held authority in the hospital setting and took an oversight or delegating role when making transfer decisions. It is noted that the Kane study applied to doctors only and was a targeted literature review which may not reflect their actual practice.

From the findings in my study it became evident that each profession tended to concentrate on their discipline specific role. The occupational therapists conducted assessments of function, cognition and supports; similarly, the physiotherapists assessed function and supports. These assessments informed their transfer decisions. The emphasis on functional capacity and supportive elements is also featured in a discussion paper on multidisciplinary health professional's safe and timely hospital discharges in the United Kingdom by Johns et al. (2011). The social workers and registered nurses were more likely to use informal assessments and attempted to look at the whole picture of what was happening for the older patient, family, and carers. This was particularly evident for those nurses who worked

in specialised discharge planning and management roles, although the social workers tended to try to 'pull things together' to make a comprehensive transfer decision.

A qualitative study on the role of social workers in transfers from hospital to residential aged care by Phillips and Waterson (2002) also found that social workers' assessments were central to transfer decision making, yet they preferred to focus on the person not the assessment process. Similarly, Johns et al. (2011) described that social workers role in transfer decision making involved reviewing their own assessments in the context of the physiotherapist and occupational therapist's assessments in order to develop a comprehensive transfer plan. While this was the ideal, in my study the social workers found it difficult to consistently communicate effectively with the multidisciplinary team which led to conflict and potentially unsuccessful discharges. One reason for this may be that the hierarchical nature of the transfer decision process was where medical dominance at times overrode team decisions.

Interestingly, in my study there was only one registered nurse that provided direct patient care who described their lived experience of making transfer decisions with older patients. However, this registered nurse did not describe any transfer specific assessments or participation in the multidisciplinary decision-making process. This is in contrast to the study conducted by Wright et al. (2001), which found that registered nurses who worked in hospitals in the United Kingdom conducted assessments when transfer to residential aged care was being considered, although it was not clear what these assessments were and there was no discussion of further involvement from nurses.

The absence of the registered nurse in transfer decision making was identified by a social worker in my study as a gap in the transfer decision process. This was also witnessed in the multidisciplinary team meetings, where registered nurses who took a patient load did not attend and there was an overall lack of discussion of nursing considerations. Instead, nursing discussions were limited and predominately focused on clinical treatments. Registered nurses spend the most time with the patient and are in a unique position to understand older patients' abilities and wishes (Abdool et al., 2016). It is acknowledged that nurse unit managers and discharge planning nurses have an oversight role which differs to the role of a registered nurse. While discharge planning nurses and nurse unit managers may well collaborate with registered nurses before multidisciplinary team meetings, this was not observed or described by the participants in my study.

One reason for this could be that nurse discharge planners may have taken on this task for the registered nurses who already had a high workload and possibly did not have the time needed to arrange complex transfers. This is supported by other studies which found that registered nurses felt they had no formal role in transfer decision making to residential aged care (Reed & Morgan, 1999) as they preferred to refer patients, who were not recovering as expected, to the multidisciplinary team for more complex discharge planning (Johns et al., 2011; Rhudy et al., 2010).

The absence of registered nurses in the multidisciplinary team meeting and transfer to residential aged-care decision process is a major aspect of the findings in my study. This was unsurprising to me in terms of my career, as I was aware that registered nurses were not included in the transfer decision meeting or the transfer decision process. However, I did not expect that they were still not included in these meetings, given their unique knowledge of

the older patients' abilities. As registered nurses have the most direct patient contact (Abdool et al., 2016) they gain their understanding of an older patient's capabilities through ongoing care provision rather than targeted assessments. This means they are more likely to know whether the patient can safely take medications, manage their food and fluid intake and initiate the activities of daily living.

As previously noted, it was a difficult task to suspend my judgement, as I knew that the input of registered nurses was not valued. I consistently applied the epochē and used the reflective journal to ensure that I was staying connected to the participant's experience. My journaling allowed me to maintain some objectivity within this phenomenological endeavour. Developing the phenomenological reduction (section 3.9.3) by identifying my preconceptions and documenting them in my reflective journal helped to support the development of the epochē and reduction. This ensured that participants' experiences were heard.

The first major aspect of the findings in this study is that registered nurses, who took a patient load, were not consistently included in the transfer decision-making process. This has implications for the effectiveness of transfer decision making, as the health professional who spends the most time with the patient is not included.

5.1.1.2 Health professionals' assessments

The second major aspect of the findings is that health professionals conducted a range of assessments to inform their transfer decisions, yet they predominately drew on their experience to make a transfer decision with minimal, if any, evidenced-based, comprehensive transfer decisional tools. Occupational therapists and physiotherapists often used functional assessment tools, yet other health professionals rarely used formalised

assessment tools. The use of analytical assessment tools by some health professional's, but not by others is interesting. From a cognitive continuum theory perspective this indicates that some health professionals used a balance of intuition and analytics to make decisions, while others used analytical decision making. Analytical decision making is more likely to be applied through standardised assessment tools. Yet analytical decision making of assessments that predominately focus on function, on their own, are not as reliable as when it includes other factors such as intuition and patient preferences.

This is supported by other studies which reported that standardised assessment tools that support health professionals' transfer decisions are often focused on functional ability (Jette et al., 2003; Phillips & Waterson, 2002; Unsworth, 2001; Wright et al., 2001) rather than the opportunity to improve (Hoare, 2004), and do not include the older patient's choice (Kendall & Reid, 2017). In my study, discipline specific assessments were often conducted independently, and the outcome discussed with the multidisciplinary team. When conducting assessments that informed transfer decisions it appeared that the health professionals had a job to do and they predominately stayed in their discipline specific silo. In some ways this is similar to the findings by Wright et al. (2001) who reported that discipline specific assessments were often repetitive, disjointed, contradicted other members of the multidisciplinary team and focused on identifying problems with no link to solutions. It is recognised that the study published in 2001 is older and it was hoped that this was not the case now, yet it appears that there has been little change in this area.

The lack of comprehensive multidisciplinary assessment tools and decisional supports for health professionals' transfer decision making raises concerns in an evidenced based environment. There are screening processes to identify patients who require more

comprehensive discharge support (Department of Health NSW, 2011) and predict a discharge destination in a specific situation (Unsworth, 2001). Yet, validated assessment and decisional support tools for multidisciplinary health professionals transfer decision making were not evident and even if they were, the health professionals were unlikely to use them. Through the cluster "exploring options" and the thread of 'identifying cues and triggers' this idea was brought out, as the participants' experiences of making transfer decisions did not involve consistent use of assessment tools. In fact, the lack of assessment tools appeared to suit them, as they felt these decisions did not fit a 'tick a box' system.

In terms of assessing, nurses, in dedicated discharge planning roles felt they had a key role in transfer decision making as coordinators of the discharge plan. However, as Rhudy et al. (2010) found, ward registered nurses' role in transfer decision making in the United States of America was aimed at transfers that progressed as expected and they referred patients to the discharge planner if there were any barriers to transfer. The nurses in my study, who worked in designated discharge planning or management roles, reported and were observed to significantly contribute to transfer decision-making processes and plans. However, I noted from the interviews that the less experienced health professionals appeared to avoid taking a coordinating role. The more experienced health professionals developed their assessment and transfer decisional skills over time — for less experienced health professionals there were minimal decisional supports.

From a Cognitive Continuum Theory perspective, the lack of validated transfer assessment tools may limit health professionals' ability to utilise analytical decision making and overly rely on intuition. Since intuition, especially for those health professionals with minimal experience, is unreliable, it is concerning that there are minimal assessment tools that support a transfer decision. While assessment tools exist, they predominately focus on

function and do not provide a guide to what this means in terms of transfer decision making. This is concerning and is likely to impact on the effectiveness of their transfer decision making. Ideally, the task of transfer decision making should include a combination of intuitive and analytical cognition, as this is the most reliable decision-making process. The lack of decisional support tools is a new major aspect of the findings and is consistent with my own experience where I have identified that comprehensive multidisciplinary assessment tools and transfer decision support were not evident.

5.1.2 Informing decisions: enablers, barriers, and satisfaction with the process

The health professionals in my study described factors that informed their transfer decisions. Through these descriptions they also identified the factors that enabled, or were barriers to, their transfer decisions. The multidisciplinary team meetings which I observed confirmed and sometimes contradicted their own descriptions. It is not clear why this was the case. In an attempt to understand this, I used the epochē as a way to immerse myself in their experience and seek to understand why their descriptions of what they did was different to what happened (example in section 4.5.2). I do not mean to indicate this was always the case, but it did occur sporadically and was interesting, as they seemed to want things to be a certain way and were brought back to the real transfer decision-making world where things did not always go how they wanted.

Section 5.1.1 addressed the first, second, and third objectives in this study and presented two of the four aspects of the findings in this study. The next section addresses the second, fourth and fifth objectives and presents the third aspect that emerged through the adapted Step 7 of Colaizzi's approach as a key factor that impacted on their transfer decisions. The third aspect of the findings relates to the lack of education to support health professionals'

clinical judgement in transfer decision making. The first component presented in this section is the importance of health professionals' clinical judgement, developed through experience, to enable their transfer decisions. The next component was the impact of time pressure on clinical judgement and decision making. This is followed by the challenging process of making transfer decisions with older patients with cognition problems. The final component that impacts on the health professionals' clinical judgment is the ability to access supports.

5.1.2.1 Clinical judgement

Experience enabled the health professionals to recognise patterns that indicated an older patient may require transfer to residential aged care. Their experience also informed their clinical judgement and helped them identify potential risks as well as support the needs of the carers. The impact of risk and the needs of carers on health professionals' transfer decision making is also considered in other studies (Atwal et al., 2012; Clemens, 1995; Cox, 1996; Denson et al., 2013; Devnani et al., 2017; Kendall & Reid, 2017; Popejoy, 2008; Potthoff et al., 1997; Rhynas et al., 2018; Wright et al., 2001). Yet, the impact of education and training to develop health professionals' transfer decision making skills with older patients from hospital to residential aged care has not been previously been reported. This is the third aspect in this study.

