An investigation of the inter-relationship between the registered nurse and the healthcare assistant with reference to workforce policy implementation in the South-East of Ireland;

Waterford Institute *of* Technology
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Thesis submitted in fulfilment of the requirements for the Degree of Masters by Research

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Declaration

I Maria Beagan, declare that this thesis is submitted as partial fulfilment of the requirement for the degree of Masters by Research is entirely my own work, except where otherwise accredited. It has not at any time either whole or in part been submitted for any other educational award.

Signed ______________________ (Candidate)

Date___________________________

Statement 2

I Maria Beagan, hereby give consent for my thesis, if accepted to be available for photocopying for interlibrary loans and for the title and summary to be made available to outside organisations.

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Dedication

This thesis is dedicated to the memory of my mother Teresa Walsh

The price of success is hard work, dedication to the job at hand, and the determination that whether we win or lose, we have applied the best of ourselves to the task at hand. Keep your dreams alive. If you believe in yourself and have dedication and pride - and never quit, you'll be a winner.

Vince Lombardi

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Abstract

There is a constant reconfiguration of the roles of healthcare personnel worldwide in relation to workload, practice responsibilities and reporting relationships. Within this context, the role of the registered nurse (RN) continues to expand whilst that of the healthcare assistant (HCA) is developing in terms of role identity and inter-relationships with other healthcare professionals. With this in mind, it is now timely to examine current practice and policy as they relate to role reconfiguration of both the RN and the HCA and the professional relationship that exists in terms of nature, extent and significance. This study therefore explored the '*nature*' and '*impact'* this role relationship has with regard to respective role identities of the RN and HCA.

A qualitative descriptive approach was adopted. One ward where RNs and HCAs involved in a reciprocal role relationship was purposefully selected. Participants were observed and seven of those observed were interviewed using a semi-structured interview topic guide. Interview data was analysed using a thematic analytical framework.

The findings of this study relate to the inter-professional relationship that exists between RNs and HCAs which makes collaborative working functional and effective. Findings are presented under four themes: (1) the time to care, (2) a knowing relationship, (3) routine of ward life, and (4) organisation of care. The healthcare organisation is viewed as impacting the dynamic of care causing tension and stress.

Overall, this study suggests that RNs are consumed largely by documentation. RNs appreciate that having HCAs embedded within the skill mix and knowing that individual HCA's are competent allows for informal delegation and supervision. However, HCAs are largely unaware of their work being supervised, seeing supervision as a negative concept. Both RNs and HCAs feel that the HCA role is expanding without support or guidance from the organisation with no career pathways identified. This study makes recommendations in relation to (1) workforce policy (2) practice and (3) future research initiatives.

Keywords; role relationship, registered nurses, healthcare assistants, documentation, organisation of care, role expansion, skill mix, HCA career pathway

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Glossary of Abbreviated Terms

CNM Clinical Nurse Manager

EWS Early Warning Score

HCA Healthcare Assistant

HSE Health Service Executive

INMO Irish Nurses and Midwives Organisation

NMBI Nursing and Midwifery Board Ireland

PEG Percutaneous Endoscopic Gastrostomy

RM Registered Midwife

RN Registered Nurse

WHO World Health Organisation

Definition of Key Terms

Accountability: Is understood as being able to give an account of one's nursing and midwifery judgements, actions and omissions. Accountability is about maintaining competency and safeguarding quality patient care outcomes and standards of the profession, while being answerable to those who are affected by one's nursing or midwifery practice.

An Bord Altranais: Regulatory body governing the registration of nurses in Ireland, now known as NMBI (Nursing and Midwifery Board Ireland).

Collaboration: Healthcare professionals cooperatively working together, sharing responsibility for problem-solving and making decisions to formulate and carry out plans for patient care.

Direct Supervision: The supervising nurse or midwife is actually present and works alongside the student or the regulated or unregulated healthcare support worker when they are undertaking a delegated role or activity.

Healthcare Assistant (HCA): An assistant to nurses in providing direct patient care and other duties under the delegation and supervision of the registered nurse.

Indirect Supervision: The nurse or midwife does not directly observe the student or the regulated or unregulated healthcare support worker undertaking a delegated role or activity.

National Framework of Learning: The Qualifications frameworks describe the qualifications of an education and training system and how they interlink. National qualifications frameworks describe what learners should know, understand and be able to do on the basis of a given qualification.

Obs monitoring: The recording, documenting and reporting of patient vital signs**.**

Registered Nurse (RN): A registered professional nurse that holds and maintains a professional registration within the Irish state.

RNforecast: An organisation undertake studies how organizational features of hospital care impact on nurse recruitment, nurse retention and patient outcomes.

Specialing: A colloquial term for providing one on one care for a patient that requires constant supervision.

Chapter One
Introduction

1.0 Introduction

Nursing skill mix has long been a topic of debate and the use of unregulated workers is prevalent as a means to assisting RNs in their delivery of basic nursing care (2005; Duffield *et al.*, 2016; Jacob *et al.*, 2015). In the Irish context HCAs are the unregulated entity that work under the direction and supervision of the RN (NMBI, 2015b). Due to a shortage of RNs, HCAs are coming to the fore in delivering direct patient care while role flexibility is being demanded of the RN. This changing dynamic of care is being contested by the role expansion of the RN to encompass more technical skills (Department of Health and Children, 1998; 2012) and the formalisation of the HCA role through education (Department of Health and Children, 2001; 2003a; b; 2004). This study therefore explores the '*nature*' and '*impact'* this role relationship has with regard to respective role identities of the RN and HCA.

Section 1.1 outlines the issues pertaining to the study such as, role boundaries, competency, supervision, delegation, and accountability. Section 1.2 describes the search strategy. Section 1.3 explains the catalyst for the study; while section 1.4 outlines the research design applied to this study. Section 1.5 explains the significance of the study particularly in relation to nursing. In section 1.6 relevant workforce policies from an international and national perspective is outlined in relation to the nursing workforce and links workforce policy to this study. Section 1.7 concludes the chapter, while section 1.8 outlines the structure of the thesis.

1.1 Issues Pertaining to the Study

Skill mix is the flexible element of the human workforce that can allow for role flexibility and cost effectiveness (Duffy, 2014; Kopishke, 2003). The role of the RN is currently being reconfigured to allow for flexibility and autonomy while the role of the HCA is being formalised and is increasingly providing more direct patient care. However, the skill mix between RNs and HCAs is not without its issues and a review of the literature concluded that despite twenty years of research and skill mix management a tension between RNs and HCAs continues to exist (Crossan and Ferguson, 2005).

Role boundaries are perceived to be the most common reason why this role relationship is tense. These issues are rooted in the competence of HCAs (Vaughan *et al.*, 2014; Kleinman and Saccomano, 2006), the delegation and supervision RNs must provide (Barter *et al.*, 1997; Tardivel, 2012; Vaughan *et al.*, 2014) and the resulting accountability RNs must assume for the work of the unregulated HCA (Perry *et al.*, 2003; Alcorn and Topping, 2009). It is also accepted that these issues originate in the organisational structure of the HCA role and rushed manner in which the role was introduced (Waldie, 2010; Spilsbury and Meyer, 2004; Orne *et al.*, 1998; McGillis Hall, 2003). Therefore, it is important to investigate if this changing context and dynamic of care relates to the role relationship between the RN and HCA in the Irish healthcare setting.

1.1.1 Research Aim:

The aim of this study is to explore and analyse the role relationship between the RN and the HCA within the clinical social space and how this impacts on care delivery.

1.1.2 Research Objectives:

1. To conduct a scoping review of the literature on the respective roles of the registered nurse and the healthcare assistant in the delivery of patient care;

2. To observe and analyse the nature of the ‘day to day’ interactions between the registered nurse and the healthcare assistant;

3. To analyse the nature of communication that occurs between the registered nurse and the healthcare assistant within the social space of care;

4. To describe and analyse the impact of the relationship between the registered nurse and the healthcare assistant with regard to their respective role identities;

5. To make recommendations on enhancing collaborative working between the registered nurse and the healthcare assistant within the social space of care.

1.2 Search Strategy

Databases searched were: Cinahl, Medline, Cochrane, Ovid and PsychINFO, from 1994 to 2017. Search terms used included: healthcare assistant, HCA, nursing assistant, unlicensed worker, support worker, assistive healthcare personnel, healthcare aide, nurse, RN, workforce, skill mix, nurse mix, relationship, inter-professional relations, professional role and communication, delegation of authority, collaboration, patient safety and work policy. Follow-up search strategies involved hand searches of reference lists from published peer reviewed studies. Articles beyond the search years were reviewed to establish relevance. Searches of the Nursing and Midwifery Board of Ireland (NMBI) website and Department of Health website for policies, draft policies and competency frameworks was also carried out. Google alerts were set up to help identify new relevant information. The outcome of the database search strategy is represented in figure 1.2

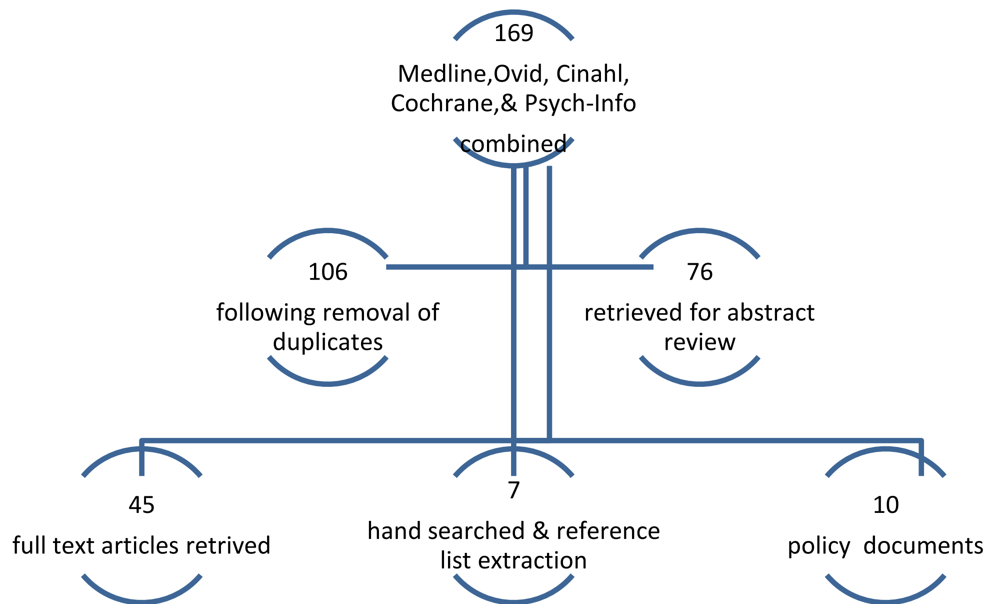

Figure 1 Database Search Results

1.2.1 Inclusion and Exclusion Criteria

It is important to set an inclusion and exclusion criteria when scoping a breath of literature. According to Arksey and O'Malley (2005) systematic reviews develop inclusion and exclusion criteria to assist in consistency of decision making with regard to the relevance of the identified studies.

1.2.1.1 Inclusion

- Research studies discussing role relationship between RNs and HCAs and all organisational associated issues;
- Literature reviews discussing role relationship in relation to the HCA and/or RN role in either the acute or long term care setting;
- Government documents relating to education, employment or workforce issues regarding HCAs and RNs;
- Guidance documents from NMBI in relation to delegation and supervision;
- Published opinion pieces from relevant magazines;

1.2.1.2 Exclusion

- Literature not available in English;

- Articles where full text was not available.

1.3 Catalyst for Study

In an era when managers and policy makers are concerned about the rising costs of healthcare and with a continued shortage of healthcare personnel, particularly RNs, the role of ancillary staff, such as HCAs are increasingly coming to the fore in the delivery of personal care at the bedside (Kleinman and Saccomano, 2006; Keeney *et al.*, 2005; Butler-Williams *et al.*, 2010). There is a constant reconfiguration of the roles of healthcare personnel worldwide in relation to workload, practice responsibilities and reporting relationships (Clark and Thompson, 2015; Conway and Kearin, 2007). Within this context, the role of the RN continues to expand whilst that of the HCA is developing in terms of role identity and inter-relationships with other healthcare professionals. With this in mind, it is now timely to examine current practice and policy as they relate to role reconfigurations of both the RN and HCA and the professional inter-relationships that exist in terms of nature, extent and significance.

A number of factors reflecting my personal and professional experience provided the inspiration to embark on this study exploring the role relationship between RNs and HCAs. At a personal level, I embarked on a dual career in nursing and further education teaching at a time when the formalisation of the role of the HCA through education was gaining pace (Department of Health and Children, 2004). The role of the RN continues to expand reflecting changes within the healthcare landscape and this requires the role development of RNs (Department of Health and Children, 2012). I felt that that the topic of role relationship needed to be investigated to understand the current relationship that exists

between the QQI (Quality and Qualifications Ireland) level 5 educated HCAs and the RNs who are seeing their role evolve.

This study's findings will be published and inform local policy in relation to skill mix models, job descriptions, collaborative learning practices and seek to address the organisational issues surrounding the RN/HCA skill mix.

1.4 Research Design

A qualitative descriptive design was used for this study and was dictated by the research question of investigating the inter-relationship between RNs and HCAs. Skill mix studies are numerous in healthcare; most have concentrated on the most effective use and distribution of staff within nursing, and measured this by quantitative means (Duffield *et al.*, 2016; Yang *et al.*, 2012; Aiken *et al.*, 2017; Sermeus *et al.*, 2011), and while these studies sought the views of RNs it was done so by survey and HCAs were not included. The relationship between RNs and HCAs is complex and there is a value to investigating the barriers and enablers of this relationship, and despite twenty years of research this relationship remains contentious (Crossan and Ferguson, 2005).

To gain a true insight into the nature of the day-to-day interactions between RNs and HCAs it is important to observe and analyse the relationship within the social space of care. A structured observational chart was developed with flexibility to capture uncharted observations and the researchers' reflexive notes by means of description. In order to examine the impact the relationship has on RNs and HCAs, semi structured interviews, informed by the literature and the observational findings with RNs and HCAs were carried out. Therefore the qualitative descriptive nature of this approach allows for a unique insight from those who experience the RN/HCA role relationship.

1.5 Significance of the Study

There is a role reconfiguration underway of healthcare personnel, their duties and workloads within the health service (Duffield *et al.*, 2011). In an era where managers and policy makers are concerned about the rising costs of healthcare and with a continued shortage of healthcare personnel, particularly RNs, the role of unqualified staff, namely HCAs is evolving to meet the demands of a cost constrained health service with an increasing patient acuity (Aiken *et al.*, 2017; North and Hughes, 2012). The role of the RN is expanding to encompass more technical skills (Pearcey, 2008). The role expansion of the RN appears to be largely welcomed but it is not without its issues such as the role relationship, delegation and supervision, accountability and competency (Pearcey, 2008; Spilsbury and Meyer, 2005a; Kleinman and Saccomano, 2006; Thornley, 2000). RNs are seen as managers of care (Clark and Thompson, 2015) as opposed to direct patient care providers, a duty that is being subsumed into the HCA role and leaving RNs conflicted about their own role.

The role of ancillary staff, such as HCAs are increasingly coming to the fore in the delivery of personal bedside care (Jacob *et al.*, 2015). The benefits of such reconfigured roles may be positive in terms of the personalisation of health care delivery. However, there are difficulties in successfully achieving reconfigured roles, such as cost, diversity of roles, professional resistance, education of HCAs and decreasing numbers of RNs are reasons why this development is tense (Waldie, 2010). Professional resistance of RNs to the HCA role are due to the organisation of the role with; blurred boundaries, associated with poorly defined roles leading to role threat (King *et al.*, 2015). Issues of delegation, supervision and the associated competency of HCAs hinder the successful integration of HCAs into the RN skill mix in the acute setting (Vaughan *et al.*, 2014; Cavendish, 2013). These issues are rooted in the lack of formal workforce and skill mix policy guiding organisations in their integration of

the HCA role into the nursing skill mix (Buchan and Aiken, 2008; Duffy, 2014; Attree *et al.*, 2011).

1.6 Healthcare Workforce Policy and Planning:

Healthcare is labour intensive and it is imperative to the business of healthcare that there is an adequate workforce available to meet the level of service agreed within the healthcare service plan (Buchan and Aiken, 2008). A review of sixty years of methodological research, states that the effective use and deployment of the appropriate staff is paramount to the effectiveness of a service in terms of cost effectiveness, quality of service and efficient service delivery (Lopes *et al.*, 2015).

The Attree *et al.* (2011) review of workforce policy in five European countries posits that there is a global imbalance in the supply and demand of RNs and doctors. There is no single global measure of the extent and nature of the imbalance (Buchan, 2008), but the reasons are multifaceted and include an ageing workforce that is retiring with no replacement of key staff, coupled with a growing and ageing population with increased risks of non-communicable diseases such as cancer and heart disease (Buchan and Aiken, 2008; Global Health Workforce Alliance, 2013). There is also a decrease in the younger population entering the traditional professions, such as nursing, as it is not seen as attractive a profession it once was (Kleinman and Saccomano, 2006). This imbalance together with the aging population is impacting on the global and domestic supply and demand of the healthcare workforce (Attree *et al.*, 2011; Humphries *et al.*, 2012).

1.6.1 International Healthcare Workforce Policy and Planning

Within the EU there is a limited supply of domestically trained RNs resulting in an international imbalance caused by the active recruitment of international healthcare

personnel, especially RNs (Humphries *et al.*, 2008). The World Health Organisation (2010) Global Code of Practice requested that EU member states sign up to a code of ethical recruitment of healthcare staff in an effort to protect developing and small island international countries. Humphries *et al.* (2008, p. 264) referred to the recruitment campaign of 'overseas' RNs as 'rapid and remarkable'. This code, although voluntary, has had implications for the Irish nursing workforce, as active recruitment of nurses from developing and small island countries is no longer a sustainable way of suppling nurses for the Irish workforce. This requires the limited available healthcare workforce to be flexible in its approach to the delivery of patient care and altering skill mix is seen as a way of addressing the shortages of RNs available to deliver care (Bowman, 2003; Jack *et al.*, 2004; Orne *et al.*, 1998; Crossan and Ferguson, 2005). This altering of skill mix urges caution as the benefits of reconfigured roles may be positive in terms of cost effectiveness but may have consequences for delivery of quality care (Duffield *et al.*, 2011; Yang *et al.*, 2012). The Francis (2013) report into gross omissions of care at the Mid Staffordshire Trust in England found that the organisation was so focused on the business of care and meeting performance targets, that patient care was put at risk. The findings of the Mid Staffordshire Investigation were many, but in relation to the skill mix of unregulated workers (HCAs), a recommendation was made to consolidate and formalise the role of the HCA. It also recommended that the registration of HCAs be a matter of priority.

The formalisation of the role of the HCA should occur through standardisation and unequivocally identifying this group of workers as a separate entity to RNs (Francis, 2013). The Francis Report (2013) recommended that there should be a national standard set for the education and training of HCAs. The attainment of this qualification, along with a set

code of conduct for HCAs to be guided by, could allow for the registration of HCAs with a governing body. It was also recommended that this register be prepared and maintained by the Nursing and Midwifery Council. It is envisaged that through this recommendation that any failure by a HCA to comply with these measures would result in the individual HCA being unable to secure employment in any care setting (Francis, 2013).

Some recommendations from the Francis Report (2013) were adopted and reflect the current situation for HCAs working in the UK; all HCAs must obtain a 'Care Certificate'. In attaining this certificate standards, competences and behaviours are expected, while adherence to a code of conduct is requisite (Skills for Care and Skills for Health, 2013b; a). They remain, as do their Irish counterpart an unregulated entity within the nursing skill mix.

1.6.2 Healthcare Workforce Policy and Planning: An Irish Perspective

In Ireland, the recent recession saw health budgets cut resulting in fiscal consolidation and being responsible as the core driver for change (Nolan, 2014). The migration of RNs, due to the recession, combined with not training the significant number of RNs required to meet the demands of an ageing population and no longer having reliance on nurse immigration, has led to nursing shortages (Humphries *et al.*, 2012). Both nationally and internationally, this shortage and fiscal constraint has seen a more flexible approach to workforce policy and planning (Department of Health and Children, 2009).

The use of HCAs in the delivery of direct patient care is routine in Ireland both in the private and public sector. However, the correct skill mix is open to much debate (Scott, 2013; Duffield *et al.*, 2016). To provide context to the relationship between RNs and HCAs it is important to look at how government policy has shaped this relationship throughout the recent past.

Historically, ancillary nursing staff, under the 1985 Irish Nurses Act could be entered into a register that was maintained by An Bord Altranais. However this part of the act was dormant and the Commission on Nursing (1998) recommended that this be deleted, as this profession of HCA was not connected to the registration of RNs. The Commission was conscious of not creating a two-tier nursing system that could confuse the general population and it was felt that this group of non-nursing personnel should be managed directly by their employer. In contrast to this view, Coffey (2004) felt that nursing was not owned by RNs and that HCAs and lay carers should be valued for their contribution to nursing. Regardless, a conclusion needs to be arrived at in relation to HCAs either being a profession separate to nursing or that they are part of the nursing profession, as the contribution that HCAs make to the delivery of patient care is significant (Pearcey, 2008).

The Commission on Nursing (1998) also recommended establishing standard criteria in relation to the entry requirements, education qualifications and training for HCAs across the health service. The working group for the 'Effective Utilisation of Professional Skills of Nurses and Midwives: Report of the Working Group' (2001) was drafted in response to the recommendations made by the Commission (1998) to deal with the formalisation of the role of the HCA. It recommended that the title of HCA be uniformly used across all healthcare settings and recommended that a job description be developed; a training programme be established to aid the training of HCAs and that additional resources be made available to integrate the role of HCA into the workforce. It was also the focus of this report to encompass the impact of RNs and RMs in the training and understanding their role as delegators to the HCA (Department of Health and Children, 2001). In 2004 the 'Final Report of the Review Group on Health Service Care Staff' (2004) recommended that due to the

success of a pilot programme that took place in 2001 regarding the education and training of HCAs and the previous report 'Evaluation of the Irish Pilot Programme for the Education of Healthcare Assistants' (2003a), that a national programme of education for HCAs be rolled out. McKenna *et al.* (2005) assessed the views of teaching staff and clinical assessors in the vocational training of HCAs. They found that a training programme promoting patient safety and quality of care assisted in the competence of HCAs, but that RNs require support in the form of mentorship training and education.

In 2005, FAS, the Irish training and employment authority, published its 'Healthcare Skills: Monitoring Report', and identified that the demand for HCAs was growing nationally at a rate of 1% annually and estimated that in 2003 there were 8,465 positions in existence. However, it was unable to predict accurate future projections as the role was so relatively new to the Irish healthcare system (Foras Aiseanna Saothair, 2005).

In 2006 the Health Service Executive (HSE) set out a generic job description for HCAs, providing direction to RNs in relation to their role and responsibility with regard to delegating to HCAs and the scope of practice of HCAs. A HSE sub group was formed to develop an eight hour educational awareness programme for RN staff which included topics such as; accountability, delegation, preceptorship and the assessment process for HCAs (Department of Health and Children, 2006). To date, the HSE generic job description has remained largely unchanged.

A European wide project was undertaken in 2009 to capture the significance of the HCA role within the EU (SANCO/1/2009,Neary, 2009). The study captured that HCAs remain unregulated. In Ireland, educational courses for HCAs are at least a level 5 on the national framework of learning, but are not mandatory.

A 2012 review of undergraduate nursing degrees recognised that RNs and RMs make up over one third of the professional healthcare workforce and recommended that expertise and skills were needed to develop a more flexible, autonomous RN (Department of Health and Children, 2012). This role flexibility requires RNs to take on more skilled technical work. This skilled technical work undertaken by RNs means a gap is left in the basic nursing care needs (Kleinman and Saccomano, 2006).

In response to this gap and to encourage HCAs to engage with formal education and training, an incentivised scheme was established by the health service executive, for HCAs currently employed by the HSE to undertake the new education programme (Health Service Executive, 2013). For the duration of the programme HCAs assumed the role of paid student (Department of Health and Children, 2003b).

In 2014, the Taskforce on Staffing and Skill Mix for Nursing was established to develop a framework to determine appropriate staffing and skill mix of RNs. While this is an ongoing project, the methods by which skill mix is being determined is largely by quantitative methods, using some of the Irish data from the RNForecast (Scott, 2013). On completion of the work of this taskforce, chaired by the Chief Nursing Officer and supported by the nursing union (INMO) it is hoped a true insight into the value of the appropriate skill mix of RNs and HCAs can be provided. Analysis of the interim report suggests that HCAs are not being represented on the national consultation platform, as they do not have a regulatory or other body to represent them. While this is the first workforce policy to tackle the issue of skill mix earnestly, it is important that the issues facing HCAs as well as RNs be considered equally.

The Neary (2009) EU (SANCO/1/2009) (as mentioned earlier) country profile remains relevant for many reasons; HCAs continue to have many titles and work at different levels in the acute, long-term care and community settings. Hindrance to the full integration of HCAs mentioned in this situation statement was the concept of delegation to HCAs by RNs, and the implications from a regulatory perspective. The 2015 Scope of Practice for RNs and RMs clarifies the issue of delegation by outlining considerations to be made by the RN when deciding to delegate to HCAs (NMBI, 2015b), but presently NMBI has no role regarding HCAs in terms of education and training or regulation.

The lack of formulated strategies that ground the use of HCAs in policies and procedures, is leading to significant variations in the role of HCAs and the nature of the work they undertake. This can lead to HCAs being used and misused with little chance of them resisting work intensification (Spilsbury and Meyer, 2004; Clark and Thompson, 2015). There is a change in the context in which patient care is delivered, as reconfiguration of the traditional roles of nurse staffing models has become a priority in workforce planning. It is important that when considering workforce planning and role reconfiguration that it is done with the core objective of ensuring better outcomes for patients and not just an exercise in cost saving, (Lopes *et al.*, 2015). The implications of this role reconfiguration can result in a tense and stressed workforce.

1.6.3 Healthcare Workforce Policy Conclusion

Ireland has only started to tackle health workforce planning (Humphries *et al.*, 2012). Robust data collection systems are required to inform workforce planning processes. Further research in an Irish context be undertaken, to develop Irish data on the relationship between RN staffing, ward-level factors and patient outcomes (Department of Health, 2016). It is envisaged that this thesis will contribute to the empirical body of knowledge.

1.7 Conclusion

This chapter has outlined the issues pertaining to the study and the importance of the aim of the study in exploring and analysing the role relationship between RNs and HCAs. The search strategy was described and the catalyst for the study explained. The rationale for undertaking a qualitative descriptive design was discussed and the significance of the study outlined. Relevant healthcare workforce policy both internationally and nationally were identified demonstrating a link with this study.

1.8 The Structure of this Thesis

This thesis consists of six chapters. Chapter one introduces the study and workforce planning policy and its significance in relation to RNs and HCAs working within the social space of care. Chapter two provides a scoping literature review of the recurring factors that influence the professional role relationship between RNs and HCAs within the social space of care and how this impacts on care delivery.

Chapter three presents the process of investigation in terms of the methodological approach chosen. The justification for the qualitative descriptive design adopted by Sandelowski (2000, 2010) and Bradshaw *et al.* (2017). Issues in relation to qualitative descriptive approach such as design, sampling, data collection and analysis procedures are illustrated. Also, measures adopted to ensure quality in the study are also discussed, along with ethical considerations.

The observational findings are presented in chapter four and chapter five presents the participants views and opinions with regard to role relationships between RNs and HCAs. These findings are presented under four themes of (1) the time to care, as RNs are consumed largely by documentation (2) a knowing relationship, relating to HCAs being regular members of the skill mix (3) the routine of ward life, which dictates delegation and

supervision of HCAs by RNs and (4) the organisation of care, relating to the expansion of the HCA role without involvement from RNs or HCAs.

Chapter six discusses the findings with regard to the theoretical and empirical literature relating to role relationships and makes recommendations with regard to (1) workforce policy (2) practice, and (3) research initiatives. The limitations of adopting the qualitative descriptive approach are acknowledged.

Chapter Two
Literature Review

2.0 Introduction

This chapter describes and analyses the literature regarding the issues pertaining to the role relationship between RNs and HCAs and sets the context for this study. The themes associated with the role relationship between RNs and HCAs were identified when repetition of issues was noted across the literature. Thematically identifying issues was assisted through the creation of a database collating important information including the outcomes of each study, this was crucial in identifying reoccurring themes and also ensuring empirical rigour an example of this vast data is illustrated in Section 2.1. Section 2.2 provides perspective to the evolution of the RN and HCA role relationship. Section 2.3 discusses delegation and supervision as an issue within the relationship while section 2.4 discusses the impact of accountability on delegation and supervision. Section 2.5 investigates clinical competency and the impact this has on the role relationship between the RN and HCA with section 2.6 outlines the various issues which arise from the role flexibility required of RNs and HCAs.

