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Is It a Dangerous Game?

*Registered Nurses' Experiences of
Working with Care Assistants in a Public Hospital Setting*

*A thesis presented in partial fulfilment of the requirements
for the degree of Master of Arts in Nursing
at Massey University*

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2001

ABSTRACT

Financial constraints in the rapidly changing health care climate have resulted in a trend towards the employment of care assistants in public hospitals. Registered nurses are often the staff who work most closely with these care assistants. The aim of this qualitative descriptive study was to explore the experiences of registered nurse participants who worked with care assistants in a particular public hospital setting. Although there is a considerable amount of international research on registered nurses working with care assistants and issues relating to this topic, this topic has not been researched in the New Zealand context.

This study's participants were drawn from a regional hospital that formally introduced a training programme for care assistants in the mid-90s. Before this some hospital aids with no formal training were employed by the institution. These hospital aids were then encouraged to join the care assistant programme.

Eight registered nurses participated in semi-structured interviews. The data were analysed using Burnard's (1991) thematic content analysis, which led to the development of three overarching themes. The first theme, 'I'm not sure what care assistants should be doing', reflected the perception of the participants that the role of the care assistants was ill defined, and that the care assistants' contribution was limited by their lack of qualification. In the second theme 'we have overall responsibility for the work of the care assistant', the participants perceived that their job had become more difficult with care assistants, and that they had to be careful when assigning tasks to the care assistants for fear of compromising patient safety. The participants' perception of the registered nurse being responsible for unregulated care assistants and the legal implications this could have on their own nursing practice was of concern. The final theme, 'we were never really taught to delegate' reflected participants' concerns that they had no formal education in delegating to and supervising care assistants. Furthermore, the participants' lack of involvement in care assistants' training and in assessment of their competency resulted in the participants being unaware of the care assistants' capabilities.

Overall, the study suggests that clear directives be put in place for registered nurses when working with care assistants', and that registered nurses require further education about their own legal obligations as health professionals. If registered nurses are to be involved in delegating work to and supervising unregulated staff, then they need to have formal education in these skills.

ACKNOWLEDGEMENTS

I extend my gratitude and thanks to the many people who have contributed to the completion of this thesis. It was their encouragement, support and interest in what I was doing that inspired me through this sometimes long, challenging and often frustrating process of completing a Masters thesis.

The participants who made this study possible, I would like to thank you for your participation in this research and for sharing your experiences and thoughts with me.

To my research supervisor, Lesley Batten. I offer my sincere gratitude and special thanks for your guidance, support and encouragement. Without your support and belief in me this work might not have been completed.

A special thank you to my family and friends for your tolerance, your understanding and belief that I could do it. Thank you for allowing me the time and space to complete this thesis.

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CHAPTER ONE

Background To The Study

Introduction

As the pressures of fiscal and political constraints continue to increase in the public and private health sectors in New Zealand, there have been changes to nursing care delivery systems. This has occurred quite dramatically in recent years and is most noticeable in alterations to the skill mix of staff that results in the introduction of minimally trained, inexpensive, unregulated care assistants. The Nurses Act 1977 has provision for registered nurses to direct and supervise enrolled nurses but care assistants are not covered by this Act. It has now become common practice for registered nurses to work closely with care assistants' and registered nurses are legally responsible and accountable for activities they delegate to this group. Registered nurses are regulated by law, and are required to reach certain competencies to achieve their professional status of registered nurses. In the past there did not appear to be formal preparation for registered nurses in the skills of delegation and supervision of work to care assistants; however, this is now noted in programme specification for Bachelor of Nursing programmes (Nursing Council of New Zealand, 2000a).

With this in mind it seemed prudent to explore the experiences of registered nurses who work with care assistants in a public hospital setting to discover if any important issues for nursing existed. As will be shown in the literature review chapter, there is no New Zealand research literature available on the topic, although it has been researched overseas.

The Study

The aim of this study was to explore registered nurses experiences when working with care assistants in a New Zealand public hospital using a qualitative descriptive design. It was anticipated that information from this study could be used to inform nursing practice.

Care assistants were introduced into this regional hospital in the mid-90s. Initially care assistants were employed in elderly care services; however, they have since been employed in many clinical areas. At the time of their introduction a formal training programme commenced, which included competency assessment of the care assistant by a registered nurse. A nursing policy outlining care assistants training programme and registered nurse responsibilities was instigated at that time.

A qualitative research method was suitable for this study because it was useful for describing phenomena from the emic perspective. Data collection was through a process of semi-structured interviews with registered nurses, offering them the opportunity to describe these experiences. This study utilised Philip Burnard's thematic content analysis as the method for analysing the qualitative textual data, allowing the emergence of recurring themes (Burnard, 1991).

The Researcher's Interest

The researcher's interest in this topic developed following the introduction of care assistants and the subsequent difficulties registered nurses appeared to experience in directing them in their assistant role. Registered nurses make professional judgements when delegating tasks to care assistants. Although theoretically these tasks do not require nursing knowledge, care assistants are often supervised by a registered nurse. Regardless of who delivers care to patients, the registered nurse is the one ultimately responsible and accountable for managing the provision of safe nursing care.

From the researcher's experience there were a number of concerns when care assistants were introduced into clinical areas, sometimes with little consultation between management and the registered nurses. While registered nurses had indicated they required assistance to deliver care, there was a reluctance to accept this help when it arrived in the form of care assistants. They were unsure of their role when delegating to care assistants, and although they have a responsibility to practise within their scope of practice they were concerned that they had inadequate preparation in the skills of delegation and supervision.

They were also unsure of the competency of care assistants and their roles. Sometimes, the role of the care assistant was seen as providing basic nursing care and direct patient contact, with these tasks being delegated by registered nurses. The question of what was described as 'basic nursing care' and therefore able to be delegated to care assistants was also a concern for registered nurses as this could encompass anything from bed making and giving out meals to patient care such as toileting, making patient's comfortable, and assisting with showers. Basic nursing care was frequently ill defined and was dependent on the health institution policy and care assistant educational model the particular institution was offering. Sometimes tasks defined in one institution as basic nursing cares were defined in another as non-nursing duties, resulting in confusion as to the roles of both the registered nurse and the care assistant.

There were concerns for registered nurses about legal and professional responsibilities, and nursing care. Lack of clear guidelines for both care assistants and registered nurses resulted in a blurring of the boundaries. There was also a concern that registered nurses might lose some direct patient contact to care assistants and that this had the potential to compromise patient safety. As the numbers of care assistants have increased considerably over the last decade little thought appears to have been given to how registered nurses would manage working with this group. From the researcher's own experience, and that of colleagues, of working with care assistants, there were issues that needed to be examined (Gunn, 1997; Manchester, 1997).

Nurse Assistants in New Zealand and Internationally

The International Council of Nurses (1993) suggests that historically registered nurses have always had some form of nursing support worker. This was evident both nationally and internationally. Although this assistance was not necessarily recognised as such, it had in fact been the basis of the nursing structure that was to continue for many years.

In the United States assistants to nurses have been known by up to sixty-five different titles and work under the supervision of a registered nurse (Orne, Garland, O'Hara, Perfetto & Stielau, 1998). In New Zealand the title also varies, for instance they are known as nurses' aides, hospital aides, caregivers, auxiliaries, and health care assistants but for the purposes of this study, these workers will be collectively referred to as care

assistants, although their roles may differ in different institutions. The common features are that they are employed as assistants and are not regulated by law.

There have been two levels of nurse most of the way through the history of New Zealand nursing, and as far back as 1939 the role of registered nurse aide existed. As the name implies this was an assistant role to the registered nurse (first-level nurse). Registered Nurse Aides came under the Nurses and Midwives Act 1925, and were replaced in 1966 by the Registered Community Nurse who was identified as a second-level nurse. Registered Community Nurse training allowed them to practise nursing in cooperation with and under the supervision of a first-level nurse. In 1977 the registered community nurse was given a new title, 'Enrolled Nurse', along with a reduced training programme from 18 to 12 months (Brownie, 1993; Nurses Act, 1977).

Restructuring of health funding in New Zealand's public health system in the mid-1990s gave Health Funding Authorities the opportunity to purchase health services. Contracts were offered publicly to a very competitive market, allowing both public and private sector to tender their services. Many larger hospitals were committed to continuing to provide their existing services. However, this was made difficult given the present structure of some of these hospitals to compete not only with other hospitals but also with private institutions for the provision of these services (Dransfield & Bland, 1997).

Recent health reforms in New Zealand have resulted in fiscal constraints, as is evident, amongst other things, by the closures of many small rural hospitals. As a result of these reforms and in an endeavour to achieve an efficient cost-effective health delivery system, nursing budgets are often the first to be examined (Dransfield & Bland, 1997; Ministry of Health, 1999). Nursing is usually the largest consumer of the staffing budget in both the public and private sectors. There was a trend in the private sector of health delivery towards using unregulated care assistants to provide personal care. This practice when integrated with service tasks, enabled the private provider to offer a more cost effective delivery of services. As a result, some hospitals initially introduced care assistants to their continuing care facilities. However, since their introduction, there has been a noted trend towards the use of care assistants in other health service areas (Brownie, 1993; Dransfield & Bland). Consequently, with each wave of health reforms, existing nursing

structures were reviewed, often resulting in alterations to staff mix, an increase in the number of care assistants' and a reduction in the number of regulated nursing staff (Brownie; Dransfield & Bland).

Because of these changes to staff mix and the continued need to be cost effective, each successive wave of health reforms in New Zealand has led to a gradual decline in the number of enrolled nurses employed. Brownie's (1993) study strongly suggests that the employment of enrolled nurses became less desirable due to "the increased economic rationalisation" (p. 44). This resulted in hospitals ceasing to offer enrolled nurse programmes and in the increasing use of care assistants as the 'cheaper' alternative. Although there has been no enrolled nurse programme since 1995, the roll remains open (Nursing Council of New Zealand, 2000b). Currently, only overseas nurses who met the criteria have been placed on this roll. The Nursing Council of New Zealand has, however, recently approved competencies for enrolled nurses, and it is anticipated that enrolled nurse training programmes will be reintroduced (Nursing Council of New Zealand, 2001). What is not known is how the reintroduction of enrolled nurse training will impact on the employment of care assistants.

When enrolled nurse education ceased in New Zealand there was an increase in the employment of care assistants who were prepared under various schemes throughout the country. Some of these care assistants had previously been trained and employed as enrolled nurses. Care assistant training programmes differ in terms of the length of training, the tasks and responsibilities taught, and the involvement of registered nurses in the training programme. A training programme was implemented in the hospital which employed the participants in this study, and registered nurses were required to carry out assessments of care assistants to see if they had reached a level of competence to meet the mandated competency modules that were in their training booklet. When these competency modules were completed and checked by the registered nurses, the care assistant was then able to perform the task under the supervision of the registered nurse.

Conclusion

No previous research was located on this topic in New Zealand, so this study provides a preliminary description of the experiences of registered nurses who work with care

assistants in a single public hospital. It was anticipated that issues would exist for registered nurses, as they are involved in delegating tasks to care assistants and also in supervising the care provided. There is no national consistency in the employment of care assistants, whether their role includes basic nursing cares and direct patient care or tasks defined as non-nursing duties, nor in the type of training necessary as preparation for this role.

Thesis Outline

Chapter two: Review of the literature

Concentrates on selected literature published over the last decade relevant to the research, outlining some of the issues for registered nurses working with care assistants.

Chapter three: Research design and method

Focuses on the design and method employed in this study, including the processes of data collection, data analysis and the management of ethical issues.

Chapter four: Theme: I'm not really sure what care assistants should be doing

A presentation of the first of the three themes that emerged from the data. In this theme the participants expressed their uncertainty of the functional role of care assistants.

Chapter five: Theme: We have overall responsibility for the work of the care assistant

A presentation of the second of the themes concentrating on registered nurses' concerns of the legal implications when working with unregulated care assistants.

Chapter six: Theme: We were never really taught to delegate

A presentation of the final theme revolving around the issues related to registered nurses delegating to and supervising the work of care assistants.

Chapter seven: Discussion

Key issues are discussed, the limitations of the study are identified, and recommendations for future research and the implications for nursing practice and education are identified.

CHAPTER TWO

A Review of the Literature

Introduction

This chapter focuses on the literature that pertains to the experiences of registered nurses working with care assistants in the public hospital setting. Discussion will be presented regarding the rationale for reviewing literature in qualitative research. Themes developed from the literature from both New Zealand and relevant international sources will be discussed.

The use of literature in qualitative research raises a certain amount of discussion. It is necessary to review the literature, but to what extent is debatable. According to Streubert and Carpenter (1995) a qualitative study does not require an extensive review of the literature before the start of such a study. The rationale for this is to protect the researcher from influencing the outcomes of the research with the knowledge of previous research. Streubert and Carpenter indicate that the purpose of reviewing the literature may be useful in focusing the study; however, the aim is not necessarily to “establish grounds for the study or to suggest a theoretical or conceptual framework” (1995, p. 21). Berg (1998), Field and Morse (1985), and Holloway and Wheeler (1996) suggest that a review of the literature is required to establish a comprehensive overview of previous studies of the topic in question. This will allow the topic studied to be seen in relation to previous works of a similar nature. The researcher then has the opportunity to determine whether any problems were experienced in these other studies, the limitations of the research, and whether the study can be generalized to other areas or countries. The literature can also be seen to add to the value of the research as another data source, supporting the data, or allowing debate to develop in relation to the previous findings (Holloway & Wheeler). The literature is not a directive for the researcher and should only be used selectively, allowing the researcher to remain open and informed (Berg, 1998).

Literature Search

Literature was reviewed by using the available electronic databases. An initial search was carried out to see what New Zealand literature was available. There proved to be very little literature on registered nurses working with care assistants in the public hospital setting, the only literature located being anecdotal. However, there was a considerable amount of international research associated with this topic. This international research was included when it was relevant to the New Zealand context.

Traditionally, New Zealand registered nurses have always had some form of support worker to help them, and various titles have been used for these unregulated support workers. The international literature, most coming from United States of America (USA), United Kingdom (UK), and Australian sources, can frequently be related to the New Zealand public hospital setting. Issues from the literature included changing trends and the use of care assistants, the lack of clarity of the care assistant's role, registered nurses' attitudes towards care assistants, discussion on basic nursing care and non-nursing functions, issues raised with the delegation and supervision of care assistants, and the legal responsibilities of working with this unregulated group. Care assistants have various levels of training not only in different countries but also in different organisations. The skill mix in these other countries as portrayed in some of the literature cannot therefore be directly associated with the registered nurses experiences with care assistants at the regional hospital described in this study. As a result, I have restricted the literature reviewed to those with similar training, roles and positions as the New Zealand setting.

The literature

As previously mentioned, no New Zealand nursing research was located on the topic of registered nurses working with care assistants in the public hospital setting. A review of the New Zealand literature revealed only anecdotal articles relating to registered nurse experiences of working with care assistants (Dransfield & Bland, 1997; Gunn, 1997; Ministry of Health, 1999). Following discussion between Nurse Educators, the New Zealand College of Nurses, and Nursing Council of New Zealand, the New Zealand Ministry of Health (1999) presented a discussion paper. The paper offered a research-based discussion on information from literature emphasizing the principles of safe

practice necessary for registered nurses to ensure patient safety when working with care assistants. In an attempt to clarify those issues of supervision and delegation not defined in the Nurses Act (1977), the Nursing Council of New Zealand (1999b) have published a position paper offering guidelines for registered nurses. The 1977 Nurses Act only distinguishes between registered nurses, midwives and enrolled nurses, and it does not specify any other type of health care worker. The Nursing Council of New Zealand (1999b) recently published guidelines for supervision and direction following submissions from their discussion papers. The Nursing Council's document clearly demonstrates the supervision and direction roles of the registered nurse.

Where health service assistants are employed, or the client's family are assisting with the care of the client/patient/woman, and the registered nurse or midwife accepts responsibility for the supervision and/or delegation of that care, criteria for direction and supervision apply and accountability for nursing processes and outcomes remains (1999b, p. 2).

The Nursing Council of New Zealand (2000b) presented a document with a focus from a nursing perspective of the second-level health worker of the future. Until recently, the enrolled nurse has been seen to be the second-level nurse (Brownie, 1993). With the introduction of the care assistant there has been some confusion about the title, second-level nurse. This has occurred due to a reduction in the employment of enrolled nurses and an increase in the numbers of care assistants. Therefore the question arose whether the care assistant was a third-level nurse. This document was presented to promote discussion on the possible scope of practice and the future programme development of this support worker. Since the presentation of the 2000 paper, another discussion document has been released to develop competencies for the new second-level nurse (Ministry of Health, 2001a). The Minister of Health has indicated that the new second level nurse will again be called an 'enrolled nurse'. The Nursing Council of New Zealand has also recently approved competencies, and will guide further development regarding the re-implementation of the enrolled-nurse programme (Ministry of Health, 2001b).

Indications in international literature are similar to those in of New Zealand, showing marked increases in the use of care assistants. This literature included empirical works on the use and impact of unlicensed assistive personnel (care assistants) on the delivery of patient care (Blegen, Gardner & McCloskey, 1992; Huston, 1996; Krainovich-Miller et al., 1997; Salmond, 1995). A considerable number of studies were carried out as a result of changes to existing health services and ensuing health reforms to meet the fiscal constraints being imposed internationally on health services (Hansten & Washburn, 1996; Huston, 1996; Krainovich-Miller et al.; Salmond). In many health organisations this has resulted in a reduction of the number of registered nurses within a health service. This was achieved through a process of restructuring within these organisations, often followed by an increase in the number of inexperienced and minimally trained health-care assistants (Blegen et al.; Cavanagh & Bamford, 1997; Hansten & Washburn; Huston; Krainovich-Miller et al.; Krapohl & Larson, 1996; McLaughlin, Barter, Thomas, Rix, Coulter, & Chadderton, 2000; McLaughlin, Thomas, & Barter, 1995; Orne et al., 1998; Salmond).

Issues And Themes From The Literature

Changing trends and the use of care assistants

In an American review of the literature, Cavanagh and Bamford (1997) discuss how hospital administrators, as a consequence of competitive market practices, offer alternative ways to deliver care by exploring the registered nurses' roles and responsibilities to ascertain whether indeed they are needed. This has resulted in the investigation and exploration of alternative ways of producing cost-efficient and effective delivery of health care; the outcome being the introduction of care assistants to the health care arena. In many cases less staff, especially registered nurses, are being employed. This is supported by Huston's (1996) article that evaluates whether the use of care assistants is motivated by an economic-driven response evidenced by the increased use of these workers in the health delivery service and the gradual decrease of registered nurses overall. The literature certainly appears to direct one to believe that a shortage of registered nurses in the late 80s and early 90s may have been part of the initial trend towards the use of care assistants. The changes from hospital-based education to tertiary education for nurses have also influenced this trend, both nationally and internationally.