The more experience the health professional had making transfer decisions, the more likely they were to have developed specific transfer clinical judgement which helped them to accept higher levels of risk. The result was that their transfer decision making was more patient-centred, as they were prepared to accept the older patients' wishes even if they were risky, while the less experienced health professionals were more likely to select safer transfer destination options, even if this was not what the older patient wanted. This is

supported by Atwal et al. (2012), who found that occupational therapists and physiotherapists experiences in making transfer decisions in the United Kingdom helped them accept higher levels of risk than inexperienced health professionals. However, this was specific to occupational therapists and physiotherapists so it may be difficult to extrapolate to other health professionals.

The concept that health professionals' transfer decision making becomes more intuitive as they gain experience is supported by cognitive continuum theory. The theory is that as we gain experience, we develop our intuition, which when combined with reliable evidence becomes a more robust decision. However, from a review of the literature there was minimal peer-reviewed evidence available to support analytical transfer decision making. As Hammond et al. (1987) explained, intuitive decision making is likely to support a high level of confidence in the decision but a low level of confidence in how they made the decision, while analytical decision making has a low level of confidence in the decision but a high level of confidence in the way they reached a decision. It appears that this was the case in transfer decision making where health professionals made intuitive decisions which, for the most part, they felt was the right decision, yet they found it difficult to clearly explain how they reached the decision. This meant that the health professionals needed to develop their own intuition. They showed their resilience by learning to make transfer decisions from hospital to residential aged care through experience. The more experience they had, the more intuitive their decisions were, which enabled them to accept a higher level of risk. This was their only way of learning how to make these decisions, as educational programs and validated transfer decision-making tools were minimal. It was unsurprising to me that even if there was a transfer decision-making tool, it was unlikely that it would be used. Instead they

preferred to use their experience as a tool to make decisions on a case-by-case basis. They relied on their experience and the multidisciplinary team to support their clinical judgement and help them reach a decision. While I suspected this to be the case, applying the epochē helped me to see this from their perspective so that I could gain an understanding of their experience.

Interestingly, the health professionals preferred to learn by doing rather than using formal education strategies. This is similar to the finding by Jette et al. (2003), who interviewed occupational therapists and physiotherapists about their transfer decision making in a large hospital in the United States of America and reported that formalised education did not contribute to the health professional's transfer decision making, rather they learnt on the job. While the studies of Atwal et al. (2012) and Jette et al. (2003) were focused on only two health professional disciplines the findings are likely to be similar for other health professional groups. The health professionals in my study developed their clinical judgement through their individual experience, which helped them make difficult decisions. However, as each health professionals' experience is unique it was apparent that transfer decision making with older people from hospital to residential aged care relied on individual experience rather than rigorous evidenced based education and systems.

A search of education for health professionals on transfer decision making or discharge planning revealed few standalone courses to support the development of this skill. This new and important aspect of the findings shows that learning through experience is helpful, yet formalised education that is grounded in ethical and legal requirements as well as specific to each professional discipline does not appear to be available. While discharge planning and transfer decision making may be covered in units in undergraduate or post-graduate

curricula the importance of this task for patients, families, carers, health professionals and hospital administrators means it is important to have a stand-alone education program to support the development of this complex skill. Ideally, transfer decision-making education should be included in both undergraduate and post graduate curricula which encourages health professionals to make evidenced based transfer decisions.

5.1.2.1.1 Strategies to support clinical judgement

The health professionals described strategies that helped them make a transfer decision. These strategies were developed through policies that aimed to support health professionals' transfer decision making. The strategies that health professionals found that supported their transfer decision making were case conferences and multidisciplinary team meetings. Case conferences were often conducted in hospitals, especially when there were complex transfer problems that needed to be addressed. Differently from the multidisciplinary team meetings, case conferences usually included the older patient, family, carers, external care providers such as general practitioners and community service providers as well as the health professionals involved in the transfer plan.

In my study there were mixed views on case conferences. While health professionals felt that case conferences supported their clinical judgement and transfer decisions, others described these meetings as barriers, as the older patient's voice was not heard. Interestingly, and of some concern, literature on case conferences with older patients in hospital did not emerge in the literature search. The reasons for this are unknown, as case conferencing occurs regularly in hospitals, particularly when there are complex issues. There is an overall lack of evidenced based studies on case conferencing in hospitals with older patients at risk of transferring to residential aged care. As found in my study, health

professionals' experiences of case conferences and their effectiveness in supporting transfer decisions were diverse. While case conferencing supported health professionals transfer decision making it was also a barrier, especially if the older patients wishes were not heard. The use of case conferences to get everyone together supports collaborative decision making yet it became apparent that they were not always supportive.

Case conferences could be challenging due to the predetermined decisions that were put to the older patient in a case conference under what seemed to be the guise of a collaborative patient-centred focus, but was possibly more coercive than supportive. I found this particularly worrying, as it was evident that the health professionals felt they were acting correctly when they had set up a case conference, yet the manipulation of the discussion to achieve the desired outcome was also apparent at times. I wondered how they came to this point where they felt they were doing what was needed, but also seemed aware that they were applying questionable practices. They appeared caught between the pressure of discharging older patients quickly, ensuring that the older patient had the ability to exercise choice and remain connected to their professional discipline ethos. In some way they appeared to overly emphasise that they were doing the right thing, possibly because they wanted to practise ethically and responsibly, yet they felt they had no other options. They were caught between weighing up what the older patient wanted, what the hospital wanted and what the carer wanted. While they searched for an appropriate answer, the reality was that there was often not one and it was clearly disturbing for the health professionals at times. They were caught in a conundrum, no matter what decision they made they were not doing what they wanted, and neither option was good but they were aware they needed to pick one and someone was always going to be unhappy.

In contrast to case conferences, the multidisciplinary team meetings offered an opportunity for the health professionals to discuss risks and make collaborative decisions which supported their clinical judgement. These meetings were often used as a way to support multidisciplinary transfer decision making from hospital to residential aged care (Rhynas et al., 2018) This is substantiated by Atwal et al. (2012), who found that the multidisciplinary team acted as a safety net for health professionals' transfer decision making. While examining the use of residential care teams, made up of social workers to facilitate the transfer decision in a hospital in Australia, Leahy and Lording (2005) found that the presence of these teams at the multidisciplinary team meetings improved transfer decision making. This was achieved through education, collaborative decision-making practices, and improved communication. In effect achieving a form of validity through consensus.

Similarly, in my study transfer discussions were necessarily robust and essentially provided a live representation of a peer-review process. In this way, the health professionals seemed to have developed their own application of cognitive continuum theory where the multidisciplinary team meetings represented the middle ground of the continuum. In this space their quasi-rational, intuitive and analytical processing come together to make collaborative, peer reviewed decisions. They had made their own form of analytical decision making through peer review and validation from the multidisciplinary team. They did this as there was no other way to substantiate their transfer decisions due to the lack of reliable peer-reviewed evidence. Admittedly, in the absence of reliable evidence it was a different form of analytical decision making but it was all they had, and it worked for them. They were reassured when they could take decisions to the multidisciplinary team, as it not only shared the burden but also gave them confidence that their transfer decision had been scrutinised.

However, it is concerning in the report by Leahy and Lording (2005) that the social workers were all employed by the hospital that ran the trial and were selected to be part of the residential care teams as a result of their knowledge of the needs of the hospital to reduce length of stay and increase discharges. While the authors commented that an ethical approach to decision making was used, which benefitted older patients, the focus on reducing length of stay and increasing discharges may well limit the time the older patient, family and carers have to make this decision.

In the meetings it was clear to me that while the Nurse Unit Manager conducted the meetings, the doctors led the discussion. The doctors, in the observational component of my study, explained the treatment plan for the patient and determined the estimated date of discharge. This is supported by the findings by Johns et al. (2011), who reported that doctors should set a realistic plan for medical as well as physical treatment and improvement in preparation for discharge. In the meeting that doctors did not attend, an estimated date of discharge was developed by the attendees. Developing the estimated date of discharge is usually the doctor's responsibility (Johns et al., 2011), although, as the doctors did not attend this meeting, the team made this decision. While it is the responsibility of doctors to decide the estimated discharge date, this should be done in conjunction with the multidisciplinary team. It is acknowledged that doctors have admitting and discharge responsibilities, yet this requires the consideration of wider factors. Older people are more likely to have several co-morbidities, which means that alterations in health can lead to physical as well as functional changes. As a result of these changes, older people are more likely to require assistance with the activities of daily living.

To support an older patient to be able to manage at home the multidisciplinary team conducts assessments and provides discharge recommendations to address any care needs. However, this occurs in conjunction with doctors who are an integral part of the multidisciplinary team. I consider the lack of doctor input in the multidisciplinary team meeting to be a barrier to transfer decision making as it is difficult to see how effective the multidisciplinary team meeting can be without doctors who have a significant role in a patient's journey from admission to discharge.

Overall, the pace of the multidisciplinary team meetings limited the effectiveness of the health professionals' transfer decision making as there was minimal time for a discussion and resolution of the issues. The lack of time combined with a noisy, busy ward environment contributed to the sense of confusion which impacted on health professionals' clinical judgement. This minimised the effectiveness of these meetings as the health professionals often struggled to make collaborative, effective decisions.