2.1 Collation of Emerging Themes

The collation and management of data in a meaningful manner is imperative to a systematic literature review which provides a critical summary of the evidence gathered (Aveyard, 2010). The following except is extracted from a large volume of work consisting of sixty-two summarised articles and reports and demonstrates the themes that guided the themes underpinning the literature review.

Year	Database	Author	Place	Article title	Methodology	Population	Aims of Study	Themes	Gaps in Literature
2003	Medline	Baldwin, J., Roberts, J. D., Fitzpatrick, J. I., While, A. and Cowan, D. T.	Nursing Home **UK**	'The role of the support worker in nursing homes: a consideration of key issues'	Literature Review	RN, Support workers	To critically consider the role of the support worker in the nursing home sector with reference to the UK system	1. Majority of the role focuses on direct patient care, however, a lack of role clarification was evident 2. Differing views of RNs & support workers regarding place of support workers in the care process; 3. SW saw their role as similar to RN 4. Inadequate preparation & subsequent supervision of SW; 5. Role clarification, appropriate preparation & continuing development needs consideration.	Further research is needed if the SW role is to be used effectively & efficiently.
1997	CINAHL complete	Barter M., F E., McLaughlin & S. Sue.	Acute Hospital **USA**	Registered Nurses Role Changes and Satisfaction with Unlicensed Assistive Personnel	Descriptive cross sectional study design; Survey	RNs	To examine RN perceptions of changes in the role of the RN & RN satisfaction with the use of UAPs in acute hospital care delivery	1. RNs reported dissatisfaction with UAP's ability to perform delegated tasks, communicate pertinent information and provide more time for professional nursing activities;	Qualitative research related to the attitudes of RNs working with UAP would provide nursing administrators with additional information to redesign roles for new systems of care delivery, and attend to issues related to role stress, ambiguity, and overload.
2008	Medline	Siegel E., Young H., Mitchell P. & Shannon S.	3 Nursing Homes, **America**	Nurse Preparation and Organisational Support for Supervision of Unlicensed Assistive Personnel in Nursing Homes	Ethnographic approach; 31 interviews; 170 hours of passive participant observations; Document review;	RNs, UAPs, Management	To describe the organisational, managerial & RN level factors associated with RN role as Supervisor	1.Considerable variation in organisational resources, systems & process to support organisation & operation of the supervisory role; 2. Limited evidence of RN estimation of the potential benefits of training to support supervisory practice & the complexity of the supervisory role;	Conditions under which the supervisory role is organised and operated at the work-unit level, taking into account workloads RN/LPN staffing & role expectations.
2004	Wiley	Spilsbury, Karen Meyer, Julienne	Hospital **UK**	Use, misuse and non-use of health care assistants: understanding the work of health care assistants in a hospital setting	A single case study design using mixed methods survey, interviews, participant observations, focus groups and documents)		Understanding the work of HCAs in a UK hospital setting. The study is built upon what health care assistants say they do, compared with what they actually do in practice.	There are policy expectations associated with the work of health care assistants. The study reveals significant deviations from these goals. Findings suggest dynamic patterns of use, misuse and non-use of the health care assistants as a resource to patient care.	The competence of health care assistants to carry out nursing work needs to be reassessed, monitored and supervised to ensure quality standards.

Year	Database	Author	Place	Article title	Methodology	Population	Aims of Study	Themes	Gaps in Literature
2013	Cinahl	Munn, Zachary Tufanaru, Catalin Aromataris, Edoardo	Authored in **Australia**	Recognition of the health assistant as a delegated clinical role and their inclusion in models of care: a systematic review and meta-synthesis of qualitative evidence	Systematic review of qualitative studies	RNs, HCA	To synthesise qualitative data regarding the appropriateness of strategies used to establish the HCA role as a recognised delegated clinical role and to promote their inclusion in models of care	1. There are barrier to incorporating the assistant role; 2.These barriers may include lack of clarity regarding roles, 3. Negative perception of assistants by professionals; 4. Effective strategies have been used to promote inclusion, including education/ training programmes incorporating collaborative learning; 5.Issues with mentoring and supervision were identified;	Types of models of care need to be considered and researched further before integrating the role of the HCA
2004	Medline	McKenna, H., Hasson, F. & Keeney, S.	Authored in **Ireland**	Patient safety and quality of care: the role of the health care assistant	Literature review	RNs HCAs	To explore the issues around, regulation, clear boundaries, education & training	1.HCAs are answerable to managers not RNs; 2.Distinguishing between , RN & HCA is blurring; 3.RNs need to define & control work practices before they lose claim to these core skills associated with nursing; 4.HCAs see themselves are powerless while they wait for policy makers to address the issues; 5.In the meantime, lack of recognised training, regulation & their undefined role put patient quality at risk.	Lack of training and impact on patient care
2006	Medline	Kleinman, S. Saccomano S.	Authored in **America**	Registered Nurses and Unlicensed Assistive Personnel: An Uneasy Alliance	Literature review	RNs HCAs, patients		1. The use of unlicenced assestive personel fills the void created by the current shortage of RNs & decreases the cost of providing care; 2. Although RNs are frequently asked to delegate & supervise patient care related activities, they do not feel qualified to do this effectively; 3. Continuing education is an effective way for RNs to learn the supervision & delegation skills required & should be supported by academic & clinical educators.	An education program of responsibilities of the job needs to established

Year	Database	Author	Place	Article title	Methodology	Population	Aims of Study	Themes	Gaps in Literature
2004	CINAHL complete	Jack, B., Brown, J. and Chapman, T.	Sstudy 1 large Acute Hospital **UK**	Professional issues. Ward managers' perceptions of the role of healthcare assistants',	Survey, (N=35) Response rate of 94% descriptive statistics; Open ended questions analysed for emerging themes	Ward Managers	The study explored hospital ward managers' views on the current and potential expansion of the healthcare assistant's role.	1. HCAs carry out a wide diversity of procedures ranging from general tidying to carrying out complex clinical procedures 2. 82% (n = 27) of the managers reported that the HCA role could be expanded, 3.Concerns were raised regarding additional training of HCAS and supervision by RNs. 4. There is evidence to suggest that there is a lack of a clearly defined role for HCAs; 5. There is a potential for HCAs to expand their role with the increasing opportunities with NVQ level 2 and 3 training.	Research that includes exploring what the healthcare assistants themselves see as their non-clinical and clinical activities coupled with exploring the time spent on the different tasks would be useful. Clearly, a qualitative study using in depth interviews or focus group interviews and observation of the healthcare assistants would also be of value.
2009	OVID	King, P., & Crawford D.	Childrens ICU, **Scotland**	Healthcare Assistants in the Children's Intensive Care Unit	Literature review	RSCN, HCA	To debate the use of HCAs in a CICU	1. the evolution of the HCA role in CICU requires a comprehensive strategy to ensure appropriate education, training & supervision are in place; 2. Career development pathways need to be in place; 3. Role accountability needs to be clearly defined at the different stages of the pathway	
2016		Allan, H., Magnusson, C., Evans, K., Ball, E., Westwood, S., Curtis, K., Horton, K & Johnson, M.	3 Hospitals, **UK**		Ethnographic case study; Participant & non participant observation (230 hrs) Interviews,(50)	Newly qualified RNs, Ward Managers; HCAs	To understand how Newly Qualified RNs (NQRN)decontextualiz e knowledge to allow them to delegate & supervise when working with HCAS	NQN learn invisibly by 4 ways; 1. learning through mistakes; Level of risk associated with delegation of certain tasks to HCAs which require more or lesser levels of supervision should be flagged to NQN 2. learning from difficult experiences; Providing NQN with adequate support will enable them to support HCAs to whom they delegate & supervise; 3. Informal learning from colleagues; Over reliance on HCA supporting NQN leading to a 'reverse delegation' 4. 'muddling through' Impact of over burdening the HCA while NQN muddles through.	Delegation & Supervision appear not to be taught or assessed to the same as other skills

Year	Database	Author	Place	Article title	Methodology	Population	Aims of Study	Themes	Gaps in Literature
2008	Cinahl	Standing, T. S. and Anthony, M. K.	Acute Care **USA**	'Delegation: what it means to acute care nurses',	Phenomological Study 17 RNs interviewed	RNs with over 6month post reg experience	To examine the meaning of delegation for RNs to UAPs in terms of nature & significance	Examining the meaning of delegation in terms of its nature & significance underscores the importance of the communication & relationship issues between UAP & RN.	The UAP trust in the RN requires further study.
2012	Grey Literature	Kærnested, B. and Bragadóttir, H.	Acute medical units **Iceland**	'Delegation of Registered Nurses Revisited: Attitudes towards Delegation and Preparedness to Delegate Effectively'	Descriptive correlation design study Paper & Pencil Questionnaire	71 RNs	1. Identify the attitudes of RN towards delegation, 2. Preparedness to delegate effectively, 3. To determine if attitude & preparedness is related to age, experience, education in delegation, workload & job satisfaction.	Most participants have a positive attitude towards delegation; However, there is potential for improvement; Age, experience & former education on delegation are significantly related to a number of attitude & preparedness issues regarding confidence in delegating; mutual trust, collaboration & communication between assistance personnel	1. Further research to gain deeper understanding of delegation by RNs; 2. Examination through observation is required of what RNs do & what RNs delegate to others; 3. The judgements upon which the intervention & delegation decision are being made need to be examined in detail;

2.2 Role Relationship

There is a professional role relationship that exists between the RN and the HCA. By virtue of the common goal that RNs and HCAs share in delivering patient care, the role is interdependent (Spilsbury and Meyer, 2005b). The role of both the RN and HCA are currently undergoing expansion as is evidenced in international research (Duffy, 2014; Pearcey, 2008; Berta *et al.*, 2013). This is driven by cost-cutting measures and the demands by the healthcare environment to have a more flexible workforce (McGuire *et al.*, 2007).

The role of HCAs has long been associated with domestic ward duties and introduced to the nursing workforce to alleviate RNs from non-nursing tasks to allow them spend more time with the patients (Keeney *et al.*, 2005; Jack *et al.*, 2004). Due to cost constraints and a shortage of RNs, HCAs are coming to the fore in providing direct patient care and are now internationally recognised members of the multidisciplinary team (Waldie, 2010; Kleinman and Saccomano, 2006).

The quality of the RN and HCA relationship can vary, from being 'tense and stressed or functional and effective' (Munn *et al.*, 2013, p. 10). These negative feelings can be multifaceted, owing to blurring of roles, role threat, role identity and role conflict. Role conflict according to McGillis Hall (2003) between RNs and HCAs may occur at an organisational level as opposed to the day-to-day working relationship. Healthcare organisations play a significant role in the type of relationship that exists between RNs and HCAs, with the positives of good working relationships rooted in positive organisation structures (Baldwin *et al.*, 2003; Barter *et al.*, 1997).

2.2.1 Role Blurring

The organisational demand of role flexibility is leading to role blurring and boundary issues among RNs and HCAs (Baldwin *et al.*, 2003). Protection of role boundaries occurs when role

extension is introduced as a means to address professional staff shortages or when driven by policy and organisational demands (King *et al.*, 2015). RNs have difficulty defining their roles (Perry *et al.*, 2003; Pearcey, 2008) while HCAs define their roles in terms of what they cannot do (Perry *et al.*, 2003; Bellury, 2016; Tardivel, 2012). There is a lack of a clear defined role for HCAs (Jack *et al.*, 2004; Baldwin *et al.*, 2003). This is leading to blurring of roles with both RNs and HCAs feeling conflict, with RNs worrying about the encroachment by HCAs into the profession of nursing and the HCAs feeling that the role is not understood by RNs and their contribution to care is not valued (Coffey, 2004).

There are more similarities in the roles of RNs and HCAs than there are differences (Spilsbury and Meyer, 2005b). These similar roles or soft role boundaries are rooted in policy; the 'Effective Utilisation of Professional Skills of Nurses and Midwives: Report of the Working Group' (2002) which called for a broad national core job description to encompass the broad spectrum of healthcare settings where HCAs work (Department of Health and Children, 2001). This leads to role ambiguity as there is a lack of clarity about duties and authority with conflict occuring when there is ambiguity in the specific assignment of duties to roles (Barter *et al.*, 1997).

Role boundaries allow for safer practice when team members are clear about roles and responsibilities (Flynn *et al.*, 2015). RNs and HCAs have a co-dependence on each other to fulfil their respective roles (Spilsbury and Meyer, 2005b). Effective healthcare teams are important for patient care delivery and an understanding of their own and each other's team members' value is imperative to collaborative patient care delivery (Lloyd *et al.*, 2011). Role boundaries are contested by the flexibility that the organisation demands seeing an abdication of roles as opposed to a nurse led collaborative working relationship arising with

RNs appearing passive in guiding the future roles of HCAs, this is evident in the UK based studies (Pearcey, 2008; Coffey, 2004). The blurring of role boundaries and the feeling of encroachment on both HCA and RN respective roles is impacting this role relationship (Orne *et al.*, 1998).

The role of HCAs remains poorly defined and this allows for boundary blurring. The consequence is RNs are uncertain about the role of HCAs and they are concerned that some aspects of the role may be assumed by HCAs with the extension of the HCA role leading to a loss of RNs delivering nursing care resulting in RNs feeling their role as nurses under threat (Daykin and Clarke, 2000; Pearcey, 2008).

2.2.2 Role Threat

RNs fear that the extension of the role is leading to a loss of patient care and that there is a lack of thought as to what this extension means, conceivably causing RNs to feel threatened and therefore resulting in frustration and tension (Pearcey, 2008; Barter *et al.*, 1997). This fear of replacement and the feelings of threat are hindering the full integration of the HCA role. Henderson (2012, p. 4) disagrees that RNs should feel threatened and in her open letter to RNs about the introduction of the HCA role to the nursing skill mix stated, '*The HCA model is not about challenging the legitimacy of nursing professionals, it is about fulfilling our promise to deliver safe quality care to our patients*'.

HCAs make a valued contribution to patient care but this work largely goes unrecognised as there is generally a lack of understanding of the role of the HCA, since the introduction of HCAs there has been an overlap in duties and that there are more similarities than differences in the roles of the HCA and the RN; and while HCAs see it as an opportunity to develop, RNs see it as a threat to the role (Spilsbury and Meyer, 2004; Keeney *et al.*, 2005;

Daykin and Clarke, 2000) as they feel they can be replaced by a cheaper workforce (Chang, 1995; Orne *et al.*, 1998). According to Spilsbury and Meyer (2004) role threat is one factor leading to the HCA being underutilised, as their roles are being limited by the work the RN will allow them do.

The limiting of HCAs' work stems from the frustration of RNs with the manner in which HCAs were introduced into the skill mix believing that little thought was given to the impact this would have on the RN workload (Orne *et al.*, 1998) and acceptance of the HCA role is imperative to the collaborative working relationship (Keeney *et al.*, 2005), this is a finding across all jurisdictions. RNs need to be included in HCA role development and the education and training of HCAs (Baldwin *et al.*, 2003; Coffey, 2004), as this would see less of RNs relinquishing of nursing care to HCAs (Pearcey, 2008).

RNs feel frustrated that they are not being supported by the organisation in guiding the HCA role (Shearer, 2013; McGillis Hall, 2003; Barter *et al.*, 1997; Trybou *et al.*, 2014). Contrary to this Coffey (2004) found that RNs had little interest in the training of HCAs, with RNs citing that they had too little time or were not trained to teach. RNs should be part of the training and clinical assessment of HCAs, (Barter *et al.*, 1997). Holland's (2015) opinion piece stated that it is essential that RN leaders are at the policy table to provide an empirical perspective on workforce planning Henderson (2012, p. 4) urged that HCAs are not an '*either or*' situation but an '*also*' and *'included'*. RNs need to be explicit in their identity and the role that they play in quality patient care delivery to prevent the feeling of threat (Pearcey, 2008; Heath, 2006).

2.2.3 In-Group Identity

In-group identity refers to a group that one ascribes to due to a commonality for example, in terms of the healthcare setting an RN or HCA ascribe to the group with which they share an occupational commonality. The people within the group generally strive to achieve or maintain a positive social identity, resulting in positive self-esteem (Brown, 2000).

This membership of an 'in-group' can lead to difficulties when collaboration is required. HCAs see themselves as a close-knit, 'in-group' that shares a low level status within the healthcare team, with little prospect of career progression (Spilsbury and Meyer, 2005b; Clark and Thompson, 2015; Schneider, 2010). This low level status can put them at a disadvantage in deflecting work overload and can result in them being exploited (Clark and Thompson, 2015).

The RN and HCA relationship can be both rewarding and a source of devaluation, as RNs protect their professional identity by excluding HCAs in care planning, patient care discussions, and discouraging communication with family members, despite HCAs having relevant information to contribute (Lloyd *et al.*, 2011). Spilsbury and Meyer (2005b) uncovered that HCAs would not divulge relevant information to RNs in order to bolster their own status. This oversubscription to the group can be isolating and can interfere with collaborative working relationships (Lloyd *et al.*, 2011). According to Bellury (2016, p. 337), HCAs work in *'parallel spheres'*, keeping information and resources to themselves. These are disquieting findings as mutual respect is required for collaborative work practices (Senior and Swailes, 2007).

2.3 Delegation and Supervision

Appropriate task delegation is critical to healthcare delivery (Lopes *et al.*, 2015) and government policy dictates that RNs delegate duties to and supervise the work of HCAs

(Department of Health and Children, 2006; NMBI, 2015b). The evolving role of the HCA results in RNs being unsure of the HCAs role (Pearcey, 2008), especially when HCAs are becoming more involved with direct patient care.

RNs struggle with the notion of delegation and supervision (Allan *et al.*, 2016). The RN is responsible for determining the appropriateness of delegating a task and ensuring competency (Kleinman and Saccomano, 2006). The delegation framework set out by NMBI (2015b) outlines key considerations when delegating. The word '*competence*' is used when prompting the RN to ascertain if the duty to be delegated is appropriate and while the person delegated to, is accountable for accepting the delegated task, supervision, monitoring and evaluation are key components of delegation. HCAs work alone and unsupervised while carrying out direct care to patients, with HCAs reporting little or none of their work being supervised (Spilsbury and Meyer, 2005b; Thornley, 2000). HCAs work outside of the remit, with the knowledge of the RN (Pearcey, 2008) and while Keeney *et al.* (2005) reported that patients found HCAs to be very helpful, they assumed that they would not carry out any tasks for which they had not received training. These findings are concerning and have implications for quality of care and could be an indicator as to why RNs report that they are reluctant to delegate tasks to HCAs (Pearcey, 2008). Despite an intense workload, RNs sometimes choose not delegate tasks to HCAs, as they find it too time consuming and find it easier to do the task themselves (Kærnested and Bragadóttir, 2012; Shearer, 2013). RNs report the double-checking of work done by HCAs leads to a waste of time, especially when work is left undone or changes in the health status of the patient goes unreported by the HCA (Shearer, 2013). However, it cannot always be assumed that the HCAs are at fault as perhaps the skill of the RN in communicating the delegation is deficient.

In 1992 a RN recorded her thoughts in a survey regarding the use of and delegation of tasks to HCAs, and stated that: *'If you clearly define and structure the assistants role, work with her to guide, clarify, educate, motivate, and most importantly, support her, she'll become a very functional member of your team'* (Blegen et al., 1992, p. 31).

2.3.1 Delegation as a Collaborative Issue

Delegation by RNs to HCAs is an issue that appears to hinder the evolution and integration of the expanding role of the HCA into the healthcare team (Vaughan *et al.*, 2014). RNs have reservations in delegating certain tasks to HCAs (Bowman, 2003), based on the uncertainty of competency, legitimate authority, clarity of roles and responsibility for the actions of unregulated staff (Kopishke, 2003; Baldwin *et al.*, 2003). These issues are seen as a barrier to the utilisation of HCAs to their full potential (Baldwin *et al.*, 2003). This barrier exists because no guidelines exist on how and what to delegate to HCAs, leaving RNs vulnerable and the HCA role open to abuse, (Keeney *et al.*, 2005).

Effective delegation can result in RNs having more time to deliver care to the patients increasing job satisfaction, leading to a positive effect on teams (Clark and Thompson, 2015). However, RNs often lack the skill to legitimately authorise a delegated task and supervise the HCA effectively (Baldwin *et al.*, 2003; Kleinman and Saccomano, 2006).

2.3.2 The Skill of Delegation and Supervision

RNs struggle with delegation and supervision skills (Allan *et al.*, 2016) and are not focused upon in nurse education, RNs often rely on these skills being developed by other means, such as through previous professional experiences, observation of colleagues and personal experiences (Siegel *et al.*, 2008). While the Blegen *et al.* (1992) survey of RNs found that RNs with more years of work experience were more likely to delegate work than younger counterparts, why this occurs was not determined. Shearer (2013) identified that an

increase in workload is a reason for RNs not willing to delegate to HCAs. However, HCAs would seek RNs out when clinical judgement is needed or to assist them in activities (Tardivel, 2012). This suggests that HCAs understand the boundaries of their capabilities and RNs understand their role in supervision, they are also aware the supervision element is often lacking (Spilsbury and Meyer, 2005b).

NMBI (2015b) states that delegation can be supervised either directly or indirectly, and while the HCAs might feel that they are working unsupervised, RNs could well be supervising by re-checking the work (Shearer, 2013). A recent ethnographic case study of three acute hospital sites by Allan *et al.* (2016, p. 2) investigated how newly-qualified RNs delegated and supervised. They discovered RNs re-contextualised concepts by extracting meaning and applying it to the relevant situation to allow them to delegate and supervise HCAs. Their study identified that re-contextualising occurs by invisible learning and that this learning transpires by four means, namely, (1) learning through mistakes, (2) learning from difficult experiences, (3) informal learning from colleagues and (4) '*muddling*' through. Delegation to and supervision of HCAs is expected of the RN role, RNs feel they are not educationally prepared for this role (Kleinman and Saccomano, 2006). This results in the RNs ability to supervise ranging from purposeful to hesitant with management being vague in the instruction on the way supervision is to be carried out (Siegel *et al.*, 2008). Consequently, RNs do not attribute the same need for further training in relation to the skill of delegation and supervision as managers do (Siegel *et al.*, 2008). This suggests RNs see the role as delegator and effective supervisor as a *'soft skill'*, despite the breakdown in these skills leading to unintended medical errors (Ray and Overman, 2014, p. 64).

Education is fundamental in the development of the skill of delegation and supervision (McKenna *et al.*, 2005). Clinical and academic educators are being challenged to provide theory and practical skills in delegating and supervising as it is RNs who retain accountability for these delegated tasks and the adequate supervision of these tasks to unregulated workers (Kleinman and Saccomano, 2006). Regardless of skill level in these areas RNs still remain concerned regarding their accountability for HCAs as there have been reports of this group of workers working outside of the remit. Thornley (2000) identified that HCAs are more likely to under-report their roles, as the work tasks they carry out are done so without approval. Jack *et al.* (2004) revealed that not having the availability of RNs to supervise would see the expansion of the HCA role hindered; accountability was also raised as an issue. To successfully advance the role of the HCA, the RN needs to be an adequately prepared as a supervisor and manager of HCAs (Kleinman and Saccomano, 2006). The management of the HCA role, RN role and accountability associated with delegation and supervision and the policy level of responsibility requires discussion (Siegel *et al.*, 2008).

2.4 Accountability and RN Responsibility

Professional accountability is seen as a way to protect the public and ensure the delivery of quality care (Francis, 2013; McKenna *et al.*, 2004). Accountability for RNs is considered by NMBI (2015b, p. 17) to be;

' the RNs' or RMs' ability to take account of one's own judgement, actions and omissions and is about safeguarding patients through quality care and being answerable for professional decisions'.

RNs and RMs are responsible in the decision to delegate to and provide supervision either directly or indirectly to HCAs. Through this delegation and supervision RNs are accountable

for the actions of the HCAs. RNs' concern regarding accountability for HCAs' actions or omissions is causing disquiet among RNs (McKenna *et al.*, 2004).

The Francis report of the failings of staff to provide care at the Mid-Staffordshire Trust calls for HCAs to be accountable through regulation (Francis, 2013), currently HCAs remain an unregulated group and RNs remain accountable for duties delegated to HCAs. Both HCAs and professionals have concerns regarding responsibility and accountability and it is felt that adequate supervision and mentoring of assistants by professionals with clear accountability for roles is required (Munn *et al.*, 2013). Accountability is also a priority for government with the Department of Health and Children (2001) stating that at all times RNs retain accountability for practice and a clear line of accountability should be established between the RN and HCA.

2.4.1 RN Accountability for Delegation

RNs feel that HCAs should be accountable for their own actions despite delegation by RNs (Alcorn and Topping, 2009). Pearcey (2008) identified that RNs understood HCAs to be accountable for their own practice, with one junior RN not understanding why a HCA was paid considerably less than an RN, when HCAs could carry out all the work of an RN except for medication management. While this was an isolated comment it is a demonstration of the misinterpretation of the role and responsibilities of the RN and the profession of nursing. Newly qualified RNs may over rely on the support of the HCAs which Allan *et al.* (2016, p. 8) coined as *'reverse delegation'*. The more years of experience the RN has, the more understanding the RN has in relation to accountability. Shearer (2013) found RNs to be critical of the time wasted in delegation and supervision of HCAs due to RNs double checking work. This is suggestive of RNs understanding that they retain accountability for patient care.

RNs learn delegation and supervision practices through invisible learning, meaning that these skills are essentially learned *'on the job'* (Allan *et al.*, 2016, p. 1). Undergraduate and continuing education is an effective way for RNs to develop these skills (Kleinman and Saccomano, 2006). This would assist RNs in consolidating their understanding and seek to address their own difficulties in accepting accountability for the work of HCAs.

2.4.2 Difficulties faced by RNs and Accountability

The varied titles given to any person assisting RNs with caring poses a threat to patient safety, as any person can refer to themselves as a HCA (McKenna *et al.*, 2004). Despite HCAs making up a large portion of the healthcare workforce, the work placement decides their competencies and these can be open to interpretation, resulting in both the professional working with HCAs and the public in terms of competence and skill level (McKenna *et al.*, 2004; Jack *et al.*, 2004; Bowman, 2003). There is a passive assumption that all health professionals are trained to carry out the work they do (Hancock and Campbell, 2006). Thornley's (2000, p. 454) study of HCAs reported that they carry out work tasks in an '*unofficial*' or '*informal*' manner; and this is a source of concern for RNs, who are accountable to the Nursing and Midwifery Regulation Board for either the direct or indirect supervision of unregulated HCAs. This can lead to RNs limiting the work of HCAs (Spilsbury and Meyer, 2004). Accountability encompasses criminal and civil liability contract of employment and professional liability (Burns, 1995). Skills for Care & Skills for Health (2013) is the adopted code of conduct for HCAs and social workers in England which requires this group of workers to be accountable for acts or omissions.

In Ireland a job description is used in determination of what HCAs can do. This is not a safe method of assessing if a person is competent to carry out the role, as competency of the particular HCA is not considered (Kalisch and Lee, 2014). The job description of HCAs in the

Department of Health and Children (2006) report simply states that HCAs are accountable for their actions and must not carry out any duty they are not trained for, RNs need reassurance that HCAs will not carry out any task for which they were not trained (Tardivel, 2012).

Management need to support RNs in the role of delegation (and therefore, accountability) by developing clear guidelines, in relation to the role and competency of the HCA (Baldwin *et al.*, 2003). Collaborative learning between various grades of licensed and unlicensed healthcare providers is one suggestion as to how an understanding of each-others roles, responsibilities and accountability could be developed (Munn *et al.*, 2013).

2.4.3 Assisting RNs in Delegation

Education of RNs in delegation skills is seen by Kleinman and Saccomano (2006) as a way of developing RNs' understanding of accountability in delegating tasks. By means of supporting understanding, the National States Boards of Nursing developed a delegation decision making 'tree', to assist RNs in making decisions regarding the appropriateness of delegating a task and the subsequent accountability of the RN in delegating the task (Kleinman and Saccomano, 2006). In the Irish context, the Code of Professional Conduct (2014) states that RNs are accountable for tasks that are delegated to a person that is not an RN or RM (NMBI, 2014). The Scope of Practice Framework outlines key principles to be considered when delegating to a HCA (NMBI, 2015b). These considerations require that the RN be satisfied that the HCA is competent to carry out the delegated task.

Ensuring competency appears to be an issue that hinders the role of the RN in delegating to HCAs. Defining the notion of competency is difficult, as there is still a lack of consensus about a standard definition for competence (Becker, 2007). RNs also report that they are

unaware of the content of the training programme that HCAs come through (McGuire *et al.*, 2007). Therefore, there is a lack of understanding by RNs of the competencies achieved by individual HCAs.

2.5 Clinical Competency

Clinical competence is seen as the way forward in standardising the HCA role (Dean, 2009). There is a cultural context of competency, where duties are allocated based on what is viewed as competent in a particular ward or department and also based on what people can do as opposed to what they know (Hancock and Campbell, 2006). But yet the word competency is indiscriminately used, especially when discussing the accountability of the RN in ascertaining whether or not to delegate a task to a HCA. RNs worry about being accountable for HCAs' mistakes and having more to lose as RNs have a registration to protect while HCAs do not (Cavendish, 2013).