Since then the process of restructuring to incorporate care assistants into the skill mix has gathered momentum as fiscal constraints continue to be a factor almost guaranteeing these workers a permanent place in the health care delivery structure.

A number of issues were raised international literature, with the American authors Krapohl and Larson (1996) and Huston (1996) having completed major reviews of the literature on the impact of care assistants on health care delivery. In an exploratory study, Barter, McLaughlin and Thomas (1997) stated that all respondents of their research identified major changes as a result of restructuring, indicating care assistants with little experience and non-standardised training were being introduced to practice settings where patients require increased levels of nursing care.

The results of a review of the literature by Krainovich-Miller et al., (1997) support the view that there has been a reduction in the numbers of registered nurses, which in turn has further reduced the time spent with patients and families. This resulted in less time to devote to education, to the provision of basic nursing care, and to documentation. Added to this is a concern for patient safety. Overall indications are that there are fewer registered nurses to care for more patients with complex health problems, and that care assistants are being used more frequently. This review of the literature revealed no conclusive evidence regarding the benefits of using care assistants.

The care assistant role requires clarification

The Nursing Council of New Zealand's 2000 discussion document states, "A non-nursing care assistant role has developed in all settings. This health care assistant role varies between assisting with ward maintenance activities and assisting the registered nurse with various nursing care activities either with direct or indirect supervision" (2000b, p. 3). The New Zealand Nurses Organisation (NZNO) provided guidelines for nurses working with support workers. These guidelines provide the following definition:

An unregulated caregiver is a person who provides help to health or disability consumers while they are receiving treatment or services. The help that caregivers provide varies widely but usually includes assistance with activities of

daily living, and simple aspects of treatment or service... But they could legally provide most nursing services which are not licensed (1998, p. 1).

In New Zealand, Dransfield and Bland (1997) and Manchester (1997) wrote of the preparation and introduction of care assistants into public hospitals. Their role was to relieve registered nurses of non-nursing activities, allowing them more time to spend with patients and in clinical practice. The role of care assistants differed with some employed to perform basic nursing care while the others were restricted to non-nursing activities (Dransfield & Bland; Manchester).

A pilot project carried out by Neidlinger, Bostrom, Stricker, Hild, and Qing Zhang (1993) evaluated the effect of incorporating care assistants in an existing nursing model of practice. Findings from this study suggested that problems were less likely to occur in this working relationship of registered nurse and care assistant if the care assistant role was clearly defined. Care assistants require time to learn their role and registered nurses to learn to trust. Equally, in a descriptive study Reeve (1994) used a questionnaire to address registered nurse perceptions of their knowledge base and attitudes towards care assistants. Findings indicated that registered nurses have poor knowledge of care assistant issues, which results in them being used inappropriately. There was uncertainty in the roles and the capabilities of these workers from the registered nurses' perspective. There are also indications that registered nurses were concerned with the competence level and lack of initiative these care assistants displayed (Huber, Blegen & McCloskey, 1994; Malby, 1990). In their survey Huber et al., offered evidence that some registered nurses believed that anyone could become a care assistant.

Salmond (1995), in a descriptive research project, indicated there was a lack of care assistant role clarity and ineffective training. Also supported in the literature is that registered nurses were ill prepared to work with this group (Huber et al., 1994; Salmond, 1995). Often there were deficiencies in the structures to support nursing care delivery models and a need to have evaluation systems in place. In a study by Reeve (1994), implications were that registered nurses do not spend a higher proportion of their time on patient-centred care when care assistants are present. Registered nurses did not have confidence in the care assistants' abilities. This often resulted in them doing the work

because it had either not been done or completed by the care assistant. At times, the registered nurses felt that in the interests of patient safety it was better to do it themselves (Orne et al., 1998). Barter et al., (1997) support these findings saying that registered nurses reported that they do not have more time to practise nursing activities because they are too busy supervising care assistants; adding to their already busy workload, as they were now checking to see the care assistant had safely completed the activity they were assigned. Salmond (1995), in support of this, reported that registered nurses thought their workload had actually increased when working with care assistants, whereas in their study, Bernreuter and Cardona (1997) were unable to establish whether the workload of registered nurses had increased or decreased since the introduction of care assistants.

Attitudes towards care assistants

The introduction of care assistants to the regional hospital whose staff were involved in this study was at a time of restructuring that resulted in changes to staff mix. This was a challenging time for all health professionals (Dransfield & Bland, 1997). Although the timing of the introduction of care assistants in other countries may have differed, the local negativity towards them was supported in international literature (Huber, et al., 1994; Malby, 1990; Orne et al., 1998).

While there were indications in the literature that registered nurses believed they needed the support of care assistants in the work place, there was a general feeling of reluctance to accept these support workers due to fear and uncertainty in the registered nurse's own role (Huber, et al., 1994; Orne et al., 1998). Registered nurse reactions to the use of care assistants were included in an American review by Krainovich-Miller et al. (1997). They indicated that the response from registered nurses was less than supportive towards care assistants, as did Huber et al., (1994), when they spoke of registered nurses being uncertain and fearful of care assistants. In a phenomenological study by Orne et al., concerns were expressed by registered nurses working in relationship with care assistants as the introduction of care assistants to acute care areas created numerous problems. They reported the majority of registered nurses were resentful and frustrated, which caused conflict and confusion as they endeavoured to maintain a safe environment for patients. Care assistants were often viewed as "inexperienced and sometimes dangerously

inept” (Orne et al., 1998, p. 109), with few registered nurses viewing their experience working with them in a positive light. In contrast, Reeve (1994) in a descriptive study based in the UK, discovered that most registered nurses had a positive attitude towards care assistants, even though their knowledge of the care assistant role was limited. This finding may have reflected difficulty in the analysis of the survey as more participants gave incorrect responses than correct ones.

Basic nursing care and non-nursing functions

A number of authors including Davis and Farrell (1995), Blegen et al., (1992), Dewar and Clark (1992) and Chang (1995) refer to the term ‘non-nursing’ activities. Together with this is the term ‘basic nursing care’ and both these terms are frequently used without reference to their meaning. The terms non-nursing and basic nursing care are ill defined and could describe many activities, including certain patient cares such as showering, dressing or feeding. Non-nursing activities, therefore, can include basic nursing care/activities. When reference is made to these terms, they should be clearly defined and understood.

A New Zealand project by Walton (1989) also discussed the term ‘basic nursing care’ and ‘non-nursing’. References were made to non-nursing functions, which for reasons that are not entirely clear can represent both non-nursing and basic nursing care. Walton’s research proposed “nurses see basic nursing care as meeting client’s needs, physical and psychosocial; comfort measures; assistance with daily activities; and technical interventions such as dressings, recordings, and the administration of drugs” (1989, p. 29). Walton’s research indicated that work that was not basic nursing care was non-nursing care. Walton went on to suggest that that the largest percentage of non-nursing care was in the area of housekeeping and clerical activities. However, findings also indicated that high technical activities and basic nursing care were also included in this category. Blegen et al., (1992) refer to non-nursing activities in conjunction with these being part of the care assistant role, allowing registered nurses the opportunity to do clinical patient-related care.

Although Dewar and Clark did not attempt to define the term non-nursing there was reference to housekeeping in conjunction with non-nursing activities. However,

according to Dewar and Clark (1992) one problem that appeared in the literature is the reluctance of registered nurses to assign these activities to care assistants. Doing these simple activities was often seen as stress relievers for registered nurses. There was no literature to support this claim, therefore some thought should be given to why registered nurses have retained these activities.

In an article in 1991 Gardner discussed non-nursing activities related to registered nurse and care-assistant practices. Gardner's article also raised the question of what constituted non-nursing and nursing activities. Although not clearly defined it was stated, "The most frequent non-nursing functions identified related to pharmacy, housekeeping and transportation" (1991, p. 42). It was reported that a list of non-nursing functions was to be eliminated from registered nurses' practice, allowing them to practice in accordance with the patient level of need.

A study from Hong Kong by Chang (1995), where the health care and hospital system are based on the UK system, show them facing similar challenges with the introduction of care assistants. This research supports the major non-nursing functions as being housekeeping, clerical activities and transport. Hayes (1994) suggested that non-nursing functions are an issue for registered nurses. Inexperienced registered nurses wanted to omit non-nursing activities, preferring to do what they described as professional nursing activities. Hayes (1994, p. 121) defines non-nursing functions as "non-clinical activities often performed by RNs [registered nurses] that should or could be performed by support service staff or NAs [nurses' aides]".

Delegation and Supervision

Registered nurses have been made responsible for organising the work of the care assistant and in many cases this is the supervision of and delegation to the care assistant of what had previously been nursing activities. It becomes apparent from the literature that education plays an important part in the registered nurse's role to delegate and supervise. Some authors (Hansten & Washburn, 1996; Orne et al., 1998; Thomas & Hume, 1998) agree that educational programmes have not prepared registered nurses in the skills of delegating activities to care assistants, as previously this group of unregulated workers did not exist. Research results indicated education in the skill of

delegation and supervision significantly improved registered nurses' ability to make competent delegation decisions (Bethel & Ridder, 1994; Krapohl & Larson, 1996; Lengacher et al., 1993).

As previously mentioned, the New Zealand Ministry of Health (1999) recently released a document offering guidelines for nurses who delegate and supervise health care assistants. The Nursing Council of New Zealand closely followed this document by presenting a position paper recommending these Ministry of Health guidelines. The regional hospital also provided a nursing policy outlining the process for registered nurses to follow when delegating direct patient care related activities to care assistants when they were first introduced.

Generally, the literature indicated a scarcity of research in the area regarding delegation of activities by registered nurses, with deficits in delegation technique and curricula requirements. In particular, an article by Jung (1991) considers that registered nurses are skilled as individual practitioners, and therefore have little or no need to delegate activities, although there appeared to be no other evidence to support this claim. Regardless of Jung's claim, there is still a requirement for nurses to be competent in the skill of delegation and supervision, especially as care assistant numbers grow to cope with the increasing cost containment in health-care delivery systems. Registered nurses now find themselves delegating to unregulated staff. Supporting literature was presented by Bethel and Ridder (1994), Crawley, Marshall and Till (1993), and Lengacher et al., (1993), who also claim that registered nurses have in the past mainly delegated only to other registered nurses.

Krapohl and Larson (1996), in a review of the literature describing the use and evaluation of care assistants, reported there were major concerns as registered nurses required extra preparation in delegating and supervision when working with care assistants. Davis and Farrell (1995), Dewar and Clark (1992), Gardner (1991), Hansten and Washburn (1996), and Jung (1991) all argue that registered nurses are ill prepared in the skills of delegation and supervision. Thomas and Hume (1998), in a USA research study, questioned how well prepared registered nurse graduates were to delegate. Their findings supported the argument that registered nurse education has deficits when it

comes to teaching delegation and supervision. This is evidenced with registered nurses at undergraduate level being inadequately prepared to delegate both effectively and efficiently. Huston (1996) has suggested that even with education registered nurses sometimes still feel uncomfortable about delegating to unregulated support workers (care assistants) due to the legal obligations of delegation and the ill-defined role of the care assistant. Huston claims there is a strong indication that “registered nurses who are asked to assume the role of supervisor and delegate need preparation to assume these leadership tasks” (1996, p. 68). This is supported by Neidlinger et al., (1993), with this study suggesting registered nurses require more training to delegate to these workers appropriately.

An important issue was raised in a USA study conducted by Anthony, Standing and Hertz (2000), whose research found that when an activity was delegated to a care assistant there needed to be sufficient communication and supervision involving routine observation to contribute to a positive outcome. This was supported in an article by Parkman (1996), who discusses the following issues on delegating safely, and suggests the need for clear communication between nurses and the care assistant, at the same time establishing the care assistant’s ability to perform activities. Parkman states that delegation is “transferring responsibility for the performance of an activity...while retaining accountability for the outcome” (1996, p. 43). This was also supported by Barter et al., (1997); however, they not only determined that care assistants often had limited ability to perform delegated activities competently, but that there were also limitations in their ability to communicate relevant information to registered nurses.

The presence of care assistants did not necessarily indicate that registered nurses were able to spend more time with patients and on professional nursing activities. Registered nurses’ ability to delegate needs to be addressed, as Barter et al., (1997) suggested there were times when the care assistant’s limited ability resulted in the delegated assignment not being performed competently. Registered nurses’ differences in expectations of care assistants’ practice varied between units. This supported the idea that registered nurses should have access to care assistant records of achievement of competencies on a database where care assistant assignments should be based on skill level.

It is interesting to note that the study of Orne et al., (1998) indicated that registered nurses had not addressed any of these problems of delegation and supervision with management. To add to these problems is a lack of standardization of the care assistant role/job description where these limitations needing definition. At present the absence of definition and limitations to their role is causing ambiguity, ambivalence, and frustration among registered nurses.

Boucher (1998), in an American article, discusses how the compromising of patient safety becomes an issue when delegation and supervision are inappropriate. Delegation of activities varies depending on the care assistant job description and, in many cases, on unit expectations. Boucher suggests that registered nurses must remember care assistants are not trained to be critical thinkers and therefore may not notice those subtle clues to a patient's condition that a registered nurse would observe. There are indications in this article that as the number of care assistants increases in the workplace there is an expectation that they will do more nursing care. Meanwhile, registered nurses' numbers decrease as more care assistants are employed to maintain economic outcomes. Anthony et al., (2000) offer similar support to this inference.

Legal responsibilities

As registered nurses adjust to the changes within the public hospital setting they often find it challenging when they are working with care assistants. While they have a responsibility to be aware of their legal obligations when working with this group of unlicensed care assistants, some of the literature suggested that this was not always so.

An area of concern discussed in the national and international literature by Hansten and Washburn (1996), Jung (1991) and Ministry of Health (1999) was that of accountability and responsibility for the actions of the health care assistant if they were completing activities delegated to them by the registered nurse. In relation to this is the realisation by registered nurses that they are ultimately responsible for any error of judgement made by these care assistants. With this in mind both Gardner (1991) and Malby (1990) support the notion that if registered nurses are to maintain a high standard of patient care they should have more control over issues related to their practice and therefore contribute to determining staff skill mix in their practice setting.

Barter and Furmidge (1994) discussed some of the legal issues relating to standards of practice for registered nurses, with an emphasis on delegation and supervision of the unlicensed care assistant. They point out that delegating nursing care remains clearly within the scope of nursing practice. If registered nurses are not taught to delegate and supervise care assistants to an acceptable standard of competence they may place themselves in a very precarious position indeed. In their study Barter and Furmidge state that the legal implications are that “the registered nurse is not being held liable for the negligent act of her subordinate, but for her lack of competence in performing the independent duties of delegation and supervision” (1994, p. 37).

Elliott (1995) reported in a Canadian study that although registered nurses have a legal responsibility to delegate and supervise support workers (care assistants) there was uncertainty that this was in fact their responsibility. This uncertainty by registered nurses could well be associated with the idea that “perhaps the link between directing/delegating and supervising is not well understood by registered nurses” (1995, p. 60). If this is so, it raises questions regarding education of registered nurses not only for now but also for the future.

Many issues are raised in the literature, of which registered nurses need to be aware, regarding the care assistant role due to the unregulated nature of these workers. There were indications that registered nurses lacked knowledge or understanding of their regulations and practice standards, along with a lack of awareness when it came to their organization policy requirements and expectations both of registered nurses and of care assistants.

Summary

The literature raises professional issues for registered nurses, and the lack of literature from New Zealand researchers is surely a concern in the light of the rapidly growing number of care assistants being employed in the health sector. It is important to note that there was no literature available of research having been completed on this topic in New

Zealand. The available non-New Zealand literature, however, is applicable to the New Zealand setting, as local nursing follows similar trends to those of international nursing.

The literature presents some issues for registered nurses when they are working with care assistants. There are issues surrounding the way that care assistants are utilised in the workplace. A review of the literature established that not only are care assistants employed differently in a given hospital setting but that the activities they perform vary considerably from unit to unit. This variation in the way care assistants are employed and utilised also contributes to the confusion about their role, which is exacerbated by having no standardised training programme for care assistants both nationally or internationally. Claims that registered nurses have found it difficult to establish exactly what the care assistant limitations were are substantiated in the literature. There is no conclusive evidence to justify the notion that the use of care assistants allows registered nurses more time to spend in clinical practice, in fact the literature suggested quite the contrary, as registered nurses often found they spent more time involved in supervising the activity they had delegated.

Attitudes towards care assistants varied from one setting to another, with some studies arguing they found registered nurses quite positive about the inclusion of care assistants in the staff mix, while others had negative experiences and attributed these to the lack of certainty surrounding the care assistant role, which in turn led to frustration of role expectations. The literature suggested this frustration was more often than not attributed to the belief that registered nurses should retain certain nursing activities. Basic nursing care and non-nursing were terms frequently used in the literature; both having different meanings within a setting. These terms were not often defined in the literature, which ultimately complicated the registered nurses' decision when it came to which activities care assistants should perform.

An important issue that became apparent in the literature was that of delegation and supervision. The importance of this issue became clearer as it became obvious that registered nurses in many instances had not before delegated activities to care assistants. There was evidence from some of the literature to suggest that delegating to an unregulated care assistant with minimal training was quite different from delegating to a

registered nurse. The implications of this procedure were also fraught with problems as the literature indicated that some registered nurses were not really fully aware of the legalities that governed them nor the policy of the organisation that employed them. Overall, the issues present in the literature when registered nurses work with care assistants are similar both nationally and internationally.

CHAPTER THREE

Research Design And Method

Introduction

This chapter will provide an account of the research process used in this qualitative descriptive study that has explored registered nurses' experiences of working with care assistants in a public hospital setting. Semi-structured interviews were the method of data collection, and this textual data was analysed using thematic content analysis as outlined by Burnard (1991). Issues relating to the selection of participants, the management of ethical considerations, and the reliability and validity of the research method will be discussed.

Qualitative research

The choice of a qualitative research design was influenced by the desire to explore a nursing practice issue from the experience of individual nurses. Qualitative research methods can be used to explore the lived experience of participants while focusing on the individual's unique life situation. Recognising humans as complex beings, with their own experiences and realities allows the researcher to make sense of the individual's perspective (Burnard, 1991; Clarke, 1995; Field & Morse, 1985; Hek, Judd & Moule, 1996; Oiler Boyd, 1993). The qualitative researcher works from the belief that individuals are able to express their reality subjectively as they perceive it, and it is this that is shared with the researcher. In this way qualitative research methods are useful for exploring phenomena from an emic perspective, making it appropriate to use for this research study. Holloway and Wheeler (1996) suggest the advantages of doing qualitative research lie in its explanatory strengths and the researcher's close proximity to the data. This by far outweighs the main disadvantage, being that the process of qualitative research is quite time consuming.