5.1.2.1.2 Time pressure

The pressure to make transfer decisions quickly impacted on the health professionals' clinical judgement. The health professional's saw this as a significant barrier as it often limited the effectiveness of their transfer decision making and increased their dissatisfaction with the processes. The pressure to make decisions quickly stemmed from an awareness that there were other patients waiting for a hospital bed and that older patients, who were no longer acutely unwell, could have their needs met elsewhere. This is consistent with the findings of Johns et al. (2011) who reported that to reduce access block, there was a focus on discharge at admission, while Abdool et al. (2016) explored vulnerable older people's transfers from hospital and found that health professionals' transfer decision making should

focus on ensuring the patient has choice. This can take time, and may limit the ability of people in the community to access a hospital bed should they need it (Abdool et al., 2016). From my perspective, these two points contradict each other. It is important that people have access to a hospital bed if they need it and it is equally important that those people who have been admitted to hospital should be able to stay there until they have recovered enough to participate, if possible, in decisions about where and how to live.

This puts the health professionals in a precarious position of trying to find the balance between what is right for the patient in front of them compared to what is right for the wider community. The Council of Australian Governments (COAG) recently reached an agreement to, amongst other things, ensure that the health system delivers quality care to people in the right place at the right time (Council of Australian Governments, 2018), although, it is possible that the concept of the right place at the right time may well contribute to the problem. This generic term has often been used in health, and while it sounds good, it is also ambiguous and difficult to achieve. Interestingly, The Better Care Fund (2017) considered that for every delayed transfer there is a patient in the "wrong place at the wrong time" (p. 1). Either way, it was often left up to health professionals to determine what the right place and right time was with limited parameters or guidelines on how to make this decision and negative connotations if there were delays.

Internationally, the inclusion of diagnosis related groups and the respective length of stay that goes with them are often used as measure of costs and hospital efficiency (Cylus, Papanicolas, & Smith, 2016). In Australian hospitals diagnosis related groups are used to estimate the cost to the hospital of providing treatment to a patient which then contributes to the amount of funding a hospital receives (Curtis et al., 2014), although, these statistical

measurements do not provide a foundation for determining whether being admitted to or discharged from hospital is the right thing at the right time for that person. This was a larger problem for health professionals who tried to make effective transfer decisions, often under time pressure, about whether an older patient was in the right place at the right time.

The study by Ekdahl et al. (2012) also found that health professionals felt that due to the pressure to make transfer decisions quickly they were not able to do their job effectively, which left them dissatisfied and frustrated. Similar to other studies by Hoare (2004), Jette et al. (2003) , Laugaland et al. (2014), Moats (2006), Morgan et al. (1997) and Potthoff et al. (1997), my study also found that transfer decisions were heavily influenced by pressure to make quick decisions. Keeping pace with this pressure, while attempting to determine the older patient's, family and carers' wishes as well as access to suitable transfer options was difficult. Making well considered transfer decisions was difficult in this environment, yet they tried to do their best and reach a transfer decision that met the needs of all stakeholders. However, this was not always possible.

The slower recovery time for older patients meant that they may transfer to residential aged care prematurely which led to concerns that this decision should not be made in hospital where older patients were deconditioned and recovering from an alteration in their health status. The pressure to make decisions quickly, impacted on the health professionals' clinical judgement and therefore their transfer decision, although where this pressure came from was, for the most part, unclear. While one social worker described feeling pressure from a Director of Nursing and medical teams as well as discharge planners to conduct assessments and discharge patients faster, others described a general pervasive pressure that came from inanimate forces such as wards and policy, not people.

The impact of policy on transfer decision making may indeed contribute to the pressure. In Australia and the United Kingdom an estimated date of discharge is required to be developed within 24-48 hours of admission (Department of Health NSW, 2011; Johns et al., 2011; Ou et al., 2011). Developing the estimated date of discharge on admission is aimed at coordinating practices and enhancing throughput. However, as explained by Johns et al. (2011) older people can require more time to recover from changes in their health. While the estimated date of discharge may not be consistently formulated with older patients (Ou et al., 2011) it is possible that the immediate emphasis on discharge sets the tone for the rest of the admission. This raises questions about the subliminal, and at times, explicit emphasis on discharge and the effect this has on health professionals' transfer decision making. The impact of time pressure on clinical judgement is significant. Health professionals are often learning on the job to make transfer decisions under time pressure with minimal education on how to make these complex, risky decisions.

5.1.2.1.3 Cognition and guardianship

Cognition problems made the health professionals' transfer decisions more complex especially when an application for guardianship was being considered. This is supported by the findings of Jette et al. (2003); Kendall and Reid (2017) and Unsworth (2001), who also found that an older patients cognition impacted health professionals' transfer decisions. In my study, health professionals felt they were doing the right thing when recommending an older patient with cognition problems to transfer to residential aged care as this was the safer option. The care needs of an older person with cognition problems can be complex and include a level of risk. Nevertheless, making a transfer decision was problematic, as there were differing views amongst the health professionals of risk and strategies to minimise that risk. This is consistent with the findings of Atwal et al. (2012), who identified that problems

with cognition increased the risk of injury for an older patient and prompted health professionals to consider transfer to residential aged care, even though the impact of a change in health status for an older patient can trigger an exacerbation of their pre-existing cognitive problem. Therefore, it is unlikely that health professionals would see the older patient at their mental and physical best. This was raised by participants in my study who wondered whether, if given more time, the older patient may have been able to return home.

The right of patients to participate in decisions of where and how to live was counterbalanced with concerns about transfer to a safe environment, especially for older people with cognition problems. While health professionals wanted to support an older patient's right to participate in the decision of where and how they live, they also wanted to ensure that an older patient with cognition problems was transferred to a safe environment. This is consistent with other research findings of Atwal et al. (2012) and Denson et al. (2013). Both of these studies used a vignette to describe an older patient's admission and history. Participants were asked a series of questions related to what they would do in the given scenario. While this is a reliable approach it is difficult to make transfer decisions without seeing, assessing, and talking to the older patient, family, carers and the multidisciplinary team. Therefore, the findings should be considered with the awareness that participants were not able to have contact with the older person and were also making a recommendation out of context and devoid of pressure.

In rare cases health professionals used coercive methods to ensure the older patient was transferred to residential aged care. This is consistent with the findings of Clemens (1995), which reported that older patients felt they had little influence over the transfer decision,

while carers reported feeling coerced and pressured to transfer their relatives to residential aged care. It is acknowledged that the paper by Clemens is older, yet in my study there is an indication that this remains the case. The lack of formal guidelines and education on decision making and consent for patients who have altered cognition meant that health professionals were left without guidance to ensure their transfer decisions were ethical.

Making ethical transfer decisions with older patients in hospital is challenging, especially for individual health professionals who have minimal decisional support. As explained by Denson et al. (2013), health professionals require education to develop their transfer decision-making skills in complex ethical situations, even they may also benefit from education on ethically challenging transfer decisions, especially in relation to guardianship. Having access to education on how to manage some of the ethically challenging scenarios associated with transfer decision making with older patients may assist health professionals' decision-making skills and improve their overall satisfaction with the process.

5.1.2.2 Access to supports

The fourth aspect of the findings that informed health professionals' transfer decision making was the ability to access services and supports of family and carers. This was particularly challenging for older people with cognition problems. Similar to the quantitative Australian study conducted by Unsworth (2001) my study also found that a key factor that informed health professionals' transfer decisions was the older patient's ability to access supports either through family, carers or community services. This was both an enabler and a barrier. Having access to supports enabled health professionals' transfer decision making, as it minimised the risk associated with recommending an older patient transfer home. This was because having access to a reliable carer or other supports ensured there were 'eyes in

the home' that could summon help if needed. This is substantiated by other studies that found that access to supports was directly related to an older patients' ability to return home (Cox, 1996) and minimised risk of injury (Atwal et al., 2012; Denson et al., 2013; Popejoy, 2008). However, not being able to access community services was a barrier to their transfer decisions, especially in the absence of a reliable carer.

In the context of my study accessing aged care community services in Australia is through privately funded or government funded services. These include home care packages (HCP), transitional aged care (TAC), community home support packages (CHSP), adult day care services, private community services and paid or unpaid carers, yet accessing this support was found to be challenging by the study participants. In Australia, services such as home care packages and transitional aged care are regulated by the federal government and in order to access them an older person needs to have an assessment completed by a delegate of the aged care assessment team (Department of Health, 2018b). It was evident in my study that transfer decisions were at times impacted by system delays in getting an aged-care assessment completed and then wait for services to be organised and commenced. An older patient who is assessed by the aged care assessment team as eligible for a home care package is likely to have a median wait time for the package of services to start of 62 days (Visvanathan et al., 2019). The high wait time rules this out as a realistic option for an older patient in hospital. While accessing transitional aged care is often quicker the delay in waiting for the aged-care assessment was problematic, as it extended the length of stay, which led to pressure to discharge older patients.

Overall, the health professionals often found it challenging to arrange services in the community. Similarly, a qualitative study conducted in the United Kingdom by Morgan et al.

(1997) as well as an Australian study by Denson et al. (2013) and the Northern Ireland qualitative study by Taylor and Donnelly (2006), found that arranging and accessing services in the community was difficult and impacted on their transfer decision. The inability to access community supports meant that transfer to residential care for some older patients was the only realistic option.

Through the interviews and observations, it was evident that having a reliable carer reduced the risk associated with recommending an older patient transfer home. Yet the participants were aware that carers could become exhausted as the older patients care needs increased. This is substantiated by the findings of Denson et al. (2013) who compared older people, younger relatives and health professionals' experiences of discharge planning before making a transfer decision to long term care.

In my study it was difficult for the health professionals to balance the needs of the carer and the needs of the older patient. It appeared that as the needs of the older patient increased their opportunity to choose where and how to live decreased. The health professionals walked a fine line between supporting autonomy for the older patient and concern for the wellbeing of the carer. Health professionals reported limited avenues to access decision support to address these ethical dilemmas – instead, they collaborated with the multidisciplinary team to try to reach an appropriate decision. This is supported by Moats and Doble (2006) who conducted a literature review on occupational therapists' ability to manage risk while supporting autonomy when making transfer decisions from hospital to residential aged care and found that collaborating with the multidisciplinary team can support ethical decision making. This is in contrast to the findings of Clemens (1995), who

reported that care givers felt coerced into placing their relatives in residential aged care due to the focus on risk and safety.