A job description does not ensure competence, as the Department of Health and Children (2006) through the HSE job description for HCAs was unsuccessful in tackling the issue of competence. The Cavendish (2013) report highlights that the lack of clear job descriptions and competences can make RNs unsure about what they can delegate. Webb (2011) identified that HCAs are being left with insufficient knowledge and competence to carry out delegated tasks. To gain further insight into the complex issue of competence, there are two issues to be deliberated. One issue relates to the HCA regarding their perceived and actual clinical competencies, the other relates to the RN and their level of competency in delegating and supervising.

2.5.1 HCA Perceived Competency

HCAs are confident in describing their role in terms of what they cannot do, like medication administration or dressings (Perry *et al.*, 2003). HCAs feel deskilled by the restriction of RNs

in allowing them to carry out skills they feel they are competent in, such as simple dressings. RNs argue that there are considerations involved when changing dressings and this knowledge is only acquired through nurse education (Spilsbury and Meyer, 2004). In the Moseley *et al.* (2007) study of the training needs of HCAs, HCAs were found to be self-critical, this matched the findings of management in terms of where the issues of HCA knowledge deficit lay. This is encouraging and provides insight into the ability of the group to think critically, which challenges the criticisms of the HCA ability by RNs, who see HCAs as capable of task orientated work only (Keeney *et al.*, 2005).

RNs are ultimately accountable for the care of the patients (Spilsbury and Meyer, 2004). Regardless of the level of training or education the HCA comes through, RNs will remain unwilling to accept the role of the HCA in tasks where knowledge is considered to be required because of the accountability, despite the proof of competency a training programme might offer.

However, training of HCAs to a higher standard and educating RNs in the role and function of HCAs would help them in applying the skills of HCAs to the patient bedside (Yang *et al.*, 2012; Munn *et al.*, 2013). Regardless, the transfer of skills cannot be assumed from one situation to another (Crossan and Ferguson, 2005) and each situation requires assessment to be carried out to establish if the task is appropriate to delegate (Kærnested and Bragadóttir, 2012; NMBI, 2015b). This appears to do little to ease the pathway for the RN in their duty as delegator and supervisor of a clinically competent HCA. Conversely, Thornley's (2000) study proposed that a national vocational qualification of HCAs is challenging these norms. For RNs to fulfil their professional duty, they must be confident that HCAs are prepared adequately for the roles RNs are required to delegate.

2.5.2 RN Competency in Delegating to HCAs

RNs ability to delegate to and supervise HCAs is vital to quality patient care with Alcorn and Topping (2009) proposing that RNs are not suitably educated to delegate and supervise HCAs. Kleinman and Saccomano (2006) concurred with this and found that delegation and leadership skill training is lacking in the formal training and is learned by trial and error. This can be seen as a flaw in the nurse programme of education and while senior RNs may have gained the ability to delegate through experience, more junior RNs may err in judgement in their role as delegator by either delegating inappropriately or overloading the HCA, or not feeling the legitimate authority to delegate (Kleinman and Saccomano, 2006). This ill judgement can lead to role stress for the RN (Barter *et al.*, 1997).

RNs do not feel the legitimate authority to delegate to HCAs. An observational study conducted by Clark and Thompson (2015) found that RNs work largely on technical and clinical governance issues, which are very time consuming. RNs '*shed*' tasks to HCAs who in turn have no one to deflect to as they are the lowest subordinate group of workers (Daykin and Clarke, 2000; Clark and Thompson, 2015). This '*shedding*' of work can lead to poor job satisfaction for HCAs and can result in a professionally poor relationship, with stilted collaboration (Kalisch and Lee, 2014).

RNs require further education and guidance in relation to their role as managers of care (Siegel *et al.*, 2008; Kleinman and Saccomano, 2006). Development of clear guidelines regarding what duties HCAs can safely carry out to ensure quality of care would reduce the vulnerability of RNs in deciding what to delegate to HCAs and reducing the possibility of *'shedding'* inappropriate workloads by RNs to HCAs (Keeney *et al.*, 2005; Baldwin *et al.*, 2003). It is also claimed that the regulation of HCA would increase patient safety (McKenna *et al.*, 2004; Webb, 2011; Francis, 2013).

2.5.3 Regulation of the HCA

Regulation is seen as a deterrent for HCAs working beyond their scope (McKenna *et al.*, 2004; Webb, 2011; Francis, 2013). On the contrary, Vaughan *et al.* (2014) states that regulation alone does not prevent abuse of patients, as RNs and doctors have abused the professional relationship with the patient despite them being a registered profession. Nevertheless, it is felt that the existence of a register would alert employers to past abuses from potential HCAs, and also RNs, as the situations arises of RNs, who have been struck from the nursing registry, take up employment in the unregulated HCA sector (McKenna *et al.*, 2004).

The current practice of a job description as a determent of what HCAs can do, is not a safe method in assessing if a person is competent to carry out the role (Kalisch and Lee, 2014). However, as part of upholding a registration it is incumbent on the person seeking maintenance of a registration to be clinically competent by proving professional development. The issue of regulation is worthy of a national conversation, as the use of a job description is not adequate. Other countries like Scotland and England are seeking to address the issue of regulating the unregulated healthcare support worker, through mandatory, competence based standards or regularity options (Dean, 2009).

2.6 Conclusion

The role of the HCA is a constant feature of the nursing skill mix (Duffy, 2014). Healthcare organisations are demanding role flexibility among direct healthcare providers such as RNs and HCAs (Kopishke, 2003; Duffy, 2014). The issues of role blurring, role threat and this new identity experienced by RNs is impacting on the collaborative nature of this role relationship (Baldwin *et al.*, 2003; Pearcey, 2008; Spilsbury and Meyer, 2005a; Lloyd *et al.*, 2011; Munn *et al.*, 2013). The role and skill of the RN in delegation and supervision of the HCA is one

with which RNs are not comfortable (Kleinman and Saccomano, 2006; Pearcey, 2008; Shearer, 2013). The burden on RNs to accept accountability for the actions or omissions of the HCA whose competence they cannot be sure of is hindering the full integration of the HCA role (Munn *et al.*, 2013; McKenna *et al.*, 2004). These issues are grounded in the organisation of the HCA role, as opposed to the day-to-day working relationship between the two groups (Baldwin *et al.*, 2003; McGillis Hall, 2003; Barter *et al.*, 1997). This role relationship requires further analysis.

While the evidence gathered for this literature review employed many quantitative and qualitative methods, few studies were conducted in the Irish setting with no identified study undertaken in recent years. Due to the changing complex nature of the roles, it is imperative to explore and analyse the role of the RN and HCA in relation to the changing context and dynamic of care, relative to workforce policy.

Chapter Three
The Process of Investigation

3.0 Introduction

Throughout the process of investigation it is significant for the researcher to make clear the research design applied; its motivation, practice and the reflexive element which affects decision making. The research philosophy and paradigm underpinning the study are described in section 3.1. Section 3.2 explores the qualitative descriptive research methodology and justification in terms of the research aims and objectives. Section 3.3 describes the research design, its application, rationale, site selection and the limitations of the qualitative descriptive design approach. In section 3.4 sampling selection is discussed. The data collection section 3.5 outlines the procedures adopted. Section 3.6 explores data analysis where the observations are guided by Robson and McCartan (2016) theory while a frameworks approach utilising Ritchie and Lewis (2003) analytical framework is described in guiding the analysis of the interview data. The measures adopted ensuring quality in the study is discussed in section 3.7 while section 3.8 presents the ethical considerations for the study.

3.1 Research Philosophy

It is important to the research process that the researcher outlines their philosophical perspective, as this allows the researcher to be clear in their stance in relation to the philosophical assumptions (Sandelowski, 2010). The various philosophies of research are encompassed by the terms epistemology (what is known to be true) and ontology (a belief about reality) (Ritchie and Lewis, 2003). The emic stance of the researcher impacts on the study; through subjectivity but also by the degree of interpretation that's required in the analysis of the data (Bradshaw *et al.*, 2017). This emic stance is acceptable within qualitative research and a reflective approach needs to be adopted as according to Patton (2002)

researchers have an obligation to monitor and report their own analytical procedures and processes completely and honestly as possible should the evaluation be truly meaningful. It is therefore important to set out the beliefs that influence the researcher's actions. This is achieved by declaring the paradigm by which the researcher ascribes to; be it positivist or constructivist.

3.1.1 Positivist and Social Constructivist Research Paradigms

A paradigm is a basic set of beliefs that influences actions. These beliefs dictate how the question is to be formulated and researched and how we seek the information to answer the question (Creswell, 2013). The paradigm in which we ascribe to, tends to be either within the positivist or the constructivist paradigms, influenced by the belief about our reality (ontology) and how we interpret the reality (epistemology) or philosophical questions related to the topic of inquiry (Polit and Beck, 2012). Positivist assumptions are based on the objective observable reality, deducted by cause and order. The fundamental features of positivism and social constructionism are presented in the following table by Ramanathan (2008)

	Positivism	**Social Constructionism**
The observer	Must be independent	Is part of what is being observed
Human interests	Should be irrelevant	Are the main drivers of science
Explanations	Must demonstrate causality	Aim to increase general understanding of the situation
Research progresses through	Hypotheses and deductions	Gather rich data from which ideas are induced
Concepts	Need to be operationalised so that they can be measured	Should incorporate stakeholder perspectives
Units of analysis	Should be reduced to simplest terms	May include the complexity of 'whole' situations
Generalisation through	Statistical probability	Theoretical abstraction
Sampling requires	Large numbers selected randomly	Small numbers of cases chosen for specific reasons

Table 3.1 features of positivism and social construction philosophical approaches

Constructivist inquiry believes in many interpretations of reality, with significance given to the subjective experience (Creswell, 2013). The constructivist philosophy aims to generate

meaning from the participants within the context of the participants' natural setting, where the researcher is seen to be involved with the participants. The researcher brings with them personal values or emic stance into the study which theorises and validates the accuracy of the findings (Bradshaw *et al.*, 2017). An overall conclusion is not sought in constructivism, but improved understanding of the phenomena (Creswell, 2013), where the voice of the participants are still heard (Bradshaw *et al.*, 2017).

Due to the nature of the research question being asked, the constructivist paradigm allows for the individual experiences of RNs and HCAs within a role relationship in the clinical space of care to be explored. For this reason a qualitative descriptive approach is adopted, because the descriptive approach is different to other research methods (Doody, 2016).

Qualitative description research seeks to provide a rich description of a phenomenon for which little may be known (Bradshaw *et al.*, 2017). This addresses the meaning individuals or groups ascribe to a human or social problem (Creswell, 2013). This is known as an interpretivist epistemology, where the researcher must place themselves into the reality of the situation, in this instance the role relationship between the RN and the HCA, to be able to interpret that reality. A qualitative descriptive methodology lends itself to the ontological and epistemological stance of the researcher and also the exploratory nature of the question being asked as outlined in table 3.2 Qualitative research should happen within its own natural setting, to provide a humanistic view (Bradshaw *et al.*, 2017; Creswell, 2013; Sandelowski, 2010).

• An inductive process (describes a picture of the phenomenon that is being studied, and can add to knowledge and develop a conceptual and/or theoretical framework). • Is subjective (each person has their own perspective and each perspective counts). Recognizes the subjectivity of the experience of not only the participant but also the researcher • Designed to develop an understanding and describe phenomenon (not to provide evidence for existing theoretical construction). • Researcher is active in the research process (researcher becomes part of the phenomenon being studied as they talk directly to participants and/or observe their behaviours). • An emic stance (an insider view which takes the perspectives and words of research participants as its starting point) but is influenced by the researcher not only because of subjectivity but also when a degree of interpretation occurs. • Conducted in the natural setting (data collected in the natural setting of the participants who experience the phenomenon

Table 3.2 Philosophical Underpinnings of Qualitative Descriptive Approach

3.2 Research Methodology

The methodology is guided by the research paradigm and indeed the ontological and epistemological stance of the researcher. Ritchie and Lewis (2003) argue that different methodological approaches are underscored by particular philosophical assumptions and that researchers should remain consistent between the philosophical assumptions and the research approach adopted. Maintaining consistency provides clarity and is seen as a way of producing more valid findings (Morse *et al.*, 2011).

The researcher extracts the information using a number of methods such as interview, observation, documents and artefacts rather than just one instrument (Lambert and Lambert, 2012; Creswell, 2013). While all qualitative methods of inquiry strive to reach a similar endpoint in understanding a particular phenomenon, choosing the specific methodology depends on the research question (Streubert and Carpenter, 2011).

Qualitative studies are akin to the nursing philosophy as nursing is humanistic (Parahoo, 1997). The distinction between qualitative and quantitative approaches lies in the assumptive base that underpins the research design and thus data collection (Broom and Willis, 2007). Both approaches have a role to play in the empirical world, with the quantitative approach being aligned with the positivist tradition and the qualitative

approach aligned with naturalistic enquiry (Polit and Beck, 2001). Both quantitative and qualitative approaches have merits, with qualitative approaches growing in importance and legitimacy with qualitative research increasingly being used by nurses to inform healthcare policy (Broom and Willis, 2007).

3.2.1 Research Aim

To explore and analyse the role relationship between the registered nurse and the healthcare assistant within the clinical social space and how this impacts on care delivery;

3.2.2 Objectives

1. To conduct a scoping review of the literature on the respective roles of the registered nurse and the healthcare assistant in the delivery of patient care;

2. To observe and analyse the nature of the 'day to day' interactions between the registered nurse and the healthcare assistant;

3. To analyse the nature of communication that occurs between the registered nurse and the healthcare assistant within the social space of care;

4. To describe and analyse the impact of the relationship between the registered nurse and the healthcare assistant with regard to respective role identities;

5. To make recommendations on enhancing collaborative working between the registered nurse and the healthcare assistant within the social space of care.

3.2.3 Selecting a Qualitative Research Approach

Groups and indeed individuals are related to each other and comprise of a vast array of social networks with many social concepts of interests being social processes. Although quantitative approaches contribute to knowledge, Morgan and Drury (2003) proposes that

the approach is deficient in providing insight into the complexity of human behaviour and experience.

The qualitative approach was chosen for two reasons, firstly the complex nature (phenomenon) of the role relationship between RNs and HCAs is difficult to measure utilising a quantitative approach, which lends itself to positivist assumptions, (Patterson and Morin, 2012). Secondly, the inductive nature of the phenomenon being studied relies on establishing patterns, drawing on theory and establishing how things may be improved for the group studied (Broom and Willis, 2007). The adoption of a qualitative descriptive approach is particularly relevant where the information required needs to directly come from those experiencing the phenomena under investigation (Bradshaw *et al.*, 2017).

3.3 Research Design

The purpose of this study was to observe, describe, document and analyse the role relationship between RNs and HCAs as it naturally occurs (Polit and Beck, 2008). Following a comparison between the aim and objectives of this study and the strategy of the qualitative descriptive research design as posited by Sandelowski (2000) a qualitative descriptive approach emerged as the most appropriate choice, as it philosophically underpinned the study because, it is an inductive process, subjective, designed to develop and understand and describe a phenomenon, the researcher is active in the process has an emic stance and is constructed in the natural setting (Bradshaw *et al.*, 2017). According to Brink (1998) the use of a qualitative descriptive approach is appropriate when a complete description of an understudied single, variable or concept within a population is required. The role relationship between RNs and HCAs is an understudied concept within the Irish context.

The nature of this study is descriptive as a comprehensive summarisation of specific events experienced by individuals or groups of individuals is required (Lambert and Lambert, 2012). The qualitative descriptive theory supports the naturalistic view, which implies a commitment to study something in its natural state. The RNs and HCAs working on the ward was the natural state in this study.

Qualitative descriptive studies are different in the view on the analysis of the data, from phenomenology, ethnography and grounded theory, with the qualitative descriptive theory requiring the researcher to remain 'close' to the data, (but still interpreting the data) unlike the other methods that require complex extraction of the data (Lambert and Lambert, 2012).

3.3.1 Applying a Qualitative Descriptive Design to this Study

A qualitative descriptive design can be adopted once a complete description of a single broad variable or concept (role relationship) within a given population (RNs and HCAs that work together) is understudied[1] or unstudied (Brink, 1998). According to Sandelowski (2010) the design can be explicit and characterised as emergent with purposeful sampling, minimally structured with open-ended modes of data collection and textual analysis.

The design strategy that seeks to answer the research question of this study explicitly adopts an emergent and rigorous strategy that allows the researcher to follow the data in a credible, confirmable, dependable and transferable way (Bradshaw *et al.*, 2017). Purposeful sampling was undertaken to ensure capture of the relevant group to be studied (RNs and HCAs) and a rapport built with the participants throughout the study. The methods adopted were structured but flexible observations. Semi-structured interviews that were informed

[1] See chapter 2 section 2.5

by the observations and the literature were conducted. Reflexive note taking, a prominent activity throughout the study contributed to rigor (Bradshaw *et al.*, 2017).

Observations were analysed descriptively as a means to keep as close to the data as possible (Sandelowski, 2010). Data analysis of the interviews followed Richie and Lewis's (2003) structured framework. This framework of analysis scaffolds the data, demonstrating the building blocks of the explanations arrived at, which is in keeping with the confirmability of the qualitative descriptive approach (Bradshaw *et al.*, 2017).

3.3.2 Rationale for using a Qualitative Descriptive Approach

Descriptive studies are regularly criticised for the lack of conceptual frameworks, leading to studies adopting this approach being criticised in how it promotes nursing knowledge or how the results lead to further work (Brink, 1998). However, if the researcher can relate the methods chosen to the research results of the study, rigor will be demonstrated and a flexible plan of enquiry justified (Bradshaw *et al.*, 2017).

Furthermore, due to the array of methodologies available, researchers often feel an obligation to connect their work to grounded theory, phenomenology, or ethnography when in fact it is none of these (Sandelowski, 2010). This can result in what Neergaard *et al.* (2009) calls postulating of the more 'popular' theories and disregarding the benefits of the alternative approach namely qualitative descriptive.

3.3.3 Site Selection

An acute setting within the South-East of Ireland was chosen, where RNs and HCAs work together within a skill mix that is a regular feature of ward life. No other pre-selection variables were imposed. This underpinned the flexible nature of the study in allowing the

researcher to be taken where the study demanded. Once the site has been selected one must consider what design will best capture and describe the phenomenon under study.

3.3.4 A Qualitative Descriptive Design

Qualitative descriptive design research studies seek to discover and understand a phenomenon, a process or the perspectives of the people involved (Caelli *et al.*, 2003). It is important to always be cognisant when considering the design of a qualitative descriptive approach the purpose of undertaking the research in the first place and also what data is needed to answer the research question.

Qualitative descriptive studies have design features that require the study to be undertaken in the natural environment, in this instance it is an acute ward setting. The qualitative descriptive method has typical approaches to sampling tending to deal in small purposeful samples. Data collection is underpinned by a mixed methods approach such as interviews which consist of minimally or moderately structured interviews, allowing for a broad collection of information about the phenomenon (Sandelowski, 2000). The adoption of observations triangulates the data confirming or refuting what is being said when compared to what is being observed. This type of triangulation confirms findings and brings a different perspective adding breath to the phenomenon (Carter *et al.*, 2014).

Data analysis co-exists with data collection in a qualitative descriptive design. Data is gathered and analysed to inform and refine the area of interest (Sandelowski, 2000). This study carries out observations, which informs the interviews, but still allows the flexibility required within the design. The content of the gathered data is analysed using coded systems or as Crabtree and Miller (1992) call it, template analysis. Ritchie and Lewis (2003) framework analysis is suited to the coded or template analysis due to its hierarchical

approach to the analysis of the data considering the manifest or how often a code is mentioned and the latent or meaning content of the data (Sandelowski, 2000).

The researcher undertaking a qualitative descriptive design approach is obliged to comprehensively and accurately detail the versions of the phenomenon or process. Because of the intensive contact required and while this limits the generalisability of the findings, this accurate summary is valuable as both an end point and also as entry points for further study (Sandelowski, 2000).

3.3.5 Limitations of the Qualitative Descriptive Design

The qualitative descriptive approach, is seen in the academic world as inferior to other more theory based approaches and can be interpreted as the poor relation (Neergaard *et al.*, 2009; Sandelowski, 2000; 2010). However, it is believed that the qualitative descriptive approach does not get the credit it deserves as an approach as it is considered (when applied appropriately) to provide a rich description of experiences and processes that researchers and participants would agree are accurate, providing a unique emic perspective on how the participants see their world (Bradshaw *et al.*, 2017).

Generalisability is limited however, due to the descriptive nature of the design and can only be attributed to the data at hand. Regardless, such summaries should not be dismissed as the description may yield categories for future theory laden research (Neergaard *et al.*, 2009), or may inform practice or transform culturally sensitive healthcare services (Bradshaw *et al.*, 2017; Neergaard *et al.*, 2009).

In an attempt to stay as close to the data as possible Neergaard *et al.* (2009) urges caution in relation to the subjective nature of the data analysis. However Bradshaw *et al.* (2017) counters this, with the requirement of the researcher to demonstrate reflexivity throughout

the research process. Qualitative descriptive approaches are dependent on proving rigor to validate the worth and the steps to ensure this rigor are discussed in section 3.7.

3.4 Sampling

Sampling is an important phase of the data collection process. Gaining access to and establishing a rapport with participants ensures engagement of participants resulting in collection of rich data (Creswell, 2013). The aim of qualitative research is not to generalise, but to elucidate particulars, specifics (as cited by Pinnegar in Creswell, 2013). According to Patton (2002) all sampling is purposeful in qualitative sampling. Regardless of the strategy i.e. typical, critical or snowballing, the aim is always to identify and select information rich samples (Coyne, 1997).

3.4.1 Sample Selection

The target population for this study included RNs and HCAs that work together within an acute hospital setting in the South-East of Ireland. Each individual represents varying perspectives in terms of the role relationship they experience. These participants were purposefully selected based on their experience of working within the RN and HCA skill mix. Typical purposeful sampling is the approach undertaken for this study as this allows a focused site where RNs and HCAs typically work together (Patton, 2002). Typical purposeful sampling is seen as the best way to gain an understanding of the research problem and central phenomenon in the study (Creswell, 2013). In identifying a typical case, it can be helpful if key informants or in this case the gate keepers, assist in identifying who or what offer a typical sample of the phenomena being studied (Patton, 2002).

3.4.2 Sample Size

Sample size is dependent on what you want to know, the purpose of the inquiry and what will be useful (Patton, 2002). The purpose of this study is to gain depth of the phenomena

being studied; therefore it is seen as useful to gain insight into one typical purposeful sample as opposed to multi-site samples, which is in keeping with the qualitative descriptive methodology (Bradshaw *et al.*, 2017). Maximum variation within the participant sample allows for enrichment and challenges the concepts discussed in interview is valuable (Polit and Beck, 2012). Purposeful sampling therefore displays multiple realities rather than the most common (Lincoln, 1985). In terms of sample size, there were two different sample sizes involved during data collection. The observation phase consisted of all of the available population of RNs and HCAs on the ward, which is in keeping with the descriptive design (Silverman, 2005). During any particular observation, the average of seven participants were observed, at any one time, which was the total number of RN and HCA staff working on any particular shift.

The second phase of the study was interviews. There are no rules for sample size in qualitative research (Patton, 2002). All observed RNs and HCAs were approached nearing the end of the observation phase and invited to take part in the interview phase of the study. Expression of intention to participate in the interview phase could be placed in the designated sealed box that was available on the ward. It was hoped that at least five RNs would be included in the interview phase along with four HCAs. However, the numbers were lower with four RNs coming forward to be interviewed and three HCAs.

3.4.3 Access to Sample

There are many layers of contact to be negotiated in order to gain admittance to the study site, with gaining access, to organisations, sites and individuals being challenging (Creswell, 2013; Mays and Pope, 1995). The first point of access is with the stake holders, to ascertain interest, and possible access of the study site. The hospital was approached by email initially to elicit if support would be granted. Following receipt of a letter of support (appendix 1) by

the Director of Nursing, a meeting was arranged and held with the director of nursing of the acute hospital, and the clinical nurse manager (CNM) of a proposed ward. I attended this meeting with my supervisor. The purpose of this meeting was to establish a rapport, demonstrate my knowledge of the topic under study (Robson and McCartan, 2016) and to seek permission to access a clinical setting. The purpose and process of the study including the logistics for conducting the study was also discussed. This rapport proved invaluable to the research process as the Director of Nursing introduced me to the Clinical Risk Manager and support from her was granted and consent from the General Manager was successfully sought (appendix 2).

The next level of access negotiated was an informal meeting with the CNM of the ward that attended the initial meeting. It was felt by the Director of Nursing and the CNM that the identified ward typified RNs and HCAs working together, with the CNM identifying that the staff had a willingness to participate. At this meeting the CNM introduced me to some of the staff, who she had previously gathered support from. I supplied the available staff with the study information sheet and answered questions. Posters informing staff, patients and visitors of the observational phase of the study, were placed on all entry and exit doors within the ward. A timetable of my attendance on the ward and study information sheets were provided and placed on the staff notice board, along with my contact details. For the first week or ten days of the study I would meet staff I had not previously seen, due to the shift rotation on the ward and I would supply them with an information sheet outlining the aim of the study and the role of the researcher. I answered questions and informed them that observational check list tool and protocol being used to focus the observations was available on the notice board for staff to familiarise themselves with, if they so wished.

A sealed box to insert their contact details for intention to participate in interviews was made available in the room where staff receives daily formal handover. Nine participants expressed interest and were contacted with seven participants agreeing to be interviewed.

3.5 Data Collection

Data collection is seen by Creswell (2013) as a series of interrelated or cyclical activities aimed at collecting good information to answer the research question (see figure 3.1). Data collection involved two phases; (i) structured observations and (ii) semi-structured interviews. Once purposeful sampling was completed the data collection phase could begin in earnest. The aim of the structured observations was to inform the semi-structured interviews.

Figure 3.1: Data Collection Activities

3.5.1 Data Collection Phase

Data collection consisted of two phases, observations and interview. Observations were deemed appropriate as the literature review uncovered complex issues impacting on role relationships[i]. It was important to illicit if these or other issues were of significance within this sample of RNs and HCAs, working together on an identified unit in the South-East of

Ireland. This reflects the appropriate use of the qualitative descriptive design as little is known about the phenomena (Bradshaw *et al.*, 2017), that phenomena being the role relationships between RNs and HCAs within the Irish context. More than 30 hours of observations averaging three hours per observation period over a one month timeframe covering morning, day and evening shift patterns where both RNs and HCAs worked together were observed (HCAs did not work nights). It was the aim of observations to provide a lens from which the interviews would be shaped, along with the issues uncovered within the literature review.

3.5.1.1 Observations

The use of observations in research is a useful method by which to gather data, as watching what people do is an obvious choice in real world research, (Robson and McCartan, 2016). To record, describe, analyse and interpret what we have observed, in other words, looking with a purpose (Palys, 1997). There are advantages associated with observation as it is seen to compliment virtually any other data collection instrument. Sandelowski (2010, p. 81) see methods as '*bleeding*' into one another or in this situation where one (observations) feed the other (interviews).

Observations adds rigour to the data as with interviews alone people tend to say one thing and do another (Robson and McCartan, 2016). While it was not the aim of this study to 'catch people out', but to assist in shaping the interviews, to ensure the exploration of key issues that affect RNs and HCAs with regard to role identities within the clinical space of care.

Observations sat nicely within this study as knowledge can be generated through observing 'real life' settings which reveals data. Also my background as a RN allowed me the position

of ‘knower’ because of my own experiences and while I cannot claim to have a perspective from all the participants and actors involved, I do feel epistemologically privileged (Mason, 1996). Sandelowski (2010) see this ‘knowing’ stance as requiring reflexivity of their stance as there is no such thing as a view from nowhere and once these preconceptions are addressed and the research is willing to be moved from this stance than rigor can be claimed. Bradshaw *et al.* (2017) sees the researcher as having an emic stance because of the subjective epistemology of the researcher and also the degree of interpretation of the data that is required.

My role in the study was the subject of much discussion as to whether I should assume the position of a participant observer, which was my preference and would allow me to engage actively with the participants. But for ethical reasons considered by the ethics board in relation to protecting patient confidentiality, my role was one of observer as participant, a role I struggled with. This struggle was rooted in the skills and ability I possess as an RN that could be used in times of work overload, see box 1. Regardless of my struggles I was an ‘insider’ researcher meaning that as a nurse I had an intimate knowledge of the social nuances and relationships that exist, this according to Bonner and Tolhurst (2002) allows for the telling and judging of the truth.

> I am getting a feeling that staff is suspicious of my presence. I approach them more today to engage them, but they just want to know what I’m hoping to find. One staff member in particular has been very friendly throughout, but when I ask her if she is willing to be interviewed, she is very cagy; I don’t think they trust my motives.

Box 1 Field Note

Adopting the observer as participant role allowed me to develop and observe in a largely checklist manner, determining if a behaviour was present or absent (appendix 3). This

technique remained true to the qualitative nature of this study by recording notes in the margins, with no definitive answers reached by this phase of the study, but to guide the further probing at interview.

Observational tools are plentiful in measuring team performance (Agency for Healthcare Research and Quality, 2014; Chiu *et al.*, 2013; DiBenigno and Kellogg, 2014). However, no single checklist was found to capture the exact measurement of the day-to-day interactions and the nature of communication that occurs between the RNs and HCAs which was one of the objectives of this study.

The development of an observational tool informed by the literature and adapting an already existing coding scheme as Robson and McCartan (2016, p. 335) advises. In doing so, '*adds another brick to the existing grand scientific enterprise*'. A review of identified conceptual models was undertaken as no one tool existed to seek the answers of the study. A collation of items from existing tools was used with the main expression of the heading, sub-headings and the frequency idea being rooted in the PACT tool (Chiu *et al.*, 2013). Items were added to reflect the relevant literature associated with role relationships. The new reconfigured tool was organised into the categories of the; 1. 'nature of interactions' and 2. 'impact of role identities'. Due to the development of the tool being undertaken by myself only, training in the use of the tool consisted of the researcher carrying out a test phase for the duration of three hours to determine reliability and if changes needed to be made. No changes were made to the tool at this stage as it was felt that the while not all behavioural markers were witnessed during the test phase, they were mentioned frequently in the literature and therefore removing these would be unwise.

In term of the practicalities, comments from different members were recorded in the margins to provide context (Robson and McCartan, 2016). Notes were recorded in the margins as reminders to look for additional information, an interpretive idea recorded and also my personal impressions and feelings, including my thoughts (see box 2).

> I am not witnessing check back? Is it not happening? Is the corridor too busy for me to hear this? Am I missing it as it's happening in the patient areas? Or is it because this is largely an American concept not adopted in the Irish system?

Box 2 Field Note

Epistemological privilege is to the fore in my reflexivity as biases such as selective attention, where I choose what to observe and maybe to the detriment of another more capturing observation, or selective memory which I limited by the reflection of each observational period written up or verbally recorded using a mobile phone app as soon as I leave the unit being studied, as allowing time to lapse between the observation and writing the narrative can lead to distortion of the event (Robson and McCartan, 2016). Although it is near impossible to be totally objective, reflective practice through the keeping of a reflective journal, the reflections entered into the journal aids in limiting my bias influencing the study. Reflection is seen as a way to understand the significance of the total situation (Johns, 2000a). An example of this type of reflection is exemplified in box 3.

> I am not witnessing supervision. Is it happening or not? It is frustrating not having access to the individual patient bay. It appears that RNs and HCAs work very closely together, both spatially and in co-ordinated teams to deliver patient care. I wonder if supervision is happening indirectly. I need to ask about this at interview to RNs and HCAs.

Box 3 Field Note

The reliability of the observational tool was determined by the repeated nature in which the behaviours were observed. Intra observer reliability or observer consistency was obtained

as many of the same behaviours were seen to occur on different occasions (Robson and McCartan, 2016). However if this tool was to be adopted in future studies then inter-observer agreement would need to be reached to ensure consistency.

3.5.1.2 Interview Protocol

A semi structured interview protocol was adopted (appendix 5). This was informed by the literature initially and marginally refined following the observations to include observed phenomena that could not be explained through observation, this is keeping with flexible nature of the qualitative descriptive design as Sandelowski (2010) sees data collection instruments needing to be minimally structured with open ended modes of data collection employed. The interview schedule did not change drastically following observations, the flexibility in the design allowed this to happen if it was required.

3.5.1.3 Managing the Interview Process

The interviews were arranged by text or phone-call, as this was the preferred route by which participants indicated to be contacted by. Interviews usually took place in the late afternoon or evening times. Prior to the commencement of each interview, participants were asked to complete a form outlining basic demographics.

The researcher ensured that the participants were made fully aware of their role in the interview process. Time was then taken to ensure participants could clarify any issues or queries they may have had. Participants were requested to sign a consent form (appendix 6). Participants were made aware of the small voice recorder, which was placed between the interviewer and the interviewee. The use of a voice recorder was considered necessary to avoid distraction and ensuring an accurate account of the interview, enhancing overall rigour (Bryman and Bell, 2001). Once any issues were clarified, informed and signed consent was obtained.

The duration of each interview varied from twenty-five minutes to fifty-six minutes, averaging an overall forty-one minutes. Throughout the interview process, the comfort and well-being of the participant was foremost in my mind. While all participants appeared relaxed and happy to participate, they were always asked if they would like to add or comment further on any aspect of the interview.

Interviews occurred over a relatively short period of a two week timeframe. Once the interview phase concluded, immersion into the data commenced, with the aim of analysis guided by (Ritchie and Lewis, 2003) analytical framework.

3.6 Data Analysis

Qualitative descriptive design requires the researcher to stay close to the original data during analysis and a *'factist'* approach is adopted where the researcher assumes the position that the data is assumed to be relatively accurate and seen as documentary traces of reality (Sandelowski, 2010, p. 80). There are common features to the processes of data analysis. According to Miles and Hubberman (1994) the process consists of, affixing codes, noting reflections, sorting and sifting through, to identify phrases, relationships and variables. Isolating patterns commonalities and taking them to the next phase of gradually elaborating a small set of consistent generalisation, confronting the generalisations with a formalised body of knowledge in the form of constructs or theories. According to Mason (1996) how data analysis is processed is rooted in the philosophy of the researcher. As reasoned earlier the philosophical stance of this research is grounded in the interpretivist epistemology and that reality is constructed, whereby, explanatory models of underlying mechanisms which are said to account for empirical observations. The data analysis method that needs to be adopted, is one which allows for the forwards and backwards movement between data analysis and the process of explanation (Mason, 1996). Therefore Ritchie and

Lewis (2003) analytical hierarchy suited the interpretivist approach as this framework allowed for the upwards and downwards motion that Mason (1996) suggested to be in keeping with the epistemology of the qualitative descriptive design where the process of analysis is thematic (Bradshaw *et al.*, 2017).

3.6.1 Process

When analysing data the intention is to find answers to the research aim and objectives. Analysing qualitative descriptive data consists of three stages of data management, descriptive accounts and explanatory accounts (Ritchie and Lewis, 2003). Thematic analysis was chosen for this study as it offers a flexible strategy to analysis which is compatible with the researcher's epistemology, research methods and design.

3.6.2 Strategy

The strategy adopted in analysing the data from this study is Ritchie and Lewis (2003) analytical hierarchy framework, as this framework allows for what Yin (2003) calls a general analytical strategy that encompasses (1) categorising strategies (2) connecting strategies and (3) memo and display. The choice and use of a thematic analysis framework is vital to ensuring the rigor of the data (Bradshaw *et al.*, 2017).

3.6.3 Thematic Analysis

According to Ritchie and Lewis (2003) thematic analysis occurs by means of a hierarchy by which findings are built upon from the original data. This allows the researcher flexibility and researcher with finite resources move forward with the data to understanding and interpretation of the evidence, (Miles and Hubberman, 1994) Throughout the analysis Ritchie and Lewis (2003) analytical framework was adopted which consists of (1) Identifying initial themes or concepts, (2) labelling data by theme, (3) sorting data by theme (4) synthesising the data, (5) identifying elements and dimensions, refining categories,

classifying data (6) establishing typologies (7) detecting patterns, (8) developing explanations and (9) seeking application to wider theory/policy strategies. This guide can be clustered under the three headings of (1) data management, (2) descriptive accounts and (3) explanatory accounts.

3.6.3.1 Data Management

In Identifying initial themes or concepts, emersion in the data was achieved firstly by listening to the full recording of each participant's interview. Each interview was transcribed verbatim, by the researcher as this avoids inaccuracy in transcribing that can occur with the out sourcing of this task or relying on computer software to complete the task (Streubert and Carpenter, 2011). While this was a very time consuming activity is was seen as an active approach to data management as opposed to passive whereby transforming the data into relevant information (Lapadat, 1999).

Labelling data by theme was achieved by highlighting important data sections within each participant's transcribe and labelling the data by a broad theme. The sorting of the data by theme was achieved by aggregating each participants thematic label in a tabled format and synthesised with others in the cohort, that is, RNs thematic coded data was synthesised with other RNs thematic coding and the same was done for HCAs thematic coding. Each broad theme was colour coded within the raw data to ensure important labels were not missed.

3.6.3.2 Descriptive Accounts

In identifying elements and dimensions to the themes Ritchie and Lewis (2003) claims that the nature of the phenomena being studied needs to be descriptively analysed in the actual words and the assigned meaning as this forms the nucleus of qualitative evidence. Categories were refined with consideration for the words and the assigned meaning. The

classifying data evolved into more abstract dimensions and typologies were established. This was time consuming and evolved from the growing understanding of the data, this is as Richards (2009) says it should be. Patton (2002) see typologies to be illustrative endpoints in discovering how people construe their world by the way they talk about it. However, Patton (2002) cautions against constructing typologies that are not really in the data, but urges for analyst constructed typologies to be adopted, but to remain close to the people whose world is being investigated, so as they can see themselves within the typology.[2] Sandelowski (2010) concurs with this and feels this is where qualitative description is being criticised as not being analytical enough, however it is through this analytical process that the data moves and the researcher makes sense of the data.

3.6.3.2 Explanatory Accounts

In detecting patterns a higher level of analysis is occurring in linking the patterns to association with and attempting to account for why those patterns occur, cause and effect as it were. However there are criticisms of the cause and effect analysis, as Giddens (1998) states that the purpose of intended behaviour will often bring about an unintended consequence.

It is the aim of the analysis and in keeping with Ritchie and Lewis (2003) view, that the developing explanations are rooted in the aim of seeking clarity to the nature and inter-relationships with contributing factors or influences with some certainty being evidenced in the data. Therefore its application can be linked to wider theory/policy strategies or hypotheses that require further testing (Bradshaw *et al.*, 2017; Neergaard *et al.*, 2009).

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[2] See chapter 5 section 5.2

3.6.4 Use of Software in Data Analysis

There is an abundance of software tools assisting in computer aided analysis. However due to the small numbers of participants it was decided in consultation with my supervisors that the use of software was not necessary. This was beneficial to the analysis as the transcribing verbatim, allowed the data to come alive, as during the analysis I could 'hear' the voices of the participants and this enabled the context of the data to be retained (Bradshaw *et al.*, 2017). This context can get lost in the in the adoption of software to aid analysis (Bryman and Bell, 2007).

3.7 Quality Standards

Demonstration of quality regarding the research process and the subsequent data collection is imperative to the research process. Parahoo (1997, p. 292) argues that qualitative researchers shuns the concepts of reliability and validity preferring terms such as 'accuracy' 'truth' and 'credibility'. However Bradshaw *et al.* (2017) contextualises these concepts as providing (1) credibility, (2) confirmability, (3) dependability and (4) transferability and in doing so provide rigor to the qualitative descriptive research study.

3.7.1 Credibility

According to Bradshaw *et al.* (2017) credibility is established through building a rapport with participants prior to commencing the interview, to allow for a trusting relationship to develop. This rapport building began in this study before and during the observational phase, with my positive engagement with the staff I came into contact with during the month long observational phase. Compassion and empathy was expressed as appropriate throughout the study.

Bradshaw *et al.* (2017) and indeed other academics offer that rigor, in qualitative research is generally determined by the participant's themselves (Streubert and Carpenter, 2011). To

ensure credibility of the data analysis, it was hoped that one participant would review their analysed transcripts, (member checking) but due to time constraints this was not practicable. This is seen as a limitation to the study. However an analysed transcript of one interview was reviewed by the academic supervisors and it was felt that the commentary captured the participant experiences and there was evidence of a framework approach to data analysis.

3.7.2 Confirmability

To confirm the rigor of the study and in keeping with Bradshaw *et al.* (2017) framework reflective notes were recorded during every contact with participants both at observational and interview phases. Reflexivity was developed as a skill with training in King's College Summer School in London. An audit trail was adopted in the analysis of the data in keeping with Ritchie and Lewis (2003) analytical framework, which was supervised by two experienced supervisors'.

A description of the demographics was recorded and published within the interview findings chapter within this dissertation[3]. While member checking did not occur to confirm or refute the claims the audit trail and the analysed transcript being reviewed by the supervisors served as verifying of the data. Findings were also confirmed through the use of direct quotations from participants which lend itself to the confirmability of the study.

3.7.3 Dependability

Dependability according to Bradshaw *et al.* (2017) is achieved through the establishment of an audit trail that describes the study's procedure or processes. The formulation of this chapter and the mapping of the research process along with ethical applications approval and the development of the data collection tools lend itself to the dependability of this

[3] See chapter 5 section 5.2

study. Acknowledging and accepting the changes that occurred in the study with regard to the ethical concerns raised by the ethics committee limiting me to public only areas where observations could occur, confirm dependability. It is accepted that these limitation were put in place to protect a vulnerable group, i.e. patients. However it must also be acknowledged that this has a limitation to the study as complete observations could not occur, as the reflective note in box 4 demonstrates.

> I see an RN and HCA engage in conversation, which I believe is a negotiation about care delivery, I walk towards them, as they are at the other end of the corridor, but by the time I reach listening distance, they have walked into the patient area and are still talking, but I can only hearing mumblings, I find this very frustrating and yet again I wish I was a fully participating observer.

Box 4 Field Note

3.7.4 Transferability

The maintenance of a reflexive journal as exemplified in box 4 was compulsory in critical self-reflection, it forced me to limit my bias and assumptions and be honest in my epistemological and ontological position. Transferability is also achieved, through the production of this dissertation, which provides rich and sufficient study details to allow for recreation of the study, as is in keeping with the requirement of Bradshaw *et al.* (2017) qualitative descriptive framework.

3.8 Ethical Considerations

Ethical consideration and management is pertinent to any research study, from the initial stages to the completion. Ethical issues naturally impinge upon qualitative research (Mason, 1996) and must be met with a plan for potential and actual ethical issues. Creswell (2013) outlines the phases and the potential ethical issues that may arise throughout the research process and is invaluable in guiding the research process (figure 3.2). Seeking ethical

approval from relevant bodies is crucial in the research process and needs to be sought prior to the commencement of the study (NMBI, 2015a). Ethical conduct standards guiding the profession of the researcher need to be adhered to. Merriam (2009) posits that it is the integrity of the researcher in the burden of producing an ethical study regardless of regulation, with the best the researcher can do is to be conscious of the ethical issues pertaining to the study and examine their own philosophical view. Therefore the researcher reflected on potential and actual ethical issues throughout the whole process guided by Creswell (2013) framework, as figure 3.2 depicts that planning strategies to ensure the research meets the high standard which are vital elements of the research process.

Table 3.2 Ethical Issues in Qualitative Research

Where in the Process of Research the Ethical Issue Occurs	*Type of Ethical Issue*	*How to Address the Issue*
Prior to conducting the study	• Seek college/university approval on campus • Examine professional association standards • Gain local permission from site and participants • Select a site without a vested interest in outcome of study • Negotiate authorship for publication	• Submit for institutional review board approval • Consult types of ethical standards that are needed in professional areas • Identify and go through local approvals; find gatekeeper to help • Select site that will not raise power issues with researchers • Give credit for work done on project; decide on author order
Beginning to conduct the study	• Disclose purpose of the study • Do not pressure participants into signing consent forms • Respect norms and charters of indigenous societies • Be sensitive to needs of vulnerable populations (e.g., children)	• Contact participants and inform them of general purpose of study • Tell participants that they do not have to sign form • Find out about cultural, religious, gender, and other differences that need to be respected • Obtain appropriate consent (e.g., parents, as well as children)
Collecting data	• Respect the site and disrupt as little as possible • Avoid deceiving participants • Respect potential power imbalances and exploitation of participants (e.g., interviewing, observing) • Do not "use" participants by gathering data and leaving site without giving back	• Build trust, convey extent of anticipated disruption in gaining access • Discuss purpose of the study and how data will be used • Avoid leading questions; withhold sharing personal impressions; avoid disclosing sensitive information • Provide rewards for participating

Where in the Process of Research the Ethical Issue Occurs	Type of Ethical Issue	How to Address the Issue
Analyzing data	• Avoid siding with participants (going native) • Avoid disclosing only positive results • Respect the privacy of participants	• Report multiple perspectives; report contrary findings • Assign fictitious names or aliases; develop composite profiles
Reporting data	• Falsifying authorship, evidence, data, findings, conclusions • Do not plagiarize • Avoid disclosing information that would harm participants • Communicate in clear, straightforward, appropriate language	• Report honestly • See APA (2010) guidelines for permissions needed to reprint or adapt work of others • Use composite stories so that individuals cannot be identified • Use language appropriate for audiences of the research
Publishing study	• Share data with others • Do not duplicate or piecemeal publications • Complete proof of compliance with ethical issues and lack of conflict of interest, if requested	• Provide copies of report to participants and stakeholders; share practical results; consider website distribution; consider publishing in different languages • Refrain from using the same material for more than one publication • Disclose funders for research; disclose who will profit from the research

Sources: Adapted from APA, 2010; Creswell, 2012; Lincoln, 2009; Mertens & Ginsberg, 2009.

Figure 3.2 Ethical Issues in Qualitative Research (Creswell, 2013)

3.8.1 Seeking Ethical Approval

As a registered general and public health nurse, I am bound by the code of ethics governing my profession (NMBI, 2015a). These guidelines dictate that ethical approval be sought by the academic institute and the health service concerned with the study before undertaking any research. Prior to the commencement of this study ethical approval was sought from the two relevant ethics committee, Waterford Institute of Technology and the Health Service Executive Regional Ethics Committee. This application process was very detailed and included the submission of a research proposal. Meetings took place with both committees separately to discuss any potential harmful aspects of the study. Concerns regarding the researchers contact with patients was raised and to limit any potential harmful impact this study may pose on the patient population (who were not a concern of this study) a decision was taken to restrict the observations to public areas only, a revised application was made

outlining these modifications and ethical approval was granted on the 26th of May 2016 (appendix 7).

An ethical application reflecting the restriction on observations was placed with the Health Service Executive Regional Ethics Committee and a meeting was held where ethical aspects of the study were discussed. Ethical approval was granted on the 7th of November 2016 (appendix 8).

3.8.2 Protecting Individual Participants

Observations were only concerned with the public spaces where RNs and HCAs would be observed naturally by the public, every RN and HCA involved in the observation phase of the study was supplied with a participant information leaflet (appendix 4) and provided with an opportunity to state if they did not want to be observed.

'Studies based on observation in natural settings must respect the privacy and psychological wellbeing of the individuals studied. Unless those observed give their consent to being observed, observational research is only acceptable in public situations where those observed would expect to be observed by strangers'

(The British Psychological Society, 2010, p. 25).

It was planned for, that if any staff did not wish to be observed they could approach me privately, I would explain that I would not follow them or record any personal or generic details with regard to them or their actions, if this was unsatisfactory for them it would be arranged that observations would not occur while they were on duty. However, this did not arise as an issue. A timetable of the researchers presence on the ward was made available

on the notice board the Friday prior to each week of observation, this allowed time for staff to voice opposition to my presence, this however did not occur.

Prior to each interview, participants were provided with information regarding the interview process and included a signed consent (see appendix 6). They were informed that participation was voluntary and that they could stop or withdraw from the process at any time. It was ensured that they were happy to commence the taped interview. Voluntary, basic demographic information was collected from each participant prior to commencement.

Ethical principles used to guide the research process included respect for persons, autonomy, beneficence, non-maleficence, justice/fairness, veracity, fidelity and confidentiality (Polit and Beck, 2012). This was kept to the researches fore-mind with the use of a checklist to ensure that standards were being met.

3.8.3 Confidentiality and Anonymity

The most likely source of harm in social science research is the disclosure of participants personal information (Denzin and Lincoln, 2005). Throughout this study measures were implemented to protect participants' identity. Participants were informed verbally and also through the study information leaflet of the measures that were in place to protect confidentiality and anonymity.

Throughout the interview process, the researcher ensured doors were closed at all times and interviews were held in an area with minimal distraction. Choosing an area that is quiet and conducive to audio recording is an important practical implication in the interview process (Creswell, 2013). Following the interview process, the recordings were transferred to a password protected computer and removed from the recording device. The data was

returned to a secure location in Waterford Institute of Technology. Field notes were verbally recorded onsite, transcribed into a reflective journal and password protected. Written field-notes were locked in a secured filing cabinet. Codes were promptly allocated to participants' names and the key code kept separately and securely from the data.

Through data analysis themes emerging from the data require supporting quotations. These quotations will not be identifiable to any one participant and quotes that have a potential to reveal a participant identity will not be used. As Bradshaw *et al.* (2017) posits, the more information researchers give depicting a theme the greater danger of participant identification. Based on this principle it was decided to label all terms used for the HCA as HCA, to avoid participants being identified through colloquial terms for the HCA. RNs and HCAs are referred to in a gender neutral manner. This seeks to assure participant anonymity due to the small number of participants within each cohort.

The gathered data is protected under the Data Protection Act (Commissioner, 2018). Training provided by the institute was attended to ensure compliance. In line with the Data Protection Act all computerised data in relation to the study will be removed and destroyed, five years after completion of the study.

3.9 Conclusion

This chapter discussed the process of investigation for this study relating to the role relationship between RNs and HCAs within the clinical social space of care in the South- East of Ireland, issues with regard to identifying and selecting a research methodology were explored. The justification for adopting a qualitative description approach was discussed. The merits of engaging in this approach as outlined by Sandelowski (2000); Sandelowski (2010); Bradshaw *et al.* (2017); Lambert and Lambert (2012) were presented. Procedural

issues relating to sampling, data collection, data analysis, quality and ethical procedures and principles were explored.

Chapter Four
Observations relating to the nature and impact of interactions between RNs and HCAs within the social space of care

4.0 Introduction

This chapter presents the observations of more than 30 hours, averaging three hours per observation period over a one month timeframe covering morning, day and evening shift patterns where both RNs and HCAs worked together (HCAs did not work nights), undertaken by the researcher in an acute hospital ward setting within the south-east of Ireland. Observation requires the researcher to record what people say and do, uncovering behaviours and routines that the participants themselves may not even be aware of. As it is impossible to record everything this is inevitably a selective process and relies on the researcher to be the instrument and document the world they observe in a systematic manner including his or her feeling to the situations observed (Mays and Pope, 1995). Observations and the analysis of observations and field notes occur concurrently as this allows the focus of inquiry to be refined (Pope *et al.*, 2000). Concurrence is essential for two reasons; firstly, initial analysis adopts self-reflection and self-reflection is crucial for understanding the emerging of sense in any research study. Second, initial analysis reveals emergent themes. Identifying emergent themes while observing allows for a change in attention in ways that adopts a more developed study (Emerson, 2011) .

The observations are interpreted using Ritchie and Lewis (2003) framework of analysis and presented under the two main themes of the 'nature of the interactions' and the 'impact on role identities'. The behavioural markers under which the observations were structured are organised into the sub categories of; team structure, leadership, mutual support and communication (Chiu *et al.*, 2013).

Section 4.1 provides a summary of all the observations, section 4.2 describes the overall interpretations of the observations and section 4.3 illustrates my reflexive thoughts throughout the observations. Section 4.4 lays out the nature of the interactions observed and section 4.5 details the observations in relation to the impact of the RN and HCA roles on role identities. Section 4.6 concludes this chapter and demonstrates how the observations shaped the semi structured interview schedule.

4.1 Overall Summary of Observations

The unit observed is a general medical ward where CNMs, RNs and HCAs work together providing nursing care to patients. Student nurses, ward clerk, catering and cleaning staff are also a normal feature of ward life, with MDT members regular visitors to the ward. CNMs are distinguishable by navy trousers and navy tunic tops, RNs are distinguished by navy trousers and white tunic tops, while HCAs are signified by navy trousers and green tunic tops. The use of a distinguishable uniform is in keeping with professional boundaries, which is important to healthcare professionals in terms of grade and in assisting the public in identifying each professional associated with the colour of the uniform they wear (Timmons and East, 2011).

The corridor of the ward is 'L' shaped. The patient areas branch off the corridor, with the nurses' station at the intersection of the 'L'. The patient information board is located at this intersection. This is where I placed myself primarily, as it provided a good vantage point for me to observe the day-to-day interactions between HCAs and RNs without encroaching on patient space[4]. However, the level of activity on the ward and the length of the corridor often resulted in me not always being able to hear the content of people's conversations and while I would move towards my area of interest, it was often too late, this I found to be

[4] See Chapter 3 Section 3.7.1

overwhelming at times (see box 5), a common issue with researchers in the field (Creswell, 2013).

> The ward is busy and bustling with people, I see an RN and HCA chatting in a purposeful manner, I move closer to hear, but by the time I reach them the conversation is over and they go their separate ways, I am annoyed I didn't move faster, but I didn't want to be perceived as nosy. I wish I was better at this.

Box 5 Field Note

RNs work in teams, of which there are two, for the duration of the shift. Each team consists of two RNs and one HCA, or one RN and one CNM1, the CNM2 is present in a managerial capacity, an important role that the Taskforce on Staffing and Skill Mix for Nursing (2018) recommended 100% of the CNM2 role be supervisory and invest in succession planning of the CNM1. Student nurses are also present, but not a concern of this study. The ward is divided into two sections, each team has responsibility for its section. It is assumed that skill mix has been considered and is not the focus of this study. There are work stations outside patient areas of each section, where the medical and nursing notes are retained, with access to a telephone. This is where the RNs and HCAs anchor their working day, returning to the nurses' station frequently (see Box 6). The unit operates at full capacity with extra beds on corridors for periods of time throughout the duration of the observations, an ongoing issue within the Irish hospital setting (O' Connor, 2018).

> RNs and to a lesser extent, HCAs appear to anchor themselves outside the patient areas at work stations and carry out their administrative work from these areas. RNs are pre-occupied with documenting and communicating care and doing medication rounds, this is where they appear to spend a lot of their time.

Box 6 Field Note

4.2 Overall Interpretation of Observations

My overall interpretation of the observations is that the unit is a busy place to work. Role overlap is a regular feature of ward life as both RNs and HCAs were observed to carry out the same tasks, like vital sign monitoring and answering patient call bells, which is supported in the literature (Spilsbury and Meyer, 2004; Keeney *et al.*, 2005; Daykin and Clarke, 2000). The distribution of the tasks appear to be equal and collaborative in nature in delivering basic patient care, as I often witnessed HCAs and RNs walk into patient areas together, having put on gloves and gowns simultaneously. I interpreted the acquaintance and ease at which all team members spoke to and interacted with each other as a sign of familiarity (DiBenigno and Kellogg, 2014). I felt that the ward was clean, pleasant and organised, an objective of the Productive Ward series (2008) that aimed to streamline ward based routines to release time back to teams to care for the patients. Patient rounds, medication rounds, vital sign monitoring and doctors rounds all had regular patterns attached to them (see box 7). HCAs know the routine of the ward and appeared to understand what was expected of them without RNs delegating routine tasks to them, an example of this is illustrated in box 8.

> I can see a pattern of routine emerging where every day that I have observed, I notice at this time, the medication round is carried out and HCAs and the other RN are busy either delivering patient care or carrying out ancillary tasks like laundry.

Box 7 field Note

I am of the view that the ward has positive team relations, where the delivery of patient care is always the focus of the staff members, where team members are considered and information is exchanged appropriately. This is demonstrated by the patient focus the teams maintain in their interactions, the respect and authority that RNs and HCAs always

show when speaking to or about each other, other team members, management and the patients, this is demonstrative of skills for teamwork (Sutton *et al.*, 2011).

There was very little downtime or time to engage socially during the shifts I observed and while social engagement is important (Trybou *et al.*, 2014; DiBenigno and Kellogg, 2014) excessive social downtime can adversely affect inter-professional team work (Lloyd *et al.*, 2011).

> HCAs go into the bays at the start of the shift to begin the task of caring, without attending handover or being delegated too by RNs before the RNs received handover.

Box 8 Field Note

Both teams are well defined by the ward layout, where no crossover of staff occurred for the duration of the shifts observed. There was no rivalry noted between the teams and a friendly assistance by a HCA to their opposing HCA was noted to occur at the end of one particular shift I observed (see box 9).

> Teams have no cross over with each other, in terms of assigned patients, but HCA did offer to help out on the opposite team before finish of shift

Box 9 Field Note

RNs were often observed to be pre-occupied with documentation, medication rounds and communicating care to other MDTs appeared to consume their time. This partly concurs with Clark and Thompson (2015) who observed RNs to be preoccupied with the management of care as opposed to the delivery of patient care. However, I observed RNs appearing to engage in direct basic patient care delivery (I did not have access to patient areas to confirm or refute this but the observation of the frequent use of gloves and aprons by RNs would be very suggestive of work they were going into patient bays to carry out). RNs appear to do everything to get the job done, like clean drip stands and pack up patients

belongings (see box 10). RNs appear to move about in an efficient manner, but the impression of the way with which they move is that they are managing a lot of tasks.

All staff appear to know their role and get on with the task in hand, no barrier appears to be present in answering call bells, RNs and HCAs will answer patients calling, for example, call bell in patient toilet alights and RN locks drug trolley, without looking for HCA and goes to answer call bell.