Qualitative research and nursing

Many qualitative methods were originally derived from the disciplines of sociology, philosophy and anthropology (Berg, 1998; Field & Morse, 1985; Oiler Boyd, 1993; Streubert & Carpenter, 1995). Nurse theorists have since developed some of these

methods, focusing on nursing ontology (LoBiondo-Wood & Haber, 1994; Field & Morse; Holloway & Wheeler, 1996). The purposes of qualitative research methods include description, explanation and interpretation and/or the development of theory, to help nursing understand what is happening in a specific situation or environment. The purpose of this study is description, as there is little previous New Zealand research or literature on which to build.

Research Design

Approval process

The Massey University Human Ethics Committee and the regional Health Funding Authority Ethics Committee approved this study. The researcher also obtained written approval for the study from the Chief Executive Officer of the Crown Health Enterprise where the participants were employed. A letter was then sent to the Charge Nurse/Unit Manager in each clinical setting informing them about the study. This letter also requested they display the flyers (Appendix 1) and information sheets (Appendix 2) in their unit staff rooms. If they felt uncomfortable with this request or did not approve, they could either contact the researcher or dispose of the information.

Participants

Morse (1991, p. 129) suggests that in qualitative research sampling is purposive and the participants are “those who have undergone the experience and whose description is considered typical”. The purposive sample can be described as those who have knowledge or expertise and are representative of the population to be studied (Berg, 1998; Field & Morse, 1985). Therefore, in this study the required participants were those who were registered nurses who had worked in a specific hospital with care assistants at some time since their introduction to the organisation in the mid 1990s. Participants were either working with care assistants at the time of the interview, or had previously worked with them for shorter periods of time. Some participants were no longer working with them. Part of the reason for this variation was due to the length of time the registered nurse had been practising. The registered nurses’ area of clinical practice varied, with participants working in different clinical areas from one another.

According to Holloway and Wheeler (1996) and Field and Morse (1985) there are no constraints on the size of the sample group in a qualitative study. However, if the sample are a homogeneous group, indications are that it is acceptable to have a smaller sample. Homogeneous groups are described by Holloway and Wheeler and LoBiondo-Wood and Haber (1994) as groups with similar characteristics or belonging to a subculture. In this study, the sample of registered nurses would be classed as a homogeneous group, as although they had practised for varying lengths of time and in different clinical areas, they were all working in the same hospital, within the same policy guidelines, and with care assistants who had all completed the same training.

Field and Morse (1985) suggest it is often difficult to predict the final number of participants in the sample before the research is begun as generally data are collected until no further new information is forthcoming. Eight registered nurses participated in this study, which appeared to be sufficient as the interviews no longer generated any substantial new information. Therefore, no further advertising for participants was required.

Recruiting Participants

Flyers were also distributed around the hospital in public areas and it was hoped that potential participants would see and read them. An advertisement was to be published in the staff newsletter; however, due to unforeseen circumstances, the article was not published as planned. The researcher was reliant on the flyers and information leaflets.

It was anticipated that some participants would respond to the study advertisements and some might also be obtained by informal snowballing. Snowballing or networking is a technique “based on the assumption that people with like characteristics, behaviours or interests form associations” (Hek et al., 1996, p. 72). If snowballing occurred, then those potential participants could contact the researcher for further information. One participant was recruited via informal snowballing after hearing about the study from another participant.

The interested potential participants were to make contact with the researcher by phone after reading the flyers and information leaflets. Within the first week of the flyers and

information leaflets being distributed there were two responses from potential participants. It took a further 3 months to obtain a total of eight participants. When each participant contacted the researcher they were given the opportunity to ask further questions regarding their involvement in the study.

Informed consent

Potential participants were then sent the information sheet to read and were told the researcher would contact them within several days to see if they still wished to participate in the study. A date, time and a venue was then arranged to suit the participant to meet the researcher and gain the participant's written, informed consent. This was to be obtained in a manner that did not make the potential participant feel coerced in any way. The participants were also informed at this time that if the researcher had additional questions or needed further clarification she might contact them and that the process of validating the data analysis might also include an additional interview, if the participant agreed. The participant's consent was also requested verbally before the start of any additional interview.

Informed consent was obtained once the participants had been advised of the purpose of the study and of their rights as voluntary participants. This information was included in the information sheet (Appendix 2). Participants were given written and verbal explanations of the process of data collection, including that the audio-taped interviews would be approximately 1 hour. They were informed that they could request the recording be stopped during an interview or could refuse to answer particular questions. Participants had the right to withdraw from the study and therefore withdraw their information at any time before returning the final transcript to the researcher. Written, informed consent was obtained from all participants (Appendix 3).

Confidentiality and Anonymity

Confidentiality was assured and anonymity maintained by removing any personally identifiable information from the data. Participants were given the opportunity to select a pseudonym before the interview began. The written consent form was stored separately from the audio tapes and transcriptions.

The typist signed a confidentiality contract (Appendix 4). As soon as the interviews had been transcribed, the researcher removed all identifying features, and pseudonyms were inserted where appropriate. Data from the interviews were kept in a locked secure cupboard and, following transcription, were only accessed by the use of a password on the researcher's personal computer. Audio tapes of the interviews will either be erased or destroyed at participant's request or given to them to dispose of after the thesis has been examined (Tolich & Davidson, 1999).

Safeguarding participants from risk

It was important that the participants could not be identified by their employer, and this possibility was minimized by the researcher never contacting the participants at their workplace. To the researcher's knowledge no staff member was aware that the participants were involved in the study unless the participants themselves divulged this information. Interviews were not carried out on the institution's premises nor during the participant's working hours.

Prevention of risk to the participant needs was taken into consideration as Munhall (1993) suggested gathering data might evoke unpleasant responses in some situations. The researcher was prepared in the unlikely event of this situation occurring to offer support to the participant if appropriate or refer them to a professional agency such as an employee assistance programme offered by the institution. Fortunately, this was never an issue.

It is recognised that there can be some benefits to individuals participating in a qualitative research study (Munhall, 1993). Through the process of interviews and data gathering trust was established between researcher and participant. Establishing trust was a process that started when contact was made by the potential participant through phone conversations and with informal conversation before interviews began. The fact that the researcher was a registered nurse, together with the researcher's sensitivity and responsiveness to the participants' questions contributed to establishing credibility and trust. Once this was established, participants were given the opportunity to verbalize and share their experiences, which could result in their developing a sense of satisfaction knowing that their experiences would help to inform nursing practice.

As a registered nurse and a researcher involved in researching nurses, consideration was given to the issue of a participant disclosing unsafe or illegal practice. It was planned that disclosure of a serious nature would be discussed with the research supervisor and the Chairperson of the Massey University Human Ethics Committee. It was also considered that the researcher has a professional responsibility and might be required to report the incident to the Nursing Council of New Zealand. Participants did not disclose any information of this nature.

Interview Format And Data Collection:

Data collection took place during an audio taped semi-structured interview between participant and researcher of approximately 1 hour's duration. Later the researcher phoned all the participants and arranged a time to ask them a few further questions about issues raised and also as confirmation of the data analysis to date. This involved asking participants for their verbal consent again and arranging a time that suited them. One participant could not be contacted for a second interview.

Burnard (1995, p. 461) suggests that qualitative research methods are being used more frequently to explore nursing issues and considers that "such methods involve the use of unstructured or semi-structured interviews". Semi-structured interviews involve the use of a small number of set questions or prompts, with most of the interview developing around an exploration of the participant's experience. The set questions, if used at all, do not have to be asked in any particular order, allowing participants to talk about their experience from their own perspective. The semi-structured interview format was the chosen data collection method in this study because the researcher had some knowledge of the subject but did not know the views of the participants. Barriball and While (1994) state that semi-structured interviews "are well suited for the exploration of the perceptions and opinions of respondents regarding complex and sometimes sensitive issues and enable probing for more information and clarification of answers" (p. 330).

Example: Questions and prompts

1. I'd like you to think back to when you first started working with care assistants and give me an example of what this was like for you ...Can you elaborate?
2. Are you able to describe any changes to your role as a registered nurse when working with care assistants? ...Can you tell me more?

The participants were asked questions and prompts were used as necessary, as shown in the example. These questions gave the participant the opportunity to describe or explain their experience. At the beginning of the first interview participants were initially asked a little about themselves. This was to give the researcher an idea of the length of time they had been practising, their overall experience of working with care assistants, and their nursing education. This discussion was also used to help the participant relax and to help establish rapport between the participant and the researcher. Participants were also asked if they agreed to the researcher jotting down notes as a reminder of questions or topics they alluded to during the interview. This was done so as not to interrupt them during conversation.

Field notes are a reflection of what the researcher experiences during the interview that can be used to identify ideas and supplement the taped interview (Field & Morse 1985). Field notes were written from the notes that the researcher had taken following the interviews. These gave the researcher the opportunity to write objectively in more detail the events that took place during the interview, and about the observations, interactions and descriptions of events as they occurred. The following examples are from three participants' field notes.

Examples of Field notes.

1. Once the interview started she was nervous and still unsure about confidentiality. I reassured her and spoke about ethical requirements, etc., and off we went again. She started to talk about specific incidents and then asked me to turn off the tape. We then discussed confidentiality and I explained that any identifying words, etc., would be removed. She then became more relaxed and then spoke freely about her experiences.
2. Transcripts were done and I noticed almost immediately that early on in the interview I had missed the cue to ask about losing registration, although I had noted it down during the interview to remind myself to ask later, which I eventually did.
3. The atmosphere in her home was relaxed, an oil burner was going. The participant became more relaxed as the interview continued. I tried to listen carefully and pick up on the cues. I was conscious of trying not to lead the participant and trying to be a researcher and not a nurse. The interview went well.

Following each interview the audio tapes were transcribed. When transcripts were returned from the typist the transcript was read while listening to the audio tape to ensure that it had been accurately transcribed. Each transcript was numbered by line and page to assist in the analysis. These transcripts were then returned to the participant to read, allowing them the opportunity to examine or amend any portion and add anything to the discussion. The participants returned the transcripts indicating they were satisfied with them.

Data Analysis

Method of data analysis

Burnard's (1991) method of thematic content analysis was used in this study because this method is valuable when using data from semi-structured interviews. This method is

useful to explore nursing issues and produces a “detailed and systematic recording of the themes and issues addressed in the interviews” (Burnard, 1991, p. 461-462). The process of analysis is systematic: the researcher works through each of the 14 stages, making the links between the themes and the data under a category system. Burnard developed this form of analysis “from Glaser and Strauss’ ‘grounded theory’ approach and from various works on content analysis” (Burnard, p. 461). There are therefore components both of grounded theory, especially constant comparative analysis, and of content analysis within the method of thematic content analysis.

Grounded theory is a qualitative research method that is mainly inductive in nature, incorporating a systematic approach to generating theory regarding social processes (Clarke, 1995; LoBiondo-Wood & Haber, 1994; Skodel-Wilson, 1993). Content analysis is a method that can be employed alone or in conjunction with other methods (Downe-Wamboldt, 1992; Massey, 1995). Berg (1998) indicates that data are not adaptable to analysis “until the information they convey has been condensed and made systematically comparable. An objective coding scheme must be applied to the notes or data. This process is commonly called content analysis” (p. 223). Burnard has combined these methods to develop a coding system, the aim of which is the development of themes. Components of thematic analysis are also present.

According to Morse and Field (1995), analysis of the data in thematic analysis involves searching for and identifying common threads or themes that are present throughout the transcripts. At times these themes are obvious, but they can also be quite obscure and difficult to unearth, and here the researcher is required to stand back and observe the data from an inquiring perspective. It is often then that the underlying themes common throughout the data become apparent. Morse and Field stated, “Once identified, the themes appear to be significant concepts that link substantial portions of the interviews together” (p.140). DeSantis and Noel Ugarriza (2000) defined the term theme after a review of the literature. “A theme is an abstract entity that brings meaning and identity to a recurrent experience and its variant manifestations. As such, a theme captures and unifies the nature or basis of the experience into a meaningful whole” (DeSantis & Noel Ugarriza, p. 362).

Thematic analysis is described by Boytzis (1998, p. 5). as “enabling scholars, observers, or practitioners to use a wide variety of types of information in a systematic manner that increases their accuracy or sensitivity in understanding and interpreting observations about people, events, situations, and organisations”. These definitions have similarities as all identify themes from the data as a result of systematic analysis, and are essentially concepts that link sections of the data together, bringing meaning and significance to recurring experiences or events. It must be mentioned that Burnard’s thematic content analysis is just one method of carrying out qualitative data analysis.

“Once the qualitative researcher has collected the data, he or she has, of necessity, to make sense of these data” (Burnard, 1995, p. 237). This method of analysing qualitative textual data progresses through fourteen stages. This involves a systematic process of organising, categorising and coding of textual data in identifying emerging themes.

Stage 1

This was the initial phase by the researcher of the analysis process. Following each interview, notes had been taken of how the interview had progressed and to remind the researcher of any issues that had occurred. At this time and throughout the analysis process the researcher also jotted down thoughts/memos to serve as reminders of ideas that might be useful later in the study (Burnard, 1991; Field & Morse, 1985).

Stage 2

Once each interview was transcribed the researcher was involved in reading and re-reading the data to become totally familiar with the data. During this process the researcher took notes/memos as a reminder of any issues or ideas that might recur during the analysis process. This process lets the researcher consider the possible outcomes as the researcher notices similarities to other sections of the data. These memos were used during the reading of the transcripts to enable the researcher to become more aware of the participants’ experience. At this time further notes were made that might have some importance to the themes, which helped the researcher become totally familiar with the data. The following example relates to interview three, 5th April, when it was noticed that the previous two participants had described the care assistant role differently.

Example of notes/memos

- Participants are describing the care assistants role differently: some say they do this, while others say they do other things
- It was becoming clear that care assistants had different roles in different clinical settings. This could be a category emerging 'care assistants' roles differ'.

Stage 3

The next stage involved the reading of the transcripts on a number of occasions by the researcher who was now becoming quite familiar with the data and at the same time questioning the data by asking, what is happening here? Why is this happening? Notes were again made and notes from the previous stage were utilised to examine the general themes in the transcripts. Immersion in the data continued to help the researcher become more aware of the participants' world. This was also the beginning of the reduction of the data to more manageable categories, which eventually become themes. This process was time-consuming and required sections of the text to be moved from the original transcripts to be viewed separately as part of the process that would eventually result in the development of themes. The process of reducing the transcripts into the development of categories and sub-categories continued. For example, the notes in the transcripts described how registered nurses were not really sure of the care assistant's role, as this appeared to be a major category and sub-categories related to this were also noted.

Transcripts were re-read with sub-categories and categories continuing to be generated by the researcher. This involved the removal of unusable 'fillers' that are present in interview data. Field and Morse (1985) referred to this, describing it as the removal of 'dross', which referred to the information that was irrelevant to the topic being discussed in the interview. Furthermore, they stress that the researcher should be aware of the value judgements they make, as the removal of dross is an exercise that relies wholly on the researcher's judgement.

Berg (1998) referred to ‘open coding’ of the transcripts, and this continued during the next stage of analysis. This method allowed categories to be freely generated, and was achieved by having the transcript in one column and the open coding in the opposite column. This process allowed the researcher to compare the original transcript with the coding process as dross or unnecessary data was reduced. This process allowed for the majority of the interview transcript to be retained.

Example of open coding

<i>Interview transcript (6:12)</i>	<i>Open Coding</i>
<p>Yeah, quite often as, as that, like, I still even though I have delegated tasks, I haven't actually taken my hands off the task, I still have to go back and oversee it. I feel responsible for the task and I will go back and check that it's done or that they know what they are doing and I check that they understand what the task is first.</p>	<ul style="list-style-type: none"> • Have delegated tasks to care assistant • Haven't taken my hands off the task • Go back and over see the task • Feels responsible for the task... • See if they have done task... • See that they know what they're doing... • See that they understand first

Stage 4

The list of sub-categories and categories were then grouped together by the researcher and the sub-categories further reduced. For example, the some registered nurses described how they were not really sure if the care assistants would perform the delegated tasks. This appeared to be a major category with related sub-categories.

Example of category and sub-categories.

<p><i>Category: Delegates and supervises</i></p> <p>Like, I still go back, even though I have delegated tasks, I haven't actually taken my hands off the task, I still go back and oversee it...I still feel responsible for the task, and I will go back and check that it's done or that they know what they're doing and check that they understand what the task is first.</p> <p>(6:12)</p>	<p><i>Sub-categories</i></p> <ul style="list-style-type: none">• I feel legally responsible...• I delegate tasks but still go back and oversee• I check if care assistant knows what they're doing...• Check to see if they understand the task first
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The researcher achieved this through a process that involved placing the data into similar groups. Repetitive labels were removed, enabling the reduction of the number of categories. This process continued with the collapsing of similar quotes into broader named categories.

Example of collapsing into one category.

- Some registered nurses feel responsible for tasks
- Registered nurses delegate, then oversee tasks
- First check they know what to do
- Check they understand the task
- **Registered nurses are responsible for delegating and supervising**

Stage 5.

This stage involved the researcher working through the categories and sub-categories to produce a final list. This list still contained a large number of categories and sub-categories.

Stage 6.

Burnard suggested that the aim of this next stage was an “attempt to enhance the validity of the categorising method and to guard against researcher bias” (1991, p. 463).

To achieve this, the researcher asked another researcher (the research supervisor) to generate category systems of three transcripts independently. These category systems were then compared with the researcher’s categories to see if there were similarities, then the lists of categories were discussed and adjustments were made as required. The validity of the categorising method is discussed in further detail under a separate heading in the following section.

Stage 7.

This phase involved re-reading the transcripts against the list of categories and sub-categories to ensure all aspects of the interviews were covered. As this stage of the process continued, the researcher made final adjustments, further reducing any similar categories and sub-categories until a final list was established.

Stage 9.

Copies of the transcripts were utilised for the researcher to maintain the context of the coded sections. As the process of analysing the data continued it became obvious that the researcher could not use all the available textual data. However, in the process of reduction, the core themes that emerged during data analysis could illuminate the participants' experience.

In a later article, Burnard (1995) discusses alternative ways of interpreting text, suggesting that to maintain the interviews in their original format would keep the data in context. This is not necessarily practical, and would deprive the researcher of the opportunity to interpret the textual meaning. Also, the aim of data analysis is, in this case, to expose the themes embedded in the data, which are context dependent. Sandelowski (1994) reiterates the importance of retaining the context of the data, and suggests that it is the participant's words that provide evidence of the experience; that verbatim extracts validate the researcher's data analysis.

Stage 10.

Having cut and pasted the sections on the computer, the data were placed under the appropriate categories and sub-categories. As suggested by Burnard (1991), original transcripts were also kept.

Stage 11.

