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Exploring nursing competence to care for older patients in municipal in-patient acute care: A qualitative study

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Abstract

Aim: To identify critical aspects of nursing competence to care for older patients in the context of municipal in-patient acute care.

Background: An increasingly complex and advanced primary healthcare system requires attention to the extent of nursing competence in municipal services. However, competence in complex and advanced care settings must be explored using perspectives which acknowledge the complexity of nurses' performance.

Design: A phenomenological hermeneutic, qualitative approach with individual in-depth interviews was used. COREQ reporting guidelines have been applied.

Methods: A sample of eight nurses and two physicians employed in municipal in-patient acute care units (MAUs) were purposively recruited to participate. Data were collected between May and June of 2017. Analysis and interpretation were conducted systematically in three steps: naïve reading, structural analysis and comprehensive understanding.

Findings: Two main themes were revealed. The first was the following: "The meaning of the individual nursing competence" including the themes "Having competence in clinical assessments, decision-making, and performing interventions"; "Having competence to collaborate, coordinate and facilitate"; and "Being committed." The second was the following: "The meaning of environmental and systemic factors for nursing competence," included the themes "Having professional leadership"; "Having a sufficiently qualified staff"; and "Working in an open, cooperative and professional work environment."

Conclusion: Individual nursing competence in MAUs should include the capability to detect patient deterioration and to care for older patients in a holistic perspective. In addition, the professional environmental culture, supportive leadership and systemic factors seemed to be crucial to success.

Relevance to clinical practice: This study illustrates the nurses' responsibility for older patients' safety and quality of care in the MAUs. These findings can act as a foundation for the development and adaptation of educational programmes

to accommodate requirements for nursing competence in MAUs. The broad perspective of nursing competence can give directions for quality improvements in MAUs.

KEYWORDS
acute care, advanced nursing, municipality, older persons, phenomenological hermeneutic

1 | INTRODUCTION

Nursing competence is emphasised as a valuable resource to promote equitable access to quality care worldwide (WHO, 2016). A competent workforce prepared to accomplish appropriate work performance is crucial to meet quality requirements and achieve positive outcomes in health services (Flinkman, Leino-Kilpi, Numminen, Jeon, & Kuokkanen, 2017; Sandberg & Pinnington, 2009).

Due to the demographic changes, health reforms have been implemented in several EU countries to strengthen primary health care and to reduce the use of hospitalisation (OECD/EU, 2016). These health reforms have often led to increasingly complex primary healthcare services, making nursing competence a critical issue of concern for health authorities (Maier & Aiken, 2016; Maier, Aiken, & Busse, 2017).

OECD (2016) refers to the 1978 Alma-Ata declaration and defines primary care as the "first level of contact for the population with the health care system, bridging health care as close as possible to where people live and work" (p. 38). MAUs are parts of the primary healthcare services. In this study, in-patient care refers to medical treatment provided in a municipal facility and which requires at least one overnight stay.

In Norway, the number of people that have passed the age of sixty-seven is estimated to increase to double the current figure during the next three decades, while the combined working-age population will not have changed (Report No. 47 to the Storting (2008–2009), 2009). The incidence of diseases is commensurate with the ageing population, and accordingly, the need for healthcare services is increasing. As is the case in several EU countries, these demographic changes imply increased pressure on the welfare state's capacity and result in the need for reform measures in the health and social sectors (Report No. 47 to the Storting (2008–2009), 2009). In the Norwegian Coordination Reform (Report No. 47 to the Storting (2008–2009), 2009), one of the initiatives has been to arrange for in-patient acute care in specially adapted acute care units (MAUs) in the municipality. To adapt professional competence to the current changes in primary health care, more knowledge is needed about the implications for professional nursing practice (Maier et al., 2017). This study provides an additional understanding of professional nursing competence in acute care for older patients in municipal in-patient facilities.

What does this paper contribute to the wider global clinical community?

- This study contributes to a better understanding of the complexity of the nurse`s practices in acute care for older patients and illustrates the nurses' responsibility for older patients' safety and quality of care.
- The findings can act as a foundation for the development and adaptation of educational programmes in nursing to accommodate care to older people in municipal acute care settings.
- A broad perspective of nursing competence in municipal in-patient acute care facilities can contribute to service innovation and implementation.

2 | BACKGROUND

Although it is not established by the national authorities which patient groups are meant to be served in the MAUs, an important purpose is to reduce hospitalisation especially for the older population (Swanson, Alexandersen, & Hagen, 2016). The Norwegian government requires that the MAUs are capable of providing appropriate health care and to provide equal or better services to patients than hospital admission. However, it is a prerequisite for admission to a MAU that the patient's condition does not require advanced medical treatment in hospital. Furthermore, the patient's stay should not exceed three days (Report No. 47 to the Storting (2008–2009), 2009). The Norwegian Directorate of Health (2016) has developed guidelines for establishing MAUs in the municipalities. These guidelines underline that a competent workforce to provide safe professional care to patients is crucial and requires registered nurses' (RNs') attendance twenty-four hours seven days a week. Further, the staff are required to have appropriate competence to observe, assess, make decisions and handle acute care situations such as cardiac arrest, as well as general professional care competence. The staff in MAUs must be competent to handle advanced procedures such as oxygen (O_2) treatment, blood sampling, catheterisation, administration of intravenous fluid and drug treatment. Further, competence to handle medical technology such as electrocardiogram (ECG) and pulse oximeter. Relational competence to care for people who experience a mental crisis, or a difficult life situation is also underlined

(The Norwegian Directorate of Health, 2016). The Norwegian Directory of Health pictures a complex arena for nursing care which shows that advanced nursing competence is required. The minimum requirement for RNs working in MAUs is that they have a bachelor's degree in nursing. It is nevertheless preferred, although not specified in the guidelines, that RNs also have supplementary education in advanced and/or geriatric care.