It is difficult to consider what it would be like for an older person to have a change in health status that required transfer to hospital which resulted in other people deciding that they are not able to return home and need to enter institutional care. This unexpected change may trigger relocation stress. Relocation stress is an accepted North American Nursing Diagnosis Association (NANDA) nursing diagnosis and includes transfers where the person either perceives or is actually forced to move into a residential aged-care facility (Carpentio, 2013).The main characteristics of relocation stress include feeling lonely, depressed and angry, which can significantly impact an older persons' physical and mental wellbeing. Access to services in the community, such as transitional aged care, may increase an older patient's chances of returning home even if this is only for a short time. However, the limited access to services and supports impacted on health professionals' transfer decision making as it reduced the options they had to choose from.

5.2 Implications and Contributions to Knowledge

This section presents the implications that were derived from the findings in this study as well as the contributions to knowledge. The first implication was the lack of inclusion of the older patient in transfer decision making. The second was the input of the registered nurse who looked after the patient was missing. The third was the impact of the environment on health professionals' transfer decision making. This is followed by the lack of collaborative assessments within the multidisciplinary team, which may minimise the comprehensiveness of the information they use to inform their transfer decisions. The fifth implication is the lack of formalised education for health professionals to learn how to make transfer decisions.

5.2.1 Inclusion of older patients in decision making

A new and important contribution to knowledge for transfer decision making was that older patients were often not included or heard in the transfer decision. Through the participants' descriptions as well as observations it was apparent that the voice of the older patient was absent in the transfer decision-making process. Transfer to residential aged care can be a significant life event for an older person, particularly if the decision is made on the back of a sudden change in health that has led to a hospital admission. Older people are more likely to experience depression on transfer to residential aged care, especially if they were not involved in the decisions (Giles et al., 2009). This has significant implications for the older patient who may experience depression and a lower quality of life which could trigger an overall deterioration of physical and psychological health. Therefore, it is important that older patients are included in such an important decision. A deeper understanding of the experience and participation of the older patient in transfer decisions from hospital to residential aged care is also needed to ensure that strategies are constructed from targeted, reliable research.

5.2.2 Inclusion of the registered nurse in transfer decision making

A crucial finding from my study is that registered nurses, who provided direct patient care, did not appear to be included in the transfer decision-making process from hospital to residential aged care. The inclusion of the registered nurse is essential to ensure that all health professionals have access to information from the staff member who spends the most time with the patient. This means they are more likely to know what the patient can and can not do. Older patients who are at risk of being transferred to residential aged care direct from hospital are assessed by the multidisciplinary team to determine the older patients' functions and abilities. These assessments may be conducted over a period of time,

yet the registered nurse has contact with the patient throughout the shift and has a deeper understanding of the patients' abilities developed over a period of time. It was not evident in my study how or if this information was passed onto the multidisciplinary team. The lack of inclusion of the registered nurse in my study highlights a gap in transfer decision making that may reduce the effectiveness of the transfer decision, as vital information is missing.

5.2.3 Multidisciplinary decision processes

The multidisciplinary team meetings are an important part of transfer decision making, yet little is known about the effectiveness of these meetings in the context of transfer decision making to residential aged care. The findings from my study indicated that the pace of these meetings minimised the ability to make transfer decisions, as there was not enough time to consider the issues and develop a transfer plan before the meeting moved on to the next patient. In addition, the environment of these meetings, which is more commonly the main nurses' station on a ward, was less than ideal and presented a privacy concern. The implications of this may mean that transfer decision making is minimised due to the challenges that are inherent to these meetings. The multidisciplinary team meetings provide the opportunity for health professionals to come together and develop a plan of care for patients. However, they may not be the best place for transfer decision making from hospital to residential aged care due to the complex nature of these decisions.

An important finding in this study was that case conferences for transfer decision making could be challenging for the health professionals, and the older patients' wishes may not be heard. This limited the older patients' ability to express their wishes and diminished health professionals' sense of patient-centred care. It is important to ensure that older people are able to exercise choice about where and how to live, yet this appeared to be minimised in

case conferences. The implications for the older person of having limited opportunities to participate in the decision of where and how to live can be profound on the older patient, family, carers, and health professionals.

5.2.4 Assessments

The health professionals in my study predominately conducted individual assessments to inform their transfer decisions. Discipline specific tools exist, which record a patient's function or demographics, but do not provide transfer decision-making support. Transfer decision-making processes are intended to be multidisciplinary and patient centric, although it was evident in this study that there were barriers to achieving this. In my study, the assessments that were used by health professionals were discipline specific, fragmented, and often individually designed. The implications of this are that transfer decisional tools were either not used or not fit for purpose, as they appeared to focus on assessments but did not trigger a transfer decision. Therefore, their transfer decisions were developed based on individual experience and ethics rather than evidence based tools.

In my study health professionals rarely used assessment tools as they preferred to use their experience to guide them. However, for those health professionals who have less experience making transfer decisions, the absence of decisional support tools may limit their ability to make effective decisions. This means that older patients, family, and carers may not be being provided with effective support through the transfer decision-making process from hospital to residential aged care.

5.2.5 Education

The lack of formalised education in discharge planning in both undergraduate and post-graduate health professional programs is a significant problem. While this topic may be

covered as part of a unit, a standalone course that addresses this complex and often high-risk decision making is important to ensure that processes as well as decisions are rigorous, inclusive and supported by evidence. Transfer decision making with older patients is complex and can have a significant effect on families, carers and the older patient. Health professionals aim to make effective transfer decisions, yet they learnt how to make transfer decisions as they went, with limited, if any, educative support. The implications of a lack of transfer decision education is that the health professional's decisions are more likely to be made based on their experience rather than evidenced-based education and support. While it was not the focus of my study to explore this, the need to ensure that health professionals are equipped with the skills and knowledge needed to make these complex decisions is vital.

5.2.6 Cognitive continuum theory

Cognitive continuum theory was used in my study as a way to understand health professional's transfer decision making. While the theory has been used to explain decision making in a health context, to my knowledge, it has not been applied in a multidisciplinary health professional context. This theory provides the opportunity to gain a deeper understanding of multidisciplinary team decision making in a variety of settings and context. Cognitive continuum theory could also be used in other multidisciplinary health settings to explore decision making across single or multiple health professional groups. This offers a way to understand multidisciplinary health professionals decision making in a range of settings and contexts. Using this theory in other contexts could support a stronger understanding of health professionals' decision making in a multidisciplinary context.

In the context of cognitive continuum theory, an unexpected outcome of this study was that in the absence of education on transfer decision making and rigorous evidence to support

their decisions it seemed that the health professionals developed their own approach. Using the multidisciplinary team meetings as a checking process where decisions were informed through intuition and experience and reviewed by their peers, acted as a validation process in the absence of reliable evidence. However, further exploration of the decisional choices in the absence of high-quality evidence could also be considered as well as the role of peer review to support transfer decision making in a hospital setting.

5.2.7 Adapting Step 7 of Colaizzi's approach

A contribution to knowledge derived from my thesis is the development of a new way to synthesize Colaizzi's phenomenological interview and observation analysis approach, into an overarching statement that comprehensively described the phenomenon being explored. The interviews were analysed using Colaizzi's 7 step approach, while the observations were analysed using Colaizzi's perceptual description approach. Combining the outcome of these two approaches led to a deeper, fuller comprehensive description of health professionals' transfer decision making with older people in hospital.

A further contribution is the adaptation of Colaizzi's Step 7 to include methodological triangulation, supervisor's reviews as well as audit trail and phenomenological reduction. This provides an alternative to member checking which may help other researchers who wish to apply an alternative to member checking when using Colaizzi's approach (Northall et al., 2020). Section 3.9 presented the adaptation of Step 7 in Colaizzi's approach which provided a new way to access participants' experiences. The adaptation of Step 7 supported the development of an understanding of health professionals' experiences, yet it is one of several strategies that offered a way to understand the phenomenon and enhance trustworthiness in my study. The use of a reliable method to analyse qualitative data

supports the development of trustworthy findings (Northall et al., 2020). However, this needs to be made explicit through the provision of a decision trail that is connected to the theoretical, analytical and methodological stance of the study (Saunders, 2003).

In my study Step 7 was adapted, yet remained connected to the phenomenological methodology and philosophy. By combining Colaizzi's seven-step approach with his perceptual description I was able to apply within methods triangulation which supports the development of trustworthy findings. The use of the phenomenological reduction, accessed through the epochē, provided the opportunity to, as Finlay (2009) explained, access the phenomenon clearly and unaltered by the researcher's assumptions. In addition, my supervisors reviewed each step of the analysis to support the development of findings that accurately presented the participants' experiences. The ability to review each step of the analysis of the data was made possible through Colaizzi's 7 steps and the perceptual description. It is important that research methodology is trustworthy and reliable, otherwise it would not be possible to apply the findings to other settings or use them in clinical practice.

The strategy of combining interviews and observations to gain a deeper understanding of the phenomenon together with the adaptation of Step 7 of Colaizzi's approach has implications for other researchers. Applying methodological approaches to specific research topics can be challenging for novice researchers and can lead to confusion, or worse, findings that are not reliable. Providing other researchers with a way to analyse interviews and observations through a congruent methodological approach may be useful for researchers who want to employ more than one qualitative method of data collection to synthesize and validate findings using a phenomenological approach.

5.3 Recommendations for Research, Education, and Practice.

Based on the contributions to knowledge and implications derived from the findings in this study, recommendations for research, education and practice are provided. The recommendations came from the use of a phenomenological approach informed by Colaizzi to explore health professionals' lived experience in making transfer decisions with older patients in hospital.