Participants who had previously given consent were contacted to check whether the category system was appropriate. These participants were satisfied that this was appropriate, so adjustments were not required. This was necessary to check the validity of the categorising process. This is discussed in detail in the following section.

Stage 12.

During this stage the researcher is advised to file each section together to allow reference to these during the writing process. It was also necessary to keep copies of the original transcripts and the audio tapes accessible as these are often used during the writing up, should something be unclear.

Stages 13 and 14.

The final two stages of the analysis were the writing up the findings. One of Burnard's suggestions during this writing stage was to relate "the findings alongside references to the literature" (1991, p. 464). Throughout this stage the researcher had the opportunity to refer back to the full transcripts and audio tapes of the interviews thus enabling the researcher to retain the original context of the data.

Validity

Validity, at times referred to as trustworthiness, signifies to what extent the findings represent reality (Field & Morse, 1985; Holloway & Wheeler, 1996). During the process of analysis, consideration must be given to the question of validity. According to Burnard (1995), the search for validity in the analysis of the data is a contentious subject. Morse and Field (1995) and Burnard (1991) recommend processes to validate the researcher's category systems, and also suggest inviting other researchers or participants to assist in the validation of the categorisation process. Burnard (1991) indicated there were two possible methods to check validity. One of Burnard's methods of checking validity is to use a colleague who is familiar with the thematic content analysis process but who is not involved in the study. This person is asked to identify a category system in some of the transcripts and the resulting categories are then discussed and compared with the researcher's category system, to identify similarities between the two. This was achieved by asking another researcher (the research supervisor) as referred to in stage 6. Burnard considers that the outcome of this method is "that the agreement of two independent parties over the category system helps to suggest that the system has some internal validity" (1991, p. 465).

Burnard's (1991) other suggestion to further check validity involved some of the participants. Three of the participants were to be asked to check that their own quotes fitted into the developed categories to enhance the validity of this category system. These quotes from their transcripts were fitted into the categories offered by the researcher. The selected participants had agreed to take part in this process at the time of their first interview. Before the researcher sent them this information they were also given the opportunity to withdraw from this process if they wished. Three participants took part in this process and all three were satisfied that the categories were appropriate. The data

were sent to the participants and they posted the results back to the researcher. The participants did not find it necessary to make any changes, therefore indicating validity (Burnard, 1991). In a later article, Burnard (1995) presents the notion that aside from validating the data, researchers still have the ability to influence textual data during interpretation as they impose their “own perceptions of the text” (p. 236). As the text is that of the participants and represents their words, the researcher should retain the context of the interview throughout the analysis process and interpretation of the findings.

In a discussion on the rigour of qualitative research, Sandelowski indicates there are no standard rules for appraising validity. The question of trustworthiness is evidenced by the researcher’s practices which are “visible and therefore auditable” (1993, p. 2). Therefore, it is for the researcher to show how validity was achieved, thus practising what was proposed in the analysis method. It is important to acknowledge Sandelowski’s (1993) comments that no two researchers would produce the same results from one qualitative work. It is almost inevitable that there would be different philosophical and theoretical outcomes. The researcher has endeavoured to follow Burnard’s (1991) proposed measure of validity by utilising his methods, thereby maintaining consistency and adding to the validity of the study.

Summary

In this chapter the discussion has focused on the research method and the processes used to analyse the data. It has also included supporting references to clarify some of the issues associated with carrying out research. The method used to carry out the data collection through the format of audiotaped interviews was well suited to this exploration of participants’ experiences. Participant inclusion in the research has been guided by ethical considerations. The question of rigour has been discussed in conjunction with validity, and how this was achieved. The findings from analysis of the data are discussed in the following three data chapters.

Key to abbreviations of the data chapters

[....]	Indicates a section of the quote has been missed out
[name]	Indicates a name or setting etc., has been replaced to maintain confidentiality
...	Indicates a gap/pause in what the participant is saying
(name, 1:1)	Indicates participants' pseudonym, number of interview and page number of quote
Indent	Signifies quotes from the participants or researcher

CHAPTER FOUR

I'm Not Really Sure What Care Assistants Should Be Doing

Introduction

This theme '**I'm not really sure what care assistants should be doing**' evolved from the data. Participants saw the role of the care assistant as being ill defined and consequently felt that their own role as registered nurses was threatened by this lack of clarity. This was further complicated by the participants having their own idea of the type of assistance they required with their workload, which perhaps differed from that of management. Although hospital policy identified that care assistants do 'basic nursing care' there was an element of difficulty in accepting that care assistants could in fact do this. The title for this theme was derived from this participant who said that:

I think it's... sometimes, it needs to be more closely defined. Just exactly what they [care assistants] do and what they don't do. (Rose, 8:14).

The data analysis resulted in the following sub-themes that are interrelated with the theme:

(a) '**The roles got blurred**'. This was expressed by some of the participants and interlinked with the original theme through the uncertainty of roles. This was then further complicated as participants showed they had different expectations of care assistants.

(b) '**They should have a qualification**'. This interrelated with the idea that the participants preferred an enrolled nurse to work with, as they saw a need to have another staff member to help them with their work. Because care assistants have different abilities the participants stated there were some limitations about their suitability for their area of placement.

The theme illustrated in this chapter and its interrelatedness to the sub-themes are further influenced by underlying components that all overlap to some degree. The blurring of roles makes it more difficult for the registered nurse to define what the care assistant

should do. The clinical settings and the registered nurses' differing views of what care assistants do all interact on one another. This in turn influences registered nurses' ability to delegate tasks safely to care assistants, and they believe that if they had enrolled nurses these concerns would no longer be an issue.

The Roles Got Blurred

Some participants spoke of how there was no obvious delineation between their role and that of the care assistant. The following participant described this lack of clarity between the roles:

They are taking on responsibility that they shouldn't because nurses are busy doing other things, because we are short staffed, so roles become mixed and if the care assistant takes on too, too many of our roles then I think, um, she expects that she can do those tasks and the nurses, um, or the registered nurses do see the care assistant as helpful and feel that they can impart some of their responsibilities to her, knowing that she will do them and she is there to help, but are not actually themselves getting the care assistant to report back, just leaving her to it, going away and doing other things, and I think the roles got blurred (Anne, 1:22).

This is supported in an American study by Orne et al., (1998), who discussed the lack of clarity of roles, and discovered that registered nurses at times had unrealistic expectations of care assistants' responsibilities. Because care assistants observed registered nurses they consequently attempted to take on the responsibilities of registered nurses, believing they were as able as registered nurses. Salmond (1995) in an American research project discussed how care assistants were being used in the clinical setting and considers there is a lack of clarity, with neither group understanding the responsibilities assigned to each role.

Our expectations of care assistants differ

Registered nurses have different expectations of care assistants' and this was highlighted when participants were not consistent in what they perceived care assistants should be doing. This was also compounded with each clinical area using care assistants in different

ways. Each participant's experiences of working with care assistants was very much influenced by the clinical setting in which they and the care assistant were employed. The uncertainty of the care assistant's role was an issue for the participants as illustrated by Sara's expectations of a care assistant as she explains:

And sometimes they are sent by nurses to take a blood pressure and things like that, and that they can do.... They might have, yes, they have I think been taught to take a blood pressure, but as far as being able to, um, look at the results and, and, you know, they have to come running back to the nurse, the trained nurse and say, um, you know, 'This is what it is' rather than trying to interpret the results, which some of them do try and do, um. I find that that can be very dangerous. Well, it is dangerous (Sara, 4:6).

Sara had expectations about care assistants taking blood pressure, but their ability to interpret the results she saw as dangerous. It became evident that registered nurses allowed care assistants to do certain functions in one setting but not in another. There is concern that care assistants may not understand the rationale for doing observations. Chang and Lam (1998) supported this in a study from Hong Kong. They indicated that care assistants should not carry out activities requiring professional knowledge. This problem could well be related to the considerable difficulty participants had describing the care assistant role and the issues of inappropriate use of care assistants.

Mary said:

I mean how... how... what's their job description? How strict? [...] well in our ward there is only one, so her role has been defined by her own expectations of the role... and who the charge nurse and the nurses are in her ward, so she has basically moulded herself a role that mightn't necessarily, could be totally different from the care assistant in the next ward. Yeah, there is no one to compare her with... Yeah, and what our expectations of her are, too, maybe... (Mary, 3:16).

The job description and the expectation of the person in charge (charge nurse) of that area predetermined care assistant activities within the clinical area. This in turn

influenced registered nurses in their decisions to utilise them. This participant had no other care assistant to compare her with, resulting in acceptance of this care assistant's role as Mary explains:

I mean, maybe the girls in the ward that I am working never had those expectations that she do a bit more of the physical looking after the patient [...] I mean, I suppose I am contradicting myself because in some ways I expect her to do a lot more, and in the next breath I am reluctant to delegate, so I am contradicting myself... (Mary, 3:16).

Mary had mixed expectations of the care assistant role. Her reference to the care assistant doing more of the basic nursing care was possibly influenced by what care assistants did in other areas. However, Mary's lack of awareness of that role is supported by some of the other participants. There was a suggestion that other registered nurses in this clinical area were also unsure what care assistants were authorized to do. The pressure of work, as described by this participant, also influenced the care assistant role:

So, when we are wearing those hats we think it is great because someone else can come and take away from us consciously our basic nursing cares, so we can turn, turn a blind eye to that and go away, do those other things and, um, and I think we have lost, lost the idea of what the care assistant's role actually was and, um, we have lost what we were supposed, what we are supposed to be doing for them, providing them with supervision and support. We don't tend to do that as much as we should now (Anne, 1:23).

This supports the theme of participants not really understanding what care assistants should be doing. Registered nurses' expectations very much influence the tasks care assistants are assigned, and although they may be capable of performing given tasks, they are not trained to interpret an observation or analyse a possible outcome. These issues were also identified in a study of the perceived functions and use of care assistants from Hong Kong (Chang, 1995). The realisation also comes that not only are some registered nurses ill informed of the care assistants' role, but with time registered nurses have perhaps become a little complacent about their own role in this relationship.

One participant told how while she was taking a care assistant through some competency modules she discovered that some of the competencies they had achieved were not utilised at all by registered nurses in her clinical setting. Cassie explained that:

What's really interesting is that with these competencies work that they do, like they have modules on, say, one of them had to empty a catheter bag and I had to sign them off, but on the ward we never actually asked them ever to empty a catheter bag and where these people practise is actually more than we imagine it to be, and I think it's very interesting (Cassie, 6:4).

The use of care assistants should allow registered nurses the opportunity to focus on performing the professional activities of their practice, and this would allow care assistants to function within their role description (Chang, 1995; Salmond, 1995). Perhaps a lack of awareness of the training and required competency levels of care assistants has resulted in registered nurses having differing ideas of what care assistants should be allowed to do, as this participant continues to describe:

... it's only through [care assistant] modules I have actually realised what these care assistants are actually being taught to do, and we don't utilise them enough (Cassie, 6:7).

I think they have the potential to do a lot and with all those modules that they have been doing and, like, that was a surprise to me and I, and you've never actually been educated as to what a care assistant can do, what you tend to do is pick up the culture on the ward and see what they do normally and just copy that... (Cassie, 6:13).

...and you tend to just watch them and see what other people do and we have never actually sat down and said, 'Ok, this care assistant can do this for you'. (Cassie, 6:13).

It would appear that there was not only a lack of knowledge of the care assistants' competencies but that registered nurses did not accept that care assistants were competent to perform certain activities. This was also indicated in a US study by Salmond (1995). Had this participant not been assessing a care assistant for competencies for a module she would not have been aware of the functions care assistants can perform under the organisation's policy. The reference by this participant to the ward culture is interesting as most of the participants probably learnt about the care assistant role in a similar manner. This is indeed a problem for registered nurses as they are ultimately responsible for delegating to and supervising care assistants. Without the knowledge of their role description this cannot be carried out safely.

Although the participants said there was definitely a place for care assistants, this was problematic, as the participants felt they could not depend on them. However, most believed care assistants should do something, but not necessarily basic nursing care, as this was seen as 'nursing'. The implications of care assistants performing 'basic nursing care' have created much confusion, not only from the registered nurse perspective but also for care assistants. This in turn has created conflicting ideas of roles, and much uncertainty over the boundaries of care assistant roles. This comes from the participants' reference to their uncertainty of what exactly care assistants should be doing when they do basic nursing care. Even though registered nurses discussed there being a place for care assistants most still suggest enrolled nurses should be included in the staff mix. The following participants supports their presence in the clinical setting, as Jo said:

Well, I think there is definitely a place for care assistants (Jo, 2:29).

Although Pat agreed she still had some doubts:

...so I presume I would think that there is a place for them, but you can't get away from the enrolled girls, as well (Pat, 7:21).

Cassie also thought that care assistants should be employed, as she could not imagine what it would be like without them. She does have some doubts about having to depend on them:

There is definitely a place for them but I wouldn't like to have to solely depend on them, and at the same time wouldn't want to be without them, so there is definitely a place for them (Cassie, 6:17).

As their own workload increased, all participants could envisage care assistants being necessary; however, how they made use of them seems to be the stumbling block.

Some are more capable than others

All the participants referred to care assistants having different abilities, there was concern regarding their ability to perform tasks. Participants discussed how some were very good while others really were not:

I know that some are more capable than others and I tend to pick up who that is and who I delegate to and what kinds of job that I give them (Cassie, 6:12).

The following example is of a situation that took place during a busy period, and the participant explains why she delegated this care assistant tasks that were not usually performed by her. Cassie's rationale for her actions appeared to be related to the care assistant also undertaking her comprehensive nursing training concurrently with her employment as a care assistant.

[...] we would have delegated more than we probably would have normally done because of the fact we were more stressed [...] You see, but we wanted the jobs done... she is [...] months into her training. Normally, when we delegate... we know that they are capable of doing it (Cassie, 6:19-20).

And they are the tasks normally that we delegate; and in that situation we would delegate tasks that were probably something that she had done before, because we were so busy (Cassie, 6:20).

In this situation, because the care assistant had started her nursing education and the registered nurses were very busy, they knew this care assistant would be capable so they

delegated tasks she had done before but they were not necessarily successfully achieved competencies. The following participant explains how she makes a decision on which care assistants were capable of having tasks delegated to them:

And then, if the patient was happy and they had done it for me before, I would have no hesitation in letting them do that for me without, and having them come back if there is a problem, but actually letting them do it only for simple things like showering and, and mostly those things I wouldn't have a problem (Anne, 1:49).

Previously this participant had said that she now asks care assistants what modules they have achieved before delegating them tasks. Literature suggests that care assistants' current levels of competency should be available for registered nurses as this would be beneficial for assessing the suitability of the care assistant to the delegated task (Barter & Furnidge, 1994; Neidlinger, et al., 1993).

Care assistants don't understand our role

It is of interest to note the following participant's perspective on how she thinks care assistants see registered nurses. It would seem that the registered nurses perceived a lack of understanding of the registered nurse role by care assistants:

I remember that the care assistants mostly sort of had... this was only by somebody making a comment... had the idea that the RNs used to sit in the office and the care assistants were out doing the... the real stuff. But, that was what they were employed for, they knew that they were care assistants... (Jo, 2:10).

This suggests that care assistants may have very little concept of the registered nurse role. Salmond (1995, p. 56) suggests "assistants may not understand the co-ordination role of the staff nurse or the indirect care responsibilities".

Which modules have they done?

The regional hospital from which the participants were drawn provides a training course and competency modules for the care assistant, and these competencies are assessed by a

registered nurse before the care assistant performs the defined tasks. There were only a few participants who discussed how they had been involved in assessing care assistants for their competency modules. The following participant was one who was aware of the care assistant job description for her area and had assessed care assistants for competencies, as she explains:

Um, my care assistants have job descriptions which are fairly precise and, um, and we virtually go by that job description [...] and I have been helping them with, you know, going through their manuals as far as cleaning of the person's teeth, hygiene and all those other work sheet sort of things [...] yeah, the modules. In fact I have been through them all, with every one of the care assistants that I work with (Helen, 5:34).

Huston (1996) and Parkman (1996), writing about the use of care assistants in the USA, suggest that registered nurses must make themselves aware of the care assistants' ability to perform given functions. Parsons' (1997) study suggests that registered nurses should have knowledge of the care assistant job description and completed competencies, so it was of interest to note that few participants indicated they had this knowledge. Another concern was over what tasks these care assistants had previously carried out. Some participants were aware of the competencies that should be attained by the care assistant, others were not. Anne had previously assessed care assistants for their competencies and consequently would ask about previous experiences before she delegated tasks:

My expectations is that they have actually completed all ten of the certificates in the... within the care assistants' programme [...] I would be asking the care assistant how much of the actual care assistant programme they've done and what certificates they have received it in and then, depending on what they have actually got, then I would delegate them jobs (Anne, 1:49).

Anne continues:

If it was for something like mobilising a patient or showering a patient, if I didn't actually know the care assistant's work habits or how capable they were, and to

actually be fair, I'd be watching them when they're helping do the task with me. If we had a sick sick patient I take the care assistant with me... (Anne, 1:49).

Helen was very much aware of the modules as she had previously assessed care assistants for these, therefore she knew what they could do when she said:

Um, that they will do what I ask them to do, just because I know that I am not going to ask them anything unreasonable, you know that they will do what I ask them to do without me having to remind them or nag them or anything like that (Helen, 5:33).

The modules for care assistant training are available to the registered nurses who work with care assistants. There is an expectation by the organization that assessment for these modules be done by registered nurses.

We're very protective about our practice

The appropriateness of the care assistant's functional role was not always accepted by the participants. This participant in particular indicated this quite clearly:

Mainly, us registered nurses, I think we are very protective about our profession, and the fact that care assistants, we expect them to empty rubbish bins, make the beds, do the teas, do those sorts of things and... like I said earlier about... they are doing these modules to say they can empty catheter bags and we never utilise them for that, for those reasons, and so and I think because of that we feel less worried and so we just sort of make sure they do the things they know how to do and we don't sort of get them involved in other things (Cassie, 6:6).

The participants appeared to want to protect both their patients and the role of the registered nurse. However, there was a fear that change might result in parts of the role of the registered nurse being lost to care assistants. This fear of loss of control of their roles as registered nurses was consequently demonstrated by underutilization of care assistants so that care assistants were not allowed to perform tasks they had successfully achieved in the competency modules. Nursing structure changes brought about by the

introduction of care assistants as part of the restructuring process do indeed influence the utilization and acceptance of care assistant. This is supported in an American study by McLaughlin et al., (1995) that indicates that registered nurses require assistance in dealing with this process.