Box 10 Field Note

HCAs also bustle about in a methodical manner which leads me to interpret that HCAs are regular members of staff. HCAs are constantly on the move and at certain times of the day appear to work independently of RNs when carrying out household duties, vital sign monitoring and some patient care tasks and while the time spent working independently was not measured quantitatively like the Hasson *et al.* (2005) study, it did concur that HCAs spend time caring directly for patients and indirectly by carrying out household duties, therefore supporting RNs in their role. The Hasson *et al.* (2005) study did not observe HCAs to engage in the recording of vital signs, unlike this study, demonstrating the rapid expansion of the HCA role.

I feel that my exposure to observe delegation and supervision was limited due to my restricted view of patient areas. I did observe a few episodes of delegation but never an instance where supervision was obvious. NMBI (2015b) supports indirect supervision of HCA and this requires further probing at interview, as I regularly observe HCAs to work in a close geographical proximity to RNs as depicted in box 11.

I see the same HCAs over and over, I see HCAs working independently of RNs, but RNs are never too far away from them, I cannot see if supervision is occurring, as I do not have access to patient areas, where supervision may be observable?

Box 11 Field Note

4.3 Overall Reflexive Observations

Reflexivity is an important textual and positional activity in qualitative research due to the human element, where the voice of the researcher needs to be heard in laying out an honest and open account of the experiences and processes throughout the research process (Mazzei, 2008). Hammersley and Atkinson (1995) state that the researcher needs to recognise the reflexive nature of the social research. Reflexivity in this context has two components; these are the interactions of the researcher with the choice of research subject and the interactions of the researcher with those who are the subject of that research (Kleinman and Kopp, 1993). In order to reflect '*we must critically review our own behaviour, build theory from our observations drawing on generalisations, make decisions and resolve uncertainty to emancipate ourselves*' (Moon, 1999, p. 23) that being said it is the researchers choice as to determine the exact focus of the observations (Emerson, 2011).

It was an objective of this study to observe and analyse the nature of the interactions between RNs and HCAs. Therefore the focus was on the role relationship between the two. On reflection of the relationship that existed between the RNs and HCAs, it was one of familiarity. The same HCAs were a constant feature of ward life and this I felt was an important feature to the relationship and impacted on the nature of the delegation and supervision; this was not conclusive and required probing at interview. My own preconceptions of how the relationship would be and my response to being the researcher as opposed to a nurse are captured in a mid-study reflective journal entry in box 12 below;

I am perplexed at how well RNs and HCAs get on socially and professionally, having read the literature I was expecting some element of hostility, at some stage of the process, and while not overtly, I was expecting something! But this has not transpired. I do know that the relationship functions on a day to day basis, as I have worked with plenty of HCAs but I did expect that they would 'give out' about each other at some point? I wonder if they do have issues with each other and that because they see me as an outsider, they are guarded? I have seen them disappear out of my ear shot when I 'casually' approach. They do appear to be very busy and I wonder if I'm paranoid?

I hate being out of my comfort zone, I am used to being in control. I'm used to doing 'real' work. I like to be part of a team and I am not part of this team. I wish they could get to know me though. I really wished I had pushed to be a participant observer; I didn't realise how important being part of the team is to me and using my social skills to gain access to people. My folder holding, corridor walking, no- uniform wearing researcher me is not what I want to be seen as and I feel like I am standing out like a sore thumb.

I need to ask about what the relationship is like when the HCAs or RNs are not regular members of staff?

Box 12 Reflective Journal Entry

I struggled at times with my role as researcher and it was important to maintain a reflective journal throughout the whole process, to assist me in my journey. When practitioners look back, they can view the journey through the shifting accounts of their reflected experiences (Johns, 2000b). In terms of my impact on the ward and staff being observed at all stages of my observations I found staff to be polite. I was engaged positively about the study especially when the CNM introduced me to the ward staff. Quickly, the level of engagement from staff approaching me dwindled. The ward was busy and if I came across member(s) of staff I had not met before I would introduce myself and the study but I felt awkward and intrusive within their social space, I shared Labaree (2002) as cited in Creswell (2013) dilemma in terms of disclosing myself, sharing relationships and disengaging myself from

the site. I was unsure of the level of interaction I could engage with staff. Having discussed my feelings with my supervisors I was reassured with regard to the level of interaction with the staff and was encouraged to ask questions about patterns of activity I could not decipher for myself. This level of engagement with staff, I felt, was helpful in embedding me within the unit. However, due to my non-participatory observational role I felt it was easy for staff to be 'put off' by my presence, despite nobody saying they did not want to be observed. I do wonder if this was my issue as opposed to any particular member of staffs' issue as I felt I should be doing something to help (box13).

> I feel awkward walking up and down the corridor, trying to blend into the wall, I hate carrying a folder and ticking boxes, I'm sure I'm unnerving staff, even though I get the impression they are too busy to even notice me.
>
> I need to minimise the clipboard look.

Box 13 Reflective Journal Entry

For the duration of the observational phase of the study, there was a patient on the ward who would wander regularly and engage with me hoping I could show him the way home. I was unsure of what role I should assume with regard to this, for example should I follow him if he was leaving the ward, should I encourage him back to his room? The staff would be very busy but were always kind with regard to this and I learned to engage in pleasantries with the patient and a member of staff would soon emerge and assist the gentleman in the right direction. However, I would miss potential observations due to this patients' level of engagement with me (see box 14).

A confused pleasant gentleman, keeps approaching me for a chat, I am struggling with my dual conscience here, I engage with him as I know the staff need him to stay on the ward, plus as a nurse I want to chat with him to reassure him, but the researcher me wants to capture accurate data and I keep missing potential valuable observations, when he engages me.

Box 14 Reflective Journal Entry

However as time went on and I was a regular feature of ward life, staff would engage with me wondering what I hoped to get out of the study, I felt under pressure by this and would deflect back to the aim of the study (see box 15). I wonder if this unsettled some staff.

A staff member approached me today, very friendly, but asking what I hoped I would get out of the study, I felt very anxious by this line of questioning as I am afraid to divulge any information that could be interpreted as an ethics breach? I feel out of my comfort zone. I know my answer wasn't satisfactory and that if it was me that was being observed I would too ask the question and also be sceptical if they didn't give a straight answer.

Why am I struggling with this engagement about the study? I think it's because of ethics and also because I know there is a potential for this to be a contentious issue? Even though I have observed nothing but collaboration, the potential still exists. I want to be good at this process and capture the true nature and impact of the relationship.

I need to practice how I will answer these questions at home

Box 15 Reflective Journal Entry

In the final week of the observational phase I felt some staff cautious of me, I would offer smiles and pleasantries but some staff had little interest in me. I started to wonder if they felt 'watched' by me, however, Parahoo (1997) feels it is possible to become part 'of the furniture' and maybe this is what was happening. I did wonder if I was wrong in my assumption as the ward was very busy during this time, the pressure they were under was visible, as all staff bustled purposefully in and out of rooms, documenting care, liaising with

MDT and between themselves and the CNMs, my thoughts around this are captured in a field note entry, as illustrated in box 16.

> I wonder if they think 'we know she's a RN, you think she would help us'? I feel that I should be helping them out.

Box 16 Reflective Journal Entry

Towards the end of the observational phase of the study I found a significant percentage of the study information sheets along with the expression of interest forms that I had given to staff, left back, unsigned under my expressions of interest box. I felt very dejected by this (see box 17), coupled with a HCA who I had engaged with positively throughout the study also informed me that he was unsure about willingness to be interviewed. I wished at this stage that I had chosen a participatory role for the observations, as this would allow me to engage with staff and reassure any concerns they had about the study, or just demonstrate that I too was one of them.

> I think the RNs are getting tired of my presence; they are very busy, documenting and liaising with doctors… I think they feel watched… I have discovered under the sealed expressions of interest box, five information sheets with the contact details forms left back in under the box, blank, I feel so dejected… non-participant observation was the wrong approach, I should have participated.

Box 17 Reflective Journal Entry

4.4 Concluding Comments

According to Mays and Pope (1995) field notes gathered can be highly descriptive, detailed and a cumbersome process to decipher, this was true of this study but the themes of familiarity and routine were identified at a relatively early stage within this process allowing me to focus my lens and reflect on why familiarity was an important feature of this

relationship and question what was the impact of the routine of ward life on the RN and HCA relationship, if any (Emerson, 2011).

The data gathered during the observations was also interpreted using Ritchie and Lewis (2003) analytical framework. This allows for themes to emerge and to further focus the areas of interest (Emerson, 2011). The data was gathered under the two major themes; (1) the nature of the interactions and (2) the impact of the relationship on role identities.

4.5 Nature of Interactions

It is important to bear witness to the types and nature of interactions RNs and HCAs engage in, as the analysis of the interactions between RNs and HCAs can provide insight into the functioning day-to-day relationship of the two groups of direct care providers and how they navigate the social space of care to collaborate in patient care delivery (Hasson *et al.*, 2005; Mays and Pope, 1995). Observing the nature of the interactions allows for examination of what is occurring within the social space of care (Mays and Pope, 1995) with regard to; team structure, leadership, mutual support and communication.

4.5.1 Team Structure

The unit observed consists of a skill mix consisting of a CNM1, CNM2, RNs, HCAs and student nurses. There are two teams for every shift and consist of two RNs (or one RN and one CNM1) and one HCA, the CNM2 is present in a managerial capacity but assists the teams in times of work overload. HCAs do not work night duty on the unit observed. This percentage of skill mix grade has a higher HCA rate with the national average of 85%/15% of RN/HCA (Scott, 2013) and more in keeping with the English ratio (Royal College of Nursing, 2012). This is not a cause for concern as the Department of Health (2016) Taskforce on staffing and skill mix cautions that skill mix should be carried out on a case by case basis.

In terms of the nature of the interactions between team members, CNMs, RNs and HCAs intersperse with each other during all the shift patterns I observed and they moved with familiar ease throughout the unit. While social downtime was very limited throughout the observations, it was noted that RNs and HCAs would intermingle with each other during this limited time and engage with each other in a friendly, familiar manner. I observed an RN and HCA share ideas about wedding invites in an acquainted sociable manner.

It was difficult to ascertain through observation of the public areas if HCAs were featured in the handover team. I asked a HCA and an RN what the routine of handover was. Handover is taped and RNs will attend in the mornings, HCAs can listen if they want and will listen if they are coming back after a few days leave. If they have been working for a few days the RN will provide updates with regard to patient changes. Handover of patient care to the HCA is important within the team and requires leadership from RNs as it is the responsibility of the RN, it also provides for better quality of care (Hindmarsh and Lees, 2012).

4.5.2 Leadership

Ward leadership is an important factor in creating and sustaining a positive ward environment, the role of the CNM2 is that of a leader and supervisor and should always be safeguarded (Department of Health, 2016). I witnessed times when leadership was obvious for example the CNM reorganised team members to accommodate staff shortages. RNs will also provide leadership in the form of delegation and it became apparent as the observations progressed, that non-routine tasks only were delegated for example; a RN said to a HCA; '*will you take blood to the lab*'.

The supervisory role of RNs was difficult to capture in a tick box manner as this is a complex role as RNs can provide supervision either directly or indirectly (NMBI, 2015b). RNs work

very closely, in terms of their vicinity to HCAs. I did witness HCAs appearing to deliver direct patient care in single occupancy rooms by themselves without the supervision of an RN. Therefore, indirect supervision by RNs of HCAs may account for my inability to capture this as an observation. This required further investigation at interview.

4.5.3 Mutual Support

There appears to be a co-operative spirit on the ward, where staff regularly and mutually supports each other to get work done. RNs and HCAs collaborate in carrying out routine patient care; RNs will dispose of dirty linen, HCAs will fetch drip stands. The roles appear to overlap when it comes to providing direct patient care; (Spilsbury and Meyer, 2004; Keeney *et al.*, 2005; Daykin and Clarke, 2000) HCAs and RNs will work together during busy periods, such as when providing direct patient care, an example of this is noted in my field notes (see box 18)

> Two RNs are going to provide care to a 'heavy' patient, the HCA sees them and speaks a few words to the RNs (out of my range of hearing) HCA stops what they are doing and goes with the RNs to assist with the patient.

Box 18 Field Note

Everyone appears to have a role and gets on with the work in hand. A collaborative, mutually supportive relationship according to DiBenigno and Kellogg (2014) is based on finding a common ground consisting of social familiarity, allowing for the lines of cross professional boundaries to be appropriately blurred and fostering an effective team approach.

There appears to be balanced distribution of tasks relative to the role, I have made this conclusion based on the observation that all staff are busy all of the time; even though they are busy with different tasks, for example, when RNs are preparing medications the HCA will

be stocking the cupboards. During rare social downtime, both groups (HCAs and RNs) are equal in this downtime, the only examples of downtime occurring was when the shift was coming to an end and staff were waiting for the new staff to come on duty. All staff would gather around the nurses' station and chat while they would engage in light duties, like clearing away notes, filling in a diet sheet or writing the team members on the information board for the next shift. This social downtime is important in collaborative relationships as it allows for teams to form and maintain relationships by discovering commonalities between each other as people, outside of the professional title they hold (DiBenigno and Kellogg, 2014).

4.5.4 Communication

Communication that is timely, complete accurate and understood is imperative to patient safety (Donahue *et al.*, 2010). Information sharing appeared common and effortless, for example, the CNM, RN and HCA discuss a patient discharge at ease and all three staff communicated easily, with elements of negotiation between all parties, everyone appears to understand the plan for discharge for the patients. The ward appears to foster a very open communication style as conversations between all grades of staff is relaxed and happens in an informal manner, an example of this can be seen in box 19. This describes the direct conversation style when a new admission is booked for the ward.

RN and HCA engage with one another about an admission to the ward; the RN asks the HCA; '*Does he need a mattress?*' HCA replies; *'it's all set up down there'* RN responds to HCA saying *'give me half an hour before he comes up'*

Box 19 Field Note

This informal style of negotiation is suggestive of a level of familiarity and the ease with which they work together. Social exchange was present between RNs and HCAs throughout

the observations, as I witnessed many pleasantries shared between and among groups, an important feature of successful cross professional relationships (DiBenigno and Kellogg, 2014).

I observed the CNM seek the RN and HCA out to information share by calling them to the patient information board and say; '*let's go through the board*'. I witnessed both a RN and HCA information sharing and also RNs only discussing care at times. In relation to HCAs being sought out to provide patient related information or clarity, this had mixed outcomes, from obviously not being asked, for example, HCA and the RN were standing together, when another healthcare professional approached asking about basic care issues with regard to a patient, the HCAs opinion was not sought and information was not offered by the HCA. With regard to the nursing team HCAs appeared to be included in patient discussion, but I did not witness them being called out specifically to provide clarity. This concurs with Lloyd *et al.* (2011) findings that HCAs are neither formally or informally included in the communication with the wider team and only occurs in an ad-hoc manner, which can lead to missed care, despite them being viewed as the 'eyes and ears' of the ward (Spilsbury and Meyer, 2004, p. 415). HCAs offered information before it was asked of them, I observed, a HCA letting the RNs know that they were free to help. This is in contrast to Spilsbury and Meyer (2005b) study that found HCAs to keep information to themselves to bolster their own status.

I witnessed very little check back style of communication, but this could be happening out of my view, I am also conscious that this is an American concept, where information is directed at a person and the person reiterates what has been asked of them to assure understanding (Chiu *et al.*, 2013; Donahue *et al.*, 2010). Staff in the Irish setting, may not be conscious of check back as a method of communication.

Informing directly refers to the positive manner or tone in which a communication is delivered to get a task done, informing directly suggests that there is an atmosphere of open communication with respect and value for different grades of staff, direct informing was common amongst HCAs, this suggests that they feel like their input is valued (DiBenigno and Kellogg, 2014), examples of this are illustrated in box 20.

I am observing direct informing from HCA to RN and also RN to HCA as a HCA says to a RN, '*can you help me to get* 'patient name' *up the bed, please*' and an RN to HCA *'come on, let's go'* the tone and manner is light hearted and friendly.

Box 20 Field Note

Capturing if RNs or HCAs ask for assistance prior to or during task overload was particularly difficult to be conclusive about as I did not have access to patient areas, however HCAs regularly offered help, if they saw an RN passing them and looking busy they would ask if they could help with anything. I observed an RN ask a HCA; '*can you give me a hand down here please*'. I spoke to a HCA about this and generally they inform RNs that they are going to provide care and that they will need help with, for example, a transfer, and the RN will automatically come to help when the transfer is required. I did not witness any conflict between staff members however, there was a difficult patient on the ward and I observed different grades of staff supporting each other, by rotating the exposure each staff member had to the patient.

The nature of delegation is difficult to be conclusive about through observation of common areas. Delegation does happen, for example I witnessed the CNM asking the HCA, if they would go and provide direct care to a patient; delegation could also be happening regularly within the patient care areas, to which I am not privy. When a new patient arrived on the ward I asked a HCA and an RN separately, what happens in relation to the tasks that need to

be carried out, both said that the RN would delegate the new care (HCA did not use the word delegate).

Supervision is also difficult to be conclusive about, however, the observations suggested that RNs and HCAs work so geographically close to each other and appear to have a good working relationship with each other that supervision is happening indirectly.

It is imperative to investigate at interview what HCAs understand about the concept of delegation and supervision as there is little known about this phenomena.

4.6 Impact of Role Identities

As discussed in chapter two role development and role flexibility are important requisites of healthcare organisations and one of the most important factors to flexibility is the people factor and the behaviour of individuals and groups, which is dominant in organisational change. Kilgore and Langford (2009) state teams must overcome respective role boundary barriers to have a mutual understanding of each other's role in patient care and delivery. Role identities are important to observe as the impact of these identities can either enable or pose a barrier to role development (Duffy, 2014) and collaborative working.

4.6.1 Team Structure

The ward is divided into two teams that consist of RNs and HCAs and student nurses. All team members are assigned to a particular side of the ward. The impact of this type of structure is that teams do not change during the shift and appear to have little professional interaction with each other for the duration of the shift, but do interact on a social level. Responsibilities appear defined, for example, the RN is doing a drug round and the HCA is carrying out household duties.

RNs and HCAs appear to know the duties that are required of them and get on with the task in hand, both HCAs and RNs answer call bells, attend to patients' toileting needs, and carry out patient vital sign monitoring. In the course of one observation an example of this is obvious and exemplified in box 21;

> RN sees a call light in a toilet going off, RN does not look for HCA, but locks the drug trolley and goes to answer the call bell, this provides a practical example of an occurrence of role overlap.

Box 21 Field Note

Despite this overlap, tasks appear to be distributed and performed relative to the role, as both RNs and HCAs provide direct patient care. HCAs also carry out household duties and vital sign monitoring, while RNs document, liaise with doctors and other MDT members, administer drugs and spends time with students.

With regard to HCAs being approached by MDT members I have witnessed incidence where HCAs have been approached by an MDT member looking for notes or to provide basic patient information and also an incident where a HCA was not engaged at all by an MDT member despite them standing next to each other choosing to converse only with the RN. In relation to the observations concerning paramount teamwork, which refers to a competition between the two teams to complete tasks (Miller and Kontos, 2013), there was no evidence to suggest this occurs.

4.6.2 Leadership

Effective leadership impacts a team positively (Taskforce on Staffing and Skill Mix for Nursing, 2018). The behaviour displayed by all staff in relation to management, appeared to be no different than in other staff communication, attitude or behaviour. HCAs and RNs speak freely and easily to the managers, clarifying management decisions without hesitation a good example of this is reflected in box 22 ;

CNM informs HCAs that one of them must go to a different ward and to decide between them, CNM leaves to go to handover and while the HCAs politely decide between themselves, an agency HCA arrives on the ward to commence duty. Both HCAs suggest the agency should go to the different ward, one HCA freely, without hesitation goes to the CNM in the office, knocks on the door and returns quickly where she tells the agency staff to go to the other ward.

Box 22 Field Note

Organisational support of the HCA role was apparent as a HCAs lunch break was facilitated to allow the HCA attend a meeting and also the HCAs spoke about past training days. This demonstrates a leadership style that is accessible, visible and value staff input, this is considered by Urden and Monarch (2002) to be an excellent management style. This style of management is one factor seen to have a positive impact on working relationships (Marriner Tomey, 2009).

4.6.3 Mutual Support

The impact of staff mutually supporting each other resulted in me observing staff being respectful of each other, this was demonstrated both in their general interactions with each other, for example they would greet each other with familiarity at the start of a shift. They would also willingly assist each other, especially during busy periods RNs would carry out duties like, packing patients' belongings to go to another ward, or wash down a drip stand, without appearing to be burdened by this work. HCAs will carry out vital sign and blood sugar monitoring. This leads me to believe that they are respectful and apply a teamwork attitude to ensure patient care is delivered and positive work environments impacts quality of care (Aiken 2008).

Team members work in such close geographical proximity to each other that there was no incident that I observed where they needed to seek each other out, as team members

regularly knew where other team members were, break times, side room or off the ward. This supportive work environment fosters collaborative working as RNs rate this as an effective way to supervise and communicate with HCAs (Siegel *et al.*, 2008).

4.6.4 Communication

I perceived the atmosphere on the ward to be friendly, which impacted positively on the ward environment as interactions between staff members were pleasant and informal, an example of this can be seen in box 23;

> RN says to HCA; *'Can you give me a hand?'*, HCA replies, *'Can you give me two minutes to finish this?'* (washing a bed) RN replies *'Yeah, sure, give me a cloth and I'll help'*

Box 23 Field Note

I observed HCAs and RNs socialise together, they would leave and go to break together and know details of each other's lives outside of work. RNs would socialise with RNs, as would HCAs socialise with other HCAs, but not to the intentional exclusion of another group, social exchange is an important feature to role relationship as it builds trust and helps with staff retention which is important to collaborative relationships (Lloyd *et al.*, 2011; Trybou *et al.*, 2014).

Briefs throughout the observation appear to happen informally, with no regular pattern or routine associated with it, however I did witness one incident where all relevant staff, RN and HCA being called by the CNM, to the information board to share and update patient and operational information, Siegel *et al.* (2008) suggests that heavy workloads are a barrier to this formal communication occurring. For me, this does not make a conclusive finding and needed further investigation at interview.

HCAs carry out household duties independently of RNs and also appear to carry out direct care independently when the assistance of one is required in delivering patient care; however, they do work in a geographically close environment to RNs. All the staff has access to all areas and all facilities, there was no physical space on the unit where all team members did not have access to. Everyone had use of the fax, phone, office, treatment room, store-room kitchen and patient areas, unlimited access to all areas by all staff solidifies collaboration and promotes informal communication (DiBenigno and Kellogg, 2014).

4.7 Conclusion

This process of observation was a journey in itself, where I learned as much about myself as I did about the RN/HCA relationship. Observations are essential in this process, despite my concerns about being a non-participatory observer. I am of the opinion that the ward environment is largely routine in nature and the context in which the care is delivered could be one of familiarity. The insight into the nature of the interaction and the impact these interactions have on role identity is critical in developing an understanding of how these two groups of direct care providers work together within a changing context and dynamic of care within this social space.

Following on from the observations it was important to bring forward what was uncovered during the process and reshape the interview process to include further areas for probing such as, communication, delegation and supervision and also confirm or refute my claim that the ward is routine, what this means for the role of RNs in delegation and supervision and also if the relationship between RNs and HCAs is one of familiarity. The concept of delegation and supervision for HCAs also required fleshing out and the contribution HCAs

make in the sharing of patient information. These and all findings of the interview process are revealed in chapter five.

Chapter Five
Participants' views relating to the role relationship between RNs and HCAs within the clinical social space of care

5.0 Introduction

This chapter presents the participants views in relation to the role relationship between RNs and HCAs within the clinical social space of care. Four typologies were identified; (1) 'Time to Care', (2) 'A Knowing Relationship', (3) 'The Routine of Ward Life' and (4) 'The Organisation of Care'. Ritchie and Lewis (2003) analytical hierarchy of analysis was used creating each typology consisting of sub-themes (or classifying data) and thematically presented.

Section 5.1 presents the demographic characteristics of the participants. Section 5.2 outlines the typologies and the sub-themes that informs each typology. Section 5.3 presents the findings with regard to the overall typology of 'Time to Care', which consist of the sub-themes of RNs not having enough time, the pressure of nursing, documentation being time consuming and handover and its issues. Section 5.4 the typology of a 'Knowing Relationship', is presented and is sub divided into the themes of; a positive relationship, familiarity, a close working relationship, HCAs cannot say no and imbedded. In section 5.5 the typology of 'the Routine of Ward Life' consists of the sub-themes of; delegation, supervision, the HCA approach and accountability. The final typology is presented in section 5.6 the 'Organisation of Care' and the sub-themes for this typology are; organisational support, organisation of the HCA role, the progressive role, the struggle with role expansion and HCA as a career choice. Section 5.7 concludes the findings and provides context for the discussion chapter.

5.1 Demographic Characteristics of Participants

Table 5.1 illustrates the age of the participants (n=7), four RNs and three HCAs, with a majority (43.2%) aged in the 18-25 catagory. Both sexes were represented in the sample.

Variable	Frequency	Percentage
Age (in years)		
18-25	3	43.2%
26-33	1	14.2%
34-41	1	14.2%
42-49	1	14.2%
50-57	1	14.2%

Table 5.1 Demographic characteristics of participants (n=7)

The length of hospital experience within the hospital studied since attaining their qualification is presented in table 5.2. The majority (57.4%) has 1-9 years' experience.

Hospital Experience (years)	Frequency	Percentage
1-9	4	57.4%
10-19	1	14.2%
20-29	1	14.2%
30-39	1	14.2%

Table 5.2 Length of hospital experience of participants

With regard to the qualification received all HCA participants hold a QQI level 5 major award on the national learning framework in Healthcare Support.

5.2 Typologies and Classifying Data

Utilising Ritchie and Lewis (2003) analytical framework, the four typologies of (1) Time to Care (2) A Knowing Relationship (3) The Routine of Ward Life and (4) The Organisation of Care, were identified. These typologies evolved as a result of immersion in the data where codes emerged and became concepts. Meaning could be attributed to these concepts when the same concepts appeared across the data set. Refined concepts were extracted from this data set and the data was classified once origins and extent were distinguished, becoming sub-themes. The clustering of similar sub-themes together were labelled typologically

adhering closely to the original data as advised when using a qualitative descriptive study design (Bradshaw *et al.*, 2017), outlined in table 5.3.

	RN Findings		HCA Findings
Typologies	**Sub-themes**		**Sub-themes**
Time to Care	• RNs don't have time • Documentation is time consuming • Handover has its Issues		• The Pressure of Nursing
A Knowing Relationship	• Positive Relationship • Close Working Relationship • Imbedded		• Familiarity • HCAs Cannot Say No
The Routine of Ward Life	• Delegation • Accountability		• Supervision • The HCA Approach
The Organisation of Care	• Organisational Support • The Progressive Role • The Struggle of Role Expansion		• Organisation of the HCA Role • HCAs as a Career Choice

Table 5.3 Detected patterns identified utilising Richie and Lewis (2003) analytical framework.

5.3 Time to Care

The typology of 'Time to Care' evolved from the awareness of RNs in needing more time to care for the patients. Providing RNs with more time to deliver care is not a new concept. 'Releasing Time to Care™, The Productive Ward' series adopted in the UK and piloted in select Irish hospitals aims to improve healthcare working environments by increasing efficiency to release time back to healthcare workers to provide direct patient care (NHS, 2008).

The following sub-themes of (1) RNs don't have enough time (2) the pressure of nursing (3) documentation is time consuming and (4) handover has its issues, are the views held by RNs and HCAs in relation to the communication between them and the impact this working relationship has on role identities.

5.3.1 RNs Don't Have Time

How RNs spend their time is a regular feature within the literature. RNs are increasingly consumed with the intensification of administration of care. All RNs spoke about how busy the ward is and how they '*don't have enough time*' in the day and are concerned about having '*more time*' with the patients, as the ward is '*constant go*'. One RN participant judged what a good day in work feels like and compared it to what a bad day feels like;

> *'I became a nurse because I like working with people and a good day is you go home and at least I looked after all my patients today and another day I was so busy I barely said hello to him, you really want more time with your patients'*
>
> (RN4)

Another RN feels that the pre-occupation of non-nursing tasks by the RN leaves the HCA taking responsibility for carrying out patient related tasks to allow the RN carry out what is essentially non-nursing tasks.

> *'I find myself as a nurse my whole time doing jobs that wouldn't necessarily fall under the role of a nurse, but need to be done….. and that takes away from what you could be doing for the patient and then that responsibility kind of lies with the HCA for doing what you should be, would have being doing if the HCA had not being there, if that makes sense?'*
>
> (RN1)

In discovering what is consuming RNs time both RN and HCA participants spoke about non-nursing duties that consumed RNs time.

> *'They are under so much pressure, the doctors are constantly hounding them, different units seeing is this patient ready, is that patient ready, all the paperwork is just crazy for them'*
>
> (HCA1)

While RNs are frustrated by this, they carry out the tasks regardless as the end result is a more seamless patient experience, despite them feeling that these are someone else's tasks to carry out. RNs gave examples like, answering a query regarding a prescription following a patients' discharge, chasing doctors, ordering and collecting pharmacy supplies at the

weekend. These duties result in them being physically taken away from the patients to fulfil what should be someone else's role and leaving them feel that '*people not understanding the pressure*' they are under and even devalues the role of the RN.

> *'Like the nurse always gets the responsibility, if it's the doctor, the pharmacy list, or someone goes home and they ring back in with a medication query and you have to go and find the notes, even though you haven't looked after the patient, you're thinking, ring his bleep, they always ring the ward….It's easier to just do it yourself, by the time you find out who the doctor is'*
>
> (RN4)

RNs are grateful with regard to the time HCAs have, as this releases time for them to carry out other duties.

> *'…they are going to do things that I don't have time to do'*
>
> (RN3)

HCAs did not necessarily feel that they have more time than RNs, but acknowledge they have more time available at certain times.

> *'…you can imagine an RN in the middle of her writing and you are available and somebody needs this….it's not practical'*
>
> (HCA2)
>
> *'…they are freeing up a bit of time, they are taking things over from me…that I won't stretch to…'*
>
> *(RN2)*

RN2 feels that the time HCAs have to provide care, equates to a quality care. RNs are dismayed by their own lack of time to spend with the patients, but accept it as the status-quo and are happy that if it can't be them that give the patients time, at least the HCA can and the patient is receiving care and that is what really matters.

> *'…the care they provide is second to none, because they have the time; they physically have the time…. They have the time to sit and talk to them, where unfortunately, we don't.'*
>
> (RN2)

> '*I'm just glad the patient has someone they can say, that they've built up a relationship with, that they can feel safe, it doesn't matter if it's an RN or a HCA, that they feel they can ask for a glass of water or can you bring me to the toilet?'*

(RN3)

RNs are grateful for the role HCAs play and the skill set they possess in helping them to deliver patient care. They are grateful of their presence as it helps them in their *'time management*' and see them as the eyes and ears of the ward when the RNs are consumed with tasks such as documentation, caring for an acutely ill patient or while RNs attend handover.

> '*At least I know that there is someone else on the floor to keep an eye out'*
>
> (RN4)
>
> *'…they are our hands on the floor while we go in and have handover…'*
>
> (RN2)

5.3.2 The Pressure of Nursing

HCAs are able to identify that the nature of RNs work is pressurised and that collaboration is important. RNs understand that mutual respect is necessary for teamwork, this is not always felt by some of the HCAs.

> *'On a good day the team you are working in is brilliant and you are all sharing the workload'*
>
> (HCA2)

However, the pressure RNs are under can impact HCAs negatively in two ways; one being the workload that falls to them when RNs are called away by doctors, acutely ill patients and documentation. The other effect, is the personality of the RN in dealing with the stressful environment which can also impact on the HCA by '*making your job hard'*;

> *'…sometimes it's difficult to get a nurse to give you a hand and most of the time it's totally out of their control. If they have a sick patient they are completely tied down…and it can be you then left with five or six other patients…..but when it's just me I'm like, ugh, where do I go, who do I go to'*
>
> (HCA2)

Two HCAs spoke about a small minority of RNs impacting negatively on the dynamic of the relationship between RNs and HCAs.

'…sometimes you can feel that some nurses are expecting a little bit too much from you'

(HCA2)

'…when the ward is short and the ward is under pressure, they feel that the weight of the ward is on their shoulders and everyone is against them and it's not, everyone is there for the same reason and just get on with it'

(HCA1)

All RNs interviewed spoke positively about the relationship they have with HCAs and place a value in terms of their contribution to the ward. There is however a suggestion, that globally, not all RNs feel the same.

' I think maybe historically, that's only my thinking now, maybe they don't see them as equals…but it's important to have a good working relationship with your HCA'

(RN2)

5.3.3 Documentation is Time Consuming

All participants' feel that documentation is time consuming and interfering with the RNs ability to spend time caring for the patients. None of the RNs are happy with the level of documentation that is required of them.

'The role is changing and getting bogged down in paperwork'

(RN1)

With RNs seeing this level of documentation increasing all the time, being *'more and more'*. One RN found that admitting a patient to the ward is very time consuming in terms of the documentation as opposed to the complex nature of the patient.

'An admission used to take two minutes max, now it's fifteen to twenty minutes to do the paperwork, for your typical medical patient…'

(RN3)

Two RNs identified that the level of documentation is not helpful to them in providing better care to the patients; in fact they found it to be repetitive in nature.

'It's too much, cumbersome, why can't they change that, to a tick box and that your time could be back with the patient'

(RN1)

'…but other days you are doing the same stuff over and over'

(RN4)

RN4 found it exhausting keeping up with the regular changes to policy and work practices.

'They keep coming out with new policies, so you have to read the policies….there is something new every-day'

(RN4)

This RN also spoke about the attempt by the ward manager to *'cut down a little bit on the paperwork'* by introducing a test of change, however it is felt that change is difficult to implement as RN2 states

'…there is HR implications to this changing'.

(RN2)

Therefore, RNs rely on HCAs to provide care to patients while they are consumed with other duties including paper work.

'They free up our time to do the amount of paperwork that we have to do'

(RN2)

'…nurses will tell you that it helps them, big time, doing obs really helps the nurse….I think they are getting to their writing sooner, because of the obs…'

(HCA2)

However, if they are not consumed by documentation they would carry out the task themselves, but instead find themselves delegating in order to fulfil the demands made on them to document.

'You know if I'm documenting, I might say, would you mind doing a set of obs on so and so, but if I was free I'd do it myself'

(RN3)

There is a pressure associated with documenting while trying to balance the demands of the role of the nurse in the delivery of bedside care.

'…when trying to do a discharge and you know you need to get it done, [documentation] when they are under pressure to get them out or whatever, otherwise, but when help is needed, it's needed and you get on with it'

(RN4)

The same RN spoke about delegating from the note trolley to HCAs and is frustrated by this and wants to be free from the burden of documentation. When asked if you could change anything?

'I'd through away the documentation'

(RN4)

HCAs also feel that documentation is too consuming of RN time and saw it as the dominant feature of the RN role.

'Nurses do more paper work than patient care; it's crazy, half the paperwork is not even necessary'

(HCA3)

'…the nurses' role is changing a lot, they are all kind of, [pauses] ours is practical and theirs is all bookwork...'

(HCA1)

5.3.4 Handover has its Issues

RNs feel that the process of handover is not an effective use of their time and want to see this change. They feel that audio recorded handover is consuming too much of their time especially in the mornings, when things are '*manic*'. While they want it to change they also see the implications of changing this in terms of HR issues, like the person giving the verbal handover, getting time back. Regardless of the HR issues, they feel it is '*bad time management'.*

'…I just hate going in and listening to half an hour…'

(RN3)

While RNs did not collectively attend handover, they routinely, as close to the beginning of a shift, attend a taped handover. The routine with which RNs follow for attending handover is not replicated in the HCAs routine as their attendance is less frequent and occurs in an ad-

hoc manner. Attendance is voluntary and HCAs regularly receive a handover by other informal means including RN verbal handover, reading nursing notes, bed signs, or verbally from another HCA if there is one present during the shift changeover.

> *'HCAs tend to go out on the ward, we'll go in and assist the patients to sit up and who needs assistance, one of the nurses will go into handover, while the other does the drug round and the HCA is around and then do swap overs'*
>
> (RN42)

> *'…get full handover, there is no problem…can read the notes, access is there for all the staff…sign over beds can help you determine the level of assistance required…or ask the nurse'*
>
> (HCA3)

It is felt that audio poses a health and safety issue as RN1 feels that;

> *'…with audio, you are sitting up people for breakfast that you haven't met beforehand, I don't like that type of handover…'*
>
> (RN1)

One RN feels that the way in which HCAs receive handover is a good idea;

> *'They [HCAs] know they can go [to handover],but a lot of the time they would say, just run through, coz I know I would love if someone would do that for me, because I just hate going in and listening to half an hour'*
>
> (RN3)

None of the RNs identified that HCAs receive handover from reading patient notes. This could be suggestive that they are unaware of this occurring. The importance of all staff receiving a handover is highlighted as needing to be a priority.

> *'…safety has to take precedence over the rush in the morning…'*
>
> (RN2)

But the reality did not match this as one HCA feels that due to the routine of the ward they are unintentionally excluded from handover.

> '*We often miss out on the communication at the board in the morning as we are feeding patients,…it's not intentional…but that's the routine of the ward…my CNM is quite good, she knows handover is an issue for HCAs, but nothing is changing…'*
>
> (HCA2)

5.3.5 Concluding Comments

All RNs interviewed value the role of the HCA as part of the nursing team. RNs are very grateful for the role HCAs play in assisting them with patient care and the resulting effect this has on the management of their time, despite them still not having enough time. The personality of the RN can impact on the HCA; while mostly positive it can also be negative. There is a sense from one RN that not all RNs share the view of HCAs being a welcome addition to the skill mix[5].

RNs want to spend more time with the patients by limiting the amount of documentation and the amount of time documentation occupies. RNs want to reduce the time spent away from the patients, by attending to essentially non-nursing but knowledge requiring tasks. The transfer of information between the RN and HCA is ad-hoc, with HCAs time not being protected to attend formal handover.

5.4 A Knowing Relationship

A 'knowing relationship' relates to an established personal and professional rapport between RNs and HCAs, an important feature to cross professional relationships (DiBenigno and Kellogg, 2014). It evolved as a typology when RNs spoke about the significance of working with regular HCAs. Having HCAs as regular members of staff especially when the ward is short staffed is valuable. Working with regular HCAs has a positive impact on the RNs working day as opposed to working with agency HCAs. Delegating and supervising of work to a HCA whose competency the RN is not sure of is more time consuming.

HCAs discussed the impact both positive and negative of being a regular staff member has on their workload. The following sub-themes of; (1) a positive relationship, (2) familiarity, (3) close working relationship and (4) imbedded are sub-categories of what is essentially a

[5] See Chapter 2 Section 2

'knowing relationship'. RNs essentially have an established professional relationship with the HCAs that are regular members of the nursing team on the ward. This is a contrast with the relationship of working with agency HCAs.

5.4.1 Positive Relationship

All RNs opened their interview using positive language in describing how they feel about the relationship they have with the regular and consistent HCAs that they work with on a day to day basis. All RNs see them as an addition to the ward with participants stating;

> *'I just don't know what we did without them'*
>
> (RN4)
>
> *'I feel the HCAs are fabulous…'*
>
> (RN1)
>
> *'Definitely an addition to the ward'*
>
> (RN2)

However it is RN3 that captured in one sentence the sentiment of what the other RNs made reference to throughout their interview;

> *'I know them on a personal basis, I know who I'm dealing with and I know what they are capable of doing and I know exactly where I am and how much supervision I need to give them'*
>
> (RN3)

This positive language did not always extend to agency HCAs as RNs feel not knowing a HCA impacted on their day and while nobody used the word 'negatively' it is inferred. When RNs are asked about how they feel working with agency HCAs, they feel their level of supervision increases as they are not sure of their competencies and will sometimes do the work themselves or will make a point of '*double checking*' every aspect of their work until the HCA proved they are competent or trustworthy. None of the RNs extended the status of trust to agency HCAs, even though it is acknowledged some agency HCAs are of benefit to the ward. The status of a trusting relationship is only extended to regular HCAs.

'That changes things, [working with an agency HCA] as in, I feel I need to supervise them more than our regular staff….whereas with an agency HCA, you may not be sure of their level of competency'

(RN3)

'It's harder when they are agency and you don't know them'

(RN1)

'Agency is very hit and miss… you would direct more and you wouldn't trust them and you'd be checking what they are or are not doing'

(RN4)

Not having that 'knowing relationship' or established level of trust with the HCA negatively impacts on the RNs willingness to delegate.

'…I would really have to be comfortable with the HCA I was going to delegate to…and sometimes it's nearly faster to do it yourself than go and ask someone [agency HCA]…I'm inclined to do it myself and then I know, I know where I'm at, instead of having to go back…'

(RN3)

5.4.2 Familiarity

The concept of familiarity drew positive and negative meanings for HCAs. The positive of familiarity is the feeling of being part of the team on the ward. The negative is associated with what one HCA coined as the over familiarity and the resulting increase in workload for the HCA. The positive effect on being familiar to the RNs is being known to staff and also not having to worry about how other wards worked.

'The nurses would know me; the ward I'm on at the minute is really good…'

(HCA1)

'…this is what you need to know about this ward, you don't have to worry about other wards'

(HCA3)

The HCA is happy to help out and feels like part of a team, but the consequence of over familiarity has a resulting impact on the workload expected of the HCA, without the support of formal training.

'…I know I'm not technically meant to know how to do them [blood sugar monitoring], but when the ward is crazy and your asked, someone will go, would you mind? Yes of course… I definitely think training should be provided'

(HCA1)

'…it's about being familiar, to the nurses, the CNM and all of that, they know you and what you are capable of, what you are competent of and whether it's your job or not they know what you're able to do, they do expect you to do what your able to do'

(HCA2)

One HCA in particular feels that despite having competency required to carry out blood sugar monitoring, the HCA role is expanding to suit the ward and during busy periods over extension of the role is acceptable. One HCA is concerned that this overextension of roles is becoming part of the HCAs routine tasks and two HCAs stated that training was not being provided for these roles.

'In one sense it's a positive thing as when the nurse is really busy, tied down with a sick patient of course you want to help, you know you are competent…but on the flip side, you don't want it to be expected of you, that has happened already with a few of the smaller duties…and they know on paper, it is not your duty, we are not trained…so then you are kind of questioning, why are they asking me to do them, when they know I shouldn't be doing it?'

(HCA2)

This HCA assumes that RNs know the job description of the HCA. RN2 spoke about her experience of a HCA coming to the ward without having seen a job description. When the HCAs are asked if they had received a job description, there is mixed responses suggesting it is not a standard procedure to receive a job description at commencement of employment.

'No, no, not that I believe [seen a job description]'

(HCA3)

''…we have had some HCAs come to the ward and are unsure…feels too much is being asked of them…went through the job description, which they never got a job description, they did [then] understand that the role is non-exhaustive…'

(RN2)

RN2 believes that a progressive job description and a grading system for HCAs will solve the problem of asking HCAs to do tasks that maybe they are not competent to carry out.

'…the job description should be progressive, so they can be graded…that way we know what they can do and we don't expect any more of them and we know exactly what we need when we are looking for HCAs, like blood sugars and obs monitoring and one or two that will do the household stuff'

(RN2)

All HCAs agreed that a grading system would help, but that some HCAs feel that they have an inability to deflect work intensification as they are in a minority and flexibility within the HCA role is what is required of them.

'…you kind of don't have an option; you can't go against it [being moved off the ward to go and supervise a patient elsewhere]

(HCA1)

'HCAs are in a minority, we are always going to be the minority, no matter what my opinion is or how I feel about it, is the back-up really there? Because it suits everyone for you to do it'

(HCA2)

5.4.3 Close Working Relationship

In classifying the data, the concept of, a 'close working relationship' has a double meaning by which RNs physically work with HCAs. It also refers to the reliance of RNs on HCAs to support them in the provision of patient care. The observational phase of the study suggested and the RNs themselves confirmed that they do work closely with HCAs in carrying out direct patient care. They also rely on the collaborative relationship that they have with HCAs to allow them to carry out other duties knowing that the HCA will support them by providing them with relevant information and getting on with the routine work of the ward.

In terms of geography;

'…generally if I'm going to change a patient, I'll try and work with them'

(RN3)

'…when they are with you, they are working with you…'

(HCA1)

In terms of a co-dependence by the RN on the HCA to keeping them informed of patient changes;

> *'If the HCA tells me they aren't great [a patient], maybe she isn't chewing great, I will go and assess that myself and then contact the dietician'*
>
> (RN4)

The HCA understands that RNs are relying on them to provide relevant timely information.

> *'…unless I believe it's a major issue, say blood pressure, heart rate or temperature is up, I will report that to the nurse straight away…'*
>
> (HCA3)

RNs are grateful for knowing their HCAs which stems from them being a regular feature of the RN team. RNs and HCAs see themselves as team members. Collaboration is an important feature, where patient care is always the primary focus. When asked about teamwork RN3 stated that;

> *'Yes, well actually, it's all about the patient'*
>
> (RN3)

Other colleagues agreed with these sentiments and furthered;

> *'…I would say the ward I'm on teamwork is a big trait…we are always like, we are in it together'*
>
> (RN1)

> *'Yes, I think it's positive [RN and HCA relationship], I think I myself am valued and my opinion is valued also, I feel a very important member of the team…'*
>
> *(HCA3)*

5.4.4 Imbedded

The concept 'imbedded' evolved from RNs speaking about the permanence of the current HCAs that they work with and what this means to them in terms of the advantage that this affords RNs in knowing the HCAs, their competencies and indeed their ability to work independently of RNs in providing a quality of care to patients.

> *'… having a HCA delegated to the ward helps as they know the personality of the nurse and they know they can come to them with anything'*
>
> (RN1)

> *'…I mean, some of them [regular HCAs] there wouldn't be a bother, they would one hundred percent, you know, our own would say, this is happening, have a look at this, but that's our own staff'*

(RN3)

When speaking in terms of supervision of the regular HCAs, it is the 'knowing' factor that leads RNs to trust the regular HCAs. This in turn is a determination of the level of supervision required and while RNs did supervise, this supervision would be prioritised to indirect supervision, a legitimate form of supervision (NMBI, 2015b), but only once the HCA is an established member of staff and proved they are competent.

> *'If I have been working with somebody a long time, I know that they are telling me the truth, but I will still check at some turn, I will still make it my duty to make sure'*
>
> (RN1)

One RN spoke about how the dynamic feels when the new HCA role was introduced to the ward and the burden of supervision the RNs felt at that time. Nevertheless, the relationship evolved into a trusting partnership once the RN staff knew the HCAs;

> *'….they probably are [burdened by supervision], but not now at the minute, probably not, because our HCAs are embedded now, but initially yes, because it was all new to us, we had to monitor them, …….now that we know them and they know us and the run of the place, it's fine…'.*
>
> (RN2)

HCAs are largely unaware that any of their work is supervised and even feel the word 'supervision' has a negative meaning. When HCAs are asked at interview about supervision HCA3 immediately assumed it had a negative meaning.

> *'No, I don't feel like I have to look over my shoulder the whole time, there is a lot of trust between the nurses and HCAs'*
>
> (HCA3)
>
> *'I never feel supervised, never… I think it probably is a familiarity thing, they know what you are competent in…and I never feel supervised, ever'*
>
> (HCA2)

One HCA acknowledged supervision in the early days, but it now seems like a strange concept. Another HCA acknowledged that the relationship is built on trust but;

> *'…if someone isn't up to the job it would be spotted a mile away'*

(HCA3)

However, the connection between this failure to perform and the supervision that's required to arrive at this conclusion is not made by this HCA. HCA3 also feels RNs did not have time to be supervising and saw the HCA role as '*looking after*' the RNs.

> *'To be honest; nurses don't have time to be supervising, they have twenty four patients, they don't have time to be looking after the people that are looking after them'*
>
> (HCA3)

5.4.5 Concluding Comments

This typology of a 'knowing relationship' describes the importance and consequences of an established relationship between RNs and HCAs and the impact this has on the RN and HCA in the daily workings within the social space of care. This relationship is determined by time and the advantage of having permanent assigned HCA staff to the ward. This allows RNs to establish a long term professional relationship with the HCAs. This relationship is largely positive but can negatively impact the HCAs ability to deflect work overload. This 'knowing relationship' similarly allows RNs to supervise indirectly leading HCAs to believe no supervision occurs, seeing the concept of supervision to mean being '*watched*'.

5.5 The Routine of Ward Life

The typology of 'the routine of ward life' is established by all participants who associated the term '*routine*' when describing ward life. The nature of this routine sets the context and determines the dynamic of care. The sub-themes of (1) delegation (2) supervision (3) the HCA approach and (4) accountability are all features of ward life and how routine patient care is delivered by the nursing team.

The routine of ward life and patient care needs, decides the level of delegation to HCAs by RNs. Delegation is mostly informal and relies heavily on the communication between the

two groups. A trusting relationship plays a large part in the indirect supervision of HCAs. This supervisory role is an unfamiliar concept to the HCAs.

5.5.1 Delegation

Delegation and the resulting supervision play a key part in role relationship literature[6]. Delegation does occur, it occurs informally by way of a conversation, where both groups will speak directly to each other, which is a positive attribute in the relationship. This is due to the nature of the ward activity being routine and the regular HCAs knowing the routine of the ward, therefore routine tasks are not delegated by the RNs.

> *'There is an understanding there, they don't have to be told…or others [meaning HCAs] will tell you I'm going to feed, be doing this, or some will automatically go and do it'*
>
> (RN3)
>
> *'…HCAs come in and they have a routine, it's a very routine ward'*
>
> (RN4)
>
> *'…that's the routine of the ward…'*
>
> (HCA2)

Communication occurs by way of informal conversation where the tasks are decided through mutual agreement between the two groups of direct care providers and does not adopt a formal method of communication.

> *'…between us as a group we will decide who needs to be done [meaning patients], if they are assistance of two, will we do this gentleman first, you know, that way'*
>
> (RN1)

HCAs agree that the communication is informal and RNs will provide HCAs with the required information to carry out the required care in an informal and friendly manner. HCAs did not attach any negative words to the way in which RNs delegate to them. Nevertheless when I used the word 'delegation' at interview they allied the concept of delegation as negative and associated it with being '*ordered about*'.

[6] See Chapter 2 Section 2.2

'... the nurse would never order you about...we will decide who we are going to do together...it would never be, you go do him, him and him and come back to me when you are finished, it's never like that'

(HCA1)

'...it's not delegated like as in, you will need to feed them; you will need to wash him, no the information is relayed in an informative manner'

(HCA2)

RNs will assess patients before they delegate a task. RNs appear to need to satisfy themselves that they know the patients themselves before they are willing to delegate.

'...in terms of a new patient, we always try find out what their level is before I go and delegate'

(RN1)

'...sometimes I like to do that myself, [vital sign monitoring] especially if it's a new patient or I don't know the patient'

(RN4)

Once an assessment has been carried out, RNs will then delegate the routine of vital sign monitoring to HCAs, but will retain a role in this task.

'...now that's not to say RNs don't do obs, of course they do obs, but generally the routine obs is very flexible'

(HCA2)

RNs will ascertain the competency of regular HCAs by knowing them, working closely with them and trusting them. Competency of agency staff will be ascertained by conversation, talking to them and keeping a close eye on their work. One HCA wonders if the HCA role is limited when RNs worked with agency HCAs.

'...it might be different if an agency HCA replaced me...do they stick to the role better there'?

(HCA2)

5.5.2 Supervision

Supervision of HCAs work occurs by two means, either by working closely with the HCAs and directly supervising or more commonly indirectly supervising the regular HCAs work by '*double checking*'. HCAs have no awareness of the role of the RN in the supervision of their

work. The type of supervision is reflective of the type of relationship that exists between the RN and HCA. RN1 compared the working relationship between regular HCA staff and agency HCA and described the impact this role has on the dynamic.

> *'…if you know your HCA and you work with them regularly, you know what they are capable of, but if you get a HCA you never met before, you are keeping a closer eye, I know that's a terrible thing to say, but for their own sake and everybody else's sake…but I know some people [HCAs] if you delegate, sometimes they are so eager, they might say yes and it goes back to again, to the start of the day and making sure [that the RN engages positively with the HCA to foster open communication]'*
>
> (RN1)

However, regardless of whether they are working with regular or agency HCA staff, they will always double check the work.

> *'…but I would always check myself, because I find, that they are in my care, so whatever happens on that shift I'm responsible for them, so I always check anyway…'*
>
> (RN1)
>
> *'…the guys [HCAs] come and they give you the list, what the EWS is, you are still checking and writing the notes'*
>
> (RN4)
>
> *'…I wouldn't be leaving that off; I'd be going and checking'*
>
> (RN4)

HCAs did not mention their work being double checked by RNs and are largely unaware of any level of supervision of their work occurring. When speaking about *'double checking'* a HCAs work and uncovering discrepancy, one RN stated diplomacy would be used in the wording.

> *'I would say it in a nice way that we, collective, need to keep an eye on it and the next time you check it, let me know, but I would keep more of an eye on it, than if they had told me'*
>
> (RN1)

RNs engage in open informal conversation to information share and HCAs are informally called out to provide information.

> *'If the CNM is asking about a patient, she is asking the RNs, first port of call and if the RN doesn't know, she will say so and call the HCA out to speak'*

(RN4)

'…but often, I'd be saying to them [HCAs], did he feed himself yesterday…so there is a two-way thing there'

(RN3)

5.5.3 The HCA Approach

As the observations suggested and the interviews uncovered, HCAs are approached by multi-disciplinary team members other than RNs. This approach goes unnoticed by RN staff. According to the HCA inclusion in information sharing can be ad-hoc. HCAs feel they can miss out on information sharing due to the routine of the ward.

'We often miss the communication at the board in the mornings as we are feeding patients…it's not intentional, but it's not highlighted enough, but that's the routine of the ward'

(HCA2)

All HCAs stated that they are approached by MDT members while the RNs stated they are not aware and if they are that they would be able to answer their questions.

'I'm really not aware of anyone else approaching the HCAs, apart from us…'

(RN3)

'…when we are not around and are well able to answer…'

(RN2)

However HCAs do not routinely attend handover and no formal system of communication exists for the HCAs to share that they have communicated patient information to MDT members and while RNs trust the word of the HCA, as it illustrated here;

'I've never had a problem; I've never come to a EWS of ten and nobody to have told me'

(RN3)

It is important that the routine of handover is always inclusive of the HCA (Health Service Executive, 2014), to ensure quality of care.

5.5.4 Accountability

Accountability is another regular feature in nursing literature and the findings contained within this section were largely in keeping with the findings of other studies[7]. The '*double checking*' of HCAs work by RNs stems from the RNs understanding of the accountability they have to the patients. RNs see themselves as the only ones accountable for patient care. While all RNs are accepting without issue with regard to their responsibility to the patients, the responsibility they have for the care HCAs deliver is questioned. HCAs understand that RNs are accountable, but also see themselves as accountable and see accountability as part of any job within the hospital.

> *'…I'm really responsible for the patient…. So why am I responsible for the HCA….I don't feel it [responsible for HCAs], I am'*
>
> (RN3)
>
> *'The responsibility lies with the nurse all the time, and there is no responsibility on the HCA'*
>
> (RN2)

The HCA also feels accountable for patient care, but acknowledged that in the current system it is the RN who holds total responsibility.

> *'I feel I have responsibility towards the patient, I think you have a responsibility no matter what you do, in a hospital anyway…at the moment the final line stops with the nurse but it should be the care team responsibility'*
>
> (HCA1)

One RN highlighted the all-embracing responsibilities that RNs routinely contend with and found it to be just an accepted part of nursing life.

> *'Well, as the RN you are responsible for the patient and the student nurse and yeah, you are responsible for the HCA, I don't find that overbearing, it's just part of your job, you're in charge of this ward, this bay, this section and everybody in it'*
>
> (RN1)

Again, RNs spoke about how knowing the HCAs makes it easier to accept accountability for the work of the HCA as they know their competencies.

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[7] See chapter 2 section 2.3

'This is probably a terrible thing to say, but I would be more trustworthy, if that is the right word to use, of a HCA that I know and I know that HCA is going to tell me and I know that HCA knows what that means, so I probably will end up checking myself and I won't say anything to the agency HCA because I don't want to offend, but I have the responsibility of this patient and I am signing my name to this and I need to know…'

(RN1)

One HCA understood that HCAs have a responsibility to say '*no*' if they are delegated a task they are not comfortable with.

'I wouldn't do anything I didn't feel competent doing, I wouldn't I definitely wouldn't and there has been times where I have been like, oh gosh, I haven't done that before sorry'

(HCA2)

However the same HCA questioned where accountability lay when carrying out a task where official training had not been received.

'…practice is dangerous, somebody is going to do something wrong, who's gonna be at fault? Is it gonna be the nurse that asked them to do it or is it gonna be the HCA who did it, knowing they are not trained to do it, it's not a nice environment to have that in the back of your mind…'

(HCA2)

Two HCAs ascertained that competency could only be achieved through formal structured training in their current setting. They were unsure if the education and training they had received in other healthcare jobs could be transferred into the acute setting, with the RN understanding the HCA role to be limited by the organisation.

'We trained in medication management, PEG feeds, stoma management…'

(HCA2)

'…every ward is different and expects different things, some wards do blood sugars, more don't, there is not a set thing, a lot of HCAs would have done blood sugars, PEG feeds in the community before they came in here, now they can't do any of that'

(RN2)

Furthermore the HCA suggests that they are unsure of informing RNs about previous skills acquired through formal training and education.

'I would not be telling people [about skills acquired from other areas of work] as this could lead me down, people telling me to do that and the other and I know it's not my duty here, and if something goes wrong, who's accountable?'

(HCA2)

Two HCAs find that the organisation does not support them in their training. One HCA gave an example of no clear guidelines being provided to HCAs as a collective group from management in relation to the carrying out of blood sugars, despite HCAs requesting clarity.

'… it's not part of your job description but, I'm not going to tell you not to do them…what that tells me is that we have no back-up, they know that it suits the nurses and the CNMs to have the HCAs doing blood sugars, but in the meantime there is no training, so who is liable, who's accountable…'

(HCA2)

Another HCA contended that sufficient training had been given from the RNs and by '*applying*' themselves, following supervision by RNs to ascertain competency, the RNs are happy for the extra duties to be carried out.

'…I put myself forward, and asked the nurses would they be willing to show me how it's monitored and then when they have time they do show you these things...monitored me initially but once I was is getting it right and we are both happy…'

(HCA3)

With regard to HCAs accepting accountability for patient care most staff agreed that they would like some level of documentation to be carried out by the HCA. Documentation of basic nursing care carried out by HCAs would be helpful as they feel they are writing the word of the HCA.

'…I feel they should be able to document some of the care that have done, because I haven't done it…'

(RN3)

HCAs had not given documentation and their role in it too much thought and while they are not strictly opposed to it they did feel that they reported everything.

'I suppose if it is feasible, but we report all that to the nurse'

(HCA3)

However, one RN is concerned about what documenting care by HCAs would mean for the role of the RN. This RN overcomes the issue of accountability and documenting care not carried out by them by documenting using a passive voice.

> *'…I document in a way that I am not saying I is the one that assisted him…'*
>
> (RN4)

The HCA as a regulated entity feels like a positive notion to RNs;

> *'..and being accountable for what they do instead of it always landing on the nurse'*
>
> (RN2)

> *'But of course they should be, they are a profession within their own right'*
>
> (RN1)

5.5.5 Concluding Comments

RNs will always assess the patients prior to delegation. Routine tasks are not delegated to HCAs as the nature of the ward is routine and they know the routine. The route by which delegation occurs is one of conversation. Informal negotiation of tasks is a strong feature of the relationship between RNs and HCAs. This leaves HCAs feeling unsupervised and seeing delegation as a negative concept. RNs believe they are solely responsible for the care of the patients and HCAs. This is in contrast to the HCAs as they feel they have a responsibility to the patients and that it is a team effort.

HCAs are regularly approached by the MDT, which is largely unnoticed by the RN team, with no formal communication pathway for this information to be shared. Poor role definition is a cause of concern for HCAs and a well-documented concern within the field of nursing skill mix models[8] and their inability to deflect an ever increasing workload and would like to see this change at an organisational level.

[8] See chapter 2 section 2.1

No system currently exists for RNs to formally ascertain competency of the individual HCA. This demands each RN to closely and directly supervise a new or agency HCAs, resulting in them feeling burdened or unwilling to delegate as it is '*easier to do it myself*'. For the regular HCAs, they are unsure of their role and what skills they are allowed to undertake within this organisation.

5.6 The Organisation of Care

The typology of the 'Organisation of Care' refers to the organisation of the skill mix and that the HCA role is complex and disorganised. This typology evolved when RNs highlighted issues such as how the role was introduced to *'stem the flow of there not being enough RNs'* to carry out patient care, with little discussion or debate surrounding the HCA role. This typology consists of the sub-themes of (1) organisational support (2) the organisation of the HCA role (3) the progressive role (4) the struggle with role expansion and (5) HCA as a career choice. While the role of the HCA is expanding in its nature, it appears to be stilted in its progression. The RNs interviewed appear to be protective of their role and while they want to see their HCA colleagues have career progression, they are guarded in what this means for them as a professional group. HCAs themselves want career progression but not necessarily into the nursing profession, as they can see the profession changing into one consumed by documentation.

5.6.1 Organisational Support

According to the RNs interviewed skill mix does not appear to be realised at an organisational level and while the ward level manager attempts to achieve it, ongoing nursing staff shortages make it a difficult mix to accomplish which sees HCAs replacing RNs in times of shortages of available RNs. RNs would like to see a decrease in the nurse to patient ratio and also like their union to be a stronger voice for them in relation to the issue

of extra beds being placed on corridors, further increasing the nurse to patient ratio. If these issues were addressed RNs feel quality of care and overall job satisfaction would increase.

> *'…our unions are letting us down; we wanted to go on strike to stop the beds on corridors…'*
>
> (RN2)

> '*I'm disappointed in terms of the patient ratio to the nurse, especially on nights, it's overwhelming…that's too much…you go home thinking, I didn't look after my patients as I had too much to do, you are prioritising patient care and things get missed, that really bugs me'*
>
> (RN1)

It is felt by those interviewed that while they are supported by their ward level manager, they feel the next levels of management is more concerned with '*numbers to fill a gap*', and are largely '*invisible*' and '*silent*' in their communication with the staff. With no thought put into the HCA role and the support structures required for this group of direct care providers. RN2 gives an account of the rushed manner in which the HCA role was initially introduced.

> *'it's a new initiative here [the use of HCAs in the RN skill mix], I think it was used to stem the flow of not enough nurses, I don't think there was enough thought put in, it is just another pair of hands, I don't think there is any thought put into what we actually want or need from a HCA'*
>
> (RN2)

HCAs feel that no-one at management level guides or is even interested in the HCA role.

> *'…we only have a management role in here looking over us and is more so to do with off-duty, it's not really to stand for us to fight for different education, different roles…'*
>
> (HCA1)

Skill mix is not achieved by the management as staff are difficult to retain for reasons believed to be due to staff not being appreciated and end up leaving the organisation;

> *'Nurses come in and they are gone…..because they are not looked after, they are just being sent from Billy to Jack…'*
>
> (RN4)

'…by the time you qualify, you are nearly burned out… you are more inclined to leave, if you don't support the staff you have…you are not going to have more staff…'

(RN1)

The consequence of the nursing shortage is that RNs are not available through relief or agency to replace existing staff when sick.

'…a HCA is sent down to replace a nurse that is out sick last night….'

(RN2)

'It would be whatever they could supply, nurse or HCA'

(RN4)

RNs feel that this practice is becoming more frequent as they *'cannot recruit'* and when asked if they complained about this, the impression is one of resignation that RNs are not an available resource. Sometimes when RNs are replaced by agency RNs it isn't always satisfactory.

'Look, I suppose it's better to have a pair of hands, than have nobody at all'

(RN2)

'Well, ideally you would like a nurse, but sometimes with the agency nurses, I would prefer to have our own HCAs'

(RN3)

This replacement of RNs by HCAs is concerning to RNs as while replacement of a pair of hands with another skilled pair of hands is welcomed, the knowledge required cannot be equated.

'…skills mix is important and that the responsibility is very different, I'm not saying you can't replace a nurse with a HCA, but, if you have a very sick patient, you are relying on the nurse working with you, you are relying on the HCA as-well, but you are relying on the nurse for their knowledge, if you take that away, you are more isolated as a nurse'

(RN1)

HCAs understood that a HCA replacing an RN is not ideal. They did however like working with extra HCAs as it meant more practical work is done.

> *'…only time you will have an extra HCA is when you are down a nurse…but it's probably not great from the nurses point of view as they have more documentation to contend with, but as a HCA, with relation to direct patient care, it's an extra pair of hands, for feeding, washes, toileting, you know, you are not really pulled in another direction…'*
>
> (HCA2)

It was also stated that HCAs that come on relief should possess the same skills as their own regular HCAs, as RNs need them to fit in with ward life quickly.

> *'…if you are going to be replacing an RN with a HCA, you need someone that's going to be well upskilled…we still need someone that can do the likes of blood sugars and obs and you do still get HCAs that come on relief and don't do any of that, that's not good enough…'*
>
> (RN2)

One HCA provided insight into why HCAs are not coming to the ward upskilled and suggested that the organisation was failing to provide direction in relation to the skill that the wards are demanding from HCAs.

> *'…the nurses want them to do blood sugars, the CNMs want them to do blood sugars, but the powers that be don't provide training and the management that's meant to have our back won't provide clear direction…'*
>
> (HCA2)

This upskilling will require investment of time from the RNs who are very busy, but they will invest time in the HCAs to ensure their competencies are fit for practice. When speaking about a HCA on relief whose competencies are below the expected level RN2 outlined the management of such an issue.

> *'… let them do the obs, observe them, explain it to them, show them, teach them…try to upskill them as best we could on the ward before I'd take it further'*
>
> (RN2)

When those interviewed described the issues they had with the organisation they felt they are not visible in their daily working lives and that higher level management did not communicate with the front line staff.

'…no matter what happens, nobody comes to see ...'

(RN3)

'…don't have much dealings with management, so can't say if it is good or bad'

(HCA3)

However, one RN suggested that management should come to the ward to support them in the difficult conditions in which they sometimes work. RNs understand they cannot '*invent staff*', but it would be of value if their challenges are acknowledged.

'…there is no communication from the top down, you don't necessarily see the top people on the ground level, I don't know why they don't do a ward round every day and see, what it's actually like…'

(RN1)

5.6.2 Organisation of the HCA Role

All HCAs commented on the way in which the role of the HCA is organised. The HCAs commented on the role being poorly defined, with them not seeing a job description. Their management structure at ward level is valued but is unclear at an organisational level. The way in which the HCAs spoke about their role gave rise to the understanding that the HCAs did not have a strong voice within the organisation.

The HCA role is seen as flexible with no definition and this lack of definition is causing the role to be interpreted. This interpretation of the role affects HCAs as they cannot deflect an ever increasing workload.

'…with the areas of specialing, it's automatically the HCA goes…you kind of don't have an option, you can't go against it'

(HCA1)

When asked what did the job description state;

'One on one care is, so that's what specialing is, one on one care is in the job description'

(HCA1)

Two of the HCAs stated that they had not received a job description. When HCAs are asked if the role is well defined, it is felt that it isn't and reflects the interpretable nature of the HCA role.

> *'Role is not defined, grey areas; it's different depending on who you are working with'*
>
> (HCA2)

> *'No not really, it covers a whole range, but then doesn't cover everything, it's a lot of words, but meaning care of the patient, it doesn't define it, it doesn't just gives you a description of what you are supposed to be doing'*
>
> (HCA1)

HCAs feel they do not have a clear management structure and that this affects them in deflecting workload intensification.

> *'…there is nobody supporting our role really, we are here to do anything that makes things easier on lots of other people and there is no protection really, I feel that it's very hard for the HCA to say no, that people would think that you are lazy…a nurse can say no to, for example a doctor, and that is acceptable and she will be supported by other nurses, but who's backing up the HCA…'*
>
> (HCA2)

5.6.3 The Progressive Role

The progressive role is rooted in the high esteem in which RNs hold their partners in the delivery of care and feel that role progression should be afforded to them, in the format of a grading system, which is established within the English HCA system. RNs interviewed felt that core competencies, introduction of mandatory standards and regulatory options should be considered within the Irish system also.

> *'HCAs are getting increased responsibilities… there scope is increasing all the time in what they can do, which is a major help from a nurses point of view'*
>
> (RN1)
>
> *'…let some HCAs do that [equipment checks] and upskill others to an enrolled nurse status, grade them and pay them accordingly, I would love to see that for them…'*
>
> (RN2)

All those interviewed agreed that the grading of HCAs and all that would mean for them as a group of support workers would be welcome.

'Everyone needs a potential to go on and I feel the HCAs aren't appreciated enough…'

(RN4)

'…the job description should be progressive, so they can be graded…that way we know what they can do and we don't expect any-more of them and we know exactly what we need when we are looking for HCAs'

(RN2)

RNs have seen the HCA role within their ward develop exponentially since the introduction of the role, in terms of the HCAs skill set. While role progression is stalled, expansion of the duties HCA carry out is being extended all the time.

'the role of the HCA has expanded, sure when I started first there is no HCAs, then they aren't trained in obs or blood sugar monitoring, now they are, it's like in the last two or three years that has expanded'

(RN 48)

HCAs are largely happy to see their role expand but feel that they are taking on too much without being acknowledged from the organisation for this flexibility.

'..we are silly for taking on, doing obs without extra pay as other hospitals have dough their heels in and refused to take on the role, they won't even do the training until they know for certain it will affect their pay…'

(HCA2)

One HCA feels door-stopped with regard to their ambition to progress further.

'…HCAs are not allowed to apply for these roles, like lab aids, because the number of HCAs are down and there is no one to replace a HCA if the HCA moves into that role'

(HCA1)

5.6.4 The Struggle with Role Expansion

RNs struggle with the expanding role of HCAs and what it means for them. RNs are quick to support the grading of HCAs in its current format, they are not so eager to see the role expand further, fearing encroachment into their own role. When RNs are asked directly if they would like to see the HCA role expand further they are uncertain;

'*I wouldn't like it to take away from the basic care that the nurse provides…I became a nurse to care and if you take the 'to care' aspect out of it, what am I left with? I'm just left with documentation and that's not nursing'*

(RN1)

While RNs acknowledge the help HCAs are to them in their current relatively new role of recording the vital signs of patients, the role appeared to be introduced without any major input from the RNs into how the role of the HCA in vital sign monitoring should be shaped.

> *'I did yeah, a little protective, but I suppose everything changes and it helps us with our jobs…'*
>
> (RN4)

When asking the opening question to RN2 about how what the working relationship is like with HCAs, the response is curious;

> *'It's good; I've no fear of HCAs'*
>
> (RN2)

This may well be very telling in terms of the resistance RNs have in relation to the fear of this perceived encroachment by HCAs into their role. The HCAs reported that RNs have suggested that the HCA role is likened to the traditional role of the RN.

> *'…the majority of the RNs would say the job you do is the job I signed up to as nursing…'*
>
> (HCA1)

5.6.5 HCA as a Career Choice

While RNs have concerns regarding infringement upon their profession, HCAs are happy to remain as HCAs, so long as there is a career pathway developed for them which will allow them to expand their knowledge. HCAs feel that nursing as a career is not the only career pathway available to them and that if grading was afforded to them they would be content.

> *'I would love to expand my knowledge and training….between people not wanting to be nurses and just wanting to be HCAs, they are gonna be given more roles, because of the lack of nurses in the country'*
>
> (HCA3)

> *'I think if they opened up the HCA role, like if it is a graded system, that I could broaden my knowledge, then I would be very happy to stay [as a HCA]a pay-scale would also be required'*

(HCA1)

'…you very seldom hear nurses say I love my job, coz it's all paperwork'

(HCA1)

5.6.6 Concluding Comments

RNs are eager for HCAs to be recognised for their valuable contribution into the nursing team and to see the current HCA role consolidated to include grading and defined accountability. Conversely, RNs are not so eager to see the role expanding further, as there is a view that the RNs role will become even more preoccupied with documentation.

HCAs long for a career pathway for them-selves to allow for career progression. This would see HCAs commit to their career for the long-term.

5.7 Conclusion

This chapter presents RNs and HCAs views in relation to the nature and impact of their day-to-day working relationship, in an acute hospital ward setting. The views presented are both positive and negative. The positive aspects make the relationship functional and effective and relate to the 'knowing' and 'close working relationship' they share. HCAs are embedded and regular members of staff, allowing for delegation to be informal and supervision to be indirect. The flexibility within the HCA role is also seen as a positive by RNs and also by HCAs, but is not without its issues.

Familiarity and the pressure of nursing however sees HCAs carry out tasks they don't feel entirely comfortable to carry out, even when educational and competency are attained from another organisation. HCAs feel they are not supported by the organisation with regard to competency and feel restricted with little opportunity to progress despite the expansion of the role. These negative aspects of the role relationship are leading to stress and tension.

The positive attributes that impact the relationship are seen as enablers. While the barriers are the attributes that cause the relationship to be tense and stressed. Barriers and enablers within role relationships is not a new concept as Duffy (2014) explored this issue with regard to role development and found that a robust partnership between workforce planners, line managers, other professionals and education providers to be important in supporting the clinician undergoing role development. Chapter six will discuss these findings and position them within the existing literature.

Chapter Six
Discussion and Recommendations

6.0 Introduction

This chapter discusses the findings of the observations and interviews of this qualitative descriptive study with regard to the theoretical and empirical literature in relation to the role relationship between RNs and HCAs within the clinical social space of care. In section 6.1 the significance of participants views in relations to the aims and objectives of this study are discussed. Section 6.2 explores and analyses the issues surrounding the RN and HCA inter-relationship while section 6.3 explores and analyses the organisational influences on the RN and HCA relationship. Section 6.4 examines the implications of this study in relation to collaborative working practices whilst section 6.5 addresses recommendations and future directions in terms of (1) policy (2) practice and (3) research initiatives. Section 6.6 describes the limitations of a qualitative descriptive approach and section 6.7 concludes this research project.

6.1 Participants views

This study explored and analysed the impact of role relationship between RNs and HCAs within the clinical social space of care. Exploring participants views with regards to their relationship with each other and how the organisation impacts them are significant in comprehensively addressing the three objectives of this study. They were; (1) to observe and analyse the nature of the day-to-day interactions between RNs and HCAs; (2) to analyse the nature of communication that occurs between RNs and HCAs within the social space of care and (3) to describe and analyse the impact of the relationship between RNs and HCAs with regard to their respective role identities.

Establishing what effects this role relationship in terms of what makes the relationship 'functional and effective' or 'tense and stressed' is essential in understanding this complex dynamic (Munn *et al.*, 2013, p. 10). Exploring these issues is important in order to guide and facilitate collaborative working between RNs and HCAs within the social space of care.

6.2 Exploring and Analysing Inter-Relations

In exploring the issues surrounding the RN and HCA professional relationship it is important to look at the inter-relational issues influencing the relationship. The identified key findings are grouped under the two headings of 'functional and effective' and 'tense and stressed'. Functional and effective elements relate to what make the relationship a positive one. While the factors that make this relationship 'tense and stressed' has negative significances for both RNs and HCAs. The two groups of findings are expressed in table 6.1.

The major findings of this study relates to the inter-professional relationship that exists between RNs and HCAs which makes collaborative working 'functional and effective'. However, the impact the healthcare organisation has on the way in which care is delivered can cause the relationship between RNs and HCAs to be 'tense and stressed'.

Functional & Effective **Inter- Relations**	**Tense & Stressed** **Organisation**
Positive Relationship	The Pressure of Nursing
Close Working Relationship	Familiarity
Embedded	RNs Don't Have Enough Time
Delegation & Supervision	Delegation and Supervision
Routine	Formal Communication
The Progressive Role	Progressive Role
	The Struggle of Role Expansion
	Organisation of the HCA Role
	Lack of Organisational Support
	Role Expansion
	HCA as a Career Choice

Table 6.1 Participant views grouped

6.3 Functional and Effective Inter-Relations

Functional and effective relationships are important to collaborative working practices (Munn *et al.*, 2013). The factors that influence this positive relationship as identified by this study is the close working relationship between the RNs and HCAs is grounded by the HCAs being embedded in a ward that is routine in nature. This allows the RNs to delegate and supervise in an informal manner. However, where the HCA role is progressing to is both a positive and a negative dynamic within the relationship.

Having a positive, close working relationship between RNs and HCAs is important to collaborative working[9]. Of equal importance, as identified in this study is having regular HCAs embedded within the ward environment. HCAs knowing the routine of the ward assist RNs in their time management. This furthers Spilsbury and Meyer (2005b) argument for a value to HCAs being permanent members of staff and something that needs to be explored and considered when addressing skill mix for the ward.

Regular HCAs being embedded in ward life allows for effective trusting and collaborative relationships to develop (Siegel *et al.*, 2008). The advantage of having regular HCAs embedded in ward life comes to the fore when this study identified that RNs rely on knowing the HCAs and their competencies when delegating and supervising the work of the HCA. NMBI (2015b) states that the RN must consider the experience and competency level of the person being delegated to, ensuring that the delegated task is appropriate to the skill set of the delegated person, while deciding the level of supervision required. This study identified that the established relationship between RNs and HCAs facilitates a functional and effective relationship in the delivery of patient care.

[9] See chapter 2 section 2.2.1

The importance of RNs knowing the competency of each of the HCAs impacts on the RNs role in delegation and supervision. This relevant finding cannot be over-stated as while previous studies focussed on the relationship between HCAs and RNs[10] (Kalisch and Lee, 2014; Siegel *et al.*, 2008; Perry *et al.*, 2003; Keeney *et al.*, 2005; Bowman, 2003; Pearcey, 2008; McGillis Hall, 2003; Spilsbury and Meyer, 2005b; Lloyd *et al.*, 2011; Orne *et al.*, 1998; Bellury, 2016) no identified study compared and contrasted what the relationship was like when RNs worked with permanent HCA staff as opposed to when RNs worked with agency or irregular HCA staff members.

A key finding of this study was RNs 'knowing' the competency of HCAs. RNs reported knowing competencies by having a close working relationship as opposed to any formal structure of documented competencies. This close working relationship allowed for RNs to communicate informally with HCAs as they did not delegate routine tasks and RNs could provide supervision indirectly. While this style of management has benefits as Siegel *et al.* (2008) saw collaborative working as a means effectively communicate and supervise. It was also recommended that further studies are needed to elicit the conditions under which the role of the RN in supervision is organised and operational. This study found that RNs decide on the level of supervision required by how well they know the individual HCA and their competencies and regularly provide supervision indirectly, which is supported by the Irish nursing regulatory body (NMBI, 2015b).

Indirect supervision by RNs was not largely considered in the literature[11], with HCAs reporting in this study that they felt their work is unsupervised and associated the words

[10] See chapter 2 section 2.1
[11] See chapter 2 section 2.2

delegation and supervision negatively[12]. It is reported in the identified literature that if RNs were not seen to be directly supervising, then supervision was not occurring on any level (Thornley, 2000; Spilsbury and Meyer, 2005b). Siegel *et al's* (2008) study reported that RNs were aware that supervision was lacking and reported that time constraints were a barrier to supervision, however this study did not identify barriers in relation to this role as all RNs spoke about their role in providing direct supervision to HCAs they did not know or indirect supervision to the HCAs they did know. This study would postulate that RNs mostly indirectly supervise the HCAs competencies they discern, by 'double checking' and working closely with the HCAs.

In relation to agency or non-regular HCA staff, RNs either decide not to delegate a task, choosing to carry out the work themselves as Shearer (2013) found or they work closely with the HCA and offer supervision in this capacity, as opposed to stating that they are going to supervise a particular HCA carrying out a certain task. Why RNs are not forthcoming to HCAs in their role as supervisors may well be rooted in either the reluctance they have in assuming responsibility for a task delegated to a HCA (Keeney *et al.*, 2005) or the uncertainty they have with regard to their legitimacy to supervise (Kleinman and Saccomano, 2006). The uncertainty of the legitimacy of RNs to supervise was hinted at within this study[13] and requires further investigation but is somewhat reflected in the literature with Siegel *et al.* (2008) and Kleinman and Saccomano (2006), claiming that the issue of HCAs not feeling supervised is entrenched in RNs needing to be authorised by the organisation in the legitimate authority of the RN in delegation and supervision.

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[12] See chapter 5 section 5.3.1/5.3.2

[13] See chapter 5 section 5.3.2

This issue needs to be addressed at an educational level, with only twenty-five percent of participants in Siegel *et al.* (2008) study claiming they had received formal supervisory training. The HCA also requires education in the role of the RN in delegation and supervision, to remove the barrier of HCAs seeing these terms to have negative meaning. RNs need to be educated and equipped better with regard to their skill of delegation and supervision as Ray and Overman (2014) saw these as a soft skill and leading to RNs learning these skills informally.

The introduction of a competency based framework is also an area requiring discussion as this would assist RNs in deciding to delegate and accept responsibility for a delegated task to a HCA they do not have a close working relationship with, therefore, limiting the amount of time spent by RNs in double checking work (Shearer, 2013). A competency framework would also seek to consolidate the HCA as a legitimate and progressive patient care team member.

6.3.5 Concluding Comments

The factors of a positive, close working relationship with embedded HCAs influence a functional and effective relationship with delegation and supervision occurring unceremoniously emerged as a key finding from this study. This is rooted in the RNs '*knowing*' the HCAs and through this '*knowing*' RNs know the competencies of the individual HCAs. Delegation and supervision requires addressing at an educational level for both groups and further investigation is required into the area of a competency framework being established to assist in the clarity of roles and responsibilities for RNs and HCAs.

6.4 Tense and Stressed Organisation

A tense and stressed organisation refers to the impact the healthcare organisation has on frontline workers. Within this study the issues contributing to a tense and stressed work

environment are time management issues, the organisational issues of the HCA role, and the role of the RNs in guiding the future of the HCA role.

While the introduction of the HCA role was to relieve RNs from non-nursing duties to allow them spend more time with the patients (Keeney *et al.*, 2005; Jack *et al.*, 2004), the findings of this study are that documentation is consuming of RN time. HCAs inclusion in formal communication is occurring irregularly, despite them increasingly being called to provide information to professional members outside of the nursing team. The organisation of the HCA role is expanding without much thought for the impact this expansion is having on the RN role identity. The expansion of the HCA role is occurring without a legitimate career progression for HCAs.

The organisation of the HCA role is evolving to meet the changing landscape of care but is negatively impacting on the HCA in terms of the expanding expectations placed on them without the organisational support. The negative impact this has on the identity of RNs is that they feel their own role is changing and they are being consumed with documentation, leading to a decrease in job satisfaction as they are being taken away from the patients.

Documentation is consuming RN time and this is an important finding of this study. Infrequently, studies gave documentation as being the most significant source for consuming RN time, with Venturato and Drew (2010) identifying that documentation was fitted in around clinical duties. Pearcey (2008) qualitative study found paperwork, extended nursing roles and the introduction of the HCA role reasons for decreasing RN patient contact time. While this study agreed with these findings, documentation in this study, was always a priority only secondary to assistance required by a HCA to deliver patient care, despite its

repetitive nature, leaving HCAs to fill the gap left by RNs (Spilsbury and Meyer, 2005b) RNs felt that documentation was a priority.[14]

Effective measures to streamline time consuming activities require implementation to release RNs time to go back to the patients. These effective measures need to be proven in their effectiveness. The ‘Productive Ward’ series (NHS, 2008) is one such example designed to ‘*engage*’ and ‘*empower*’ teams in providing improved quality of care. The implementation of non-empirical based interventions can lead to fatigue among staff (White, 2017, p. 2420). Fatigue from interventions was noted by one participating RN in this study.

There has been a bibliometric review carried out in the current body of knowledge by White *et al.* (2014) which suggests that the thirst for success in healthcare improvements has peaked and is suffering from fatigue in the UK. However they do note that internationally it still creates interest. While Walshe (2009) points to the importance of being selective in the improvements that are chosen and carried out to avoid this fatigue and truly implement the appropriate change to see an improvement in quality.

There is a counter argument to this and that it is felt that healthcare is being ‘McDonaldised’ and being pushed into a measurable, controllable, calculated and extremely efficient corporate entity. The concern is that the shift from patient care towards customer service will erode at the core values of the nursing profession (Austin, 2011). It is these types of measures which made the Mid-Staffordshire trust appear to be meeting targets when the reality was, they were failing in the fundamentals of compassion and care (Francis, 2013). Considering the issues it is important going forward that a balance achieved.

[14] See chapter 5 section 5.1.3

It must also be noted that Spilsbury and Meyer (2005b) in her interviews of RNs reflected that maybe RNs placed a prestige to the documentation, leaving the HCAs to answer call bells. While this study did not observe this to be the situation, as mutual support was often observed[15] it does pose a question for teams that are not so welcoming of the HCA role.

The organisation is committed to the HCA role in so far as a HCA is a regular feature of the nursing team skill mix; however HCAs are often used to substitute for RNs due to RN shortages which are reflected in international literature (Shearer, 2013; Ball, 2016; Spilsbury and Meyer, 2005b). This shortage of RNs is leading to HCAs expanding their skills, as was reported in this study[16] and a recognised feature of the role relationship within the literature (Baldwin *et al.*, 2003; Orne *et al.*, 1998). Expansion of the HCA skill set is done so in an unofficial manner as HCAs reported in this study that they were unsure of what constituted 'training' in making them competent and if they were allowed to utilise their prior competencies from previous jobs and who was accountable for HCAs carrying out duties they felt they were not officially trained for. The Francis Report (2013) made findings with regard to this and recommended that formal training linked with a competency framework would resolve uncertainty with regard to the skill, knowledge and competency of the HCA and allow for appropriate delegation of tasks by the RN.

Spilsbury and Meyer (2004) established that RNs would limit HCAs work by not allowing them to carry out duties they had received previous training for. While this study found the opposite to be true, as HCAs reported 'over use' both studies resulted in a deviation from the policy expectations of the organisation. This deviation was a cause of stress for the

[15] See chapter 4 section 4.4.3
[16] See chapter 5 section 5.4.3

HCAs[17] as they feel clear guidelines should be set down to prevent as Spilsbury and Meyer (2004) titled research labelled as ‘the use, misuse and non-use’ of HCAs.

A finding of this study is RNs and HCAs feel that HCAs undertaking tasks for which they are competent should assume responsibility. This responsibility should be graded and include regulation. Grading should be based on core competencies required to be achieved by HCAs in order to progress to the next grade. Grading of HCAs remains undeliberated within the Irish context. However the grading of student nurses is an established concept within the Irish setting and could be transferrable into the HCA domain. Grading of HCA staff would be beneficial in two ways, as it would allow for greater clarity of roles with a clear linkage to competencies and also allow for a career pathway for HCAs.

This study found that a lack of a clear job description is a source of tension and stress for HCAs. HCAs reported that their job description is vague with use of descriptive words all ‘meaning care of the patient’[18]. Kleinman and Saccomano (2006) identified that a job description is used as a means of assessing competency. This is unhelpful to the RN who must decide if a person is competent, has the experience and the scope while accepting responsibility in deciding to delegate (NMBI, 2015b).

While the organisation facilitates HCAs to be core members of the nursing team, allowing RNs to know the competencies of the individual. It is important that grading be adopted and should be clearly defined in terms of competencies. Barter *et al.* (1997) called for each RN to have access to a database outlining the competencies of individual HCAs to allow RNs safely delegate appropriate tasks. However, little has changed. While England, Scotland, Wales and Northern Ireland plan to address this issue through various means like regulation

[17] See chapter 5 section 5.2.2
[18] See Chapter4 section 4.6.2

Ireland has yet to consider this issue. However, it is hoped that when the Taskforce on Staffing and Skill Mix for Nursing (2018) completes its work, there might be empirical evidence to provide weight to this studies finding, that a competency framework is the safest way forward, as the current situation of role ambiguity is not acceptable. Thornley (2000), however identified that there is a lack of attention given to the HCA role and the contribution it makes to the nursing team. HCAs see themselves as a low subordinate group of workers, who find it hard to deflect work overload[19](Clark and Thompson, 2015).

All participants of this study felt that regulation was a good idea and this is reflected internationally. Of note, within the English system the Mid-Staffordshire NHS Trust recommended vast changes to the way patient care is delivered (Francis, 2013). Camilla Cavendish (2013) felt that if regulation is not addressed those who are committed to the caring profession will be lost. This was reflected as a finding in this study where two HCAs felt that if their knowledge was broadened they would remain committed to the HCA role. What this study identified as being important to HCAs is that they did not necessarily want to be RNs.

RNs welcome role progression for HCAs but are concerned that expansion of the role would encroach upon their role. Role ambiguity exists within the RN and HCA skill mix and can impede teamwork (Coffey, 2004; Keeney *et al.*, 2005; Spilsbury *et al.*, 2011). RNs are concerned about what HCA role expansion would mean for their role identity[20]. However, the irony is that HCAs do not want to be RNs. HCAs want their own career pathways[21]. To avoid encroachment into the RN role it is imperative that RNs guide the HCA role, with

[19] See chapter 2 section 2.4.2
[20] See chapter 5 section 5.4.4
[21] See chapter 5 section 5.4.5

regard to training, grading, clear job descriptions and regulation of this grade of nursing, to compliment the skill mix (Coffey, 2004; Baldwin *et al.*, 2003; Waldie, 2010). Siegel *et al.* (2008) study of organisational support found that academia, industry, supervision education, and policy are required to enhance partnerships, which concurred with some of the findings from this study.[22] Siegel *et al.* (2008) also found that RNs do not participate in organisational change, preferring to deal with issues at a local level, which would concur with the RNs and HCAs in this study finding ward level management to be supportive with the same not been extended to the organisation beyond that[23].

HCAs require a consistent management structure to support and guide the HCA role in terms of pragmatism and in guiding the future progression of the HCA role. Organisations need to support and encourage RNs in guiding this role to reduce the risk of unwanted encroachment of the RN role (Holland, 2015).

6.4.4 Concluding Comments

In exploring and analysing the organisation of care, the findings from this study are in agreement with relevant empirical literature. It is postulated that RNs need to voice their concerns regarding the amount of time they are spending on documenting care and what this says about the direction of the profession of nursing. Only rigorous interventions should be adopted to avoid fatigue and failure (Walshe, 2009).

HCAs also require guidance in the form of grading to ensure their contribution to nursing is valued. Grading should include a competency framework and RNs need to be involved in this process at a policy and local level in terms of education, training, competency and job description.

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[22] See chapter 5 section 5.4
[23] See chapter 5 section 5.4.1

6.5 Implications of the Study

The literature suggests that role relationship issues are complex.[24] Barter *et al.* (1997); Munn *et al.* (2013) reiterate that this relationship can be tense and stressed or functional and effective. This study provides findings on the issues which are largely organisational, encountered by RNs and HCAs who navigate the social space of care together in the South-East of Ireland. Such findings can be used to inform organisations in the facilitation of HCAs and indeed RNs in making the relationship more functional and effective and less tense and stressed.

In this study, the impact of the organisation emerged as a significant finding, it is necessary therefore for the organisation to appreciate RNs and HCAs are under-supported in terms of role relationship. There is an ad-hoc approach to the HCA role, with a lack of clear job description, formal training and role progression. This lack of formal training for HCAs in broadening their skill base and ensuring competency is a contentious issue among HCAs. Adoption of suitable measures to guide the HCA role could lead to a career pathway for HCAs as HCAs and reassure RNs that their role will not be encroached upon. It is believed by the participants of this study that little thought for the impact increasing documentation is having on the role of the RN in patient care.

Arguably, based on the findings of this study, organisations need to engage more with the RNs and HCAs that deliver direct patient care, to ensure a tense and stressed relationship is minimised, RNs and HCAs should be actively engaged in the direction of the HCA role. Policy developments need to recognise and actively engage with the issues facing local teams. Policy in turn needs to be underpinned by developed and proven strategies to meet the

[24] See chapter2 section 2.1

needs of the RN and HCA skill mix and limit the risk of fatigue by staff to unproven strategies.

6.6 Recommendations and Future Directions

Throughout this study, a number of issues have been found which relate to the RN and HCA skill mix role relationship. Pertinent issues include the impact the organisation has on the relationship. Upon consideration of the implications of the study's findings, certain recommendations can be made with regard to ensuring functional and effective RN and HCA skill mix relationships with regard to; (1) workforce policy (2) practice, and (3) research initiatives.

In relation to workforce policy, policy makers, service providers and educators should ascertain local practice to effectively formulate policies and initiatives with regard to the competency of HCAs and the training of RNs in the role of delegators and supervisors. These policies should address the needs of RNs and HCAs by securing the effectiveness of the RN and HCA skill mix. Proposed policy initiatives should be realistically attainable. In doing so, current practice must be reviewed and the areas for reform, such as the grading of HCAs and streamlining of documentation must be addressed to ensure that internationally proven resources are targeted at consolidating this relationship and releasing RNs time back to provide direct patient care to collaborate effectively with their partners in care, the HCAs. Furthermore, effective practice developments such as, training and development in relation to supervision and delegation should be implemented nationally to ensure a national standard, which will further enhance effectiveness.

In terms of practice, findings indicated that the organisation impacted on the role because of poor job descriptions and role definition. Job descriptions, where roles are clearly defined

should be developed in line with the service requirements. Workshops consisting of current RN and HCA staff should be developed to explore and educate RNs and HCAs of each other's roles and responsibilities to consolidate the RN/HCA relationship. Individual HCAs should remain regular members of the nursing teams and the inclusion of HCAs at formal communications times should be protected, especially if they are to provide patient information to other MDT members. The benefit to the organisation of regular assigned HCA staff to a ward is limiting the amount of time RNs must orientate, delegate and directly supervise irregular of relief HCA staff, which results in a release of some time for RNs to provide patient care, which in turn increases job satisfaction for RNs and HCAs and needs to be considered in skill mix management.

In terms of research initiatives, findings from this study suggest that the organisation needs to address several factors if the role relationship between RNs and HCAs are to minimise the negative impact on role identity. The literature has highlighted that role relationship is an important factor in collaborative working, though the nature and extent of these issues within the Irish context are under researched and while this study has unearthed these issues, due to the qualitative descriptive nature of the study, further investigation is required to address the significance of the issues identified within differing populations. Competency based grading of HCAs and the consolidation of this role requires exploration. A clear definition nationally of the HCA role and a local job description specific to the area of work needs to be investigated to address the issue of ambiguity, alleviating the concern for RNs that the further expansion of this role will encroach on the RN role.

Longitudinal studies exploring the evolution of this relationship in relation to workforce policy change would be beneficial. In order to evaluate the impact this relationship has on patient care the views of patients' needs to be explored in future studies.

Irish research that informs good policy will positively impact the practice of RNs and HCAs leading to improved relationships leading to better outcomes for patients.

6.7 Limitations of the Qualitative Descriptive Approach

The qualitative descriptive approach is a valid and appropriate method for adoption in the undertaking of this study. However, like all methodologies, it is not without limitations. Transferability is a limitation due to the small sample size. The target for recruitment for the interview stage of this study was ten participants, five RNs and five HCAs, seven participants were interviewed, which could be interpreted as not reflective of the population observed. Regardless the aim of a qualitative descriptive study is to develop an understanding of topics such as professional relationships (Neergaard *et al.*, 2009).

6.8 Conclusion

The overall aim of this study was achieved by exploring and analysing the role relationship between the RN and the HCA within the clinical social space of care and how this impacts on care delivery. The findings from this study suggest that the role relationship is negatively impacted at an organisational level and presents challenges for the participants within the social space of care. The key findings were (1) HCAs as regular members of the RN skill mix dictates delegation and indirect supervision, (2) RNs are consumed largely by documentation (3) the HCA role is progressing without a formal structure and formal career pathway guiding the role and (4) RNs struggle with HCA role expansion, but are not included at an organisational level in guiding the role.

In terms of the implications of this study, this study can assist the organisation in the facilitation of HCAs and indeed RNs in making the relationship more functional and effective and less tense and stressed. Recommendations and future directions in relation to; (1) policy (2) practice and (3) research initiatives. To conclude, this study provides valuable insights, which may be used to directly assist in the organisational guidance of the RN and HCA relationship.

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Appendix 1: Letter of Support

HSE South

Ireland

07th September 2016

Private and Confidential

Michael Bergin PhD
Course Leader BSc in Psychiatric Nursing & MSc in Nursing
Department of Nursing & Healthcare
Waterford Institute of Technology
Cork Road
Waterford

Re: An investigation of the inter-relationship between the registered nurse and the healthcare assistant with reference to workforce policy implementation in the South- East of Ireland.

Dear Mr. Bergin

I fully support the undertaking of this research and believe it will be of value for all of us working in the acute setting and how we measure skill mix going forward.

Kind regards

Yours sincerely

____

A/Director of Nursing

Appendix 2: Managers Consent to Participate in Research Study

Title of study: An investigation of the inter-relationship between the registered nurse and the healthcare assistant with reference to workforce policy implementation in the South-East of Ireland.

Principal Investigator: Ms. Maria Beagan PHN, RGN, BSc.

- I give my consent for the above study to be conducted in clinical setting _______________ in hospital_______________.
- I understand that participation in the study is voluntary and that the hospital _______________ may withdraw support at any stage.
- I understand that observation and interviews will be undertaken during data collection and that interviews will be digitally recorded. The contents of the tapes will also be transcribed.
- I understand that staff members may not wish to be observed and efforts will be made to accommodate such identified staff.
- I understand that the hospitals identity will not be made known to anyone and that the research team and participants will be the only persons with knowledge of its identity.
- I understand that this research study has ethical approval from Waterford Institute of Technology and the HSE South East research ethics committee.
- I understand that in the event of any issues revealed during observation, or the interviews uncover unethical or malpractice behaviours, such events will be reported.
- I understand that clinical nurse manager________________ and the director of nursing ______________________have been identified within the research site to report such issues.
- I have received the information leaflet and any concerns or questions regarding the study have been addressed.
- I am aware that the researcher is bound by the Code of Professional Conduct and will report any concerns regarding mal-practice to the clinical nurse manager.
- I am aware that in the case of institutional mal practice being uncovered the researcher will discuss these concerns with the supervisors of the study.

Signed: _________________________ (Director of Nursing) Date; _______________________

Signed: _________________________ (General Manager) Date; _______________________

Signed: _________________________ (Medical Director) Date; _______________________

Appendix 3: Observational Protocol, Checklist and Reflexive Note-taking

Observational Protocol

- I will be a complete observer and only exchange pleasantries;
- Structured observations will be carried out using an agreed schedule;
- The observations will occur for a one month period;
- Observations will occur for periods of time for the duration of the shift, covering the 24-hour roster, over a seven-day period;
- At the commencement of the study general observation will be conducted at the site, this will aid in the decision of the final observation schedule;
- The 'team' to be observed will consist of registered nurses and healthcare assistants that are present for the particular rostered shift, selected for observation;
- Observations are general and will not be concerned with any one person;
- A new observational record will be used if extra staff are recruited in to help with workload or if staff member(s) go off duty for any reason;
- Observational data will be recorded in a tick box fashion and observational field notes will be recorded;
- Field notes will be taken in the margin as they occur to prompt reflexive thoughts;
- Following any one specific period of observation the researcher will leave the unit and go to a private space within the hospital and make notes of the observed period;
- The event will be summarised, interpreted and reflected upon, using the headings of; summary of observation, interpretation of observation and reflexive observation;
- Each observational schedule and corresponding reflexive narrative will be kept together and coded using the alphabet;
- To provide confidentiality and safeguard anonymity the alphabet will correspond to the shift time and date that I observed;
- The observational checklist and field-notes will be transcribed and inputted into NVivo 11 to facilitate thematic analysis of data;

CODE:

Nature of Interactions;

Field-Notes

Behavioural Markers	Frequency		
Team Structure			
1. Do all core workers providing direct patient care look like they belong on the ward	P	A	NA
2. Do HCAs attend handover	P	A	NA
3. Are RNs & HCAS interspersed during the shift	P	A	NA
4. Do all core members of the ward intersperse during social downtime	P	A	NA
Leadership			
5. Are the relevant direct care providers included in briefs during the shift	P	A	NA
6. Does the leader delegate duties/responsibilities	P	A	NA
7. Do RNs appear to spend a large proportion of their time in a supervisory role	P	A	NA
Mutual Support			
8. Is co-operation obvious	P	A	NA
9. Is there balanced distribution of the routine tasks	P	A	NA
10. Is collaboration to complete a task obvious	P	A	NA
11. Do RNs appear to delegate duties to HCAs	P	A	NA
12. Does the RN appear to supervise the delegated duties	P	A	NA
13. Are there competing demands made on HCAs by RNs	P	A	NA
Communication			
14. Is their social exchange present	P	A	NA
15. Are HCAs sought out to provide patient information/clarity of care	P	A	NA
16. Do HCAs offer information before it is asked of them	P	A	NA
17. Is there active communication between RNs and direct care providers	P	A	NA
18. Is there closed loop communication (check back)	P	A	NA
19. Is information sharing happening in a timely manner	P	A	NA
20. Do HCAs inform directly or indirectly to RNs	P	A	NA
21. Is conflict managed positively	P	A	NA
22. Do RNs ask for assistance prior to or during periods of task overload	P	A	NA
23. Do direct care providers ask for assistance prior to or during periods of task overload	P	A	NA

Frequency Scale: Present (P) the behaviour is present Absent (A) the behaviour is absent Not Applicable (NA) there was not an opportunity for the team to demonstrate such behaviour

CODE:

Impact of Role Identities

Field-Notes

Behavioural Marker	Frequency		
Mutual Support			
1. Do all team members seek each other out if missing	P	A	NA
2. Is there mutual respect	P	A	NA
Communication			
3. Do HCAs work independently of RNs	P	A	NA
4. Do team members socialise independently of their affiliated group	P	A	NA
5. Is there a friendly atmosphere	P	A	NA
6. Are there limitations to the access of IT/phones/areas,	P	A	NA
7. Are all staff involved in providing direct care, included in briefs during the shift	P	A	NA
Team Structure			
8. Are roles and responsibilities well defined	P	A	NA
9. Are tasks distributed and performed relative to specific roles	P	A	NA
10. Outside of RNs, are other team members approached by other healthcare professionals	P	A	NA
11. Do members of staff identify as part of a team	P	A	NA
12. Are all team members providing direct care work assigned to a person (RN or manager), or a group of patients	P	A	NA
13. Is teamwork paramount	P	A	NA
Leadership			
14. Does the organisational climate support the team (rostering, job sharing, training)	P	A	NA
15. Does the CNM or senior nurse in charge empower team members to speak freely and to ask questions	P	A	NA

Frequency Scale:

Present (P) the behaviour is present Absent (A) the behaviour is absent
Not Applicable (NA) there was no opportunity for the team to demonstrate such behaviour

Glossary of Terms

Active Communication: All staff asks and answers questions freely
Balanced Distribution: All staff has near to equal downtime during a shift
Closed Loop Communication: The sender of the information checks that the receiver has understood completely the content of the information
Competing Demands: Conflicting requests made of HCAs by different grades of RNs & CNM
Interspersed: A mix of grades of staff e.g. RNs &HCAs congregate together in no formal combination
Paramount Teamwork: Teamwork is the primary focus and those that do not contribute are marginalised

Reflective note taking:

Code:

Shift Pattern:

Activity:

Participants:

Length of Observation:

Summary of Observation:

Interpretation of Observation:

Reflexive Observation:

Appendix 4: Participant Information Sheet

Title of study: An investigation of the inter-relationship between the registered nurse and the healthcare assistant with reference to workforce policy implementation in the South-East of Ireland.

What is the study about: The focus of the study is to explore and analyse the role relationship between the registered nurse and healthcare assistant in the clinical setting and how this impacts on care delivery. This will be achieved by observing the nature of the 'day to day' interactions and the nature of communication and the impact this has on the role relationship between registered nurses and healthcare assistants. What is currently known is that the role of the nurse is expanding and the role of the healthcare assistant is being formalised, but what requires further investigation is how nurses and healthcare assistants relate to each other and to what level these changes are guided by workforce policy.

What will be your role during the observational phase?

- The environment in which you work will be observed;
- The observations are of the working environment and not of any one specific individual;
- The observations will occur for a one month period;
- Observations will occur over periods of time for the duration of the shift, covering the 24-hour roster, over a seven-day period;
- I will observe the communication relationship that occurs between healthcare assistants and registered nurses for periods of time during the day and record the observations;
- This information will be recorded in a tick box fashion (please see attached) and notes will be taken;
- No personal data will be recorded;
- I will only be recording observational data in non-patient areas for example the nurses station, the unit corridors, designated handover space;
- A weekly timesheet of my presence on the unit will be available from the Friday before of each week;
- Posters will be placed on the unit to inform hospital staff, patients and all visitors to the unit informing them that an observational study is been undertaken;
- If you do not wish to be part of the study, you can approach me privately and I will not record any observation involving you; If this is unsatisfactory for you I will arrange not to conduct observations while you are on duty;
- The researcher, Maria Beagan as a registered nurse is bound by NMBI's Code of Professional Conduct and Ethics in relation to conduct of research and observation of practice;
- In the event of any issues revealed during observation, or the interviews disclose unethical or malpractice behaviours, such events will be reported.
- A clinical nurse manager and the director of nursing have been identified within the research site to report such issues.

What will your participation involve during the interview phase?

(This is a sample of the type of topics that may be used to shape the interviews as currently the literature supports these themes)

- Talking to me about your views on relationships between healthcare assistants and registered nurses;
- I will explore with you your views on issues relating to delegation, communication and role relationship;
- If you choose to participate you are free to withdraw your consent at any time without obligation to anyone;

- I am aware that talking about these issues may be sensitive and you can refuse to answer any question, turn the tape recording off, or stop the interview at any time;
- All your answers will be confidential;
- I will be the only person who knows who you are;

The interview

- The interview may last between 45 and 60 minutes.
- It will be held in a private office within the hospital and at a time that is suitable to you.
- The interview with your permission will be tape recorded, as it would not be possible for me to remember all that is said. However, if you do not wish to have the interview tape-recorded, I would ask your permission to make notes of what is said.

What will happen to the information when it is collected?

- The taped information will be transcribed;
- Your comments (or part of them) may be used in different formats such as paper and/or electronic to share with others the benefits of informing workforce policy and add to the general body of knowledge with regard to role reconfiguration;
- The tape recording and transcripts of the interview will be stored in a locked cupboard in my office at work;
- Any information transferred to a computer will be password protected;
- The only people who will have access to the tape recordings are the members of the research team;
- At no stage will your name appear on the interview tape or the transcript;
- Each tape recording and printed transcript will be given a number for identification purposes only;
- I will be the only person who knows these numbers and who you are;
- I will not disclose this information to anyone;
- When the research is finished all material will be destroyed;
- I will not inform anyone of your participation in the study;
- Information that might identify you will not be used in any publication or presentation resulting from the study. However, you are free to talk to people of your participation in the study, if you so wish;

Any further questions:

If you have any further questions, please feel free to write or telephone me at the contact details below:

Maria Beagan

Department of Nursing
School of Health Sciences
Waterford Institute of Technology
087247876
Email: mariatwalsh@eircom.net

Appendix 5: Interview Topic Guides

Interview Topic -Guide for Registered Nurses;

Establish rapport with the interviewee, inform the interviewee of their role in the research process, seek written consent and gain permission to digitally record and take minor written notes during the interview process, inform them of the duration of the interview, remind the interviewee that they can stop or withdraw from the process at any time and guarantee confidentiality within the precepts of the Code of Professional Conduct and Ethics for Nurses, ensuring that it is understood that during the interview, if any issues of malpractice are identified, the people involved will be reported to the relevant authority and in this instance confidentiality cannot be guaranteed.

Opening Statement;

I am interested in hearing about the working relationship that exists between registered nurses and other healthcare providers, for example healthcare assistants.

Ground Mapping Questions *(non-specific and opening up the subject, minimal probing, service used provider can raise issues that are of most interest to them).*

- Tell me about your working relationship with other healthcare providers, for example healthcare assistants

Dimension Mapping Questions (used to focus more on particular issues).

- What are your views in relation to other healthcare providers that provide direct patient care?
- Do you like working in a skill mix environment?
- Can you tell me who you work with in providing direct patient care?
- Tell me your views of working with this group?
- Who you delegate tasks to?
- What are your views regarding health care assistants in terms of their skill and knowledge levels for practice?
- Tell me your views in relation to supervising healthcare assistants?
- How do you feel about the formalisation of the role of the healthcare assistants?
- Do you feel other healthcare providers are part of the MDT?
- Would you like if healthcare assistants documented care (Why/ Why not?)
- Who do you feel should be responsible for the care healthcare assistants deliver?

Perspective-Widening Questions *(more in-depth uncovering of issues).*

• Understanding of the formalisation of the role	• Handover
• Understanding of RN duty to supervise	• HCAs documenting care
• Understanding of competency	• Inclusion of HCAs in discussions (formal &informal)
• Social engagement with HCAs	• Responsibility
• Formal communication	• Collaboration

Interview Topic -Guide for Healthcare Assistants;

Establish rapport with the interviewee, inform the interviewee of their role in the research process, seek written consent and gain permission to digitally record and take minor written notes during the interview process, inform them of the duration of the interview, remind the interviewee that they can stop or withdraw from the process at any time and guarantee confidentiality within the precepts of the Code of Professional Conduct and Ethics for Nurses, ensuring that it is understood that during the interview, if any issues of malpractice are identified, the people involved will be reported to the relevant authority and in this instance confidentiality cannot be guaranteed.

Opening Statement;

I am interested in hearing about the working relationship that exists between registered nurses and healthcare assistants;

Ground Mapping Questions *(non-specific and opening up the subject, minimal probing, service user and provider can raise issues that are of most interest to them).*

- Tell me about your working relationship with registered nurses

Dimension Mapping Questions (used to focus more on particular issues).

- Do you like working with registered nurses?
- Tell me what you see the role of the healthcare assistant to be?
- Do you think you have received adequate training for the care that you deliver?
- If not, what kind of training do you think is important for you to have for practice?
- Are you ever asked by registered nurses to carry out duties that are beyond your skillset?
- Tell me about the duties and manner in which these duties are delegated to you?
- Tell me about the supervision you receive, in relation to the tasks you are delegated?
- How do you feel about the formalisation of the role of the healthcare assistants?
- Do you feel you are part of the MDT?
- Would you like if healthcare assistants documented care (Why/ Why not?)
- Who do you feel should be responsible for the care healthcare assistants deliver?

Perspective-Widening Questions *(more in-depth uncovering of issues).*

• Understanding of the formalisation of the role	• Handover,
• Understanding of RN duty to supervise	• HCAs documenting care,
• Understanding of competency	• Inclusion of HCAs in discussions formal and informal
• Social engagement with RNs	• Responsibility
• Formal Communication,	• Collaboration
• Regulation of HCAs	

Appendix 6: Consent to Participate in a Research Study

Title of study An investigation of the role of the registered nurse in relation to the changing context and dynamic of care and workforce policy.
Principal Investigator: Ms. Maria Beagan PHN, RGN, BSc.

- I give my consent to be included in the above study.
- I understand that my participation in the study is voluntary and that I may withdraw at any stage.
- I give permission to be interviewed and for the interview to be audio recorded. The contents of the tapes will also be transcribed.
- I understand that I can request to review my taped transcript to review, amend, clarify or delete any aspect their interview.
- I understand that I may decline to answer any questions during the interview, and also, can request to have sections of the interview erased or that the total interview be not used for the purposes of the study.
- I understand that my identity will not be made known to anyone and that the principal researcher will be the only person with knowledge of my identity.
- I understand that this research study has Waterford Institute of Technology's and the HSE research ethics committee approval.
- I understand that in the event of any issues revealed during observation, or the interviews disclose unethical or malpractice behaviours, such events will be reported.
- I understand that a clinical nurse manager and the director of nursing have been identified within the research site to report such issues.
- I have received the information leaflet and any concerns or questions regarding the study have been addressed.

Signature of participant: Date:

Signature of researcher: Date:

Appendix 7 Ethical approval Waterford Institute of Technology

Instititiúid Teicneolaíochta Phort Láirge | Waterford Institute *of* Technology

Port Láirge, Éire.
T: +353-51-302000
info@wit.ie

Waterford, Ireland.
T: +353-51-302000
www.wit.ie

REF: 16/NUR/03

26th May, 2016.

Ms. Maria Beagan,
Castlepark,
Hugginstown,
Co. Kilkenny.

Dear Maria,

Thank you for submitting your amended documentation in relation to your project *'An investigation of the inter-relationship between the registered nurse and the healthcare assistant with reference to workforce policy implementation in the South-East of Ireland'* to the WIT Research Ethics Committee.

Based on the revised WIT ethical approval application form and supporting documentation, I am pleased to inform you that we fully approve the conduct of this project.

We will convey this decision to Academic Council.

We wish you well in the work ahead.

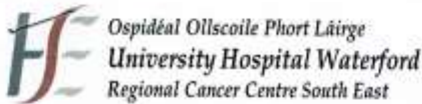
Yours sincerely,

Michael Harrison

Dr. Michael Harrison,
Acting Chairperson,
WIT Research Ethics Committee

cc: Prof. John S. Wells
Dr. Michael Bergin

Appendix 8: Ethical Approval Regional Ethics Committee



Research Ethics Office
Old School of Nursing
University Hospital Waterford

Tel: 051- 842026/051-842391

7th November 2016

Ms. Maria Beagan,
Castlepark
Booleyglass
Hugginstown
Co. Kilkenny

STUDY TITLE: "An investigation of the inter-relationship between the registered nurse and the healthcare assistant with reference to workforce policy implementation in the south east of Ireland"

STUDY STATUS: *APPROVED*

Dear Ms. Beagan,

The Research Ethics Committee, HSE, South East reviewed the above study and are happy to grant you Full Ethical Approval.

The following documents were reviewed and approved:

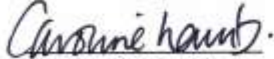
1. Standard R.E.C. Application Form
2. Research Proposal Form
3. Participant Consent Form
4. Study Information Sheet
5. Phase 2 Interview Topic Guide
6. Phase 1 Observation
7. Letter to General Manager, Director of Nursing and Clinical Director requesting permission to access staff/site.

The following documents were received:

1. Signed Hard Copy of Declaration Page
2. C.V. Of Principal Investigator, Ms. Maria Beagan
3. Insurance Cover Letter

Please notify the Research Ethics Committee Office, Old School of Nursing, Waterford Regional Hospital on completion of Research.

Yours sincerely,



Ms Caroline Lamb
Research Ethics Committee Coordinator
Health Service Executive, South Eastern Area

The Research Ethics Committee, HSE, South East is a recognized Ethics Committee under Regulation 7 of the European Communities (Clinical Trials on Medicinal Products for Human use) Regulations 2004 and as such is authorized to undertake ethical review of clinical trials of all descriptions and classes for the Republic of Ireland.

The Research Ethics Committee, HSE South East issues ethical approval on the basis of information provided. It is the responsibility of the researcher to notify the Research Ethics Office of any changes to a study to ensure that the approval is still relevant.