Through the application of this approach it was identified that further research into the barriers and enablers of older patients' participation in transfer decision making from hospital to residential aged care is needed so as to gain more of an understanding of this phenomenon in different settings. In my study I interviewed and observed health professionals transfer decision making in five hospitals in New South Wales, Australia. This provided an initial understanding of health professionals' transfer decision making, yet the older patient should also be considered in this process. The findings from my study showed that older patients were often not included or were voiceless in the transfer decision. While this was not a focus of my study, it was identified that strategies such as case conferencing, which were meant to support patient-centred practices, could be used as a tool for coercion rather than collaboration. Through the application of Colaizzi's approach to the interview and observation data it became evident that older patients' wishes were often overridden by the wishes of the carer. Further research is needed in this area to gain a better understanding of the enablers and impediments to older patients' participation in case conferencing and transfer decision making in hospital.

Another consideration that arose through my study was that registered nurses had little involvement in the transfer decision from hospital to residential aged care. This was

discussed in Chapter 2 in section 2.4.3 and Chapter 4 in section 4.5.2 where registered nurses were not included in the transfer decision process. It is possible that the nurses were aware that they were not included and preferred to step back and let the multidisciplinary team work through the transfer decision, possibly because they were already overloaded. While there was a small amount of literature on registered nurses transfer decision making, it was concerning that the heath professional that spent the most time with the patient was not consistently reported in the literature related to transfer decision making from hospital to residential aged care.

While nurses in dedicated discharge planning roles are represented in the literature the registered nurses' input into transfer decisions is not prevalent. I see this as a significant gap that may reduce the effectiveness of team decision making. Registered nurses are in a unique position to understand a patients abilities and wishes as they spend the most time with the patient. Not including the registered nurse in transfer decision making has potential implications for the older patient and transfer decision making. This is because the registered nurse may hold information about the older patient's wishes, strengths and levels of dependency which have been observed over a shift or a period of days. This gives them an understanding, developed over time, of the capabilities of the older patient. Providing this information to the multidisciplinary team, through established systems, may inform health professionals' transfer decision making and has the potential to provide a deeper level of understanding of the patients' abilities learnt over an extended period of time.

Further understanding of the barriers and enablers of including the registered nurse in the transfer decision-making processes is needed. This may include research that focuses on their understanding of the transfer decision-making process, ability to participate as well as the contributions they could make to the transfer decision.

Research is also recommended into the multidisciplinary transfer decision process. Research and practice should focus on exploring the effectiveness of the multidisciplinary team meetings for transfer decision making with older people from hospital to residential aged care. It was evident from the findings in my study that there were issues in the multidisciplinary team meetings when making transfer decisions related to older patients from hospital to residential aged care. The main concern was that the pace and place of these meetings did not fit with the complex nature of their decisions. Consideration of the challenges in relation to the location of the meetings in terms of maintaining privacy and confidentiality should be included, as the lack of privacy, noise and distractions made it difficult to have the comprehensive discussions needed to make these decisions. Further examination of the pace and place of these meetings in the context of efficacy, attendance (ward registered nurses and doctors), as well as privacy and confidentiality may enhance the effectiveness of these meetings.

It was surprising to find that there was a lack of education for health professionals that focused on validated strategies and approaches to support individual and multidisciplinary transfer decision making from hospital to residential aged care. Clinical decision making is usually informed by rigorous peer reviewed evidence. Yet, as presented in section 5.1.2.1 there was minimal evidence or education on transfer decision making to support health professionals to learn how to make these decisions. Instead, the health professionals tended to rely on intuition and clinical judgement learnt through experience. This means that health professionals had to find their own way of making these decisions through experience and practice with, what appeared to be, minimal educative support. It is recommended that education on transfer decision making should focus on assessments, collaborative processes,

risk acceptance, multidisciplinary team meetings and patient-centred transfer decision making from hospital to residential aged care.

Conducting assessments is an important first step towards reaching a transfer decision, yet there was a lack of comprehensive assessment and transfer decision tools for the health professionals to use. This is particularly important for those health professionals who have minimal experience making these decisions. The lack of transfer decision-making assessment tools has implications for older patients, health professionals and service providers who, in the absence of other options, need to find their own way to make a transfer decision. To develop transfer decision-making tools requires significant research to ensure that tools are validated, multidisciplinary, comprehensive, and inclusive. It was noted in my study that the health professionals predominately conducted their own individual assessments. These came together to support a transfer decision, yet carrying out assessments together as a multidisciplinary team not only supports collaborative practices but has all the information in one place. This reduces the potential for repeating unnecessary assessments and is a more collaborative comprehensive and educative approach.

A further recommendation for future practice that is indirectly related to my study, but important to highlight, is the development of processes that provide a clear separation between patient flow and health professionals' transfer decision making. The health professionals described a pervasive and constant awareness of pressure to move people through the hospital quickly. Through the findings it appeared that older patients were often targeted for transfer when there was pressure to discharge people quickly. The reasons that older patients may be targeted for transfer are unclear and were not the focus of my study. Making transfer decisions is complex and there are many factors to be considered — one of these should not include patient flow. Separating patient flow from transfer decision making

for the older patient, family, and carers should always ensure that processes are patient-centred.

5.4 Strengths and Limitations of the Study

This study examined health professionals' transfer decision making with older patients from hospital to residential aged care. All studies have strengths and limitations and that is also the case with this study. My primary goal was to understand multidisciplinary health professionals' lived experience in making transfer decisions with older patients from hospital to residential aged care. Having a multidisciplinary focus is seen as a strength, as it provides perspectives from the key health professionals that are involved. A further strength is the use of interviews and observations to collect data. This provided a unique opportunity to see how they made transfer decisions as well as hear, from their perspective, how they made transfer decisions.

It might be argued that one limitation is that I did not member check as Colaizzi suggested in Step 7. In the design phase of this study it became apparent that observation of the meetings would be a better way to access the health professionals' experiences. As the study developed the concept of adapting Step 7 was considered to support the development of trustworthy findings. Tailoring Step 7 was achieved through methodological triangulation, phenomenological reduction and the keeping of a rigorous audit trail which is explained in Chapter 3. This adaptation provided a way to access a deeper insight into health professionals' experiences and may also assist other researchers who wish to combine interview and observation data using a phenomenological perspective (Northall et al., 2020).

A further limitation was the difficulty in recruiting registered nurses who provided direct patient care, in my study. While multiple attempts were made to recruit more registered

nurses, there was no response. This was possibly due to nurses feeling that they were not part of the transfer decision-making process and therefore did not want to be part of the research. It was also noticed that nurses did not attend the multidisciplinary team meetings. This may be because the meetings are held early in the morning which is a busy time for nurses who are doing rounds with doctors, giving medications and providing nursing care to patients. Nurse unit managers and other nurses who worked in transfer decision roles did participate in my study, but the nurses, who provided direct patient care did not volunteer to participate.

As I reflected on the difficulties in recruiting nurses who provide direct patient care, I considered that one reason they did not express interest in participating could be that they may have felt the topic did not relate to them. This led me to consider that a more effective step for this group would be to first explore their knowledge and understanding of transfer decision making from hospital to residential aged care, to gain insight into their involvement of this complex phenomenon. Exploring nurse involvement in transfer decision making from hospital to residential aged care is important, as they spend the most time with the patient. This means they are more likely to have an intricate knowledge of the older patient's capabilities. Exploring their lived experience can provide a fuller description of their participation in transfer decision making with older patients from hospital to residential aged care.

5.5 Chapter Summary

This chapter presented a discussion of the findings, developed in the context of the literature and the methodology. Through this discussion it became apparent that there were similarities in the findings of other studies and my study. At the same time, I was aware that a significant difference was that, prior to my study, transfer decision making had not been explored using a phenomenological lens, along with a multidisciplinary cohort that included observing how they made transfer decisions as well as hearing their descriptions of their experiences making these decisions. In doing this, I went further than other studies in a concerted attempt to describe their experiences. Through the application of the study's methodological and philosophical approach I was able to explore their experiences and identify the main findings in this study.

The main findings derived from the interviews and observations of health professionals transfer decision making were: a lack of inclusion of the older patients' choices when making transfer decisions; the absence of the registered nurse who provide direct patient care in multidisciplinary team meetings and transfer decision making; the challenges of using multidisciplinary team meetings and case conferences for transfer decision making; the lack of comprehensive assessment tools and transfer decision support; the health professionals' clinical judgement which was developed through experience; the lack of education to prepare the health professionals to make transfer decisions; the absence of doctors at some multidisciplinary team meetings; the significant time pressure to make decisions quickly and the potential impact of developing an estimated date of discharge on or close to admission.

The implications and contributions to knowledge derived from the findings include: the lack of involvement of the older patient and registered nurse in transfer decision making; the

challenges associated with multidisciplinary team meetings for transfer decision making which may reduce their ability to make effective transfer decisions; the lack of validated transfer decision assessment tools to support health professionals' transfer decisions; a lack of education on how to make transfer decisions and the impact this may have on the effectiveness of their decisions; the use of cognitive continuum theory to understand transfer decision making; and the adaptation of Step 7 of Colaizzi's approach.

In contrast to other studies my study has examined how the health professionals made transfer decisions and it was surprising to me how open the health professionals were as they described their experiences. They accepted me into their multidisciplinary meetings and went about their work with no obvious awareness of me. This gave me an opportunity to see and hear their transfer decision-making strategies. Through the application of the epochē I was able to see the phenomenon, as it was, for the participants. This required careful consideration of my previous experience through the reflective journal and application of phenomenological reduction.