We wanted to protect our patients

The participant's apparent motivation to protect their patient's safety also generated a considerable amount of reluctance by registered nurses to accept care assistants in their sanctioned role. The notion that registered nurses feel threatened by the presence of care assistants is not new, as this participant describes:

Um, so I sort of wanted to, I suppose, protect my patients and, and, and push them [care assistants] out of the way and say 'No, I prefer if I did that myself' or have them work with me. But then I would give them the cue as to what I actually wanted them to do for me, and I actually explained that because I believe, especially some of the young ones came in, came in and thought, hey, you know, I can do that as well as you can, but didn't actually understand why I wanted to do it so much (Anne, 1: 4).

Not only do registered nurses want to protect their patients, as depicted by Anne, they also want to protect what they perceive as their role. While registered nurses are trying to sort out what they should allow care assistants to perform, care assistants are attempting to work out what their boundaries are. It raises the dilemma of registered nurses wanting some help with their work but at the same time being ambivalent about relinquishing part of their work to the care assistant. In a British article, Redfern (1994) discussed how difficult it is to define exactly what registered nurses' contribution to health outcomes are, as their position is often shaped by what other health professionals and management impose on them. Clearly there are indications that registered nurses remain unsure of the care assistant role, and have not really established for themselves what that role is. As a consequence, registered nurses appear to challenge the care assistants' boundaries and the roles continue to be blurred.

Their role is limited

Participants spoke of how limited the care assistant's role was. They were often so focused on the task at hand they were unable think of the consequences. Sara said:

But, I have found that their scope of practice is so limited that they are unable to think laterally and it is an unsafe issue as far as I am concerned (Sara, 4:5).

Before the 'formal' introduction of care assistants there were some who already had similar positions in the organisation. These earlier care assistants had undertaken certain tasks delegated to them by registered nurses. Some tasks were perceived by the participants as being inappropriate and unsafe for the care assistants to carry out, and this practice was stopped. This resulted in those care assistants being uncertain as to just what they should be doing as Jo comments:

And, so the lines were sort of blurred for them, they had been allowed to do something and then it was sort of taken back (Jo, 2: 19).

Participants spoke of incidents where care assistants attempted to define their own role because they were unaware of their boundaries. From the following incident it appears that care assistants were unaware of their own role limitations and responsibilities. Anne did not view the following as a care assistant function. She explains:

Sometimes she is even on the computer doing our patient's lists, updating our patient's condition screen, rather than doing what I believe her role is (Anne, 1:15).

Although Anne did not see this as a care assistant role, the function had in fact been delegated to the care assistant by another registered nurse. Anne was concerned when the care assistant updated the patient condition status screen because she had done so without consulting the registered nurse responsible for the care of those patients. Sara's concern was also directed at what she saw as care assistants being unaware of the limitations of their functional role:

They should first of all know their boundaries, and I wonder whether the care assistants have got a protocol for knowing their boundaries? This one certainly didn't know her boundaries, so... (Sara, 4:21).

Sara was quite definite on what care assistants should be able to perform. Her own experience with care assistants led her to believe that even with clear boundaries some care assistants would never understand that their role was limited. She explains:

Well, I knew that they couldn't come and usurp something the doctor had said or tell a patient about the drugs they are on or their diet or something like that. I certainly knew all that...but, I don't think she [care assistant] did... she was going to exceed the boundaries of her role no matter what (Sara, 4:21).

This demonstrates the confusion care assistants and registered nurses have over who is responsible for certain functions, which continues to complicate the way in which care assistants are utilised.

They do basic nursing care

Part of the rationale for introducing care assistants into this hospital was that registered nurses complained of not having enough time to care for their patients. This participant describes her perspective:

Because the hospital gave us the assumption that care assistants would be brought in to do the majority of the basic nursing cares, allowing us the time to do wound dressings, IVs and things, because we as a body actually complained that we didn't have enough time, could we have more staff. And their answer was 'Care assistants can do those jobs for you and you could have that time to do the... the things requiring skilled staff', so that's when they introduced the programme, trained up some care assistants, put them, placed them into the areas, and that's what their role was to be (Anne, 1:7).

Basic nursing care is a concept that is very much open to discussion as the debate on definition continues. In the following description the participant suggests that:

...if there were tasks to be done, patients who needed very basic sort of personal attention, baths, there was cleaning and stuff like that, it was sort of... it was the job of the care assistants to do that (Jo, 2:10).

This participant explains the care assistant role in her clinical setting as:

...Cleaning beds down, making new beds up for patients, coming and going all the time, that's mostly their work during the day... is doing that. Isolation rooms, cleaning them. Replacing curtains and a lot of that sort of work, you know... um, yeah, not, not a lot of nursing work done by them at all, unless you specifically ask them to do something... they [care assistant] have no patients at all (Mary, 3:3).

Sara was quite specific about the care assistant role when she said:

Um, no patient contact, not at all, and I don't, it's difficult to say but there would certainly have to be strict guidelines so that we knew... the care assistants knew, even about feeding patients (Sara, 4:21).

While reference to basic nursing care raises the concept that this will involve direct patient care, this was not always clear. The results of a New Zealand study by Walton (1989) indicate that basic nursing care is care that meets a patient's needs, as described in Chapter Two. Basic nursing care can be described under the headings of direct nursing care and indirect nursing care. The nursing literature attempts to define what constitutes direct nursing care and indirect nursing care. Direct nursing care, of which basic care is a component, could be described as delivered in the patient's presence, while indirect nursing care was not delivered directly to the patient but contributed to the patient's care (Chang, 1995). Other literature offered similar suggestions, indicating that although both indirect and direct nursing care are in the presence and absence of the patient, they both directly influence patient outcomes (Chang, Lam & Lam, 1998; Warr, Gobbi & Johnson, 1998).

They are task orientated

Some of the work delegated to care assistants has released registered nurses from the more routine tasks. Because of the nature of this work, a participant indicated that care assistants were task orientated:

Right from the beginning comes to the ward, does the morning and afternoon teas, give out the meals, ah, that sort of scenario. Mm, but I don't. Very, very very task orientated... (Sara, 4:14).

You know, they start at the beginning of the ward, they see the end of the ward and they have got to get there. It doesn't actually matter what happens on the way, it doesn't... they will chuck a tray on a patient's locker, you know, won't undo the gladwrap off it, they won't, um, make sure the cup of tea is within reach, they won't make sure the tray is within reach, as long as they have achieved their task. So that's the very narrow focus... (Sara, 4:7).

Some authors suggest that registered nurses are coming to realise that the delivery of nursing care is being manipulated towards routine, task-orientated delivery as opposed to holistic patient-centred care, and this is consequently seen as a threat to nurses' professionalism (Daykin & Clarke, 2000; Warr et al., 1998). Over the last two decades nursing in New Zealand has moved towards tertiary-based education. With this move, nursing curricula have focused more on the principles of care, leaving some of the strict routines behind. Many registered nurses perceive this as progress. However, some of the old traditions become valuable as registered nurses attempt to protect what they see as their role.

They Should Have A Qualification

Participants expressed concern that care assistants had no qualifications, even though they were aware some training occurred. Their perception of care assistants having insufficient training was revealed in the data. Registered nurses did not see care assistants as being the qualified staff they had hoped for when they had voiced their concerns about staff shortages, nor did they understand how care assistants would fit into the clinical

setting. The participants perceived care assistants as unqualified in comparison with enrolled nurses whom they saw as qualified:

Well I think they should have some formal qualification if they...if...if their role is going to be hands on then they have got to have formal, a reasonable amount of formal qualification...but the way I am heading with this conversation is I'm going to head to enrolled nursing training right back there again, I can see it now even before I am finished...(Mary, 3:17).

The following excerpt from Helen's interview suggests that care assistants were employed because they were inexpensive. She goes on to say that in her clinical area they were very little involved in patient care:

Yeah, they were all...when I, when I started this job then it was that I knew that I would be working with a care assistant... so the cheapest body that you can find is a care assistant [laughter] and, um, and so I, I knew that it was going to happen before I started the job, um, and I already knew the care assistants that were in that, in that position so I already knew them as people before I actually started working with them... (Helen, 5:4).

Even though Helen accepted that she would work with care assistants she went on to say that this working relationship did create its own problems. Highlighting the lack of peer support, she explains that:

I didn't really have any major problems, um. I guess that, that it means that you haven't got so much of the peer support that you know, in a ward [...] But with the care assistants you can't, well you can, you can say, but [laughter], um, and so you know it was, it was like, um, you have to rely on yourself... (Helen, 5:7)

In a British article Edwards, (1997) suggests that most nurses acknowledge 'unqualified' and 'untrained' in the context of care assistants as one and the same. A study from Hong Kong by Chang and Lam (1998) supports this when they refer to care assistants

providing assistance to registered nurses; however, they are still considered unqualified due to their limited training.

I'd rather have enrolled nurses

Further comment from some participants demonstrated a preference for staff similar to enrolled nurses' rather than care assistants. The participants commented that because enrolled nurses are no longer being trained, registered nurses would like to have an assistant with a qualification that is similar if not the same as enrolled nurse training. Mary demonstrated her preference for enrolled nurses:

So, basically, I have gone back to saying they should become enrolled nurses again (Mary, 3:23)

If they were more able or wanted to...I don't know, or I mean I suppose I think bring the enrolled nurses back, I think to take over that care, to free up the staff nurses to do what they do and can do... (Mary, 3:6).

Previous experience appears to influence the participants' preference for enrolled nurses, as the following participants explain:

I would much rather have enrolled nurses, that, working in the [ward] with an enrolled nurse to me is much better, much, much, much, much, much better than working with a care assistant (Helen, 5:2-26).

I would always, I would prefer to have an enrolled nurse, you know, if I'm not working with a staff nurse then I would always prefer an enrolled nurse... (Helen, 5:35).

To help me with my job? An enrolled nurse, they'd be a back up for me (Anne, 1:52).

[...] and they were actually, I have to say they are good... It's that little bit of knowledge that they have gained along the way and with their training that gives them the advantage over a care assistant (Anne, 1:52).

The ideal people are really the enrolled nurses... who have worked in a particular area for some... but then some care assistants are very good too. I would prefer an enrolled nurse but if push comes to shove I would prefer one of the better care assistants (Rose, 8:21-22).

Sara's experience led her to believe there was a need for further training of care assistants:

Well, how...how about saying that they either have patient contact or they don't. If they do have patient contact, there must be more accountability, more protocols, more areas of responsibility. Um, I think that if that...they are going, going to have care assistants that they need to be almost... and if they are going to have patient contact, they need to be on an enrolled nurses sort of training type thing. But if they are not, I don't think they should have patient contact at all (Sara, 4:8).

There appears to be expectations by registered nurses that there should be another level of health worker between the registered nurse and the care assistant. There was a definite leaning by these participants towards a reintroduction of the enrolled nurse. The reasons for having enrolled nurses varied from their having had sufficient training to understand the rationale for certain procedures and therefore not requiring close supervision, to the fact that many had been working for a number of years and so had experience that the care assistants did not. However, this was not always the case, as Sara said later that she actually would like a type of registered nurse who was perhaps a second-level registered nurse. Another participant said enrolled nurses actually meant more work as registered nurses had to countersign most of their documentation. McClung (2000) in a review of the US literature, and McGillis-Hall (1997) in a Canadian article, both discussed care assistants receiving different levels of training, which would enable them to perform

either more nursing or more technical tasks. Some participants support this idea, and although the majority wished to retain enrolled nurses, some saw other options.

It's unfair on the care assistant

The care assistant role was perceived in different ways by most of the participants. In the following quote it is suggested that it is dangerous for care assistants to perform basic nursing care. Anne describes what she perceives as dangerous:

... one ward in particular in the hospital has two care assistants, one at each end of the ward, that's on a morning and an afternoon shift, and I know that nursing staff dangerously allow them to do the basic nursing cares. (Anne, 1:13).

Although Anne suggested that it was dangerous for care assistants to do basic nursing care, her reason being that it gave extra responsibility to the care assistant, she goes on to explain:

They take half the ward and they go through and do the sponges and washes and all those other things while the nurses go along and do the big nursing jobs like IVs and observations, you know, which I have an issue with and a problem with... (Anne, 1:13).

Anne takes issue with this practice and suggests:

... it would be good if we had two care assistants, because it would ease up a lot of our workloads, but I think it is unfair to give them that responsibility, and I actually heard that from a care assistant who actually worked there (Anne, 1:13).

The following participant explains how she sees the care assistant fitting into the clinical area:

Other roles were to empty the linen container, make the beds, pan the patients that were on bedrest...and things like that... To give the food out, make them cups of tea, you know... (Sara, 4:16).

Most participants had quite different ideas on what care assistants should be able to do. One participant initially suggested that care assistants could be responsible for bed making, and cleaning, which she implied were their main jobs; however, later she said that they could help sponge patients if asked. Another participant indicated that their role was one of support, to do as she directed; while another two participants saw the care assistant role as ‘just doing basic things,’ ‘they just do the basics’. The idea that care assistants help alleviate the registered nurse workload by doing basic nursing care will continue to be problematic until registered nurses know exactly what the role of the care assistant is.

Limited knowledge could be dangerous

Two participants perceived that some care assistants had a limited knowledge base that could be partially attributed to their minimal training. The following participant described how difficult it was when some care assistants were unable to comprehend what was required of them. Sara felt one care assistant in particular had difficulty in understanding the tasks she should be doing:

...I feel it was dangerous because of her lack of knowledge, her lack of vision, her lack of lateral thinking. You know, still to this day I know she says to the, the Charge Nurse, ‘Oh this jam here, can I give it to this diabetic?’ And you can tell her 100 times a day that you can’t give jam to a diabetic... (Sara, 4:5)

Another participant also had similar issues with a care assistant who had been employed with the organisation for a number of years:

...I knew I didn’t get my point across, so I actually discussed it with the other registered nurse that works with [care assistant] and said, ‘you know, can you try and get the point across as well?’ And then you know, a few months later a similar, not the same thing happened, but a similar...you know, in the same sort of vein... just a couple, oh, probably months now, it feels like a couple of weeks ago it happened again... (Helen, 5:11).

This appeared to contribute to the barrier of accepting care assistants as part of the skill mix to deliver care to patients. Consequently, registered nurses were apprehensive about delegating functions to them.

Summary

This chapter offers some insight into why registered nurses are unsure of the care assistant role within their nursing practice. The theme has many underlying influences, with the subthemes offering considerable support to the participant's uncertainty of that role. Their perception of the care assistant role is complicated by their ambivalence to care assistants in general. For the participants, there was the fear of losing some of the practice of nursing, and it appears that this in turn has contributed to registered nurses underutilising care assistants in some clinical settings. There were also instances of care assistants exceeding their boundaries with apparent registered nurse approval.

The different role of care assistants in each clinical setting continued to confuse the issue because of the participants' differing expectations. Participants contradicted themselves on several occasions: initially most stated a preference for work with enrolled nurses as opposed to care assistants, however, some participants later offered alternatives.

There was a lack of overall acceptance that care assistants should be performing basic nursing care, and some debate as to what constituted basic nursing care. Participants' lack of consistency about what care assistants should do complicates the issues further.

CHAPTER FIVE

We Have Overall Responsibility for the Work Of Care Assistants

Introduction

The theme of this chapter is **'We have overall responsibility for the work of care assistants'**. This belief was influenced by a number of factors and endorsed by underlying sub-themes as the participants in the study made reference to care assistant work being their responsibility. The sub-themes link registered nurses' concerns regarding care assistants' unregulated status, the legal issues that arose from this relationship, and the impact of being responsible for them. The title of this theme was derived from the data but was best expressed by the following participant:

[...] it was seen as the RNs problem...Because the RN was overall responsible for what the care assistant did (Jo, 2:30).

The following sub themes are interrelated to the theme:

(a) **'Sometimes you have got to be really careful.'** This complex issue was at times contradicted by the behavior of participants when they delegated tasks that were outside the care assistant role. There were also occasions when patient safety may have been compromised by care assistants overstepping the boundaries of their job description without understanding the potential for problems.

(b) **'We are concerned about the legalities.'** This stemmed from registered nurses acknowledging that at times they were unaware of the legal implications of working with unregulated care assistants.

In this study, the participants talked about their responsibility for care assistants when they performed 'basic nursing care' as referred to in the previous chapter and defined by the organisation's policy on care assistants. Their perception of this responsibility became apparent as they realised the implications of this on their own nursing practice. There was the added concern that the outcome of patient care was mainly perceived as

being a reflection of registered nurses' practice, even if the care assistant was providing some of the care. The theme and the sub-themes are interlinked to the issues in such a way that it is difficult to separate these from one another. Because of the need to supervise the care assistant, the registered nurse finds this adds to her already busy workload. Further complicating factors occurred when care assistants did not know their limitations, and registered nurses were not always clear about the role of the care assistant.

Sometimes You Have To Be Really Careful

This sub-theme evolved from the realisation that care assistants might not be aware of all of the components associated with a task assigned to them. The participants realised that care assistants required supervision when being assigned a task, and this is well illustrated in the following quotes:

[...] if they are taking someone to the toilet, and they are really quite short on breath and, gee, their ankles are a bit puffy, but, oh well, you know that... that can get missed as well, so we have to be careful... (Pat, 7: 21).

Very different, very different unfortunately, yes it is. For a care assistant, I guess... I have to be more cautious, more vigilant, give more information... ah, they don't tend to come and read the patient notes that they are specialising, from what I have seen [...] Um, they just get a hand over... a verbal hand over, whereas the enrolled nurse that's coming on wanted to read through the notes, read back about what had been going on. Quite a difference [...] So the care assistant is really just getting a general overview... yeah, and then we go and talk to them and, and tell them what we know of that patient... And what to look out for and go through it... (Pat, 7:23).

This sub-theme supports the theme of registered nurses identifying that they believe they have overall responsibility for care assistants. It interrelates also to the fear of possible legal implications in relation to working with care assistants, and originated from the following example where the participant describes how she was confronted with a situation that might have had disastrous results. She describes how a patient had a:

[...] *tracheostomy and we suction [patient] and I sort of noticed one of the care assistants was in there and just about had a fit because... we have been putting it [medication] on the swab and swabbing [patient's] mouth and here was this care assistant dropping it into this person, into their throat [tracheostomy tube] and I just sort of said "Hey, what are you doing?" And she goes 'Oh, this [patient] has this'. I said, 'Oh, no that's not the way that we do it [care assistant]' (Cassie, 6:5).*

The participant stopped the care assistant from administering the medication (which the care assistant was going to dispense without the registered nurse's knowledge). Dispensing medication in a public hospital can be only carried out by a registered nurses, doctors and pharmacists; unregulated care assistants are not legally able to do this. The participant then managed the situation by explaining to the care assistant:

You know, and I explained about what a trachy is, and the fact that they're aspirating and having all these other multiple problems... and it's just, like it hits you sometimes that you have got to be very careful, yeah (Cassie, 6:5).

I questioned why the care assistant had taken such action:

So, so who told the care assistants to do it? (Researcher, 6:5).

