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**Who Cares? A Case Study to Explore
Health Care Assistants' Jurisdiction
in a Hospital Setting**

Karen Spilsbury

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A thesis submitted to City University in accordance with the requirements
of the degree of PhD

Department of Adult Nursing
St Bartholomew School of Nursing and Midwifery

January 2004

For Julia

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DECLARATION

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ABSTRACT

Changes to the work of registered nurses (RNs) has generated increasing concern about the ways in which HCAs are used and the basis for the division of nursing work tasks and roles. The theoretical and empirical foundations upon which these divisions lie are often weak. Empirical data are often lacking, or of sufficiently poor quality to be questioned. This thesis seeks to understand the division of work between HCAs and RNs in adult general care in one acute NHS hospital.

The thesis makes use of an interactionist perspective to frame the study's examination of the micro-social processes surrounding the daily negotiation of HCAs' work. In doing so, connections are made to the wider (macro) processes that influence nursing work. An in-depth case study approach using documents, survey, interviews, focus groups and participant observation was used to collect data on the demographic and biographic characteristics of HCAs; their perceptions of their work; the nature of observed work; the ways in which their work is supervised; their interactions with other nurses; and RNs' perspectives of HCA work.

National, professional and organisation policy expectations emphasise the HCA role as one of *assisting* RNs under their *supervision*. This study reveals significant deviation from these policy goals. The workplace arena - and the negotiations that take place in it - actively shapes HCAs' work and yet policy makers often appear to disregard this characteristic. Differing amounts of power associated with the occupational groups in hospitals influence the nature and outcome of work-related negotiations at the organisational level - the results of these negotiations are variable, and lead to dynamic patterns of use, non-use and misuse of the HCA resource. These patterns led to some unintended outcomes: a resentful workforce, the creation of gaps in the application of nursing care, and traditional quality assurance mechanisms left wanting.

ABBREVIATIONS

A&E	Accident and Emergency
ADN	Assistant Director of Nursing
CL	Clinical Lead Nurse
DHSS	Department of Health and Social Security
ECG	Electrocardiogram
GNC	General Nursing Council
GSCC	General Social Care Council
GUM	Genito-Urinary Medicine
GWC	General Whitley Council
HCA	Health Care Assistant
HIV	Human Immunodeficiency Virus
ICN	International Council of Nurses
NCVQ	National Council for Vocational Qualifications
NHS	National Health Service
NMC	Nursing and Midwifery Council
NPSA	National Patient Safety Agency
NSF	National Service Framework
NVQ	National Vocational Qualification
RCN	Royal College of Nursing
RN	Registered Nurse
SEN	State Enrolled Nurse
SCVQ	Scottish Council for Vocational Qualifications
TPR	Temperature, Pulse, Respiration (Systemic observations)
UK	United Kingdom
UKCC	United Kingdom Central Council for Nursing and Midwifery
US	United States
WHO	World Health Organisation

CHAPTER 1 - INTRODUCTION: DEVELOPMENT OF THE NURSING WORKFORCE AND THE HEALTH CARE ASSISTANT GRADE

This thesis is concerned with understanding the work of health care assistants (HCAs) - the non-registered proportion of the nursing workforce – in adult general care in an acute hospital setting. Whilst the HCA has always had a key role in the provision of nursing care to patients (Redfern, 1994), writers over the past 25 years have highlighted that the contribution of the non-registered nurse has been largely unacknowledged and that there is a general lack of understanding about their work (Hardie, 1978a; Salvage; 1985; Thornley, 2000). Since HCAs are providing nursing care to patients, it is crucial to gain an understanding of their work by examining their contribution to patient care and considering their potential for improving patients' experiences of care.

There are over 100,000 non-registered nurses, including HCAs, employed by the National Health Service (NHS) in the UK, supporting a registered nursing workforce of over a quarter of a million (Buchan and Seccombe, 2002). Table 1-1 shows the whole-time equivalent number of nursing and midwifery staff employed by the NHS in England, 1997 to 2000. There has been a developing trend of increasing numbers of HCAs being employed in the NHS; their numbers rising by 10,000 (10.8%) over four years. Between 1997 and 2000 the numbers of non-registered nurses being employed in the NHS increased at twice the rate of registered nurses. More recent figures suggest that between 1999 and 2001 the numbers of registered and non-

registered nurses have increased at similar rates of 7 per cent (Buchan and Seccombe, 2003). HCAs, therefore, constitute a significant proportion of the nursing workforce.

However, despite the growing numbers of health care assistants in the wider NHS nursing and midwifery workforce there is only minimal data on their numbers because of a lack of consensus on classification of this type of worker (Buchan and Seccombe, 2002). There are estimates that there may be over 300 titles for assistant workers in health care (Johnson *et al.*, 2002). A review of the international literature for this thesis revealed a range of titles (Table 1-2).

Table 1-1 Whole-time equivalent number of nursing and midwifery staff employed by the NHS in England, 1997 to 2000

	1997	1998	1999	2000	% change 1996-2000
Qualified (registered nurses)	246,010	247,240	250,650	256,280	4.2%
Unqualified & HCAs (non-registered nurses)	101,960	105,290	108,850	112,970	10.8%
Learners (student nurses)	2,250	2,080	1,880	1,970	-12.4%
Others (enrolled nurses)	590	430	490	70	-88%
TOTAL	350,810	355,050	361,870	371,290	5.8%

Source: Department of Health Statistical Bulletin 2001/3, as cited by Buchan and Seccombe (2002: 25)

Table 1-2 Titles of non-registered nurses identified in the literature review

Country	Non-registered nurse title
UK	Health Care Assistant; Support Worker; Support Personnel; Ward Auxiliary; Generic Helper; Care Assistant; Ward Co-ordinator; Sister's Assistant; Generic Support Worker; Clinical Support Worker; Healthcare Support Worker; Care Team Assistant; Nursing Assistant; Ward Assistant; Theatre Assistant; Community Care Worker; Home Carer; Bedmaker; Housekeeper
USA	Nursing Aides; Nursing Technical Assistant; Patient Care Technicians; Nurse Extenders; Unlicensed Assistive Personnel; Patient Care Aide; Clerk Environment Technician
Australia	Assistant in Nursing; Patient Care Assistant

The roles, as well as titles, of HCAs are diverse. HCAs may be used in the delivery of nursing care to supplement, complement or replace (substitute for) registered nurses. Gardner (1991) and Krapohl and Larson (1996) present five main models of assistant roles and these are summarised by Table 1-3.

Table 1-3 Models of assistant roles: Duties and responsibilities

Models of assistant roles	Duties and responsibilities
'Traditional' aides/ assistants/ auxiliaries	Mainly trained on the job, performing simple nursing tasks in support of registered nurses
Non-clinical assistants/ extender clerks/ aides	Mainly involved in non-clinical/ housekeeping work (can be multi-skilled support workers)
Technical assistants/ operating department assistants	Have a specified remit in relation to complex technological processes, assisting nurses
Primary practice partner nursing assistants	Work alongside primary nurses to maintain delivery of care by primary nursing
Vocationally trained/ qualified carers	Have undergone a specified additional programme of training which leads to a vocational qualification to take on nursing care responsibilities under the direction and supervision of registered nurses

REGISTERED AND NON-REGISTERED NURSES

The process by which the nursing workforce segregated itself into registered and non-registered nurses has been well documented (Abel-Smith, 1960; Baly, 1986; Dingwall *et al.*, 1988; Witz, 1992). The shape of nursing practice today is the result of varied and complex socio-political interactions occurring over time, in a variety of social arena and at differing policy levels (Rafferty, 1992). Many historical accounts of nursing refer to the registration process and the quest for professional status by registered nurses (Hector, 1973) and ignore the implications of these processes for non-registered nurses. Examination of non-registered nurses should begin with the creation of their complement – registered nurses – and the Registration Act.

The Registration Act

The Registration Act was implemented in 1919 (Dingwall *et al.*, 1988) and enabled nurses to register with the General Nursing Council (GNC). The GNC was formed out of the Nurse Registration Act. Proponents of registration wanted nurses to undergo general training, producing ‘transferable’ skills, applicable to different patient groups, across differing hospital settings and clinical specialities.

‘Registrationists’ – a term used by Dingwall *et al.* (1988) to define nurses pursuing registered status for other nurses – proposed three key changes to the organisation of nursing workforce following registration. First, an autonomous professional body to centralise the control of nursing labour; secondly, a self-governing body with a majority representation of nurses; and finally a one-portal system of entry to nursing to establish standards and duration of training (Witz, 1992). These key changes for the organisation of the registered nursing workforce were core features of nursing’s ‘professionalisation’ project and are returned to in Chapter 4.

The Registration Act marked an important turning point in the development of the nursing workforce. Significantly, the nursing workforce was (broadly) divided into two groups of clinicians - the registered and non-registered. This was to have significant implications for the position of the non-registered nurse in the delivery of nursing care. By establishing nursing as an occupation, controlled via registration, it was anticipated that nursing would be closed to all but those with the credentials necessary for registered participation.

Occupations are usually made up of a group of people with distinctive shared skills; skills which are then applied to society. Possessing the credentials to define oneself as a member of an occupational group is not simply a theoretical or cultural device for excluding elements of society. Occupations are also defined – in part – by their abilities to make successful jurisdictional claims over areas of work. Society enters into a form of social contract with the most successful occupational groups: professions. This contract ostensibly allows occupations to carry out licensed activities and to control their sphere of operations:

'An occupation consists in part in the implied or explicit licence that some people claim and are given to carry out certain activities rather different from those of other people...they will also claim a mandate to define – not merely for themselves, but for others as well – proper conduct with respect to the matters concerned in their work.' (Hughes, 1984: 287)

The concepts of licence, mandate and jurisdiction are returned to in later parts of the thesis, yet it is important to note here that the granting of this societal mandate

depends in part on the quality assurance mechanisms associated with the occupation. The process of claiming membership of an occupation, with reference to an associated system of credentials, not only creates 'insiders' and 'outsiders' but also (where the occupation is registered) necessitates working to a legally binding level of competence. Specifically, the level of competence that can reasonably be expected of any member of that group.

Registration, Credentials And The Continued Use Of Non-Registered Nurses

During the First World War, probationer nurse intakes expanded considerably but the additional nursing input needed to care for the casualties of war was provided mainly by women of the Voluntary Aid Detachments (VADs). The VADs tended to come from upper- and middle-class backgrounds and received a three to four month training program for their role (Dingwall *et al.*, 1988). The VADs were involved in care provision similar to that of nurses and as a result posed a considerable threat to the established order of nursing because they were involved in similar care provision. Such divisions within nursing further influenced the debates about the organisation of nursing into an occupation by defining its boundaries and establishing status in the division of labour (Dingwall *et al.*, 1988).

Nurse registration was aimed at bringing some order to the wide range of people providing nursing care. Registrationists argued that the register would, '*Form nursing into a distinct profession [and] clearly define who are and who are not real members of the profession*' (Nursing Record 1888: 26; as cited in Witz 1992: 133). However, nurses did not solely drive the Registration Act. It has been argued that the eventual introduction of the 1919 Nurses Registration Act was influenced by the government's

intention to create a national health service after the First World War (Dingwall *et al.*, 1988; Rafferty, 1996). This service required some rationalization of nurse training and so economic factors were also perceived as playing an important part in the establishment of the Registration Act. Despite the introduction of a register, nursing work continued to be provided by a variety of workers.

Abel-Smith (1960) points out that the idea of recognising a second level nurse had first been proposed in debates about registration in 1905, but had been strongly opposed by nursing leaders. However, the demand for nursing care created by the Second World War provided an opportunity for official recognition of a second level grade: the State Enrolled Nurse (SEN). The SEN was also regulated by the GNC (Dingwall *et al.*, 1988) and yet the control of entry to the SEN grade by the GNC failed to provide the numbers required to deliver care. This led to the unplanned growth of another grade of nurse, the nursing auxiliary (Abel-Smith, 1960). In 1947, the Wood Committee (Ministry of Health, 1947) identified the value of an auxiliary grade and suggested that they would have a shorter and more practical training than the SEN and could practice without legislative recognition or regulation.

Nursing auxiliaries formed a significant proportion of the non-registered workforce; they outnumbered SENs, and were involved in the delivery of personal care to patients (Abel-Smith, 1960). The grade was officially recognised in 1955 by the General Whitley Council (GWC) and provided with a definition of the grade and a pay scale. The GWC was established to promote fair and equal conditions of service employment for all staff working in the NHS. However, there was no formal training, legislative recognition, or regulation associated with this type of worker. Therefore,

despite the registrationists' campaign to establish order and to develop a fully registered nursing workforce, registration did not become the prerequisite for employment in nursing work. Nursing care was still being provided by a group of workers excluded from the developing registered nurse occupation.

Development Of The HCA Grade

Prior to 1987, the non-registered nurse had been referred to as a nursing auxiliary. Nursing auxiliaries were integral to the provision of direct patient care. However there was no formal, or nationally established, training programme to prepare them for their nursing work. This created variability in both the content and the amount of training that nursing auxiliaries received (DHSS, 1972; Hardie, 1978b). Despite the Briggs Report (DHSS, 1972) commenting on the fragmentation of education for non-registered nurses its recommendations for in-service training of this proportion of the nursing workforce were largely ignored. It was only during consideration of the implications of Project 2000 (UKCC, 1987), that serious consideration was given to the auxiliary grade, their training needs and their role in supporting the registered nursing workforce (Beardshaw and Robinson, 1990).

Project 2000 had major implications for the structure of the nursing workforce and preparation for practice. A single point of entry into nurse training was established. The SEN grade and pupil nurse training were abolished, and existing SENs were offered conversion courses leading to registered nurse status. Project 2000 placed nurse education within higher education establishments and led to the award of a nursing diploma. There were also an increasing number of nursing degree courses being established in universities at this time. The government's acceptance of the

Project 2000 reforms depended on the introduction of a new category of support worker: the health care assistant (HCA). It was anticipated that the HCA would make up for the loss in student nurse numbers from the ward (Project 2000 awarded supernumerary status to student nurses). HCAs were to support the smaller, highly-skilled, registered nursing core.

The introduction of the HCA grade was also accompanied by the government's plans for formal training of this group of workers. It was proposed that National Vocational Qualifications (NVQs) would provide HCAs with work-based vocational training to prepare them for their role (Beardshaw and Robinson, 1990). This vocational training was to be the distinguishing factor between the 'old' style nurse auxiliary and the 'new' health care assistant role. It was also anticipated that such training would enable clearer differentiation between the registered and non-registered nurse role.

Credentials For Non-Registered Nurses

The Scottish and National Councils for Vocational Qualifications (S/NCVQ) were set up to produce a coherent framework of national vocational qualifications (Manpower Services Commission and Department for Education and Science, 1986). Such qualifications were based on employment-led occupational standards and assessed in terms of competence. Two major reviews in the early 1990s – the Beaumont Review of S/NVQs (Beaumont, 1996) and the Dearing Inquiry into Higher Education for the 21st Century (Dearing, 1997) – emphasised the establishment of a National Framework of qualifications. This framework was intended to establish progression routes and clearer pathways between academic education and vocational training.

Within health care, a range of NVQs are available for HCAs, ranging from level 1 to level 3 (Table 1-4). Vocational qualifications at levels 4 and 5 are also available but are aimed at ‘registered’ workers rather than support staff (Department of Employment, 1995).

Table 1-4 National Vocational Qualifications (Adapted from Roberts and Barriball, 1999: 138)

Level	Competence in
1	...performing a range of varied work activities, most of which are routine and predictable.
2	...a significant range of work activities, some of which are complex or non-routine, require some individual responsibility or autonomy and may require collaboration with others.
3	...a broad range of work activities, most of which are complex and non-routine. These activities are carried out in a range of contexts, involve considerable autonomy and responsibility for one’s own work and that of others, and may involve allocation of resources.

Despite the proposals for wide spread training of HCAs in Project 2000, the uptake of vocational qualifications by HCAs and employers to date has been poor. A recent report suggests that only about 30% of HCAs have any NVQ training (Meadows *et al.*, 2000; Thornley, 2000) and as many as a third of NHS Trusts do not offer NVQs (Thornley, 1999). Girvin (1999) suggests that the role and career prospects of HCAs do not necessarily improve on attainment of a NVQ.

Currently health care assistants in the NHS are not required to have any formal training or to hold a recognised qualification. In hospital settings, the majority of training for this group of workers is provided informally by learning ‘on the job’ (Rhodes, 1994). The absence of national mandatory educational programmes for HCAs has led to wide variations in standards of training (Kenward *et al.*, 2001; Field

and Smith, 2003). However, within the social care sector the General Social Care Council (GSCC) are establishing guidelines for the training and regulation of health care assistants, such that by 2005, 50 per cent of HCAs will have a NVQ (Department of Health, 2002c). The reforms of Project 2000 and the plans for a trained assistant workforce to support the smaller, highly trained, registered nursing core have generally not materialised in practice (Meadows *et al.*, 2000; Thornley, 2000). The nursing press presents conflicting perspectives of registered nurses associated with the relevance of NVQs for preparing HCAs to practice (Rowe 1994).

An important objective of the original Project 2000 reforms was to clearly differentiate between registered and non-registered nursing staff (UKCC, 1987). However, the introduction of NVQs was perceived, by some, as having the opposite effect: it blurred the boundaries between the two even further (Dingwall *et al.*, 1988; Hughes, 1993). The introduction of an alternative qualification for nursing work in the form of vocational qualifications was perceived as being in direct competition with professional nursing qualifications (Shaw, 1993). As such, vocational qualifications were also perceived as providing managers of nursing care the opportunity to utilize non-registered nursing staff with NVQs where care may have been previously provided by registered nurses (Warr, 1998b).

PROFESSIONAL, MANAGERIAL AND POLICY VISIONS OF NURSING

The professional and managerial visions of nursing are very different and as such project different versions of the future role of registered and non-registered nurses. Allen (2001: 1) uses extracts from writers in the 1990s which reflect the developments taking place in the UK at the time. The managerial vision of nursing,

as described by Eric Caines (Naish, 1993: 25), emphasises quality, economy, efficiency and competition. Whereas the professional vision of nursing, as described by Rosemary Gillespie (Davies, 1995: 89), stresses the importance of holistic care and health education. These conflicting visions of nursing are reflected in the wider literature addressing skill mix and the division of nursing labour. More specifically, who should be doing what in nursing work.

Within nursing, there has been increasing tension between the professional vision of nursing, where all aspects of care are carried out by registered nurses, and the management perspective which aims for cost effective services and ways of deploying professional skills more efficiently. In a health service climate, with finite resources available, policy encourages the rethinking of human resource use and flexible working. This has led to bold statements being made about cost savings that could be made if doctors are replaced by nurses (Richardson & Maynard, 1995) and registered nurses replaced by health care assistants (Audit Commission, 1991). New ways of deploying both registered and non-registered staff to provide care within the health service are being considered to make efficient and cost effective use of the nursing resource. Such debates are not solely within the nursing domain but also paralleled in areas such as teaching, where the roles of teaching or classroom assistants are developing. As in nursing, tensions exist between 'registered' teachers and assistants (Curtis, 2002) and concerns are being voiced among professionals about the expanding role of assistants in teaching (O'Kane, 2002).

The Labour government set out plans for the modernisation of the NHS (Department of Health, 2000b). Modernisation refers to a range of initiatives aimed at

restructuring and reorganising the health service at national and operational levels. This is based on plans for improving access to services for users, achieving health gain targets and maintaining a performance management culture. Policy reviews emphasise partnership, quality, flexible working practices and the importance of users in service planning. Reviews of nurse education highlight the importance of preparing a workforce fit for practice and purpose within rapidly changing contexts of care (UKCC, 1999a; 2001). The nursing workforce is recognised in the government's plans as having a key role in the modernisation agenda; as such, both registered and non-registered nurses need to be appropriately skilled and deployed.

The roles of registered nurses have changed considerably over the last ten years to take on a wider range of tasks and complex roles. For example, registered nurses in acute care routinely perform intravenous drug administration and practice nurses in the community have increased their role in chronic disease management. The expanding role of the registered nurse has led to increasing debates focusing on the activities registered nurses should retain and those they should delegate to other workers, such as HCAs. Indeed it has been proposed, that the changing face of nursing is to provide skilled care through involvement in care management and planning, and the supervision of the 'hands-on' care delivered by health care assistants (Meadows *et al.*, 2000).

The Nursing and Midwifery Strategy (Department of Health, 1999a) identifies the HCA as having a key role in the delivery of fundamental care. However, just as concerns have been voiced about the registered nursing workforce and their preparation for practice, there has also been increasing interest in the role of the non-

registered workforce, and the educational preparation designed to prepare them for supporting the professional workforce in health and social care services (Department of Health, 2000a; 2000b).

FLEXIBLE WORKING BETWEEN NURSES AND HCAS

The Wanless Report (2002) claims to be the first evidence-based assessment of the long-term resource requirements for the NHS. The report identifies key factors that will require addressing in order to deliver a high quality health service over the next two decades: the changing health needs of the population (in particular an ageing population); the rising expectations of service users; technological and medical advances; and the use of the health service workforce. It is this latter factor which is of particular significance to this thesis.

The review points to the increasing use of registered nurses to undertake doctors' work and the effect on support workers: an extended role for HCAs over the next twenty years. It is envisaged that HCAs will undertake a large part of the routine work currently undertaken by nurses in primary and secondary care (Wanless, 2002: 58). However, the detail associated with this increased role for HCAs is not dealt with by this report. Visions of the expanded HCA role in the future have been addressed elsewhere (Department of Health, 1999a; Conroy *et al.*, 2002).

The third Future Healthcare Workforce report (Conroy *et al.*, 2002) more explicitly describes the future role of the HCA by outlining the types of activities that the assistant worker might be able to perform in health and social care settings. These activities include personal care, monitoring a patient's condition, implementing the

care planned by a registered practitioner (such as mobilisation or wound management), undertaking investigations (such as blood tests, ECGs), education and support of patients and carers, assistance with formal documents (such as benefit claims) and liaison with other agencies and services (Conroy *et al.*, 2002). This report envisages the deployment of HCAs working with a level of responsibility, accountability and skill rarely observed in the health service at present, and going well beyond the delivery of fundamental care. However, the success of any of these plans for an increased role for HCAs depends on flexibility within the nursing workforce so that there are fewer barriers between team members to provide patient centred care.

The government's Nursing and Midwifery Strategy (Department of Health, 1999a: 35) recommends a new career framework for the nursing workforce which recognises the HCA grade as integral to the delivery of nursing care. The strategy sets out plans for HCAs' training and career development through NVQs and widened entry into professional nurse training. The HCA is viewed as having a key role in the delivery of fundamental care to patients and carrying out a limited range of routine clinical tasks under the supervision of a registered nurse. As such, the HCA is envisaged as taking over the caring role which is gradually being removed from registered nurses because of the increasing emphasis on technical skills.

Despite the government's plans for investment in the HCA workforce, critics of the reforms point out that there are no firm commitments from the government on a number of key issues. First, there are no clear recommendations for the provision of training to develop a *fully* qualified HCA workforce (Rogers, 2002). This is an interesting development in healthcare provision where it is being proposed that the

'unqualified' worker needs to gain credentials to legitimise their practice. Secondly, a decision has not been made in relation to the regulation of HCAs in the health service (Johnson *et al.*, 2002). Patient safety and protection is a key issue for policy makers. The importance of this has been observed in recent reforms to professional regulation (Department of Health, 2001e), protection of vulnerable adults (Department of Health, 1999d) and the inspection of social care providers (Department of Health, 2002c). However, despite recommendations for a review of the role of HCAs in health care settings (JM Consulting, 1998) and the submission to the Department of Health of a report into Health Support Workers - conducted by a team at De Montfort University in 2000 (Johnson *et al.*, 2002) - there are no decisive plans for the regulation of HCAs. This represents something of a policy contradiction as plans exist for HCAs in social care settings to be regulated by the General Social Care Council (Department of Health, 2002c). Thirdly, recent discussion reports from professions about the delivery of nursing care promote the role of the registered nurse in all aspects of nursing care, including fundamental aspects, and as such fail to acknowledge the contribution of HCAs to this aspect of nursing care (British Medical Association, 2002). This resistance to HCAs as part of the nursing workforce was also powerfully demonstrated through the continued exclusion of HCAs from membership of the Royal College of Nursing (RCN) until 2000, followed by conditional RCN membership for HCAs completing NVQs (Coombes, 2000; Thomas, 2001).

OVERVIEW OF THE THESIS

Non-registered nurses are an integral part of the nursing workforce and their numbers are gradually increasing. However, there has been little attention given to

understanding the work of this group of workers in terms of the content, control and differentiation of their work from registered nurses.

This thesis is primarily concerned with the shaping of the work of HCAs in a single NHS Trust in the UK. Because this shaping process occurs in an organisational context the social arena in which this process takes place should take centre-stage. Accordingly, Chapter 2 provides the context for the theoretical and empirical work that follows. Chapter 3 provides a review of the literature, with particular emphasis on the empirical basis for the lines of demarcation drawn between registered and non-registered sections of the nursing workforce. Nursing practice is informed by a wide array of theories from other disciplines (McKenna, 1997: 85) and this is reflected in the review. Chapter 3 frames the literature according to three main areas: the roles and activities of HCAs, perceptions of the HCA role and skill mix. The chapter builds on the recognition that extensive scrutiny of specialist and advanced registered nurse practice has not been matched by commensurate levels of scrutiny of the role of non-registered nurses. Building on this review the case study focuses on an acute NHS Trust and the thesis outlines four aims:

- To describe the skills and experience of HCAs.
- To describe the content of HCAs' work.
- To explore the negotiation of HCAs' work with registered nurses and the extent to which they supervised it.
- To explore the relationships between HCAs and RNs in practice.

In meeting these four aims, the methodological problems of studying human activity and social interactions must be addressed – the focus of Chapters 4 and 5. Chapter 4

presents the theoretical lens through which activity and interaction are viewed and empirical findings framed. The chapter explores the position of HCAs in a 'continuum' of caring activity. HCAs are considered in relation to the sociological literature of professions and informal or family care. The thesis makes particular use of the work of Hughes (1984), Abbott (1988) and other Chicago-School influenced scholars. Using a theoretical perspective provides a view of the world which helps to describe, explain or predict events, or prescribe actions enabling events to occur or not (McKenna, 1997: 127). By understanding the structure and process underpinning interactions and jurisdictional claims within contemporary nursing, explication of the work and position of HCAs in the overall system of nursing becomes possible.

Rigour and trustworthiness should be at the heart of any social research endeavour, therefore Chapter 5 describes the process of the research study. The study took place over three distinct - but sequential and developmental - stages. Stage one involved a survey and interviews with HCAs (n=33) to better understand the demographics of the HCA workforce within the hospital, their perceptions of work role, and perceived tensions between the HCA role and that of the registered nurse. In recognising that what people say they do, and what they actually do, in practice rarely coincide (Silverman, 1985; Kuper, 1991), stage two involved participant observation of ten HCAs, generating data on their day-to-day practice (n=220 hours). Observation of HCAs also revealed an insider perspective on the tensions between the roles of HCAs and registered nurses. Stage three involved convening four focus groups with registered nurses of different grades to gather their perspectives of the HCA role, supervision issues and tensions.

The results of the methods applied form the basis of Chapters 6 and 7. Chapter 6 reports on findings from stage one of the study: survey and interviews with 33 HCAs working in adult general wards in the hospital. Chapter 7 reports the findings from stages one (survey and interviews with HCAs), two (participant observation and documentary evidence) and three (focus groups with RNs). Whilst Chapter 6 describes what HCAs say they do, Chapter 7 extends this to the processes surrounding the negotiation of HCAs' work. Finally, chapter 8 discusses the findings, pulls together the analytical, theoretical and empirical threads, and offers a conclusion. This final Chapter also considers the implications of the study for policy, practice, education and future research.

CHAPTER 2 - SETTING THE SCENE

A significant motivation for this thesis was a previous review of the literature examining the nursing contribution to patient outcomes (Spilsbury and Meyer, 2001). The review addressed the relationship between nursing outcomes, skill mix and the changing roles of nurses. It was apparent that research predominantly focused on *registered* nurses' contribution to patient care, and in particular the growing interest in the development of specialist and advanced practice. Research has largely ignored the changing roles and contribution of *non-registered* nurses (HCAs) to patient care, despite their increasing numbers in the nursing workforce (Buchan and Seccombe, 2003).

In 1999, the study underpinning this thesis attracted funding from a London Teaching Hospital. The Nursing and Midwifery Strategy *Making a Difference* (Department of Health, 1999a) was published that year and as a result the Trust was keen to review the roles of Health Care Assistants (HCAs). The study was funded to run alongside the Trust's own HCA development project (described later in this chapter) and was to inform their practice development work. The study was conducted in one hospital setting. The findings are therefore associated with a specific group of people, in one setting, during one particular historical period. As with all case studies, generalising from the particular to the general relies on the reader being provided with detailed context of the site (Sharp, 1998).

The thesis views generalisation from two perspectives. First, it acknowledges the need for *theoretical generalisation*: using a theoretical perspective to explain the

findings (Burns and Groves, 1997; Woods, 1997; Sharp, 1998; Yin, 2003). In doing so, a logical connection between the data and theory enables generalisation from the case study to a wider population of cases. The findings are viewed and framed from an interactionist perspective (reported in Chapter 4). In particular, this chapter outlines how theories originating in the work of Abbott (1988) and Hughes (1984) can be used to illuminate the work of HCAs. Chapter 5 discusses theoretical generalisation in more depth.

Secondly, the thesis attends to the need for *naturalistic* generalisation: using ‘thick’ description to enable readers to make a judgement about whether the findings are applicable to cases other than that studied by the researcher (Guba and Lincoln, 1989; Koch, 1994; Stake, 1994; Gomm *et al.*, 2000). In doing so, the reader assesses the degree of similarity between the case investigated and those to which the findings are to be applied. Again Chapter 5 discusses naturalistic generalisation in more depth. The thick description is generated through the use of data gathered from interviews with participants, the researcher’s observations within the organisational setting, or by the use of organisational documents. At times, quotes from participants or extracts from the researcher’s diary are used to illustrate the context.

THE CONTEXT

NHS Beacons, launched in 1999, were a key part of the NHS Modernisation strategy. They were specially selected by the Department of Health because they had achieved a high standard of service delivery. They were regarded as centres of ‘best’ practice and received funding for disseminating their practices. The case site was selected on account of the hospitals’ NHS Beacon status for a Trust-wide initiative in human

resource management. As such, the case site was considered to represent best practice in relation to staff support and development.

The Hospital

The hospital, which opened in 1993, is situated in a densely built up area of outer London. It is located on a busy main road that houses many restaurants, bars, boutiques and shops. Indeed, on approaching the hospital and entering through the main doors, one could mistake the hospital environment for a shopping mall; the open spaces of the atria, the natural lighting, a coffee shop and gift shop, the glass lifts and elevators, the overhead walkways, the sound of lunchtime musicians and the displays of art work.

The locale has very attractive residential environments but also some deprived areas. There is an obvious contrast between established wealth and poverty in the area. The hospital provides health care to a diverse local population of circa 411,000. The local population comprises British, other European, African and Caribbean groups. Estimates suggest that within the local population of schoolchildren 136 different languages are spoken. Local households primarily comprise single people under pensionable age and couples with no children. Consequently, the proportion of families and pensioners is lower than other London areas.

The hospital is a modern teaching hospital with 580 beds on five floors. On opening, it brought together – in a single site - the services of five other hospitals from the London area and gained National Health Service Trust status in 1994. The Trust employs about 2,000 staff, about half of which are nursing staff. When compared

with other hospitals in London the Trust does not have the same problems with recruitment and retention of nursing staff reported elsewhere. The Trust provides a range of acute services but is also recognised as an international centre of excellence for some specialist services: Human Immunodeficiency Virus (HIV) and Genito-Urinary Medicine (GUM) Services, Maternity Services and the Assisted Conception Unit. Approximately 220,000 outpatients and 37,000 inpatients and day cases are seen in the hospital each year. There are five directorates within the Trust - Medicine, Surgery, Women and Children, HIV and GUM, and Anaesthetics and Imaging.

The Medical Directorate includes cardiology, chest medicine, dermatology, gastroenterology and medicine for the elderly. The Surgical Directorate includes general surgery, trauma and orthopaedics, ophthalmology and an Accident and Emergency (A&E) department which sees 74,000 people a year, including 15,500 children in a specialised Children's A&E department. The Women and Children's Directorate is the largest speciality and includes maternity services, neonatal intensive care unit, gynaecology services, assisted conception unit, and medical and surgical services for children. At the time of the study the maternity services were rapidly expanding to include high-risk maternity and neonatal services. The HIV and GUM Directorate is a leading national and international centre for HIV and AIDS services and has inpatient beds, day care and outpatient clinics. The Anaesthetics and Imaging Directorate comprises operating theatres, an intensive care unit, day surgery and imaging services such as ultrasound and X-rays. Health Care Assistants work in most areas across the hospital in small numbers; the exception being the A&E departments. The largest numbers of HCAs are located in the Medical Directorate.

Widespread plans for the reconfiguration of services across the London region by 2007 were creating uncertainty about the type and range of services to be provided by the Trust in the future. At the time of study these were being debated by the Trust Board. Whilst the proposed changes did not impact directly upon this study, it is important to note that the Trust Board expressed concerns about the implications of these developments for the hospital and the services it would provide in the future. The context of service provision was one of threatened change and future uncertainty.

The hospital has teaching status: being part of an undergraduate School of Medicine and with links to two universities providing pre-registration nurse training at diploma and degree level. At the outset of the study there was no provision of National Vocational Qualifications (NVQs) in care for the support staff. However, during the period of study, a link university was contracted by the Trust to provide NVQ training at level 2 and 3 for support staff in the hospital. In addition, the in-service training for HCAs was restructured during the study period. This was part of a development project in the Trust reviewing the roles of HCAs as a response to the government's Nursing and Midwifery Strategy (Department of Health, 1999a). This development project is presented in more detail below.

The hospital has its own training and resource centre providing '*all staff with appropriate and accessible learning opportunities to support both personal development planning and organisational needs*' (Trust document). The room is equipped with multimedia workstations for use with computer based training packages in business skills, communication and attitude, management and leadership, personal skills, computer skills and clinical skills. Textbooks, videos and other open

learning materials are also available within the centre. The centre also has up-to-date information on a wide variety of external short courses and details on formal courses of study. It is open to all Trust staff, regardless of job role, prior education, and qualifications. As such, the Training and Resource centre offers opportunities for HCA development. Many of the HCAs reported attending the Centre's training course on communication and customer skills.

The Political Climate

The study occurred during the second term of a Labour government. This time period has been marked by increasing emphasis on measuring quality, clinical targets and performance in public services. Government initiatives - such as National Service Frameworks, clinical effectiveness, and clinical governance - were being deployed as routes to a modernised vision of service delivery. In addition, hospital performance was captured by NHS Trust performance statistics published by the Commission for Health Improvement. Organisational performance was rated on clinical and managerial effectiveness measures - such as cancelled operations, cleanliness and staff morale - on a scale from zero (bottom of scale and worst performance) to three (top of scale and best performance). In the 2002/2003 performance ratings the Trust scored 'two stars' and demonstrated improvement on the previous year, when it scored 'one star'. The government launched the star ratings procedure to reduce performance variation amongst Trusts by making managers more accountable for service provision to the public. However, a major criticism of rating Trust performance in this manner is the focus on management rather than standards on the quality of care (Batty, 2003). The increasing emphasis on performance monitoring

placed great stress on management teams within the Trust. Nurse Managers described having to continually address the next '*paper exercise*'.

At the outset of the study there were no national standards relating to the work of HCAs in hospital settings. However, during the course of the study, the General Social Care Council (GSCC) was formed - following recommendations in the Care Standards Act (Department of Health, 2002c) - to develop standards in private sector care settings. The GSCC was charged with responsibility for setting National Minimum Standards in social care settings, developing codes of practice for social care workers, registration of the social care workforce and regulation of social work education and training. Health Care Assistants working in such settings will therefore be subjected to closer scrutiny and monitoring. However, despite widespread debate (Johnson *et al.*, 2002), there are no equivalent systems established within the NHS for monitoring the performance of HCAs and ensuring care standards through registration and training.

The Managerial Climate

During the study (2000 - 2003) there have been considerable changes in the Trust's senior management team, and especially within the nursing management structure. A new Chief Executive was appointed in May 2000. In addition, the Director of Nursing, Human Resources Director, Director of Strategic Development and Clinical Governance Manager were all new appointments in 2000 and 2001. There have been many changes within the four Assistant Directors of Nursing positions. On completion of the study, none of the original Assistant Directors remain in post. This period of change within management structures has created commensurate feelings of

uncertainty for other nursing staff, especially where nurses are trying to introduce change. Some nurses reported a lack of progress with their work because of a lack of availability of a senior nurse manager to offer approval and facilitate change at a strategic level.

At the outset of the study thirty-four HCAs were employed in the wards of the hospital. During the study period three HCAs left - two from Medical Wards and one from the Gynaecology Ward. Of those who left, two had gone on to do registered nurse training and the other had gone to work as a HCA at another hospital. A further fifteen HCAs were employed during 2001 to 2003 - eight in the Medical Directorate and seven in the Surgical Directorate. This means that the numbers of HCAs employed by the Trust has increased during the study period by almost a third (n=12), from thirty four to forty six HCAs.

The Trust has a well-established Nursing Practice Development Team. The main focus of their work was supporting the professional practice of registered nurses within the Trust, to support nursing research and development, and to support and facilitate the 'Return to Practice' and overseas nurse conversion programmes and pre-registration students. Prior to the publication of the Nursing and Midwifery Strategy (Department of Health, 1999a), the non-registered nurses had not been acknowledged in the day-to-day work of the Nursing Practice Development Team. However, implementation of the strategy within the Trust necessitated a review of the HCA role. To this end, in 1999, the Trust's Director of Nursing set up a Working Group and Project Board to review the role of healthcare assistants in the Trust and to develop the HCA role.

Review Of The HCA Role Within The Case Site

The overall aim of the Trust's review was to determine how the HCA role met service requirements, and how it might be developed to provide a more effective role in the provision of future patient care. The Working Group had a broad membership of representatives from 'the shop floor' and included registered nurses from clinical directorates, midwives, therapists and support workers. This included one HCA and one support worker from therapy and maternity services respectively. A Practice Development Nurse led this Working Group. The Project Board was placed at a more 'strategic' level and included the Director of Nursing, the Director of Human Resources, Therapies Service Manager, the Director of Midwifery Services, an Assistant Director of Nursing and the Directorate Manager for Women and Children's Services. Despite reviewing the support worker role there was no HCA at this strategic board. The Project Board, facilitated by the Working Group Lead, met monthly to provide support and direction for the Working Group. This lack of HCA representation at a strategic level was noted by participants in the study as a reflection of the value attached to support workers in the Trust. HCAs reported that they had no forum within the Trust where they could express their views and discuss their concerns with senior nurse managers. They subsequently felt that the '*voice*' of the HCA was not heard at a management level and therefore largely invisible within the organisational structure.

At inception of the Trust's review of the HCA role, and in stage one of this study (interviews with HCAs) HCAs reported feeling undervalued in the Trust. Despite seeing themselves as the '*backbone*' to service delivery they reported poor morale,

feeling ignored, low pay, and a lack of training, education and development opportunities:

'Despite being a flagship Trust, it does not do a lot for HCAs. Other Trusts support HCAs to do NVQs.' (HCA49: Interview)

Whilst HCAs were aware of plans within the Trust to review and develop their role there was cynicism regarding the likely benefit for them. This was particularly so for HCAs who had been associated with the hospital for a number of years and who felt they had heard promises about training and development and better working conditions before:

'Change takes time. Since I have been here nothing has been done for HCAs and soon I shall be retired. There have been a lot of empty promises.' (HCA5: Interview)

At a management level, there was a general scepticism about the work of HCAs in the Trust. Across the clinical directorates there was a high skill mix ratio of RNs to HCAs. Discussions with nurse managers at the beginning of the study revealed that there were strong oppositions to the role of the HCA in the hospital. Some perceived the role as a *'professional threat'*. Others suggested that there was no need to employ HCAs because of the Trust's ability to attract registered nurses. There were polarised views of the value of HCAs in the ward team. Some managers articulated a role for HCAs within the nursing team. Yet others did not see a role, wanting the wards to be staffed by a fully registered nursing workforce. In other areas, such as A&E, the HCA role had been introduced into the clinical team; but on auditing the role, the manager had rejected its value and the role was abolished.

Moreover, there was a general resistance at the directorate level to the HCA role in the Trust. As a result, this research study, and the work of the Project Board, was initially treated with suspicion and viewed as being carried out with the aim of replacing RNs with HCAs. See the following extract from research diary field notes:

The Assistant Director of Nursing (ADN) came into my office and said she wanted to tell me about an incident just before Christmas. She had been walking around the wards and she had overheard a senior nurse discussing my project with the charge nurse. The discussion had been initiated by the arrival of a Christmas card that I had sent to the ward that also included some study information. The senior nurse was suggesting to others that the purpose of my study was to undertake a cost review for management, which would result in fewer qualified registered nurses on the ward and more HCAs. The ADN suggested that I should present the project at a directorate meeting to dispel any myths about the research. (Research Diary Field Notes: 01/01)

Despite scepticism amongst some senior registered nursing staff, a number of developments relating to the work of HCAs were established through the Project Board and Working Group (2000 - 2003). These developments included: monthly support staff forum meetings for HCAs and other support staff to get together to discuss concerns and meet with a senior nurse manager; a review of support staff grading and pay to address inequalities across grades and prepare for Agenda for Change (Department of Health, 1999b); an orientation programme for HCAs new to the Trust and a yearly update for existing HCAs to ensure HCAs had adequate orientation to the Trust and their role and ongoing development; the purchase of

National Vocational Qualifications from a local institute of higher education; and the secondment of HCAs to do their registered nurse training to support their career pathways.

The Trust also appointed an Education and Training Facilitator for Support Staff (September 2001), as a member of the established Nursing Practice Development Team. This marked an important departure within the Practice Development Team, which had predominantly focused on registered nurse development. It was also significant that some HCAs identified a lack of advice in relation to their careers and suitable training:

'There is nobody to approach regarding training issues. You seem to be passed from one person to the next. We (HCAs) are left out.' (HCA29: Interview)

The focus for the facilitator post was the development of a career pathway for Trust support staff (Appendix 1), including their supervision and support whilst studying for a NVQ, and completing in-house training programmes.

Having explained the overall climate in the hospital and developments occurring in relation to the HCA role at the time of the study it is also relevant to describe the wards where the HCAs worked.

The Wards

HCAs working in surgical and medical wards were the focus of this study. These areas employed significant numbers (n=25; 73.5%) of HCAs. At the time of

observation all the wards had an established Charge Nurse in post. Some of these Charge Nurses were undertaking the Clinical Leadership Programme at the Royal College of Nursing. Advancing clinical leadership is viewed by the government as a key component in the modernisation of the NHS (Department of Health, 1999a). The aims of the programme are to enable leaders to develop their skills in managing their clinical and managerial roles, in establishing effective working relationships with their team and colleagues, and to understand the influence of political and managerial agendas within the Trust.

The wards had between 22 and 24 beds, made up of three bays with 6 beds, and single and double side rooms. The wards provided care using a team nursing approach: the care of patients was divided between two teams, typically made up of RNs, HCAs and student nurses. Where possible, the nurses remained within the same team so that patients on the ward could get to know 'their' nurses. However, sometimes due to staff shortages or problems with skill mix, such as an unequal distribution of registered and non-registered nurses in each team, staff moved to the other team.

The nursing handover of patient information at shift change, for example early to late shift, occurred in two stages on the wards. First, a report was provided in the office. The nurses coming on duty heard name, age and medical diagnosis for all patients in the ward. Secondly, they went around the patients' beds for the team they were working with to hear about the condition of the patient during the past 24 hours and any investigations or planned discharge arrangements.

Nursing care was planned by registered nurses using a system of nursing diagnosis originating from the U.S. (North American Nursing Diagnosis Association, 1999). The care plan was computerised and updated by registered nurses on a daily basis. The HCAs did not have access to the care plans on the computer. In addition, they suggested that the computer print outs of the care plan did not make much sense to them because they were not easy to follow and were written in jargon. The relevance of this for their work is explored in later chapters. More recently the hospital had introduced Electronic Patient Records, which allow health care professionals to access patient data, such as medical records, treatment and therapy regimes and scheduling information. It is one of the first hospitals in the UK to implement a portable, wireless system to provide information and reporting facilities directly to clinicians at the bedside.

As already presented, the hospital was newly built and rather impressive when entering the main doors. However, the wards themselves were experiencing many of the problems that other hospitals experience. The cleaning contract had gone out to tender and nurses on the ward were unhappy with the standard of cleanliness in the ward. On a number of occasions during observation, patients reported that some of the ward areas were unclean. Lack of equipment and linen in the ward also created problems for the nurses when attempting to deliver care.

The context is now set for the case study. This should be born in mind when considering the events and data gathered during the period of study from 2000 to 2003. The role of the HCA had been neglected within the Trust for a number of years. But the turn of the century marked a significant change as the Trust

implemented many initiatives to support and develop the HCA role as part of implementing the government's Nursing and Midwifery Strategy, *Making a Difference* (Department of Health, 1999a). Many of these initiatives were in the early stages of development and may not always have been acknowledged by staff in the clinical areas. But it is important to note that the study occurred during a time of development and change in relation to the work of HCAs.

Since the focus of this study was HCAs' work, it is important to describe who these workers were so that the reader can make a judgement about the representativeness and distinctiveness of the group.

THE HEALTH CARE ASSISTANT POPULATION IN THE CASE SITE

The HCAs were predominantly mature women with significant amounts of clinical experience as HCAs and informal caring experience as a parent or relative caring for a dependent. They were generally of white or black origin. The majority of HCAs worked in the Medical and Surgical Directorates and despite having enormously variable experience and qualifications were employed at 'B' grade level. A substantial number of HCAs supplemented their income by working extra shifts with a nursing agency. Many of the HCAs reported satisfaction with their role, but low pay and poor conditions of employment, development opportunities and career guidance. There was a perceived lack of acknowledgement of their contribution to patient care from registered nurses, and unclear role guidance.

HCAs are often referred to in the literature as the '*untrained*' or '*unqualified*' proportion of the nursing workforce. Yet HCAs in the study demonstrated wide

variation in terms of their training and education. Many HCAs had studied for a NVQ; smaller numbers had achieved a degree (not health care related) or had gained a registered nurse qualification in the past. The majority of HCAs had also undertaken general training for their role in areas such as moving and handling of patients, customer care skills or infection control. Therefore, to suggest that these workers were 'untrained' or 'unqualified' fails to recognise the range of training and qualifications this group had for their role. Chapter 6 presents more detailed demographic and biographic information of the HCA participants.

Finally, the reader needs to know something about the researcher (Mays and Pope, 2000). In particular, their personal biography, characteristics, experience and education. Such information can be contrasted with the description of the study participants and highlights the ways in which the researcher may have influenced the study. This process of self-awareness – known as reflexivity – is built on the recognition that the researcher's beliefs are (at least partially) social shaped and their values might impact on interactions and interpretations in research settings. Until this point in the thesis, reflexivity has been largely anonymous. It is relatively easy to satisfy *oneself* as to the adequacy of bracketing and memoing as tactics for ensuring explicit reflexivity. It is much more difficult to persuade the *reader* of the adequacy of this, somewhat nebulous, concept's operationalisation. To this end, it is important the reader has the opportunity to judge the influence (even if this influence only implicitly enters the analysis) of my personal characteristics, values and position in society.

THE RESEARCHER

An awareness of the differences between the HCAs and myself was an essential component of the reflexive process - on occasions these differences were profound. I am the product of a white, European, middle class upbringing. I have enjoyed a relatively untroubled trajectory through a conventional career route ranging from primary school, through secondary education, adequacy in examination performance at this level, and finally to a university education.

My University degree was in nursing in a department heavily influenced by academic nursing theorists and – during the 1990s - at the forefront of graduate preparation for practice. Like my secondary education, the cohort of peers to whom I belonged was white and middle class. Moreover, my peers were almost exclusively female.

Education is a key factor in determining the cultural and social capital that one draws on in social life. My educational background and attainment was very different to almost all the HCAs encountered in the two years of data collection. As well as social capital, one's financial capital is also partly determined by educational attainment. As a consequence of my career progression, I was also paid far more than the HCA participants in the study - a fact which most were aware of.

Following University I secured clinical positions in leading clinical centres, each of which stressed the value of professional development, and in many ways epitomised the set of values referred to in the 1990s as 'new nursing'. Primary nursing, the care planning process, the influence of nursing theory, practice development and patient centred care were all topics which I saw operationalised on a daily basis – regardless

of the unit I worked on. Although the degrees to which any of these were ever 'successful' feel very varied to someone who was 'on the inside'.

Whilst uncomfortable, I should acknowledge that minority ethnic nurses have not been a feature of my clinical career as equals in the nursing hierarchy. At the start of this project I had been in London for 5 years and in that time have had to become aware of a range of cultural backgrounds, and sensitive to questions of ethnicity, difference and diversity. At times during my training and early clinical career ignorance of issues of ethnicity arose. As has already been highlighted, at least half of the HCAs taking part in this study were from non-white backgrounds.

Again, the purpose of this brief section is to provide the reader with the opportunity to use their own knowledge of the impact of 'difference' on social relations, capital and interpretation of action. It would be misleading to pretend that my personal characteristics played no part in the interactions and analysis associated with this thesis. However, armed with this knowledge, information on the validation strategies employed in data collection and analysis, and the results themselves, I hope that enough information has been presented to promote confidence in the thesis.

CHAPTER 3 - LITERATURE REVIEW – NURSING SKILLS, ROLES AND THE LACK OF FOUNDATION FOR LINES OF DEMARCATION

Changing societal demands for healthcare and the means by which it is delivered have significant implications for the complex relationships that exist between policy, the NHS workforce and end-users of services. The skills, roles and competencies that the workforce requires in order to maintain its 'fitness for purpose' are the focus of scrutiny from professionals, policy makers and consumers. Consequently, the delicate balance of the 'raw ingredients' necessary for sating society's desire for quality occupational input into services is facing both direct and indirect pressures for change. Recent policy initiatives provide important examples of this scrutiny of roles, skill and competence, and the resultant pressures for change:

- National Service Frameworks (NSFs) (Department of Health, 1999c; 2000c; 2001d; 2002a; 2003b) specify the optimal organisation of services for patients with broadly defined medical conditions;
- clinical effectiveness (Department of Health, 2000b) initiatives specify the optimal processes and desired outcomes for securing the greatest possible improvements in health gain for the greatest number of patients;
- clinical governance (Department of Health, 1998b) provides an administrative infrastructure and material support for organisations, as well as renewed emphasis on risk assessment, risk management and evidence based practice;
- the emphasis on continuing professional development - as part of a wider policy aim of life long learning - as a vehicle for promoting an up-to-date and reflexive workforce; a policy emphasis reinforced by (in theory at least)

organisational and professional incentives and reward schemes (Department of Health, 2002b);

- an awareness that occupational self regulation (in the traditional mode) is just a necessary, but not sufficient, cornerstone of the NHS' duty to promote patient safety (Department of Health, 2000d).

Crucially, none of these initiatives and the challenges they represent are the sole and exclusive preserve of the registered 'professional' workforce (Wanless, 2002).

The lines of demarcation between HCAs and registered nurses are both a product of history, and simultaneously, a driver for future policy direction. The development of this demarcation has been described previously in Chapter 1 (Abel-Smith, 1960; Dingwall *et al.*, 1988; Witz, 1992). This chapter is concerned with describing the balance of skills, roles and competence surrounding nurse activity (focusing on the HCA in particular) and exploring the lines of demarcation between the registered and non-registered sections of the nursing workforce. However, in doing so, the chapter demonstrates that the foundation for these splits is built on occasionally tenuous arguments; arguments for which empirical data are often lacking, or of questionable quality. Before critical examination of these studies, the reader needs to understand the process through which they were identified.

THE APPROACH TO THE LITERATURE REVIEW

Traditional unsystematic literature reviews have the potential to introduce bias (Mulrow, 1987). Reviews often lack transparent inclusion criteria, have unclear objectives, and ad-hoc syntheses of findings. An awareness of these limitations and

the potential biases they introduce has led to an increasing interest in the development of guidelines for critically appraising the quality of reviews (Chalmers and Altman, 1995). With the need for transparency in mind, I have been explicit regarding the nature of the literature search, the criteria for appropriateness of the included studies, the interpretation of these studies, and the rationale for excluding studies.

Search Terms

The focus for this thesis is the role of the health care assistant in the UK. Studies and reviews contributing to an understanding of HCAs' work, or their international equivalent (such as nursing aides in America), are included here. The heterogeneity in titles used to describe this type of worker in the UK (Johnson *et al.*, 2000), alongside diverse titles for similar grades of workers internationally (Table 1-2), merit the use of broad search terms for the literature review. For pragmatic reasons, and influenced by changes in the structure of UK nursing education (UKCC, 1987), the literature review concentrates on studies of HCAs' work after 1987 - although some reviews may include literature published prior to this date.

The scanning of titles and references in the literature generated search terms for this review. Using these established terms, keywords, MESH headings and the thesaurus function in OVID were used with the CINAHL database (1982-June 2003). The thesaurus function enabled widening of the scope of the search as detailed in Table 3-1.

Table 3-1 Search Terms Used (CINAHL 1982 - June 2003)

<p>HEALTH CARE ASSISTANT as keyword in the thesaurus function, generated: nursing assistant (scope includes: nurses' aides; orderlies; nurse extenders; assistants in nursing; nursing assistant; nurse's aides; nursing aides) health personnel, unlicensed (scope includes: personnel, health, unlicensed; unlicensed health personnel; assistive personnel; support personnel; unlicensed assistive personnel; health employee unlicensed; employee, health, unlicensed; unlicensed health employee; health employees unlicensed; employees, health, unlicensed; unlicensed health employees)</p> <p>NURS*(E) (ING) AUXILIARY as keyword</p> <p>SUPPORT WORKER as keyword</p> <p>SKILL MIX as keyword</p> <p>DIVISION OF LABOUR as keyword</p> <p>NURSING ROLE/EVALUATION as keyword</p> <p>NATIONAL VOCATIONAL QUALIFICATIONS as keyword</p> <p>CHANGING ROLES as keyword in the thesaurus function generated: professional role nursing role clinical nurse specialist role change</p> <p>CONSULTANT NURSE as keyword</p> <p>ADVANCED PRACTICE as keyword</p> <p>NURSING OUTCOMES as keyword</p>
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The search was repeated on other databases, including Medline (1987 to June 2003), British Nursing Index (1985 to June 2003) and ASSIA (Applied Social Sciences Index and Abstracts) (1987 to June 2003). The Cochrane Library was searched for reviews of HCAs' effectiveness, and the National Research Register searched for any ongoing and completed projects that may not have been previously identified. Hand searching of journals and books was also carried out.

The search was restricted to research articles and reviews. An unrestricted search yielded 1,012 articles. These 1,012 articles were narrowed down by excluding

editorials or opinion pieces based on anecdote. Whilst such articles provide insights into authors' views of health care assistants, and so provide useful contextual information, they do not in themselves constitute evidence helpful for the design of the study underpinning the thesis.

Reference titles and abstracts were scrutinised, and those relating to the HCA role retained. Following retrieval of the original papers, the bibliographies of each article were scanned for new references to increase the comprehensiveness of the search (Knipschild, 1995). The search was stopped when no new references appeared in bibliographies of the most recently acquired publications. Conference attendance¹ and academic and professional networking revealed unpublished theses and conference papers.

The studies of HCAs' work (n=30) identified via the search were subsequently clustered into three main areas: the roles and activities of HCAs; perceptions of HCAs' work and activities; and the impact of HCAs' work on patient outcome. Through a critique of these studies a gap in the research-based literature was identified; this gap represents one need for this thesis.

THE ROLES AND ACTIVITIES OF HCAS

Research focusing on the roles and activities of HCAs describes what it is that HCAs do and how this is differentiated from the work of other groups of nurses, such as RNs

¹ Royal College of Nursing International Research Conference (1999, 2000, 2001, 2003)

British Sociological Association Medical Sociology Conference (1999, 2001, 2002, 2003)

Royal College of Nursing Vocational Qualifications Forum Conference (2000, 2002)

and Student Nurses. These roles and activities can be linked to the models of assistant roles described by Gardner (1991) and Krapohl and Larson (1996) in Chapter 1 (pp.18) ('traditional', 'non-clinical', 'technical', 'primary practice partner' and 'vocationally prepared' assistant models). However, a model not identified by them is 'extended' assistant roles: where HCAs take on the work of, and substitute for, registered nurses. To capture the diversity of HCA roles and activities the literature has been separated to replicate this division between 'traditional' and 'extended'.

Traditional Roles and Activities of HCAs

The roles and activities of HCAs are widely debated in the nursing literature. HCAs are identified as significant contributors to hands-on care delivery, yet the reasons for differentiation of the work of HCAs and registered nurses in practice remain unclear (Dewar, 1992; Chang and Lam, 1998). Workplace processes play an important part in determining HCAs' roles (Allen, 2001), yet there is limited understanding of the negotiation of nursing work from the HCAs' perspective. Since work is a social activity it is insufficient to describe the activities of HCAs outside the context of which they work and without giving due consideration to the skills, experience and qualifications of this proportion of the workforce and how this influences their roles and activities.

Whilst HCAs care for vulnerable groups of patients (Badger *et al.*, 1989; Davies, 1992) there is limited understanding of the supervision and support of HCAs. The context in which care is provided, the organisation of care, and the relationship between HCAs and RNs are important influences on the ways in which HCAs contribute to patient care (Robinson *et al.*, 1989; Bond *et al.*, 1990; Thomas, 1992a;

Ahmed and Kitson, 1993a). Again, however, the characteristics of the HCA workforce are not disclosed in these studies. The following section considers evidence which contributes to our understanding of HCAs' roles and activities within the 'traditional' model.

Overlap of Nursing Activities and Attempts to Differentiate Nursing Roles

Studies have observed the roles and activities of nurses and enable a comparison of the work of HCAs with other groups of nurses (Dewar, 1992; Chang and Lam, 1998; Allen, 2001). Both Dewar (1992) and Chang and Lam (1998) report that HCAs engage in similar *amounts* of work as other groups of nurses (RNs and Student Nurses), but that differences occur in the *content* of their work. Whereas, Allen's (2001) study makes observations of the ways in which HCAs' roles and activities are differentiated from RNs via workplace processes. These studies simultaneously highlight the overlap in activities between the different levels of nurses and provide *some* differentiation of nursing work.

Dewar (1992) reports on a qualitative study of nurses (RNs and HCAs) working in a primary nursing ward in the UK. She examined their work (RNs and HCAs) and attitudes to their roles by gathering participant observation and interview data. Whilst staff engaged in similar amounts of direct care with patients, Dewar reports that RNs also engage in more indirect care activities than HCAs. The HCA role is therefore focused on direct care, whilst the RN role is more diverse. Crucially however, Dewar (1992) reports how RN and HCA participants were unable to articulate any real difference between their roles. One possibility for their inability to articulate differences in role might be that they actually share a similar knowledge base. Much

of the knowledge required for successful caring is tacit (as opposed to formal and codified). This tacit knowledge is notoriously difficult to verbalise (Case, 2002) and yet the *communities of practice* (Wenger *et al.*, 2002) that share such knowledge manage to discuss issues of role and task with *each other* quite successfully.

Chang & Lam (1998) conducted a small scale study in Hong Kong comparing the type and pattern of work activities of HCAs and student nurses. Data were collected by non-participant observation of staff activities in four separate clinical areas in one hospital. Wards were selected because they were piloting the HCA role (n=8).

Again, no significant difference was found in overall *amount* of activities between nurses. However, further analyses show differences in direct ('basic' and technical) and indirect (housekeeping and clerical) care activities. HCAs perform more 'basic' care activities (comfort, mobility and exercise; dealing with elimination, hygiene or personal care; feeding and nutrition; and communication) and indirect care activities (housekeeping and clerical). Student nurses perform more technical activities (dressings or wound care; drug administration; and IV therapy) but less 'basic' and 'indirect' care. Chang and Lam (1998) suggest that HCAs' activities, and in particular basic care, require less knowledge and skill – a conclusion borne of a value judgement as opposed to any empirical evidence.

Both of these studies focus on *amount* of activity, rather than quality of care, and any conclusions should be viewed with this in mind. Additionally, the activities of HCAs are taken out of context and so there is little understanding of the relationships between the different levels of nurses and the ways in which this may have influenced the activities being carried out by nurses. Neither of the studies provides detail of the

HCA's characteristics (skills, experience or qualifications) therefore it is difficult to draw any conclusions about the skills and competence of the HCAs and how qualifications or experience may influence the role. The transferability of Chang and Lam's (1998) findings can be questioned because of the different cultural and health systems in Hong Kong and the UK.

Allen's (2001) study partly overcomes this problem (taking the activities of groups of nurses out of context) by using an ethnographic approach to examine workplace processes and the negotiations that shape nursing work. One medical and one surgical ward in the UK were the focus for her study of the shaping of *registered nurses'* work. As part of this much larger study, the RNs' relationship with HCAs was explored. Data collected includes field notes and audio tape recordings derived from participant observation in the study site, tape-recorded semi-structured interviews and analysis of documentary evidence.

Allen reports HCAs having an important role in the provision of hands-on care, but the extent to which they work within formally defined (by Senior Nurse Managers) practice boundaries is determined by staff at the point of care delivery. The division of nursing labour is based more on the personal relationships that exist between RNs and HCAs rather than through formal definitions. Allen describes this relationship as being influenced by the RNs trust, and knowledge of HCAs' clinical skills, rather than formal credentials.

Whilst, Allen addresses the boundary between RNs' and HCAs' work and provides insight into the nature of their relationship and the ways in which this influences the

HCA's role, her focus is on *registered nurses'* management of HCAs. Missing from the existing evidence-base is a context-specific understanding of the role and activities of HCAs from *their* perspective, *their* understanding of relationships in practice shaping *their* work, and further explication of the skills and competence necessary for *their* work.

The importance of the HCAs' role in the provision of hands-on or basic care is highlighted by these studies. However, they do not provide information about the *types* of patients being cared for by care assistants. The literature review revealed two studies providing detail of HCAs' involvement in caring for older, vulnerable and dependent patients. Warr (1998a) and Thornley (2000) highlight the HCAs role in caring for this group of patients. The importance of the HCA workforce in providing care for older people, in both health and social care, is also recognised by policy makers (Department of Health, 2002c). As the ageing population increases in number, alongside a declining registered nurse workforce, it is likely that HCAs will have an important role in this area of care.

Caring For Vulnerable And Dependent Patients

Within UK community settings HCAs have been identified as caring for some of the oldest and most vulnerable patients, with minimal input from registered nurses (Badger *et al.*, 1989). Rather than focusing on the care worker, Badger *et al.* built their research design around a cohort of patients (n=202) being cared for in their own home. The cohort was either physically disabled, frail elderly or elderly mentally infirm. They then examined who (HCA or RN) was caring for these patients. The study found that 40% (n=80) of patients were seen solely or primarily by a HCA.

They also found that patients seen by HCAs tended to be older, live alone, have no lay supporter, to have been '*on the books*' for longer and to receive more community and social services input than other patients. Patients seen by HCAs were in need of basic nursing care, monitoring, and support and advice, as well as non-nursing duties such as bed making. Other studies have also highlighted that in acute care settings, HCAs are expected to care for vulnerable, dependent patients with complex care needs without the direct supervision of RNs (Warr, 1998a and 1998b; Thornley, 2000). Ahmed and Kitson (1993a) suggest that patients' needs are not always the most important influence in the deployment of grade mix. These studies are considered in more detail in later sections.

In recognizing the important contribution of HCAs to care of older people, Davies (1992) analysed the content of registered and non-registered nurses' conversations with older people in a continuing care setting in the UK to ascertain whether there were any differences between the two levels of nurse. Equal numbers (not stated) of registered and non-registered nurses were randomly selected from the staff list in the setting. Patients were selected in order to provide a representative sample of all residents in relation to their level of verbal ability. Interactions between nurses and patients were tape recorded for a 2-hour period between 8 and 10 a.m. – a time when the majority of activity and interaction took place between patients and nurses.

The study revealed that although the two levels of nurse used *broadly* the same range of verbal communication strategies, registered nurses were more likely to promote dignity, self respect, choice and independence. Davies (1992) proposes that these

findings have implications for the training, supervision and support of non-registered nurses to prepare them for their role in caring for this group of patients.

The importance of supervision and support of HCAs has been identified in studies (n=4) exploring the ways in which RNs' and HCAs' work is differentiated and how they work together when care is organised by using different models (Robinson *et al.*, 1989; Bond *et al.*, 1990; Thomas, 1992a; Ahmed & Kitson, 1993a). These studies highlight the importance of context and relationships between RNs and HCAs for understanding HCAs' roles and activities. All of these studies were carried out in the UK.

The Importance of Nursing Care Organisation on HCAs' Roles

The organisation of care is an important influence on the roles of HCAs (Robinson *et al.*, 1989). Robinson *et al.* interviewed senior staff (n=22) in 3 Health Authorities about the division of nursing labour and observed staff activity in 8 medical and surgical wards. Activity analysis was structured, using the modified Criteria for Care tool (Ball *et al.*, 1984), into direct, indirect, associated and non-productive care. In wards organising care delivery through primary nursing, HCAs did not provide direct care to patients - this was the domain of the registered nurse. In wards, where care was organised along more 'traditional' lines, HCAs were involved in direct care activities. Despite differences in organisational models some common themes were identified in relation to the assistant role: assistant autonomy in domestic duties; working beyond their job descriptions; and a general devaluation of the role by the registered nursing team. However, conflicting evidence exists regarding the HCAs' contribution to direct care delivery in primary nursing wards. Specifically, the level

of involvement of HCAs in direct care provision is positively associated with the extent to which HCAs are integrated into the nursing team.

Bond *et al.* (1990) and Thomas (1992a; 1992b; 1993; 1994) examined two wards in a community hospital to explore the implications for nurses when care was organised according to team or primary care nursing models. The studies employed a mixed qualitative-quantitative design to determine differences in the work of registered and non-registered nurses within the two settings. Methods used included: non-participant observation of nursing activity, taped verbal interactions between staff and patients, semi-structured interviews with staff, and measurement scales to record workload, patient dependency, and the work environment.

The most significant differences were found *between* the different ways of organising care. Registered nurses and HCAs *within* organizational categories engaged in similar patterns of work. In the ward using a primary nursing model, HCAs worked alongside high numbers of registered staff. Within the team nursing ward, HCAs often worked alone because of fewer numbers of registered staff. HCAs on the primary nursing ward performed more fundamental care and domestic duties than HCAs on the team nursing ward. There were more verbal interactions from HCAs with patients on the primary nursing ward. Interaction included dealing with requests, commands, instructions, explanations, encouragement and self-care. The findings indicate that the organisational setting in which HCAs work and their relationship with registered nurses influences the way in which their work is performed. Being part of a team, accountable to registered nurses, and role modelling, are important factors for the HCA and their performance. Thomas (1992a) concludes that HCAs

tend to work in the same manner as the RNs with whom they work and by whom they are supervised.

Ahmed and Kitson's (1993a; 1993b) study of the role of the HCA within a professional nursing culture further supports these conclusions. They investigated whether HCAs were deployed differently in a setting where the role of the RN had been made explicit. The Oxfordshire Nursing Services Theoretical Framework proposed the following main activities for professional registered nurses: assessment of patients; establishing care plans; monitoring, evaluating and implementing care plans. Registered nurses were seen as active clinical decision makers with responsibility for delegating and supervising the nursing care given by HCAs.

The investigation focused firstly on the prevailing ideology amongst the RNs and HCAs in each setting, and the extent to which the theoretical framework was explicitly used to organize day-to-day care. Secondly, the roles and functions of RNs and HCAs were scrutinized. Thirdly, by explaining the type and the extent of involvement of RNs and HCAs in the care of clients or patients. Finally, taking the above factors into account, the consistency and continuity in the planned care of the client or patient.

Multiple methods of data collection were employed including documentary evidence, semi-structured interviews, informal opinions, non-participant observation and collection of field notes. For Ahmed and Kitson (1993a) the deployment and use of HCAs was strongly influenced by the way RNs understood and operationalised their

roles. This role was, however, affected by the personal ideology of each individual nurse.

Additionally, the study illustrated the lack of influence of patient need in the deployment of grade mix. In community hospital units, primary nurses were principal caregivers regardless of whether the patient constantly needed 'qualified' RN input. In the control unit there was a lack of recognition that RNs may be needed to understand the changing needs of clients. Ahmed and Kitson (1993a; 1993b) conclude that HCA roles are influenced by the perspective and ideology of the care setting, the beliefs and values of registered staff, support from registered staff, and recognition of the HCA contribution through extrinsic and intrinsic reward systems.

UK studies of the organisation of nursing, support the integration of the HCA into the nursing team under the supervision of registered nurses. An explicit model of care organisation, role modelling, support and recognition for the HCA are important influences on their role. When these characteristics are observed, the HCA makes a positive contribution to patient care and teamwork. The importance of organisational characteristics on nurses' work and patient outcomes are widely reported in studies of 'Magnet Hospitals' in America (McClure *et al.*, 1983; Aiken *et al.*, 1994; Havens and Aiken, 1999; Scott *et al.*, 1999; Aiken *et al.*, 2000) and by an international study of nurses' work environments (Aiken *et al.*, 2003a). These studies primarily focus on registered nurses and so are not critiqued in detail here. However, it is important to recognise that care organisation and its effects on quality of care, effective staff deployment and job satisfaction are not the exclusive preserve of the registered

nursing workforce: the scale of the HCA workforce in the UK means that examination of the organisation of nursing work should also include them.

Over the last ten years, the service context and roles of nurses have changed. The growing interest in progressive nursing roles is demonstrated by the explosion in the numbers of research studies addressing nurse-led, advanced, specialist and (more recently) consultant nursing practice (Spilsbury & Meyer, 2001; Daley and Carnwell, 2003). Studies of nurse-doctor substitution and its effects on patient care have used (relative to the HCA-nurse substitution literature) robust methods: reviews or meta-analyses (Feldman *et al.*, 1987; Brown and Grimes, 1995; Richardson *et al.*, 1998; Buchan, 1999; Richards *et al.*, 2000) and randomised controlled trials (Shum *et al.*, 2000; Kinnersley *et al.*, 2000; Venning *et al.*, 2000). The findings from these studies significantly inform and advance debates on the effectiveness of nurse-doctor substitution and the benefits for patient care. However, this research interest has not extended to explicating the changing roles of non-registered nurses (HCAs) in supporting the registered workforce.

Extended Roles And Activities Of HCAs

Researchers examining roles in the nursing workforce have thus far placed greater emphasis on the activities and roles of registered nurses in contemporary healthcare. This is particularly the case in relation to the roles and activities that registered nurses are *acquiring* (Daley and Carnwell, 2003). Far less common is scrutiny of those activities registered nurses are *discarding* to HCAs as a result of these changes, the implications of these changes for the HCAs' role and patient care, and HCA-RN substitution (Spilsbury and Meyer, 2001). There are a limited number (n=3) of UK

studies reporting on the changing roles of HCAs (Camden and Islington Health Authority, 1996; Rolfe *et al.*, 1997; McIntosh *et al.*, 2000) and one randomised controlled trial evaluating post-natal support workers (Morrell *et al.*, 2000).

Camden and Islington Health Authority (1996) report on an initiative in seven GP practices to release practice nurses from 'non-nursing' administrative tasks by introduction of a HCA grade. The expected outcomes of the initiative were: the release of practice nurses from tasks that do not require a nursing qualification; the development of the nurse practitioner role as a result of the release in time; improved waiting times for patients; better use of financial resources; and greater uptake of health screening.

The evaluation used a survey with practice nurses and patients, and semi-structured interviews with the practice nurses and primary care team. Initially, practice nurses expressed concerns about the implementation of the HCA role within the practices because they perceived the role would lead to deskilling, less accountability and erosion of role. However, following implementation, six of the seven practice nurses, all of the practice teams and patients surveyed, were unanimous in their approval of the role and activities of the HCAs.

The activities that HCAs had 'taken over' in all of the practices included new patient screening, measurement of patient height and weight, urine testing, blood pressure measurement, phlebotomy, sterilisation of instruments and equipment. In some of the practices the HCAs also assisted with minor surgery sessions, baby clinic and ECG testing. Concerns raised by the practice teams related to appropriate training and

coordinated development of the HCA role, the support of the practice nurses, and misconceptions of the role leading to misuse. These concerns have also been raised following initiatives to develop a generic healthcare support worker in a rehabilitation setting (Rolfe *et al.*, 1997).

Rolfe *et al.* (1997; 1999) used action research and mixed methods of data collection to explore and develop the role of a new generic healthcare support worker in a high dependency rehabilitation service. The role was introduced to assist a number of professions to improve patient care delivery by increasing continuity of care, providing 'holistic' care, improving cost effectiveness, improving job satisfaction for the support workers, and promoting interdisciplinary co-operation. The findings reflect a diverse range of issues associated with the introduction of a generic support worker including: the challenge to professional boundaries; issues related to being a generic worker (competence, responsibilities and role strain); service provision and patient care; implementing the role, and changes to established ways of working. The study does not evaluate the effect of the role on patient outcomes or enable comparison of care provided by the generic support worker with registered practitioners or their associated support workers (for example HCAs or therapy assistants).

Despite the potential benefits of HCAs taking on additional roles and responsibilities, concerns have been raised about the uncoordinated development of HCA roles when substituting for registered nurses. McIntosh *et al.* (2000) studied the role of HCAs in the community. Using an ethnographic approach, based around observations and interviews in 21 district nursing teams in 2 areas (Area 1 and Area 2), McIntosh *et al.*

explored the way in which grade and skill are taken into account in the delegation of nursing care.

Delegation processes in the two areas were evolutionary, occurring in an uneven and *ad hoc* manner. This resulted in inconsistent use of the skills across the district nursing teams. This was exemplified in the assumption of traditional G grade specialist nursing responsibilities by some staff nurses, but not others; by the diminishing role of the enrolled nurses in Area 2; and an expansion of the HCA grade in Area 1. Quality of care delivered by HCAs was monitored via in-service training for any extension of role, and supervision by G grade nurses. Supervision was provided through three mechanisms: the G grade and HCA working together; the G grade quality-assuring HCA-provided care by later visiting patients; and discussion of patient care between G grade and HCA. The study concludes that the G grade nurse *working alongside the HCA* and *providing leadership* are central components of the delivery of good quality patient care. As grade dilution in the district nursing workforce becomes increasingly apparent, and the delegation of activities to HCAs continues to evolve, McIntosh *et al.* (2000) propose that the specialist skills of the G grade will need to be better utilised. The importance of HCAs working alongside higher grades of registered nurses has been reported in other studies (Carr-Hill *et al.*, 1992).

One randomised controlled trial has been carried out to examine assistant roles in community postnatal care (Morrell *et al.*, 2000). The intervention involved HCAs providing additional postnatal support to mothers, compared to usual care provided by midwives. A total of 623 postnatal women were allocated at random to an

intervention (n=311) or control (n=312) group. The main outcome measures were general health status (SF-36) and risk of postnatal depression (Edinburgh Postnatal Depression Scale). Breastfeeding rates, satisfaction with care, use of services and postnatal costs were also measured.

At six months there was no significant improvement in health status among the women in the intervention group; costs were higher in the intervention group when compared to control group; and there were no differences in use of social services or personal costs. Morrell *et al.* (2000) conclude that there is no health benefit with additional home visits by postnatal community HCAs compared with traditional community midwifery visiting and there was no cost saving for the NHS over the six months. Some women commented that if the role was not widely implemented because of costs then they would be willing to be charged for the service.

Summary of HCAs' Roles and Activities

A variety of studies have examined the roles and activities of HCAs by focusing on their activities (amount and content) compared to other groups of nurses; describing groups of patients that they care for; considering the influence of care organization on the HCAs' role; and exploring developments in their role. However, these studies fail to capture the skills, experience, qualifications and competencies of HCAs and how this relates to their roles and activities.

When the patterns of HCAs' work and activity are scrutinised, and particularly when that scrutiny includes comparison with RN work activity, it would appear that there are more *similarities* as opposed to clear *differences* between the groups. Moreover,

one of the strongest themes running through studies (and yet often the least noted) is the sense of co-dependence between the two elements of the workforce for successful fulfilment of their occupation roles. However, studies fail to capture the negotiation of HCAs' work, particularly from the understanding of HCAs, and the importance of power in relationships for the control and differentiation of nursing work between the two groups.

The following section highlights the importance of perceptions for influencing the roles and activities of HCAs. Importantly, this highlights the varying perspectives associated with the HCAs' role. Depending on who is asked – HCA or RN – there will be a different view about the 'appropriate' use and deployment of HCAs.

PERCEPTIONS OF HCAS' WORK AND ACTIVITIES

Studies exploring the perceptions of various stakeholders rely on the use of surveys or interviews. They offer insight into various perspectives, identifying areas of agreement and areas of tensions in the HCAs' role. Whilst role development may be perceived by HCAs as an opportunity, RNs may perceive this as a threat to their own role. It is important to distinguish between these perspectives so that the complexity of perspectives is presented. Therefore, this section considers studies relating to RNs (Malby, 1990; Chang, 1995; Francomb, 1997; McKenna and Hasson, 2002) and HCAs (Thornley, 2000; Workman, 1996; Warr, 2002) separately before addressing those studies that have addressed both (Boyes, 1995; Daykin and Clarke, 2000; Perry *et al.*, 2003).

Perceptions of Registered Nurses

Some commentators take as their starting point registered nurses' perceptions of those activities suitable for HCAs. Malby (1990) conducted semi-structured interviews with RNs and found that 'non-nursing' maintenance tasks formed a significant proportion of the work that registered nurses would like to pass on to HCAs.

However, two other key roles for assistants were proposed: 'enabling' and 'assisting'.

The enabling role was subdivided into tasks associated with the ward clerk and general housekeeping. The assisting role involved helping professionals to provide direct patient care. In addition, the assisting role might involve performance of some technical tasks, thereby allowing the professional to concentrate on direct patient care.

The reporting of this study is poor because it does not provide details of sample size, data collection or analysis and so the insights revealed should be treated cautiously.

Additionally, there is a lack of clarity in the difference between 'non-nursing' duties and the 'enabling' role. However, the classification of HCAs' work into general care and 'non-nursing' duties is replicated in most other studies exploring perceptions of the HCAs' role.

RNs have different perceptions and expectations of the HCAs' role in nursing care, depending on their grade (Chang, 1995). Through open-ended interviews and questionnaires, Chang explored the perceptions of RNs, Nursing Officers, Senior Nursing Officers and Chief Nursing Officers regarding the duties that could be carried out by HCAs to assist RNs with care provision in Hong Kong. Findings revealed a number of agreed HCA activities (67.5% agreement) across registered nurse levels. However, some activities remain contentious; with a small percentage of activities undecided (only 10% agreement).

The disagreement between levels of practising nurses was associated with 3 activities: recording fluid and diet intake and output in care documentation, support and reassurance of patients, and checking equipment/ instruments. Whether these activities should be part of the HCAs' role was the focus of disagreement between RNs and Nursing Officers; with Senior and Chief Nursing Officers feeling that it should be. These differences in opinion partly reflect concern and uncertainty at the clinical level about delegating, but also highlight contradictions within roles in the clinical setting. For example whilst the HCA can take away bedpans and serve meals – an agreed activity - they cannot record information on charts. As such, the process of care delivery is potentially hampered by the arbitrary boundaries drawn between registered nurses and HCAs, such that HCAs can feed people and monitor urine and excrement but are not allowed to directly input into the official record of the patients' stay in hospital. Consequently, the risk of omitting input or output is heightened with possible consequences for patient safety and the management strategies of other professional groups, such as doctors.

The focus of the assistant role on non-nursing and general care duties is also found in studies exploring midwives' perceptions of a midwifery assistant role (Francomb, 1997; McKenna and Hasson, 2002). Francomb (1997) used postal questionnaires distributed to 56 midwives within one NHS integrated maternity service regarding their perceptions of the role of the midwifery assistant. McKenna and Hasson (2002) used Delphi consensus methods, postal questionnaire and secondary analysis of data to investigate midwives' perceptions (194 qualified midwives and 79 student

midwives) of the skill mix requirements of a midwifery service based in the Republic of Ireland.

Both studies highlight the midwives' perceptions that the assistant role should focus on housekeeping, hotel, clerical and general care duties (such as assisting mothers with hygiene needs). Unsuitable domains of practice were also identified by these studies and included psychological and sociological aspects of care; accurate clinical record keeping and documentation; liaison with other health professionals; teaching student midwives and parents; bereavement counseling; transferring emergency patients; undertaking drug administration and care rounds. However, when HCAs were asked about their roles and activities they reported doing much more than basic care and non-nursing duties (Thornley, 2000).

Perceptions of HCAs

Thornley (2000) presents the findings from a series of national surveys with HCAs in the UK conducted during 1996-1999 (Thornley, 1996; 1997; 1998). The surveys explore the activities and conditions of employment of the non-registered nursing workforce (HCAs and nursing auxiliaries) within hospital and community settings. Whilst Thornley's earlier studies concentrate on the pay and conditions of these workers, the study in 1998 provides a wealth of data on the non-registered nursing workforce profile and roles. The study used a questionnaire administered to 32 UK NHS Trusts.

It is apparent from the survey results that the boundaries between 'ancillary' work and 'nursing' work are highly blurred and fluid; with workers engaging widely in nursing/

clinical (including direct personal care or phlebotomy), and non-nursing duties (for example clerical or portering duties). Some HCAs also reported being involved in what they termed 'advanced' or technical tasks (such as drug administration, giving telephone advice to patients or being in charge of a shift). Appendix 2 details the nursing /clinical, non-nursing and advanced /technical tasks reported by the HCAs. This survey provides detailed evidence of the overlap in duties between non-registered and registered nurses. The study highlights the need for a reappraisal of the skills and experience of the non-registered nursing workforce and of their potential. However, in critiquing this study it is important to note that self-reporting may not reflect actual activity in practice because what people say they do is not always a reflection of their work in practice.

Training has an influence on how HCAs' perceive their role and activities (Warr, 2002). Warr (2002) presents the findings of an interview study exploring the perceptions and experiences of six HCAs who completed level 3 NVQ. The sample consisted of experienced nursing auxiliaries (range 4-27 years), aged 22-45 years. The perceptions and experiences of these HCAs were categorised into four main themes: changing role boundaries and lack of clarity; 'pecking order'; being 'in-between'; and 'real' nursing.

Participants reported an increased repertoire of skills and added responsibility following NVQ training, often undertaking activities previously the sole preserve of RNs. However, this new role led to a blurring of boundaries between their role and that of the RN, creating difficulties in relation to issues of accountability, the limitations of the role, and managing the increasing expectations of others. HCAs

discussed moving upward in the nursing hierarchy and were more closely aligned to registered nurses than auxiliaries following training. However, the HCAs reported that some registered nurses perceived them as a 'threat' and that their relationship with auxiliaries (not vocationally trained) had changed because they were able 'to do more'. Participants described themselves as a distinct sub-profession (sic.) of nursing. The changes associated with having completed an NVQ led to differentiation from their previous role and functions, but simultaneously kept them separate from the registered nurses. Participants were clear that their role was about 'real' nursing - a practical, rather than academic, activity. Registered nurses were viewed as being preoccupied with activities other than direct care, such as managerial and administrative duties.

These findings illustrate some of the issues related to the introduction of a new grade of care worker. Following training HCAs change their working practices and whilst HCAs perceive that this has benefits for patient care it *appears* that it also creates tensions between their work and that of registered nurses. However, the responses of other professional groups require consideration if changes are to be managed effectively. Studies have also explored, simultaneously, the perceptions of HCAs and RNs about the roles and activities of HCAs.

Perceptions of RNs and HCAs

Boyes (1995) assessed the tasks and levels at which HCAs operate in Accident and Emergency settings. A postal questionnaire was sent to registered staff and HCAs based in 297 major accident and emergency departments throughout the UK. The findings illustrate the lack of consensus surrounding HCA roles. Common to all

units, however, was the fact that HCAs were performing more than basic care, housekeeping, and clerical duties – although it is not clear what these additional roles are. However, Boyes is concerned that HCAs “*often perform tasks that would otherwise be the domain of qualified nurses*” (1995: 9). Again, these findings rely on the reports of RNs and HCAs. The reporting of the differences in perceptions between HCAs and RNs was poor and there was no way of validating the results. A problem heightened by a possible response bias in the studies, as indicated by the lack of publication of questionnaire response rate.

HCAs ‘taking over’ the tasks of registered nurses are raised within a number of studies exploring perceptions of HCAs’ roles and activities (Workman, 1996; Warr, 2002). Workman (1996) explored HCAs’ and RNs’ perceptions of the HCA role (using interviews) and found tensions between the work boundaries of HCAs and RNs. HCAs with training, experienced role ambiguity because they were no longer viewed as ‘untrained’ carers, but yet neither were they ‘qualified’ professionals. RNs perceived HCAs as a *threat* to their nursing role. Workman suggests that the role of HCAs is closely linked to the characteristics and attitudes of RNs and the extent to which RNs are prepared to assume a supervisory role.

Daykin and Clarke (2000) also report the ‘threat’ of level 3 NVQ prepared HCAs as perceived by RNs. Their study - evaluating the perceived impact of a skill mix project in two wards in a NHS Trust in 1997 - focused on the introduction of a new tier of health care assistants (trained to NVQ level 3); reductions in the ratio of qualified nurses to HCAs; a ‘flattening’ of the nursing team hierarchy; and restructuring of the organisation of nursing care to team nursing (from primary

nursing). The paper describes the registered nurses' (n=17) and health care assistants' (n=12) perceptions about the division of nursing labour following these changes. Semi-structured interviews were conducted using pre-identified themes (changing roles, job satisfaction, quality of care, and management issues in relation to the skill-mix project).

The findings from this study highlight RNs' perception of the skill mix project as a threat to their professional status as HCAs were undertaking similar work.

Conversely the HCAs were enthusiastic about the project as it offered scope for their development. This enthusiasm was developed in the context of RNs' reluctance to support, supervise, and offer feedback to, the HCAs on their work. Moreover, the concept of holistic care was described as an ideal, rather than a reality, in the ward; consequently HCAs found themselves, for the most part, focusing on the physical care of patients, whereas the qualified nurses' role was more varied.

The diversity of RNs' work, when compared to the 'hands-on' work of HCAs, is also evident in other care settings, such as nursing homes. Perry *et al.* (2003) content-analysed semi-structured interviews from a purposive sample of nine RNs and twelve HCAs from four nursing homes in order to develop understanding of the differences in RN and HCA roles and function. The interviews were designed to encourage participants to describe their role both independently, and in relation to, the roles of others working in the home.

The findings suggest that RNs have difficulty in defining and limiting their roles. They describe a role requiring them to do 'everything and anything' because of their

professional accountability for residents' care. This creates difficulties for RNs when delegating activities to HCAs. The HCAs define their role in terms of what they are *not allowed* to do. The HCAs were recognised by both groups as contributing predominantly to 'hands-on' care provision with residents. RNs suggested that they often engaged in personal care 'to help the HCAs'. As such, the RNs appeared to be assisting the HCAs rather than the HCAs doing the assistant job that they were initially introduced to do. Both RNs and HCAs suggested that more assistant staff would increase the quality of fundamental care to patients.

Summary Of Literature Exploring Perceptions

Research examining perceptions of HCAs' work has taken into consideration both the perspectives of HCAs and RNs. However, these perceptions present a complex picture of HCAs' work and highlight considerable overlap between the work of registered and non-registered nurses. This overlap is described in studies of RNs' perceptions as a 'threat' to the RNs' role. However, HCAs view these overlaps as an opportunity for role development. Training is an important determinant for the ways in which HCAs view their role. NVQs are associated with bringing HCAs closer to RNs, in opposition to their 'untrained' colleagues. This suggests a split in the HCA grade; but it is unclear whether this split, between 'trained' and 'untrained' HCAs has an impact on their respective roles. However, in exploring the perceptions associated with HCAs' roles, further understanding is gained of the changing patterns and distribution of nursing work between grades of nurses.

Studies of perceptions rely on surveys and interviews. As such, caution has to be exercised when interpreting findings of studies relying on self-reported activity. The

phenomenon of self-report bias has been illustrated in other studies examining 'sensitive' areas of occupational activity, such as information use in clinical decision making (Covell *et al.*, 1985; Thompson *et al.*, 2001a; Thompson *et al.*, 2001b; Thompson *et al.*, 2002). Taking the lessons learned from these studies it is important to supplement descriptive accounts of HCAs' work with studies designed to overcome the problems associated with self-reported activity.

The final area addressed by the literature review is concerned with studies or reviews examining the impact of HCAs' work on patient outcomes.

THE IMPACT OF HCAs' WORK ON PATIENT OUTCOME

The impact of HCAs' work on patient outcome has been widely debated in the literature, primarily through discussion articles. Undoubtedly, over the past two decades, nurses' work and the tasks carried out by different levels of nurses have come under increasing examination. External (to the profession) commentators and policy makers, and the profession itself, have questioned whether, as registered nurses' roles change to take on more technical tasks, some of their work could be performed by HCAs (DHSS, 1986; Robinson *et al.*, 1989; Hendrickson *et al.*, 1990; Robinson and Stilwell, 1990; Audit Commission, 1991; Crouch, 1992; Blee, 1993). However, the simple substitution of one group of workers for another is not an apolitical activity. Concerns have been voiced suggesting that the increasing use of HCAs essentially devalues the skills of registered nurses and may negatively impact on patient care (Edwards, 1997; Orne *et al.*, 1998). It is important to examine the research evidence available (albeit limited) linking the use of the nursing resource on patient care and outcomes. This evidence-base is located within studies of skill mix.

Skill Mix Studies

Skill mix is an important issue in nursing (and healthcare more generally) because of the need to deploy the scarce nursing workforce resource in ways that deliver quality, cost effective, services (DHSS, 1986; ICN, 1993; Buchan and Seccombe, 1994; Kolehmainen-Aitken, 1998; WHO, 2000; Buchan and Dal Poz, 2002). A commonly quoted definition of skill mix in the nursing literature is:

'The balance between trained and untrained, qualified and unqualified, and supervisory and operative staff, within a service area as well as between different staff groups. The optimum skill mix is achieved when a desired standard of service is provided at the minimum cost, which is consistent with the efficient deployment of trained, qualified and supervisory personnel and the maximisation of contributions from all staff.' (RCN, 1992: 1)

Within nursing, there are competing views regarding the optimal ratios of registered to non-registered nurses for patient care. The polarisation is fuelled by historical, social and political debates, but is most visibly influenced by the economics of health care (including cost containment), and difficulties recruiting and retaining the nursing workforce (skills shortages). Despite some nurse leaders proposing a fully registered workforce, the economics of health care provision help sustain arguments favouring cheaper second level nurses – at least at the prima facie level. The nursing resource constitutes the largest expenditure within the NHS (Audit Commission, 2001). As such, senior managers and policy makers attempt to provide care using available nursing resources in the most cost effective manner; that is, providing a standard of

care that is uncompromised by altering the proportions of registered to non-registered nurses.

Additionally, there are concerns about the current crisis in the availability of registered nurses (Seccombe and Smith, 1997). This lack of availability is occurring alongside an increasing demand for nursing care as a result of demographic change - an ageing population and workforce (Butler, 1997), changes in care provision and professional roles (UKCC, 1999a) and increasing numbers of non-registered nurses in the overall workforce (Buchan and Seccombe, 2002 and 2003). Cost containment and threats of a skills shortage support arguments for a mixed economy in the nursing workforce: the continuing presence of registered, and non-registered, nurses.

However, there are few studies of HCA impact on patient care and almost all have significant conceptual and methodological limitations. The complexities of studying skill mix and determining the HCAs' impact require closer scrutiny.

Two studies in the UK have examined the impact of HCAs' work on patient outcome using case study methods (Carr-Hill *et al.*, 1992 and 1995; Warr, 1998a and 1998b). In the US, there are a limited number (n=5) of larger scale retrospective studies which contribute to our understanding of skill mix (Blegen *et al.*, 1998; Blegen and Vaughn, 1998; Aiken *et al.*, 2002; Needleman *et al.*, 2002; Aiken *et al.*, 2003b; Unruh, 2003).

Case Studies Of HCA Impact On Patient Care

Carr-Hill *et al.* (1992 and 1995) used a series of case studies to examine the relationship between nursing skill mix and the quality and outcomes of nursing care. The sample was made up of 15 wards (including acute medical, surgical and elderly

care wards) at seven hospital sites. The study used 'Qualpac' (Wandelt and Ager, 1974), a validated quality of care measurement tool, to assess the quality of psychosocial, physical and general care, communication, and professional activity. In addition, outcomes of care over which nurses were assumed to have a degree of control were also assessed. The outcomes included hygiene, nutrition and hydration, pressure sores and skin integrity, intravenous therapy, discharge planning, pain control, education/ rehabilitation and elimination.

Carr-Hill *et al.* (1992) argue that quality of care is directly associated with higher grades of nurses; to the extent that 'qualified' (registered) nurses provide both cost-effective and cost-efficient service:

'Investment in employing qualified staff, providing post qualification training and developing effective methods of organising nursing care appeared to pay dividends in the delivery of good quality patient care.' (Carr-Hill *et al.*, 1992: 144)

However, a finding from this study which is less commonly cited, is that there are lower variations in quality of care between grades of staff when higher graded staff work in combination with lower graded staff (Carr-Hill *et al.*, 1992). This suggests that nursing auxiliaries provide better quality care when working alongside, and being supervised by, higher grades of registered nurses. This is also supported by those studies examining organisation of care on HCAs' roles and activities. Where role modelling, support and supervision were observed the HCAs made a positive contribution to patient care and teamwork (Bond *et al.*, 1990; Thomas, 1992a; Ahmed and Kitson, 1993a). However, this study does not provide further detail on

supervision issues, or the management of auxiliary work in practice that led to lower variations in quality of care.

The study conducted by Carr-Hill *et al.* (1992) was undertaken before the implementation of vocational training programmes. Over the past ten years increasing numbers of HCAs have undertaken vocational training. This distinguishes HCAs from the 'old' style auxiliary (UKCC, 1987). Recognising these changes in the assistant workforce, Warr (1998a and 1998b) went on to study the impact of training and development of HCAs on their contribution to patient care. Warr's evaluation of a sample of HCAs trained to level 3 National Vocational Qualification (NVQ) versus other grades of nursing staff used the same methodology as Carr-Hill *et al.* (1992).

Warr's (1998a and 1998b) study was carried out in a single acute hospital Trust in medical, surgical and elderly care settings on a purposive sample of nine HCAs trained to level 3 NVQ. The results suggested that vocationally prepared HCAs can provide care which is as good, or of higher quality, than that provided by D grade RNs. The results indicated that the caregiving role of D grade nurses could be undertaken by the 'higher level' HCAs with no loss of quality. However, the mandate afforded to registered nurses by society becomes apparent when one considers that there are statutory responsibilities associated with the RN grade, such as medicines administration and assessment, which could not be carried out by the HCAs.

In some aspects of direct care, the NVQ prepared HCAs also performed better than E grade RNs. The parity between HCAs and RNs was therefore not simply a product of the D grades' limited experience. Warr suggests that the multi-faceted role of the RN

- which includes direct care and other associated activities - may compromise their ability to focus on direct care activities. Therefore, the level 3 NVQ-prepared HCA may constitute a worker able to concentrate on defined areas of care and offering high quality care to patients with minimal conflicting demands on their time.

Warr's (1998a) study builds on the work of Carr-Hill *et al.* (1992 and 1995) by suggesting that experience and training are more important influences on the quality of patient care than clinical grade. The effect observed was such that vocationally trained HCAs provided care of at least comparable, and sometimes better, quality than registered nurses. Warr's study lends weight to the popularly expressed concerns of the occupation that grade is an unreliable indicator of skill (Benton, 2003). It is worth noting however that these objections are rarely extended to their logical conclusion: that the lowest grades (occupied almost exclusively by HCAs) may have comparable skills to registered nurses. Professional objections to grades appear (albeit anecdotally) to only apply to the 'registered' territory of grades D – H or Staff Nurse to Sister or Charge Nurse. Despite the entirely plausible lack of connectivity between grade and skill, both Carr Hill *et al.* (1992) and Warr (1998a) imply the existence of *skill* within what are essentially studies of *grade* mix.

Gibbs *et al.* (1991) offer a measure of clarity in describing the distinction between grade and skill mix. Grade mix represents numbers of grades of staff (for example the numbers of Ward Sisters, RNs, and HCAs). More subtly, skill mix refers to the skills and experience of staff *within* those grades, represented for example by years of experience in a clinical speciality and qualifications. Heath's (1994) criticism of skill mix reviews is founded on their failure to recognise that skill is a composite of not

only grade, but also experience and ability. Criticisms can be levelled at Carr-Hill *et al.* (1992) and Warr (1998a) because of their concentration on grades rather than skills. Carr-Hill *et al.* fail to specify who the auxiliary nurses in their study were. Similarly, despite Warr's emphasis on the vocational preparation and former experience of the HCAs studied, the actual skills of this group of workers remain unaddressed. Moreover, in both studies, the lack of description of the work of assistant grades means that judgements of the appropriateness of the outcome measures used are hard to reach.

Warr's study however does add to our understanding of the *potential* contribution of vocationally prepared HCAs. Although the small numbers examined (the HCA subgroup only contained nine subjects) mean that the study does not have enough power to detect any differences beyond chance between the grades of nurses.

Moreover, both Carr-Hill *et al.* (1992 and 1995) and Warr (1998a and 1998b) utilised surveys as opposed to experimental designs. The consequent susceptibility to bias in the designs means that significant caveats should be attached to the conclusions.

Despite these caveats, the studies do offer a flavour of the empirical and methodological possibilities associated with greater sophistication in the thinking around the relationship between skill and grade.

The limitations of the primary research into skill and grade mix are replicated (by virtue of the nature of the included studies) in secondary research into the area.

McKenna (1995) reviewed US and UK research studies relating to skill mix, substitution, and quality of care; the aim being the testing of three key assumptions underpinning studies in this field. First, that skill mix weighted in favour of qualified

staff is both inefficient and ineffective. Second, that skill mix weighted in favour of unqualified staff is also inefficient and ineffective. Finally, that rich skill mix – the combination of skills from mostly qualified staff supplemented by unqualified staff - is a highly efficient and effective way to run a health service.

McKenna (1995) concludes that the evidence supports the retention of a rich mix of registered nurses because this is related to a number of improved outcomes for patients including: reduced lengths of patient stay, reduced mortality, costs, and complications, increased patient satisfaction, recovery rates, quality of life, patient knowledge, and compliance (McKenna, 1995). Again however, these results should be viewed cautiously. The included studies have significant conceptual and methodological limitations, as well as clinical and methodological heterogeneity perhaps reflecting the complexities of reliably measuring skill mix, a particular problem for those studies using retrospective analysis of existing data.

HCA's And Large Scale Retrospective Studies

Four North American studies using large data sets and retrospective analysis, suggest that higher proportions of registered and licensed practical nurses (an American term for 2nd level nurses with a minimum of 2 years nurse training) decrease adverse patient incidents (Blegen *et al.*, 1998; Blegen and Vaughn, 1998; Aiken *et al.*, 2002; Needleman *et al.*, 2002; Unruh, 2003). The adverse patient events used were chosen as these were considered sensitive to the registered nurses' contribution. They included medication errors; patient falls; skin breakdown /pressure sores; patient and family complaints; urinary tract infections; post treatment infections; pneumonia; shock; premature deaths /'failure to rescue'/ cardiac arrest; upper gastrointestinal

bleeding; length of hospital stay; and lung collapse. These studies concluded that improved patient outcomes, and therefore quality of patient care, are correlated with increased numbers of nurses at higher grades and levels of skill (Blegen *et al.*, 1998; Blegen and Vaughn, 1998; Aiken *et al.*, 2002; Needleman *et al.*, 2002; Unruh, 2003). The link between grades, skills and patient outcomes is supported by a recent study, again in the US, examining educational attainment and patient outcomes (Aiken *et al.*, 2003b).

Aiken *et al.* (2003b) studied whether hospitals in Pennsylvania (n=168) with higher proportions of direct-care RNs educated at baccalaureate level or above have lower risk-adjusted mortality rates and lower rates of failure to rescue (deaths in patients with serious complications). Findings reveal that in hospitals with higher proportions of nurses educated to baccalaureate level or higher, surgical patients experienced lower mortality and failure to rescue rates. Additionally, nurse experience did not independently predict either outcome. Aiken *et al.* conclude that educational preparation for practice, at degree level, may therefore be more powerful in determining outcomes for surgical patients than nurse experience (Aiken *et al.*, 2003b).

The power of these reported studies lies in the large size of their datasets and their ability to accurately detect associations between numbers of registered or licensed nurses and adverse incidents and patient outcomes. However, all the studies rely on secondary datasets compiled by organisations. The accuracy of their findings is therefore dependent on the quality of the original datasets. Analysis of the UK National Patient Safety Agency's structured adverse event reporting system, which is

accompanied by extensive guidance, suggests that problems of lack of completeness, loss of data, gaps in taxonomic classifications and limited accuracy of reporting are likely to be a feature of the datasets examined (Sheldon *et al.*, 2002).

In addition, because the analyses are retrospective and rely on historical controls, then some inflation of effect due to skill-mix changes and population maturation should be expected (Shultz *et al.*, 1995). The focus of these studies is registered and licensed practical nurses, nursing aides, the American equivalent of HCAs in the UK, are rarely included in the analyses - with the exception of Needleman *et al.* (2002). Consequently, there is a lack of acknowledgement of the variation in skills, experience and qualifications that exist within HCA grades in these large-scale studies. Additionally, outcomes were selected because they were sensitive to RNs' contribution. These may not be sensitive to HCAs' contribution; examples being medication errors or failure to rescue. The transferability of these findings to the UK is also limited because of the different cultural and healthcare contexts between North America and the UK. Analyses of any large datasets in the UK need to address these issues if we are to gain further understanding of the contribution of different grades of nurses (both registered and non-registered) to patient care and outcome.

Summary Of Skill Mix Literature In Nursing

Studies of skill mix suggest registered nurses make a difference to patient care by improving quality, outcomes and patient safety. However, within these studies, the contribution of HCAs is often invisible. This relative lack of attention to the hidden skills *within* teams means that the basic equation of higher numbers of registered nurses = higher quality and better outcomes requires a caveat. Ignoring the

contribution of HCAs when deploying skills may be something of a false economy for two reasons. First, research evidence highlights the lower variation in quality of care when staff of higher grades work alongside and supervise lower grades of staff (Carr-Hill *et al.*, 1992). Secondly, vocationally prepared HCAs provide care of equal, and sometimes better, quality than lower grades of registered nurses at D and E grade (Warr, 1998a and 1998b). In the absence of good quality outcomes studies, consistency in process – from a patient’s or service manager’s perspective – is arguably as important as final outcome. The process by which the registered and HCA workforce co-exist requires further consideration when addressing issues of quality in health care. In sum, the basic skill-mix equation requires the inclusion of more variables. Improved outcomes result from improved processes, and these processes are improved by recognising the HCA-registered nurse interaction effect, as opposed to suppressing it.

The wider socio-political context represented by imperatives such as cost containment and the skills-expectation gap necessitate the delivery of care by two levels of nurse. However, the optimal mix of registered nurses and HCAs required to provide quality, cost effective care to patients remains unknown. Quality of care is a function of local contexts, societal expectation, and political acceptability and so the optimal skill mix ‘magic bullet’ may elude researchers and policy makers for sometime to come. The heterogeneity in solutions borne of local context is recognised by Buchan *et al.* (2001). Quality relies as much on relative social judgements as it does on measured performance against absolute targets. This relativity is often missing from the existing skill mix knowledge base.

Moving Towards A Better Understanding Of The Skills, Roles And Demarcation Of HCAs' Work

Research examining the work of HCAs can be grouped into three main themes: the roles and activities of HCAs; perceptions of HCAs' work and activities; and the impact of HCAs' work on patient outcome. A variety of methodological approaches have been used to study their work. As a result, the literature is fragmented and offers a sketchy picture of their role. Thus far we know:

- there is overlap in the roles and activities of HCAs with other groups of nurses (such as RNs and Student Nurses) (Dewar, 1992; Chang and Lam, 1998);
- the role of the HCA is influenced by workplace processes (Allen, 2001);
- the role is influenced by models of care organisation, role modelling, support and supervision and by integration into the nursing team (Robinson *et al.*, 1989; Bond *et al.*, 1990; Thomas, 1992a, Ahmed and Kitson, 1993a);
- the perceived roles and activities of HCAs depend on who is being asked; highlighting a lack of consensus in perspectives from HCAs and RNs (Malby, 1990; Boyes, 1995; Chang, 1995; Workman, 1996; Francomb, 1997; Daykin and Clarke, 2000; Thornley, 2000; McKenna and Hasson, 2002; Warr, 2002; Perry *et al.*, 2003);
- HCAs provide care to vulnerable, dependent patients with complex care needs (Badger *et al.*, 1989; Davies, 1992; Warr, 1998a; Thornley, 2000);
- the roles of HCAs are extending but there are process difficulties associated with their introduction: variable training and competence; potential for misuse; lack of integration; and unknown implications for patients (Camden and Islington Health Authority, 1996; Rolfe *et al.*, 1999; McIntosh *et al.*, 2000);

- there are lower variations in quality of care when HCAs work alongside higher grades of nurses (Carr-Hill *et al.*, 1992; Bond *et al.*, 1990; Thomas, 1992a, Ahmed and Kitson, 1993a);
- vocationally prepared HCAs can provide care which is as good, or of higher quality, than lower grades of RNs (D and E grade) (Warr, 1998a).

It is clear that HCAs are a heterogeneous group of workers, engaging in wide ranging and varying levels of nursing work. However, there remains a limited understanding of the skills, competence, experience and qualifications of this group of workers. Studies exploring perceptions of HCAs' work provide insights into their roles and activities but are limited by their use of self-report and the potential for bias that this introduces. Studies describing the work of HCAs are also limited because of the lack of importance attached to the (socio-political) context in which HCAs practice. Work is a social activity, and as such it is important to understand relationships between workers and the negotiation of work. Allen (2001) recognises the importance of workplace processes, but views them through the registered nurses' management of HCAs rather than explicating the HCAs' perceptions and claims on nursing work. Studies of skill mix neglect to describe the work and skills of HCAs and so the contribution of HCAs to patient care may be ignored. These studies suggest that when HCAs work alongside RNs or have vocational training they demonstrate a positive contribution to patient care. However, the processes by which the RNs and HCAs 'co-exist' requires further consideration if issues of quality in care are to be fully understood.

Importantly, the majority of the literature exploring the work of HCAs is written by registered nurses (or professional groups). Authors have their own ideas and values about what RNs and HCAs should or should not be doing. The majority of methods used (surveys, interviews, observations) are susceptible to bias. Authors using qualitative methods do not write themselves into their accounts or acknowledge their subjectivity. These traits make determining the rigour and trustworthiness of the reports difficult. Additionally, these reports view the work of HCAs out of the context of the social organisation, by focusing on 'tasks'. This is problematic; to divorce HCAs' work from the social contexts in which it is located ignores the relevance of negotiations and the influence of power dynamics within and between the groups being studied. Studies therefore fail to address contextual details that influence the delegation and construction of work tasks.

The study underpinning the thesis addresses both the gaps in the literature and acknowledges these methodological problems. A case study design is used to generate an in-depth description of HCAs' work and recognises the importance of researcher reflexivity throughout this process. Four research questions are addressed:

1. What do 'skills' and 'experience' look like in one hospital's HCA workforce?
2. What is the content of HCAs' work?
3. How is HCAs' work negotiated in practice and to what extent is their work supervised?
4. What does the relationship between HCAs and RNs look like in practice and what tensions (if any) does this invoke?

Examining these questions takes place in the context of a health care organisation; with all the intricate social connections that this implies. However, studying human activity, social interaction and shared meanings is a complex business. Such complexity requires a theoretical starting point if it is to be managed (McKenna, 1997). The next chapter presents the theoretical start point which frames and guides the exploration of the questions outlined above.

CHAPTER 4 - PROFESSIONALS, NON-PROFESSIONALS AND NURSING CARE WORK

This thesis is concerned with understanding Health Care Assistants' (HCAs) work. Developing this understanding means exploring the work of HCAs, the social meaning attached to their work and the changing position of the HCA within the nursing division of labour. Moreover, this understanding has to be located within the context of changing health care services and the wider social and policy arenas. In sum, the thesis centres on the those macro processes influencing societal recognition of HCAs' work, whilst also giving due analytical weight to those micro-social informal processes which shape their daily clinical practice.

Achieving these aims requires an appropriate theoretical starting point. Choosing this starting point is a significant part of any social investigation. A theoretical framework provides parameters for the study, guides data collection and provides an anchor for interpreting the data (Moody, 1990). Theory promotes the weaving together of facts in a meaningful way. As such, a theoretical framework is the researcher's organising image of the phenomena to be studied.

Segregating the nursing workforce into registered and non-registered nurses has important implications for nursing care work. One of these - the Registered Nurses' (RNs') pursuance of professional status - has been an important parallel characteristic of the segregation process (Hector, 1973). Striving for professional status by the registered proportion of the nursing workforce has meant that - by default - the non-

registered nurses (HCAs) have been referred to as '*non-professional*' nurses. In linguistic terms alone, this terminological apartheid serves to divorce a sector of the workforce from the societal benefits (and of course responsibilities) of being labelled 'professional'. What is required in the thesis at this stage is a means of making sense of the patterns and trends associated with the split between registered and non-registered nurses. This requirement is met, in part, by using the sociological theory of healthcare professions, as an analytical device through which to scrutinise nursing work and the contribution of HCAs, as exemplars of the term 'non-professional'.

As an occupational group, HCAs have been the recipients of scant attention or scrutiny by sociologists. A fact which is surprising given the significant amount of nursing care which can be attributed to them. For example, HCAs are involved in the personal care (such as washing) of patients. This gap in scrutiny deserves to be considered in the light of the increasing volume of sociological literature concerned with 'professionals' and 'informal' carers. However, HCAs fall between these two categories of carers. They are neither considered professionals nor are they informal carers. In essence, this gap provides the rationale for the thesis. HCAs are located in this continuum of care but there remains a lack of scrutiny of their position within this continuum. The absence of a high-quality, specific, research and theoretical knowledge base mean that significant challenges – both empirical and theoretical – must be overcome. This chapter represents one element of the response to this challenge in that it proposes a theoretical framework – a way of viewing and making sense of HCAs' work – which provides a sound foundation for the collection and analysis of empirical data to come.

This chapter explores the continuum of care by focusing on care provided by *informal* carers before going on to examine the sociology of professions. HCAs are considered in relation to this body of work and then *positioned* between professionals and informal carers within a continuum of care. I go on to argue that the location of HCAs within this system lends itself to a view of HCAs' work borne of a critique of the theories of professions: interactionism. This interactionist perspective recognises that the societal position and work of an occupation can only be fully understood by examining the context and methods in which the occupation interacts with other occupations. In particular, the thesis draws on the work of Hughes (1984) and Abbott (1988). Hughes' and Abbott's theses offer insightful perspectives in that their focus is on *work* rather than professions. This subtle, but analytically significant, shift in focus makes possible the assertion that to understand the work of the 'non-professional' (non-registered) nurse one must examine their interaction with the 'professional' (or registered) nursing workforce within the system of caring work. Consequently, what this chapter offers is an interactionist perspective of HCAs' work at micro- and macro-social levels.

A CONTINUUM OF CARE: 'INFORMAL' AND 'FORMAL' CARE PROVISION

Nolan *et al.* (1996) suggest that the rise in 'informal' care giving is due to a combination of economic, demographic and ideological factors. There are about 5.7 million people providing informal care and, of these, about 800,000 people will provide unpaid care for 50 hours a week or more (Office for National Statistics, 1998). However, informal carers occupy an ambiguous position in relation to health service provision. They are both a focus for health services and also part of the taken-

for-granted reality against which services operate (Twigg and Atkin, 1994). The relationship between an informal carer and a dependent is based on a number of factors that create bonds between the two.

Distinguishing Between Formal And Informal Care

The motivations for becoming an informal carer are derived from the relationship between the carer and individual being cared for. Twigg and Atkin (1994) suggest that informal caring is based upon: the nature of caring tasks, kinship obligations, emotional ties and a sense of responsibility. It is the combination of these factors that make up the informal caring relationship.

First, caring is concerned with the performance of tasks for people: tasks that they cannot do for themselves, including personal care such as washing, toileting and moving. Such caring tasks go beyond the normal reciprocities common between adults, or the 'servicing' duties performed within mutually supportive relationships (Waerness, 1984). These caring tasks are physically demanding.

Secondly, informal caring takes place within a framework of kinship obligations (Finch, 1989; Qureshi and Walker, 1989). Intimate care tends to be carried out by close family members. Where friends and neighbours provide such care, this is usually because of some earlier social experience that has transformed their relationship to one in which they have become the 'primary' carer.

Thirdly, informal caring is closely linked to emotional ties; and in particular 'love' between the carer and the individual being cared for. Love and similar feelings are a

key element of the bond of obligation within the caring relationship. This duty of obligation contributes to why people care and also influences the experience of caring. Just as physical care can be physically demanding, the duty of obligation has been conceptualised as a form of 'emotional labour' (Hochschild, 1983; James, 1989; Smith, 1992). Caring is not just about tasks; carers also support and encourage the individual being cared for and, in doing so, engage in emotional care which can sometimes affect the experience of caring more significantly than the performance of physical tasks. Of course, the opposite can also hold true in that carers who fail to fulfil this emotional role can negatively impact on the lives of the people they care for.

Finally, the duty of obligation is closely allied with feelings of 'being responsible' for the cared-for person (Twigg and Atkin, 1994). The carer may feel responsible for monitoring the dependent's situation, negotiating with a variety of services, stepping up their caring involvement and adjusting their actions to meet any service shortfalls. This sense of responsibility is a core feature of informal care-giving (Twigg and Atkin, 1994) and a clear line of demarcation with formal carers, such as professionals.

Nurses constitute a significant proportion of the caring workforce, however, the nature of the relationship with the dependent is different to that of informal carers. The nurse-patient relationship is based on contractual bonds rather than on obligation; although often these bonds are implied or tacit rather than formal and explicit.

Alongside the device of registration as a means of controlling who are nurses, a proportion of the nursing workforce sought, and continues to seek, societal

recognition as professionals: part of a process of professionalisation. These claims are based on: undergoing formal education based around the application and development of a unique body of knowledge related to caring; registration with a professional body following formal examination as a visible indicator of professional competence; and regulated caring practices within a code of professional conduct. These conditions form the basis for the relationship between the professional carer and the patient. In contrast, non-registered nurses were excluded from this professionalisation process. They are not registered and have not gained formal recognition for their caring work through professional status. Whilst their relationship with the patient is based on contractual bonds they do not possess the conditions of practice that accompany professional caring work. However, neither do they possess the duty of obligation to care associated with informal carers. They are located along this continuum of care.

Having outlined the demarcation between formal and informal care provision, the thesis turns now to the question of how might examining the sociology of professions shed light on the work of HCAs.

PROFESSIONALS AND NON-PROFESSIONALS

Salvage (1992) argues that what constitutes a profession is ideologically and politically contested territory. This is reflected in the growing body of sociological theory in relation to the role and nature of professions in modern society, highlighting the importance of professions and professional activity in contemporary culture. A variety of standpoints have been developed and advanced as explanatory frameworks for the growth in the phenomenon of the professional in society.

Structural Functionalist And Trait Approaches To Professions

One of the key proponents of structural functionalism was Talcott Parsons. Parsons (1937) argued that through the influence of socialisation – or the processes by which people learn to conform to social norms - people learn how to play various social roles that they will adopt throughout their lives. Social expectations are therefore translated into individual action through the learning of social roles. By conforming to the rules and laws that govern social roles, a stable social system is created.

According to Parsons (1951), professions (such as medicine) possess attributes that allow them to fulfil effectively their function in society. The social actors subsumed under the professional label of doctor embody affective neutrality (an emphasis on unemotional and impersonal interactions), universalism (objective evaluation of the subject of the medical gaze), achievement (status related to performance of role), specificity (relationship restricted to health care) and collective orientation (addressing the needs of public service rather than pursuing monetary benefit). He argued that the social system of the doctor-patient relationship enabled medicine to *manage* illness (Parsons, 1951). Moreover, social value attached to the function of medicine is such that its practitioners are afforded a privileged position in society (Turner, 1987).

A derivation of the functionalist approach - the trait approach - defines professional occupations by a core set of characteristics which when possessed in full equate to the ideal-typical profession. Traits include skills based on theoretical knowledge, specialised training and education, formal examinations as a test of competence, the

development of a professional organisation, a professional code and the development of altruistic service (Millerson, 1964). What the trait approach allows for is the placement of occupations on a continuum of more or less professional according to the degree to which the traits are operationalised within the occupational group.

Structural functionalists and proponents of trait approaches (Goode, 1957; Greenwood, 1957; Carr-Saunders and Wilson, 1962) viewed medicine (rather uncritically) as the 'model profession'; proclaiming the attributes achieved by medicine could be used as a measure by which occupations' claims to professional status could be judged. This ability to 'measure' professional status led to nursing and other groups, such as social work and therapies, being labelled as 'semi-professional' (Etzioni, 1969). These groups were seen to have developed only some of the attributes of what was taken to be a 'full' profession. As such, they were viewed as inferior to professions such as medicine.

Trait and functionalist models were extremely influential up until the late 1960s in macro-sociological work on the nature and role of professions in society (Saks, 1983). By the late 1960s however, the theoretical counter arguments began to develop in sophistication and volume. Criticism centred on three main deficiencies. First, the essential traits for professional status, the central strand of the approach, were contested. The definitions and attributes were identified by elites within professional groups and therefore reflected the dominant ideological view of the profession itself, rather than a critical list of characteristics. In addition, the trait approach failed to explain why some occupations that possessed a large number of professional traits had discomensurate amounts of professional status, for example pharmacists. Second,

trait approaches ignored the role of power in the process of professionalisation. With professional status and the privileges enjoyed by professional bodies came the opportunity to control and manipulate the labour market and their clients. Finally, functionalist perspectives ignored the historical dimension to the acquisition of professional status. Specifically, unique and contingent contexts were seen as allowing a window of opportunity for professions' development. An example, of such a 'window' would be the commitment to public service that became a visible part of the development of medicine in post-war Great Britain. Prior to the development of the NHS, doctors had a direct payment relationship with patients and consequently the commitment to public service was questioned by some parts of society – primarily the poor (Porter, 1997).

Neo-Weberian And Neo-Marxist Approaches To Professions

A more critical approach to the study of professions was offered in the work of neo-Weberian and neo-Marxist theorists; focusing on the ways in which professionals achieve positions of autonomy and dominance. Indeed, for Freidson (neo-Weberian theorist), the monopoly rights which medicine secured through *autonomy* and *dominance* were at the very heart of professional identity. Autonomy refers to the ability to control one's own work activities, and dominance to the control over the work of others in the division of health care labour:

'Organised autonomy is not merely freedom from the competition or regulation of other workers, but in the case of such a profession as medicine... it is also freedom to regulate other occupations. Where we find one occupation with organised autonomy in a division of labour, it dominates the others. Immune from legitimate regulation or evaluation by other

occupations, it can itself legitimately evaluate and order the work of others. By its position in the division of labour we can designate it as a dominant profession.’ (Freidson, 1988: 369).

According to Freidson (1988), autonomy and dominance, rather than collegiality and trust, are the hallmarks of professionalism. Elston (1991: 58) refined the idea of autonomy further by subdividing it into:

- *economic autonomy*, the right of the profession to determine their remuneration;
- *political autonomy*, the right of the profession to influence policy decisions;
- *clinical autonomy*, the right of the profession to set its own standards and control clinical performance.

The exercising of autonomy within the profession is made easier if the profession is closed to outside interference - especially from other professions. Weber’s (1968) theory of social closure describes the mechanisms by which social collectives attempt to close off from another group by restricting access to resources and advantages.

The argument adopted by neo-Weberian theorists is that professions have succeeded in monopolising the market supply of labour through processes of credentialism (the tendency for societies to award positions on the basis of educational or vocational qualifications) and legalism (the processes of professional registration). Parkin (1979) argued that two major forms of social closure can be identified: ‘exclusion’ and ‘usurpation’. Exclusion is associated with the exercise of power in a downward direction through the subordination of socially defined inferiors. Usurpation refers to the upward push of occupational groups on higher privileged groups to gain and usurp

some of the higher groups' power. Social closure is by definition often hidden, hard to track and consequently contested (c.f. Johnson, 1972; Freidson, 1970b and 1988).

Johnson's (1972) analysis of occupations reveals the importance of acknowledging power structures in the development of professional status. He argues that professions attain their powerful position through the use of at least three strategies: monopoly of the market supply; occupational homogeneity via collegiate control to prevent challenges to this monopoly; and promoting an image of altruism and ethicality by claiming to deploy high level complex skills which take time to learn and which are inaccessible to 'lay' citizens – the competency gap. For commentators such as Johnson (1972), collegiate control and maintaining the gaps in competency between professions and others are means of exerting control over the patient, '[professionalism is] *a particular type of occupational control rather than an expression of the inherent nature of particular occupations*' (Johnson 1972: 45). Thus, by examining professions in the context of social power structures their claims of altruistic service for the greater social good become harder to sustain.

Explanations of what happens to the professions are seen as the outcome of the workings of societies based on capitalist relations of production (Macdonald, 1995: 22). Neo-Marxist theories centre on the relations between the professions and the state. Thus, the autonomy of the profession depends on the power of the state, and a profession's privileged position secured by the influence of the state that sponsors it. It is *not* the knowledge per se that professions claim that gives them their status in society, but the value that such knowledge has in so far as it promotes the capitalist system (Carchedi, 1975; Johnson, 1977).

Whilst accepting many of the arguments of neo-Weberian and neo-Marxist theorists, feminists have criticised the approaches for being gender blind. For feminist scholars, women's' position in society should be the central challenge in developing a sociology of professions (Garmonikow, 1978; Crompton, 1987; Witz, 1990). Witz's (1992) study of nursing's own professionalisation project advances the neo-Weberian stance by describing the effects of gender on occupational status and market position. Witz (1992) argues that nursing is an occupation that is involved in dual closure strategies. She employs Parkin's (1979) concepts of exclusionary and usurpatory closure by arguing that nurses adopt both of these strategies in their struggle to be professional. Whilst nursing tries to usurp medical power by challenging the medical definition and control over what nurses do, they also exclude others, namely non-registered nurses (HCAs) from nursing's professionalisation project through three main tactics: having a single point of professional entry and controlling acceptable credentials (the key manifestation of credentialism); professional registration (or legalism); and a centralised, controlling, professional body run by nurses.

Nursing's attempts to define a unique knowledge base gathered momentum in the latter decades of the twentieth century with the advent of a series of nursing theories. Some of which the profession tried to operationalise; one prominent example being the nursing process (a systematic, problem-solving, patient-centred approach to care). The 'New Nursing' (Salvage, 1992), as it was termed, had important implications for nursing work.

Its proponents asserted that nursing was 'patient-centred' rather than 'task-centred' and that nurses were 'professionals of care'. This ideology of 'new nursing' aimed to enhance the role of the nurse by emphasising nurses' competence in care giving and providing fundamental care tasks, such as bathing. Crucially, the advocates of this stance afforded these 'fundamentals' a central place in what might be thought of as a hierarchy of registered nurses' work. Importantly these fundamental care tasks were given equal importance to the other - more technical - tasks handed to nurses from doctors (Salvage, 1992). However, 'new nursing' has its critics in that it was predominantly normative and heavily ideological, as opposed to an accurate descriptor of clinical practice. The professional vision of nursing has tended to be associated with the professional elite - such as the educational sector and a 'minority' of the nursing workforce - rather than with the majority of nurses providing care (Melia, 1987). A study of surgical nurses by May (1992) demonstrates how the bio-medical approach to patient care dominates, and that psychosocial issues (a new nursing preoccupation and perceived point of demarcation from medicine) are secondary. It is the signs and symptoms of the patient that are given most importance in determining care and therefore the (largely rhetorical) notion of patient-centred 'holistic' care was viewed as more of an ideal than a clinical reality (May, 1992).

The relationship between knowledge and control of work is perceived by the profession as central to the success of nursing's professionalisation project. This interplay has provided ammunition for the struggles between nurses and doctors (Porter, 1992 and 1995; Witz, 1992 and 1994) and between registered and non-registered nurses (Daykin and Clarke, 2000). The incorporation of nurse education into undergraduate programmes within universities (Davies, 1995) and the extension

of nursing roles into domains formerly occupied by doctors (Walby *et al.*, 1994; Mackay, 1993; Cooke, 1993) are often seen as indicative of success in managing the relationship between the two forces.

Towards the end of the twentieth century, the power attributed to some health care professionals, and in particular medicine, has arguably decreased because of changes in capitalist society. Changes labelled 'proletarianization' by neo-Marxists and 'deprofessionalization' by neo-Weberians have been recognised within the structure and context of healthcare settings.

Changes To Professional Power In Health Care

The proletarianization thesis emphasises the changing conditions in healthcare work. This is apparent in the work of doctors and their consequent loss of power. Marxist writers (Oppenheimer, 1973; Mckinlay and Arches, 1985; McKinlay and Stoeckle, 1988) argue that capitalist development has forced the progressive loss of medicine's autonomy and skills and that the profession is increasingly forced into considerations of industrial and post-industrial modes of production. Elston (1991: 63) describes medicine's loss of societal privilege with reference to, deskilling due to increased specialisation and the role of technology in medicine; the subordination of medicine to managerial control; increasing unionisation of doctors; and the increasing challenges to doctors' authority by the lay public. Ironically, threats to the supply and delivery of labour have also been cited as a reason for the increasing unionisation of medical activity by some authors (Budrys, 1997). A trend, when viewed from the proletarianization perspective, appears counterproductive.

Within the deprofessionalization thesis healthcare workers lose their immunity from the general trends of rationalisation and the development of critical public attitudes to professional knowledge (Haug and Lavin, 1983). Haug (1973) argues that:

'professional occupations ...[have lost] their unique qualities, particularly their monopoly over knowledge, public belief in their service ethos and expectations of work autonomy and authority over clients' (1973: 197).

The rise of consumerism (in all its guises), alongside changing attitudes to gender, class and ethnicity in society, mean that society is less willing to give professions free rein and more likely to question their performance (Salvage, 2002).

Although there may be general agreement within sociology that professionals' autonomy and dominance are being challenged by economic and social changes, proletarianization and deprofessionalization fail to fully reflect the complexity associated with this decline (Elston, 1991; Freidson, 1994). Annandale (1998: 231) points to the lack of testable hypotheses in the positions of proletarianization and deprofessionalization and that, as such, it is not clear what evidence is necessary for the outcome of these concepts (Wolinsky, 1993). The same indicators may be read in different ways – are professions being successful in protecting their interests by maintaining their position; or does the existence of challenges to professions by the public indicate that their power is on the decline (Annandale, 1998).

Freidson (1994) suggests that although there are challenges to professional dominance because of changes in health care provision, he proposes that this will not have a big impact on professional power. This statement, concerned with the medical

profession, refers to the collective power of medicine as opposed to individual practitioners. Freidson argues that stratification within the profession - with the rank and file on the one hand and on the other the disciplinary, educational and administrative elite - helps to maintain *collective* power but undermines the autonomy of some parts of the profession. He argues that professions are subject to 'countervailing pressures' for change which have a variety of effects. Some of these pressures may undermine but yet others may enhance professional powers. As such, Freidson (1994) advocates that professions should be studied in the context of health care provision and that those studies should focus on how the *work that professions do* is played out in practice. Coburn and Willis (2003: 378) also suggest that sociologists are preoccupied with professional power to the neglect, perhaps, of other dimensions of the profession such as the changing nature of *actual* healthcare work.

Light (1995) argues that the idea of countervailing pressures:

'focuses attention on the interactions of powerful actors in a field where they are inherently interdependent yet distinct. If one party is dominant... its dominance is contextual and eventually elicits counter-moves by other powerful actors, not to destroy it but to redress an imbalance of power.'

(Light, 1995: 26)

The position of one occupation can therefore only fully be understood by examining the context and the ways in which the occupation interacts with other occupations. Inter- and intra-professional interactions are becoming increasingly complex in health care today and the boundaries between different health workers are in a constant state

of flux. This is highly relevant for the study of nursing and the position of the HCA in nursing work.

Whilst the nursing workforce is broadly separated into registered and non-registered nurses this has been further divided within the registered nursing workforce - during recent years - by the development of consultant, and specialist and advanced practice nurse positions. A crucial question for nursing, and implied by Freidson's thesis, are how changes in intra-occupational boundaries affects the power of some groups of nurses and the results of these processes for other segments of the nursing workforce. Freidson's (1994) thesis that internal restratification protects professional status can be applied to nursing. Changes in the boundaries between different segments of the nursing workforce have implications as nursing work is 'played out' in practice settings. Witz (1994) writes:

'the paradoxical situation where nurses' rhetoric of professionalisation seems to be winning through in spite of a more general attack on professional monopoly, particularly that of the medical profession, may well have more to do with the cost-cutting potential of a nursing service – at the core of which are a smaller number of highly educated 'knowledgeable doers' surrounded by a peripheral workforce of cheaper care assistants – than a successful re-negotiation of occupational boundaries between doctors and nurses, or a significant challenge on the part of nurses to the traditional dominance of doctors over nursing.' (Witz, 1994: 40)

This is reflected in the increased employment of health care assistants over recent years (Thornley, 2000). As the organisation of health care work changes this, as

already discussed, has created changes in the work of professionals but also has implications for the work of non-professionals. Attempts have been made to explain the changing organisation of professional work through Fordist and post-Fordist theorisation (Walby *et al.*, 1994).

Fordism relates to the simplification of jobs that can be carried out by cheaper and less skilled workers. In health care, this means that tasks are subdivided and workers have narrowly defined duties. Patient care is delivered by a number of workers with expertise each performing their defined duties. Post-Fordism, is characterised by flexible working, whereby workers at the more elite end are en-skilled, and are more autonomous in their practices and decision making in response to the patient. Piore and Sabel (1984) argue that when human resources and work are organised to enable workers to use their full range of skills this has benefits for everyone. Post-Fordism in health care aims to ensure that patients receive care tailored to their needs; workers have greater autonomy, enjoy their work and therefore work better; resources are used more efficiently; and employers ensure cost effectiveness. However, other versions of this style of working are more pessimistic and suggest exploitation of some workers. Atkinson (1986) argues that flexibility of post-Fordist working is not merely 'functional' where a minority of workers 'at the top' are en-skilled but is also 'numerical' where a peripheral workforce bears the brunt of fluctuations in the demand for labour. The 'core' workers exercise power over the workers on the periphery. Therefore, the flexibility of post-Fordist working does not benefit everyone. Whilst some workers are able to work more creatively the majority face uncertainty in their working terms and conditions.

In nursing, whilst clinical nurse specialists, advanced nurse practitioners, nurse consultants and nurse managers may have experienced enhanced autonomy and opportunities to work creatively, the majority of other nurses, such as junior registered nurses and HCAs, have been expected to take on more responsibilities with limited resources, facing uncertainty in their working hours, pay and conditions (Annandale, 1998). The power attributed to a minority of the professional group has consequences for the majority of the workforce. Witz (1994) refers to these model flexible workers as being on the 'dark-side' of post-Fordist work organisation.

The changing nature of professional work has led to an increasing focus on the work of non-professionals and the ways in which their contribution to care can be better integrated. This requires nurses to have a new vision of professionalism. Davies (1996) suggests that nurses should not promote old-fashioned professional concepts such as mastery of knowledge, unilateral decision making (the patient as dependent and colleagues deferential), autonomy and self-management, individual accountability, detachment and interchangeability of practitioners. Instead, she argues that nurses should develop professionalism that promotes reflective practice, interdependent decision processes (the patient as empowered and colleagues involved), supported practice, collective responsibility, engagement and specificity of practitioners' strengths.

This vision is further supported in a later paper by Salvage (2002), who calls for a 'rethinking' of professionalism for the delivery of patient-focused care. She argues that discussions about professionalism need to encompass the role of support workers, such as HCAs, and also the role of voluntary workers and lay carers. This requires a

re-evaluation of the potential of traditionally subordinate occupations to nursing, the non-registered nurses. She argues that new professionalism should have at its centre the consideration of the position of these groups in the health care team and their interrelationship with the professions. This approach to professionalism is very much in line with the NHS Modernisation Agenda which emphasises the need for flexible working and the breaking down of traditional boundaries between health care workers to deliver patient-centred care.

Theories of health care professions, the professionalizing strategies and the challenges to this, and new visions of professionalism are of relevance when considering the work of HCAs and their development in the delivery of care. The extent to which registered nurses have achieved professional status has been viewed through these theoretical perspectives. However, it is apparent that there is a lack of focus on the non-registered nurse and their contribution to nursing work. As an occupational group, HCAs have received very little attention and scrutiny by the sociological literature. The relevance of an interactionist perspective, and in particular the work of Hughes (1984) and Abbott (1988), for the study of HCAs, is presented below.

Interactionist Approaches To Professions

A growing body of work stresses the interactionist approach to social relationships and work. Functionalists and interactionists differ in the key area of societal institutions and structures. For functionalists these are a form of constant or given. Interactionists, on the other hand, regard them as socially constructed and constantly reshaped through human interpretation and normal social action and reaction. From this perspective, to understand social structures there must be an examination of the

actions that sustain them. Interactionists direct attention away from the macro-social structural functionalist approaches towards the micro-social processes of negotiating role, function, objectification of work subjects and societal value of an occupation's workforce – negotiations at the very heart of the development of professional status.

George Herbert Mead is commonly accepted as being the founder of the interactionist approach. Mead's central thesis was that through interaction, accommodation and adjustment human beings strive to coordinate their behaviours with others. Drawing on the theoretical insights of Mead, Blumer (1969) used the term symbolic interactionism to describe this model of social behaviour and develop a social theory of interactionism. Blumer (1969) suggested that interactionism is built on three key premises:

'The first premise is that human beings act towards things on the basis of the meanings that things have for them... The second premise is that the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows. The third premise is that these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he (sic.) encounters' (Blumer, 1969: 2)

The interactionist perspective then is concerned with the manner in which human beings go about the task of assembling meaning. These meanings are constantly being built through interaction with others and, as such, meaning is dynamic, emergent and ultimately ambiguous. It is not the individual or society per se that interactionists focus on. Rather the joint acts through which lives are organised and societies assembled. Central to this focus is the philosophical notion of the *self*. A

term, which if accepted, logically introduces its complement: the *other*. At its root, interactionism is concerned with how people do things together (Becker, 1986).

As with any theoretical position, interactionism has its critics. For some its concentration on the micro-social realm is at the expense of a loss of explanatory power regarding the influence of human behaviour on wider social structures and historical process (Saks, 1983). The importance of social structure *has* been recognised in interactionist studies. Specifically, by conceptualising structures as a series of building blocks it can be seen that the interactive order within the structure may be interconnected to many levels of social life, including roles, groups, organisations and societies (Plummer, 1996: 239). The term ‘mesostructure’ has been used to describe the domain between face-to-face encounters and the wider social structure. As such, mesostructure connects the micro and macro social worlds, or societal and institutional forces, with human activity (Maines, 1982:10)

The idea of ‘negotiated order’ was introduced by Strauss *et al.* (1963) to describe the workings of social organisations through the active participation of its members; and in doing so, demonstrating the link between micro and macro social worlds. Social interaction and negotiation, from this perspective, contribute to social order.

Conversely, organisational structures (such as hierarchies, policies and rules) are seen as reciprocating by contributing to micro negotiation patterns. Strauss (1978) introduced the concepts of *negotiation context* and *structural context* to sensitize researchers to the relationship between negotiation processes and organisational constraints.

One interactionist who used the field of occupation as a test-bed for his ideas was Everett Hughes. His work is of particular importance for this thesis (Hughes *et al.*, 1958; Hughes, 1984). In a study of the nature of nursing work, Hughes' (1958) interactionist perspective extends the debate on health work and function by arguing that health care is not simply a technical exercise but more essentially a moral one. He argues that nursing involves the performance of dirty and dishonourable work and those workers attracting prestige and professional status are largely dissociated from this dirty work. Hughes believed that as nurses acquired the work delegated to them by doctors, they in turn passed on tasks to the support worker. It was this ability to shed 'dirty' tasks by nurses, and pass them on to others, that Hughes saw as a key component of the process by which nursing was becoming a profession.

Hughes' influence has produced a significant stream of empirical and theoretical work focusing on the interactions between individuals and groups and the construction of work through participation in the social world (Becker *et al.*, 1961; Freidson 1970a; Abbott; 1988). In nursing, Allen (1997a; 1997b; 2000; 2001) draws on Hughes (1984) and Abbott (1988) to analyse the changing shape of registered nursing practice in contemporary health care. Her study examines the boundaries between nurses, other health care workers (including support workers, management and doctors) and patients. In doing so, she places the occupation of nursing within the broader division of labour in health and society. In addition, she examines the importance of workplace processes and the negotiation of nursing work in daily practice.

Although Allen addresses the boundary between nurses and support workers, the findings of which are presented in Chapter 3, her focus is on nurses' management of

the support worker in general. The aim of this study is on the emic understanding of HCAs' work and the development of their role. Whilst locating the HCA within the broader context of nursing work (the wider social and policy arena being a feature of this thesis), the analytic gaze is firmly on non-registered nurses' work. This is an important point of differentiation between Allen's (2001) work and this thesis.

THE STUDY OF NON-PROFESSIONAL WORK

The starting point for this thesis is that the work of an occupational group can only be fully understood by examining the social system of which it is part. As such, this study of HCAs' work is framed by the interactionist perspectives of Hughes (1984) and Abbott (1988). The use of their theoretical approach is supported by their focus on work, rather than professions per se, and therefore it lends itself to a study which aims to gain a better understanding of HCAs' work within a hospital setting. Hughes' and Abbott's theses are considered here in detail, presenting the key concepts of their work and the ways in which this is used to frame this study. In addition, a critique of their work is presented with consideration of how these identified weaknesses in their perspectives have been addressed throughout this study.

Occupations As Social Roles Within A System

Hughes' central argument (1984) is that the division of labour occurs in a social system and that the internal dynamics of an occupation are important to understanding its boundaries. According to Hughes, people act. He suggests that an occupation is not simply a set of particular activities but rather the part, or social role, played by individuals in any ongoing system of activities. He argues that it is impossible to describe the work of an individual without reference to others with whom they work.

Such that, whilst the 'division of labour' is a term which is used for the differentiation of function in a social whole, Hughes suggests it is not so much about the division of labour but the *connections* between different parts in the social system of work that are important:

'The division of labour, in its turn, implies interaction; for it consists not in the sheer difference of one man's kind of work from that of another, but in the fact that the different tasks and accomplishments are parts of a whole whose product all, in some degree, contribute to. And wholes, in the human social realm as in the rest of the biological and in the physical realm, have their essence in interaction.' (Hughes, 1984: 304)

In emphasising the social significance of work, Hughes makes an analytic distinction between the role and task components of work. He refers to two types of division of labour: *technical* and *moral*. The *technical division of labour* refers to the allocation of tasks ('what I do') and the *moral division of labour* to the role component ('who I am'). He argues that the two types of division of labour, technical and moral, are inextricably linked together and therefore a study of tasks has to be about a study of the people who perform those tasks. For Hughes, it was the moral component of work that was essential for the performance of nursing work because such work involves carrying out dirty work. The symbolic value attached to this dirty work is central to Hughes' interpretation of the process by which nursing has attempted to gain professional status.

According to Hughes (1984), an occupation is made up of a 'bundle' of tasks. He argues that activities may be bundled together because they are performed by one

person with a particular occupational title or because they naturally seem to be part of an occupational role. Alternatively, the bundles might be held together because they require similar skills or because they can be carried out conveniently at the same time. The various activities which make up an occupation are given varying values by both the people 'inside' and 'outside' the occupation. Not all tasks are awarded the same value or require the same type or degree of skill. Both technical and moral factors can affect the tasks in the bundle. Hughes argues that by examining the changes in bundles of activity and their value and function in the total system, the historical development of an occupation can be described. The tasks in a bundle are not fixed and their symbolic value may change as a result of other shifts in the system of work. The dropping of certain tasks whilst acquiring others with higher symbolic value happens as occupations develop into professions.

Within nursing there are two contrasting trends operating simultaneously because of advances in medical technology and changes in service delivery. Doctors are handing on tasks to registered nurses and in turn registered nurses are passing on tasks to HCAs. As such, a section of the nursing workforce is being 'upgraded' as it moves closer to the doctor in techniques and spends more time in the supervision of assistants who perform tasks that they (RNs) have handed on to them. According to Hughes, this dropping of low prestige work to assistants captures the process by which nursing is gaining professional status. Such changes in the technical division of labour may create role problems and the repercussions of these changes may be felt beyond the positions immediately affected, touching every position in the system. As such, no line of work can be fully understood outside the social matrix in which it occurs or the social system of which it is part. This is highly relevant within the

system of health care where the boundaries of workers are continuously being disputed and renegotiated.

There are two key concepts in Hughes' thought, namely licence and mandate.

Licence refers to the activities that an occupation is granted to carry out by society, whilst mandate refers to the jurisdictional claims of an occupation. These concepts are not fixed and can be expanded or contracted by an occupation, particularly where an occupation is aspiring to be a profession. Of social significance is the questioning of an occupation's license and mandate. In relation to the work of registered nurses and health care assistants there has been increasing questioning about the activities of registered nurses and whether or not a HCA could perform such activities. The power of an occupation to protect its license and to maintain its mandate, and the circumstances in which licenses and mandates are attacked, lost, or changed, are important matters in the study of occupations. As such these concepts are useful for the study of the changing content of HCAs' work.

The social and institutional matrix in which things are done for people is certainly becoming more complex in most professional fields; there are more kinds of workers in the division of labour and constantly changing boundaries between one person's work and another's. However, Hughes argues that it is not the numbers that are the problem but the differing conceptions of: what the work really is or should be; what mandate has been given by the public; what is possible to accomplish; and by what means. In addition, this relies on the particular part to be played by those in each position within the system, their proper responsibilities and rewards.

The professional works with a host of *non-professionals* and these workers, such as the HCA, bring their own conceptions of: what the problem is; their rights and privileges; and of their careers and life-fate. They may be of a different class or element of the population to those who pursue professional qualification. Such workers will probably not completely accept the role-definitions handed down from above. In communication with peers and in interaction with the people served, treated, or handled, they work out their own definition of their work. They build up an ethos, and a system of rationalisations for the behaviour they consider proper given the hazards and contingencies of their own positions. Despite this, there remains a relative lack of examination of what HCAs think their role should be and what they actually do. This study addresses the gap. Before going on to explain how this study was executed, this chapter addresses the work of Abbott (1988) and its application to this study. Abbott (1988) develops Hughes' ideas in his analysis of professions in nineteenth and twentieth century England, America and France.

Jurisdictional Claims: Linking Occupations To Their Work Within A System

The starting point for Abbott's (1988) theory on professions is its focus on work; the content, the control and the differentiation of work that gives rise to internal occupational divisions and external conflict with other occupations over jurisdiction. The concept of jurisdiction is central to Abbott's thesis. He describes jurisdiction as the link between a profession and its work:

'The central phenomenon of professional life is thus the link between a profession and its work, a link I shall call jurisdiction. To analyse professional development is to analyse how this link is created in work, how it is anchored in formal and informal social structure, and how the interplay of

jurisdictional links between the professions determines the history of the individual professions themselves. (Abbott, 1988: 20)

Abbott argues that professional work and the professions' claims to their jurisdictions take place within a system. His theory is concerned with the interrelations of professions and how occupational groups control their skills and knowledge. The links between a profession and their work are not absolute or permanent and so professions make up an interacting system. Professions compete within this system, and a profession's success reflects as much the situations of its competitors and the system structure as it does the profession's own efforts. From time to time, tasks are created, abolished, or reshaped by external forces with consequent jostling and readjustment within the system of the professions. Larger social forces (technological, organisational and knowledge-based developments) have their impact on individual professions through structures within which the professions exist. The influence of macro-social processes on the micro may be seen in Abbott's proposals about jurisdiction. He suggests that there are cultural and social structural aspects to jurisdiction.

The cultural aspect refers to the construction of tasks into professional problems. The distinguishing factor between craft occupations and professions is the way in which professions control their knowledge and skill. Craft occupations emphasise control over techniques whereas a professional practice is based on *abstract knowledge*. The practical skills of professions grow out of an abstract system of knowledge and control of professional work lies in the control of this abstraction. The tasks of professions are turned into professional problems through the profession engaging in

'cultural work'. This cultural work ensures that clients, competitors, the state and the public acknowledge that the problem warrants the granting of jurisdiction to that profession:

'The jurisdictional claims that create these subjective qualities have three parts: claims to classify a problem, to reason about it, and to take action on it: in more formal terms, to diagnose, to infer, and to treat. Theoretically these are the three acts of professional practice.' (Abbott, 1988: 40)

The emphasis of Abbott's analysis of knowledge is on the active work that professionals have to put in, or '*act*', to maintain their jurisdictional claims and their niche in society. This academic, formal, abstract knowledge system is also continuously advanced to maintain the professional jurisdiction of practice and such abstract knowledge has to be '*effective enough to compete in a particular historical and social context*' (Abbott, 1988: 9) so that the profession can define its problems, seize new problems and defend its existing domain from competitors.

The social structural aspect of jurisdiction refers to the how jurisdictional claims are made in the public, legal and workplace arenas. In the public arena, professions claim for the legitimate control of a particular kind of work and the exclusion of other groups from the performance of such work. These claims can take decades to develop with public images of professions remaining fairly stable. Abbott (1988) suggests that public jurisdiction concerns an abstract space of work, in which there exist clear boundaries between professions and their tasks are objectively defined.

The formal control of work and monopoly is conferred in the legal arena and claims of jurisdiction here are even more explicit. Contests for legal jurisdiction take place in three areas: first in legislature, which grants statutory rights to certain professional groups; secondly in the courts, where such rights are enforced; and finally, by registration with professional bodies. Legally established jurisdiction is a slow process and usually occurs after the profession has won a public position. Legal jurisdiction attempts to abolish uncertainty in relation to professional jurisdiction by firmly delineating formal definitions of boundaries to professional work but as such, and as Abbott points out, these definitions have little resemblance to real life situations.

In the workplace, jurisdiction is a simple claim to control certain kinds of work. Within organisational settings, the work of professionals may be formalised by job descriptions. However, Abbott suggests that these formal divisions of labour have a vague relation to reality. Actual divisions of labour are established through negotiation and custom and are extremely vulnerable to organisational perturbations. Within organisations the division of labour often locates professionals in settings where they must assume extra professional tasks and cede many other tasks to other workers. Abbott suggests that the boundaries between professions in organisations can disappear, especially in overworked sites:

'There results a form of knowledge transfer that can be called workplace assimilation. Subordinate professionals, non-professionals, and members of related, equal professions learn on the job a craft version of a given profession's knowledge systems.' (Abbott 1988: 65-66)

Whilst these other workers, which include non-professionals, lack the theoretical training that justifies membership in that profession, they generally acquire much of the diagnostic, therapeutic, and inferential systems. In this way, HCAs may acquire the skills of nursing work performed by registered nurses and perform similar work activities even though they may not have the credentials of the RNs. Abbott proposes that there is a contradiction between the formal arenas of jurisdictional claims – public and legal – and the informality of the workplace. He argues that jurisdictional boundaries are perpetually in dispute, that full jurisdictional control is not often achieved and so professional groups may use other forms of jurisdictional settlement. These settlements include: sharing an area of practice with explicit division of labour; advisory control over certain aspects of work by a profession; division of jurisdiction according to client rather than content of work; or subordination of one professional group under another. According to Abbott, the internal differentiation of professions both generates and absorbs system disturbances. He suggests that the most important division of labour is that which divides routine into non-routine elements. These elements then fall to different segments of the profession or even to outside groups and result in the degradation of what was previously professional work to non-professional status.

Abbott also examines the impact of wider social forces on the system of professions. Technological and organizational changes have reshaped professional work. Abbott (1988) views these as generally positive suggesting that *'they have created vast areas of work for professions and have destroyed relatively few'* (1988: 146). He also recognises that there are cultural changes that have also reshaped the work of

professionals: the rising amount and complexity of professional knowledge; new types of legitimacy claimed for that knowledge; and the rise of the university.

Critical Reflections Of Hughes' and Abbott's Theoretical Perspective

In adopting a theoretical standpoint it is also important to recognise any deficiencies in the perspective and how this is addressed when it is applied to a study. To be aware of the weaknesses and not acknowledge these would limit the potential contribution of this study to the development of theory. Abbott's thesis of professions may be criticised on two main points.

First, he fails to acknowledge work that falls outside 'the system of professions.' Allen (2001) criticises his approach because of its failure to address the relationship between professions and other informal workers (Allen, 2001). This relationship is particularly significant for the study of nursing care where professional (registered) nurses provide care alongside non-professional (non-registered) nurses and informal carers. The relationship between formal and informal caring is crucial for nursing's professional project, and for this study, the location of the HCA within this continuum of care (formal – informal) remains largely unarticulated. However, Abbott does acknowledge that within the workplace there is a process of assimilation whereby subordinates and non-professionals assume a craft version of a profession's knowledge system. In nursing this means that craft, as opposed to professional abstract, knowledge is being reintroduced into work but by a group of workers who are not attributed the same status as RNs. It is this process of assimilation that is of particular interest in examining the work of HCAs. In addition, assimilation recognises the changing nature of professional work within a system such that where

the professional is overworked non-professionals may take over jurisdictional vacancies created in the work setting. Therefore this approach can be applied to the study of the non-professional nurse within the system of nursing care work.

A second main criticism of Abbott's thesis is related to his lack of consideration of the importance of power in inter-professional competition; namely the meanings and motives of the actors and their embodiment in a 'professional project' (Macdonald, 1995). However, Abbott (1988) does consider power in relation to how professions retain their jurisdictional claims. Professionals maintain their jurisdiction through 'settlements': these settlements prevent others from making claims on professional work, or enable the professional to treat other workers as subordinates. These settlements are relevant when examining the system of nursing work and the division of labour between RNs and HCAs.

Allen (2001) also criticises Abbott's lack of consideration to power in relation to how dominant societal ideas might systematically devalue the skills of certain groups within society, such as women. Hughes has also been criticised for his lack of consideration of the effects of gender on structuring the experience of work. Oakley has highlighted the lack of attention in sociological studies of work to women's unpaid work in the form of housework (Oakley, 1974) and motherhood (Oakley, 1979). However, over recent years a body of literature has emerged highlighting women's experiences and attempting to develop theoretical understanding of women's position in the world of work. Yet within this, nursing work (as women's work) is about care, and James (1992: 106) argues that this usually remains invisible and is commonly viewed as not *real* work.

In nursing, Garmonikow (1991) and Witz (1992) have analysed the relationship between gender and professionalisation and have argued that gender made a difference to the outcome of nursing's professional project. This study of HCAs takes place within the context of debates about gender and professionalism and recognises that caring work may be devalued by society and as such impair nursing's attempts to be recognised as a profession. However, as Daykin and Clarke (2000) also point out, this study recognises that the professional project in nursing might also undermine lower paid non-registered nurses and their contribution to caring work. These debates on gender form a backdrop to this particular study.

SUMMARY

To recapitulate, the aim of this study is to better understand HCAs' work. In order to do this, the thesis explores the work carried out by HCAs, the social meaning attached to their work and the changing role of the HCA within the nursing division of labour. Moreover, the study aims to understand how HCAs' work and development can be understood within the context of changing health care services and the wider social and policy arena. In order to achieve these aims a theoretical starting point is required. This chapter has considered the concept of informal care and then examined in detail the sociological literature pertaining to professions. The HCA is considered in relation to these and identified as occupying a unique position within the continuum of informal – formal caring work because they are neither a professional nor informal carer. The lack of attention to this worker in the sociological literature makes them a highly relevant group to study in understanding the provision of care in hospital settings.

A critique of the theories of professions identifies a theoretical framework for the study of HCAs: interactionism. This perspective recognises that the position and work of an occupation can only be fully understood by examining the context and ways in which the occupation interacts with other occupations. The interactionist perspectives offered by Hughes (1984) and Abbott (1988) provides a useful framework that can be utilised for this study of HCAs because of the central focus on work. However, a broader range of sociological theories of professions have been reviewed because they offer explanatory value for understanding the relationship between HCAs and RNs.

The system of work is dynamic and as such occupations change. Jurisdictions expand and contract, and the activities performed by an occupational group may modify in value and status. The boundaries between registered and non-registered nurses are changing and these are negotiated and renegotiated by the participants. These interactions take place within public, legal and workplace arenas and are influenced by wider structural factors. Therefore, to understand HCAs' work, they should be studied in context with a focus on how the work that non-professionals do is played out in practice; how they act and interact with registered nurses and the influence of power dynamics in nursing work; and how their work is negotiated through participation in the social world of caring work. This study therefore focuses on the micro-social informal processes that negotiate the daily practice of HCAs but also connects this to the wider macro process that influence societal recognition of their work. To achieve the purposes of this study, a case study approach has been employed.

CHAPTER 5 - METHODOLOGY AND METHODS

The case study method has a long and distinguished history within social science (Yin, 2003; Creswell, 2003). Despite (or perhaps because of) this heritage the term case study has been attributed a number of meanings (Hakim, 1987; Stoecker, 1991; Platt, 1992; Stake, 1995; Sandelowski, 1996; Burns and Groves, 1997; Yin, 2003). Therefore this chapter outlines the application of the case study approach and data collection methods used in the thesis.

The study of HCAs' work is essentially a study of social action and the complex processes surrounding this action. The case study makes use of data generated through self-reporting of activity, observations of practice and interactions, and documents. Analysis looks across, as well as within, data sets derived from different methods, all within the detailed social context of an individual case site. This research agenda presents significant methodological challenges. A monomethodological approach is unlikely to generate a useful framework for research given these challenges. Indeed, even applying mixed methods of data collection as a series of monomethods viewed in isolation, is equally unlikely to generate a robust methodological way forward. Rather, as Brewer and Hunter (1989) argue:

'Social science methods should not be treated as mutually exclusive alternatives among which we must choose... Our individual methods may be flawed, but fortunately the flaws are not identical. A diversity of imperfection allows us to combine methods... to compensate for their particular faults and imperfections.' (Brewer and Hunter, 1989: 16-17)

With these limitations in mind it is important that the reader views this thesis as an exemplar of a *mixed methodological* approach. Such designs, as Tashakkori and Teddlie (1998) assert – whilst firmly rooted in pragmatism – also represent complex research endeavours in their own right. Such endeavours must, however, address issues of internal and external validity, reliability, rigour and ultimately trustworthiness.

The case study makes use of a variety of data collection methods to develop an understanding of HCAs' work in the case site. These data collection methods occurred in three distinct but sequential stages to build a picture of the complex interplay of factors influencing HCAs' work. Stage one involved survey and interviews with HCAs (n=33) to better understand the characteristics (demographic and biographic) of the HCA workforce within the hospital, to find out their perceptions of their role and any tensions between their role and that of registered nurses (RNs). Data collected for this stage were used to purposively sample a group of HCAs to observe in practice. Stage two subsequently involved participant observation of HCAs day-to-day practice (n=220 hours). The need to move beyond perceived role results from an awareness that what people say they do, and what they *actually* do in practice, rarely coincide (Silverman, 1985; Kuper, 1991). In addition, observation explores the supervision of HCAs' work and any tensions between the roles of HCAs and registered nurses. Stage three completes the emerging picture of HCAs' work by carrying out focus groups (n=4) with RNs (of different grades) to gather their perspective of the HCA role, supervision issues and tensions.

At the end of each stage, findings were reported back to a research steering group comprised of senior nursing staff from the hospital (Director of Nursing, Assistant Director of Nursing, and Training and Education Facilitator for Support Staff). These meetings served to inform the development of subsequent stages of the research, validate the findings, and inform the hospital's development work in relation to the HCA role as part of implementing the nursing strategy, *Making a Difference* (Department of Health, 1999a). Throughout the study period I have also attended relevant meetings and fora² to better understand the organisation's structure and systems. National, professional and organisational documents and reports were also collected to provide detail of the contexts in which HCAs practice and to provide further understanding of the ways in which the HCA role is developing.

In order to make sense of this wide-ranging data, multi-level (embedded) analysis is required (Yin, 2003). The rationale for adopting an embedded design for this study is to capture the multiple perspectives of all the stakeholders associated with the HCAs' role. Units of analysis include HCAs, RNs, other key stakeholders, and clinical areas within the single case (an acute NHS hospital).

CASE STUDY RESEARCH AND SOCIAL ACTION

The work of HCAs involves social action. Case study provides the ideal strategic choice when researching issues of social action, especially in organisational settings (Yin, 2003). The strengths of case study lie in its ability to cope with, and provide

² Meetings attended include: Ward Sister/ Charge Nurse monthly meetings; Trust Nursing & Midwifery Advisory meetings; HCA role development project meetings; Support Staff Forum meetings

insights into, complex real world developments (Robson, 1993; Keen and Packwood, 2000).

Hughes (1984) proposes that work involves social interactions and that particular occupational roles can only be understood within the social matrices in which they occur or the social system of which they are part. This thesis explores HCAs' work in one hospital setting. The qualitative approaches adopted focus on the participants in their natural work settings and generate and use naturally occurring data. As such, the case study is designed to capture HCAs' social action within the social system of nursing and health care delivery.

It is important to recognise the variety of case study designs that exist (Yin, 2003). Distinctions can be drawn between single- and multiple- case studies, and units of analysis used: single (holistic) or multiple (embedded) units of analysis. Thus, for the case study strategy, four types of design can be adopted: single-case (holistic) design; single-case (embedded) design; multiple-case (holistic) design; multiple-case (embedded) design. This study uses a single-case (embedded) design, the rationale for which is presented below.

The Single-Case (Embedded) Design

Yin (2003) argues that the single-case is an appropriate design under the following circumstances:

- it represents the critical case in testing a well-formulated theory;
- it is an extreme or unique case and as such any single case is worth documenting and analysing;

- it is a revelatory case by offering the researcher an opportunity to observe and analyse a phenomenon previously inaccessible to investigation;
- it is an exploratory case and therefore the prelude for further studies.

The rationale for adopting a single-case study design is based on the exploratory nature of this study and the lack of research examining the work and skills of HCAs.

The aim of using a single-case, in the form of one hospital, is to generate a descriptive account of HCAs' work located within its physical, social, temporal organisational and economic context.

This study is built upon what HCAs say they do and observations of what they do in practice. It explores how, or indeed whether, the work of HCAs is supervised in practice, tensions between the work of RNs and HCAs, and subsequent effects on teamwork and patient care. In exploring their work, multiple sources of data are used (Sturman, 1994). Data collected includes interviews, observations, focus groups, documents and reports.

Despite the strengths associated with case study design, methodological concerns have been voiced about the value of case study findings. These concerns include: the lack of representativeness of the case; lack of rigour in data collection and the introduction of bias from the researcher or research participants; and a lack of generalisability from case findings (Hamel, 1993; Holloway and Wheeler, 1996).

JUDGING THE QUALITY OF CASE STUDY RESEARCH DESIGNS

Hammersley (1992) and Kirk and Miller (1986) argue that all research involves subjective perceptions and observations, and that different research methods produce different representations of the social phenomena studied. With the increasing use of qualitative methods in health service research there has been increasing scrutiny of researchers' claims of the findings obtained through such methods (Mays and Pope, 2000). Whilst validity and reliability are commonly used to establish the quality of quantitative research (Bowling, 2002), these tests are not widely accepted by qualitative researchers when establishing the credibility of their research (Becker, 1958; Lofland, 1971; Murphy *et al.*, 1998; Bowling, 2002). Guidelines for doing and judging qualitative studies have been developed (Blaxter, 1996; Popay *et al.*, 1998). However, some methodologists reject the labels of reliability and validity and replace them with the desirable criteria of rigour and trustworthiness (Guba and Lincoln, 1981). The techniques required to provide trustworthiness in qualitative analyses are: triangulation, reflexivity and respondent validation. I have adopted this stance and used similar techniques to promote transparency and rigour in the study findings.

Triangulation

A particular strength of case study research is that many sources of evidence may be collected to explore a phenomenon. The use of multiple sources of evidence allows the researcher to address a broader range of historical, attitudinal and behavioural issues (Yin, 2003). The most important advantage, however, is the ability to develop converging lines of inquiry, or triangulation.

One form of triangulation (between-method) involves the comparison of the results from two or more different methods of data collection and is generally accepted as a means of ensuring the comprehensiveness of a set of findings (Mays and Pope, 2000). Within this thesis, triangulation offers the opportunity for exploring multiple views within the case study site. For example, the perceptions of HCAs can be compared with perceptions of RNs; or the self-reports of HCAs about what they do can be compared with what they are observed to do in practice.

Both correspondence and discrepancies in the data are valuable. Where two sources give the same message then, to some extent, they cross validate each other; and where there is discrepancy, further investigation may help explain the phenomenon of interest (Robson, 1993). Thus, triangulation assists with the interpretation of complex inter-related study findings by encouraging reflexivity in analysis.

Reflexivity

Mays and Pope (2000) define reflexivity as:

'sensitivity to the ways in which the researcher and the research process have shaped the data collected, including the role of prior assumptions and experience, which can influence even the most avowedly inductive enquiries.'

(Mays and Pope, 2000: 96)

During the study, I was acutely aware of the importance of the researcher as a possible effect on the research process (Burgess, 1984; Lipson, 1991). Burgess (1984) expands on the importance of the interactions between researcher and participants and such relationships being a fundamental aspect of the research.

Atkinson (1990) argues that an awareness of the processes by which the researcher 'understands' strengthens the process of critical reflection.

To ensure credibility of findings situated in this thesis, an account is provided in Chapter 2 of my personal characteristics and professional status, and the possible effects this may have had on data collection. In addition, I have kept reflective research notes during data collection and analysis to record my reactions to events occurring throughout the research process. Where relevant, these reflections are incorporated, presented, and highlighted as part of the analysis. In doing so, these strategies provide an opportunity for the reader to judge any possible bias I may have introduced through my role as researcher.

The final technique suggested by Guba and Lincoln (1981) to increase trustworthiness of qualitative findings is respondent validation.

Respondent Validation

Lincoln and Guba (1985) regard the process of respondent validation as the strongest check on the credibility of a research project. This thesis uses this process to validate some of the study's findings. The analyses of data sets has been presented to a research steering group (comprising hospital staff) and groups of study participants (including HCAs and RNs), to establish the level of agreement between my own interpretations and the accounts provided by participants. The reactions of participants at these feedback sessions have been taped, transcribed and incorporated into analyses. It has been highlighted by Bloor (1997) that researcher and participant accounts may be different: the former designed for a wider audience and the latter the

account of an individual informant. However, rather than simply allowing for checking of findings, this process has also allowed for error reduction in analysis and the generation of further data which has been included in the study.

Another form of respondent validation, and therefore a way of improving the quality of case studies, is to have 'draft' case reports reviewed by those who have been the subject of study (Yin, 2003). This procedure has been identified as a way of corroborating the essential facts and evidence presented in a case report (Schatzman and Strauss, 1973). Study participants and academic peers have been included in the critique of reports from the three stages of the study and the final thesis.

The techniques of triangulation, reflexivity and respondent validation have therefore been used to increase the credibility and transparency of the thesis.

Transparency

Hakim (1987) offers a definition of transparency:

'the methods and procedures used can be made visible and accessible to other parties (be they professional colleagues, clients, or the public audience for the study report), so that the implementation as well as the overall research design can be assessed.' (Hakim, 1987: 48)

The processes of negotiation and methods of data collection, sampling and analysis are presented to enable the reader to judge the appropriateness of methods deployed, and the relationship between the findings and the data on which these findings are

based. Transparency is achieved through establishing an audit trail (Koch, 1994) or chain of evidence (Yin, 2003) through the research process.

DATA COLLECTION: TRANSPARENCY OF PROCESSES AND METHODS

A range of methods have been used in the conduct of this case study to generate a deeper level of understanding about HCAs' work in one hospital setting. These methods include interviews, observations, focus groups and documentary sources of evidence. The following section provides detail of the methods and the ways in which the research was carried out. However, it is important to share at this point the processes by which the case study was negotiated and access gained to the case site.

Negotiating Access

Burton (2000) suggests that to gain access to a research setting it is necessary to seek permission for entry through the formal mechanisms in place within the organisation. Pope and Mays (2000) highlight the importance of gatekeepers in this process of negotiation: people who allow and, often, facilitate access to the research environment. Because such access is dependent on gatekeepers' locations in the social structures of the organisation, then negotiation has to occur at a number of points including at management, ward and individual participant levels.

Negotiation At Trust Level

The study protocol was developed collaboratively with the Trust's Director and Assistant Director of Nursing, at a time when the Trust had started to examine the roles of HCAs as part of implementing the nursing and midwifery strategy, *Making a*

Difference (Department of Health, 1999a). As such, the study's relevance was accepted and supported reasonably well. However, key stakeholders still had to be persuaded of the operational detail of the methods to be used. By forming a rapport with individuals occupying positions of social significance within the organisation, a number of important relationships for the success of the study were facilitated and include:

- access to study participants by being invited to attend and present the project proposal at a Trust-wide Ward Sister /Charge Nurse meeting, the Trust HCA Project Board meetings and HCA Forum meetings;
- access to information within the Trust through identification of key informants.

Despite general acceptance of the project, some staff within the organisation developed their own interpretations of the study's purpose and my role within the organisation. For example, a Senior Nurse suggested to ward staff that the study aimed to undertake a cost review for management that would result in fewer RNs on the ward, and more HCAs. This charge required a prompt response from myself to prevent the spread of inaccurate accounts within the Trust that could potentially jeopardise my access to the clinical settings.

Negotiation, and ensuring support of the project at the ward level, was to prove as crucial as gaining access to the Trust and the consent of individual HCAs.

Negotiation At Ward Level

In order to further understand the day-to-day work of HCAs, I worked alongside them in clinical practice to observe their work. However, HCAs do not work in isolation but are part of a ward team. As such, ward staff (by default) also became part of the research process. Charge Nurses were the necessary initial point of contact for negotiating the possibility of carrying out participant observation at ward level.

This proved to be a time consuming process and created challenges associated with arranging, and unexpectedly rescheduling, meetings. The short time allocated to this initial meeting by the Charge Nurses meant that it was essential that they received concise study information prior to the meeting. Appendix 3 details my correspondence with the Charge Nurses for negotiating access to the clinical environments. The purpose of the meeting was to ensure their consent for me to work on the ward as an observer, to approach HCAs in their clinical area, and to clarify any practical issues. Table 5-1 details the practical issues associated with this study and discussed with Charge Nurses.

Carefully preparing for the negotiation process, and formulating clear guidelines at the outset, ensured the consent of ward staff and facilitated my introduction into the field. However, the process of negotiation did not stop at this point. Once inside the clinical area I had to continually renegotiate my presence.

Table 5-1 Practical issues to be discussed with Charge Nurses

- The role is one of researcher rather than nurse. The researcher is supernumerary to clinical staff.
- The intention of the researcher to wear a HCA uniform.
- The anticipated level of researcher's participation in HCAs' activities.
- The intention of the researcher not to intervene in HCAs' work. The exception being if a patient's safety is at risk.
- Plans to ensure that ward staff are informed about project. This includes: contacting the nurse in charge of any shift that the researcher plans to observe so that they are aware of researcher's presence in the clinical area; displaying a poster and study information within each clinical area; and being present at handover (the start of a shift) to introduce self and project to nurses working on that shift and to address any concerns.
- The intention to respect individual's right to anonymity and confidentiality (names not recorded in field notes).
- The procedure for staff to deal with any concerns about researcher's conduct in the clinical area.
- That no feedback can be given to the charge nurse on an individual HCAs' work unless there is a risk to patient safety.

The clinical environment is staffed by a dynamic and somewhat transient community.

Whilst it was possible to inform the nurses of my presence on the ward at the outset of a shift, there were a number of people who were not aware of the research or me.

Doctors, therapists, domestics, phlebotomists and patient relatives all came and went during the data collection period. The dilemma for the participant observer is to ensure that people are informed as necessary. Whilst this study was overt, rather than covert, the extent to which all members of the setting knew of the research varied enormously.

Dingwall (1980) suggests that participant observation research requires continual, informal negotiation of access and consent; the extent of which depends on circumstance. This sometimes involved reminding people that data were being collected for research purposes, a practice described as 'process consent' (Munhall, 1991). However, this practice had to be balanced with being unobtrusive, so the

actions of the HCA were as natural as possible. Some ethnographers have cautioned that being too overt in participant observation can influence the behaviour of participants (Hammersley and Atkinson, 1995). I had to tread a very fine line between the roles of participant and observer. Clearly, not emphasising my role as observer could be open to abuse. However, the most interesting and rich data were often gained at times when participants had seemingly forgotten my research presence.

Negotiation At The Level Of The Research Subject

In the initial phases of a research project, developing a rapport with participants is seen as an aid to quality data collection. As a registered nurse attempting to explore the work of HCAs this raised particular problems. The HCAs did not view me as 'one of them' (sic). Whilst other researchers may also experience this problem, there were particular issues associated with the dynamics of the relationship attributable to level of nurse training; myself a registered nurse and participants as non-registered nurses.

When considering how to approach individuals for consent to observe their work it is necessary to consider the group in which they belong, their characteristics, and their previous exposure to research. At the outset of this study, the Trust HCAs had no prior experience of being part of a research study. There was a general feeling within the Trust that the role of the HCA had been neglected for some time and it was only recently that project work had started to address issues associated with the role. As a result, the HCAs treated me and the research with some suspicion.

Stage one of the study involved interviews with all HCAs. Prior to approaching individual HCAs, a letter explaining the study and an invitation to participate were distributed to all HCAs in the Trust (Appendix 4). All HCAs approached agreed to participate. Crucially, these interviews also gained the HCAs' approval of the research project and facilitated the participant observation stage. Letters inviting a purposive sample of HCAs to take part in the observation stage were all accepted (Appendix 5). HCAs were also provided with information about what is involved when observed in practice (Appendix 6). In practical terms, the initial interview contact with all HCAs meant that they were aware of the project aims and so were not approached 'cold' for the subsequent observation stage.

Having addressed design characteristics of the chosen approach, the thesis now turns to the details of the data collection methods employed. Each method contributes to the emerging picture of HCAs' work within the case site.

Interviews

An interview has been described by Cannel and Kahn (1989) as:

'[A conversation] initiated by the interviewer for the specific purpose of obtaining research-relevant information and focused by him on content specified by research objectives of systematic description, prediction or explanation.' (Cannel and Kahn, cited by Cohen and Manion, 1989: 307)

Interviews with HCAs have been used in the case study to gather demographic and biographical data and to further understand the perspectives of HCAs in the Trust about their work, their skills, supervision issues and any tensions between their own

work and that of RNs. All health care assistants working with registered nurses in the case site were eligible for interview. The Human Resource Department in the Trust provided names and clinical areas of these workers from their database of staff. A total of 34 HCAs were identified working in the ward areas. Only one of these was not interviewed because of long term sickness.

A semi-structured interview schedule to gather data on the Trust's HCA workforce was designed using both focused and open-ended questions. The development of the interview schedule is detailed below. A copy of the final schedule is presented in Appendix 7. The schedule addressed the following areas:

- Who are the HCA population in the Trust?
- What experience and skill (education, training, work and life) do they bring to their role?
- What are the HCAs' perspectives and opinions of their role?

The focused component of the interview generated data on HCA demographics, grade, role, clinical area, length of employment at the Trust, work history, educational qualifications and training for their role, informal caring experiences and satisfaction with their current job. As well as gathering facts on the HCA workforce, open-ended questions offered an opportunity for HCAs to contribute additional information that offered further insights into their role, supervision, and overlap in duties with RNs.

I carried out face-to-face interviews with assistants in the Trust over a four-month period. The schedule was completed during the interview and notes were made of qualitative comments. Detailed reflective interview notes were written up

immediately after the interview. Interviews lasted anything between 30 to 75 minutes. All interviews were conducted in the afternoon or evenings because HCAs and managers identified that morning were a busy time for HCAs and so they could not be freed from the clinical setting for interview. Interviews were carried out in a private room. These ranged from the comfort of the Charge Nurse's office to the practical space of a cupboard or sluice.

Design Of The Interview Schedule

The types of questions to be asked of the assistants were informed by the literature review, discussion with professionals interested in HCA work (e.g. Health Care Support Worker Trainers and researchers), HCAs, and by giving consideration to the sampling frame required to purposively sample for observation. The interview schedule questions were designed in order to allow comparison between the Trust's HCA population and a national sample of assistants (Thornley, 2000). Some of the questions related to demographics and life experiences were adapted (with permission) from a questionnaire designed to evaluate career pathways of newly registered nurses by the Nursing Research Unit, King's College London (Robinson *et al.*, 1997).

A combination of both closed and open questions has therefore been used. Factual information was gathered through a series of questions with tick-box answers. Other questions relied on respondent recall, for example work history and qualifications. Despite being closed questions, respondents were encouraged to add any information they thought was being missed and space was provided for this information to be recorded.

Prior to wider implementation, the interview schedule was pre-tested. As with any semi-structured interview schedule the researcher makes a judgement about what respondents will know, the language they will understand, the sorts of information they can and will provide, and the response tasks they can perform. Testing these assumptions is only possible through pre-testing.

The pre-test is a set of procedures used to determine whether the interview schedule works in the manner intended by the researcher. In the early phases of pre-testing the purpose is to get feedback on individual question items, whilst in later phases the purpose is to test the entire interview procedure. There are no definitive answers about which method is best given a particular circumstance (Presser and Blair, 1994). The pre-tests employed in the design of this schedule were consultation with a panel of key informants and a focus group with HCAs.

Key informants were used to critique the draft interview schedule. They were considered expert because of their experience of designing and using survey methods or because of their experience of working with and/ or teaching HCAs. Appendix 8 provides a list of the key informant panel members. These researchers or clinicians identified any problems within the questions and planned analysis. The schedule was redrafted based on their comments and then tested with a group of health care assistants from another unconnected London NHS trust.

Six health care assistants at a London NHS Trust were invited to a focus group (1 hour long) to discuss the subsequent draft of the interview schedule. I led the group

with the help of a Support Worker Clinical Support Nurse. The HCAs were given the schedule to complete but were also asked to ‘think aloud’ – a procedure from cognitive psychology (Lamond *et al.*, 1996) – whilst answering questions that did not immediately make sense to them. By asking the participants to think aloud the respondents verbalise the things they are considering when answering a question. This provides insight into comprehension or problems such as difficulty with information recall. With the participants’ permission this session was tape-recorded.

During the focus group a number of difficulties with the questionnaire were revealed. These included: varying interpretations of some of the questions by HCAs; the burden of responding because of the length of the schedule; difficulty for some HCAs in following the instructions of the schedule; variable and poor comprehension amongst HCAs of certain words (for example attain); and varying levels of literacy amongst the HCAs. The questionnaire was redesigned taking the issues raised into consideration. Additionally, a decision was made to interview HCAs, rather than expect self-completion of the schedule.

Observation

Direct observations may be another source of data for case study and may range from formal to casual observational activities (Yin, 2003). From point of entry into the case site, casual observations were made providing detail of the behavioural and environmental context. More formal observations were made of meetings or interviews with individuals. These observations detail my progression through the study and associated relationships, from being a person who is largely anonymous in the Trust to someone visible and identified with the work of HCAs.

Accompanying these general observations, more detailed and purposeful observations were made of the work of individual HCAs using a technique known as participant observation. Ten HCAs (representative of HCAs within the case site) were theoretically sampled to gain an understanding of their work in practice.

Theoretical Sampling

Sampling involves decisions about group(s) or setting(s) and decisions about who or what to study within the group or setting. Hammersley and Atkinson (1995) state:

'Decisions must be made about where to observe and when, who to talk to and what to ask, as well as what to record and how. In this process we are not only deciding what is and what is not relevant to the case under study but also usually sampling from the data available in the case... it is important to make the criteria employed as explicit and systematic as possible, so as to try and ensure that the data about the case have been adequately sampled.'

(Hammersley and Atkinson, 1995: 46)

This case study is concerned with theoretical generalization, rather than empirical generalization (Hammersley, 1992). Silverman (1989) argues for the use of theoretical sampling in case study research on the grounds that the aim of such research is to exhibit or test some identified theoretical principle, rather than to achieve representativeness. For him, case study research is dependent upon the adequacy of underlying theory rather than upon empirical generalization. Firestone (1993) outlines the logic of generalizing to a theory, using theoretical sampling. The

researcher uses theory to make predictions and then seeks cases that will allow the testing of the robustness of such predictions under different conditions.

Theoretical sampling is used in this case study to purposively select the HCA sample for observation. This approach enables the sample to reflect the wider population of assistants within the case study site. Thompson (1999) suggests that:

'In qualitative research, sampling is guided not by the need to generalise about people but rather by the need to select subjects and data likely to generate robust, rich, and deep levels of understanding.' (Thompson, 1999: 816)

The researcher uses a range of sampling techniques, including the study of negative, critical, discrepant and deviant cases to explore and extend existing theory (Gubrium *et al.*, 1982; Firestone, 1993; Le Compte and Preissle, 1993). As case studies progress, one important form of theoretical sampling is that of seeking out critical tests of the general validity of the hypotheses (Silverman, 1989). Here the researcher deliberately sets out to study cases where it seems least likely that the hypotheses will be true. This maximizes the possibility of finding non-confirmatory evidence and aiding generation of conceptually dense theory (Henwood and Pidgeon, 1993).

Sampling A Group Of HCAs To Observe

For observation fieldwork, ten HCAs were sampled to represent the characteristics, conditions of employment and qualifications of the larger group (n=33). Hammersley and Atkinson (1995) identify three major dimensions along which within-case sampling occurs: people, context and time. The sample of HCAs selected for

observation therefore includes participants who vary according to demographic detail; grade; clinical area (medicine, surgery, trauma and orthopaedics); length of employment at the Trust; work history; education and training (as an indicator of level of preparation for role); life caring experience; and expectations and feelings about their role. The HCAs were also observed at different times of the day because patterns of work and activity may vary according to time of day and day of week. The nature of patient demands also may vary according to the time of day and reflects the changing shifts and availability of staff. Nine of the HCAs were employed as 'B' grades and one as an 'A' grade. At the time of observation, there were no 'C' grade HCAs. Table 5-2 and Table 5-3 provide details of the sample of HCAs observed.

Table 5-2 Characteristics and conditions of employment of sampled HCAs

HCA No.	Age (years)	Gender	Ethnicity	Grade	Hours worked	Shift pattern	Clinical area	Length time at hospital	Length of clinical experience elsewhere
HCA5	48	Female	Black Caribbean	B	FT	Rotation	Surgical	8 yrs	1 year
HCA16	27	Male	Black African	B	FT	Rotation	Medical	3 mth	3 yrs
HCA17	36	Female	Black African	B	FT	Rotation	Medical	4 yrs	1 mth
HCA34	22	Female	White	A	FT	Rotation	Medical	3 yrs	2 yrs
HCA41	50	Female	White	B	PT	Early	Medical	7 yrs	24 yrs
HCA42	41	Male	White	B	FT	Rotation	Medical	6 mth	4 ½ yrs
HCA45	59	Female	Black Caribbean	B	FT	Rotation	Surgical	6 yrs	3 yrs
HCA47	44	Female	Black Caribbean	B	FT	Rotation	Medical	4 yrs	2 yrs
HCA59	48	Female	Minority*	B	FT	Rotation	Medical	6 yrs	24 yrs
HCA68	41	Female	Black African	B	FT	Rotation	Medical	2 yrs	9 yrs

*Due to the small number (n=5) of HCAs who report belonging to a minority ethnic group, the term 'minority' is used to protect the anonymity of the participant.

Table 5-3 Educational qualifications of sampled HCAs

HCA No.	Grade	Total time as HCA	Highest recorded qualification	Has NVQ level ²	Has NVQ level ³
HCA5	B	9 yrs	NVQ2	Yes	No
HCA16	B	3 yrs 3 mth	GCSE	Yes	No
HCA17	B	4 yrs 1 mth	Degree	Yes	No
HCA34	A	5 yrs	GCSE	No	No
HCA41	B	31 yrs	NVQ2	Yes	No
HCA42	B	5 yrs	Access to nursing	No	No
HCA45	B	9 yrs	NVQ2	Yes	No
HCA47	B	6 yrs	NVQ2	Yes	No
HCA59	B	30 yrs	NVQ3	Yes	Yes
HCA68	B	11 yrs	NVQ2	Yes	No

The purposive sampling of HCAs reflects the wider population of HCAs within the case study site. This method of sampling was used to generate robust, rich, and deep levels of understanding about the work of these HCAs.

Participant Observation

Observational research produces data which often contrasts with that generated by other techniques, such as interviews or questionnaires. This desirable attribute makes participant observation an ideal approach for examining the provision of health care, and perhaps contributes to its increasing popularity in health care research (Savage, 2000).

Participant observation has its origins in the work of sociological and anthropological proponents, such as Malinowski (1922). The crux of Malinowski's approach was living amongst informants for extended periods of time and 'joining in' the daily routines and activities of informant communities. This joining in promotes the capture of the reality of people's actions in their social context (Malinowski, 1922; Silverman, 1985; Kuper, 1991). Mulhall (2003) offers further support for the use of participant observation techniques by arguing that observation provides insight into interactions within groups, illustrates the whole picture rather than snapshots, captures context and processes, and the influence of the physical environment on behaviour.

When exploring the occupational role boundaries of HCAs, the theoretical benefits of participant observation are clear: the method provides the opportunity to gather rich and unique data about HCAs' work and produce descriptions and explanations appropriate to the ways in which they behave in context. The technique does this without making significant demands on HCA time and with minimal interference from the researcher. However, the approach raises challenges relating to how the researcher interacts with participants and executes the participant-observer role.

Participant Observer: Looking And Being The Part

As a registered nurse needing to gain access to and the trust of HCAs, I had to consider the symbolic role of the uniform in a group (James, 1984). In early discussions (with the Project Steering Group) about fieldwork, the issue of uniform was discussed. Managers suggested I should wear a practice development style uniform (similar to a Ward Sister's uniform). The suggestion was problematic as it

was likely I would be viewed as a registered nurse, an uncomfortable prospect for at least three reasons. First, I had not practised as a clinical nurse for some time and lacked confidence in some clinical skills. Therefore, a uniform denoting a relatively senior nursing position was not appropriate. Secondly, the uniform of a registered nurse would artificially define my ability and purpose in the eyes of both nurses and patients. Finally, I was concerned that the uniform might create a barrier between myself and the group being studied (HCAs) by sartorially reinforcing any differences in status they may have perceived.

HCAs were asked for their opinion about the balance of researcher and participant that should be adopted when observing their work and the most appropriate attire for myself. They suggested that if an accurate picture of their work and issues they faced in practice were to be understood, then I had to work alongside them and look like one of them. In addition, the majority of work by HCAs is physical hands on care, much of which takes place behind closed curtains. By being in HCA uniform I would be seen to share a caring purpose, and therefore have a legitimate reason to be part of activities 'behind the screens' (Lawler, 1991). By being in uniform, I gained access to these areas and increased the opportunities for observation of HCA activity. Additionally, the uniform provided a form of clinical legitimacy. In uniform I participated in activities such as making beds, washing patients or providing help to someone at meal times. As a registered nurse these activities were familiar to me and by being in HCA uniform it was easier to 'get into role'. The decision to wear HCA uniform proved to be a significant decision within the research.

Having adopted the role of HCA, I had to act out the part. Indicators of the successful operationalisation of this role were marked; one of the most vivid being shouted at by a domestic to clean up a urine spillage that a registered nurse had made. The uniform also allowed me to better understand the spaces occupied by HCAs in their working day and to appreciate comments made by the HCAs such as '*Come to my office*' (the dirty sluice). The uniform provided an opportunity to gather data that would otherwise not have been possible. However, the uniform also raised some professional concerns for me on a personal level.

Concerns centred on my presentation of self to the outside world and my anxiety around how other nursing colleagues would react to me when in HCA uniform. In HCA uniform my personal background largely disappeared. Uniforms help to keep everyone 'in their place' in social hierarchies, because of which they affect power relations and constitute something of a right of passage (Pearson *et al.*, 2001).

Salvage (1985) suggests that nursing is notoriously status conscious. Nurses demonstrate rank in the code of coloured dresses and belts, and progress in a nursing career tends to be described through uniform and title. The reactions of a number of practice development staff, that I shared an office with at the time, reinforced this view: '*We don't see that colour of uniform in this office*' and '*Why would you want to look like a HCA? You are a nurse.*'

By wearing the HCA uniform I brought the HCA worker into an office space that they did not usually occupy. In addition, I was made to feel that somehow I was taking a retrograde career step by looking like a HCA. In comparison to 'professional'

colleagues, the HCAs liked the fact that I had gone into their uniform, passing comment that *'You look the part'* and *'I did not recognise you.'*

Role Ambiguity Within The Participant Observation Approach

Byrne (2000) suggests that before entering the research setting, the participant observer must decide which role to adopt – participant or observer. However, the role of participant observer is not one role. Schatzmann and Strauss (1973) emphasize the importance of different modes of participation in fieldwork situations, rather than mutually exclusive roles. They suggest researchers should make different tactical choices at different times to suit the data collection process.

Allen (2001), whilst studying nursing activities, had three main participant observer roles: researcher as 'helper', 'observer' and 'shadow'. I chose a different approach, shadowing an individual (HCA) and adapting the observer role as the context dictated. In this shadow capacity, I adopted roles suggested by Gold's typology (1969): complete participant; participant as observer; observer as participant; or complete observer.

The different roles were complicated due to my clinical preparation as a registered nurse, meaning that there were opportunities where my clinical skills might take precedence over the research role. Awareness of these conflicting roles maintained an emphasis on the research role. I worked closely alongside HCAs in activities such as bathing, toileting and making patients comfortable; observing their actions and following their lead. At times this was challenging, for example when an HCA

looked to me (in my capacity as a registered nurse) for advice or support. This was checked by asking who they would go to or what would they do if I were not there.

At other times, strategies (such as helping a patient to eat a meal) were employed so that I could sit and observe the work of others and absorb the flow of ward activities. Sitting at the nurses' station was not appropriate because this was not a space that HCAs tended to occupy. Patients interacted with me as a nurse, often asking for help with activities such as getting a commode. Whilst in uniform these sorts of requests could not be ignored. But such activities were recorded and the circumstances in which requests made documented, for example the geographical position of the staff at the time of the request and what activities they were engaged in.

My ultimate goal was to blend in with the workforce whilst not jeopardizing the researcher role. The goal appeared to have been achieved with participants sometimes forgetting my research presence. At other times, the research context felt very obvious and participants clearly felt uncomfortable with observation. It was important during the shift to be aware of participant fatigue and to allow time for the HCA where they did not feel as though they were under the microscope. The HCA was observed for an entire shift but only for one to two hour periods at a time. This break in observation was used as an opportunity to write up field notes.

Developing A Relationship With Participants

There are tensions inherent in the participant observer approach, between the insider and outsider role:

'The unending dialectic between the role of member (participant) and stranger (observer and reporter) is essential to the very concept of fieldwork and this all participant observers have in common: they must develop a dialective relationship between being researchers and being participants.' (Hughes, as cited by Gans, 1982: 54)

Some commentators report that researchers often endeavour to develop close ties with participants (Kleinman and Copp, 1993) whilst simultaneously trying to maintain some sort of distance (Hammersley and Atkinson, 1995). From an initial standpoint of HCA suspicion, there was a gradual change in the ways HCAs responded to me: treating me with increasing familiarity. As I became increasingly recognised by participants and their relationship with me changed I became aware of the need to minimise exploitation of research subjects and to collect data in a sensitive, ethical and reflexive manner. Lawton (2001) suggests that the ways in which data are used reflect the researcher's discretion and integrity.

Emerson (1981) argues that all relationships predicate situated access and that data must be understood as a product of the relationship between the researcher and the researched given a particular context. The researcher's own demographic and biographical characteristics will have an impact on the data obtained (Emerson 1981; Easterday *et al.*, 1982; Silverman, 1993). It is important to note that those being studied will always make judgements about the kinds of information appropriate for sharing with another individual. This study was no exception.

The theoretical literature cautions against going native within a study. Going native is when the researcher loses awareness of their research purpose and becomes a full member of the setting, being seduced by the participant's perspective (Bryman, 1988). The line between going native and empathetic understanding is a fine one. I attended clinical supervision during this stage of the study, as a vehicle for reflecting upon the implications of any feelings and to achieve analytic distance from the participants.

Focus Groups

Focus groups are unstructured interviews with small groups of people who interact with each other using the group dynamics to stimulate discussion, gain insights and generate ideas in order to pursue a research topic in depth (Bowling, 2002). The group interactions provide a distinctive type of data because rather than people simply responding to questions, they are encouraged to talk to one another, ask questions, exchange anecdotes and comment on each others experiences and points of view (Kitzinger, 1994). In doing so, the aim of the focus group is exploration and clarification of group views in ways that would be less easily achievable in one-to-one interviews.

Focus groups may be used at any stage during the research process, depending on their purpose. Bloor *et al.* (2001) suggest at the outset to provide the contextual basis for surveys, or mid-way through the study as an extension of methods and an interpretive aid, or towards the end of the study to communicate findings whilst simultaneously generating new insights on earlier results. Focus groups have been used in this case study to clarify, extend, qualify and contest findings from the interviews and observations of HCAs, by capturing the registered nurses' perspective.

In doing so, the aim of the focus groups was to deepen understanding of HCAs' work within the case site.

I conducted focus groups with registered nurses, of different grades and working in a variety of clinical areas across the Trust, to gather their perspectives on the nature of HCAs' work, the supervision of HCAs and any tensions between their own role and the role of HCAs. Four focus groups were carried out to include the following grades of nurses:

- Clinical Lead Nurses (n=22 nurses)
- Charge Nurses (n=14 nurses)
- E Grade Nurses (n=19 nurses)
- D Grade Nurses (n=14 nurses)

The focus groups with Clinical Leads and Charge Nurses were structured to gain their response to the study findings generated by interviews with HCAs (stage one) and participant observation of HCA practice (stage two). I presented the findings from these stages of the project and an open discussion followed, led by the nurses' response to the findings. Each of these groups had a discussion which lasted between 30 to 45 minutes. The groups were facilitated by myself and another academic colleague.

The focus groups with D and E Grade Nurses were structured differently at the request of the Assistant Director of Nursing. I provided a broad overview of the purpose and progress of the research study but no study findings. The nurses were informed that the 'missing' part of the case study data were the nursing perspective.

The focus group was therefore presented as an opportunity to gather these data. A loose structure was required to guide the interviews. Consequently, three key areas were presented for discussion:

- The nature of HCA work
- The RN's role in the supervision of HCAs
- Tensions (if any) between the roles of RN and HCA

Appendix 9 provides a summary of the introduction to the focus group sessions with D and E Grade RNs. The groups were facilitated by myself and another academic colleague. Each of the discussions lasted 1 hour, with a 15-minute introduction. The four focus groups were tape recorded with consent from participants and notes taken of group interaction and dynamics.

Kitzinger (2000) advocates a sampling strategy for focus groups that promotes diversity in areas such as age, class, and ethnicity, but that also might offer a unique insight into the discussion focus. For this purpose, some of the participants in the focus groups had worked as HCAs before undertaking their registered nurse training. As such, it was anticipated that they would contribute another angle for discussion during the focus group interactions.

There are practical problems associated with organising focus groups because of the need to remove staff from clinical areas for an hour, or more, to attend. Focus groups were located within existing meetings in the Trust to minimise interruptions to service delivery. The Charge Nurse and Clinical Lead focus groups were allocated time in their monthly meeting. The D and E Grade focus groups were allocated time in the

Staff Nurse development programmes in the Trust. This meant larger numbers of participants than would normally be expected within focus groups but did not inhibit discussion or interaction. However, the group was demanding and we (as researcher and facilitator) were called upon to use both interviewing and social skills to manage the group dynamics.

The gathering of data within ‘naturally occurring’ groups has another important advantage over designing a bespoke focus group for the sole purposes of the research; within such groups, friends and colleagues can relate to each other’s comments to actual incidents in their shared daily working lives (Kitzinger, 2000). This might raise challenges amongst participants on contradictions between what they profess to believe and how they actually behave. An example of this was observed in the E Grade RN focus group, where a few nurses challenged their colleagues about sitting at the nurses’ station and expecting HCAs to answer call bells rather than the RN.

Documents And Reports

A number of types of documents may be used within a case study (Yin, 2003). The following were systematically collected in relation to the role of HCAs within the case site:

- Letters, memoranda and other communications;
- Agendas, announcements and minutes of meetings, written reports of events;
- Administrative documents – proposals, progress reports, other internal documents;
- Formal evaluations of same site under study.

Archival records may also be relevant to a case study. Some have been used in this study and include:

- Service records – names of HCAs in the Trust and spreadsheets which indicate staff joiners and leavers in the Trust;
- Organisational records – annual reports for the Trust;
- Maps and charts – details of the geographic characteristics of the hospital;
- Survey data – census records or data collated about the hospital (Commission for Health Improvement Report).

The most important use of documents and archival records is to corroborate and augment data from other sources (Yin, 2003). Where they are contradictory rather than corroboratory, further investigation may be prompted. A particular strength of examining documents is that they provide a longitudinal dimension to a study when a sequence of documents extending over a period of time is available. This is the case with documents associated with the Trust HCA development project and therefore allows for analysis of change over time.

ANALYSIS OF THE DATA

The interviews with HCAs generated quantitative data enabling description of the HCA workforce in the hospital. SPSS (Statistical Package for the Social Sciences) (Version 9.0) was used to manage and perform the analysis of these data. The quantitative interview data were analysed using frequency distributions and descriptive summary statistics. Descriptive statistics enabled representation of the range in these data, for example youngest and oldest HCA. The importance of this

analysis was also to facilitate comparison of the case study sample of HCAs with those represented by national statistics from Thornley's (1999; 2000) survey data.

Qualitative data generated by interviews and observation were analysed according to the broad principles and techniques of grounded theory (Glaser and Strauss, 1967). This process is represented by four sequential stages: developing coding schema; refining codes; achieving saturation; and cross-case themes analysis. However, it should be noted that the analysis of the qualitative case study data was not linear. The use of multiple methods of data collection within the case study approach and triangulation of data sets meant that some analyses had to be revisited as new data were produced and as understanding of the case developed.

Transcripts and field notes generated during the course of the study were imported from word documents into QSR NUD*IST NVivo package (Version 1.0) to enable data management. Once imported each transcript or set of field notes was initially coded according to three descriptive (first level) codes:

- Content of HCA work and HCA skills;
- Supervision of HCA work;
- HCA-RN work tensions.

The next level of data analysis and coding was more interpretive. For example, within the category of HCA-RN work tensions, 'professional threat' was a useful interpretive category. Development of these interpretive categories involved capturing the dimensions within professional threat. For example, threat related to

HCA's gaining vocational qualifications or HCA's taking over aspects of the RNs' work.

The next stage of analysis attempted to ensure that data analysis and collection were complete, or saturated. Strauss and Corbin (1998: 136) define saturation as the stage where *'no new information seems to emerge during coding, that is when no new properties, dimensions, conditions, actions or interactions or consequences are seen in the data.'* This stage also involved identifying any negative, or disconfirmatory, cases and explaining the conditions in which such cases were located. For example, a common theme to emerge related to the lack of value attached to HCA's work. However, there were a few HCA's who felt valued and so these were contextualised within their circumstances or settings. This also relates to the final stage of analysis aimed at identifying cross case themes.

Cross case thematic analysis involved establishing themes that occurred across the data sets, for example, between individual HCA's or between HCA's and RNs. Where themes did not cross, such as the negative case, these were examined within the context of data gathered about the setting and individual. For example, the relationship between RN and HCA appeared to be related to the grade of RN such that junior D grade RNs experienced difficulties with HCA's that were not experienced by some of the more senior RNs at Charge Nurse level.

A number of documents and reports have been gathered during the course of the case study. These documents were analysed using content analysis. Krippendorff (1980: 21) defines content analysis as *'a research technique for making replicable and valid*

inferences from data to their context.' The documents were analysed according to their context and purpose of the document as well as institutional, social and cultural aspects. The original purpose of the document was important for gaining understanding and interpreting the results of the document analysis.

ETHICAL CONSIDERATIONS FOR THE CASE STUDY

The study proposal was initially reviewed by the Nursing Research Forum (within the case site) and subsequently approved by the Local Research Ethics Committee (LREC). Approval was granted on a yearly basis by reapplying (Appendix 9). The study has been registered with City University's Data Protection Registrar. Ethical considerations that I outlined in the original case study proposal are detailed here.

Normand *et al.* (2003) highlight four ethical principles relevant to research undertaken on human beings: non-maleficence (do not harm); beneficence (do positive good); autonomy (show respect for rights of self determination); and justice (treat people fairly). These ethical principles were adhered to in the design of this case study.

During the study period, the government launched its Research Governance Framework for Health and Social Care (Department of Health, 2001c). This framework requires that all research which involves human subjects, human samples, patient data, or NHS staff or facilities adheres to explicit guidelines and principles.

This means that as well as gaining ethical approval the researcher must also demonstrate scientific rigour in terms of the appropriateness of the study and the methodology, and demonstrate their capacity and skills to undertake such work.

Regular meetings with a research steering group comprised of senior staff from the hospital enabled scrutiny of the research and its progress.

Marshall and Rossman (1999: 69) suggest that a realistic case study site is one where: entry is possible; there is a high probability that a rich mix of processes, people, programs, interactions, structures of interest are present; the researcher is able to build trusting relations with the participants in the study; and data quality and study credibility are reasonably assured. Initial contact with the Director of Nursing at the case site occurred in 1998 whilst I carried out a literature review for the NHS Executive North Thames (Meyer and Spilsbury, 1998). This review identified a gap in research examining the role of HCAs and their contribution to nursing care. Further discussions with the Director of Nursing led to the collaborative development of the research proposal (November 1999) because of the Trust's interest in development of the HCA role as part of implementing the nursing strategy (Department of Health, 1999a). Entry to the case site was therefore established through collaboration at an early stage. Further issues associated with gaining access to clinical areas and individual research subjects have already been addressed.

A growing number of researchers argue that the emergent methodological design of qualitative research studies requires a process of ethical consideration that has the flexibility to adapt as the study progresses and responds to changes in the study contexts (Ramos, 1989; Robley, 1995; Murphy *et al.*, 1998; Carpenter, 1999; Cutcliffe and Ramcharan, 2002; Normand *et al.*, 2003). Whilst this case study had clear questions at the outset, the proposal indicated that as the study progressed new avenues of inquiry might emerge. As such, the proposal was granted ethical approval because of its commitment to a professional relationship between the researcher and participants which promoted respect for the individuals, protection of participants

from harm, honesty between researcher and participants, gaining informed consent, confidentiality and anonymity. During the study period, Winter and Munn-Giddings (2001) published guidelines for ethical practice in action research. Their work has further informed and influenced the processes used for feedback and dissemination of the findings from each stage of data collection during the study period.

Informed consent was gained from any participant interviewed. This was achieved by providing information about the study prior to interview and then allowing time for any questions or concerns to be addressed before the interviews commenced. For the observation stage, individual HCAs provided written consent for participation.

However, it was not possible to gain consent from all staff within the clinical environment where HCAs were observed. I made attempts to inform nursing staff of the study by being present at ward report, displaying posters in the ward area on days when observation occurred and clearly wearing a name badge. I used opportunities throughout the day to introduce the project. By responding to issues of consent as they arise, rather than having to follow a prescriptive model, I was able to develop rapport and relationships with participants. Moore and Savage (2002) outline the difficulties associated with having to follow an ethical committee's demands for day-by-day informed consent. Therefore, following principles of ethical practice was an advantage for this study and did not compromise the rights of participants.

All participants were reassured of confidentiality and anonymity. Coding systems were used to separate subjects from data. Names were never recorded on interview schedules or in field notes. Data collected were stored in a locked filing cabinet. Personal computerised data were coded in recognition of the Data Protection Act

1998 to prevent the data being traced to study participants. Reports and publications have been anonymised to prevent identification of individuals and research setting. Data from the study has been used in a sensitive, ethical and reflexive manner to minimise any exploitation of research subjects.

In conducting an observational study it was necessary to consider my actions in advance if I were to observe unsafe practice. As a Registered Nurse, I adhered to the Code of Professional Conduct (UKCC, 1992a; NMC, 2002). It was agreed that if during observation there was risk to patient safety then I would terminate observation, ensure patient safety and inform those responsible and accountable for care being delivered of the nature of any concern in relation to patient safety. I would also document the incident and my actions.

Observation of practice can, in some circumstances, create anxiety for participants. I offered opportunities for participants to discuss any concerns. The time spent observing participants was limited to two-hour periods to decrease participant burden. However, I also ensured that participants were aware that they could terminate observation periods at any point during the study period.

In summary, every attempt was taken to ensure that ethical considerations were adhered to during the case study period. Attention was given to ensuring participants were aware of the study's purpose to provide consent. I endeavoured to respect the participants and the information they have provided, such that it was handled sensitively and in ways that maintained confidentiality and anonymity.

GENERALISING FROM SINGLE CASE DESIGNS

Generalisation refers to the extent to which the findings of an enquiry are more generally applicable, for example in other contexts, situations or times, or to persons other than those directly involved (Robson, 1993: 66). Generalisation (or external validity) in quantitative research is based on choosing representative samples and using ideas about probability and chance to estimate the likelihood of events occurring in similar cases outside the sample (Seale, 1999). In addition to external validity, the authenticity of results is also judged by their reliability and internal validity (Polit and Hungler, 1995). Reliability refers to the reproducibility and consistency of the instrument and internal validity is an assessment of whether an instrument measures what it aims to measure (Bowling, 2002). Generalisation of quantitative findings therefore relies on these attributes of validity and reliability.

Qualitative researchers argue that the unequivocal determination of the validity and reliability of findings in interpretive research is not possible (Becker, 1958; Lofland, 1971). There are threats to generalisation of qualitative findings because they are specific to a group, setting or historical period being studied. However, it is argued that whilst the findings from case study research cannot be generalised in the statistical sense to other populations, they can be generalised to theory (Burns and Groves, 1997; Woods, 1997; Sharp, 1998; Yin, 2003). For many qualitative researchers generalisation depends largely on contextual similarity between two settings. This has been referred to as: 'naturalistic generalisation' (Stake, 1994); 'transferability' (Guba and Lincoln, 1989); or 'fittingness' (Koch, 1994).

Producing findings that are of relevance beyond the setting from which they are initially derived is an important goal of case study research (Sharp, 1998). Mitchell (1983) argues that theoretical generalisation depends on logic rather than probability, *'We infer that the features present in a case study will be related in a wider population not because the case is representative but because our analysis is unassailable'* (Mitchell, 1983: 200). Theoretical reasoning is used to explain the findings and as such the researcher has confidence that a logical connection between the data and theory enables generalisation from a case study to a wider population of cases.

Transferability (also referred to as naturalistic generalisation or fittingness) implies that readers of a case study report must themselves determine whether the findings are applicable to other cases than that studied by the researcher (Gomm *et al.*, 2000). For readers to make such a judgement, the researcher must provide a description of the case studied that is sufficiently 'thick' to allow users to assess the degree of similarity between the case investigated and those to which the findings are to be applied (Guba and Lincoln, 1989: 241). Through rich description of the context in which the study occurs and transparency of the research process the researcher persuades the reader that it is reasonable for the results to be transferred to other similar settings or cases. In addition, Geertz (1988) refers to the thick description associated with participant observation where the researcher undertakes long periods in the research setting and provides rich detail which persuades readers that they have, in his terms, 'been there':

'Ethnographers need to convince us... not merely that they themselves have truly "been there", but... that had we been there we should have seen what they saw, felt what they felt, concluded what they concluded.' (Geertz, 1988: 16)

This thesis is based on the study of one acute NHS hospital. Whilst the case study is of intrinsic interest and has some unique features it is anticipated that by describing the case study in-depth, ensuring the research process is transparent and generalising to theory, the study identifies factors or makes propositions about factors that may be found in other settings or cases (Yin, 2003).

SUMMARY OF METHODOLOGY AND METHODS

Case study is an appropriate method of choice when researching issues of social action and locating these within context. As such, it lends itself to the study of HCAs' work by capturing their social actions within the social system of nursing and health care and wider developments. The exploratory nature of this study supports the use of the single-case embedded design advocated by Yin (2003).

Data collection has occurred in three distinct stages. Stage one involved interviews with HCAs to better understand the characteristics (demographic and biographic) of the HCA workforce within the hospital, to find out what they perceive their role to be and any tensions between their role and that of the registered nurse. The second stage involved participant observation of HCA practice to observe what they do day-to-day, the supervision of their work in practice and tensions between the roles of HCA and RN. As such both interviews and observation can be used to provide more in-depth

descriptions of people's work. The final stage involved focus groups with registered nurses of different grades to gather their perspective of the HCA role, supervision issues and tensions.

The case study approach is complex and requires careful negotiation and management to ensure success. The process by which access was gained to the site and ethical considerations have been presented for the reader to judge the openness and ethicality of the researcher. In addition, techniques used throughout the study have been presented, providing confidence for readers in the trustworthiness of the data collection and analysis, and include triangulation, reflexivity and respondent validation. Generalisation of the case study findings to other settings is facilitated by in-depth 'thick' description, ensuring the research process is transparent and by theoretical inference. Chapters 6 and 7 present the findings of the case study.

CHAPTER 6 - WHO CARES? REVEALING THE HIDDEN WORKERS

The general health care assistant (HCA) workforce is poorly defined in terms of their demographics, qualifications and clinical experience. They are often referred to as the 'unqualified' or 'untrained' proportion of the nursing workforce. Yet this does not represent the rich mix of people working as HCAs. Thornley's (1998) national survey gathered data about HCAs in the UK and revealed the diversity of the HCA workforce in terms of age, years experience and qualifications. This suggests that when studying the work of HCAs, a relatively under researched group of people, there needs to be further analyses of the characteristics of these workers. Thus far, studies of HCAs have failed to relate the characteristics and skills of HCAs to their work. By capturing these data, this study builds on a gap in extant research.

At the outset of the study, the Human Resource Department in the hospital were not able to provide detailed information about the characteristics, experience, education and training of the HCA workforce. It was important to gain further understanding about the HCAs to enable more detailed analyses of their work. Additionally, these data enabled a purposive sample to be selected for observation. Drawing on survey and interview data, this chapter provides detail of the HCA workforce in the case site in relation to their characteristics, experience of caring, level of formal educational preparation and training opportunities.

THE HCA WORKFORCE

In April 2000 (commencement of study) the Trust employed ninety nine support workers in a range of areas. This included nursing, midwifery, physiotherapy, occupational therapy, phlebotomy and radiography. The focus of the thesis was HCAs working with registered nurses in acute ward settings. HCAs working with RNs in these settings made up about a third (n=34; 34.3%) of the total support workforce. The Trust support worker profile is provided in Table 6-1.

Table 6-1 Profile of Trust support workforce

Support worker	Number (n=99)	Percentage (%)
Health Care Assistants (ward and outpatients)	34	34.3%
Theatre Health Care Assistants (day and main theatre)	14	14.1%
Therapy Assistants (occupational therapy and physiotherapy)	9	9.1%
Maternity Assistants	29	29.3%
Phlebotomists	9	9.1
Radiography assistants	4	4.1%
TOTAL	99	100%

Of the thirty four HCAs, only one was not interviewed because of her unavailability due to long-term sickness. The following sections provide detailed analyses of the characteristics of the thirty three HCA interviews conducted in stage one of this study.

Mature Women With Caring Experience: Characteristics Of The HCA

Workforce

The mean age of HCAs in the hospital was 43 years; this ranged from 22 years to 61 years. The majority of the HCAs were female (78.8%; n=26). Over half of the HCAs described themselves as married (n=20; 60.6%), having children (n=23; 69.7%) and other dependents (n=20; 60.6%), such as elderly relatives or long term

sick/ disabled family members. The numbers reporting to be informal carers were notably high. Ethnic grouping was predominantly white (45.5%; n=15) or black origin (39.4%; n=13), with a minority (15.1%; n=5) from other groups (Philipino, Mauritian or Iranian). HCAs identified their own ethnic grouping based on the categorisation codes in use in the hospital rather than the researcher categorising ethnic grouping. The numbers of white HCAs in the hospital is low when compared with available national statistics – 95% of HCAs in a national survey (Thornley, 1998) and 89% of registered nursing, midwifery and health visiting staff in the NHS (England) (Buchan and Seccombe, 2002) identified themselves as white.

Participants had worked in their current job as a HCA at the hospital for a mean of 45 months (3 years, 9 months). This ranged from a minimum of 3 months to a maximum of 96 months (8 years). Some of the HCAs had therefore worked at the hospital since it opened in 1993. In addition, almost two thirds of the HCAs had worked at one of the five other hospitals that merged into this one site (n=20; 60.6%). These data revealed that these HCAs had been associated with the hospital, and merged hospitals, for a mean of 88 months (7 years, 4 months). Therefore HCAs demonstrated a long term commitment to care provision in the hospital. Table 6-2 presents the length of time at the hospital (maximum of 96 months or 8 years because it opened in 1993) and the total time associated with the hospitals that merged on to the one site. Some HCAs had been associated with the hospitals for over 30 years.

Table 6-2 Experience working at hospital and merged hospitals (months)

Experience at hospital	Number	Mean months	Median months	Min. months	Max. months
Length of time HCA worked at hospital	33	45	45	3	96
Time HCA worked at merged hospital	20	88	72	3	370

HCA's in the study also reported their previous experience of working as HCA's in other hospitals or in the community. Almost three quarters of the HCA's (n=24; 72.7%) had experience working as a HCA at another hospital for a mean of 110 months (9 years, 2 months). Fewer of the HCA's (n=6; 18.2%) had experienced working in the community (Table 6-3).

Table 6-3 Past experiences as a hospital or community HCA (months)

	Past experience as hospital HCA	Past experience as community HCA
Number (total n=33)	24 (72.7%)	6 (18.2%)
Mean (months)	110	35
Minimum (months)	2	6
Maximum (months)	298	60

This information provided a picture of the 'type' of person who was working as a HCA in the hospital at the time. The majority were mature women who demonstrated significant amounts of both clinical experience working as a HCA and informal caring experience as a parent or relative caring for a dependent. Some of the HCA's had worked in a HCA role for a number of years and, as such, had made the transition from being called an auxiliary nurse to HCA. The HCA's perceived that this level of experience was highly relevant to their role as a HCA and helped them meet the demands of the HCA's' work.

One Grade Does Not Fit All: HCA Conditions Of Employment

Almost two thirds of HCAs worked in medical wards (n=21; 63.6%), seven HCAs (21.2%) in surgical wards, two HCAs (6.1%) in outpatient departments and three HCAs (9.1%) in the children's ward. The majority of HCAs were employed at 'B' grade level (87.9%; n=29). This was significant when considering the variation in the characteristics of HCAs employed at this grade in terms of their years working as a HCA or qualifications. A HCA with NVQ level 3 and 20 years experience was employed on the same grade as a HCA with no formal training who had a couple of years experience.

The inequalities across the grading systems were a major issue brought up by HCAs at interview. Over four fifths (n=29; 87.9%) were employed at a 'B' grade level and HCAs reported that this one grade did not reflect the diversity of HCAs experience and qualifications. Being kept at this one grade created a situation whereby HCAs felt that there was a lack of career progression and reward for working as a HCA in the hospital. Once employed as a 'B' grade, many felt that there were few opportunities to progress:

'The pay scale for assistants needs to be reviewed. There needs to be a way of going up a grade, linked with training. There should be a reward for taking on extra work and duties.' (HCA 5: Interview)

'The longer you are in the trust the more responsibility you take on. There should be a 'C' grade given and more clinical training.' (HCA 17: Interview)

The only option for many of the HCAs to progress their careers was to enter registered nurse training. However, many would have liked to develop in their current role because of the opportunities it offered for patient contact:

'I do not really want to do my training but it is the only way that I will get recognition for what I am doing. I am in the situation where I have to train as a [registered] nurse or leave because as a HCA there is no chance of development. I am privileged in this role because I get most contact with the patient.' (HCA 38: Interview)

It is interesting to note here that HCAs perceived that they currently had more contact with patients than the registered nurses because of other demands on the registered nurse's role which took them away from bedside care. This issue is picked up again in the next chapter.

Only one HCA reported to be employed at a 'C' grade level in the hospital. However, the HCA felt that his skills were not fully utilised in the clinical area and that he did not carry out any additional work when compared to HCAs employed at 'B' grade. This led to feelings of being deskilled because the HCA had completed NVQ level 3 in care and had also been able to perform a wider range of duties when working elsewhere.

Most of the HCAs had full-time contracts (n=28; 84.8%) and worked on rotation shifts (n=20; 60.6%), which included: early shifts; late shifts; long day shifts; and night shift (Table 6-4). The rationale for the introduction of rotation shifts was to reduce labour costs. There were no HCAs employed on permanent night shifts.

Some of the HCAs expressed discontent with this arrangement because they would have preferred night shifts to fit in with family commitments. Some of the registered nurses commented on the changes in shift patterns for the HCAs and suggested that this was better for the HCAs personal development because on night shift some HCAs 'got stuck in their ways.'

Table 6-4 Hours worked by HCAs

Hours worked	Number (n=33)	Percentage (%)
Day unsocial (early & late shifts between 07.20 and 21.30)	8	24.2%
Rotation (early, late, long days & night shift)	20	60.6%
Day normal (day shift 08.30 to 16.30)	4	12.1%
Early only (07.30 to 15.30)	1	3.0%
TOTAL	33	100%

As well as full-time employment in the hospital, over half of the HCAs worked extra shifts on top of their normal working hours with the hospital staff bank (n=16; 48.5%) or another nursing agency (n=5; 15.2%). Almost two thirds of the HCAs in the study reported that they considered themselves to be the main household earner or said that they made an important contribution to household income (n=20; 60.6%). As such, they had to supplement their salaries with additional earnings from nursing agency and bank shifts. This was partly attributed to a change in their pay and conditions as HCAs; they were not paid unsocial hours and any overtime was not financially rewarded. HCAs referred to the additional hours that they worked and did not get paid for. Some felt this was exploitation of the HCA workforce:

'We work hours that we are not paid for. I am talking to my boss about the situation. I am paid to work thirty seven and a half hours per week.

Sometimes I work seven to nine days in a row. I would say that every four weeks I am working seven to fifteen hours overtime that is not paid. I am paid

a basic wage. I get time back but no extra money. I am sensitively trying to deal with the situation and human resources have to be commended for the support they are giving me. This is a situation that has to be fought for all HCAs in the trust. This is slave trade in the West.' (HCA 17: Interview)

HCA's that had worked as nursing auxiliaries in the past and had been protected by the Whitley Council conditions of employment were particularly frustrated by this change to their working terms and conditions. They perceived that they were being paid less for, what was essentially, the same job with a different title. The picture being presented of the HCA workforce was of a working class occupational group, who had to work additional hours on their days off to meet the demands of living in London, such as expensive mortgages and rents for properties. In addition, HCAs from black communities indicated that they often came to the UK to find employment and were sending money back to their home countries to support their families as well as meeting the costs of living in the UK. It is pertinent to note, the HCA in the quote above referred to the '*slave trade*' when discussing the terms and conditions of HCAs' employment.

Despite reporting discontent with some of their conditions of employment, over half the HCAs (n=20; 60.6%) reported being satisfied with their job (Table 6-5). This was recorded using a five point Likert scale and HCAs rated their level of satisfaction with their current job.

Table 6-5 HCA self-reported level of satisfaction with job

Level of satisfaction	Number (n=33)	Percentage (%)
Very satisfied	7	21.2%
Satisfied	13	39.4%
Neither satisfied or dissatisfied	10	30.3%
Dissatisfied	2	6.1%
Very dissatisfied	1	3.0%
TOTAL	33	100%

However, despite high levels of satisfaction amongst the group, two thirds (n=22; 66.7%) said they had considered leaving their job during the past year. This discrepancy between levels of satisfaction and considering leaving their job reflects the problems of relying on structured instruments when attempting to understand the work of an occupational group. When asked to discuss their reasons for considering leaving a number of issues were identified which provide insight into the problems encountered by HCAs in their daily work: their poor pay and working conditions; a lack of personal fulfilment and opportunity to develop; low morale; a lack of respect and value for their contribution to patient care from registered nurses; a lack of clear guidance about their job and absence of feedback about their work; and to further develop their career by taking a higher grade job at another hospital.

‘Qualified’ Workers: HCAs Educated To Varying Levels

Despite being referred to as the ‘unqualified’ or ‘untrained’, HCAs in the hospital demonstrated that they had varying amounts of educational preparation for their role. Therefore, it could be argued that they were ‘qualified’ for their work.

HCAAs were asked to record the highest qualification they had achieved. For many HCAAs this was a NVQ (n=18; 54.4%). A further four HCAAs had a NVQ at Level 3 (NVQ total n=22; 66.7%) but did not record this as their highest qualification. Only two (6.1%) of the HCAAs said they had no recordable qualifications. The variety of other qualifications is detailed in Table 6-6 and demonstrates the range from GCSE (or equivalent) to diploma and degrees. The diploma/ degrees were not health care related but achieved in business and management. Two (6.1%) of the HCAAs reported that they had gained a registered nurse qualification. Both explained that the reason they were no longer working as RNs was due to leaving the workforce to bring up a family. On returning to work, after a number of years, they had decided to work as a HCA to re-orientate to nursing work. Subsequently, they had remained as HCAAs because they thought the RN role had changed during their time away from nursing. They both expressed that they wanted to be at the bedside with patients rather than engaging in paperwork and technical tasks. This again raises the issue of the changing nature of registered nursing work to be addressed in the next chapter.

Table 6-6 Highest recorded qualification by HCAAs

Qualification	Number (n=33)	Percentage (%)
No recorded qualification	2	6.1%
CSE/ O'Level/ GCSE (or equivalent abroad)	5	15.2%
NVQ Level 2	11	33.3%
NVQ Level 3	7	21.1%
Access to nursing	2	6.1%
A'Level/ Scottish Higher	1	3.0%
Registered nurse	2	6.1%
Diploma	1	3.0%
Degree	2	6.1%
TOTAL	33	100%

When interviewed, five of the HCAs reported that they were undertaking further studies. This included access to nursing courses (n=2), degrees (n=2) and a diploma (n=1). Therefore, some of the HCA workforce demonstrated that they had qualifications for their work and so dispels the commonly held belief amongst registered nurses that they are unqualified or untrained. However, HCAs also reported that NVQs and the skills that they gained from such qualifications, did not always correspond with the work that they performed in practice.

Two thirds (n=22; 66.7%) of the HCAs had a NVQ; eleven at Level 2 and eleven at Level 3. Of the third (n=11; 33.3%) that did not have a NVQ, over half (n=6) said they would like to have the opportunity to study for one. However, HCAs perceived that they were not able to practise the skills that they had gained through NVQs in the clinical areas nor were they rewarded for gaining qualifications:

'I have NVQ 2 and 3. Yet I am not allowed to do certain things and I am employed as a B grade.' (HCA 21: Interview)

'NVQs are like carrot waving. The manager gets praise for getting people through it. The assistant gets nothing. I have a NVQ. What do I get for doing it? A badge!' (HCA 17: Interview)

The notion of being allowed, or not, to perform activities is considered in more detail in the following chapter exploring the negotiation of HCAs' work.

The HCA workforce is diverse in terms of their education and training. Reference to them as untrained or unqualified is therefore not fully justified. HCAs in the case site

made efforts to undertake formal qualifications, work towards higher qualifications - for example undertaking NVQs to enter registered nurse training - as well as to use opportunities to learn on-the-job. However, for some, the incentives to undertake qualifications and training were diminished by a lack of progression in their roles, a lack of reward for their efforts, such as grading and pay, and the lack of financial support for further study.

The Importance Of Learning On-The-Job And Training Opportunities For HCAs' Work

As well as formal educational preparation for their role, HCAs were asked where they considered they had learnt the majority of skills for their work. The ward environment and learning on-the-job was commonly quoted as the setting where HCAs gained most of their skills (n=13; 39.4%). The importance of the clinical environment for learning HCA skills was also identified by participants who had received some classroom training (n=16; 48.5%). Only three (9.1%) HCAs, who had a NVQ, thought they had learnt their skills predominantly in the classroom.

The types of training courses that HCAs attended were predominantly generic in nature. The majority of HCAs (n=30; 90.9%) attended the yearly update programme in the Trust. This consisted of one day study, away from the clinical area, and provided training in manual handling, infection control, cardiopulmonary resuscitation, fire, health and safety. Fewer HCAs (n=8; 24.2%) indicated that they had undertaken training in specific skills for their clinical area. Those that had studied specific skills to their field had attended study days covering HIV and AIDS awareness, diabetes care, stroke care and mental illness. Only two HCAs (6.1%) said

they had undertaken any training to prepare them specifically for their role as a HCA but for them this had been undertaken elsewhere, a number of years ago, as a nurse auxiliary.

Over three quarters of HCAs in the hospital wanted more training for their role (n=26; 78.8%). When asked to identify the skills that they felt they needed training in, these related to specific tasks to support them for their current role, to extend their practice, or training to support their personal development. HCAs said they would have liked to have been given instruction on how to perform systemic observations, a task undertaken by all HCAs as part of their role. HCAs performed this activity with electronic equipment but stated that they had never had the task demonstrated to them by a registered nurse – often learning only by watching other HCAs – nor their competence assessed. As a result they said that they did not understand the relevance of measurements:

'Nobody taught me how to do a blood pressure reading or temperature. The [registered] nurses assume you know how to do it. It would be good to have someone who told you whether or not you have done the right thing and explain what it means.' (HCA 42: Interview)

HCAs identified specific skills that could extend the role of the HCA. These commonly included: wound care and dressings, phlebotomy, ECG monitoring and blood sugar monitoring. To undertake such activities in their daily practice the HCAs said they wanted training in these skills. The HCAs made comparisons between their own training needs and those of registered nurses. They suggested that differences existed between the amounts of training that the two groups got, yet argued that this

difference should not exist when new skills were being developed, regardless of job title:

'If I do jobs outside my role to help the registered nurse, for example blood sugar monitoring, then I expect training. We are not given any learning outcomes. Our work should be overseen. Learning outcomes only seem to exist for qualified nurses.' (HCA 65: Interview)

The HCAs also quoted a number of other training opportunities for their own personal development, such as computer skills, writing and communication skills. They viewed these opportunities positively.

SUMMARY

This chapter provides detail about the population of HCAs in the hospital setting. By presenting interview data and describing the HCA workforce, the reader has a clearer understanding of the characteristics of the workforce, their conditions of employment and their training and educational preparation for their role. The HCAs tended to be mature women who demonstrated significant amounts of clinical caring experience working as a HCA and who also had informal caring experience. Together, this caring experience, was perceived by HCAs to help them cope with the demands of their caring role.

The HCAs reported poor pay for their work and, as such, many worked extra shifts with nursing agencies and banks to supplement their income. A high percentage of HCAs were employed at 'B' grade level but there were perceived inequalities associated with this because of the diversity within the HCA population in terms of

characteristics, experience and qualifications. HCAs possessed diverse qualifications and indicated that learning skills on the job was important to their development. They were keen for more opportunities to develop their skills and careers as HCAs. However, there was a lack of incentive for such development because of a lack of reward and career progression.

Overall, the characteristics of the HCA population in the hospital had a striking resemblance to those described by Thornley (1998). The only points at which there were notable differences related to: ethnicity - only 45.5% of HCAs in the case site reported their ethnic grouping as white, compared to 95% in the national sample; conditions of employment - lower numbers of HCAs in the case were on part-time contracts (15.2%) when compared to national sample (42%) and higher numbers were employed at B grade (87.9%) when compared to national figures (17%); additionally there were more HCAs in the case site that had achieved NVQs at level 2 and 3 (66.7%) when compared to the national survey sample (38%). However, similar issues were raised both within the case site and nationally about increasing expectations associated with the HCA role, the lack of supervision associated with their role and the lack of importance attached to NVQs when considering pay and other working conditions, such as grade.

The interview data, whilst important in its own right, also provided a framework by which HCAs could be purposively sampled for observation of their work. Ten HCAs were sampled to represent the characteristics, conditions of employment and qualifications of the larger group (n=33). This enabled a sample of HCAs to be observed who differed in terms of age, gender, ethnicity, clinical area, length of time

at the hospital, clinical experience, and educational attainment as an indicator of level of preparation for role and expectations and feelings about their role. Detail of the HCAs observed is provided in Chapter Five. The following chapter presents findings from documentary evidence, interviews, and participant observation to explore the content of HCAs' work, the ways in which this work was negotiated and inherent tensions between the work of HCAs and RNs.

CHAPTER 7 - THE SHAPING OF HEALTH CARE

ASSISTANTS' WORK

By drawing on data from interviews, observations and documents, this chapter explores the negotiation of HCAs' work in the hospital. The interactionist perspective employed in the thesis recognises that the societal position and work of an occupation can only be fully understood by examining the context and methods in which the occupation interacts with other occupations. The chapter will argue that negotiation is a key form of (and form for) this interaction. As well as the formal arena of official 'policy', the informal arena of clinical practice plays an important role in shaping negotiated activity. By examining negotiation in these dual contexts the multi-layered nature of the interactions shaping HCAs' work is made clearer.

Thus far the thesis has concentrated on Abbott's (1988) theory surrounding the jurisdictional claims of *professional* groups within systems of work. In the UK National Health Service (NHS) both registered (professional) *and* non-registered (non-professional) nurses perform nursing work. Moreover, both groups of workers make jurisdictional claims on that work. The negotiations that surround these claims constitute both the focus and one of the contributions of this thesis to knowledge on the changing work of HCAs in the provision of nursing care.

FORMAL NEGOTIATIONS: NATIONAL, PROFESSIONAL AND LOCAL POLICES AND THEIR INFLUENCE ON THE HCA WORKFORCE

The previous chapter describes the characteristics (both demographic and biographic) of the HCA workforce. However, simply understanding these characteristics is insufficient. In order to fully explicate the work of HCAs it is necessary to understand the forces that shape their work. HCAs' work is shaped through formal policies at three levels. Firstly, at a national level through government policy and central control of educational credentials in the form of the National Vocational Qualification curriculum. Secondly, at a professional level through normative descriptions of the Nursing and Midwifery Council and Royal College of Nursing of the ways in which registered nurses should manage the work of HCAs. Thirdly, at a local organisational level through job descriptions and policies related to HCAs' work. These documentary and cultural outputs indicate the strategic, professional and organisational expectations surrounding HCAs' work.

National Policy Expectations Of The HCA Workforce

The modernisation of health services is a central component in contemporary health policy (Department of Health, 2000b). The success of the modernisation initiatives relies, in part, on flexible working practices in the NHS. Since the nursing workforce constitutes the largest proportion of the health care workforce, nurses are expected to play a key role (Department of Health, 1999a) – an expectation that extends to both registered and non-registered nurses.

The nursing and midwifery strategy (Department of Health, 1999a) outlined a new career framework for the entire nursing workforce. The strategy proposed that HCAs were expected to provide:

'.. basic and routine personal care to patients/clients and a limited range of clinical interventions routine to the care setting under the supervision of a registered nurse, midwife or health visitor.' (Department of Health, 1999a: 35)

Other policy documents report that the current arrangements for service provision lead to the under utilisation of HCAs' skills (Department of Health, 2000a). Clearly, if HCAs are to be prepared adequately for these roles, and used appropriately in service provision, then the training of HCAs is paramount.

The training and preparation of HCAs for their roles has, historically, been largely neglected (DHSS, 1972; Hardie, 1978b; Beardshaw and Robinson, 1990; Harrison-Power *et al.*, 1990; Rhodes, 1994; Thornley, 2000). The nursing strategy (Department of Health, 1999a) indicates that HCAs will be expected to undertake a NVQ to prepare them for their role in direct patient care and clinical activities. NVQs are based on employment-led occupational standards and assessed in terms of competence. NVQs in care at level one prepare HCAs for a range of work activities, most of which are routine, predictable and supervised by a RN. However, NVQs in care at level two and three are intended to produce skilled HCAs capable of undertaking non-routine activities and taking responsibility for their own work (Roberts and Barriball, 1999). The amount of direct supervision that HCAs will

require from registered nurses should (in theory) vary from HCA to HCA, depending on their recognised skills.

The sizable financial investment in training and education associated with the development of occupational standards, and proposals for their regulation (Department of Health, 2000b; 2001a), are a tangible indicator of governmental commitment to achieving the potential of HCAs in the delivery of healthcare.

Professional Policy Expectations Of The HCA Workforce

The Nursing and Midwifery Council (NMC) - which replaced the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the four National Boards for England, Northern Ireland, Scotland and Wales - provides a single professional body regulating the practice of *registered* nurses. The primary function of the NMC is to protect the public. It concerns itself with: the maintenance of a register of qualified practitioners; codes of conduct; defining appropriate tasks; levels of nursing workforce education; and role boundaries. Whilst the NMC concerns itself with *how* registered nurses should work *with* HCAs, HCAs themselves are not registered. Consequently, much of the documentary output of the NMC reflects professional expectations of the relationship between registered and non-registered nurses.

The reference points for judging the expectations of registered nurses are the UKCC's *Code of Professional Conduct* (UKCC, 1992a) and, the more expansive, *Guidelines for Professional Practice* (UKCC, 1996). The *Code* – more recently updated by the

NMC (2002) - provides advice on professional conduct and exhorts RNs to consider the extent of their professional accountability; the interpretation of which was emphasised by the publication of *The Scope of Professional Practice* (UKCC, 1992b).

Historically, employers insisted on RNs undertaking further training and collecting extended role certificates for extra 'tasks', such as intravenous drug administration and suturing (DHSS, 1977). Conversely, 'Scope' (UKCC, 1992b) – as it became known – departed from this policy trajectory and made explicit the professional regulating body's expectation that individual RNs would ensure their own competence for performing professional duties. In doing so, *Scope* has been described as a significant force in encouraging registered nurses to respond to the changing needs of practice through development and learning (Redfern, 1997; Pyne, 1998). At the heart of professional policy expectation is the notion of accountability as a reference point for guiding performance and reassuring the stakeholders of professional activity.

Accountability And Professional Expectation

Lay conceptualisations of accountability involve individuals answering for their actions and omissions. Accountability for the registered nursing workforce presents itself in three key forms: *professional accountability* to a professional body – the NMC; *personal (or moral) accountability* to oneself; and *contractual accountability* subjected by law. HCAs' accountability is personal (based on their moral duty to care for other human beings) and contractual (based on their contractual agreement with

their employer). Despite a lack of professional accountability, they still have to answer for their actions as members of society and as employees of an organisation.

However, the lines of demarcation relating to accountability are often blurred. For example, professional accountability indirectly relates to the work of HCAs because RNs carry some burden of accountability for the HCA's actions:

'You [registered nurse] may be expected to delegate care delivery to others who are not registered nurses or midwives. Such delegation must not compromise existing care but must be directed to meeting the needs and serving the interests of patients and clients. You remain accountable for the appropriateness of the delegation, for ensuring that the person who does the work is able to do it and that adequate supervision or support is provided.'

(NMC, 2002: 7)

Clearly then, HCAs also have a responsibility to ensure that they have the necessary skills and knowledge to undertake the work delegated because of their accountability as member of society and as an employee of an organisation. Yet, professional nurses, as the registered practitioners, are presented in policies as having control over the activities of HCAs in terms of what they can do and ensuring this is performed safely. Despite widespread policy interest in regulating the work of HCAs via the institution of professional accountability through a regulating body, it looks as if the work of HCAs will continue to be under the control of RNs in the immediate future.

Local Policy Expectations Of The HCA Workforce

Local expectations of HCAs' work are largely expressed through job descriptions. Job descriptions provide organisational statements of what one particular worker does or, more accurately, is supposed to do. Within the hospital examined there were a variety of job descriptions for HCAs, each particular to the clinical areas examined.

The focus of this study was the general (medical and surgical) wards and so only job descriptions from these areas were analysed. The main duties and responsibilities for HCAs working at 'A' and 'B' grade in these areas fell into three areas of practice: supporting registered nurses and providing direct care to patients; housekeeping duties and looking after the ward environment; and performing clerical and reception duties.

Analyses of these job descriptions highlighted the minimal differences in organisational expectations of the 'A' and 'B' grade HCAs. Both were expected to perform activities in the three areas identified above. The duties applying to the 'B' grade only are detailed in Table 7-1. As might be expected there was a discernible hierarchical and additive structure to the grade-based job descriptions. For example, whilst 'A' grade HCAs were expected to support RNs in providing pressure area care, 'B' grades were expected to deploy knowledge of pressure relieving aids.

Job descriptions - as representations of organisational policy - emphasised the need for HCA work to be directed and supervised by registered nurses. However, the job descriptions for HCAs employed at 'A' and 'B' grade revealed few differences in the duties they were asked to perform. Moreover, job descriptions did not relate HCA

qualifications to subsequent roles and responsibilities. Therefore, the skills and qualifications of HCAs were not related to their occupational roles and work content.

Table 7-1 Additional organisational expectations of 'B' grade HCA when compared to 'A' grade HCA

Support of RN and direct care duties

To assist RN to recognise & monitor patient pain & discomfort

To assist with patient dietary & fluid needs

To be aware of dietary & special needs for nutrition

To record fluid & food intake as prescribed

To gain knowledge of pressure relieving aids

Housekeeping and environmental care duties

To escort patients to other departments

Clerical and reception duties

To use Hospital Information and Support System (HISS) & provide support for others

These formal policies at national, professional and local level determine the expectations of HCAs in the provision of care. Direct patient care, housekeeping and clerical duties are all accepted activities by organisations, but the registered nurse is viewed as playing a key role in determining whether HCAs have the appropriate skills and knowledge to undertake such work. Additionally, the work undertaken by HCAs remains largely within the supervisory gaze of registered nurses. However, at a national level there is increasing emphasis on the development of HCAs' skills so that they are able to expand their practice to take on extra clinical duties and to work more autonomously. Yet, this potential is not always recognised in local policies because of the lack of integration of qualifications and grading with the increasing expectations and duties relating to these qualifications.

Having established what is expected of HCAs at strategic, professional and organisational levels, the following section addresses the work of HCAs at the practice level. The discrepancies between policies made outside the workplace setting and the experience of workers in practice has already been alluded to. Lipsky (1980) studied the working position of individuals providing public services - such as teachers or health workers - and their interpretation of public policies. He argued that the decisions of these workers, the routines they establish, and the mechanisms they invent to cope with uncertainty and work pressure, effectively become the public policies that they carry out. As such, tensions arise between policies at the point of inception at a formal level and the point of implementation and operationalisation at the informal level:

'..public policy is not best understood as made in legislatures or top-floor suites of high-ranking administrators, because in important ways it is actually made in the crowded offices and daily encounters of street-level workers.'

(Lipsky, 1980: xii)

In sum, the study of HCAs' work in practice is important in understanding the ways in which nursing work is not only influenced by official policies but also the much softer, and harder to unpack, influences contained within social and organisational contexts.

INFORMAL NEGOTIATIONS: THE USE, MISUSE AND NON-USE OF HCAs IN PRACTICE

By examining HCAs at a practice level, through interviews and participant observation, it was apparent that the HCAs' work was also shaped through the key mechanism of informal interaction and negotiation. The rest of the chapter unpacks these interactions by examining the work of HCAs structured along three distinct patterns of activity and (somewhat perversely) occasional enforced inactivity. First, the ways in which HCAs are used in practice. Secondly, by addressing the ways in which they are misused in practice. Finally, the chapter considers ways in which the HCAs are not used in practice.

The Use Of HCAs

The main focus for HCAs' work is the delivery of direct bedside care to patients. However, HCA job descriptions offer a broader definition of their work which includes housekeeping and clerical duties. As such, HCAs only partly fulfil their job descriptions in practice. Moreover, RNs had to change their working practices to meet the changing demands of care. These changes created difficulties in relation to the supervision, control and monitoring of HCAs' work by RNs. Using HCAs to deliver care created tensions between the RNs and HCAs. The following section explores these tensions and the ways in which formal policies and informal processes influence the negotiation of nursing work between RNs and HCAs in practice.

Job Descriptions Fail To Capture the Real Work of HCAs

HCA job descriptions clearly identified three key areas of work for HCAs in the hospital - direct care, housekeeping and clerical duties – regardless of clinical area. However, RNs reported that they found the job descriptions confusing and that they failed to reflect the work of HCAs in practice. The main criticisms of these descriptions related to vagueness in the expected role of the HCA and the number of competing job descriptions that existed in the hospital. The vagueness lent itself to interpretation at the micro-policy level:

'There is a complete lack of clarity around what is a HCA? And what is the role of the HCA? You know, there are a number of job descriptions around for a HCA. So if there are so many job descriptions around, how can staff actually know what it is that the HCA does?' (Senior RN, CL20: Focus Group Interview)

Despite differing job descriptions for HCAs in different clinical directorates, analysis revealed similar expectations of the HCA role in supporting RNs in the delivery of direct care, housekeeping and clerical duties. Differences across the job descriptions were primarily semantic.

Observation of HCA practice revealed only partial fulfilment of the duties outlined in their job descriptions. HCAs focused on direct care activities at the bedside, rather than housekeeping and clerical duties. However, RNs emphasised the importance of these neglected duties in supporting them in the provision of care. Hence, the HCAs were not meeting the expectations of the RNs. The overlap in direct care work

between RNs and HCAs created additional role confusion for RNs. In some circumstances HCAs were performing additional clinical duties not in their job descriptions, for example carrying out ECG recordings.

Job descriptions themselves also emphasised the role of HCAs as one of assisting the RN – an expectation commensurate with national and professional formal policy (Department of Health, 1999a; Nursing and Midwifery Council, 2002). However, in practice the HCAs both reported, and were observed, working predominantly alone, with their work largely unsupervised:

'I work on my own, or with students, caring for twelve patients. I have a lot of responsibility.' (HCA 41: Interview)

'By right we are supposed to work with staff nurses. But they just do not have the time. So you just have to get on with it.' (HCA 19: Interview)

This pattern was perceived by both RNs and HCAs as having implications for patient care, safety, and nursing teamwork.

HCA Work Focuses On Direct Care Work

Direct care was characterised by nurses in the Trust as those face-to-face activities that occur between nurse and patient. This work includes bedside care duties, also referred to as fundamental or basic care. Duties included helping patients with physical activities they were unable to do for themselves, for example bathing, dressing, eating, drinking, moving and toileting. These activities involve close and

intimate contact between the nurse and patient. In performing these activities nurses were expected to be involved in emotional activities, such as supporting and reassuring the patient.

Within the case site, HCAs claimed that they made an increasing contribution to the delivery of bedside care and perceived that they were the predominant figure at the patients' bedside providing such care:

'Who does the hands-on caring work? It is the HCA who is close to the patient and gives the most direct care.' (HCA 25: Interview)

Observation of HCAs revealed the centrality of fundamental care to their role. At the beginning of each shift the HCA was allocated to a team of nurses to care for about twelve patients. The registered nurses shared out the responsibility for patients within the team, whereas HCAs were expected to work with all of the patients in the team. At the outset of each early morning shift HCAs had a similar pattern of activity. They would stock a trolley with linen, towels and night clothes; grab a linen skip; put on an apron and then enter into the bay areas to help patients out of bed for breakfast; and assist with personal care. For at least 2 hours at the start of each shift this activity was the central focus of their work. Observation revealed that HCAs performed this sort of activity far more often and regularly than the RNs.

Junior RNs ('D' and 'E' Grades) confirmed that HCAs were increasingly relied upon to provide bedside care to patients. Junior RNs described their own role as dealing with other issues in patient care, such as drug rounds and co-ordinating care with

other professionals. These roles were often perceived as occurring within contexts, such as poor staffing levels, which created extra pressure for RNs. These RNs perceived that they had less involvement in direct care than the HCAs:

'I mean you could have three qualified nurses say, on an early shift. You could be the only qualified nurse looking after twelve, responsible for twelve, patients. So you could have two 'B' grade HCAs working with you. So people tend to come and ask you [the RN] the questions. They don't come and ask HCAs the questions. By the time you've done the drugs round, answered everybody's telephone calls, dealt with all enquiries, because, they don't go to HCAs, they come, they seek you out. You could be doing something with a patient and you've got a queue of people waiting at the bedside wanting to talk to you. So, you might have lots of HCAs, but they are not able or allowed to do other things and other people want you.' (Junior RN, E8: Focus Group Interview)

In contrast, senior RNs (Clinical Lead and Charge Nurses) were sceptical of HCAs' claims of being the majority provider of care at the bedside. Indeed, for some, bedside care was still firmly a RN responsibility:

'Nowhere where I've worked do [registered] nurses just sit and not give [bedside] care. Every ward I have worked in, in this hospital, the [registered] nurses do give bedside care. You may have one 'E' grade on a shift who has other things to do but the other [registered] nurses will be giving care to their patients.' (Senior RN, CN9: Focus Group Interview)

These findings reflect the conflicting claims on bedside caring between HCAs and senior RNs and the discrepancy between junior RNs' accounts (who work alongside HCAs in the wards) and RNs working at management level. However, observation revealed that the performance of bedside care by RNs was being threatened by competing demands on their time. The changing focus of registered nurses' work was recognised by both RNs and HCAs and was also observed in the case site.

The Decreasing Value Of Bedside Care By Registered Nurses

Alongside the increasing use of HCAs to provide bedside care, HCAs reported the decreasing contribution of RNs to this aspect of care because RNs were carrying out additional duties:

'The computer seems to have taken over. [Registered] nurses never have the time for patients. In the eighties, even early nineties, they would sit down and talk to patients but now they have not got the time.' (HCA 19: Interview)

There was some agreement amongst senior RNs that nursing may have jeopardised the value of fundamental care in the pursuit of other nursing roles and responsibilities:

'I think we [registered nurses] have devalued the nursing role. We have made it seem like, you know, we think there is something better than doing that basic fundamental care.' (Senior RN, CL9: Focus Group Interview)

There was a rhetorical dimension to RNs' reflections on fundamental care in practice. Whilst they expressly claimed fundamental care as central to their role, this care was most often performed by HCAs. HCAs recognised that fundamental care activities,

such as bathing and dealing with incontinence, were often delegated to them, whilst RNs performed more technical aspects of care, such as medications or wound dressings:

'You know, what is really bad though Karen is that whenever there was something about personal care the nurse looked at me. But if it was technical, she looked to the agency [registered] nurse. The [registered] nurse placed me with the dirty jobs.' (HCA 59: Observation Fieldnotes)

HCAAs viewed registered nursing as moving away from fundamental care duties towards activities such as technical duties, paperwork, computer care planning, liaison with other health care professionals (hospital and community) and discharge planning. Some of the HCAAs placed a high value on the delivery of fundamental care and suggested that registered nurses might be relinquishing their traditional perspective on what constitutes important care for patients:

'I do feel that parts of nursing have been lost, for example nutrition of patients. Other care might be more exciting but if a patient were not eating well then what would be the point of doing the rest? The patient is not going to get well if their diet is poor. Too much emphasis is placed on clinical grading. Who is the better nurse? A D grade who is good at patient care or the F grade who does the paperwork and computers well? Why do they take the more experienced nurse away from the bedside? It is important that there are 'good' assistants to give that care.' (HCA 52: Interview)

The apparent shift in registered nurses' priorities was also pointed out by the RNs. Registered nurses suggested that aspects of 'being a nurse' were being lost for the RNs and that they were being trained for a role which they were unable to fulfil due to competing demands on their time:

'I know why I became a nurse. I know what I wanted to do. I wanted to look after people. Not to say the HCAs can't do it or shouldn't be able to do it. But the more jobs HCAs get, the more you get removed from the patient. And what do you become – the discharge manager, the ward clerk, the drug giver. You, the actual hands-on 'I want to touch a patient' type and actually look after someone gets taken away. So I think they [HCAs] are capable and I'm not saying that they're not. I'm not saying they shouldn't be able to do it. But for purely selfish reasons I don't want them to do it because I want to do it, you know.' (Junior RN, E8: Focus Group Interview)

Registered nurses felt that their role was involuntarily changing to meet wider change agendas in health care provision. These changes to their role were not always wanted or valued. Indeed some registered nurses explained their frustration with having to take on activities that diverted them from direct patient care:

'On the phone. Behind the desk. Dealing with ordering this, ordering that. Chasing up people. You know, part of the thing I like about nursing is the hands-on nursing. Patients. Fellow-human contact. And I think it is getting less and less. That's what I think. Because we are expected now to do a lot of secretarial work.' (Junior RN, E4: Focus Group Interview)

Whilst this quote describes the diversionary activities taking registered nurses away from the bedside it is significant to note that some of these activities could be fulfilled by a HCA; for example, secretarial work. However, RNs were giving up fundamental care to perform these other duties despite being trained for the provision of fundamental care and expressing a preference for such work.

RN accounts revealed a degree of defensive rationalisation for their performance of activities, other than fundamental care. These activities other than fundamental care were viewed as important to patient care by RNs; as such, the questioning of these 'other' activities by the HCAs was seen as inappropriate. Provision of nursing care was viewed by RNs as more than simply fundamental care. RNs suggested that within contemporary care, patients' needs and the contexts of care are increasingly complex. Therefore, these activities required the skills of the registered, and by inference more skilled, nurse. This created tensions within the nursing workforce because RNs felt that HCAs did not understand the importance of these additional duties:

'There are times we [RN] absolutely can't do fundamental care. And they [HCA] need to understand why it is actually important what we are doing while we are sitting at the desk. But they may not sometimes view it like that. And it could be a very essential bit of work that you are doing and they [HCAs] just aren't able to do that, or allowed to do that, so it has to be you that does that. And it is hard because we are in charge and we have allocated patients. So... often you are asking somebody else to help you do things to

patients because you are dealing with something else. And I'll say to them 'Come and get me' even though I emphasise that what I'm doing is contributing to patient care.' (Junior RN, E5: Focus Group Interview)

However, asking HCAs *'to do things to patients because you are dealing with something else'* raises issues about RNs' ability to supervise and monitor the care provided to patients by HCAs.

Despite RNs maintaining a rhetorical claim on fundamental care activities, observational data suggest that RNs did not always take up opportunities to be involved in bedside care activities. It was suggested by some RNs, that they asked HCAs to perform fundamental care tasks, such as toileting, because they felt that the work did not require their skills. Registered nurses were observed transferring this work by asking HCAs to answer the call bells of patients. If the patient requested the toilet the HCA would deal with it and where something else was requested, such as pain relief, the HCA could pass this information on to the RN. One RN commented:

'I've seen nurses, um, quite regularly actually, sitting down at the nurses' station and there is a HCA with them. A call bell goes off and they look to the HCA to go and answer it. They're not doing anything, they're not documenting anything, they're not on the phone to somebody, and they're not waiting for a bleep. Yet they say to the HCA "Can you go and see who that is?" [There is agreement by other participants in the focus group]. *This isn't fair. But I, I can understand why they are thinking well "I'm skilled; I'm*

waiting for my skills to be needed. [Laughter from participants]. *I'm going to wait for something only I can do, then I'll go.*' (Junior RN, E2: Focus Group Interview)

Whilst dressed in HCA uniform, I was also placed in situations that reinforced this perception. For example, being told to mop up a urine spillage that a RN had left (the RN knowingly observed me carry out this task) and being told by a Student Nurse that cleaning an incontinent patient was the job of a HCA. As such, this further reinforced the HCAs' perception that they provided the hands-on, and defiling, care whilst RNs do 'other things'.

The value attached to paperwork, rather than bedside work, and sending HCAs to answer call bells to undertake tasks that any nursing worker could do, perhaps provides a reflection of the prestige awarded to such work by the registered nurses.

Whilst fundamental care might be claimed by RNs as integral to their work the changing nature of nursing work - from caregiver to co-ordinator of care - necessitates re-evaluation of nursing work being performed by registered and non-registered nurses. The registered nurse '*waiting for their skills to be used*' perhaps reflected the wider changes in bundles of tasks being attached to the roles of different levels of nurse in the future.

RNs' Advisory Control Of Direct Care Activities

Whilst HCAs were observed providing a significant amount of direct care, RNs maintained some control over *which* direct care activities HCAs performed. Take the

following example from field note observations of a lunchtime handover report at the patients' bedsides:

The nurses [RN, agency RN and HCA] go to the first patient and the registered nurse talks to the agency registered nurse about technical aspects of care and discharge arrangements. She then turns and says to the HCA that the patient has just been incontinent but she has not had time to change his bed. She asks the HCA to do it. At the second patient the RN explains to the agency RN about tablets, then looks to the HCA and says the patient has not had a bath yet. The RN instructs the HCA to do this. At the third patient the RN advises the nurses that the patient is self-caring. The RN comments that patient four has just been incontinent and the RN looks at HCA saying they have not had time to clean him. At the fifth patient the HCA says she can smell faeces and says she will help the patients that have been incontinent first. The HCA performs these activities. None of the registered nurses helped her. There were registered nurses sitting at the nurse's station. (HCA59: Participant Observation Fieldnotes)

The RN instructed the HCA about fundamental direct care activities. This can be contrasted with the other direct care activities that were reported to the agency RN, such as medications, discharge arrangements and technical tasks related to gastric feeds and wound dressings. Therefore, whilst HCAs' work concentrated on direct care, it was evident from observations of HCAs' work that this involved predominantly 'dirty' work (Hughes, 1984), rather than other direct care duties such as wound care. However, this dirty work is a significant element of nursing functions.

Concerns were voiced amongst both RNs and HCAs that RNs were becoming over-reliant on HCAs performing such work.

Over Reliance On The HCA Role By RNs

RNs identified with asking HCAs to perform activities whilst they were getting on with 'other things' and that this may cause over reliance on the role of the HCA. Indeed, for some, this over-reliance exceeded reasonable expectations of the HCA role:

'On a surgical ward, sometimes, there is a lot of reliance on the HCAs to do [systemic] observations while you [RN] are doing other things. But sometimes it can be for a period of two hours or more, you know. I think sometimes it is too common that a qualified nurse actually isn't disciplined in checking and making sure that everything is alright because you are the one who is the named nurse for that patient, not the HCA, and you know there seems to be a reliance sometimes that, "Oh they're doing the obs. It's fine. I can go and do something else." But that does happen a bit much probably and that's not really their responsibility to look after a post-op patient for a while by themselves.' (Junior RN, E5: Focus Group Interview)

The systemic observations of patients, such as blood pressure recordings, were mainly carried out by HCAs and student nurses on the wards. HCAs tended to use electronic machines for these recordings. At set times of the day (10.00, 14.00, 18.00, 22.00) this task would be performed by HCAs and recorded in the chart at the end of the patient's bed. Some of the more junior HCAs did not always understand the purpose

of recording a patient's systemic observations or the importance of informing a RN when recordings appeared to be abnormal for a patient. For example, on completion of the observation rounds the researcher would ask HCAs if they felt they had anything they needed to inform the RN about in relation to abnormal readings, such as a high temperature. This observation revealed that HCAs did not understand the importance of temperature recordings post-operatively. Additionally, some of the HCAs reported that they had never been shown how to measure and record systemic observations. More importantly, RNs presumed HCAs knew how to do it and HCAs performed the activity without asking to be shown.

There were additional aspects of care that reflected the over reliance of RNs on HCAs. RNs suggested that they had expectations that HCAs would ensure certain aspects of care were provided to patients. A particularly important example related to nutrition and hydration of patients, and in particular, assisting patients to eat meals:

D5 *And also a lot of staff nurses feel that it is the HCAs responsibility to feed the patient. It isn't. I don't think it is.*

D3 *It is everybody's responsibility.*

D5 *And yes it is but you come across the staff nurses who are like 'Feed that patient.'*

D3 *But when I go around with the drug trolley, I mean our drug time is the worst time possible because it hits dinnertime. And so whilst I'm doing that then yes they {HCAs} have to get on with it.*

(Junior RNs, D3/D5: Focus Group Interview)

The reliance on HCAs to ensure patients were fed whilst RNs carried out other activities meant that at times HCAs were observed trying to feed two patients at the same time. The quality of interaction between the HCA and patients was limited because of pressure on the HCA to get the task done. This over reliance resulted in HCAs performing tasks with patients in a depersonalised way. Take the following extract from observation field notes:

The HCA is assisted by the RN to sit patients up in bed in the two side rooms. The RN is giving out medications. The HCA then works between the two rooms to ensure that both men have their breakfast. She gives the first patient a few mouthfuls of cereal and then goes to the next patient and does the same before returning to the first. This style of feeding continues until both men have had their cereal and then she helps them with a cup of tea. She stands at the bedside when helping to feed the patients. She does not sit with either of them. (HCA41: Participant Observation Fieldnotes)

The over reliance on HCAs in the delivery of such aspects of care was often attributed (by RNs) to the pressures experienced by RNs in the delivery of care and the consequent reactive renegotiation of tasks amongst nursing teams as a means of ensuring the continued delivery of care to patients. However, the increasing use of HCAs in the delivery of bedside care impacted on their abilities to fulfil other aspects of their job description: housekeeping and clerical duties.

HCA's Neglect Aspects Of Their Job Descriptions

The neglect of clerical and housekeeping duties contrasted sharply with what senior RNs expected HCAs to do. Senior RNs identified that HCAs would better support the RN workforce if these indirect care activities formed a greater proportion of their work. It was suggested that the HCAs neglected these duties in preference for direct patient care:

'Yeah but what seems to be happening is they're [HCAs] coming in and doing all the bedside care and still nobody is doing the other things, such as clerical work and housekeeping activities. And that's the reality.' (Senior RN, CN1: Focus Group Interview)

The HCA grade was introduced to support and assist the RN in the delivery of nursing care (UKCC, 1987). However, in the study hospital, the HCAs were not fulfilling their job descriptions. As a result, the type of assistance required by RNs with nursing work was not forthcoming in the majority of the wards.

The negative cases which illustrate the value of HCAs' undertaking more indirect care duties than direct care work were found in specialist wards. In these environments the HCA took on duties that the registered nurses passed to them, enabling the RN to concentrate on direct bedside care activities. In performing these indirect duties, the HCA was perceived as making a significant contribution to the smooth running of the ward. In these areas, the HCA's work included activities such as administrative duties, ordering ward stock and cleaning. The following quote from the Charge Nurse depicts a HCA who acted (and was referred to in conversation) as a faithful and loyal

servant to the registered nurses:

'She [HCA] can actually go and find the notes for me [Charge Nurse]. She can find the X-rays. She can even admit the patient for me, do transfers and that. And I have found that has really made her very useful to me and she finds that she is doing something slightly different that she may in time be able to use for her own benefit. She also does the stores. She sorts this. And so she orders things that we [RNs] may be running short of and that. And so she has a good relationship with the stores so that when we need something she can sort that out, or if we have problems she knows who to ring. And that keeps us going, and it keeps the ward tidy, and we don't have to worry about running out of things.' (Senior RN, CN3: Focus Group Interview)

Analysis of interview and observation data revealed that HCAs were often not *explicitly* instructed about the work that they should perform. This was despite the fact that the evolution of their work patterns resulted in a role which patently often failed to support RN activity.

HCAs' Work Lacks Clear Direction And Supervision From RNs

Many HCAs perceived that they often worked beyond the level of an assistant and worked independently. HCAs provided bedside care to patients without the support and supervision of RNs:

'By right we are supposed to work with [registered] nurses. But they just do not have the time to work with us and so you just have to get on with it.' (HCA 19: Interview)

This perception was supported by observation of HCAs in practice. They were observed to work alone in the clinical areas. A consequence of this was that HCAs required assistance with their workload from the registered nurses. This was contrary to the job descriptions:

'The HCA calls the nurse to help, yet the job description suggests it is the other way around; the HCA should assist the nurse.' (HCA 21: Interview)

The registered nurses were aware of their responsibilities in supervising the work of HCAs. Professional policy is very clear about the responsibility of registered nurses to appropriately delegate and supervise the work of HCAs. They recognised the need to be aware of HCAs' work – a recognition often framed in terms of accountability:

'[Registered] nurses have to be on top of supervision issues because if HCAs make a mistake, the [registered] nurses are accountable. And so [registered] nurses have to think about that and have to watch what HCAs are doing.'

(Junior RN, D3: Focus Group Interview)

Despite RNs recognition of the importance of HCA supervision, RNs agreed that there was generally a lack of supervision of HCAs in the hospital. This lack of ownership was attributed to work pressures and a shortage of RNs in the clinical areas which made supervision difficult. However, this argument did not transfer to the supervision of student nurses. RNs, despite feeling pressured by time and resources, incorporated the supervision of students into their daily work. However, an additional problem that RNs identified as preventing the supervision of HCAs' work related to

the physical environment of the wards. The environment acted as a barrier for effective supervision:

'I mean I can see one of the things with my unit is I have eight side rooms and that can affect supervision. Because a lot of things that HCAs do goes on behind closed doors. That environment does impact upon supervision and is a factor.' (Senior RGN, CN1: Focus Group Interview)

A substantial proportion of HCAs' work went on behind closed doors; in side rooms and bathrooms, and behind curtains at the bedside. The concealment of this activity meant that RNs were not always aware of HCAs' performance. By being at the bedside with HCAs as they provided care to patients, data were gathered which demonstrated the wide variation in HCAs' practice.

HCAs Demonstrate Variable Abilities In Bedside Care Provision

Whilst variability would be expected of a group of workers with varying levels of experience and qualifications in caring work, it nevertheless raises concerns about the quality of care provided. HCAs were originally intended to provide assistance to RNs and be supervised. However, observation and interviews suggest increasing provision of care to patients, often without direct supervision and direction from RNs.

Some HCAs exhibited demonstrable skills in personal care through their attention to detail and in their approach to patients. Take the following as an example of skilled personal care provided by a HCA:

The HCA is gentle in her approach to the patient and in physical touch. She pays attention to things such as putting the ladies hands in water to wash them

and attempting to wash her nails, which look dirty. She rubs her back with talc and looks at pressure points to assess how they appear. Once the patient is comfortable in bed, the HCA combs her hair and offers to clean her dentures and provides a mouth wash. (HCA 17: Participant Observation Fieldnotes)

This level of attention and skill was not always observed. There were also situations where HCAs demonstrated that they did not have skills in personal care. Take the following example where a HCA is helping a patient who has recently suffered a stroke to wash. There were three particularly negative aspects to this encounter: the HCA shaving the man without using any shaving foam or soap; removing an incontinence pad in a manner which resulted in faeces being smeared up the man's back; and moving the patient from bed to chair without assistance which resulted in the man slumping into his chair. The HCA did not fully complete personal care with this patient by missing out related activities. The following was recorded in field notes:

The HCA has left the man in his chair in a position where his affected foot is inverted and weight bearing on lateral aspect. His arm is left hanging over the side of the chair. The HCA has moved on and is gathering together another patient's toiletries to help them to have a wash. The patient is looking at me across the room. I am now positioned at the entrance to the bay. I approach him and ask if he would like his trainers put back on? He nods and

so I assist with this. I reposition his foot and get the man to hold on to his affected arm. The HCA has left the catheter tube lying on the floor. I put the catheter bag back on to a stand. (HCA 16: Participant Observation Fieldnotes)

From a clinical perspective, there are a number of important observations in these field notes that suggest that this HCA was doing more harm than good. First, in relation to the positioning of the patient, evidence suggests that positioning of stroke patients is an important factor in relation to functional recovery from a stroke (Jones *et al.*, 1998) and recommendations for correct positioning are available (Carr and Kenney, 1992). These recommendations emphasise the importance of maintaining the position of the foot and ensuring the patient is aware of their affected limb. It is therefore not good practice to leave the patient's foot lying on its outer side and his arm hanging over the side of the chair. Secondly, the catheter tube left lying on the floor provided an infection risk to the patient (Penfold, 1999). Finally, the HCA moved on to another patient without paying attention to detail, such as helping the man to put his trainers back on.

These exemplars reflect the diversity of skills and ability within the HCA workforce in one Trust. It is not possible to isolate why the second HCA demonstrated consistently poorer practice than the first – both had similar amounts of clinical experience and NVQs. However, in both situations their work was unsupervised. As an assistant role, RNs should be instructing, supervising and monitoring the care provided by HCAs in practice. Additionally, the RN has a responsibility to challenge the care being provided by HCAs which may not be acceptable. Whilst in many

situations the RNs were not aware of poor care because it was being provided behind closed doors, there were circumstances where RNs were in close proximity to HCAs but did not challenge their behaviour towards a patient. Take the following example from field notes:

I am helping the HCA to make beds in a bay area. We make a bed for a patient and he [HCA] says to me that we must leave the bed up high to stop her [patient] from getting back in to it. He says the lady would spend all day in bed and so this is the only way to stop her from doing so. He starts to walk away; the bed is up high. She asks him to lower the bed but he ignores her. The lady asks him repeatedly and so the HCA eventually says he will help the lady back into bed at 10 am. We carry on the mornings work and throughout the morning the lady keeps asking the HCA the time and if it is time to for her to get back on to her bed. He does not tell the lady the correct time, always indicating that it is much earlier so that she can not get into bed. The registered nurse witnesses this on a number of occasions whilst giving out medications to patients in the bay. She does not challenge the HCA about the appropriateness of such behaviour towards a patient and does not lower the bed either. (HCA 16: Participant Observation Fieldnotes)

Again, a number of issues arise from these observations which highlight poor practice by the HCA and which also go unchallenged by the RNs. First, the HCA disorientates a patient who had already demonstrated some confusion. The HCA provided the patient with incorrect information about the time because he was aware of her mild confusion. This also suggests a lack of respect towards the patient

because it is unlikely he would have used a similar tactic with a younger patient who was not confused. Secondly, the patient was reported to have heart failure, although this was not her primary reason for hospital admission. She had visibly swollen ankles as a result of her heart failure and so there were medical reasons why she may have preferred to, and would have benefited from, lying on the bed. Thirdly, by leaving the bed up high the HCA put the patient at risk of falling if the patient had attempted to get into bed herself. Finally, the RN did not challenge the HCA about his behaviour towards the patient. By not challenging such behaviour the registered nurse unwittingly reinforced poor practice. Indeed, the HCA did not fully understand his actions and so the RN missed an opportunity to provide a learning opportunity for the HCA.

HCA's also demonstrated variable ability when responding to patients' requests for information about their care, condition or treatment. Some of the more experienced HCA's endeavoured to respond to requests based upon their prior experience. Take the following example from observation field notes:

A patient was preparing for a sigmoidoscopy and was anxious about the instructions that she had been given by the RN to prepare for the investigation. The patient asked the HCA to explain it to her. The HCA based her explanation on what she had observed with other patients, using them as an example for the patient, and supplemented this with a procedure leaflet kept on the ward. (HCA 5: Participant Observation Fieldnotes)

Whilst in this example the experienced HCA was able to respond to the patient's request for information, in other circumstances they were observed referring the patient to the RN, or attempting to find out the answer from the RN and report back to the patient. Some of the more junior and inexperienced HCAs avoided answering patients' questions, and failed to identify someone who could. Take the following example where a patient observed and commented on an HCA's inability to answer his questions:

The patient repeats his question about whether or not he has put any weight on. The patient is being weighed daily. The HCA tells the patient his weight. The patient comments that this is more than he weighed yesterday and enquires whether he should be at all concerned that his weight has gone up. The HCA is moving about the room and appears not to have heard the question. The patient repeats the question three times. I am standing in the room near to the HCA and I have clearly heard the questions but the HCA repeatedly fails to acknowledge the patient or the question. The patient then turns to me and says that this particular nurse never stands still long enough to listen to questions and that he is constantly rushing about. (HCA 16, patient comment: Participant Observation Fieldnotes)

This example highlights that the provision of bedside care is not simply about performing a task, such as weighing a patient. Patients may have concerns that they would like reassurance about. HCAs were sometimes limited in their ability to provide answers for patients, but also demonstrated that they did not always seek help for the patient.

HCA's Workplace Visibility Shapes Patient Care

The duties performed by HCAs and RNs influenced the 'spaces' that they occupied in the ward areas. HCAs were observed locating themselves in the patient bays for the provision of bedside care or in areas such as the dirty sluice, which some referred to as *'the office'*. RNs were observed in the bays when delivering direct care but spent significant amounts of time at the nurses' station. This difference in location related to the tasks that were being undertaken by the two levels of nurse. RNs used computers and telephones at the nurses' station for part of their nursing work and were involved in discussion about care with other professionals who tended to gather by the nurses' station for ease of access to patient notes. HCAs did not have to undertake these duties away from the bedside and so did not need to be at the nurses' station. HCAs were therefore predominantly located in areas where they were visible to patients.

The visibility of HCAs in these areas influenced their development of relationships with patients. The HCAs were available to engage in conversations with patients whereas the RNs' interactions with patients were predominantly limited to times when activities, such as drugs rounds or wound dressings, were being performed. By being visible to patients, HCAs perceived that their relationships with patients were different to those between patients and RNs:

'Patients talk to HCAs. They might see the registered nurse but not talk to them. They want someone who is there - talking, laughing and holding their hand - not sitting behind a computer.' (HCA 21: Interview)

By working at the bedside, HCAs had a social role with patients because they engaged in daily interactions and observed patient behaviours. These interactions enabled HCAs to gain an understanding from day-to-day of how a particular patient was feeling and progressing. Registered nurses also recognised the importance of visibility at the bedside. However, RNs suggested that this visibility enabled HCAs to be more responsive to patient requests, rather than facilitating development of relationships between HCAs and patients:

'They [HCAs] are often the staff member who is visible to the patients and therefore are there to respond to patient demands.' (HCA 16, RN comment: Participant Observation Fieldnotes)

These opposing perspectives of the value of the HCA at the bedside were important in relation to RNs' claims over the provision and control of bedside care activities. However, HCAs felt that they often knew a patient's daily condition better than the registered nurse because of the amount of time they spent in direct contact with patients. RNs, however, viewed these interactions as task focused: that the HCA was simply responding to the requests and physical demands of patient care. Observations of the contact between HCAs and patients revealed that not only did HCAs play an important role in responding to patient requests, as described above, but they had an important role in the transfer of information to RNs.

HCA's Contribution To Communication: The HCA – Nurse Flow Of Information

The development of relationships between patients and HCAs, because of their involvement and location at the bedside, meant that HCAs were a potential source of patient care information to RNs. This role involved the transfer of information to RNs. HCAs were observed learning about the patient's condition whilst carrying out bedside care activities and listening to or observing patients. The HCAs gathered a variety of information including: systemic observations that were out of 'normal' limits, such as a high temperature; a change in bowel condition, such as diarrhoea; patient reports of pain; patient's skin condition; patient referral need, such as to a chiropodist; any deterioration in the patient's condition, for example decreased mobility or increased levels of confusion; carer's concerns; and the completion of treatment regimes, such as IV drugs. As has been shown, some HCAs demonstrated that they were sometimes doing more than simply performing a task when at the patient's bedside.

However, the passing on of this information appeared to rely upon the relationship that existed between individual RNs and HCAs. Such that, if the HCA felt that their contribution to care was respected by the RN then they were more likely to share information about care and freely passed on details of anything they had noted about patients. At other times, where the HCA felt that the RN did not value their work, the HCAs did not pass on information. In these circumstances, HCAs waited to be asked for information to gauge whether or not the RNs valued their contribution:

'The clever ones [referring to RNs] ask me if I have anything to tell them.

They write it down. They know I give the hands on care.' (HCA 17:

Interview)

The possession of patient care information sometimes placed the HCA in a powerful position in that they were able to exercise an indirect influence over nursing decisions and through their reports they influenced the modification of diagnoses. This position of power was achieved because of their location at the patient's bedside that enabled them to gather information about patients. For example, passing on information about a patient's skin condition – such as early development of pressure sores – had the potential to influence discharge arrangements to nursing homes, or by reporting diarrhoea the HCAs could influence the commencement of investigative procedures and limit infection risks for other patients.

RNs commented on the importance of HCAs reporting any patient abnormalities.

Junior RNs appreciated the input of the HCAs because they were struggling to meet the competing demands of the RN role:

'They [HCAs] are like the eyes and ears of the ward as well. 'Cos too often you're short staffed and the [registered] nurses don't get the chance to pay enough attention that they maybe want to, to the patient. Whereas the HCAs, they may not know the medical reason why, but they might know that Mrs So and So is not quite well today, she is a little bit out of sorts. And they may not know why but take note of that as well. And they play an important role in that way.' (Junior RN, E3: Focus Group Interview)

The result of relying on the HCAs' discretion, their initiative, and the relationship with RNs were ad hoc systems of information transfer. The hospital lacked systems for the *formal* transfer of information between HCA and RN. Computerised nursing care plans were used in the hospital, and RNs were solely responsible for the assessment, planning and evaluation of these care plans. HCAs were restricted from using the computerised care plans. Whilst the care plan was printed out and put in a folder at the end of the patient's bed the HCAs seldom referred to these. Reasons for not referring to the care plans related to their length – there is a large amount of paperwork involved with the care plans – and the intellectual inaccessibility of the language. Examples of the care planning language that HCAs found difficult included: high or low body temperature written as '*ineffective thermoregulation*', poor circulation written as '*altered peripheral tissue perfusion*' or decreased sensation and movement of a limb as '*peripheral neurovascular dysfunction.*' RNs agreed that the care plans did not have any meaning for the work of HCAs:

'It [the care plan] is a vast amount of writing even to read through when they [HCAs] are going to be doing tasks. It is not very clear even when you print it out, when you have to hunt through all these phrases, trying to find the bit relevant to you. Because once ordered on the computer, once printed out, it continues through all the sheets. They are more likely to go with what they think is right at that particular time than to go through what looks like a centimetre thick sheet of notes.' (Junior RN, E2: Focus Group Interview)

This lack of engagement with formal communication technologies meant that unless RNs told HCAs of any particular planned care, the HCA determined patient care requirements for themselves. The RN in the quote above suggested that the HCAs performed tasks. Therefore doing what *'they think is right at that particular time'* appeared to be accepted practice. However, this study suggests that HCAs were doing more than tasks, they were also providing care and monitoring patients. The only documentation that HCAs were able to complete was systemic observation charts, food intake charts, fluid balance charts and ongoing communication sheets. RNs reported that the ongoing communication sheets were not used. HCAs were aware of this and therefore did not complete them. The lack of opportunity to document the care that they provided to patients caused frustration for HCAs because they felt that this contributed to the lack of acknowledgement of their work. They felt that they passed on information about care they had completed and then it appeared that the RNs had completed the work:

'The qualified nurse might not touch a patient but they write in the care plan and then take all the credit. If I do not report back to them how can they write in the care plan? For example if I have given pressure care, how do they know I have done this?' (HCA 38: Interview)

As well as a lack of opportunity to document care, HCAs had no recognised role in the ward report at the shift handovers. HCAs attended the handovers but were rarely asked for their opinion or input, even in areas in which they had intimate knowledge, for example, in relation to the functional abilities of patients or patients' skin integrity.

Examining the ways in which HCAs were used in practice, reveals that HCAs work in ways that are not reflected in the formal arenas of national, professional and local policy. The ways in which the HCA resource is deployed has direct implications for patient care, for example in the transfer of information to and from patients.

However, the ways in which HCAs are sometimes used also has implications for the HCAs themselves.

The Misuse Of HCAs

HCAs were sometimes *misused* in practice by RNs. RNs reported situations in practice where HCAs were used in ways that were beyond the expectations of formal policies and which resulted in exploitation of the HCA role.

HCAs Asked To Perform Additional Tasks When RNs Under Pressure

The RNs admitted to sometimes asking HCAs to do activities that were recognised by RNs as being outside the '*accepted*' HCA role within the Trust. This occurred when circumstances on the ward were such that it suited the RN to have the HCA undertake certain additional activities. The circumstances that resulted in the use of HCAs in this way were related to an increased workload and inadequate staffing numbers. To illustrate the misuse of HCAs consider the following example. RNs repeatedly reported that, according to organisational policy, blood glucose monitoring (BMs) was not to be carried out by HCAs. In fact, organisational policy clearly stated that a worker who had received in-house training and had been assessed as competent in the

procedure could perform blood glucose monitoring. At the time of the study HCAs did not undertake this training course and so, whilst not explicit, the Trust policy excluded HCAs from performing this duty. Regardless, RNs sometimes asked HCAs to perform this activity to assist with their workload. As such, this demonstrated how local policies did not always influence work place practice:

'It's like the classic case of BMs. HCAs are not allowed to do blood glucose monitoring. But we do ask them. But Trust policy still says that HCAs can't do it until they [the Trust] change the policy. Even though HCAs are doing it, and they're brilliant at it. Anyone can do it. And it is really helpful to have somebody on the ward who can run around and do the BMs while tea comes and while you are doing the drugs. It's really helpful.' (RN, D3: Interview)

Sometimes, the practical situations faced by staff on the wards required negotiations that generated conflict with organisational policy. Where RNs faced a number of tasks they sometimes felt it was appropriate to get HCAs to carry out certain additional duties. This was to alleviate workload pressures and to ensure that patients were cared for. The alternatives available to the RN in the above situation would have required that patients wait to have their meal, because the RN is giving out the drugs prior to checking anybody's blood glucose, or the RN would be late in distributing the drugs. Where an alternative option was possible, for example when a HCA was asked by a RN to do the blood sugar recordings, then the RN's practice would conflict with organisational policies.

The above example might imply that it was a good idea for HCAs to perform blood sugar monitoring despite Trust policy. This particular RN reported that HCAs were not only able to perform the activity but were *'brilliant at it'* and covered gaps in care. However, HCAs were not trained to perform this aspect of care nor were they assessed as competent in the procedure. Moreover, there is little reason to suspect that the HCA variability exhibited in other areas of performance would not also occur in this task. The task was only given to the HCA at times when the RN was under pressure. It is these components that make the delegation of certain activities to HCAs inappropriate and constitute misuse, or abuse, of the assistant role.

Some more extreme examples of HCA misuse were provided. Take the following example described by a RN. This was reported to have taken place in another Trust. The RN described how she thought the HCA was placed in a difficult situation because of being asked to assist in an operating theatre:

'I think also you can fall into a trap that you ask too much of them. And I think there can, may be abuse of them, of what a HCA should be. I heard recently about a theatre that was very short staffed. A hospital linked to the Trust, and a very basic procedure in theatre. I do know a HCA is not meant to assist in theatres but she felt pressurised and it was a simple task that she was asked to do. And I think that is an abuse of their role really.' (Junior RN, E6: Focus Group Interview)

There are legal implications associated with these examples because of the potential risk to patients. The HCA role is meant to be one of assistance. Therefore, it is

misuse of the role where they are asked to perform a duty for which they have had no preparation or lack direct supervision. In addition, HCAs are not registered or regulated. Whilst they have a moral and legal accountability, the professional accountability for the HCAs' work rests with registered nurses. If patient care is jeopardised because RNs are not able to perform certain duties then it is important that these areas are identified and HCAs trained and assessed to undertake these duties in place of the RN. Misuse of HCAs resulted in a lack of consistency for the work of HCAs and the ad hoc development of their roles.

Consequences For HCAs Where There Is A Lack Of Consistency In Their Work

HCAs reported that staffing levels influenced their work activity. Such that when there was a shortage of permanent RNs, HCAs would be asked to take on more work and responsibility:

'If a nurse wants me to do an activity, then that is okay. But some days when there are enough qualified nurses they then don't let me do things and that can be frustrating.' (HCA 17: Interview)

During the study period, the observed ward settings were generally well staffed – for example an early shift would typically have six to eight staff. However, on occasions when HCAs were observed to work with agency RNs, there were increased expectations of the role. The type of work that HCAs were asked to perform included activities such as helping with blood sugar monitoring and wound dressings, offering support to agency nurses and an increase in physical caring work. At times when the ward was short staffed HCAs were observed caring for all patients in the ward rather

than being allocated to a team. This created extra physical duties. Additionally, they were the most likely members of staff to be called upon by a RN to help with activities such as moving patients, for example out of bed to a chair. The physical demands of the work were sometimes difficult for the HCAs, particularly since many of them were aged forty or above.

RNs reinforced the value of having permanent HCAs when the ward was short of permanent registered nurses:

'I think HCAs, due to whatever circumstances, that have been on the same ward and for a number of years are experienced and whatever. It might sound obvious but they are much better than. Well, what I find is that a lot of staff that come from the bank or agency straight on to the wards, one they don't know the wards, and to be brutally honest some are just there just to make the money on the shift and they don't give a fuck anyway. I think the Trust should employ more HCAs on each ward rather than using agency or bank or whatever. I think more permanent HCAs are needed.' (Junior RN, E4: Focus Group Interview)

Despite acknowledgement of HCAs, by some RNs, for their contribution to patient care and ward work at these times, this aspect of HCAs' work remained largely hidden. HCAs were not rewarded for taking on this level of responsibility. In addition, HCAs reported that even though they demonstrated their skills in management and execution of nursing work in times of staff shortages they were not able to continue care provision at this level at times when sufficient permanent RNs

were on duty. A further misuse of the HCA within the organisation.

This fluctuating demand for HCA skills, reported by both HCAs and RNs, is reminiscent of the old state enrolled nurse (SEN) grade; a second level nurse who was expected to take on extra duties when there were not enough first level nurses available (Francis and Humphrey, 1999). Despite fundamental differences between the SEN grade and the HCA grade – related to education and training, registration and regulation - there appear to be similarities associated with the relative lack of prestige attached to the work of these grades and variable expectations of the role from RNs. Where the duties and responsibilities of a worker change from day-to-day as a result of changing circumstance, rather than rational planning and strategy, it is reasonable to assert that this constitutes a form of worker misuse.

There were additional consequences associated with lack of consistency in HCAs' work: the creeping development of HCAs' roles and ad hoc permission from RNs for HCAs to perform duties in some clinical areas. HCAs in some clinical directorates were performing certain duties not performed by HCAs in other areas, for example ECGs. The organisation did not support HCAs performing these activities, which meant HCAs were not offered training or guidance for these activities. However, once HCAs had started to perform a task in the clinical area it became increasingly difficult for them to later refuse this work. In addition, it created challenges for those

RNs who did not want HCAs performing these duties. The result was confusion within the workforce and haphazard skills accretion, rather than a structured and supported deployment of skills within the organisation.

Whilst the performance of additional duties is one area of misuse there was another large area of work that HCAs performed that went unrecognised and was not rewarded: the 'hidden' work of HCAs to cover gaps in care.

The 'Hidden' Work Of HCAs: Covering Gaps In Care

HCAs filled gaps in care provision but their efforts went unrecognised in their job descriptions and consequent grade and pay structures. Within this there is a paradox: on the one hand HCAs are delegated the 'dirty' work of direct care (discussed above) whilst on the other they ensure that gaps in care left by higher status, but still junior, nursing staff (such as newly registered RNs and student nurses) are covered.

HCAs reported at interview that they perceived newly registered nurses as poorly prepared during their training for practical hands-on nursing work. The length of formal training (commonly quoted as 3 years by RNs and HCAs) was perceived as too short for many of the RNs to gain competence in practical skills. HCAs perceived that they covered the gaps in these skills whilst newly registered nurses gained confidence working in the clinical environment. They suggested that RNs required time after registration to practice these skills:

'Young nurses who have just finished training are not equipped with the skills to do the job. They are not interested in hands-on care. Some of them have trouble doing a manual blood pressure and so ask the HCAs to do it. I would suggest that there is a system for [registered] nurse training like that in law; the degree takes three years and then you have one-year apprenticeship to learn about the 'real' job. They should work for a year, not paid as a qualified nurse, to practice their skills. After the year they should then negotiate their working terms and conditions.' (HCA 17: Interview)

This quote also accentuates the need to have practical skills valued and rewarded. Such that, by demonstrating practical skills learnt through apprenticeship, the RN would be able to negotiate their working terms and conditions. It also reflects the HCAs' moral claim to direct care work. Practical skills therefore provide currency in negotiations, giving these skills a position of importance within nursing work.

The majority of HCAs reported the acquisition of their practical skills *'on the job'* through their hands-on experience in practice. In doing so, they suggested that this was a better way of learning skills for practical nursing work. The HCAs reported, and were observed, working alongside newly registered nurses providing guidance on practical skills and care management to newly registered and student nurses:

'Sometimes I am working with a newly qualified nurse and I end up telling her what it is we should be doing and how.' (HCA 69: Interview)

However, this aspect of HCAs' work and their contribution to the consolidation of practical skills with some registered nurses was unacknowledged within the hospital:

'HCAs are involved in the training of newly qualified staff in practical skills.

This is something that HCAs do that goes unacknowledged.' (HCA 21:

Interview)

Junior RNs supported the HCAs' perception. They also reported that HCAs supported them during their training, even though the HCA roles was not addressed during their nurse education. It was HCAs that explained much of the day-to-day nursing work, and in particular bedside care activities, to student nurses:

'During our training they never explained to us what the role of a care assistant was necessarily. You just go on to the ward and you see them and they are kind of like your best friend as a student nurse because they take time to explain to you the things that [registered] nurses don't have time to explain in the first instance.' (Junior RN, D2: Focus Group Interview)

HCAs were observed working alongside the student nurses in the provision of bedside care to patients. This reinforced the perception that it is often the non-registered nurses that provide bedside care rather than registered nurses.

The support and supervision of newly registered nurses by HCAs was particularly attributed to HCAs who had worked in the role for a number of years and demonstrated their experience of caring work. Take the following example of a HCA supporting the RN in the workplace. A third year student nurse had been looking

after a patient (Patient X). The newly registered nurse witnessed the student performing a task which was putting the safety of Patient X at risk because the student's actions could potentially dislocate the patient's hip joint or result in a fall. The RN called upon the HCA to practically help manage the situation and the HCA then acted in an advisory capacity to the RN:

Following the management of the situation the RN goes to find the student nurse and discovers that she can not find him anywhere on the ward. The RN asks the HCA how she should best manage the situation with the student. The HCA points out that this is an issue of competence and that the student had put a patient at risk of falling. The HCA also indicates that the student has left the ward short staffed because he has disappeared and this is not professional behaviour. The HCA advises the RN that she should fill in a clinical incident form just in case there is any damage to the lady's hip that may not be immediately obvious. The HCA also advises her to call the nurse in charge of the hospital to seek further advice regarding the student nurse. (HCA 5: Participant Observation Fieldnotes)

This incident demonstrated the extent to which RNs sometimes rely on both the practical skills of HCAs and their judgement for handling clinical situations. Whilst there were other nurses available on the unit during this incident, the RN consulted the HCA because she said she '*trusted*' the HCA.

The following example also illustrates where a gap in care was covered by an experienced HCA. In addition, it demonstrated the HCA's careful management of

nursing team dynamics. The context for this field note report was that during bedside handover (at 1pm) the junior RN (D Grade) had reported that Patient Y was having hourly urine measurements. The RN informed staff that this had not been done for a number of hours because there was no urine draining through the catheter. Following bedside handover the HCA returned to Patient Y and the following activity was recorded in field notes:

Whilst there is no urine in the urometer box there is urine in the catheter tube. The HCA moves the catheter tube. She is checking for urine and whether a recording is possible. The HCA says to me that the RNs should really have bled the catheter tube earlier because this can encourage the catheter to drain further. She also points out that because the catheter tube is wrapped around the drip stand and the catheter bag is on a bed that is high this does not encourage drainage either. The HCA says she is very concerned that, despite Patient Y being on hourly urine measurements, no urine output has been recorded by the RNs since 6.30am. (HCA 5: Participant Observation Fieldnotes)

In this example, the HCA was carrying out work that had not been completed by RNs. The HCA in the above example also explained that HCAs get on with this work and report their actions to RNs rather than confronting RNs about deficiencies in care. In this way, this sort of HCA activity remained largely hidden:

The HCA explains that she did not like to say anything about her concerns in handover because the RNs do not like HCAs to interrupt in handover and they do not like HCAs to be telling them what they should be doing. She says it is therefore best to do what needs to be done for patients and then tell the RN about it quietly afterwards. (HCA5: Participant Observation Field Notes)

Rather than confront the newly registered nurse about this lack of care, the HCA managed the situation and then told '*the RN about it quietly afterwards*'. This demonstrated the subtle interplay of power relationships in the clinical environment that existed between the registered and non-registered nurses. HCAs learned to deal with conflicts so that patients received the necessary care but did not upset the expected RN-HCA dynamic. As such, this work was largely hidden within the everyday activities of HCAs. It can be considered misuse because of the lack of acknowledgement of the contribution that HCAs make to the bedside care of patients beyond personal care activities.

So far this chapter has presented the ways in which HCAs were used and misused in practice. A final aspect of HCAs' work relates to their non-use. Interview and observation data revealed that HCAs possessed skills that were not fully utilised in practice and this also had implications for patient care.

The Non-Use Of HCAs

The non-use of HCAs refers to the ways in which HCAs were prevented from using their skills in practice. Whilst formal Trust policies outline the work of HCAs in terms of what they were expected to do, the most significant control of HCAs' work was exerted by RNs at ward level. This control dictated the ways in which HCAs were used and sometimes misused in practice. RNs prevented HCAs from using some of their skills through four main mechanisms. First, RNs used credentials to prevent HCAs taking on nursing duties. They reserved the title of 'nurse' for RNs. Secondly, HCAs performed similar direct care activities across clinical areas regardless of their available skills, experience and qualifications. Thirdly, RNs restricted HCAs' involvement in technical aspects of nursing care (for example, wound care). Finally, RNs ignored the HCAs' knowledge of the organisation and local community that they gained through experience. It is worth highlighting each of these 'limiting' mechanisms in turn.

Credentials As A Lever For The Control Of Nursing Work

Occupational groups attempt to control their work through the use of credentials. Other workers are excluded from performing this work because they have not completed formal training, attained the relevant qualifications nor demonstrated their competence. Registered nurses used credentials to differentiate between the role of RNs and HCAs.

RNs indicated that the title 'nurse' should be reserved for those who had undertaken a period of formal training – usually of three years - and achieved a professional qualification. Take the following discussion between two D grade RNs:

D11 *Well, some people have worked, well I have worked with people with fourteen years experience as HCAs. They can do what the [registered] nurse can do from their point of view.*

D3 *But you're not a 'nurse' until you do 3 years training.*

(Junior RNs, D11/ D3: Focus Group Interview)

HCAs disapproved of the protection of the title 'nurse' solely for registered nurses. They argued that because they provided bedside nursing care to patients they should be called 'nurse' assistants. They argued that the title 'health care' assistant did not accurately reflect their work. HCAs viewed themselves as nurses despite not having a registered qualification for such work:

'Nursing is not always about getting top marks in an assignment. It is also about the hands-on caring work provided by health care assistants.' (HCA 5: Interview)

All levels of RNs held the view that the title nurse should be protected for those that undertake formal training. However, more senior RNs also recognised that completion of this training did not always equate with greater skill in nursing work. They suggested that sometimes there was little difference between the work of experienced HCAs and newly registered nurses:

'It just seems to me as if the difference between 'C' grade [HCA] and 'D' grade [RN] is not that much. Yet it is a whole 3 years of training.' (Senior RN, CL23: Focus Group Interview)

Senior RNs suggested that HCAs gained skills and knowledge in nursing work through experience of working in a clinical speciality caring for patients. This reinforces the HCAs perception that by learning on-the-job they were equipped with practical caring skills beyond those taught in registered nurse training. There was recognition that despite undertaking formal training the newly registered nurse may be no more prepared than an experienced HCA in the provision of fundamental care:

'I think perhaps it is something that is, perhaps, the crux of the developments really. It's the kind of perception in the room that a HCA can never replace a trained nurse. So, I suppose what I would put to you, is if you have a newly qualified D grade nurse who provides basic nursing care, are we saying that the HCA with ten years experience of providing care can not provide the same kind of care?' (Senior RN, CL21: Focus Group Interview)

This view clearly challenges the perceptions of some RNs that HCAs can never replace a registered nurse. Indeed, it goes further in suggesting that perhaps in some circumstances the HCAs are as able, if not better, in the provision of certain aspects of care. Some HCAs had also gained qualifications for their work in the form of NVQs. Therefore, in some circumstances HCAs were being trained for nursing work. Over half the HCAs in the hospital (n=22; 66.7%) had a NVQ and, following financial

investment in HCAs' training in the hospital, increasing numbers had enrolled for NVQ training. This further challenged the view held by RNs that the title 'nurse' should be reserved for the RNs.

The lack of consideration given to the knowledge and skills of HCAs in the hospital was apparent through the labelling of nurses based on grade and appearance, or uniform. HCAs were often labelled as 'unqualified' and therefore less skilled than RNs. However, basing assumptions on grade or uniform did not always reflect the competence of individual workers:

'We might suggest that some HCAs might in fact have a higher level of competence than some of the registered nurses that are supposedly supervising them. So it challenges that whole thing about how we place these labels because people wear a different uniform and the ways in which we see those roles. And the status that applies to that as well.' (Senior RN CL7: Focus Group Interview)

The labelling of different grades of nurses based on appearance was inappropriate. As already highlighted in Chapter 6, the HCA workforce was diverse. Therefore assumptions were not possible based on appearance alone. The following quote from a RN highlights this issue:

'There is such a variety of HCAs. Some of them are actually qualified nurses or even doctors in some cases, from another country, and they come here and they are working as HCAs. I mean I had an instance where a HCA found a patient with collapse. I was trying to see to someone else who was really

unwell and he [HCA] said I really needed to go with him. And he was actually a trained doctor and so he wasn't your 'average' HCA. He had a lot more knowledge. But then I didn't actually realise at the time that he had been a doctor and you can just sort of put an assumption on how much they know. Sort of think they know less, but they may know more than we know. Sometimes they can be much more capable than us [registered nurses] in some cases, you know. You can have someone with ten or twenty years more experience than me and for some reason is working as a HCA; they haven't kept their registration up or whatever. And they can pick up on something that I haven't seen.' (Junior RN, E5: Focus Group Interview)

The registered nurse's use of the term 'average HCA' in the quote above is particularly interesting. This thesis argues that perhaps there is no such thing. The skills and experience within this group - of mainly mature women - were diverse. A clinical lead nurse noted the organisation had an opportunity to capitalise on the knowledge and develop the skills of the HCA workforce in the hospital in the future:

'I think we have a group of staff who have been in this trust for several years. With the NVQ programme being more established they have got their NVQ level 3, or are working towards their NVQ level 3, and have worked in this Trust for several years. They have very valid experience within different care areas, particularly different directorates, got very specialised experience and we need to capitalise on these people.' (Senior RN, CL20: Focus Group Interview)

This marks an important departure from the way in which the HCAs had been managed in the hospital in the past. The future use of HCAs' skills was perceived as having potential benefits for service delivery and patient care. However, such developments created tensions between the work of HCAs and RNs. The negotiation and control of activities between RNs and HCAs was a powerful determinant of the non-use of HCAs skills.

HCAs Could Do More Work Than They Are 'Allowed'

Regardless of experience or qualifications, HCAs were observed carrying out similar work across general clinical areas in relation to bedside care activities. HCAs perceived that they could do more work than RNs 'allowed' them to do. The HCAs felt that the non-use of their skills could be attributed to three main reasons. First, HCAs reported that certain tasks had been taken away from them over time. An example of a task taken away was care planning. HCAs who had worked at the hospital for many years reported that they used to help the RNs update care plans. However, following the launch of computerised care plans using nursing diagnosis, HCAs were excluded from the care planning process. HCAs suggested this caused frustration because they were not able to document the care that they provided to patients.

Secondly, HCAs perceived that RNs prevented them from using certain clinical skills, such as wound care, that they had developed whilst working elsewhere. On commencing work in the hospital, some HCAs reported that they were told not to

perform certain duties regardless of whether they possessed the necessary qualifications and skills:

'I felt de-skilled when I arrived in this Trust because things [tasks] were taken away from me. I used to do simple dressings such as gauze dressings and remove catheters. I mean anyone can do that. I used to change IVACs, and change colostomy bags. But I can't do any of these things here.' (HCA 38: Interview)

Finally, HCAs reported that the work they performed did not reflect their qualifications nor fully utilise their skills. HCAs were observed performing similar duties regardless of NVQs or other qualifications. In addition, some HCAs reported that they had certified qualifications that they were told they were not to use in their role as an assistant. For example, one HCA was a trained dietician but was told she could not give patients dietary advice. Numerous HCAs worked as phlebotomists with health care agency services but were told that they could not take blood as part of their role as a HCA. This occurred, despite poor staffing levels in the Trust's phlebotomy service, and registered nurses being reluctant to take on phlebotomy as part of their role. Indeed, there were certain clinical tasks that RNs did not permit HCAs to do.

RNs Limit HCAs' Involvement In Technical Dimensions Of Care

Whilst HCAs were sometimes asked to perform certain additional duties by RNs, such as blood sugar monitoring, there were certain activities that RNs did not want HCAs to be doing. These activities related more to technical dimensions of care

rather than the fundamentals of care. For example, RNs were very clear that they did not want HCAs to perform ECGs, wound care or phlebotomy. However, some of the HCAs reported that they had skills in these areas, reporting that they were able to change simple dressings and possessed training in phlebotomy skills. Taking the example of wound care. RNs refused to allow HCAs to be involved in this area of practice. Wound dressings were consistently reported as being the RN's job. The following quote provides a RN's detailed justification for this area of work remaining within the RNs' domain of work:

'But there is much more to checking a dressing than just changing it. [Agreement among participants in the group]. In a way there are lots of other things to think of. HCAs are just taught to do a dressing but there are so many other things involved. We've been thinking about this in the session we just had on wound care earlier, you know. It highlighted a lot of other issues like - the environment, the patient's psychological state and such things. I think, you know, you get that from three years of training and the rest from your experience and so it's not enough to have a crash course in wound care without the underlying knowledge.' (Junior RN, E5: Focus Group Interview)

The justification for the exclusion of HCAs from this area was the multi-dimensional nature of wound care - *'there is much more to checking a dressing than just changing it'*. Yet this argument was not applied to other areas of nursing work that RNs willingly handed over to HCAs, for example assisting patients at mealtimes. It could be argued, such activities were also multi-dimensional and complex.

Assisting a patient to eat a meal is not just about putting food in a patient's mouth. There are physical, social, psychological and environmental factors associated with this activity. Nutrition is an important part of patient recovery and yet it is an area that is poorly managed in hospital settings (Holmes, 2003). RNs were not explicit about the importance of this aspect of care and, as already reported in this chapter, HCAs were often left to assist patients with feeding and were sometimes left to spoon feed two patients at once. The value attached to technical activities such as wound care was not transferred to basic care activities such as feeding. Perhaps this pattern reflected the symbolic value attached to certain tasks by RNs. RNs emphasised the value of technical work over the basic nursing care activities, which they rhetorically supported as a key element of nursing.

Discussions about technical tasks, such as wound care, actively excluded HCAs. These discussions centred on protection of duties for the registered nurse rather than the use of HCAs' skills, the development of HCAs' practice or meeting the needs of patients. Take the following example, which implies that if HCAs were involved in wound care then there should be limits on this involvement:

'What you were saying about wound assessment and stuff though. Like D3 was saying that a care assistant might say they have noticed this red sore or whatever. They detect those things but I don't think we should be teaching them to report that it is a grade 2 wound or whatever.' (Junior RN, D8: Focus Group Interview)

It has already been seen that HCAs provided the majority of bedside care to patients. It therefore seems logical that they are the best worker to notice a patient's skin condition. RNs appeared to agree that this might be the case, but argued for imposed limits on the deployment of HCAs' knowledge and skills in this particular area. Therefore, whilst a HCA might notice that a patient's skin is discoloured the RNs did not want this finding reported to them in the technical language of the profession. However, if HCAs are working at the bedside and noticing pressure sores it could be argued that they need this shared language. Indeed, wound care is covered in NVQs at level 3 and so HCAs working at this level could be supported by RNs in this area of practice. The only reason to exclude HCAs from these technical activities is to protect the area for RNs and to facilitate the jurisdictional claims of the more powerful occupation.

A final dimension of non-use was related to HCAs who had been associated with the hospital and the local community for a number of years. These HCAs established experiential knowledge and skills as a result of this length of service. However, this was largely ignored by RNs.

Experiential Knowledge And Skills Of HCAs Ignored

The lack of use of HCAs' experiential knowledge was recognised by both HCAs and more senior RNs. The senior RNs suggested that HCAs with this knowledge could potentially contribute to patient care but this experience was generally not recognised and used by the registered nurses. The types of knowledge that HCAs made claims to included knowledge about how the hospital system worked and established contacts

between the HCAs and other hospital workers. This enabled HCAs to facilitate care:

'A lot of HCAs have been here a long time and so they've got tacit knowledge. Like, you know, if you want a porter quickly the HCA is the best person to link in because they have got those relationships and are key to getting things done. There are certain things that maybe a nurse or midwife would not know because they have not been there for long enough. Whereas, a HCA will know these things.' (Senior RN, CL3: Focus Group Interview)

HCAs were observed using this knowledge of the hospital system to facilitate care.

An example from observation notes demonstrated that a HCA was able to locate equipment in the hospital. A RN asked where she could get a hand splint. Another RN said that it was necessary to complete a form and order the splint from the physiotherapy department. However, the HCA intervened and said it was possible to get a splint from outpatients. She said she knew whom to ask and so could go and get a splint for the RN immediately rather than having to wait for an order.

Length of service in a particular locality was also recognised as enabling HCAs to make a contribution to knowledge about the local community. When utilised, this insight proved valuable in planning care for patient discharges. HCAs were more likely to be employed from the local community and stay in the Trust for a period of time. Whereas RNs were more likely to come to London for the work experience and, as described here by a Charge Nurse, were more likely to move on:

'One of the most valuable things I found, particularly from my first ward, was related to the transient nursing population. They [RNs] were moving quite a lot but the HCAs, where there were 3 and 20 staff nurses, they stayed. I mean this worked a lot better because they were valued in the sense that they knew the local community. They were actually in and they knew the local community, ethnicity and culture and just where places are for discharge planning and simple things like that. So that was, I always found them really valuable in that sense. They can contribute a lot.' (Senior RN, CN1: Focus Group Interview)

However, HCAs were not used in this way. Whilst observing HCAs it was noted that RNs did not involve HCAs in discussions about patient care and discharges. Again, non-use of the skills and experience of HCAs.

SUMMARY

The work of HCAs has been studied as part of the wider system of nursing work. The negotiation of nursing work, and therefore the HCAs' role in provision of nursing care, is not a static process but one that requires participant reshaping and redistribution of tasks. There are policy expectations associated with the work of HCAs which emphasise the role as one of assistance to, and as being supervised by, RNs. By studying their work in practice the use, misuse and non-use of HCAs illustrates the points of deviation from these policy goals. The workplace arena plays an important part in the shape of this occupational groups' work. Formal policies and organisational statements are inadequate for framing the work of HCAs. The

negotiations that take place in practice between RNs and HCAs have an important influence on the HCA role.

The study has demonstrated that the ways in which HCAs were used in practice in the case site lie outside the formal arenas of national, professional and local policy. The main focus for HCAs' work was the delivery of direct bedside care to patients. Yet they failed to meet other expectations of their role, such as housekeeping and clerical duties. As such, the HCAs were not fully supporting the work of RNs. RNs had changed some of their working practices to meet the changing demands of care. These changes decreased their involvement at the bedside and increased their focus on technical medical aspects of care and administrative duties. This created tensions between the role of HCA and RN, and difficulties for RNs in relation to the supervision, control and monitoring of HCAs' work. Some of the ways in which the HCAs were used had direct implications for patient care, for example in the transfer of patient information and in meeting patients' requests for information. However, the ways in which HCAs are sometimes used also has implications for the HCAs themselves.

HCAs were misused in practice because they were sometimes expected to work beyond the defined boundaries of their role to support the registered nurses. As such, there was often exploitation of, and over-reliance on, the HCAs. RNs delegated work seen as too menial, given their knowledge and skills. The misuse of HCAs may reflect the wider processes of change in the roles of RNs, as RNs take on additional duties and become increasingly concerned with the co-ordination (rather than

delivery) of patient care. However, the use of HCAs to take on additional work can only be considered legitimate, and not constitute misuse, if HCAs are adequately prepared for the tasks and able to perform such work regardless of work pressures for RNs and staffing shortages. Additionally, the largely 'hidden' work of HCAs deserves some recognition for its contribution to patient care and nursing teamwork. However, this study also revealed that HCAs' skills were sometimes not being fully used in practice.

The non-use of HCAs was reliant on control by RNs. However, whilst RNs attempted to control their own work through gaining professional skills and knowledge there has been increasing development of credentials for HCAs. Such developments may create a threat to the status of the RN. However, despite the HCAs developing their own skills for nursing work, the RNs continued to play a key part in whether or not such skills were used in practice. In response to the control that may be exerted over HCA work by RNs, HCAs developed strategies to challenge the restrictive practices and privileges of RNs and to gain advantages for their own work.

The study of HCAs' work is relevant to health care today because there are implications for practice when care is being delivered by this group of workers – and yet not formally recognised. These implications centre on the fitness for practice of this group of workers and the monitoring of care standards to ensure patients' needs are being met. By studying the formal and informal negotiation processes at play in determining the work of HCAs this thesis argues that the work of HCAs is determined largely by the workplace negotiations between HCAs and RNs. By understanding the

points of tension with formal policy a deeper understanding of the issues faced in nursing work is uncovered. The following chapter discusses these issues in more detail using Abbott's theory of jurisdiction as an analytical framework for understanding the negotiations surrounding HCAs' work and explores the importance of the concept of power for understanding these negotiations.

CHAPTER 8 DISCUSSION AND CONCLUSION: NEGOTIATION AND POWER IN CARING WORK

This thesis is concerned with HCAs and their role in nursing work. This chapter draws together the study findings underpinning the thesis and examines these in the broader context of the literature. In exploring the HCA role, the thesis makes use of Abbott's (1988) concept of jurisdiction, as a theoretical lever for gaining purchase on how the role is manifest in one UK NHS hospital site. Whilst Abbott uses the term jurisdiction to describe the links between a *profession* and their work, the term has considerable utility for understanding *non-professional* work: as professionals acquire new tasks, non professionals must necessarily – if only in the short-term – fill the gaps in tasks that remain. Specifically, the thesis has shown how the content, control and differentiation of work gives rise to the division of nursing work between HCAs and registered nurses in acute care. Additionally, the sociological concept of jurisdiction has not been applied to the development of an emic understanding of HCAs' work before.

HCAs have their own conceptions of their role in nursing care. This includes their own understanding of their work, their rights and privileges and of their careers. In some circumstances, they may originate from a different class or element of society to those who pursue professional nursing qualifications. Hughes (1984) argues that such workers are unlikely to fully accept the role-definitions handed to them by others but establish their own definition of their work through communication with peers and in interaction with the people they care for. They build up an ethos, and a system of rationalisations for the behaviour they consider proper for their role given the hazards

and contingencies of their own positions. In the study of HCAs' work, this thesis seeks to unpack what HCAs think their role *is* and *should be*, what they *actually do* in acute hospital settings and the *tensions* between their own work and that of registered nurses.

NURSING JURISDICTION REVISITED

In moving towards an understanding of HCAs' jurisdiction it is necessary to reconsider the concept of jurisdiction itself. There are cultural and socio-structural aspects to jurisdiction (Abbott, 1988).

The cultural aspect refers to the transformation of occupational tasks into professional problems. In the social construction of professional work, professions attempt to control acceptable knowledge and skill by developing unique and abstract systems of knowledge. The development of this knowledge base constructs boundaries between the work of a profession, its professionals and those outside the profession - the non-professionals.

During the 1980s and 1990s, registered nurse education moved into universities and there was a shift in focus from practical skills to a more theoretical basis for nursing practice (UKCC, 1987). This was embodied by 'new nursing' (Salvage, 1992).

These changes within nursing knowledge and education reflect efforts to develop a unique knowledge base for professional practice and engagement in an intellectual project – trends proposed by Abbott (1988) as part of the professional jurisdiction process. However, certain aspects of nursing work, and in particular fundamental care, remained the (contested) concern of *both* registered and non-registered nurses.

The study of HCAs' work reveals that such work is considered a craft that can be learned through experience and vocational training. As has been argued previously, a pivotal theme of nursing's professionalisation project is the development and control of knowledge for practice. Unfortunately, for nursing, the knowledge required for effective practice is a combination of abstract knowledge and experiential knowing acquired from undertaking the role and gaining feedback on performance. Whilst it may be possible to exclude HCAs from the former (abstract) body of knowledge, it is very difficult to prevent them accessing the world of practice. It is possible, however, to shape the means by which they access practice knowledge derived from undertaking their role.

The socio-structural aspect of jurisdiction refers to successful claims over work in public, legal and workplace arenas. As described in Chapter 4, claims for public and legal jurisdiction involve formal processes aimed at establishing the role of the profession within society. These forms of jurisdiction can take decades to develop but, once established, they remain fairly stable over time. Public and legal jurisdictional claims can be contrasted with the more informal context of the workplace. In the workplace, jurisdiction is a simple claim to control certain kinds of work. Workplace jurisdiction is defined partly in job descriptions but predominantly defined by workers via negotiation, custom, and responses to organisational perturbation (Abbott, 1988). As such, these claims are less stable and are vulnerable to change. These changes in professional roles in the workplace can be seen in the changing roles and responsibilities of workers within health care; changes aimed at meeting increased demands for care.

Increasingly the boundaries between professional groups have become blurred. The development of registered nurses' roles has involved acquiring new skills and tasks and, in particular, the taking on of work previously undertaken by junior doctors. Whilst, in part, this was a response to recommendations from professional bodies for expansion of nursing roles (UKCC, 1992b), it was also related to other initiatives aimed at reducing the hours of junior doctors (NHSME, 1991; Department of Health, 2003a). However, in taking on extra roles and responsibilities and expanding their jurisdictional claims, RNs have also had to concede some of their duties to HCAs.

It is interesting to note the similarities between the changing jurisdictional boundaries between medicine and registered nurses, and those of registered nurses and HCAs. Whilst medicine has transferred much of its mundane work to RNs, so RNs have passed on their mundane work to HCAs. Additionally, both medicine and RNs have limits to the tasks that they want to pass on. Allen (1997a) reports that medicine wants to retain diagnostic testing and clerking and RNs in this study seek to maintain assessment and particular skilled work such as wound management. These areas of work are integral to the focal tasks of the professions.

An increasing body of evidence suggests that there are service benefits when registered nurses substitute for doctors (Feldman *et al.*, 1987; Brown and Grimes, 1995; Richardson *et al.*, 1998; Buchan, 1999a; Richards *et al.*, 2000; Shum *et al.*, 2000; Kinnersley *et al.*, 2000; Venning *et al.*, 2000). In particular, the focus of much of the work examining changing roles in nursing focuses on the developing roles of registered nurses (Spilsbury & Meyer, 2001; Daley and Carnwell, 2003); particularly in relation to progressive developments such as specialist and advanced practice.

However, there is not the same emphasis on evaluating HCA substitution for registered nurses. As the occupational boundaries of HCAs change, it will become increasingly important to address this neglected area of research, to ensure the quality of care to patients is not being adversely affected by such substitution and to facilitate the effective deployment of the scarce nursing resource.

As well as professionally-initiated jurisdictional claims, wider social forces impact on and shape the system of work: technological, organisational and knowledge-based developments that simultaneously increase opportunities for professionals to undertake new work whilst at the same time destroying others (Abbot, 1988). Professions seek to legitimise their work with reference to the value system of societies (Ibid). For example, the increasing visibility of efficiency as a societal good has led to a focus on measurable results in healthcare. This has been reflected in the growing trends towards audit, benchmarking and outcome measurement in nursing. Similarly, the rise in consumerism and a discourse emphasising public involvement in the planning and delivery of health care have introduced the public into what were previously closed professional or bureaucratic domains. The patient and carer perspective is one of the National Service Framework themes for assessing NHS performance in *The New NHS* (Department of Health, 1998b). This concept is also found in nursing ideology, emphasising the importance of involving family and friends in the care of significant others (Brooking, 1989; Meyer, 1993; Allen, 2000).

Despite the beguiling simplicity of Abbot's (1988) stance, his argument manages to capture the complexity in linkages between inter and intra professional forces and changes in jurisdictional claims:

'By treating jurisdiction not only in the work environment but also in the much more formal public and legal environments I have tried to handle what I regard as the classic problem of interactionism – its inability to explain the evident stability of many interactions over time. My solution, and again it is a familiar one, is to demonstrate several layers of interaction, each operating at a different speed, such that slower ones afford stability to the elements that are negotiated in the faster ones.' (Abbott, 1988: 113)

By understanding the structure and process underpinning jurisdictional claims within contemporary nursing, explication of the work and position of HCAs in the overall system of nursing becomes possible. Jurisdictional claims are made in part via processes of negotiation between workers. The product of these processes can be found in the patterns of use, misuse and non-use of HCAs observed and described in Chapter 7.

NEGOTIATION OF 'NURSING'

Cummings (1977) highlights the centrality of negotiation in understanding the roles of workers:

'[Organizations are] arenas within which actors play out their own agendas or as performances without script or program. That is, organizations are seen as being enacted in process.' (Cummings, 1977: 61)

Extending the sociological gaze to the concept of role, functionalists imply that roles are provided by the social system and that individuals enact their work-role as if reading from a script (Parsons, 1951). Conversely, interactionist perspectives stress

that roles are often unclear, ambiguous and vague (Hughes *et al.*, 1958; Becker *et al.*, 1961; Freidson, 1970a; Hughes, 1984; Abbott, 1988). As such, roles are negotiated through interaction processes between individuals and the meanings attached to roles then lead to actions. Whether scripted or improvised, the underlying frameworks are dynamic. That is, systems change and scripts must be revised. Similarly, meaning borne of interaction in context, is uniquely bound to that context. Stasis and non-negotiability are not a feature of social life and cooperative action.

The crucial importance of negotiation to social order was recognised by Strauss *et al.* in their study of two psychiatric hospitals in North America (Strauss *et al.*, 1963 and 1964). The term ‘negotiated order’ was used by them to conceptualise social order as a process of social interaction in which participants work out shared agreements and tacit understandings in response to everyday contingencies. However, there are limits to what is negotiable at any given time and the concept of negotiated order was criticised for its lack of attention to factors that limit negotiation in social settings (Day and Day, 1977).

Strauss (1978) responded to this criticism by emphasising the importance of the relationship between negotiation processes and extra-situational constraints. He introduced the concepts of *negotiation context* and *structural context* to facilitate the study of negotiation and what is negotiable within contexts at any particular point in time. In doing so, he argues that understanding negotiation processes and their bearing on social orders offers insight into the maintenance of social order, how they change, and how structural limitations interact with the capacity of humans to reconstruct their worlds.

In examining dynamic and negotiated social systems – and NHS based work in particular – it is necessary to consider the issue of power. Johnson (1980) in his study of work argues that power is central to the study of health care professions. Similarly, power needs to be considered when examining the work of non-professionals. Power both limits and promotes negotiations in organisations. The presence of power structures in organisations puts people in unequal positions before the processes of negotiation begin. Power provides an organisational resource for people to draw on, inflating (sometimes artificially) the value of social capital, and playing a significant role in workplace relations. According to Abbott (1988), professional power can be operationally defined as the ability of a profession to maintain jurisdiction. As such, jurisdictions, and power relationships, need further consideration in order to fully understand the negotiation of HCAs use, misuse and non-use in nursing care work.

THE IMPORTANCE OF POWER IN NEGOTIATION

Power is a heavily contested concept, but almost all discussions of power refer to the transformative capability of individuals to alter a course of events. According to Weber '[power is] *the possibility of imposing one's will upon the behaviour of others*' (Weber, 1954: 323). Power is not a linear (one-way) relationship but can be exercised by all the actors in a particular social context through different mechanisms and at different times. As such, it can be thought of as a web in which all social actors are caught.

There are two broad approaches to power within the literature: power as an element of social action and power as a feature of social relationships.

The Power Of Social Actions

The central debates of power as an element of social action are summarised by Lukes (1974: 25). He proposes three dimensions to action perspectives on power:

1. situations of observable decision-making, focused on key issues over which there is overt conflict concerning the subjective interests of the individuals or groups involved;
2. situations of 'non-decision-making' in which only some potential issues become explicit, where there is covert as well as overt conflict concerning the subjective interests of individuals or groups;
3. situations in which the social agenda is established (that is, potential and explicit issues are created), in which there is actual (overt and covert) and also latent conflict over both objective and subjective interests of individuals or groups.

The difference between these dimensions can be illustrated with an example from the study of HCAs' work. The one-dimensional approach only permits the application of the concept of power to an analysis of one of the 'actors' actions. For example, the one-dimensional view would only apply to a RNs' actions in a situation where a HCA refused to carry out a particular order, such as recording a patient's blood sugar. This is an observable instance of conflict, which can be understood, in one-dimensional terms. The two-dimensional view also allows for consideration of situations in which the HCA covertly conflicts with the registered nurse over recording the patient's blood sugar but where the registered nurse's actions avoid the possibility of an overt refusal. The three-dimensional view moves beyond these views in that it allows for consideration of situations in which the HCA agrees to carrying out the task of

recording the patient's blood sugar, but where this agreement conflicts with their objective interests (for example, they are aware that they are not supposed to perform this task because of organisational policy, they have not been trained and they do not know what the recording means). The power of the registered nurse can be seen in the acceptance of the task by the HCA.

Lukes argues that the third dimension is the most useful conceptual tool because it includes, and extends, the other earlier approaches to power and provides clearer distinctions between coercion, influence and authority as forms of power. There are two important elements in the three-dimensional view of power. First, the system is not simply and passively sustained by a series of individual acts, but is socially structured and culturally located. The hierarchical structures in nursing and the divisions in education and training of the registered and non-registered nurses, reinforce the position of the RN above that of HCAs. Secondly, questions are raised about the resistance or compliance of the powerless, or less powerful:

'A may exercise power over B by getting him to do what he does not want to do, but he also exercises power over him by influencing, shaping or determining his very wants. Indeed, is it not the supreme exercise of power to get another or others to have the desires you want them to have?' (Lukes, 1974: 23)

Not only is power socially and culturally located, at times it also has the appearance of consensus. HCAs may be in agreement with the RNs requests for tasks to be carried out, such that the RNs' exercise of power over the HCAs is part of everyday life in the wards. The RNs ability to shape the work of HCAs in terms of use, misuse

and non-use demonstrate the power of the RNs in shaping the role of the HCA in practice. Taking the idea of consensus one step further, it could be argued that HCAs now desire training and education to better fulfil the roles that have been shaped for them by the registered nurses.

Hugman (1991) proposes that there are two implications of the three-dimensional view that are important for an understanding of caring professions. First, individuals or groups may be unaware of exercising power and may even reject the idea that they do. He argues:

'The lack of apparent conflict in the perceptions of either the powerful [RNs] or the powerless [or HCAs as less powerful] may be a distortion of the power which provides the basis for their interaction. Therefore, any apparent consensus within a profession, between professions or between professionals and users of their service [or assistant workers] must be taken as the object of enquiry as much as any observed conflict.' (Hugman, 1991: 33)

Secondly, he suggests that the three-dimensional view raises the question of the links between the activity and inactivity of social groups and institutional structures within which they act. Therefore, what RNs and HCAs do and do not do, what each group sees as their concern and not their concern must be examined in relation to the structural position of the workers both within the organisation and in wider society.

The Lukesian three-dimensional approach to power through social actions has explanatory utility when examining the power relationships between HCAs and RNs.

This is because of its focus on covert, overt and latent conflict, and also the objective and subjective interests of the two groups.

Power In Social Relationships

An alternative approach to power - power as a feature of social relationships - is proposed by Habermas (1977). In this approach, power is exercised through the manipulation and/ or distortion of communication, in which different groups have a different say in the construction of what passes for consensus. Communication, from this stance, is directed towards using the tool of *discourse* for the achievement of goals belonging to those whose interests are being expressed. Power, in this view, is pervasive and is exercised in the structuring of the social framework within which interests, ideas and issues are formed and known. This concept of power is useful for understanding the relationship between RNs and HCAs and the shaping of nursing knowledge, language and skills for nursing work.

Discourse relates to the interplay between language and social relationships and is central to the power of the professional. It represents, and simultaneously shapes, the interface between knowledge, skills and ways of talking (Hugman, 1991). Sometimes discourses are so influential that the interests and ideas of the professional group become the dominant way of thinking and talking about issues (Philp, 1979). As such, the power of professionals over others, including other occupational groups and service users, is expressed through discourse (Fairclough, 1989).

Abbott (1988) refers to the development of abstract knowledge systems by professionals as the means by which tasks are recast as professional problems. The

control of these tasks in the professional domain is determined in part by the profession's control of the knowledge brought to bear when defining problems. The 'nursing process' - first introduced by Lydia Hall in 1955 (De la Cuesta, 1983) - was pivotal to the subsequent development of nursing's unique knowledge base. The nursing process, alongside a 'new nursing' ideology (Salvage, 1992), had important implications for the organisation of nursing work by integrating tasks into a process of total care for patients (patient-centred care) and reaffirming the caring skills of registered nurses alongside technical aspects of their role. Critics of these 'new' approaches to nursing suggested that the development of nursing's knowledge base was predominantly about occupational legitimacy and a strategy for gaining professional status (Dingwall *et al.*, 1988; Traynor, 1999). In practice, it was observed that the application of these knowledge systems by registered nurses had the effect of excluding HCAs from certain areas of nursing work. Registered nurses essentially controlled the language used to describe nursing work. This was evident in the study through the language used for care planning and for particular aspects of nursing care, such as wound or pressure area care. By limiting HCAs understanding of this language, their participation in nursing work was restricted.

Within the case site, care plans were based on a system originally developed in North America known as nursing diagnosis (North America Nursing Diagnosis Association, 1999). Nursing diagnosis was used to facilitate the care planning process in the Trust so that registered nurses were able to articulate their judgements about patients' needs for care using a common or shared language. However, this common language did not extend to include usage by the HCAs. HCAs described the language of the care plans as inaccessible. Examples of nursing language which HCAs found difficult

included high or low body temperature written as '*ineffective thermoregulation*', poor circulation written as '*altered peripheral tissue perfusion*' or decreased sensation and movement of a limb as '*peripheral neurovascular dysfunction*.' Whilst the computerised care plans were available to HCAs in a folder at the end of patient's beds the HCAs did not consult them. This was attributed to the lack of meaning of the instructions, the complex way in which the care plan was presented and the length of the care plans. Thus, the notion of 'common language' was the preserve of registered nurses, enabling them to exert control over nursing work.

The lack of common language was also evident by the control of language for certain aspects of nursing care. Nowhere, was this more evident than in relation to pressure area and wound care management. Despite HCAs being involved in the day-to-day bedside care of patients and being in a prime position to assess changes in the condition of patient's skin, the RNs did not permit HCAs to engage in the language associated with this area of care. Phrases such as "*grade 2 pressure sore*", "*cloudy exudates*" or "*granulation*" were not shared between the two levels of nurse. HCAs demonstrated that they made assessments of patients' skin condition and yet their ability to pass on information to registered nurses was restricted through their limited vocabulary in the area. RNs did not want HCAs to be using the same language as RNs in relation to this aspect of care enabling them to maintain control.

In essence, the lack of a common language within the nursing workforce created 'scripts' for nursing work that only a proportion of the workforce were able to fully rehearse and utilise. As such, registered nurses were able to fully engage in and participate in the performance of practice, but HCAs were only partially able to act

out nursing work. Discourse was therefore a powerful device by which RNs could influence their social relationships with HCAs and achieve a position of power and dominance over nursing work. Language in nursing becomes a central aspect of discourse through which power is reproduced and communicated between RNs and HCAs. The control of language was closely linked with the control of knowledge for nursing work.

HCAs' jurisdiction was based on processes of negotiation. By examining the processes of negotiations between HCAs and RNs and the subsequent use, misuse and non-use of HCAs in the performance of nursing work, the issue of power was identified as playing paramount role in both limiting and promoting the negotiation of HCAs' work. The subsequent shaping of HCAs' work exposed a number of effects, sometimes unintended, associated with the *processes* of negotiation and the influence of power to determine HCAs' work.

OFFICIAL POLICY AND POLICY IN PRACTICE

The findings revealed how the official policies associated with HCAs' work – originating at national, professional and organisational levels – did not always reflect the actual work of HCAs in practice. The concept of *discretion* has some explanatory utility for this observation. Discretion acted as an important device through which RNs determined the work of HCAs and maintained control over nursing work. Davis (1974) defines discretion thus:

'a public official has discretion whenever the effective limits of his power leave him free to make a choice among possible courses of action or inaction.'

(Davis, 1974: 4)

Lipsky (1980), in his study of 'street-level workers' (for example, teachers, police officers, health visitors), uses the concept of discretion to offer an explanation as to why discrepancies occur between policies originating in the formal arenas and policies implemented at the informal level of practice.

Discretion And The Split Between Formal And Informal Policies

Lipsky (1980) argues that tensions arise between policies at the point of inception at a formal level and the point of implementation and operationalisation at the informal level because of the *discretion* of the street-level worker. He proposes that these workers experience a number of conditions in their work over which they exercise a considerable degree of discretion through their regular interactions with the public.

The distinguishing feature between registered nurses – as street-level workers – and HCAs – as lower participants in organisations (Mechanic, 1961) – was that RNs exercised discretion in determining the nature, amount and quality of nursing care. Discretion is largely brought to bear in the rationing of resources in a situation where there are scarce resources and large caseloads; increasing demands for services; ambiguous, vague and conflicting role expectations; and difficulties in measuring work performance. These conditions of street-level work can be used to explain the tensions in the formal and informal negotiation of nursing work.

Registered nurse participants reported that they had fewer resources, in terms of numbers and time available, for them to meet the demands of their workload. As a result, the RNs felt that they were unable to fulfil their mandated responsibilities. The

increase in their roles and responsibilities had necessitated their increased use of, and reliance on, HCAs in nursing care provision. Some of these duties fell within HCA's job descriptions, but others conflicted with organisational policies, for example use of HCAs to measure a patient's blood sugar at meal times. RNs suggested that where HCAs were used in ways that did not match policy recommendations this was to cope with the demands for care. RNs exercised discretion over nursing work contrary to formal policy.

A distinct characteristic of work undertaken by street-level bureaucrats is that the demand for services tends to increase to meet the supply (Lipsky, 1980). If more resources are made available, pressures for additional services utilising those resources will be forthcoming. This situation is evident in nursing work. There are increasing demands for RNs to take on more roles and responsibilities. However, they are still expected to fulfil their existing roles. In response to this situation the roles of HCAs appear to be changing to meet demands for bedside care that RNs have less time to provide. However, it can also be seen that as the roles and responsibilities of HCAs change they are then being expected to take on more and are involved in clinical duties such as systemic observations, and there were discussions about expanding the role of the HCAs further so that they could perform phlebotomy. Demand for nursing care is likely to continue to increase due to an ageing population. As professional roles change across health care, the roles of HCAs are likely to continue to change. This will inevitably involve HCAs taking on increasing amounts of work that were formerly performed by RNs.

Another reason for tensions between formal and informal policy is that nursing work characteristically has conflicting and ambiguous goals that are difficult to measure, in terms of performance. Lipsky (1980) argues that the less clear the goals and the less accurate the performance feedback, the greater the onus on individual workers to work alone and the more difficult it will be for managers to exercise control over policy. Conflicts arise in nursing work because of discrepancies between meeting goals with clients whilst simultaneously meeting the goals of the organisation. Registered nurses have to meet the individual needs of patients whilst also meeting the needs of the organisation to process work quickly, using the resources at its disposal. Registered nurses have to find ways to resolve their professional orientation toward client-centred practice and organisational demands for expedient and efficient practice on the other. The increasing use of HCAs to provide care is one response to meet these opposing demands. In the exercising of discretion and power, RNs shaped HCAs' work so as to ease work pressures for RNs by getting HCAs to take on work that RNs considered required lower levels of skills, such as personal hygiene and feeding. This type of work has been referred to as 'dirty work' (Hughes, 1958).

THE DELEGATION OF 'DIRTY' WORK TO HCAS

Each of the caring professions has generated associated areas of work, which - over time - have been defined as appropriate for groups of workers with 'lower' levels of qualifications and, by inference, skills (Hugman, 1991). In a study of social work, Howe (1986) argues that professions make increasing claims to higher status activities based on theoretical knowledge whilst 'ditching the dirty work' on ancillary subgroups. This echoes Hughes' (1958) classic sociological study of work, which suggested that an occupation attempting to gain enhanced status should chose its work

carefully. This is because certain areas of work are awarded more prestige than other areas by those within and outside the 'aspiring' profession. In choosing work, choices need to be made about how the available tasks are divided up.

Hughes (1984) proposed two inexorably linked types of division of labour; the *technical division of labour* refers to the allocation of tasks ('what I do') and the *moral division of labour* to the role component ('who I am'). In studying tasks one also has to remain mindful of the people who perform those tasks. For Hughes, it was the moral component of work that was essential for the performance of nursing work because such work involves carrying out 'dirty' work. The symbolic value attached to this dirty work is central to Hughes' interpretation of the process by which nursing has attempted to gain professional status.

Nursing work has been historically associated with fundamental care aspects and, 'being' a nurse, has involved the performance of such care (Dingwall *et al.*, 1988). What appeared to be happening in practice was that the balance of work for RNs was changing towards the medical-technical aspects of care, rather than the morally justifiable (along traditional lines) dimension. HCAs in the study referred to the movement of RNs away from dirty work and in doing so argued that 'good' HCAs could perform this work. As well as physically moving in to fill the gaps caused by RNs' shifts away from dirty work, there was a sense in which HCAs sought to reclaim dirty work as a moral enterprise.

Work may be classified as dirty in two ways: either by what is being done, or with whom it is being done. The dirt in dirty work may be literal - for example physical

contact with human faeces - or it may be metaphorical, involving contact with low-status groups. The direct care being carried out by HCAs in the study focused predominantly on the dirty work activities described above. Much of their day-to-day activity involved tasks such as assisting patients to the toilet, dealing with incontinent patients or helping patients to wash. Additionally, they were often left to care for the physically dependent patients or patients who were confused and therefore dependent. This can be contrasted with other aspects of direct care undertaken by the RNs. The emphasis on more 'glamorous' work by professionals, rather than dirty work, has been referred to as *virtuoso roles* (Nokes, 1967; Davies, 1985).

Virtuoso roles can be considered as centrally concerned with technical tasks - for example medicine administration or monitoring the patient condition using electronic equipment - and can be distinguished from those caring roles focusing on 'tending', for example, personal hygiene and comfort. The distinction is sometimes rather crudely characterised as curing versus caring (Davies, 1985), but this rather blunt dichotomy ignores the blurring of boundaries in areas such as palliative care, or the 'cure as well as care' homogenous combination of skills and knowledge found in clinical specialists and advanced practitioners. It is sometimes argued that these 'tending' roles do not have the same status as those concerned with curing, and as a result are the roles generally discarded to ancillary groups (Hawker and Stewart, 1978; Johnson, 1978; Reverby, 1987). The study findings revealed that the HCAs had predominantly taken over this tending role in nursing, as opposed to providing assistance to the registered nurses with this aspect of care. Moreover, they were making jurisdictional claims to this aspect of work. However, the care remained

under the control of RNs; they were reluctant to hand over this aspect of care to the HCAs and any claims granted were hard-won and non-binding.

JURISDICTIONAL SETTLEMENTS: RNS' CONTROL OF 'DIRTY' WORK

Abbott (1988) has argued that professional groups do not always achieve full jurisdictional control and as such they may use forms of settlement: allowing areas of work to be shared with others, but leaving work within the professional's control. This process of settlement allowed HCAs to undertake fundamental direct care, but control of this work remained with the RNs. Jurisdictional settlements involve one or more of the following strategies (Abbott, 1988): sharing an area of practice with explicit division of labour; advisory control over certain aspects of work by a profession; and/ or subordination of a group under the profession. The RNs used all of these strategies to control the work of HCAs.

Sharing An Area Of Practice

Registered nurses defended their continued involvement in bedside care alongside HCAs because they argued that they performed additional activities whilst carrying out such care. They argued that nursing work was not simply about the performance of tasks, but also about the ways in which tasks, and associated activities, were carried out. RNs were observed carrying out fundamental care in association with other (more complex) activities. For example RNs would help a patient to wash because they then planned to change the patient's wound dressing. This involvement in fundamental care by RNs was also noted by Allen (2001), who used the term 'strategic multi-tasking' to explain the use of mundane work by RNs for the purpose of performing other (more complex) activities.

The registered nurses' pivotal position in patient assessment was also used as a powerful defence by the RNs to maintain their jurisdictional claims over bedside care. HCAs were not viewed by RNs as having a role in assessment whilst providing such care. Jamous and Peloille (1970) suggest that one of the ways in which professions attempt to defend their jurisdictional boundaries, where tasks are being taken over by other competing groups - as in HCAs taking over aspects of bedside care from RNs - is to reduce the role of the competitor to that of a 'technician'. By excluding HCAs from having a role in assessment HCAs were rhetorically produced as making a mechanistic contribution to bedside care when compared with the perceived complexity of the registered nurses' interactions and assessments when providing such care. This division of fundamental direct care work into 'dirty' for HCAs and 'dirty plus glamorous' for RNs ensured that RNs maintained jurisdictional control of this area of work.

However, in practice, HCAs with clinical experience demonstrated that they were assessing and gathering additional information from patients whilst carrying out tasks. Examples included changes in bowel condition, levels of pain, skin condition, decreased mobility, or increased levels of confusion. Whilst HCAs might not have fully understood the cause of certain changes in the patient's condition, their clinical experience alerted them to such changes. Additionally, more experienced HCAs demonstrated that they were filling gaps left in care by less experienced RNs and student nurses; an example being the HCA who monitored the patient's fluid balance. However, this role remained largely unrecognised and a 'hidden' aspect of HCAs'

work. As such, the contribution of HCAs to the assessment of patients remained unacknowledged within nursing work.

Advisory Control

Despite HCAs suggesting at interview that their work was not directed by RNs, observation revealed that RNs did advise on this aspect of care, both implicitly and explicitly. This provided another mechanism by which they could maintain their claims on fundamental direct care work. This advisory control was sometimes explicit at the bedside, for example where RNs would instruct HCAs about tasks that needed to be carried out during handover report. At other times it was an implicit part of the daily structure and organisation of ward work: HCAs would focus on fundamental care activities whilst RNs might be involved in ward rounds or administering medications. Other implicit areas of RNs' control of fundamental care included the RNs' expectations that HCAs would answer call bells and respond to patient requests, but for HCAs to know when to refer the request to the RN. For example, if a patient complained of discomfort HCAs could assist patients into a more comfortable position but would need to refer to the RN for pain relief drugs. The control of HCAs' work in these ways has been explained through the Lukesian (1974) approach to power through social actions.

Additionally, fundamental care was controlled by RNs through care documentation and reporting mechanisms. Power through discourse (Habermas, 1971) has been presented as useful for explaining the control of HCAs' work by RNs through the control of knowledge, language and skills. However, as already described, and explored later in this chapter, RNs do not have absolute power. HCAs were not

involved in care planning activity nor did they have a significant role in information transfer during ward handover reports. Therefore, when a HCA completed fundamental care work and associated activities, they then reported it to the RN. It was the RN who would write the information in the care plan and pass it on to other RNs during ward report. This acted as an effective device for RNs to maintain control over fundamental care work.

The Subordination of HCAs

The delegation of 'dirty' work and the need for HCAs to refer to, and inform, RNs about fundamental care, served to ensure that HCAs were maintained in a subordinate position to the RNs. Comments were made by participants about the position of the HCA within the hierarchical structure of nursing. RNs placed the HCA at the bottom of the nursing hierarchy, below the position of student nurses. HCAs did not feel part of the nursing team and commented that their contribution to nursing work was neither acknowledged nor valued. One HCA suggested that if the organisation was viewed as a body, then the HCAs were '*the feet of the organisation*'. She went on to explain the analogy of HCAs and feet; HCAs were essential to the structure of the organisation, they were 'used' daily to carry out nursing work and yet were not given any acknowledgement for their contribution to the functioning of the organisation.

The exclusion of HCAs from being recognised for their contribution to nursing work can also be interpreted through Parkin's (1979) concept of social closure as exclusion. Parkin argued that exclusion of a group of workers is associated with the exercise of power by another group in a downward direction. RNs, overtly and covertly, exercised power over the HCAs, and as such subordinated them and contributed to a

social definition of HCAs as inferior to ‘proper’ (or registered) nurses. Jurisdictional settlements (Abbott, 1988) may also be interpreted in nursing as an expression of the power relationship between RNs and HCAs that enables RNs to maintain control over nursing work. However, actions are not the only means by which power is exerted; indeed, actions result – in part – from the influence of the knowledge and language used in social relationships.

PROFESSIONAL AND VOCATIONAL KNOWLEDGE IN NURSING CARE

In the study of nursing work, registered nurse participants emphasised the importance of registered training for nursing work. Participants commented that to be considered a ‘nurse’ one had to undertake formal registered nurse training. As such, the title ‘*nurse*’ was exclusive to those who had completed such training. The title ‘*health care*’ assistant was attributed to those who had not undertaken registered nurse training, even though a significant proportion of HCAs’ work was about bedside *nursing* activities. Additionally, national vocational qualifications (NVQs) - formal work-based qualifications undertaken by HCAs - were not awarded prestige. This lack of prestige was despite the explicit focus of NVQs on practical skills for nursing practice.

Significant numbers (two-thirds) of HCAs in the case site had NVQs. However, there was no way of differentiating in practice those HCAs who had NVQs and those who did not. HCAs were employed on the same grade and performed similar tasks regardless of NVQ preparation. HCAs who had undertaken NVQs described that RNs did ‘*not allow*’ them to use practical skills and knowledge that they had acquired during their vocational training. Additionally, the grading system did not reflect the

clinical experience of HCAs; HCAs with 30 years experience in nursing work were the same grade as newly appointed HCAs.

The lack of prestige and respect awarded to vocational knowledge and 'craft' skills is not just a feature of nursing work (Wragg, 2002). This is a wider problem within contemporary society. In studying HCAs - some with substantial experience of nursing work and relevant vocational qualifications - it was clear that, on occasion, HCAs' demonstrated *practical* skills and knowledge for nursing work often exceeding that of the newly registered (and inexperienced) nurses. However, this was not recognised by the RNs, or rewarded by the organisation through grading of HCAs based on skills, or provision of career development opportunities. The value of knowledge can only be established when the means of describing it are in place. Codified, formal, expressions of knowledge (common language) are a key characteristic of professions. Controlling that language is a key component of professional activity at every level and serves to exclude non-professionals from certain activities.

It would be naive to presume that HCAs were passive participants in the act of nursing work. Whilst RNs exerted their power, discretion and influence in determining the work that HCAs were 'allowed' to perform, the HCAs also brought their own influence to bear in shaping their work and that of RNs.

POWER OF HCAs AS 'LOWER PARTICIPANTS' IN ORGANISATIONS

To imagine that negotiation of HCAs' work was influenced solely by the power exerted by RNs would ignore the subtle but effective ways in which the HCAs managed their own work, and that of the RNs, through subversive strategies.

Mechanic (1961) argues that workers occupying the lower ranks of an organisation can assume and wield power and influence that may not be obviously associated with their formally defined positions within the organisation. In sociological terms, Mechanic (1961) argues that such workers have considerable 'personal power' but no authority. The personal power achieved by HCAs resulted mainly from their location within the organisation.

The predominant focus of HCAs' work was direct care. As such, this work placed them at the bedside, in daily contact with patients. In this role the HCAs were able to gather considerable information about patients. They made assessments of patients, for example whether there had been a change in the patient's skin condition, whether the patient appeared more confused, or whether the patient had a problem with incontinence. This was the very information that registered nurses needed to collect in the formal assessment and evaluation of patient care. Therefore, HCAs were a potential valuable source of information about patient care for the registered nurses. However, the HCAs were in a position of power to decide what, when and whether to pass on this information to RNs. By being at the bedside and gathering information about patients, the HCAs asserted a degree of power over RNs and the care of patients.

The processes and interactions for the transfer of information between HCAs and RNs were important for the quality of patient care. By studying the interactions between HCAs and RNs in practice, it was noted that HCAs' resentment of RNs, and frustration with the HCA role, sometimes affected the ways in which information was passed from HCAs to RNs. Some of the HCAs waited for RNs to ask them for patient care information. They suggested that '*clever*' RNs recognised their contribution to care and that they were a potential source of patient information. The possession of this information placed HCAs in a powerful position because they had an indirect influence over nursing decisions and through their reports could influence the modification of diagnoses. Allen (2001) has also noted the importance of relationships between HCAs and RNs for influencing the flow of information between the two levels of nurse.

In other circumstances, the interactions between HCAs and RNs were reminiscent of the 'doctor-nurse game' (Stein, 1967). Within the hierarchical structures of most health care organisations the negotiations going on between professionals and workers may be very subtle. Stein's (1967) account of the 'doctor-nurse game' provides an illustration of the subtle influence of nurses on doctors' work as a means of maintaining an illusion of the doctor as all-knowing. Later studies have indicated that the doctor-nurse game no longer exists as the predominant form of interaction between doctors and nurses (Hughes, 1988; Stein *et al.*, 1990; Svensson, 1996; Allen, 1997). These studies suggest that doctor-nurse interactions are more diverse and situation-specific than the hierarchical models emphasising professional dominance and subordination allow (Snelgrove and Hughes, 2000). However, the subtle interplay between registered nurses and HCAs and the influence of HCAs on nursing

work was reminiscent of this game. Examples included situations where HCAs did not challenge inexperienced RNs in front of patients or their registered nurse colleagues, or where they performed an activity and then later informed the RN of their work. In these ways the RNs' positions was not threatened. The HCA acted in a way that appeared subservient to the RNs. However, this game was one of the ways in which the power of a 'lower participant' in the hierarchical structures of nursing was observed to manifest itself in practice.

Another way in which HCAs were able to exert their personal power was through their organisational knowledge. HCAs demonstrated their long service history with the Trust and during this time they had established a number of contacts within the hospital - predominantly with other 'lower participants' such as porters, cleaners and other assistant workers (such as therapy assistants) - and had gained knowledge about the way the organisation operated. The HCAs exercised control over whether or not to share this knowledge with the RNs. Some examples of when this occurred included when HCAs provided or withheld information about quicker ways of obtaining equipment, because the HCA knew the 'right' person to ask. These personal relationships established between HCAs and others meant that HCAs were sometimes in a better position than RNs to be able to negotiate the completion of work.

As the nature of health care work changes and renegotiations of nursing work take place there appeared to be some difficulties for the RNs. Whilst they appeared to take on more clinical duties and responsibilities, act as co-ordinators of care within clinical areas and accept tasks delegated to them by doctors, they did not always appear to

have the necessary support from HCAs to delegate nursing work. In the delegation of nursing work, RNs were at times fearful of some sort of reprisal from HCAs. This was particularly the case for junior D grade RNs who were working with experienced HCAs. In these situations the position of the RNs was sometimes not respected by HCAs. RNs described situations that made their working life uncomfortable because HCAs did not want to work with them. Whilst HCAs' work was changing and they occupied some of the gaps in nursing work, the willingness of these workers to accept delegated duties was thrown into question as they attempted to exert some control over their own work.

Creating A 'Resentful' Workforce

Despite HCAs being able to exert some power over their work, many were resentful, frustrated and angry about their work and position in the nursing hierarchy. HCAs complained that they were not always working as assistants to RNs but undertaking nursing work in their own right. This work concentrated on the 'dirty work' of nursing. This situation has been noted in earlier studies of social work where assistant grades have taken over tasks that social workers no longer performed because they were regarded as 'too highly qualified' (Parsloe and Stevenson, 1978; Hey, 1980).

The HCAs commented on the apparent shift in registered nurses' work and the subsequent increasing reliance on HCAs to provide bedside care. Whilst RNs attributed these shifts to a shortage of RNs, at times it was evident that this was not always the case. The case site did not have the same recruitment and retention problems that might be being experienced in other areas of London or the UK. The wards were often adequately staffed. Yet HCAs provided the majority of personal

care. Additionally, RNs admitted that there were times when they would send HCAs to deal with patient requests because they had other things to do that would 'better use' their skills. Therefore, using staffing levels and time as a defence for changes in RN activity is only part of the explanation for what is going on in practice. Realising that this is the situation in practice for HCAs, helps in understanding the levels and sources of resentment about their changing work patterns and careers.

HCAs were unhappy about their working terms and conditions. They felt that their skills went not rewarded. They felt that there was a lack of career development for HCAs. The majority of HCAs were employed at B grade level regardless of years experience or qualifications gained. As such there were gaping differences between HCAs within this grade and this created frustration and resentment. However, such resentment went beyond the assistant grade with HCAs expressing that they resented newly registered nurses being on a higher grade and being paid more than them. This was because more experienced HCAs felt that they often supported and trained these RNs and provided care of an equal, if not sometimes better, quality than new RNs.

Studies of skill mix, or more accurately grade mix to denote skill, have not studied the implications of vocational qualifications and 'actual' skills and competencies within grades. Whilst Carr-Hill *et al.* (1992) reported that quality of care was associated with higher grades of nurses this study was carried out before the introduction of vocational qualifications. In a small-scale replication of Carr-Hill *et al.* study, Warr (1998a; 1998b) proposed that vocationally prepared support staff could provide care which was as good, or of higher, quality than that provided by D grade RNs. This suggested that the care-giving role of D grade RNs could be undertaken by more

experienced support workers with no loss of quality. However, more recent evidence examining outcomes data for 232,342 surgical patients (risk-adjusted mortality and incidence of failure to rescue) suggests that degree-level educational attainment for nurses is associated with improved patient outcomes (Aiken *et al.*, 2003b). Perhaps what is happening in nursing practice is that there are clear distinctions to be made between the practical skills of junior staff – to include HCAs and newly registered nurses – and more senior staff, and the clinical judgements of degree registered nurses and others. Aiken *et al.* (2003b) report that clinical experience did not independently predict mortality or failure to rescue, nor did it alter the association between educational background or of staffing and either patient outcome. As such, degree-level educational preparation is placed as more important than experience for determining patient outcomes. What is lacking from this evolving picture of education and outcomes is an examination of the relationships between other forms of education for registered nurses and vocational qualifications for HCAs to draw clearer distinctions between the contributions of these two levels of nurse.

Government plans for the modernisation of NHS pay scales may compensate for some of the reported and observed discrepancies between skills of newly registered nurses and experienced HCAs (Department of Health, 1999b). These modernisation plans may support some of the concerns and frustrations of HCAs in this study and the gaps that they currently cover in nursing work.

MIND THE ‘NURSING’ GAP

The importance of studying jurisdictional claims to nursing work lies ultimately in exploring the implications of any changes for patient care. This study has

demonstrated the ways in which HCAs were attempting to occupy gaps in nursing work created by changes in the work of registered nurses. These 'jurisdictional vacancies' in nursing work comprise gaps in bedside care, practical skills and continuity of care. However, despite HCAs contributing to these important gaps in nursing work, their work was largely hidden within nursing structures and measures of process. Their occupation of these gaps was negotiated on a daily basis through interactions between HCAs and RNs. These negotiations were often not explicit and were underpinned by overt and covert applications of power; as such, HCAs were prevented from making any claims on these aspects of work.

Finding that HCAs were the predominant carers at the bedside highlighted the rhetorical contradictions associated with popular professional discourse surrounding RNs' practice. Other aspects of the RNs' role, such as care planning, co-ordination of patient care and technical tasks, received more of the registered nurses time than fundamental bedside care activities. Work being taken on by registered nurses in the case site included administration of intravenous drugs, venepuncture, ECGs, male catheterisation and intravenous cannulation. Additionally, RNs did not always use the opportunities available to get involved in the provision of such care. Registered nurse participants reported, and it was observed, that the provision of 'hands-on' nursing work had largely fallen to HCAs.

Allen's (2001) study of RNs' jurisdiction examined the relationship between registered nurses and HCAs and found similar discrepancies between the value placed on fundamental care by RNs and their subsequent involvement. She found that in practice RNs placed greater emphasis on technical-medical aspects of their work

rather than fundamental care and that HCAs carried out a significant proportion of fundamental care work. HCAs therefore make a significant contribution to bedside care provision.

Findings also revealed the ways in which HCAs covered gaps in care left by newly registered nurses. More experienced HCAs reported, and were observed, to support and guide newly registered nurses with practical skills. Indeed, newly registered nurses were often observed referring to the experienced HCAs for advice with regard to practical skills. HCAs felt they were able to fulfil this role because they had learnt their practical clinical skills through ‘apprenticeship’ in nursing work over a number of years or through work-based qualifications. Whereas some of the newly registered nurses had not had the opportunity to learn many practical skills during their training and so needed a period of time to learn these skills upon registration. The extent of this problem beyond the case study is highlighted by a number of national reports which indicate that, upon qualification, newly registered nurses demonstrate a lack of clinical skills (While *et al.*, 1995; Hickey, 1996; Luker *et al.*, 1996, Macleod Clark *et al.*, 1996; Bradley, 1998; Runciman, 1998).

The support of newly registered nurses formed part of the HCAs daily work, yet it remained largely hidden. Where HCAs offered help this would usually be during a face-to-face encounter with a RN or sometimes HCAs would carry out an aspect of work and inform the RN about it away from the patient’s bedside and other colleagues. In doing so, HCAs covered gaps in patient care but did not upset the expected dynamic between the RNs and HCAs. This has been alluded to above as having similarities to the doctor-nurse game (Stein, 1967).

The hidden work of HCAs was further evidenced when considering the ways in which HCAs worked alongside agency nurses and ensured that the needs of both the patients and the unit were met at times when the ward was short of permanent registered nurses. In filling this gap, the HCAs ensured some continuity of care. HCAs demonstrated in these circumstances that they could be flexibly deployed, taking on aspects of work normally carried out by a registered nurse, such as blood sugar monitoring and wound dressings. Additionally, they demonstrated their abilities to prioritise work and meet increased demands for physical care. However, where there were enough RNs, HCAs were subsequently excluded from these tasks and the management of caseloads for personal care. However, the individual competence and abilities of HCAs had implications for the quality of care delivered by HCAs. Chapter 7 demonstrated the diverse ability of HCAs to provide personal care and to respond to patient requests for information about their care (pp. 226-227). Patient's experienced variable levels of quality in care provision. This pattern was accompanied by an apparent lack of mechanisms for monitoring and supervising the work of HCAs.

MONITORING AND SUPERVISING CHANGES IN NURSING WORK

HCAs were introduced to support the role of the registered nurse and to work under their direction and supervision (UKCC, 1987). More recent policy documents emphasise the role as one of assistance and the statutory responsibility of the RN to determine the level of supervision required by HCAs based on their level of qualifications (Department of Health, 1999a; NMC, 2002b). However, in this study RNs were not fulfilling their mandated responsibilities. There was an apparent lack of

supervision and monitoring of the bedside care delivered by HCAs despite the variation in HCAs' abilities and the demonstration of poor care standards (for example the HCA providing personal care to a patient who had suffered a stroke). There was a general lack of ownership amongst registered nurses for the assessment of HCA competence, the supervision and monitoring of their work, despite their mandated responsibility to ensure that HCAs worked under their supervision.

In part, this lack of supervision and monitoring could be attributed to the lack of mechanisms in place for HCAs to inform RNs about their work and a lack of opportunities for discussion of patient care between the HCAs and RNs. HCAs did not write in care plans, nor were they involved in the contribution of information to the reports of patient care between shifts. As it currently stands the only defence between HCAs and the provision of poor care to patients are RNs.

An Organisation with a Memory (Department of Health, 2000d) reports that within health care systems a huge number of factors are at play at any one time, which influence safety. Whilst human error may precipitate an adverse incident it is suggested that there are usually deeper, systemic factors at work which, when operating effectively, prevent the adverse incident or act as a safety net to mitigate its consequences (Department of Health, 2000d: ix). As long as HCAs remain solely under the supervision of RNs, this minimises the number of defences between the actions of HCAs and patient care. Education and training, registration, regulation and formal mechanisms by which to report and document their contribution to care would (theoretically) introduce further defences. Since patient complaints often relate to issues of personal care - such as privacy, hygiene and meals - and HCAs have a key

role in these aspects of care, this constitutes a significant area for further development. It appears paramount that consideration is given to the ways in which the RN-HCA boundary can be best managed in practice to ensure that adequate amounts and quality of care are delivered to patients. As it currently operates the RN-HCA boundary creates problems for patient care because of the resentment that HCAs have about their relationship with RNs, and the subsequent lack of acknowledgement of their contribution to patient care.

It could be argued, and at times was alluded to by HCAs and RNs, that HCAs were being placed in a similar position as SENs. However, there are important distinctions to be drawn between SENs and HCAs. SENs undertook a compulsory two-year training programme for their role. They were then registered with the same professional body as RNs and, as such, their practice was regulated. It is not (at this point in time) compulsory for HCAs to undertake any training for their role. Where HCAs undertake training for their role, in the form of work-based national vocational qualifications, these do not qualify HCAs to be registered nor regulated.

At this stage, the future involvement of registered nurses in the preparation and regulation of HCAs remains uncertain (Johnson *et al.*, 2002). However, for many years, and drawing on past evidence, RNs have been ambivalent towards the HCA role and their training for nursing work (Cole, 1989; Reeve, 1994; Rhodes, 1994; Girvin, 1999; Warr, 2002). With the issue of HCA regulation a high priority for policy makers the time is ripe for an informed debate about the relationship between HCAs and RNs, the work performed by HCAs to support the work of RNs, and the implications of the deployment of the nursing workforce for patient care.

REFLECTIONS ON METHOD

This thesis has contributed to an understanding of the processes by which the work of HCAs is negotiated in practice. An interactionist lens was used to frame the study with the aim of gaining an in-depth emic understanding of HCAs' work. As such a qualitative methodology was utilised. The choice of methodology had associated strengths and limitations.

Case study design was selected as the most appropriate approach because of its focus on social actions. The strengths of case study lie in its ability to cope with, and provide insights into, complex real world developments (Robson, 1993; Keen and Packwood, 2000). Data collection methods included interviews, observations and documentary evidence. The use of this approach and methods were vindicated by the opportunities afforded for in-depth exploration of the processes of negotiation for determining HCAs' work. The participants were able to raise issues of importance to them and their work was considered within context. In particular, this approach was useful for gaining further understanding of what HCAs *say* they do and want to do, alongside observation of what they *actually do* in practice. The approach also afforded the opportunity to explore tensions between the work of registered nurses and HCAs in practice.

Within qualitative work there are no 'standardised' sample size requirements. Samples depend on what the research is attempting to find out, what will have credibility and what can be done within the practical constraints of time and resources (Patton, 1990). The sample size should therefore be based on theoretical and informational factors, to maximise the information provided (Lincoln and Guba,

1985; Patton, 1990). Sampling to 'saturation' is the ideal situation (Lincoln and Guba, 1985). Saturation refers to the point when no, or very little, new information is gained from further data collection.

This study commenced by interviewing *all* HCAs within the case site to represent the available population for observation (n=33). Purposive sampling was subsequently used to select ten HCAs who represented the characteristics, conditions of employment and qualifications of the larger group. As such, the sample represented a range of ages, genders, ethnicity, clinical areas, clinical experience, educational attainment (as an indicator of level of preparation for role) and expectations and feelings about their role. By focusing on smaller numbers of HCAs it was possible to observe the HCAs over a period of time (over 20 hours of participant observation per HCA) and to analyse the collected data in-depth rather than going for maximum coverage of HCAs and less analytical depth.

Since the participants were recruited from one case site, questions are necessarily raised about how 'typical' the HCAs were and the applicability of the findings to other contexts. Chapters 2 and 6 presented detailed information about the context for the study and the HCA population. In providing this information, the reader is able to judge the relevance of the findings for themselves and their practice situation.

Additionally, the HCA population were compared with data from Thornley's (1998 and 2000) national study of HCAs. Overall, the characteristics of the HCAs in the hospital resembled those described by Thornley (1998). Points of difference included ethnicity; grading and contracts; and NVQs. However, similar issues were raised, both

within the case site and nationally, about increasing expectations of their role, lack of supervision and irrelevance of NVQs to role.

When carrying out qualitative studies there are also concerns about the ways in which the researcher influences the research process because of their characteristics, experience and education. A process of self-awareness, or reflexivity, has been utilised to clarify how my beliefs have been socially shaped and how my values might impact on interactions and interpretations in the research setting. Such reflexivity has been integral to the thesis and efforts have been taken to persuade the reader of the operationalisation of this concept.

Additionally, the research process has been made transparent for the reader to judge the quality of the thesis. To promote transparency and rigour in the study findings, and to provide trustworthiness in qualitative analyses, the techniques deployed by this study have included triangulation, reflexivity and respondent validation. Additionally the processes of negotiation and ethical considerations have been made explicit.

The emphasis on process has neglected due consideration to outcomes and financial costs associated with the work of HCAs. However, by gaining a deeper understanding of the content and control of HCAs' work the platform is now set for studies to evaluate outcomes and quality of care associated with HCAs' work. In particular these studies should focus on the educational preparation of HCAs and how this might influence outcomes for patients. Indeed, this area of research is much needed to explore the effectiveness of HCAs substituting for RNs to parallel

methodological developments in research evaluating the substitution of doctors by registered nurses.

CONCLUSION

The process of jurisdiction, and the negotiation nested within these processes, has much to offer when examining the nature and shaping of nursing work in the NHS. The classic interactionist texts and perspectives of Abbott, Hughes and the other Chicago-school-influenced scholars offer valuable levers for understanding the jurisdictional claims and shifting role boundaries that accompany all professionalisation 'projects'. In particular, when real healthcare provision is viewed through the theoretical lens that their ideas represent, it quickly becomes apparent that power – in its many and varied forms – is a crucial variable in the processes, structures and interactions underpinning the creation and filling of jurisdictional vacancies.

Power, from a Lukesian perspective informs the overt tensions and conflicts between the powerful and powerless (or at least the less powerful). It plays a central role in shaping the choices of HCAs and the wider social scripts which HCAs are required to rehearse and enact. Moreover, the interview, observational, and documentary evidence from the site, reveals the centrality of language (Habermas, 1977) as a means of controlling HCAs. They were excluded from key communication fora, discouraged from making use of the language of the more powerful group, denied access to linguistic expressions of knowledge which RNs felt was 'too complex' or unsuitable for 'them'. Extending notions of power to include the ability to manipulate

communication itself (via control and promotion of a particular discourse) helps explain these patterns.

The exercising of power is not a unidirectional phenomenon. HCAs had clearly developed sophisticated cultural, behavioural and psychological mechanisms for subverting, manipulating and rationalising RNs' attempts at control. As such, they exercised considerable degree of power over RNs – although rarely of the overt variety. The product of this subtle interplay and negotiated order were variable and dynamic patterns of use, non-use and misuse of the HCA resource. This variability led to some unintended (when judged against the goals of organisational, national and professional policy) outcomes: a resentful workforce, the creation of gaps in the application of nursing care, and traditional quality assurance mechanisms (RN supervision and monitoring) left wanting. The impact of these patterns and products clearly merit quantification and further interrogation, as do interventions to improve the RN-HCA dynamic. This dynamic is complex, contingent and yet malleable, and interventions to address it will need to be informed by a solid theoretical and descriptive foundation, built on the reality of organisational relations. This thesis is intended to offer a starting point for the construction of such foundations.

ISSUES FOR FUTURE CONSIDERATION

The findings from this case study raise important considerations for practice, policy, education and future research.

Policy makers, service planners, managers and registered nurses need to be more sophisticated in the way the HCA resource is viewed. HCAs – like other members of

the healthcare team – constitute a scarce resource. Maximising the value of this resource depends, at least in part, in the ways in which it is utilised. Currently there is a sub-optimal use.

As well as a greater sophistication in deployment there is much that can be learnt from evaluating new and innovative ways of using the HCA resource. Alongside greater sophistication in use, there is a need for a greater sophistication in evaluations of HCAs and their work. These evaluations should be devoid of prejudice and preconception; or at the very least make use of methods which minimise potential biases and /or make them explicit.

There needs to be recognition of the socially shaped nature of the boundaries between HCAs and RNs. Recognising the social nature of the lines of demarcation between the groups is valuable for two reasons. First, it highlights the fact that there is little in the way of solid theoretical (or research based) foundations for the inflexible task-based boundaries that some proponents would support. Second, it helps explain the fluid, dynamic and contingent nature of the relationship between HCAs and RNs which exists when descriptions are based on their *actual* working relationship and take in to account the negotiated order of the workplace.

The lack of recognition that formally defined roles of HCAs will always be manipulated at the micro-level of service delivery tends to be labelled (often with an implicit negativity) as a policy-practice gap. When viewed from this perspective policy will always lag behind best practice and innovation – or conversely, fail to address worst practice and stasis. Linking policy and practice through a recognition

that policy messages will be actively interpreted at lower policy levels will only partially maximise the value of the HCA resource. Full and detailed attention must be paid to the nature, composition and processes involved in the enactment of policy. Such knowledge is essential if HCAs' work is to be influenced and shaped effectively. The thesis has illustrated the differing nature of the negotiations that exist at macro, meso and micro policy levels. Negotiations between and within occupational groups in a single Trust are very different to those that take place between national representatives of the same groups, or between policy makers. Only by understanding the key decision nodes, points of tension and convergence within these negotiations can external players hope to influence them.

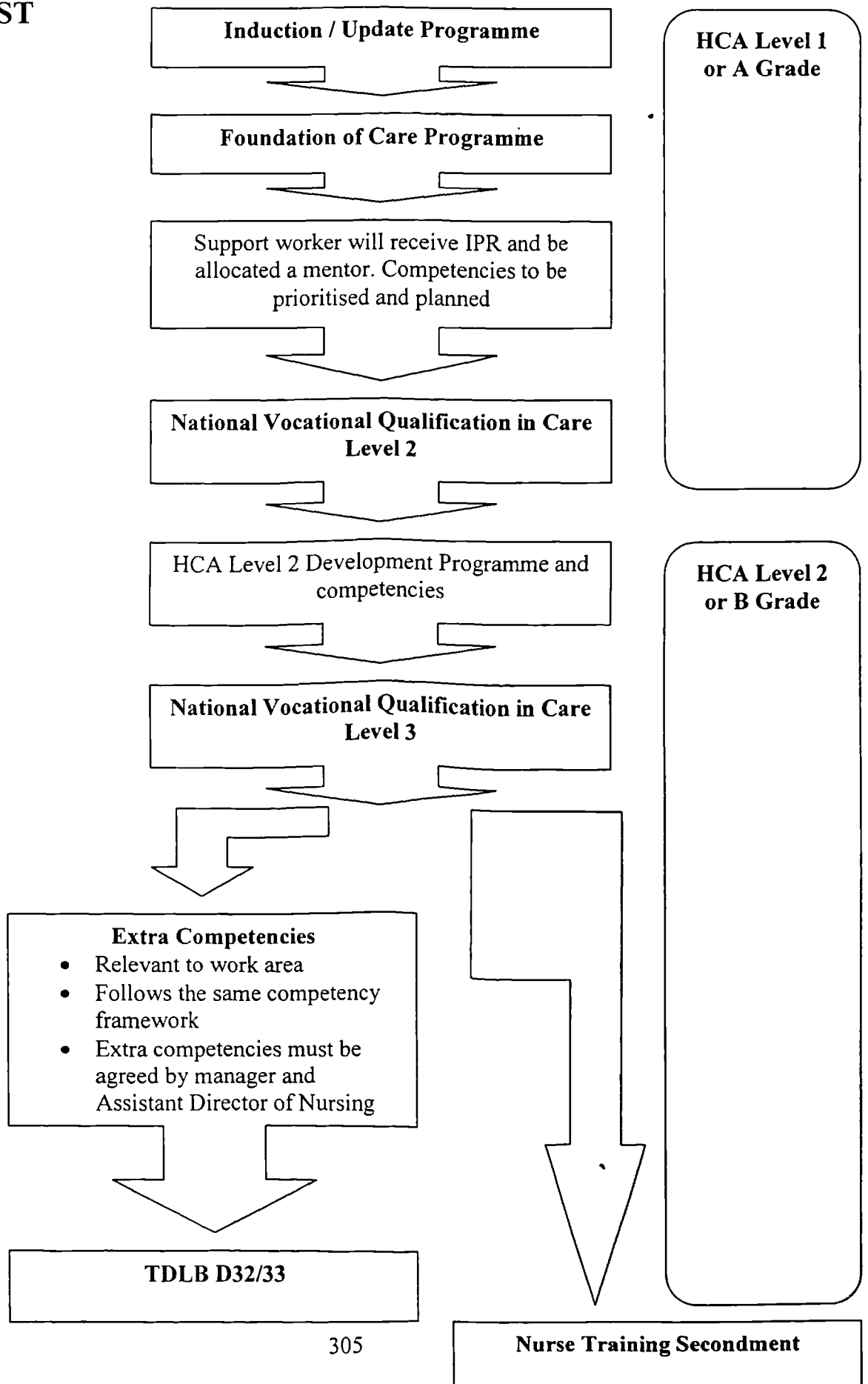
There needs to be a shift in the focusing of scholarly activity away from skills *acquisition*. The hypothesis that skills acquisition by registered nurses (at any cost) is a universal societal good appears to be almost a given in policy and research debates. However, it is clear that there is probable merit in considering the value *lost* by needlessly *discarding* elements of role which go largely unexposed to a critical evaluatory gaze. The classic exemplar must be the seeming paradox of the RNs shift away from the bedside, whilst simultaneously making rhetorical claims on the need to control bedside care. Jurisdictional claims on new activity are part of a complex interwoven fabric of organisational politics, values, resource awareness and societal expectation – patient benefit is only one element of this matrix. Jurisdictional claims need to be examined prior to being granted. There needs to be a shift away from acceptance of the *prima facie* and the rhetorical in the jurisdictional claims of occupational groups, and towards the evidence-based and the demonstrable.

Credentials are an important currency in the negotiations surrounding work and the filling of the skills and task gaps left behind when jurisdictional claims are granted. However, there is a lack of parity of esteem associated with the credentials held by RNs and HCAs. The acquisition of National Vocational Qualifications by HCAs does not appear to lead to significant changes in their roles, tasks undertaken, social status or remuneration. Until NVQs have real worth in the workplace then there appears little incentive for HCAs to engage in NHS-relevant education and training – a disincentive with significant ramifications for policy makers keen to develop the NHS workforce as a whole.

The shift away from a rigid – and occasionally dysfunctional – system of task-based clinical grades, and towards a system of recognition based on role and skills has the potential to benefit HCAs. However, without an understanding of the intellectual and skills capital that HCAs can bring to the negotiating table, then *Agenda for Change* (Department of Health, 1999b) has the potential to artificially inflate those clinical roles which are well mapped and understood, at the expense of those which are not. It is vital that the true worth of this capital is known if the HCA workforce is to be used and developed most effectively.

This section of the thesis has deliberately avoided the exposition of ‘quick-fix’ solutions. The empirical and theoretical work underpinning the thesis was primarily descriptive and analytical. It is hoped that by highlighting some points for consideration, and for the reader to consider them in the light of the thesis as a whole, that any solutions arrived at will reflect the unique and local contextual factors that surround all negotiation.

APPENDIX 1 CAREER PATHWAY FOR HCAS IN THE TRUST



APPENDIX 2 THE ACTIVITIES OF THE NON-REGISTERED NURSING WORKFORCE

'NON-CLINICAL' DUTIES:

Clerical
Cleaning
Portering and/ or transport or messenger
Laundry

'NURSING'/DIRECT CARE DUTIES:

Talk to/ reassure patients and relatives
Make beds
Help bathe patients
Telephone liaison (patients/relatives/departments)
Monitor/ record patient observations
Help feed patients
Obtain specimens
Help with catheter care
Participate in meetings about patient care
Dressings and wound care
Assist in drawing up patient care plans
Handle syringes/ equipment
Help with drug administration
Clinical stock control
Invasive procedures
Take blood samples

'ADVANCED' & 'TECHNICAL' TASKS:

Giving drugs without supervision
Running clinics single-handed
Phlebotomy/ venepuncture
Running therapeutic groups
Organising and chairing client review meetings
Training agency staff
Giving advice on the phone
Setting up all instruments for theatre
Making up instrument trolleys for doctors
Computer evaluations
Acting as a scrub nurse
Tracheotomy emergency suction
Writing care plans and keeping them up to date
Initiating admissions and discharges
Speech therapy assessment
Plastering
ECGs
Massage in cardiac arrest cases
Preparing patients for suturing
Being in charge of a shift
Assisting mothers with breastfeeding
Dealing with doctors
Infection control
Ward rounds
Restraining aggressive patients
Setting up diagnostic machines and feeds
Student nurse and newly qualified RN supervision

Thornley (2000)

APPENDIX 3 PARTICIPANT OBSERVATION: CORRESPONDENCE WITH CHARGE NURSES

Letter to arrange meeting with Charge Nurse



Contact details

Date

Name ward sister/ charge nurse

Name of Ward

Name of Hospital

Dear [name],

Re: HCA project “Exploring the practice, supervision and perceived impact of health care assistants’ work”

I am currently working in the hospital on the above project. Stage One of the project (completed) involved interviews with assistants working in the Trust to establish their perceptions of their work. I have recently commenced Stage Two, which involves observation of HCAs in practice.

I would like the opportunity to meet with you to discuss the possibility of observing a HCA on [name] Ward. I have enclosed information about the background to the project, the stages of the research and information given to HCAs when seeking their consent to observe practice.

If you are agreeable, I would like to work alongside the HCA (in HCA uniform). I am a registered nurse by background and have been working in research for six years on a variety of projects.

Thank you for considering this request. I will contact you by telephone in the next few days in the hope of arranging an appointment to discuss this with you further.

Yours sincerely,

Karen Spilsbury (Research Fellow)

Project summary for Charge Nurses

Exploring the fitness for practice, supervision and perceived impact of health care assistants' work

**Karen Spilsbury & Professor Julienne Meyer (City University)
in collaboration with [name] Trust**

Project summary

A literature review by the researchers, *Defining the Nursing Contribution*, explored the research available to support claims about the nursing contribution to patient care and outcome (Meyer and Spilsbury, 1998). The changing nature of health care has led to developments within nursing to take on activities that were previously the domain of other health care disciplines. Research exploring these new roles, generally suggests that these developments have a positive impact on patient care and multidisciplinary teamwork. As the range of tasks and level of complexity of roles undertaken by nurses increases, the issue of substitution inevitably arises and with it questions about the definition of nursing and who should be doing what. As nursing activities diversify and continue to evolve in response to change, the extent to which nursing retains 'certain' activities, or delegates to support staff, is increasingly being debated.

The roles of health care assistants are also developing yet there is little evidence examining the changing roles of these workers and the subsequent impact on patient care. This constitutes a significant gap in the research-based literature. Such role changes have led to bold statements being made about cost savings that could be made if doctors are replaced by nurses (Richardson & Maynard, 1995) and registered nurses are replaced by health care assistants (Audit Commission, 1991). Senior nurses are increasingly being put under pressure to make evidence based decisions on appropriate skill mix and the current crisis within the UK nursing workforce (Buchan et al. 1998) emphasises the importance of such decisions.

Health care assistants have an important role in the delivery of patient care. The nursing strategy, *Making a Difference* (Department of Health, 1999), recognises that support workers may be able to play a more significant role in some care settings. A national survey by Thornley (1998) describes the type of work that nurse assistants are involved in. This work centres on patient care and includes nursing (or direct patient care) duties, 'non-clinical' duties and 'advanced' nursing duties. However, there remains a significant gap in the literature about the effect on patient care and outcome when health care assistants perform such duties. A study that explores the nature of the work of health care assistants, the supervision of their work and the impact on patient care is of immediate concern to practice, policy, education and research.

In recognising the value and contribution of health care assistants, [name] Trust have funded researchers from St. Bartholomew School of Nursing and Midwifery (City University) to carry out a project to explore the contribution of these workers to patient care and to consider ways in which their roles may be developed in the future.

The study will explore the practice, supervision and training of health care assistants and the perceived impact of their work on patient care. The study commenced on 1 April 2000 and is funded for three years. The study will provide data to inform work currently being undertaken within the Trust to review and develop the role of the health care assistant. Where possible findings from the study will be placed within the national context.

The specific aims of this study are to explore:

- the fitness for practice (knowledge, attitudes and skills) of health care assistants
- the supervision of health care assistants in a variety of health care settings
- the perceived impact of health care assistants work on patients from a range of perspectives (health care assistants, patient and health care professionals)

A multi-method approach to data collection (in-depth interviews, observation, documentary analysis and structured instruments) will be utilised to explore these areas. Health care assistants across the Trust, working in a variety of roles, will be studied.

We are looking forward to working with you on this project. If you have any comments, questions or concerns then please contact Karen:

University contact details

Hospital contact details

References

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Summary of research stages for Charge Nurses

Exploring the practice, supervision and perceived impact of health care assistants' work

Stages in the Research Project

Negotiation and ethical approval

Considerable time has been invested in raising the profile of project. The project involves a wide variety of clinical areas and so it was important to ensure that clinical staff and managers are aware of the study for the successful completion of subsequent stages.

[Name] ethics committee has granted approval for this work. The study has also been peer reviewed by the Interprofessional Research Forum within the Trust.

Access into a clinical area is negotiated with individual Sister/ Charge Nurse.

Stage 1: 'Mapping' the HCA workforce - COMPLETED

There is generally a poor level of understanding about the characteristics of the assistant population. This stage of the project (December 2000 to May 2001) aimed to map out the assistant workforce at the Trust. There are 86 HCAs within the Trust (working in nursing, therapies and maternity) who have been included in this stage of the study. Data collected are being used for purposive sampling to ensure there a variety of assistants are selected for observation of practice.

A questionnaire was designed for this stage of the study to collect data about demographic details, role/ grade, clinical area, and length of employment at the Trust, work history, educational qualifications, and training for assistant role, life caring experience and satisfaction with job. Piloting the questionnaire highlighted issues about levels of literacy within the HCA population and motivation to complete the questionnaire. Face-to-face interviews were therefore carried out with the assistants, to complete the questionnaire and this gave additional opportunity for them to talk about their role and perceived issues faced in practice.

A 100% response rate was achieved in the first stage and in addition assistants have consented to being observed in the next part of the project.

A detailed profile of the workers is being prepared as well as a summary of the issues raised by HCAs during their interviews.

Stage 2: Observation of practice - CURRENT

The next stage of the project (June to December 2002) is to observe HCA practice and the supervision of this practice. Approximately 15 HCAs of varying levels of experience, age and training preparation will be selected.

Participant observation techniques will be used to gather the data. During the interviews (Stage 1), HCAs and nurses were consulted about how best to undertake this work and a decision was taken that the researcher would wear an HCA uniform.

The rationale being that the researcher would get a better understanding of the HCA role and the way in which staff relate to them.

Stage 3: Focus groups - FUTURE

The final stage of data collection will be focus groups with key stakeholders in the Trust to discuss themes emerging from the interviews and observation.

Ongoing data collection

Data are being collected throughout the three years so that a rich description of the case is presented. Such detail will enable readers to judge the relevance of the findings to their own practice contexts.

Data being used for description includes documentary evidence, Trust HCA Project Development work (including Steering Group meetings), Support Staff Forums, research diary notes and interviews with key individuals.

The anticipated completion date for this project is July 2003.

APPENDIX 4 CONTACT WITH HCAS ABOUT INTERVIEWS



City University
London

Trust Logo

December 6, 2000

Dear Colleague,

Research study to explore the work of 'assistants' at [name] Hospital

Thank you for taking the time to read this information about a study that is currently being carried out to explore the practice, supervision, training and perceived impact of 'assistant' work at [name] Hospital. In the near future, you will be approached to consider whether or not you feel able to help with this study.

Why is this study important?

There are increasing numbers of assistant staff in the NHS who have a vital role in the delivery of care. However, knowledge about who makes up this workforce and what they do is poor. The way in which care is delivered to patients is constantly changing, and alongside these developments there are subsequent changes in roles for health care workers. In view of this, the work of assistant staff needs to be better understood.

How will the findings be used?

The findings from this study will be of relevance at a local level to plan for the future practice, supervision and training of assistants in the Trust. The findings will also be of interest at a national level to inform practice, policy, education and future research.

Why are you important for this study?

You are important to this study because you currently work at [name] Hospital in an 'assistant' role.

Making contact.

I will be contacting all assistants working in the hospital over the next two months to ask if they would be willing to answer a questionnaire. This questionnaire is designed to map out the assistant workforce in the Trust. Your participation in this study is very important. If you do not like filling in questionnaires and would like help in doing so, I shall be happy to provide it.

Confidentiality.

The information that you provide will not be stored or published in any way that could reveal your involvement in the study. The researcher will be the only person to look at the completed questionnaire forms. The information collected will only be used for the purposes of this study.

Do you have any questions?

If you have any questions about any aspect of this study please feel free to contact me on ext. ----.

I look forward to speaking to you in the near future.

Yours sincerely,

Karen Spilsbury (Researcher)

APPENDIX 5 LETTER INVITING HCA TO TAKE PART IN STAGE TWO: PARTICIPANT OBSERVATION OF PRACTICE

Researcher Contact Details

[Date]

Dear [HCA name],

Re: Research study exploring the work of health care assistants

You may remember that earlier this year I interviewed you for the above study? I would like to thank you again for your time.

At the interview I explained that the next stage of the study would involve me observing HCA practice by working alongside HCAs in the clinical area. I have now started this stage of the study, hence my reason for contacting you again. I wonder if you might consent to me observing your day-to-day work, so that I may further understand the activities you are involved in and any issues that you might face in practice.

I have enclosed some information about this stage of the study, which outlines what would be involved if you agreed to take part. If you are interested then perhaps I could come and discuss this with you further. Please let me know whether or not you might be interested so that I know if I should contact you again. My ext. is ----.

Thank you for your time.

Yours sincerely,

Karen Spilsbury
Research Fellow (City University)

APPENDIX 6 COPY OF INFORMATION FOR HCAS AND CONSENT FORM



Information for staff: Observational work

Do they make a difference? Exploring the fitness for practice, supervision and impact on patient care of health care assistants work

We invite you to take part in a research study, which we think may be important. The information that follows tells you about it. It is important that you understand what is in this leaflet. It says what will happen if you decide to take part. Whether or not you do take part is entirely your choice. Please ask any questions you want to about the research and we will try our best to answer them.

You have been identified as suitable to take part in the research because you currently work within the Trust as a health care assistant. The purpose of this research is to explore the practice, supervision, training and impact on patient care of health care assistants' work. The aim is to describe the contribution of health care assistants work to patient care and to consider ways in which the work of health care assistants may be developed in the future. This work is timely given the changing nature of health care delivery and the subsequent development of roles for health care workers.

If you agree to participate in this study a researcher will observe your work by 'shadowing' you in the clinical area during your normal shift work. The researcher will observe your work over a number of shifts. The researcher will make written notes of her observations. Please note that your name will not be recorded at any stage to protect your right to confidentiality and anonymity. Findings will not disclose the identity of any individual. The researcher is the only person to have access to data which will be coded and locked in a filing cabinet. Data will only be used for the purposes of this study.

You are free to decide not to co-operate with the data collection or to drop out at any time.

If you have any queries or worries you will always be able to contact the researcher to discuss your concerns and/ or get help.

Contact details: Karen Spilsbury (Research Fellow)

Hospital address

University address

Telephone number

Telephone number

E-mail address

WRITTEN CONSENT FORM

Do they make a difference? Exploring the fitness for practice, supervision and impact on patient care of health care assistants work

Name of participant:

Address:

The study organisers have invited me to take part in this research.

I understand what is in the leaflet about the research. I have a copy of the leaflet to keep.

I have had the chance to talk and ask questions about the study.

I know what my part will be in the study and I know how long it will take.

I know that the Trust Research Ethics Committee has seen and agreed to this study.

I know that personal information is strictly confidential. I know the only people who may see the information about my part in the study are the research team or an official representative of the organisation which funded the research.

I know that the researchers will/ might tell my manager about my part in the study.

I freely consent to be a subject in the study. No one has put pressure on me.

I know that I can stop taking part in the study at any time.

I understand that agreement or refusal to take part will make no difference to my career.

Karen Spilsbury (Research Fellow)

Hospital address

University address

Telephone number

Telephone number
E-mail address

Participant's signature:

Date:

As the Researcher responsible for this research, or a designated deputy, I confirm that I have explained to the participant (named above) the nature and purpose of the research to be undertaken.

Researcher's signature:

Researcher's name: KAREN SPILSBURY.....

Date:

Mapping out the 'assistant' workforce at [name] Hospital

Thank you for agreeing to answer this questionnaire.

The information that you provide will remain confidential and will not be stored or published in any way that could reveal your involvement in the study.

The questionnaire should take about 30-45 minutes to complete.

DATE: ___/___/___.

STUDY NUMBER: _____

YOUR CURRENT JOB

Job details

Please answer all the questions.

1) What is your job title?

2) How long have you been in the job you **have now** (in years, or in months if less than 1 year)? (Do not include the total time you have worked in (rust - you will be asked about this in a later question).

----- years ----- months

3) What is your current grade? Please tick the appropriate box:

A grade	
B grade	
C grade	
Other grade. Please give detail below:	

4) Where do you work? Please state the clinical area(s), e.g. medicine, outpatients, maternity.

5) Which professional group manages your day-to-day work? (e.g. nurses, physiotherapists).

6) What hours do you work? Please tick the appropriate box:

Day shifts unsocial hours (e.g. early and/ or late shift)	
Night shift	
Rotation (day and night duty)	
Day shift normal hours (e.g. 9am-5pm)	
Other. Please give detail below:	

7) Do you work full-time or part-time? Please tick the appropriate box:

Full-time (37 hours or more per week)	
Part-time. Please state hours worked per week below:	

8) Which **ONE** of the following statements best describes the contract you have? Please tick the appropriate box:

An open-ended/ permanent contract •	
A fixed period/ temporary contract (e.g. 1 year). Please state how long the contract is for below:	

How do you feel about your current job?

Not all of these questions will relate to you. Depending on your answer, please follow the arrows which direct you to the next appropriate question.

9) How satisfied are you with your job? Please tick the appropriate box:

<input type="checkbox"/>	Very satisfied	⇒ go to 10
<input type="checkbox"/>	Satisfied	⇒ go to 10
<input type="checkbox"/>	Neither satisfied or dissatisfied	⇒ go to 10
<input type="checkbox"/>	Dissatisfied	⇒ go to 10
<input type="checkbox"/>	Very dissatisfied	⇒ go to 10

10) During the last 6 months have you considered leaving the job you have now? Please tick the appropriate box:

<input type="checkbox"/>	Considered leaving	⇒ go to 11
<input type="checkbox"/>	Not considered leaving	⇒ go to 14
<input type="checkbox"/>	Not relevant (have not been in job for 6 months)	⇒ go to 12

11) Please list the reason(s) you considered leaving the job you have now in the box below:

⇒ go to 13

12) Please list any reason(s) why you left your last job in the box below:

⇒ go to 14

13) Are you still considering leaving the job you have now? Please tick yes or no below:

<input type="checkbox"/>	Yes	⇒ go to 14
<input type="checkbox"/>	No	⇒ go to 14

14) Are there any changes that would improve how you feel about the job you have now? Please tick yes or no below:

<input type="checkbox"/>	Yes	⇒ go to 15
<input type="checkbox"/>	No	⇒ go to 16

15) Please list any changes that would improve how you feel about your current job in the box below:

⇒ go to 16

WORK HISTORY

16) In the table below, please give detail of (up to) the 10 most recent jobs that you have held in paid and voluntary employment since you were 16 years old. Please indicate if the jobs were in **health and/ or social care settings (and include the clinical area) or elsewhere**. You have already provided information about the job you have now, **DO NOT** repeat this information here. However, you may have worked in other wards or departments at NHS Trust, and if so, please provide information about these jobs in the table below. The table continues over the page.

Do not include details of any work with an agency and/ or bank. This will be asked for in question 18.

Detail of jobs in the past

Job title (and grade)	Name of health/social care setting and clinical area/ department OR company name	Length of time in job (years/ months)	Part-time	Full-time	Paid	Voluntary
1		____years ____months				
2		____years ____months				
3		____years ____months				
4		____years ____months				
5		____years ____months				
6		____years ____months				

CONTINUED Job title (and grade)	Name of health/social care setting and clinical area/ department OR company name	Length of time in job (years/ months)	Part-time	Full-time	Paid	Voluntary
7		___ years ___ months				
8		___ years ___ months				
9		___ years ___ months				
10		___ years ___ months				

⇒ go to 17

17) If you have had more than 10 previous jobs, please tick the box, or both boxes, below to indicate whether these jobs were in a health and/ or social care setting or elsewhere.

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

I have had jobs in health and/ or social care which I have not listed above

I have had jobs in other settings which I have not listed above

⇒ go to 18

18) In the table below, please give detail of any work you have undertaken with an agency and/ or bank. You may have worked full-time or part-time for an agency or bank and indeed may still work with one, in addition to the job you have now. Please provide details of this work below and tick boxes to indicate whether the work is full time or part time and whether or not you are still working with the agency and/ or bank.

Detail of agency/ bank nursing						
Job title (and grade)	Name of agency/ bank	Length of time (years/ months)	Full-time	Part-time	Continue to work with agency/ bank	No longer work for agency/ bank
		__ yrs __ mths				
		__ yrs __ mths				
		__ yrs __ mths				
		__ yrs __ mths				
		__ yrs __ mths				
		__ yrs __ mths				
		__ yrs __ mths				
		__ yrs __ mths				
		__ yrs __ mths				
		__ yrs __ mths				

⇒ go to 19

EDUCATIONAL QUALIFICATIONS

19) Please list any qualifications you have completed (e.g. O'level, GCSE, NVQ, degree) in the table below.

For example:

Qualification	Level	Year obtained

Insert your qualifications below:

Qualification	Level	Year obtained

Qualification	Level	Year obtained

⇒ go to 20

20) Please list the qualification and level of any course(s) you are currently studying for.

Qualification	Level

⇒ go to 21

TRAINING

You may have undertaken training courses for the job that you currently do. Below are a series of questions about such training. Please follow the arrows to guide you through the questions.

21) How much training have you had for your job as a health care assistant?

	I had none, but didn't want any	⇒ go to 24
	I had none, but wanted some	⇒ go to 24
	I had sufficient	⇒ go to 22
	I had some, but wanted more	⇒ go to 22
	I had more than I wanted	⇒ go to 22

22) Please list the training courses that you have completed for your work as a health care assistant (e.g. resuscitation, manual handling etc). Please tick to indicate whether these were completed at NHS Trust or elsewhere.

Name of course	At Trust	NHS	Elsewhere

⇒ go to 23

23) In which of the following ways have you received training for your current job?

	Ward based ("on the job")	⇒ go to 24
	Classroom based ("off the job")	⇒ go to 24
	A combination of ward and classroom based	⇒ go to 24

24) Do you want training in the future to do your job?

	Yes	⇒ go to 25
	No	⇒ go to 27

25) Please list the skills that you would like training for below:

	⇒ go to 26
--	------------

26) How would you like this training to be provided?

	Ward based ("on the job")	⇒ go to 27
	Classroom based ("off the job")	⇒ go to 27
	A combination of ward and classroom based	⇒ go to 27

NATIONAL VOCATIONAL QUALIFICATIONS (NVQ)

Please follow the arrows to direct you through the questions related to NVQ qualifications.

27) Have you got a NVQ qualification?

Yes
No

⇒ go to 29

⇒ go to 28

28) Would you like to study for a NVQ?

Yes
No

⇒ go to 31

⇒ go to 30

29) Would you like to study for a higher grade NVQ?

Yes
No

⇒ go to 31

⇒ go to 30

30) Please list the reason(s) why you would not like to study for a NVQ?

⇒ go to 32

31) Please list the reason(s) why you would like to study for a NVQ?

⇒ go to 32

PROFESSIONAL STUDY

32) Would you like to study for a registered professional qualification (e.g. physiotherapist, nurse etc)?

Yes
No
Not decided

⇒ go to 33

⇒ go to 34

⇒ go to 34

33) Please state profession you would like to study for (e.g. physiotherapist, nurse etc).

⇒ go to 34

ABOUT YOU

These questions ask you for a few details about yourself. The purpose of this information is so that the staff working as health care assistants at Hospital may be compared with others nationally. Please answer all the questions if you feel able.

34) How old were you last birthday? _____ years old

35) Are you (please tick appropriate box):

Female	<input type="checkbox"/>
Male	<input type="checkbox"/>

36) Please tick appropriate box to indicate which **ONE** of these groups you consider you belong?

White	<input type="checkbox"/>
Black - Caribbean	<input type="checkbox"/>
Black - African	<input type="checkbox"/>
Black - Other	<input type="checkbox"/>
Indian	<input type="checkbox"/>
Pakistani	<input type="checkbox"/>
Bangladeshi	<input type="checkbox"/>
Chinese	<input type="checkbox"/>
Other. Please state in box below:	<input type="checkbox"/>

37) Which **ONE** of the following describes your marital status at present? (Please tick appropriate box):

Single	<input type="checkbox"/>
Married	<input type="checkbox"/>
Widowed	<input type="checkbox"/>
Divorced	<input type="checkbox"/>
Married and now separated	<input type="checkbox"/>
Other. Please give detail in box below:	<input type="checkbox"/>

38) Do you live with a spouse or partner?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

39) Are you the **main** household earner?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

⇒ go to 40

LIFE CARING EXPERIENCE

Education and training are not the only things that equip people to perform their job. People have life experiences that influence the way in which they carry out their work. Since you are currently working in a caring role, the life caring experiences that you have had are important. This question asks you about children and other dependants that you may have cared for. Please follow the arrows to guide you through the questions.

Children

40) Do you have children living with you?

Yes	⇒ go to 41
No	⇒ go to 43

41) Please insert the age of each child living with you in a box below:

Child number(s)									
1	2	3	4	5	6	7	8	9	10

⇒ go to 42

42) Do you have children that do not live with you?

Yes	⇒ go to 44
No	⇒ go to 45

43) Do you have children that do not live with you?

Yes	⇒ go to 44
No	⇒ go to 46

44) Please insert the age of each child that does not live with you in the box below:

Child number(s)									
1	2	3	4	5	6	7	8	9	10

⇒ go to 45

45) Are you:

a) the main carer for children that live with you?

Yes
No
Shared caring responsibility
Not applicable

b) the main carer for children that do not live with you?

Yes
No
Shared caring responsibility
Not applicable

Other Dependants

46) Other than children, do you have any individual(s) who is **dependent on you for CARE** at the **PRESENT TIME**?

	Yes ⇒ go to 47
	No ⇒ go to 48

47) For each person please insert information about them and tick the appropriate boxes. If you have more than 3 people dependent on you *at the present time* then more space is available on the next page for you to insert details.

	Person 1	Person 2	Person 3
Age:			
What is their relationship to you? (tick):			
Parent			
Brother/ sister			
Husband/ wife/ partner			
Friend			
Other. Please state:			
Where do they live? (tick)			
Your home			
Their own home			
Another relative's home			
Nursing home			
Residential home			
Other. Please state:			

Please describe the ways in which the person is dependent on you.

Person 1

Person 2

Person 3

⇒ go to 48

47) CONTINUED

	Person 4	Person 5	Person 6
Age:			
What is their relationship to you? (tick):			
Parent			
Brother/ sister			
Husband/ wife/ partner			
Friend			
Other. Please state:			
Where do they live? (tick)			
Your home			
Their own home			
Another relative's home			
Nursing home			
Residential home			
Other. Please state:			

Please describe the ways in which the person is dependent on you.

Person 4

Person 5

Person 6

⇒ go to 48

48) Other than children have you had any individual(s) who was dependent on you for CARE in THE PAST?

	Yes ⇒ go to 49
	No ⇒ go to 50

49) For each person please insert information about them or tick the appropriate boxes. If you have had more than 3 people dependent on you *in the past* then more space is available on the next page for you to insert details.

	Person 1	Person 2	Person 3
Age:			
What was their relationship to you? (tick):			
Parent			
Brother/ sister			
Husband/ wife/ partner			
Friend			
Other. Please state:			
Where did they live? (tick)			
Your home			
Their own home			
Another relative's home			
Nursing home			
Residential home			
Other. Please state:			

Please describe the ways in which the person was dependent on you.

Person 1

Person 2

Person 3

⇒ go to 50

49) CONTINUED

	Person 4	Person 5	Person 6
Age:			
What was their relationship to you? (tick):			
Parent			
Brother/ sister			
Husband/ wife/ partner			
Friend			
Other. Please state:			
Where did they live? (tick)			
Your home			
Their own home			
Another relative's home			
Nursing home			
Residential home			
Other. Please state:			

Please describe the ways in which the person was dependent on you.

Person 4

Person 5

Person 6

⇒ go to 50

OTHER ISSUES

50) If there are any issues related to your work that you would like to tell me about, that have not been already asked in this questionnaire, then please use the space below to express these issues.

Thank you for taking the time to complete this questionnaire. I will feedback findings to you once the questionnaire has been completed with assistants across the Trust.

My contact details are:
Karen Spilsbury (Research Fellow)
Ext.

APPENDIX 8 PRE-TESTING THE INTERVIEW SCHEDULE – KEY INFORMANT PANEL

The following people commented on and critiqued early versions of the interview schedule. They were chosen because of their experience of designing and using survey methods or because of their experience of working with and teaching HCAs.

Katherine Anstey	PhD Student	City University
Charlotte Ashburner	Research Fellow	City University
Jane Bentley	Research Fellow	City University
Kate Bowers	R&D Nurse	London NHS trust
Jackie Bridges	Research Fellow	City University
Nicky Fairclough	Clinical Support Nurse for Health Care Support Workers	London NHS trust
Jo Kane	NVQ Co-ordinator	London NHS trust
Dr Louise Marsland	Senior Research Fellow	King's Collège London
Professor Julienne Meyer	Professor of Adult Nursing (Care for Older People)	City University
Margaret McGlynn	Practice Development Nurse	London NHS trust
Scott Reeves	Research Officer	City University
Sharon Rouse	Training Advisor for Health Care assistants	London NHS trust
Dr Carl Thompson	Senior Research Fellow	University of York
Dr Carole Thornley	Senior Lecturer	Keele University
Dr Jeremy Warr	Senior Lecturer	University of Southampton

APPENDIX 9 STRUCTURE OF D AND E GRADE NURSE FOCUS GROUPS

- 1 Provide summary of research study (*not* findings)**
 - 1.1 Context and relevance of study (national and local)
 - 1.2 Methods used
 - 1.3 Importance of systematically gathering nurse perspective

- 2 Focus group being used to get nurses to reflect on issues related to**
 - 2.1 The nature of HCAs work
 - 2.2 The supervision of HCAs
 - 2.3 Tensions (if any) that arise between the role of RGNs and HCAs

- 3 Introduction to focus group**
 - 3.1 Purpose
 - 3.2 Group rather than individual interview
 - 3.3 Reflect on questions asked by interviewer
 - 3.4 Hear each other's responses and make additional comments as topic is discussed
 - 3.5 Not necessary to reach any kind of consensus nor for people to disagree
 - 3.6 No right or wrong answers

- 4 Aim**
 - 4.1 To gather high-quality data in a social context where people can consider their own views in the context of the views of others

- 5 Role of researcher and co-facilitator**
 - 5.1 Ask questions
 - 5.2 Facilitate open discussion of issues
 - 5.3 Manage the interview (such as conflict, domination)
 - 5.4 Taking notes

- 6 Gain consent to tape record session**
 - 6.1 Accurate record of discussion
 - 6.2 Researcher only person to listen to tape
 - 6.3 Reassurance of confidentiality and anonymity
 - 6.4 Tape locked away and destroyed when transcribed

- 7 Key areas for discussion are**
 - 7.1 Role of the HCA
 - 7.2 Supervision of the HCA
 - 7.3 Tensions (if any) between role of RGN and HCA

APPENDIX 10 LETTER OF APPROVAL FROM LREC AND RESEARCHER'S APPLICATION FOR ETHICS RENEWAL

Ms K Spilsbury
Research Fellow
St Bartholomew School of
Nursing and Midwifery
Alexandra Building
Philpot Street
London
E1 2EA

Dear Ms Spilsbury,

**RREC 2329 - Do they make a difference? Exploring the fitness for practice,
supervision and impact on patient care of health care assistants work**

The Chairman, _____ has asked me to write to inform you that approval for the above study has now been renewed by Chairman's Action.

Please note the following conditions which form part of this approval:

- [1] Your study has been assigned a unique reference number. This number must be quoted in any correspondence with the Committee concerning this study.
- [2] This approval is for a limited period only. A letter from the principal investigator will be required in order to extend this period of approval.
- [3] Any changes to the protocol or investigator team must be notified to the Committee. Such changes may not be implemented without the Committee's approval.
- [4] Any revised study documents submitted must be given a new version number/date.
- [5] For projects with an expected duration of more than one year, an annual report from the principal investigator will be required. This will enable the Committee to maintain a full record of research.
- [6] The Committee must be advised when a project is concluded and should be sent one copy of any publication arising from your study, or a summary if there is to be no publication.
- [7] The Committee should be notified immediately of any serious adverse events that are believed to be study drug related or if the entire study is terminated prematurely.
- [8] Please note that research conducted on NHS Trust premises must receive the approval of the relevant Research and Development department. Approval by the Committee for your project does not remove your responsibility to obtain this approval.
- [9] You are responsible for consulting with colleagues and/or other groups who may be involved or affected by the research, e.g., extra work for laboratories. Approval by the Committee for your project does not remove your responsibility to negotiate such factors with your colleagues.
- [10] You must ensure that nursing and other staff are made aware that research in progress on patients with whom they are concerned has been approved by the Committee.

[11] Pharmacy must be told about any drugs and all drug trials, and must be given the responsibility of receiving and dispensing any trial drug.

[12] All documents relating to the study, including Consent Forms for each patient (if applicable), must be stored securely and in such a way that they are readily identifiable and accessible. The Committee will be conducting random checks on the conduct of studies, and these will include inspection of documents.

May I take this opportunity to wish you well in your research. If any doubts or problems of an unexpected nature arise, please feel free to contact me at any time.

Yours sincerely

Miss
Administrator
Research Ethics Committee

(On behalf of the Chairman,)

Research Ethics Committee has approved the following:

RREC 2329 - Do they make a difference? Exploring the fitness for practice, supervision and impact on patient care of health care assistants work

Ms K Spilsbury

Approval for this study has been renewed by Chairman's action.

This study was first approved on the: 09/03/2000.

Approval for this study now expires on the 09/03/2003.

Study History:

	Comments
Application Form (01/03/00)	Approved 09/03/01
RENEWAL	Approved 15/04/02
Renewal for 12 months	

March 21, 2002

[LREC address]

Dear [name],

Extension of ethical approval: RREC 2329

Do they make a difference? Exploring the fitness for practice, supervision and impact on patient care of health care assistant work

The above three-year funded study is being carried out at [name] Hospital. The study is progressing as per the original proposal.

Ethical approval for the study has thus far been granted on a yearly basis and as I enter the third year of the project this is now due for renewal on March 28th. Please could you advise if this study may be granted an extension so that I may complete the final year? I would be happy to forward any necessary documentation to support this application.

I thank you for your time spent in considering this matter.

Yours sincerely,

Karen Spilsbury (Research Fellow)

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