All municipalities in Norway had, by January 2016, established MAUs in diverse organisational forms. Most of the MAUs' consist of one or two beds and are usually located on and are part of an ordinary municipal nursing home. Some municipalities pay to dispose of one or two beds at a medical centre or local hospital, where the municipality is responsible for the treatment and care of these patients. Some of the MAUs are organised as a collaboration between two or more municipalities (Tjerbo & Skinner, 2016). In addition, there is a great deal of variation when it comes to the physicians' presence in the units. Some MAUs have a physician employed full-time, while in other MAUs they are attendant a few days a week. (Swanson et al., 2016). Swanson et al. (2016) found that older patients had significant reductions in acute hospital admissions after the MAUs were introduced. Further, this was associated with physicians being full-time employed. However, studies indicate that the capacity of MAUs remains largely unused (Nilsen, Hunskaar, & Ruths, 2017; Swanson et al., 2016), and the competence of the care providers is questioned (Skinner, 2015a; Swanson et al., 2016). Previous studies indicate that municipal acute care services as alternatives to other emergency wards might be beneficial to older persons, as they are met with favourable attitudes and geriatric knowledge (Hope, 1994) and holistic care (Zurmehly, 2007), particularly regarding social and interpersonal aspects of care (West, Barron, & Reeves, 2005). MAU patients have reported satisfaction connected to the units' geographical proximity, atmosphere and time allocated for care (Leonardsen et al., 2016). Still, the patients' right to participation in own care planning did not seem to be complied with (Johannessen, Tveiten, & Werner, 2017).

To fulfil the prerequisite for competence and qualifications in staff, a well-educated nursing workforce is crucial (Maier & Aiken, 2016). However, research shows that the quality of primary healthcare services is challenged by a lack of well-educated nurses, particularly those who are capable to care for older patients with complex and acute health problems (Bing-Jonsson, Hofoss, Kirkevold, Bjørk, & Foss, Christina, 2016). Although research has focused on different perspectives of the MAUs, few studies have examined the significance of nursing competence in MAUs (Skinner, 2015b; The Research Council of Norway, 2016).

2.1 | Professional nursing competence

A broad perspective on the content of nursing competence is presented in the literature (Bing-Jonsson, Bjørk, Hofoss, Kirkevold, & Foss, 2013; Flinkman et al., 2017; Halcomb, Stephens, Bryce, Foley, & Ashley, 2016; Poikkeus, Numminen, Suhonen, & Leino-Kilpi, 2014). In a systematic and psychometric review based on measurement from use of the Nurse Competence Scale, Flinkman et al. (2017) found correlations between competence and more work experience, higher age, higher education, permanent employment and participation in educational programs. Higher competence was also associated with quality of care and critical thinking, commitment, empowerment and positive practice environments. In another systematic review, Bing-Johnsen et al. (2013) found that nursing competence in municipal health care is mostly understood and defined in a behaviouristic perspective, focusing on skills, tasks, abilities, performance and behaviour. Halcomb et.al. (2016) also found aspects such as research, information technology, teamwork, problem-solving, integrated into the concept of competence. Poikkeus et al. (2014) found that ethical decision-making, ethical sensitivity, ethical knowledge and ethical reflection were important aspects of nursing competence.

Nevertheless, due to the abstract nature of the phenomenon, no agreed-upon definition is presented (Flinkman et al., 2017). According to Riley, Beal, and Lancaster (2008), professional nursing competence might be viewed as an interaction between the individual nurse's attributes, that is what the nurses *are* and professional behaviours, that is what the nurses *do* (Riley et al., 2008). However, professional competence to provide care in complex and advanced settings must be explored in a wide, but thorough, perspective, which acknowledges the complexity of the performance (O'Connell et al., 2014). Although basic task-oriented competencies are acknowledged as a necessity (Halcomb et al., 2016; O'Connell et al., 2014), professional competence in complex and advanced settings also includes capabilities. The term capability can be understood as a potential which may be used. A person's capability includes a combination of knowledge, values, skills and self-esteem which enable the person to handle change (O'Connell et al., 2014). O'Connell et al. (2014) suggest that these capabilities include the following:

> "appropriate and effective action to formulate and solve problems"; "apply competencies in unfamiliar and familiar situations"; "mindfulness, awareness and openness to change;" "being able to engage with social values relevant to action;" and to "work well with others" (p. 2733).

When founded in the nurse's competencies, capabilities enable the performance of professional practices in advanced contexts (O'Connell et al., 2014). Professional competence is mostly referred to as entities, either connected to the work performer or a body of knowledge (Sandberg & Pinnington, 2009). Yet, Sandberg and Pinnington (2009) also underline the relational perspective of professional competence and argue that competence is defined by a social–relational system integrating the subject, the object and also things, by their usefulness (Sandberg & Pinnington, 2009). In this study, our understanding of the term nursing competence includes both task-oriented competencies (Halcomb et al., 2016; O'Connell et al., 2014), capabilities as described by O'Connell et al. (2014) and ethical competence. Moreover, we acknowledge that professional nursing competence includes a

TABLE 1 Overview of the participants' education, experiences, current position and length of interviews