Oh, they obviously just used their initiative, it was sitting there... and the care assistants are quite used to working with this person and knows that this person has [medication] and it is sitting by the bed and knows what it is for... but obviously, you know, I was there when she was about ready to give it and I said 'Hey', you know, and I got quite flustered and said 'What are you doing?' (Cassie, 6:5).

This incident resulted in the participant being cautious about delegating any further tasks to that particular care assistant. Registered nurses place themselves and their patients at risk if errors occur from any unsafe practice by care assistants. In a literature review

Krainovich-Miller et al. (1997) agreed that unsafe practice might compromise patients' safety. The following participants made reference to this:

[...] I am taking responsibility for what they do, so I want to know they are doing it properly (Mary, 3:10).

Well, well, we were responsible... for the care assistants ... (Jo, 2:9).

Yes, it is our responsibility as a registered nurse, we are accountable, we write the reports, we do the care plans. It's our responsibility...(Pat, 7:22).

The participants are aware they had some legal responsibility when working with care assistants. The regional hospital policy states that registered nurses/midwives are to practice in accordance with their policy and this includes responsibilities for the delegation of designated direct care-related tasks to care assistants. However, under the Code of Health and Disability Consumers' Rights, the organization would be responsible if a care assistant breached any of the rights (Ministry of Health, 1999; NZNO, 1998).

Our job is harder with care assistants

The participants identified there are definite changes in the workplace with the introduction of different levels of health-care personnel. The organisation of the participants' work changes to accommodate the care assistant; however, this process is sometimes difficult. One participant described how she found her work habits changed, and claimed that the extra responsibility for care assistants made her role more difficult:

Yeah, no, I do believe that registered nurses need... need to take on the responsibility of the care assistant. I mean, that is more work for us, but if we want them to assist us with our... our basic nursing cares with our patients, then we need to... for the benefit of our patients, to be seen to be doing that instead of imparting that responsibility solely to the care assistants (Anne, 1:30).

I think, I think my role with the care assistants has actually got harder. Um, I feel now I'm having to watch my back. I watch, I look over my shoulder, go back and check my patients more often, um. Not that I wasn't doing that, but if I give the responsibility of doing some, a basic nursing care, like a sponge for example, or having them shower a patient, that I need to go back and check that that's actually happening, making sure that they are actually, um, doing what I have actually asked of them, um. I mean, if I asked one of the care assistants to shower any of my patients I actually end up getting the patient to the shower, setting the patient up, asking the care assistant to come in, introducing the care assistant, um, getting, you know, getting the shower started, making sure it's the right temperature, then walking away and then within 2 minutes I am going back and making sure that the patient and the care assistant are okay, and where they are up to in the showering, have they done everything, what they are up to, what they are going to do next, walking away again, and coming back. You know, making, seeing if the patient's had a, um okay, if they are ready to come back to bed. Often they say thank you to the care assistant and I take the patient back so I'm a little bit, not dubious, but more aware that they are not as qualified as they should be... that it could be someone walking down the street who could come in and do that task for me, so I have got to make sure that the patient is okay. So in the end I would say it was easier for me to just do it myself. So I suppose I've gone back to doing those nursing cares myself, and even now when I sometimes require assistance I will end up going to a registered nurse first rather than having a care assistant help me (Anne, 1:13).

Anne's uncertainty about the care assistants' ability to perform the assigned tasks makes her role more difficult. Anne was always checking on what the care assistant was doing and if the patient was safe. She considered that part of this difficulty was that by delegating basic cares, such as showering, to care assistants meant that she missed the opportunity for that patient contact, when patients often expressed any problems or issues they had. She said:

I didn't believe they were actually qualified to pick up on things that you only pick up on when you are actually working and doing things like showering or sponging a patient (Anne, 1:5).

You know any issues. Um, and the things that I find out in the shower, um, without leading patients to tell me what I want to hear from them... Um, unqualified people such as care assistants aren't capable of doing so (Anne, 1:14).

The care assistant was therefore, in this case, perceived as being a liability rather than an asset. This participant perceived her role had become more difficult, with a similar scenario being described in a study by Orne et al. (1998). She thought having care assistants would help ease the workload whereas the workload had actually increased. As a consequence, Anne found it less time consuming to get other registered nurses to assist her with her nursing practice.

Care assistants overstep the boundaries

The registered nurses considered that care assistants themselves placed patients in potentially dangerous situations when they exceeded the boundaries of their functional roles.

[...] but we also had to be responsible for the things the care assistants did and we needed to be very sure that they knew their limitations and when they were perhaps sort of stepping into areas that might be, what's the word, overstepping their boundaries... (Jo, 2:13).

[...] like, I still, even though I have delegated tasks...I haven't actually taken my hands off the task, I still have to go back and oversee it... I still feel responsible for the task, and I will go back and check that it's done or that they know what they are doing and I check that they under, understand what the task is first (Cassie, 6:12).

Sometimes participants had problems with a care assistant who required a considerable amount of supervision. This was both time-consuming and could have resulted in compromising the patient's safety. Helen comments:

So [care assistant] actually said a couple of weird things to patients when, when the supervisors were there and I wasn't there, because it usually happens when we are in [clinical setting]...So [care assistant] was spoken to by the supervisor and hasn't, hasn't said anything like that again...[care assistant] said something to a patient... I said, um 'Well, actually that's not right, um, this is blah, blah, blah'... Kept it as sort of low key, but corrected it as fast as I possibly could and then, and then said to [care assitant], 'You cannot say things like that', and the next time [care assistant] went to say something like that, because I knew [care assistant], you know how you know that [care assistant] is going [laughter] to put their foot in it, then I, then I sort of was prepared for it...and had, had a little practice and jumped in, but, um, but I actually spoke to...to, um, my Project Manager about that... The patient could have done weird things. [Patient] was a diabetic (Helen, 5:15).

There was an underlying concern on the part of the participants that care assistants did not understand either the task or the limitations of their role. Care assistants have competency modules to complete, as outlined in Chapter One. These competencies, once assessed and signed off by a registered nurse, detail what a care assistant is able to perform. However, the fact that they attempt to perform outside their sanctioned role indicates they are not fully aware of their own job specifications. As a result participants were spending more time checking and finishing tasks assigned to care assistants than before the introduction of care assistants, thus making their role harder. At times it would seem that some care assistants assumed responsibility without consulting a registered nurse, raising the question of care assistants' use of initiative. The following participant discussed this:

[...] I suppose they don't use a lot of initiative, but are they allowed to use a lot of initiative, too? That's the next question...I mean, how much initiative are they

allowed to use? I mean how... how... what's their job description?... (Mary, 4:16).

While questioning care assistants' use of initiative Mary went on to explain that on some occasions it was acceptable for some care assistants to use their initiative. This is linked to participant perceptions of some care assistants being more capable than others:

Depending how good the... depending how good the person is, it's an individual thing, too, isn't it. You have got like somebody who has got a few clues, who wants to get in, you can see that, like, so and so wants a pan and has made a mess and needs to be cleaned up so she will go ahead and do that... She's got initiative. So that's a personal choice, I think, a lot of the time... (Mary, 4:7).

Registered nurses' expectations of care assistant functions are in fact different from what they are saying they should be doing. The information that registered nurses receive on working with care assistants is in hospital policy, which in turn is guided by the Nursing Council of New Zealand. The programme for care assistant training modules gives information on the care assistant role and what is expected from them. However, this role did not appear to be very clear to the participants. Because care assistants were to perform basic nursing care, registered nurses appeared to believe that they were there to replace enrolled nurses. The role differences of the care assistant and the enrolled nurse need to be clearly defined. The following participant believed there was an assumption by some care assistants that they were as capable as registered nurses. Jo commented on the past practice of:

[...] giving out of medication, that was something that needed to be very specifically set down, that the RN gave out the medications that was dispensed. There was a bit of bother at one stage where a care assistant and a RN would dispense the medication and the care assistant would then go and give it. But that was, I think, one time we sort of had an audit that was... now we were told that, that wasn't acceptable and I think some are, for some care assistants they sort of saw that as, you know, well, we [care assistants] are careful, we [care assistants] are just as careful as RNs... (Jo, 2:19).

So when you were audited and it came out that you... it shouldn't be done. That's what you said isn't it? (Researcher, 2:19)

Yes... it was the responsibility of the RN to do that. To give the medication and if it was by mistake given to the wrong person, or if there were questions about it, you know, what do the care assistants know, because some patients will sort of, they will know what their medication is, and they will look at it and say, you know, 'What's the purple one for?' or 'I have got one too many here'... the care assistant knows nothing of that, so it was the RNs responsibility... (Jo, 2:20).

Registered nurses should have knowledge of their workplace policy when dispensing medication to patients and also know the legalities of this action. However, there seems to have been some uncertainty by registered nurses, as they allowed the care assistant to assist with this task. In the first quote, it had previously been common practice for care assistants to deliver medication to patients. The issue of care assistants delivering medication occurred in one other area, and here again a potentially dangerous action was noted. Registered nurses say they are responsible for the care assistant, which is complicated by some being uncertain of their own legal responsibilities or obligations of practice. The issue of registered nurses having to be careful is reinforced when the participant refers back to a previous potentially dangerous incident. She goes on to suggest that lack of experience may have resulted in a completely different outcome:

Mm, I guess it can be an issue for perhaps a new grad. I came fortunately with that experience but there is a potential for a, problems. Yes, if I go back to that trachy and, yeah (Cassie, 6:11).

There is sort of a bit of a grey area and now the care assistants are, you know, are now just coming in and doing the nursing jobs, and we are not taking responsibility for that and are leaving them to it (Anne, 1:22-23).

While Anne perceives that care assistants should not be performing nursing tasks, it is difficult to judge what 'nursing tasks' are, especially when registered nurses in the study

have different ideas of what constitute nursing tasks and basic nursing care. The situation is contradictory as registered nurses wanted assistance with their work, to which the regional hospital responded with care assistants, whose role includes some of the tasks normally performed by nurses, which nurses find difficult to accept. However, the concept of 'nursing' is obviously an issue, and its complexity makes it difficult to define (Kitson, 1987; Warr et al., 1998). When delegating functions to care assistants, the Ministry of Health (1999) states that registered nurses are required to exercise professional judgement, by assessing patient requirements and the care assistant's ability to perform the function.

Because of the lack of clarity about the role of the care assistant, and the lack of acceptance of what was an appropriate skill level of a care assistant, some participants perceived that care assistants were sometimes not practising with an appropriate level of skill:

I think, I mean, I hate to use the word neglect, but they [care assistants] did what I say is the basic, basic and then just walked away and thought 'Well that's me. I have done everything I need to do for the day', and left, left the patient to it, didn't sort of go back and do things that we [registered nurses] do, like regular turning, or going back and seeing how they are, making sure they are okay, or didn't actually report back to me to say that they had actually finished the job or they needed a hand. They would just go on and do their own thing... (Anne, 1:6).

Um, do you think, do you know why they didn't report back, was there any reason for them not reporting back to you? (Researcher).

Um, I can make an assumption and they might have thought that they would, that they didn't need to. Um, but otherwise I can't. I mean I ... probably I mean maybe I should have told them but I didn't think I would need to (Anne, 1:6).

This participant had assumed the care assistant would know to report any issues to her. However, it is important that when registered nurses delegate tasks to care assistants the process of delegation includes clear communication.

Care assistants are given too much responsibility

Although registered nurses said they were responsible for care assistant actions this was contradicted on occasions when some participants gave care assistants responsibility to do additional tasks, encouraging them to exceed the boundaries of their functional roles. Some participants discussed how in some clinical settings they perceived that on occasions colleagues placed extra responsibility on the care assistant which could result in possible patient compromise:

It is with... with the short staffed issue and with not having, um, Charge Nurse role, not having a full-time physio, not having a full-time O.T. or social worker, we pick up a lot of other roles, so how we...we wear many hats and that to a patient is hard to grasp, and therefore at times I believe probably some of the nurses shoulder more responsibility on the care assistant than they actually should because they are wearing all those other hats at the time, so I believe that is a problem (Anne, 1:12).

[...] the fact that the care assistants had been introduced to pick up some of our tasks, that yes, the bed stay and the, um, has... has been shortened and we are turning over our patients quicker, but that we are compromising their safety by, um, by imparting some of our responsibilities to a care assistant, so therefore we are missing a lot of... of patient's requirements, so we are not just... we are not successfully nursing our patients, caring for our patients, preparing our patients (Anne, 1: 21).

Just, they do their set tasks and that's what they do, they don't go outside those boundaries unless it is, um, for instance, where we get busy and they have to (Cassie, 6: 26).

And they are the tasks normally that we delegate, and in that situation we would delegate tasks that were probably something that she had done before because we were so busy (Cassie, 6:20).

This participant referred to the day-to-day tasks that the care assistants carried out and the boundaries she spoke of were in fact within their mandated competencies. However, because some registered nurses were unsure of these competencies they did not normally delegate these tasks:

At the end of the day, I was with the care assistant in [clinical setting] and said to her, um, that at last we have got through the day and she said, um, 'Well I had a really good day,' because she's a care assistant that's training to be a nurse... She said, 'Its been good, because it was so busy that I have been able to do more than I'm usually allowed to do'... And it is probably quite true, because we would have delegated more, um, than we probably would have normally done because of the fact we were more stressed... We would have delegated more to her than we would have normally... And, plus the jobs that she would normally have got and that's what she was saying... You see, but we wanted the jobs done (Cassie, 6:19).

These participants indicate that at times, due to workload commitments they delegate extra responsibility to care assistants, which may be outside their official job description and tested competency level. In a UK study Reeve (1994) indicated that when registered nurses are unaware of care assistants' boundaries they may be used inappropriately. Whereas Orne et al. (1998) indicated that some registered nurses expected too much from the care assistant and too soon. This inappropriate use of care assistants may be related not only to confusion between the previous role of enrolled nurses and the job description of care assistants, but also a response to the way in which experienced enrolled nurses were often delegated tasks outside of their job description.

It is obvious that there is some difficulty about trying to differentiate between the roles. The boundaries often appear invisible and as a consequence are challenged. This is demonstrated in the following example, when a registered nurse asked a care assistant to perform neurological observations. This participant perceived this as being an unsuitable function for a care assistant:

Yeah, I have had an issue with other... a staff nurse trying to give the care assistant jobs, who knew that the care assistant was a care assistant... as a staff

nurse she tried to give the care assistant a job that was well outside, neuro obs. for goodness sake, and got quite shirty when it was refused (Helen, 5:18).

To compound matters even more, it appeared that care assistants' functional roles varied from unit to unit. Their roles ranged from cleaning, bed making, through to direct patient care under the supervision of the registered nurse. Unfortunately, the lack of definition of their roles contributes to the registered nurses' problems as Rose expressed it:

No, I have never seen a job description... Except for [area], there's a list of things the care assistant, the various care assistants are meant to do. And just generally from experience I learnt what they're supposed to or not do... Well, I just assumed that they did the basic work and didn't give out medications (Rose, 8:20-21).

Once this participant was aware of the care assistant role in her clinical area she felt that they did not always meet her expectations of that role:

Oh, they... they have a list of exactly what they're meant to be doing but it's a matter of them following that. They don't always follow-up, no... (Rose, 8:14).

It's not so much exceeding their boundary as not doing their boundary (Rose, 8:15).

Jo spoke of a similar experience:

Oh, there were two of us, perhaps the same age, who didn't have quite the same sort of ideas about what care assistants should be sort of doing, because both of us did not have a background of nursing, we had come into nursing as older... So we didn't have such dyed-in-the-wool ideas about now what care assistants should be doing. But from that sort of start, some of the care assistants sort of drew their line in the sand as well, and made it very clear about what they were going to be doing (Jo, 2: 8).

The role of the care assistant was influenced by their job description and also by their own aspirations as care assistants, as illustrated by Jo. She felt that some had low self esteem which in turn influenced their work:

Depending on how much a care assistant was wanting to learn and develop their role, as to how well it worked. Some have this, have a mentality of what I would sort of call 'care assistant role' where they sort of thought that, you know, that was all they were going to sort of be in life, it was all their aspirations, if not sort of developing it (Jo, 2: 20).

This participant appeared to consider that care assistants should be developing the role further, although this contradicts other participants who believed that some care assistants overstepped their boundaries, and this was potentially dangerous. Orne et al. (1998) supports the notion that unrealistic expectations from both care assistants and registered nurses result in the boundaries being challenged. There is also evidence that when challenging the boundaries care assistants may be unaware or misunderstand the limitations of their role (Huston, 1996).

I need to know they are capable

One participant's experience of working with care assistants was limited due to her relatively new role as a registered nurse. Mary did not feel she had enough experience, and certainly was not willing to take on the responsibility of delegating her work to a care assistant:

That's, that's got to be one of the biggest things, um, yeah, I am more worried about my own practice and making sure that I practice safely, um, I don't know how I would feel in a year's time, I mean before I got anyone to go off and do anything for me I would be making sure that they are capable of doing it as much as possible. You know, it is certainly a big responsibility (Mary, 3:10).

I know that some are more capable than others, and I tend to pick-up who that is and who I delegate to and what kinds of job that I give them (Cassie, 6:12).

Mary was still coming to terms with her own new role and found it difficult to delegate to someone else for whom she would be responsible. Cassie, on the other hand, had identified which care assistants were capable of performing a delegated task. Participants had some preconceived ideas of what care assistants should do; however, this was dependant on their clinical setting. Some difficulties for registered nurses when delegating to care assistants were related to their lack of awareness of the care assistant's job description and completed competencies. This participant talks about how she gained her knowledge of what a care assistant could do:

I think they have the potential to do a lot, and with all those modules that they have been doing and...and, like, that was a surprise to me and I...and you have never actually been educated as to what a care assistant can do, what you tend to do is pick up the culture on the ward and see what they do normally, and just copy that... (Cassie, 6:12).

Parkman (1996) suggests that registered nurse involvement in education and performance management of care assistants could be beneficial and this is supported by some of the participants. When they are more familiar with care assistant training this could create a better working relationship based on trust and understanding rather than on preconceived ideas of what they think care assistants should be doing.

We Are Concerned About The Legalities

The participants voiced concerns about the legal implications when working with care assistants. Certainly the data demonstrates this clearly, with each participant referring to their responsibility for care assistants' work. The Ministry of Health (1999), the Nursing Council of New Zealand (2000a), and the Nursing Council of New Zealand (1999b) all discuss the legal responsibility of registered nurses when working with care assistants. A number of the participants expressed concern for patient care, as Cassie said:

And I think we are concerned about the legality of care and therefore we only tend to let them do the real basic things and we really notice them when they are not there (Cassie, 6:10).

[...] *with the care assistants, it's the legalities of it... (Cassie, 6:6).*

There is no legal requirement under the Nurses Act (1977) for registered nurses to supervise care assistants, as this refers only to enrolled nurses. However, if they delegate they are then responsible for the outcome of that task. Registered nurses do have an obligation to maintain their practicing certificate and follow the code of conduct for nurses and midwives of New Zealand (Nursing Council of New Zealand, 2000a).