From my reading and research, the findings disclosed through this phenomenological study provide an initial first step into understanding health professionals' transfer decision making from hospital to residential aged care. As it sits, currently, it appears that there are issues that could be addressed to improve the experience of making these decisions for older patients, family, carers and health professionals. It is acknowledged that there are likely to be competing priorities between these groups, which should be discussed more openly so that there is less of a feeling of secrecy related to the way the health professionals make transfer decisions. I understand why the health professionals did not want to overtly tell older patients that the reason they needed to be discharged was because they no longer

required hospital care and that the best place for them was residential aged care. The health professionals were aware that the focus on discharge appeared to contradict the empathy and patient-centredness to which they aspired. Instead they tended to exclude the older patient and relied more on the input of family and carers. In terms of the epochē, I know from my own experience that health professionals sometimes take this attitude as a way of protecting themselves from the consequences of the decisions they make. It is not clear that this was the case in my study, but it may be a consideration for future research.

It was considered a strength in my study to include multidisciplinary health professionals as transfer decision making is not the purview of one professional group. They worked as a team, aware of their own focus, to develop transfer decisions. The multidisciplinary team meetings also supported them in making transfer decisions. The meetings were collaborative and at times combative, which is as it should be. Decisions needed to be critiqued and validated. As there was a lack of peer-reviewed, quality evidence, the multidisciplinary team served as a validating step for their transfer decisions.

Disclosing these aspects was made possible through the adaptation of Step 7 of Colaizzi's approach. In the next chapter I present my concluding remarks that have developed from of this study. remarks are presented from a personal perspective and outline what I have learnt and where I am planning to go from here.

Chapter 6
Concluding Remarks

In Chapter 6 I present some concluding remarks. In phenomenology it is very difficult to form an absolute conclusion to a question or problem, as there are many aspects to take into account when articulating findings. For example, my own position as a researcher needs to be always at the forefront. I have attempted to achieve this attitude through careful attention to the epochē. It is important in phenomenology to emphasise the health professionals themselves and how they have described their experience. In this way, their voices will not be lost. I begin by describing my thoughts and reflections on the decisions I made throughout this thesis, which were guided by the theoretical and methodological approaches used in my study. Following this are my thoughts on what I have learned about health professionals' transfer decision making. In this way, I hope to add further light on how the epochē may be operationalised.

My study examined multidisciplinary health professionals' lived experience in making transfer decisions with older patients from hospital to residential aged care. I was particularly interested in this topic as I had worked as a discharge planner in hospital and found that these decisions were often ethically and emotionally challenging. I wanted to gain a better understanding of health professionals' experience making transfer decisions, so I decided to use Husserlian phenomenology in this study, as it provided a better way to understand the depths of their experience. This gave me a philosophical lens to explore the phenomenon. Husserl also offered a way to access health professionals' lived experience through the epochē. This was particularly important in my study, as I have previous professional experience in this area. Developing the epochē was difficult and I was often not

sure that I was achieving it. I did not realise that I had developed the epochē until almost the end of this thesis. I wondered whether this was as it should be, as doubting my ability to establish the epochē seemed to support my ongoing efforts to achieve it. Looking back on my thesis journey, I feel it was my level of concern that I was not achieving the epochē that actually helped me develop it.

To explore the health professionals' lived experience, I applied Colaizzi's approach, which gave me the opportunity to discover new understandings of the lived experience of making transfer decisions. I found that by listening to the participants describe how they made transfer decisions, and by observing transfer decision making through the multidisciplinary team meetings, I was able to reach an understanding of the similarities, differences and complexities of their experiences. This enabled me to develop a description of the phenomenon that could capture the essence of their experiences. To better understand their decision making, I viewed their transfer decisions through the theoretical framework of cognitive continuum theory.

Originally, I did not fully see the importance of using a theoretical framework on decision making, but as the thesis progressed I began to understand how useful cognitive continuum theory was to explain health professionals' decision-making processes. I found that applying this theory to health professionals decision making, added a perspective of which I was unaware. Possibly unknowingly, the health professionals moved between intuitive and analytical decision making depending on the situation. I was surprised how quickly they were able to adapt to difficult problems as they made transfer decisions, especially as they rarely had any formalised training in how to make these decisions. By the end of this thesis I realised the adaptability, determination and courage health professionals display when

making transfer decisions with older patients, families and carers. They are an impressive group of people who advocated, in difficult circumstances, when they could and accepted situations they were not able to change. They dealt with conflict and pressure to make effective decisions quickly. Their resilience was remarkable.

The importance of examining health professionals' transfer decisions was to gain an understanding of this unexplored aspect of clinical experience. An initial understanding of a health professional's experiences making transfer decisions has been provided in this thesis, yet there is more that could be done in this area. As I mentioned earlier in the thesis, I think it is important to include the older person, family and carers in research relating to the way older people enter residential aged care. The older persons' experiences are often not heard in research for a range of factors but it is important to focus on those who are living the experience of transferring from hospital to residential aged care. I am aware of the conundrum here, as in this research I did not include the older person, family and carers. I knew I wanted to understand the transfer decision-making process from hospital to residential aged care for older people, families, carers and health professionals but this would be difficult to do in the depth required in one study. In discussions with the supervisory panel, a decision was made to focus on health professionals because they had the most knowledge about making these decisions and could provide a professional understanding of this complex phenomenon.

Through my study I became aware of the complexities of transfer decision making from a multidisciplinary perspective. The health professionals in my study showed their resilience and their frustration in making transfer decisions, yet they received little education or support. It was evident that the health professionals who made these decisions needed

support through strategies such as education and policy reform; and rather than there being limited options that only health professionals can choose from, older patients themselves should be offered a range of options that could give them the opportunity to return home if they wanted. I am aware that there are financial considerations here, as the cost of providing comprehensive support to older people in the community is high, yet in terms of social capital and quality of life, the significant contribution of older people to society is important and benefits us all.

From listening to and observing the health professionals who make these decisions, what stood out to me was their ability to make these decisions with limited decisional supports and without any formal training. Their decisions were often made under challenging circumstances and there was little doubt that this could be very stressful for them. Typically, transfer decision making is collaborative, and while this is ideal I reflected on whether health disciplines should remain, on some level, detached within their own discipline specific focus. This does not mean that there is no collaboration: through this study, the participants enabled me to see that some discipline separateness is desirable, ensuring however that they are not working at cross purposes to each other and that the older patient, family and carer are central to the decision. Without this, it becomes a question of disciplines and not the older patient.

Nearing the end of my thesis I began to wonder whether transfer to residential aged care direct from hospital should only occur in certain circumstances. I realised how far we need to go to get to the place where older people are the principal decision maker of where and how to live. Through this study I have developed a deeper understanding of transfer decision making and believe that the transfer decision should start off from a point where if the older

patient wants to go home then that should be the only option. While it could be discounted as an option as transfer decision making progresses, it should start from a place where the older patient's wish is followed. Instead, it seemed to me that the default decision was to first consider transfer to residential aged care and only exclude it if there were better alternatives such as access to a reliable carer or existing services that could be increased. It appeared that transfer to residential aged care was always on their minds as it was the best way to ensure the older patient received the care they needed. However, there was also an awareness that transfer to residential aged care could minimise readmissions to hospital and ensure the older patient was safe, even though the older patient may experience poorer quality of life as a result of transferring to residential aged care.

It is possibly part of the problem that the increase in the older population is often seen as a global burden rather than an opportunity, and I am aware that older people can be vulnerable as well as marginalised when they are recovering from a change in health in an unfamiliar hospital environment. It was concerning that the marginalisation of the older patient was described and witnessed in this study. We need to reconsider the way we care for older patients in hospital. Education for health professionals is essential to ensure that they are making transfer decisions with an ethical and equitable foundation that includes policies and processes to support older people, so that they to have time to recover and be included in all discussions of where and how they live.

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Glossary

Term	Definition of terms
Aged Care Assessment Team	A team of multidisciplinary health professionals including medical, nursing and allied health professionals who assess the needs of older people and their carers. Access to residential aged care and other government supported community services can only be approved by the aged care assessment team, based on a comprehensive assessment.
Cognitive continuum theory	A theory that describes decision making.
Diagnosis Related Group	A classification system that standardises hospital payments for specific treatments and diseases.
Estimated Date of Discharge	The estimated date that the patient will be discharged from the hospital.
Multidisciplinary team	A group of health professionals from a variety of disciplines who collaborate together to make decisions and recommendations.
Multidisciplinary Team Meeting	A meeting where multidisciplinary clinicians involved in a patient's care meet to discussion the plan for treatment and therapy. The team leader is responsible for task allocation and documentation of the estimated date of discharge.
Placement	A term used to describe the placing of an older person in a residential aged-care facility,often referred to as residential aged care placement.
Residential Aged Care	A 24-hour facility that provides accommodation and care for people who are no longer able to live independently at home. Eligibility to enter residential aged care is determined by the aged care assessment team.
Transitional aged care	A short-term program that supports older people, through therapy and services to recover and restrengthen following a hospital admission. Access to transitional aged care is approved by the aged care assessment team.
Registered nurse	A registered nurse who works in a hospital and is responsible for the nursing care and management of patients in hospital

Appendices

Appendix 1	Health service ethics approval
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Appendix 10	Participant information sheet (Observations)
Appendix 11	Participant consent form (Observations)
Appendix 12	Conferences
Appendix 13	Publication and awards

Appendix 1 Health service ethics approval

Research and Ethics Office

[redacted]

21 July 2014

Mrs Tiffany Northall

University of Western Sydney

Locked Bag 1797

Penrith NSW 2751

Dear Mrs Northall,

Project Title: Multidisciplinary decision-making: Transfer of older people from acute to residential care

HREC Reference: HREC/[redacted]

SSA Reference: SSA/[redacted]

Local Project Number:14/139

SITE SPECIFIC AUTHORISATION

Thank you for your correspondence received 11 July 2014 in response to our request for further information dated 18 June 2014.

I am pleased to inform you that the Chief Executive has granted authorisation for this study to take place at the following site(s):

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

The participant documents approved for use at this site are:

- Participant Information Sheet (Group), site specific, Version 1.1, dated 18 June 2014

  Based on Master Version 1.1, dated 18 June 2014

- Participant Information Sheet (Individual), site specific, Version 1 .1 , dated 18 June 2014 Based on Master Version 1.1, dated 18 June 2014

- Consent Form (Group), site specific, Version 1.0, dated 1 April 2014

  Based on Master Version 1.0, dated 1 April 2014

Consent Form (Individual), site specific, Version 1.0, dated 1 April 2014

Based on Master Version 1.0, dated 1 April 2014

Note: CV's for Mrs Northall and associated investigators are not required to be submitted for future 2014 projects as there is now one on file.

The following conditions apply to this research project. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval:

1. Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project, and which are submitted to the lead HREC for review, are copied to this office.

2. Proposed amendments to the research protocol or conduct of the research which may affect the ongoing site acceptability of the project, are to be submitted to this office.

3. Please note that you are responsible for making the necessary arrangements (e.g. identity pass and vaccine compliance as per NSW Health Policy Directive PD2011 005) for any researcher who is not employed by the [redacted] and is conducting the research on-site.

Yours sincerely,

[redacted]

Manager, Research and Ethics Office

Appendix 2 Western Sydney University reciprocal ethics approval

Locked Bag 1797

Penrith NSW 2751 Australia

Office of Research Services

ORS Reference: H10791

Human Research Ethics Committee

5 August 2014

Professor Esther Chang

School of Nursing and Midwifery

Dear Tiffany,

I wish to formally advise you that the Human Research Ethics Committee has ratified the external HREC approval of your research titled: “Multidisciplinary decision making: Transfer of older people from acute to residential care” under the UWS number H10791.

Conditions of Approval

1. Please advise UWS HREC of amendments approved by the Administering HREC.
2. Please advise UWS HREC of any serious or unexpected adverse events reported to the Administering

HREC

3. As the Administering HREC has approved the protocol until 17 July 2019, the UWS record will close after that date unless we are advised that the Administering HREC has approved an extension.
4. Please provide a copy of the Final report to UWS HREC.

Please quote the registration number and title as indicated above in the subject line on all future correspondence related to this project. All correspondence should be sent to the email address humanethics@uws.edu.au as this email address is closely monitored.

Regards

Human Ethics Officer on behalf of UWS HREC

Appendix 3 Participant information sheet (Interviews)

Participant Information Sheet

Non-Interventional Study - *Adult providing own consent*

Coordinating Principal Investigator/ Principal *Tiffany Northall*

Part 1 What does my participation involve?

1 Introduction

You are invited to take part in this research project because you are a health professional working in the acute setting and have experience making decisions to recommend an older person transfer from acute to residential aged care. The aim of this research is to explore and describe the factors that influence health professional's decision making when recommending transfer of an older person from acute to residential aged care. Currently little is known about how health professionals reach these decisions. Many older people transfer from acute care into residential aged care and they rely on the information they receive from health professionals to guide their choices. This study aims to provide an understanding of how health professionals reach these decisions in order to guide policy development, contribute to care and improve knowledge.

This Participant Information Sheet/Consent form tells you about the research project. It explains the research involved. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about.

2 What is the purpose of this research?

The research is being undertaken by Tiffany Northall as part of her Doctor of Philosophy degree under the supervision of Professor Esther Chang, Associate Professor Amanda Johnson and Doctor Deborah Hatcher. The findings will form part of her thesis.

3 What does participation in this research involve?

To participate in this research you will need to be a doctor, occupational therapist, registered nurse or social worker who has two years or more working with older people in acute care. Participation in this research involves one interview that will last between 45-60 minutes. This interview can be conducted in person or by phone. Prior to attending the interview a consent form will need to be signed and returned to the researcher. The entire research project is expected to finish in 2017, however as a participant you will only be required to attend the interview and discuss the factors that influence your decisions to recommend an older person transfer from acute to residential aged care. The interview will be audio taped and transcribed. In addition you will be asked to provide some information on your highest level of education, years of clinical experience, the hospital you are employed at and the health profession discipline you are employed as. All identifying information will be removed and pseudonyms will be allocated to protect participants' privacy. The research will be monitored by experienced research supervisors from the University of Western Sydney.

There are no costs associated with participating in this research project, nor will you be paid.

4 What do I have to do?

To participate in this research you will need to be involved in one interview that will take approximately 45-60 minutes. In this interview you will be asked to discuss your decision making when recommending an older person transfer from acute to residential aged care.

5 Other relevant information about the research project

This project is being conducted in [redacted]

6 Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

If you do decide to take part you will be given this participant information sheet to keep.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with [redacted] or University of Western Sydney.

7 What are the possible benefits of taking part?

The possible benefits of participating in this research are that health professional's decision making in the transfer of older people from acute to residential care will be better understood. This knowledge can contribute to policy development and formalised processes which can benefit health professionals.

8 What are the possible risks and disadvantages of taking part?

If you become upset or distressed as a result of your participation in the research, the researcher will be able to arrange for counselling or other appropriate support through the employee assistance program (EAP) or lifeline. Any counselling or support will be provided by qualified staff who are not members of the research project team. This counselling will be provided free of charge.

9 What if I withdraw from this research project?

If you decide to withdraw from this research project, please notify a member of the research team before you withdraw. There is no penalty for withdrawing from the project. If you do withdraw your consent during the research project, the researcher will not collect additional personal information from you, although personal information already collected will be retained to ensure that the results of the research project can be measured properly and to comply with law. You should be aware that data collected by the researcher up to the time you withdraw will form part of the research project results. If you do not want them to do this, you must tell them before you join the research project.

10 Could this research project be stopped unexpectedly?

This research project may be stopped unexpectedly for a variety of reasons. These may include the principal investigator withdrawing from the degree.

11 What happens when the research project ends?

On completion of the research project the findings and results will be complied and published to add to existing knowledge.

Part 2 How is the research project being conducted?

12 What will happen to information about me?

By signing the consent form you consent to the researcher using personal information about you for the research project. Any information obtained in connection with this research project that can identify you will remain confidential. All information will be de-identified and on completion of the research will be securely destroyed. Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law.

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified, except with your permission.

In accordance with relevant Australian and/or New South Wales privacy and other relevant laws, you have the right to request access to the information collected and stored by the research team about you. You also have the right to request that any information with which you disagree be corrected. Please contact the research team member named at the end of this document if you would like to access your information.

Any information obtained for the purpose of this research project that can identify you will be treated as confidential and securely stored. It will be disclosed only with your permission, or as required by law.

13 Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this research project have been approved by the HREC of [redacted] and UWS.

This project will be carried out according to the National Statement on Ethical Conduct in Human Research (2007). This statement has been developed to protect the interests of people who agree to participate in human research studies.

14 Further information and who to contact

If you want any further information concerning this project which may be related to your involvement in the project, you can contact the principal study researcher on [redacted].

15 Complaints contact person

This study has been approved by the [redacted] Human Research Ethics Committee. Any person with concerns or complaints about the conduct of this study should contact the [redacted] email [redacted] website: [redacted] and quote 14/139.

Thank you for taking the time to consider this study.

If you wish to take part in it, please sign the attached consent form.

This information sheet is for you to keep.

Appendix 4 Participant consent form (interviews)

CONSENT FORM

Decision making acute to residential care

1. I,.....

   of.....

   agree to participate in the study described in the participant information statement set out above *(or: attached to this form).*

2. I acknowledge that I have read the participant information statement, which explains why I have been selected, the aims of the study and the nature and the possible risks of the investigation, and the statement has been explained to me to my satisfaction.

3. Before signing this consent form, I have been given the opportunity of asking any questions relating to any possible physical and mental harm I might suffer as a result of my participation and I have received satisfactory answers.

4. I understand that I can withdraw from the study at any time without prejudice to my relationship with the [redacted] or University of Western Sydney.

5. I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.

6. I understand that if I have any questions relating to my participation in this research, I may contact Tiffany Northall on telephone [redacted], who will be happy to answer them.

7. I acknowledge receipt of a copy of this Consent Form and the Participant Information Statement.

_____ _____ _____

Signature of participant Please PRINT name Date

_____ _____ _____

Signature of witness Please PRINT name Date

_____ _____ _____

Signature of investigator (if applicable) Please PRINT name Date

[redacted]

Appendix 5 Counselling supports

Counselling services

Service Provider	Contact details
Employee assistance program (EAP)	[redacted]
Salvation Army	[redacted] www.salvoscounselling.salvos.org.au
Beyond Blue	1300224636
Lifeline	131114

Appendix 6 Ethics amendment to include physiotherapists

Research and Ethics Office

Leadership • Quality • Governance

[redacted]

16 March 2015

Mrs Tiffany Northall

University of Western Sydney

Locked Bag 1797

Penrith NSW 2751

Dear Mrs Northall,

Project Title: Multidisciplinary decision making: Transfer of older people from acute to residential care

HREC Reference: HREC/14[redacted]

SSA Reference: SSA/[redacted] Local

Project Number: 14/139

Thank you for your Summary Sheet for an Amendment to an Approved Protocol dated 2 May 2015 for the recruitment of an additional 5 physiotherapists. I am pleased to inform you that the [redacted] Human Research Ethics Committee has reviewed and approved this request.

Approval has been granted for the following site(s):

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

Conditions of approval'l

1. The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including: ▫ any serious or unexpected adverse events; and ▫unforeseen events that might affect continued ethical acceptability of the project.

2. The Principal Investigator will report proposed changes to the research protocol, conduct of the research, or length of HREC approval to the HREC in the specified format, for review. For multi-centre studies, the Chief Investigator should submit to the Lead HREC and then send the amendment approval letter to the investigators at each sites so that they can notify their Research Governance Officer.

3. The Principal Investigator will inform the HREC, giving reasons, if the project is discontinued before the expected date of completion.

4. The Principal Investigator will provide an annual report to the HREC and at completion of the study in the specified format.

5. The Principal Investigator must reassure participants about confidentiality of the data.

6. Proposed changes to the personnel involved in the study are submitted to the HREC accompanied by a CV where applicable.

Yours faithfully,

[redacted]

Manager, Research and Ethics Office

[redacted]

Appendix 7 Recruitment flyer

Research participants needed

Attention

Doctors, Occupational Therapists, Physiotherapists Registered Nurses and Social Workers

I am currently doing research on how doctors, occupational therapists, registered nurses and social workers make decisions in hospital to recommend an older person transfer to a nursing home.

I am looking for people who have more than 2 years clinical practice and have worked with older people in hospital.

Your participation will involve:

One interview (approximately 45 minutes) with the researcher

Participation is confidential and your information will remain anonymous.

Please call or email on [redacted] for further information

Appendix 8 Semi-structured interview questions

What do you feel is your role in the decision to transfer an older person to residential aged care?

When assessing an older person what helps you decide to recommend or not to recommend transfer to residential aged care?

What facilitates you to make these decisions?

What makes it more difficult to make these decisions?

How do you feel about the decisions you make?

Appendix 9 Participant demographic form (interviews and observations)

Demographic information

What is your highest level of qualification?

- Diploma
- Bachelor degree
- Master Degree

Other: _____

Which health professional group do you belong to?

- Doctor
- Occupational Therapist
- Registered Nurse
- Social Worker

Physiotherapist

How many years of clinical experience do you have?

_____ years

How many years of experience do you have making decisions in the transfer of older people from acute to residential care?

_____ years

Appendix 10 Participant information sheet (Observations)

Participant Information Sheet

Non-Interventional Study - *Adult providing own consent*

[redacted]

Title Decision making acute to residential care

Coordinating Principal Investigator/

Tiffany Northall

Principal Investigator

Location [redacted]

Part 1 What does my participation involve?

1 Introduction

You are invited to take part in this research project because you are a health professional working in the acute setting and have experience making decisions to recommend an older person transfer from acute to residential aged care. The aim of this research is to explore and describe the factors that influence health professional's decision-making when

recommending transfer of an older person from acute to residential aged care. Currently little is known about how health professionals reach these decisions. Many older people transfer from acute care into residential aged care and they rely on the information they receive from health professionals to guide their choices. This study aims to provide an understanding of how health professionals reach these decisions in order to guide policy development, contribute to care and improve knowledge.

This Participant Information Sheet/Consent form tells you about the research project. It explains the research involved. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about.

2 What is the purpose of this research?

The research is being undertaken by Tiffany Northall as part of her Doctor of Philosophy degree under the supervision of Professor Esther Chang, Associate Professor Amanda Johnson and Doctor Deborah Hatcher. The findings will form part of her thesis.

3 What does participation in this research involve?

To participate in this research you will need to be a doctor, occupational therapist, registered nurse or social worker who has two years or more working with older people in acute care. Participation in this research involves one interview that will last between 45-60 minutes. This interview can be conducted in person or by phone. Prior to attending the interview a consent form will need to be signed and returned to the researcher. The entire research project is expected to finish in 2017, however as a participant you will only be

required to attend the interview and discuss the factors that influence your decisions to recommend an older person transfer from acute to residential aged care. The interview will be audio taped and transcribed. In addition you will be asked to provide some information on your highest level of education, years of clinical experience, the hospital you are employed at and the health profession discipline you are employed as. All identifying information will be removed and pseudonyms will be allocated to protect participants' privacy. The research will be monitored by experienced research supervisors from the University of Western Sydney.

There are no costs associated with participating in this research project, nor will you be paid.

4 What do I have to do?

To participate in this research you will need to be involved in one interview that will take approximately 45-60 minutes. In this interview you will be asked to discuss your decision making when recommending an older person transfer from acute to residential aged care.

5 Other relevant information about the research project

This project is being conducted in 5 hospitals [redacted].

6 Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

If you do decide to take part you will be given this participant information sheet to keep. Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with [redacted] or University of Western Sydney.

7 What are the possible benefits of taking part?

The possible benefits of participating in this research are that health professional's decision making in the transfer of older people from acute to residential care will be better understood. This knowledge can contribute to policy development and formalised processes which can benefit health professionals.

8 What are the possible risks and disadvantages of taking part?

If you become upset or distressed as a result of your participation in the research, the researcher will be able to arrange for counselling or other appropriate support through the employee assistance program (EAP) or lifeline. Any counselling or support will be provided by qualified staff who are not members of the research project team. This counselling will be provided free of charge.

9 What if I withdraw from this research project?

If you decide to withdraw from this research project, please notify a member of the research team before you withdraw. There is no penalty for withdrawing from the project. If you do withdraw your consent during the research project, the researcher will not collect additional personal information from you, although personal information already collected will be retained to ensure that the results of the research project can be measured properly and to comply with law. You should be aware that data collected by the researcher up to the time you withdraw will form part of the research project results. If you do not want them to do this, you must tell them before you join the research project.

10 Could this research project be stopped unexpectedly?

This research project may be stopped unexpectedly for a variety of reasons. These may include the principal investigator withdrawing from the degree.

11 What happens when the research project ends?

On completion of the research project the findings and results will be complied and published to add to existing knowledge.

Part 2 How is the research project being conducted?

12 What will happen to information about me?

By signing the consent form you consent to the researcher using personal information about you for the research project. Any information obtained in connection with this research project that can identify you will remain confidential. All information will be de-identified and on completion of the research will be securely destroyed. Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law.

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified, except with your permission.

In accordance with relevant Australian and/or New South Wales privacy and other relevant laws, you have the right to request access to the information collected and stored by the research team about you. You also have the right to request that any information with

which you disagree be corrected. Please contact the research team member named at the end of this document if you would like to access your information.

Any information obtained for the purpose of this research project that can identify you will be treated as confidential and securely stored. It will be disclosed only with your permission, or as required by law.

13 Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this research project have been approved by the HREC of [redacted] and UWS.

This project will be carried out according to the National Statement on Ethical Conduct in Human Research (2007). This statement has been developed to protect the interests of people who agree to participate in human research studies.

14 Further information and who to contact

If you want any further information concerning this project which may be related to your involvement in the project, you can contact the principal study researcher on [redacted].

15 Complaints contact person

This study has been approved by the [redacted] Human Research Ethics Committee. Any person with concerns or complaints about the conduct of this study should contact the Ethics and Research [redacted]

and quote 14/139.

Thank you for taking the time to consider this study.

If you wish to take part in it, please sign the attached consent form. This information sheet is for you to keep.

Appendix 11 Participant consent form (Observations)

[redacted]

CONSENT FORM

Decision making acute to residential care

1. I,.....

   of.....

   agree to participate in the study described in the participant information statement set out above *(or: attached to this form).*

2. I acknowledge that I have read the participant information statement, which explains why I have been selected, the aims of the study and the nature and the possible risks of the investigation, and the statement has been explained to me to my satisfaction.

3. Before signing this consent form, I have been given the opportunity of asking any questions relating to any possible physical and mental harm I might suffer as a result of my participation and I have received satisfactory answers.

4. I understand that I can withdraw from the study at any time without prejudice to my relationship with the [redacted] or University of Western Sydney.

5. I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.

6. I understand that if I have any questions relating to my participation in this research, I may contact Tiffany Northall on telephone [redacted], who will be happy to answer them.

7. I acknowledge receipt of a copy of this Consent Form and the Participant Information Statement.

_____ _____ _____

Signature of participant Please PRINT name Date

_____ _____ _____

Signature of witness Please PRINT name Date

_____ _____ _____

Signature of investigator (if applicable) Please PRINT name Date

[redacted] Page 1 of 1

[redacted]

Appendix 12 Conference presentations

AAG & ACS Regional Conference-5th-6th March 2015 (Batemans Bay NSW)-Transferring from acute to residential care: Complex decisions for consumers, carers and health professionals.

Australian Nursing and Midwifery Conference-15th-16th October 2015 (Newcastle NSW)-Complex decisions: Nurses decision-making in the transfer of older people from acute to residential care.

7th World Congress on Nursing and Healthcare-17th-18th June 2019 (London England)-Difficult decisions: Nurses transfer decisions from hospital to residential care homes.

Research Futures Forum–School of Nursing and Midwifery, Western Sydney University

23rd July 2014-The role of qualitative inquiry to explore decisions to transfer older people from acute to residential aged care.

22nd September 2015-Complex decisions: Nurses decision-making in the transfer of older people from acute to residential care.

28th-29th June 2016-Application of Colaizzi's method to interview and observational data.

26th-27th October 2017-Health professionals' transfer decisions with cognitively impaired older people in acute care.

2nd-3rd July 2018-Nurses' transfer decisions from hospital to residential aged care-Best senior HDR presentation.

4th-5th July 2019-Health professionals' transfer decisions with older people in hospital.

2nd-3rd July 2020-Case conferencing in transfer decision-making: collaboration or coercion.

Appendix 13 Publication and awards

Publication

Northall, T., Chang, E., Hatcher, D., & Nicholls, D. (2020). The application and tailoring of Colaizzi's phenomenological approach in a hospital setting. *Nurse Researcher,28*(2), 20-25.doi:10.7748/nr.2020.e.1700

Awards

August 2014- The role of qualitative inquiry to explore decisions to transfer older people from acute to residential aged care. Best junior research presentation (Wiley)

29th June 2016- Winner of School of Nursing and Midwifery 3 Minute Thesis–Transferring from hospital to an aged care facility

2nd-3rd July 2018 Nurses' transfer decisions from hospital to residential aged care-Best senior HDR presentation