Participant no	Education (year of graduation) *Continuing education*	Clinical experiences/MAU experiences (all MAUs have been established during 2012 or later)	Current position(s) in MAU	Length of the interviews in minutes
1	RN (2012) *Advanced nursing*	Worked 4 years in the rural nursing home where MAU beds are located	Bedside responsible	31
2	RN (2015)	Worked 2 years in the urban hospital where MAU beds are located Previous: municipal elderly care as enrolled nurse	Bedside responsible, projects work	55
3	RN (2013)	Worked 3 years in the urban hospital where MAU beds are located	Bedside responsible, team leader	53
4	RN (2005) *Master's in Nursing Science*	Worked 2 years in the urban hospital where MAU beds are located Previous: geriatric medical hospital wards	Bedside responsible Professional Development nurse	52
5	RN (2008) *Palliative care Geriatric nursing*	Worked 3 years in the urban nursing home where MAU beds are located Previous: medical hospital units, home care nursing, municipal palliative care.	Bedside responsible	60
6	GP (1998)	Worked 4 years (20% position) in the rural nursing home were MAU beds are located. In addition: GP in the municipality	Medical responsible	60
7	GP (1999)	Worked 7 years (100% position) in the rural medical centre were MAU beds are located. Previous: GP in the municipality	Medical responsible	61
8	RN (1996) *Supervision, rehabilitation and palliation*	Worked 19 years in the rural medical centre were MAU beds are located.	Bedside responsible	68
9	RN (1999) *Human resource management and development*	Worked 3 years in the rural nursing home were MAU beds are located. Previous: nursing home and orthopaedic hospital ward	Bedside responsible, team leader, Professional Development nurse	64
10	RN (1992)	Worked 25 years in the rural medical centre were MAU beds are located	Bedside responsible, team leader, Professional Development nurse	48

social–relational system in which the nurse, other persons and "things" are integrated (Sandberg & Pinnington, 2009).

3 | METHODS

3.1 | Aim

The aim of this study was to explore critical aspects of nursing competence to care for older patients in the context of municipal in-patient acute care, as experienced by nurses and physicians.

3.2 | Design

A qualitative phenomenological hermeneutic approach was applied, and data were collected through individual in-depth interviews. Phenomenological hermeneutics explores an individual's lived experience in order to capture the essential meaning of a phenomenon. Lived experience derives from a human being in the world (Lindseth & Norberg, 2004). In the current study, the intention was to explore the lived experience of nurses and physicians working in MAUs related to phenomenon of nursing competence in these units. Phenomenological hermeneutics facilitates a research design that both provides a phenomenological description and interprets meaning to gain a deeper understanding of a phenomenon. In this study, this approach was mainly used for interpreting the interview texts.

Criteria for reporting qualitative research (COREQ), that is the 32 items checklist for interviews and focus groups (Tong, Sainsbury, & Craig, 2007), was adhered when preparing the manuscript (See Appendix S1).

3.3 | Participants

A purposive sample of eight RNs and two physicians (general practitioners—GPs) were recruited from five different MAUs in Southern Norway. To capture a valid and rich picture of experiences and reflections regarding nursing competence in MAUs, the criteria for inclusion aimed to endeavour representation that captured a diversity of contexts.

When recruiting informants, it was emphasised to include participants from MAUs who were different in terms of organisation and

localisation, from both rural and urban areas, with variation in the number of MAU beds and employment of physicians. The inclusion criteria for RN participants were that they had at least two years' nursing experience and at least one year of experience working at an MAU. Preferably, they would also be RNs with experiences in geriatric and/or advance nursing, and some should have postgraduate education accordingly. The criterion for participating GPs was that they were employed in a MAU. To enrich the perspective on the phenomenon of nursing competence in MAUs, we included two GPs in the sample, as they are formally responsible for medical treatment of the patients. In addition, nurses and physicians work in close cooperation and have a joint responsibility to provide safe medical treatment.

Leaders of five MAUs were contacted and asked to identify persons in the staff who they considered as suitable for an interview about the phenomenon of nursing competence and who fulfilled the inclusion criteria. The leaders provided written information about the study to actual persons and asked them to participate. It was underlined that participation was voluntary. The participants' legal rights to withdraw at any time and confidentiality were assured. The leaders scheduled time for the interviews.

3.4 | Data collection

The interviews were conducted by the first author between May and June 2017. Eight interviews were conducted in the participant's workplace, and two interviews were conducted by telephone. Two of the participating nurses were not able to meet the interviewer as first planned; hence, telephone interview was agreed and conducted. In these cases, telephone interviews were chosen by participants as the most appropriate alternative.

To arrange for more complete and rich answers, the interviews had an open approach which implied that no interview questions were planned. In advance, participants were informed that the focus for the interview would be the experiences regarding nursing competence at the MAU. In addition, the interviewer followed up the participants' contributions and asked them to deepen and narrate experiences which illustrated issues of nursing competence or lack of competence (Lindseth & Norberg, 2004). The interviews lasted between 31 and 68 min (M = 55.1 min). Length of the interviews for each participant is listed in Table 1. The interviews were audiotaped and subsequently transcribed verbatim. Data saturation was examined, discussed and decided by the authors.

3.5 | Ethical considerations

The study was conducted in accordance with the Declaration of Helsinki () and approved by the NSD—Norwegian Centre for Research Data (ref. 2017/53126). Permission to conduct interviews was provided by the responsible leaders of the MAUs. In addition to written informed consent from participants, information about the study was repeated prior to each interview, and assurances were provided regarding the participants' legal rights regarding their participation and confidentiality.

3.6 | Data analysis

A phenomenological hermeneutic analysis approach, as developed by Lindseth and Nordberg (2004), was applied. This analysis approach is inspired by Ricoeur's philosophy (Ricoeur, 1976) and includes three steps. First, naïve reading is conducted where the transcribed texts are thoroughly read several times to get an initial understanding of the meaning as a whole. This phase has a phenomenological descriptive approach and provides direction for the next phase. Second, through structural analysis the texts are thematically structured and main themes, themes and subthemes are identified and formulated. The themes were validated by reflecting in the light of the initial naïve understanding. Lastly, comprehensive understanding is gained when the main themes, themes and subthemes are reflected on in relation to the research questions and the context of the study. The texts are read again in a naïve understanding, now with the validated themes in mind. It is designed to be as open as possible, although the researchers' preunderstanding is actively used (Lindseth & Norberg, 2004).

The first step of the analysis was conducted by the first author. All authors were included in the second and third steps to discuss and reach agreement of the interpretation and understanding of the texts' content. NVivo pro 11 was used initially to structure the texts.

3.7 | Trustworthiness and preunderstanding

To understand and improve our practices, we must reflect on the meaning of our lived experiences. Qualitative research interviews aim to reveal participants' lived experience. As researchers we take part in these experiences, we interpret and understand the meaning of them, purposely using our preunderstanding (Lindseth & Norberg, 2004). Preunderstanding is, according to Lindseth and Norberg (2004), a prerequisite for meaning and essence to appear. The first author's previous clinical experience from acute care settings was purposively used in data collection, interpretation and understanding during analysis and discussion. According to Lindseth and Norberg (2004), it is a part of human nature to be party to preconceptions in our understanding of the lifeworld. Preconceptions might lead to prejudices which are, in turn, pitfalls that impact the trustworthiness of research. Prejudice might impact both the participant who is presenting his/her interpretation of the lifeworld and the researcher's interpretation of the text in questions. To address this concern, Lindseth and Nordberg (2004) suggest that the participants narrate from lived experience. Narratives help the participants to bracket prejudices, and drawing conclusion influenced by prejudice is less likely when stories are told (Lindseth & Norberg, 2004). In the present study, the participants were encouraged to narrate their experiences and to speak out freely during the interview without interruptions and impact

TABLE 2 Examples from the structural analysis

Meaning units	Condensations	Subthemes	Themes	Main themes
"Most of our patients are elderly and multimorbid. These patients need time. It is a serious responsibility to care for them in a satisfactory way" (8, nurse)	It is a serious and time-consuming responsibility to care for geriatric patients	Handling a wide range of care tasks	Having competence in clinical assessments, decision-making, and performing interventions	The meaning of the individual nursing competence
" "I asked how he was. "Fine", he said, "but a little cold". Then I touched his skin and realized he had a high fever… so I thought: from the urinary tract it escalates extra fast.	Being able to understand the patients' condition	Making qualified decisions		
…. we started examining the patient's vital parameters, assessing the CRP, establishing the PVC, administering fluid…and then the emergency team came. After a short time, he was sent to the hospital with sepsis"" (8, nurse)	Knowing what to do to verify suspected sepsis, to reduce escalation and to ensure that an appropriate decision is made.	Performing required treatment and care		
"The relatives declined discharge to a short-time unit due to previous negative experiences from that place… So, I sat down with them and heard what they had to say. Then I said: "okay, this is your experience, but what do you expect from them?" Then I suggested a meeting with the nurse in charge …called up the unit and arranged for it…"" (3, nurse)	Listening to the relatives and taking their preferences' seriously.	Cooperating with patient and relatives	Having competence to collaborate, cooperate and communicate with others	
	Preparing for a planned and predictable patient transition	Cooperating with the patient's residential environment and municipal health services		
"I had only been a nurse for half a year and I was scheduled to do two nightshifts. On the first night I thought, no, we were two nurses, and she is less experienced than me. If there was to be a patient with cardiac arrest… or acute deterioration, it would be up to me. I was not confident with my own competence, how to handle different situations. It was not safe, so I used a self-certification for the last night" (2, nurse)	Having only unexperienced and newly graduated nurses on duty is not safe for the patient in advanced settings.	Having sufficiently qualified nurses with clinical experience	Having a sufficiently qualified nursing staff	The meaning of environmental and systemic factors
"If you are alone as a nurse (RN)… you have others (enrolled nurses), but they neither have that experience nor the responsibility. It would be safe for me if we were two (RNs) to exchange … and help each other" (8, nurse).	Being unable to discuss and assess patient issues and share responsibilities with other qualified nurses	Having access to collegial support		
"There might be patients who need intravenous antibiotics. At the hospital we had to be two nurses to do the medication control, this is not possible here" (9, nurse).	Lacking opportunity to double-check the administration of medication			

TABLE 3 Overview of main themes, themes and subthemes

Main themes	The meaning of the individual nursing competence			The meaning of environmental and systemic factors for nursing competence		
Themes	Having competence in clinical assessments, decision-making and performing interventions	Having competence to collaborate, coordinate and facilitate	Being committed	Having professional leadership	Having a sufficiently qualified nursing staff	Working in an open, cooperative and professional work environment
Subthemes	Handling a wide range of care tasks Making qualified decisions Having clinical experience Performing required treatment and care	Collaborating with physicians Collaborating with the municipal health services Coordinate and facilitate patients' care and services Collaborating with patients and relatives	Dedicated to nursing in different settings of patient care Enjoying learning and being challenged Enjoying working with different tasks	Having a leader who facilitates a professional culture Having a leader who is accessible and approachable Having a clearly defined leader	Having sufficiently qualified nurses with clinical experience Having access to collegial support	Being in a supportive and respectful environment Being in a supportive, learning-promoting environment

from the interviewer's prejudgement of the phenomenon of interest. The interviewer requested participants to elaborate or explain further if necessary (Lindseth & Norberg, 2004). In order to minimise the researchers' bias in the interpretation and understanding of the data, making a distinction between preunderstanding and prejudice was emphasised, and it was strived to bracket prejudice (Lindseth & Norberg, 2004). Three researchers were involved, consecutively discussing and accounting for all phases in the research process after data collection.