Who's accountable in a court of law?

It is questionable whether care assistants are fully aware of their functional roles and the limitations these impose on them. Although they are non-regulated, they have certain obligations to their employer through contractual agreements and relationships that require them to be accountable for what they do:

Then who's accountable in a Court of Law, and of course that comes in the same with the care assistants. Like, NZNO [New Zealand Nurses Organisation] I know is very particular about my working with care assistants and who takes responsibility for them, and it's a bit scary sometimes (Cassie, 6:6).

Pat also had concerns, as she described how she was ultimately responsible for the care assistant:

[...] and when they [care assistants] go into sudden overload, well, it's on our head... (Pat, 7:17).

The care assistant's ability to perform the task appeared to be a problem for registered nurses. The regional hospital's policy for care assistants requires the registered nurse to explain the expected outcome of the function and to be sure the care assistant understands what is being delegated.

It meant that, you know, it sort of came back to the same old thing again...that the onus was on you: if you saw that other people weren't sort of doing what they

were meant to be doing, you had to be prepared to sort of say something and perhaps being seen in a negative light... (Jo, 2:25).

The competencies for performance criteria required for nurses to gain entry to the Register of Comprehensive Nurses have recently been amended to read: "Legal Responsibility' No 6.7: 'Exercises responsibility in direction and supervision of enrolled nurses, and in delegation of appropriate functions to health service assistants and the client's family/carers" (Nursing Council of New Zealand, 2000a, p. 16).

There seems to be some confusion among the participants as to who is accountable for the outcome of the delegated task. Comparisons were made by a majority of the participants about care assistants' and enrolled nurses' responsibilities. In the following example, the participant perceived the registered nurse as being less accountable when working with care assistants as opposed to enrolled nurses. There continued to be an element of uncertainty regarding this issue:

Now, where as with a care assistant we feel, um, although we are legally accountable, we don't feel as much accountable...in other ways. Yeah, that way and so they are not accountable as much, and we don't have to put our name next to anything that they have done (Cassie, 6:22).

Participants were uncertain about who was accountable and this is a reflection of the confusion that surrounds this issue. Sara has experienced problems with issues of safety arising from the care assistant's inability to understand her role. She felt that care assistants were not accountable, because they were not regulated by law:

Never held to account, and that's what bothers me with all care assistants (Sara, 4:12).

She had to be watched for the safety of the patients, so my role I guess became supervisory, didn't it, really? (Sara, 4:18).

The Nursing Council of New Zealand (1999b) and Ministry of Health (1999) consider that registered nurses are both responsible and accountable for nursing outcomes, especially during the process of delegation and supervision of care assistants.

It's dangerous nursing

The legalities of working with care assistants are an issue for the registered nurse. These participants gave examples of the registered nurse being the one held responsible for patient outcomes.

If something goes wrong it is not them [care assistant] that have to shoulder the responsibility, it is us, and it is us that we'll end up losing registration because of something that they do. So I think that way it is dangerous, it's a dangerous game (Anne, 1:5).

Anne placed much emphasis on the dangers of working with care assistants:

It's dangerous. It's dangerous nurs...nursing, It's dangerous in the fact that if something goes wrong... that I mean a patient's life is at risk, well, a patient is involved and you can't expect the care assistant to know what to do in that situation, I think. From their perspective, that's... that's not fair to them and also for the nurses... that's...that's their registration on the line if something goes wrong and I mean where's... I mean I can't understand where their [nurses] logic is, to be perfectly honest. I don't. Yeah (Anne, 1:10).

The following participant also had concerns, as she believed that:

Well, if they are not, if they [care assistants] are not bound by any regulations, if they have got no accountability to anybody, I mean where does that leave us, where does it leave them? I mean, unsafe for everybody. I don't, you know, I don't...yeah, I disagree with that totally... I mean they've got to be accountable. We've all got to be accountable now (Mary, 3:18)

There was concern that if registered nurses assigned care assistants tasks that exceeded their mandated competencies this could lead to litigation. The participants perceived that they were responsible for the work of the care assistant. However, The Ministry of Health (1999) guidelines state “Delegation requires professional judgement and RNs must take full responsibility for delegating and the provision of adequate supervision of HSAs (health service assistants)” (p. 7). They also indicate that “ HSAs are responsible for carrying out all tasks as defined in their job description, and are accountable to their employer for this aspect of their performance” (1999, p. 8). Registered nurses have certain expectations of what care assistants should or should not do. Each registered nurse had a basic idea of the functions care assistants could undertake but at the same time were uncertain; and this may be related to fear of placing patients at risk. There was fear of litigation or loss of registration should an error of judgement be made by a care assistant. It would appear that the care assistant role and the lack of clarity are problems for registered nurses. Because care assistants were carrying out basic nursing care, the assumption was they should have been able to communicate what was described as potential problems to the registered nurse supervisor.

What if some thing goes wrong?

The fear for registered nurses is that care assistants may not perform the delegated function correctly, therefore compromising patient safety. If this was to occur it might result in disciplinary proceedings for the registered nurse. Sara voices her concerns:

Yeah. If they have patient contact and something goes wrong in the shower or something like that, then whose responsibility is that? That is, I think that is a concern... if they fall over in the shower and that, that's my patient, a registered nurse's patient where... where does the accountability lie there? Mm. That's right (Sara, 4:6).

To the new graduate, the role of being responsible for care assistants is quite overwhelming as this participant found. Her new role, as a registered nurse was enough to deal with, without the added stress of being responsible for care assistants:

Especially as a new staff nurse I don't want somebody else doing...I don't want to be responsible for someone else's work unless I know that person inside out. I mean, that's a really big thing. I mean, I am concerned enough about my own safety and my own nursing practices... (Mary, 3:9)

And I want them to be safe, but I don't really want to take total responsibility for somebody else's nursing practice who I don't know...(Mary, 3:9).

Some participants perceived their workload had increased with the responsibility of care assistants and, as a consequence it became more difficult trying to remain focused on patient safety. Their workload had increased with the changes to skill mix as well as to institutional policy. Trained care assistants were not the same as qualified nurses who did not need constant supervision, so the participants' workload appeared to increase (McLaughlin et al., 2000).

Summary

In summary, registered nurses are concerned about their responsibility for care assistants when working with them. However, their awareness of their ongoing responsibility in the form of supervision is not consistent which is evident when care assistants are encouraged to carry out functions outside their designated role. Legal consideration for being responsible for care assistants who may compromise patient safety continues to be a concern for registered nurses. The recently released guidelines for registered nurses working with care assistants should help to clarify some of these issues (Ministry of Health, 1999; Nursing Council of New Zealand, 1999b). The regional hospital policy is quite specific as to the competencies care assistants are able to perform. Nevertheless, it is of concern that registered nurses do not seem to be really aware of their own legal responsibilities when it comes to working with this non-regulated group. Not only do registered nurses require more information and guidelines that contribute to a better understanding of how the care assistant fits into the present skill mix, but care assistants themselves also need clarification of their position in this institution.

CHAPTER SIX

We Were Never Really Taught to Delegate

Introduction

The issue of how registered nurses actually delegate to care assistants is the theme in this chapter. The process of delegation could have a huge impact on the delivery of care to patients if not performed safely. Registered nurses' experience when working with care assistants revolves around the issues of delegation. How they perceive their role in conjunction with care assistants will influence how they actually carry out the skills of delegation. Supervision of an assigned task is interlinked to delegation in such a way that it is difficult to separate one from the other. Therefore, it is important to illustrate how this complex issue '**We were never really taught to delegate**' is influenced by the underlying sub-themes in this study, expressed here by Mary:

How did I learn and delegate and supervise? ... It's a sort of learned thing really, isn't it? I um ... No, no one taught me to delegate or supervise... No teaching involved at all on that one (Mary, 3:28).

Also resulting from the data analysis are the sub-themes below which are interrelated to the theme:

(a) '**They take direction and action from our cues.**' While the participants are influenced by their understanding and interpretation of delegation, it would appear that the skills of delegation were not formally taught to any of them.

(b) '**We still go back and oversee it.**' This action of overseeing or supervising the tasks the care assistants were doing differed between the participants. Some directly supervised the task, others came back and checked that it was done.

Delegation is a process to be concerned about, and this is also associated very closely with supervision as expressed in the sub-themes, which are further influenced by the

overlapping nature of the supporting data. Accountability needs to be discussed in the context expressed in the participants' experiences. Delegation is described as being a process where "you give someone else the authority to carry out a care task, but you remain accountable for the overall nursing care of the patient" (Parkman, 1996, p. 44).

Delegation is a topic that has had considerable focus because of recent trends towards employment of care assistants in the public hospital setting both nationally and internationally. Literature suggests that as a result, a number of organisations and individuals have developed guidelines for the delegation and supervision of nursing care to the care assistant (McMurray, 1991; Ministry of Health, 1999; Nursing Council of New Zealand, 1999b).

They Take Direction And Action From Our Cues

Consideration of the ability of registered nurses to delegate is influenced by education and experience. Registered nurses are frequently required to delegate, either to other non-regulated staff or to enrolled nurses. Experience will influence the process, impacting on how these skills are carried out. Various factors, including how and where care assistants fit into the skill mix within a particular clinical setting, their own understanding of delegation and how they respond to supervision, are also influenced by their previous experiences. This will ultimately have an effect on the outcome of the process. This participant considered it was different to delegate to a care assistant:

Yeah, and it's a lot different from delegating to, say, an EN (Cassie, 6:11).

Cassie's reasoning was based on her experience with enrolled nurses, as their training gave them greater knowledge, which therefore required less supervision following delegation of an assigned task. Interestingly, the teaching of delegation and supervision as a process has become more topical as registered nurses discovered that delegating to care assistants has different legal implications to delegating to enrolled nurses. The issues of delegation are of importance when looking at the differences between delegating to regulated and non-regulated groups (Warr et al., 1998).

To me delegation is quite scary

As a relatively new registered nurse with little experience in delegating, this participant describes how she felt about delegating to care assistants:

To me...to me delegating is quite scary. I mean, I am still getting to grips with my own role...and to delegate parts of that off... (Mary, 3:14/15).

Delegation was a concern for most participants; Mary in particular hesitated to delegate at all. This was based both on her inexperience and on her uncertainty of the care assistant role, which resulted in her choosing not to delegate her work:

I don't delegate my work, so I probably don't find I have a problem. I mean, I tend to do my own work. I usually, as I said before, because I am new I want to do it properly and I am quite fussy... and I want to do it myself and I don't like delegating (Mary, 3:14).

Mary's concern was that if she delegated a task that then resulted in an unsatisfactory outcome for the patient this would be seen as a reflection on her nursing practice. Because of her position as a new registered nurse she was reluctant to accept the responsibility of care assistants doing patient care.

To delegate to an enrolled nurse, for example, is a process that is quite clearly stated in the Nurses Act 1977. Enrolled nurses, because of their training, require less direct supervision than care assistants, who have minimal training. Guidelines in the institutional policy and Nursing Council of New Zealand (1999b) require a care assistant to have direct or indirect supervision. Direct supervision requires the registered nurse to be present, working with and directing the care assistant under supervision, whereas indirect supervision requires the registered nurse only to be in the same facility and accessible. The process of delegation and supervision is also influenced by the care assistant job description in their area of work (Nursing Council of New Zealand, 1999a or b).

So um, it's really... I don't delegate, um, patients, direct patient care to the care assistants unless I am actually there, and then I am not really delegating... it to them, because I am on the other side of the bed (Helen, 5:33).

Helen found that her clinical relationship with care assistants did not require her to delegate very often. When she did delegate she directly supervised rather than indirectly supervised because of the close proximity of their clinical setting.

We learned delegation from others

Participants said they were never specifically taught to delegate. The following participants offered examples when questioned on how they learned these skills:

By being delegated and supervised to myself [laughter] (Anne, 1:49).

Um, from watching other people (Cassie, 6:21).

I just learned it on the job...no, there was nothing about that in training (Rose, 8:20).

Registered nurses appeared to accept that delegating was a skill they obtained through experience; they said they gained their knowledge by watching how other registered nurses delegated and supervised, consequently copying this observation (Barter & Furnidge, 1994; Parsons, 1997). Anne describes how she delegates to care assistants:

So in that... that to me means that they assist me when I need... need their assistance. They take direction and action from my cues, and if they believe... if they see something that needs reporting, I think it is their responsibility to tell their supervisor, which is a registered nurse (Anne, 1:13).

Yeah, so I believe it is really important to delegate, and if the care assistants are free and they are around I do use them (Cassie, 6:11).

To delegate to a care assistant there needs to be an assessment by the registered nurse of the suitability of the function to be performed, the patient's condition, and the suitability of the care assistant to perform the function safely (Boyes, 1995; Huston, 1996; Parkman, 1996). As registered nurses take on the role of supervising and delegating to care assistants it becomes obvious that they have had little preparation in these skills. The majority of the literature supports the idea that for registered nurses to become confident in this skill they require specific education on delegating (Crawley et al., 1993; Davis & Farrell, 1995; Dewar & Clark, 1992; Krainovich-Miller et al., 1997; Lengacher et al., 1993; Parsons, 1997; Siehoff, 1998).

The experience to delegate

Newly appointed or inexperienced registered nurses may feel insecure when placed in a role that carries with it an expectation to delegate to others. McMurray (1991) considers staff have a tendency to return to the more familiar skills such as clinical functions rather than take on skills required for a new position. This initially appears to happen when registered nurses first graduate, as they feel uncomfortable with the process of delegation:

Now that I am capable, like, I am a lot more experienced than I was as a new grad. and I have all my second levels and first level IVs, I see them as more important, and I am actually one of the only people on the ward that can do certain things and so therefore what I try to do is delegate my workload, and it usually gets delegated to the care assistants if it's just something basic, so, yeah, I do now that I can see my time is probably more important in some areas... (Cassie, 6:10).

There is a certain amount of frustration expressed by the participants with care assistants' abilities to perform a delegated task and, on completion, to report any relevant information to the registered nurse (McLaughlin et al., 2000). The issue here is associated with the information that the care assistant was given when the task was delegated. Before the task is delegated to the care assistant the competency should have been successfully completed by the care assistant and assessed by a registered nurse. The

problem is clear cut, as often the registered nurse is unaware of what competencies the care assistant has actually done, unless she has been the one assessing the competency.

Who should assess the patient?

Some of the participants had preconceived ideas of what the care assistant role would be when doing basic nursing care, and some had an expectation that they would help by doing non-nursing duties. The belief that registered nurses need to do basic nursing care to assess the patient is still open to discussion as suggested by this participant:

Some would argue, we could say showering is a good one of those, but then nurses would argue it's a great time to assess the patient, to look at the patient, but I think nurse aides could be trained or care assistants could be trained to look at that, you know [skin] integrity and things like that, because it is very [time] consuming for some people to be showered, and it takes a big chunk out of your day (Cassie, 6:14).

This participant showed concern, suggesting that care assistants were unable to assess patients:

Yeah, basic, basic nursing cares as in... but they... they are not trained to look any further as to what it can lead to... (Pat, 7:21).

Although care assistants training may exclude assessment skills they are able to perform basic nursing care according to hospital policy. The registered nurses' role is to assess the patient then make an informed decision about the suitability of the function to be assigned to the care assistant, as indicated in the Ministry of Health guidelines. Within this role registered nurses have an obligation to ensure they supervise the delegated care provided by care assistants.

We Still Go Back And Oversee It

Registered nurses have become comfortable with delegating to enrolled nurses who only require minimal supervision. Barter and Furmidge (1994) consider that as a large number of registered nurses have been practising for a number of years, they are not accustomed

to delegating to those who require more direct supervision. This has made it a challenge for them as they try to adjust to the changes required when working with care assistants:

I actually prefer to get to... to do my own basic nursing cares myself, and have them [care assistant] come and assist me. I tell them what I want from them, what they need to give me a hand with (Anne, 1:8/9).

Um, so I sort of wanted to, I suppose, protect my patients and... and push them [care assistant] out of the way and say 'No, I prefer if I did that myself', or have them work with me, but then I would give them the cue as to what I actually wanted them to do for me... (Anne, 1:5).

Anne was referring to when care assistants were first introduced to the hospital where she worked. Since then she has started to delegate to certain care assistants as she has come to know their individual capabilities.

Do they understand the task?

Although the participants have delegated tasks to care assistants they are still responsible for a safe patient outcome. This resulted in them questioning the care assistants' ability to understand what was required of them:

[...] a basic nursing care like a sponge, for example, or having them shower a patient, that I need to go back and check that that's actually happening, making sure that they are actually doing what I have actually asked of them (Anne, 1:18/19).

[...] that they know what they are doing and I check that they under... understand what the task is first (Cassie, 6:12).

I just... I just tell them [care assistant] what needs to be done and how to do it... (Helen, 5:33).

Better communication with care assistants could result from registered nurses giving clear, concise instructions that enable the care assistants to understand the requirements of the task (Nursing Council of New Zealand, 2000b).

We do supervise

It is important to discuss how the participants supervised care assistants. Most used the term oversee rather than supervise, or talked about not taking their hands off the task. Cassie describes how she supervises the task she has delegated to a care assistant:

[...] even though I have delegated tasks, I haven't actually taken my hands off the task, I still have to go back and oversee it... I still feel responsible for the task, and I will go back and check that it's done... (Cassie, 6:12).

Um, it's more just going back and seeing whether something was done properly, or making sure that they are confident enough to ask if they don't know (Cassie, 6:20).

This participant has accepted that care assistants are able to do some of the functions that she has less time for. Her assessment of the competencies may have helped her to understand that care assistants were employed to do a particular job. She has used a process of delegation that enables her to assess the suitability of the task to and the safety of the patient for the ability of the care assistant.

But anything I need, I think they should be aware of, like, in fact the only patients that I would really give her, though, would be straightforward ones, but it maybe only then they need supervision rather than anything more, and basically I leave it up to them then, yeah. And I might pop in and see how she is going with the shower and that she keeps the patient comfortable... And are safe and all that sort of thing, but basically I leave it all to them to a certain extent... I suppose, yeah, I supervise, probably (Mary, 3:27).

Initially Mary did not like to delegate, however, with a little more experience in her new role she has now accepted that some patients would be suitable to be assigned to care

assistants, whereas the following participant is quite clear that she is responsible for supervising the care assistant:

Initially, I believe that the care assistant role is to assist the registered nurses under the supervision of the registered nurse (Anne, 1:13).

As previously discussed, care assistants were introduced to the hospital specifically to assist registered nurses.