4 | RESULTS

4.1 | Sample and setting

Three of the five included MAUs were located at nursing homes, both in urban and rural areas. One of the MAUs was located at an urban hospital and one at a rural medical centre. The MAUs differed extensively in relation to number of beds and intensity of physicians employed available on duty, which ranged from half a day three times a week to 24 hr, 7 days a week. All participating RNs had experience from bedside geriatric nursing, either from hospital settings, medical centres, nursing homes or from home care nursing. The timeframe for the participants' nursing practice experience varied from 2–25 years. Five of the RN participants had continuing education qualifications, including one with advanced nursing and one with geriatric nursing. The two participating GPs were medically responsible for the MAU where they worked. One had four years' experience from the nursing home at which the MAU was located, and the other one had seven years' experience from the medical centre's MAU. Characteristics of participants and settings are presented in Table 1.

4.2 | Naïve understanding

Nursing care in MAU includes competence to perform basic nursing care as well as advanced clinical observations, assessment and interventions. A lack of predictability regarding the severity of the older patients' conditions and variability regarding cooperation with the medical services, requires nurses' capabilities to manage advanced assessment and decision-making in potentially critical situations. Further, a lack of qualified nurses in the workforce throughout the day and night represents challenges to the quality of care. Working in a collaborative, supportive and professional environment is important for developing and strengthen nursing competence in MAUs.

4.3 | Structural analysis

Two main themes regarding nursing competence in MAUs were revealed from the structural analysis: the meaning of individual nurse competence; and the meaning of environmental and systemic factors. Examples of the structural analysis are shown in Table 2. Overviews of main themes, themes and subthemes are presented in Table 3.

4.4 | The meaning of the individual nursing competence

4.4.1 | Having competence in clinical assessments, decision-making and performing interventions

All participants perceived the acutely ill older patients' conditions as unpredictable and complex. Occasionally, diagnoses were not clarified, and adequate medical treatment was not prescribed before admission to the MAU.

> "A precondition to be admitted to MAU should be a clarified condition and a complete medical prescription from the admitting physician should be available. But tell me, what patient over 75 years is clarified? The older the patient, the less clarified." (6, physician).

The patients were referred to MAU by a GP or from a municipal emergency medical service. Whether the referral went through the MAU physician or directly to a MAU nurse was dependent on how the medical service was organised in the MAU and time of the day. However, the nurses' preparation before the patients' arrival was mostly based on telephone communication with a GP.

> "Obviously, the information you get on the phone from the GP does not always match what you actually see when the patient arrives at the unit" (10, nurse).

Reasons given for the disparity were inadequate enrolment, that is lacking information from the referring GP, or that it could take hours between the GP's consultation and the patient's arrival at the MAU, while in the meantime the patient's condition might have deteriorated. Occasionally, nurses also experienced lack of communication between the physicians responsible across the shifts, thus the responsible physician lacked knowledge about the patient. The nurses' ability to question and assess patients' health condition and make the right decisions based on these changing needs and assessment was considered a complex and challenging responsibility. This included performing relevant interventions, deciding when to call the physician and communicating adequate and relevant information to the physician. It was underlined that this responsibility, which required nursing at an advanced level, also should include geriatric assessment competence.

> "The situation could easily be an emergency, due to the severity of their (patients') condition when they arrive, then you have to be prepared" (9, nurse).

Of their reliance on nurses, physicians reported:

> "We are dependent on having eyes that are good at seeing and ears good at hearing, that is extremely important" (7, physician).

The term "having the clinical gaze," which was frequently used by most of the participants, seemed to include an intuition based on experiences, such as the ability to follow and understand physiological trends in order to predict and detect early signs of patient deterioration.

> "Unexperienced young nurses appreciate the Early Warning Score (EWS), but they must learn to practice the clinical gaze in addition…., pathophysiological understanding is a prerequisite, especially due to the number of patients who don't fit into the scores e.g. older patients …" (4, nurse).

Standards and scoring systems, however, seemed to be useful tools for clinical observations and assessments, even for experienced nurses.

> ".. it is about making precise observations for signs of deterioration, such as infection development…." (8, nurse).

> "…we typically use the EWS measurement as a standard tool, … but we should, however, … due to the limitation of the EWS, also implement a tool to predict sepsis development in older patients …" (10, nurse)

Competence in performing required tasks mirrored the broad scope of nursing care to older patients in MAUs. All participants highlighted the ability to act appropriately in acute critical situations. As examples, they mentioned administration of intravenous fluid and drug treatment, competencies to handle medical technology and procedures. Occasionally, the responsibility for assessing the need for and initiate oxygen therapy was delegated to the nurses.

> "We have a lot of patients admitted with COPD exacerbation, … we assess the patient and deliver oxygen if needed …" (1, nurse).

Proficient use of procedures and standards, such as cardiopulmonary resuscitation (CPR)/Advanced CPR, early warning score (EWS), and tools to improve communication, were considered crucial to ensure patient safety.

> "If I call the physician and tell her that the patient is deteriorating, - what does that mean? nothing actually ""what do you mean … how deteriorating?"" (3, nurse).

> It was a cardiac arrest situation…. we followed the CPR algorithm, use a standard communication tool ISBAR (which is a model of communication between healthcare professional's teamwork around a patient's

condition) and EWS … the communication was clear and calm" (3, nurse).

Furthermore, tools for assessing older patients' nutritional state, predicting fall risk and self-care ability were considered valuable to provide holistic care.

The concern for the patient's general condition, self-care ability and life situation seemed also to be an important focus for the nurses. Several participants expressed their concerns about older patients who were malnourished and dehydrated upon admission to the unit.

> "… older people, frail … who need to be seen to a little bit, then nutrition is important, perhaps poor nutrition at home… it's good for them to come in here and feel a bit taken care of… get up to go again, they get a bit stronger… their condition might improve, then the need for health services (at home) might change" (9, nurse).

The nurses' ability to systematically map, plan and initiate interventions to improve the patients' conditions was highlighted, but these tasks were sometimes difficult to accomplish due to heavy workloads and lack of time.

4.4.2 | Having competence to collaborate, coordinate and facilitate

Clear and precise communication and cooperation between nurses and physicians were considered crucial for medical treatment, patients' progress and safety.

> "The physician is always in charge of medical treatment, but the responsible nurse, who cares for the patient, is the one who observes, documents and gives feedback, which is alpha and omega to the physician" (5, nurse).

Hence, the nurses' ability to understand and clearly present relevant, unequivocal and precise information and assessments to the physicians was considered important.

> "…. one must base the services on experienced and competent nurses, they are the ones who see and are close to the patients, and report to the physician when things are not going the usual way" (6, physician).

According to the physicians in the sample, the nurses' capability to be aware, critically reflect and discuss the medication with the physicians was considered important in order to administer and follow up their prescriptions.

> "They pick up things, they record minor changes. They are good at remembering things… like - has anyone remembered prescribing so and so…. no one, its forgotten. They are on the alert all the time … if we write things that are unclear, or maybe incorrect, in a prescription or so… they arrest us immediately" (7, physician).

Knowledge and experience were considered important prerequisites for being active and proactive contributors, and sometimes directors, in the medical care for the patient.

> "Because if you are new, you don't yet have that self-confidence, you do not dare to confront the doctor directly, as you may think you are wrong" (3, nurse).

In general, the participants experienced a constructive and collaborative relationship between nurses and physicians. Nevertheless, apparently due to many different physicians in charge and some of them unexperienced, communication was occasionally unclear and cooperation unpredictable.

> "I notice that they (the responsible physicians) are very different and how quickly they act when we observe changes in the patient's condition. I may think "this patient has an upcoming sepsis, it`s urgent, he needs hospital admission". There is a very big difference in how quickly they (the patients) are sent to the hospital" (5, nurse).

The participants reported that proximity to and local knowledge of the patients' residential environment and the municipal health services were beneficial to better understand the patients' preferences. Thus, cooperating with the home care services seemed to facilitate adequate care provision to the patient as well as a satisfactory transition and follow-up after discharge.

> "We know some of the nurses in home services, it's easy to make that phone call…. we understand each other's work and cooperate well, and we all want the best for the patient" (9, nurse).

However, while it is recommended to comply with patients' and relatives' preferences and wishes, it was not always possible to accommodate them.

The participants emphasised the importance of listening to the older patient and their stories and acting in their best interest. For example, they noted that patients were sometimes offered a prolonged stay in the MAU until the home care services could offer a satisfactory follow-up arrangement after discharge. Furthermore, in situations where relatives carried a heavy care burden at home, the patients could sometimes have a few more days at the MAU to give their relatives a much-needed break.

> "Dialogue is really important … listen to what the patients and the relatives think about discharge, do

they need to stay longer … maybe exhausted relatives needing a break (1, nurse).

4.4.3 | Being committed

The meaning of being committed was connected to the nurses' interest, engagement and dedication to nursing.

> A good nurse is interested in nursing … to keep dedication and stay in job they need to get the opportunity to supply their professional knowledge" (6, physician).

Terms as "enjoying work" and "being engaged" were frequently used by the participants and seemed to refer to patient encounters and relational settings, as one participant said:

> "You must enjoy working with people. In my fifteen years of experience as a nurse with all those individual patients encounters, it has never been boring… … being engaged is important" (4, nurse),

Enjoying and being engaged were also related to learning and being challenged, for example by the inherent unpredictability which characterises acute care units.

> "I learn something new nearly every day…. You must handle challenges. Suddenly there is a phone call from the casualty clinic, admitting a patient, you must always be prepared to deal with unpredictability, you never know what you will encounter" (9, nurse).

However, being dedicated to nursing in different settings of patient care and enjoy working with different tasks, not only acute care, was considered as important.

Interest, engagement and dedication to nursing was also considered as a potential to promote innovation, progress and improvement in the MAUs.

4.5 | The meaning of environmental and systemic factors for nursing competence

4.5.1 | Having professional leadership

Having an accessible and approachable leader of the unit, who facilitates a professional culture, was emphasised by all participants.

> "The caring culture must be built, and that is primarily the leader's responsibility" (3, nurse).

> "I have a leader who considers it important that a nurse engages with nursing development, that we get the opportunity to immerse ourselves, implement things, gain responsibility and experience a sense of belonging. That's why I work here" (5, nurse).

Some participants reported the importance of a leader who engaged in planning adequate and effective daily routines. Furthermore, the leader's ability to take control of and handle disagreements between staff was important. When more staff was needed to cover all shifts with qualified nurses, the leader's ability to argue with the granting authorities to gain adequate resources was valued by participants.

4.5.2 | Having a sufficiently qualified nursing staff

Several participants experienced that the lack of RNs beyond regular daytime was a major challenge. The problems were most prominent at night, where there often was only one RN on duty together with an enrolled nurse. Consequently, tasks which RN qualifications were needed to perform, that is medication administration and control, patient assessments and monitoring, advanced procedures and so forth, sometimes had to be handed over to enrolled nurses who were not sufficiently qualified. Access to support from colleagues, who can provide second opinions in patient assessment and follow-up, was considered as a crucial factor of quality, but was not always present at MAUs.

Several participants also experienced that high workloads could challenge the intention of providing holistic care to patients. A lack of qualified nursing staff could prevent the attention needed to provide holistic care for the older patients.

4.5.3 | Being in an open, cooperative and learning professional work environment

The meaning of being in a professional team could be seen on two levels. The first level represented the general professional atmosphere, in which attitudes and actions were founded on a collective understanding of the aims and scope of the services.

> "It has become a culture in which everyone, I think, feel that they are a crucial part of the joint work we do" (7, physician).

Furthermore, it was emphasised that a diversity of competencies should characterise the professional nursing team in the units.

> "Due to the diversity of patients' conditions it is beneficial to have a diversity of competences in the unit…" (4, nurse)

Second, being part of a professional team could be viewed on a situation specific level, that is the way of communicating and cooperating in acute and critical situations, where action and timing are crucial. Being in a supporting and respectful environment was

considered a prerequisite to maintain, develop and make use of competencies and capabilities in the staff.

> "In the beginning, the cooperation between nurses and the physician was a bit tense and inhibitory, …if the physician doesn't take us seriously, for example our assessment of the need for pain relief, it is a major problem for the treatment of the patient, …but due to the focus on communication and collaboration skills, this is much better now" (4, nurse).

Due to the different level of competencies among care personnel in the MAU, it was still emphasised by participants that tasks should be adapted to the nurses' professional competence and responsibility.

All participants highlighted the importance of being in a learning culture in which individual and collective professional improvements were promoted. Learning was considered important both to provide high-quality care to the patients and to maintain engagement and pleasure in work performance. A learning culture seemed to include two aspects. One was about the formal and planned teaching, training and supervision in the unit, which could be provided by internal or external resources. Learning provided by internal resources could be the regular, scheduled training to manage acute and critical situations and external learning could be facilitation of enrolment in postgraduate courses at a university. The other aspect of learning culture was the daily knowledge exchanged among the staff. Some nurses had experience and knowledge in specific field of nursing and had responsibility to share their knowledge to improve nursing competence and practice in the unit.

5 | DISCUSSION

The aim of this study was to explore critical aspects of nursing competence in the context of MAUs, as experienced by nurses and physicians.

5.1 | The individual nursing competence

The findings showed that older patients admitted to MAUs have a variety of conditions and diagnoses, often complicated by multimorbidity, cognitive and functional impairment. Thus, as O'Connell et al. (2014) suggest nurses' capabilities to apply competencies in unfamiliar and familiar situations and to effectively identify and adequately solve complex problems, might be crucial. Moreover, our findings suggest that nurse's capability to capture even marginal signs of change in the patient's condition might be decisive to apply early interventions and prevent critical situations. This capability might be described as a process of pattern recognition, in which the nurse compares the patient's signs and symptoms with patterns recognised from recalling memories of similar situations. The literature highlights the similarities between pattern recognition and intuition in clinical decisions processes. However, intuition occurs on an unconscious level and pattern recognition at conscious level (Banning, 2008; Manias, Robyn, & Trisha, 2004). Ability to recognise patterns increases in line with knowledge and experience in the specific area of nursing (Banning, 2008). However, relying solely on pattern recognition in decision-making could be inadequate and misleading due to limitations in the person's memory (Banning, 2008). Thus, the value of tools to assist in decision-making processes might reduce the risk of inadequate assessments (Nannan Panday, Minderhoud, Alam, & Nanayakkara, 2017). Nevertheless, competence to devote attention to the limitations of the tools that are used is necessary (Churpek, Yuen, Winslow, Hall, & Edelson, 2015; Downey, Tahir, Randell, Brown, & Jayne, 2017). The findings in our study showed that experienced nurses acknowledged and used scoring tools and measurements to validate an intuitive perception of the patients' deterioration. However, our findings also underpin that early warning scores never should replace clinical judgement in decision-making. These findings are also in line with previous studies (Nannan Panday et al., 2017; Odell, Victor, & Oliver, 2009).

Our findings indicate that systematic use of EWS and handover tools to improve communication was valuable especially in the novice nurse's practice and to perform accurate and clear communication with the attending physician (Anderson, Malone, Shanahan, & Manning, 2015; Downey2017). Moreover, to implement scoring tools to map for instance the patient's nutritional and functional state as shown in this study might be a contribution to provide nutrition and activity of daily living in geriatric care (Nielsen, Maribo, Westergren, & Melgaard, 2018).

Although physicians are formally responsible for medical treatment in the MAUs, our findings showed that the physicians' decision-making often leans on the bedside nurse's observations and assessment, to provide safe medical treatment. This underlines that the nurse's competence to communicate, cooperate and collaborate is decisive to accommodate quality requirements in the services (Kirsebom, Wadensten, & Hedström, 2013; Lopez, 2009; O'Connell et al., 2014; Tsai, Tsai, & Huang, 2016). Further, the diverse organisation of the medical service in the MAUs evidently impacted on physicians' continuity in patient follow-up and, thus, seemed to cause extended reliance on nurses' capabilities to make adequate assessments and decision-making. Studies exploring the transfer of care responsibility from physicians to nurses have found that nurses in advanced settings produce high-quality care, which positively impacts on patient experiences, outcomes, safety, hospital admission and mortality (Laurant et al., 2008; Maier et al., 2017; Martínez-González et al., 2014; McDonnell et al., 2015; Morilla-Herrera et al., 2016).

Our study underpins nurses' responsibility to focus on the health-promoting aspect of care for older patients, although their MAU stay exceeds a few days. This includes the patients' health condition, self-care ability and life situation in general. The nurses' competence to systematically map, plan and initiate interventions is essential. One example is to improve nutritional status, as malnutrition is prevalent in geriatric patients and it is associated with reduced activity of daily living (Nielsen et al., 2018). In a systematic review by Morilla-Herrera et al. (2016), they underline the advanced nurse's capabilities to take

an active role as consultants and collaborators in multidisciplinary teams, and to initiate and facilitate the development of individualised evidence-based care plans.

Our study showed that the nurses' commitment is an important aspect of nursing competence in MAUs. The finding is in accordance with Coventry, Maslin-Prothero, and Smith (2015), who concludes that committed nurses who participate in continuing professional development, promote high-quality care and safe patient outcomes. Furthermore, O'Connell et al. (2014) suggest that nursing in advanced care settings requires the capability to engage with relevant social values. Indeed, studies have shown that development of professional competence must evolve in a gradual process, in which the nurses must take an active role (Tabari-Khomeiran, Yekta, Kiger, & Ahmadi, 2006).

5.2 | Environmental and systemic factors

A respectful and supporting atmosphere and a collaborative culture in which both nurses and physicians emphasise and engage in improvement of nursing care, seemed to be crucial to accommodate quality requirements to the services in MAUs. This is in line with the findings reported by Odell et al. (2009). This suggestion gains support by Sandberg and Pinnington (2009), who also argue that professional competence, is defined by social–relational unity.

A professional culture promotes patient safety (Metsala, 2014; Riley et al., 2008) and might have a self-reinforcing effect. But clearly, findings in this study showed that an open, learning-promoting and professional care culture must be supported by a professional leadership which distributes and organise staff according to required qualifications and facilitates plans and space for competence development. Previous research shows that high RN staffing is associated with improved patient outcomes (Lankshear, Sheldon, & Maynard, 2005) and further, that collegial verification can improve and expedite the decision-making process (Thompson & Lulham, 2007). Thus, it is important that the leaders use their position to report and negotiate the need for a qualified workforce. This suggestion receives support from literature which shows that nurses' abilities to improve and participate in professional development depend on culture, leadership and workload (Coventry et al. 2015; Havig & Hollister, 2017; Poikkeus et al., 2014). However, due to the lack of access to qualified nurses in primary health care (Bing-Johnsen et al., 2016), the planning for a qualified nursing workforce in primary health care might become a political concern (Maier & Aiken, 2016; Maier et al., 2017; OECD/EU, 2016).

Based on the findings in this study, it seems to be an essential prerequisite for RNs working in MAUs to have knowledge and understanding about the care of older people. Furthermore, both based on the current findings and in order to comply with Norwegian government guidelines (The Norwegian Directorate of Health, 2016), it is recommended that the RNs in MAUs should hold formal competence in advanced nursing. However, stipulating an advanced nursing qualification as a prerequisite at the point of recruitment for RNs would probably not be realistic for the MAUs to achieve. Thus, as the findings of this study have shown, a learning culture, which facilitates the improvement of the individual nurse's capabilities and performances in MAUs, might be crucial to ensure safe nursing care for the older patient in the units. In that regard, a present professional leadership in MAUs which facilitates both formal and experience-based learning in the nursing workforce is essential.

Due to the variety of conditions and diagnoses that accompany acutely ill older patients admitted to MAUs, a variety of competencies represented in the RN workforce to enrich the overall clinical nursing competence in the unit in question seems to be beneficial. However, in order to inform policy, practice and education in relation to what competencies this might entail, further research is needed.

5.3 | Limitations

The sample size in this study was limited. However, to capture the variability in experiences, we endeavoured to recruit participants from MAUs which differed in terms of size, localisation and organisation. We also included both nurses and physicians to explore different aspects of the phenomenon of nursing competence. Our interpretation of the findings might be one out of many. Due to the nature of qualitative research, interpretation of the findings could have been different if conducted by other researchers, and the perspectives of the researchers involved must thus be considered. The participants were recruited by the leaders of the units, which could affect the composition of the sample due to the "gate keeping" bias (effect).

6 | CONCLUSIONS

To provide high-quality care in MAUs, nursing competence should include the capability to recognise and handle deteriorating older patients while at the same time maintaining a holistic perspective. Thus, critical aspects of nursing competence seem to include competencies to care for the patients' basic needs, but also capabilities to provide acute care and geriatric assessment at an advanced level. Hence, formal educated nursing staff holding advanced nursing competence should be required qualifications for working in MAUs. Furthermore, a professional and collaborative work culture, and a committed nursing staff supported by professional leadership would contribute to professional care, learning and development in MAUs. Further research should focus on the role of leadership to promote nursing competence in in-patient acute care in municipal healthcare services.

7 | RELEVANCE TO CLINICAL PRACTICE

This study contributes to a better understanding of the complexity of the nurses' practices in municipal in-patient acute care, and it illustrates how comprehensive the nurses' responsibility for older

patients' safety is, as well as the quality of care. The findings can act as a foundation for the development and improvement of educational programmes to increase MAUs' access to competent nurses. The findings can also be useful for development of nursing competence standards and give directions for quality improvement in MAUs.

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CONFLICT OF INTEREST

The authors declare no conflicts of interest.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

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