Summary

It is clearly demonstrated that the participants found that delegation and supervision were difficult because of a lack of formal training. It becomes obvious that historically it was usual to gain the skills of delegation and supervision through experience and the observation of other registered nurses. Having no formal training in these skills was complicated by the introduction of care assistants into the skill mix in the public hospital. Participants had little knowledge of care assistants' mandated competencies, which caused inconsistencies when assigned tasks were delegated. This lack of awareness hindered the process of delegation, as the capabilities of care assistants were not always known. Supervision of care assistants varied as the participants had their own ideas on the amount of supervision required when a task was delegated. These actions included everything from direct supervision, occasionally checking on the safety of the patient, to an expectation that care assistants would report anything untoward.

Overall, the issues of delegation and supervision of care assistants by the participants were problematic. There was an obvious hesitation in the process of delegation until the participants could become familiar with the care assistant's ability to perform a task. Knowledge of the care assistant's levels of competency should be readily available to registered nurses; the accessibility of this information would have reduced some of the complications of delegation and supervision. Registered nurses require education on the decision-making process if delegation and supervision of care assistants is to be a success.

CHAPTER SEVEN

Discussion

Introduction

This chapter explores the themes that emerged from the data analysis in relation to the implications for nurses and nursing practice, nursing education, policy making and further research. While findings of this small qualitative, descriptive study cannot be generalised to other settings, they do illuminate the concerns that surround registered nurses' practice when working with care assistants. The recommendations from this study are for further research and nursing practice. The title of this study is derived from participants who questioned whether working with care assistants was safe – one described it as 'a dangerous game'. This was demonstrated in the major themes as they depict registered nurses' uncertainty of the care assistant role. Their legal responsibilities for the delivery of care to patients when delegating to and working with care assistants all demonstrate the possibility of patient care being compromised.

Limitations of the study

By design, this was to be a small, qualitative, descriptive study exploring the experiences of registered nurses in one public hospital in New Zealand. The findings therefore represent the experiences of that particular group of participants, and cannot be generalised to other groups or settings. Another limitation was that the participants were not representative of all of the clinical areas in the institution. Also some of the participants only worked day shifts, while others worked at night, which may have influenced the way they worked with care assistants.

It is necessary to mention at this point that the findings from this study do provide insight into these participants' experiences. Given that the introduction of care assistants to the skill mix was not a recent event, it is interesting to note that some of the registered nurses were still uncertain of the care assistant's role. Some of the participants also reported that they preferred to work with enrolled nurses, as their training was more in depth. Most of the participants perceived that care assistants were in effect there to

replace enrolled nurses: as the numbers of enrolled nurses decreased, the numbers of care assistants increased.

Implications for nursing practice and education

Implications of this study for nursing practice and education are apparent from the study findings. Overall, the findings suggest that the majority of participants accepted that care assistants were indeed helpful to their nursing practice, albeit with reluctance and with some reservations. However, care assistant training was limited and this presented numerous challenges for the participants. The study also revealed that registered nurses were often ill prepared to work with care assistants. Their limited knowledge of the care assistant capabilities contributed to the difficulties they had when delegating and supervising. The participants' responsibilities resulting from working with an unregulated care assistant created fear and uncertainty of the consequences of the care assistant's actions, the participants' primary concern being that of the patient's safety. The following discussion demonstrates that the findings suggest a number of implications for nursing and education.

I'm not sure what care assistants should be doing

The findings from this research indicated quite clearly that the participants perceived the function of the care assistant role as being ill defined. The issue of the lack of clarity of the care assistant's role was also supported in the review of the literature (Neidlinger et al., 1993; Orne et al., 1998; Reeve, 1994; Salmond, 1995). Registered nurses' perception of the care assistant role and their attitudes toward care assistants are evident in the literature (Huber, et al., 1994; Kravinovich-Miller et al., 1997; Malby, 1990; Orne et al., 1998). The lack both of standardised training and of definition surrounding basic nursing care is also demonstrated in this literature (Blegen et al., 1992; Chang, 1995; Davis & Farrell, 1995; Dewar & Clark, 1992; Hayes, 1994; Walton, 1989). The participants demonstrated this when they indicated they were uncertain what care assistants should be doing. This was also reflected in the registered nurses' own role, as some participants said they felt threatened by the unknown limitations of the care assistants' functional role. These study findings show that the majority of participants underutilised care assistants, in relation to the breadth of the job description of care assistants in this institution, as the participants suggested they were protecting their own practice. This

was influenced by the fear of losing some of their clinical practice to this group. Participants also suggested that their reluctance to accept the care assistant was to protect their patients' safety.

The findings showed that although the participants saw a need to have assistance with their increasing workload they discovered that the abilities of the care assistants varied. Often their area of placement limited their suitability to a specific clinical area. In conjunction with this, some participants reported that care assistants not only challenged the boundaries of their functional role but also at times exceeded these boundaries with apparent registered nurse approval, potentially compromising patient safety.

The participants suggested that care assistants should have a qualification, as this would enable them to do work similar to that of an enrolled nurse. The findings indicated that there was a place for care assistants in the skill mix; however, the participants were not consistent in what they thought the care assistant should be doing.

Findings from the study present some insight into why registered nurses are uncertain of the care assistant role within their practice. The participants' perception of this role is complicated by their ambivalence towards care assistants in general. The majority stated they would rather have an enrolled nurse. These findings show that each participant had a different expectation of care assistants' functional role, depending on the particular clinical setting. Registered nurses used care assistants as appropriate to the clinical setting, rather than the functional role for which they were trained.

This study's findings suggest that 'basic nursing care' continues to be a difficult issue, even though the participants indicated that the reason for introducing care assistants was to release registered nurses to allow them to focus on the more complex issues of their practice. Some participants had identified that care assistants' mandated competencies, when completed, should allow them to do 'basic nursing care' as depicted by hospital policy. Findings suggest that the phrase 'basic nursing care' is ill defined, giving rise to different interpretations that frequently result in ambiguity. This is further complicated by some participants suggesting care assistants should do no more than make beds. Some participants felt they should retain 'basic nursing care,' as that was when they assessed

the patient. They felt care assistants had insufficient training to notice subtle health changes, easily detected by a registered nurse.

These findings need to be addressed to clarify the care assistants' functional role, not only for registered nurses but also for care assistants themselves. Registered nurses must have a clear understanding of the care assistant job specifications and training to ensure that care assistants are used appropriately. Registered nurses must also be clear about what constitutes 'basic nursing care' in the context of their own practice.

Recommendations for further research are to:

- Define 'basic nursing care' in the context of the care assistant role
- Establish systems of care delivery, i.e. partnership models of registered nurse/care assistant suitability specific to clinical settings
- Develop an acceptable care assistant role in collaboration with registered nurses, nurse educators and hospital personnel
- Establish the effectiveness from the patient's perspective of the quality of care in the present skill mix of registered nurses working with care assistants

We have overall responsibility for the work of care assistants

The findings indicated that the participants were aware that, as registered nurses, they had a responsibility for the work delegated to care assistants. Both the findings and the literature established that registered nurses were concerned about their responsibility for care assistants when working with them (Hansten & Washburn, 1996; Jung, 1991; Ministry of Health, 1999). The literature also supports this theme, with references to registered nurses' concerns about care assistants unregulated status, and the legal responsibilities of delegating work to this group (Barter & Furnidge, 1994; Elliott, 1995). However, their awareness of this ongoing responsibility was not always consistent, and it is evident that care assistants were encouraged to perform activities outside their functional role. Because the participants are required by law to reach and maintain certain standards of practice to remain registered, they were concerned about both the legalities of practice when working with unregulated care assistants, and the implications that might occur should the care assistants exceed the boundaries of their functional role. One participant identified a situation that could have resulted in tragic

consequences for a patient when a care assistant attempted to carry out a procedure reserved for a registered nurse. However, if the care assistant performed this task that was not delegated to her, the care assistant is then responsible for her actions. The concept of being legally responsible for a care assistant who might compromise patient safety continues to be a concern. In an attempt to clarify some of these issues, guidelines have recently been published.

The study findings suggest that the unregulated status of care assistants and the legal issues that arose from this were recognised by some participants. They stated that at times they had to be really careful for fear patient safety might be compromised. Other participants acknowledged they were not fully aware of the legal implications of working with unregulated care assistants. These findings also suggested that although participants were concerned that there were legal issues when working with care assistants, they did not seem to be clearly aware of their own legal responsibilities when working with this non-regulated group.

The implications from these findings suggest that at times registered nurses are not fully conversant with the Nurses Act (1977). Registered nurses require more information and guidelines that will contribute to a better understanding of how the care assistant fits into the present skill mix. This could best be achieved through educational requirements if care assistant training was standardised throughout New Zealand. This would enable hospitals and educational facilities to incorporate such guidelines into future curricula and policy. Some participants' suggest that care assistants too need to have a clear understanding of their own functional role.

Research is recommended in the following area:

- How registered nurses learn of their legal responsibilities when working with care assistants
- Definition by care assistants themselves of their understanding of the breadth of their role
- Clarification of deficiencies in registered nurses' knowledge of nursing legislation

We were never really taught to delegate

The study provided evidence that the skills of delegation and supervision were lacking as all participants reported they had no formal training in such skills, and were never actually taught to delegate or supervise. This was not something any of them remembered as being part of their pre-registration curriculum. These findings were also clearly demonstrated in the literature (Bethel & Ridder, 1994; Davis & Farrell, 1995; Dewar & Clark, 1992; Gardner, 1991; Hansten & Washburn, 1996; Huston, 1996; Orne et al., 1998; Thomas & Hume, 1998). It appears that it has been acceptable for registered nurses in the past to gain these skills through experience and by observing others. This lack of formal training created problems in delegating to care assistants. The participants reported that delegating to unregulated care assistants was quite different from delegating to and supervising the enrolled nurses. This was further complicated by participants' inconsistent knowledge of the mandated competencies of minimally trained unregulated care assistants. This lack of knowledge might contribute to compromising patient safety if a registered nurse delegated a task outside the functional role of the care assistant. The findings suggest that unsafe delegation and supervision could very well compromise patient safety. The majority of participants admitted to a lack of knowledge regarding the care assistants' functional role. A few participants had been involved in assessing care assistants for their competencies and consequently were more aware of their functional role. It would be advantageous if individual care assistant's records showing competency achievements were more accessible to registered nurses in a database or something similar. This information would require regular updates as care assistants progress through their competencies. The greater accessibility of this information would reduce some of the complications of delegation and supervision for these participants.

The findings suggested that the delegation of an action resulted in two types of supervision. Some directly supervised the action, while others came back and checked that the action had been completed. The guidelines for practice include both types of supervision. The provision however is that the registered nurse makes an assessment both of the patient's condition and of the care assistant's competence to carry out the activity being delegated before any action takes place. Only then can an informed

decision be made ensuring a safe outcome for the patient, the care assistant and the registered nurse.

The study findings suggest that although care assistants can be of help to registered nurses they were not always fully utilised in the clinical setting. This was in part due to registered nurses checking on care assistants to see if they had completed the activity delegated to them because the registered nurse was unsure of the care assistants' level of achieved competency. The alternative practice was that of the registered nurse carrying out the activity herself in the knowledge that it had been done to her satisfaction.

Overall, registered nurses need someone to help them with their increasing workloads, as suggested by the participants. The majority of participants supported the idea of the employment of enrolled nurses, as for them they were the ideal second-level nurse because of their level of training and the fact that they were regulated. Other participants suggested that they did not mind working with care assistants but there would need to be changes to their training. It is interesting to note that only two participants suggested that the ideal person to work with would in fact be another registered nurse but in reality, because of restricted funding, this would never happen. The conflicting views of the usefulness of care assistants were very much influenced by the inconsistencies of the registered nurses' own knowledge of the care assistants' functional roles.

Recommendations:

- Research should be undertaken of registered nurses' understanding of delegation and supervision processes.
- A process of educating registered nurses to delegate and supervise unregulated care assistants and other levels of nurses should be developed

Further considerations

Recommendations are that further research is required to explore the experiences of registered nurses in other public-hospital settings where care assistants are employed and trained. The findings in this research indicate that for registered nurses working with care assistants there are issues that need addressing. Consideration should be given to regional hospital orientation programmes for registered nurses to include information on

the care assistant role inclusive of their competency modules and their legal responsibilities under the institution's policies. Appraisals of registered nurses to meet a competent level of delegation and supervision should also be considered by the institution.

It is suggested that the present system of delivery of care that has registered nurses working with care assistants be further evaluated to see whether it is effective. In the light of this, further research needs to establish exactly where the deficiencies are.

Conclusion

In conclusion, this qualitative, descriptive study allowed the researcher to explore registered nurses' experiences of working with care assistants at one regional public hospital. This is seen as a limitation to the study, therefore the findings are not intended to be generalised to other hospitals. The size of the sample also imposed limitations, as did the method of research and the numerous clinical settings from which the participants were drawn.

Findings from this study did, however, raise some issues for registered nurses both in practice and in education. There are implications for nursing practice and education when registered nurses work with care assistants. Recommendations have been suggested for future research in terms of knowledge of care assistant's roles and their achieved competencies, the registered nurses' responsibilities when working with these unregulated care assistants, and the deficiencies in registered nurses' competences when delegating to and supervising care assistants. While the findings appear at first to be negative, they need not be seen so; they should be viewed as a positive contribution to improve nursing practice and educational requirements.

The researcher feels that the study findings do contribute towards filling the gaps in New Zealand literature in this area, and the adjustments they highlight need to be recognised by nursing to accommodate New Zealand's constantly changing health system.

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REGISTERED NURSES ARE INVITED TO
PARTICIPATE IN A
RESEARCH PROJECT

**WORKING WITH CARE ASSISTANTS:
WHAT ARE THE ISSUES FOR REGISTERED NURSES?**

**I AM A REGISTERED NURSE ENROLLED IN A MASTER OF ARTS
(NURSING) AT MASSEY UNIVERSITY UNDERTAKING A RESEARCH
PROJECT THAT WILL EXPLORE REGISTERED NURSE EXPERIENCES OF
WORKING WITH CARE ASSISTANTS**

REQUIREMENTS FOR TAKING PART IN THIS PROJECT

- YOU NEED TO BE A REGISTERED NURSE
- YOU ARE EMPLOYED BY [Hospital]
- YOU NEED TO WORK, OR HAVE WORKED,
WITH CARE ASSISTANTS
- YOU NEED TO BE AVAILABLE FOR 1-2 INTERVIEWS LASTING
APPROXIMATELY 1 HOUR ON EACH OCCASION
OVER THE NEXT 6 MONTHS
- IF YOU ARE INTERESTED PLEASE CALL:

CHRIS HERD

Phone [REDACTED]

or

[REDACTED]

“Permission for this study has been granted by [Hospital]”



WORKING WITH CARE ASSISTANTS: WHAT ARE THE ISSUES FOR REGISTERED NURSES?

INFORMATION SHEET

My name is Chris Herd and I am currently undertaking a research study as part of my Master of Arts (Nursing) degree at Massey University. I am a registered nurse undertaking my study part time. At present I practice as a charge nurse in Elder Care facility in the private sector. This research study is a requirement of this degree. My supervisor for this study is Lesley Batten who is also a registered nurse.

I am seeking participants in the study described below and I invite you to participate. You are free to ask questions before making a decision and you are under no obligation to participate.

Study outline:

The purpose of this study is to explore the experiences of registered nurses working with care assistants in the public hospital setting.

Your Participation:

If you agree to participate in this study, your involvement will consist of one or two interviews, each of these lasting approximately an hour. An initial meeting will be to discuss the study and to gain your consent and if you agree we may have the first interview at this time. I may invite you to participate in a second interview at a later date if I need to gain further information. With your consent these interviews will be audio-taped and then transcribed onto paper. Following the interviews you will be sent a copy of the transcript giving you the opportunity to read this and amend any portion or add anything to the discussion. At this time I may also ask you to identify the main points from our discussion. You have the right to decline to participate at any stage of the interviews, you may refuse to answer any questions asked and have the right to withdraw from the study and therefore withdraw your information at any time prior to returning the final transcript to the researcher.



Confidentiality and Anonymity:

At the first interview I will ask you to choose a pseudonym by which you will be known during the study. At no time will your real name or any other information be used that could identify you be included in the verbatim excerpts from the transcripts which will be included in the research document, reports and publications. The pseudonym you give and the deletion of any identifying features should maintain your anonymity. The audiotapes will be locked in a cupboard once they have been transcribed (typed onto paper). Only my supervisor, the typist (who will sign a confidentiality agreement) the examiner of the thesis and myself may read the transcripts. At all other times they will be locked in a secure cupboard.

Your Rights:

- Prior to the study I will ask you to sign a written consent form. This will be your agreement to participate, and to demonstrate that you understand what is required of you by your participation in the study.
- The consent form will state that you have the right to withdraw from the study and therefore withdraw your information at any time prior to returning the final transcript to the researcher.
- Please feel free to ask any further questions about the study as they occur to you during your participation.
- You may also refuse to answer any particular question at any time during the study and request that the audio-tape be turned off during the interview.

At the conclusion of the study, I will provide a summary of the research findings for you. You will also have access to a copy of the completed thesis. I will submit a copy of the research report to [Hospital]. Your identity will not be revealed in any of these documents. You will be able to contact my supervisor or myself at any time during the study.

Thank you for taking the time to read this information sheet. If you are interested in being involved in this study please phone me.

Chris Herd

Phone [REDACTED]

Lesley Batten (supervisor)

Phone 06 350 5799 ext 2247

School of Health Sciences,

Massey University



WORKING WITH CARE ASSISTANTS: WHAT ARE THE ISSUES FOR REGISTERED NURSES?

CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand that I may withdraw from the study and therefore withdraw my information at any time prior to returning the final transcript to the researcher.

I may also decline to answer any particular questions.

I agree to provide information to the researcher on the understanding that my name, or any other potentially identifying information will not be used in the research or any publications arising from this study.

I am aware that any disclosure of information that relates to an illegal act of a serious nature may, under certain circumstances, be subject to the due process of the law.

I agree / do not agree to my interviews being audio-taped. I also understand that I have the right to ask for the audiotape to be turned off at any time during the interview.

I am aware that I have the option of either having the audiotapes returned to me or erased by the researcher after the thesis has been examined and the study completed.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signed:

Name:

Date:





WORKING WITH CARE ASSISTANTS: WHAT ARE THE ISSUES FOR REGISTERED NURSES?

CONFIDENTIALITY AGREEMENT (typist)

I agree that the tapes that I am to transcribe contain confidential information.

I agree to maintain confidentiality by not disclosing any aspects of the tapes or typed transcripts with any other person, apart from the researcher for the sole purpose of clarifying content.

No other person will have access to the tapes or typed transcripts while they are in my care.

Tapes, transcripts and the computer disc will be returned to the researcher as soon as they are finished with.

No information will be stored on hard drive/disc.

Signed:

Name:

Date: