

**THE WORK OF REGISTERED NURSES**

**AND CARE ASSISTANTS**

**WITH OLDER PEOPLE**

**IN NURSING HOMES:**

**CAN THE OUTCOMES BE DISTINGUISHED?**

**A thesis submitted for the degree of Doctor of Philosophy**

**by**

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**March 2006**

# **ABSTRACT**

**The need for Registered Nurses (RNs) in the long-term care of older people is being questioned, particularly in the context of nursing shortages, while suggestions for 'professionalising' Care Assistant (CA) roles are emerging. Despite ongoing debates about the importance of their work, research has so far been unable to provide an evidence-base for the outcomes of the work of either RNs or CAs in UK care homes.**

**Using a multi-method interpretive approach, adopting a structure-process-outcome framework and grounded in the philosophical hermeneutics of Hans-Georg Gadamer, this qualitative research sought to illuminate the distinct contributions made by RNs and CAs to outcomes for older people in care homes.**

**RNs and CAs from around the UK contributed 'significant' examples of their work for Phase 1 of the study and Phase 2 comprised researcher fieldwork (observation, interviews and documentary analysis) in three care homes around England. Participants included RNs, CAs, older residents, relatives, home managers and professionals working in the homes.**

**The findings offer a rich and detailed analysis of the realities of the work, much of which takes place 'behind closed doors' and has been described to a limited extent in the literature. They suggest that the CAs' daily support helps residents to function and to feel valued, and that close, reciprocal, family-type relationships develop. The health knowledge and clinical expertise of good RNs is critical in determining residents' health outcomes, particularly in the long-term, and RNs' 24-hour 'perceptual presence' can make life or death differences in acute or emergency situations. RNs also influence the environment, atmosphere and quality of care in the home.**

**In the context of the literature, the findings offer new insights into the role and contribution of RNs and CAs, the outcomes of their work and the priorities of residents. The study produced new models of RN and CA roles in care homes, encompassing dimensions not previously acknowledged in the literature or their job descriptions, and a new framework within which the outcomes of care for older people could be evaluated. The research offers a positive image of work with older people in independent sector care homes.**



## **ACKNOWLEDGEMENTS**

### **Sincere thanks**

*to all of the participants in the research*

*to my supervisors*

*Dr Frances Reynolds, Brunel University*

*Professor Andree le May, University of Southampton*

*to peers and colleagues who supported the study in a range of ways  
including reviewing data, transcripts or draft chapters  
and offering valuable critique and advice*

*Abigail Masterson, Brendan McCormack, Lynne Phair, Deborah Sturdy,  
Jane Buswell, Janet Evans, Jim Marr, John Evans,  
Julienne Meyer, Mary Clay, Mary Cooke, Mary McClymont,  
Pauline Ford, Rosemary Strange, Sharon Blackburn and  
Tina Naldrett*

*to my sister Beryl who conscientiously transcribed all the data  
and many true friends for all the support*

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# **INTRODUCTION**

Services offering long-term support for older people in United Kingdom care homes face a looming crisis according to widespread warnings and, while these focus largely on funding problems (House of Commons Health Committee 2005), staffing is a major concern. Shortages of Registered Nurses (RNs) are now acute in some areas and, in the absence of clear evidence on what nursing achieves, the need for RNs in care homes for older people is being questioned.

A recent major qualitative study of senior executives, claiming to represent 30% of the care sector in England, identified 68% who believed that skill mix reviews are likely to lead to RNs being replaced by Care Assistants with NVQ qualifications. Among the benefits highlighted were “enhancing cost levels” and “releasing nurses back to acute hospitals” (English Community Care Association [ECCA], P&G Professional, Laing and Buisson [L&B], September 2004, p 72). Following her extensive work on skill mix in care homes, Blackburn (2003, p 7) wrote: “I am not proposing that older people should not have access to RNs on a regular basis but I am suggesting that a radical review is carried out regarding what nurses really do on a day to day basis in care homes. Are RNs really required in the numbers specified in the present staffing notices? Should the roles of nurses in care homes be re-examined?”. In November 2004, the Royal College of Nursing organised a debate entitled “Is there a future for nurses in care homes?” (RCN 2004).

While the need for RNs is being questioned, the potentials for development of the Care Assistant (CA) role are expanding, for example through National Vocational Qualifications (NVQs) and the Skills for Health (SfH) initiatives which are developing competency frameworks across health and social care (Training Organisation for Personal Social Services [TOPSS] 1999, 2004). Respondents in the survey by ECCA et al (2004, p 74) highlighted the advantages of “professionalising the role [of CAs] and marketing it positively to potential employees and the general public”.



**This research examines the work that RNs and CAs undertake with older people in UK Independent Sector (private and voluntary) care homes.**

It does not seek direct comparisons between RNs and CAs, which would be questionable on many grounds, not least of which, as Edwards (1997) suggests, is the vast difference in the training that RNs and CAs usually receive.

Rather this study:

- **seeks to articulate the distinct contributions that RNs and CAs make to the care of older people living in care homes**
- **seeks this understanding within the context of how their roles interact in the realities of day-to-day care, and**
- **seeks to offer insight into what might be the outcomes of the work of RNs and CAs.**

Debates about the relative contributions of various grades of staff within the ongoing support of older people, and particularly what RNs contribute in long-term care settings, have not suddenly arisen. Rather they are the culmination of over half a century of trends influenced by government policies which have prompted subtle and gradual shifts from defining long-term care services for older people as health to social and, within this, definitions of the contributions of the grades of staff. Within these trends, fundamental nursing work has, stage by stage, been redefined as personal care and ultimately as a 'bolt-on extra' to general care.

### **THE GRADUAL REDEFINITION OF NURSING IN LONG-TERM CARE**

Almost as soon as the distinction between health and social care was enshrined in legislation (within the National Health Service Act 1946 and National Assistance Act 1948) the boundary between government-funded healthcare and means-tested social care began to shift. In ensuing guidance, as Means (1986) reported, residential care was gradually redefined to include people with conditions originally conceived as health needs, and Social Services began to provide and fund care previously provided and funded by the NHS. The health to social care shift was exacerbated during the 1980s and 1990s when most of older people's long-term care moved into independent sector care homes and the NHS gradually withdrew from its provision (Glasby and Littlechild 2000).



Local authorities took over responsibility for assessing and funding people entering care homes, including those with nursing (Department of Health [DH] 1990a, para 1.7-1.9).

Arguably the most significant policy decision influencing the health to social care shift was that the NHS would be responsible for funding only 'specialist medical or nursing supervision' (DH 1995). At the time the House of Commons Health Committee (1996, para 78, p xxv) expressed concern that, as a consequence, "many people who are now cared for in nursing homes on a means-tested basis would in previous decades have been cared for by the NHS without charge".

The Committee was particularly concerned about "the ambiguous position of nursing and nursing care following the assumption of responsibilities for purchasing nursing home care by local authorities" (1995a, p xlviii) but the impact was potentially more subtle and far-reaching. A policy analyst who witnessed oral evidence to the Committee, wrote that, while much of the debate focused on the difficulties of defining health and social care, "the most difficult and contentious boundary to draw was within nursing" (Wistow 1995, p 235). "The crucial distinction is between circumstances in which nursing is funded by the NHS and those in which local authorities or individuals meet their costs" (Wistow 1995, p 236). He concluded: "these reforms ended the universal access to nursing care, free at the point of delivery and irrespective of care setting which existed since the establishment of the NHS". Following their implementation, general nursing in care homes, the major constituent of long-term care for older people, was firmly under the social care umbrella and means-tested.

The Royal Commission on Long-term Care (1999) agreed that the system was complex, unfair and needed to be changed. It defined nursing as "care which involves the knowledge or skills of a qualified nurse, either in a nursing home or a home which is registered to provide both nursing and residential care" (p 62) but, alongside this, offered a definition of personal care which encompassed many 'activities' traditionally viewed as nursing (p 67). Examples include the monitoring of medication, assessment of continence and "the associated teaching, enabling, psychological support from a knowledgeable and skilled professional" (p 68). In addition the Commission acknowledged that such care would be delivered by people who were not nurses, particularly CAs employed

by social services departments or agencies (p 67). Work traditionally viewed as nursing and delivered by RNs was thus re-defined as personal care and delivered by non-nurses.

While the Commission's recommendation that personal care should be NHS-funded was not accepted for implementation in England and Wales, the government did acknowledge the unfairness of nursing care being NHS-funded in all other settings except nursing homes and pledged NHS-funded nursing care to all who needed it (DH 2000a). The definition of nursing as "registered nurse time spent on providing, delegating or supervising care" was criticised for being "ambiguous, meaningless in practice and viewing nursing solely in terms of a series of tasks" (Ford 2001, p 38), but its consequences found resonance in subsequent debates suggesting that "few tasks needed to be provided by a registered nurse" (Laing and Buisson 2001, p 40). As Ursell (2004, p 26) observed, nursing was thus viewed as "a 'bolt on' to the general care provided in a care home".

Despite protestations that "older people in need of healthcare should not be required to receive that care in a socially driven model " (Ursell 2004, p 26), that is exactly what has happened and, from April 2004-2005, care homes were regulated by the Commission for Social Care Inspection (CSCI).

In addition to government policies, unrelated trends have fuelled the questioning of the need for RNs in care homes, and the debates between the need for RNs and their availability have seemingly become intertwined.

### **THE REDUCING AVAILABILITY OF STAFF FOR CARE HOMES**

Independent sector care homes are the largest employers of nurses outside the NHS and difficulties in recruiting and retaining qualified RNs are reported around England, especially in the south (Laing and Buisson 2004). As Seccombe (2000, p 1) commented, "it is widely acknowledged that the supply of skilled and experienced staff is not meeting current demands and shortages threaten to undermine the effective delivery of health care".



The nursing population is ageing (Buchan 1999) and the proportion of RNs in the UK likely to retire within the next ten years could be as high as 37% (Buchan and Seccombe 2002). There is also evidence that those working in nursing homes are generally older than those in the NHS (United Kingdom Central Council for Nursing, Midwifery and Health Visiting [UKCC] 2002). In addition to shortages resulting from retirement, competition from the NHS to recruit RNs is becoming more intense.

The shortage of trained staff is now recognised as a major limitation to improving NHS healthcare delivery and NHS Plans (Buchan and Rafferty 2003). Furthermore, as the NHS increases RN salaries through the government's initiative *Agenda for Change* (the new NHS grading and salary structure) and more nurses are required in order to meet targets in the NHS Plan (DH 2000b) and the National Service Framework for Older People (DH 2001a, 2003a), care homes will experience considerable pressures in terms of competition for RNs. Between 2000 and 2010, Laing and Buisson (2001) predict that more than 10,000 whole time equivalent RNs will transfer out of the independent care home sector and into the NHS.

In a predominantly female workforce (UKCC 2002, Buchan and Rafferty 2003, DH 2004), the decline in the numbers of females aged 15-29 is a major contributor to shortages of staff in both the care sector and the NHS (Laing 2004b, p 205) and, as with RNs, the Care Assistant (CA) workforce is ageing. In 2000, it was estimated that approximately 25% of Health Care Assistants overall (including the NHS) were 45-54 and 10% 55-64 (Buchan and Seccombe 2002). While shortages of CAs are generally not as acute as those for RNs, many care homes report difficulty attracting suitable staff. Local competition for low-paid, part-time workers is strong, particularly from other service industries and retail outlets, described as 'the Tesco factor' (ECCA et al 2004). There is also competition for CAs from local authority and NHS services, particularly as more attain NVQ qualifications. As Laing (2004a, p 9) observed, pay and conditions offered by NHS and local authority providers are more generous than those affordable by the private care home sector. He concluded: "The gap in pay conditions between care homes and other sectors for similarly skilled jobs is likely to remain a potent factor leading to staff turnover in the future, until such time as it becomes affordable for care homes to equalise pay"

## **FUNDING PRESSURES ON CARE HOMES**

Three quarters of care home residents, mainly older people and people with dementia, are state-funded, and the fees paid by most social services departments throughout the UK are still inadequate to offer reasonable returns to independent sector providers (Laing 2004b, p 235). Despite above-inflation increases in fees from some local authorities, homes remain generally under-funded and it has been estimated that councils would need to pay an extra £127 per person per week for nursing care and £83 for the personal care of older people in order for homes to meet the more demanding care standards set by Government for the new homes registered after April 2002. On that basis, providing for a 'fully modernised' care home sector would cost an extra £1 billion a year at 2003-4 prices and volumes of demand (Laing 2004a).

Many care homes are undoubtedly under-funded. The Registered Nursing Home Association (RNHA 2003) highlights that, while local authority fee increases have been around 3-5%, some as low as 1.5%, care homes face a 20% increase in their registration fees, a 141% increase in fees for Criminal Records Bureau checks (now required for all staff) and additional costs for staff checks under the newly-introduced PoVA (Protection of Vulnerable Adults) scheme. Homes are also facing increased staffing costs through increases in the national minimum wage and holiday entitlements under the European working time directive. In addition to enhanced environmental standards imposed in care homes within the Care Standards Act (DH 2000c) and National Minimum Standards (DH 2001b), 50% of care staff (excluding RNs) must achieve NVQ level 2 or equivalent by 2005. Although some grants are available, care homes have to fund this training. As funding pressures increase Laing (2004b, p 34) predicts that care home owners will find opportunities to increase their profit margins by reducing the number of RNs they employ.

## **AN ABSENCE OF STAFFING GUIDELINES**

While national staffing guidelines have been promised, the DH has indicated that, for the time being, the staffing requirements of the now defunct health and local authority inspection units will continue to apply. A DH-Commissioned



project (Residential Forum 2002) proposed some bandings for personal care but these, at present, apply only to new homes and homes which have varied their registration since April 2002 (Laing 2004a, p 11). No guidance has been published for qualified nursing input in nursing homes but, in reply to a parliamentary question, a government minister said the Residential Forum was working on this and work would be completed by Summer 2002 (Laing 2004b, p 231). To date this has not been published. The government's reluctance to publish such recommendations is understandable. On the one hand it does not want to be seen to dilute standards but, on the other, does not want to increase the payments it makes (Laing 2004b, p 235).

There are principles which can help in calculating skill mix requirements, i.e. the ratio of qualified nurses to other care staff (Heath and Masterson 2000, Residential Forum 2002, Masterson 2004) but, in the current context of RN shortages and pressures on care homes, dilution of skill mix would appear to be inevitable.

### **SKILL MIX DILUTION**

In the current funding shortfalls, staff wages are an obvious target for cutting and, particularly given the shortages of RNs, cost pressures could be mitigated in homes providing nursing care if the skill mix falls below the current benchmark (around 1 RN : 3 CAs).

Laing (2004b, p 205) believes that regulatory agencies will relax skill mix requirements and that the path for this has already been laid in the abolition of the distinction between nursing and residential homes following the Care Standards Act and the introduction of NHS-funded nursing care (DH 2000c). As the hours of nursing input that the NHS will be willing to pay for assessed nursing care needs will be lower than the current levels, Laing and Buisson (2001, p 166) predict that this will result in "a very substantial reduction in the number of nurses working in care homes".

Such changes have been criticised as a 'dumbing down' of nursing homes, as being short-sighted, as potentially leading to a reduction in quality provision that puts individuals at risk, and as in conflict with government 'best value' policies

(Laing 2004a). The contrary view is that skill mix dilution would not compromise quality if complemented by increased training of CA staff to achieve NVQ or similar qualifications (ECCA et al 2004). As Laing and Buisson (2003, p 47) conclude: "such an outcome would also have its attraction to the government by freeing up scarce nurse resources for development within the NHS".

### **NURSING'S LIMITED INFLUENCE**

Despite being the largest professional group in health care, constituting over 80% of NHS staff and consuming nearly one quarter of all health expenditure (Traynor and Rafferty 1997) nursing has not strongly influenced health policy (Gough, Maslin-Prothero and Masterson 1998). In long-term care, even with nurses as the lead clinician in most nursing homes (RCN 2005), national debates have focused on health versus social need and funding with little reference to the contribution that nurses can or do make (Masterson 1997, Maslin-Prothero and Masterson 1998, p 549). Only in the last five years or so have debates about NHS-funded nursing care brought into focus the contribution of RNs but this does not feature prominently in the policy literature, for example the ECCA et al (2004) survey barely mentions nursing.

### **THE INCREASING DEMAND FOR LONG-TERM CARE**

The need for long-term care in the future is assured. As many as one in three women and one in five men will eventually require long-term residential care (House of Commons Health Committee 2005). Despite increasing emphasis on people receiving care at home, Laing and Buisson (2004) argue that, because non-residential alternatives cease to be affordable beyond a certain level of dependency, there will always be a demand for care homes.

The risk of living in long-term care increases from 1% in the population aged 65-74, to 4.8% in those aged 75-84, and to 20.9% in those over 85. Currently four fifths of UK nursing home beds are occupied by people aged 65 or over and two fifths by people 85 and over. Although from 2000 to 2004 the numbers of people aged 85 and over dipped slightly as a result of the reduced birth rate during World War 1, from 2005 onwards this demographic driver in demand for



care home places will reassert itself as the proportion of people aged 85 and over is projected to increase from 2.2% of the population in 2001 to 5.2% in 2056 (Laing and Buisson 2004). As a consequence, the RNHA (2003) estimates that, from 2005 onwards, the demand for nursing home care will begin to increase steadily and the number of places will need to rise by 65% by 2031.

While the numbers of older people are increasing, the numbers of younger people decline. The most recent national census in 2001 showed that, for the first time ever, there were more people aged over 60 than children and by 2031 the numbers of older people will likely outnumber the younger group by 24% (Office of Population Censuses and Surveys 2003). While the connotations of a 'demographic time bomb' are arguably overly negative, the implications of this population shift must be recognised (Henwood 1999).

## **THE IMPLICATIONS**

In the circumstances the need to establish ways of using the skills of all staff to best effect is becoming increasingly urgent. To achieve this we need to learn more about the work that RNs and CAs undertake with older people in care homes, specifically focusing on each role, in order to understand their distinctive individual contributions to care and what might be the outcomes of these.

Such understanding is vital for humanitarian as well as financial reasons. Older people living in care homes comprise one of the most vulnerable populations in the UK, with unique combinations of multiple physical and mental illness (Royal College of Physicians, Royal College of Nursing, British Geriatrics Society [RCP, RCN, BGS] 2000, p vi), coupled with social vulnerability (Royal Commission into Long-term Care 1999, Netten, Darton and Curtis 2001). Long-term care services are vital within the cycle of health and social care (Laing 2004b) and, although considerable ongoing support is provided in private households, most high-cost care is still provided in care homes (Netten et al 2001, p 9). Care homes are also significant in terms of the level of both public and private finance invested in them. In April 2003 the value of the UK care home market was estimated at £10.2 billion (Laing 2004b). Overall annual expenditure on long-term care for older people was estimated to be £10.5 billion and by 2031 (based on 1996 figures) this is projected to increase to 24.5 billion (Wittenberg, Pickard,



Comas-Herrera, Davies and Darton 2001). The average gross lifetime cost to social services of a placement in a nursing bed is £32,000 (at 1996 prices) but the cost varies and about 10% of placements cost over £100,000 (Henwood 2001). Staff costs are by far the largest expenditure item for care homes, consuming 50-60% or more of fees (Laing 2004a).

Despite claims that "nursing home nurses care passionately for their patients" (Ursell 2004, p 27), nursing has been unable to clearly articulate its contribution in long-term care and "within nursing homes the RN presently has a wide role but one that remains overtly defined by legislation and restrictive procedural mores" (RCP, RCN and BGS 2000, p 12, para 6.1).

In the context of the government's "tightly defined category of nursing" and "the huge ethical, conceptual and practical difficulties in distinguishing between the 'nursing' and 'personal' care" which to many are "unfair, unhelpful and unworkable" (Royal Commissioners 2003, para 17), it is timely to look at what RNs and CAs are doing. Thornley (2000, p 457-458) calls for "a reawakening of the historic debate about what 'nursing' work really consists of, and about who is fitted to be a nurse". She argues that "RNs should welcome a more fluid and progressive role for non-registered nurses" and that, "failing that welcome, managers will continue to 'undercut' existing registered staff with their 'cheaper' non-registered nursing team colleagues".

As Henwood (2001, para 108) warns: "if we do not have the understanding to use available staff resources to best effect for older people, the forces behind the steady build-up of pressure at the current time are likely to become even more intensive, and to force a genuine crisis in the care and support services".

The following chapter explains how the research began and the context of the literature within which it sits.

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# **CHAPTER 1: FIRST STAGES** **IN THE RESEARCH** **AND REVIEW OF THE LITERATURE**

This chapter explains how the research began and how the contextual influences were explored. It clarifies the initial concepts and perspectives, including a section which makes explicit my pre-conceptions and 'prejudices' as a researcher embarking on my research journey.

The methods used to study the literature are described, followed by detailed review, deconstruction and critique of the literature covering:  
the work of Care Assistants with older people in long-term care  
the work of Registered Nurses with older people in long-term care, and  
outcomes in nursing and long-term care for older people

The chapter draws conclusions from the literature in order to establish the context and rationale for the study.



## **SECTION 1.1: BEGINNING THE RESEARCH:** **INITIAL CONCEPTS AND PERSPECTIVES**

### **1.1.1: EXPLORING THE BACKGROUND AND CONTEXTUAL INFLUENCES**

The need for the research, the factors potentially influencing it and the feasibility of undertaking it were discussed by the researcher with a broad range of individuals working in the field of older people's care around the United Kingdom (UK). In the early stages of the work, I was linking with 'grass roots' nurses in the field through the membership networks of the Royal College of Nursing (RCN), attending conferences, contributing to projects aiming to develop thinking concerning the work of Registered Nurses (RNs) and Care Assistants (CAs) with older people in care homes, and representing nurses working with older people in emerging Government policies. This helped to ground the research within a realistic and dynamic context.

The research initially encompassed UK perspectives but, as devolution impacted on health and social care policy, the contextual influences on work with older people in care homes became increasingly distinct in the four countries. Phase 1 of the research includes examples from around the UK. The detailed probing of issues within Phase 2 was undertaken in three homes in different counties in England and the policy context discussed, for example how registered nursing is funded, is specific to England.

### **1.1.2: INITIAL CONCEPTS AND PERSPECTIVES**

From analysis of the background and contexts for the study, and informed by my professional experiences, the research process began with the development of some rudimentary orientating constructs in the form of:

- Some definitions to clarify the concepts to be used in the study and the perspectives from which the work was undertaken

- A set of questions to be used initially in interrogating the literature.

I also recorded my personal 'starting point' for the research, including my influencing experiences, beliefs and values.

The use of rudimentary constructs as heuristic devices is recommended on the grounds that researchers inevitably bring their own orientations and ways of thinking as they construe and analyse social phenomena. Rather than claiming inductive purity, Miles and Huberman (1994) suggest that research is 'better' when the researcher's frameworks are made explicit.

### TERMINOLOGY AND DEFINITIONS

Definitions for the terms used in the research include:

**Nursing care:** A service for older people who have their nursing needs identified by a nurse, receive that care either directly or under the supervision and management of a nurse who is registered by the [Nursing and Midwifery Council] (RCN/Age Concern 1997).

**Registered Nurse (RN):** A nurse currently on any part of the register held by the regulatory body. Nurses are described as 'registered' in order to draw the distinction with care assistants who can be described as 'qualified' if they have National Vocational Qualifications (NVQs).

**Care Assistant (CA):** A person offering personal care to older people who may or may not have NVQs.

**Personal Care:** The care offered in response to "care needs, often intimate, which give rise to the major additional costs of frailty or disability associated with old age" (Royal Commission 1999, p xxiv).

**Older people:** Defined in this research as individuals over 65 years of age but the majority of residents in care homes are over 80. The term 'older', rather than 'elderly', is used to acknowledge the heterogeneity in the upper age groups (Wilkin and Hughes 1986).

**Older people's services:** This term acknowledges the increasing policy emphasis on consumer-led services.

**Long-term Care:** This term was adopted by the Royal Commission (1999) in order to acknowledge dependency that is ongoing and likely to be permanent. Laing (1993, p 18) defines long-term care as "all forms of continuing personal or nursing care and associated domestic services for people who are unable to look after themselves without some degree of support". The terminology 'long-term care' avoids the confusion surrounding such terms as continuing or continuous and, although ongoing care is provided by families at home, the term 'long-term care' is most usually equated with institutional care (Ebrahim, Wallis, Brittis, Harwood and Graham 1993).

**Care home:** The Care Standards Act (DH 2000c) removed the legal distinction between nursing and residential homes and all homes are now described as care homes. Those with nursing beds are called care homes with nursing. **For ease of reference, the term 'nursing home' is used in this study to denote 'care home with nursing', as defined within the Act.**

**Nursing home (care home with nursing):** "An establishment which provides residential and nursing care for sick, disabled or elderly infirm people, including the elderly mentally ill ... run usually by the private or voluntary sector. Some nursing homes are dually registered as nursing and residential homes" (Royal Commission 1999, p xxiv).

**Residential care home:** "An establishment which provides residential care, not including nursing, for disabled or elderly infirm people including the elderly mentally ill" (Royal Commission 1999, p xxv).



**Gerontological nursing:** This “encompasses the definition of gerontology (the study of ageing), geriatrics (medical treatments of old age and disease) and geriatric nursing (care of an older person during wellness and illness)” (Wade and Waters 1996, p 5). Nolan (1996, p ix) suggested that gerontological nursing has now become “more than a sum of its parts, creating a new and exciting direction for work with older people and their family/ carers.”

### **QUESTIONS TO GUIDE THE INTERROGATION OF THE LITERATURE**

In view of the breadth of the literature to be interrogated, questions to guide this were formulated. The questions helped me to know in which direction to channel energies initially, to make preliminary decisions about issues, sampling and data gathering devices. Such questions, albeit that they are provisional, help maintain the focus of the research as it develops (Miles and Huberman 1994). They were considered within three main themes (and definitions of the concepts used are given in Appendix 1.1).

#### **The work of Registered Nurses (RNs) and Care Assistants (CAs) with older people in nursing homes**

- How is knowledge on the topic structured and organised?. What are the ontological, epistemological and methodological groundings for this knowledge?
- How have theorists and researchers attempted to investigate and articulate the role and contribution of RNs and CAs with older people in nursing homes/long-term care? What can be learned from this work of relevance to the proposed research? How was previous work successful or problematic?
- What are the key concepts, definitions, theories and debates relevant to this topic? What issues do leading theorists and researchers in the field consider to be the priorities for research?
- What should the proposed research contribute to this understanding?

### Incorporating an outcomes focus

- What conclusions can be drawn from the literature about the usefulness, or otherwise, of incorporating a focus on outcomes or a framework of structure-process-outcome (Donabedian 1966) within the proposed research?
- How could this focus and framework best be utilised?

### The methodology for the study

- Where and how should the proposed research be grounded philosophically, epistemologically, ontologically? What methodology would be most appropriate for the study?
- What are the important considerations, advantages, challenges with each of the methods being considered (e.g. ethical and practical implications of observation)?
- While reading the literature, it would be helpful to reflect on aniological issues (e.g. personal values, beliefs, ethics) that, as the researcher, I bring to the study. How can these best be acknowledged, encompassed and managed within the research?

### RESEARCHER REFLECTIONS: BEGINNING THE JOURNEY

Many scholars argue that no research is value-free in that researchers will never be able to totally extricate themselves from their motivations for undertaking their work, the circumstances within which it came about, or how their research developed. Denzin (1998, p 315), for example, argued that: "life and method ... are inextricably intertwined. One learns about method by thinking about how one makes sense of one's own life. The researcher ... fashions meaning and interpretation out of ongoing experience". Rather than attempt to dismiss one's influences as insignificant, therefore, it is better to acknowledge and work with them.

This study was born in the course of a professional journey. In undertaking, developing and bringing the work to fruition, my values and experiences influenced its framing, its processes and its interpretation. I have therefore made my personal perspectives explicit and have tried to work with them in ways which are open, reflexive, self-challenging and iterative.

This section explains the influences that led me to undertake the research.

From early in my professional career there seemed to be something special about working with older people and so much that could be achieved by good nursing. Older patients often took longer to regain their health and experienced more complications. When they did recover, whether this was after a comparatively long period in an acute ward or within our drastically under-resourced but euphemistically described 'rehabilitation and continuing care' units, there could be such a transformation from the person we first encountered.

Unfortunately my enthusiasm for working with older people, and my beliefs in the complex nature of the work, did not seem to be widely shared. The perception of most of the nurses with whom I worked was that nursing older people was 'just basic care', demanding little knowledge but 'lots of patience and a strong back'. The worst nurses were sent to geriatric units as punishment. The perceptions of other professions were similarly dismissive, particularly the physicians and surgeons who would walk past older people in acute wards saying "refer to the geriatricians" or, in the staff rooms, make remarks such as "the surgical wards are full of rubbish" (i.e. older people that could not be cured by surgery). There was little written about the complexities of nursing older people and what there was suggested it was routine work. Specialist services for older people were housed in the worst facilities (e.g. an infectious diseases complex built in the late 1800s where the rodents outnumbered the patients). Research for my BA(Hons) revealed particularly negative attitudes to older people in acute hospital wards, for example where the nurses would place the older patients at the far end in what they called "the cabbage patch" or "the penthouse suite" so they "could forget about them" (Heath 1988).



As my understanding developed through practice, studying, research and teaching I learned about the value and complexity of nursing with older people and expressed this through writing for academic assignments and publication in nursing journals (Heath 1989, 1993a, b, 1994). The opportunity then arose to promote the value of this work through the emerging national policy agendas and, as the Royal College of Nursing (RCN) Adviser in Nursing and Older People and subsequently the Chair of the RCN's membership group for nurses working with older people, I contributed to a range of policy work (RCN 1993a, b, Heath 1995, 1996a, b, Ford and Heath 1996, 1998a, b), including the 1995 Department of Health continuing care guidance (DH 1995). At this time the lack of recognition of what nurses could contribute to the health and wellbeing of older people, particularly in long-term care settings, seemed widespread, and frustration about this led a small team, under the leadership of the RCN, to try to find ways of demonstrating that expert nurses could make a difference (RCN 1995, 1997a, b, Heath, McCormack, Phair and Ford 1996a, b).

My final spur to undertaking this research was the response from members of the House of Commons Health Committee when I was invited by the RCN to give evidence on the role of nurses with older people in long-term care. Despite detailed descriptions of what nursing could offer in long-term care settings being included in the evidence of both the RCN and the British Geriatrics Society, the response to my examples was "that's a fine oratory ... but where is the evidence". Some committee members remained firmly in their view that outcomes for older people would be little different if care 'tasks' were delivered by family members, care assistants or expert nurses. Their response prompted the then General Secretary of the RCN, Christine Hancock, to comment: "I am horrified that I have left [the honourable member] over such a long period of time in such woeful ignorance of what nursing is" (House of Commons Health Committee 1995b, p 50). Recognition of the scope of what nursing could offer did not appear in the final report.

In all of these key policy developments, there was little research evidence that could be mustered to support the claims that expert nurses with older people could likely offer better care outcomes than others without that expertise. This proved to be an ongoing problem which was brought even more sharply into focus when I contributed

to the preparation of the RCN's evidence to the Royal Commission on Long-term Care (RCN 1998, Royal Commission on Long Term Care of the Elderly 1999).

The need for research into the realities within long-term care settings for older people was obvious. There was little work that picked up the challenge of illuminating and articulating what expert RNs could contribute to the care of older people in long-term care settings. There were also few studies on the work of CAs in long-term care. Because all grades of staff work so closely together in long-term care settings, studying the work of CAs alongside that of RNs appeared to be a priority.

## **SECTION 1.2: LITERATURE REVIEW METHODS**

### **1.2.1: THE OVERALL APPROACH**

A literature review has been defined as "the selection of available documents (both published and unpublished) on the topic, which contain information, ideas, data and evidence written from a particular standpoint to fulfil certain aims or express certain views on the nature of the topic and how it has been investigated, and the effective evaluation of these documents in relation to the research being proposed" (Hart 1998, p 13). According to Hart, a quality review systematically extracts key ideas, theories, concepts and methodological assumptions from the literature, effectively analyses and synthesises these, and encompasses breadth and depth, rigour and consistency, clarity and brevity. The key objective is to provide a clear and balanced picture of current leading concepts, theories and data relevant to the topic of study. This basic requirement is not an end in itself but a starting point for planning the research.

Systematic reviews according to the guidelines developed by the Cochrane Collaboration (NHS Centre for Reviews and Dissemination 2000) are generally considered to be the most rigorous, reliable and transparent, but the principles are based on quantitative research concepts that can be problematic in qualitative research. Rather than qualitative research adopting a 'handmaiden' approach, Booth (2001) argues for a methodology that is more sympathetic to qualitative paradigms encompassing its principles of conceptual and thematic analysis. While it is important for the search process to be free from bias, he argues, it is more important that it be systematic, explicit and reproducible than comprehensive. Thoroughness in this context applies to the rigour of the search process, not to its comprehensiveness. His guidance on qualitative literature reviews informed the current study, i.e:

- The intention is not to identify all literature on a particular topic, rather the major 'schools of thought' in a particular area while being alert to the identification of



variants, minority views and negative or disconfirming cases which add richness to the insights in the review.

- Acknowledging the existence of multiple views. Seeking different perspectives on the topic in hand by searching a broad range of literature.
- Using complementary electronic and manual search techniques to ensure materials are not missed either through the inadequacies of indexing or the selective coverage of databases.

The literature review in this study aimed to be systematic, explicit and reproducible. It employed techniques established in the social sciences in which clusters of ideas is identified and questions are posed to the literature. Using analogies from qualitative fieldwork procedures, each information source can be considered a 'research site' and each author an 'informant'. The literature is searched for relevant and significant contributions to the topic. A cumulative approach is used across a number of databases until repetition of materials occurs and relevant new material is no longer emerging from further exploration. From the questions posed to the literature, critical elements are distinguished, conceptualised, and linked as an organised statement on the existing body of knowledge. The knowledge informs the original cluster of ideas, thus creating a theoretical framework for the study (Helmericks, Nelsen and Unnithan 1991).

Various approaches to searching the literature were adopted and the variety of search methods proved useful in different ways.

**THE BROAD BRUSH APPROACH:** Using keywords and key authors, appropriate electronic databases were searched for relevant and significant items.

**THE INCREMENTAL APPROACH:** Relevant and seemingly significant items were also incrementally tracked. Key articles or other sources within each theme were identified and, from content analysis of the literature and systematic surveillance of the literature lists, additional key items and key authors could be identified. This technique is sometimes described as 'snowballing' (Burnard 1993, p 57).

**MANUAL SEARCHING:** Pertinent bibliographies and publication lists were searched for relevant and significant items.

**RANDOM SERENDIPITY:** This was a continuing process of opportunistically seeking information relevant to the study, such as the archives at the Royal College of Nursing. The work was also discussed with individuals working in the field, who made suggestions or offered key sources.

### **1.2.2: SEARCHING ELECTRONIC DATABASES**

The selected keywords focused on four aspects:

- (Old\* or elder or geriatric or geront\* or aged)
- (Nurs\* assistant or auxiliary or support worker or care assistant)
- (Nursing home or long-term or long-stay or continuing or residential)
- (Outcome or effect\* or quality)

Additional keywords were used to search for literature of methodological relevance.

Key words were truncated to expand the search term (e.g. nurs\* truncated to include nursing, geront\* to include gerontology and gerontological).

The following databases were searched:

Age-Info (Centre for Policy on Ageing database)

British Nursing Index (BNI)

CINAHL

Cochrane Collaboration and the NHS Centre for Reviews and Dissemination.

The Cochrane Database of Systematic Reviews (CDSR)

The Database of Abstracts of Reviews of Effectiveness (DARE)

The Cochrane Controlled Trials Register (CCTR)

The Cochrane Review Methodology Database (CRMD)

English National Board for Nursing, Midwifery and Health Visiting

Medline

UK Clearing House for Health Outcomes (Nuffield Institute)

Unicorn (The King's Fund database)

United Kingdom Central Council for Nursing, Midwifery and Health Visiting / Nursing and Midwifery Council

Searches were also made using the names of the authors whose work appeared to be relevant.

### **1.2.3: MANUAL SEARCHING**

Manual searches of relevant published and unpublished sources were also made, using keywords where appropriate.

#### **BIBLIOGRAPHIES:**

Royal College of Nursing

RCN Steinberg Collection

Centre for Policy on Ageing

#### **PUBLICATION LISTS:**

Royal College of Nursing

Age Concern (England)

Centre for Policy on Ageing

Council and Care

King's Fund

Major nursing publishers.

#### **JOURNALS:**

Journal of Advanced Nursing

Journal of Clinical Nursing

Nursing Older People (formerly Elderly Care)

#### **EXPERTS:**

The advice of experts in the field was also sought.



**LIBRARIES USED IN THE SEARCH PROCESS:**

The libraries used in the search were at the Royal College of Nursing, King's Fund, Centre for Policy on Ageing, Brunel University. Other services, such as the RCN's clinical effectiveness unit, also contributed.

**1.2.4: CRITERIA USED TO REVIEW THE LITERATURE**

<b>SEARCH ASPECT</b>	<b>CRITERIA FOR INCLUSION</b>	<b>RATIONALE</b>
<b>Date</b>	1989 to date	The social policy context of long-term care changed following 1990 Community Care Act (DH 1990) but large-scale, relevant and widely-cited studies were conducted in 1989.
<b>Focal literature</b>	Research in UK independent sector care homes.	Older people's long-term care is now firmly established in the independent sector (see Introduction) where roles and staffing structures are different to within the NHS (see Section 1.3).
<b>Background literature</b>	Relevant research in UK NHS settings.	There is a paucity of research in independent sector care homes. In addition some staff transfer from NHS to independent sector (UKCC 2002).
<b>Peripheral literature</b>	Research in non-UK settings (e.g. USA, Australasia or Europe) is reviewed for potential relevance to the current study.	Studies in areas with an established body of research (e.g. outcomes in USA long-term care facilities) could offer ideas.

<b>Information Sources</b>	All sources; published and unpublished material.	To avoid publication bias. Some key sources are unpublished.
<b>Evidence levels</b>	All levels of evidence.	Breadth and depth of coverage are sought, but critical reviewing will acknowledge level of evidence. 'Opinion' papers can influence thinking.

### **1.2.5: THE LITERATURE REVIEW OVERALL**

The volume and breadth of literature produced by the search was large but the inclusion criteria and 'interrogation' questions proved valuable in maintaining the focus of the review. The range of strategies adopted achieved triangulation in search methods.

Arguably no literature review will encompass the entire body of research and other literature relevant to a topic, particularly one which encompasses such breadth of literature as the current study. In addition, it is questionable whether any search could be entirely reproducible. As Strauss and Corbin (1998, p 48) highlight, "the researcher brings to the inquiry a considerable background in professional and disciplinary literature" and, as Sindhu and Dickson (1997) conclude, even with a comprehensive search, the results of a review may be biased by study selection and analysis. Overall, however, the approaches used helped to produce a broad but focused review of relevant literature.

## **SECTION 1.3: LITERATURE REVIEW: INTRODUCTION**

Although the characteristics of the bodies of literature varied between the topics explored, some general observations can be made.

Research in UK care homes is limited, likely due to the fragmentation and multiple independent ownership of care homes which has not prioritized research. The dearth of research in Independent Sector homes has been highlighted in successive literature reviews. Bartlett and Burnip's (1998a) search of the literature from 1980-1998 revealed that the majority of research had been conducted in hospitals and, of the 46 UK studies in long-term care settings only 11 involved nursing homes. Davies's (2001, 2002) reviews of the literature on the continuing care of older people drew similar conclusions, as have comprehensive reviews by Nolan and his team (Nolan, Nolan and Booth 1997, Nolan, Davies and Grant 2001, Nolan, Brown, Davies, Keady and Nolan 2002).

The small number of relevant studies which have been conducted in UK Independent Sector care homes are discussed in some detail in the following sections. Most of these focused on specific aspects of the work of staff, for example work stress, verbal interaction or emotional labour. Few studies focused specifically on staff roles and functioning and there appears to be virtually no recent research looking into the outcomes of the work of staff in UK care homes.

Studies exploring the roles and functioning of RNs and CAs in UK settings other than care homes, mainly NHS acute units, are acknowledged in this review as they could potentially contribute some background to the current study, particularly as the UKCC's (2002) research into the needs of registrants working outside the NHS suggested some staff movement between the NHS and the Independent Sector. Literature searching also identified conceptual and theoretical frameworks developed in other UK NHS-based specialties which could potentially offer some background to the current research, notably work by Nolan, Nolan and Booth (1997) in rehabilitation settings. However, it is important to acknowledge that there are generally fundamental differences between the NHS and the Independent Sector in terms of



staff roles, the structure of staff teams and available multidisciplinary support (UKCC 2002). Differences between care services are particularly marked when looking at outcomes. As West and Rafferty (2004) highlight, outcomes in acute care are commonly driven by volume (number of cases treated, throughput, outputs). Outcomes in rehabilitation services are often framed within the World Health Organisation IDH framework, i.e. the reduction of impairment, disability, handicap (Nolan et al 1997). In contrast, outcomes in long-term care tend to focus around quality of life issues (e.g. Bowling 1997, 2001, Raynes 1999, Nolan 1999).

Particularly noticeable in some areas of the review, for example on nursing home outcomes, is that most of the work originated in USA. There are suggestions in the literature that USA work has some potential for informing policy and practice in the UK. Indeed some published papers include USA studies in their reviews without acknowledging the distinct contexts (e.g. Perry, Carpenter, Challis and Hope 2003, Baldwin, Roberts, Fitzpatrick, While and Cowan 2003). This literature review concludes, however, that there are clear limitations to the transferability of knowledge, and this view is supported by others (e.g. Buchan, Seecombe and Ball 1996, West and Rafferty 2004). Work within UK and USA care homes is distinct in a range of ways, for example:

- While emphasis on outcomes in UK care homes has historically been minimal, nursing home outcomes research in USA is well advanced, driven largely by legislative, regulatory and reimbursement requirements.
- Most US studies are based on, or at least incorporate aspects of, MDS/RAI (Minimum Data Sets/Resident Assessment Instrument) which is mandatory in US nursing homes and used in other countries but not widely in UK nursing homes. MDS/RAI is a standard instrument for assessing needs and monitoring care and outcomes (Redfern 1999) developed for the UK by teams including Challis, Carpenter and Trask (1996), Sturdy and Carpenter (1995), Perry, Carpenter, Challis and Hope (2003).
- Cultures of care are distinct, for example heightened litigious awareness in USA can lead to more active treatment of older people in long-term care settings than UK, such as nourishing older people with advanced dementia through surgically inserted PEG (percutaneous endoscopic gastrostomy) tubes.

- Nursing roles, particularly in the speciality of gerontological care, are distinct between UK and USA and whereas gerontological nurse specialists have been established for well over a decade in USA these have only developed in UK in comparatively recent years (Heath and Masterson 2000)
- Nursing grades are different. In USA much of the care in nursing homes is given by licensed practical nurses (LPNs), a role which currently does not exist in UK.

Staffing in USA homes is distinct from UK. Ryden, Snyder, Gross, Savik, Pearson, Krichbaum and Mueller (2000, p 654) explained that the licensed nurses who manage care in nursing homes are practical nurses prepared in one-year technical programmes. They estimated that 74% of registered nurses (RNs) in USA long-term care were graduates of diploma or associate degree programmes, 22% had baccalaureate degrees and 3% had masters degrees. In the UK, the percentage of RNs in nursing and residential homes with academic qualifications at diploma or above is estimated to average around 20% (UKCC 2002).

Ultimately therefore, although the literature reviewed encompassed a broad range of work, items selected for detailed discussion are those which constitute the 'focal theory' within which this study nests, i.e. the role and contribution of RNs and CAs working with older people in UK care homes and the potential outcomes of this. In this chapter particular attention is given to discussing studies which are in any way direct precursors to the current research. As identified in the inclusion criteria (Section 1.2.4), and discussed above, studies offering 'background theory', mainly those conducted within UK NHS settings, are acknowledged, as are key findings of studies which are 'peripheral' to the current focus, mainly non-UK work.

The following sections review, deconstruct and critique the literature on:

- The complementary roles and functioning of RNs and CAs - Section 1.4.
- The role and contribution of CAs working with older people in long-term care - Section 1.5.

### Section 1.3: Literature review: introduction

- The role and contribution of RNs working with older people in long-term care - Section 1.6.
- Outcomes in nursing and caring, of varying staffing mix and in long-term care for older people – Section 1.7.

Section 1.8 draws conclusions from the review of the literature in order to establish the context and rationale for the study.



## **SECTION 1.4: LITERATURE: THE ROLES AND FUNCTIONING OF REGISTERED NURSES (RNs) AND CARE ASSISTANTS (CAs)**

### **1.4.1: OVERVIEW OF THE LITERATURE ON RNs AND CAs**

This section reviews the small number of studies which include both RNs and CAs, and particularly those which focus on their complementary roles and functioning. Discussion of this research precedes that focusing specifically on either CAs or RNs in order that the subsequent sections can draw conclusions for the distinct roles and contributions of the two staff groups.

The literature relevant to this section of the review encompassed:

- a few studies in UK care homes, mainly investigating specific aspects of the work
- a few studies in UK NHS hospital and community hospital settings
- a few studies investigating RN perceptions of CA roles
- studies including RNs and CAs in non-UK care homes, mainly USA
- opinion articles

A foundation for distinction between the roles of RNs and the staff who assist them was laid by the UK Central Council for Nursing, Midwifery and Health Visiting (UKCC) in 1988 when they recognized that Support Worker (SW), Nursing Assistant / Auxiliary (NA) and Care Assistant roles were widely developing. The Council believed that the exact nature of specific roles should be determined at local level but they offered some scenarios illustrating how RN and CA roles could be distinguished. These suggested that a CA and RN could carry out the same procedure but that the RN would simultaneously be assessing the condition of patients. For example, the skill required to assist a patient from a bed to a chair would involve the same mechanical manoeuvres but the RN would simultaneously exercise judgement about clinical factors such as respiratory or cardiovascular status

and condition of the skin. The scenarios imply that, compared with CAs, RNs offer some 'added-value' in terms of assessment and clinical judgement.

The UKCC suggested that the SW role could be divided into direct and indirect care and, at the time, the direct care/nursing support role was more contentious with claims that it was creating another level of nurse. The Council acknowledged that SWs were now integral to nursing teams but emphasized that they should at all times be supervised by RNs.

### **1.4.2: RESEARCH IN UK CARE HOMES**

#### **THE ROLES OF RNs AND CAs**

One investigation particularly relevant to the current research, conducted after its instigation, was that of Perry, Carpenter, Challis and Hope (2003). In the context of current policy trends, this highlighted the importance of determining how the RN role could be differentiated from the CA role. Drawing on literature also identified in the current review, the authors highlighted the lack of clarity around CA roles and the difficulties experienced by RNs in defining the nursing role. In order to understand the main differences between their roles and functions, these researchers interviewed nine RGNs and 12 CAs in four English nursing homes. The findings (Perry et al 2003, p 497) suggested that:

- **Registered Nurses** find it difficult to define and limit their roles because they do 'everything and anything' within the home. Coupled with their sense of professional accountability for resident care, this leads RNs to experience difficulty in delegating tasks to CAs.
- RNs do 'anything medical'.
- RNs are 'monitoring and assessing all the time' and, unlike CAs, will notice every resident. According to the RNs, although the CAs knew the residents well, they lacked the training and skills to pick up subtle changes.
- RNs 'continue to perform some personal care activities', possibly because 'they have difficulty limiting their role and feel ultimate responsibility for the residents under their care'.



- **Care Assistants**, by contrast, define their role by what they are 'not allowed to do'. The CAs said they 'could not do things' because there were always trained staff around.
- They had difficulty thinking of areas that were solely their responsibility other than escorting residents to appointments and hospitals.
- The CAs felt some responsibility for the things they did for the residents but said that the RN had ultimate responsibility and accountability.
- They said they would notice change in residents and notify the nurse in charge.
- The CAs commented on not having time to provide adequately for the emotional side of residents' care, merely the 'basic personal care'.

According to both RNs and CAs there were three factors dictating when a nursing task might be handed to a CA, namely policies and procedures, the level of NVQ training of the CA and the RN's sense of accountability. The authors recommended the development of job descriptions that clearly define the roles and responsibilities of both RNs and CAs so that caregivers at all levels understand each others' roles and work together to co-ordinate, plan and provide resident care. Both RNs and CAs agreed that an increase in the number of assistive staff was needed to provide residents with good care and suggest that a measure of resident dependency would be a good method by which to determine staffing levels.

This study offers indicators towards further research and the authors claim that their results may be applicable to most nursing homes. Although the interviews took place in four different nursing homes across England, little contextual information or detail of the homes is offered in the published paper and, given the diversity of care homes, applicability to most homes seems a bold claim. The study also offers insights into the views of what the researchers describe as 'a small convenience sample of nursing home staff' but, in the absence of other perspectives, specifically observation, the results represent an account of the perceptions of the participants rather than of what actually happens in practice. The schedule for the semi-structured interviews was developed following a review of the nursing literature describing the roles of RNs and CAs, but virtually all of the papers listed in this review focused on UK NHS or USA care settings. Although nurse researchers also



contributed to the development of the interview schedule, the potential transferability of key issues in the literature between sectors or internationally was not questioned in the published paper. The researchers also claimed that, in the course of their analysis, the views expressed by the RNs and CAs became repetitive, with no new information being presented and thus 'saturation of the categories was attained'. Given the breadth of the interview schedule coverage and the small number of interviews, the attainment of category saturation could be questioned. The researchers also 'increased' the 'trustworthiness' of their data by reporting the preliminary analysis of the interviews to a 'consultancy panel of individuals interested in the nursing home sector' and modifying their final report according to the panel's feedback. Given this process, it is unclear what specific aspects of the reported results came from the RNs and CAs in the homes and which from the panel.

The authors concluded that further research is necessary to distinguish clearly between the roles and functions of RNs and CAs and their relationship to other factors in the care environment.

### VERBAL INTERACTION

In a continuing care setting Davies (1992) identified communication as a significant difference between RNs and CAs, suggesting that untrained staff were less able to respond to patients' cues or to guide or encourage patients appropriately. From the 24 x two-hour periods of patient care that Davies (1992) tape-recorded, she concluded that trained nurses verbalised their assessment and suggested interventions more frequently than untrained staff. A possible explanation could be that untrained staff did not have the knowledge base and skills required to recognise changes in the patient's condition or felt that it was outside their remit to make such suggestions. RNs also used reality orientation as a verbal strategy more frequently than untrained staff. Davies concluded that RNs need to be sensitive to hidden meanings in conversation and be prepared to offer the opportunity for further self-expression. Rather than simply making value judgements about what is 'good' or 'bad' communication, Davies recommended further research in order to identify patient outcomes in relation to specific elements of verbal behaviour. Video data would provide useful supplementary information.

## WORK SATISFACTION AND STRESS

Dunn, Rout, Carson and Ritter's (1994) questionnaire survey of 112 care staff in 11 nursing homes in the Manchester and Redditch areas examined staff stress.

Following a pilot, a measure of nursing home stress was developed. From questionnaire responses (67% from CAs, 14.5% from enrolled nurses and 18.2% from RGNs), five major stress groupings were identified:

- differing expectations about patient care
- management factors (unsatisfactory wages, shortage of essential resources, insufficient staff per shift, feeling undervalued by management)
- lack of support from other staff (i.e. colleagues who were happy to let others do the work)
- feeling inadequately trained to deal with job demands (e.g. lifting heavy patients)
- work-home conflicts

Examination of the effects of stress showed that many staff were under pressure, with high levels of smoking and alcohol intake.

As the authors acknowledge, their findings may have been influenced by methodological factors, for example they thought that the length of the questionnaire deterred some staff from responding and, as questionnaires were returned to the matron, some staff may have been selective in their answers. Dunn et al (1994, p 182) conclude that there is a need for more research looking at CAs as a group and specifically to study stress and coping from a longitudinal perspective (p 183).

In two UK independent (not-for-profit) residential care homes for older people, Jenkins and Allen (1998) tested their hypothesis that staff burnout/distress would be negatively associated with the quantity and quality of social interactions with residents. Eighteen residential workers (15 with no qualifications, two with relevant City and Guilds, one EN) completed self-report questionnaires and were observed using non-participant, time-sampling and coding of staff-resident interactions. The results suggested that staff who reported higher levels of personal accomplishment (i.e. lower levels of burnout on the personal accomplishment subscale) exhibited significantly more staff-resident interactions. Those who perceived more



involvement in decisions relating to their work showed significantly fewer negative staff-resident interactions. The researchers concluded that staff burnout/distress would appear to be negatively associated with the quantity and quality of social interactions between staff and residents but warned that, because of the diversity of measures used, it was difficult to draw conclusions. Also, while the correlations appeared strong, it was not legitimate to infer causal relationships, and replication of the findings in other contexts was recommended. The authors also highlighted that considering such factors as distress, burnout and job satisfaction together could be misleading as these may have distinct and independent effects on staff behaviour. The study was small, cross-sectional and within group.

In a nursing home in South London, Redfern, Hannan, Norman and Martin (2002) studied the feasibility of working with care workers and very frail service users to investigate links between the levels of work satisfaction and stress of the staff, and the quality of care and morale of the residents. Thirty one staff (20 CAs, 11 RNs) and 18 residents participated. Detailed discussions were held with care staff during pilot work, following which validated scales were used to measure staff job satisfaction, work stress, organisational commitment, perceived quality of care, morale and mental health. Staff-resident interaction was also observed as a direct measure of quality of care and residents were interviewed. The findings reveal that, although staff were generally committed to the home, they experienced high levels of stress and job dissatisfaction. Most stress arose from colleagues not pulling their weight, back-biting among staff, coping with death, coping with residents' pain and distress, and disagreements about good practice. Issues not appearing to cause stress were the service being inadequate, not knowing how to deal with situations, knowledge not respected by managers and relatives' attitudes. Redfern et al (2002) reported significant correlations between satisfaction, commitment, stress and quality of care perceived by staff, specifically that:

- high job satisfaction was associated with high organisational commitment, good home atmosphere, low role conflict/ambiguity and low job stress,
- high commitment was related to good home atmosphere, low conflict/ambiguity and low job stress,
- high conflict/ambiguity was associated with high job stress.

They concluded that job satisfaction is positively related to quality of care.



Redfern et al (2002) acknowledged that the findings may be optimistically biased because some staff did not participate, but they emphasised the importance of staff commitment to the nursing home as this strongly correlated with low conflict and ambiguity, high satisfaction and good quality of care. The authors also highlighted that the period spent by one of them working in the home as a CA was extremely important – probably essential, in securing commitment and trust from residents and staff. Even so, they reported that considerable effort was needed to secure a good response rate from staff and some CAs preferred to respond to the questionnaire items during an interview with the researcher rather than taking it away to complete alone.

The study was small and, as the authors argue, it demonstrates the need for a mixed-method approach so that the links between context, process and outcomes for residents and staff can be understood. They suggest (p 516) that further research along these lines could explain how perceptions of workers, quality of care and outcomes for service users interconnect and conclude that their study “supports the need for further research using a case-study approach in a small number of homes because of the labour-intensive nature of the data collection and the importance of triangulating data from many sources” (p 512).

### **1.4.3: STUDIES UNDERTAKEN IN THE UK NATIONAL HEALTH SERVICE**

Based on the primary nursing framework of Pembrey (1986a, b) in Oxfordshire, Ahmed and Kitson (1993) used semi-structured interviews, participant observation and documentary analysis in two community hospitals for people with learning disabilities. The authors found that, in practice, the deployment pattern of both the qualified and unqualified nursing staff in all settings was influenced by the philosophy which existed in their respective units and the experience and attitude of individual primary nurses. They also identified that lack of clarity in the CA role led to ambiguity and conflict. Ahmed and Kitson (1993) proposed that care for patients with frequently changing nursing needs, due to acute illness, rehabilitation or teaching needs, should be provided by RNs. CAs should be involved in direct care

for people with relatively stable conditions, such as those handicapped by physical or mental disability or trauma. The research concluded that, with the appropriate level of preparation, support and supervision, CAs could be delegated the major responsibility for their care. These authors emphasised the importance of therapeutic relationships. They recommended that RNs should have responsibility for making clinical decisions and appropriately delegating and supervising the nursing care given by CAs, who require support, teaching and role modelling from qualified staff.

Thomas (1994) also concluded that the greatest influence on the amount of communication was the ward organisation, with primary nursing wards offering more communication, regardless of staff grade, than team nursing or functional wards. In nine hospital elderly care wards, Thomas (1994) compared the differential contribution to patient care of 12 RNs and 12 NAs in primary, team and functional nursing wards using nurse-patient verbal interaction as a measurable qualitative indicator. Attempts were made to control for observer effects on the data coding. The findings showed that the most important differences in verbal interactions were found largely across primary, team and functional wards, with RNs and NAs within each ward type engaging in similar patterns of verbal interactions with patients. Although there were differences in the amount and type of communication offered by RNs and NAs, Thomas argued that "auxiliaries are capable of providing therapeutic care for elderly patients within an overall therapeutic ward philosophy and with appropriate qualified nurse role models" (p 242).

Pearcey (2000) aimed to explore and identify the self-perceived role of auxiliary nurses (ANs), to clarify the expectations and knowledge of trained nurses about the role of ANs, to highlight the differences and similarities, to provide clear implications and suggestions for 'role complementation' within nursing teams (p 56). Interviews with ANs and G grade nurses in one hospital trust highlighted role ambiguity between trained and untrained staff; that RNs should ensure they know what all members in their teams were doing and a need for training for unqualified staff. Subsequently 266 returned questionnaires from ANs in nine hospitals in Yorkshire and Humberside region (25% of returns from medical elderly wards) showed that, unbeknown to RNs, ANs may be undertaking work beyond their grading or job



description. However, the results should be viewed with caution as misinterpretation could have occurred. For example, an AN could have agreed with the statement "I decide when a patient gets up" when in fact she did not make this decision. The researchers identified that there can be no substantive evidence that ANs are making such decisions, but questioned the impact on standards of care if they merely think they are.

#### **1.4.4: STUDIES INVESTIGATING RN VIEWS OF CAs**

A range of studies in the NHS, mainly acute hospitals, have explored Registered Nurses' perceptions of CA roles. For example, from a questionnaire survey of the knowledge and attitudes of 120 RNs within a Plymouth Health Authority, Reeve (1994) concluded that RNs were poorly informed about the role of CAs. They lacked any knowledge about CA use, training and competencies and that, although a majority viewed CAs as useful in clinical areas, the uncertainty surrounding their role and function could mean that they were not appropriately utilised.

McLaughlin, Barter, Thomas, Rix, Coulter and Chadderton (2000) used an investigator-developed survey instrument and narratives to examine RN perceptions of, and satisfaction with, nursing care assistants (NCAs) in UK and USA acute hospitals. The team concluded that UK nurses were more satisfied with NCAs and this was, in part, due to greater clarity in the scope of the RN role and the standardised training and duties of NCAs.

In her explorative, descriptive study in a London hospital, Workman (1996) interviewed 13 RNs and eight CAs with some training in order to identify how the RNs perceived the CAs and how the CAs saw themselves. The CAs saw themselves as support workers to the qualified staff but saw little difference in their roles to those of RNs. The CAs believed they acted as a link between patients/carers and qualified staff and provided time for trained nurses to use in therapeutic activities. Ambiguity in their roles arose, so the CAs believed, because the roles of qualified nurses lacked clarity and this affected their expectations of CAs. They also suggested that RNs perceived them as a threat in that they deprived them of the 'real' nursing work.



Workman's self-selected sample was small but the detail in the analysis offers a basis for further research. Her findings also concur to some extent with those from other studies in NHS settings.

#### **1.4.5: IMPLICATIONS FOR THE CURRENT STUDY**

There is limited research looking at the complementary roles and functioning of RNs and CAs working in older people's long-term care. Some distinctions have been identified in care homes (Perry et al 2003) and continuing care settings (Davies 1992). Perry et al's (2003) study, particularly relevant to the current research and discussed in Section 1.4.2, suggested that RNs saw their role as 'anything and everything' while CAs, in contrast, defined their role in terms of what they were not allowed to do.

A theme in the research was the lack of role clarity among CAs (Ahmed and Kitson 1993, Reeve 1994), and the RNs supervising them (Ahmed and Kitson 1993, Reeve 1994, Workman 1996, Pearcey 2000), in both the UK and USA (McLaughlin et al 2000). Other related concepts in the findings were role ambiguity, role ambivalence (Workman 1996), role stress, role strain, role conflict and role overload (McLaughlin et al 2000). Lack of clarity seemed to be exacerbated when CAs had received training, as this blurred the boundaries between their work and that of RNs, and there was also suggestion that some RNs saw CAs as a threat, particularly when the CAs have undertaken NVQ qualifications (Thomas 1994, Workman 1996).

Some studies suggest that the philosophy and organization of individual care settings strongly influence the way RNs and CAs work, and also that CAs are capable of delivering therapeutic care to older people within appropriate ward philosophy and given appropriate role models (Ahmed and Kitson 1993, Thomas 1994). The suggestion was also made that, with RN supervision, CAs could be delegated the major responsibility for the direct care of patients with stable health and support needs, while RNs focused on those with changing needs (Ahmed and Kitson 1993).

#### Section 1.4: Literature: The roles and functioning of RNs and CAs

Studies offer insights into a range of stressors for staff working in care homes (Dunn et al 1994, Jenkins and Allen 1998), how these relate to job satisfaction and quality of care and the potential for involving residents in research (Redfern et al 2002), discussed in Section 1.4.2.

This literature also raises methodological issues which have implications for the current study. From their research, Redfern et al (2002) recommend mixed-method approaches and triangulation of data from many sources in a small number of homes in order that the links between context, process and outcomes for residents and staff can be understood. These authors also highlighted that the period spent by one researcher working in the home was important in securing commitment and trust from residents and staff.

Overall, this body of literature highlights the need for further research into the work of RNs and CAs in care homes, their roles and contributions to care and how they interact within the context of their day-to-day functioning. A particular gap in the literature would appear to be research looking at the outcomes of the work of both RNs and CAs in UK care homes.

## **SECTION 1.5: LITERATURE: THE ROLE AND CONTRIBUTION OF CARE ASSISTANTS (CAs)**

### **1.5.1: OVERVIEW OF THE LITERATURE ON CAs**

Care Assistants (CAs) have long been the 'backbone' of the workforce in long-term care for older people (Adams and McIlwraith 1963, Wells 1980, Norton 1990, Davies 1992, Edwards 1997) and currently constitute the major staff group in long-term care settings (Henwood 2001, Laing 2004a, b). However, this literature review, and all of the studies within it, identify that research into CA work is limited. Given their importance in care delivery, and particularly in comparison with the volumes of literature focusing on informal carers and professionals such as nurses or social workers, the limited research is surprising (Jacques and Innes 1998).

There are few studies into the work of CAs in UK care homes and this has been highlighted by previous reviews. Baldwin, Roberts, Fitzpatrick, While and Cowan (2003) reviewed the literature from 1989 specifically to critically consider the role of the support worker in UK nursing homes. Finding no empirical studies conducted in this sector (just two early literature reviews, Gibbs, McCaughan and Griffiths 1991, Dewar and McCleod-Clark 1992, and a discussion paper, Redfern 1994), the authors reviewed 12 empirical studies in UK NHS settings and a few in USA nursing homes. In their review of the UK and USA literature, McLaughlin, Barter, Thomas, Rix, Coulter and Chadderton (2000) also found little research into the work of CAs and what there was had mostly been conducted in acute hospitals. Moniz-Cook, Millington and Silver (1997) similarly concluded from their literature review that little was known about the experience of CAs in care home settings.

The body of literature identified in this review encompassed:

- limited research in UK care homes
- limited research in UK NHS long-term or continuing care units
- some research in UK NHS acute and other settings
- some research in USA and other non-UK settings



- literature reviews
- opinion articles

In addition, reviews of the work of CAs in care homes have been undertaken for the purpose of informing or influencing government policy, but the scope of these is broader than CA work. For example, the King's Fund Inquiry (Henwood 2001) examined the quality of physical, practical and emotional support to adults who need help for reasons of, for example, frailty in old age. Evidence was gathered from invited written submissions, discussions with key 'witnesses' and consultative meetings with service users and carers. A similar range of approaches was adopted by the Centre for Policy on Ageing (Dalley and Denniss 2001) who were commissioned to investigate the skills and competencies of CAs in homes for older people. The Fawcett Society Report (1997) collated statistical and survey evidence in order to highlight the undervalued, underpaid nature of women's employment in care homes.

In attempting to deconstruct the literature on the work of CAs, it becomes impossible to make meaningful comparisons between a vast array of roles in very different situations. For example the job titles identified by Thornley (2000, p 453) included generic support worker, clinical support worker, healthcare support worker, care team assistant, nursing assistant, ward assistant, community care worker, carers, scientific helper, doctors' assistant, and even bed-maker. In addition, as Edwards (1997) and Baldwin et al (2003) observed, the diversity among CA roles is increased when duties are assigned individually by RNs. According to Thornley (2000, p 453) the confusion around roles is "compounded by a widespread official ignorance about whether these workers are engaged on nursing or direct patient care or clinical duties, or solely on ancillary duties". In addition, there may be differences between the perceived and actual roles of CAs (Baldwin et al 2003) exacerbated, as Lee-Treweek (1994b, p 2) identified, by the fact that much CA work in care homes takes place "back-stage", thus inaccessible to all who do not observe or participate in it.

### **1.5.2: RESEARCH IN UK CARE HOMES**

A few small scale or single researcher studies have been conducted in UK care homes, mostly on specific aspects of CA work.

#### **EMOTIONAL LABOUR AND BODY CARE**

Lee-Treweek's (1994a) ethnographic research in the South West of England sought to reveal the underlying discourse of women working as CAs in two care homes (one nursing, one residential) and specifically the nature of body care, the form it took and how it was enacted. Through 179 hours of non-participant observation of shifts, plus in-depth interviews with staff and analysis of documents such as communication books, data were collected over four weeks. The researcher maintained a 'close research relationship' with the staff and residents in the home, which was owned by friends of her family, over two years.

The CA role, according to their job description, was all-embracing, including physical care, emotional care and general management of the settings. 'General chores' stated on the job description included helping with bathing, serving meals, general domestic duties and talking to residents. From her data, Lee Treweek (1996, p 122) reported that the CAs embellished home life with emotion work not officially defined as part of the job, such as cuddling, kissing, tucking residents in at night and mediating in resident disputes. She suggested that the CAs had developed an autonomous emotional order, which operated independently from formal training or management rules, and that this was a useful resource for them in organising and making sense of the work in the home. This order had set patterns and often involved negative emotional behaviours towards the residents such as control and coercion. Lee Treweek (1996, p 121) suggested that care homes contain many "emotionally displaced people" who were typified by CAs into categories of emotional states, such as 'the lovelies', 'the disliked' and 'the confused'. The CAs in her study perceived emotions as:

- in need of balance because of their mercurial nature
- having an infectious quality that needed controlling
- very dangerous and in continual need of monitoring and ordering



The successful organisation of emotion was presented by CAs as correct and in the best interests of residents. This emotion work operated in subtle ways as part of “the hidden side of care” (1996, p 119), particularly as much of the CAs' work took place “backstage” in residents' bedrooms. Lee Treweek (1994b, p 2) concluded that, in this “hidden” work, “bedroom abuse” takes place and mistreatment becomes “part of the daily grind of getting through the work - of organising people in conveyor belt fashion to time and chore constraints”. The ultimate aim of their work was “the creation of the acceptable patient for public view”, or “the lounge standard patient”.

Lee Treweek's (1994a) research presents a vivid picture of the work in these care homes and it illustrates how pivotal emotions can be in the context of a small organization. She suggested (1996, p 117) that the events and the structure of life in her account were recognized by the CAs in the homes, but acknowledged that hers is only one of a number of possible accounts of the work.

### CARE OF DYING PEOPLE

Using qualitative semi-structured interviews with eight CAs in four Nottinghamshire nursing homes, Miskella and Avis (1998) explored their contribution to the care of dying nursing home residents and their views on their role, preparation, support and supervision. They found generally inadequate preparation for their role, inadequate support and supervision and difficulty accessing formal training. This left CAs feeling uncertain about their ability to care for dying people, lacking in confidence and isolated. CAs tended to see dying older people as a homogeneous group and, although CAs were in an ideal position to develop relationships with residents, some put up barriers to entering what would ultimately be a terminal relationship. Nursing home work was commonly organised around task allocation, and training commonly consisted of more experienced CAs passing on their methods to newer staff. The study concluded that CAs' values and perceptions of dying residents may have an impact on the overall care given and that, although training, support and supervision for CAs may be beneficial, decreasing the isolation experienced by nursing home staff may also make a positive contribution to the care of dying residents.



While this study offered valuable insights into the work of CAs with dying people, it had limitations. The convenience sample, two CAs from each of four nursing homes, selected on the basis of their availability and willingness to be interviewed, was small and possibly subject to selection bias. The interview schedule was generated from the literature, talking to healthcare professional and personal experience of working as a CA. Along with the interview technique, this could have been improved had a pilot been conducted. Also, as the researchers highlighted, participant observation would have enhanced the comprehensiveness of the findings. The research could have been strengthened by the inclusion of conceptual or theoretical framework(s).

### BEDTIME RITUALS

Using semi-structured interviews, Warner (1997) sought to explore the extent to which CAs met individual older residents' bedtime rituals choices in a nursing home. Methodological details in the published paper were incomplete and the author suggested that, as the convenience sample of 14 CAs and five residents was small, the findings were offered as tentative. Warner concluded that CAs need more information and that the contribution of skilled CAs should be more widely acknowledged.

### 1.5.3: STUDIES UNDERTAKEN IN THE UK NATIONAL HEALTH SERVICE

Thornley (2000, p 451) claimed "the first national sample survey evidence and detailed case studies" of nursing auxiliaries/assistants and health care assistants/support workers in the NHS". Data included detailed national questionnaire surveys, in-depth case study interviews in NHS Trusts, and documentary analysis over two years, followed by interviews with Human Resources/Personnel Managers, Nursing Directors and Managers, looking at specific issues of roles, competencies and training. Thornley (2000) found the boundaries between 'ancillary' work and 'nursing' work in the NHS to be highly blurred and fluid, with both the traditional grade of NA and the new grade of HCA engaging widely in 'nursing' duties with job titles used almost interchangeably in most Trusts. Minorities of HCAs and NAs were undertaking 'technical and advanced' tasks including giving drugs without

supervision, running clinics single handed, phlebotomy, running therapeutic groups, organising and chairing client review meetings, training agency staff on nights and giving advice on the telephone (p 454). Thornley (2000) concluded that a fundamental re-appraisal of the real skills and experience of non-registered HCAs and NAs and of their potential was necessary. Her research was comprehensive and surveyed a broad range of NHS Trusts but it did not include direct observation of CA work. The work was supported by the Trade Union UNISON.

#### **1.5.4: EDUCATION AND CARE ASSISTANTS.**

The conclusions of the literature analysed in this review were unanimous that, despite widespread acceptance of the importance of training it is generally recognised that the CA workforce is 'under-trained' (O'Kell 1995, Local Government Management Board 1997, Residential Forum 1998, Hall, Hallam, Jarfe and Meech 1998, TOPSS 1999) and training has particularly been overlooked within the care home sector (Nolan and Keady 1996, Dalley and Denniss 2001).

Dalley and Denniss (2001) conducted a literature review, a postal survey of a stratified sample of care homes in England and Wales and a series of visits to care homes to explore issues emerging from earlier stages. 17% of their sample were nursing homes and 12% dual registered homes. They investigated the extent and content of training for CAs in care homes by exploring the views of owners and managers and identifying some of the problems associated with improving their position. Most home managers felt that there were considerable benefits from training, particularly in improved quality of care and also in the CAs' self worth and career development. A smaller number felt that training was important in developing the CAs' knowledge-base. There was variation in opinion on how far the benefits of training had an impact on staff morale and staff turnover but about one fifth of managers expressed negative and hostile views about training, claiming that staff had no interest and that it increased staff turnover. Dalley and Denniss (2001) concluded that, although there is no shortage of training provision across the country, its availability and probable quality is uneven. Few care homes maintained a dedicated training budget or training strategy and there were some serious gaps in



training, particularly that omissions in induction were not always compensated for at later stages. They stated that in future training will no longer be an optional extra and that care homes will have to establish a training culture for all their staff.

Training to care for people with dementia was highlighted as lacking in some literature, particularly as the proportions of care home residents with dementia is increasing (Silver, Moniz-Cook and Wang 1998, Jacques and Innes 1998).

Despite their lack of training, studies looking at the caring abilities of CAs suggested that they had the potential to deliver therapeutic care (Edwards 1997) if they were provided with appropriate role models and if their work setting operated within a therapeutic philosophy (Ahmed and Kitson 1993). There are also reports that many CAs felt positively about their work and showed high levels of commitment and enthusiasm (Henwood 2001).

There is an assumption that improved levels of training for care staff will have a direct and beneficial impact on the quality of care delivered and this view is supported by government initiatives. However, in the absence of research on the outcomes of CA work, claims that training leads to improved quality of care remain unsubstantiated (Dalley and Denniss 2001).

#### **1.5.5: FINDINGS WITHIN THE LITERATURE ON CAs**

The literature overall suggests that the major aspect of CA work is direct patient care but there are wide variations in what are considered appropriate 'tasks' for CAs to perform (Baldwin et al 2003). Those identified include 'technical' tasks such as bathing, dressing, feeding, toileting and ambulating (Schirm, Lehman and Barton 1996) and advising and counselling patients (Workman 1996) but always underpinned by caring (Neal Garland and Schirm 1998). Some localities around the UK have developed protocols to enable care home CAs to undertake delegated tasks in skin, bowel, bladder, eye, mouth, nail, stoma and diabetic care (O'Kell 1995). Other studies concluded that RNs 'do the paperwork' while CAs 'give the care' (Workman 1996, Thornley 2000), or that CAs give patients the time that the



qualified nurses are not able to give (Workman 1996), 'fill the gaps, talk to patients when no-one else has the time to talk to them', 'anything and everything - the polyfilla' (Ahmed and Kitson 1993).

The few studies conducted in UK care homes, some of which are described in Section 1.4.2, found that many CAs felt under pressure. A range of potential stressors including management factors, such as low wages, shifts, lack of resources, lack of support and some aspects of patient care such as lifting heavy patients or challenging behaviour (Moniz-Cook et al 1997, Dunn, Rout, Carson and Ritter 1994). High job satisfaction was associated with high organisational commitment, good atmosphere, low role conflict/ambiguity and low job stress (Redfern, Hannan, Norman and Martin 2002) and staff stress could be minimised by positive interactions with residents (Jenkins and Allen 1998).

The literature overall highlighted a lack of training or knowledge among CAs to provide optimum care (Baldwin et al 2003). Many CAs are inadequately trained to deal with specific job demands such as challenging behaviour (Moniz-Cook et al 1997, Dunn et al 1994) and people who were dying (Miskella and Avis 1998).

Overall, the small number of studies that have begun to describe the world of CAs working in UK Independent Sector care homes are to be applauded in that they have laid some foundations, highlighted a range of issues to be explored in further research and offered pointers to methodological issues. Some of the investigations into the work of CAs had methodological limitations, many of which were acknowledged by the researchers. For example most were cross sectional, many used single method, such as interviews (e.g. Miskella and Avis 1998), were within group, within one setting and the sample sizes were small (e.g. Workman 1996, Warner 1997). In much of the work there was little explanation of any underpinning theory and consequently the findings were not related to theory. Many also offered no conceptual framework or clarification of the key concepts of the research, with consequent confusion in the results. For example Jenkins and Allen (1998) highlighted that considering distress, burnout and job satisfaction together could be misleading as these may have distinct and independent effects. In addition, much of the work included little contextual information and therefore important influences on

the work, such as care culture or staffing ratios, were not acknowledged. As Frogatt (1998, p 87) commented when critiquing the research by Miskella and Avis (1998), exploration of the care culture and the structure of the division of labour within nursing homes could provide a better means of understanding the CAs' accounts. Jenkins and Allen (1998) also emphasised the influence of context in that the relationships identified could be context-specific and time-specific. Staff behaviour and perceptions of work were also strongly influenced by management factors such as philosophy of care, organisational structure and the characteristics of staff and residents.

#### **1.5.6: IMPLICATIONS FOR THE CURRENT STUDY**

Overall, this review of the literature suggests that, despite CAs being the major staff group in health and social care services, research into their work has been limited, particularly in comparison with other staff groups, and the need for further research is evident. As Spilsbury and Meyer (2001, p 11) concluded from their literature review, the lack of "evidence related to the changing roles of health care assistants" represents "a significant gap in the research-based literature".

This review suggests a need for further research into the reality of everyday CA experiences, what they actually do, how they see their work, the challenges they face and their aspirations. Pearcey (2000) supports this view. CAs are at the front line of care work and, as Jacques and Innes's (1998, p 36) review concluded, "until we have an understanding and hear many more accounts of what it is like to be a care assistant - the difficulties and frustrations as well as the motivations and satisfactions - it is going to be difficult to 'tap into' their world". Davies (1998) concluded that there is a pressing need to articulate more clearly how 'care work' in long-term care environments can be satisfying and rewarding.

It is important to understand more about the competencies possessed by CAs and what they perceive as their training needs. This is also identified as a priority by Nolan and Keady (1996), Edwards (1997), Dalley and Denniss (2001) and Henwood (2001). From her broad surveys, Thornley (2000, p 457) concluded that "there is a



need for a fundamental reappraisal of the real skills and experience of CAs, and of their potential".

Another perspective not widely acknowledged in the literature on CAs is that of service users. For example, Stokes and Warden's (2004, p 36) report on the development of the Care Assistant role identified no research into what service users want from CAs.

The most striking gap in the literature is the lack of research into the outcomes of CA work, or indeed what Thomas (1994, p 231) described as "their effectiveness on any parameter". The same conclusions were reached by Dalley and Denniss's (2001) investigation in UK care homes. Even in the USA, where an outcomes focus has a longer and stronger tradition than in the UK, reviews by Schirm, Lehman and Barton (1996, p 98) and Neal Garland and Schirm (1998) identified no research focusing explicitly on the outcomes of the work of CAs. Given the current and future realities where CAs are major determinants in care outcomes for older people, research into the results of their work, and preferably linking the processes of CA work to resident outcomes, is vital particularly, as Baldwin et al's (2004) literature review concluded, in order that the CA role is used effectively and efficiently within the increasingly important care home sector.



## **SECTION 1.6: LITERATURE: THE ROLE AND CONTRIBUTION OF REGISTERED NURSES (RNs)**

### **1.6.1: OVERVIEW OF THE LITERATURE ON RNs**

Research into nursing older people started well with the multidisciplinary work of Norton, McClaren and Exton-Smith (1962) but, as Nolan (1995, p 144) observed, it then "lost its way" until it did "not appear prominently on many agendas". The characteristics of nursing older people in long-term care identified in the early studies have run as recurring themes through subsequent decades of research and, following Baker's (1978, 1983) work, became widely described as 'routine geriatric style' care. In 1986 Kitson reported that, without exception, studies demonstrated how nursing care for older people was depersonalised, routine-orientated and lacking in goal direction. In 1995 Nolan, Grant and Nolan confirmed that "such findings are unequivocal. The list of studies which have described such a picture is as impressive as it is salutary" (p 529). In 2002 the multi-stage, multi-method study by Nolan, Brown, Davies, Keady and Nolan found impoverished environments, a lack of basic equipment, poor staffing levels, staff exhibiting negative attitudes and standards of care that students considered unacceptably low. In fact, concluding on their own and other extensive literature reviews, Nolan, Nolan and Booth (1997, p 24) suggested that simple literature reviewing is inadequate in that it merely results in "more of the same". What is needed, they suggest, is a critical assessment which attempts to deconstruct general assumptions and return to basic questions such as "what is this thing called ... ?".

In the context of the current study, the basic question is "what is this thing called nursing in long-term care for older people?".

The body of literature identified in this review encompassed:

- limited research in UK care homes
- some research in UK NHS long-term or continuing care settings
- some research in UK NHS acute and other settings

- a range of studies in USA and other non-UK settings
- literature reviews
- opinion articles

Studies have focused on a range of issues both within, and relevant to, nursing older people in long-term care, but few incorporate analysis of the role and contribution of the Registered Nurse.

### **1.6.2: RESEARCH IN UK LONG-TERM SETTINGS**

With the exception of Perry, Carpenter, Challis and Hope's (2003) study, discussed in Section 1.4, no research looking specifically into the role and contribution of RNs in UK independent sector care homes was identified in this review. There was, however, one study investigating expertise in nurses working in long-term care wards for older people.

#### **NURSING EXPERTISE IN LONG-TERM CARE**

Inspired by the work of Benner (1984) in critical care settings, Reed (1994) sought to adapt phenomenological methods and use critical incident technique to investigate expertise in nurses working in long-term care wards for older people. The nurses in the wards seemed enthusiastic to participate in the study, agreeing that for too long research had concentrated on what they did wrong rather than on what they did well. Reed spent a short period of semi-participant observation with each nurse, during which she observed their activities, noting any incidents which she could identify as incorporating skills such as communication and relationship skills, planning and organizing skills or decision making skills. The notes were sparse and Reed found it difficult to identify anything other than relationship skills as the work seemed to proceed seamlessly and automatically with everyone knowing what was expected of them. Reed was not perturbed by this, believing that the expertise was likely 'hidden' to an observer. Following the observation sessions, Reed conducted three interviews on one ward, after which she curtailed the research as not only were no incidents uncovered which could demonstrate expertise, but the nurses were unable



to identify any incidents at all. One said: "I'm sorry, I can't think of anything that stands out. You must feel you've come to a really boring place – we don't do much here, not that's interesting to outsiders ... perhaps you should try an acute ward" (Reed 1994, p 339). Reed concluded that critical incident technique had disadvantages as well as advantages, especially when used in areas where work was not clearly episodic. The problem is compounded by the possibility that some expert practitioners do not recognize their own expertise (Meerabeau 1992) and this may be particularly the case when their area of practice has been consistently seen as one which involves few skills.

### RELATIONSHIPS BETWEEN NURSES AND PATIENTS

Using discourse analysis of audio-recordings of interactions between 30 older patients and the nursing staff on three wards within two long-stay hospitals in South Wales, Grainger (1993) identified four modes of discourse: routine management, nurturing, sick/dependent and personal. While the nurses offered a façade of personalized caring, Grainger identified that physical care took higher priority than psychological care and that task-orientated goals took precedence over relational considerations. She highlighted that patients were objectified and that the requirements of the institution were prioritized over the needs of individuals. Social distance was constructed and maintained between patients and nurses and nurse-patient talk in these settings contributed towards patients' general experience of loss of personal identity, esteem, control over their own environment and meaningful social contact. Grainger suggested that the 'reality' experienced by patients may well be damaging to their psychological health if it contradicts their own basic human desires for dignity, support, privacy and self-determination.

### INTERACTION AND ACTIVITY

A few studies have investigated interaction and activity levels in various environments including long-term care. Armstrong-Esther, Brown and McAfee (1994) in an acute medical geriatric unit and psychiatric unit, Nolan, Grant and Nolan (1995) in respite care, short- and long-stay units. Armstrong-Esther et al (1994) used a questionnaire and time-sampling, non-participant direct observation. Despite



306 nurses of various grades ranking talking to patients as important and an objective for themselves and the unit, interaction time between nurses and patients was only 4% of the total observation time for 'confused' and 'demented' patients, and 0.2% of the time observed for those who were lucid. Armstrong-Esther et al (1994) observed no instances of staff engaging patients in social activities or prolonged informal conversations and a virtual absence of stimulation to enhance quality of life. Nolan et al (1995) coded naturalistic field observation and identified 12 broad types of activity. Although the activities varied between the types of units, the authors concluded that, despite nursing staff reporting high commitment to activity and communicating with patients, in reality this was accorded relatively little priority. They entitled their study "busy doing nothing". Payne, Hardey and Coleman (2000) explored nursing interaction within the context of handovers and sought to identify the clinical discourses used by RNs, student nurses and CAs in acute elderly care wards in order to determine their influence on the delivery of patient care. The study adopted an ethnographic approach to data collection which involved observation of end-of-shift handovers, interviews and an analysis of written nursing records. The grounded theory analysis indicated that handovers were formulaic, partial, cryptic, given at high speed, used abbreviations and jargon, required socialized knowledge to decode and interpret. Overall they were presented in the passive voice as a collective and impersonal account of care.

### OTHER ASPECTS

Assessment practices in both long-term and acute wards for older patients were described in Reed and Bond's (1991) qualitative study. The researchers conducted interviews and observations with nurses and examined records. The findings suggested that values of cure and discharge from hospital were dominant. Part of this study highlighted the domination of medical models of care and that rehabilitation was not viewed as an appropriate goal in long-term care even though some patients may have benefited from rehabilitation (Reed and Watson 1994). Nurses commonly viewed physiotherapists not as colleagues but as competitors for control over patients and they acted as gatekeepers to non-medical team members (Reed 1993). The authors called for closer examination of how semi-professional

groups in healthcare work together in order to develop alternatives to the medical model.

Rehabilitation units for older people have also been used for research. In a small exploratory study Waters (1994) employed non-participant observation to investigate the morning routines for ten patients. She found a routine dressing style with patients as passive recipients and the style of early morning care characterized not by the nature of nursing intervention but the lack of it. Waters termed this style 'leaving them to it' and concluded that this approach to nursing potentially created dependency. Waters and Luker (1996) used a conversational style of interviewing with 56 nurses working in rehabilitation wards for older people. The findings suggest that nursing was viewed as being separate from rehabilitation and the therapists were often as seen as experts. They suggested there is a need to further examine the reality of multidisciplinary teamwork in rehabilitation, particularly with respect to maximizing the potential contribution of nurses, with the ultimate goal of improving patient outcomes.

### **1.6.3: FINDINGS FROM THE RESEARCH**

Most of the studies in older people's care settings conclude that the 'routinised geriatric care' identified in early research still persists in hospitals and also in nursing homes which, while situated in the community, may import many of the worst attributes of hospital care associated with older people, namely restrictive routines and an organisational system which nurses find difficult to penetrate (Waters and Luker 1996). It also exists on rehabilitation units caring for older people (Waters 1994). Overall, researchers suggest that developments in nursing practice have left many care of the elderly areas untouched (Pursey and Luker 1995) and new definitions of nursing are largely unreflected in their discourse (Grainger 1993, Payne, Hardey and Coleman 2000).

Authors have also identified that the literature is dominated by pathology (Nolan 1994), gerontological problems (Johnson 1991) and a biomedical construction of ageing (Koch and Webb 1996). The biomedical model is seen to predominate, even in environments where it is not appropriate (Reed and Bond 1991, Evers 1991, Reed



and Watson 1994, Koch and Webb 1996) and a 'cure' ethos also seems to predominate, even in environments where cure is impossible (Reed 1993). This biomedical dominance was evident in the end-of-shift handovers observed by Payne et al (2000) in which the representation of older people was largely limited to their status as biomedically defined bodies.

The characteristics of 'routine geriatric style' care identified in the literature could be summarized as follows:

The focus of care was assistance with activities of daily living and 'getting through the work', 'getting straight', i.e. achieving a tidy unit. The care was custodial with institutional regimes (Bartlett 1993), task-orientated (Grainger 1993) and prioritizing physical care (Waters 1994), basic nutrition and hygiene, but maintaining choice and independence was not a high priority (Nolan et al 1995). Little psychological or relational care was observed (Grainger 1993) and there was little attention to social needs (Armstrong-Esther et al 1994, Nolan et al 1995). The work was described as 'hard and heavy' – 'beds, backs, baths and bowels, backs, baths and bowels (Nolan et al 1995). In addition, although the 'cure' ethos dominated and priorities were dictated by medical staff, in many areas the medics had largely withdrawn from non-cure work and handed this over to nurses, who felt discouraged and 'second-class'. Professional priorities predominated, rather than the needs of patients (identified by, for example, Norton et al 1962, Baker 1978, 1983, Clark 1978, Wells 1980, Waters 1994). Facilities and equipment were identified as inadequate and this led to nursing problems (Nolan et al 2002). Clothing was also inadequate (Norton et al 1962, Wells 1980) and there were too few staff (Clark 1978).

Nurses socially distancing themselves from patients was also identified in a range of studies (e.g. Grainger 1993) and nurses often seemed to make strangers of their patients (Armstrong-Esther et al 1994). Nurses also commonly appeared to value compliant, co-operative and less demanding older people. The most interesting and socially skilled and appreciative patients received most attention from nurses. Staff often either reinforced dependent behaviours through social contact or gave their time and attention to those who were more gregarious (Nolan et al 1995).



The consequences for patients of 'routine geriatric style' are that care becomes depersonalized and individual needs are not recognized. Styles of care were defined in some studies as reminiscent to 'warehousing' (as first identified by Miller and Gwynne 1971) or as 'personalised' or 'minimal warehousing' (identified by Evers 1981, 1984). Older people were stigmatised (in terms of Goffman's 1963 concepts) and commonly treated like children (Norton 1990). Care could be inadequate, inhumane or even abusive. Patients were socialized into dependency, which increased morbidity and mortality (Miller 1984, 1985). Consequences for staff included a struggle to maintain standards of care and routinised patterns of work could be adopted as a means to cope in the face of immense difficulty and stress (Clark 1978, Armstrong-Esther et al 1994).

Some authors conclude that nurses do care but are not aware of what this caring means in their own reality (Ellis 1999). Others suggest that most professional care is still predicated on the basis of benevolent oppression i.e. care infused with kindness but that patronises elderly persons and removes their adult rights and personhood (Nay 1998). Nay (1998) also suggests that inappropriate practices of caring based upon experiences of care associated with mothering and the medical/hospital are prevalent. She claims that nurses clearly do care but in many situations this reflects an assumption that nurses 'know what is best' for older people and this results in residents at best being infantilised and at worst being totally objectified. Grainger (1993) also concluded that patients are objectified and the requirements of the institution are prioritised over the needs of patients. Overall, Armstrong-Esther et al (1994, p 271) concluded that older people's units "warehouse older people until they die ... in most cases what we offer is a life sentence with patients sitting clean and quietly rather than a lifestyle that, whenever possible, promotes the major goals of adulthood such as activity, independence and interdependence through engagement".

#### **1.6.4: DECONSTRUCTING THE LITERATURE**

It attempting to deconstruct the literature on the work of RNs in older people's long-term care, several key challenges arise, particularly when published articles contain

limited information on how concepts were defined, the contextual and other influences on the research, and methodological issues.

Conceptual clarity is an issue. Some research reports, particularly early work, do not clearly define the concepts used, even those central in the studies. For example, the term 'attitude' is used in a range of studies in order to analyse perceptions of nursing older people but potential elements of attitude such as cognitive, emotional and behavioural intention are not discussed. This is important as how people believe they feel about something does not necessarily predict how they will behave towards this. Smith's (1992) study highlights the importance of this in that, although student nurses generally had negative feelings about working with older people they did not show these to their patients, with whom they sometimes formed close relationships. Much of the research looking at attitudes to older people also fails to distinguish between attitudes to older people as individuals, to older people as patients, to older people collectively, to the state of being old, or to the processes of ageing.

Overall, the conclusions of the literature on older people's long-term care, and particularly research in the 1980s and 1990s, suggest widespread poor care and negative attitudes. The contextual influences on this, however, should not be underestimated. These services carried the stigma of the workhouses in which they were born and, even into the 1990s, many acute services rejected older people as 'chronic', 'irremedial' and 'clinically uninteresting'. Those working in long-term care were viewed as second class professionals, with inferior skills to those working with other patient groups, and unsatisfactory staff were commonly sent to long-term care units for punishment. Many long-term care facilities were among the most unsuited for purpose, having previously been infectious disease or maternity units, and were lacking in diagnostic and treatment facilities. Crucially these services were commonly chronically underfunded (Norton 1990, Heath 1999). In 1986 The British Medical Association summarized perceptions of older people's care as a second-rate speciality looking after third-rate patients in fourth-rate facilities.

Other historical and contextual issues influence the literature. Much of the research highlights the inappropriate domination of an acute hospital ethos of care. During the 1960s-1980s however, most services operated according to 'the residual model'



whereby medium and long-term care for older people was in NHS hospital wards, albeit on sites outside the main acute centres. Staff and students working within a District Health Authority could work around different sites. In addition, although routinised and medically-dominated care is highlighted negatively in some research, arguably most NHS hospital care was such until well into the 1980s and in some places later. Indeed 'The Nursing Process' was introduced in the 1980s in order to focus care on nursing individuals rather than routinised rounds of tasks.

Education also influenced perceptions and care. For example, it is clear why Fielding's (1986) student nurses had negative attitudes when their teaching emphasised 'a decremental model of ageing (physical and mental deterioration), older people characterised as a highly dependent group who were a strain on resources, and work with older people as strenuous, needing lots of energy and patience'. Smith (1992) also observed an interesting shift of emphasis through the course of student nurse training. At the beginning the emphasis was on 'basics' and 'people', towards the end to absolute facts of 'disease, drugs and therapy'. If this is how student nurses were taught and socialised into nursing older people, it is not surprising that their perceptions are negative.

Care environments and staff working conditions also influence perceptions of nursing older people. For example poor staffing, poor working relationships, lack of recognition, inadequate salary and lack of autonomy coupled with poor image, stigma, ageism, negative attitudes of society towards older people (Carr and Kazanowski 1994) will likely result in negative perceptions. Pursey and Luker's (1995) findings led them to challenge the common assumptions that nurses do not want to work with older people due to their attitudes. They concluded that the high dependency levels of older people and the structure of nursing work with older people means that fewer nurses make this area a positive career choice.

An added dimension in unpacking research in work with older people is that the relationships between individual influences and their manifestations are complex, particularly in the context of one's own ageing and early life experiences. For example:



- In a geriatric ward, female nurses were found to depersonalise older female patients much more than older men, to place them under stronger pressure to conform to ward routines and show submissive behaviours (Evers 1981). The researcher concluded that, confronted with a deteriorating image of their future selves, female nurses found it difficult to carry out basic care work for female patients.
- In the researcher's own experiences, student nurses who came into their 'older people placements' with the most positive attitudes appeared to be those who had experienced positive relationships with their grandparents and other older people in their formative years (Heath 1993, 1999).

Once the research literature into perceptions of older people's care is deconstructed and the complexities acknowledged, the results are not all as negative as they would appear. For example, despite negative views of their work, 75% of nurses working in long-term care in Carr and Kazanowski's (1994) study preferred to care for older adults. The results suggested that it was not their own ageism but the ageism in society that devalued the older people with whom they worked and their living environments that impacted on the staff's working conditions. Despite the negative findings in their research in long-stay, short-stay and respite units, Nolan et al (1995) identified that RNs described their work in positive terms and expressed satisfaction. Despite identifying impoverished care environments and negative staff attitudes, the results of Nolan et al's (2002) comprehensive study provided no indication of enduring negative attitudes in student nurses, the vast majority considering work with older people to be challenging and stimulating and a highly skilled job. The researchers concluded that there was considerable potential to favourably influence the likelihood of students choosing to work with older people by ensuring they had positive experiences of such work during their training.

Although much of the research into nursing work with older people seems to have produced predominantly negative results, there would appear to have been a shift towards more positive literature in recent years. This could possibly have been influenced by the National Service Framework for Older People (DH 2001a, 2003a) raising the profile of older people's care. It could also possibly have been influenced by the appointment of over 50 Older People Consultant Nurses around the UK

(Sturdy 2004a, b) and the increasing numbers of Professors of Nursing or Nursing Research who are passionate about older people's care. It could have been enhanced following the launch of the new International Journal of Older People Nursing. Research and publications from these sources are reported in this review where they are relevant.

#### **1.6.5: DEFINING THE NURSING CONTRIBUTION**

During the last twelve years the Royal College of Nursing (RCN) has undertaken a range of projects aimed at defining and articulating the contribution of RNs to the care of older people. All of the following were co-authored by the researcher. Reports such as *The Value and Skills of Nurses working with Older People* (RCN 1993a), *Older People and Continuing Care: The Skill and Value of the Nurse* (RCN 1993b) and *Nursing Homes Nursing Values* (RCN 1995) made statements about what expert RNs could contribute, but there was little evidence to support these. A small team then developed a toolkit to assist RNs working in older people's continuing care to identify the clinical outcomes of their work (Heath, McCormack, Phair and Ford 1996a, b, RCN 1997a, 2004). The RCN Nursing Older People Assessment Tool (RCN 1997b) offered a framework for undertaking a nursing assessment and also a means of calculating the number of RN hours needed for each patient's care but it was also designed to help RNs articulate their distinct contribution. The tool was tested for acceptability, internal consistency and inter-rater reliability in a pilot study in seven nursing homes (Ford and McCormack 1999) but, other than this report, there appears to be no published research demonstrating the validity and reliability of the tool. In addition, there still appears to be little research which could offer an evidence-base for many of the claims made in the RCN's projects.

In 2003 the Royal College of Nursing (RCN) issued a definition: "Nursing is the use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death". Supporting this definition were six defining characteristics on nursing's purpose, mode of



intervention, domain, focus, value base and commitment to partnership (p 3). The nursing press debated the applicability of this definition within differing healthcare environments and the RCN acknowledged that nursing would need to respond to people's need for nursing within the rapidly changing environment of health care, to changes in the way care delivery systems are organised, the way in which it is regulated and the way in which practitioners are prepared. This literature review identified no studies exploring the applicability of this definition of nursing to long-term care settings for older people and, prior to this, the only definition identified was that adopted for this study and given in Section 1.1 (RCN and Age Concern 1997). Although this definition offers some clarification around the care delivered, it becomes potentially problematic in situations where people have nursing needs identified by non-nurses (particularly during multi-agency, multidisciplinary single assessment processes), have nursing needs which go unmet, or have nursing needs which are met partially by non-nurses.

Nurses in many specialties have struggled to describe their distinct contribution to care and work the gerontological nursing research team at Sheffield University developed a framework based in rehabilitation nursing that has wider applicability and some natural links to nursing with older people. Following extensive literature review and curriculum analysis, Nolan et al (1997, p 3 and 21) concluded that the generic nurse role is confined largely to five distinct areas:

- Maintenance of the physical well-being of patients by attention to basic needs, e.g. skin, nutrition, hygiene and so on. (Patients are clean, comfortable and ready for therapy). Some suggest this is nursing's major contribution to rehabilitation.
- Specialist role in continence and skin care.
- Reinforcing the input of others, mainly therapists (Johnson 1995 saw this as providing the 'glue or mortar' that holds the bricks, i.e. the therapy, together)
- Creating and sustaining a suitable environment for rehabilitation which facilitates the identification of patients' motivation, hopes and aspirations and their active participation in rehabilitation.
- 24 hour presence is often portrayed as nursing's unique contribution.



Waters (1994, 1996) and Waters and Luker (1996) described the first two as 'general maintenance' and 'specialist' roles, and the last three as 'carry on' roles.

While such types of roles could offer a framework for analysis, researchers using this have not produced positive results. Waters' (1994) and Waters and Luker's (1996) research identified that nurses often lacked the skills in both the 'specialist' and 'carry on' roles, that their practice was based on routine rather than sound evidence and that patients were often passive recipients of rehabilitation. Nolan et al (1997) questioned what nurses actually DO with their 24 hour presence and thus their 'unique' contribution. In fact Nolan (1998) questioned the usefulness of the whole 'invisibility of nursing' argument and urged nurses to make their contribution more explicit.

Recently a team at Glasgow Caledonian University set out to develop a practitioner-led description of gerontological nursing and articulate the principles which underpin its practice. As one cycle of a larger action research project, a representative sample of 30 Scottish nurses worked together as a Community of Practice to develop a description of gerontological nursing that would be useful in practice and in the development of best practice care guidance. Data were collected through group interviews and records of on-line discussions. Following content analysis of the data, the emerging description was verified through external consultation with nursing colleagues and older people. Participants believed that nursing older people was perceived as low status and that a positive reframing was needed. The resultant operational definition offered was: "gerontological nursing is a person-centred approach to promoting healthy ageing and the achievement of wellbeing, enabling the person and their carers to adapt to health and life changes and to face ongoing health challenges" (Kelly, Tolson, Schofield and Booth 2005, p 14-15).

#### **1.6.6: IMPLICATIONS FOR THE CURRENT STUDY**

Recent positive developments are encouraging, but the overall literature on the work of RNs in long-term care highlights this service's impoverished history, environment, resources and enduring low priority. Perhaps the saddest aspect in the literature,

along with recent nursing press and other media coverage, is that the 'routine geriatric style' of care appears still to exist in some environments.

Overall, the nursing role with older people, and particularly in long-term care which is now firmly under the social care umbrella, remains poorly articulated. Significantly, claims for what RNs do or achieve appears not to be reinforced in medical, gerontological or social care texts. As Nolan et al (1997, p 22) identify, "the fundamental problem is the failure to clarify and define the nurse's role ... and its invisibility in the wider literature ... Nursing and nurses are notable in the literature ... by their virtual absence".

This review of the literature clearly demonstrates the need for further research. In attempting to answer the question "what is this thing called nursing in long-term care for older people?" some indicators have been identified, namely that there appears to be:

- a lack of a recognized and defined role for RNs in care homes
- a lack of an agreed purpose or aims for care and models for care delivery
- a lack of agreed outcomes for the nursing of frail older people in need of ongoing care
- a lack of research into, and evidence on, what RNs in care homes do and what their work achieves in terms of outcomes for older residents

Further research is clearly needed and pleas for this are widespread in the literature. In their review article Nolan and Tolson (2000) comment that, far from their work being valued, RNs in care homes often feel isolated, undervalued and marginalized. They conclude "we would contend that this situation will not improve until there is greater recognition of the contribution that nursing makes to the care of older people in nursing homes and the essential role of nurses in providing quality of care". As Nolan (1995, p 144) warns: "if action is not taken, many aspects of nursing will disappear by default, rather than design. The continuing care needs of older people is a case in point. Unless we begin a well-informed debate in these areas, there may be no subject to debate".



## **SECTION 1.7: LITERATURE: OUTCOMES**

### **1.7.1: STRUCTURE-PROCESS-OUTCOME: CONCEPTS AND APPROACHES**

The results of the work of clinicians have always been their primary concern and, according to Philp (1997, p 9) "since Florence Nightingale classified patients in the Crimean War as dead, relieved or cured, the assessment of patient outcomes has become more sophisticated, but seldom bettered". The focus on outcomes has increased in recent years (Keith 1995, p 73). Fuelled by government policies increasingly emphasizing value-for-money and the achievement of optimum results at minimum cost, the measurement of the outcomes of clinical and other interventions has become a cornerstone of research in health services (Bowling 1995, p 11). In addition, in the last five years or so, the shortage of Registered Nurses (RNs) has stimulated a surge of research activity investigating the outcomes of varying mixes of staff, usually referred to as skill mix reviews.

The methodology for evaluating long-term nursing home outcomes has largely developed in the USA, driven by concerns about increasing numbers of nursing home patients, spiralling costs of care and the "unsustainable burden" (Palmore 1990, p 172). In 1986 an Institute of Medicine Report, the Nursing Home Reform Act (part of the 1987 Omnibus Budget Reconciliation Act (OBRA) legislation) called for more attention to the outcomes of nursing home care. Outcome emphasis in USA nursing homes research is thus primarily for the purpose of regulation and reimbursement to nursing homes (Bliesmer, Smayling, Kane and Shannon 1998).

In the UK, research into long-term care outcomes was not developed until the late 1980s when the creation of three NHS-funded nursing homes prompted several major studies (Bond and Bond 1990, Bond, Bond, Donaldson, Gregson and Atkinson 1989a, Bond, Gregson, Atkinson and Newell 1989b, Bond, Gregson and Atkinson 1989c, Clark and Bowling 1989, 1990, Bowling, Formby, Grant and Ebrahim 1991, Bowling and Formby 1992). Since then there appears to be little outcome-focused research in care homes, presumably due to privatization and fragmentation of the long-term care sector.



Outcomes in social care received little attention until the mid 1990s but, prompted by the government's Outcomes of Social Care for Adults (OSCA) programme, research projects have recently been commissioned, some of which attempt to define outcomes, others of which report on the use of outcomes measures in evaluations (Qureshi 1999, Warburton 1999).

Despite the recent surge in interest, research into nursing and care outcomes remains problematic and, as West and Rafferty (2004, p 21) conclude, further research is needed to more fully understand the impact of staff on patient health.

This section discusses the concepts of structure, process and outcome as originally conceived by Donabedian (1966). It then reviews the literature on:

- Outcomes of varying staffing mix and the implications for nursing homes
- Outcomes from nursing and caring
- Outcome-focused research in long-term care for older people

It discusses conceptual issues in outcomes research, the challenges in conceptualizing outcomes for frail older people and the challenges of conceptualizing outcomes in long-term care.

The section concludes with the implications of the findings from the literature review for the current study.

### **1.7.2: DONABEDIAN'S CONCEPTS**

Donabedian first proposed his now well-known triad to structure-process-outcome in his classic 1966 article on evaluating the quality of medical care.

structure ----- process ----- outcome

Structure, according to Donabedian (1966), entails all of the factors which influence the production of care, including human, physical, financial and organisational resources. Structure influences the kind of care that is provided by increasing or decreasing the probability of good performance.

Process includes the way in which the service is organised and the care delivered. According to Donabedian, it should encompass both technical and interpersonal aspects because, although technical care relates directly to improved health status, its achievement is dependent on the interpersonal processes between care provider and care recipient.

Outcomes are the end results. They are the (desirable or undesirable) changes in the status of recipients of care confidently attributable to antecedent care, including:

- changes in health status
- changes in patients' or families' knowledge that may influence future health
- changes in the behaviour of patients or family that may influence future health
- satisfaction with the care and its outcomes experienced by patients and family

Overall outcomes may include social, psychological, physical, physiological and attitudinal including satisfaction, as components of current health, or as contributions to future health.

Donabedian (1988, 1989, 1992) contended that there was a fundamental functional relationship between the three elements. Good structure promotes good process, which in turn promotes good outcomes. Donabedian also emphasised that outcomes can be used as indicators of quality only in so far as the structure and process of care actually affect them. Moreover, he argued, outcomes do not directly assess the quality of structure or processes; they permit inferences to be made. By matching structure, process and outcome, the ability to demonstrate the effect of the process of care delivery on the outcomes becomes more visible, and based on evidence rather than inference.

### **1.7.3: LITERATURE ON THE OUTCOMES OF VARYING STAFFING MIX**

In the last few years, comprehensive literature reviews have been undertaken both within UK (Spilsbury and Meyer 2001, Carr-Hill, Currie and Dixon 2003, Hewitt 2003) and acknowledging international literature (Buchan and Dal Poz 2002, American Agency for Healthcare Research and Quality (AHRQ) 2003, Westwood, Rogers and



Sowden 2003, West and Rafferty 2004). As with some other sections in this literature review, most of the research has been conducted in the USA and in UK acute settings. Spilsbury and Meyer (2001) reviewed UK literature (1992-1999) on nursing outcomes, skill mix and changing roles. Carr Hill et al (2003) reviewed UK literature and workforce confederation data and surveyed all acute trusts in England and Wales. Carr Hill et al (2003) concluded that the UK picture overall was of ad hoc local change at high speed that threatened to ignore existing evidence regarding staffing and patient outcomes and which therefore needed to be carefully monitored in terms of health care costs and patient impact. Both reviews emphasized the need for further research. Commissioned by the Royal College of Nursing, West and Rafferty (2004) undertook an independent review of the evidence of the impact of Registered Nurses on patient outcomes. They concluded that there is a growing body of evidence suggesting that higher numbers of RNs and a higher proportion of RNs within the nursing workforce are associated with reductions in:

- Patient mortality
- Incidence of respiratory, wound and urinary tract infections
- Number of patient falls
- Incidence of pressure sores
- Medication errors

and with improved:

- Patient functional independence
- Patient experience and perception of healthcare

There are various methodological issues in this literature. Skill mix reviews often look at grade mix and assumptions that higher grade equates with higher skill are not necessarily correct. Grade provides little evidence of the experience or skills of the individual (Spilsbury and Meyer 2001). While many of the recent systematic literature reviews were not solely conducted by nurses (so arguably free from accusations of professional bias), some express caution about the methodological limitations of both secondary data analysis and observational studies (Carr Hill et al 2003, Hewett 2003, West and Rafferty 2004). For example Buchan and Dal Poz (2002) reviewed skill-mix research undertaken for the World Health Organisation (1986-1996) and English language studies (1996-2000), and concluded that, despite a growing world-wide interest in skill mix and a growing body of literature, there are



substantial methodological limitations because secondary analyses of cross-sectional data are dependent on the initial quality of information, and site-specific observational studies tend to be small scale and too restrictive in terms of the roles studied. They advise that findings should be interpreted with caution.

Despite the common suggestion that the quality of care in nursing homes could be enhanced by increasing the ratio of RNs and reducing the reliance on unqualified CAs, there has been much less attention to the effect of skill mix in nursing homes. Although her work pre-dates the comprehensive reviews detailed above, Davies (2001, p 92) concluded that few studies addressed the issue of whether resident outcomes are affected by the skill mix of the nursing team or whether similar outcomes could be achieved by varying skill mix combinations.

There are unlikely to be simple answers to skill mix issues due to the varying needs of service users, the varying skills of staff and the varied nature of care contexts. Ultimately, while skill mix literature contributes to debates about the outcomes from varying numbers of different types of staff, further research is needed, particularly in long-term care settings, to identify what staff actually do (the processes in their work) and how these processes influence outcomes. There remains, as Spilsbury and Meyer (2001, p 9) conclude, “a significant gap in work examining the interface between registered nurses and support workers and the subsequent effect on patient outcome”.

#### **1.7.4: OUTCOMES FROM NURSING OR CARING**

There are considerable methodological challenges in articulating the outcomes distinct to RN or CA work. As Spilsbury and Meyer’s (2001) review of the literature concluded, many of the studies examining nursing outcomes conceptualise nursing outcome as being the completion of certain activities, such as the work of Carr-Hill, Dixon, Gibbs, Griffiths, Higgins, McCaughan and Wright (1992) and Higgins, McCaughan, Griffiths and Carr-Hill (1992). For example, although describing desired outcomes for pain control as ‘pain resulting from illness or surgery will be controlled or alleviated’, the measurement tool actually observed the nursing staff’s performance in assessing the patient’s need and taking action to relieve pain. No

assessment of changes in the patient's condition was included, and thus the effectiveness of the activity and the resultant changes in the patients' condition are not measured (Griffiths 1995). Such studies have reduced nursing to a series of activities that can be defined, observed and counted, and implicit in this is that a certain standard of nursing care can be reached if a defined frequency of specified nursing activity is given to patients in different dependency groups. As Spilsbury and Meyer (2001) argue, while this type of research addresses notions of quantity, it says little about the quality of nursing care given or indeed its appropriateness or acceptability to the patient.

The literature identifies a range of conceptual, philosophical, practical and methodological factors which contribute to the complexity of evaluating the outcomes of nursing or caring and significant challenges remain (Meyer and Sturdy 2004).

A multitude of factors contribute to the outcome of care for each patient, including care given by other professionals, as well as organizational, environmental (Hegyvary 1991, Bond 1992, Griffiths 1995, Philp 1997) and social influences. Many influential elements are individual to each patient, such as inherent restorative processes (Spilsbury and Mayer 2001, p 8). It is difficult to identify outcomes that are amenable to nursing intervention and solely attributable to nursing intervention (Philp 1997, Meyer and Sturdy 2004). If studies are looking at nursing as a whole, the indicator has to be broad, e.g. mortality rates, but then the breadth of such indicators makes it difficult to tease out nursing care from the wide range of other factors which affect outcomes. There is also a dearth of commonly agreed and validated health outcome data (Buchan, Seccombe and Ball 1996) and reliable and valid measures of outcomes relevant to nursing intervention (Bond and Thomas 1991, Hegyvary 1991, Waltz, Strickland and Lenz 1991, Waltz and Sylvia 1991).

Many of the actions common to nursing and caring, and the outcomes of these, are not quantifiable, such as the results of listening, supporting, doing with, being present or being available. Much of this time-intensive work may not have a readily measurable outcome (Carberry 1998) and is highlighted in the literature as the 'invisibility' of nursing. The challenge of articulating the outcomes of nursing work due to its 'invisibility' is commonly described. For example, McKenna's (1995)



literature review concluded that most of the important effects of RNs are “invisible to the naked eye”. The RCN (1992, p 1) also acknowledged this: "Good nursing care is often demonstrated by the fact that you can't see it. In units caring for elderly people, where good nursing is being provided, the place looks ordinary. People are well dressed and comfortable, undertaking as much as possible for themselves, and living in a setting which is full of home comfort. This cannot be achieved without skill and experience in nursing elderly people. Privacy and dignity of patients or residents is maintained by making it look as if they are not being nursed". As Spilsbury and Meyer (2001) identify, however, the 'invisible' aspects of nursing work are not widely acknowledged in the research-based literature.

The need for further research into nursing outcomes is identified in virtually all of the literature in order to offer insight into:

- the impact of nursing care on patient outcomes
- nursing-sensitive outcomes, and outcomes sensitive to variations in nursing inputs (Griffiths 1995)
- what is not being adequately acknowledged and measured because present tools cannot account adequately for the complex and interdependent factors which produce health outcomes (Carberry 1998)
- the 'invisible' aspects of the work

A great deal of the literature also identifies the need to look at both processes and structural elements that contribute to nursing-sensitive outcomes (Carberry 1998, Spilsbury and Meyer 2001). As Griffiths (1995) emphasised, because outcome data are complex to collect, measures of structure and process may be the best quality indicators. In addition, research needs to identify which aspects of structure, linked with which aspects of process, result in particular outcomes for both patients and nurses (Thomas and Bond 1991, p 309).

There are also pleas for more qualitative work to define the nursing contribution to patient care and outcome. Spilsbury and Meyer (2001, p 10) questioned whether large scale randomised controlled trials could ever capture the complex activities of nursing and demonstrate its impact on patient outcome. They argued that the evidence-based movement is gradually accepting the value of qualitative methods



and that new approaches are needed in order to 'unpack' the nature of clinical judgement and to understand better how to achieve effective change in healthcare settings. Qualitative methods could help to capture the complex activities of nursing, to build a picture of the evolving nature of nursing work and thus demonstrate its impact on patient outcome (Spilsbury and Meyer 2001, p 11). Meyer and Sturdy (2004, p 133) recommend more participative methods and practitioner-centred approaches which could better capture the 'invisible' aspects of nursing. Research based on the realities of practice could generate a different level of findings which may be of more value and interest to practitioners. Other authors (e.g. Bond 1991, Bond and Thomas 1992a, Rolfe 1998) also recommended the use of practitioner-centred research approaches which capture practising nurses' views on salient outcomes, their personal and experiential theories, as well as their scientific knowledge. Rolfe (1998) contended that, by describing single situations, richer descriptions of nursing activity and the environment within which such activity occurs will be generated and, through these reflexive approaches, the 'invisible' aspects of nursing may ultimately be captured.

Examining the logic of generalising from single situations, case studies and other non-representative samples, Sharp (1998) argued that the generalizability of such research is often under-estimated, because of a fundamental confusion about two quite distinct logical bases upon which generalizations can be made: empirical and theoretical. He suggests that single cases are a useful means by which theoretical explanations of phenomena can be generated.

One important perspective to be included in future outcomes research is that of service users. As Meyer and Sturdy (2004, p 131) argue, current approaches and methods often retain control with the researcher; "the voice of older people needs to be heard more, through their engagement in the design of research and in identifying what is meaningful to them as measures of quality".

Many authors warn that, while it may be possible with good study design to make confident decisions that a particular intervention or innovation in nursing caused a particular change in outcome, it will probably never be possible to specify which of the thousand of intervening social, biological, medical or other variables was the

precise process which led to it (Griffiths 1995, p 1097) and thus to define the nursing contribution to patient care. This is complicated by the ever changing nature of nursing and the constantly-evolving environments in which nurses work (Spilsbury and Meyer 2001). Douglas and Robb (1995, p 30) conclude: "the whole concept of outcome measurement is potentially complex. If nursing is to speak authoritatively in this area, we must be willing to explore this concept, to define our outcomes and to articulate our perspective to nurses and the other groups providing health care. If we fail to do this the whole area of outcomes will remain elusive and nursing's potential contribution may never be recognised".

#### **1.7.5: OUTCOMES RESEARCH IN LONG-TERM CARE FOR OLDER PEOPLE**

Although a central purpose in the major UK studies conducted around 1990 was to compare the outcomes of care in the newly-developed NHS nursing homes with those in traditional NHS long-term care settings, they offer important and wide-ranging insights into the methods which might, or might not, be useful in researching outcomes in older people's long-term care. This research was reported by Bond, Bond, Donaldson, Gregson and Atkinson (1989a), Bond, Gregson, Atkinson and Newell (1989b), Bond and Bond 1990, Clark and Bowling, 1989, 1990, Bowling, Formby, Grant and Ebrahim (1991), Bowling and Formby (1992), MacDonald, Higgs, MacDonald, Godfrey and Ward (1996) and Higgs, MacDonald, MacDonald and Ward (1998). Encompassing large randomised controlled trials (RCT), longitudinal, multi-method and both quantitative and qualitative approaches, these studies produced extensive data. For example Bond et al (1989a, b), randomised 464 residents and measured outcomes using the Crichton Royal Behavioural Rating Scale, a psychiatric assessment schedule; semi-structured interviews of quality of care and self-rated health; life satisfaction index; and survival rates. Bowling et al (1991), Bowling and Formby (1992) randomised 122 older people assessed appropriate for long-term care to either a nursing home or long-stay hospital ward and used validated questionnaires and scales, plus observations and interviews.

All of these trials suggest that both processes of care and outcomes in terms of the residents' and staffs' day-to-day life were better in the NHS nursing homes than in



traditional long-stay settings particularly in such respects as more choice and flexibility, more positive feelings towards staff and later waking times. However, the differences were subtle and identified through non-participant observation and interview rather than the more quantitative measures. The researchers concluded that conventional outcome measures, such as disability or behaviour scales, are not very useful in long-term care contexts. Even the range of validated instruments applied over the course of time offered limited insight into how the outcomes of care differed between the hospital and nursing home settings, perhaps due to the multiple factors affecting the health and well-being of the diverse residents (Wilson-Barnett 1992). The observations and interviews produced particularly enlightening data which Wilson-Barnett suggested could be seen as equally powerful and perhaps more meaningful for nurses. The researchers also concluded that qualitative techniques provide insights that quantitative measures do not, for example into behaviours, moods, interactions and atmospheres, which are difficult to measure using traditional survey approaches (Clark and Bowling 1989, p 123, Bowling and Formby 1992).

There appears to be little outcome-focused research in UK long-stay settings since these studies, presumably due to the privatisation and fragmentation of the sector which occurred through the 1980s and, by the 1990s, had reached its peak.

#### **1.7.6: CONCEPTUAL ISSUES IN OUTCOMES RESEARCH**

In addition to other challenges, the literature identifies a range of conceptual issues related to outcomes research, such as:

- A lack of conceptual clarity and consistency
- A range of traditions and use of the term 'outcome'
- The complexity of the concept of outcomes and also of related concepts.
- Causal relationships are difficult to demonstrate, i.e. to what interventions outcomes can be attributed.
- Outcome and outcome indicators are not absolute and may be interpreted differently.
- The assessment of performance criteria may be subject to interpretation



- Particular structure and process elements may be difficult to distinguish and have been defined differently in different studies.

The lack of conceptual clarity or consistency across the literature increases the challenges associated with research into outcomes. The health and social care literature identifies a broad diversity of traditions and terminology. As Ray (1999, p 1021) identified, "one need only do a Medline search using the term 'outcome' to see the vast diversity of articles which have referenced the term". This has resulted in diverse terminology.

The literature identifies that, while considerable progress has been made on the technical development of outcome measures, this has not been matched by commensurable energy devoted to the theoretical and conceptual side of outcomes (Keith 1995, p 73, Ray 1999) and the conceptualisation of outcomes remains controversial (Bowling 1997, p 1). The literature contains pleas for greater consideration of conceptual and theoretical elements of outcome research (Ray 1999, Keith 1995).

Outcome research has also tended to reflect the perspectives and priorities of the diverse range of stakeholders (Keith 1995, p 76-77), for example health economists emphasising efficiency and value for money, nurses focusing on the effectiveness of care and service users valuing how they feel or how they access services (Ray 1999). Traditions deeply-rooted in disciplinary socialization and linguistic traditions have dictated the research focus and methods (Ray 1999).

The concept of outcome itself can be complex, for example what is identified as a health outcome depends on one's basic concept of health (Bowling 1997). In addition, many of the concepts related to outcome can be complex, for example quality of life (Bowling 1997, p 6) or quality of care which are complex to define and even more complex to evaluate.

Particularly complex in outcome research is the establishment of a causal relationship between the change in a patient's condition and the care given, in order to meet Donabedian's (1988) assertion that, in order to be defined as an outcome, a

change must be attributed to antecedent health care. As Keith (1995, p 74) highlights, this causal attribution can rest on assumptions about how treatment works. Also, because of the multifarious influences in the everyday realities of nursing and care work, causal relationship is particularly difficult to establish.

Additionally, outcomes and outcome indicators are not absolute. Even measures such as temperature or weight relate to social norms and expectations (Keith 1995, p 75). Performance criteria assessment are also subject to variation among clinicians, facilities and regions of the country. Clinicians tend to be influenced by their own norms, personal or professional experiences and often have difficulty in agreeing such common rating adjectives as mild, moderate or severe (Keith 1995, p 76).

From reviewing the literature, it also became apparent that it can be difficult to distinguish structure, process and outcome. For example, Closs and Tierney (1993) used the structure-process-outcome framework in order to evaluate discharge planning for older people in Scotland. They experienced conceptual difficulties in the isolation and/or integration of structure, process and outcome. Frequently it was impossible to decide into which of the three categories a particular aspect of nursing or health care would fit, for example systems of communication, such as care documentation, might be described in terms of either structure or process.

### **1.7.7: CONCEPTUALISING OUTCOMES FOR OLDER PEOPLE IN LONG-TERM CARE**

Conceptualising outcomes of care for people who are very frail is not straightforward. Self-rated health status measures have reportedly been better predictors of service quality than disease-orientated assessments but feelings about care may be difficult to obtain from a frail, vulnerable and dependent population, as many studies have demonstrated (Bowling 1997, 2001). Residents are diverse, usually have multiple pathology with a range of chronic conditions for which multiple medications are prescribed and hence scales measuring progress with single diseases are inappropriate. Health is often precarious and can deteriorate quickly. Prognosis is commonly uncertain. Underlying problems may be unobservable and undetectable



until they manifest (Shapiro and Tate 1995) so that even single outcome indicators, such as infection rate or pressure ulcer development, will not always reliably indicate effective or ineffective care. Even priorities for quality of life or goals for quality of care may be distinct for each resident.

In care homes a variety of factors influence outcomes - the environment, staff, funding levels, equipment, relatives and the residents themselves. Influences cannot be considered independently of their context, and the nature of the environment is multi-dimensional and interactive (Bond et al 1989a). Relationships between residents and staff have been found to be important yet the outcomes of these are not easily measured (Harding and Beresford 1996, Qureshi 1999). Also in long-term care the timing of outcome measurement can be challenging. In the standard 'medical model' outcome would be measured at the end of treatment but this is not always appropriate in long-term care. Outcomes measured at one point can be meaningless when considering that the 'care careers' of people can stretch over months or years (Ebrahim, Wattis, Brittis, Harwood and Graham 1993).

#### **1.7.8: IMPLICATIONS FOR THE CURRENT STUDY**

Overall, the literature suggests that, while considerable progress on the technical aspects of outcome measurements, conceptual issues in outcomes research need more attention (Keith 1995, Ray 1999). Much of the research has focused on cost i.e. maximising the output per unit of input (Keith 1995, p 78) and is based on 'disease' models, i.e. medical conditions of which signs and symptoms are indicative (Bowling 2001). Much has been determined by available instruments, databases or statistical requirements. Variables have commonly been selected because they change readily not because they represent an improvement in the underlying issue (Ray 1999) and, while batteries of tools exist, the validity, reliability and user-friendliness of these are very variable (Bowling 1997, 2001). Much of the outcomes research in older people's care has focused on gross measures of outcomes such as mobility, (often measured by functional ability), and mortality (Cotter, Salvage, Meyer and Bridges 1998), physical and mental status and social satisfaction, but gross screening tools lack sensitivity to the small increments of change that typically

result from interventions in the long-term care population (Bond and Bond 1990, Phillips 1992, Philp 1997). Even some of the widely-used outcome indicators or proxy measures such as skin breakdown or infection rates are insensitive to variation in the quantity and quality of care (Ebrahim, Wattis, Brittis, Harwood and Graham 1993, p 202). Most research has been quantitative in approach, used survey techniques and extraction of information from records (e.g. deaths, hospital admissions) and assumes the circumstances of older people can be completely measured using such scientific approaches (Clark and Bowling 1989, p 143). While these approaches may probe causal connections between particular forms of care and outcomes, they cannot in themselves explain why a treatment is or is not effective (Bond and Bond 1990a, p 11). In addition, some studies do not acknowledge the context in which the work took place, for example experimental approaches which treat the processes of care as a 'black box' (such as Castle and Fogel 1998). Little of the outcomes research has involved older people, and the views of service users and carers are virtually absent in the outcomes literature.

Despite the challenges, virtually all of the literature recommends that further outcomes research be undertaken, particularly qualitative studies which can access the everyday realities and perspectives of practitioners and patients. The literature identifies that eliciting both staff and patient perspectives on outcomes could identify potential outcomes or outcome indicators for evaluating care. This could enhance the understanding of the value they place on different elements in care, thereby alleviating gaps that can exist between residents' and providers' assessments of quality care (Schirm, Albanese, Neal Garland 1999). Overall much of the literature also recommends that future research should focus on both structural and process influences on care, as well as outcomes, as this would help to establish the relationship between these three elements. As Peters (1989, p 184) concluded that "the complexities of assessing outcomes in long-term care cannot be overstated. Long-term care settings deal with a diverse population and are not defined by a medical model. In addition, long-term care offers various goals, is provided in diversely structured settings, frequently is delivered in fragmentation, and does not lend itself to highly measurable criteria. Making adaptations in quality measurement from acute care is inappropriate. Developing valid, meaningful outcomes becomes the challenge".



## **SECTION 1.8: LITERATURE REVIEW: CONCLUSIONS**

The broad literature analysed in this review sets the context for the research. It also offers strong indicators towards what the research could seek to achieve, what could be its focus and how it could be conducted. Further research is clearly needed in order to better understand the work that RNs and CAs undertake with older people in care homes and specifically to clarify their distinct roles and contributions to care. Outcome-focused research, which also acknowledges the processes and structure that influence outcomes, is widely recommended. Qualitative approaches could offer insights not achieved in previous studies and the employment of mixed methods alongside the triangulation of data from a range of sources is believed to offer particular potential for capturing the reality of everyday work in care homes. Encompassing a range of perspectives on RN and CA work could add richness to a study and the views of older residents are deemed an important perspective to include. Working in a small number of homes is recommended and the importance of contextual information is emphasized. Conceptual clarity and rigour are essential in future studies.

### **The complementary roles and functioning of Registered Nurses (RNs) and Care Assistants (CAs)**

There is a clear need to understand better the work that RNs and CAs undertake in independent sector care homes and what might be the outcomes of this. As discussed in Sections 1.4, with the exception of one single-method study, this review of the literature identified no research specifically focusing on the complementary roles and functioning of RNs and CAs in care homes. A theme in the research reviewed, acknowledging the limitations of this, was the role ambiguity, conflict, overload and general lack of clarity around CA roles both among CAs and the RNs supervising them. Boundaries between CA and RN roles seemed especially blurred when CAs had received training and, in the context of the government's target that, by 2005, 50% of CAs in nursing homes should attain NVQ Level II or equivalent (DH 2000c, 2001b), this lack of clarity could become exacerbated. Overall, as discussed in the introduction to this study, there remain "huge ethical, conceptual and practical

difficulties in distinguishing between the 'nursing' and 'personal care' aspects of the work (Royal Commissioners 2003, para 17). Research into the distinct roles and contributions of RNs and CAs, and crucially how these interface in the practical day-to-day realities of care home life, could contribute towards greater understanding.

### **The role and distinct contribution of RNs in care homes**

This study began by highlighting that the need for RNs in care homes is being questioned and this literature review has offered only limited research-based evidence on the distinct contribution that RNs make to the care of older people in care homes, or even more broadly in long-term care services. Although positive developments in recent years are encouraging, the literature overall reflects the impoverished origins and legacy of older people's care as a specialty with 'routine geriatric style' care running as a theme through decades of research. There is little UK research into the outcomes of the work of RNs in long-term care and virtually none in UK care homes. Ultimately, the RN role and distinct contribution in care homes remains poorly-articulated in the research-based literature.

In the context of the questioning of the RN contribution in care homes, and what many predict as the inevitability of fewer RNs being employed in these settings (e.g. Laing 2004b), further research is clearly needed into what RNs actually do in care homes, the realities of their everyday work and the influences upon this, their perceptions of what they do, their challenges and aspirations, their motivations and the aims for their care. Crucially, it is vital to understand what are the outcomes and potential outcomes of the distinct contribution of RNs in care homes.

### **The role and distinct contribution of CAs in care homes**

CAs are becoming increasingly important in the provision to care to older people. Their roles are expanding, particularly in the context of diminishing numbers of RNs, and recent literature identifies the potential to 'professionalise' the role of CAs (e.g. English Community Care Association, P&G Professional, Laing and Buisson 2004). Despite their increasing significance, there has been little research into the work of



CAs in independent sector care homes, and there are methodological limitations among the smaller studies.

Research is clearly needed into what CAs actually do in care homes, the realities of their everyday work and the influences upon this, their perceptions of what they do, their challenges and aspirations, their motivations, and the aims for their care. Research which offers insight into CA competencies and training needs could also make a useful contribution to an aspect of their work where there is limited understanding (e.g. Dalley and Denniss 2001).

Crucially, as CAs are now and for the foreseeable future major determinants of outcomes for older people in care homes, research is urgently needed in order to better understand the distinct outcomes and potential outcomes of their work. This review identified no studies into the outcomes of CA work, or indeed their effectiveness on any parameter, and this represents a significant gap in the research literature (Spilsbury and Meyer 2001).

### **Outcome-focused research**

The policy literature and the medical, nursing and social care literature suggests an increasing focus on the outcomes of care and arguments are widely presented for more outcomes-focused research. The literature highlights, however, that there are considerable challenges in outcome-focused research, both conceptually and methodologically. The challenges are clearly articulated in the literature on outcomes in nursing, on care for older people with complex needs and in long-term care in general. From reviewing the literature, key questions to be addressed in the research could be:

- What counts as an outcome, particularly for vulnerable people in long-term care?
- How should outcomes be defined within individual services, settings or research studies, and for individual service users?
- When should outcome achievement be measured or assessed, in other words, when are decisions made about whether an outcome is achieved or not?
- Who should determine the achievement of the outcomes?

- What language and terminology should be used in the framing and assessment of outcomes, and particularly if service users are to be actively involved, e.g. professional or 'lay'?

Addressing such questions to the overall care could help to identify and distinguish what the distinct contributions of RNs and CAs achieve in terms of outcomes for residents and could perhaps also identify new ways of conceptualising and articulating the outcomes of care for older people in care homes.

### **Process and structure in outcome-focused research**

Many authors in this review argue the importance of acknowledging structure and process elements, as well as outcomes. Indeed Donabedian (1988) stated that the most direct route of an assessment of the quality of care is an examination of that care, that is the process of care. Some authors argue that, particularly in evaluating long-term care services, process data are as valuable as outcome data (e.g. Carberry 1998, p 2). Moreover, some suggest that the processes of care are of the greatest importance in determining whether care in a home is good or bad, arguing that good care can be given in poor environments and bad care is possible even in some of the smartest homes (Ebrahim, Wattis, Brittis, Harwood and Graham 1993). Examination of the processes of care can also help to explain variations in the outcomes of care (Bond and Bond 1990). Process data could include aspects such as the way people are treated, respect for the person and the promotion of personal autonomy on the grounds that "excellent nursing homes have been discerned from ordinary homes by the personal attention staff pay to residents" (Ebrahim et al 1993, p 201).

Contextual information and structural data are also important to include as these help to explain the influences on care and the realities of work in care settings. Some experimental approaches have treated the care settings and processes of care as a 'black box' but, as Bond and Bond (1990, p 8-9) argue, "in order to begin to provide explanations of outcomes it is necessary to enter the black box to discover what actually happens ... at first hand".



### **Qualitative approaches**

Much of the quantitative research reviewed, and particularly that using single measurement tools, has identified the limitations of such approaches. For example Bond and Bond (1990, p 11) conclude that, while experimental studies can probe causal connections between particular forms of care and outcomes, they cannot in themselves explain why a treatment or care regime is or is not effective. Qualitative approaches, on the other hand, can provide an understanding of the factors which explain variations in the processes and outcomes of care. Qualitative approaches can access participants concepts, frameworks and meanings and thus, as Qureshi (1999) argues, explore what the idea of outcome means to different stakeholders towards developing a common language. Qualitative methods, and particularly observation, could therefore offer insights accessed to only a limited extent in previous research in this field.

### **Conceptual clarity**

Important among methodological considerations are the defining of the key concepts underpinning any research study and also the potential value of explanatory models or frameworks within which to organise relevant concepts and their inter-relationships. This is particularly so in the current study because, as highlighted by Bond, Bond, Donaldson, Gregson and Atkinson (1989a, p 354), outcome research in long-term care deals with imprecise, ill-defined and unrobust units of analysis that are context-dependent.

### **Mixed method approaches, multiple research sites and triangulation of data**

Despite decades of research into the work of RNs in older people's care, studies have seemingly produced merely "more of the same" (Nolan, Nolan and Booth 1997, p 27). Conversely, studies into independent sector care homes offer a range of interpretations of 'the realities' of the work, including 'conveyor belt care' and 'bedroom abuse' (Lee Treweek 1994b). Studies in single research sites, using single methods and single data sources access single realities. Particularly in the context of the vast diversity among independent sector care homes (Laing 2004 a, b)

broader perspectives in research are recommended. Following their research in care homes, Redfern, Hannan, Norman and Martin (2002) recommend mixed-method approaches and emphasise the importance of triangulating data from many sources. Recognising the labour-intensive nature of data collection, they recommend that future research should be conducted in a small number of homes. Research along these lines, they argue, “could explain how perceptions of workers, quality of care and outcomes for service users interconnect” and thus offer understanding into the links between context, process and outcomes for both residents and staff (p 516). Among available methods, observation is particularly highlighted as an excellent means of assessing and monitoring care in a systematic and realistic way (Clark and Bowling 1990), and observation followed by interview has been found to be particularly revealing (Clark and Bowling 1989, p 143-144, Bond, Bond, Donaldson, Gregson, Atkinson 1989a). Some authors highlight the importance of researchers spending time in care homes in order to secure the trust and confidence of both staff and residents (e.g. Lee Treweek 1994a, Redfern et al 2002).

### **Accessing the reality of everyday life in care homes and the perspectives of all who experience this, including older people**

The literature suggests that seeking the views of RNs and CAs, and attempting to access their realities, could identify areas of potential significance that have not been accessed through previous research. Carberry (1998) argues that we need to ask what is not being adequately acknowledged because the methods and tools we have used previously cannot adequately account for the complex interdependent factors which operate within care settings and ultimately produce health outcomes.

Particularly notable in the literature have been the challenges experienced by researchers in identifying what RNs DO with their 24 hour presence, claimed as their ‘unique’ contribution to care (Nolan et al 1997), and the ‘invisible’ aspects of nursing (Meyer and Sturdy 2004) or indeed caring. Research which was able to access and articulate these aspects could make a major contribution to knowledge in this area.



Research should seek to understand the realities of life and work in care homes from the perspectives of those who experience it day-to-day, including different types of staff, residents and relatives. Particularly important to encompass are the views of older people, not only to acknowledge current thinking and UK policy momentums emphasizing the involvement of service users, but also because pleas for this are widespread in the literature (e.g. Meyer and Sturdy 2004). Arguably, as many authors highlight, it is their views that count the most (e.g. Bowling 1997, Qureshi 1999). Were older people offered the opportunity to identify their priorities for the outcomes of their care and to express their views on what CAs and RNs contribute to these, such perspectives could help to confirm or refute CA/RN claims for what their work achieves. Seeking older people's views is particularly important in view of the literature highlighting the discrepancies between the views of professionals and those of older people identified in previous studies (e.g. Bartlett and Burnip 1998b). Research involving older people is not without challenges, particularly ethical, practical, and those concerning the power differential between professionals and vulnerable people. As Annas and Glantz (1986, p 1157) conclude from their research: "properly conducted and monitored research on this population can improve their care and treatment, but it raises critical issues of how to protect their rights and welfare when they serve as subjects in research". There are important ethical and professional lessons that could be learned from seeking the participation of older people with complex needs and who may be vulnerable. In addition, as some researchers highlight, communicating from the vantage point of those involved in the care-giving alongside those who receive the care could contribute towards identifying a basis for theory-building and priorities for future research (Bond and Bond 1990, Bond and Thomas 1992b).

**Overall, this literature review concludes that further research is needed in order to:**

- **Understand the work that Registered Nurses and Care Assistants undertake with older people in care homes, what they do, how they see their work, and what are their distinct contributions to care.**
- **Articulate and distinguish the outcomes and potential outcomes of the work of CAs and RNs.**
- **Attempt methodological approaches which could access and articulate insights not achieved in previous studies.**

As Bartlett and Burnip (1998b, p 259) conclude, having reviewed literature and surveyed nursing homes: "given the scale and diversity of this new and changing sector of care, more research is urgently needed to improve the quality of life for residents and the delivery of nursing care".



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## **CHAPTER 2: METHOD**

This chapter explains how the research was undertaken and the rationale for the decisions made.

It begins in Section 2.1 with the aim of the research, research questions, a 'map' of the overall scope of the study and the framework of structure-process-outcome which served as a heuristic device in the research.

Section 2.2 explores the philosophical hermeneutics of Hans-Georg Gadamer within which the study was grounded. Gadamer's key concepts are explained and examples of how these operated within the research are offered.

Section 2.3 details important ethical considerations specific to the study and particularly those relevant to working with research participants who may be vulnerable.

Section 2.4 sets out the procedure for data collection and analysis. It explains the sampling strategy, then details how the 'significant examples' for Phase 1 of the research were collected and analysed. The procedure for Phase 2, the fieldwork in three nursing homes is then explained, along with how data were collected and analysed. Brief rationale for the methods employed are offered and details of the participants in the samples are given. The section concludes with comments about the achievement of coherence in the study and the interpretive account.

The final section, 2.5, acknowledges key concepts concerning rigour and sets out the criteria used to evaluate rigour in this study.



## **SECTION 2.1: RESEARCH AIM, QUESTIONS AND FRAMEWORKS**

### **2.1.1: RESEARCH AIM AND QUESTIONS**

#### **RESEARCH AIM**

To illuminate and articulate the distinct contributions made to the care of older people living in nursing homes (care homes with nursing) by Registered Nurses (RNs) and Care Assistants (CAs).

#### **RESEARCH QUESTIONS**

What do CAs do and how does this impact on outcomes for older people in nursing homes?

What do RNs do and how does this impact on outcomes for older people in nursing homes?

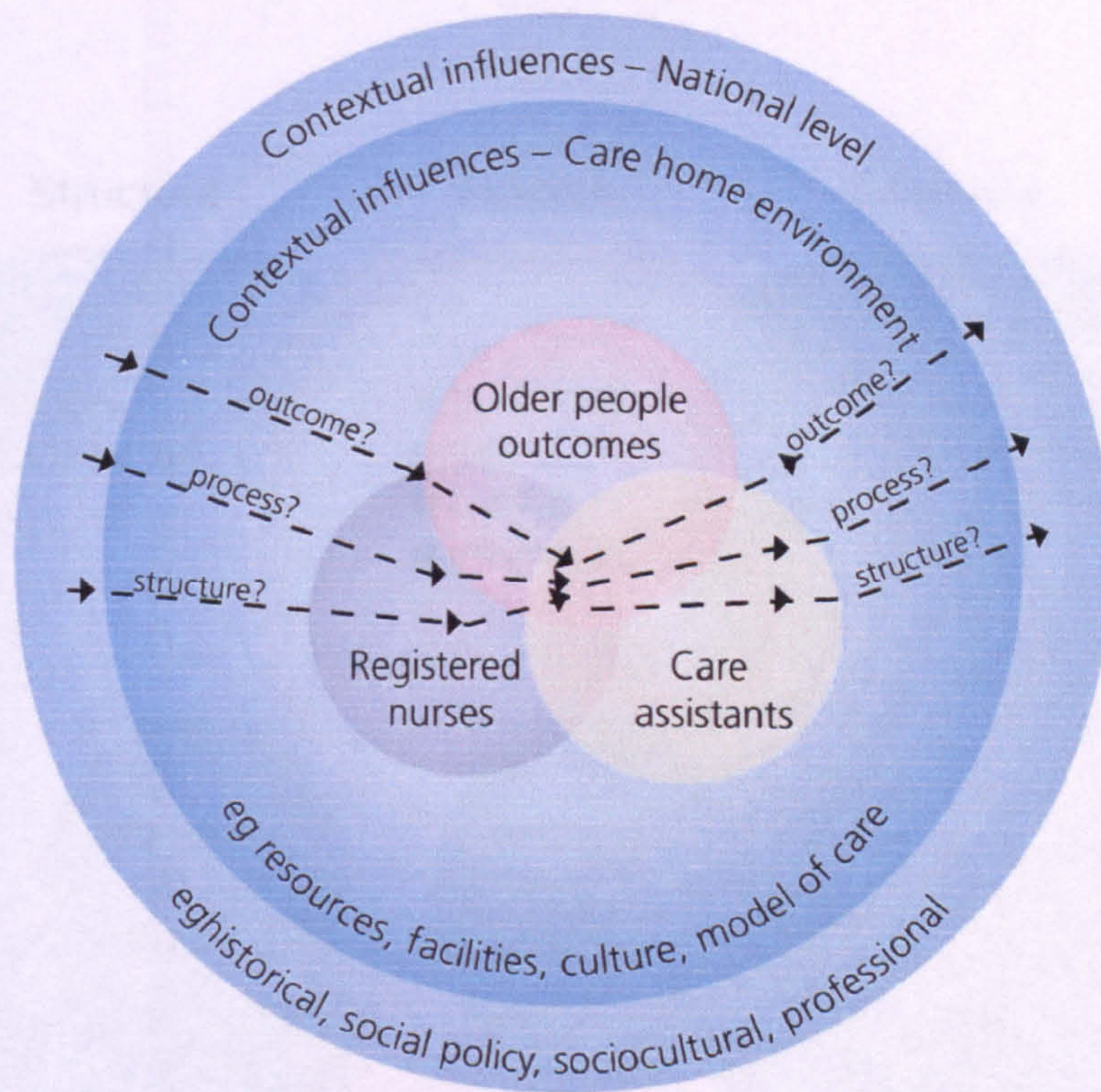
What are the distinct outcomes, and potential outcomes, of the work of RNs, compared with those of CAs, for older people in nursing homes (for example in relation to physical health, functional capacity, wellbeing or quality of life)?



**2.1.2: OVERALL SCOPE OF THE RESEARCH**

Based on the results of the literature review, the rudimentary map shown below (Figure 2.1) outlines the scope of the research. This helps to establish, in philosophical hermeneutic terms, the 'whole' area of the research before studying the 'parts' (Gadamer 2003) (See explanation in Section 2.2).

**FIGURE 2.1: INITIAL MAP: THE SCOPE OF THE RESEARCH**

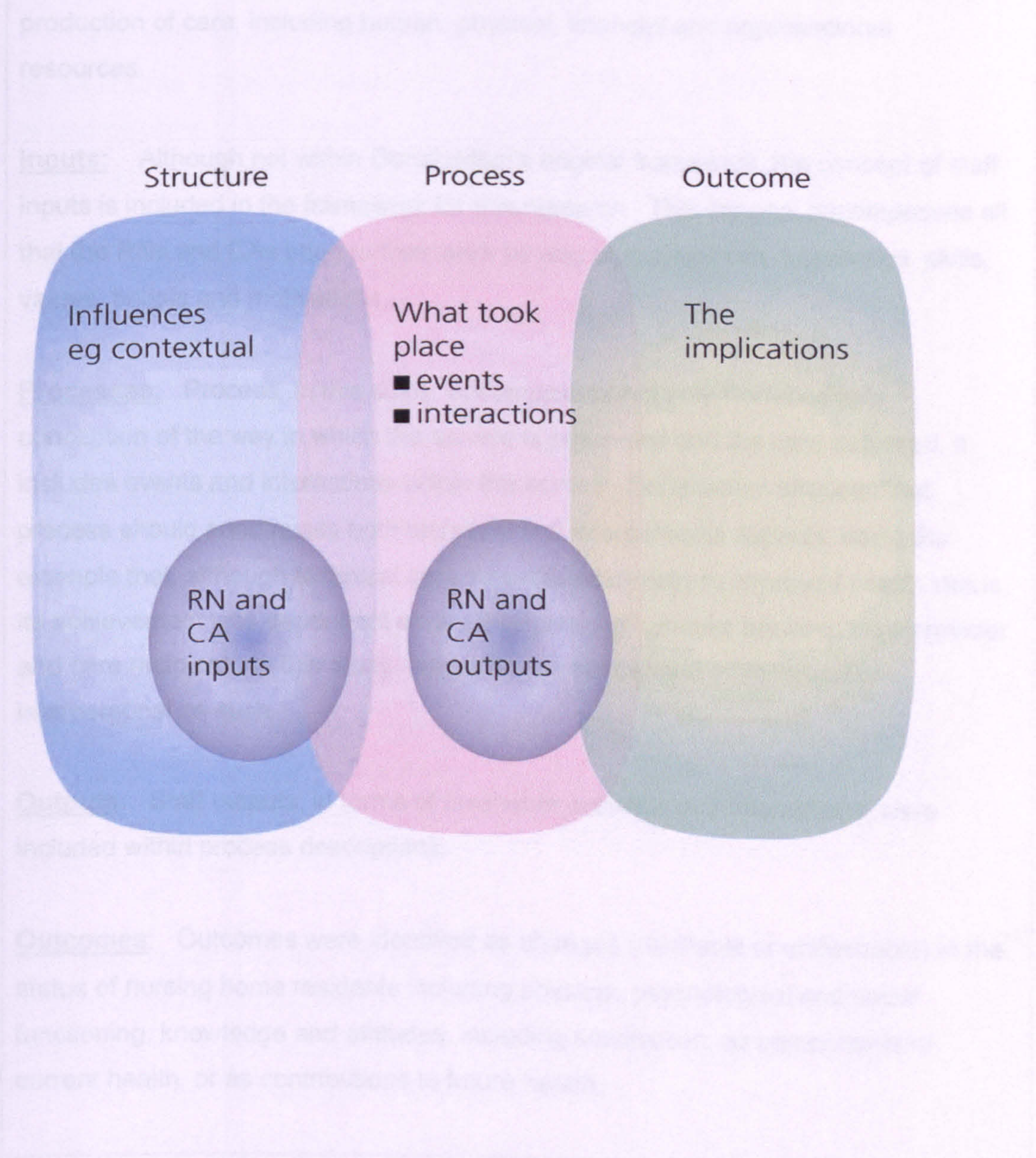


Structure-process-outcome are usually presented sequentially but at this stage of the research it is unclear which elements of structure, process or outcome arise within, or impact upon, which areas of the 'map'. It is also unclear how structure, process and outcome influence each other, for example do outcomes influence structure in any way? For these reasons structure, process and outcome are shown on separate dotted lines crossing all areas of the 'map' and are presented with question marks.



**FIGURE 2.2: STRUCTURE-PROCESS-OUTCOME FRAMEWORK**

A structure-process-outcome framework was developed from the literature reviewed in Chapter 1 to serve as a heuristic device in the research (as illustrated in Figure 2.3). Definitions of the concepts are offered.





**DEFINITIONS OF THE CONCEPTS WITHIN  
THE STRUCTURE-PROCESS-OUTCOME FRAMEWORK**

**Structure:** Based within Donabedian's (1966) concepts (outlined in Section 1.7.2), the definition of structure encompasses all of the factors which influence the production of care, including human, physical, financial and organisational resources.

**Inputs:** Although not within Donabedian's original framework, the concept of staff inputs is included in the framework for this research. This concept encompasses all that the RNs and CAs bring to their work by way of experiences, knowledge, skills, values, beliefs and motivations.

**Processes:** Process, in this study, encompasses not only Donabedian's conception of the way in which the service is organised and the care delivered, it includes events and interactions within the homes. Donabedian stressed that process should encompass both technical and interpersonal aspects, using the example that, although technical care was related directly to improved health status, its achievement was dependent on the interpersonal process between care provider and care recipient. In this study, elements are not defined as technical or interpersonal as such.

**Outputs:** Staff outputs, in terms of their work activities and interactions, were included within process descriptions.

**Outcomes:** Outcomes were identified as changes (desirable or undesirable) in the status of nursing home residents including physical, psychological and social functioning, knowledge and attitudes, including satisfaction, as components of current health, or as contributions to future health.



## **SECTION 2.2: PHILOSOPHICAL GROUNDING**

### **2.2.1: INTRODUCTION TO PHILOSOPHICAL HERMENEUTICS**

This research is grounded within and steered by the philosophical hermeneutics of Hans-Georg Gadamer [1900 -2002], whose work is central to the evolution of contemporary hermeneutic philosophy (Pascoe 1996). Gadamer's work was influenced by his teacher Martin Heidegger [1889-1976], to whom he was "indebted for the decisive matters" (Gadamer 2003, p 552). Heidegger was in turn influenced by his teacher Edmund Husserl [1859-1938], acknowledged as the father of phenomenology. This research also draws on the ideas of Paul Ricoeur [1913- ] specifically those relating to 'text as action'.

This section offers an explanation of the philosophical concepts which underpinned and steered the research. It ends with a summary of the overall philosophical approach in this study and Figure 2.3, The Hermeneutic Circle, which offers a diagrammatic representation of how the research was conducted (page105). An evaluation of the use of philosophical hermeneutics in the research and examples of how Gadamer's concepts operated are given in the conclusions to this research.

The hermeneutics developed by Gadamer is not "a methodology of the human sciences, but an attempt to understand what the human sciences truly are, beyond their methodological self-consciousness, and what connects them with the totality of our experience of world" (Gadamer 2003, p xxiii). In seeking "to discover what is common to all modes of understanding" (2003, p xxxi), Gadamer's work focuses on the understanding of texts and, to illustrate this, he uses the metaphor of the understanding of art (aesthetics).

The fundamental concept in Gadamer's approach is the notion of 'historical consciousness' (2003, p 165), but translated differently in different texts as 'historically operative consciousness' (1960), 'effective historical consciousness' (1979) or 'historically effected consciousness' (2003, p 341). This concept underpins Gadamer's arguments about how one reaches a valid understanding, the role of the interpreter, prejudice and objectivity.

## **2.2.2: THE PHILOSOPHICAL CONCEPTS UNDERPINNING THIS RESEARCH**

### **HISTORICAL CONSCIOUSNESS**

In his concept of historical consciousness, Gadamer reflects some of the hermeneutical thinking of both Hegel and Heidegger. Gadamer (2003, p 235) uses the term 'historical consciousness' to describe "a maturity of experience which places one in openness to the past and the future". Palmer (1969, p 195-6) comments that historical consciousness encompasses "a non-objectified, non-objectifiable accumulation of understanding, which we call wisdom; a knowledge of people, of the way things are, which cannot really be put into conceptual terms". The authentic openness intrinsic in historical consciousness "no longer simply applies its own criteria of understanding to the tradition in which it is situated, nor does it naively assimilate tradition and simply carry it on. Rather, it adopts a reflective posture toward both itself and the tradition in which it is situated. It understands itself in terms of its own history. Historical consciousness is a mode of self-knowledge" (Gadamer 2003, p 235).

To Gadamer, human experience and understanding are intrinsically:

- historical
- dialectical (engaging in dialogue and debate) and
- linguistic.

### **UNDERSTANDING AS HISTORICAL, DIALECTICAL AND LINGUISTIC**

We belong to a certain time and place in history. Everyday concepts, which we take to be self-evident, such as 'art', 'experience', 'style', 'symbol' or 'expression', actually contain a wealth of history (Gadamer 2003, p 9) i.e. they have intrinsic historicity. To Gadamer, history moves not only in events but through our experiences and in understanding itself. Rather than a stream of perceptions through which we assimilate informational knowledge, experience is a happening, an event, an encounter in which we participate and through which we gain understanding. Understanding therefore "is to be thought of less as a subjective act than as participating in an event of tradition, a process of transmission in which past and



present are constantly mediated" (Gadamer 2003, p 290). Human experience is thus intrinsically historical and true experience is experience of one's own historicity (Palmer 1969, p197), heritage, cultural and traditions. The historical and cultural factors that condition our understanding of text influence both the 'text' itself and the interpreter of the 'text'. Meaning must therefore be interpreted historically and include both the interpreter and the 'text'. Understanding is achieved through dialectic between the meaning in both 'text' and interpreter and, as a consequence of this dialectic, understanding is always in a state of being formed.

The nature of the dialectic in human understanding, and hermeneutic understanding in particular, resembles the question and answer process of true dialogue but in terms of the subject matter, rather than person-to-person. To understand a 'text', a reader remains open to the meaning in the 'text' as a subject in its own right. Questions are addressed to the 'text' and, in a deeper sense, the 'text' addresses questions to its interpreter. Thus understanding, Gadamer asserts, has its dialectical fulfilment "not in a knowing, but in an openness for experience, which is itself set in free play by experience" (Palmer 1969, p 198).

To Gadamer, experience, thinking and understanding are intrinsically linguistic and are disclosed to us through language. But language is far more than lexicon (the words used) and grammar (the way the words are put together); behind the language is a 'text' which has a specific content of meaning apart from all connection to the person saying or writing it. It is this 'text' that, as a subject in its own right, addresses itself to the reader. Language is the medium in which the 'text' conceals itself and through which it is transmitted, but the words which communicate to us are not random, they belong to the situation and speak for themselves (Palmer 1969, p 207).

Because 'text' is concealed within, and transmitted through, language, it is not always initially accessible to researchers seeking to understand specific circumstances. For example, a participant's language could appear to be communicating a light-hearted approach to a situation whereas the true 'text' is that the person is using humour as a means of dealing with a profound source of unhappiness. Although the participant's language (seemingly communicating light-

heartedness) may appear contradictory to her true feelings (of unhappiness), her light-heartedness is, in fact, an integral aspect of her 'text' in that it is her means of dealing with her unhappy situation. Researchers can achieve understanding of this through Gadamer's processes of looking at 'whole and parts', foregrounding, distanciation and working in the hermeneutic circle (explained below). An example of how this arose in the research is described in the conclusions (Example 2).

Linguisticity thus provides the medium and a common ground for understanding. Because we belong to, and participate in, language, as does the 'text', common 'horizons of meaning' become possible (Palmer 1969, p 208). For this to occur, interpreters must remain open to what the 'text' is communicating and it is this authentic openness to the elements identified above that Gadamer describes as 'historical consciousness' (2003).

The following sections explain the other key concepts in Gadamer's work.

### WHOLE AND PARTS

One "rule" in hermeneutics, according to Gadamer, is that "we must understand the whole in terms of the detail and the detail in terms of the whole". He explains that: "as the single word belongs in the total context of the sentence, so the single 'text' belongs in the total context of a writer's work, and the latter in the whole of the literary genre or literature. At the same time, however, the same 'text', as a manifestation of a creative moment, belongs to the whole of its author's inner life" (Gadamer 2003, p 291).

Interpretation begins with the whole, for example as one would look at a work of art overall and anticipate some meaning in this, then study the detail. Gadamer (2003, p 291) explains: "We must 'construe' a sentence before we attempt to understand the linguistic meaning of the individual parts of the sentence. But the process of construal is itself already governed by an expectation of meaning that follows from the context of what has gone before. It is of course necessary for this expectation to be adjusted if the 'text' calls for it. This means then that the expectation changes and that the 'text' unifies its meaning around another expectation. Thus the movement of



understanding is constantly from the whole to the part and back to the whole. The harmony of all the details with the whole is the criterion of correct understanding". He summarises: "The anticipation of meaning in which the whole is envisaged becomes actual understanding when the parts that are determined by the whole themselves also determine this whole".

Researchers beginning a new study or entering a new research site usually have a sense of the 'whole' that they seek to investigate. Aspects or 'parts' of the 'whole' then address us as important in some way – perhaps as significant, unusual or perturbing. Through looking at both the 'whole' and the 'parts', foregrounding, distanciation and working in the hermeneutic circle, understanding can be achieved. An example of how this worked in this study is given in the conclusions (Example 1).

### PREJUDICE

To Gadamer (2003, p 270) "all understanding inevitably involves some prejudice". In Heidegger's (1962, p 191) terms, prejudice is a fore-structure of understanding which lays "the essential foundations for everyday circumspective interpretation", which links understanding with interpretation and upon which all interpretation is grounded.

Gadamer highlights that the role of prejudice in interpretation has been concealed or neglected by 'modern science'. Also, some of his predecessors in the hermeneutic tradition, specifically Husserl, had argued for the suspension, or 'bracketing', of the interpreter's pre-understandings in order that the phenomena being studied could communicate through the 'lived experience' of the participants.

For Gadamer, prejudice is not a barrier to truth or something that must be eliminated if truth is to be achieved, rather it precedes this and makes it possible. He argues that, "if we want to do justice to man's finite, historical mode of being, it is necessary to fundamentally rehabilitate the concept of prejudice and acknowledge the fact that there are legitimate prejudices" (2003, p 277).

Prejudices in terms of individual values are integral in nursing practice and, many would argue, in research. Denzin and Lincoln (1998, p 28) argue that, to some

extent, all research is guided by a set of beliefs and feelings about the world and how it should be understood. Denzin and Lincoln (1998, p 23) refer to researchers being 'biographically situated'; i.e. they bring their own values, beliefs, accumulated wisdom and 'historical consciousness'.

Gadamer's approach helps researchers to make their prejudices explicit and work with them openly as the dialectic within the study develops. From her hermeneutic research, Koch (1996, p 179) explains: "I attempt to make my concerns and position clear regarding ethical issues, ... physical environment, ... organisation of nursing care and my graphic experiences in the wards". If researchers do not make their pre-judgements specific, they may not be aware of the ways in which they are influencing the research. By becoming more conscious of their horizons of pre-understanding, nurses can begin to ask different questions in a new way, thus enabling them to understand nursing more completely (Thompson 1990).

### DISTANCE AND DISTANCIATION

Texts and works of art are created at a point in history, within a tradition or culture, by individuals belonging to nations, classes and their own traditions and cultures. Interpreters are also situated at their individual points in history, traditions and cultures which they bring to their interpretations. Gadamer (2003, p 296) describes how "every age has to understand a transmitted 'text' in its own way, for the 'text' belongs to the whole tradition whose content interests the age and in which it seeks to understand itself. The real meaning of a 'text', as it speaks to the interpreter, does not depend on the contingencies of the author and his original audience. It is certainly not identical with them for it is always co-determined also by the historical situation of the interpreter and hence by the totality of the objective course of history". For example, interpretations are offered of contemporary works of art but Gadamer (2003, p 289) suggests that "only when all their relation to the present time have faded away can their real nature appear, so that the understanding of what is said in them can claim to be authoritative and universal". Interpretations over the course of time are thus made in the positive conditions of 'distanCIation', 'historical distance' or 'temporal distance', through which the intrinsic content of a work "appears only after it is divorced from the fleeting circumstances that gave rise to it"



... "the relative closure of a historical event (which allows us to view it as a whole) and its distance from contemporary opinions concerning its import" (Gadamer 2003, p 289).

Gadamer's concept of distanciation encompasses not only temporal distance but a conscious and positive distancing in order to open the possibilities of interpretation and "as a positive and productive condition enabling understanding" (Gadamer 2003, p 297). Distanciation helps to remove interpreters from familiarity or contingent elements and consequent potentials for collusion. Although itself undergoing "constant movement and extension", distanciation performs a filtering process and can "distinguish the true prejudices by which we understand, from the false ones by which we misunderstand" (Gadamer 2003, p 298). In so doing, distanciation creates a situation comparable to the objectivity of the natural sciences. Ricoeur (1981, p 74) summarises that, to understand a 'text' "is firstly to confront it as something said, to receive it in its textual form, detached from its author", then to distance oneself from the 'text'. This distancing, he contends, "is ultimately part of any reading whereby the matter of the 'text' is rendered near only in and through distance". He concludes: "distance is a fact; placing at a distance is a methodological attitude".

Employing distanciation as a 'methodological attitude' can make the difference between achieving an understanding of a research circumstance, and not achieving this. For instance, researchers may sometimes need to withdraw from a study or research situation, and create distance in both place and time, in order to progress with the work. An example of how this occurred in this study is given in the conclusions to this study (Example 3).

### FOREGROUND AND BACKGROUND

Placing into a foreground or background is also a methodological attitude. When interpreting a painting or work of art we can focus on specific elements by bringing them, one by one, into the foreground of our attention while other elements remain in the background. The elements in the foreground or background of our attention are not as the artist intended in creating the work, rather as we attend to them in the course of our interpretation. So it is with interpreting 'text'.

Also placed into a foreground or background can be our prejudices. Gadamer (2003, p 299) describes how foregrounding a prejudice governing our understanding, in other words making it conscious or explicit, helps us to suspend the validity of the prejudice for us. It thus assists us to isolate the meaning in the 'text' from our own meaning, and to value it as another. "For as long as our mind is influenced by a prejudice we do not consider it a judgement" (p 299).

Foregrounding a prejudice is not straightforward. As Gadamer (2003, p 299) contends, "it is impossible to make ourselves aware of a prejudice while it is constantly operating unnoticed but only when it is, so to speak, provoked". Encounter with 'text' can provide this provocation. The first condition of hermeneutics, as described, is that understanding begins when something addresses us and asserts itself in its own separate validity. If we remain open to the possibilities as they address us and we address them, our prejudices come to the fore and we can examine them. Gadamer (2003, p 299) advises that, "if a prejudice becomes questionable in view of what another person or a 'text' says to us, this does not mean that it is simply set aside and the 'text' of the other person accepted as valid in its place. In fact our own prejudice is properly brought into play by being put at risk. Only by being given full play it is able to experience the other's claim to truth and make it possible for him to have full play himself".

Foregrounding, backgrounding and distancing are particularly valuable in nursing research. Nursing practice is multidimensional. In the 'messy' realities of everyday work, the phenomena embedded within practice are not straightforward to identify and have proved elusive to understand (Pascoe 1996). Hermeneutics can help researchers to capture the intricacies and particularities which build a picture of holistic practice without reducing nursing to mere characteristics, absolute properties or 'brute data' (Plager 1994). In hermeneutic inquiry the elements problematic in our understanding, the gaps or contradictions in our everyday practice which we habitually gloss over, present themselves to us and, through interpretation, can be illuminated. Through foregrounding and distancing we can better understand what we do automatically. This is particularly helpful in areas where institutionalised or ritualised practice has been traditional.



### THE FUSION OF HORIZONS OF MEANING

The prejudices we bring into hermeneutic situations constitute a horizon beyond which it can be difficult to see, but this is not fixed. As Gadamer (2003, p 306) explains, "the horizon of the present is continually in the process of being formed because we are continually having to test all our prejudices". He explains that, although there can be no understanding of the present without understanding of the past, the historical horizon is one only phase in the process of understanding and is overtaken by our present horizon of understanding. Each researcher and each participant in a research study will bring his or her own historical horizons and horizons of meaning which, through the interactions and experiences in the research process, come to the foreground, are shared, may be 'tested' and may be reformed. Discussing emergent propositions with research participants can thus enrich the interpretation. In the process of understanding, a fusing of horizons occurs, which means that, as each person's historical horizon is projected, it is simultaneously superseded. As horizons fuse, layers of understanding are formed. Working in the hermeneutic circle can help researchers understanding the ever-changing situations characteristic of nursing and the meanings that nurses, older people and other actors give to situations within their context.

### THE HERMENEUTIC CIRCLE

Through the processes described, understanding is always in a state of being formed. As Gadamer (2003, p 375) states, "to understand a question means to ask it. To understand meaning is to understand it as the answer to a question". As we bring our backgrounds and prejudices into new experiences which we question and which question us, "questioning opens up possibilities of meaning, and thus what is meaningful passes into one's own thinking on the subject" (Gadamer 2003, p 375). These meanings are, in turn, incorporated into our prejudices, and so it continues in a circular configuration (as illustrated in Figure 2.3, page 105)

As the research progresses, the interpretation develops, as Miles and Huberman (1994, p 64) suggest, through a dialectic between the horizons of meaning, for example from:

- researchers, who are refining or recasting the conceptual structures and meanings they brought to the study, i.e. revisiting their 'prejudices'.
- the field site, which has a life of its own that becomes more meaningful and decipherable as the researcher spends more time there, sharing the daily routines of the actors in the setting, i.e. as the researcher attends to the 'whole' and the 'parts', different elements become 'foregrounded'. The field site emits a continuous stream of leads, mysteries, themes and contradictions that need to be pursued and that will never fit perfectly into a pre-coded conceptual frame or even a more grounded, emerging code system, i.e. through the interpretive processes of the hermeneutic circle, 'foregrounding', and distancing, different 'horizons of meaning' emerge and can be 'fused' into the interpretation and developing understanding .

Gadamer (2003, p 298) explains how "the discovery of the true meaning of a 'text' or work of art is never finished; it is in fact an infinite process. Not only are fresh sources of error constantly excluded, so that all kinds of things are filtered out that obscure the true meaning, but new sources of understanding are continually emerging that reveal unsuspected elements of meaning". Heidegger (1962, p 195) describes this as the 'circle in understanding', but the circle is not formal in nature. Rather "it describes understanding as the interplay of the movement of tradition and the movement of the interpreter" (Gadamer 2003, p 293).

### 'TEXT' AS ACTION

Gadamer's philosophical hermeneutics focus on the interpretation of written texts and works of art, not action, and here the writings of Paul Ricoeur are helpful, specifically his *Model of the Text* (1977). Ricoeur aimed to establish that written discourse and social action exhibit sufficient similarities for the method of textual analysis to be extended to the analysis of action. Fundamentally, Ricoeur argues that hermeneutics is a process of deciphering which goes from manifest content to the meaning, to latent hidden meaning and deeper significance. The object of interpretation, i.e. the text in the true broadest sense, may be the symbols in a dream, symbols in literature or symbols in action. By suggesting parallels between written texts and text-as-action, Ricoeur is not arguing for an equivalence of an



identity between them. Rather he argues that because of this parallel (the 'fixed' nature of both) the two phenomena can be analysed with a similar methodology (Ricoeur 1979). Fundamentally, the meaning of an action as well as a written text is established by appealing to common (ordinary language) understandings. The contention here is that actions, like words, have meanings that are constitutive of everyday understandings and these meanings are, in both cases, fixed.

Nursing, as all human action and interaction, is complex and ambiguous, often not totally understood by nurses themselves. As Packer (1985, p 1089) observes: "everyday action is generally taken for granted and goes unexamined. We understand people so facilely, ordinarily, that we fail to appreciate the complexity of what we understand or its implications". But thoughts, feelings and actions can be made evident through language and accessing the 'text' behind this can make explicit what was hitherto invisible.

Ricoeur (1977, 1979) helpfully shows how hermeneutic textual analysis can be extended to the analysis of social action, but Ricoeur's arguments differ in one very important respect from Gadamer's. Ricoeur aims to provide 'objective data' for the social sciences and clearly argues that texts have an objective meaning that is distinct from the author's intention because it is fixed in the process of writing. This objective meaning constitutes a "limited field of interpretation" that excludes certain interpretations (1977, p 331). Ricoeur agrees with Gadamer that the meaning of the text is determined by the prejudices of the author, but this would appear to contradict the term 'objective' as objectivity entails the elimination of prejudice. Gadamer argues that objectivity cannot be attributed to the 'text', the interpreter or the interpretation. The horizon of meaning in the 'text' cannot be said to be objective because it can be interpreted differently in different historical periods and these interpretations will be influenced by the effect of the 'text' on subsequent historical events. Furthermore, interpreters are not objective because they cannot stand outside of their historical and cultural presuppositions (prejudices). Each interpretation therefore is unique as, through a dialectical process, the horizons of the interpreter and the 'text' fuse into a unique entity. There is, therefore, no 'correct' interpretation of the 'text' and interpretations are subject to revision.



**2.2.3: SEEKING UNDERSTANDING: A SUMMARY OF THE PHILOSOPHICAL APPROACH IN THIS STUDY**

**FIGURE 2.3: THE HERMENEUTIC CIRCLE**

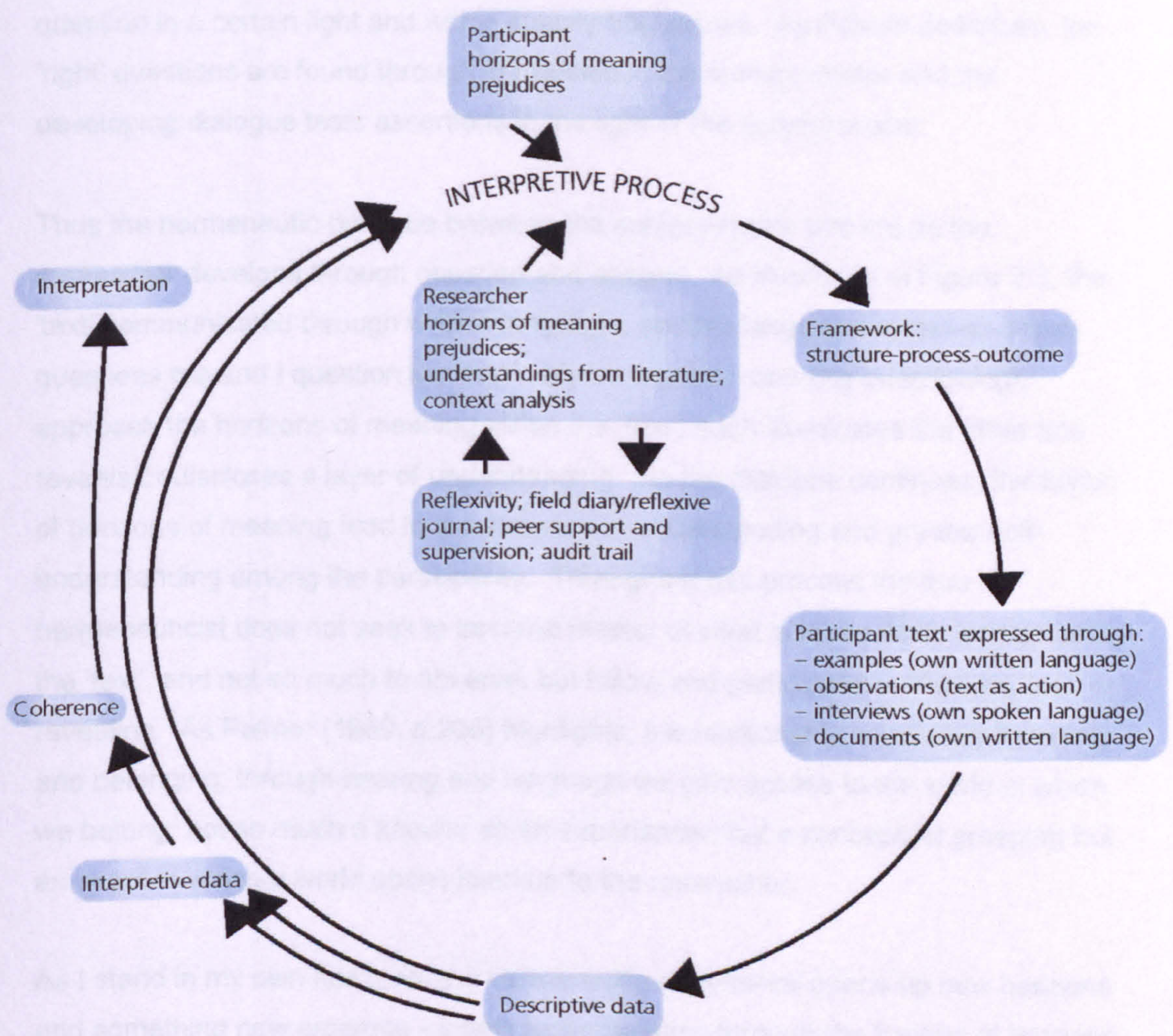


Figure 2.3 illustrates how the research was conducted and how the philosophical concepts operated within the study.



This research, and each cycle within it, began when a subject addressed itself as important to me, the researcher. I knew that I did not understand and wished to understand more thoroughly. I began to question the subject and to be questioned by this, and sought to remain open to the developing dialogue. As Palmer (1969, p 199) highlights, however, this questioning and openness to being questioned is not absolute because they always have a certain direction. The influences on the subject matter and me as the researcher at a specific historical time place the question in a certain light and within specify boundaries. As Palmer describes, the 'right' questions are found through immersion in the subject matter and the developing dialogue tests assertions in the light of the subject matter.

Thus the hermeneutic dialogue between the subject matter and me as the researcher develops through question and answer. As illustrated in Figure 2.3, the 'text' communicated through written language, spoken language or text-as-action questions me and I question the 'text'. My horizons of meaning questioningly approach the horizons of meaning within the 'text'; each illuminates the other and reveals or discloses a layer of understanding. As the dialogue continues, the fusion of horizons of meaning lead to a coherence in understanding and greater self-understanding among the participants. Throughout this process the true hermeneuticist does not seek to become master of what is in the 'text', but servant of the 'text', and not so much to observe, but follow and participate in what the 'text' is revealing. As Palmer (1969, p 209) highlights, the relationship is between listening and belonging; through hearing and language we gain access to the world in which we belong; not so much a knower as an experiencer; not a conceptual grasping but an event in which a world opens itself up to the reseracher.

As I stand in my own horizons, the hermeneutic experience opens up new horizons and something new emerges - a new understanding through the fusions of horizons of meaning. Gadamer's concept of the fusion of horizons thus enables interpretation to go beyond the self and join the 'self' with the 'other'. "Understanding is a productive activity" but this is not necessarily "better understanding. It is enough to say that we understand in a different way, if we understand at all" (Gadamer 2003, p 296)

## **SECTION 2.3: ETHICAL CONSIDERATIONS**

### **2.3.1: INTRODUCTION TO ETHICAL CONSIDERATIONS**

Addressing ethical issues is vitally important in qualitative research. "If we gloss over the potential power of communicating our ethical questions, decisions and actions ... we [will] ultimately have acted in ways that gloss over the rights of those we study and our responsibilities to them" (Miles and Huberman 1994, p 289).

The ethical issues addressed here are those raised by the methodology for the study. These include specific ethical considerations when undertaking research involving vulnerable people.

It is important to highlight that the ethical, legal and professional guidance governing research in nursing homes is changing. Were this study to be undertaken today the researcher and the research would be subject to newly-enforced:

- ethical guidelines on procedures for research
- legal checks by Criminal Records Bureau (CRB) or within Protection of Vulnerable Adults (PoVA) regulations
- professional guidance for anyone working in clinical settings as participant observers (such as attending accredited updating in cardiopulmonary resuscitation, moving and handling, health and safety or first aid).

### **2.3.2: APPROACHES, PERMISSIONS AND ETHICAL APPROVAL**

**PHASE 1:** Following ethical approval for the study from Brunel University, permission to enter care homes and to seek examples from staff was given by the homes' management.

Staff who participated did so willingly. Those who did not wish to participate did not do so. As this phase of the research did not involve vulnerable people, no further ethical approval was necessary.



**PHASE 2:** Approaches for permission to undertake the fieldwork were made through the Directors of Nursing or Care of the organisations owning the participating sites. Permission also needed to be obtained from the organisations' Chief Executives and their respective Executive, Medical or Long-Term Care Boards.

Approval was also sought from, and granted by, the three Local Research Ethics Committees (LRECs) for the areas in which the nursing home fieldwork took place. (Details of these processes, comments and conditions are given in Appendix 2.3). Explanations of approaches to, and obtaining consent from, research participants are given in Section 2.4.

### **2.3.3: ETHICAL PRACTICE IN THE RESEARCH**

A care home is first and foremost the private residence of the individual citizens who live within it. This must remain a primary consideration for anyone entering the home. In addition, nursing homes also offer clinical care and are thus, in some respects, clinical settings. Research in clinical settings, according to Madjar and Higgins (1996, p 132) should be founded on commitment to the ethic of care, even if not articulated as such. The primary concern is for individual good. In the complex reality of everyday caring practice, this ethic is understood and contextualised in 'situated meanings' and particular relationships. Moral decisions are integral to caring and respectful dealings with others. These rely on the integrity of individual researchers who have to translate established principles of behaving ethically in the field into concrete actions. Current guidelines on obtaining consent contain a criterion in which healthcare professionals can assume 'general authority to act reasonably', and thus make decisions within their professional codes of conduct.

My role throughout the study was explicitly that of a researcher, not a nurse, but the Code of Professional Conduct within which nursing practice is based was used as an ethical framework for the work. This Code of Professional Conduct issued by the Nursing and Midwifery Council (2002), offers principles relevant for researchers. It emphasises the shared values of all UK healthcare regulatory bodies to:

- Respect the patient/client as an individual
- Obtain consent before giving any treatment or care

- Protect confidential information
- Co-operate with others in the team
- Maintain professional knowledge and competence
- Be trustworthy
- Act to identify and minimise risk to patients/clients.

Key issues are discussed here.

### RESPECTING RESEARCH PARTICIPANTS, AND PARTICULARLY VULNERABLE PEOPLE, AS INDIVIDUALS

Respect for persons as individual human beings, rather than research participants, is fundamentally important, particularly in contexts such as care homes where residents can be vulnerable and researchers can, albeit inadvertently, intrude upon the most personal and intimate aspects of their lives. There are also important additional considerations when seeking the involvement of vulnerable people in research.

Research with older people encompasses particular ethical considerations, for example (British Medical Association and Royal College of Nursing [BMA/RCN] 1995, p 6-7):

- Older people are more likely than most other adults to experience erosion of their rights
- People who are perceived, or who perceive themselves, as dependent upon the services of others may experience difficulty in asserting their rights
- It may be difficult to judge what a person wants if his or her body or mind is failing

Older people living in care homes are one of the most vulnerable populations in the UK, with unique combinations of multiple physical and mental illness and a broad spectrum of personal care needs (Royal College of Physicians, Royal College of Nursing and British Geriatrics Society [RCP, RCN and BGS] 2000, p vi). They are socially vulnerable, being single, widowed or divorced, as the existence of a caring partner is an important factor in keeping people out of care homes (Netten, Darton



and Curtis 2001). Their vulnerability is compounded by the social exclusion they experience with which society colludes, according to The Royal Commission into Long-term Care (1999), by regarding them as out of sight and out of mind.

In addition, care home residents are highly dependent on the staff and this imbalance of power can inhibit older people in expressing their views (Brooker 1995, 1997, Bartlett 1995). From their research, Clark and Bowling (1989, p 128) and Bowling and Formby (1992, p 51) concluded that the older long-stay residents were reluctant to express their true feelings or to criticize due to fear of repercussions. Typical responses were: "it isn't for me to say", "It's alright", "I'm thankful there are people to take care of me", "I don't have any likes, I just take what I get. If people do things for you, you can't grumble".

While such statements may indeed be manifestations of fear of repercussions, there are additional subtle yet profound issues in care homes that influence how older people express their views. As Madjar and Higgins (1996, p 135) highlighted: "in this context the relationship between nurses and residents is often a longstanding one, with mutual expectations, commitments and obligations. It depends on residents generally acceding to nurses' requests, instructions and suggestions. That is not to say that residents are unable to express opinions, wishes or preferences, but their ability to exercise freedom of choice is much more limited than outside observers may often realise".

### OBTAINING CONSENT FROM RESEARCH PARTICIPANTS

In England, the law governing consent is currently under review but the legal principles currently in force for obtaining the consent of patients to treatment or care can be applied to the process of conducting research. Department of Health (DH 2001g) principles, adapted to research, rather than treatment and care, are:

- Before you [undertake research with] competent adults you must obtain their consent.
- Giving and obtaining consent is usually a process, not a one-off event. People can change their minds and withdraw consent at any time. If there is any doubt,

the researcher should always check that the person still consents to [participate in the research].

- People need sufficient information before they can decide whether to give their consent. If a person is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent may or may not be valid.
- Consent must be given voluntarily: not under any form of duress or undue influence.
- Consent can be written, oral or non-verbal. A signature on a consent form does not itself prove the consent is valid - the point of the form is to record the patient's decision.

Additional ethical considerations are required when gaining informed consent from older people, and particularly those who are frail, vulnerable and dependent on others to care for them (British Medical Association and Royal College of Nursing [BMA and RCN] 1995). The BMA and RCN (1995) emphasise the importance of providing adequate advice and information, in accessible language, to enable older people to make a valid, independent decision. They highlight that people in a situation of dependency may feel under pressure to conform to the wishes of others and stress that "it is therefore essential that they are given the opportunity to consent freely to participate in research and that they know they can withdraw their consent at any time" (BMA and RCN 1995, p 31).

All the informants in the current study participated willingly. The study did not include older people whose 'capacity' to consent (in the legal sense) was compromised in any way. 'Capacity to consent' was defined as (BMA and RCN 1995, p 15):

- Understand, in broad terms and simple language, what the [research] is, its purpose and nature, and why [it is relevant to] them
- Understand its principal benefits, risks and alternatives
- Possess the capacity to make a free choice (i.e. free from pressure)
- Retain the information long enough for an effective decision.

People who were physically, cognitively, emotionally unwell or 'unstable' were not included as the researcher did not wish to risk any upset or distress to persons who



were less than well. The contribution of older people to the study was highly valued but was not central to the developing theory. Rather it offered one of a range of peripheral perspectives on the research questions.

### PROTECTING CONFIDENTIAL INFORMATION

Steps were taken throughout the research to maintain the privacy, confidentiality and anonymity of participants. Codings were applied to all data and the single lists with the names of research participants, along with their consent forms, were kept in a locked cabinet separate from all the examples, transcribed interviews and observation notes. All participant's personal and health information has been kept confidential. No individual is identifiable from the published results and care was taken to ensure that individuals are not recognised from their quotations. Coding was used to ensure that informants were not identified in the printed examples or transcripts of observations or interviews. Where quotes are used in the discussion, codes are used. The lists identifying the names of the homes and respondents were kept separately from the other data and the quotes would be recognisable only by the researcher and the participant.

Issues of privacy can be subtle and can surface only when there are unexpected reluctances, or an outpouring of information beyond what the person meant to say, or a confidence overheard by others. However, working collaboratively with participants and discussing the emerging findings can help identify any risks to breach of anonymity in that participants often spot information that would identify them or threaten their interests.

### CO-OPERATING WITH OTHERS IN THE TEAM

There are some particular, some would say 'unique', considerations to which researchers in nursing homes should be sensitive.

The business ethos and competitiveness between independently-owned care homes may result in a reluctance to allow entry to researchers, to spend time with them or to share ideas on care. The pressures on staff should also not be underestimated.

In their clinical intervention trial in USA nursing homes Ouslander and Schnelle (1993, p 182) highlighted that staff experienced considerable financial constraints and time pressures. Also, care homes are small communities in which the same group of people interact on a daily basis. Ouslander and Schnelle (1993) suggest that "nursing home staff are always threatened, at least initially, by an outsider who will be observing their care routines, as well as by the possibility that the research may lead to more work". Research with nursing home staff can be complicated by institutionalized routines and any conflict or jealousy among staff (Higgins 1998) but it is important for researchers to remember that the primary responsibility of staff in their everyday work is the care of residents (Madjar and Higgins (1996).

#### **2.3.4: ETHICAL PRINCIPLES IN PRACTICE**

While ethical principles and codes governed the research, these were interpreted in the research settings within the ethic of care. My experiences as researcher resonated with those of Madjar and Higgins (1996, p 137) in that "ethics is something that we 'lived' in the exercise of practical judgements as we tried to navigate our way over the uncertain, misty and sometimes confusing terrain. We believe that we succeeded, not by following rules, but by negotiating our way through social situations, sensitive as much as possible to others' needs and wishes".



## **SECTION 2.4: RESEARCH PROCEDURE** **AND PROCESSES**

This section describes how the research was conducted, i.e. the procedures through which data were collected and analysed, and the rationale for the methods used.

It begins with details of the sampling strategy.

It then explains Phase 1 aims, data collection procedure and rationale for the methods. Information about the participants and the data collected is given, followed by details of how the data were coded and analysed and the rationale for the analysis strategies used.

This is followed by an explanation of Phase 2 aims, data collection procedures, how the fieldwork sites were selected, how the methods were piloted, the observation undertaken and the rationale for observation, the interviews conducted, the outline interview schedule and the rationale for interview. Phase 2 data analysis is then explained.

Section 2.4 ends with a summary of the overall data collection procedure, methods and sources, followed by some concluding comments on achieving coherence and presenting the interpretive account.

### **2.4.1: THE SAMPLING STRATEGY**

The samples were purposive in that they selected participants who would most facilitate the exploration of a particular aspect of the research or development of the emerging findings. The people within the sample population either possessed characteristics, knowledge or experience, or lived/worked in circumstances relevant to the phenomenon being studied. As described by Field and Morse (1985, p 95), participants have specific characteristics or knowledge which will add to, support or

(with negative cases) refute the findings, thus enhancing the researcher's understanding of the setting and illuminating common links or categories shared between the setting and others like it. The sample was also, of necessity, opportunistic. Some realities of the care home sector are discussed in the Introduction and, in the climate of competition, owners and managers are not always prepared to allow external researchers to have access to work in their homes for a range of reasons including the funding pressures on homes and the competitive nature of the market. Homes could view research as consuming the time of their staff, distracting from the prime focuses of the work, or intruding on the residents. Managers could also be concerned about the researcher observing and writing about aspects of the home that they would not wish to be reported, for example staff shortages, or of sharing the home's 'good ideas' with competitors.

Congrent with Gadamer's hermeneutics (2003), I looked first at the 'whole', i.e. the whole home or unit, and then at the 'parts'. Miles and Huberman (1994, p 34) suggest that researchers go first to the meatiest, most study-relevant sources and those which might provide 'typical' or 'representative' cases, in Phase 1 the RNs and CAs who were enthusiastic to provide examples of their work and in Phase 2 those who were happy to be observed and interviewed. However, Miles and Huberman (1994) also promote the advantages of working 'on the peripheries'; of talking with people who are not central to the phenomenon but neighbours to it - in this study non-RN/CA staff working in the homes, the residents and relatives. Peripheral sampling can obtain contrasting and comparative information which helps 'decentre' the researcher from one way of viewing the subject of study (Miles and Huberman 1994) .

The sampling was guided by the developing interpretations and evolved during the course of the study, the issues that addressed themselves to me as the researcher and were 'foregrounded'. This then guided further sampling and data collection as key elements or relationships revealed facets to be studied with other subjects or in other circumstances, as indicated in the hermeneutic circle (Figure 2.3)

In order to enhance the effectiveness of the sample, I purposefully sought to sample a range of participants working in different circumstances. Seeking maximum



variation in sampling is recommended by Denzin and Lincoln (1998). By seeking diversity, researchers can identify common patterns. It is also desirable to sample within each 'class' for certain processes (in this case RNs and CAs with and without education in caring for older people; with and without previous experience with older people). Many authors also advocate deliberately seeking atypical, negative or 'disconfirming' cases (Miles and Huberman 1994, p 34). These help to set the limits or boundaries for a researcher's conclusions and to highlight under which circumstances the main patterns still hold. They can also force researchers to clarify their concepts more precisely and alert to when samples are too narrow.

#### **2.4.2: PHASE 1: AIMS**

Phase 1 aimed to establish a dataset encompassing a diversity of RN and CA perspectives from a greater variety of homes and a broader geographical area than could be achieved in fieldwork. It also aimed to:

- build a broad database from around the UK
- facilitate the articulation of the participants' perspectives and realities
- highlight a broad range of aspects within the work that the participants themselves considered to be 'significant' (clarification of this terminology is given below)
- access dimensions of care and the participant's thinking processes which could be inaccessible through observational methods
- identify themes and theme clusters
- develop frameworks which could guide, and be developed by, further stages of the study
- alert the researcher to any factors which could be important to examine during subsequent fieldwork

#### **2.4.3: PHASE 1: DATA COLLECTION FORMAT**

RNs and CAs working with older people in a diversity of nursing homes around UK were invited to describe an example of their work which they identified as

'significant'. (Rationale for using the terms 'significant' and 'example' are given below and the sampling frame is shown in Appendix 2.1). I devised a form for collecting the examples, building on ideas developed during the RCN work on outcome indicators in continuing care (Heath, McCormack, Phair and Ford 1996a, b, RCN 1997) and honed through feedback from ten peers with expertise in older people's long-term care. The final version was piloted with RNs and CAs in three nursing homes. The headings on the form were as follows:

**HEADINGS ON SIGNIFICANT EXAMPLE FORM**

**The Example:** Choose an example which highlights the particular value of your work and/or your knowledge or skills. Describe the circumstances and the actions you took.

**The Results:** What might be the consequences of your work in this situation, or what could be the consequences in the course of time - for the older person; for relatives/friends/supporters of the older person; for you, other staff, or the home? What might have happened if you had not acted as you did? (Are there any ways in which you can support these results by 'objective' means, e.g. measurement tools or the assessments of others such as relatives?)

**The Knowledge:** What particular knowledge did you use in the actions you have described?

**The Skills:** What particular skills did you use in the actions you have described?

**Experiences:** What previous experiences (either personal or related to work) influenced your actions in the situation you have described?

**Intuition, instinct or 'gut feeling':** Write about any insight or understanding of 'things' that you 'knew' almost automatically, without necessarily thinking through the situation, but that influenced your actions.

**Other influences:** What other factors influenced your actions in this situation?

**Personal details:** Qualifications, education, experience and age range



#### **2.4.4: PHASE 1: DATA COLLECTION PROCEDURE**

RNs and CAs around the UK were invited to submit examples by two methods:

- Researcher visits to nursing homes
- Individual homes and staff who heard about the research and wanted to contribute

I visited twelve care homes with nursing in the areas of East London, Essex, Lincolnshire, Surrey, Norfolk, Oxfordshire and North Yorkshire. Homes were selected on the basis of those where access could be gained through professional contacts. The approach, explanation and information offered was the same in each home. During the visits, I met with willing RNs and CAs to explain the purpose of the research and, should they choose to submit examples, that these would be anonymous. All were free to participate or decline to do so. Some declined but all those submitting examples did so willingly. If RNs or CAs were interested in participating, I discussed with them how they could identify and record examples which they felt were significant in illustrating the value of their work, and particularly where they felt they made a contribution to an older person's (and perhaps family's) health, functioning or quality of life. During the discussion, I encouraged each individual RN and CA to identify an example, showed him/her the pre-designed form on which examples were to be written and left copies with them. Each RN/CA was asked to submit one example from her/his own experience on the form.

In order to obtain a broader sample, I attended two seminars for RNs working in nursing homes, one in Kent and one in Lancashire. Each had over 50 delegates. As previously, I explained the study and invited the nurses to take part. In addition, RNs and CAs working in other nursing homes who heard about the research offered to send in examples. These individuals were given verbal and written explanations of the research, the ethical safeguards and the forms to use.

#### **2.4.5: PHASE 1: RATIONALE FOR THE METHODS USED**

RNs and CAs each have their own unique perspectives on their work and their views are of primary importance in understanding their experiences, realities, intentions

and what they see as the potentials in their work. The technique was selected because it could offer individual accounts in all their richness. It was thus capable of capitalising on participants' own stories and perspectives on situations, avoiding the loss of information which occurs when complex narratives are reduced to simple descriptive categories (Norman, Redfern, Tomalin and Oliver 1992).

The approach could be compared with Critical Incident Technique (CIT), first described by Flanagan in 1954, and defined as "a systematic, inductive, open-ended procedure for eliciting verbal or written information from respondents" (cited in Norman, et al 1992, p 591) or, more specifically, as "a method of obtaining data from study participants by in-depth exploration of specific incidents and behaviours related to the matter under investigation" (Polit and Hungler 1991, p 642). This has been widely used in nursing, specifically by Benner (1984) and her colleagues to describe domains of nursing practice, major competencies of nurses at varying levels of skill acquisition and the use of intuition. CIT was initially positivist in its approach and criteria. For example, Flanagan (1954) maintained that an incident could be considered valid only if full details could be given by the reporter of the incident and its context, and that the reporter could identify observed behaviours that were both meaningful and significant in the aim of the activity. Because of its positivist origins, CIT in its pure form was not used as such in this research.

The terminology 'significant example' was selected in preference to 'critical incident', or even 'significant incident'. Many of the participants in this study were not focusing on one incident, even though they might initially have appeared to do so. However, I was keen to avoid misunderstandings, particularly following the experiences of Reed (1994) described in Section 1.6.2, and the research-specific usage of the terms 'critical' and 'incident' differ greatly from their meanings in the everyday parlance of the participants in this study. As found in Reed's (1994) research, the work in environments where older people live is not widely regarded as episodic and the term 'incident' would be used in everyday parlance to refer to something of an acute nature, usually with potential detriment to residents or staff. Used in the context of CIT, the word 'critical' suggests that the incident must have a discernible impact on some outcome; it must make either a positive or negative contribution to the accomplishment of some activity of interest.



Ultimately the term 'example' was used in order to be able to incorporate events over a range of time spans, not necessarily on one occasion and not time-limited. The term 'significant' was used to encourage participants to write about what they saw as important, as worthy of special consideration or as outstanding in their memories. The two terms together aimed to remove suggestions of acute, life-or-death, time-limited episodes.

#### **2.4.6: PHASE 1: RESEARCH PARTICIPANTS**

The samples were predominantly female.

Care Assistants (CAs): Of those offering biographical details with their significant examples, the age range of most of the participants was from 21-40. One was under 20 and one was in the age range 51-55. Most were in the age ranges 21-25 and 36-40.

Most CAs had worked with older people as a CA in a nursing home from three to five years. The shortest time was six months. One had worked for nine years and one for 11 years. The average time was just over four years.

Approximately one third of the CAs submitting examples had undertaken level 2 or 3 or BTEC in direct care or mental health. Although most of the CAs had undergone some training and updating for their work, particularly in manual handling, fire and first aid, this was not commonly cited by them as a major influence on their work and one could not remember the name of the course she was undertaking.

Registered Nurses (RNs): Of those offering biographical details with their significant examples, 18% were in the age range 36-40, 23% were 41-45, 41% were 46-50 and 18% were 51-55. This meant that approximately two thirds of the participants were in their 40s, a higher age range than the sample of Care Assistants.

The majority of RNs submitting examples had been registered as a nurse for over 20 years. One had been registered for only seven years, three for 16 or 17 and one for 40 years.

All but one of the RNs submitting examples listed study days they had attended; only one RGN listed no updating or development; she had been qualified for 23 years.

Taken as a percentage of those who completed biographical details

- 94.5% had attended at least one study day/updating day and most had attended a range of these
- 33% had attended National Board Courses and all of these had attended two or more
- One participant (5.5%) had attained a BSc and a Certificate in Education, and another participant had an MSc in Advanced Clinical Practice (Care of the Elderly).

#### **2.4.7: PHASE 1: DATA COLLECTED**

Some participants willingly sent examples but many who had appeared keen did not send anything. Telephone calls to the homes I had visited brought a few more examples but the response rate overall was low. I then sent a letter to individuals who had agreed to participate enclosing a form on which they could let me know why they had not sent an example and a stamped addressed envelope. The primary reason for the low response appeared to be lack of time and pressure of work. The research was not a priority in their busy lives. Participant comments included: "I've been very busy at work having just been appointed Home Manager and have been having to attend various study sessions related to my job", "working 10 extra hours a week", "working 'flat out' continually", "doing ENB 998 and NVQ Assessors course", "very tired and joint problems". A secondary but important reason was that the participants did not feel confident about writing on the form. They said they were unsure whether their examples would be useful because they were 'nothing special' or whether they would be 'right' for the research. There also appeared to be issues of writing in that some participants felt daunted by the form, one RN said it looked as if it would take a long time to complete so put it to one side. One participant commented: "as I progressed I couldn't see clearly what my role in the situation was and also because the situation changed for what I thought would be the better, but it wasn't. I did find it difficult, once I sat down, to think about my role. You do things every day, but when you come to break things down and explain it, it is quite difficult".

Ultimately of well over 100 RNs who offered examples only 34 submitted them and, of over 50 CAs who offered, 18 were received.



The dataset for Phase 1 was therefore:

<u>Registered Nurses</u>	<u>Care Assistants</u>	<u>TOTAL EXAMPLES</u>
34	18	52

These examples illustrated a range of situations and achievements that RNs and CAs identified as significant in their work. Each of the examples was distinct and the data provided some rich descriptions of practice. They suggested some strong themes towards developing the theoretical focus of the research and highlighted the key domains of the work. They also offered categories towards the development of a framework of outcomes for the work, and inputs to the work, which could be used as coding frames. Most of the examples contained personal reflections, perspectives and descriptions of what the participants valued, what motivated them and how much they cared about what they do. Elements in some of the stories were extremely poignant.

These data were analysed as they were collected and all from Phase 1 were analysed before the commencement of Phase 2. The data analysis strategy is described below.

#### **2.4.8: PHASE 1: ANALYSING THE DATA**

The examples were initially reviewed within separate datasets according to whether or not I had met individual participants but no distinguishing features were found between these datasets, so they were merged.

#### **THE DESCRIPTIVE ANALYSIS**

RN and CA data were analysed separately.

The focus of each example was noted (topics described in Appendices 3.1 and 4.1). The data were then systematically coded and arranged under categories and sub-categories according to the principles of analysis and coding scheme, described below.

In order to code the data, I:

- reviewed the detail written by participants and identified codes under the main headings of Outcomes, Inputs and Other Influences
- identified and coded categories included by the participants in their examples (e.g. 'being treated like a person'; 'privacy and dignity'; 'safety and security');
- under these category headings, the statements, exactly as written by the participants, were listed (e.g. 'feels more in control'; 'enjoys a joke'; 'no longer aggressive');
- identified sub-headings from within the examples (e.g. under the main heading of Inputs, a sub-heading 'skills', then further sub-headings of 'personal skills' and 'clinical skills' were identified),
- under these sub-headings, the statements, exactly as written by the participants, were listed (e.g. 'empathy - convincing the daughter I understood how she felt' [under the heading of personal skills]; 'setting up the aseptic trolley for catheterisation' [clinical skills]);
- identified defining characteristics for the categories generated.

In order to remain as close as possible to the participants' 'text' I retained their language, i.e. used exactly the words they had used, throughout the descriptive analysis.

### INTERPRETIVE ANALYSIS

Following the descriptive analysis, an interpretive, thematic analysis was undertaken towards developing the focal theory of the study and answering the research questions. Key quotes were identified.

For peer support and supervision, as shown in Figure 2.3, two professional colleagues with expertise in working with older people in care homes reviewed much of the original data, the descriptive analysis and the interpretive analysis. Both felt that the analysis was an accurate and fair interpretation of the original data. One suggested that categories could be condensed under headings such as 'accountability' or 'reciprocity' but, particularly at this early stage, I was keen to retain the exact words of the participants, the breadth of description and the richness of the detail.



### **2.4.9: RATIONALE FOR DATA ANALYSIS STRATEGY**

The process of data analysis was not the last phase in the research process, or even a distinct phase, but one aspect in the research process. Data analysis began during data collection as the data gathered were analysed and it shaped the ongoing data collection (Pope, Ziebland and Mays 2000). Analysing the data was a reflexive, cyclical, interactive and iterative process, as indicated in the Figure 2.3. Analysis progressed through the cyclical process of repeated interactions between the data and the developing conceptual constructs and focal theory (Coffey and Atkinson 1996, p 6). Initially, I read all the data many times in order to gain an overall understanding and insight into possible themes. Returning to the text, to the participants and to the settings help to clarify or disagree the interpretation as this emerged. Comparing and contrasting texts also helped to identify and describe shared practice and common meanings. Packer (1985, p 1091) describes how hermeneutic analysis involves "returning to the object of inquiry again and again, each time with an increased understanding and a more complete interpretive account. An initial understanding becomes refined and corrected by the work of interpretation; fresh questions are raised that can be answered only by returning to the events studied and revising the interpretation".

In order to identify, organise and manage the most meaningful elements within the data, a coding process was used. Codes are tags or labels, based on a researcher's concepts, which assign units of meaning to the descriptive or inferential information compiled during a study (Miles and Huberman 1994). They function as signposts and links between sets of concepts located in the data and are, in that sense heuristic devices. As Coffey and Atkinson (1996, p 26) observe, the term 'coding' can imply somewhat mundane and mechanistic processes but coding can be used in a variety of ways to organise and condense the mass of data into analysable units by systematically creating categories with, and from, the data. Coding is never wholly mechanistic in that researchers need to decide, for example, which aspects of the data to tag with codes and also at what level of detail or generality to focus.

Coffey and Atkinson (1996, p 32) emphasise that codes are organising principles and tools with which to think. There is no 'right' set of codes. In heremeneutics,

these emerge from a fusion of the horizons of meaning offered in the 'text' and those of the interpreter. They are not set in stone but can be changed as ideas develop through repeated interactions with the data. Codings link together fragments of ideas or instances in the data which the researcher defines as having a common element or property to create categories or themes related to a particular concept. Coding is not the analysis in itself. The fundamental analytic work lies in how the codings are used to rigorously examine the data and identify and generate key concepts, themes and patterns.

Prior to Phase 1, an initial 'start list' of codes was developed from the literature, the rudimentary map showing the scope of the study and the research questions, as recommended by many authors (Field and Morse 1985, Miles and Huberman 1994, Coffey and Atkinson 1996, p 32, Mays and Pope 1996). The initial list was 'held lightly' (Miles and Huberman 1994) and developed through the course of the analysis as the new data interacted with the 'start list'. New codes were added as categories gradually emerged. The 'anchor' throughout the analysis was the focus of the research, as articulated through the research questions.

The coding list from Phase 1 was used as the 'start list' for Phase 2. At the beginning of Phase 2 the frameworks produced from Phase 1 were 'held lightly', applied to the first sets of field notes, and then examined closely for fit and power. The coding lists developed and changed as new data interacted with the 'start list'. The code list thus developed through the course of the analysis. It soon became apparent that additional and distinct aspects were emerging from the fieldwork and interviews to those which emerged from the significant examples in Phase 1.

Some of the codes were derived directly from participants' words (e.g. "looking beyond the obvious", "where there's life there's hope"). Others suggested themselves from within the data but the term chosen as the title for the category was suggested by me as the researcher (e.g. 'personhood'). These reflect the researcher's personal conceptual orientation and pre-understandings. It was also noted that some of the more detailed sub-codes tended to overlap or intersect (e.g. 'mental health' with 'wellbeing', 'leadership' with 'determination to obtain better care'). The same segment could therefore sometimes be labelled with more than one code,



although I found that, by analysing the segment's component concepts, labelling became more straightforward.

During the analysis and data collection, particular attention was paid to representative, atypical and negative cases, which tended to address themselves to me. Representative cases can be defined as those which appear with regularity and encompass a range of behaviours described within a category; atypical cases are those which occur infrequently and are distinct from the majority of cases in some way; negative cases are those episodes that clearly refute an emergent theory or proposition. Negative cases are important as they help to clarify additional causal properties which influence the phenomena under study (Field and Morse 1985).

The coding thus worked through "iterative cycles of induction and deduction to power the analysis" (Miles and Huberman 1994, p 65). The perspectives and the emerging maps were thus constantly developed and reshaped. The ultimate power of field research lies in the researcher's emerging map of what is happening and why. As Miles and Huberman (1994, p 62) emphasise, "there is more going on out there than the initial frames have dreamed of. Some codes work others decay but care needs to be exercised". Through the hermeneutic circle, fieldwork understanding developed through fusions of horizons of meaning, in stages and layers. This meant periodically re-reading the data collected earlier in the cycle when new codes became salient or new inferences/patterns were suggested by new data.

Coding can complement foregrounding and distancing by helping to focus on the aspects most relevant to the research and pay less attention to what Miles and Huberman (1994) describe as the 'dross' which is inevitably collected in qualitative fieldwork. They do, however, caution against complete discarding of the 'dross' as this may subsequently prove to be highly relevant. Developing coding schemes can also help to drive the data collection by forcing researchers to seek understanding of new data which do not readily fit within them. Miles and Huberman (1994) believe this encourages differentiation and integration of the emerging 'map', while remaining flexible. Atypical, equivocal or missing data can be clarified during the next fieldwork session and potential bias in the analysis can be challenged.

#### **2.4.10: PHASE 2: AIMS**

Phase 2 of the research aimed to build on the findings of Phase 1, and to further develop the frameworks and themes emerging from the data towards answering the research questions.

The OBSERVATION aimed to:

- identify naturally-occurring events and interactions in natural contexts in order to witness the complexity of events, interactions and relationships as they unfold in the natural world.
- observe RNs and CAs as they went about their work in order to identify any aspects (i.e. 'text-as-action') additional to, or distinct from, those identified in their significant examples or interviews and of which they may be unaware.
- identify perspectives of the research participants (e.g. their 'prejudices' or 'horizons of meaning').
- describe the contexts in which the work took place and identify any contextual influences on this.
- alongside the other methods, to enhance the depth and/or breadth, consistency and rigour of the conclusions (Adler and Adler 1998, p 90), especially in triangulation of data collection methods (Denzin and Lincoln 1998).

The INTERVIEWS aimed to:

- offer participants an opportunity to reflect on their work and specific events or interactions which I had observed
- explore participants' individual values, beliefs, subjective experiences, concepts and frameworks of meaning ('text'), while documenting my own influence on the interviews.

The DOCUMENTARY ANALYSIS aimed to:

- identify any additional or alternative perspectives on the work of RNs and CAs as a way of confirming (or otherwise) the findings from other methods.



### **2.4.11: PHASE 2: DATA COLLECTION PROCEDURE**

I worked in three participating fieldwork sites, distinct in a variety of ways including geographical location, size, ownership and resident population.

#### **SELECTING THE FIELDWORK SITES**

Through the networks of older people's nurses, I made known that I was seeking research sites. A variety of organisations volunteered and three homes were selected on the basis of the sampling frame (given in Appendix 2.2). Care homes with nursing (i.e. those who would be registered under Part II of the Registered Homes Act 1984) were selected as these usually care for older people who have the broadest range of complex health and social care needs. All of the homes were keen to participate and ethical procedures were followed, as described in the previous section.

**HOME 1:** A 138-bed nursing home in semi-rural Essex, organised within four separate units, two designated for people with physical frailty (with 31 and 49 beds) and two designated for older people with mental health needs, primarily dementia (with 28 and 30 beds).

**HOME 2:** A 48-bed nursing home in a residential area in Surrey, organised into two main units or 'communities' with a central lounge, dining room and kitchen area. Each 'community' had two wings, each with 12 bedrooms. One main community unit catered for older people with dementia and the other for older people with physical frailty. The home specialised in offering care for people with a high level of mental health need.

**HOME 3:** A 67-bed dual registered home in residential area in North Yorkshire (with 45 nursing and 22 residential care beds), organised into two nursing wings and one residential care wing. The home offered care for people from a distinct 'culture' and the home's published admission criteria were applied before new residents move in. These criteria excluded people with mental health needs but when residents developed mental health needs the home would continue to care for them as long as possible, particularly if physical care needs were predominant.

(Further details of the three homes and the units in which fieldwork took place are given in Appendix 2.10).

#### **2.4.12: PILOTING THE FIELDWORK METHODS**

Following approval from the management boards of the homes' owners (described in Section 2.3), the proposed approaches and methods of working were discussed with the Directors of Nursing and Care for the three homes to be used for fieldwork. The Director of Nursing, Manager and Matron of Home 1 were keen for the research to be undertaken and, during the three months while ethical approval was being obtained, I was able to work with staff in order to develop and pilot the methods.

#### **2.4.13: THE OBSERVATION UNDERTAKEN**

As a participant observer, I worked alongside RNs and CAs, initially for periods of up to four or five hours. I usually started the shift at the same time as the staff. This enabled me to 'pick up' prompts to staff actions as soon as they came on duty (at about 07.30, 14.00/14.30, and 20.00/21.00). I also tried to work with the staff through the natural sequence and flow of work. The observations also encompassed specific situations, e.g. the lunch and handover period, the evening and preparation of residents for sleep, or times specifically convenient to the staff. In order to gain as complete a picture as possible, observations were conducted at all times of the day and days of the week, thus encompassing the 24 hour-a-day, seven day-a-week nature of the work.

Fieldnotes were written in shorthand on a tiny pad that frequently emerged from my pocket and all participants were aware that I was making notes for the research. Fieldnotes generally comprised activities, interactions or events that addressed me as important or significant in any way. I particularly highlighted aspects that could be discussed in ensuing interviews, for example:

- the activities of the RN or CA - i.e. what they are doing, e.g. helping Mrs A to wash, taking J to the toilet in the wheelchair, bending down to kiss G on the cheek.
- any activities or conversations which seemed to be purposeful, i.e. as having an intention behind them that may offer insight into decision-making processes



relevant to the research questions, e.g. asking a resident or relative questions in order to identify the source of a problem.

- any verbal or non-verbal interactions which might indicate skill or insight, e.g. a care assistant cleaning a colostomy and changing the bag and, every ten seconds or so, she looked directly and strongly at the resident's face and smiled or winked.
- any data which might communicate the 'reality' of the work, such as the humour in interactions, or its contextual influences e.g. discussions about staff shortages.

Fieldnotes were transcribed as soon as possible after the observation sessions.

#### **2.4.14: THE RATIONALE FOR OBSERVATION**

Observation was an important aspect of the study. The literature strongly suggested that some dimensions of the work, specifically the tacit dimensions and those relevant to expert practice are only accessible, if at all, by direct observation and facilitated reflective interview (Meerabeau 1992). Observation was particularly relevant in that it offered the opportunity to uncover behaviours or routines of which the participants themselves might be unaware, thus helping to overcome the shortcomings of methods relying solely on self-report. In addition, observation could help to develop understanding on why the examples presented in Phase 1 of the research were so diverse, and perhaps the reasons for this (e.g. do most RNs work at a range of levels within each shift, do RNs practise in very different ways, were the differences between RNs and between CAs related to skill, motivation, life experiences, education or any factor yet unified in the study?).

I adopted the role of 'participant as observer', one of four observational roles defined by Gold (1958) and described by various writers including Adler and Adler (1998, p 84) and Mays and Pope (1996, p 21). The defining characteristics are that all actors in the setting are aware of the research and the observation is overt. By becoming involved in the activities taking place, as well as observing them, the researcher attempts to minimise her/his impact on the environment and the subjects being studied.

### **2.4.15: THE INTERVIEWS CONDUCTED**

After the observation period, the RNs and CAs were interviewed. The interviews sought to capture the staff's perceptions, for example of their intended outcomes for the actions, or knowledge, skills, experiences, and other influences on decision-making, such as personal values and motivations, that were not accessible to observation. The outline interview agenda is shown below.

#### **OUTLINE AGENDA FOR INTERVIEWS WITH RNs AND CAs**

**Role as a RN / CA ?**

**What are your particularly trying to achieve in your work?**

**What are the results of your work for the older people who live in the home?**

**E.g.**

- \* Health status / functioning / wellbeing / quality of life
- \* Specific clinical outcomes : nutrition, continence,  
prevention of pressure damage, infections, falls/accidents.

**What are the particular skills or knowledge that you bring to your work?**

**What helps you to achieve what you want to in your work?**

**What are the challenges in your job?**

**What are the distinctions between the role of a RN and a CA?**

**How do RNs and CAs inter-relate and where are the boundaries between the roles?**

**How would things change if there were no RNs in the home?**

**Discussing specific examples from the observation session:**

**What were you trying to achieve ?**

**What do you think were the results of your actions?**

**What might have happened if you had not acted as you did?**

**What were the specific knowledge and skills that you brought to the situation?**

**Any other examples which you think illustrate the benefits of your work?**



Interviews took place according to the preference of the interviewee. This was ideally in a quiet room (e.g. unused lounge, clinical room or unoccupied bedroom) but, if the staff felt the need to 'keep an eye' on the residents, this was respected and the interview took place somewhere central to the unit, usually with numerous interruptions and some background noise (including arguments and sing-alongs).

Interviews generally lasted 20-30 minutes. Interviews with Senior Nurses and Matrons or Home Managers were usually around 45 minutes. When possible, interviews followed directly on from observation periods. Interviews were audiotaped and I noted key points during the interview. Biographical details were collected from staff (the form for this is given in Appendices 2.6 and 2.7).

I also interviewed other staff who influenced care in the home and also offered a perspective on the work of RNs and CAs. These included, physiotherapists, General Practitioner, Clinical Psychologist, Activities Organiser.

A sample of the older people living the home were also interviewed. They were invited to give their view on how they felt the RNs and CAs helped them, or did not help them, and any aspects they felt relevant to this. In these interviews, I also sought opinions on any distinctions which the participants could make about the respective contributions of the RNs compared with the CAs. Older people were only invited to participate in the research if they had been assessed by the Senior Nurses responsible for the unit as cognitively able to participate. In accordance with the ethical principles of the research, these individuals were only invited if, following discussions with me, they were keen to participate. (The explanation to residents/relatives and invitation to participate is given in Appendix 2.8 and the consent forms in Appendix 2.9). In addition, I interviewed any relatives who visited the home regularly and spent some time there.

The interviews were semi-structured in that they explored key aspects, with flexibility to explore aspects raised by the interviewees and to discover their own frameworks of meaning. The outline interview agenda for residents is shown in the following box. This was adapted for relatives and other professionals working in the home.

**OUTLINE AGENDA FOR INTERVIEWING RESIDENTS**

**What do the CAs do for you ?**

**What are the results of what the CAs do for you ?**

**How do they help ?**

**E.g. health / functioning / wellbeing / quality of life or specific clinical outcomes :  
nutrition, continence, prevention of skin damage, infections, falls/accidents.**

**Is this what you want?**

**Could it be done differently so that it would help you more ?**

**What particular skills or knowledge do the CAs have ?**

**What do the RNs do for you ?**

**What are the results of what the RNs do for you ?**

**How do they help ?**

**E.g. health / functioning / wellbeing / quality of life or specific clinical outcomes :  
nutrition, continence, prevention of skin damage, infections, falls/accidents.**

**Is this what you want?**

**Could it be done differently so that it would help you more ?**

**What particular skills or knowledge do the RNs have ?**

**What are the distinctions between what the RNs do and the CAs do?**

**What are the differences in their training ?**

**How do they tend to work together or relate with each other?**

**How would things change if there were no RNs in the home?**

**Discussing specific examples from the observation session:**

**What do you think the RN/CA was trying to achieve ?**

**What do you think were the results of what they did?**

**What might have happened if they had not acted as they did?**

**What specific knowledge or skill do you think they brought to the situation?**

**Other examples of how the RNs/CAs help you?**



#### **2.4.16: THE RATIONALE FOR INTERVIEW**

The focus of the interviews was on the participants' views and experiences and, while asking all the key questions on the agenda, the order of these and supplementary discussion were determined by the course of the conversation. Koch (1996, p 176) describes how, in hermeneutic research, "conversations are non-directive so that [participants] are able to tell their stories in whichever way they wish ... the approach is open, allowing the participants to take you with them in their narration". In hermeneutic research it is also important to document the researcher's influence on the interviews. As Miles and Huberman (1994, p 8) argue, an interview is a collaborative act on the part of both parties, not a gathering of information by one party. Events occur within a social and historical context which deeply influences how they are interpreted by both insiders to this (research participants) and the researcher as outsider. It can be difficult to separate out external information from what researchers themselves have contributed when decoding and encoding the words of participants and working with these requires self-awareness and care on the part of the researcher.

Throughout the fieldwork, and particularly during the interviews with residents and relatives, I was sensitive to their potential vulnerability. One-to-one interview is widely recommended as the preferred method for seeking older people's views for a range of reasons (King's Fund Centre 1991, Brooker 1997). The health problems they experience can limit their ability to participate in interviews or focus groups, and to read questionnaires (Bartlett 1995). Also, with older people in care homes, impairment of cognitive functioning commonly co-exists with physical disorders (Cotter, Meyer and Roberts 1998). While people known to have impaired cognitive function were not included in this research, it was important for me to remain vigilant for older people's reactions and this could be achieved in one-to-one interview.

#### **2.4.17: PHASE 2: RESEARCH PARTICIPANTS**

The participants were predominantly female.

**Care Assistants (CAs):**

The average age of the CAs who participated in fieldwork were 40.5 years old in Home 1, 35 in Home 2 and 38 in Home 3.

The average years of experience for the CAs who participated in the fieldwork were seven years in Homes 1 and 2 and 15 in Home 3.

In Home 1 the CAs had generally received little or no training other than in-house manual handling and fire training. What additional training they had received was haphazard.

In Home 2 the staff in the home had generally received good educational and training input. Most listed a number of courses they had attended. All staff had attended manual handling training, fire training and the one-month induction. Many had taken first aid or food hygiene courses.

In Home 3 all staff had undergone yearly moving and handling updates and fire training. Some had first aid certificates. There was a systematic planned career progression through NVQs. Virtually all of the staff had also undergone additional training and had attended a variety of courses. Those listed by CAs included: Bereavement Counselling, Palliative Care, Parkinson's Disease, Infection Control, Preventing Falls, Care of the Feet, Health and Hygiene, Blind Awareness, Hearing Aid Training, Target Zero Pressure Care, dealing with difficult situations, preventing accidents in the home, communication skills.

**Registered Nurses (RNs):**

Of the RNs in the homes, one was under 30 and one was over 55. About half were in their 40s, a quarter aged 36-40, ten per cent aged 31-35 and the same proportion over 50. The average age of the RNs who participated in fieldwork were 39 in Home 1, 48 in Home 2 and 41 in Home 3.

Of the RNs in the homes, the nurse in her 30s had eight years of experience. All of the other participants had between 12 and 29 years of experience. The average years of experience for the RNs who participated in the fieldwork were 17 in Home 1, 21.5 in Home 2 and 21 in Home 3.

In Home 1 the RNs had varied experiences before entering the home. Some had undertaken courses in, for example, terminal care and symptom relief, tissue viability, ophthalmics and operating theatre.



In Home 2 RN courses included diabetes, urodynamics, dementia care, dealing with challenging behaviour and care of the dying.

In Home 3, courses undertaken by RNs included: Health and Safety, English National Board courses on Care of the Dying infection control for nursing homes, teaching and assessing, Continence promotion and management, pain tolerance, asthma, reminiscence therapy, Parkinson's Disease, Alzheimer's Disease, Nursing Ethics, basic food handling. Some RNs were NVQ Assessors.

#### **2.4.18: PHASE 2: THE DATA COLLECTED**

DATA ON THE HOMES were collected, including details of the environment, the facilities and services, resident 'dependency', models of care and staffing levels. These are incorporated into Appendix 2.10.

The Phase 2 fieldwork took place in all nursing units at the participating sites, i.e. four in Homes 1 and 2 and two in Home 3.

The number of OBSERVATION SESSIONS has been approximated as some were full shifts working with individuals, some were specific observations such as shift-to-shift handovers and some were periods spent working around the homes.

INTERVIEWS were as shown in the following table.

DOCUMENTARY DATA within the homes, such as resident care plans, progress and evaluation sheets, medication prescription charts, medical or therapy notes, tools to measure dependency or care need and tools to measure pressure risk, incontinence, manual handling; audits of pressure ulcers, falls and accidents. These are discussed below.

#### **DATA ON THE HOMES**

The information about the homes, such as facilities, services, resident 'dependency', models of care and staffing details provided useful contextual detail.

THE OBSERVATIONS AND INTERVIEWS IN THE HOMES INCLUDED:

	<u>HOME 1</u>	<u>HOME 2</u>	<u>HOME 3</u>	<u>TOTAL</u>
<b><u>INTERVIEWS</u></b>				
Registered Nurses	8	8	6	22
Care Assistants (no NVQ)	6	6	4	16
CAs with NVQ Level II		2	2	4
CAs with NVQ Level III			4	4
Home Manager (RGN)	1	1		2
Deputy (RGN)			1	1
Physiotherapist	1	1	1	3
Clinical Psychologist		1		1
General Practitioner		1		1
Head: Residential Care			1	1
Residents	10		8	18
Relatives	1	3		4
<b>TOTAL</b>				<b><u>77</u></b>
<b><u>OBSERVATIONS</u></b> <b><u>(approximately)</u></b>	30 (plus 5 pilot)	20	18	<b><u>73</u></b>

THE OBSERVATIONS: witnessed naturally-occurring interactions, relationships and patterns of work. Researcher perceptions, including aspects of the work unrecognised by participants, were able to confirm, or otherwise, the findings and interpretations achieved through the other data collection methods. These added greatly to the richness of the results.

Potential contextual influences on the work were also identified through the observations. While some influences on the work were broadly relevant to all care



homes, the culture within each home was distinct, as described in Appendices 2.10, 3.2 and 4.2. Where leadership was strong and inclusive, the staff worked more as a team and good care became automatic within the daily regimes. Where the leadership was detached or ineffective, sub-cultures began to develop among the staff with feelings of being undervalued.

The shift to shift handovers and staff meetings offered interesting insights into how teams worked and what each staff member contributed to this. At one staff meeting the staff discussed their respective roles. The handovers in Home 1 were RN to RN and focused on medical conditions. Handovers in Homes 2 and 3 were more detailed, and particularly in Home 3. In these, the CAs tended to report, the RNs question and advise, and whoever was leading the care, usually a Sister or Senior Sister, would make the decision. These data fed into the developing understanding and interpretation.

INTERVIEWS WITH RNs AND CAs: offered participants the opportunity to reflect on their work, including the actions and situations observed by the researcher of which they might be unaware. They also facilitated exploration of participants' 'text', 'prejudices' and 'horizons of meaning' as well as their priorities and motivations.

OTHER INTERVIEWS: While the number of interviews achieved with older residents, relatives and other professionals working in the home was smaller than with RNs and CAs, the data added to the richness of the work by offering alternative perspectives on the research questions and focal theory of the research. The perspectives of the residents were particularly valuable.

THE DOCUMENTARY DATA COLLECTED AND ANALYSED INCLUDED:

The residents':

- care plans, progress and evaluation sheets
- medication prescription charts
- medical or therapy notes, when available

Tools used to measure resident dependency or care need, such as:

- the Revised Elderly Person's Dependency Scale (REPDS)
- the RCN Nursing Older People Assessment Tool

- a dependency measure developed in the nursing home
- a tool to assess resident wellbeing, i.e. Dementia Care Mapping

Tools to assess and monitor specific aspects of care, such as:

- Pressure ulcer risk
- Incontinence
- Manual handling
- Nutrition

Audits taken regularly in the home, such as:

- Monthly audits of pressure ulcers
- Monthly audits of falls and accidents

Documents examined in the three homes included:

#### HOME 1:

- Monthly audits were made of pressure sores and accidents in the home.
- Resident dependency was assessed using the Revised Elderly Persons Dependency Scale (REPDS), which was supposed to be assessed six-monthly.
- Entries were made daily on each resident's 'Progress and Evaluation' sheet, which was kept with the care plan.

#### HOME 2:

- Quarterly audits were made of falls, pressure risk, resident and staff accidents.
- Every six months an assessment was conducted on all residents using the RCN Nursing Older People Assessment Tool
- Dementia Care Mapping was also conducted six-monthly in the dementia care unit, including one session observed by the researcher in the mental health unit
- Entries were made by CAs daily on the progress page of each resident's care plan. These were countersigned by RNs.

#### HOME 3:

- Monthly audits were also taken of pressure risk, falls and accidents
- Staff to patient ratios were measured monthly.
- Resident dependency was assessed on the home's own computerised dependency scoring system.



- Additional documentation included continence assessments and manual handling assessments
- Entries were made by RNs or NVQ III Team Leaders on each resident's computerised care plan.

#### THE DOCUMENTARY DATA:

These were helpful in confirming the scope and focus of the work and the categories within the outcomes framework. They were, however, of limited use in confirming the staff's claims about the outcomes of their work. Particularly on the manual care plans used in Homes 1 and 2, entries by both RNs and CAs primarily recorded activities of daily living with which the person had received assistance, e.g. 'had a bath', or what the resident had done that day, e.g. 'up to sit in day room', 'went to the hairdressers'. Occasionally the RN would write something clinical, e.g. 'wound healing well'. Other than this, I was unable to distinguish any patterns between the entries of the RNs and CAs. Progress reports were generally written hurriedly and little attempt was made to evaluate the achievement, or otherwise, of the goals on the care plan.

Six-monthly 'dependency' scores were similarly unhelpful in distinguishing the distinct contributions of different staff groups. Particularly in Home 1, the dependency descriptions varied widely according to who undertook the assessment and the scores were often not completed. Records of 'adverse incidents' such as accidents or the development of pressures could not be related to staffing levels or any other specific factor such as individual nurses in charge of the unit. Accident details were also difficult to relate to other factors, for example most of the resident falls or accidents occurred while they were 'exercising independence'.

The job descriptions were useful in identifying distinctions between the written role specifications and how the staff were actually working. For example, the CA job descriptions focused on physical care whereas their main motivation was their relationships with the residents. RNs brought elements to their roles that were not mentioned on their job descriptions.

### **2.4.19: PHASE 2: ANALYSING THE DATA**

Field notes were analysed separately from the interviews. Data relevant to CAs, RNs and residents/relatives were analysed separately.

As with Phase 1 analysis, the participants' language was retained in order to stay as close as possible to their 'text'.

#### **THE DESCRIPTIVE ANALYSIS:**

I analysed the transcripts of field notes and interviews and coded each section. Sections of the text in both the field notes and interview transcripts were then sorted under headings according to how they had been coded. For example 'helping residents to eat' was pasted under the heading 'Nutrition and Fluids'; 'cleaning dentures' under 'Oral health'.

#### **INTERPRETIVE ANALYSIS:**

The datasets were then analysed interpretively for emerging themes and theme clusters. Key examples from the field notes and quotes from the interviews were identified. Conclusions were drawn in order to inform and guide data collection in the subsequent field sites.

#### **VERIFICATION OF INTERPRETATION**

The cycle of data collection - analysis - collection - analysis continued throughout the fieldwork and I aimed to work with participants in a way which facilitated reflective, collaborative and shared interpretation (as illustrated in Figure 2.3). Participants were generally not interested in reading the transcribed observation or interview notes as they found this to be an overwhelming amount of information but collaborative interpretation was helpful in reviewing the dimensions of the RN and CA roles, for example whether they represented the work over 24 hours. From time to time during the research process, peer supporters and supervisors also read transcribed fieldnotes and interviews along with the descriptive and interpretive analysis.



#### **2.4.20: RESEARCHER REFLEXIVE JOURNAL AND AUDIT TRAIL**

In order to make explicit the researcher's role in collecting data, experiences, reflections and insights were recorded in a reflexive journal and audit trail, and iterated through peer support and supervision sessions. Examples of entries are offered through the results chapters and in the evaluation of the study. Some investigators stress the importance of tracking the development of the thinking and interim summaries, such as at the end of Phase 1, are useful for pulling together what the researcher knows after each stage of the analysis (Miles and Huberman 1994, p 79).

#### **2.4.21: SUMMARY OF THE DATA COLLECTION PROCEDURE**

As the study encompasses two phases, a range of individual participants and participant research sites, mixed methods and data from varied sources, a summary of the data collection procedure is offered in the box below.

#### **SUMMARY OF THE DATA COLLECTION PROCEDURE**

##### **PHASE 1:**

RNs and CAs working in nursing homes around the UK contributed examples which they selected as significant in highlighting the value of their work and/or their knowledge and skills.

##### **PHASE 2:**

The researcher undertook fieldwork in three nursing homes in different counties around England.

Data about the homes, such as bed numbers, type of residents, range of facilities etc. were collected.

In addition:

- Observations and interviews with RNs, CAs and other professionals working in the home
- Observing other aspects relevant to the research questions, such as shift-to-shift handovers
- Analysing documentary information, such as care plans and resident dependency measurements
- Analysing documents such as job descriptions
- Interviewing older residents who lived in the homes and relatives who visited frequently.

**OVERALL:**

The range of data sources from a variety of care homes around the UK and the range of data collection methods aimed to identify the scope and elements of the work of RNs and CAs with older people and offered triangulation in both data sources and methods.

- The significant examples in Phase 1 sought the views of the RNs/CAs on what they did, what they brought to their work and what they believed this achieved.
- The observation in Phase 2 sought to illuminate aspects of the work from an observer's perspective, including aspects of which the participants could be unaware.
- The interviews in Phase 2 sought to offer the RN and CAs an opportunity to reflect on their work, including the actions and situations observed by the researcher of which they were unaware at the time. The interviews also highlighted their priorities and motivations. The interviews with older care home residents, relatives and other professionals frequently in the home sought additional perspectives.

Surveying documents provided background, contextual and comparative data (e.g. documented job descriptions compared with how RNs and CAs described their work)



#### **2.4.22: COHERENCE AND PRESENTING THE INTERPRETIVE ACCOUNT**

Coherence is achieved when there is a resonance, consistency and a 'feeling of whole' but coherence was reached in some aspects of the research before others. The final 'whole' at the conclusion of the research was very different to the one identified at the start and this highlighted that, as Gadamer argues, understanding is always historical. The examples given in the conclusions illustrate this. Deciding when to conclude the analysis can be challenging for qualitative researchers. Both Lincoln and Guba (1981) and Strauss (1987) suggest that coding and recording are over when the analysis appears to have run its course, in other words when all incidents can be readily classified, when categories are 'saturated' and sufficient numbers of regularities emerge. Against such thinking, Miles and Huberman (1994, p 62) warn that fieldwork understanding comes in layers and the longer researchers stay in the fieldwork environment the more layers appear to surface. "The choice of when to close down, when to go with a definitive coding scheme or definitive analysis, can be painful. That choice may be dictated as often by time and budget constraints as on scientific grounds. When those constraints are relaxed, saturation can become a vanishing horizon - just another field trip away, then another ...".

In hermeneutic research, interpretation can be offered when there is coherence, comprehensiveness, and a 'sense of whole'. Once the interpretive account was complete, five peer supporters, all experts in older people's care, and two supervisors, read all of the results and four met with me to discuss these. Their perspectives were highly valuable particularly in identifying what might be the significance of individual aspects of the study and in putting the results into context for the discussion.

As Packer (1985, p 1092) highlights, hermeneutic interpretive accounts may be more modest in their aim than from other methods but, at the same time, "subtle and complex, intellectually satisfying, and more appropriate to human action, embracing the historical openness, the ambiguity and opacity, the deceptions, dangers, and delights that action manifests". Through the reflexivity involved in hermeneutic research, the researcher also gains greater self-understanding; by understanding others we come to understand ourselves.

## **SECTION 2.5: RIGOUR**

### **2.5.1: DEVELOPMENTS IN THINKING ABOUT RIGOUR**

The last two decades have witnessed an evolution in thinking about how to evaluate qualitative research, as the traditional tenets of quantitative research, such as validity and reliability become increasingly problematic to uphold within qualitative contexts. Over time these have evolved through a process of being championed, translated into alternative criteria, exiled, redeemed and surpassed (Emden and Sandelowski 1998, p 207).

Some authors suggest pairing traditional, positivist, terms with others proposed as viable alternatives for assessing the value of qualitative research (Guba and Lincoln 1981, Sandelowski 1986, p 29, Miles and Huberman 1994, p 278).

For example:

<u>Common 'positivist' criteria</u>	<u>Suggested alternatives for qualitative research</u>
Internal validity	Credibility; truth value; authenticity
External validity	Applicability; fittingness; transferability
Reliability	Consistency; auditability; dependability
Objectivity	Neutrality; confirmability
Utilization value	Utilization; application; action orientation

Even the suggested alternatives, however, continue to reflect a search for order and certainty more characteristic of quantitative work (Emden and Sandelowski 1998, p 207). As Sandelowski (1993, p 1) emphasises, the 'uncompromising harshness and rigidity' implied in the term 'rigour' threaten to take researchers away from the artfulness, versatility and sensitivity to meaning and context that mark qualitative works of distinction.

Fundamentally, as Emden and Sandelowski (1998, p 207) argue, "goodness is as much about where and how researchers derive their beliefs, assumptions, motivations and ways of working, as about judgement on research procedures and findings reached via the application of specific criteria". According to Sandelowski



(1993, p 3), "even when confronted with the same qualitative task, no two researchers will produce the same result; there will inevitably be differences in their philosophical and theoretical commitments and styles". The responsibility then lies with the writer to demonstrate the way in which the study attempts to address the issue of rigour and for the reader to decide if this is trustworthy and believable (Koch 1996).

Sandelowski (1993, p 8) concludes: "we can preserve or kill the spirit of qualitative work; we can soften our notion of rigor to include the playfulness, soulfulness, imagination and technique we associate with more artistic endeavours, or we can further harden it by the uncritical application of rules. The choice is ours: rigor or rigor mortis".

### **2.5.2: EVALUATION CRITERIA FOR RIGOUR IN THIS STUDY**

The following sections explain the principles and criteria that this study used in order to define, implement and evaluate rigour. These are based within Gadamer's (2003) philosophical hermeneutics and encompass some broader principles of evaluating qualitative, interpretive work, specifically the work of Madison (1988), Koch (1994, 1996) and Miles and Huberman (1994).

#### **SUMMARY: HOW THE RESEARCH ACHIEVED RIGOUR OR 'GOODNESS'**

##### **Coherence, appropriateness, authenticity, agreement**

The account presents a unified 'whole' picture

The 'parts'; within the whole are authentic to the 'text', including the contradictions

The questions are those raised by the text itself

The authenticity means that the account and the text are in 'agreement', i.e. the same issues and perspectives are represented in both

Participants in the research, and others knowledgeable in the field, could identify with the account as authentic (i.e. there is coherence as it addresses their own 'text' and horizons of meaning).

**Trustworthiness, representation, auditability**

The research was conducted in honesty and openness with participants

The account truthfully articulates the processes in the research, including the 'glitches'

The account clearly articulates the perspectives represented (i.e. the participants, the researcher, and both through the interpretation)

My own prejudices are made explicit through the research

The stages of development and decisions influencing these are auditable

**Comprehensiveness, thoroughness, contextuality**

The account gives a sense of the 'whole' contextual and historical nature of the 'text', including the situatedness and temporality of the participants.

The account deals with all the questions posed

**Penetration, usefulness, application, suggestiveness, potential.**

The account attempts to address an issue of concern or "a central problematic" (Madison 1988, p 29)

The work has a usefulness or application to participants, others who work in the field, scholars or researchers

The account offers insights, questions, critical discussion and possibilities that could be illuminating for future events or stimulate further research.

In Gadamer's terms, the interpretation, offered at a point in history, understands its own tradition in which it sits. It understands in a different way to that which existed before, with questioning, reflective and authentic openness, which offers dialectic for the future.



**The following chapters report the findings from the analysis of all datasets in order to answer the research questions.**

**Chapter 3 reports on the work of Care Assistants**

**Chapter 4 reports on the work of Registered Nurses**

**Chapter 5 reports on the distinct outcomes, and potential outcomes, of the work of RNs, compared with those of CAs, for older people in nursing homes.**

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## **CHAPTER 3: FINDINGS:**

### **THE WORK OF CARE ASSISTANTS (CAs):**

This chapter reports on the findings of the research into what Care Assistants do and how this impacts on outcomes for older people living in nursing homes.

It reports on the specific findings in terms of the:

- Inputs to (and structure influencing) the work of CAs: Section 3.1
- Processes within (and outputs from) the work of CAs: Section 3.2
- Overall role and contribution of CAs: Section 3.3

Summaries are offered in each section and at the end of this chapter.

The overall findings suggest a model of the work of CAs in nursing homes (Figure 3.1) and a range of influences upon this (Figure 3.2), which are presented at the end of the chapter.

The findings paint a rich and vivid picture of the work that CAs undertake with older people in nursing homes, including how this is perceived by the CAs themselves, staff working with them, residents of the home and their relatives. The findings also clearly illustrate, primarily through the CAs' significant examples and interviews, what they aim to achieve in their work and what motivates them. Inputs to and outputs from the work were also described by the CAs in their examples and interviews, and confirmed through the observations. A range of challenges confronting CAs in the everyday realities of their work were also identified, primarily through the observations and interviews.

The key themes which emerged from the data held strongly across all datasets and in the three fieldwork nursing homes, despite the homes being different in many ways. Appendix 3.2 illustrates the distinctions between the homes and how the themes developed.

Seeking to communicate the findings as clearly as possible, and in the context of wordcount restrictions, some data are offered in Appendices:

- Appendix 3.1: The focus of the CAs' significant examples
- Appendix 3.2: Comparison between the CAs in the three fieldwork care homes: findings from the observations and interviews
- Appendix 3.3: Summary of inputs to CA work identified in all datasets

Data sources cited in this chapter are identified as follows:

- 'Example' denotes a section from a participant's significant example submitted for Phase 1.
- 'IV' denotes a quote from an interview in Phase 2
- 'Obs' denotes a section or a quote from transcribed researcher fieldnotes written during the Phase 2 observations.
- 'RD' denotes an entry in the researcher's diary.



## **SECTION 3.1: THE INPUTS TO CA WORK**

This section reports on the knowledge, skills, experiences, values, beliefs and motivations that the CAs believed they brought to their work and that influenced their work. A list of all the inputs identified by the CAs in all datasets is given in Appendix 3.3 and the inputs identified through the different data collection methods are summarized at the end of Section 3.1.

In the significant examples submitted by CAs in Phase 1 and in their interviews in Phase 2, the most commonly-occurring inputs were the CAs' personal qualities, skills and motivations, particularly, for example, caring about people, an interest in people, liking people, knowledge and/or understanding of people and people skills. The CAs' examples of their knowledge and skills were often linked to the older people with whom they worked and for whom they obviously cared a great deal. Individual intuition and personal values and beliefs also featured strongly. The observations generally confirmed the claims made by the CAs about the inputs to their work and, moreover, suggested that the CAs brought a great deal of skill and caring.

### **INPUTS IDENTIFIED BY THE CAs IN THEIR EXAMPLES AND INTERVIEWS**

THESE ARE DESCRIBED UNDER THE HEADINGS:

- PERSONAL VALUES, BELIEFS, QUALITIES
- PERSONAL AND WORK EXPERIENCES
- KNOWLEDGE AND SKILLS
- MOTIVATION AND COMMITMENT

### **3.1.1: PERSONAL VALUES, BELIEFS, QUALITIES**

Common throughout the datasets was the belief among the CAs that the most important element they brought to their work was themselves as individuals.

Comments in the Phase 1 examples included:

*"that's just the way I am", "that's just me", "much of what I do is me", "what I do comes from within me", "I've always been like that".*

A second major element that the CAs believed they brought to their work was "just common sense" or "the things you pick up over the years".

*"Most of the job is common sense. I don't do anything to others I wouldn't want done to myself and I think if you work from that you can't go far wrong"*  
(IV CA509)

*"It's just the stuff you learn over the years ... it's really just common sense"*  
(IV CA514).

The data strongly suggest that the CAs were interested in people and valued people as individuals, regardless of age, illness or disability. These broader values were especially apparent in the significant examples and interviews.

*"I don't see them as old - just people; People should be treated as a person, they shouldn't be treated any different because they're younger or old; I have always been taught that despite elderly people having dementia they still deserve to be treated like a human being and should be respected and helped to retain their dignity"* (IV CA514)

*"People should be treated as a person, they shouldn't be treated any different because they're younger or old"* (Example CA 1.2).

In all datasets, the CAs showed a liking of older people, an enjoyment of working with them and a strong desire to want to help them. They enjoyed being with people, particularly older people and specifically the residents in the homes.

*"I like old people. I've always liked old people. They're nice. They need your help"* (IV CA716)

*"I like elderly people. I enjoy knowing that the residents were young, energetic. They were young like us and some of them had a good life and*



*when you think about that, and when you take care of them you're doing it because you remember they were young and had everything in life and they're getting old now" (IV CA704).*

*"I enjoy caring for the elderly. I feel that I'm doing all I can for them in their last days" (IV CA910).*

One aspect that CAs particularly enjoyed was 'hearing their stories'.

*"They're so good to be with ... I like listening to their past history, when they were married, where they lived, their jobs and children and what they used to do ... I love all the stories - brothers and sisters, hand-me-down clothes - but they were some of their happiest times. Everybody was in the same position, nobody had any money - ration books and the shilling in the meter ... lovely things" (IV CA705).*

Apparent in the examples, observations and interviews was that the CAs cared very much about the older people with whom they worked.

*"Caring for other people that are needy - hands on" (IV CA706)*

*"It's caring for them and showing someone cares about them, they are not on their own, even though they have disabilities, someone does care" (IV CA716)*

CAs enjoyed being with residents and wanted to be with them. They missed the residents when they were not with them, even when they were on holiday.

*"I find myself thinking about the place when I'm off duty and wondering if they're alright" (IV CA715)*

*"when you're not here you wonder if they're alright – it's just nice to be in with them again and know they're all alright" (IV CA514).*

Also identified was a personal sense of loss that the CAs felt when a resident died.

*"You get to know them pretty well and it's quite hard if you've looked after them for a lot of years and they pass away, especially if you're working very close" (IV CA709)*

*"When you lose people its very upsetting because you do get close to them. When we lost the first person when I was here and I was asked if I would like*

*to wash them and get them ready I was a bit nervous but now I want to do it because that's the last little thing that I can do for them and I always go to their funerals especially this D, we had become very, very close to him and when I went on holidays and came back and he'd look 'round and you could see his face ..."* (IV CA514).

The desire to help people, older people and the residents was apparent.

*"I like helping people, caring for them, talking to them, just helping someone go to the toilet and things like that ... generally being able to look after them"* (IV CA714).

*"I personally like to do good things for people ... so that they enjoy themselves and they're looking good and happy (Example CA 1.1)*

*"I have always been interested in people's wellbeing; I'm giving my time and that's what I want to do; I try to give people all of me (IV CA907 NVQ II)*

Also clear was the belief that the residents deserved the best care possible.

*"I always see them as someone's mum and dad and they need the extra care now because whatever they did in life should be rewarded - they've done good in their life and they don't deserve what's happened to them and I think that now you've got to help them make the best of their lives"* (IV CA514)

### **3.1.2: PERSONAL AND WORK EXPERIENCES**

Difficult experiences in their own lives had influenced their personal values, beliefs, motivations and their current work. This was more apparent in the significant examples than the other datasets.

*"I have been in an orphanage for two years and I didn't have any friends and I was always crying and the last year my mum saw I was unhappy but that took her two years to realise and I wanted her to realise just to get out of there. And when I was out of there that really did change me very quickly and I started talking and going out with my friends"* (Example 2.3).



*“some of my own life experiences regarding sad situations enable me to empathise and give support when needed without being intrusive and helpful to the relative and client at this distressing time” (Example 10.2).*

Previous experience of being a carer in their families, identified primarily in the examples and interviews, included:

*“parent of three children”, “my mother is a major epileptic”, “I supported my mother after my grandmother had a major stroke leaving her paralysed down the right side and unable to speak which made her confused, disorientated and frightened. She also suffered total incontinence”, “I helped my mother until she died”, “both my grandfathers were in hospital at the end of their lives”, “when I am not at work I look after my mother and know how she changes - how her face changes and the way she talks etc when she is unwell”.*

Previous work experiences were diverse, for example:

*“working with children for ten years”, “as a hairdresser”, “in a factory”, “in a bar”, “as a traffic warden” and one who came into caring having run her own business with 80 employees for many years.*

The CAs commonly had previous experience as a nursing auxiliary and they described experiences of being with people who, for example, had a stroke, were dying, were in pain, mentally confused or incontinent.

### **3.1.3: KNOWLEDGE AND SKILLS**

Knowledge included an understanding of residents as individuals through getting to know them, working closely and intimately with them, knowing them over the course of time, wanting to get to know them and working to get to know them better, persevering even in difficult circumstances to understand them better, working within the team and learning from the views of team members, working with families.

A range of examples of the knowledge to deliver care were offered, such as that *"plenty of fluids"*, *"preventing hydration"* and *"the need for good nutrition and dietary intake"*. Enhanced understanding was observed in the CAs who had undertaken NVQ II and further enhanced knowledge and skills in those who had undertaken NVQ III, specifically in clinical skills such as dressing wounds. Overall it appeared that some of the knowledge used by the CAs in their everyday work came with them into the work situation, and some from specific training, but most was given by supervisors in particular care situations, e.g. for a resident to be given hourly fluids or her position changed every two hours. Knowledge varied considerably between individuals.

Personal communication skills included watching, observing, listening and talking, passing on important information.

Skills in working with and caring for people included *"putting yourself in the person's shoes"*, *"showing sympathy"*, *"showing reassurance and support"* (IVs)

Skills to gain trust and confidence included *"taking me into such situations as they may a relative or friend"*, *"being open and honest"*, *"learning what residents want"*, *"explaining why you're there"* (IVs)

Examples of interpersonal skills in delivering care included *"working to resident's priorities and at resident's pace"*, *"calmness and gentleness in manner and approach"*, *"making a joke"*, *"showing affection"*, *"tender loving care"*, *"a kiss and a cuddle"* (IVs)

Intrapersonal skills included *"thinking things through"*, *"being realistic"*, *"positive thinking"*, *"time management"*, *"adapting to situations"* (IVs)

Practical skills in delivering care were the main focus of everyday work, the main focus of job descriptions and the main focus of training. They included skills such as helping to wash, dress, bath, use the toilet.



### **3.1.4: MOTIVATION AND COMMITMENT**

Commitment to the residents and motivation to help them, look after them, make their lives better and do a good job was paramount to CAs involved at all stages of the study and identified in all datasets.

Their motivation was their commitment to looking after the residents and trying make their lives better.

*"hopefully make people's lives in here a bit more bearable - so they're not looking at four walls all the time. If you pass the door and nip your head 'round and say a few words it breaks that quarter of half an hour up before they might see someone else. Just brightening people's days and by getting them up, dressing and cleaning them and helping them maintain their dignity"* (IV CA509)

*"Making their lives a bit easier - just being there and listening to them"* (IV CA705)

*" ... doing all I can for them in their last days"* (IV CA910)

Also described was a motivation and commitment to doing a good job.

*"It is very important to me that I always do my utmost to make sure they are as happy and comfortable as possible because I may never see them again. I am very proud of our Nursing Home; I am very fortunate to work in a good, loving caring home and I know that we give older people their dignity, love and of course, good nursing. We have a very good matron and very good sisters and their carers who put older people first and respect their wishes and their family's wishes; privacy should be there when you're changing them and making sure all their bits are covered up. (IV CA514)*

Enjoyment that they gained from doing their work and how this motivated them was described.

*"I love everything - we just love it - it makes you happy when they're pleased and they're tidy and their room's tidy and someone says 'you look nice, who dressed you this morning?'. It makes me happy when they look like they did when they cared for themselves"* (IV CA914, NVQ III).

*"I enjoy it all - everything. My husband says to me 'Why do you work?'. I'm 55 now and really enjoy coming to work. I like all the residents and all the girls and look forward to coming. There aren't many jobs you can say that"* (IV CA705).

*"when I look at them it just makes me feel good inside, like I've done something good for somebody"* (Example CA 1.1)

Job satisfaction was also a motivator.

*" That's the satisfaction if you've got somebody comfortable and they said 'I've had a good night's sleep' and you know they've been in discomfort - it gives you a kick really if you get that bit of feedback"* (IV CA907, NVQII).

*"I get a lot of satisfaction out of my work - I wouldn't want to change it for the world"* (Example CA 100.2)

CAs gained satisfaction and motivation from working in a good team. This was especially in Home 1 where the CAs had strong camaraderie and in Home 3 where there was a strong emphasis on teamwork:

*Three CAs have worked in the home since it opened. The teamwork, mutual support and understanding seem to be the backbone of the unit. There seems to be a great deal of 'tacit' support between them. The colleagues are J's [CA 503] main stated reason for coming to work and C (CA 506) said "It's the team that keeps me, otherwise I wouldn't stay"* (RD Home 1).

*"On nights we spend 11.5 hours together and help one another out. We work together really well. I don't think there's ever been any ill feeling among any night staff. We all swap and cover. We all look after each other. I've worked here 19.5 years and I've never known any rows - we all pull together"* (IV CA906, NVQII, Home 3).

### **3.1.5: INPUTS IDENTIFIED IN THE OBSERVATIONS**

The CAs' skills, knowledge and experiences were apparent in the way in which they worked and, despite their humility in both the examples and interviews, CAs displayed very effective caring and interpersonal skills.



Offered below are extracts from the fieldnotes taken during two observation sessions with CAs working Home 1.

These are followed by extracts from the interviews with these CAs in which the researcher invited them to reflect on a specific interaction.

**Observation Notes (unit for physical frailty):**

*Cleaning L's genitals and buttocks ... kept looking at L's face, smiling and winking. This looked attentive and reassuring.*

**Interview transcript:**

When invited to reflect on this interaction the CA said:

*"If you do things in a matter of fact way - if it's done right, they don't feel they're losing control. It's bad enough that they do mess themselves or wet themselves. If somebody comes along and says 'how on earth have you done that' it makes it more rotten. If you can do it matter of factly be talking to somebody and talking about something entirely different they might not even notice that you're doing it then it's done and they're in the chair and you're still having the same conversation with them then that's a happy day ... Eye contact is a lot with me, I like to keep eye contact because if you're cleaning somebody's rear end and underneath you've got to keep eye contact because it's very embarrassing - I wouldn't like to done to me, it's not very pleasant" (CA509)*

**Observation Notes (unit for people with dementia and mental health needs):**

*V often becomes really distressed but CA seems to be able to settle her more effectively than other staff.*

**Interview transcript:**

When invited to reflect on her work with this resident the CA said:

*"V's my best. When she came here she was very aggressive and they kept her at the end because of the other residents. I'm her keyworker ... and her sister when she comes can't believe how she is now. Where she was before they just used to give her sweets and come out because they couldn't take what she was like, but now they sit and have tea and chat with her. They can get conversations out of her – it's just rewarding ... every day she's doing a little bit more. We found out if you give her a sandwich at 11 o'clock it keeps her quiet ... I found out that she doesn't like orange juice because she was pushing it away so I gave her tea and she said 'oh that's lovely'. The other day they had steak and kidney pie and I always tell the residents what they're eating and I told her and she said 'kidney yuk' - so they might spit the dinner out because there's some kidney but they're still hungry, then you write that down" (CA514)*

The observations were able to capture aspects of the care of which the CAs could be unaware or that the CAs would perhaps not spontaneously identify were they invited to describe what they did.

The observations and the CAs' reflections on them were also able to capture detail not widely articulated in the significant examples. In such reflections, CAs spoke warmly about the residents and how they worked with them. As illustrated by CA514 above, they clearly cared a great deal about the residents, and particularly those with whom they felt they had established a close relationship, and those they believed they had been able to help.



**3.1.6: INPUTS TO CA WORK: SUMMARY OF FINDINGS**

<b><u>INPUTS TO CA WORK: A SUMMARY OF FINDINGS OBTAINED THROUGH DIFFERENT DATA COLLECTION METHODS</u></b>	
<b>Significant examples and interviews</b>	<p>The main influences on CA work were identified as:</p> <p><b><u>PERSONAL VALUES, BELIEFS AND QUALITIES</u></b>                      "Just the way I am"                      "Just common sense"                      valuing people, caring about people, wanting to help them</p> <p><b><u>PERSONAL AND WORK EXPERIENCES</u></b>                      Difficult experiences in life                      Experiences as a family carer                      Experiences as a care assistant</p> <p><b><u>KNOWLEDGE AND SKILLS</u></b>                      Knowledge of residents                      Knowledge to deliver care                      Skills in working with and communicating with people, caring for people, gaining trust and confidence                      Intrapersonal skills</p> <p><b><u>MOTIVATION AND COMMITMENT</u></b>                      Motivation and commitment to look after residents, make their lives better                      Doing a good job, job satisfaction,                      Working in a good team</p>
<b>Observations</b>	<p>The full range of inputs mentioned in the examples and interviews were identified in the observations.                      Despite their humility, CAs displayed very caring and effective interpersonal skills.                      CAs who were exceptionally caring were able to offer highly effective and highly skilled care by drawing from their greater understanding of the residents.</p>
<b>OVERALL</b>	<p>CAs brought a great deal of caring and humanity to their work. They seemed to work 'from the heart'.                      They took for granted their knowledge and skills, dismissing these as "just me" or "just common sense". They saw "nothing special" in what they did.                      Experiences as family carers or "just mums" were widely identified.</p>

## **SECTION 3.2: PROCESSES WITHIN** **THE WORK OF CAs**

This section offers a thematic analysis of the data on processes within the work of CAs from all datasets, i.e. the situations and events that they described or which were observed. It details what the CAs did in their work, their actions, their interactions, what they said and the decisions they made which, altogether, constitute the processes within and outputs from their work.

It is important to highlight that the processes within the work of CAs in nursing homes are strongly influenced by the context in which they work and the RNs who supervise them (in terms of the structure-process-outcome framework these elements constitute the structure). These are illustrated in Figure 3.2 which is shown at the end of this chapter.

The box below summarises the themes from all datasets and this is followed by details of each of the themes with quotes from participants.

### **THE PROCESSES WITHIN CA WORK:** **SUMMARY OF THEMES FROM ALL DATASETS**

1. CLOSE RELATIONSHIPS BETWEEN CAs AND RESIDENTS
2. CAs AND RESIDENTS KNOWING EACH OTHER WELL
3. CAs AND RESIDENTS ACCEPTING EACH OTHER AS INDIVIDUALS
4. CAs AND RESIDENTS APPRECIATING EACH OTHER AS INDIVIDUALS
5. THE RECIPROCAL NATURE OF CA/RESIDENT RELATIONSHIPS
6. HUMOUR IN THE WORK
7. CAs IDENTIFYING WHEN 'SOMETHING IS WRONG'
8. PERSISTENCE AND PERSEVERANCE IN THE FACE OF CHALLENGES
9. CONCEPTS OF 'FAMILY' WITHIN THE WORK

THE DATA ALSO IDENTIFIED A RANGE OF CHALLENGES IN THE WORK.



### **3.2.1: THEME 1 - CLOSE RELATIONSHIPS**

The relationships formed between the CAs and the residents were close.

*"I didn't realise that AC would become very close to me for the next 5.5 years ... I got to know AC so well that I knew if she was in pain or if something had upset her ... sadly I wasn't there when AC passed away but I was told later that in the morning she was asking for me and that made me happy. I know that doesn't sound right but it did because I knew that I had got very close to AC ... I still go to bed and think of AC, a little tear will appear, then I hear that famous little chuckle she had and a smile appears"* (Example CA 102.4).

*"You see them every day so you get closer and even if they drive you mad you still get to know them - they're just so familiar to you. It's strange when they go"* (Example CA 10.2)

### **3.2.2: THEME 2 - KNOWING EACH OTHER WELL**

Because they worked closely with them day after day, year after year, the dependence of the residents on the staff and closeness in the relationships, the CAs came to know each resident very well.

*"I have worked in this nursing home for 11 years and each patient comes in you get to know them really well and understand each and every one"* (Example CA 100.2).

*"We know what they like and what they don't like." "You get used to their little ways".* (IV CA506)

Undertaking intimate caring for the residents also helped to make the relationships closer.

*"They see you all the time and you're doing the intimate things"* (IV CA508)

*"We're doing some of the more personal things for them we get to know them a bit better. Because it's consistent, it's the same faces. When I went into K this morning she said 'oh you again!'"* (IV CA509)

### **3.2.3: THEME 3 – ACCEPTING EACH OTHER AS INDIVIDUALS**

CAs seemed to accept each resident as an individual who had 'good days' and 'bad days'.

*"I just love being amongst all these people ... they're all different characters ... sometimes the crabbiest ones you love the most" (CA906 NVQII)*

*"... one day they can be wonderful, another day they could be very aggressive" (IV CA514)*

*"I don't mind if people don't like me. I may not like some people but I don't and can't show it. Not everybody likes everybody, you just stick a smile on your face, grit your teeth and get on with it" (IV CA509)*

### **3.2.4: THEME 4 - APPRECIATING EACH OTHER AS INDIVIDUALS**

CAs clearly appreciated the residents as individuals and, for the mostpart, liked them very much.

*"He's a lovely man and I've got to know him - he's got a nice character"*  
(Example CA 1.2)

*"Mr DS has a smile that can light up a room, although this doesn't happen often. If I can get a smile from him all his aggression is forgotten. He loves to sing and, with encouragement, will join in and sing with you" (Example CA 102.1).*

Residents also said how much they appreciated the CAs.

*"I'm on very good terms with them and I have got nick names for them. They also use a nickname for me. I was the headmaster in a secondary modern school for 15.5 years - 600 boys. You can see I'm quite a big man and they used to call me Jumbo behind my back, they didn't think I knew. It's nice to have a friendship with the people who look after you. I get on with all of them". (IV Resident 952)*



### **3.2.5: THEME 5 - THE RECIPROCAL NATURE OF THE CA / RESIDENT RELATIONSHIPS**

It was clear from all datasets that the CAs gained from the residents and the residents gained from the CAs. The CAs said:

*"when D was here I used to tell her all my problems" (IV CA506).*

*"Some of them are interested in carers' lives and it's nice ... I know they're interested in me" (IV CA709)*

*"We talk to them about our husbands and children. E has photos of all the babies and she's left space for T's baby ... I took my husband to see Miss S. She poured us a drink and we chatted ... she bought my husband a big cake ... It's lovely to see them laugh and we're always laughing and joking - the things we talk to them about! B's room is our rest room. I sit on the commode or her chair. If I have a cold or sore throat she says 'have a drop of whisky and there's a bottle in the wardrobe -help yourself" (IV CA704)*

*"I was with BS and it was the anniversary of my dad's death and I told her and she started crying and I think I shouldn't have said that but I was depressed and I cuddled her and gave her a drink ... I go into DF and she opens her eyes and says 'oh my legs are aching and it's because of your lovely smile it makes me look forward to another day" (IV CA705)*

Residents explained how their relationships with the CAs were reciprocal.

*"and their future happiness often comes in the conversation. They keep me up to date with outside, and their lives in general. Their lives and their futures are very important ... When they're happy together doing their jobs their companionship is the nicest thing of all" (IV Resident 510)*

*"One of the staff has a son who is rather aggressive. We talk about it - he wasn't doing very well so now he's in a special school. I like to talk to the staff about their lives and try to help them if I can". (IV Resident 951)*

*"There's one member of staff who's been getting larger and larger and the baby is now two weeks old. She brought the baby in to see me. I enjoy relating to different age groups. I've been a carer and I've tried in various ways, and always wanted to help people who are less well off than oneself". (IV Resident 957)*

### **3.2.6: THEME 6 - HUMOUR**

Humour was a strong feature in the work and the relationships between CAs and residents which was particularly apparent in the observations and interviews with both CAs and residents. The humour was distinct between each CA and each resident and in different situations.

*“Some of the residents (e.g. B) will tell me a saucy joke, so if I hear one I’ll come and tell her - then her grandson will leave a note with saucy jokes written on it for her and she’ll let me read that - it’s just jollying people along. I am of that personality - I don’t like to see a long face, it’s just me - bouncy! ... I enjoy talking and joking with the residents - keeping people’s spirits up is as important as keeping them clean. Emotionally wise, if you’re down you give up. You’re not going to be happy if everyone around you has a long face - if I can come in and crack a joke and get somebody laughing, or laugh about something that happened to them 30 or 40 years ago and start a conversation, that way it starts them remembering ... keeps the memory going - it’s nice for them - instead of me coming in saying I’m going to wash your face, give you a wash all over and then I’m going again. Quite often with K we’ll sing saucy old songs and that brightens her up for the morning, and I tell them jokes and they tell me jokes” (IV CA509)*

*“They want to laugh and joke some of the time because that’s all they see most of the time basically – us! How I think about it, you are here - it’s not the funniest place, but you can bring a smile from the outside to the inside ...I bring a smile, even when I’m tired, and laughing and talking and teasing” (IV CA510).*

In one home which offered significant examples the staff were laughing because a French CA, who admitted her English was not good, wrote in her report: *“we could not collect any oui”*.

Residents in the fieldwork homes, particularly Homes 1 and 3, said how they appreciated the humour they enjoyed with the CAs. For example:

*“I like to laugh. The other morning the care assistants found three mint imperials in my bed. ‘don’t worry” I said “I’ve been ovulating” (IV Resident 506).*



*"With our staff you get jokes and giggles and I said to them one day 'I'm glad you're all barmy!' I do think humour is important but not if it's self-conscious. The funniest things arise naturally out of a situation" (IV Resident 957)*

### **3.2.7: THEME 7 - IDENTIFYING WHEN SOMETHING IS WRONG**

As a consequence of the closeness in the relationships, and the fact that the CAs worked with the residents every day, they were able to identify subtle changes that might indicate a change or a health problem.

*"I do pick up when things are wrong. Sometimes it's not anything you can put your finger on it's just a change in manner - the way they say good morning" (IV CA509)*

*"Mainly it tells in their eyes or they're a little bit changeable - they sleep a lot - things like that - so when I put them to bed or I'm bathing them I always check over them to see any lumps or marks or anything and tell the nurse". (IV CA514)*

*"You know when something isn't right because you get to know a resident well and you can pick up on most things when they are not right. I don't know what it is, maybe something inside me that tells me when something isn't right ... you seem to sense when someone hasn't got long to go" (Example 102.4)*

*"You can tell if something's upsetting them, if they're anxious or angry - their attitude to you will be different - their eye contact or anything different. People behaving differently - snapping and biting at you - they could have a urine infection that's coming out through the anger" (IV CA911 NVQII).*

### **3.2.8: THEME 8 - PERSISTENCE AND PERSEVERANCE IN THE FACE OF CHALLENGES**

The CAs learned to work with the residents as individuals with all their distinct idiosyncrasies. They did this in various ways, according to how they felt the individual residents would respond.

*“when there’s change they react in different ways - one person might go up to her room, some get confused, some get angry and that’s just their being upset, or some people who can’t communicate get destructive ... it’s learning in different ways, even when people can’t communicate you get tips from the nurses - ‘she wants this’. You can make people laugh and make a joke or something or sympathise with some people - they’re all individuals. They just let you know what they really need”* (Example 2.4).

*“I just use a more calm approach and treat her like a human being and if she say ‘go away’ try to explain to her ‘you might need help’ and just talking to her like a human being really made a difference. I just looked at her and I knew she could be a nice person, she’s not that horrible aggressive person and that stuff. There’s a better somebody deep inside and I could bring that better somebody out”* (Example 1.1).

Resident behaviour could be challenging to the CAs.

*“When I first met Mr JS he seemed quite bitter about his CVA and could be abusive but talking at length with him he is a proud man”* (Example 104.2).

*“every five minutes she would call for help with nothing in particular, sometimes you’d get there and she couldn’t remember what she called for - maybe peace of mind that someone was there”* (Example 8.3).

*“she had lost her self-confidence. We stuck with her walking day by day, bit by bit. She had said that if she couldn’t walk she would lose the fight to live. I knew I had a fighter on my hands and we made it!”* (Example 100.2)

*“AC was a difficult lady. If she didn’t like you then should would tell you the truth. For two years AC would only allow me to bath her which sometimes was difficult ... I did it before I went home. I did not mind because I knew it made her happy and that’s all that mattered”* (Example 102.4).

Nevertheless, CAs described how they tried to deal with these situations.

*‘You’ve got to find 101 ways of getting someone to do something they don’t want to do – they don’t want to get ready or don’t want to get out of bed. Just patience and kindness and tenacity goes a long way. You can’t afford to lose your rag with people if it’s not their fault. If they’re getting really stroppy, they*



*may not particularly want to be in here and if they have a go at you, who can they have a go at - it's their release value (IV CA509).*

*"have patience, sit and talk to them, ask them what's the matter and try to give them extra attention. It normally calms them down. If they can walk go 'round with them, show them outside and what the weather's doing ... they must be thinking of something that's worrying them .. or what they used to do ... finding what's upsetting them" (IV CA514).*

CAs tried to deal with challenges by finding more information:

*"[people with dementia] sometimes they might talk and you can't understand them but some words will come out like a name and I find out what that name is they're saying. I did the other day ... I asked the relation when they came in what that name was and they said that's her sister she was very fond of they used to go out shopping every week. It's good to talk to the relations and find out about them. Then when you're alone you can relate to what they've told you and you can become closer to them because they think that you know them as well" (IV CA514).*

Through persistence and understanding, CAs found ways of solving problematic situations in the care:

*"We had a man here who wouldn't let anybody bath him. One day I thought he must be very embarrassed with a woman bathing him, so before I pulled his trousers down I put a towel in front of him and I kept the towel in front of him until I got him in the bath and the water covered him up and before I got him out again I put the towel back. I won him over and since then I could bath him - he used to look for that towel and he had every faith. Even for a man that's not got dementia as bad, he knows I'm a woman and he's a man – so really it's just common sense (IV CA514).*

### **3.2.9: THEME 9 - CONCEPTS OF 'FAMILY' WITHIN THE WORK**

CA examples and interviews suggested that they associated their work with their experiences of family caring roles, particularly:

- conceptualising their work in terms of their family roles
- comparing their care of residents to looking after their parents or grandparents
- comparing the behaviour of residents to that of children and their care of residents to looking after children
- the notion of the residents as extended family and residents seeing the CAs as their extended family
- forming close relationships not only with residents but also with residents' families

### CAs CONCEPTUALISING THEIR WORK IN TERMS OF THEIR FAMILY ROLES

CAs appeared to conceptualise their work in terms of their own family roles.

*“The majority of us are just mums” (IV CA503)*

*“I look at them and think they could be my nan or granddad” (IV CA508)*

*“People that have children sometimes make better carers ... My mum had a colostomy and the district nurse showed me how to look after it [so I care for B's]” (IV CA509)*

### THE RESIDENTS AND STAFF AS EXTENDED FAMILY

Residents as extended family, and the CAs as extended family to residents, was also identified.

*“It's like a family, when I have problems at home I think 'cut' I've got work to go to, and the residents – it's like extended family. I just treat them as extended family. Some are nicer than my family!” (IV CA506)*

*“... like a big happy family really ... obviously we're not but we're like a family in here ... some of them aren't lucky enough to have family that come in all the time so it must be nice for them to see a friendly face ... it is like an extended family, you can get to know the relatives as well” (IV CA509)*

*“They don't just think of you as a carer - they think of you as family or friends because we spend more time with them than their family - they see us every day” (IV CA510)*



*“When I first applied for a position as a carer... I was assured that it was only an extension of bringing up a family ... and it truly is my extended family”* (Example 102.1).

*On the bank holiday I bring my mum in and then, when I go to see her she asks how the residents are and they ask how my mum is. Its like a family. If my husband or the kids are at home they come in and I introduce them to the residents - they are our family”* (IV CA705).

*“ It feels like family - you spend more time here than with your own family (IV CA910, NVQ II)*

*“ ... on the anniversary of a clients death we send a card to the family - thinking of you at this time – just the first year. Do a family tree so we know more about the family”* (IV CA902 NVQII)

Residents also confirmed that the staff, and particularly the CAs, become like 'family' to them.

*“They’re part of my life - they feel like family. If I could ever do anything to make their happiness I’d do it. They’re part of my life. I’ve known them for a long time and I try to look after them. I think it’s the love and caring for other people that keeps people going. Loving and caring is a bond which unites people together. [Are they loving and caring to you] yes”. (IV Resident 510)*  
*I’m 90 and I’m rather short of relations now but I certainly feel that one relationship is with the staff. It’s a different relationship. I need the warmth of the people around me and I get it here”* (IV Resident 957)

### LOOKING AFTER CHILDREN AND SEEING THE RESIDENTS AS CHILDLIKE

Comparisons were made by CAs between the residents and children in that they saw looking after the residents as being similar to looking after children.

*“I realise she like to be babied a little bit and I got to her and give her a cuddle and say ‘calm down calm down’ And she cuddle me back and I think ‘alright I got you’.” ... “and I think sometimes this happens with children as well, they children are not given the affection they really want to be ... my cousin’s kids and my sister’s kids were like that”* (Example 1.1).

*“It’s like a child with a lolly, when she thinks she can have it she wants it all the more, when she knows she can’t, she forgets ... I’ve worked a lot with children and I’m dead in love with children and I came to England to look after children to be an aupair. And children are always smiling and laughing”* (Example 2.3).

### LOOKING AFTER PARENTS AND GRANDPARENTS

CAs also likened caring for residents to caring for parents or grandparents.

*“my grandmother was exactly like her and if you leave her alone she’s going to be so nasty to everybody, but when you start giving sweet words to her and show her she matters .. she is nicer to everybody”* (Example 1.1).

*“in my youth I supported my mother after my grandmother had a major stroke ... I helped my mother when necessary until she died”* (IV CA510).

*“ I look after my mother and I know how she changes - how her face changes and the way she talks etc when she is unwell”* (Example 100.2).

*“I’ve got a soft spot for quite a few, which is like my granny - you’re not supposed to, I don’t know why you’re not supposed to”* (IV CA703)

*“It’s good if you identify old people with your parents - you care better (IV CA716)*

### RELATIONSHIPS WITH RESIDENTS’ FAMILIES

CAs formed close relationships with the families of the residents, particularly those who visited frequently, although relationships were not always straightforward.

*“I get on quite well with the families ... but they can make it quite hard for you. We’re lucky that our families all know what they’re like - it’s awkward when the family thinks they’re perfect - it’s better if the family realise how hard they can be. Like with R - his sister knows exactly what he’s like and you can have a relationship with their family as well. Sometimes you miss the families as much because if you see them on a regular basis, then once they’ve gone it’s tragic because it’s part of your life - it’s weird”* (IV CA510)



*“[working with people with dementia] it’s important to involve the relatives even when the resident has forgotten them - telling the resident who they are. It’s hard for the relatives as well (IV CA514)*

**SECTION 3.2.10: CHALLENGES IN THE WORK**

Although the CAs enjoyed their work, the observations and interviews highlighted that this is inherently challenging in a number of ways. Challenges were identified in all datasets but particularly in the observations and interviews.

**SUMMARY OF CHALLENGES IN THE WORK OF CAs**

THE PHYSICALLY AND EMOTIONALLY TIRING NATURE OF THE WORK  
INADEQUATE TIME TO ACHIEVE THE DESIRED OBJECTIVES  
INADEQUATE EQUIPMENT, SUPPLIES AND SUPPORT  
ABUSE FROM RESIDENTS  
BODYWORK, BODY EXPOSURE, BODILY FLUIDS AND EXCRETA  
SEXUALITY

**THE PHYSICALLY AND EMOTIONALLY TIRING NATURE OF THE WORK:**

The observation data in all three homes note that most of the CAs worked very hard throughout their shifts. They started as soon as they arrived and usually worked at least four hours on all shifts without a drink or a break. Throughout the shifts, except during the night, they were on their feet. They walked long distances, particularly in Homes 1 and 3 where there were long corridors, and they undertook a great deal of lifting, handling and moving of residents.

*Worked with S, very caring. Quite strenuous physical labour and can be emotionally draining as well – CAs work extremely hard! (RD Home 1)*

It was noticeable that the CAs became progressively tired through the week. For example one CA's pattern of work was eight consecutive early shifts. By the end of these she said she was completely exhausted.

*Worked with C. We're both very tired! She now works eight early shifts in a row and this was number 7! CA comments that tiredness is a big problem (RD Home 1)*

One CA explained that she only ever worked three days a week in order that she could give of her best. She found that working more than this left her too drained.

*"You're on the go the whole time - they all want to be first. It is quite tiring. The younger ones don't get so tired unless they've been out with their boyfriends the night before" (IV CA705)*

*"I'm beginning to find it hard because I get tired which can make you quite sharp and short tempered, so you have got to back away" (IV CA706)*

*"It's physically demanding work - emotionally it can be too - on days but not on nights because you don't always get the one to one - it can be quite rewarding to be physically exhausted because you know you've done your job - you've kept everyone safe, happy and comfortable" (IV CA709)*

In addition, because the CAs obviously cared so much for the residents and about their work, they became upset when residents were unwell, when one died, when they had not received appropriate care during the previous shift or when other staff were not seen to be 'pulling their weight'.

### INADEQUATE TIME TO ACHIEVE DESIRED OBJECTIVES

Lack of time was a recurring theme in the observations and interviews and was a major frustration to staff. Having insufficient time to accomplish all the work they wished was prevalent in the three Homes but particularly among the CAs. The CAs in Home 1 seemed particularly pressured.

*"I do like the work but if I had more time I would enjoy it more and although you get nice days sometimes its just a long hard slog – like a treadmill – out*



*of bed in to breakfast – it's a continual thing instead of seeing them – I've been on trips and things and its different and its nice to do that" (IV CA508). "Its mainly time – everybody says the same. They treat it as numbers but you shouldn't because G takes and hour to get up but you could have someone that takes 10 minutes or if someone's sick or dying but they just say you have 28 residents and that's the amount of carers. If someone's dying they take an awful lot of your time – if you're turning them every 1 or 2 hours and giving them mouth care it takes a lot out of your time - its taking time away from other things that you're supposed to be doing (IV CA510). "Lately it's been stressful because we don't have enough time to spend with the residents to talk about their backgrounds and what they used to do and it's just been rush rush rush with basic care" (IV CA706)*

Lack of time was compounded by staffing difficulties and by the variable quality of staff.

*"Getting pressured to do more and not having enough staff. The residents' needs do change and if they need more help you haven't got the time". (IV CA705)*

*"It's the quality of the carers you're working with as well, some shifts you've got no support . Some have knowledge and patience. Some people don't seem to notice their body language and the way they're dealing with it affects the residents but I can see it. If they're sharp and loud and demanding the resident to do something, they get aggressive and agitated and uptight and they can't do it then the carer gets worse and it escalates. It's tone of voice and mannerisms, being too rough or short tempered" (IV CA706)*

### INADEQUATE EQUIPMENT, SUPPLIES AND SUPPORT

Unsuitable or unavailable equipment was an issue in all three homes, and particularly Home 1. The effect on CAs is important to note because, as they deliver most of the direct care, inadequate support and unsafe practices potentially put them at risk. The observation notes, and to some extent the interviews, highlighted that the equipment which staff need to work was not always available and, even when there was equipment, this was not always ideally suited to the task in hand. Unavailable

and unsuitable equipment was particularly a problem in Home 1, where a lack of suitable equipment featured through virtually every set of observation notes. In Home 1, shortage of equipment included yellow plastic bags (for clinical waste - potentially contaminated), wipes, gloves, aprons, flannels, hibiscrub, pillow cases. Unsuitable equipment included low beds which CAs had to stoop to make; hoists, equipment in need of repair and equipment, particularly hoists, in use in another area of the home. The lack of appropriate equipment caused extra work for the CAs and much additional energy expenditure making trips to linen cupboards, store cupboards or other wings of the home to find equipment. It also potentially put them at risk. Two particular examples of this were

- when protective gloves and aprons were not available and residents with infections, including MRSA, needed care
- when lifting/moving/handling equipment was not available or the beds were too low for safe working.

### ABUSE FROM RESIDENTS

The observations and a few examples suggested that residents not uncommonly spoke abruptly, complained, were abusive or demonstrated behaviour which was potentially challenging for staff. A range of difficult situations arose. In most instances the CAs dealt with this in a 'matter-of-fact' way as 'just part of the work', particularly when resident's behaviour could be attributed to his or her condition.

*G [resident] very upset and will not allow anyone near her. She is accusing C [CA] of hitting her and shouting "I'm going to tell the council of you, you wicked old cow". CA is trying to be calming and reassuring "it's alright G, there's nothing to worry about". When G stops shouting and the CA is able to get close to her she cuddles G and says softly "Are you not feeling well today? Are you in pain? Are you fed up? Your son will be in later. Would you like some chocolate?". G calms down. (Obs notes Home 1)*

*V is reluctant to be touched and is hitting CA, who is trying to calm her (Obs notes CA506). "It's a punch and scratch day today" (quote from CA during observation).*



**BODYWORK, BODILY FUNCTIONING, INTIMATE TOUCH AND SEXUALITY**

Body work, dealing with bodily functioning and intimate touch were an integral aspect of day-to-day care of residents and particularly in the work of CAs. CAs' work concerned caring for the bodies and the bodily functioning of the residents. Mostly this was treated as 'just part of the job'. Such work could, however, be viewed as physically unpleasant or embarrassing to observers who had not previously witnessed the work. Body touch, particularly body cleaning, was a major aspect of the 'hands-on' care. This involved touching and cleaning residents' buttocks, anuses, genitalia and breasts. Although CAs carried out this work in a 'matter-of-fact' way they were aware of the potential embarrassment to residents.

*CA washing K's genitalia in the bath. K laughs (Obs notes CA503) "she giggles every time I wash those bits"* (quote from CA during observations).

Bodywork exposed the CAs to potentially highly unpleasant sights, smells and experiences. For example:

*Resident B is unable to swallow and thick mucus tends to collect in her mouth. She receives nourishment through a PEG tube but she likes to have food at mealtimes, to chew it and to spit it out. The CAs bring her food, protect her clothing and leave her alone in her room to eat. After the meal they clean her mouth, clean the chewed food and thick mucus from her front, her table and wherever else she has spat it out, and leave her comfortable. (Obs notes Home 1)*

*While J [CA] is washing H [resident] H says "I'm going" and begins to pass faeces. J places an incontinence pad under H's buttocks but, because H is suspended on the hoist, has to hold this while H passes faeces into it. J stands patiently waiting 'catching' the faeces until H has finished. (Obs notes CA503)*

*S [CA] changes B's [resident's] colostomy bag. B apologises for the smell. S says "don't worry it'll soon be gone". She completes the bag change, disposes of the used equipment immediately and opens the windows. The smell is nauseating and so pervasive that it is still present in the outside corridor half an hour after the bag change (Obs notes CA509).*

Dealing with resident's bodies was not viewed as a problem for the CAs. It was described as something to which they became accustomed or as something they would do for their children or parents without worrying. They did not seem to view it as skilled work and seemed to take these aspects of their work for granted. This was interesting when compared with the observations which showed that body work takes up a great deal of the CAs' time.

*"Dealing with bodily things is not a problem - that is part of the job, obviously it's not nice but it's a part of the job that you have to do, you just grin and bear it as such" (IV CA508)*

*"The mucky side doesn't bother me as long as there's rubber gloves and pinnies and wash your hands. When I first came here I thought yuck I can't do that but it really doesn't bother me now, something you get used to" (IV CA509)*

Issues of sexuality and the residents' sexuality expression occasionally arose, although these were not explicitly viewed as such and were generally dismissed with the least fuss possible. Examples included:

Residents exposing their bodies in communal areas.

*In the lounge R [resident] often pulled up his tracksuit bottoms and B [resident] often took off his clothes or exposed his genitals. The CAs redressed both residents and asked them not to undress themselves in the lounge. (Obs notes Home 1)*

Residents making potentially suggestive remarks to staff.

*G [resident] often says he'd like to get married. While J [CA] was bathing him he talked about his 'needs' in some detail. When she was washing him he joked with her - "you're touching my body again". J said: "you should get yourself a woman G (Obs notes CA503).*

Residents touching staff.

*A young CA reported that a resident was touching her in an intimate way. The Matron/Manager went to talk with the resident and obtained some specialist support for him (Obs notes Home 2).*



Residents, particularly those with mental health needs, forming relationships: Such a situation arose in Home 2, reported by CAs and dealt with by the Home Manager.

**FURTHER CHALLENGES IN CA WORK**

Further challenges were identified in the datasets, and particularly the observations.

These include:

- Staffing difficulties, staff shortages and sickness absence, variable quality of staff, agency and bank staff
- The complexity and diversity of residents needs
- The complexity of care needed
- Working in a closed community

Because they are relevant to the work of all staff within the homes, these challenges are discussed in Chapters 5 and 6.

**3.2.11: PROCESSES WITHIN CA WORK: SUMMARY OF FINDINGS**

<b><u>PROCESSES WITHIN CA WORK:</u></b> <b><u>SUMMARY OF THEMES FROM ALL DATASETS</u></b>
<b><u>CLOSE RELATIONSHIPS WITH RESIDENTS</u></b>
<b><u>CAs AND RESIDENTS KNOWING EACH OTHER WELL</u></b>
Facilitated through being together day after day and intimate caring activities
<b><u>ACCEPTANCE OF EACH OTHER AS INDIVIDUALS</u></b>
<b><u>APPRECIATION OF EACH OTHER AS INDIVIDUALS</u></b>
<b><u>THE RECIPROCAL NATURE OF THE CA / RESIDENT RELATIONSHIPS</u></b>
<b><u>HUMOUR</u></b>
<b><u>IDENTIFYING WHEN SOMETHING IS WRONG</u></b>
<b><u>PERSISTENCE AND PERSEVERANCE IN THE FACE OF CHALLENGES</u></b>
Finding “101 ways” to achieve the desired goals, particularly in difficult situations
<b><u>FAMILY CONCEPTS</u></b>
Family roles, resident and staff as extended family, looking after ‘children’ or ‘parents/grandparents’, relationships with residents’ families
<b><u>CHALLENGES IN THE WORK</u></b>

## **SECTION 3.3: FINDINGS: THE ROLE AND CONTRIBUTION OF CAs**

This section draws together data in all datasets in order to establish the scope and focus of the work of the CAs in the study and, through this, to identify their distinct role and contribution.

The first sub-sections identify how the data from the different data collection methods identified the scope and focus of CA work, i.e.

- How the CAs described their role and contribution in their significant examples
- What the observations revealed about the scope and focus, role and contribution of CAs in the day-to-day realities of work in the care homes
- What the documentary data suggested about their role and contribution, i.e. the statements in their job descriptions summarizing the scope and focus of their jobs, and how the CAs recorded their day-to-day contributions to the work in the residents' daily progress reports
- How the CAs described their role and contribution in the interviews.

### **3.3.1: THE ROLE AND CONTRIBUTION OF CAs IN THEIR SIGNIFICANT EXAMPLES**

Summaries of the topics of the CAs' significant examples are listed in Appendix 3.1.

The topics deemed by the CAs to be 'significant' in their work focused on:

- Building relationships with residents
- Noticing change in a resident
- Working with dying people and their families.

#### **BUILDING RELATIONSHIPS**

Particularly in their examples, CAs focused on how they had built relationships with individual residents, or with residents in general. CAs sometimes perceived residents as finding it difficult to mix with others or displaying 'challenging' behaviour.



### NOTICING CHANGE IN RESIDENTS

A major focus in the examples was how CAs noticed changes in residents, reported these to the RN and, as a result, the residents obtained the care they needed.

### WORKING WITH DYING PEOPLE AND THEIR FAMILIES

There were examples in which the CAs focused on the care they gave to dying people and their families and examples of individual aspects of their work which promoted quality of life.

Overall, these examples focused strongly on caring for, and about, the older people with whom the CAs worked. They placed strong emphasis on recognizing, understanding and treating them as individual persons, helping them to feel cared about and to enjoy life as much as they could.

### 3.3.2: THE ROLE AND CONTRIBUTION OF CAs IN THE OBSERVATIONS

The researcher's observations were able to capture perspectives, situations and events of which the CAs might be unaware. These could then be discussed during the interviews and the CAs' reflections on them explained. Contrary to how the CAs reported the focus of their work in their examples, the observations in the three nursing homes revealed that virtually all of the CAs' work was prioritised by physical care needs, and their working hours consumed by assisting residents with comfort, activities of daily living (e.g. getting up, drinking and eating, going to the toilet, hygiene, personal appearance). Housekeeping duties such as making beds, tidying rooms and caring for residents' personal possessions also consumed a considerable amount of their time. Other, very occasional, duties included charting observations (e.g. fluid intake) or escorting residents to hospital or visits outside the home. The CA role differed between the three fieldwork homes in some respects, specifically in whether they acted as key workers/key carers, served meals or held responsibility for residents' clothing. (Appendix 3.2 illustrates some distinctions and details of the homes are given in Appendix 2.10).

The observations in all three homes demonstrated that the relationships between the CAs and the residents were developed while carrying out the physical assistance. Although residents were treated as individuals, 'getting through the work' was a priority. In Homes 1 and 3 the CAs rarely stopped the physical work to speak with residents. If a resident started a conversation the CA would generally talk for a short time and then get on with the work. In contrast, in Home 2 the CAs could have longer conversations with the residents as they spent longer together in the central lounge/kitchen/dining area. The CAs could chat with residents while continuing their work and could keep an eye on the other residents at the same time. Without exception, all the CAs who participated in the study said they wanted more time to spend with the residents to talk to them, take them out, partake in activities.

### **3.3.3: THE ROLE AND CONTRIBUTION OF CAs IN THE DOCUMENTS**

#### **JOB DESCRIPTIONS**

The CA's job descriptions, summarized in Appendix 3.4, were fairly standard in the three homes. They confirmed that the basis of their responsibilities was offering a high standard of personal care to residents. Overall they focused on:

- Providing practical care and assistance to residents in their daily lives: helping with dressing, undressing, bathing and toilet
- Promoting well-being and quality of life to residents, respecting their independence and right of choice
- Monitoring resident health and welfare and reporting any significant matter.

(Only Home 2 mentioned meal serving or laundry responsibilities).

Building close and trusted relationships with residents was not mentioned.

#### **CARE PLANS AND PROGRESS SHEETS**

In all three homes CAs held responsibility for writing on the residents' notes in order to report on progress during the shift. In all homes, the CAs predominantly wrote about what tasks with which they had helped residents, typically "had a wash / bath ... walked to the day room ... went to the hairdresser".



#### **3.3.4: THE ROLE AND CONTRIBUTION OF CAs IN THE INTERVIEWS**

When presented with the reflections of situations or events noted by the researcher during the observation sessions, the CAs were able to explain how they had experienced that situation and what they perceived to have been going on. The interviews were thus able to capture the CAs explanations of their everyday realities, challenges and frustrations. The interviews were also able to capture in detail the CAs aims, motivations, priorities and visions. In the interviews the CAs described similar priorities in their work to those in the significant examples. They focused on:

- how much they liked the residents and older people in general
- how much they cared about the residents
- how they knew and accepted them as individuals
- how close relationships between CAs and residents developed over time
- how they could identify when things were not totally well with the resident and
- how they saw them as 'family'

The CAs saw the focus of their work as making life a little better for the residents by keeping them feeling as comfortable and cared about as possible. For example:

*“Just to make them as comfortable and their life more enjoyable” (IV CA503)*

*“hopefully make people’s lives in here a bit more bearable – so they’re not looking at four walls all the time ... if you pass the door and nip your head round and say a few words it breaks that quarter or half an hour up before they might see somebody else. Just brightening people’s days and by getting them up, dressing and cleaning them and helping them maintain their dignity” (IV CA509).*

#### **3.3.5: SUMMARISING THE ROLE AND CONTRIBUTION OF CAs FROM THE FINDINGS IN ALL DATASETS**

A summary of the overall findings, and those from distinct datasets, is given in the following table.

<u><b>THE ROLE AND CONTRIBUTION OF CAs:</b></u> <u><b>SUMMARY OF FINDINGS OBTAINED THROUGH DIFFERENT DATA</b></u> <u><b>COLLECTION METHODS</b></u>	
<b>Significant examples:</b>	<p>The CAs' examples of their work focused on:</p> <ul style="list-style-type: none"> <li>• Building relationships with residents</li> <li>• Noticing change in a resident</li> <li>• Working with dying people and their families</li> </ul>
<b>Observations:</b>	<p>In the practical day-to-day reality, work was prioritised by:</p> <ul style="list-style-type: none"> <li>• the physical care needs of residents (e.g. getting up, drinking, going to the toilet, personal hygiene)</li> <li>• some 'housekeeping' duties (e.g. tidying rooms, caring for residents' personal possessions)</li> <li>• occasional duties of charting observations (e.g. fluid intake) or escorting residents outside the home.</li> </ul> <p>Relationships with residents were developed while carrying out other duties.</p>
<b>Documentary data:</b>	<p><u>Job descriptions</u> focused on CA responsibilities in delivering a high standard of personal care</p> <p>Some CAs had Key Worker responsibilities.</p> <p>Some CAs were responsible for laundry or serving meals.</p> <p>Building relationships was not mentioned.</p> <p><u>Care plans and progress sheets</u> highlighted that CAs reported on what physical care they had given, not on relationships or interpersonal aspects of their work.</p>
<b>Interviews:</b>	<p>In the interviews the residents appreciated that the CAs were always available for help with anything, to be comfortable, relationships, domestic aspects and 'the little things'. This gave them peace of mind and a sense of security.</p>



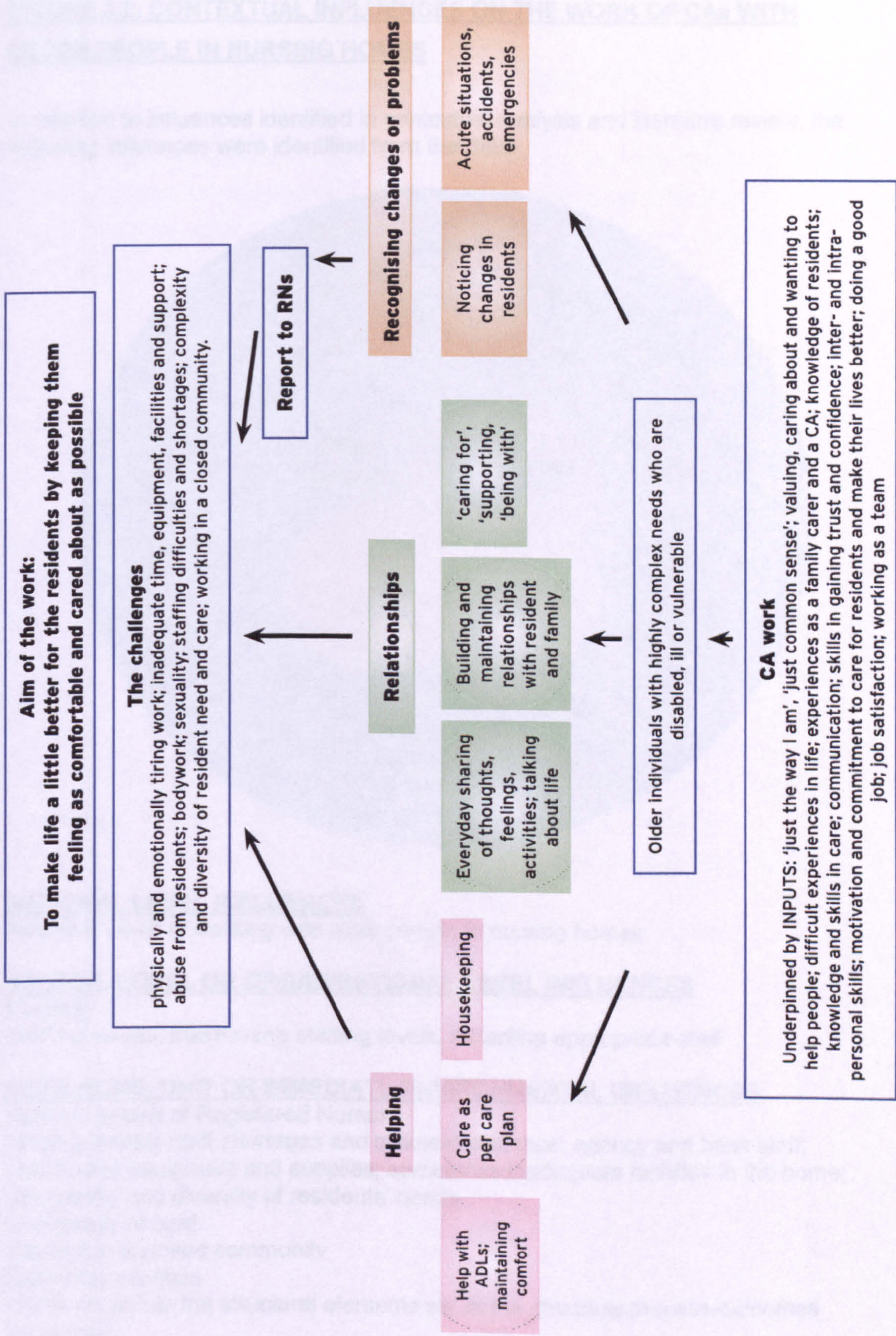
	<p>In the interviews the relatives wanted the residents to be treated with kindness understanding and compassion, receive the care they needed promptly, kept comfortable, kept clean and dressed nicely and given time to talk to them or take them out.</p> <p>In their interviews the CAs described how much they liked the residents, cared about them, formed close relationships with them, knew them as individuals and recognised when they were unwell.</p> <p>CAs saw the residents as 'family'.</p>
<p><b>OVERALL:</b></p>	<p>CAs were employed to assist residents with physical personal care / activities of daily living and this prioritised their work in their day-to-day realities.</p> <p>Yet what motivated and fulfilled CAs were the relationships they formed with residents and how these were enjoyed in their day-to-day work</p>

**3.3.6: A MODEL OF THE CA ROLE AND CONTRIBUTION**

The data overall suggested a new Model of CA Work, which is shown as Figure 3.1. It illustrates that CA work is underpinned by the inputs they identified (Section 3.1) and that they work with older individuals with complex needs. The boxes in the centre show the three main aspects of the CA role, i.e. Helping, Relationships and Recognising Change, along with the elements and dimensions of the CA role as identified through all datasets. CAs reporting changes or problems to RNs is acknowledged. The model shows the ultimate aim of CA work as this was described in the overall data. It acknowledges that, in order to achieve this aim, CAs work through a range of challenges, which were particularly highlighted in the observations. The CAs who have seen the model confirmed that it accurately represents their work. Contextual influences on CA work are shown in Figure 3.2.



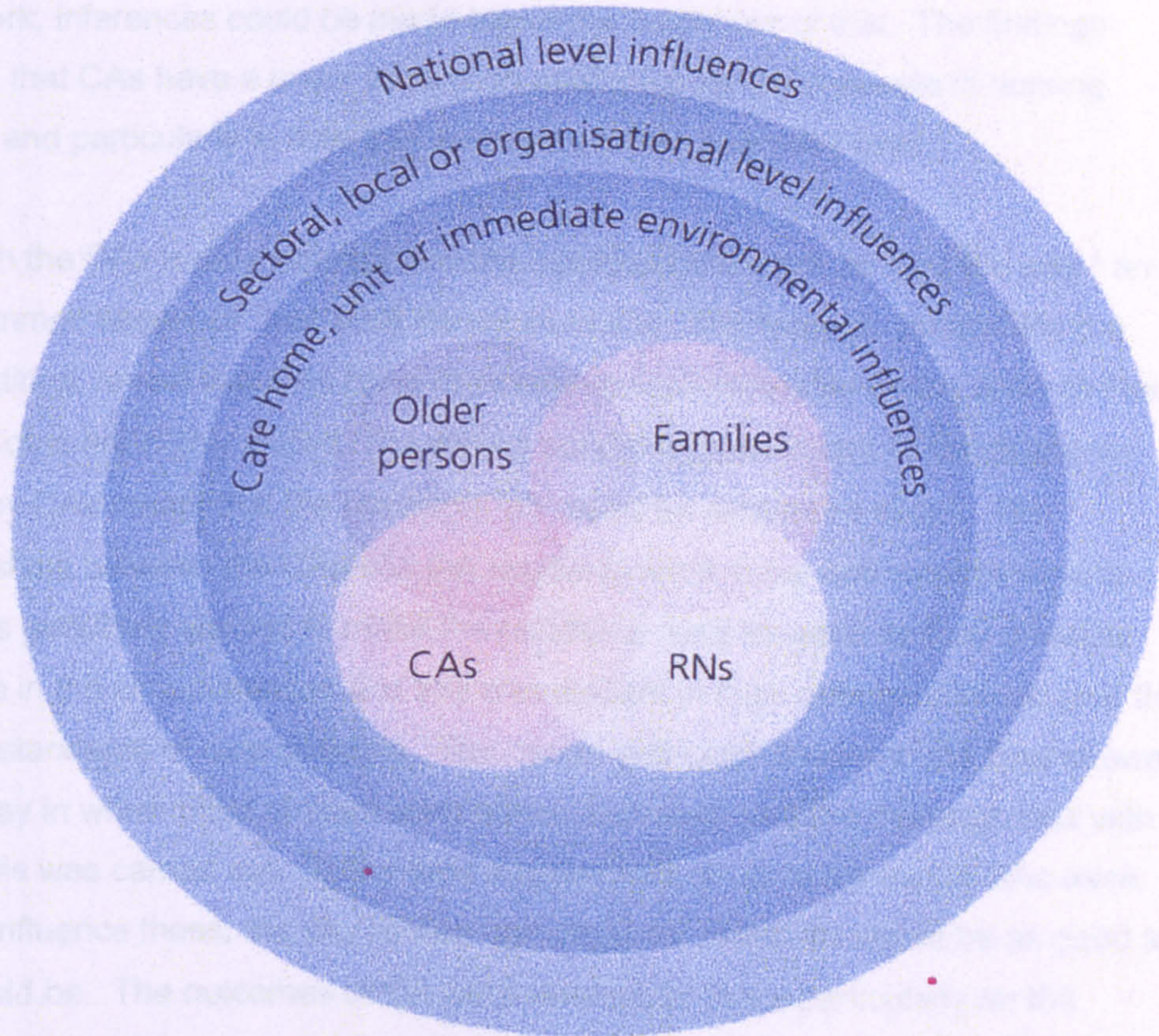
# Model of CA work identified in the research





**FIGURE 3.2: CONTEXTUAL INFLUENCES ON THE WORK OF CAs WITH OLDER PEOPLE IN NURSING HOMES**

In addition to influences identified in contextual analysis and literature review, the following influences were identified from the data:



**NATIONAL LEVEL INFLUENCES**

Negative views of working with older people in nursing homes

**SECTOR, LOCAL OR ORGANISATIONAL LEVEL INFLUENCES**

Funding

Staffing issues: maintaining staffing levels; attracting appropriate staff

**CARE HOME, UNIT OR IMMEDIATE ENVIRONMENTAL INFLUENCES**

Variable quality of Registered Nurses

Staffing issues; staff shortages and sickness absence; agency and bank staff;

Inadequate equipment and supplies; sometimes inadequate facilities in the home;

Complexity and diversity of residents' needs

Complexity of care

Working in a closed community

Balancing priorities

These constitute the structural elements within the structure-process-outcomes framework



### **3.3.7: IMPLICATIONS FOR OUTCOMES OF THE WORK OF CAs**

Through identifying the inputs to, the processes within, and the outputs from the CAs' work, inferences could be made about the outcomes of this. The findings suggest that CAs have a major impact on outcomes for older people in nursing homes, and particularly in how they experience their everyday lives.

Although the CAs widely summarized the inputs to their work as “just the way I am”, “just common sense” or “just what we do as mums”, the findings, particularly the observations, reveal that CAs bring humanity and considerable caring skills to their work. Some are highly skilled. The strong personal commitment to the residents shown by CAs meant that the residents felt cared for and cared about. The relationships between the CAs and the residents were close and were reciprocal. The CAs genuinely wanted to make the residents' lives as good as they possibly could be in the circumstances and this was evident in their determination to give the highest standards of care possible. The caring and commitment of the CAs showed in the way in which most of them went about their work and the thoroughness with which this was carried out. This would suggest that, in as much as the CAs were able to influence these, the day by day outcomes for residents would be as good as they could be. The outcomes of CA work seemed to focus particularly on the residents' physical comfort, psychological wellbeing, their daily functioning and some aspects of their everyday quality of life.



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# **CHAPTER 4: FINDINGS:**

## **THE WORK OF REGISTERED NURSES**

### **(RNs):**

This chapter reports on the findings of the research into what Registered Nurses do and how this impacts on outcomes for older people living in nursing homes.

It reports on the specific findings in terms of the:

- Inputs to (and structure influencing) the work of RNs: Section 4.1
- Processes within (and outputs from) the work of RNs: Section 4.2
- Overall role and contribution of RNs: Section 4.3

Summaries are offered in each section and at the end of this chapter.

The overall findings suggest a model of the work of RNs in nursing homes (Figure 4.1) and a range of influences upon this (Figure 4.2), which are presented at the end of the chapter.

The findings paint a rich and vivid picture of the work that RNs undertake with older people in nursing homes, including how this is perceived by the RNs themselves, staff working with them, residents of the home and their relatives. The findings also clearly illustrate, primarily through the RNs' significant examples and interviews, what they aim to achieve in their work and what motivates them. Inputs to and outputs from the work were also described by the RNs in their examples and interviews, and confirmed through the observations. A range of challenges confronting RNs in the everyday realities of their work were also identified, primarily through the observations and interviews.



The key themes emerged from all datasets including in the three fieldwork nursing homes, despite the homes being different in many ways. Appendix 4.2 illustrates the distinctions between the homes and how the themes developed.

Seeking to communicate the findings as clearly as possible, and in the context of wordcount restrictions, some data are offered in Appendices:

- Appendix 4.1: The focus of the RNs' significant examples
- Appendix 4.2: Comparison between the RNs in the three fieldwork care homes: findings from the observations and interviews
- Appendix 4.3: Summary of inputs to RN work identified in all datasets

Data sources cited in this chapter are identified as follows:

- 'Example' denotes a section from a participant's significant example submitted for Phase 1.
- 'IV' denotes a quote from an interview in Phase 2
- 'Obs' denotes a section or a quote from transcribed researcher fieldnotes written during the Phase 2 observations.
- 'RD' denotes an entry in the researcher's diary.

## **SECTION 4.1: THE INPUTS TO RN WORK**

This section reports on the knowledge, skills, experiences, values, beliefs and motivations that the RNs believed they brought to their work and that influenced their work. A list of all the inputs identified by the RNs in all datasets is given in Appendix 4.3 and the inputs identified through the different data collection methods are summarized at the end of Section 4.1.

In their significant examples submitted in Phase 1, and in their interviews in Phase 2, the RNs listed a wide range of knowledge, skills and experiences which they believed they brought to their work. Many of these highlighted their leadership and managerial roles, for example their assertiveness to challenge other professionals in order to obtain good care for residents, and resourcefulness in finding allies to help with this. Inputs also included knowledge, skills and experience in clinical care and particularly working with people. Inputs were influenced by previous experiences (both clinical and personal) and from specific learning or reading. The RNs also listed a wide range of interpersonal and intrapersonal knowledge and skills. The inputs identified in the observations are described in Section 4.1.5 below.

### **INPUTS IDENTIFIED BY THE RNs IN THEIR EXAMPLES AND INTERVIEWS**

THESE ARE DESCRIBED UNDER THE HEADINGS:

#### **LEADERSHIP AND MANAGEMENT KNOWLEDGE, SKILLS AND EXPERIENCES**

- Running the home
- Leading, supervising and working with staff
- Interprofessional working

#### **CLINICAL CARE AND MANAGEMENT**

- Clinical, nursing-related knowledge
- Clinical skills
- Particular clinical skills developed
- Assessing, planning, delivering and evaluating care



- Clinical experiences

- RMNs listed 'additional' knowledge, skills and experiences

#### **PERSONAL SKILLS, KNOWLEDGE, EXPERIENCES AND QUALITIES**

- Personal knowledge

- Interpersonal skills

- Intrapersonal skills

- Personal experiences

#### **INDIVIDUAL VALUES, BELIEFS AND MOTIVATIONS**

- Commitment to residents

- Liking of older people and the residents in particular

- Belief in the residents' right to good care

- Determination to work to improve care for older people

- Intuition, instinct or 'gut' feeling

### **4.1.1: LEADERSHIP AND MANAGEMENT**

#### **RUNNING THE HOME**

The RNs identified a range of abilities they used in running the home including the legislative, professional and ethical guidelines, forming policies procedures and protocols, budget management, quality assurance and audit requirements. They also included aspects such as "maintaining the overall picture", "overseeing all functions - the home as the home and the home as a business", attending to diverse needs and priorities, organising co-ordinating and overseeing all care, and promoting a positive atmosphere. Managing crises as they arose was also identified.

#### **LEADING, SUPERVISING AND WORKING WITH STAFF**

Many of the examples listed their abilities in leading, managing, directing, encouraging and motivating staff among the inputs to their work. Being a good role model, teacher and supervisor was considered important. The qualities listed also included understanding the importance of team spirit, good communication and knowing how to build on the self-esteem of staff so that they felt supported, were able to develop, felt involved and felt 'ownership' in the care.

### INTERPROFESSIONAL WORKING

Skills in working with other professionals in a professional manner, particularly doctors, were identified. RNs mentioned the importance of engaging and motivating other professionals and, where necessary, advocating for residents in order that they could obtain the treatment and care they needed. Also identified was the importance of knowing when and where to seek outside services, what services are available, how to obtain them, and also the funding arrangements and regulations.

### 4.1.2: CLINICAL CARE AND MANAGEMENT

#### CLINICAL, NURSING-RELATED KNOWLEDGE

RNs mentioned that their clinical knowledge was grounded in anatomy and physiology and also 'medical' knowledge, such as differential diagnoses, clinical features of illness and the likely consequences. They also had knowledge of treatments and interventions, particularly what is urgent and what needs to be referred to doctors. They highlighted their understanding of the progress of disease and likely outcomes along with their knowledge of how to prevent and recognize deterioration. Knowledge around drugs was listed, particularly analgesics and aperients, as well as knowledge of diagnostic tests and tools.

#### CLINICAL SKILLS

"All nursing skills" appeared frequently in the RNs' lists. These included taking observations, using equipment, manual handling, physiotherapy techniques, giving prescribed medicines by various routes, catheterisation, the care and dressing of wounds, and infection control procedures.

#### PARTICULAR CLINICAL SKILLS DEVELOPED

Individual RNs listed particular skills they had developed, such as venepuncture, insertion and care of sub-cutaneous infusions, using syringe drivers and PEG (percutaneous endoscopic gastrostomy) feeding equipment. Skills in mental health promotion were listed, including reminiscence and art therapy, and using photos and videos therapeutically. Rehabilitation skills were also listed, such as in music and movement, and in knowing who would likely benefit from rehabilitation input or using specific rehabilitation equipment, and who would likely not benefit.



### ASSESSING, PLANNING, DELIVERING AND EVALUATING CARE

These aspects were mentioned in the RN examples and interviews.

Assessment was seen as fundamental. It was also all-embracing in terms of “assessment of total health and social care”, assessment of physical, psychological, social, emotional and spiritual dimensions of residents’ lives, ‘medical’ needs and personal needs. RNs mentioned “assessing how someone is feeling” and assessing change. Assessing someone’s abilities, and thus when to help or when to leave them to accomplish something independently, was also mentioned.

Observation was listed, for example to detect change or deterioration, and specific examinations were mentioned, such as examining residents for distended abdomen. Care planning, goal setting, reporting, documenting and organizing staff to deliver the care was listed, as was how to evaluate progress and determine whether goals of care have been met.

### CLINICAL EXPERIENCES

In addition to clinical knowledge and clinical skills, specific clinical experiences and the accumulation of these over the years were listed by RNs.

Also listed was experience in clinical leadership roles, managing clinical areas and managing patient care in a range of settings.

RNs had experienced a wide variety of clinical situations that now enabled them to recognize what was clinically happening and how to deal with this, examples included stroke, fractured neck of femur, deep vein thrombosis and arterial embolus.

### ‘ADDITIONAL’ KNOWLEDGE, SKILLS AND EXPERIENCES LISTED BY RMNs

Registered Mental Nurses in the study identified inputs ‘additional’ to those brought by RGNs such as knowledge of Mental Health Legislation, mental health in older age, particular considerations for drugs and mental health such as the manifestations of adverse drug reactions, and specific ethical issues concerned people with mental health needs. ‘Additional’ skills included ‘highly attuned’ observation and communication skills, working in groups and dealing with challenging situations. Personal skills identified included calmness, authority and patience. Inputs from experience included learning what works for older people with mental health needs and what does not.

### **4.1.3: PERSONAL SKILLS, KNOWLEDGE, EXPERIENCES AND QUALITIES**

#### **PERSONAL KNOWLEDGE**

Personal knowledge identified by RNs included knowledge of human behaviour in order to be more empathic, how to cope with difficult situations, the importance of looking beyond the obvious and of remaining positive.

#### **INTERPERSONAL SKILLS**

Skills to work with people included how to show interest, caring and empathy, being approachable, being able to give support and reassurance, instilling confidence, and tact and diplomacy. Communication skills were widely listed, including those needed to be assertive or to handle conflict. Counseling skills were also included.

#### **INTRAPERSONAL SKILLS**

Skills to deal with personal issues included using one's humanity, being open up-front and honest, being prepared to try things and being adaptable. Will, determination and stamina were listed, as were being positive proactive and dynamic. Time management and the ability to work quickly were included.

#### **PERSONAL EXPERIENCES**

RNs tended to list professional rather than personal experiences from which they learned but personal experiences included having good role models and particularly in close family, for example grandparents.

### **4.1.4: INDIVIDUAL VALUES, BELIEFS AND MOTIVATIONS**

All datasets clearly demonstrated the RNs commitment to residents and the belief that they had a right to the best care that could be offered.

#### **COMMITMENT TO RESIDENTS**

Virtually all the RNs in the study were highly committed to older people.

*"My main influence was my commitment to F and the belief that she had a good quality of life and wanted to go on and a belief that she should be able*



*to with the appropriate medical interventions ... had I not acted as I did there is no doubt that the patient would have died'* (Example 266)

*"I care a great deal about older folk and ultimately I want what is best for them according to their needs"* (Example 105.2).

### LIKING OLDER PEOPLE AND LIKING THE RESIDENTS

RNs clearly demonstrated their liking of older people and of the residents with whom they worked.

*"I enjoy working with the elderly and used to do my extra hours on the elderly areas. You get so much from them. They have so much experience in their lives and they've got a lot to give still."* (IV RN502)

*'I just enjoy working with the elderly and everything that brings with it. I like to think they come into the home and I help to make their lives comfortable and I gain a lot from them from listening to their lifestyles and everything – enriching – I can help make them comfortable and the stories they tell and the advice they give you what to do with babies - I just enjoy it"* (IV RN504).

### RESIDENTS' RIGHT TO GOOD CARE

RNs described how they believed residents had a right to good care.

*"Patients have to be cared for - not only because they are paying for it, but in this sort of situation it makes me feel even more strongly that I must do the best I possibly can for them"* (Example 267)

*"The elderly have every right to the very best care that we can give. I believe all people should be treated the way I would treat my parents. They need all the love and attention they can get"* (Example 105.1).

### DETERMINATION TO IMPROVE CARE FOR OLDER PEOPLE

This belief was widespread throughout the datasets. One motivator in this determination to achieve the highest standards of care for the residents was the RNs' previous experiences of detrimental care, or even abuse. For example:

*"I had previously worked on a long term elderly care ward in our local hospital where I witnessed ritualistic practice e.g. removing all residents dentures and soaking in sterident in pots on a trolley ... little assessment of residents and questioning by staff, a lady with a continence problem - trussed up like a*

*chicken and I was angry at the indignity and when I tried to ask what was the reason behind that approach, I was aggressively rebuffed by the senior state enrolled nurse. I resolved then that if I was a manager I would foster an 'open climate' where questions would be encouraged". (Example 103.1)*

*"I had a bad experience as a student in a long-stay geriatric ward. I was on a late shift and all the patients were sitting on the veranda - about 35 of them. At 2 o'clock this enrolled nurse said "it's toileting time" and a commode was brought onto the veranda. It was awful. I was helping this enrolled nurse and she hauled up this little old lady called E. She had pleading eyes. The EN grabbed hold of one arm and I held the other to put her onto the commode. And E grabbed our arms because she was unsteady being hauled up and the EN said "get your shitty hands off me". And the EN said to me "do you know she used to be the Mayor of [town]" and I nearly cried - what a horrible thing to do, what a horrible thing to say. Have you no respect!" (Example 131).*

#### **4.1.5: INPUTS IDENTIFIED IN THE OBSERVATIONS AND INTERVIEWS**

The observations and interviews highlighted skills that had not been identified in the RN examples. Some of the RNs observed demonstrated broad knowledge, skills and experiences, even within a single encounter. One example is offered below. The RN was the only qualified staff member on a unit for about 30 older people with high levels of physical and mental health needs, mostly advanced dementia.

##### **Observation Notes:**

Sister: *"Oh sweetheart – what's wrong?". Sees M [female resident] crying and cuddles her.*

Sister: *"I know" holds M close and kisses her. "You are safe. You are with me. You are OK".*

Sister explains to me that M is going back to the past. She said *"I heard her say 'mummy mummy' and her face just crumpled".*

Stands cuddling her. *"It's alright".*

Asks would she like to come and sit down and leads her to a seat. Listens to M



talking and seems to be getting clues from the conversation. *"Yes it's all sorted .... Yes ... Bob has paid for it – it's all sorted – there's nothing to worry about. Close your eyes and go to sleep. She's lovely"*.

*"You're lovely"* said M *"you're my baby"*. More cuddles and kisses.

Sister gets a magazine – opens pages and M reads some words.

Sister explains to me *"M's very maternal – she loves pictures of babies and children – here she'll like this one"*. M shows interest and tries to read the words. Sister goes to get a tissue and wipes the tears from the M's eyes.

M is visibly brightening up. Notices tattoos on one CA's arm. *"Look at his arm"* she said.

Sister finds other magazines with pictures of babies and children. Looks through with M to find pictures that might interest her. M reads some words and seems interested in the pictures. *"Oh what a sweet looking girl; what a pretty girl"* she said.

Sits reading through the magazine.

M: *"I'm going to see my mum – we're going to the pictures"*.

Sister: *"what are you going to see"*.

M continues reading through the magazine and Sister leaves her.

**Interview transcript:** [What made you act in the way you did with M?]

*"I was getting on with my duties when I noticed the look on M's face - her face just crumpled. I heard her say 'Mummy mummy'. I suspected that M had gone back to the past and was feeling distressed. I tried to lessen the distress by putting my arms around her, kissing her, telling her she was loved and reassuring her. During the time she was talking I tried to pick up on the cues she was giving me and to deal with them. People in the older generations can become distressed about whether or not they have paid for something and I picked up that M was talking about Bob having paid for things - I forget the exact words but M was saying something about 'has he been upstairs for the money?'. So I said it's all paid for, it's all sorted - there's nothing to worry about.*

*I then spent time with her and tried to find something to distract her, something pleasurable. I suggested she try to sleep but M obviously didn't feel like sleeping. I could hear her voice lighten and she seemed more content so I left her with something to occupy her mind" (RMN511).*

The observations and interviews identified a similar range of inputs to those in the significant examples but virtually all RNs found difficulty in verbally identifying the knowledge, skills or experiences they brought to their work and even to a specific interaction.

#### **4.1.6: DIFFICULTY ARTICULATING SKILLS, KNOWLEDGE AND INFLUENCES ON DECISIONS**

The RNs interviewed found difficulty in explaining exactly what influenced their actions in specific situations. They recognised that they were able to attend to a number of things at one time and that their attention could encompass a range of levels. When asked specifically what they brought to a situation, what influenced their thinking and decisions, RNs found it difficult to explain.

*"Observation and communication skills. Patience skills - watching what they do and listening to what they say ... the art of conversation is to listen - I've been taught that. Or you might do something and you get a slap and then you think 'I won't do it that way again'." (IV RN501).*

*"You can learn a lot from using your intuition on people's body language, even if they're just sitting quietly" (IV RN700)*

The RNs interviewed tended to summarise their inputs as, for example,

*"all nursing skills" (IV RN512) or "knowledge of anatomy and physiology goes without saying" (IV RN504).*

There was consensus that they tended to take their skills for granted and rarely made opportunities to reflect on their actions. Common responses were:

*"well yes I suppose ... I do use X skills ... have experience in ... have a particular interest in ...".*

All of the RNs interviewed found it a constructive experience to reflect on the actions they had taken in a particular situation and what influenced their decisions.

*"I don't think we sit and reflect enough and think 'why did I do that. When people say that was really good S, that can be a surprise. You don't think about it you just do it" (IV RN501).*



#### **4.1.7: ALERT TO PROBLEMS WHEN THEY CANNOT SEE THE SITUATION**

Examples, observations and interviews suggest that RNs are alerted to problems or potential problems. In fact some RNs were alerted to a problem or potential problem even when they could not see the situation. Several RNs identified that they could be sitting in the office and still recognise that something was wrong.

*"I might not be watching a patient but I hear the tone of voice or the way something is said and I know there might be repercussions – I'm doing that all the time. And it's something that is difficult to articulate because it's just something you do" (IV RN501).*

*"you hear things and sometimes in the office if I'm doing paperwork I just think - it isn't right" (IV RN700).*

#### **4.1.8: ANTICIPATING PROBLEMS**

Anticipation and the ability to recognise when something was about to happen was mentioned.

*"It's knowing my role. The RN can anticipate and often be one step ahead in avoiding things happening which would be detrimental" (Example 216)*

*"I can see things five minutes before they happen - like five minutes before they actually explode. I'm not sure if that's something I've been taught or gained through particular experiences, but a lot of people don't see those things. Observing others sometimes, they have no awareness that something is going to happen. I'll be sitting in the office looking out and I can see what's going to happen but I can't get there in time" (IV RN501)*

#### **4.1.9: THE INFLUENCE OF TRAINING ON SKILLS**

The strongest influence on RN work was them as individuals:

*"The caring was always in me - I don't think that's something you can teach - it just comes natural to me. I do feel I've been taught some of it as well - but awareness and observation skills can be taught. (IV RN501)*

*"Some of it comes from experience but it's mostly to do with the sort of person you are" (IV RMN909)*

Also highlighted as a strong influence on the way they practiced was their training.

*"Years of experience and from my training years ago: toileting rounds before meals and after meals and in between if necessary, every two hours that stayed with me. It's experience - often I think 'I remember this - it's happened before' and you do whatever you did then if it worked" (IV RN701).*

*"The trained nurses don't panic. When I was a first year pupil nurse I was left on my own in charge on a quite acute ward. And this chap arrested - my first arrest - he was going home the next day. I ran up and thumped on his chest. I brought him 'round. I called the crash team but by the time they got there I'd got him going. I've never forgotten " (IV RN909 EN).*

*"Experience of life helps but from your training you are taught to be more observant to see inside outside and around things in that persons life - we are taught to observe not just take the top layer" (IV RN915).*

*"They don't need to verbalise, you can see how they're feeling by looking at their eyes and the response you get – if they're interested, bright or alert or a bit dull. Facial expressions simple little things you learn - they teach you how to do that – I've relied heavily on it ... you just know" (IV RN501)*

The RMNs in the study clearly attributed their "highly attuned observational skills" and ability to anticipate what was going to happen to their training as an RMN.

[What are the particular RMN skills?] *"It's seeing things in a different way ... especially in psychiatry, you have to look for things that are not obvious. They teach you how to do that. When I was doing my training we were looking out the window and a student nurse standing beside me said I wonder where that water's coming from out that pipe. Then suddenly she just legged it 'round the corner and there was someone trying to top himself in the bath. That was just an example. I was new to the unit so I didn't know to be aware of this particular patient, but they teach you how to do that and how to observe somebody's body language - how they move" (IV RN501).*



**4.1.10: INPUTS TO RN WORK: SUMMARY OF FINDINGS**

<b><u>INPUTS TO RN WORK: SUMMARY OF FINDINGS OBTAINED THROUGH DIFFERENT DATA COLLECTION METHODS</u></b>	
<b>Significant examples and interviews</b>	<p>A broad range of knowledge, skills, experiences and values which influence RN work were identified:</p> <p><b><u>LEADERSHIP AND MANAGEMENT</u></b>                      Running the home                      Leading, supervising and working with staff                      Interprofessional working</p> <p><b><u>CLINICAL CARE AND MANAGEMENT</u></b>                      Clinical, nursing-related knowledge                      Clinical skills                      Specialised or advanced knowledge and skills</p> <p><b><u>ASSESSING, PLANNING, DELIVERING AND EVALUATING CARE</u></b>                      Assessment                      Observation                      Planning care                      Care implementation and evaluation</p> <p><b><u>CLINICAL EXPERIENCES</u></b>                      Experience in leadership roles                      Experience in specific clinical situations</p> <p><b><u>'Additional' dimensions of knowledge, skills and experience were listed by Registered Mental Nurses</u></b></p> <p><b><u>PERSONAL SKILLS, KNOWLEDGE, EXPERIENCES AND QUALITIES</u></b>                      Personal knowledge                      Interpersonal skills                      Intrapersonal skills                      Personal experiences</p> <p><b><u>INDIVIDUAL VALUES, BELIEFS AND MOTIVATIONS</u></b>                      Commitment to residents                      Belief in the residents' right to good care                      Belief that the care of older people must be improved</p> <p><b><u>INTUITION, INSTINCT OR 'GUT' FEELING</u></b>                      There were mixed views on whether intuition existed. Some RNs believed in their intuition and relied upon this. Others attributed their ability to 'pick things up' to their 'highly attuned observation skills' and years of experience in recognising situations.</p>

<p><b>Observations</b></p>	<p>A range of inputs additional to those mentioned in the examples and interviews were identified in the observations.</p> <p>These varied between RNs. Some RNs were highly skilled, knowledgeable and experienced, others inadequately so.</p> <p>Some RNs were exceptionally highly skilled, particularly in identifying and managing problems and distress in residents.</p> <p>Some RNs were alert to potential problems even when they could not see the situation, e.g. they were in the office but "knew that something wasn't right"</p> <p>Some RNs had particularly highly attuned anticipation skills to "see things five minutes before they happen"</p>
<p><b>OVERALL</b></p>	<p>The RNs brought a wide range of knowledge, skill, experiences and values which profoundly influenced the care given in the homes.</p> <p>RNs did not find it easy to articulate their knowledge and skills e.g. "all nursing skills" or "knowledge of anatomy and physiology goes without saying".</p> <p>Observations and reflection on these during the interviews showed that the RNs tended to take their skills for granted and believed there was "nothing special" in what they do.</p> <p>RNs found it difficult to explain exactly what influenced their actions in specific situations.</p>



## **SECTION 4.2: PROCESSES WITHIN** **THE WORK OF RNs**

This section offers a thematic analysis of the data on processes within the work of RNs from all datasets, i.e. the situations and events that they described or which were observed. It details what the RNs did in their work, their actions, their interactions, what they said and the decisions they made which, altogether, constitute the processes within and outputs from their work.

It is important to highlight that the processes within the work of RNs in nursing homes are strongly influenced by the context in which they work (in terms of the structure-process-outcome framework these elements constitute the structure). These are illustrated in Figure 4.2 which is shown at the end of this chapter.

The box below summarises the themes from all datasets and this is followed by details of each of the themes with quotes from participants.

### **THE PROCESSES WITHIN RN WORK:** **SUMMARY OF THEMES FROM ALL DATASETS**

1. RESPONSIBILITY AND ACCOUNTABILITY
  2. COMPLEXITY OF RN ROLE
  3. CONSTANT PRIORITISING AND BALANCING OF PRIORITIES
  4. KNOWING THE PERSON / KNOWING THE RESIDENTS
  5. PERSISTENCE IN STRIVING TO GIVE GOOD CARE
  6. THE 'TAKEN-FOR-GRANTED' NATURE OF SOME ASPECTS OF THE WORK
  7. HUMOUR
  8. FAMILY CONCEPTS
  9. THE VARIATION AMONG RNs
- THE DATA ALSO IDENTIFIED A RANGE OF CHALLENGES IN THE WORK.

### **4.2.1: THEME 1: RESPONSIBILITY AND ACCOUNTABILITY**

#### **RESPONSIBILITY AND ACCOUNTABILITY**

- Responsibility for everything
- Responsibility for vulnerable people with complex needs
- Total responsibility for resident care and safety
- Continuous monitoring and assessment
- Continuity of care

#### **RESPONSIBILITY FOR EVERYTHING**

The RNs in charge held responsibility for everything that occurred in the homes, including the building and grounds. The RN may be the senior manager in the home and thus have to deal with any emergencies that arise, the sole and ever-present clinician and thus be responsible for identifying any change in the health and wellbeing of residents or anyone else in the home and taking appropriate action. RNs commented on the total responsibility and accountability.

*"I had to cope. Patients and staff were dependent on me" (Example 267)*

Further details of the scope of the RN role are given in Section 4.3.5 and 4.3.6 and it was clear that there are aspects of RN roles in care homes which are distinct from those in NHS settings.

Fire was a particular concern for some of the RNs. In Home 2 there was a fire one night because someone put a cigarette end into a bucket. All the residents and staff had to be evacuated. During one observation session in Home 1 the fire alarm went twice and the RN began to evacuate the building. On another occasion in Home 2 there was a fault on the fire alarm in the dementia unit and it repeatedly went off.

*"This was particularly challenging - we were in and out of the fire escapes. We had to evacuate the unit but we sang our way through. It was incredible. Sometimes it takes a lot less than you anticipate to calm folk". (IV RN702)*

*"I was the fire officer downstairs for the home so we were evacuating the home home, which was quite a thing in itself. I had to make sure everybody was out of the building and I was the one responsible for calling the fire brigade and any other procedure needing to be carried out" (IV RN513)*



### RESPONSIBILITY FOR VULNERABLE PEOPLE WITH COMPLEX NEEDS

The responsibilities of RNs were increased by the fact that the residents in the homes were mostly vulnerable and frail people with complex care needs. This is discussed in Chapters 5 and 6.

### TOTAL RESPONSIBILITY FOR RESIDENT CARE AND SAFETY

The RNs felt the responsibility and accountability in their clinical roles.

*"Being a sister is very difficult ... because the accountability is massive. Being a sister there's the NMC requirements and ethics and restrictions with medications. There are policies to follow and [the company] has its own policies. You have the overall view and that's quite hard. And that's why it's important also that the RNs go on study days and refresher courses. You can get very stale and you're supposed to be the motivator" (IV RN501).*

*"It's quite a lot of responsibility, especially if you giving medicines, you've got to get your mind focused on it. In the morning it's quiet and you can finish, but in evening you get part of it done and something happens or someone calls you. I stay in the dining room in the evening because there's less staff but D will need feeding, or others will need a hand" (IV RN507EN).*

### CONTINUOUS MONITORING AND ASSESSMENT

A great deal of the assessment, monitoring, staff supervision takes place while the RNs go about their work. The observations were full with examples such as:

*Recognising when resident needed support or looked tired (RN504)*

*Slowing pace of interactions in order to show kindness and caring (RN502)*

*Noticing when CAs not moving resident properly and taking time to correct (RN505)*

*Picking up on problems – e.g. J's toes had turned blue, no urine in her catheter bag, wound looking red and angry (RN505)*

This raises questions of what would happen if the RN was not present, did not notice a need or did not respond effectively.

Because RNs carried the ultimate responsibility, their work was frequently interrupted by queries or other issues with which they had to deal.

### CONTINUITY OF CARE

The RNs held responsibility for continuity in the care. This could be particularly challenging when RNs worked part-time and during periods of staffing difficulty.

*"It's difficult working only two days a week ... I've got from 7.30 to 12 which sounds a long time but I have to work in that time to pick up – where is this – have you done that. It is difficult when you haven't seen things for yourself – all you've got to go on is the care plan ... and like yesterday I gave an enema to somebody and I wrote in 'enema given and results to be written'. I know that doesn't take a minute to write the result but I came in today and there's no result I need that because I need to speak to the doctor – luckily the carer said 'minimal result' but I don't like that side of things" (RN505)*

*Sister has returned from four days leave to find the unit in a mess. The desk and clinical room have piles of paper and equipment left untidily. Drugs had not been logged in. One resident had not received his drugs for four days and was now unwell. She has not received a proper handover (Obs notes RN502)*

### 4.2.2: THEME 2: COMPLEXITY OF THE RN ROLE

#### COMPLEXITY OF THE RN ROLE

- Multi-level working. Multi-faceted working / multi-tasking
- Working towards goals within various time frames
- Multiple responsibilities
- All RNs have a breadth in their role
- RNs in nursing homes have diverse roles in different homes

#### AN EXAMPLE OF RN WORK

In order to illustrate the complexity of RN work, particularly multi-level working, multi-faceted working / multi-tasking and working towards goals in various time frames, two examples are offered. These encompass the work of one RN during about one hour. This was in a unit where most residents had profound mental health needs, particularly dementia, and whose communication was not straightforward to understand.



- The first example summarises what the RN accomplished.
- The second example focuses on a potentially critical incident. It details the observation notes taken by the researcher, and the reflections of the RN in the subsequent interview.

Additional examples illustrating the complexity of the work are offered in Section 5.3.

**EXAMPLE OF AN OBSERVATION SESSION RECORDING ONE RN'S ACTIVITY DURING ABOUT ONE HOUR**

**The RN's 'primary task': standing with the medicine trolley in the lounge and dispensing medicines from bubble packs pre-filled by the pharmacist.**

**Concurrent activities**

The RN could have merely popped the medicines out of the appropriate bubble in the pack but she was also checking the prescription charts. Because she knew the residents and their drugs, this was done fairly quickly but she was also:

- noticing any change in the drugs prescribed
- identifying errors in prescriptions
- identifying drugs that had not been given appropriately
- assessing a resident's need for drug (e.g. checking pulse before giving digoxin)
- identifying other clinical needs for medicines (e.g. laxatives, pain relief)

**Plus, in the overall environment and the overall resident population**

- knowing that three residents are still in the bedrooms and asking the CAs to ensure they receive breakfast,
- noticing residents in the corridor and asking CAs to bring them into the lounge,

**Plus, with groups of residents or individual residents**

- keeping an eye on breakfasts e.g. intervening to stop D being given ordinary orange juice instead of diabetic juice
- noticing how residents are eating, e.g. N was having trouble with her toast and

RN asked CA to take her to put her teeth in

- greeting individual residents and making pertinent conversation; responding to them and noting actions to be taken later, e.g. speaking to a relative
- noticing how residents are looking, e.g. C looks tired and RN asks if he wants to go back to bed after breakfast
- noticing how residents are dressed e.g. stocking falling down, M looks cold, asking CA to fetch cardigan.
- noticing how residents are functioning, e.g. F is not walking as well as usual, makes a note to see him later and refer to physiotherapist.
- noticing if residents are comfortable and clean, e.g. that T's trousers are wet; asking CA to attend to this after breakfast

Plus, with staff

- noticing how the CAs are working, e.g. correcting a lifting technique
- determining priorities for CAs: 'do this and then do that'
- hearing CA say she was taking breakfast to a resident in his room and asking her to take his tablets while she was going

Plus noting things for later

- remembering or noting what needs to be done later, e.g. drugs for Parkinson's disease must be given at 10 a.m.
- remembering what is happening for each resident during the day, e.g. asking CAs to put rollers in B's hair because relatives are visiting later

Plus anticipating or recognising critical situations

- anticipating or recognising situations that could be dangerous or detrimental; a resident getting up from the table with a knife; two residents are about to fight

Plus numerous interruptions

Questions, emergencies e.g. a resident has fallen; someone needs attention e.g. the technician arrives to collect the faulty wheelchair but the staff cannot find the footplates; a relative telephones; a staff member from another unit rings with a query on the Mental Health Act; the manager calls to collect staff returns.



This example shows the complex, multi-faceted, multi-level nature of RN work and how RNs can attend to a range of situations at one time. The observation skills of this particular RN were highly acute, for example noticing non-diabetic orange juice, the way N was chewing without her teeth or that residents looked cold or tired. In addition, the RN was able to connect a variety of elements such as her knowledge of a resident's health, the medicines prescribed, whether the dose was correct, how the resident was responding and whether additional medication was needed, e.g. for pain. There was an apparent geographical awareness, i.e. which residents were still in their bedrooms and asking a CA taking breakfast to a particular resident. The RN also prioritised her actions, e.g. noting things to do later, while responding immediately to potentially critical situations.

EXAMPLE OF ONE POTENTIALLY CRITICAL INCIDENT WHICH OCCURRED DURING THIS OBSERVATION AND THE RN'S REFLECTIONS ON THIS.

**Observation Notes:**

Sister in the middle of the lounge giving out drugs from the trolley while the CAs give breakfast to the residents. Observing what is happening in the lounge and visible sections of the surrounding corridor . lots of interactions and interruptions ... then she suddenly closes the trolley, walks over to the dining table and speaks to C [male resident] who has got up from the table and is walking towards another resident. *"Where's your frame C, let me find it"*.

Says to CA *"C wants to get away from these people"*. *"Come to the chair C and I'll get your toast. I want you to sit on that chair there"*. Helps C to sit in a chair and fetches toast and Zimmer frame.

**Interview Transcript:**

[What made you act in the way you did with C this morning ?]

*"My first reaction was that he was walking without his Zimmer frame and he had a knife in his hand so I knew I had to get over there, take the knife and give him his Zimmer. When I got there he said 'they're all mad over there. I don't want to sit with them'. You're using your observation skills to pick up what's happening and you know them as individuals"*.

Among all her other thoughts and activities, the RN noticed this potentially critical situation and acted immediately to prevent harm to the residents. Such situations were not unusual, particularly in the mental health units where antagonism, aggression and even fights between residents were frequently observed, but they do raise questions of what would have happened had the RN not intervened as she did.

### MULTI-LEVEL WORKING

As is illustrated in the above examples, the RNs worked at a range of levels within their role and this was particularly evident in the observations. At one time they could be managing the home and the total care environment, a section, unit or team within a home, working one-to-one with individual residents and identifying 'little things', such as that V, who has dementia, was not wearing her glasses.

### MULTIFACETED WORKING / MULTI-TASKING

It was obvious from all the data that good RNs can focus on, and accomplish, a number of things at one time. Most RNs observed were continuously monitoring and assessing whatever was going on or that needed frequent attention, they were being vigilant, anticipating what might happen and recognising changes, often subtle ones.

### WORKING TOWARDS GOALS WITH VARIOUS TIME FRAMES

RNs worked minute by minute for residents' wellbeing, comfort, dignity and personhood but were also working towards longer-term goals of care, maintenance of health, maintenance of independence and any improvements that might be possible.

### MULTIPLE RESPONSIBILITIES

The RN role comprises multiple responsibilities and, at any one time, the RN can have responsibility for:

- all residents,
- all staff in the home,
- visitors and relatives
- and also in professional relationships with colleagues such as GPs, consultant, social worker, district nurse.



**A BREADTH OF ROLE**

Many RNs undertake overall management of the home on a day-to-day basis, planning and taking responsibility for the culture and care regimes, supervising all the staff in the home (including laundry, kitchen, maintenance and other staff who do not give direct care); ordering supplies and equipment and marketing the home to the outside world. The breadth of the role is illustrated in the breadth of the outcomes of the work (See Section 5.5).

**RNs IN NURSING HOMES HAVE DIVERSE ROLES**

The RNs in different homes had different roles. This depended partly on the size of the home and the RN's position within it. Commonly, however, an RN could be responsible for a small group of residents on one day and a whole home the next. RNs were also diverse in their ways of working (discussed in Section 4.2.9 below).

**4.2.3: THEME 3: CONSTANT PRIORITISING AND BALANCING OF PRIORITIES**

There were particular issues that arose from working in a closed community, i.e. the same group of people being together for what could be years and seeing each other day after day. These are discussed in Chapters 5 and 6. Particular issues also arose from the fact that the working environment of staff was actually the residents' home and a homely, domestic atmosphere needed to be maintained. These factors meant that RNs were constantly balancing priorities. For example:

<b><u>PRIORITIES WHICH RNs HAVE TO BALANCE</u></b>	
The views, needs and priorities of residents, relatives, staff, management and everyone involved in the home	
The different needs of different residents and relatives	
The needs of the home as a whole	The needs of individual residents

The residents' need for dignity, adulthood and independence	The needs that arise from ill health and disability
Maintaining a homely domestic environment	Complex clinical need requiring clinical facilities and equipment
Freedom of choice, movement, activities	Safety regulations
What residents want	What RNs believe is in their 'best interests'
Maintaining an open culture. Work flexibility and responsiveness	Maintaining appropriate relationships, respect and discipline
Showing warmth and caring to residents	Giving the 'wrong messages'
What is targeted to be achieved and what is not, e.g. who will be offered more intensive rehabilitation input	

Many of the data demonstrated that the decisions made are not straightforward and often involve weighing a number of priorities, for example those of the resident, those of the relatives and those which the staff believe will offer the best outcomes for all concerned. These situations often involved considerable challenges and sometimes ethical decisions.

**EXAMPLES ILLUSTRATING THE PRIORITIES TO BE BALANCED**

**THE VIEWS, NEEDS OR PRIORITIES OF RESIDENTS, RELATIVES, STAFF, MANAGEMENT AND OTHERS**

*"These folks are here for life so my role is to try and give them a home and I want to give them as much freedom as possible but on the other hand I have to be organised with that freedom, e.g. if I say have breakfast when you fancy we would have 38 breakfast times. We have to have lunch at a certain time whether or not people are hungr. It's an organisational problem" (IV RN505).*



## THE NEEDS OF INDIVIDUAL RESIDENTS / THE NEEDS OF OTHER RESIDENTS AND THE HOME

*"Each resident is an individual. They have breakfast when they want but because we have a chef for lunch and supper there are set times. You can say we're having soup tonight but one doesn't want soup tonight. Trying to be flexible and trying to satisfy their requests can be difficult" (IV RN703)*

*"The doctor is looking at changing a resident's medication ... and that's purely for the safety of the other residents. I'd be quite happy to keep him but you've got to look at the safety of the others – we've got 49 in four corridors you've got to have your eyes everywhere. The girls are very good. They know the residents extremely well, except for a couple they know how to control the aggressiveness away from the other residents and in a way they're putting themselves in danger by protecting the residents" (IV RN512).*

## THE DIFFERENT NEEDS OF DIFFERENT RESIDENTS

*"Trying to meet a mixture of personal preferences can be difficult, such as one wanting to watch football on TV and another wants to watch the news. If residents are bored or frustrated they can become aggressive" (IV RN511).*

*"At night some people don't want to be intruded upon and others don't mind you popping in to keep an eye on them. Some patients get upset about being in the dark and others want it dark" (IV RN908 Night Duty)*

## RELATIVES' EXPECTATIONS

*"Sometimes relatives' expectations are too high and it's hard to say that because it is a lot of money to stay here. They expect us to be doing lots of outings and things" (IV RN700)*

*"We have one relative who's an ex nurse so she knows what to expect but she expects more than others can deliver. She tells the doctors and nurses what treatment her husband needs and I always try to sit and talk to her for five minutes when she comes in and try to reassure her - you can't say she's a bloody nuisance I'll stay over here 'til she goes - she would just ring you up and speak to somebody who doesn't know, so you might as well face it head on and get it over and done with". (IV RN703)*

## STRIKING BALANCES BETWEEN WHAT STAFF ASSESSED THAT RESIDENTS NEEDED AND WHAT RELATIVES WANTED

*"We promote continence by taking people to the toilet whereas one of our resident's wife doesn't want that, she wants a pad on. She feels that he's uncomfortable on the toilet. We've told her the options and what we would like to do but if she doesn't want it, who are we to insist. So we go along with what she wants if we can. If it was going to be detrimental to him in a big way then we would have to sit down, possibly with the GP" (IV RN700)*

*"Relatives are more demanding than the residents. A lot of residents can tell you what they want, when they want it, how they want it, then the relative says 'oh she doesn't like that'. I do what the resident wants and I don't care what the relatives say. I'm looking after the resident so you learn to cope with being in the middle and professional accountability helps that" (IV RN703)*

## DEALING WITH RELATIVES' FEELINGS

*"The guilt people feel can go on for a long time. A lot of tears and some avoid coming to visit for a little while and tears when they are going home and you see them walking out the door crying and we say 'please don't leave here feeling like that - speak to someone'. Listening to what they say.*

*They're happy they're here because they can leave them but they feel they should be doing more. Some still play a big part but it's about us being there for them too. A lot of stuff to do with their own processes" (IV RN700)*

*"There's guilt on both sides. The children feel guilty for putting the parent in here and the parent feels neglected because the kids don't care - I've looked after them all their lives and now I'm old they don't want to know. So they take it out on the nurse" (IV RN703)*

## RELATIVES BEING ABUSIVE

*"Every time her son came ... he started shouting at her and she'd start shouting at him 'leave me alone I don't want to go'. And we tried to talk to him but he said 'it doesn't matter because mum doesn't know any different'. And I thought, he doesn't know his mum at all and we know A more than he does. Because A was so distressed we got the social worker, who came to assess her and talked to the son. Eventually he agreed not to take her and*



*he came to tell us that he wasn't taking his mum any more. He said 'she's obviously happy here'. But it was taken for granted that, because she's here in what's called a dementia unit, her mind had gone" (Example 1.3c).*

*A married couple living together in a nursing home and "seemed loving ...we then noticed she was getting lots of bruises and couldn't think where they were coming from until we on several occasions found M slapping her when she was shouting ... we took M to mix with other residents when S looked stressed to give him a break from her. Neither liked this at all so we put a small table between their chairs" (Example 105.1)*

#### **HOMELY, DOMESTIC ATMOSPHERE / MEETING CLINICAL NEEDS**

Some of the residents' beds looked homely but were low for staff working. Beds of adequate and variable height had a clinical appearance. Some of the chairs residents had brought in were not helpful for their clinical conditions. Some chairs or carpet that had been purchased to protect from the effects of incontinence but were not homely. Hoists and trolleys in the corridors did not create a homely atmosphere.

#### **OPEN, FLEXIBLE, RESPONSIVE CULTURE / MAINTAINING DISCIPLINE**

Some RNs described how it could be challenging to maintain friendly working relationships among staff while maintaining discipline and respect for authority.

*"It's more challenging to be able to assert authority when you have this open culture. It's almost like we're friends but there's a line to be drawn. Carers can't be a friend and then accept that you are ultimately in charge. Everybody on first name terms has advantages to build up that good relationship with the team but then there can be the discipline factor. I don't want to be authoritative but it's creating a balance" (Matron/Manager Home 2)*

*"Trying to please everybody. You can't always. I find it hard with discipline. If they do anything to the patients that I don't agree with I say outright but if they're arguing with each other I don't like to get involved" (IV RN916)*

#### **FREEDOM AND CHOICE / SAFETY OR SAFETY REGULATIONS**

Staff wanted to encourage residents to be independent and to do whatever they wanted for themselves but this could put residents at risk, for example of falling.

*"and the fire regulations you've got to legally close the fire doors but we have patients that don't like the door shut. There's no way you can close patients in but you must point out that by leaving the door open you are causing risk not only to them but the patients on either side. You must tread carefully but it all comes back to choice. Some want to be locked in - perhaps having been frightened by wandering confused patients" (IV RN908 Night Duty)*

#### COMPENSATING FOR RESIDENT DISABILITY / DIGNITY, ADULTHOOD AND INDEPENDENCE

Some residents required clothes protection at mealtimes and the staff sought various means which would be effective but not look like a baby's bib.

#### SHOWING CARING TO RESIDENTS / GIVING THE WRONG MESSAGES

*"It can be a delicate balance - trying to show affection and being tactile, with not giving the wrong signals - particularly for people with impaired perceptions - they might think 'she's offering herself to me'." (IV RN512)*

#### RESIDENTS' WISHES / ACTING IN RESIDENTS' 'BEST INTERESTS'

*"It's a balance between what they want and what they need" (IV RN 901)*

*"Here it's encouraging self-management so, although you're empathetic with the client you are encouraging them to make the most of their own life too. We encourage them to mobilize. If they decide they don't want to walk and want to go out in a wheelchair there's always compromise - say 'walk part of the way' or 'just wash your hands and face'. It must be positive and gently encourage them. It keeps them as individuals rather than institutionalised. They know their rights and how much it costs and they feel they've come to be cosseted and to a certain extent they have but they still need to feel dignified and in control" (IV RN900).*

#### WHAT IS ACHIEVED / WHAT IS NOT ACHIEVED

Staff perceived that they had insufficient time to complete the work they wanted to achieve and this meant that they had to prioritise.

*"I have 30 minutes - do I walk with B, see how O is settling in, ring V's daughter, sort out the drug sheets or revise a care plan?" (Obs notes RN505)*



Such decisions can have far-reaching consequences, for example in targeting rehabilitation input. Most residents could benefit from rehabilitation input to improve functioning, or therapeutic input to enhance well-being and quality of life. RNs and physiotherapists had to make decisions such as to try to offer a little support to everyone or 'target' a few residents who were thought could particularly benefit.

#### 'TRYING TO PLEASE EVERYBODY'

'Trying to please' everybody was a common issue and particularly where residents were not verbally able to give consent to a situation.

*"Two residents struck up a relationship. It wasn't sexual may have developed, I don't know. They were calling each other husband and wife but on a couple of occasions the lady woke up with him next to her so there was an issue around that. Was she comfortable with it really or was it just in her confusion that she believed he was her husband? That all has to be weighed up. The nurse said I'd have to separate them. I said 'why?'. We asked the relatives. It's very much a balance of what everyone is wanting" (Example 700)*

#### **4.2.4: THEME 4: KNOWING THE PERSON / KNOWING THE RESIDENTS**

RNs DEMONSTRATED THEIR UNDERSTANDING OF THE RESIDENTS AS INDIVIDUALS, AS WELL AS THEIR COMMITMENT TO THEM. RNs:

- Had understanding of them as individuals (to varying extents between RNs)
- Had understanding of their health and clinical needs
- Were able to prioritise because know residents well
- Were able to recognise change because know residents well
- Advocated for residents, particularly with GPs, because they knew them
- Were able to work with the residents families, whom they also got to know well

RNs understood the residents' characteristics, personalities, usual ways of behaving, usual demeanor and mental state, choices and wishes, for example:

*"Knowing the resident to realise that there must a reason for her disorientation and 'wandering'" (Example 265).*

*Mr S "tends to be grumpy and demanding and complains a lot. I knew him well and, although he makes a fuss about small things, if something major happened he didn't even discuss it. He cancelled his newspaper I felt was a way of asking for attention but the CA didn't pick it up" (Example 264).  
"I knew F didn't want to go to hospital - she had previously expressed strongly she didn't and I believe she wanted to go on [living]" (Example 266).*

Usually RNs, particularly those working with people with dementia, understood the residents so well that they were able to 'guess' what might be their wishes.

*"I notice the difference - looking at her eyes, she gives you that knowing look when she's emotional and she's thinking of something. I can always tell - she's deep in her thoughts. So I will ask her 'what is it now' and she'll say 'I'm sad'. She wouldn't open the subject herself. I had to keep asking her, but eventually she'll just say 'yes that's it, that's what I'm thinking of'. It's mainly in her misty eyes, even if she's looking out of the window" (Example 1.3a).  
[how do you identify how O is feeling?] "it is difficult but it comes with knowing your client group and them as individual really well" (Obs notes RN501)*

Examples showed how RNs made a point of getting to know a resident better.

*"We compiled a biography by going through family photos with her" (Example 1.3a)*

#### **4.2.5: THEME 5: PERSISTENCE IN STRIVING TO GIVE GOOD CARE**

##### **PERSISTENCE IN STRIVING TO GIVE GOOD CARE, FOR EXAMPLE:**

- Being vigilant and alert for potential problems
- Looking beyond the obvious
- Identifying acute and potentially detrimental situations
- "While there's life there's hope": seeing the potential and remaining optimistic
- Not giving up, being persistent and patient
- Employing a range of strategies such as: advocacy, working with others using a range of 'persuasive' measures, challenging others when necessary
- Acting on best judgement



The RNs' determination to give good care manifested in a range of approaches and strategies. The examples and observations particularly illustrated that the RNs were vigilant, determined, persistent and assertive. RNs, for example:

- were vigilant for problems and alerted to these by 'something that did not make sense' within the overall scenario
- commonly refused to accept these potentially problem situations at face value and looked further for explanations and solutions
- were able to identify acute and potentially highly detrimental situations and take action in order to preserve life, health, functioning, wellbeing and quality of life
- tended to remain positive and to work towards the best possible outcomes, no matter how unachievable these might seem
- were persistent in order to achieve the desired outcomes for the residents
- employed a range of means to achieve the desired outcomes, including advocating for the resident, challenging other authorities and seeking allies.

In some of the data, and particularly the examples, the RN's determination to give the best care possible was, at least in part, motivated by their previous experiences of inadequate care for older people, or even abuse (described further in Section 4.2 Inputs to the work)

### BEING VIGILANT AND ALERT FOR POTENTIAL PROBLEMS

The RNs were vigilant in case problems arose. The data suggested that what alerted the RNs to problems was an element within an overall situation that did not make sense within their patterns of thinking and in the light of previous experiences, i.e. there was more to the situation than met the eye. Alerting factors could be subtle:

*"I personally learnt that I should try to look beyond how a person presents and appears and not assume because they are not expressing pain in a conventional way that they do not have pain"* (Example 8.2).

*"I felt there was something more serious with Mrs H than a urine infection; the way she described the pain and her general condition"* (Example 102.3).

*"Mrs F had a very sad look. She did not verbally communicate but her eyes revealed a lot of how she was feeling. Not only did she look sad but her eyes showed anger and bitterness. The way she looked made me reach out to her. I felt instantly that she was depressed"* (Example 10.1d).

*"The smell alerted me"* (Example 1.3b).

### 'LOOKING BEYOND THE OBVIOUS'

When problems or potential problems were identified, the RNs tended to refuse to accept things at face value. They would investigate further and seek solutions.

*"I had a feeling J was keeping a stiff upper lip and that inside she was desperate for help physically, mentally and spiritually. She had coped for a long time alone at home and I had the feeling that she was scared of what would happen if she let go" (Example 8.2).*

*"It seemed to me that she was not really suffering from dementia but depression" (Example 10.1c)*

*"if I had not looked further into the cause of Mrs B's distress it would have been assumed that she was constipated, causing her to become more ill, resulting in distress to her family, and possibly hospitalisation" (Example 4.1)*

*"seven years of working with the elderly have taught me that you need time to get to the bottom of most situations. The presenting needs/problems are very rarely what they seem" (Example 102.2).*

### IDENTIFYING ACUTE AND POTENTIALLY DETRIMENTAL SITUATIONS

The refusal to accept things at face value and their further investigations enabled the RNs to recognise acute situations, and particularly those which were potentially detrimental to the residents. In some instances, the recognition was enabled by the RN's clinical knowledge, for example:

*"although I hadn't seen an arterial embolus I have seen plenty of people with vascular/circulatory problems and knew that a blocked main vessel would account for the ischaemic colour of the limb and the acute pain. I knew it was a medical emergency and time was of the essence" (Example 262) .*

In other instances it was linked to clinical experience, for example:

*"I went to see her immediately and found her very breathless, poor colour and clammy and virtually semi-conscious. I immediately thought she was in heart failure ... I've seen cardiac failure many times" (Example 267).*

### SEEING THE POTENTIAL AND REMAINING OPTIMISTIC

RNs tended to see the potential for positive outcomes for the residents, to remain positive and to work towards the best possible outcomes, even if the likelihood of a positive outcome was apparently small.



*“The staff at the home all learned a good lesson on the importance of excellent total patient care right up to the end - not only because it is appropriate and what they deserve but while there is life there is hope”* (Example 263).

*“I could see the potential in Mrs MR and used my experience to involve all the staff in the care with a fantastic outcome. Hopefully it has given staff the insight to see beyond an elderly person coming into a nursing home to be looked after until the end of their days”* (Example 101.3).

*“remaining optimistic - probably not a skill but it does help”* (Example 263)

*“I and the staff were thrilled at the improvement in Mrs VG. To see someone who had been written off by others and could have been left to vegetate, become coherent, sociable and mobile were a reward for the hard work and care”* (Example 102.2)

#### ‘NOT GIVING UP’ - BEING PERSISTENT AND PATIENT

Persistence, perseverance and patience were obvious in many of the examples. Despite a range of challenges, the RNs persisted in order to achieve their goals for the residents. The persistence continued over a range of time frames, sometimes minute by minute, on other occasions over years.

*“E was so drugged she was almost semi-comatose most of the time but we didn’t give up on her. With the discontinuation of the morphine and a gradual increase in hydration and nutrition she slowly came back to life again”* (Example 263).

*“M was very deaf and just stared at the wall all day. For us to get to know them we have to know their backgrounds, so I did a profile. It was a very long process through writing. She’s able to read and I found some photographs in her suitcase so we could talk about the family. We waited nine months for an audiology appointment and are still waiting for a hearing aid a year later. She is so grateful. She says ‘you’re helping me’”. (Example 1.3a).*

#### EMPLOYING A RANGE OF APPROACHES, MEANS AND STRATEGIES

The persistence demonstrated a range of approaches, means and strategies in order to achieve the outcomes the RNs believed to be the most positive for the older person. These included advocating for the resident, challenging other authorities

and seeking allies among those who could potentially help. Often a range of approaches were adopted within one example, observation or interview.

*“I tried to motivate the duty doctor with some success ...”* (Example 266).

*“The GP reviewed her but was reluctant to challenge the diagnosis or change the treatment (particularly the morphine) as it was prescribed by a consultant geriatrician. I advised the next of kin to get a second opinion and helped him arrange it. The consultant came, agreed with my original diagnoses x 2 and organised a regime to phase out the morphine”* (Example 265).

*“Knowledge of the personalities involved and how to manipulate them to get the desired outcomes”* (Example 266).

## ADVOCACY

It was particularly evident from the significant examples and observations that the RNs worked as advocates to obtain the care they felt appropriate for their residents.

*“I felt I really had to be E’s advocate in that I was in the position where I could have a say as to whether she lived or died - sobering thought - which turned out to be the case”* (Example 263).

*“Advocacy – I really spoke out for the patient so that she got the treatment she needed where she wanted it”* (Example 266).

## CHALLENGING OTHERS INCLUDING OTHER PROFESSIONALS

If they felt it necessary, RNs challenged other professionals.

*“I contacted the duty Dr who informed me he would have to go to hospital as she did not do catheterisations. I fiercely opposed this as the patient was so frail to travel. I didn’t feel it should be necessary to put him through that ordeal”* (Example 261)

*“crucially the guts to challenge medical instructions”* (Example 266).

## ACTING ON BEST JUDGEMENT

Sometimes the RNs took a decision to work on best judgement, i.e. took professional responsibility for a decision based on experience and instinct of what seemed to be right, despite an element of risk in this approach.

[C and E both have advanced dementia]. *“C looked after E and called her ‘the baby’. E died. I said to C ‘can I have a word’. I told her the baby, E,*



*hadn't been feeling well – I said 'I'm sorry to tell you the baby passed away'. She looked at me and said 'do you know – I knew it' – just like that. So I said 'would you like to see her?' and she said 'yes'. We went into the bedroom and it was one of the most emotional things I had ever seen. She tucked her in and stroked her head and looked at me and said 'baby's gone to sleep now'. I didn't know what was going to happen but I thought that if I didn't do that C would have been looking for her for ages because she had spent so much time with her. But she didn't and afterwards obviously it registered and a couple of times later she just asked for her and we said it and she said 'oh yes' and that was it". (Example 700).*

#### **4.2.6: THEME 6: TAKING FOR GRANTED SOME ASPECTS OF THE WORK**

Much of the skill and knowledge that RNs used in their work was understated. The same held true for many of the processes of care. For example, despite the fact that the RNs and CAs were obviously continuing with fundamental care, otherwise the older people in their examples and interviews would not have maintained or improved their health and functioning, these aspects were very rarely mentioned. This would seem to suggest that the fundamental care is taken for granted. Two examples did describe such aspects but these were very much in the minority.

*"We gave her total nursing care for about a week, kept her skin intact and just managed to stop her from becoming dehydrated, although she had obvious swallowing difficulties". "Had we not given her excellent nursing care she would not have survived without complications" (Example 263)*

*"We gave her small amounts of fluid, pressure care, turns etc throughout the day" (Example 266)*

The diversity and complexity of the RN role was also under-recognised in the examples and interviews. In addition, the examples suggested that the work of the RNs could make massive differences in the lives of the residents but this, again, was under-emphasised in most of the data.

#### **4.2.7: THEME 7: HUMOUR IN THE WORK**

As with the CAs, humour was an aspect of the work but in a much less pronounced way than with the CAs.

*"Many of them have a humour through their experiences" (IV RN700)*

*"I love making them happy and smile. I'm a bit of a clown really - I like the entertainment and social side of things. We used to have a Wednesday club - I used to run riot and have them all singing on the karaoke machine and little ladies that sit in the corner day in day out don't do or say anything but they know every word of 'It's a long way to Tipperary'. They're happy singing it so as long as you differentiate between the lady that likes doing it and the lady that thinks its terrible then you're on a winner. You must be careful not to upset anyone - but I quite like making them smile and laugh". (IV RN705)*

#### **4.2.8: THEME 8: FAMILY CONCEPTS IN THE WORK**

The concept of family with also an aspect of the RNs' work but, again, in a less pronounced way than with the CAs.

*"We live in each other's pockets and I see the majority of full time staff more than I see my family, so it's family problems. There are 90 staff here so at least one will be going through a crisis at any one time" (IV RN900)*

*"You're not trying to replace their family by any means but when they know you they tell you things or when they get fed up or frightened or problems at home its quite nice they can tell you. It does feel like a family sometimes - that's probably because it's the way I want it to be. Its a nursing home but this is where they live. They haven't got somewhere to trundle off to at the end of the day. As long as you make sure you keep within their limits and you've got to work out which patients want that friendship". (IV RN908)*

*"You get to know them so well. It's more than just a nurse patient. Its totally different to working on the ward you become like family". (IV RN915)*

*"The staff become like my daughters - it's a family feeling" (IV RN916)*



#### 4.2.9: THEME 9: THE VARIATIONS AMONG RNs

It was clear throughout all datasets that the RNs' ways of working varied greatly.

##### **RNs VARIED IN TERMS OF THEIR:**

- Approach and ways of working
- Knowledge base
- Care focus and RN role
- Potential results for residents, and
- Description of model of working

##### **DIFFERENT RNs HAD DIFFERENT:**

- Styles of leadership
- Priorities in the work

If one RN was the sole deliverer of nursing care to a group of residents, it might be possible to conjecture a 'model of care' and predict likely outcomes. In reality, residents are usually cared for by a range of RNs and leadership thus becomes an issue. Depending on the approach, skills, knowledge and values of the RN leading the care, residents could experience considerable differences in the approach to the care delivered from one shift to another. There was variation among the RNs in terms of how they prioritised their responsibilities and how they described their styles of leadership but the variations were less obvious than they had been in the observations. All RNs talked about their commitment to residents and how important was the role of the RN in helping to keep them well and to have quality of life.

#### DIFFERENT STYLES OF LEADERSHIP

There was variation in how the RNs described their styles of leadership. Some stressed their firmness.

*"I'm firm but if you do your job well you won't have problems - I have eyes everywhere and I see everything. I expect for these people to be treated like bits of gold and if you do that you will get on famously" (IV RN501)*

*"I have very few rules but God help them if they don't keep them - never leave the unit without telling the nurse in charge, the lounge is never left unattended" (IV RN511)*

Some RNs led by example.

*"I'm one of those that I can show by example - I worked with them all on different occasions separately - washed the residents, got them up, showed them by my standards - that's the way I work" (RN512)*

Some emphasised the importance of working with staff and being seen to be willing to be giving 'hands-on' care as well as running the units.

*"I need to know what the carers are going through to be able to support them. I don't like to work with a 'them' and 'us' situation. You've got to be hands on. I don't think you could be a proper leader or be in charge of a unit without getting involved - it gets the whole thing together. You then have your finger on the button of everything at all those levels and you see the residents. It would really upset me if the residents didn't know who looked after them on a certain day - they know all the carers names but not the nurse" (IV RN504)*

#### DIFFERENT PRIORITIES IN THE WORK

RNs varied in the priorities in their work. Some believed that management and organisation was their priority, others made an effort to work in a 'hands-on' way with at least one resident per shift.

#### 4.2.10: CHALLENGES IN THE WORK

##### SUMMARY OF CHALLENGES IN THE WORK OF RNs

THE PRESSURE OF THE JOB

OBTAINING CARE FOR RESIDENTS

LIMITED SPECIALIST MEDICAL INPUT

OBTAINING MULTI-PROFESSIONAL INPUT AND SERVICES FROM OTHER PROFESSIONALS OUTSIDE THE HOME

INADEQUATE MEDICAL DOCUMENTATION

SUPERVISING A LARGELY UNTRAINED WORKFORCE



As highlighted in the examples, interviews and particularly the observations, RN work is challenging in a range of ways.

### THE PRESSURE OF THE JOB

RNs worked really hard, and particularly in Home 1. Carrying the total responsibility for the range of diverse residents with complex needs, as well as additional responsibilities for the home, was obviously demanding on the RNs.

*"The work is physically and mentally demanding. It takes years of training and experience" (IV RN511)*

For some, the pressures during their shift were enormous:

*"RN has worked non-stop since 7.30 a.m. She's still trying to get a cup of coffee and lunches are arriving" (Obs notes RN502).*

The fact that the RNs obviously cared for the residents added to the pressure.

### CHALLENGES IN OBTAINING CARE FOR RESIDENTS

There could be considerable challenges for RNs in achieving the care they wanted for their residents. In Home 3 the residents had individual GPs. In Home 2 all residents were registered with one GP who said, in interview, that his motivation for working in the home was the additional remuneration he received for this. His round of all the residents took about 30 minutes. The GP in Home 1 gave the impression that he had very limited time. He became impatient when he thought the team had not given all care, e.g. the RN had prescribed hourly fluids but there was nothing on the fluid chart, or when a blood pressure reading was not available. The blood pressure was very difficult to take because the resident had Parkinson's disease. Even the residents commented on his haste.

*"The doctor never has time for anything. His visits are so quick he's going out the door before he's come in" (IV Resident 506)*

GPs could be reluctant to see patients.

*Doctor is reluctant to see a patient but the RN keeps asking until he agrees (Obs notes RN505).*

The following example was not unusual. The RN on the dementia unit had noticed a resident was in pain and wanted to the doctor to order an X ray. He was reluctant.

*Dr came. Sister had called him because O [resident with dementia] had bruising on her leg and arm and pain in her hip and is on warfarin. Trying to help O to communicate to the Dr what she feels. Dr suggesting O had knocked herself. RN being assertive with doctor. "she hasn't had any trauma. Do you want to sign an X ray form, I've got it ready". Dr suggested a pathological fracture but sister didn't agree. She had examined O before the doctor came. O obviously in pain. Dr eventually agreed. (Obs notes RN501)*

#### LIMITED SPECIALIST MEDICAL INPUT

There had been no geriatrician visits to the homes within the memory of everyone asked. According to the RN in charge of one of the mental health units, the psychogeriatrician had visited only three times in the last 18 months, for example when the RN requested he see a resident whose medication seemed to be inadequate and she appeared to be very sensitive to medication. The RNs said it would be very helpful to have specialist medical input.

*"I've been asking for a psychogeriatrician because the company now has enough homes in the London area" (IV RN501).*

#### OBTAINING MULTI-PROFESSIONAL INPUT FROM OUTSIDE THE HOME

RNs had formed good working relationships with professionals within their area, for example the McMillan Cancer Relief Specialist Nurse came to Home 1 to give advice on a resident's pain relief. However RNs often faced challenges in obtaining services from outside the home.

*"Because A was so distressed we got hold of the social worker, who came to assess her and talked to the son. Her son eventually agreed not to take her [to another home] ..." (Example 1.3c).*

*"It's difficult getting medication prescribed at the right time ... we still have problems getting the communications from the GP surgery. I think it's because they're not just on tap and not as available as we would like them to be, so contact between the doctor and us is often a problem. Also between the chemist and us so you're in a triangle." (IV RN513)*



### LACK OF MEDICAL RECORDS

The observations suggested that nursing homes do not always have a resident's medical records as these are often kept within the GP practice office. This can mean that the RNs never see the resident's medical history and thus plan their care on the short notes they receive with the resident on transfer, for example, from a hospital, and the assessment they make themselves.

*Resident who has lived in the home for some years is believed to be terminally ill with a slow tumour but no notes have been received from the consultant and none made by the GP. Does she have a slow tumour or not?. This is not helpful. (Obs notes RN502)*

### RNs SUPERVISE A LARGELY UNTRAINED WORKFORCE

RNs were often the only trained or qualified person on a unit and working with a totally untrained, if experienced, workforce. Bearing in mind the vulnerability of the residents and the complexity of their needs, supervision of staff was very important.

*RN helping CAs to plan their work following a complaint from a resident (Obs notes RN505).*

*"The challenge is to pass that on to the carer ... not just because I want them to or I might come in but so they automatically do it" (IV RN505).*

*"you do have to tell the carers to quieten down a bit. It works both ways but the staff are not always as good as they should be, especially the girls, set them [the residents] off as a joke, then it starts to flare up a bit and you have to tell them to back off. But that's part of your supervision, you think it comes naturally from them, but it doesn't sink in. I don't know why" (IV RN513).*

*"You're meant to teach people but in a nursing home you've got to be more aware because there's only you to teach them and at times it is challenging because you really must keep on your toes (IV RN908 Night Duty).*

In addition, because of staffing shortages, homes could be staffed by workers who do not know the residents and are not familiar with the work. There were numerous examples of bank or agency staff being used, particularly in Home 1.

If staff are not supervised, the data showed that there were consequences, e.g.

*CA hiding in a corner to sleep (Obs notes RN505).*

Some consequences of this could be severe and residents come to harm, for example CAs not using a hoist correctly and the resident falling.

### FURTHER CHALLENGES IN RN WORK

Further challenges were identified in the datasets, and particularly the observations.

These include:

- Staffing difficulties, staff shortages and sickness absence, variable quality of staff, agency and bank staff
- The complexity and diversity of resident needs
- The complexity of care needed
- Working in a closed community.

Because they are relevant to the work of all staff within the homes, these challenges are discussed in Chapters 5 and 6.

### 4.2.11: PROCESSES WITHIN RN WORK: SUMMARY OF FINDINGS

<b><u>PROCESSES WITHIN RN WORK: SUMMARY OF THEMES FROM ALL DATASETS</u></b>
<b><u>RESPONSIBILITY AND ACCOUNTABILITY</u></b> <ul style="list-style-type: none"><li>• Responsibility for everything</li><li>• Vulnerable people with complex needs</li><li>• Total responsibility for resident care and safety</li><li>• Continuous monitoring and assessment</li><li>• Continuity of care</li></ul> <b><u>COMPLEXITY OF RN ROLE</u></b> <ul style="list-style-type: none"><li>• RNs in nursing homes had different roles in different homes</li><li>• All RNs had a breadth in their role</li><li>• Multiple responsibilities</li><li>• Working towards goals within various timeframes</li><li>• Multi-level working</li><li>• Multi-faceted working / multi-tasking (Examples are offered)</li></ul>



**CONSTANT PRIORITISING AND BALANCING OF PRIORITIES**

The views, needs and priorities of residents, relatives, staff, management and everyone involved in the home (as shown in the example in Section 4.2.3)

**KNOWING THE PERSON / KNOWING THE RESIDENTS**

Knowledge and understanding of the residents as individuals (as shown in the example in Section 4.2.4)

**PERSISTENCE IN STRIVING TO GIVE GOOD CARE**

- Being vigilant and alert for potential problems
- Looking beyond the obvious
- Identifying acute and potentially detrimental situations
- "While there's life there's hope": seeing the potential and remaining optimistic
- Not giving up, being persistent and patient
- Employing a range of strategies such as: advocacy, working with others using a range of 'persuasive' measures, challenging others when necessary
- Acting on best judgement

**THE UNDERSTATING AND 'TAKEN-FOR-GRANTED' NATURE OF SOME ASPECTS OF THE WORK**

**HUMOUR**

**FAMILY CONCEPTS**

**THE VARIATIONS AMONG RNs**

Working in individual ways

**CHALLENGES IN THE WORK**

- The pressure of the job
- Obtaining care for residents
- Limited specialist medical input
- Obtaining multi-professional input and services from other professionals outside the home
- Inadequate medical documentation
- Supervising a largely untrained workforce

Aspects of the work described above could also be challenging, e.g. total responsibility and accountability, the complexity of the RN role, the need to constantly balance priorities.

Additional challenges relevant to both RNs and CAs are discussed in Chapter 5.

## **SECTION 4.3: FINDINGS: THE ROLE AND CONTRIBUTION OF RNs**

This section draws together data in all datasets in order to establish the scope and focus of the work of the RNs in the study and, through this, to identify their distinct role and contribution.

The first sub-sections identify how the data from the different data collection methods identified the scope and focus of RN work, i.e.

- How the RNs described their role and contribution in their significant examples
- What the observations revealed about the scope and focus, role and contribution of RNs in the day-to-day realities of work in the care homes
- What the documentary data suggested about their role and contribution, i.e. the statements in their job descriptions summarizing the scope and focus of their jobs, and how the RNs recorded their day-to-day contributions to the work in the residents' daily progress reports
- How the RNs described their role and contribution in the interviews.

### **4.3.1: THE ROLE AND CONTRIBUTION OF RNs IN THEIR SIGNIFICANT EXAMPLES**

The diversity and complexity of the RN role was highlighted in the wide variety of situations they selected as 'significant' examples of their work. The examples also focused on a range of levels of functioning from 'hands-on', 'one-to-one' work with individual residents to running the whole home, including marketing its potential to the outside world. Short summaries of the topics of the RN's significant examples are listed in Appendix 4.1. These focused on:

- Leadership, management and total care of the whole home or unit over time and in day-to-day situations
- Managing the care of a resident or family over time
- Recognising 'acute' situations and taking action
- Death and palliative care



### LEADERSHIP, MANAGEMENT AND TOTAL CARE OF THE WHOLE HOME OR UNIT OVER TIME AND IN DAY-TO-DAY SITUATIONS

Nearly a third focused of the examples focused on how the RN's leadership and management of the 'total care' in the home had improved the health and wellbeing of residents. The RNs described how they had changed the environment, care regimes, care practices (for example in improving nutrition, continence, pressure area care) and how they led, managed, taught and supported the staff.

- About two thirds of these examples focused on change over time, resulting in improved health, functioning and quality of life of the residents.
- The other third of these examples dealt with day-to-day leadership, management and total care in the home, for example managing a community of residents with mental health needs, running a home with acute staff shortage, handling ethical issues which can arise.

### MANAGING THE CARE OF A RESIDENT OR FAMILY OVER TIME

Around one fifth of all the RN examples described how their intervention improved the health, well-being or functioning of one resident over the course of time.

Examples included helping a resident to rehabilitate from high dependency to going to live at home, gaining independence so that a family "had their mum back", healing what had been considered an intractable pressure ulcer, alleviating continence problems and working with a married couple with complex needs until their death.

### RECOGNISING 'ACUTE' SITUATIONS AND TAKING ACTION

About a third of the examples focused on how the RN recognised acute situations, potentially highly detrimental to residents. The examples highlighted how the RN took action to investigate, liaised with others and advocated for appropriate care. In some of these cases the resident would have died but for the intervention of the RN.

### DEATH AND PALLIATIVE CARE

The remaining 15% of the examples focused on death and palliative care. They described how the RN supported and comforted a resident and family, controlling pain and other symptoms and continued to work with the family after the death.

#### **4.3.2: THE ROLE AND CONTRIBUTION OF RNs IN THE OBSERVATIONS**

The observations offered rich data on the day-to-day realities of the RNs working in the home and how their roles operate in practice. They confirmed that the RN role is broad, complex, multi-level and multifaceted, as illustrated in the example in Section 4.2.2. The observations also confirmed that RNs face considerable challenges in their day-to-day work, not least of which is that the RN is ultimately responsible and accountable for whatever happens within a unit or a home. In the day-to-day realities this meant that, whatever the RNs were doing, they were frequently interrupted because other problems needed a decision or for the RN to deal with them. The immediate focus could thus shift from minute to minute. The observations also highlighted that RNs are very individual in the ways in which they work, their priorities in their work, their leadership styles. They are also diverse in what they bring to their work, including their knowledge, skills and experiences.

Although RNs stated that the residents were the focus and the priority in their work, the time they were able to spend with individual residents was very limited. For RNs with responsibility for one unit, a large proportion of their time was commonly spent in ways which afforded general supervision of the work on the unit, for example when doing medicine rounds, checking specifics (for example is X ready for her hospital appointment, has Y's swab been sent, is Z's urinary catheter draining properly) or completing paperwork. Generally, therefore, RNs were only able to spend time with individual residents only if specific clinical care was needed, such as a wound dressing, if a problem arose, if the RN wanted to check something particular or specifically allocated time to work with one person. The observations showed therefore that, even for RNs whose work was very resident focused, the responsibility and accountability they carried for the unit/home, coupled with their 'clinical' responsibilities (e.g. for care, medication, liaison with GPs) resulted in them having limited time to spend with individual residents and to build relationships with them. The relationships between RNs and residents were therefore generally not as close as those between CAs and residents. This was confirmed by the residents who often commented that, although they respected the professional role of RNs and wanted them to be available in the home in case they needed "medical things", they did not spend much time getting to know each other personally, as did the CAs.



### **4.3.3: THE ROLE AND CONTRIBUTION OF RNs IN THE DOCUMENTS**

#### **JOB DESCRIPTIONS**

The RNs' job descriptions are summarized in Appendix 4.4. The detail was distinct between the homes but the overall responsibilities focused on:

- Managing a unit or the whole home
- Managing service quality
- Leading and managing staff
- Leading staff development and training
- Creating and maintaining resident-focused care
- Leading, managing and supervising care
- Specific nursing responsibilities

Rehabilitative or therapeutic care were not mentioned.

#### **CARE PLANS AND PROGRESS SHEETS**

The quality of care planning and evaluation varied between RNs.

### **4.3.4: THE ROLE AND CONTRIBUTION OF RNs IN THE INTERVIEWS**

In the interviews the researcher was able to question in more detail the RNs motivations, priorities, visions and frustrations. The interviews also encompassed the RNs' explanations of particular occurrences during the observation sessions. These provided valuable reflections on aspects of their work which were not captured by the other data collection methods. Interviews emphasised that the focus of RNs' work was the residents, as individuals and as groups. The RNs described the primary focus of their work as helping to make life as good as it could be for residents, offering the best care and sorting out residents' problems where possible but they were also highly aware of their responsibilities in leadership, management and clinical care. The RNs described the focus of their work as:

- Making life as good as possible for the residents; quality of life; maintaining normal life; individual wellbeing and fulfilment
- Making arrangements for residents and helping to sort out their problems
- Quality of care

### MAKING LIFE AS GOOD AS POSSIBLE

The RNs aimed to maintain 'normal life' for the residents and relatives, individual fulfilment, helping residents to feel good about themselves, for the lives to be as comfortable as possible and for them to live to the maximum while in the home.

*"The best quality of life they are able to have. When they come in here it is the last part of their life and I want them to have a bit more than they would at home. So the last bit here is good quality" (IV RN998 EN).*

*"We try to do little things like making sure they go to the hairdresser or like with S, putting rollers in her hair because we know her granddaughters coming. Or just go and sit and read the newspaper with them or chatting what you did last weekend so you've got a conversation going. Or occasionally we might have a music session and they can sing. Or we take them out, it isn't as often in the Winter as the Summer, but they do go out. And we've got horses at the back and they love to go and see them – just things that you and I would do every day and we take for granted. And even just sitting holding someone's hand" (IV RN501 Dementia Unit).*

### MAKING ARRANGEMENTS, SORTING OUT RESIDENTS' PROBLEMS

*"... to give the residents the best possible care and sort out their problems where possible" (IV RN915)*

### QUALITY OF CARE

The RNs talked about trying to achieve the best care possible, so that residents would be happy. They aimed to prevent deterioration, encourage residents to do as much as they could and to make the environment homely.

*"My aim is to give our clients the best care that they can get and to make it as homely and to maintain as much individuality for them as possible within a caring environment, which they are unable to receive at home due to their disabilities" (IV RN513).*

*"I've been here 10 weeks. When I came the residents were well cared for but they didn't look cared for. A lot had sticky eyes, dirty nails, they were bathed regularly and their general skin was in good condition. So what I'm trying to achieve now is to get them looking as good as they are cared for" (IV RN512)*



#### **4.3.5: THE ROLE AND CONTRIBUTION OF RNs FROM THE FINDINGS IN ALL DATASETS**

The datasets demonstrate that the scope of the RN role is broad and the focus is variable. All datasets identified some key aspects of their role as leaders, managers and professional nurses. As mentioned in the Job Descriptions these were:

- Creating and maintaining the environment and the atmosphere
- Leading and managing the home including liaising with external professionals and visitors, managing the unit(s), managerial and administrative duties.
- Staffing responsibilities
- Assessing, planning, supervising, implementing and evaluating care. Observing residents, supervising staff and monitoring the units were particularly important.
- 'Clinical' work such as dressing and drugs

Particularly in the interviews, however, the RNs identified key aspects **additional to those on their job descriptions**. These were:

- Dealing with emergencies
- Risk, risk assessment and risk management
- Rehabilitation/Re-enablement
- Therapeutics, meaningful enjoyable activities, continuing previous life activities
- Health promotion
- One-to-one, hands-on/direct engagement and care. RNs felt strongly that 'hands on' care, such as washing, dressing, feeding, and direct engagement with resident's psychological and social needs were key aspects of their role.

#### **ASPECTS OF THE ROLE INCLUDED IN THE RN JOB DESCRIPTION**

##### **CREATING THE ENVIRONMENT AND THE ATMOSPHERE**

RNs identified creating and maintaining the environment and atmosphere as a priority in their work. This was particularly important in the mental health units.

*"I try to give a happy atmosphere, I have to keep reminding myself that this is their home, because I have a hospital background, so that previously I had patients in my care for say 2 weeks and if they hated it they knew they were*

*going home and they knew they would escape, but because these folks are here for their life" (IV RN505)*

*[creating the environment] "is very important. I do believe that if the atmosphere was different, you'd have a lot more incidents, aggressive outbursts and disorientation". [How do you create the environment?] "Sitting talking to them, taking time. We have some who we know are going to be anxious because of the short term memory loss. It's awareness. Knowing the client group, knowing the individuals and what works for them". (IV RN501).*

### ORGANISATIONAL AND CARE OVERVIEW / LEADERSHIP AND TEACHING

For some RNs the organisational aspects of their role were most important. They emphasised the importance of the RN having the overview and seeing all that was going on within their unit. This included assessing how all the residents on the unit were progressing and supervising and teaching the CAs.

*"It has to be an organisational role because if we're not organised then its absolute chaos" (IV RN505)*

*"It's 'seeing them all' while doing the drugs. Seeing that they take all their drugs, whether they have slept or not, are they OK? are they comfortable? are there any changes I need to know? So I generally have a look - notice whether they have changed - better or worse. From working like this I can make sure their needs are met to the best of our ability" (IV RN504)*

*"I like to know exactly what's going on with everybody – and I'm only working two days a week but I need an hour to go through their case notes, so I try to stop at 11 o'clock and go through their notes. See if their care plans are up to date, see if their families are visiting and try and have a chat. I'm looking to pick up the condition of the residents - it's ongoing". (IV RN505)*

### A SMOOTH RUNNING UNIT

*"efficient running of the unit - residents receiving the best care, CAs doing what they should, off duty is covered. Trying to achieve the best care we can give - comfortable, well cared for, well fed - happy" (IV RN901)*

*"... a smooth running unit. If it's smooth running you've then got a chance to have time with the residents because you've been organised enough to*



*complete your tasks so that you can pop somebody in a coat and whiz them 'round in the garden and pick daffodils" (IV RN505)*

*"The main thing in my mind is that I am accountable and most things stem from there really. Overseeing and checking that things are done. Regular recordings need to be done" (IV RN511).*

### ASSESSMENT AND CARE PLANNING

All RNs stressed the importance of assessment as a key aspect of their role and indeed this was fundamental in having the overview of the care of all residents.

*"I try to make sure that I usually do the breakfasts so at least one meal I can see who's eating what. I can also keep an eye on how the carers are feeding people and drinks. But you need the knowledge and skills of an RN to pick up why that might be – whether its mental state ..." (IV RN504)*

*"New resident - general assessment - ability, spending time with her, washing her, taking her to toilet, doing a transfer assessment. Her main needs are mobility but her biggest worry is getting to the toilet - it was the first thing she said this morning. That's what I'll work on. It would make her happier. We're determining the priorities for the care" (IV RN503).*

### DRUGS AND DRESSINGS

Dealing with medications and dressings were also identified by RNs as an important aspect of their role. Again, this included using the RN knowledge to teach CAs and residents and working alongside the CAs.

*"We work together, e.g. on wounds. We teach the CAs so they understand, rather than back away or misunderstand - they think they might catch something" (IV RN504)*

*"With the drugs, I explain to the residents so they understand and explain to carers so they can reassure residents. For example weeing a lot after diuretics, that with antibiotics residents can get confused or sleepy - I know why and can explain to carers. We have to do drugs ordering and a monthly drugs review with the pharmacy. There are medications to be given at specific times. And negotiating with the GP about what drugs people need - they don't always want to prescribe them" (IV RN503).*

## **ASPECTS NOT EMPHASISED ON JOB DESCRIPTIONS**

### **DEALING WITH EMERGENCIES**

Participants mentioned the RN's role in dealing with emergencies.

*"Y in the evening is in her wheelchair and may press her buzzer because she wants to go to bed, and she needs help in case she has a fall. Or one can go missing, like E, and we have to watch her ... dealing with an emergency or when someone is ill. You have to deal with that and keep everyone calm. People are sometimes taken ill. J was ill and we couldn't get his blood pressure. We eventually got it, and he had a chest infection. Two weeks ago J fell. He sometimes has fits and needs oxygen (IV RN507).*

### **RISK, RISK ASSESSMENT AND RISK MANAGEMENT**

This was particularly highlighted in Home 2. Aspects included:

- Manual handling risk assessments undertaken by nurse and physiotherapist
- Hip protectors are worn by some residents
- Pressure areas are intact despite the fact that the resident has been bedbound for six months
- RN identifying circumstances when someone is at risk of a fall
- Falls risk assessment undertaken
- Depression risk assessment tool in use
- Resident with severe Parkinson's disease is determined to try to be independent, e.g. in dusting her room or making a sandwich in the kitchen. Unable to stand, she has fallen several times. Risk assessment is undertaken, discussed with resident and daughter. The resident signed to take responsibility for the risk.
- A resident signing a form to say he agrees to take responsibility for risk if he falls. He says he has been advised to use the call bell

*"Mrs P is at risk but she's determined to do things for herself. She's fallen several times and cut herself with a knife. Her family are in agreement but we have to make sure we have assessed all the risk and everyone has agreed and signed" (IV RN703).*

*"as long as it's been documented and you have got their signature" (IV RN908 Night Duty)*



## REHABILITATION / RE-ENABLEMENT

Rehabilitation and re-enablement were mentioned.

*"Promoting rehabilitation and targeting those who can most benefit. Things like physio is a very important part for a lot of our residents – N [physio] has to concentrate on certain ones – the ones it will be of most benefit to but one particular resident came and I said to N he would be an ideal case for a rehab unit. He was just about weight bearing when he came here – we've got him walking – trying to assert himself. Another gentleman came in last week and I told N exactly the same things because rehab is my forte and love. If they will benefit from it, they will get the physio" (IV RN512).*

*"We have a man who'd been in hospital and they put him in a wheelchair because he was 96 but he can actually walk with a frame. He's visually impaired which doesn't help but we've now got him walking and the physio is out walking with him at the moment. Another man came in – a very big man – and I realised that although he was sitting in a wheelchair he could actually stand with a frame and he could support his own weight. We've now got him walking as well. So that's the sort of rehabilitation we're able to do. It may be very little but it's better than nothing. We may do hand exercises so they're able to feed themselves, or we may concentrate on walking" (IV RN513)*

## THERAPEUTICS

Therapeutics were also mentioned.

*"Therapeutics is very important. It's not just quantity of life – it's quality – it's how they view life" (IV RN512).*

*"Continuing their own interests - continuing their previous life can be good. If we can get a group interested in similar things - so they're not only socialising but are continuing with a hobby they've had in the past. We had a gentleman who'd had a stroke and he enjoyed painting. Although not a budding artist, he enjoyed it and spent hours doing it. We used to get books for him. He used to read about the artists and try and do their pictures. All our medicine pots went for paint. It was challenging but it worked out very well for him. He developed quite an interest in gardening when he started drawing flowers and we had a bird table put outside the window and he used to feed the birds from his room" (IV RN513).*

### HEALTH PROMOTION

Health promotion was identified as an aspect of the RN role.

*"I check their weights every month. If they've lost weight, if they're overweight" (IV RN701).*

Many of the health promotion elements of care were intrinsic in the care regimes. In Home 2 handovers the RN said that if residents could not eat prunes they could be offered prune juice to help keep their bowels working. In Home 1 the manager made a point of ensuring that residents walked as much as possible and that there was always a drink within reach so that they would not become dehydrated.

### ONE-TO-ONE CARE

Although it did not feature prominently on the job descriptions, all RNs mentioned the importance of one-to-one care with residents in order to assess how they were progressing.

*"I try to do the hands-on care, even if only one resident a day" (IV RN504).*

#### 4.3.6: THE OVERALL SCOPE OF THE RN ROLE

The overall scope of the RN role was large. All RNs worked within an overall scope, but the proportion of time spent working on each specific focus depended on the level at which the RN was working on that particular shift and the other RNs available in the team. It also depended to an extent on the size of the home, i.e. in a small home there may be only one RN on duty and this person will then cover the full scope of the work for that shift. RNs at some time carried ultimate responsibility for the residents, the staff the home and everything that went on within it.

*"I'm responsible for the whole range of different things - the building, the staffing, the cleanliness - it's me that's responsible. From the tile off the roof to the washing machine breaking down. I find this very difficult. I'm also doing the administration, the advertising etc. If relatives want to see me that's a priority and sometimes that gets difficult because you're always available" (IV RN700).*

The results also confirmed that there are dimensions in the nursing home RNs role which are distinct from, and additional to, those undertaken by RNs in other settings, particularly NHS acute hospitals.



### **SUMMARY: DISTINCT DIMENSIONS OF THE RN ROLE IN NURSING HOMES**

Nursing homes are nurse-led units. RNs have additional, and often total, responsibilities including for:

- the buildings and grounds and everything that goes on within these
- registration and regulatory requirements including unannounced inspection visits
- residents who leave the building or go missing
- actions in case of fire, including evacuating residents and staff
- any incident that occurs, e.g. someone is taken ill or falls
- the home as the residents' home as well as a workplace
- all equipment, assessment and suitability, ordering, adaptation or maintenance

There is limited multi-professional team support available. RNs are the lead, and usually the sole, clinicians. As such they take the lead in:

- bringing in other professionals
- suggesting care and treatment

Obtaining care and treatment for residents can be challenging for RNs.

Responsibilities extended beyond the home in terms of:

- 'business pressures', promoting and even marketing the home
- monitoring residents when they were outside the home, e.g. in hospital
- monitoring how relatives were coping and whether they needed any help

RNs in nursing homes can be professionally isolated.

### **NURSING HOMES AS NURSE-LED UNITS**

RNs have overall responsibility and accountability for everything that occurs within the homes, and how the home interacts with the outside world. The RN on duty could be responsible for a group of residents, one unit or the whole home. All datasets, and particularly the observations, clearly highlighted the responsibility and accountability of the RNs. All RNs were accountable for the safety, care, health and wellbeing of residents during a shift on a unit.

*"Even though we're just working on one unit we're responsible for everything in the home and all the other units. If accidents happen we have to go and sort it out. We're also responsible for the staffing levels throughout the home*

*so I now have to find staff for someone else on another unit, plus the fact that often the people on the EMI unit are only general nurses." (IV RN513)*

RNs are the lead clinicians. Unless working with another RN, RNs in the study made all clinical decisions, for example when to begin running sub-cutaneous fluids.

### RNs TAKE THE LEAD IN BRINGING IN OTHER PROFESSIONALS

The RNs were aware that they were the professional leaders in the nursing homes, and usually the only professional person around. Medical support was not readily available in the homes and RNs had to decide when to call them in.

*"In hospital it's yes doctor no doctor and everybody has to be ready for the doctor. But here it's different. We call the doctor and we have to know why - it is important - having a good clinical knowledge specifically with older people - as simple as a urine infection or constipation" (IV RN700).*

*"You're making a judgement as to whether that person needs 999 or whether they need the doctor to call that day or whether they can wait until he does the regular round. You're making that decision on the condition as it happens and that's about my expertise as a nurse and a leader. (IV RN701)*

*"In hospital the doctors are on site ordering the medication and treatment and you're carrying out his directive. **This** role is very much more geared towards the trained nurse observing the resident and taking different actions - ringing the doctor when needed. There's more responsibility in a different way and observation in a different way. (IV RN702).*

### RNs TAKE THE LEAD IN SUGGESTING CARE AND TREATMENT

From the observations, GPs made visits to the units where the patients for whom they have responsibility live. In Home 3 the residents had individual GPs and they only visited when the RNs requested this. In Homes 1 and 2 the GPs' visits were on set days in the week and the GP responded to the RN on duty's priorities in terms of:

- which patients he saw
- how the RN presented the problem
- what the RN recommended (investigations, actions on the results of investigations, medicines, other treatments e.g. dressings).



*Reporting to the D. Suggesting that cefprozil be prescribed for longer than one week for a resident who had the rash all over her body. Asking that B have an X ray for her shoulder. Asking Drr to check the new resident who seemed to be on lots of drugs. Making suggestions on these "shall we make this p.r.n?". The Dr wrote the drugs. Explained to the Dr that there's new research about two drugs being prescribed together ... (Obs notes RN504).*

In addition, because the RNs know the residents well, the GPs usually ask their views on the treatment to be offered.

*"I am asked my opinion - the GP will say "you tell me what you think" (IV RN501).*

### CHALLENGES IN OBTAINING CARE FOR RESIDENTS

There could be considerable challenges for RNs in gaining the care they wanted for their residents. RNs consequently often acted as advocates for the residents and employed a range of strategies in order to achieve the care they needed. Specialist medical input was not easily obtainable for the homes and the RNs reported that this resulted in residents being deprived of such expertise. The isolation and added responsibility experienced by RNs in the nursing homes was compounded by medical notes being kept in GP surgeries rather than in the homes.

### PROFESSIONAL ISOLATION

The data highlighted the professional isolation that RNs working in nursing homes can experience. There were few other professionals readily available for advice, support or help. If an incident occurred on a unit or home it was the RNs that held the responsibility for taking appropriate action. They were then professionally accountable for their decisions.

*"In a nursing home you don't have the backup. At night especially when there's only two members of trained staff. In hospital if you're a ward sister you can bleep your nursing sister. But nurses who've never worked in nursing homes think this is a dead end job - that you do this because you can't cope with hospital and you've got no brains. But we have to cope with a lot more than a nurse in a hospital because there just isn't anyone else to call on. The problems tend to be minor accidents - people falling out of bed, tripping up, fall against furniture, the wall etc. (IV RN 908, Night Duty)*

RNs explained that they felt particularly professionally isolated working in a small nursing home. In the larger homes they appreciated the support of the RNs on other units, particularly in areas where they felt they did not have expertise, for example the RNs on the mental health unit appreciated the advice of the RNs on the 'physically frail' units on such aspects as pressure sore prevention. The general RNs appreciated the advice of the RMNs on aspects of law regarding people with mental health needs.

*"I enjoy support very much – I did work for a time in a smaller nursing home and support wasn't there ... I was far more confident when I was a ward sister 10 years ago because you're in that environment with all these people around ... So I'm not as confident as I was but I need the support. So in that sense, in a smaller home without the support that wouldn't do" (IV RN 505).*

#### **4.3.7: SUMMARISING THE ROLE AND CONTRIBUTION OF RNs FROM THE FINDINGS IN ALL DATASETS**

A summary of the overall findings, and those from distinct datasets, is given in the following table.

<b><u>THE ROLE AND CONTRIBUTION OF RNs: SUMMARY OF FINDINGS OBTAINED THROUGH DIFFERENT DATA COLLECTION METHODS</u></b>	
<b>Significant Examples:</b>	<p>The RNs' examples of their work focused on:</p> <ul style="list-style-type: none"> <li>• Leadership, management and total care of the whole home or unit over time and in day-to-day situations</li> <li>• Managing the care of a resident or family over time</li> <li>• Recognising 'acute' situations and taking action</li> <li>• Death and palliative care</li> </ul>
<b>Observations:</b>	<p>In the practical day-to-day reality, work was prioritised by:</p> <ul style="list-style-type: none"> <li>• their responsibility for everything that took place within a home or care unit(s)</li> <li>• their responsibility for monitoring everything that was going on, particularly the residents and how the staff were working</li> </ul>



Section 4.3: Findings: The role and contribution of RNs

	<ul style="list-style-type: none"> <li>• their responsibility for prioritising what needed to be done</li> <li>• being alert to changing priorities and making changes when deemed necessary (e.g. a resident's health, wellbeing or safety; staff changes or actions; an emergency)</li> <li>• dealing with interruptions</li> </ul> <p>Most time was spent in:</p> <ul style="list-style-type: none"> <li>• organising or supervising a home or a unit</li> <li>• specific 'nursing tasks' such as medicine rounds, dressings and 'paperwork'</li> <li>• responding to queries or problems</li> </ul> <p>Relationships with residents were developed over time and either 'from a distance' or through the RN making a point of spending time with a resident.</p>
<p><b>Documentary Data:</b></p>	<p><u>Job descriptions</u> RN job descriptions were very detailed, suggesting an enormous scope for the role, including:</p> <ul style="list-style-type: none"> <li>• Managing the unit or whole home</li> <li>• Managing for a quality service</li> <li>• Leading and managing staff</li> <li>• Leading and managing staff development and training</li> <li>• Creating and maintaining resident-focused care</li> <li>• Leading, managing and supervising care</li> <li>• Specific nursing duties including complying with professional Code of Conduct, Health and Safety, handling of medicines, use of equipment and developing own professional and clinical skills.</li> </ul> <p><u>Care plans and progress reporting</u> The scope and focus of RN care plan documenting varied between the three homes and, within the homes, between individual RNs.</p>
<p><b>Interviews:</b></p>	<p>In the interviews the residents wanted good, caring, knowledgeable and professional RNs available to deal with health concerns, emergencies, call the doctor, sort out complex care issues, 'keep an eye on things', keep residents well, look after residents when they are ill, administer medicines, undertake nursing duties and 'anything medical', a good professional RN 'running things'.</p> <p>In the interviews the relatives wanted the residents to be valued by staff and treated positively, with caring compassion understanding and support, like human beings. They wanted good RN to take responsibility for everything, good leadership, a well-run home, appropriate staff, high quality</p>

	<p>care, reassurance and peace of mind knowing there was an RN available when residents were ill, to call the doctor, and advocate support when necessary.</p> <p>In the interviews, the RNs identified the focus of their role as:</p> <ul style="list-style-type: none"> <li>• Making life as good as possible for the residents; quality of life; maintaining normal life; individual well-being and fulfilment</li> <li>• Making arrangements for residents and helping to sort out their problems</li> <li>• Quality of care</li> </ul> <p>Other key elements were (as mentioned in the Job Descriptions):</p> <p><u>Managing</u></p> <ul style="list-style-type: none"> <li>• Creating and maintaining the environment and the atmosphere (seen as particularly important in mental health units)</li> <li>• Leading and managing the home including liaising with external professionals and visitors, managing the unit(s), managerial and administrative duties - what was described as "having the overview and seeing it all" and "a smooth running unit".</li> <li>• Staffing responsibilities</li> </ul> <p><u>Working as professional nurses</u></p> <ul style="list-style-type: none"> <li>• Assessing, planning, supervising, implementing and evaluating care. Assessment, observing residents, supervising staff and monitoring the unit were particularly important.</li> <li>• 'Clinical' work such as dressing and drugs</li> </ul> <p>Other aspects felt to be important by RNs but not emphasized in the Job Descriptions were:</p> <ul style="list-style-type: none"> <li>• Dealing with emergencies</li> <li>• Risk assessment and risk management</li> <li>• Rehabilitation/re-enablement</li> <li>• Therapeutics</li> <li>• Health promotion</li> <li>• One-to-one, hands-on/direct care and direct engagement with resident's psychological, social and mental health needs.</li> </ul>
<p><b>OVERALL:</b></p>	<p>The scope of the RN in nursing homes is broad and the responsibilities diverse and wide-ranging.</p> <p>The role includes elements distinct from, and additional to, the role of acute hospital RNs.</p>



	<p>The focus of the role could be on the whole home or beyond the home, or on individual residents' needs. Job descriptions confirmed this.</p> <p>RNs saw the main focus of the work as the residents but understood that they also held responsibility for leadership and management in the unit or home.</p> <p>In the practical day-to-day realities their work was prioritised by leadership and management these responsibilities, clinical tasks and administration, leaving little time for building relationships with residents or 'hands-on' care.</p>
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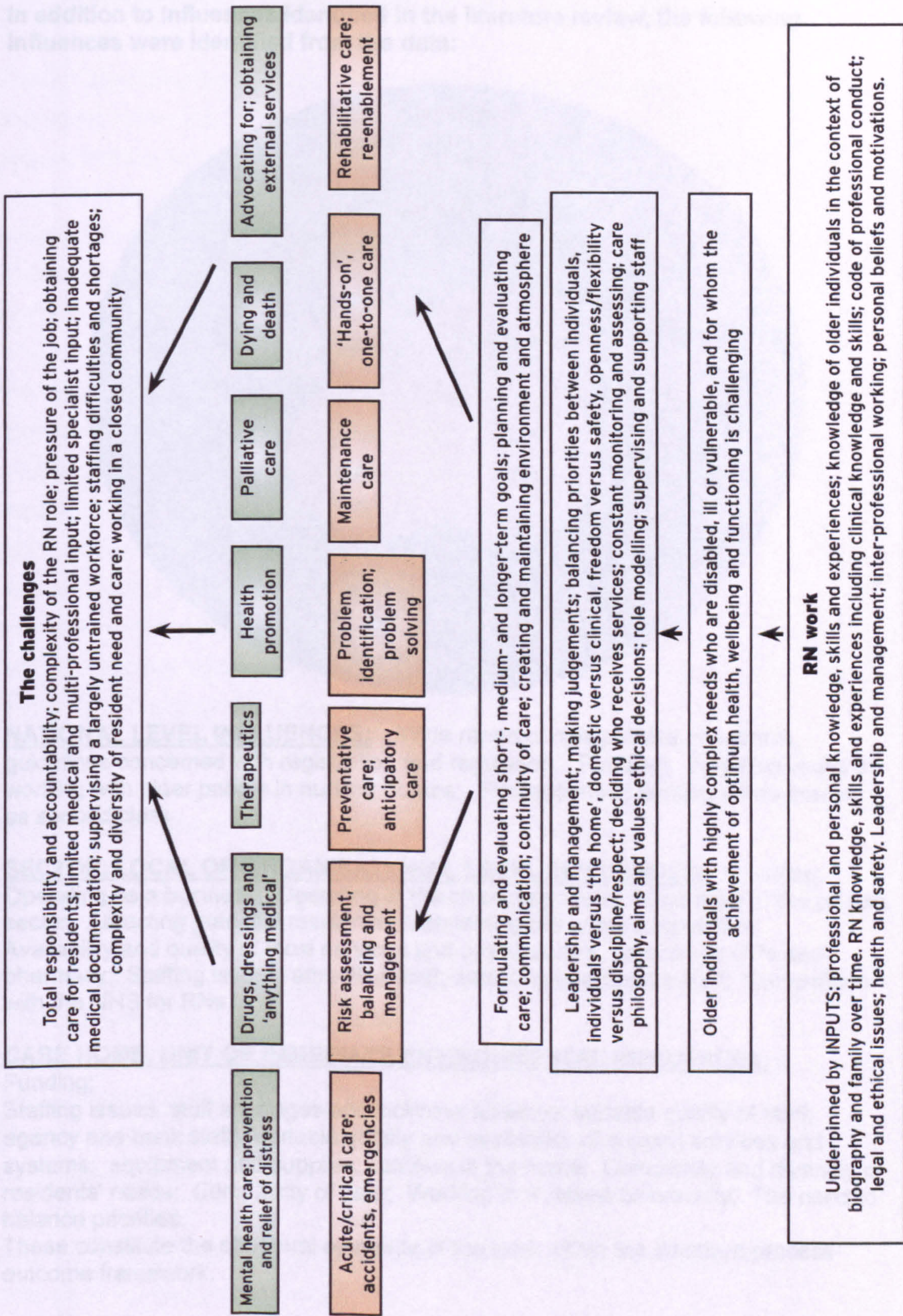
#### **4.3.8: A MODEL OF THE RN ROLE AND CONTRIBUTION**

The data overall suggested a new Model of RN work, which is shown as Figure 4.1. It illustrates that RN work is underpinned by the inputs they identified (Section 4.1) and that they manage the care for older individuals with complex needs. The boxes in the centre show the range of dimensions of the RN role as identified through all datasets. The model shows that ultimate aim of RN work as this was described in the overall data. It acknowledges that, in order to achieve their aims, RNs work through a range of challenges, which were particularly highlighted in the observations. The RNs who have seen the model confirm that it accurately represents their work. Contextual influences on RN work are shown in Figure 4.2.



# Model of RN work identified in the research

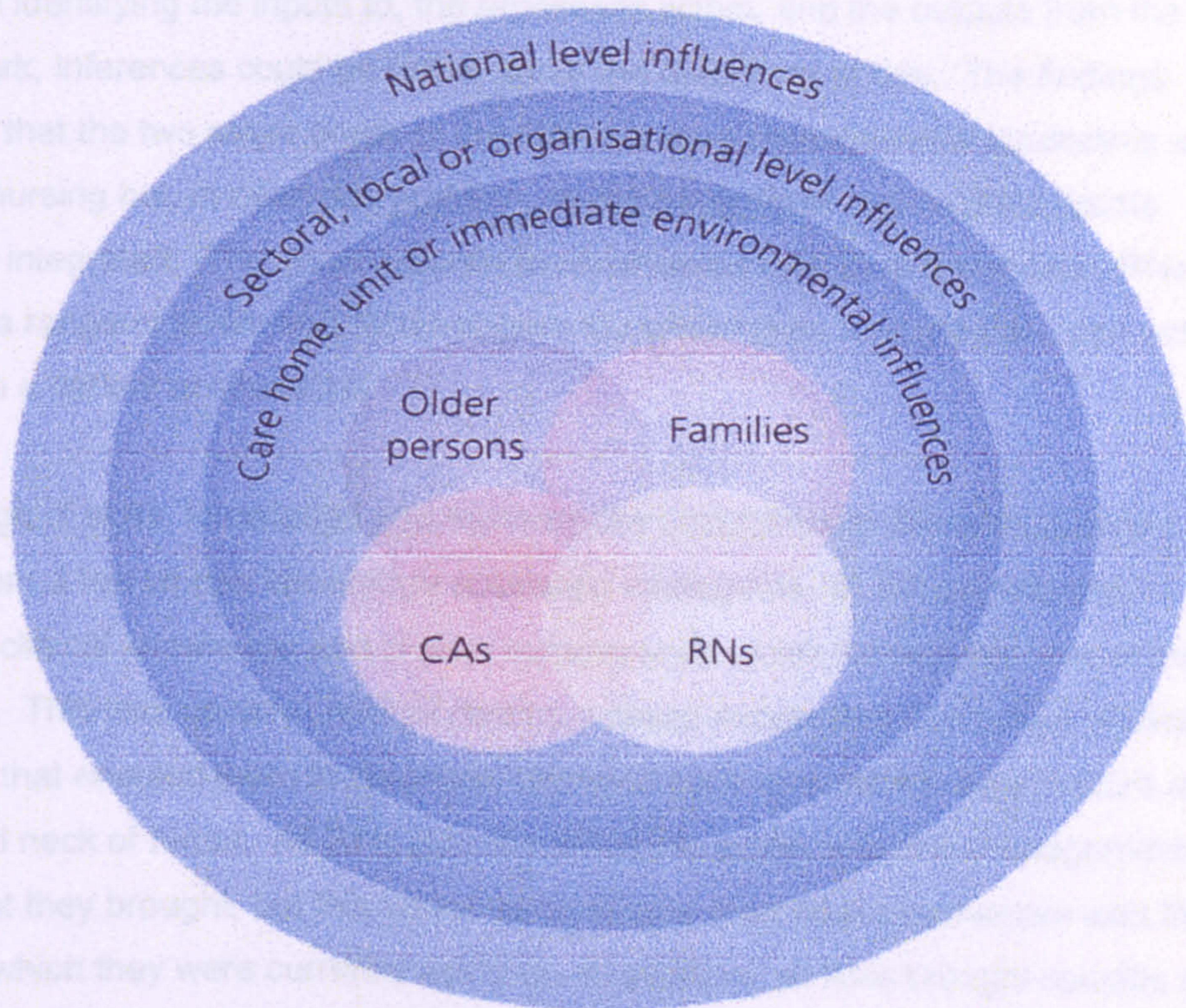
**Aim of the work: To make life as good as possible for residents; quality of life; maintaining normal life; individual health and wellbeing, functioning and fulfilment**





**FIGURE 4.2: CONTEXTUAL INFLUENCES ON THE WORK OF RNs WITH OLDER PEOPLE IN NURSING HOMES**

In addition to influences identified in the literature review, the following influences were identified from the data:



**NATIONAL LEVEL INFLUENCES:** Wide range of new policies, standards, guidelines concerned with registration and regulation; Funding; Negative views of working with older people in nursing homes; Perceptions of nursing home nursing as second class

**SECTOR, LOCAL OR ORGANISATIONAL LEVEL INFLUENCES:** Funding; Operating as a business; Operating in the charitable sector / Operating in the private sector; Attracting potential residents; Maintaining the home's reputation; Availability and quality of local services and professionals, particularly GPs and pharmacy; Staffing issues: attracting staff; attracting appropriate staff; Competition with the NHS for RNs.

**CARE HOME, UNIT OR IMMEDIATE ENVIRONMENTAL INFLUENCES:**  
Funding;  
Staffing issues: staff shortages and sickness absence; variable quality of staff; agency and bank staff; Variable quality and availability of support services and systems; equipment and supplies; facilities in the home; Complexity and diversity of residents' needs; Complexity of care; Working in a closed community; The need to balance priorities.

These constitute the structural elements of the work within the structure-process-outcome framework.



#### **4.3.9: IMPLICATIONS FOR OUTCOMES OF THE WORK OF RNs**

Through identifying the inputs to, the processes within, and the outputs from the RNs' work, inferences could be made about the outcomes of this. The findings suggest that the two major areas of the RN role were management/ leadership and clinical nursing but, in everyday practice, multiple elements and multiple facets become integrated. The observations clearly showed that, at any one time, RNs can work at a range of levels and, while apparently undertaken a single task, can actually attend to a variety of situations.

The range of skills, knowledge and experiences underpinning RN work is broad. Apart from a few whose knowledge appeared inadequate, all RN participants brought clinical knowledge and clinical nursing skills which formed the core of their practice. This was usually underpinned by a broad experience in a range of clinical settings that enabled them to diagnose changes such as a stroke, heart failure or fractured neck of femur. All RNs also identified the leadership and management skills that they brought, but this varied according to their past experiences and the level at which they were currently working. In addition, all RNs brought specific skills and interests that they had developed, for example in wound care, continence or reminiscence, and could act as a resource for other nurses.

Although RNs appeared to understate their skills and take them for granted, their influence in terms of creating and maintaining the environment and atmosphere in the home was also clear from a range of data sources.

The knowledge and skills of individual RNs, including advocating for residents and obtaining services from outside the home, made a great deal of difference to resident outcomes. Also making a considerable difference in acute situations was the ability of RNs to identify a problem about to happen, even when they could not see the circumstances, to anticipate what would result, and to take action to prevent a crisis. RNs were also able to empathise with residents to such an extent that they could recognise distress as soon as it arose, understand the possible causes of the distress and take effective action to relieve it. Such situations were particularly apparent in the mental health units.



Another interesting finding, highlighted through different data sources and methods of data collection, was that many RNs brought to their work elements that were not mentioned in their job descriptions and thus presumably not 'officially' recognised as an aspect of their role. These included rehabilitation, health promotion and therapeutics which, when implemented into the care, could potentially make a vast difference to resident outcomes.

Although in reality the RNs' work is focused on management and clinical nursing activities, RNs saw the aim of their work as making life as good as possible for the residents, achieving optimum quality of life, maintaining their normal lives and their individual wellbeing and fulfillment. The commitment of RNs to the residents showed in the determination with which they went about their work and the thoroughness with which this was carried out.

The RN role is clearly complex and there are multiple challenges but apparent throughout all the datasets was that the way in which RNs function, both in their clinical care and in their leadership management and supervision, is crucial for the care that residents receive and the outcomes of this. The data highlight how RNs have 'responsibility and accountability for everything' that happens in the home and for the health and wellbeing of everyone within it. RN actions could be life-saving or life-changing for residents and vivid examples of such situations are encompassed within the data. Ultimately it seems clear that the work of RNs has a major impact on outcomes for older people in nursing homes in all time-frames but particularly in acute or crisis situations and in terms of their long-term health, wellbeing, functioning and quality of life.

Page  
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# **CHAPTER 5: FINDINGS: THE OUTCOMES** **AND POTENTIAL OUTCOMES OF THE** **WORK OF REGISTERED NURSES** **AND CARE ASSISTANTS**

This chapter reports on the findings of the research in terms of the outcomes and potential outcomes of the work of Care Assistants and Registered Nurses with older people in nursing homes.

Section 5.1 explains how the outcomes in the work were identified and highlights some of the issues and challenges raised by the research.

Section 5.2 explains how, from the CA and RN data in Phase 1, a framework emerged for the outcomes of their work, which was developed through Phase 2.

Section 5.3 details the outcomes of CA work.

Section 5.4 details the outcomes of RN work.

Section 5.5 reports on the range of participants' views on the influence of the 24 hour RN presence on outcomes.

Section 5.6 identifies a variety of issues influencing care homes, including perceptions on the value and skill of the work.

## **SECTION 5.1: IDENTIFYING THE OUTCOMES OF THE WORK**

This research sought to identify the outcomes of the work of Care Assistants and Registered Nurses through a range of approaches. The inputs to and processes within the work were identified in Chapters 3 and 4. As shown in the Structure-Process-Outcomes framework (Figure 2.2, page 92) used as a heuristic device in data collection and analysis, the processes of CA and RN work encompass the outputs from this work. As Donabedian (1988, 1989, 1992) argued, the outcomes of care cannot be predicted by looking at processes or even outputs, but inferences can be made. Further, by studying processes and outputs of care the effects of these on outcomes become more visible and based on evidence rather than inference.

Additional more specific means through which the outcomes and potential outcomes of RN and CA work were identified in this study were:

- The Phase 1 significant examples in which the CAs and RNs stated what they believed to be the outcomes of their work.
- The Phase 2 interviews in which the CAs and RNs working in the three participating fieldwork sites also stated what they believed to be the outcomes of their work.
- The Phase 2 observations which were able to confirm many, but not all, of the claims for the outcomes of the work.
- The Phase 2 interviews with residents, relatives and other staff which were able to capture their views on the outcomes of the work of CAs and RNs and also their priorities, i.e. the outcomes they wanted from this work.

Encompassing this range of perspectives from different data sources and through different data collection methods was important in identifying the outcomes of the work. Most of the outcomes that the CAs claimed for their work in their examples and interviews could be confirmed through the observations. Most of these were then subsequently confirmed by the residents and relatives. Occasionally



confirmation of the CAs' claims was achievable through an additional source, such as the Home Manager. For example, the Manager of one of the homes submitting significant examples in Phase 1 confirmed that the outcomes for individual residents claimed by the CAs were achieved and that these outcomes were a direct consequence of the care they had personally given. (See the examples in Section 5.4.2). Most of the claims the CAs made for their work could therefore be confirmed through four methods. For example, the CAs in their examples and interviews said that a major outcome of their work was that residents were:

- kept as physically comfortable as possible
  - treated like a person, felt cared about and supported
  - helped to do what they enjoyed, such as reading or listening to the radio
- and that their immediate environments, particularly bedrooms, were kept tidy with their personal items within reach.

All of these aspects were observed in all the homes and the residents and relatives identified that these were outcomes of CA work.

Outcomes from RN work were more challenging to confirm. This was partly because, as described in the Chapter 4 findings, their roles are broad and complex. As can be seen in the Section 4.3 examples, outcomes from one action could be multiple and could impact in various time frames. This is discussed further in Section 5.4.

Particular difficulties arose in confirming outcomes which were achieved over the course of time. Some ultimate outcomes can be identified. An outcome commonly described in both RN and CA examples was "a peaceful attended death" when a resident died peacefully and pain-free surrounded by loved-ones. Such situations could be confirmed through being observed in all the homes. An alternative ultimate outcome described in their examples by both an RN and CA in one home was when a resident who had been "written off" by her doctors had come into a home supposedly for the rest of her life but after nine months was able to go back to her own home to live. While such situations were not common, they were confirmed by different staff in different homes and could thus be confirmed as an outcome of the work.

## Section 5.1: Identifying the outcomes of the work

The most challenging outcomes to confirm were those where staff input had prevented something from happening, such as preventing deterioration in resident health. This was particularly the case with the outcomes of RN work. For example RNs commonly said they prevented deterioration in residents' health by ensuring adequate nutrition, fluids, effective bladder and bowel elimination, maximum movement around the home and by optimizing and monitoring medications. Although the RNs were observed taking the actions which would result in such outcomes, and the residents confirmed that the RNs helped them in these ways, the consequences had the RNs not taken such actions were not observed.

The issues specifically relevant to CA and RN outcomes are discussed in Sections 5.3 and 5.4. A discussion of the general issues relevant to care home outcomes raised in this research, in the context of the literature, is offered in Section 6.4.



## **SECTION 5.2: THE OUTCOMES FRAMEWORK**

### **5.2.1: HOW THE OUTCOMES FRAMEWORK DEVELOPED**

The outcomes listed by the CAs and RNs in their significant examples for Phase 1 suggested a range of categories. By the conclusion of the Phase 1 data analysis, these had built into a framework for outcomes. As described in Section 2.4.8 and 2.4.9, this was 'held lightly' and developed through the course of the analysis during Phase 2 as new data interacted with the framework and new categories emerged. (This approach is recommended by Miles and Huberman 1994, Field and Morse 1985, Coffey and Atkinson 1996, Mays and Pope 1996). At the conclusion of Phase 2, the framework was as shown below. This is used to present the findings on outcomes and potential outcomes of the work of CAs and RNs identified in this investigation.

Explicit examples of how the categories in the framework developed are now offered. Initially all the outcomes written by the CAs and RNs in their significant examples were listed. In addition to the outcomes for residents that the participants were specifically asked to identify, there were also some outcomes for the relatives, for the staff and for the home in general. In a few of the RN examples, the outcomes stated for their work went beyond the home, e.g. maintaining the good reputation of the home in the community. Categories were therefore included in the framework to encompass outcomes for relatives, the staff and the home. Outcomes in the examples listed by CAs, such as residents receiving help to go to the toilet, being reminded to go to the toilet, or having continence aids changed were categorised together under the heading 'Elimination'. Residents receiving meals in their rooms, receiving help to eat, or being offered sufficient drinks were categorised together under the heading 'Nutrition and fluid intake'. Elimination and Nutrition/Fluid intake were categorised as sub-headings under the main heading of HEALTH. From the content of the CA and RN outcome lists, the concepts defining HEALTH were identified as being on a continuum between health and disease. The defining concepts of FUNCTIONING were identified as being on a continuum between ability/capacity and impairment. The category of QUALITY OF LIFE was identified

from a range of outcomes listed by participants including autonomy, happiness, safety and security and environment. The category of PERSONHOOD was adopted to encompass outcomes such as the recognition of individuality, wellbeing, spirituality and relationships. The component concepts of PERSONHOOD were recognition, respect, trust and wellbeing, as defined by Kitwood (1997) and identified in the RN examples.

The framework contains five broad domains, or categories, of potential outcomes for older people living in care homes, each with a range of sub-categories. There is also the potential to include outcomes for relatives, staff and the home in general.

The categories and sub-categories are not intended to be hierarchical. Seemingly, avoiding problems such as accidents, health breakdown or physical danger are fundamental to outcomes in all the categories. However, as suggested by the research data, individual wellbeing and sense of personhood also influence health and functioning and it would seem therefore that the precise influences and inter-relationships are distinct for each person.

Although this represents the culmination of the data in this study it is capable of being developed through further research, as discussed in Section 6.4. The categories and sub-categories are those identified by the participants in this research but there is the potential for additional sub-categories to be included or for those of lesser priority in individual situations to be removed.



**5.2.2: THE OUTCOMES FRAMEWORK DEVELOPED FROM THE DATA**

**QUALITY OF LIFE**

Autonomy – choice and control (enhanced)  
Happiness / Enjoyment (e.g. music, 'activities', outings)  
Knowledge and understanding (enhanced)  
Safety and Security (enhanced)  
Location of choice (being able to stay in the home or return to former dwelling)  
Environmental improvement

**PERSONHOOD AND WELLBEING**

*(defining concepts: recognition, respect, trust, wellbeing: Kitwood 1997)*  
Spirituality (expressed), spiritual needs (acknowledged, met)  
Relationships and sexuality (acknowledged, needs met)  
Communication or responsiveness (enhanced)  
Well-being (enhanced), calmness (enhanced), ill-being and aggression (reduced)  
Mental health (enhanced)

**DAILY FUNCTIONING, FUNCTIONAL STATUS (ENHANCED)**

*(defining concepts: continuum between ability/capacity and impairment)*  
Independence in general (enhanced)  
Sensory functioning  
Personal care activities, e.g. dressing (abilities enhanced)  
Mobility (enhanced)  
Continence (enhanced)

**HEALTH STATUS (ENHANCED)**

*(defining concepts: continuum between health and disease)*  
Nutrition and fluids  
Urine output  
Bowel function  
Sleep  
Oral Health

**DETRIMENTAL CIRCUMSTANCES (REDUCED OR PREVENTED)**

Breakdown of skin, e.g. pressure area problems, skin problems, irritation, allergy

Infections

Falls or accidents

Pain

Complications

Acute situations (prevented or managed with positive outcome)

Death (postponed, prevented or process enhanced)

**OUTCOMES FOR RELATIVES:**

**OTHER OUTCOMES:** e.g. other services obtained, drug usage optimised,  
continence product use optimised,

**OUTCOMES FOR STAFF:**

**OUTCOMES FOR THE HOME:**

**OUTCOMES BEYOND THE HOME:**



## **SECTION 5.3: FINDINGS:** **THE OUTCOMES OF CA WORK**

### **5.3.1: INTRODUCTION TO FINDINGS ON CA OUTCOMES**

The range of methods and data sources offered different perspectives towards the overall picture of the outcomes and potential outcomes of the work of CAs. In their significant examples, the majority of CA outcomes focused on the residents feeling 'cared about' and how, through feeling 'cared about' over time, their individual personalities and characters became more apparent. In their interviews, the CAs described outcomes of residents being looked after, made comfortable and their lives being a little better as a result of their work. Within the Outcomes Framework, the majority of outcomes of their work for residents identified by CAs in both their examples and interviews concerned personhood and wellbeing, aspects of quality of life and some aspects of daily functioning.

The observations suggested that the outcomes and potential outcomes of their work cover most of the categories within the Outcomes Framework, with particular emphasis on daily functioning, personhood and wellbeing, and aspects of quality of life. CA approaches to their work and the consequent relationships formed with residents were individual.

The relatives' and residents' interviews prioritised that CAs were always available, that they helped them with anything, helped them to be comfortable and helped them to get up, wash and dress, eat and drink and go to the toilet. Residents also valued their relationships with CAs and help with "the tiny little things" such as spectacles or hearing aid. Kindness in the CAs was a priority for both residents and relatives.

Section 5.3.2 lists the outcomes the CAs claimed for their work in their examples and interviews.

Section 5.3.3 analyses three of the CAs' significant examples in order to illustrate the outcomes they claimed for their work.

Section 5.3.4 offers comments on the contribution of the observations to confirming, or not, the outcomes the CAs claimed for their work.

Section 5.3.5 reports on the interviews with the residents and relatives including what they identified as the key outcomes of CA work and their priority outcomes.

Section 5.3.6 discusses issues that arose in the data concerning inadequate and inappropriate outcomes of care

Section 5.3.7 draws conclusions on the overall findings concerning the outcomes of CA work.

### **5.3.2: OUTCOMES IDENTIFIED BY THE CAs IN THEIR EXAMPLES AND INTERVIEWS**

A list of all the outcomes identified by CAs in their observations and interviews is given in Appendix 5.1. These data are important in that they represent what the CAs believed to be the outcomes of their work but they are not included in full in the main body of this thesis for two reasons. Firstly not all of the claims were supported by other datasets, and particularly those concerning the longer-term effects of CA work. Secondly, some reviewers have found the amount of detail a little overwhelming (and particularly when looking at the RN role). The following boxes summarise the outcomes the CAs claimed for their work in their examples and interviews. The participants' own words are used.

#### **PERSONHOOD AND WELLBEING**

**Being recognised and treated as a person:** Residents felt human; like a person who had worth despite losing health, independence, valued abilities and one's home.



**Being understood as an individual:** Residents' individuality was appreciated, including idiosyncracies and 'the little things'; individual needs were recognised and understood. "Everything just as they like it".

**Receiving attention:** Residents knew that someone was always there to help in case of need; they received attention to needs or wants, even when not asking for such (e.g. putting on wristwatch, winding the clock, putting on radio, bringing in magazines or items of individual interest).

**Feeling cared about:** Residents received time and affection, felt pampered and "fussed over"; reassured that they were not a nuisance; felt liked and loved; "life is a little better knowing someone cares"

**Biography and life experiences acknowledged and valued:** Residents were able to talk about their past to younger people who had genuine interest; they could share memories and photographs; were able to pass on lessons learned in life.

**Autonomy:** Residents felt in control in life, subject to the restrictions of living in a care home and as a consequence of ill-health or disability; received explanations of whatever is happening or going to happen; felt able to ask for help; were offered as much choice as possible

**Privacy and dignity:** Preserved in the way in which the CAs went about their work.

**Well-being:** Residents had greater peace of mind; felt reassured

**Humour /Happiness:** Residents were able to enjoy a joke; share funny stories; laugh with CAs at funny situations

**Relationships:** Chosen relationships were encouraged; visitors were encouraged; relationships with the home were encouraged

**with family:** Contact with family was facilitated and maintained; family welcomed when visiting.

**with other people/generally:** Residents enjoyed being with people and near to people; enjoyed closeness; enjoyed sitting and chatting with staff and other residents; had someone to listen and were able to feel that they had something to say; enhanced socialisation within the home.

**with staff:** Residents were able to enjoy relationships with staff; enjoy close relationships with some staff; sharing trust with the staff. Enjoyment of physical affection and touch with staff; wanting and receiving cuddles.

**The will to live:** Maintaining or even regaining the will to live, rather than feeling

“unwanted, unable to do anything, outlived all usefulness, no reason to live”.

**Quality in death:** Being able to prepare for death and dying according to own wishes, knowing one is cared about and receiving physical care and comfort; complications prevented through regular attention.

### **QUALITY OF LIFE**

**Quality of Life:** Residents felt they had some quality of life, despite ill-health, disability and other losses.

**Enjoyment / recreation:** Residents were encouraged to be as active as possible and engage in activities of personal choice; encouraged to continue activities enjoyed while at home (e.g. reading the newspaper, listening to the radio); encouraged to join in activities within the home (e.g. games, quizzes); enjoying life; taken out on occasions.

**Safety and security:** Residents felt safe and secure in the home; felt safe that needs would be met; had a call-bell to summon help when needed; side-rails on mechanical bed to prevent falling out of bed.

**Environment:** Room and personal surroundings kept clean and tidy but as per personal choice; equipment needed was within easy reach; personal things were in the desired place; rubbish was removed;

**'The tiny little things':** Little things were attended to, such as winding the clock, applying a wrist watch;

**Comfort:** Physical comfort was ensured as far as possible.

### **DAILY FUNCTIONING**

**Independence:** Independence was encouraged in all aspects

**Washing, grooming and dressing:** Residents received help to wash; skin was kept in condition; helped to apply deodorant, perfume, aftershave and makeup. Hair was brushed, washed, set and cut. Dressed according to individual choice; Clothes were washed/cleaned and returned; help was given to mend and replace clothes as



necessary. When unable or reluctant to clean self due to mental health needs staff awaited an opportunity to do this and employed a range of strategies to do so with minimum distress to the resident

**Mobility:** Residents were moved and 'handled' safely with explanations of procedures and the necessity for them. Encouraged and helped to move around.

**Sensory functioning:** Hearing aids and glasses were applied.

## **HEALTH**

**Elimination:** Effective and regular elimination was maintained

Residents were helped or reminded to go to the toilet / bedpan / urinal / commode. Continence aids were changed and body kept clean and dry.

**Nutrition and fluid intake:** Nutrition and hydration were maintained. Residents were helped to eat and drink; have meals brought into their room if necessary or are served at dining table; receive sufficient fluids; reminders of weight change.

**Sleep:** Sleep was improved due to pain reduction

**Oral health:** Teeth or dentures were cleaned; encouraged to seek dental advice and to wear dentures as prescribed

## **PROBLEMS AVOIDED**

Changes were recognised and reported to the RN in charge

Deterioration (and possibly death) was prevented

Residents were helped to take medications left by the RN

Pain was reduced through attention to comfort.

Pressure area problems were avoided through the administration of regular prescribed care.

Acute problems were recognised, reported to RN and dealt with (e.g. bleeding, cold/chest infection)

Infection was prevented through the adoption of infection control practices

Ineffective or malfunctioning equipment was reported

**GENERAL**

General improvement over the course of time was acknowledged, e.g. "has really improved", "she's really changed", "feel better in themselves through the care and attention received", "reduced frailty"; greater comfort; life is made as comfortable as possible; increased self-confidence; feeling able to undergo treatment due to the support received; fully recovered and able to go home

**OUTCOMES FOR STAFF**

Staff enjoyed good teamwork;  
Staff gained a sense of satisfaction and a feeling of achievement from giving good care;  
Staff gained satisfaction from their relationships with the residents, families and each other;  
Workload reduced as resident's independence improved, particularly in mobility (e.g. no longer have to use a hoist).

**OUTCOMES FOR RELATIVES**

Family felt reassured and comforted by the care given;  
Family expressed appreciation for good care;  
Family enjoyed visiting;  
Family felt less distress, apprehension, fear, stress knowing resident has good care;  
Family could be involved in resident's dying and death and felt supported in this;  
Family felt better knowing resident did not suffer



**5.3.3: EXAMPLES ILLUSTRATING SOME OUTCOMES OF THE WORK OF CAs**

Three of the CAs' significant examples are offered here. They are analysed in a manner which identifies the outcomes they claimed for their work (i.e. the changes in the residents over the course of days or weeks) as a consequence of the actions they took. The Manager of the home where these two CAs worked confirmed that the residents had changed in the ways the CAs claimed and that, in his view, these changes were a direct consequence of these CAs' individual approaches and actions. The third example contains one CA's description of how she worked with a resident on a day-by-day, sometimes minute-by-minute, basis, and what she believed to be the outcomes of this. These examples also offer additional evidence towards:

- Categories of the Outcomes Framework
- The Model of CA work shown as Figure 3.1 at the end of Chapter 3
- Inputs, processes and the overall Role and Contribution of CAs described in Chapter 3.

**EXAMPLE 1: IN A UNIT FOR PEOPLE WITH DEMENTIA**

<b>Before CA intervention</b>	<b>Changes in resident consequent to CA's intervention</b>
<p>M very aggressive Wouldn't talk to anybody</p> <p>Would scream "go away, leave me alone, I don't need any help"</p> <p>Used to scream "where's my cornflakes" She felt neglected Carers too scared to be near her Thinking she's going to tell them to go away</p> <p>Wouldn't agree to a bath</p>	<p>"she's cooling down and cooling down" Tells us stories about how she used to look after the children and how she's here because her parents are dead. Really likes being near to people. Wants to be close to people and to get the proper affection she needed. Gives cuddles to everybody and says "come here let me kiss you". Enjoys closeness and wants a cuddle. Happy, cheerful</p> <p>All the nurses go and sit next to her and talk to her</p> <p>She's really changed Agrees to a bath, gets herself to the toilet</p>

**How the CA described her work:** I just use a calm approach and treat her like a human being and if she say "go away" try to explain to her "you might need help"... just talking to her like a human being. I realise she like to be babied a little bit and I got to her and give her a cuddle and say 'calm down, calm down' and she cuddle me back and I think 'alright I got you' and she actually asked me to help her. From that day I try to sit next to her, listen to her stories. When I came in this morning she called out "come here my blackie" and I said to her "if I'm blackie, you're pinkie" and she says "you're not really black you're brown". So I joke with her. It started slowly but she really needs that motivation to be treated like a human not to be just scared of her and neglect her because she says "go away" (from written Example 1.1)

**EXAMPLE 2: IN A UNIT FOR PEOPLE WITH DEMENTIA**

<b>Before CA intervention</b>	<b>Changes in resident consequent to CA intervention</b>
<p>L was very aggressive and when we tried to help him he'd be bashing out the fists. Quiet and quite tearful</p> <p>Confused as to where he was</p> <p>Just lying on the bed the whole time and we were rolling him from side to side</p> <p>didn't want to feed himself couldn't be bothered</p> <p>couldn't stand</p>	<p>Co-operates wonderfully being a nice gentle man - he's lovely likes to sit and chat likes you to sit on his knee interacts with J [female resident] "they converse in their own little way" sometimes a bit confused but if you take time he can often understand what he's saying helps to wash his face and dry himself</p> <p>sits at the table and feeds himself sometimes he can't be bothered but we give him a walking frame and he will walk along</p> <p>his grandchildren visit more often now he's becoming such a more gentle man he's a lovely man and I've got to know him – he's got a nice character</p>
<p><b>How the CA described her work:</b> We were gentle with him and explained what we were doing. Treat him as an individual and talk to him and tell him what you're doing the whole time. Being gentle, giving him time and giving him a little kiss and cuddle, tender loving care, making a joke, stroking his tummy and saying "what's in here?" - I think that counts a lot. We just treat him as a person (from written Example 1.2).</p>	



**EXAMPLE 3: IN A UNIT FOR PHYSICALLY FRAIL OLDER PEOPLE**

**CA's description of resident:** Mr DS's health is deteriorating; quite poorly; difficulty walking; nursed in bed on a pressure relief mattress; needs all help to wash and change his bedding; doesn't communicate very much and can be very aggressive; on a 'bad day' it is not possible to care for his basic needs

Assessment	CA actions and responses	Usual outcomes
<p>Knowing Mr DS for five years you can tell when you walk into his room how he is feeling.</p> <p>... responds better on a one to one basis</p> <p>He loves to sing</p>	<p>He doesn't communicate very much but through my experience you can tell with his eyes. On a good day there is a twinkle in his eyes and if he smiles you know he is feeling quite well but if not then you know that you will have to be very patient and once again try to gain his confidence and reassure him that to wash and shave him will be to his advantage, making him feel much more comfortable.</p> <p>Go in alone, explain that I can't just manage on my own and I need a helping hand. Then, with his consent, bring in another nurse to help.</p> <p>My skill is to be pleasant and patient. Taking the time to sit and talk to him and try to explain why I have gone into his room and interrupted his privacy. If he is still unco-operative I apologise for disturbing him and tell him that I will come back a little bit later.</p> <p>When he is aggressive I speak quite firm to him and tell him that his behaviour is not acceptable explain that what you are doing is for his own comfort and wellbeing.</p> <p>When you enter his room and there is no response or aggression and your instinct tells you that there is something wrong then I would ask Sister just to look at him.</p>	<p>This eases the aggression. If shown respect Mr DS responds and co-operates much better. This action quite often works with good effect.</p> <p>It is much easier to care ... with his consent than without it.</p> <p>If I can get a smile from him all his aggression is soon forgotten.</p> <p>With encouragement he will join in and sing with you.</p>

**How the CA described her work:** "he is a very intelligent gentleman and very proud ... he can be very difficult and aggressive when I try to wash him and change his bedding. I think this is when his pride comes to the fore. I feel Mr DS needs a lot of reassuring as to why he needs a shave and a wash, especially his 'tail end' ... I think deep down Mr DS was a happy man who misses his wife who died some years ago ... my instinct tells me that he is not as bad tempered as he appears - there is lighter side to him" (from written Example 102.1)

**5.3.4: OUTCOMES CONFIRMED THROUGH THE CA OBSERVATIONS**

The observations were able to confirm most of the outcomes the CAs claimed for their work by seeing them in practice. This was particularly so for the immediate and short-term outcomes. The observations suggested that the outcomes and potential outcomes of CA work cover most of the categories within the Outcomes Framework, with particular emphasis on the help with daily functioning. Outcomes concerning personhood and wellbeing, and aspects of both health and quality of life were also confirmed throughout the observations.

**5.3.5: OUTCOMES IN THE INTERVIEWS WITH RESIDENTS AND RELATIVES**

Thematic analysis of the interviews with residents and relatives revealed that the outcomes they most appreciated of the work of the CAs focus on having help. They appreciated the CAs' assistance with their activities of daily living, and particularly that help was available if they needed anything, or needed to be comfortable. There was a strong sense of the residents' total dependency on the CAs.

**INTERVIEWS WITH RESIDENTS**

<b><u>SUMMARY: RESIDENTS' PERCEPTIONS OF THE OUTCOMES OF CA WORK</u></b>
<p>HELP IS ALWAYS AVAILABLE                      HELP WITH ANYTHING – “THE THINGS I CAN'T DO FOR MYSELF”                      HELP TO WASH, DRESS                      HELP TO BE COMFORTABLE                      RELATIONSHIPS: “CARING AND SHARING”, COMPANIONSHIP                      “THE TINY LITTLE THINGS”                      DOMESTIC ASPECTS</p>



### ARE ALWAYS AVAILABLE

All of the residents/relatives said that the CAs were “*always there*” for them. It was very important to residents that the CAs’ help was always available when needed, leading to peace of mind and a sense of security.

*“they come whenever I have difficulty or need help”* (Resident 501)

*“When I want anything it’s there. These young things are particularly pleasant and amenable and it’s nice having them in and out. I can’t see their faces but I get to know the voices or the shape of them”* (Resident 950)

*“The carers are very kind but some are dependent on them for everything. Some are ringing their bell every five minutes and for some it’s because they like a bit of a fuss, it’s not that they need anything”* (Resident 951)

### HELP WITH ANYTHING

Virtually all residents mentioned that the CAs’ “help with anything” and particularly the things they were no longer able to do for themselves such as “*making the bed*”, “*changing my colostomy*” and “*they go shopping with people*”.

*“if I’m in difficulty with anything I have only got to use my buzzer and they help me”* (Resident 501).

*“If I buzz they will come and do whatever you want, and it’s very quick, they don’t keep you waiting”* (Resident 506)

### HELP WITH ACTIVITIES OF DAILY LIVING

All but one of the informants referred first to help with activities of daily living. Priorities in their lists were washing/bathing, dressing, bringing food. There was also mention of helping to get up and lifting on and off the commode.

*“They do look after me extremely well. The carers get me up in the morning and dress the bottom half - I can’t do that. I dress the top half and have a wash - I can manage that by myself”* (Resident 952).

### HELP TO BE COMFORTABLE

Nearly all of the residents said that the CAs help to make them comfortable:

*“sometimes I’m taken bad with pain and they come in and adjust my cushions and my position and make me comfortable. They lift or lower me so I can sleep without pain”* (Resident 502).

*“they come during the day and say ‘you don’t look comfortable’ or lift me from the chair to the commode” (Resident 506)*

*“they make me comfortable. If I’m sitting here and say ‘I don’t feel comfortable’ they prop me up properly” (Resident 501).*

### RELATIONSHIPS: “CARING AND SHARING”

The residents mentioned their relationships with the CAs.

*“They make me happy - companionship - it’s very nice. They talk about up to date things that are going along - the world in general” (Resident 510)*

*“They chat if they’ve got time about your private life - what you like and what you don’t like - we have long old conversations - it makes you feel elated” (Resident 501)*

### “THE TINY LITTLE THINGS”

Several stressed the importance of “the tiny little things”

*“if you wear a hearing aid they have to put them in – put my socks on - all tiny little things like that – they help me” (Resident 501)*

*“They look after the day to day things around the home and also go out shopping with the patients and take people out on visits” (Resident 955).*

### DOMESTIC

Residents also mentioned some domestic duties such as:

*“sew labels in my clothes” (Resident 501);*

*“they clean the corridors and the toilets, although there are housekeepers” (Resident 506).*

*“they are very clean - they’re round every day and the hygiene is perfect” (Resident 502).*

*“They make my bed” (Resident 950)*

### INTERVIEWS WITH RELATIVES

The relatives interviewed were generally content with the care the residents received from the CAs but they all spoke at length about their concern in case standards of care should ever deteriorate. They were constantly vigilant to ensure the standards



of care remained satisfactory and all found it difficult to go home and leave the residents in the home. All also commented that some CAs were better than others.

With good CAs, residents (and relatives) were:

- treated with kindness, understanding, compassion and “like a human being”
- received the care they needed, particularly in aspects that they were unable to do for themselves, e.g. helped with a cup of tea, helped to go to the toilet, offered 'the little things'
- given care promptly
- kept comfortable
- given respect for their property e.g. toiletries, hairbrush, talcum powder and that this did not “go missing”
- dressed in clean, good quality clothes and that these were changed as soon as they become soiled
- given more time from CAs 'to sit and chat with them' rather than having time only to deliver the essential care
- given time to entertain them and take them out

The relatives also wanted the home to provide CAs that would offer the best outcomes for the residents. In this respect they wanted:

- regular staff who knew the residents; no agency staff;
- staff who 'came up' with ideas for improving resident's life (e.g. wearing a sports 'crop top' when a bra became difficult)
- staff who were sensitive to the fact that residents were living with people they did not necessarily want to be with and sometimes did not like
- staff who had positive attitudes to older people

The most important outcomes that the CAs' work achieved, according to relatives, were that the residents were safe and their needs were met in a kindly and understanding way. Kindness and understanding were the priorities for the relatives.

*"Compassion and talking to them as a human being - this is the most important thing" (Relative 702)*

*"One-to-one attention and warmth and love. If they get that they're happy" (Relative 704, wife had dementia)*

Attention to 'the little things' was important to them:

*"the little things matter – knowing she's cared for, making sure she gets her tea and things like that" (Relative 501).*

For CAs to recognise and attend to individual needs promptly was also important:

*"Our mother wants to go to the toilet as soon as she wakes up and it's no good them saying 'you'll have to wait'." (Relative 703)*

Relatives unanimously said that there should be more staff and a couple mentioned that the homes are making money and should be able to afford this. More staff would ensure that residents were attended to promptly and they could "sit and chat with them" or take them out rather than only having time to deliver the essential care.

*"If there were more staff that would benefit everyone" (Relative 703)*

*"The care could be improved but it's just a question of staffing numbers" (Relative 704)*

### **5.3.6: INADEQUATE AND INAPPROPRIATE OUTCOMES OF CARE**

The majority of the examples, observations and interviews suggest that the outcomes of the work of CAs would be positive in all areas of their work. It is important to acknowledge, however, that there were suggestions of inappropriate practice in a few of the examples and that the observations, particularly in Home 1, revealed that the outcomes of at least two CAs would not be positive. Two CAs were observed speaking harshly to residents and the residents in that home made reference to this. Another CA was seen to be hiding and sleeping. A resident said this CA was rough and had hurt her leg while putting on her stockings. A further CA said he no longer enjoyed his work and wanted to leave as soon as possible, although no unkindness or inappropriate practice was observed. In addition, although the residents appreciated the CAs' help, not everything was perfect:

*"They do everything really. They help me to wash and shave because, since I had the stroke this arm is useless - paralysed, I can't do anything with it so they have to help me. They're generally good but cleanliness is important. Washing your hands - and they don't always remember - I have to ask them*



*to do it. I like to wash my hands - it's important to continue your habits in life. I've always done it, even if I wipe it with a flannel". (Resident 953)*

*"The youngsters are charming if you're feeling fit but some can be too lively. And they don't always tell me when they put my underwear in the dresser so then I don't know where it is. And some are wonderfully stupid - I had one who brought me my tea. I asked for some hot water and she said 'it's in the pot". (Resident 950)*

Such instances were very much in a minority.

### **5.3.7: OVERALL FINDINGS: THE OUTCOMES OF CA WORK**

Drawing together the findings of all datasets, and expressed within the outcomes framework, the outcomes of CA work are focused mainly on:

- personhood and wellbeing,
- daily functioning, and
- quality of life.

There are also outcomes in terms of health maintenance and some concerning problem prevention.

#### **PERSONHOOD AND WELLBEING**

From the work of good CAs, each resident and relative felt valued as a person, treated as an individual and cared about as a human being. This was particularly important because, as was highlighted throughout the data, residents had lost their health, independence and, through being unable to remain in their own homes, now lived in communal establishments. The genuine interest in their biographies and experiences helped them to feel that their lives had been of value. Being viewed and treated as an individual and valued person meant a great deal to them.

Residents were able to enjoy relationships, day-to-day "caring and sharing", hearing about and participating in CAs lives and what was going on in the world. Close relationships were maintained despite potential barriers or considerable differences between resident and CA background, culture, age and life experiences.

Particularly important to residents and relatives was the constant availability of the CAs' help and that good CAs tried to ensure they were always as comfortable as possible. This gave them peace of mind and contributed to their sense of wellbeing. Also contributing to their sense of personhood and wellbeing was the way in which they were treated by CAs, not only in terms of the respect and caring they were offered, but the privacy and dignity the care of good CAs afforded them.

Through the everyday explanations that the CAs offered, and through the genuine choices they were afforded, residents could feel more in control of their lives. This was particularly important in view of the restrictions imposed by illhealth, disability and living in a communal establishment.

Through the work of good CAs, the CAs and RNs believed that residents were more able to express themselves as individual persons, rather than expressing frustration, anger, animosity and rejection of others. The work of good CAs helped residents, and particularly those with mental health needs, to reduce mental confusion, and to lessen the stress this can bring to older people. This helped to facilitate not only resident enjoyment of life in general, but also the development and maintenance of relationships between residents and other residents, staff and families. The positive outlook of good CAs contributed to the happiness of residents and there was much shared humour in the care.

Overall, rather than feel "unwanted", "unable to do anything" or that they had "outlived their usefulness", the CAs believed that their work helped residents to maintain or even regain the will to live.

Also featuring highly in the CAs' descriptions of their work, and confirmed in the observations, was the care they gave to residents in preparing for death and the process of dying. They gave touching descriptions of how residents died in a manner according to their wishes, they received regular physical care and comfort, complications were prevented and they knew they were cared about right to the end.



## QUALITY OF LIFE

CAs and RNs believed that, despite the residents' illhealth, disability and multiple losses, the support they gave enabled the residents to enjoy life more. The residents received encouragement and help to be as active as possible, to engage in activities of their choice (such as reading or listening to the radio), to enjoy the home (e.g. the garden) and to participate in organised activities. They were also occasionally able to enjoy organised outings and the CAs accompanied them.

Residents felt safe and secure knowing the CAs would respond to their needs. Safety and security was also afforded by the CAs using equipment safety and particularly in their moving and handling techniques. CA work also considerably influenced the residents' environment in terms of lighting levels, noise, tidiness, cleanliness and how their personal belongings were treated. This was very important to residents and particularly observable that, when CAs treated residents as individuals, each room in the home was very different, for example the retired gardener whose room was filled with the plants he tended, compared with the retired naval officer whose room was characterised by few possessions each item placed with stark military precision and cleanliness as a priority.

"The little things" the CAs did, however seemingly insignificant, contributed to residents' everyday quality of life. Merely, for example, ensuring that a hearing aid was in, glasses and newspaper were available and the clock was wound, made a great deal of difference to how residents enjoyed each day.

## DAILY FUNCTIONING

Their major responsibility according to their job descriptions, the daily functioning of residents was a major outcome of CA work. Residents were helped to wash, dress and groom, go to the lavatory and move around the home. They were also helped to use personal aids and appliances. The everyday outcomes of CA work in these respects was evident in the residents' appearance. The manner in which the work was undertaken and the CAs' motivations in this were, however, key determinants of longer term outcomes, particularly resident dependence/independence. If, as in

most cases observed, assistance was delivered with encouragement for residents to do as much as possible for themselves and a positive outlook on what could be achieved, resident independence would be retained for longer than if CAs did everything for them. This is important as 'doing for' residents is often an easier option than encouraging residents to 'do for themselves'.

## HEALTH

The contribution of CAs to resident health was in continuing the regimes determined by the RNs, GPs and physiotherapists and their contribution was vital in that, in reality, their everyday work went largely unsupervised. CAs were relied upon to remind and help residents to drink, eat, go to the lavatory and move around. The health of residents was also determined by the way the CAs carried out their work, for example in how they washed delicate skin, protected it from urine, infection or damage from furniture. Particular aspects of physical health described by CAs were nutrition and fluid intake, elimination, oral health and sleep. Resident health was thus maintained through the CAs' diligence, thoroughness and conscientiousness. The residents' physical health was also strongly influenced by wellbeing and outlook on life and the outcomes of CA care in these categories contributed to this.

## PROBLEMS AVOIDED

Problems for residents were avoided through sound CA care regimes and by their conscientiousness, e.g. pressure area damage was avoided through the administration of regular prescribed care, infection was prevented through the adoption of control practices and pain was reduced through attention to physical comfort. CAs also helped avoid problems by ensuring residents took their medicines as prescribed. In addition, the CAs prevented problems by recognising changes in the residents and reporting these to the RN in charge.

## OUTCOMES FOR RELATIVES

Although all of the relatives interviewed said that the CA care was mostly satisfactory, all felt considerable anxiety about their loves ones. The outcome of CAs'



work impacted greatly on relatives, particularly whether they were reassured that their loved ones were receiving high quality, thorough, timely support and that the staff genuinely cared about them.

### OTHER OUTCOMES

The CAs contributed to relationships in the home, particularly to good teamwork and to all staff gaining satisfaction from their work.

The CAs also highlighted that their good work helped to reduced workload in the longrun, i.e. good care helped residents to be more independent and thus less reliant on staff help (e.g. if residents could maintain standing and walking ability they would not need staff assistance with hoists or wheelchairs).

The team of CAs were undoubtedly the 'backbone' of the service and the quality of their work significant in the overall outcomes for the residents.

*"I don't know how I'd manage without them" (Resident 501).*

## **SECTION 5.4: FINDINGS:** **THE OUTCOMES OF RN WORK**

### **5.4.1: INTRODUCTION TO FINDINGS ON RN OUTCOMES**

The range of methods and data sources offered different perspectives towards the overall picture of the outcomes and potential outcomes of the work of RNs. Taken overall, the outcomes of RN work were broad and encompassed all categories of the outcomes framework. They also encompassed outcomes for residents, relatives, staff, the home and some had implications beyond the home.

As can be seen the example given in Section 4.2.2 (page 210) and Section 5.4.3 (page 293) one single RN action can result in a variety of outcomes. These can be at different levels, for example those listed by the RNs in Phase 1 could be as far-reaching as a “total culture change” in the home and the residents becoming “like different people” due to improved care (Example 1.3c), or greater job satisfaction and reduced turnover for staff (10.1). Outcomes for individual residents could be as profound as a life saved (263), as life-changing as going home to live having been “written off” (101.3) or as detailed as a person’s mouth kept “clean, moist and comfortable” (261).

The outcomes of the work of the RNs could also impact in different time frames, for example changes in residents over the course of days, weeks or months, such as the healing of a leg ulcer, continence regained or enhanced mobilisation so that someone can go to the toilet independently. Outcomes could also impact minute by minute as residents, particularly those with mental health need or distressed, respond to the care and interactions (as illustrated in Section 4.1.5, page 199).

Section 5.4.2 lists the outcomes the RNs claimed for their work in their examples and interviews.



Section 5.4.3 analyses three of the RNs' significant examples on their work with residents and two on their leadership/management/supervision work in order to illustrate and confirm the outcomes they claimed for their work.

Section 5.4.4 offers comments on the contribution of the observations to confirming, or not, the outcomes the RNs claimed for their work.

Section 5.4.5 reports on the interviews with the residents and relatives including what they identified as the key outcomes of RN work and their priority outcomes.

Section 5.4.6 identifies some distinctions made between the work of RNs and CAs who had undertaken NVQ Level III.

Section 5.4.7 discusses issues that arose in the data concerning inadequate and inappropriate outcomes of care.

Section 5.4.8 draws conclusions on the overall findings concerning the outcomes of RN work.

#### **5.4.2: OUTCOMES IDENTIFIED BY THE RNs IN THEIR EXAMPLES AND INTERVIEWS**

A list of all the outcomes identified by RNs in their observations and interviews is given in Appendix 5.2. These data are important in that they represent what the RNs believe to be the outcomes of their work but they are not included in the main body of this thesis for two reasons. Firstly it is difficult to confirm the RNs' claims for the longer-term outcomes of their work. Secondly, some reviewers have found the amount of detail listed in the RN tables of outcomes overwhelming.

The following boxes summarise the outcomes the RNs claimed for their work in their examples and interviews, expressed within the Outcomes Framework. The participants' own words are used.

More outcomes were listed under categories concerning health, daily functioning, preventing problems than in the CA examples. This suggested a strong focus within the RN role on the maintenance and promotion of health, functional ability, well-being and quality of life, and also in recognising acute illness and preventing problems such as falls, pressure area breakdown, pain or untimely death. There were also many more statements than in the CA examples suggesting outcomes at the level of the functioning of the home, such as improved quality of care for all the residents, improved documentation, improved staff training, satisfaction and retention. More outcomes also related to obtaining other services for residents, and potential benefits of their work for relatives, for staff and for the home in general. This reflect the leadership and managerial aspects of the RN's role.

**PREVENTING PROBLEMS**

**Breakdown of skin**: Skin breakdown was prevented. Pressure sore deterioration was prevented, appropriate treatment was given. Infection was prevented or treated.

Pressure sores healed completely thus reducing discomfort and risk of death.

**Wound Healing**: Because skilled assessment was undertaken and changes recognised leg ulcers and other wounds were treated and ultimately healed.

**Infections (reduced or prevented)**: RNs instituted infection control procedures, ensured staff followed these and taught staff the reasons for them.

**Falls or accidents (reduced or prevented)**: Falls and accidents prevented by RNs assessing risks and preventing these where possible. Falls protocols were in place.

**Detrimental complications (reduced or prevented)**: Complications and deterioration were recognised and prevented, e.g. dehydration, pressure sores, chest infections, death

**Pain (reduced or avoided)**: Pain was prevented, avoided or reduced. Residents remained, and died, pain-free. Correct medication and other measures were given and medication changes to meet resident need.

**Acute situations (with positive outcome)**

Acute situations were recognised by RNs and immediate action taken. Without this, residents could have had to be admitted to hospital, lost limbs, choked or died.



Examples include recognition of urinary retention, abdominal distension, detached retina, deep vein thrombosis, heart attack, fractured neck of femur and epileptic fit.

Appropriate action was taken in the case of choking, cerebral bleeding and cardiac arrest.

Abuse was recognised and steps taken to stop this.

**Death (postponed or avoided, or process enhanced):** Through good care, residents lived for longer. Through good communication with the family and GP, the outcome was a comfortable, peaceful death with family attending. Through 'not taking things at face value', investigating further, seeking second opinion and working with the family, recognising acute situations and taking action, residents' lives were saved

## **HEALTH STATUS**

**General health:** 'They're all much healthier now'. 'Going from strength to strength'

General health, independence and activity levels enhanced

**Well-being:** Enhanced well-being, calmness, orientation, stimulation and motivation

Reduced illbeing, aggression, distress, unhappiness, frustration, depression, withdrawal and dependency. Less likely to be labelled as confused or dementing.

Dementia care mapping helped identify well-being and illbeing on an ongoing basis

**Mental Health:** Less risk of mental health deterioration due to lack of stimulation.

Improved general mental state, mental alertness, orientation, memory. Accurate mental health assessment and diagnosis achieved.

**Nutrition and Fluids:** Residents were able to enjoy food. No longer needed thickened fluids. Dehydration was prevented, e.g. despite swallowing difficulties. Special diets and supplements were obtained. Good nutritional status was maintained

**Oral health:** Dental assessment undertaken and/or new dentures obtained. Resident's mouths were cared for, kept clean and moist, despite major or terminal illness.

**Urine output:** Healthy urine output was maintained. Urinary retention was prevented, or detected and treated. Problems were identified

**Bowel function:** Constipation was prevented, detected or treated. Residents' normal bowel function was maintained, even in people with neurological disorders.

**Sleep:** Adequate and restful sleep was facilitated

**FUNCTIONAL STATUS**

**Independence - general:** Some residents regained abilities and functioning they had lost. Residents were helped to become more independent, even to the point of going to live at home.

**Sensory Functioning:** Residents were able to 'get their hearing' and their vision 'sorted out'. Speech improved through therapy. Specialist assessment was obtained.

Communication aids were obtained, maintained and used appropriately

**Communication, responsiveness:** Residents were able to make conversations when previously they had been unable. Depression was prevented, detected or treated

**Personal Care activities, e.g. dressing:** RNs checked that washing, bathing etc was carried out appropriately. Residents were encouraged to go to the hairdresser and helped to purchase clothes through catalogues or to go shopping.

**Mobility:** Optimum mobility achieved within individual limitations. Residents were helped to be able to walk again. Resident potential for mobility was preserved through appropriate moving and handling techniques and residents received explanations about changes in manual handling.

**Continence:** Continence was preserved, maintained or improved. Specialist assessment was obtained when appropriate

**PERSONHOOD**

**Personhood:** Being viewed and treated as a person; individual strengths were recognized; staff learned individual resident's ways of communicating and behaving; residents' priorities were understood because staff took time.

**Biography:** Residents enjoyed talking about life experiences. Staff compiled biographies through talking with residents and through family photographs

**Spirituality/religion:** Residents were able to follow faith and religious rituals through daily practices, ministers visiting or going out to church.



**Relationships and sexuality:**

**Relationships with family:** Through enhanced health and well-being, more able to enjoy family and relatives, relatives felt welcome in the home, residents were helped to keep in touch with families and were able to go to relatives' homes, e.g. for Christmas

**Husband and wife and couples:** Couples could stay together, were supported in continuing to care for each other, partners supported in grieving; staff go to funerals.

**Sexuality:** Residents' sexual needs were treated with sensitivity and understanding  
New relationships were viewed and treated with sensitivity

**Relationships generally:** Isolation was avoided. Residents could share conversations or be alone when they wish. Residents were able to form friendships or relationships.

**Relationships with staff:** Residents showed appreciation to the staff for care given and could be confident in the help being offered.

**Autonomy - choice and control:** Residents felt they had control over how they spent their time. Staff offered ideas and facilities for activities and interests. Residents were asked for their views and these were listened to. Staff welcomed resident's ideas.

**Privacy and dignity:** Residents had privacy, could stay in their rooms when they wished, had privacy when taking meals if desired. Dignity was enhanced through improved health and functioning, e.g. becoming continent again

**QUALITY OF LIFE**

**Quality of life**

Residents enjoyed better quality of life through being reassured that they were able to maintain optimum health through the care they received, through knowing that there were qualified staff to help when they needed this and through living in an environment where they felt safe and could live their lives with an optimum of choice and enjoyment.

**Enjoyment of life (personal and social activities music, outings)**

Enjoyment of life to the optimum and undertaking activities of their choice, for example reading, music, exercise classes, reminiscence, art therapy.

**Knowledge and understanding**

Residents' enhanced understanding of their health changes and options for treatment or lifestyle change, e.g. diagnosis, prognosis and medicines being prescribed.

**Safety and Security**

Being in a safe environment. Potential hazards and risks recognised, minimised and managed. Health changes identified, investigated and treated.

**Location of choice**

Being able to stay, or die, in the home rather than be taken to hospital.

Returning to live in own home through rehabilitation in a nursing home despite, in some cases, being told this would never be able to happen.

**Environmental improvement**

Improved environment, physically and psychologically; controlled light, noise and activity.

**OTHER OUTCOMES**

**Other services obtained:** These included General Practitioners, Specialist Medical Consultants such as geriatricians and psychogeriatricians, specialist nurses in palliative care, continence, wound care, District Nurses and other services such as audiology, dentistry, speech therapy.

**Total culture change in the home:** Institutionalised approach to care could be changed (as illustrated in the examples in Section 5.4.3, page 298)

**Other outcomes:** The use of some drugs was reduced e.g. antidepressants, the use of incontinence pads and other aids was reduced.

**OUTCOMES FOR RELATIVES**

With good RNs the relatives said they were happy that the health of their loved ones improved and that they received good care. Relatives felt welcomed in the home and involved in the care. Relative contact was maintained by staff, even when they were unable to visit the home. Potentially difficult situations were avoided because RN understood relatives' feelings and proactively approached the problem. Fewer complaints were received.



**OUTCOMES FOR OTHER STAFF**

Through good RN leadership and management: Staff were happy, had higher morale and greater job satisfaction. Sickness/absenteeism levels were lower. Staff felt empowered. Teamwork and care were improved. Activities in the home were expanded to include art, music, singing, with consequent improvement in residents' enjoyment of life  
Improved record-keeping leads to improved inspection reports

**OUTCOMES FOR THE HOME**

**Other residents:** Potentially avoiding elder abuse due to frustrations in inadequately run home. Relationships among residents improve in well-run home

**The Home:** Situations of staffing shortage managed and atmosphere maintained. Without good management, good reputation of home is lost, increased complaints, poor inspection reports or investigation by health authority, reduced occupancy, job losses, home generally goes down.

**5.4.3: EXAMPLES OF RN WORK ILLUSTRATING THE OUTCOMES**

Three examples focusing on the care of individual residents and their relatives are offered here. These illustrate the complexity of RN work in the day-to-day practical realities. They also offer additional evidence towards:

- All categories of the Outcomes Framework
- The Model of RN work shown as Figure 4.1 at the end of Chapter 4.
- Inputs, processes and the overall Role and Contribution of RNs described in Chapter 4.

Following these are two examples illustrating the RN role in leadership, management and supervision.

### THREE EXAMPLES OF RESIDENT CARE OUTCOMES FROM RN WORK

#### CIRCUMSTANCES AND RN ACTIONS

*One morning a patient suddenly became ill and, on observation, I was of the opinion that she had had a CVA resulting in @ hemiplegia. Urinalysis also indicated UTI. She was admitted to hospital and was discharged back to us a week later for terminal care, connected to a morphine pump and a diagnosis of septicaemia. We gave her total nursing care for about a week, kept her skin intact and just managed to stop her from becoming dehydrated, although she had obvious swallowing difficulties.*

*The GP reviewed her but was reluctant to challenge the diagnosis or change the treatment (particularly the morphine) as it was prescribed by the consultant geriatrician.*

*I advised the next of kin to get a second medical opinion and helped him arrange it. The consultant came out and agreed with my original diagnosis x 2 and organised a regime to phase out the morphine unless it was indicated. I should explain that E [the patient] was so drugged she was almost semi-comatose most of the time but we didn't give up on her.*

*With the discontinuation of the morphine and a gradual increase in hydration and nutrition she slowly came back to life again.*

*Two years later she is still alive and looking forward to her 93rd birthday on Sunday. Her son is still so pleased and grateful he has brought in a dozen bottles of wine for the staff to celebrate with her.*

*Her mobility is now back to almost as it was before (already a bit limited due to fractured neck of femur and arthritis), her speech has improved so that communication is no longer a problem.*

*She is content and appears to enjoy a pretty good quality of life.*

#### WITHOUT THE RN'S INTERVENTION

**Death:** *Had I not instigated a second opinion and discussed the patients condition with him there is no doubt that she would have died – either from the morphine or a subsequent chest infection.*

**Complications:** *Had we not given her excellent nursing care she would not have survived without complications – she had a Pegasus bed, turns and mouth care and frequent sips etc.*

**Distraught relatives:** *Had things not turned out the way they did the son would have been distraught and complained to the hospital consultant.*

**RN's reflections:** *The staff at the home all learned a good lesson on the importance of excellent total patient care right up to the end – not only because it is appropriate and what they deserve but while there is life there is hope. She certainly came back from the brink.*



*Clinical knowledge and experience indicated CVA but would say I had a gut feeling as well. I knew the whole scenario of the consultant's diagnosis and treatment didn't fit – morphine for septicaemia?*

*I believed there was hope and that we had nothing to lose by reducing the morphine – we could easily have increased it again and controlled her pain if she had any.*

*"I felt I really had to be E's advocate in that I was in a position where I could have the say as to whether she lived or died - sobering thought - which turned out to be the case" (From written example 263)*

### **CIRCUMSTANCES AND RN ACTIONS**

*One morning I came on duty took over from the night nurse who mentioned – an off the cuff remark - that a particular patient didn't seem so well. I chatted to the Night Duty care assistants as I said goodbye to them and was shocked when one said she didn't think F would still be with us when she returned that night.*

*I was surprised as up until now F had been well and the Staff Nurse hadn't commented to me that she was ill.*

*I went immediately to see her and found her very breathless, poor colour and clammy and virtually semi-conscious. I immediately thought she was in heart failure. I 'phoned the duty doctor and asked for him to visit immediately and for him to bring the emergency box and I was sure she needed IV diuretics.*

*He did and there was some improvement in her condition.*

*He didn't think she would make it and if she did needed more medical attention, she would have to be admitted to hospital.*

*I asked him to prescribe oxygen but he wouldn't - said he wasn't doing the job of hospital doctors and the only way she could get that sort of treatment was to be admitted which I knew she had previously expressed strongly she didn't want.*

*We gave her small amounts of fluids, pressure area care, turns etc. throughout the day. I also informed the family as soon as possible.*

*She held her own but was not making progress so I 'phoned the doctor again in the afternoon, persuaded him to return and give her more IV diuretics and antibiotics as was now a bit chesty - to give her a chance.*

*She made some more improvement following the IVs she was alert enough to tell him she didn't want to go to hospital.*

*He was adamant he didn't want to be called again to treat her. I praised him for caring and how wonderful it was to be a doctor to be able to make such a difference to this lady's life etc.*

*The next morning I got the usual GP to get the geriatrician from the local hospital to come out on a day visit, which he did. He prescribed GTN patches and, although she did have angina, he explained how the drug had been found to help in CCF and ordered oxygen and increased oral diuretics.*

*She has made a full recovery is happy to be alive and enjoying her days back in her old routine – up to sit in the sitting room, lunch in the dining room etc.*



### WITHOUT THE RN'S INTERVENTION

**Death:** *Had I not acted as I did there is no doubt that the patient would have died.*

**Relatives loss and sadness:** *The relatives would have been very sad.*

**RN reflections:** *I would have felt that we had failed her and that the system had failed her (From written example 266)*

### CIRCUMSTANCES AND RN ACTIONS

*Mr X had only been with us for a few days admitted from a Residential Home where he had only been for a few weeks having previously been independent at home until he had suddenly deteriorated and was admitted to hospital where brain scan revealed advanced Alzheimer's and daughter was informed that his life expectancy was short.*

*On arrival he was vague but amenable and appeared to be settling in when he got up from the dining room table and fell and sustained a fractured neck of femur (R). He was admitted to hospital and returned a few days later following total hip replacement - much more frail and with a sacral pressure sore and one to his L heel and had not been eating or drinking post op.*

*On his return he was given a Pegasus bed and had his pressure sores assessed and care planned. He was started on a turns and intake and output chart since he appeared to have swallowing difficulties he was offered and took teaspoons of fluids thickened with Thick and Easy at frequent intervals which kept him from becoming dehydrated and kept his mouth clean.*

*Two days later I observed his abdomen to be distended and no record of passing urine for nearly 24 hours. GP called, catheterised and drained a massive amount of urine. Indwelling catheter continued to drain. He remained frail but stable for another two days.*

*When I came on duty on Sunday a.m. the night nurse had mentioned his catheter as it had not drained overnight and OE his abdomen was very distended. I contacted the duty Dr who informed me he would have to go into hospital as she did not do catheterisations. I fiercely opposed this as the patient was so frail to travel. I didn't feel it should be necessary to put him through that ordeal.*

*I suggested contacting the District Nurse which she reluctantly agreed to do. The DN was not happy being called on a Sunday and wanted to clarify the position as she had never been called to the nursing home before – who was going to pay? I told her the patient was in the community and should be entitled to her services free but if this was not found to be the case I'd take responsibility. She said she only had one catheter and hadn't been successful with her last 2 but I persuaded her to have a go and when she arrived I reassured her and thanked her profusely.*

*Catheterisation was successful to the immediate relief of the patient. I stressed her valuable contribution and how she had avoided hospital transfer for a very frail older person.*



*The urine was cloudy and concentrated and on testing as suspected contained leucocytes and phosphates as well as a lot of protein and blood.*

*I asked the Dr to see him next morning and he prescribed triethopim? and we sent a CSU for culture and sensitivity. Next of kin were kept informed by phone and twice daily visit .*

*Patient deteriorated and duty doctor was called on Tues. am. He did not change the treatment and felt he was dying and daughter was informed tactfully and reassured that he would be kept comfortable and not admitted to hospital.*

*At midnight the daughter's husband phoned and was abusive to the night nurse – complained re care – wouldn't treat a dog like that etc. Said he should be in hospital getting proper care and would see me in the morning to complain and give me a piece of his mind.*

*I didn't wait for him! Instead I phoned the daughter and reassured her that he had had a comfortable night and was very content although losing ground. I suggested I call the duty doctor who had seen him the day before and that she came up and chatted with him after he saw the patient again.*

*Dr visited and agreed that he was in the best place to get appropriate care and explained to the daughter that Alzheimer's was a terminal condition and that further intervention was inappropriate.*

*She was reassured and apologised for her husband making waves but she wanted to be sure she had done everything she could for her Dad. I spent a lot of time empathising with her, assuring her that she had done and was doing all she could and I was not upset by her husband's abuse. I encouraged her to spend as much time as possible with her dad.*

*We continued with all personal care, position changes to offer thickened fluids. The night staff took turns to sit with him during the night and he passed away peacefully in the early morning. The daughter was contacted before death took place but didn't come in until afterwards. She was supported and given all information verbal and written re what the procedures were after death e.g. death certificate and registrars office. She was grateful for the care we had given and glad he had not been admitted to hospital. I was unable to attend the funeral as on holiday but my deputy did and felt that the daughter really leaned on her for support throughout.*

#### **WITHOUT THE RN'S INTERVENTION**

**Deterioration, pressure sores, dehydration, dirty uncomfortable mouth, abdominal distention, urinary retention:** *Without the Pegasus bed and position changes and appropriate wound care pressure sores would have deteriorated and caused more discomfort for the patient.*

*Without thickened fluids dehydration would not have been prevented and he would not have kept his mouth clean moist and comfortable without other uncomfortable mouth care.*

*Had he not been having his output recorded and my notice of abdominal distension his urinary retention may not have been picked up so soon, and catheterisation arranged to relieve his discomfort. Again without record keeping retention may not have been picked up so quickly the second time.*

**Appropriate care would not have been obtained:** *Had I not used my initiative and suggested the DN came and persuaded her to do so there would have been no alternative.*

*I instilled confidence to the nurse otherwise she might not have been successful with her catheter.*

**Resident would have died in hospital after the ordeal of travelling:** *Had I not been assertive with the GP the patient definitely would have been transferred to hospital to have it done and had the ordeal of travelling etc. the hospital would have been likely to admit him when they found him so frail and he would have ended his days in a busy understaffed acute hospital ward. This would not only have been distressing for him but his attentive daughter.*

**Relatives unhappy and complaining:** *Had I not been proactive in contacting the daughter when I knew the family was questioning his care things could have got nasty. Instead I managed to diffuse the situation and instead of making her feel guilty afterwards I convinced her that she hadn't damaged the relationship with the home.*

**RN reflections:** *Had he not been able to stay with us the nursing home staff would have felt that we failed him as we already felt guilty, although not responsible, for his fracture and subsequent deterioration.*

*Through good communication with family and GP etc the outcome was the best that could be achieved under the circumstances - a comfortable attended death. (from written example 261)*

Fundamentally, in these examples, the RNs:

- not only identified problems, 'diagnosed' what might be happening and took appropriate action, but also anticipated what potential problems might arise, recognised what actions could be taken and acted in order to prevent the problems occurring or being exacerbated.
- used knowledge, skills and experiences in leadership and management, in clinical care and in establishing relationships with a wide variety of people
- knew what services to contact and were assertive in obtaining these for residents
- knew the wishes of individual residents, i.e. not to go to hospital
- worked with families in proactive and supportive ways
- produced outcomes that were life-changing for those involved.



TWO EXAMPLES OF OUTCOMES OF THE LEADERSHIP, MANAGEMENT AND SUPERVISION WORK OF RNs

<b>HOW THE RN DESCRIBED HER WORK</b>	
<p><i>"When I was appointed to take charge of the unit (home for people with dementia) on a permanent basis I realised that to improve the standard of care the staff needed to be re-educated into a different pattern of thinking and working ... I do not take all the credit for all the good work as everyone worked hard to ensure that the residents received the treatment that they deserved. The receptiveness of the majority of the carers seemed to show that they may have had thoughts on "person-centred approach" they just did not know how to go about it. I felt that my contribution was showing them how easily a person-centred approach could be done. This is largely due to my past experiences and, of course, my training as a psychiatric nurse" (from written example 10.1)</i></p>	
<b><u>BEFORE RN INTERVENTION</u></b>	<b><u>AFTER RN INTERVENTION</u></b>
<p><b><u>Residents:</u></b> Remained in their bedrooms throughout the care; Washed, dressed, sat in an armchair for breakfast, toilet, lunch, toilet, supper, toilet, back to bed for the night; left for long periods on their own with no stimulation; need to communicate ignored.</p> <p><b><u>Care Systems:</u></b> Carers working on "conveyor belt" system; everyone received the same approach; care centred on food and elimination; each task rushed and little time on interaction;</p> <p><b><u>Staff:</u></b> High sickness rates</p>	<p>Atmosphere in unit livelier and less fraught; Residents responded to more relaxed atmosphere. Given choice to socialise, thus ending their solitary existence</p> <p>Carers, as keyworkers, encouraged to get to know residents under their care in greater detail</p> <p>Staff sickness reduced</p>

<b><u>RESIDENTS BEFORE RN WORK</u></b>	<b><u>RESIDENTS AFTER RN WORK</u></b>
<p><b><u>Miss W:</u></b> Fairly hostile; tried to maintain independence but, not knowing she needed help &amp; due to hostile nature was allowed to go about daily routine on her own; appearance &amp; general hygiene neglected.</p>	<p>As she developed better rapport with keyworker, became more receptive to help; developed into more loveable character; often heard singing and laughing along with the carers.</p>

Section 5.4: Findings: Outcomes of RN work

<p><b>Mrs S:</b> Spend all of her time in bedroom, chairbound and reliant on carers; remained isolated.</p> <p><b>Mrs F:</b> Deaf; never encouraged to socialise; perceived as vicious character; no-one bothered to communicate. Believed to be dementing but I believed she was depressed.</p> <p><b>Mrs P:</b> Always described to daughter as deteriorating; spend days slumped in armchair in bedroom being bed, changed, lifted in and out of chair.</p>	<p>Shows a keen interest in pot plants; instructs carers to put water in plants; enjoys sitting by the window watching everyone's movements.</p> <p>Began to talk about family in Scotland; hearing aid fitted and much appreciated; so happy; will hug carers and say "I love you". (She did not have dementia but depression and this is now cured).</p> <p>Revived, alert, making comments in conversations, mobility improved, can walk short distances.</p>
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<u>RESULTS OF THE WORK</u>	<u>HAD THE RN NOT INTERVENED</u>
<p><b>Residents:</b>            Better quality of life            Being treated as a "real" person            Recognising the person's strengths and working on them            Hopefully arresting eventual deterioration</p> <p><b>Families/relatives/friends:</b>            Happier relatives; feelings of guilt lessen as they see their loved ones in a nicer environment            Greater staff/relatives rapport which improves patient care            Decrease in complaints</p> <p><b>Staff and the home:</b>            Happy workers            Greater job satisfaction            Low sickness/absenteeism level            High morale</p>	<p>Rapid deterioration            Unhappy existence            Continued isolation</p> <p>Increase in guilt (feelings of abandoning loved one)            Complaints +++            Poor relationship with staff</p> <p>Rapid turnover of staff. Low morale -&gt; high sickness/absenteeism level            ? Maybe elder abuse due to frustrations            High rate of complaints which can lead to investigation by inspection authority</p>



**EXAMPLE OF THE CHANGES MADE IN THE FIRST 23 MONTHS OF AN RN TAKING OWNERSHIP AND MANAGEMENT OF 21 BED NURSING HOME.**

**BEFORE RN INTERVENTION:**

**Residents:** Minimal, if any choices; no choices in times of getting up, going to bed, limited menu; Day set around convenience of shifts; set by RNs; No stimulating activities – all probably causing depression, withdrawal and increased dependency;

**Care Systems:** institutionalised; strict, entrenched routines; documentation poor; no assessment tools to trigger care delivery; care plans not evaluated; Residents, relatives, CAs not involved in care planning or evaluation; two drug errors found in RN's first week.

**Staff:** RNs led by CAs; RN knowledge and practice based on rituals; no research or evidence base. RNs no further training, only from visiting company reps; CAs minimal training, no ongoing training. (from written example 101.1)

**CHANGES DURING FIRST 23 MONTHS OF RN INTERVENTION**

Complete change in philosophy and delivery of care with resident choice the main element

All staff seen individually by RN; philosophy and aims for home discussed; training needs identified; staff helped to apply for courses; funding secured for training; clinical supervision set up with outside facilitator; clear objectives set with staff linking with overall changes in the home; competencies developed; new programme of retraining developed; training has "mushroomed"; successful in-house programme – well-attended and staff time paid; CAs taking NVQ and courses in tissue viability, falls prevention, exercise and mobility, stroke care+++; one RN taking diploma and one EN completed conversion course (both having worked in nursing homes for 15 years with no updating); RN commenced degree

Staff shift patterns changed to allow residents more choice in pattern of day, particularly meals; culture of rehabilitation introduced; residents encouraged helped and supervised with their care to maximise potential for rehabilitation; rehabilitation introduced into care plans; residents involved in goal setting; one RN accredited course on exercise and now runs weekly classes for all levels of ability; individual exercise plans for residents; team nursing introduced;

New medication system allowing a more robust audit trail; Documentation completely revised alongside training and with support through supervision; validated assessment tools to help trigger care planning; CAs more involved in planning and evaluating in "communication" section of documents; evaluation of new documentation ongoing;

Pre-admission assessments introduced for all new residents; new pre-admission documentation including assessment of needs and risks; time spent with residents to identify priorities, day-plan to reflect previous lifestyle, avoiding boredom etc.

Activities in the home reflect client group; run throughout the week; include inter-generational work; home made links with village community; infants come to home twice-weekly; residents go to school productions; weekly art class successful; European funding secured for resident training; trainer appointed and residents (including those cognitively impaired) learning computers; life biographies being written by CAs with help from 15 and 16 year olds; Residents involved in recruitment and interviews;

Other outcomes: staff retention and recruitment improved; occupancy levels increased; feedback from staff on IPR positive and they are motivated to continue with the developments; feedback from residents at documented quality reviews positive; improved inspection reports; improved nursing documentation and care plan audits; successful rehabilitation of residents including one who went home.

The RN concluded: *“This is only skimming the surface of the changes implemented ... there are still a number of areas that need developing ... one thing really helped me keep going – the positive feedback from the residents”*.

#### **5.4.4: THE CONTRIBUTION OF THE OBSERVATIONS TO CONFIRMING, OR NOT, THE OUTCOMES THE RNs CLAIMED FOR THEIR WORK.**

The observations confirmed many of the outcomes the RNs claimed for their interventions across all categories of the outcomes framework. In the day-to-day realities the RNs have an overview of what is going on within the units they manage, and thus on outcomes in all categories, but their individual work focuses largely on the residents' health and daily functioning and on dealing with problems or acute situations that arise.

#### **5.4.5: INTERVIEWS WITH RESIDENTS AND RELATIVES**

##### **INTERVIEW WITH RESIDENTS**

Thematic analysis of the interviews with residents revealed that the outcomes they most appreciate of the work of the RNs focused on them being available to deal with health concerns, problems or emergencies, to 'keep an eye on things', to sort out complex care issues, administer their medicines and for nursing duties, or what



some called 'anything medical'. They also appreciated that RNs had professional, supervisory and managerial responsibilities. Residents were less immediately or urgently reliant on RNs than they were on CAs but stated that RNs clearly had a valuable contribution to make within the home. Some believed that a good RN was 'the key to things'.

**SUMMARY: RESIDENTS' PERCEPTIONS OF THE  
OUTCOMES OF RN WORK**

RNs ARE AVAILABLE TO DEAL WITH HEALTH CONCERNS AND PROBLEMS  
THEY 'KEEP AN EYE' ON THINGS  
RESIDENTS ARE KEPT WELL  
RESIDENTS ARE CARED FOR WHEN THEY ARE ILL  
HEALTH AND FUNCTIONAL PROBLEMS ARE SORTED OUT AND MANAGED,  
EVEN WHEN THEY ARE COMPLICATED  
MEDICINES ARE GIVEN  
'ANYTHING MEDICAL' IS DONE  
A TRAINED PROFESSIONAL NURSE CAN TAKE CHARGE AND RUN THINGS  
CAs ARE TAUGHT AND SUPERVISED  
THE DOCTOR IS CONTACTED WHEN NECESSARY  
RNs KEEP UP TO DATE AND BRING NEW IDEAS  
RNs ENSURE QUALITY WORK AND QUALITY CARE  
GOOD NURSES ARE THE KEY

**HAVING AN RN AVAILABLE TO DEAL WITH HEALTH CONCERNS AND  
PROBLEMS**

The residents said that they appreciated the RNs being available to deal with their problems, concerns or discomforts. Dealing with pain and emergencies were particularly mentioned. Knowing that a good, caring, knowledgeable and professional RN was available was reassuring for residents, particularly that they had trained in hospitals and had wide experience of dealing with different types of illnesses.

*"I don't have as much to do with them as with the carers. But they are always there if you need them" (Resident 915).*

[Ask for the nurses?] *"Yes sometimes, if I'm concerned about anything. It's reassuring just to know they're there if you need help"* (Resident 956)

*"If I have any problems - pain and things like that"* (Resident 501)

*"For my eyes being uncomfortable"* (Resident 952)

*"Pain at night from a bad shoulder - fix me with a hot pad. Anything they can for comfort"* (Resident 950)

### TO KEEP AN EYE ON THINGS

Residents appreciated that, with their knowledge and experiences, RNs could monitor their health and their problems.

*"They keep an eye on things, like in the case of my legs, my knees arthritis"* (Resident 508).

*"looking after your ailments"* (Resident 509).

### TO KEEP RESIDENTS WELL

The residents said that RNs keep residents well by recognising what was wrong and knowing what to do about it.

*"They help keep you well"* (Resident 510)

*"I think you do need nurses because they know the right way to do things.*

*The nurses check on my health every morning and even it it's only five minutes every morning. They ask me about my health and they're trained in the more intensities of nursing".* (Resident 255)

### TO CARE FOR RESIDENTS WHEN THEY ARE ILL

The residents particularly appreciated having an RN available when they were ill and said that the RNs can make people well again. One resident remarked that the RNs recognise when they are not feeling well: *"the nurses know when you're not up to it"*. Some also mentioned that the RNs nursed people until their death.

*"My memory is terrible. When I was in hospital I had cataracts in both eyes which they said they would do but never got done. I've also got a broken ankle and had a plaster on my leg when I came here. They have helped me to get the plaster off. I had my cataract done when I was here and the staff looked after me after that".* (Resident 952)



**RNs SORT OUT AND MANAGE HEALTH AND FUNCTIONAL PROBLEMS, EVEN WHEN THESE ARE COMPLICATED**

Many of the residents had come into the home with problems which the RNs had been able to sort out, even if they were complex. Particular problems mentioned included nocturnal urinary incontinence, hearing problems and mobility problems.

*"They get on with things here. This is an instance – this boot has a calliper on. The sister who got me this said try for a week or two and then, if that's good we will get you black ones. It's been fine and has made such a difference to me. I also had ear trouble and they got the audiologist and they syringed it out and it's fine. They sort things out for me and once I can get walking I'll be feeling fine". (Resident 952)*

*"I have just had a bit of nursing that has been really marvellous. I have had a bit of trouble with lumps on my breast and something for my sleep and for some reason the mixture of medicines I was having have given me this nocturnal problem. You pass water in your sleep but don't have time to get to the lavatory. And the way they have handled this and adjusted things ... and I think we have got it right now. Last night I had a good night and they arranged for a time in the night when they woke me to go to the toilet and it worked and I didn't have any of this struggle. It was terrible at first. I had to fall about of bed and run dribbling into the toilet. It was terrible. And they have taken every care to get it right. And they were all so pleased and it makes me feel cared about" (Resident 957)*

**MEDICINES / TABLETS**

Virtually all of the residents said that the nurses look after any medicines or tablets they need to take. Pain killers were commonly mentioned. Several residents said they didn't know what the tablets were for.

*"The nurses have to look after ... like any medicine or tablets we have to take ... I don't know what they give me ... I don't know what they're for but I trust them - I have to ... whatever pill they give me does the trick" (Resident 501)*

*"The nurses bring the tablets. I don't know what they are all for but they don't know either. I ask sometimes" (Resident 507)*

*"Put my eye drops in, bring around the drugs". (Resident 952)*

### UNDERTAKING NURSING WORK / 'ANYTHING MEDICAL'

The residents also said that the RNs were able to do all the tasks that CAs could not do, including dressings, changing catheters, as well as "anything medical".

*"They look after the medical side and the others look after your general health ... if I don't feel well, headache, depressed" (Resident 510).*

*"If you have your catheter changed it has to be done by a nurse but the care assistants do change the colostomy bag. They can change the bag but mustn't insert it" (Resident 506).*

*"They do everything the others can't and aren't qualified for. If I have a cut or something medical. They put the catheter in. The CAs change the bag" (Resident 507).*

### A TRAINED PROFESSIONAL NURSE TO TAKE CHARGE AND TO RUN THINGS

Many of the residents stressed the importance of having a trained professional nurse in charge of the home, to manage the home and organise the care. Some felt this was particularly important because of the nature of the residents and their needs.

*"All through the hospital training and SRN and in hospital you get the responsibility of the ward. You learn to manage a lot of people who are ill and how to deal with all the different types of illnesses" (Resident 950)*

*"It's important to have nurses. They are nursed till the end of their lives and a lot of them ... we had a lady who had a tumour on the brain and needed a trained nurse because she was on injections to stop the pain. When they did that, they always checked that it was the right amount". (Resident 951)*

### TEACHING AND SUPERVISING CAs

Residents recognised that CAs were limited in what they could do and appreciated that the RNs were there to supervise their work.

*"They supervise all the work and make sure that things are running as they should. They bring 'round the medicines and check on the patients. The nurses are ready to join in anything. They're all very cheerful and that makes for a nice atmosphere". (Resident 954)*

### TO REFER TO THE DOCTOR

Being able to see the doctor was important for residents and the RNs arranged this.



*"If there's anything wrong the nurse sees to it. She puts it in the book and the doctor comes; for my piles, constipation and twice for my leg" (Resident 502).*

### KEEPING UP TO DATE AND BRINGING IN NEW IDEAS

Some residents noticed that RNs kept up to date, for example by going on courses, and brought new ideas to the home. A few also commented that residents' new ideas were welcomed.

*"Here they do a lot of teaching but they back up the teaching with experiences and they send them away on courses for different things, for example massage or any type of nursing. You can achieve a lot with ten minutes massage". (Resident 955)*

*"They go to London headquarters and they go to talk to the others. And they're all very efficient in the way they do things but they are open to suggestions about how things could be done. If you have an idea Matron welcomes it". (Resident 956)*

### ENSURING QUALITY WORK AND QUALITY CARE

Ensuring the quality of the care overall was important to residents.

*"Everything's thoroughly well done and it's checked, it's not just left. No moment is wasted during the day - you get full value, particularly from the Sisters. They do the checking" (Resident 955)*

*"They come around from time to time to see how the staff are spending their time or how the nursing is going. It's a pity that there aren't more centres like this". (Resident 935)*

*"I think the nurses do more specialised care on the nursing side. It's really well run and that gives me confidence because I know things will be alright. If things are a high standard it gives confidence". (Resident 955)*

### GOOD NURSES ARE THE KEY

Residents believed that good nurses were the key to a good home.

*"People with real nursing training are the key to it in the way that they influence the attitudes of those less experienced people and the way they make a link between the human side and the medical things. Because some of them have quite difficult pieces of nursing to do and as you get older you*

*need it. Of the two nursing staff, one is always fully qualified in each of the different groups around the place and I think a lot of that is the key to it. They make the link from the needs of the patients and the needs of the staff and, even when the patients talk nonsense with them, they have got their respect. This is important. And their readiness to put themselves out, even in the middle of the night. The human side and the medical side are inseparable. It's the leadership of the nursing staff. One is aware of their ability to react to the needs of the patients as human beings, not just as cases. I found that differed a lot. I have visited a lot of homes - nursing and residential. You can take anybody who needs caring and the same things apply". (Resident 957)*

### INTERVIEWS WITH RELATIVES

As with the residents, the relatives believed that the RNs were the key to a good home. They felt that, with good RNs who had appropriate values and sound expertise, knowledge and skill, the residents were valued by staff and treated positively, were treated with caring, compassion, understanding and support and were treated like human beings.

The relatives believed that good RNs took responsibility for everything in the home in order to ensure that all the influences on care were well managed. For example,

- there was good leadership in the home
- the home was well run.
- staff with appropriate attitudes were appointed, trained, led and supervised by the RNs in the home.
- high quality care was maintained in the home.
- residents and relatives felt reassured and had peace of mind knowing the care was reliable and of good quality.
- RN expertise was always available for when their relatives were taken ill, needed to be checked; RNs brought the medical care
- RN could call a doctor or obtain whatever care the resident needed.
- relatives could have advocate support when necessary

The relatives interviewed felt that RNs had far superior expertise to CAs.



*“RNs are better than CAs because they have understanding ... the fact that they have taken up nursing means that they have a certain kindness in the main. Because they’ve trained the nurses should be far superior. Nurses have more understanding so the more nurses you have the better”* (Relative 704)

Relatives who participated felt that RNs met their priorities in terms of outcomes. They greatly appreciated the RNs in the homes because their professional background, expertise and leadership skills gave the relatives, and they said their relatives, confidence that the care they were receiving was good.

*“It's important to have nurses in a nursing home because they bring the medical care. It reassures our mum that she's qualified”* (Relative 703).

Relatives said that it was the RNs who led the staff and set the standards.

*“Leadership is important because C [matron/manager] has high standards with who she takes on, if there's anything that's not right they're out of the door and that's how it should be”* (Relative 702).

The relatives wanted were RNs who had appropriate attitudes and values which they engendered in all staff, had high level registered nursing expertise, knowledge and skill, and who were caring, compassionate, understanding, supportive to both residents and relatives and 'treated them as a human being'. They also wanted regular staff in the home, not bank or agency staff. They wanted to be reassured that RN expertise was always available for when their relatives were taken ill, needed to be checked or needed the doctor to be called. They also wanted to be informed of any change or concern, no matter how slight and to have advocate support when necessary. One relative explained :

*“It's difficult for relatives because you have high standards and you want the very best for the person you love and have cared for at home until you couldn't manage any more. We realise that it isn't always possible for homes to meet these standards. We wish they could go on more outings as it's a lot easier for them to take them than for us. But the most important things are caring, and simple things - whether she has people to talk to”* (Relative 703).

#### **5.4.6: DISTINCTIONS BETWEEN RNs AND CAs WITH NVQ LEVEL III**

In Home 3 the CAs worked within a career structure. Of the CAs interviewed in Home 3, 20% had achieved NVQ Level II and 40% NVQ Level III. The Level III CAs acted as Team Leaders. Those with NVQ II reported that, through this, they could understand better how a patient might feel and about the importance of preserving respect, dignity and privacy. They felt competent in their day-to-day caring duties and would help to supervise newly-appointed CAs. NVQ III Team Leaders undertook some RN duties to the level of their individual competence. Their work included giving medications dispensed by the RN, dressings, observations (blood pressures, pulses, temperatures), urine testing, supervising daily diet, admitting new residents to the home, writing evaluations on the care plans. They would also telephone the doctors when they felt it was necessary.

When asked to draw distinctions between their work and that of RNs, the NVQ III CAs emphasised that RNs had a much broader range of competence, particularly in dealing with illness. They also emphasised that RNs had a much longer and more comprehensive training, usually many years of clinical experience in a range of settings, and ultimately their professional accountability. The NVQ III CAs said they would work within their own competence but always report to a RN if they had any doubts or queries.

*"I do anything I feel confident to do. Anything I'm worried out - a dressing that looks infected or nasty, I get the sisters in charge" (CA 915 NVQ III).*

The NVQ III CAs believed that their expertise and competence were specific to older people with long-term care needs and specific within a care home environment

*"Our training is supposedly along the same guidelines [as nurses]. I know what I'm doing with the clients here but out of this field - no" (CA 902 NVQ III)*

*"With a pregnant woman I wouldn't have a clue where an RN would. I could do blood pressure and temperature as with any human being but specifics I wouldn't have a clue. My expertise is purely with the elderly" (CA 912 NVQ III)*

*"RNs have more experience to deal with [if someone's taken ill]. Ours is work-based here in this environment" (CA 902 NVQ III)*

*"They've done the training at the end of the day" (CA 902 NVQ III)*



### **5.4.7: INADEQUATE AND INAPPROPRIATE OUTCOMES OF CARE**

The majority of examples, observations and interviews suggested that the outcomes of the work of most RNs would be positive. There were, however, a small minority of RNs whose care would be deemed inappropriate or inadequate within current 'best practice' guidance.

#### **THE SIGNIFICANT EXAMPLES**

Among the Phase 1 examples, one EN example described care that would likely be detrimental to residents and would, within current guidelines on 'good practice' (e.g. RCN 1999) be defined as restraint. The EN described that the restraint was to stop the resident falling but then stated "*in fact she did fall and could have hurt herself more so in that way it doesn't help her at the end of the day*" (example 2.5). There were other examples of inadequate care. Although the RNs described the positive actions they took and the good care they delivered, in a number of instances this was specifically rectifying inadequate or inappropriate care which had been offered by other RNs. For example when RNs took over the management of units where care had been totally routinised, to the considerable detriment of residents (examples 1.3, 101.1). There were examples of where an RN worked to heal a pressure sore (example 101.2) or a leg ulcer (example 102.2) from which the person had suffered for considerable time (in the case of the leg ulcer 15 years). This would strongly suggest that the previous care, presumably delivered by RNs although not necessarily in nursing home settings, was not ideal. In one of the examples offered above (example 266) the RN coming on duty identified a life-threatening situation that the night duty RN had not identified. Without the day duty RN's intervention, the resident could have died. There was also the suggestion in some examples of routinised or ritualised practice, for example of residents 'having' to go to the day room, or "*we usually have 12 patients in bed by 8 pm*" (example 267).

#### **THE OBSERVATIONS**

The majority of RNs whose work was observed gave sound care but there were a couple of situations where care was inadequate. An EN had a poor knowledge-base and I intervened on one occasion to prevent harm to a resident. She was dressing four wounds on a resident's upper spine, sacrum and heels. The wound on the

upper spine was infected with MRSA but the others were not. The EN was about to dress the MRSA infected wound first and then use the same equipment for the other wounds, potentially carrying the MRSA to these. The EN was unaware of the dangers in this practice. Another example was an RMN in a dementia unit claimed that the primary therapy in his unit was Reality Orientation. This was questionable for the residents on that unit and, even if it had been advisable, there were a wide variety of 'realities' in the unit (this example is discussed in the Conclusion).

#### THE VIEWS OF RESIDENTS AND RELATIVES ON THE VARIATION AMONG RNs

Residents were very clear about what they valued in RNs, as shown above, but a few residents and relatives commented that some RNs were better than others. One resident spoke in detail about the varying quality of nursing care he received. He said:

*"It's not just the numbers of staff it's the type of staff - some are better than others. Usually you get some good and some not"* (Resident 509).

He spoke with great frustration about the nurses who were not good and whom he blamed for his recent hospital admission.

*"I've had good nurses here - J and S and L - they're really brilliant, but these here, you might as well pull the plug - look at this one, she wanders around like a lost sheep - makes me wonder how some of them get their sister's badges. You'd say to J and she'd be down in two minutes and sort it out. She was well trained. Catheters, medicines, she knew all about that side of things but this lot - yuk - speak to the wall"* (Resident 509).

#### 5.4.8: OVERALL FINDINGS: THE OUTCOMES OF RN WORK.

The findings from all datasets conclude that the outcomes of RN work are broad, multi-level and impact in varying time-frames. They cover all categories within the framework. Fundamentally with good RNs problems are anticipated, avoided and dealt with so deterioration is prevented, in as much as this is possible, and optimum resident health and functioning is maintained. This, in turn, helps them to enjoy better quality of life. The RNs' 'responsibility for everything' was highlighted in all datasets. The management and leadership of RNs, coupled with their clinical



nursing inputs, were the major determinants of all outcomes. As highlighted in the examples above, RNs could bring about total change in homes. The residents highlighted that “good nurses are the key” in ensuring quality care, in obtaining services for residents and in keeping up to date. The relatives also highlighted the major influence of RNs in valuing residents and treating them with caring, compassion and understanding. The RNs were able to achieve these outcomes not only through their own actions and through teaching and supervising the CAs and other staff but also through the services they obtained from outside the homes.

### PROBLEMS AVOIDED

Through their knowledge and skills, vigilant RNs anticipated and prevented all sorts of problems, as can be seen in the examples in Section 5.4.3 (page 293) above. Those listed by RNs in their examples and interviews included skin breakdown, infections, wound problems, falls or accidents, pain, the complications of illness such as chest infection, hospital admission and death.

Problems were also avoided because RNs were ‘on the scene’ when a crisis or acute situation arose. Some RNs were able to anticipate when a crisis might arise, even sometimes when they were unable to see the full circumstances, and they were able to take action to prevent the crisis, as in the example in Section 4.2.2 (page 212). Supported by their personal and professional knowledge, skills and instincts, this RN ‘perceptual presence’ was crucial in determining the ultimate outcome of the situation – a crisis avoided or a crisis which developed with potentially detrimental outcomes for residents.

### HEALTH AND FUNCTIONING

Through their knowledge of health, disease, medicines, rehabilitation and nursing care, good RNs help to residents to maintain optimum health and regain this when lost. Residents’ health commonly improved following admission to the homes with the improved nutrition, fluids and care they were offered. Their health problems were addressed by the RNs and their medication adjusted where necessary. Most of the

RNs also focused on health promotion in order to achieve, for example, optimum bowel functioning and sleep.

Through the rehabilitative and therapeutic work of good RNs, residents were able to regain functioning they had lost and to achieve and maintain optimum functioning and independence in all aspect of life. Areas particularly mentioned in the data were sensory functioning, communication and responsiveness, personal care activities such as washing and dressing, mobility and continence. Achieving optimum health and functioning could be highly challenging in view of the complex health needs of residents, including multiple diseases and disabilities and the necessity to take multiple medication. RNs were particularly influential on resident health and functioning through the balance in their care regimes between nurturing/caring for and rehabilitating/re-enabling. The residents were particularly appreciative of how the RNs helped to keep them well and sorted out their health problems.

#### PERSONHOOD AND WELLBEING

This was achieved through the work of RNs personally and also through the regimes implemented in their care plans. Personhood and wellbeing was particularly challenging to achieve for residents with mental health needs. Personhood and wellbeing were achieved through the ways in which the RNs treated them, e.g. with dignity and respect, taking an interest in their experiences and biographies. It was enhanced when the regimes were focused on each individual. Autonomy (characterised in the data by consultation, choice and control) was achieved through the explanations and choices RNs offered to residents.

Relationships were a key aspect of personhood and these were facilitated by good RNs between residents and staff, with residents' families and between couples, some of whom lived in the homes. They were able to stay together and continue to care for each other as they wished. Residents' sexuality needs, including the forming of new relationships, were treated with sensitivity, respect and understanding.



Spirituality and religion were also key aspects of personhood and wellbeing. Residents were supported in their beliefs and religious practices in their day-to-day care and by visits from religious ministers.

Ultimately, residents could achieve peace of mind knowing there were good RNs available to care for them when needed and knowing that they were being helped to achieve optimum health and functioning.

### QUALITY OF LIFE

Through the environment and atmosphere they created in the homes, the RNs contributed to quality of life. Safety and the minimisation of unnecessary risk was important, as were the levels of light and noise. The psychological environment, e.g. whether staff were happy was also influenced primarily by RNs. RNs facilitated residents' recreational and social activities, the celebration of birthdays and Christmas, and entertainers coming into the homes. The RNs' teaching was highly influential in residents understanding their health and functioning, the medicines they were taking and actions that could be taken to optimise health and functioning. The RNs were also key determiners of whether residents were able to stay in the home rather than taken to hospital or forcibly moved, e.g. by relatives. Through good care led by RNs residents were occasionally able to go home to live.

### RELATIVES

Through the work of good RNs, relatives were happy that their loved ones were receiving good care, that contact was maintained with families even when they were unable to visit, and that relatives were welcomed in the home.

### SERVICES OBTAINED

Services from outside the homes (e.g. GPs, specialist medical consultants, district nurses, specialist nurses, audiology, speech therapy, dentistry) were obtained by RNs, sometimes only through RN assertiveness and persistence.

### OUTCOMES FOR STAFF

Under the management and leadership of good RNs, staff were happier in their work and gained greater job satisfaction, as illustrated in the examples in Section 5.4.3 (page 298). Staff sickness, absenteeism and turnover were reduced. Staff felt empowered and there was good teamwork. Through staff teaching and supervision up-to-date care was offered and some staff said that the risk of resident abuse was greatly reduced with adequate staff training and supervision.

### OTHER OUTCOMES

The work of good RNs resulted in homes achieving a good reputation, good inspection reports, reduced complaints and higher occupancy. There were also outcomes in terms of cost savings, for example for reductions in, for example, the use of unnecessary or ineffective medicines, e.g. antidepressants, the use of continence products when continence was achieved and the the level of staff input needed as residents become more independent.

Ultimately, many of the residents emphasised that RNs were the major determinant of outcomes of care and that good RNs were the key to running good homes.

*"A good nurse is someone who cares for you and can do things. Nurses know what's the trouble and how to deal with it" (Resident 509)*



## **SECTION 5.5: FINDINGS: THE INFLUENCE OF THE 24 HOUR RN PRESENCE ON OUTCOMES**

Strongly emerging from all the datasets were the implications for resident outcomes if RNs were not present and available in the homes. All participants believed that the 24 hour presence of RNs in the homes was essential because of the complexity of the residents' health needs. Their views are discussed and examples are offered.

### **5.5.1: RESIDENT AND RELATIVE VIEWS**

Although the RNs generally had less direct contact with them, the residents and relatives were adamant that, with their current care needs, they needed RNs in the homes. They said that the CAs needed someone to supervise their work.

*"You need the professional accountability that a nurse brings. The carers look up to the nurses and admire them"* (IV Resident 502)

*"Without nurses there would be nobody official to do anything and the carers would have nothing to fall back on".* (IV Resident 951)

The residents said that nurses were essential because *"they know the right way to do things"* (IV Resident 503) and the right action to take when residents were ill.

*"I feel safe because I know that, whatever happens, I will be looked after. If there's an emergency the nurses will know what to do and, if necessary, they will telephone the hospital"*(IV Resident 501)

*"There would be a lot more people sick and dying and less happiness ... And if there were no nurses here there would be more deaths, more illness, more sadness, more grief. If you haven't got nurses for making a person well, then all the patients would suffer. And the nurses do help to keep you well "* (IV Resident 510).

The residents stressed that there would be no-one to deal with problems and they would have to keep calling the doctor *"like at four in the morning"* (IV Resident 506).

*"People with real nursing training are the key to it"* (IV Resident 950)

The relatives too were unanimous that the 24 hour presence of RNs was essential. They said that *“it would be awful, it would quickly go down hill and they would keep having to get the doctor in”* (IV Relative 702). One said *“There would be no-one to dish out the medicines. You couldn’t have carers doing that. And you need a nurse in case something happens like someone falls”*. She concluded *“a lot of them wouldn’t be here for long - their health would deteriorate”* (IV Relative 703)

*“I think it would quickly go down hill. Nurses must be the strength of the place in that they have more responsibility. They’re responsible for the carers as well and have to see what the carers are doing. A [wife] fell and they immediately called the nurse. She has fallen about three times - a trial and error aspect of the drug. You couldn’t have people like this and no nurses. You need a nurse to keep an eye on how they are coping day to day - that they’re reasonably happy and not distressed”*. (IV Relative 704)

*“You couldn’t have a place like this with no nurses. The place couldn’t function without nurses”* (IV Relative 703)

### **5.5.2: CARE ASSISTANT VIEWS**

The CAs also believed that RNs were necessary in order to take charge, to take responsibility and to have accountability. They did not believe that this role could be carried out satisfactorily by a care assistant.

*“You need leaders. Its not just the knowledge it’s the confidence and how they handle thing. Organisational skills being in charge”* (IV CA510).

*“We would run into problems - I wouldn’t cope at all”* (IV CA509)

*“If there were no RNs, standards would slip. You need someone qualified in overall charge. A RN is a step apart, they’re qualified, they know more and when in charge of a group of carers they have the authority”* (IV CA509).

All of the CAs, even those with NVQs, said that, without RNs in attendance, they would not want to cope, and not be able to cope, when a resident was taken ill.

*“I couldn’t cope regarding their health. I’m not trained if someone’s ill. The nurses recognise a lot more than we can. I knew something was wrong with J*



*the other day and thought it was his heart. I called the nurses – I don't know what to do" (IV CA506)*

*"if there were no qualified staff we could dial 999 and give them oxygen, do first aid and resuscitation but, without the qualifications, I wouldn't like that put on my shoulders. I like someone qualified to take over. I will be there to back them up every step of the way and do it with them but I like someone that's been trained and has the knowledge of what to do". (IV CA509).*

*"You've got to have a nurse. With the elderly and there can be an emergency - ministrokes, or heart attacks. The relatives want someone here. They're qualified, studied for 3 4 5 years. We have common sense to see they don't look well, they are qualified to know if there's anything wrong" (IV CA508).*

*"You definitely need nurses. These people need nursing care" (IV CA503).*

*"Doctors would be called out for every little emergency because we couldn't take the responsibility. I certainly wouldn't want to" (IV CA907 NVQIII)*

### **5.5.3: REGISTERED NURSE VIEWS**

The RNs expressed concern about resident outcomes without their presence. They felt that the CAs would care for the residents and may identify changes because they were with them and had 'common sense', but they believed the CAs would not be able to identify important health changes.

*"RNs spot things the CAs can't - haematemesis, chest infections, preventing pressure sores, falls, good diet, confusion. An RN can spot a urine infection a mile off" (IV RN502)*

*"they don't always spot problems, even basic things like feet turning blue or bowels not open – things that can't be left for a couple of day. I think the residents would be looked after but there would be an awful lot of pressure sores. You or I would see an area that doesn't look red or as if its breaking down but you can see the underneath is like marshmallow so you can see its going to break down big scale but the carers wouldn't see that. They'd think of pressure areas as the actual skin being marked rather than looking at the surrounding area like we are trained to do ..." (IV RN505)*

Even if CAs recognised that something was wrong, RNs believed that they would not have the knowledge to know what should be done about the problems. Many CAs, they believed, would make assumptions on what action to take. RNs said that the CAs' natural instincts were to make someone comfortable but they could miss the urgency in the situation. The CAs would also not know how to take observations that would help to explain the condition of the resident.

*"Little sores – or basic constipation – they would say she's been to the toilet today – but I need to know was it constipated or loose – was there a lot or a little – quality and quantity – urine infections – strong smelly – they miss those things without constant reminders. They say they don't like the look of someone so we say have you checked their urine and so on. It's not picked up in residential homes and pressures sores develop quite quickly there. Even if they just have a cold and no one goes in and they're in bed with no one changing position". (IV RN901)*

*"RNs can see much deeper into problems. You don't see it superficially you look into other reasons for there being problems not just at the problem. E.g. a lady who we are sorting her night time incontinence it's not just padding her and letting her get on with it she's had a scan and we've sorted drugs after the scan. Not just making her comfortable but by trying to solve the problem. We have particular knowledge" (IV RN915 Sr)*

Many RNs said that they were able to anticipate what might happen, to recognize warning signs in advance and make decisions on what to do. Crucially they would know when to call a doctor and when the situation could be managed in the home. They could

*"make a judgement about whether someone had a stroke or a heart attack and know what to do. If someone is on the floor unconscious CA would likely call 999, RN would investigate" (IV RN916)*

RNs said that, without their presence the doctors would be called frequently.

*"GPs would be coming on a regular basis or they'd be rung so often they wouldn't come when called, which is more to the point" (IV RN915)*

The RNs stressed that they would work with doctors and other disciplines in a professional way and at a professional level. Through this, multidisciplinary care



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became a possibility. CAs, on the other hand, even those with NVQ, could not maintain such professional dialogue or advocate as strongly for resident care. Doctors sometimes asked RN advice, for example concerning continence, pressure area care, leg ulcers or wounds.

*“The doctors listen to us especially with wound care - they really don't know”*  
(RN916 Senior Sister)

RNs also said that, in addition to the knowledge to deal with situations, the confidence they brought was important.

*“RNs are non-panickers, have confidence, cope with frightening situations like choking and can show the girls”* (IV RN701).

RNs said that CAs generally tend to accept residents as they are and to work in the here-and-now without recognising the long-term potential for individuals. Conversely RNs

*“know what can be achieved and how it can be achieved and this can make the difference between someone walking and not walking”* (IV RN501).  
They can *“show staff how things can be achieved, for example a person-centred approach”* (Example 1.3c).

All the RNs believed that, without their support, the CAs would not be able to cope with deterioration in the residents.

*“Things wouldn't be picked up and would be overlooked. Standards would drop and the level of care would drop. The nursing needs wouldn't be met, or identified and residents would not have in-depth care”* (IV RN504)

*“Care would become focused on task, food and elimination”* (Example 1.3c)

RNs gave a list of things that CAs would like “bypass”. There would be

*“a lot more pressure sores and these would develop much quicker, more falls, people falling out of wheelchairs, more aggressive behaviour, sore ankles, cramps, people who have stopped walking - some people have had a second stroke and become more paralysed. Also the CAs couldn't cope with the number of medicines prescribed to the residents”* (IV RN502).

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*"Medical things. You can see the difference by going into a residential home - simple things like diabetes or angina can't be managed. They don't know. I don't think you can train someone up to NVQ level III or IV that would have the knowledge that we've picked up as general nurses over all these years. It's all our experience and not just what you learn in the text books but what you pick up and gut feeling and all that sort of thing which is even more important with residents like these". (IV RN715)*

The RNs stressed the importance of their role in supervision, leadership and management.

*"To make sure they get the diet appropriate to their condition – to monitor they are actually getting fed – some put a meal down and don't make sure they've had it. To notice how much someone's eating – go through the weight book on a monthly basis – if they're not enjoying their food – why? Is it their teeth – are their tablets affecting their taste – things like that. You know that someone whose gone from being active to being incontinent and unable to move around independently is going to become depressed. You can bladder train them or get to know when these accidents are going to happen so even though they don't manage it themselves you can 95% of the time catch them so they're not wet - and that's experience. CAs couldn't do that" (IV RN901).*

RNs also identified the importance of their knowledge and years of experience in different clinical settings underpinning their ability to care for the residents' health, prevent deterioration and deal with acute situations.

*"I've worked in lots of different clinical areas and have managed care in lots of different areas so I can recognise a stroke or fractured neck of femur because I've seen so many in casualty or orthopaedics" (IV RN505).*

*"I've got the experience and I've got the theory behind it which the NVQ hasn't - they have basic theory but not what I went into when I did my training ... say a DVT the NVQ nurses wouldn't know. That knowing comes more from experience than training" (IV RN916 Senior Sister)*



**5.5.4: EXAMPLES HIGHLIGHTING POTENTIAL OUTCOMES WITHOUT RNs**

The following examples illustrate a variety of situations in which RNs took action. They highlight the actions taken by both CAs and RNs and what could have been the outcomes if RNs had not been present in the home or had not acted as they did. These are exactly as relayed by RNs, not as interpreted by researcher, i.e. the RNs themselves suggested the likely consequences if they had not acted as they had.

<b><u>EXAMPLES OFFERED BY RNs WHERE THEY RECOGNISED WHAT WAS WRONG, KNEW WHAT ACTION WAS REQUIRED AND TOOK THIS</u></b>		
<b>THE CIRCUMSTANCES</b>	<b>ACTIONS TAKEN BY THE RN</b>	<b>LIKELY CONSEQUENCES WITHOUT RN ACTIONS</b>
Resident unwell. CAs put her to bed and CA reported her unwell when they turned her.	RN examined and found her foot cold and no pedal pulses. Sent her straight to hospital. Embolus diagnosed	CAs could have wrapped feet or applied hot water bottle and caused burns; gangrene in foot; resident could have lost foot.
Resident had indigestion; history of ulcers	RN investigated blood pressure, pulse, respirations and monitored. When pain moved into shoulder and arm RN called GP. Resident went to hospital and had heart attack. Crash team called. Resident recovered.	Could have continued giving 10 mls Gaviscon for indigestion and resident died. When pain severe resident could have realised and called for help but probably too late and would have died.
Resident had been ill with 'flu. RN went to bedbath.	RN recognised red/white demarcation around one leg. Called GP. He said "it's not a deep vein thrombosis (DVT) it's just a bit of cellulite. Keep her in bed". Few hours later RN not happy and rang for her to be taken to hospital. DVT diagnosed and treated. Resident recovered.	Resident could have lost a leg; DVT would have moved resulting in pulmonary embolus, heart attack or stroke and death.

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<p>CA called RN to see resident (who could not speak) because she thought was having a stroke</p>	<p>RN recognised that, in addition to severe pain in right arm, this was discoloured. RN recognised arterial embolus, rang for ambulance and rang A&amp;E to inform them of her diagnosis. Immediate embolectomy in hospital and resident fully recovered.</p>	<p>Resident could have lost a limb or died in pain and fear. CA had assumed that, as resident had previous strokes, this was another stroke.</p>
<p>Resident had fallen during the night and gone back to bed but was still in pain.</p>	<p>RN examined, pulled back bed covers and recognised fractured femur from leg shortening. Ambulance called, arrived within 10 minutes.</p>	<p>Resident could have remained in agony and bled internally.</p>
<p>Resident cancelled his daily newspaper</p>	<p>RN went to investigate. Resident said the sight in his eye had suddenly gone. RN sought investigation and detached retina diagnosed.</p>	<p>CA had assumed resident was being 'grumpy and demanding as usual'. Without RN, diagnosis of detached retina would not have been reached and possibility of corrective surgery explored.</p>
<p>New resident very anxious and awoke at 3 a.m. with chest pain. CAs wanted to ring 999.</p>	<p>RN recognised anxiety and thought that going into ambulance could cause heart attack. Treated resident for angina and sat with her. Angina attack passed.</p>	<p>Resident could have suffered trauma and further anxiety of going to hospital unnecessarily.</p>
<p>New resident was very unwell and deteriorating quickly.</p>	<p>RN believed resident had had a fit but nothing written anywhere, not even in drugs sheet. Found phenytoin in resident's handbag and rang relatives who confirmed resident was epileptic. Resident went to hospital and recovered.</p>	<p>Untrained staff would likely not have recognised a post-fitting state. Resident could have continued to deteriorate and died.</p>
<p>Resident choked on breakfast and went blue. CA</p>	<p>RN pulled out teeth and unblocked airway.</p>	<p>Resident could have choked to death.</p>



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panicked, "Oh God, Oh God"		
Resident choked on breakfast, went blue, lost consciousness, cardiac arrest	RN removed food and tried resuscitation for some time. Resident recovered, ambulance arrived, resident taken to hospital and recovered.	Resident would have died by choking or not recovered from cardiac arrest.
Resident rolled off the bed, hit skirting board, fractured skull and punctured cranial artery	RN put cold compress on head and rang for help. Resident recovered.	Resident could have bled to death.
Resident had a nosebleed. CA said "it's pouring with blood". Dial 999	RN knew resident's history. Monitored bleeding rate, blood pressure and for faintness. Bleeding stopped and resident recovered.	Resident could have gone to hospital or GP called.
Resident had redness and soreness under her breasts	CAs put on talcum powder to keep dry. RN recognised fungal infection, asked GP to prescribe cream and fungus healed.	Without antifungal cream, fungus could have spread. Resident would continue in discomfort.

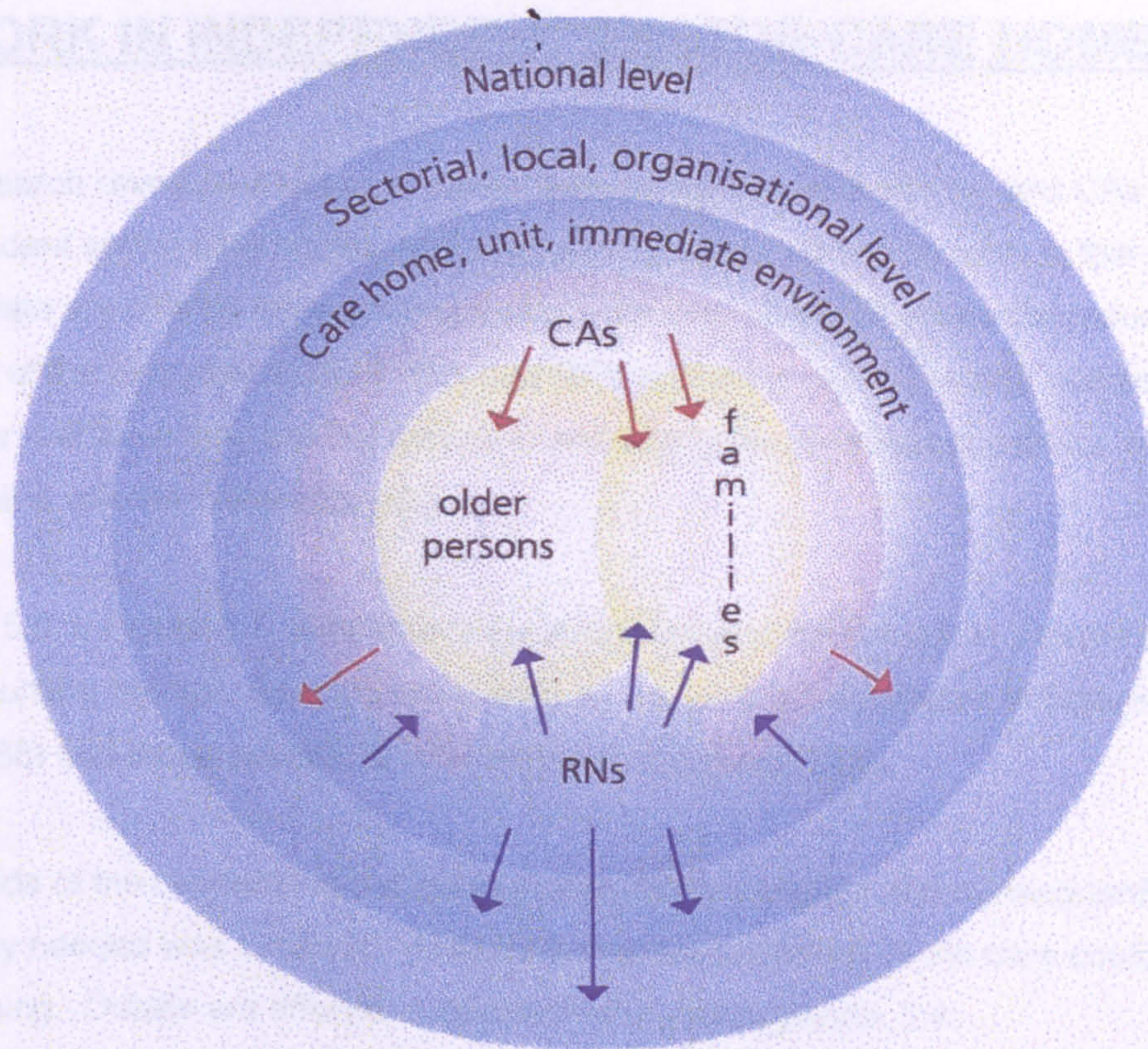
A selection of these examples are offered visually as flow charts in Appendix 5.3

**5.5.5: THE COMPARATIVE INFLUENCE OF RNs AND CAs ON OUTCOMES**

Figure 5.1 below illustrates the findings on the relative scope of the influence of RN and CA work on outcomes.



**FIGURE 5.1: FINDINGS: SCOPE OF INFLUENCE: RNs AND CAs**



The pink shading and red arrow indicate the sphere of potential influence of CAs (i.e. older persons, families, RNs and the care home, unit or immediate environment).

The blue shading and blue arrows indicate the sphere of potential influence of RNs; primarily older persons, families, CAs and the care home, unit or immediate environment. As the figure suggests, some RNs influence at sectorial, local or organisational level and a few at national level.



## **SECTION 5.6: FINDINGS: ISSUES SPECIFIC TO WORK IN INDEPENDENT SECTOR CARE HOMES**

The research revealed a range of issues influencing the work of RNs and CAs in independent sector care homes and a range of aspects distinct to work in this sector. These data are offered for examination because they vividly illustrate the nature and realities of the everyday work of RNs and CAs with older people in care homes. However, because they are not central in answering the research questions, much of the detail is offered in the appendices.

Section 5.6.1, Figure 5.7, illustrates the general influences on work in independent sector nursing homes. Specific influences on CA work are illustrated in Figure 3.2 (page 188) and those specific to RNs in Figure 4.2 (page 253).

The needs of the residents in the homes were highly complex and consequently the care they needed was complex. Achieving positive outcomes in the care could be challenging. Details are offered in Section 5.6.2 and Appendix 5.4.

The issues, challenges and advantages of operating homes within the independent sector are discussed in Section 5.6.3 and Appendix 5.5.

Staffing issues are highlighted in Section 5.6.4 and Appendix 5.6.

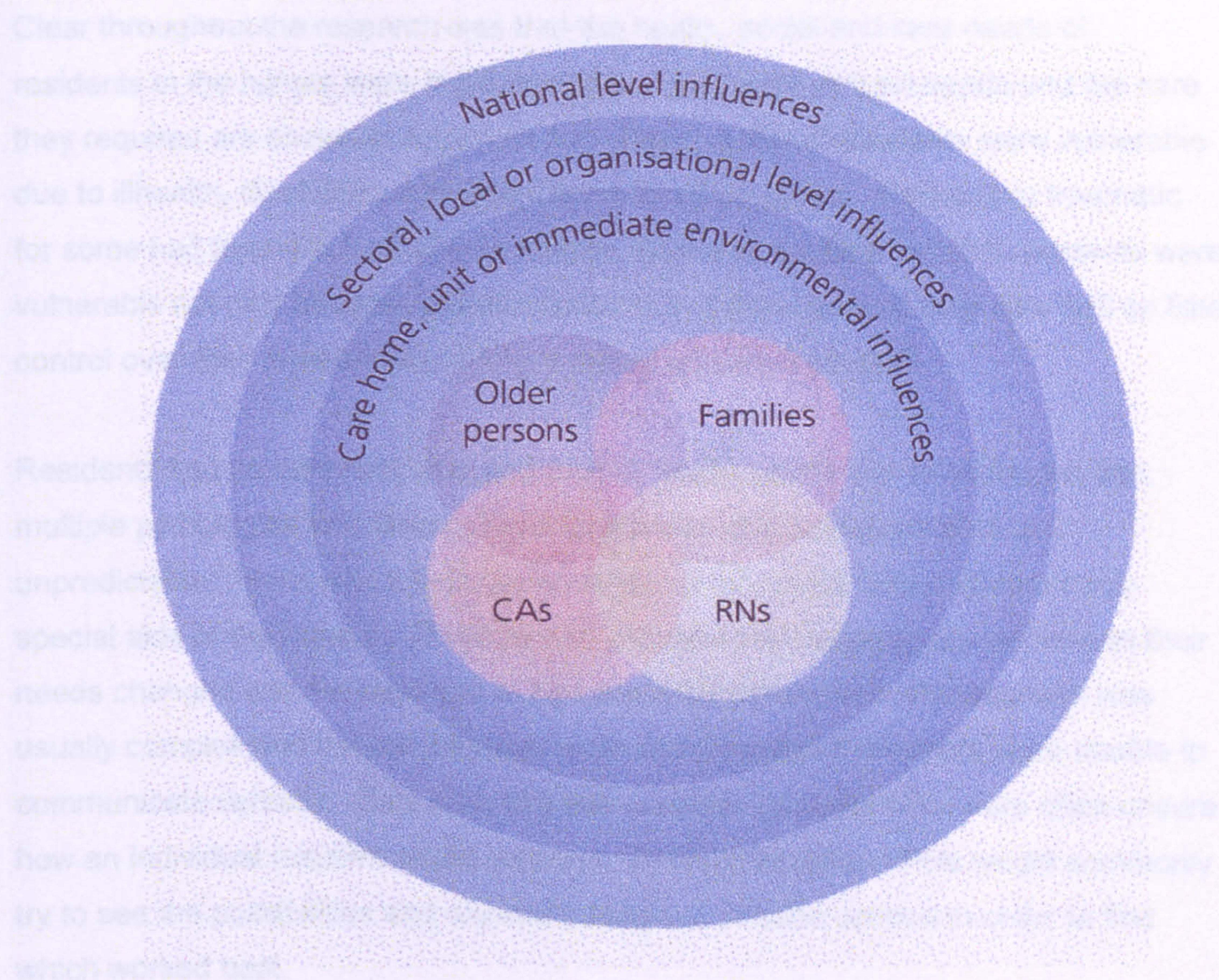
Challenges for the homes in providing adequate facilities, equipment, supplies and facilities are identified in Section 5.6.5 and Appendix 5.7.

The challenges associated with working in a closed community identified in the data are outlined in Section 5.6.6 and Appendix 5.8.

Lastly, many of the staff who participated in the study said that nursing home care was viewed as 'second class' and 'unskilled'. Their views are explained in Section 5.6.7.



**FIGURE 5. 7: SUMMARY: THE INFLUENCES ON THE WORK OF RNS AND CAS WORKING WITH OLDER PEOPLE IN NURSING HOMES**



**NATIONAL LEVEL INFLUENCES:** Historical, sociocultural, demographic, professional, health and social trends, health and social policy, perceptions of long-term institutional care.

**SECTOR, LOCAL OR ORGANISATIONAL LEVEL INFLUENCES:** Health and social care sectors, independent (private and voluntary sectors), care home market, local trends and demographics, local support e.g. professional services.

**CARE HOME, UNIT OR IMMEDIATE ENVIRONMENTAL INFLUENCES:** Resources, facilities, culture, ethos, models of care, support services and systems.



### **5.6.2: THE COMPLEXITY OF RESIDENTS' HEALTH AND CARE NEEDS**

Clear throughout the research was that the health, social and care needs of residents in the homes were highly complex. Examples of their needs and the care they required are shown in Appendix 5.4. The majority of residents were vulnerable due to illhealth, disabilities and their dependence on others. Particularly traumatic for some had been the loss of their homes. RNs also commented that residents were vulnerable not only because of their situations but also because they now had so little control over their lives and were totally reliant on care from staff.

Residents had complex physical and mental health needs due to advanced age, multiple pathologies and illness. Their health was commonly unstable and unpredictable. There was a high dependency on others for help and commonly special aids or equipment. They needed constant and ongoing assessment as their needs changed and the care had to be constantly responsive. Assessment was usually complex and the complexities were compounded if residents were unable to communicate verbally. Goal planning was complex because RNs were often unsure how an individual resident would respond. In these situations RNs would commonly try to see the possibilities and explore a range of solution options in order to find which worked best.

The range of resident needs in each of the units was diverse and, particularly in the mental health units, violence between residents or by residents on staff was not unusual. It could be challenging for the staff to make impact on resident health in the long-term and often immediate results were not apparent. Achieving positive outcomes in all categories of the outcomes framework could be challenging. Some residents needed particularly high levels of care to prevent deterioration. Examples, within the outcomes framework, are given in Appendix 5.4.

### **5.6.3: OPERATING HOMES WITHIN THE INDEPENDENT SECTOR**

The data highlighted a range of challenges that face nursing homes operating within the independent (private and voluntary) sector, along with some advantages. The

research participants raised the issues that were pertinent to them but not necessarily unique to them. Some of the issues discussed, such as operating as a business, were specific to the independent sector. Other issues however, such as problems with facilities, equipment or staffing, were not only experienced in the independent sector. In fact, throughout the datasets, staff commonly stated that they believed the problems they experienced were not as severe as some experienced in the NHS. Most staff, and all RNs, had worked in both the NHS and the independent sector. Many commented that they believed the care they were able to offer to older people in nursing homes was generally better than the NHS could offer.

Operating as a business brought particular pressure on the RNs in that the homes needed to maintain a profit. This meant there could be pressure to sustain income through ensuring beds were 'filled' and to cut costs, particularly staffing expenditure. These pressures seemed particularly great in the participating fieldwork site that was owned by a private company. The two fieldwork sites owned by charitable organisations seemed to experience less financial pressure in that they could fund-raise for whatever they needed. Nevertheless attracting potential residents and maintaining the reputation of the home were paramount in all areas. Further details and examples are given in Appendix 5.5.

#### **5.6.4: STAFFING ISSUES**

There were challenges attracting staff, particularly in terms of competition with the NHS. The homes also experienced staff shortages, sometimes acute, and employed bank and agency staff. Staffing shortages were particularly acute in Home 1 where, through their commitment to the residents, virtually all staff were working additional shifts to ensure the care was maintained. Staff were becoming increasingly tired and sickness rates were going up. This thus became a vicious circle. Agency staff could be very costly. During one observation period, one night staff member was still at work the following afternoon and the Sister in that unit had spent long periods on the telephone trying to obtain staff from agencies. In some areas the staff felt there was inadequate support, particularly administrators, and in two areas the maintenance



staff were felt to be unhelpful. In addition, as identified in Chapter 3 and 4, the quality of both CA and RN staff could be variable.

#### **5.6.5: FACILITIES, EQUIPMENT AND SUPPLIES**

The lack of basic equipment in some areas was highlighted in the observations, particularly with the CAs. Sometimes they were put at risk through, for example, not having protective gloves and aprons available for residents who had MRSA, and when moving and handling equipment was inadequate. The lack of equipment made the work harder in that CAs manually moved residents and walked long distances up and down corridors to fetch equipment from other units.

The facilities in some areas were also felt to be inadequate, for example having no quiet areas on the mental health units, and RNs described how they could give improved and more comprehensive care if they had better facilities.

#### **5.6.6: WORKING IN A CLOSED COMMUNITY**

The challenges of working in a closed community where staff and residents saw each other day after day were also identified in the data. Residents and staff described how residents commonly did not like each other and did not want to spend time together. This sometimes resulted in individual residents spending most of their time in their rooms. There was also friction among staff. There were examples of how cliques formed and how these could easily become breeding grounds for gossip.

#### **5.6.7: PERCEPTIONS OF THE WORK IN NURSING HOMES FOR OLDER PEOPLE**

Despite the challenges of working in homes, many of the staff commented that the care they were able to offer to older people was of higher quality than commonly

## Section 5.6: Findings: Issues specific to work in independent sector care homes

offered in the NHS. The staff believed that this made a great deal of difference to the health, functioning, wellbeing and quality of life of their residents.

A common perception throughout the datasets was that nursing in nursing homes was generally viewed as being less skilled than other specialities. Another was that long-stay care was slower, less interesting and less dynamic than more acute work.

*"People tend to think it's the lower end of nursing - going into geriatrics. And that's the challenge - you must be a poor nurse! Well I'm not I'm a good nurse. I like this sphere of nursing and a lot of good nurses are here. But that's what I don't like - she's obviously no good because she's gone into a geriatric home" (IV RN905)*

The GP in Home 2 linked the negative perceptions of nursing home care to how geriatric services had been in the past, and the historical legacy of these.

*"The staff here have to like working with the elderly - the elderly wards in hospital are regarded as the bastard case. It's a long time since I've been on a medical unit but years ago the long stay geriatric wards really were the pits. If people don't like patients being in nursing homes they should think back to what it was like before" (GP Home 2)*

Some staff had experienced inadequate care in nursing homes in the past and so could understand the negative perceptions to some extent but all those interviewed were adamant that the care they now offered was of a high standard.

*"The view of geriatrics as the lower end of nursing is partly to do with nursing homes really because there are a lot of poor homes about and a lot of people won't say they are poor quality and they just hand in their notice and move on. As long as that goes on they will stay bad. Since I've qualified I've only ever worked in the nursing home side and since then I've seen a big change - it is improving - now people don't get away with half they did" (IV RN905)*

Several RNs commented on the skills of nursing home RNs compared with those of RNs in the NHS.

*"When I worked in hospital, nursing home nurses were not given any credit for what they thought was right. They were viewed like second class*



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*because they're not into high tech things like the hospital they're just looking after elderly people and anyone can do that. But there's a lot more involved. We haven't got a doctor we can run to for everything. On the wards you've got house officers and all the doctors you run to you don't decide for yourself but here you have to and stand by them". (IV RN915)*

*"Nursing home nurses need a lot of skills that are different to the hospital. They need there's but we need ours. It's quite a sensitive area" (IV RN916)*

There were also comments that, in many cases, the care given in nursing homes is of a higher standard than in the NHS.

*"We're look at as Cinderellas but when we send people to hospital we have arguments because they don't care for them properly - they're not drinking but they can't reach it, she can't eat because she hasn't got her teeth in .... We give much better care". (IV RN901)*

*"The residents are much healthier than when they came in - we'd had some very ill residents ... because of the general care - they are watched far more than they would be in hospital because they've got us buzzing around interfering with them all the time, whereas in the hospital although they're washed and dressed they are really expected to care for themselves" (IV CA503).*

*"We make more of an effort here than in hospitals, to meet their needs rather than rush them around" (Matron / Manager Home 2).*

During a shift-change handover in Home 3 staff were discussing a resident who was currently in hospital and had been there for some time. The staff in the home rang the hospital ward most days to ask how the resident was progressing and visited her when they were able:

*Team Leader (NVQIII): [resident's name] - we heard this morning that they've done an X ray and she's actually impacted with faeces. So they're going to have to sort out her bowels before she comes back home again.*

*CA1: I went to see her. She was so chuffed to see someone. But it's terrible to see - her little bits were around the edge of the floor - her dressing gown is absolutely filthy and she was just sitting there - she didn't look like [resident's name]*

*Sister: We find this all the time - all the time. We care for them so well and they go into hospital and they just don't care - well I don't know whether it's to do with staffing levels or whether they just don't care about the basic nursing care. But they go to hospital and come back with a pressure sore, or come back and say "I've been in hospital for six weeks and haven't had a bath; I never had a wash unless I could do it myself". And they come and put the food there and if they can't get to it, it doesn't matter - they come back later and say "oh didn't you want that?".*

*CA1: Well her food was on her table but was out of reach so she's probably not eating.*

*CA2: Yes I've seen that - they leave the food there and come and say "haven't you eaten that yet?".*

*Sister: It's sad. I trained there and it certainly wasn't like that then. We used to do two hourly back rounds - absolutely spot on, but then the student numbers were part of the numbers on the ward; they weren't supernumary and they did a lot of the care. Anyway ... (report continued).*

Participants commented that there were definite advantages to working in nursing homes compared to the NHS.

*"There are more resources and it's less frustrating than on the NHS" (IV RN502)*

The views of the staff in this study offer the basis for a more positive image of nursing home care than is evident in the literature. One RN had re-evaluated what nursing meant to her following her move into nursing home care:

*"When I left the NHS I was told I would be wasting my experience. In fact it has been the opposite. I have really been able to make a difference here. In the NHS making a difference was so diluted by bureaucracy and extreme low morale from staff at all levels. This has probably been the most challenging period in my nursing career to date and I have spent many hours soul searching and re-evaluating my concepts of nursing" (Example 101.1).*



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## **CHAPTER 6: DISCUSSION**

This chapter discusses the findings from the research in the context of the literature.

Section 6.1 acknowledges the perspectives in the findings and specifically that these appear to offer more positive images of work in care homes than much of the previous literature.

Section 6.2 discusses the findings on the role and contribution of Care Assistants

Section 6.3 discusses the findings on the role and contribution of Registered Nurses

Section 6.4 discusses issues raised in the research concerning outcomes in older people's long-term care and some potentials for the outcomes framework developed from the data.

Section 6.5 discusses the findings on the distinct outcomes, and potential outcomes, of the work of RNs, compared with those of CAs, for older people in nursing homes.



## **SECTION 6.1: DISCUSSION:** **PERSPECTIVES IN THE FINDINGS**

### **6.1.1: INTRODUCTION TO THE DISCUSSION**

This study produced a rich and detailed analysis of the work of RNs and CAs in care homes and specifically in care homes with nursing. As discussed in Chapter 1, the body of research conducted in UK Independent Sector care homes is small and this study goes beyond much of the previous work in terms of its breadth of coverage. Using its two-phase, mixed method approach and triangulation of data from a variety of sources, the research encompassed aspects not explored in previous work, such as seeking older residents' views on the outcomes of the work of CAs and RNs.

Work in care homes largely takes place behind the closed doors of the home, the residents' bedrooms, or bathrooms, but the methodology overall, and particularly the researcher's participant observation, helped to access and articulate:

- what the RNs and CAs in the study believe they are doing and achieving, i.e. the perceived outcomes of their work
- what they are actually doing and the potential outcomes of their day-to-day activities
- the realities of their everyday work, including the challenges they face
- their motivations and aspirations
- the attributes, traits, qualities, knowledge and skills they bring to their work
- what older residents and relatives want from the RNs and CAs and what they believe are the outcomes of their work

The data also revealed elements in both RN and CA work which were not widely acknowledged in the literature and furthermore were not emphasised on their job descriptions.

The findings contribute to a range of debates within the literature, for example on outcomes of care for vulnerable older people living in care homes, on the 'invisibility' of nursing and what RNs achieve by their 24 hour presence.

From the data a new Outcomes Framework was compiled, along with suggestions on how this could be developed in practice.

As the literature review concluded, many of these areas have been identified as significant gaps in previous research.

### **6.1.2: PERSPECTIVES IN THE RESEARCH**

The findings of this study are discussed within the context of the literature focusing on UK Independent Sector care homes (constituting the focal theory of the study). Some aspects also speak to broader debates (the background theory for the study). Within the context of this literature and the key debates within it, the findings of this study offer a range of contributions. Some findings identify commonalities shared with previous research, others are distinct or even contradictory to the findings of previous studies.

It is important at this point to acknowledge that such a range of perspectives is not entirely surprising given the diversity of individual homes within the UK Independent Sector and the scope of much of the previous research. Many previous studies were undertaken in one home, a small group of homes under the same ownership, or a single locality and it is highly likely that single homes, single ownerships or single localities will offer different perspectives to other single homes, ownerships or localities. Even though the current study was able to incorporate perspectives from a diversity of homes around the UK in its Phase 1 examples, plus in-depth findings from multiple-source, multiple-method fieldwork in three very different homes in different counties around England in Phase 2, the findings will not resonate in all care homes given the diversity in the sector.

The results of this research also contradict some of the themes identified in the non-UK care home literature. Again, this is not surprising given the vast differences between the contexts, organisational cultures and roles, both in UK NHS care settings and USA care homes, compared with the settings in which this research was conducted. The differences were outlined in Section 1.3 (page 27).



Specifically the perspectives in the data and the findings overall offer more positive images of the work than in much of the literature. This is in part a factor of the approach and method. It is also likely a factor of the samples, most significantly that all three fieldwork homes were generally well-run with committed staff who gave high standards of care. The methodological implications are discussed in the conclusion to this study.

## **SECTION 6.2: DISCUSSION OF FINDINGS:** **WHAT DO CARE ASSISTANTS (CAs) DO?**

### **6.2.1: THE CONTRIBUTION OF THIS RESEARCH**

The findings from this study offer insights which contribute to debates about the work of CAs in UK Independent Sector care homes. As identified early in this report, previous research in this sector is limited. Placed within this context, and acknowledging that published research papers might contain limited information, the findings from this investigation concur with those in previous studies in some respects but in other respects they are distinct or even contradictory. This study also goes beyond previous research in some respects, as discussed in this section.

Broadly, the findings of this study concur with previous research suggesting that the major aspect of the CA role is direct patient care, research identifying a range of challenges in the work and two studies highlighting the commitment many CAs bring. It also concurs with previous conclusions that many CAs receive limited and varied training. The findings are distinct from previous research in that the CAs in this study identified strong concepts of 'family' in their work. The current findings contradicted previous research conclusions about the lack of CAs' role clarity and that they control residents through the management of emotion.

The findings of this investigation also go beyond any previous research identified in the literature review in terms of the breadth, richness and detail encompassed within the study and particularly investigating CA work through their own examples, observation, interview, documentary analysis alongside the perspectives of others who supervise them and who see all aspects of their work. The study encompassed the views and priorities of older nursing home residents and relatives in terms of the CA role and their contribution to outcomes of care. A new Model of the CA role and contribution was developed from the data, as was a new framework within which the outcomes of CA work could be evaluated.



For ease of reference, conclusions from the literature review on CAs are offered in Section 1.5.5 - 1.5.6 (pages 48 – 51), and Section 1.8 (pages 81 – 82).

Findings from this study on the role and contribution of CAs are summarised in Section 3.3.5 - 3.3.7 (pages 184-189).

A summary of findings on inputs to CA work is offered in Section 3.1.6 (page 162) and a summary of the findings on processes in Section 3.2.11 (page 180).

### **6.2.2: PERCEPTION OF THE CA ROLE**

The CAs in the study neither expressed, nor seemed to experience, the lack of role clarity, or the role ambiguity, role stress, strain or overload recorded in UK NHS studies (Ahmed and Kitson 1993, Reeve 1994, Moniz-Cook, Millington and Silver 1997, Thornley 2000, Pearcey 2000, McLaughlin, Barter, Thomas, Rix, Coulter and Chadderton 2000) and inferred in Perry, Carpenter, Challis and Hope's (2003) interviews with nursing home staff. Most CAs in the current study worked hard but were clear about what they do, the purpose of their work, what they bring and what they achieve. They understood 'their work' and assumed responsibility for this. They were clear about the boundaries and limitations of their competencies and, if they were unsure in any way, they asked their RN colleagues for advice. In contrast to the results of research in UK NHS settings into RN perceptions of CA work (e.g. Reeve 1994), the RNs in this study were clear about the CA role, and moreover the individual competencies of each CA in the team. They did not see them as a threat and there were no suggestions of any 'power struggle' (suggested in the research of Workman 1996), even with CA Team Leaders with NVQ Level III. It could be that the cultures and ways of working in the care homes investigated draw clear boundaries between the RN and CA roles, particularly as there is commonly only one RN per unit and the duties they undertake are clearly different.

### **6.2.3: THE MODEL OF THE CA ROLE AND CONTRIBUTION**

The results suggest a Model of CA work distinct to any previous work identified in the literature (Figure 3.1, page 186-7). It encompasses what the research

revealed about the inputs to CA work, the challenges they encounter and the aims of their work. It also illustrates that the three main strands of the work were:

- Helping the residents
- Building relationships with residents
- Noticing and reporting change

These aspects are discussed below.

The research revealed that, in the practical day-to-day reality, CA work is prioritised by physical care, some housekeeping duties and occasional duties such as charting observations or escorting residents outside the home. Their job descriptions confirmed the focus of their role as providing personal care and housekeeping, and care documents such as care plans and progress sheets focused on physical care given. This confirms some of the findings in the literature that their role largely comprises what were described as 'technical tasks' such as dressing, feeding, toileting, mobility (e.g. Workman 1996, Schirm, Lehman and Barton 1996) and 'delegated tasks' such as bowel, bladder, eye, nail and stoma care (Miskella and Avis 1998). What CAs enjoyed most about their jobs and what motivated them to do their work, however, was their caring for the residents, the close relationships they formed and seeing them as 'family'. Although the caring underpinning CA work was discussed to some extent in the literature (e.g. Henwood 2001, Redfern, Hannan, Norman and Martin 2002, p 36) the meaningful reciprocal relationships and concepts of family identified in this research were not to any extent.

#### **6.2.4: CA WORK ORGANISATION**

Some of the literature suggests that CA work in care homes is based on task allocation (e.g. Miskella and Avis 1998, Warner 1997). This was not the case in the three fieldwork homes. In all of the observations, the CAs prioritised their care according to individual resident need. In none of the morning or evening observations did the CAs work from one end of the corridor to the other. Rather, they prioritised the residents who, for example, might be wet, needed frequent position changing or preferred to get up or go to bed early. In two of the units for people with advanced dementia, the staff were taught to observe individual residents in order to identify the time when they might be ready to go to bed. It



was not always possible to target this precisely but the staff would make the suggestion of going to bed whenever they felt it might be timely until the resident agreed. In fact many of the staff in these units emphasised that there was no point in trying to 'routinise' residents as they would get up and go to bed when they chose, which was indeed the case.

#### **6.2.5: HELPING THE RESIDENTS**

The CAs in the study wanted to help the residents and to give the best care they could. They found satisfaction in doing this. The datasets also revealed that most of the CAs were motivated by feeling wanted and being useful in helping others, particularly older vulnerable people. Believing that their work was useful to others gave them satisfaction and this, in turn, motivated them to continue to do their best in their work, despite the challenges. Key among their motivators was strong interest in people and particularly liking and valuing older people. Most of the CAs in all datasets were strongly committed to 'their' older residents and cared a great deal about them as individuals. In some of the examples and during the fieldwork, the CAs described vividly how they loved 'hearing their stories', sharing aspects of their lives and being with them. All CAs who participated in the fieldwork wanted to be able to spend more time with the residents. There was also strong motivation and commitment to making life better for 'their' residents and, in many of the CAs, for older people in general. Such views were acknowledged to some extent in Henwood's (2001) interviews but not extensively elsewhere in the literature. Contrary to findings in the background literature, most of the CAs in this study did not have ambivalent feelings about their role. As identified in Henwood's (2001) interviews and Redfern, Hannan, Norman and Martin's (2002) care home fieldwork, the CAs had high levels of commitment, motivation and enthusiasm for their work. The majority of CAs who participated in this study felt positively about their work and enjoyed doing it.

#### **6.2.6: CLOSE, RECIPROCAL RELATIONSHIPS**

The data richly illustrate that the close relationships that the CAs formed with the residents were a key focus in their work and important to them. These were developed through spending time together, sharing everyday experiences and

talking about life in general, learning to understand, accept and appreciate each other and all of this enhanced by the intimacy of the physical caring. Humour featured strongly in many of the day-to-day encounters and the relationships were reciprocal.

While the relationships formed were generally valued by most of the CAs and most of the residents interviewed, they do raise issues of choice. A small number of the CAs identified that there were residents they liked and others to whom they did not warm, but it was important that they gave the best care to everyone and this was integral to their work. If they found difficulty in getting on with a resident there was the potential to ask to be reallocated. For the residents, however, there was generally limited choice. As some identified, they needed care and were offered someone to help them. Although most were happy with their carers, a minority said they would rather have someone else but “had to put up with it”. While the low staff numbers generally available in homes can make this difficult, it would be preferable for residents to have choice in who is ‘their’ CA and thus the person with whom they could potentially form a close relationship if they so chose. This is stipulated to some extent in the National Minimum Standards for Care Homes (DH 2000b) which state that residents should have choice in who gives them intimate care particularly, for example, where a female resident does not want a male CA for personal, cultural or religious reasons.

#### **6.2.7: NOTICING CHANGE**

The third important aspect of CA work was noticing and reporting change. A fundamental element in noticing change was that they knew the residents so well because they worked closely with them every day. They would therefore notice even subtle changes, such as the brightness of the eyes, being more tired or ‘grumpy’ than usual. This is not discussed extensively in the literature other than some reference to the CAs being the ‘eyes and ears’ of the RNs (e.g. Neal Garland and Schirm 1998). Noticing and reporting change did not strongly figure in the training CAs received, or even in their NVQ modules. Any teaching on what to look for and what actions to take tended to come from the RNs in the teams. As a key aspect of their work, it would seem appropriate for this to be include in CA training where both observation skills and the knowledge underpinning these could be sharpened.



**6.2.8: CONCEPTS OF 'FAMILY'**

Concepts of 'family' commonly arose in all the CA datasets, many of the resident interviews and, to a lesser extent, in RN datasets, e.g. CAs conceptualising their work in terms of their family roles: "we're just mums" and residents seeing CAs as extended family. With two exceptions, discussed here, family concepts were not identified in any of the research reviewed for this study. Although family concepts did not feature strongly in the results of Lee Treweek's (1994a) research, she suggested that homes promote a particular style of domestic family home-style living. Their brochures show images and text depicting the type of resident homes produce, and the type of order offered is "based on an image of amiable family-type relationships between staff and residents and between the residents themselves (1996, p 121-122). While there were studies on relatives' perceptions of, and involvement in, care home care, only one study focusing on 'family' bonds between staff and residents was identified. Using questionnaire and unstructured interview in a USA skilled nursing facility, Sumaya-Smith (1995) identified that self-report care-giver surrogate family relationships and close family bonds existed at a significantly higher rate than the literature would suggest, 92% of their sample in fact.

The development of such concepts in the reality of CA work with residents in care homes is understandable. The CAs and residents spend time together day after day and year after year, often, as some highlighted, more time than with their own families. There were comments that residents could be "nicer than families" and that when there were difficulties at home it was "nice to come to work and be with them". The CAs sometimes brought their families to visit the residents to share special occasions such as birthdays. In addition, the CAs help residents with the most private and personal aspects of their daily functioning, commonly involving close whole-body contact (e.g. helping resident to get up) and touching intimate body parts (e.g. helping to wash). This linked in some CAs' reasoning with the care they would give to their children, but there are potential dangers when such thinking is directly translated into action.

Warnings of the dangers of treating people as children, termed infantilisation, have appeared in literature on older people's care for many years and were brought to the fore in Kitwood and Bredin's (1992) theory of dementia care. Infantilisation does occur in care homes, for example from her 12 month

observation in a Scottish home, Innes (1998) reported that residents with dementia were often infantilised by the CAs. As Innes (1998, p 25) suggests, treating people as children may occur through good intentions and, as the current findings highlight, this could seem logical within relationships conceptualised as 'family' caring and nurturing. However, as Nay (1995) warns, conceptualising care in terms of 'being a mother' can influence caring practices in the direction of fostering dependency.

While family concepts featured throughout the CA datasets in the current study, there was no evidence in the observations of any of the CAs treating residents as children and there was strong leadership from most RNs in all three homes not to infantilise. As can be seen from the terminology used by the CA in Example 1, Section 5.3.3. (page 272-3), however, there could be a fine line between day-to-day caring, supporting and nurturing, particularly with concepts of family relationships being so strongly implicit, and practices which foster dependency. Ongoing awareness, care philosophies reaffirming residents as adult citizens and promoting their independence, under the direction of strong leadership, would appear to be essential in preventing this occurring.

#### **6.2.9: THE USE OF 'SELF' AND EMOTION WORK**

Most of the CAs in the study inferred that they brought the essence of who they are as individuals into the work, indicated by comments such as "it's just me" or "it's just the way I am". Some also seemed to bring the emotional learning from difficult personal experiences in their lives, often those which had been sad, difficult or traumatic, into their work and use this in their everyday encounters. It would be interesting to research further into the key influences on CA motivation, for example difficult experiences in their lives or their experiences of grandparenting, mentioned by some CAs in the study. More extensive insight into CAs' motivations could assist in recruitment and development of CAs in the future

Most CAs in the study used their emotions in their work and many seemed to work 'from the heart' in that their emotions both led and drove their actions. All the CA datasets are rich with examples of how much they used their emotions in caring for the residents, such as "worrying if they're alright" when off duty (Interview CA715, page 154), remembering them long after they have died and



“shedding a tear” (Example 102.4, page 164) or showing seemingly infinite caring and patience while a resident shouted at the CA, hit her, accused her of abuse and more (Observation CA 506, page 177).

The connections between emotions and caring have been debated extensively in nursing literature (e.g. Lea and Watson 1996) and many would argue that emotion, or affect, is integral to carework as it allows a careworker to be engaged and involved with the situation. This was the case with the CAs in this study. Such ‘emotion work’ featured strongly in the work of the CAs in Lee-Treweek’s (1996) study. She identified that this could be positive (e.g. nurturing) but were mainly negative, i.e. used to manage and control the emotion of residents and create ‘order’ in the home. These categories are also reminiscent of Smith’s (1992) comprehensive research into the emotional labour in nursing work.

There are potential consequences of emotional labour in care for patients. Smith (1992) identified that, while negative forms of emotional labour which stereotyped and labelled patients could be harmful to patient outcomes, positive forms of emotional labour could help patients to feel better. This would seem to be confirmed by the residents in this study who said how much they valued the way the CAs made them feel ‘cared for’ and ‘cared about’.

The consequence of emotional labour for staff can be stress or burnout and, as Smith (1992, p 141) speculates, if the caring commitment of staff is “repressed too often and for too long then it is likely that they will choose hierarchical relations, stereotyping and labelling as preferred forms of emotional labour”. Previous studies suggest that it is particularly important for those who care to receive support in dealing with emotional labour and managing their feelings. In Smith’s (1992) study, this came from ward sisters who created an emotionally supportive environment and acted as role models. The CAs in the fieldwork homes gained some support in their emotional labour from their fellow CAs (particularly in Home 1) or from the RNs with whom they worked but it was not unusual for CAs to deal with their emotions unsupported or to take them home.

Support for emotional labour among all staff was noticeably strong in the teamwork in Home 3 and the 30-minute afternoon handovers which served as a forum for highlighting such issues, sharing feelings and determining any ongoing support necessary. Such handovers have since ceased in that home and are

being withdrawn in other homes due to the cost. The literature highlights the importance of support with emotional labour but, as Smith (1992, p 136) suggests, “recognition and value are not enough”. She concludes “that emotional work must be made visible and valued in its own right” and that it must be costed into service provision (p 139). Given the tight funding experienced by most care homes and the current frameworks for CA training, this looks unlikely.

#### **6.2.10: KNOWLEDGE, SKILLS AND COMPETENCIES**

Contrary to much of the literature, the CAs in this study did not feel unprepared for “their work” but took a pride in this and worked hard to do their jobs. In addition to the personal experiences, learning and caring discussed above, virtually all had undergone some training, particularly in moving and handling.

Previous research suggested that CAs felt particularly unprepared to deal with 'challenging behaviours' (Silver, Moniz Cook and Wang et al 1998, Innes 1998) and caring for dying people (Miskella and Avis 1998), but this was not the case in this research. Resident behaviours which could challenge the staff were observed in all three homes and particularly in Homes 1 and 2 where many of the residents had mental health needs but interestingly the topic of 'challenging behaviours' did not feature in the observations or interviews. Within the philosophies of the units the emphasis was on individual residents, how they were, what they did and what care they needed. When caring for dying people the CAs worked under the direction of RNs and generally felt competent to undertake the physical aspects of care and the observations. Their main issue was the emotional labour in supporting the person dying and the family members. The CAs in this study relied on RNs for anything for which they were unprepared and stated that they would feel unable to offer this care without the teaching and supervision of the RNs.

The residents recognised differing levels of competence in CAs, but their emphasis was principally on whether they were kind and gentle.

Some CAs demonstrated high levels of skill in communicating with residents, identifying what they wanted and discovering which caring practices worked best, for example those whose work is described in Section 3.1.5, page 159-161.



Despite the wide range of competencies many CAs brought to their work, most described these as “just common sense” or, as discussed above, merely as what they would do for their families. All datasets strongly suggest that CAs assume their knowledge and skills are an aspect of who they are, an extension of their family roles as “just mums” or are “just common sense”. As such they take their knowledge and skills for granted. Set beside the observations and the reflections on these in the interviews, the data suggest that many CAs would seem to undervalue the skills and understanding they display in their everyday work.

### **6.2.11: CHALLENGES IN THE WORK**

Some of the potential stressors in CA work identified in the literature were also identified in this research. Those in the literature included residents being uncooperative, restless, crying, aggressive behaviour, shift patterns, the physical care environment and managing resident emotions (Dunn, Rout, Carson and Ritter 1994, Moniz-Cook, Millington and Silver 1997, Jenkins and Allen 1998, discussed in Section 1.4.2). The main stressor for the CAs in the three fieldwork homes was physical and emotional tiredness and having insufficient time to complete their work, but teamwork and support from colleagues and residents helped minimise the feelings of stress for the CAs. Other potential stressors identified in the observations were dealing with ‘challenging behaviour’ and issues concerning bodywork and sexuality. Interestingly these were not seen as major stressors by the CAs themselves, probably due to their commitment to the residents and also the support they received in dealing with the challenges.

Many of the CAs in all datasets viewed older residents positively in spite of situations where these individuals behaved in ways which were challenging to staff, or even abusive to them, and there was not the frustration suggested in the literature. The CAs would tend to try to deal with the situations themselves using the resources available to them. If the CAs could not cope they tended to call the RNs (for example the CA calling the RN because a resident was hitting her in the bathroom while she was trying to clean up after her). Dealing with challenging behaviour did not, however, feature prominently in the training the CAs had received, or even in their NVQ modules.

Bodywork was a fundamental everyday aspect in CAs' work, but it did not feature in the literature review, with the exception of Lee Treweek's (1994a) research. This suggested that aspects of the work, such as body care, that are at odds with the home's image are managed spatially by being confined to the privacy of bedrooms. The 'dirty' work of care, she suggests, is hidden in order that the institution can display the 'product' of its caring regime in the form of the 'lounge standard' resident. This was not the case for the participants in the current study. Twigg (2000) similarly suggests that bodywork is hidden because it deals with aspects of life that society does not want to think about and care workers manage these aspects of life on behalf of wider society. She also suggests that distasteful tasks are delegated to lower level staff. The bodywork identified in this study would seem to encompass the aspects identified by Twigg (2000), i.e. direct touch, negotiated nakedness and dealing with human waste. The ways in which the CAs coped with bodywork also linked with Twigg's categories (2000, p 401), which were:

- viewing bodywork as part of the job, 'buckling to' and suppressing any sense of disgust
- viewing it as part of women's inevitable role in life, linking it to motherhood
- humour and joking.

Issues of sexuality also emerged, particularly when the resident and CA were of different gender and in mental health units. There would appear to be limited research into sexuality in older people's care (Heath 2002) and, with the exception of the work of Archibald (1998) and Heath (1994), little research into sexuality in long-term care and care homes. Also, with the exception of Lawler's (1991, 1997) work, research into bodywork does not seem to be extensive. As a fundamental aspect of the work of CAs in care homes, this warrants further exploration.

#### **6.2.12: OUTCOMES OF CA WORK**

No previous research into the outcomes of CA work was identified in the literature review and there was little research seeking older people's views on the work of CAs (Stokes and Warden 2004). Some studies suggested that CAs have the potential to deliver therapeutic care (Edwards 1997) if working within a unit



operating a therapeutic philosophy and provided with appropriate role models (Ahmed and Kitson 1993) and the findings of this study confirm this.

All participants in the study, and particularly the residents, agreed that CAs are crucial in the quality of care that residents experience, particularly in the help they offer and in the supportive and reciprocal relationships they establish. The residents and relatives really valued the CAs because they were always available for help or to make them comfortable, for help with activities of living and for 'the little things'. Although these individual aspects of their work may seem insignificant everyday happenings, they are highly important to residents and can make an immense difference in their lives. The findings of this study suggest that, through their work and relationships they are major determinants of outcomes for older people, particularly in terms of day-to-day functioning, comfort, wellbeing, peace of mind and some aspects of quality of life.

#### **6.2.13: IMPLICATIONS FOR TRAINING**

The insights offered into the inputs to CA work, including their motivations and what gives them satisfaction could contribute to policies for recruitment, retention, education/training and ongoing development of the role. There is little previous research into this area and the literature on RN attitudes, in addition to being conceptually and methodologically limited, is of little direct relevance. Training remains a priority under current government directives and the target is for 50% of care staff (excluding RNs) to achieve NVQ Level II or equivalent by 2005 (DH 2000c). Such qualifications would appear to include the emphasis on the main aspects of the work identified in this research, i.e. building and maintaining relationships, caring for people with complex needs and observing and reporting change (<http://skillsforhealth.org.uk>, <http://www.qca.org.uk>, <http://www.city-and-guilds.co.uk>) but have been criticised for the lack of emphasis on older people's mental health and specifically dementia (Evans 2003). Many of the CAs in the study, particularly in Homes 1 and 2, rated the training they received from RNs 'on the job' more highly than NVQ-type training and, as various authors highlight (Schirm, Albanese, Neal Garland 1999, Dalley and Dennis 2001), in the absence of literature on the outcomes of CA work, claims that training leads to improved quality of care remain unsubstantiated.

#### **6.2.14: THE FUTURE OF CA WORK**

CAs will remain the 'backbone' of services for older people in care homes and the commitment that most bring to their work deserves greater emphasis on their role. Suggestions for 'professionalizing the CA workforce' are being raised (English Community Care Association, P&G Professional, Laing and Buisson 2004) and, although most participants in this study did not want 'professionalization', even those with NVQ III, there is much potential for development which build on the skills and motivations of the CAs. For example, as some CAs suggested, building on their role to incorporate skills in facilitating recreational activities, rather than employing activity co-ordinators.

This research identifies a more positive image of the work than in much of the literature and also often highlighted in the media. Promoting more positive images would help the good work that CAs undertake to be more widely acknowledged and valued. There is also the potential for further research into how they build relationships with older residents and how they identify change.

CAs could also benefit from support in reflecting on the skills they bring to their work. Schemes for colleague support and clinical supervision schemes are beginning to develop in care homes but slowly (Wild, Fear and Means 2005). Also beneficial could be support with 'emotion work', the physically hard work and the resentments that can build particularly in such closed communities. This was partly achieved in Homes 2 and 3 through the shift to shift handovers but these no longer take place due to financial constraints. Supervision is also important. There were a small minority (three CAs in Home 1) who did not seem interested in their work and did not seem to enjoy their work and a relative in Home 2 had also witnessed such staff whom he suggested "see it as an easy job and don't care" (Relative 704). These were, however, very much in the minority. It is important that other staff and management systems can identify such individuals and that steps can be taken to ensure their behaviour is not detrimental in any way to residents. Supervision and support were achieved through strong teams, particularly in Home 3 where there was a standard career structure for CAs. In this way they felt a valued part of a team, the RNs were able to teach and supervise and the residents appreciated the efficiency of the overall organisation.



The future need for CAs is assured in the context of increasing numbers of older people with chronic progressive disease and disability likely to require personal care services (Henwood 2001). In addition, there are currently wide-ranging proposals on the future shape of the nursing workforce and on entry routes to RN training. Ultimately, this research has shown that CAs profoundly influence outcomes for older people in care homes, particularly in their everyday experiences and sense of being valued. This study concludes, as other authors have acknowledged (e.g. Jacques and Innes 1998, Thornley 2000, Stokes and Warden 2004) that research into CA work, and particularly the outcomes of this, must be a priority for the future.

## **SECTION 6.3: DISCUSSION OF FINDINGS:** **WHAT DO REGISTERED NURSES (RNs) DO?**

### **6.3.1: THE CONTRIBUTION OF THIS RESEARCH**

The findings from this study paint a rich picture of the work of RNs in UK Independent Sector care homes, the like of which was not found in the published literature. Little previous research in this sector was identified in the literature review and the published work on long-term care concluded that there appeared to be a lack of a recognised role for RNs in care homes, a lack of agreed aims for care or models for care delivery, a lack of agreed outcomes for the nursing of frail older people in long-term care, a lack of evidence on what RNs in care homes do and what their work achieves in terms of outcomes for older residents. The findings of this study offer insights into all of these areas.

The picture painted by the data in this research is very different to the “more of the same” (Nolan, Nolan and Booth 1997, p 24) “routine geriatric style” care (Kitson 1986, Nolan 1995) in impoverished environments, lacking basic equipment, with poor staffing levels and negative attitudes (Nolan, Brown, Davies, Keady and Nolan 2002) reported primarily from NHS-run care settings for older people during the last 30 years. While there were environmental and resource issues in this study’s care homes, and much of the work seemingly involved maintenance care, the focus of many of the participant RNs was improving the residents’ health, functioning and quality of life (as identified on page 288-290). This was confirmed by the residents in the study (page 302).

Some RNs identified elements important in their work which were not broadly acknowledged in previous research and not explicit on their job descriptions. This would suggest that there are aspects of the work which are largely unrecognised but that individual RNs bring as part of their contribution. These include dealing with emergencies, acute care, risk prevention and management, preventative and anticipatory care, rehabilitation, therapeutics and health promotion.

The literature on older people’s care has for many years questioned the distinct contribution of Registered Nurses. A claim for the ‘unique’ contribution of RNs



has been their 24-hour presence but leading researchers in older people's care have questioned what nurses DO with this 24 hour presence (Nolan et al 1997). A major challenge in articulating the distinct RN contribution has been the so-called 'invisibility' of nursing, which, although widely debated anecdotally, has been acknowledged to a limited extent in the research literature (Spilsbury and Meyer 2001). This study offers some insights into what RNs in nursing homes DO with their 24-hour presence and also into how the 'invisible' aspects of nursing work can be made more visible.

Although not a central focus of the research, the findings also identify that the majority of residents with whom the RNs work in nursing homes have highly complex physical and mental health needs (described in Appendix 5.4). This raises implications for the complexity of their role and contribution.

The findings of this investigation seemingly go beyond the UK Independent Sector care homes research identified in the literature review in terms of the breadth, richness and detail encompassed within the study and particularly investigating RN work through their own examples, observation, interview, documentary analysis and the perspectives of the CAs who work with them.

The study also encompassed the views and priorities of older nursing home residents and their relatives in terms of the RN role and their contribution to outcomes of care.

A new Model of the RN role and contribution was developed from the data, as was a new framework within which the outcomes of RN work could be evaluated.

For ease of reference, conclusions from the literature review on RNs are offered in Section 1.6.3 (pages 56 - 58), Section 1.6.5 - 1.6.6 (pages 62 - 65), and Section 1.8 (pages 81 - 82).

Findings from this study on the role and contribution of RNs are summarised in Section 4.3.7 - 4.3.9 (pages 249 - 256).

A summary of findings on inputs to RN work is offered in Section 4.1.10 (pages 204 - 205)

and a summary of the findings on processes in Section 4.2.11 (pages 233 - 234)

### **6.3.2: MODEL OF THE RN ROLE AND CONTRIBUTION**

The findings suggest a Model of RN work distinct to any previous work identified in the literature (Figure 4.1). It encompasses what the research revealed about the inputs to RN work, the dimensions of their role, the challenges they encounter and the aims of their work. It also illustrates that the work of RNs is multi-focus, multi-level and, in some respects, distinct from RN roles in other settings.

The model illustrates a range of dimensions in the RNs' 'clinical' and direct work with residents which were specifically highlighted in different datasets (as below) and all confirmed in the observations. Rather than the purely 'maintenance' or 'carry on' aspects of the role identified in some of the literature (e.g. Waters 1994, Waters and Luker 1996), the model illustrates that the RNs' role and contribution encompasses drugs, dressings and 'anything medical' and problem identification/problem solving (highlighted by residents). It encompasses mental health care, the prevention and relief of distress, hands-on / one-to-one care with residents (highlighted in the interviews), advocating or and obtaining external services and acute/critical care, accidents and emergencies, palliative care and dying and death (highlighted in the examples). It also encompasses a range of aspects brought to the work by individual RNs, highlighted in their interviews and confirmed in the observations. These aspects are noteworthy in that they were not explicit on the RN job descriptions in the three fieldwork homes and did not feature in the literature. This would suggest that there are aspects of the work which are not widely recognised but that individual RNs bring with them to the work. They included:

- Dealing with emergencies, acute care
- Risk assessment and risk management
- Preventative and anticipatory care
- Rehabilitation and re-enablement
- Therapeutics
- Health promotion

All of these elements were observed in the RN work in the three homes and were apparent in many of the examples and interviews. Sometimes they were explicit, for example noted in the care plans and handovers. Sometimes they were demonstrable in subtle ways, for example an RN emphasising to CAs that a



resident needed either prunes or prune juice at breakfast in order to keep her bowels functioning (i.e. preventative care). Sometimes the balances achieved in risk management and rehabilitation were also subtle. For example, the deputy manager in Home 3 emphasised that, while many of the residents felt they had come “to be cosseted” the role of the RNs was to help to keep them as active and independent as possible. There were also the subtle skills the RNs used in their everyday work which they described and which were observed, such as the ethical decision-making or the “non-panicking”. Again, these were not mentioned on their job descriptions or identified as key in the literature on long-term care but RNs and CAs agreed that the care would be poorer were they not present.

In addition, the RN role encompasses a range of leadership and management dimensions which were made more complex by the “anything and everything” scope of the role, the vulnerability of the residents, the dual nature of care home services (i.e. primarily residential but also clinical), the dynamics of working in a closed community, and the fact that most staff are largely untrained.

The findings suggest that all of the aspects on the Model of RN work, and particularly the aspects such as preventative care, rehabilitation and health promotion, considered important by many of the RNs but seemingly not widely recognised, should be acknowledged on job descriptions and in the literature. If these are not made explicit, if the RNs working in care homes do not articulate them, or if there were no RNs in homes, they could disappear.

### **6.3.3: OVERALL SCOPE AND FOCUS OF THE RN ROLE**

The RNs stated that they carried responsibility and accountability for “anything and everything” and this confirms the findings of Perry, Carpenter, Challis and Hope’s (2003) interviews in care homes. While the RNs’ preparation and expertise was appropriate for responsibility for resident care, it could be questioned whether it was appropriate for the range of other responsibilities they held, such as for the building “from the tile off the roof to the washing machine breaking down” (Section 4.3.6, page 245). RNs also held responsibility for advertising and marketing the homes. The data, particularly the observations in Homes 1 and 2, suggest that RNs spend time on administrative and clerical responsibilities, such as answering the telephone, dealing with a broad range of

enquiries, telephoning to book bank or agency staff, checking equipment and checking deliveries, for example from pharmacies.

While it would seem sensible to acknowledge RN expertise in designing buildings, selecting equipment, marketing the home, designing protocols for enquiries about care in the home and particularly in ordering drugs, it could be effective in terms of both cost and the best utilisation of resources for homes to consider staff utilisation in these respects. Certainly the managers in homes with good administrative and maintenance support valued this. Particularly in the context of RN shortages it would seem timely for homes to reconsider support for RNs in these responsibilities, thus enabling them to focus on care.

#### **6.3.4: DEFINING THE DISTINCT CONTRIBUTION OF RNs**

The findings offer insights into fundamental questions raised in the literature about the distinct contribution of RNs.

The 'invisibility' of nursing has been described anecdotally for many years (e.g. RCN 1992 and contributions to the Nursing Standard campaign 2005) but Nolan (1998) questions the usefulness of the whole 'invisibility' argument and urges nurses to make their contribution more explicit. This research illustrates why nursing has been described as 'invisible'. Much of the work goes on behind the doors of the home and in bedrooms or bathrooms. In addition, in the realities of day-to-day care the contribution of good nurses is arguably most noticeable when it is absent, for example when the environment is not therapeutic, resident health is not maintained or no RN is available to deal with emergencies. When good RNs nurse well everything runs smoothly, residents maintain optimum health and wellbeing and the home is happy. The 'invisibility of nursing' has also possibly been argued because the role is complex and difficult to describe, but this research demonstrates that this is possible and particularly that the combination of methods is a helpful means by which to achieve this, i.e. RNs identifying and describing examples of their contribution, having their work observed, and then having an opportunity to reflect on this with a supportive and facilitative observer. It may well be that after this cycle, RNs could find it easier to identify more examples, and thus the approach could offer a basis for RN support and supervision.



The contribution of RNs during their 24-hour presence was also an issue in the literature which can be addressed by the findings. The data, from a range of sources, suggest that, during their 24-hour presence, the RNs in the homes, for example:

- Created and maintained the environment and atmosphere in the home so that it was comfortable, safe, pleasant and, where possible, therapeutic.
- Constantly monitored the residents, staff and others in the home and were thus able to assess issues such as eating and drinking, pain, fatigue, sleep patterns and distress.
- Supported and encouraged residents in maintaining their health and life activities, were able to “see the potential”, to work towards this and remain positive but also, in a day-to-day sense, were able to recognise when residents were “really not up to it”.
- Balanced the priorities listed in Section 4.2.3 (page 214), such as freedom versus risk, openness and flexibility versus control and discipline
- Prioritising the use of resources. This sometimes involved ethical decisions in prescribing and delivering care, e.g. in targeting one resident for intensive rehabilitative input as opposed to giving a little input to more residents.
- Were available to deal with queries requiring RN knowledge, problems which occurred and emergencies requiring immediate action with life-or-death consequences.

**Fundamentally, the data suggest that the presence of an astute, skilled, knowledgeable and experienced RN offers a perceptual presence – a complex, integrated, perceptual awareness that can read situations, identify problems and interpret these in terms of the potential sequelae and actions needed. This was illustrated in the examples in Section 4.2.2 (page 210-212).**

As the data demonstrate, and particularly the observations, the role of the RNs in the study is highly complex. It is broad, multi-level and multi-faceted. At any one moment an RN will likely be dealing with a range of issues, undertaking more than one task, monitoring a unit including for example 35 individuals within this, and constantly balancing priorities. The example observation of the RN administering the medicines demonstrated this (page 210). The ‘here and now’ job was giving out the medicines in the lounge but the RN also recognised the needs of individual residents, and prioritised her response to these, for example

that N did not have her teeth in from the way she was eating her toast, that D was about to be given non-diabetic orange juice, that T was wet. She was assessing whether residents needed drugs, e.g. for pain, constipation, heart regulation. In addition to the aspects identified above in the RN's 24-hour contribution, the observations suggest that astute RNs:

- have a geographical awareness, approximately 30 residents and five staff, who was where doing what, e.g. which residents were still in their bedrooms. Some also connect activities, e.g. realising that a CA was on her way to a particular resident with breakfast and asking her to take that resident's medicine.
- can simultaneously be aware of time deadlines, such as which residents needed medication at precise times, e.g. for Parkinson's disease

All of this was underpinned by the RN's knowledge of medicines and of the residents' health needs.

Such multi-tasking has been reported in the literature, particularly the work of Benner and her colleagues (e.g. Benner 1984), but this has mainly been in acute settings.

There were many instances in the examples, observations and interviews where RNs made specific clinical diagnoses, including arterial embolus, deep vein thrombosis, myocardial infarction, fits, fractured neck of femur and determining that someone had depression not dementia. The RNs appeared to do this by identifying and interpreting patterns of signs and symptoms from their previous learning and their wide range of clinical experiences.

There were also instances where RNs were alerted to potential problems because the patterns they were seeing were not entirely what they would expect. In other words, they suspected there was something not right in a situation because the pieces in the jigsaw did not seem to fit. There were many instances of this, such as Example 263 (page 293) where the RN said: "there was something in this situation that did not make sense – morphine for septicaemia?".

The RNs in the study commonly identified that there was often more to a situation than was apparent. They were often prompted to investigate further "in order to get to the bottom of things". One said that many years of working with the elderly had taught her that the way in which things present are rarely what they seem. "I



personally learned that I should try to look beyond how a person presents and appears ... “because they are not expressing pain in a conventional way” does not mean “that they do not have pain” (Example 8.2, page 222). Another example was the RN who strongly suspected that a resident with dementia had fractured her femur. Although the resident could not express how she felt, the RN believed she was in pain and walking awkwardly. She argued at length with the GP until he agreed to an X-ray, which showed a fracture (RN 501, page 23).

There were many examples in the data where RNs said they were able to read situations in their units and to recognise that something was wrong. This information came through a range of senses, such as the RN who was alerted to a pressure ulcer by a smell, or the RN who said she could be sitting in her office and, even though she could see nothing outside her office, she knew something was wrong in her unit, perhaps because the sounds had changed from the norm. Others not only knew that something was wrong but could see the likely consequences of a set of circumstances, for example the RN who could see a situation from her office. She said “I can see things five minutes before they happen; I can't always get there in time” (RN501, page 202). Some RNs believed that such abilities were due to intuition, others that they were highly developed abilities which developed through their training and experience.

The concept of intuition and its use in practice has been discussed extensively in the nursing literature (e.g. Benner 1984, McCormack 1992, Meerabeau 1992, Faugier 2005). Some RNs in the study believed in intuition, for example as soon as one RN came on duty she went upstairs first, contrary to her usual pattern of working, and found Mr H on the floor. She said she knew his tremors were becoming worse but believed it was intuition that led her to him at that moment. Other RNs believed that their intuition or ‘gut feeling’ resulted from a sophisticated synthesis of their learning and experience over the years.

From the participants' reports, perhaps such a high level of sophistication can be reached in the work because the staff know the residents so well. In Benner's work in intensive therapy units (1984), the expert RNs worked at a level of sophistication partly because they knew the environments, its sounds and smells. The same would appear to be true of expert RNs in care homes but, rather than the technology, the expert RNs knew the sounds, sights, smells and ‘sense’ of their units. They also knew each of the residents well so recognised any change.

Benner (1984, p 32) describes how “the expert nurse, with an enormous background of experience, now has an intuitive grasp of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions” and some of the RNs who participated in the current study demonstrated this. It seems from observing the RNs working, and the statements in their interviews, that astute RNs are constantly scanning and monitoring their units and the individuals within it. While astute RNs working in any setting could scan and monitor in this way, what is distinct in long-term care settings is that they know:

- their care environment – the way it looks, sounds, smells and functions at each time of the day
- the staff regimes – what staff might be doing at each time of the day
- the residents in the unit –who might be where at a particular time, how many residents might be in the lounge, their bedrooms, the bathrooms, and particularly
- the residents as individuals – at least a little about their biographies, their health issues, the disabilities they face, the support they do or do not have and, in a day-to-day sense, how they look, behave, talk and react.

Rather than conceptualising this as a pattern, the RNs seemed to see it more like a jigsaw puzzle where the frame and some pieces of the jigsaw are in place in any given situation. As further pieces are added a picture begins to build in the RN’s perception and the RN can anticipate how the picture might look when completed. An example of where an RN used her understanding of a resident and her life to place pieces of a jigsaw together was the example in Section 4.1.5 (page 199). The jigsaw pieces comprised the way M looked, the way she said “mummy, mummy”, the knowledge that the RN had of her background, family, concerns about paying the bills, liking of babies. These enabled the RN to intervene in a sensitive and skilled manner in order to relieve her distress.

The ability to read situations was highly valued by the RNs who recognised it as they believed it considerably enhanced their work effectiveness. Such skilled practitioners who work in environments where many of the elements remain stable could provide not only valuable training for developing professionals but also valuable information towards further research into how such skills operate in practice.



Overall, the findings of this study would broadly support the definition of nursing developed by RCN (shown on page 62) and the defining characteristics suggested were generally supported by the findings with some minor additions, for example, the domain of nursing in care homes includes engagement with the resident's current life to an extent not common in other settings; the residents live there until they die. The domain also includes responsibility for the environment to facilitate continuity of a person's life. The findings of this study also resonated with the gerontological nursing definition recently developed at Glasgow Caledonian University (shown on page 64). As the data in this study show, however, in care homes CAs would play a major role in achieving this.

The defining characteristics of nursing in rehabilitation settings identified in the literature did not resonate with this study's findings. Whereas in rehabilitation settings the 'maintenance' and 'carry on' work was carried out by RNs, in the care homes this was done by CAs, and whereas in rehabilitation settings the RNs reinforced the work of therapists and doctors, in the care homes with little multidisciplinary input the RNs took the lead in care. The defining characteristics of the RN role in the care homes were in leading, managing, directing, planning, supervising, delivering and evaluating care to residents, as shown in Figure 4.1.

#### **6.3.5: WHAT THE RNs BROUGHT TO THEIR WORK**

When asked about what they brought to their work the RNs tended to emphasise their professional skills and knowledge rather than personal beliefs and motivations. When asked the aim of their work, however, most emphasised that the priority for them was to make life as good as possible for the residents. This focused on quality of life, maintaining normal life, individual wellbeing and fulfilment, helping to sort out their problems, offering high quality care.

The RNs identified a range of individual values, beliefs and motivations. While the CAs tended to emphasise personal experiences and motivations, the RN emphasis was more on professional aspects, and there was less use of 'self' in the RNs' work. For example, while the CAs were strongly motivated by negative experiences in their personal lives, many RNs were strongly motivated by the poor care they had witnessed in the past, about which they spoke or wrote passionately and were determined should never happen again. It seemed as if,

while the RNs did have personal beliefs and motivations, these were channelled and operationalised through their professional roles, as they had likely been socialised to do in their professional training. As with the CAs, most of the RNs held positive views about older people and their potential. These came not only from their personal values but also through their range of clinical experiences where they had learned what **could** be achieved, for example following a stroke.

The RN lists of inputs to their work, both personal and professional, were more extensive than those offered by the CAs but arguably this would be expected. There were twice as many RN examples as CA and the RNs had undergone pre- and post-registration education encompassing a broad range of elements about which they could be explicit, for example, self-awareness or communication skills. The RNs in the study brought an enormous range of inputs in terms of professional skills, knowledge and experiences. All emphasised the assessing, planning, delivering and evaluating care and, in addition, there were skills and knowledge in the management of clinical care and in leadership. Their professional skills, knowledge and experiences gave them the confidence to advocate for what they believed the residents needed, including challenging other professionals when necessary, and the resourcefulness to bring a range of services into the home, for example Macmillan nurses, psychogeriatricians or social workers.

The number of Registered Mental Nurses (RMNs) in the study was small and this reflects the shortage of RMNs generally. In areas where the shortage of RMNs was particularly acute, special dispensation had been obtained from registration and inspection teams for RGNs to run mental health units and all of these nurses had undertaken post-registration training in dementia care. Some of the RMNs identified distinct elements that they brought to their work e.g. mental health legislation and recognised that RGNs had expertise on many physical aspects of care, for example prevention of pressure sores, that they did not possess. The observations suggested that some of the RMNs were highly skilled, particularly in anticipatory and preventative care and the prevention and relief of distress.

While all the RNs agreed that their training was important in developing their expertise, most believed that the fundamental, and most important, influence was innate to each individual, i.e. "who you are". Many believed that the caring was always within them and the training built on this.



As with the CAs, these findings have implications for recruitment and selection of RNs to work in long-term care settings with older people in that, although professional knowledge and skills were essential in order to be able to fulfil their roles, what the RNs considered most important was their caring for older people and a positive approach to what could be achieved in the care.

#### **6.3.6: VARIATION AMONG RNs**

From the beginning of data collection it became apparent that RNs seemed to be working at different levels of sophistication in their practice and demonstrated varied skills in articulation. This seemed greater than the differences among CAs, possibly because there was greater diversity in the education RNs had received and in the scope and focus of their work in general. Most RNs who participated in the study appeared to be practising with competence, caring and commitment. In terms of Benner's (1984) 'Novice to Expert' categories, most would be classified as 'competent' or 'proficient'. Some RNs in the study would clearly meet Benner's criteria as 'expert' nurses. Of the 50 or so RNs participating in the study, at least 15 could have been potentially identified as 'expert'. Identifying such levels of competence in practice was easier through observation and interview than through the significant examples.

A small minority suggested poor practice. Two RNs were delivering what could be deemed inadequate care, one because she was restraining residents, the other because she was endangering them by not checking drugs adequately and dressing wounds in a manner that would likely spread MRSA infection. Both of these RNs were ENs who had gained RN status by virtue of experience. In addition, a small minority of the examples offered by RNs as 'significant' in demonstrating the value of their work, were surprising, for example the one who described how she sang to cheer up residents. Arguably she could have seen this as contributing to the atmosphere and environmental influence in the home but it was an unusual example of RN skills. Some of the care described was totally person-centred, other examples gave the impression of task-focused care.

A few of the RNs emphasised the importance of evidence-based practice, of reading journals to keep their practice up to date and of clinical supervision, but

most did not mention these aspects and this would seem to be an area requiring further development in care homes.

The diversity among the RNs had potentially far-reaching implications in terms of the care residents received and, ultimately their health, well-being, functioning and quality of life. For example, if leading or dominant RNs were knowledgeable, up-to-date, focused on resident health and well-being and working within rehabilitative and therapeutic models, residents would likely receive good care. Conversely, if the leading RNs were unsound in their knowledge, using outdated practices and working within custodial models, residents would likely not receive good care. In the fieldwork homes, the diversity in the teams observed ensured that residents only received poor care on single shifts but the findings would have implications for very small homes with few RNs overall.

Conversely the variation among RNs offers advantages. In Home 1 RGNs and RMNs shared expertise and this was helpful for residents with complex needs. In addition, in the reality of nursing homes, residents in 'physically frail' units commonly have mental health needs and residents on 'mental health' units are often physically frail. In Home 3 each RN developed a clinical specialty, e.g. in tissue viability, continence, nutrition or moving and handling, and then acted as a specialist resource. This could work well in larger homes. For smaller homes, local networks can help to share expertise (Wild, Fear and Means 2005).

#### **6.3.7: DIFFICULTIES ARTICULATING THE RN CONTRIBUTION**

Most RNs found it difficult to articulate their specific knowledge and skills, even those they used in particular situations. They tended to take them for granted e.g. "all nursing skills", "anatomy and physiology goes without saying", or "nothing special". The study reveals why it can be difficult to articulate the RN contribution and it would also appear not to be within the culture of these nurses to do so; they just 'get on with the job'. If RNs are unable to describe their contribution this could have far reaching implications. As Johnson (1995, p 116) highlights: "when nurses themselves fail to recognise, or undervalue, their professional contributions, physicians, administrators, employing organisations and the healthcare system itself are apt to do likewise". Johnson argues that this creates a vicious circle in that if staff perceive their work as unimportant or unskilled, this



then influences the perceptions of others, including managers who then allocate fewer resources. Inadequate resources limit the ability of the service to function effectively and staff begin to lose their sense of achievement. Residents do not progress as well as they could and staff motivation reduces further. Staff turnover increases, leading to lack of continuity in care and the quality of care deteriorates.

#### **6.3.8: THE CHALLENGES IN RN WORK**

The research identified a range of challenges in the work. Those relevant to care home work generally are identified in Section 5.6 (page 326) but other challenges were specific to RNs (Section 4.2.10, page 229). The RNs held responsibility and accountability for the home and everything within it, for vulnerable people with complex needs, resident care and safety, continuous monitoring and assessment, identifying problems and continuity of care. Even those of lower grade who usually held responsibility for one unit only would likely be responsible for the whole home at sometime, usually evenings, weekends and nights, and the pressure of their responsibilities were keenly felt by most RNs observed and interviewed. Because they held such wide responsibility, interruptions to their work were a constant feature throughout the observations. These made it difficult for them to maintain concentration on their work which, as some identified, could be particularly worrying when they were dispensing medicines. There was sometimes no alternative to the constant interruptions because the RN was the only trained and accountable person in a home with all the other staff largely untrained. These aspects were not identified in the literature, probably because so little had been conducted in independent sector care homes. In NHS-provided services, including continuing care units, there would likely be support in the form of senior RNs and multidisciplinary teams.

It was commonly challenging for RNs to obtain input from professionals outside the home, even GPs, and there are instances in all datasets of where RNs persisted until they obtained the care and treatment they believed their residents needed. They also used whatever networks they could establish to obtain services such as advice on pain control from local Macmillan Nurses who offered this despite it not being a defined element of their work. The lack of multidisciplinary input to care homes appears to be an ongoing issue and concern has been raised in the literature (RCP, RCN, BGS 2000).

An additional challenge for the RNs was that the residents' medical records were commonly retained by the GPs. This could mean that, if residents became ill soon after admission to the home, the RN had no background information on which to draw other than their own initial assessment. An example of this was during one night in Home 2 where the RN suspected that the resident was epileptic but had no notes to guide her in managing the resident's seizures until she found some tablets in her handbag. This also caused problems when residents were taken to hospital in an emergency and hospital doctors were not able to access medical notes. As the RNs identified, it would seem logical for all notes relevant to each resident to be wherever the resident was.

#### **6.3.9: OUTCOMES OF RN WORK**

No recent work into the outcomes of RN work in UK Independent Sector care homes was identified in the literature review and there was little research seeking older people's views on the work of RNs in care homes. This research suggests that the outcomes of RN work are broad, multi-level and impact in varying time frames. As identified in Section 5.4.8 (page 311) fundamentally with good RNs problems are anticipated, avoided and dealt with so that deterioration is prevented, in as much as this is possible, and optimum resident health and functioning is maintained. This, in turn, helps them to enjoy better quality of life. The outcomes and potential outcomes of the work of RNs compared with those of CAs are discussed in Section 6.5.



## **SECTION 6.4: DISCUSSION OF FINDINGS:** **OUTCOMES IN CARE HOMES**

### **6.4.1: THE CONTRIBUTION OF THIS RESEARCH**

In addition to identifying the outcomes of the work of RNs and CAs (discussed in Section 6.5), the findings from this study address broader debates about the outcomes of the work in older people's long-term care and offer insights into some of the conceptual, methodological and practical challenges identified in the literature. The findings offer insights into the key questions raised by the literature (page 82) such as:

- what counts as an outcome, particularly for vulnerable people in long-term care?
- how should outcomes be defined within individual services and for individual service users?
- who should determine the achievement of the outcomes and when?
- what terminology should be used in the framing and assessment of outcomes?

It is important to emphasise that this study does not claim to offer answers to all of the challenges intrinsic to outcome-focused work in older people's long-term care. Rather, the findings from the data and the new frameworks developed through the research offer a foundation from which the debate could be taken forward.

The research offers two original frameworks within which the outcomes of work with older people in long-term care settings could be articulated and evaluated. The structure (inputs) – process (outputs) – outcomes framework developed from the literature review (Figure 2.2, page 92) proved to be a useful heuristic device not only in achieving conceptual clarity through the research process but also in facilitating the collection and analysis of the data. The Outcomes Framework (page 264-5) derived from the data offers the potential for further research and practice development.

For ease of reference, related sections in the study can be located as follows:

Conceptual issues in outcomes research in Section 1.7.6 (page 75) and specifically for older people in long-term care in Section 1.7.7 (page 77).

The outcomes literature which offers the context for the findings is summarised in Section 1.7.8 (page 78-79) and Section 18 (pages 82-3).

The initial framework of structure-process-outcome is shown in Section 2.1 (page 92) with the definitions of the concepts on page 93.

Findings from this study concerning outcomes of the work are in Chapter 5.

The Outcomes Framework developed from the data is described in Section 5.2 (pages 262-5).

#### **6.4.2: STRUCTURE PROCESS AND OUTCOME**

The study encompassed structure, inputs, processes, outputs and outcomes.

The findings suggest that a outcomes focus can be useful but also that all of these aspects are important considerations when analysing the work of staff.

The structure-process-outcomes framework developed from the literature review (Figure 2.2, page 92) proved to be a useful in facilitating data collection and analysis, particularly as it encompassed the concepts of inputs and outputs. This seemed to avoid some of the difficulties in distinguishing between structure, process and outcome noted in previous studies (e.g. Closs and Tierney 1993).

When the study began, as illustrated in Figure 2.1 (page 91), it was unclear where elements of structure, process or outcome arose or impacted. The research findings suggest that the structural influences on the work of RNs and CAs arise from the care home itself, local or sectoral factors and national policies or issues. The structural influences on CAs are illustrated in Figure 3.2 (page 188), those on RNs in Figure 4.2 (page 254) and those on nursing homes in Figure 5.7 (page 327). As Sections 5.3 (page 266) and 5.4 (page 285) illustrate, the outcomes of the work can impact on residents, relatives, other staff, the home in general or beyond the home. Some of the outcomes of the work thus, in turn, impact on aspects of structure or input, for example the outcomes of the work of RNs who were effective leaders resulted in happy, motivated staff, high quality care, the reputation of the home, and thus attracting new residents and staff.



A new framework was developed from the categories of outcomes identified by the CAs and RNs in their examples, observations and interviews (described in Section 5.2.1, page 262-265). While this is rudimentary and will require further development and validation before its usefulness can be evaluated, the research offered suggestions as to how it could be used.

### **6.4.3: THE OUTCOMES FRAMEWORK**

The research suggested that this framework could be used to identify, monitor and evaluate the outcomes of the care in care homes. The categories and sub-categories could serve as a sample menu from which priority sub-categories are identified by, and for, each resident. Outcomes are identified within each sub-category. New sub-categories can be added and those of lesser priority removed.

Outcome indicators could be used to assist monitoring and evaluation in each sub-category and these could be audited. For example,

Preventing problems: outcome indicators could include risk assessments for falls, skin breakdown, wound healing, infection

Functioning: indicators could include assessments of mobility, dexterity, continence or independence in activities of daily living

Health: monitoring of blood pressure, urine output or other aspects of health.

Personhood/wellbeing: Wellbeing, mood, depression scales; dementia care mapping

Quality of Life: Older people could express satisfaction, or not, with the achievement of their individual quality of life priorities, such as their chosen activities, or recreational pursuits.

It is vital, however, that any tools or scales serving as outcome indicators are used appropriately and consistently.

The outcomes framework offers the potential for different 'stakeholders' in care homes (residents, staff, home managers) to determine priorities within the broad categories and to evaluate the achievement of the outcomes. For example:

- older people could identify and evaluate their priorities for quality of life, personhood and wellbeing,
- RNs could determine and evaluate priorities for health, pressure damage avoidance, wound healing

- doctors could monitor clinical tests and the effectiveness of medication
- dietitians could advise on nutrition
- physiotherapists could focus on functioning priorities
- CAs, with residents, could monitor some activities of daily living such as clothing or personal hygiene, and
- home managers could evaluate outcomes for the home overall.

There is also the potential for specialist input to the identification and monitoring of outcomes and outcome indicators, for example from continence, diabetes or stoma care nurses. It must be recognised, however, that, as demonstrated in the research, multi-professional input is not in abundance in care homes and RNs would likely lead on the determination and monitoring of outcomes.

Evidence for the recommended approaches could be included, as in some current care plans.

Older people's views could be captured in a range of ways, for example through their descriptions or narratives, and support for frail or vulnerable people in this process could be offered by families, supporters, staff or advocates.

#### **6.4.4: THIS FRAMEWORK ALONGSIDE OTHER FRAMEWORKS**

Other frameworks identified in the literature were devised by Nolan (1997), a team led by the Royal College of Nursing (RCN 1997, 2004b, Heath, McCormack, Phair and Ford 1996a, b,) and previously by Challis (1981).

#### **THE NOLAN FRAMEWORK**

##### **Security:**

Older people: Attention to essential physiological and psychological needs, to feel safe and free from threat, harm, pain and discomfort

Staff: to feel free from physical threat, rebuke or censure. To have secure conditions of employment. To work within a supportive culture

##### **Continuity:**

Older people: Recognition and value of personal biography. Skilful use of knowledge of the past to help contextualise present and future

Staff: positive experience of work with older people from an early stage of career, exposure to role models and good environments of care

##### **Belonging:**

Older people: Opportunities to form meaningful relationships, part of a community

Staff: to feel part of a team with a recognised contribution, belong to a peer group



<p><b><u>Purpose:</u></b>  Older people: Opportunities to engage in purposeful activity, the constructive passage of time, to be able to achieve goals and challenging pursuits  Staff: a sense of therapeutic direction, a clear set of goals to aspire to</p>
<p><b><u>Fulfilment:</u></b>  Older people: Opportunities to meet valued goals, feel satisfied with ones efforts  Staff: to be able to provide good care, to feel satisfied with one's efforts</p>
<p><b><u>Significance:</u></b>  Older people: To feel recognised and valued as a person of worth, that one's action and existence is of important, that you 'matter'.  Staff: to feel that practice is valued and important, that your efforts 'matter'.</p>

Concerned with the lack of a therapeutic rationale for work in long-term care settings with older people, Nolan (1997) identified six 'senses' which he believed might both provide direction for staff and improve the care older people received. He chose the term 'sense' to reflect the subjective and perceptual nature of the key determinants of care for both older people and staff. Although initially conjectural, Nolan's framework has undergone considerable development and evaluation in both practice and education (Nolan, Brown, Davies, Keady and Nolan 2002) and has been adopted as the framework for practice in a range of older people's care settings (such as the acute hospital nurse and therapist-led practice development unit described in Heath 2005).

### THE ROYAL COLLEGE OF NURSING FRAMEWORK

<p><b><u>Maintenance of health status</u></b>  Maximising health status  Assessing health status  Preventing disease complications  Managing risk  Rehabilitating  Identifying and relieving symptoms</p>
<p><b><u>Prevention and relief of distress</u></b>  Providing essential care and palliation  Identifying problems and coming to terms with life  Preventing pain  Treating pain  Assessing mental health</p>
<p><b><u>Maximising life potential</u></b>  Offering health promotion and education  Developing throughout life  Fostering meaningful relationships  Contribution to life  Reciprocating  Coping with adversity</p>

This framework for outcome definition was developed by team at the Royal College of Nursing (RCN 1997, 2004b, Heath, McCormack, Phair and Ford 1996a, b). Aiming to offer insights into 'the benefits of expert nursing to the clinical outcomes in the continuing care of older people', the framework was developed by "four nurses expert in the care of older people" (RCN 2004b, p 7), including the researcher. It was based within Seedhouse's (1986) definition of health and Kitwood's (1995) concepts of personhood and person-centred care, on good practice evidence collected from experience, and a review of the literature on the care of older people. Three domains encompass the continuing care needs of older people, and the document reflects the complexity of RN work. The framework was developed conjecturally rather than on research evidence, and no literature has been identified evaluating this in practice. However, the RCN (2004b, p 2) reports that it has resonance with practising nurses and that members have found it helpful in demonstrating their contribution to the continuing care of older people. The RCN document (1997) was updated and re-issued (2004b).

### THE CHALLIS FRAMEWORK

#### **Nurturance:**

This refers to the most basic needs of an older person for comfort and security and also to an individual's ability to fulfil his/her basic minimum needs and necessities for daily living, such as self-maintenance behaviours and self-care.

#### **Compensation for disability:**

To restore patients with illness or disability to as healthy a state as possible and, despite the difficulties created by the presence of disablement, to compensate for disability and enable independent living.

#### **Maintenance of Independence:**

Not only physical ability to live independently or undertake activities of daily living independently but also refers to the felt independent and self-respect of an older person - having a greater feeling of self-direction and control over ones life. Not being a 'burden', able to retain social relationships, maintaining self-respect. Related to autonomy, environmental mastery and internal control

#### **Morale:**

Concerned with psychological wellbeing, fulfilment, ability to be 'psychologically free', live with ones feelings, increasingly aware of self and ability to experience life in the present without the adoption of continued defensive responses (p 189). Towards self-realisation as the individual attempts to negotiate the boundaries of the opportunities and risks of freedom.

#### **Psychopathology:**

Particularly undiagnosed psychiatric morbidity, such as anxiety or depression.

#### **Social integration:**

Reduction of isolation - so far as they are willing and able to take part in, and contribute to, the normal range of social life. Older people remain essentially integrated into society in terms of their values and beliefs but some become



increasingly frail and dependent, undergo a major crisis, and are likely to retain little hope or expectation of gratification from their social environment.
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<b>Family relationships and family care</b>
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<b>Community development</b>
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Fostering and encouragement of a system of social relationships.
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Challis (1981) delineated seven broad dimensions within which the effects of social services for older people could be measured. Developed for domiciliary and day care, the author suggested that the framework had some relevance to long-term care settings where older people live. The author acknowledged that the distinctions between some of the categories were rather arbitrary but at that time, as the author highlighted, outcome measurement was at an early stage. Challis (1981, p 179) stated that “outcome measurement probably represents one of the most difficult tasks of research into the effectiveness of social care” and made a plea for the development of some consensus among researchers about methods of outcome assessment. He concluded “A most valuable development would be a move toward similar criteria of measurement by different studies of social care in various contexts so that valid comparisons of different kinds of intervention can be made” (Challis 1981, p 208).

### CRITIQUE OF THE NEW FRAMEWORK ALONGSIDE PREVIOUS FRAMEWORKS

All the frameworks aim to be holistic, encompassing health and social aspects of care, and also potentially rehabilitative and therapeutic approaches. They also aim to be flexible and adaptable to the needs of older people and staff.

The framework from this research is distinct from the others in that it was developed through analysis of everyday ‘front-line’ practice and the perceptions of around 100 staff working in care homes, as well as older people and their relatives. As it is grounded within their concepts, terminology, priorities and the everyday realities of practice, it will likely have greater resonance in practice than frameworks developed conjecturally. For example, priorities contributing to the wellbeing of residents in this study were that help was always available and that ‘the little things’ received attention. The new framework can accommodate such priorities.

Comparisons between the frameworks are offered below.

### METHOD OF INITIAL CREATION AND PURPOSE

Nolan (1997): Created conjecturally in order to identify therapeutic rationale in long-term care; to provide direction for staff; to improve care.

RCN (1997): Created conjecturally in order to identify the RN contribution to continuing care.

Challis (1981): Created conjecturally in order to measure the effects of social services in domiciliary and day care.

Heath (2006): Created through research seeking to identify the outcomes of the work of RNs and CAs in care homes. The results are now offered as a framework or tool which could be used to identify and evaluate the outcomes for older people of the work of staff in care homes

### CONCEPTS, TERMINOLOGY AND USER-FRIENDLINESS

Nolan (1997): focuses on the perceptions of older people and staff, and Nolan et al (2002) claim that it has been found user-friendly with older people, staff and nursing students. Before use, however, discussion with older people, relatives and staff is necessary in order to achieve mutual understanding and to determine personal goals within broad categories. Because the categories are broad, some defining concepts or characteristics need to be developed in order to make these meaningful to individuals. There is potential for overlap between the categories which could make evaluation complicated, for example one staff action could achieve a range of senses for everyone involved in the home.

RCN (1997): focuses on priorities for nursing and the concepts would be meaningful to nurses. This framework would not necessarily reflect older people's priorities in all aspects of their lives and relationships. There is the potential for overlap in some of the concepts, e.g. 'identifying problems and coming to terms with life' (under the heading of 'the prevention and relief of distress') and 'coping with adversity' (under the heading of 'maximising life potential').

Challis (1981): Some of the professional concepts and perspectives (e.g. terms such as 'social integration', 'undiagnosed psychiatric morbidity' or 'environmental



mastery') would be alien to many staff and older people. As the author acknowledged, the distinctions between some of the categories were rather arbitrary and could thus be challenging to apply in practice.

Heath (2006): Grounded in the concepts, terminology and everyday realities of staff and older people in care homes, this framework would be more readily user-friendly for staff and residents.

### POTENTIALS IN PRACTICE

Nolan (1997): While this has been used successfully as a 'philosophy' and framework for practice, and could potentially encompass a broad range of outcomes of care, aspects of health or daily functioning are not specifically identified. It would not readily identify the contributions of individuals or specific staff groups to the achievement of different 'senses'.

RCN (1997): The RCN (2004b) reports that RNs have found the tool to be useful in articulating their specific contribution to care. With adapted terminology, it could be used by other staff.

Challis (1981): Would likely need further conceptual development before everyday use in care home work.

Heath (2006): Could be used by all staff and residents in care homes, each with specific responsibilities for identifying and evaluating outcomes in distinct categories. Outcome indicators and measurement tools, such as for mobility, dressing or continence, could also be used alongside the framework. As identified by one Director of Nursing in the study, the framework also offers the potential for managers to identify where individuals and groups of staff are focusing their care (e.g. are the CAs focusing on physical care rather than 'personhood' and 'wellbeing').

### POTENTIALS FOR DEVELOPMENT

Nolan et al (2002, p 28) claim "that the senses framework has application beyond long-term settings, offering a degree of analytic generalisability which can help to inform service developments across a range of care environments".

The RCN and Challis frameworks could offer similar potential but would need further development before doing so.

Heath (2006) also offers potential for analytic generalisability across a range of care environments. As a starting point towards this, the framework is ready to be piloted and representatives from a variety of care homes have expressed interest in piloting the framework.

#### **6.4.5: THE ADVANTAGES OF AN OUTCOMES FOCUS / FRAMEWORK**

This research suggests that an outcomes focus offers many advantages in care homes. The outcomes framework could contribute to this, particularly as it is flexible, adaptable to individual situations and, having been developed from the 'text', language and everyday realities of practitioners, will likely to resonate with them.

It could contribute towards overall evaluation of the quality of care and can encompass multiple methods. It encompasses a broad range of outcomes, including quality of life and complications, and can accommodate process measures for both the care received by the patient and the activities of the RN or CA.

It addresses 'ordinary living' which, as Norman (1997) highlights, is not widely acknowledged in current quality of care measures (other than possibly Dementia Care Mapping), and relationships between older people and staff that, as Norman (1997) argues, are the hallmark of high quality care for older people. The framework also offers potential to encompass 'the whole picture' without losing sight of the 'component parts' which, as identified by Redfern (1993) has long been a challenge in evaluating the quality of care.

This research, and other literature, identifies that older service users, even those who experience frailty or vulnerability, generally welcome the opportunity to discuss the help they are offered. Relatives also welcomed this opportunity.



<b><u>SUMMARY: THE ADVANTAGES OF THE OUTCOMES FRAMEWORK</u></b>	
<b><u>Stakeholders / service participants</u></b>	<b><u>Advantages the Outcomes Framework could offer</u></b>
Older service users	<p>Opportunities to identify their individual components of quality of life.</p> <p>Opportunities to determine personal priorities and goals in care planning.</p> <p>Opportunities to discuss and evaluate the help received.</p> <p>Their care plans expressed in language and terminology which are meaningful to them.</p>
Relatives	<p>Opportunities to participate in decisions about care and quality of life issues for older residents.</p> <p>They can monitor the care offered in language they can understand.</p>
Service managers	<p>In care evaluation, to identify the achievement, or not, of outcomes of care determined by staff and residents.</p> <p>They can identify where individual staff, or staff teams, are focusing their work.</p> <p>If legal or ethical issues arise, effective use of the framework could offer insight into shared decision-making and individual responsibilities within this.</p>
Registered Nurses	<p>Could easily identify the outcomes of the care for which they are especially responsible, e.g. day-to-day health care, the prevention of problems and maximising health and functioning in the long-term.</p>
Care Assistants	<p>Could participate in determining and evaluating outcomes of the aspects of care for which this research has identified they hold responsibility, e.g. residents' personal care, daily functioning, and relationship with residents, plus the residents' priorities for help being available and for 'the little things'.</p>
Multidisciplinary Professionals	<p>Could determine and evaluate goals within their specialist expertise. Using examples suggested by this study, physiotherapists could measure mobility and dexterity; dieticians could evaluate nutritional status of residents with PEG tubes; speech therapists could evaluate changes in residents following strokes at hospital appointments and this could be incorporated into the documentation in the home.</p>
Service Regulators	<p>Would have easily-accessible documentation upon which to base their inspections on which the priorities determined by residents and staff are clear.</p>
Educationalists	<p>Could identify where education, training and ongoing development needs to be priorities and could evaluate the impact of such support on the care documented.</p>
Researchers	<p>Could identify priorities for research.</p> <p>Could conduct research using the outcomes framework.</p>

### A POSITIVE APPROACH TO CARE PLANNING AND EVALUATION

An outcomes focus can be comprehensive and reflective. It can encompass contributions from clients and team members and evaluate care, skill and clinical judgement, as highlighted by Peters (1989). The outcomes framework is not problem-focused, as so much care planning has been. Rather than focusing on incapacity, disability or handicap, care can focus on older people's abilities, goals and aspirations. Such an approach is much more rehabilitative, enabling and empowering than focusing on deficits and problems. It can address issues of both process and structure, for example the building of reciprocal relationships which both residents and staff valued and came about through the day-to-day processes of care, supported by structural elements, such as sufficient staff, adequately trained and well motivated. The research suggested that, although therapeutic and rehabilitative approaches are adopted by some RNs, these are not always made explicit in care plans and the work is not overtly outcome focused. By changing the focus from the traditional problem-orientated approach, there is even a possibility that it could help to move away from routinised approaches to the work. Focusing on the outcomes of staff work could also offer a more positive approach than those focusing on individual staff competencies, performance or effectiveness, which can seem punitive. Directors of Nursing/Matron Managers involved in the study suggested that their organisations would find the outcomes framework useful in identifying where their staff were focusing their work and, through this, ensure that the psychosocial, as well as physical, needs of residents were being addressed.

### THE CENTRALITY OF OLDER PEOPLE, WELLBEING AND QUALITY OF LIFE

By focusing on the goals and priorities of individual older people the approach and framework promote the values of 'person-centred care' which feature so strongly in current government policies, such as the National Service Framework for Older People (DH 2001a) and the minimum standards by which care homes are regulated (DH 2001b). This also acknowledges the key influence of wellbeing and individual resources on health and functioning. In the literature, many authors argued that "patient perspectives, and specifically patient wellbeing, must remain in focus and the changes (positive or negative) that occur, irrespective of external intervention" (Griffiths 1995, p 1093). This



approach could highlight outcomes such as quality of life and its elements which, although the subject of volumes of literature, some of which suggested it to be the ultimate aim of long-term care, did not feature prominently in the care plans observed in the homes. The research findings suggest that the domains cannot be hierarchical as all are integral to quality of life, sense of self, health, wellbeing, functioning and avoiding detrimental situations. The framework is holistic in that it acknowledges the relationship between elements such as health and wellbeing and also that as outcomes result from a range of personal traits and resources, the outcomes for each individual will be distinct.

As identified in the literature and this research, the importance of including older people in designing and prioritising the outcomes for their quality of care and quality of life in care homes should not be under-estimated (Bowsler 1994). To achieve quality of life, care must be tailored to individual needs (Davies, Laker and Ellis 1997) and partnership with older people are integral to this (Meyer and Sturdy 2004). It is also important to address the differences in perspectives between staff and older people which were clear in the literature (Bartlett and Burnip 1998a, b, Ray 1999). The outcomes framework can encompass both.

#### MULTI-AGENCY/MULTIDISCIPLINARY WORKING WITH OLDER PEOPLE

The framework focuses on the changes experienced by the service-user or observed by an appropriate staff member. As such, it assists towards multi-agency/ multidisciplinary working because outcome categories and priorities are agreed by all 'stakeholders' including older people, relatives, all professions, care assistants and home managers. It could thus link with, and follow on from, the results of the Single Assessment Process which older people are supposed to experience before entering a care home (DH 2001a). Because staff and residents would be working in an integrated way within the framework, this could help to avoid jargon and establish a common language around older people's care. As the literature highlighted, because outcomes are fraught with conceptual and technical difficulties, identifying suitable outcomes has been a major issue (Keith 1995, Ray 1999). By including older people, relatives, managers and a range of staff groups in determining priority outcomes, some consensus around the meanings which attach to concepts can be achieved. Concepts can be defined according to local understandings.

As both the literature and research data suggest, there is little 'normative' information on anticipated outcomes for older people in long-term care, and usually a lack of overall statements about the purpose of the service, other than mission statements in the homes. As Qureshi (1999) highlights, all 'stakeholders' have tended to determine their priorities according to their professional socialisation and priorities and for different purposes. Indeed she argues that "the information requirements of different purposes do not appear to be necessarily compatible" (p 264). Particularly strong have been the traditional distinctions between health and social care which are now, as discussed in the Introduction, coming together in long-term care services. While health care has increasingly focused on outcomes, Qureshi (1999, p 262) argues that professional culture in social care mitigates against an orientation to outcomes. Qureshi (1999) suggests that there is less lay recognition of the technical expertise involved in social care and therefore more room for contested debates about objectives, outcomes and appropriate inputs (p 261). The information collected through the outcomes frameworks could contribute to evaluation for a variety of purposes and at various levels. Such integration in approach, particularly from both health and social care perspectives, is vital to the care of older people, and particularly those with complex mental health needs.

Using the framework in this way would also address the issue identified in the literature of the shortcomings of outcomes evaluated solely by service users, particularly those who have low expectations and those who feel vulnerable or disempowered and consequently reluctant to criticise staff or services (Brooker 1995, 1997, Bartlett 1995). Resident and relative perceptions of the achievement of outcomes can be evaluated alongside those of staff and management.

#### IDENTIFYING THE INPUTS AND EFFECTIVENESS OF STAFF GROUPS

Such an approach would offer the advantage of identifying outcomes which are, for example, nurse-sensitive or care assistant-sensitive, and thus assist in evaluating the effectiveness of specific inputs. This would seem to be particularly important if numbers of RNs in care homes continue to reduce. The framework could facilitate the inclusion of evidence on new practice to be incorporated, as this becomes available. Care assistants could have responsibility for working with older people in outcome planning and evaluation. The research suggested they



would welcome this. However, as identified by the study participants, the CAs did not tend to take a long-term view or to plan strategically towards such.

### A HOLISTIC APPROACH TO NURSING AND CARE PRACTICE HIGHLIGHTING NEGLECTED ASPECTS OF THE WORK

This approach moves away from seeing nursing and care work as a series of tasks. It acknowledges the many 'invisible' activities in nursing and caring, such as listening, supporting, doing with, being present or being available, which have not been widely encompassed in the research-based literature (Spilsbury and Meyer 2001), but which the older people in the study clearly said they valued.

It acknowledges the complex and interdependent factors which contribute to health outcomes which are not widely acknowledged in the literature largely, according to Carberry (1998), because the tools currently used cannot adequately account for them. These include the 'hidden' aspects of health promotion or functioning, such as the prunes to prevent constipation, or the mobilisation regimes to prevent joint stiffness or chest infection.

It could also highlight the occurrence of 'adverse incidents', and the causal factors in these, which, according to research studies (e.g. Redfern, Hannan and Norman (2004) result from staff overwork, stress, burnout. Such situations will be particularly important to monitor if staffing skill mixes are increasingly diluted.

### ENCOMPASSING A RANGE OF OUTCOMES AND OUTCOME INDICATORS

The framework would facilitate the evaluation of outcome achievement within various time frames, which the research has shown to be a characteristic of the work. It could, for example, assess a person's wellbeing in terms of minute-by-minute changes as they respond to situations and people around them, as measured in dementia care mapping (DCM) (Kitwood and Bredin 1992). DCM can be repeated over time and could thus offer a means of evaluating wellbeing. Outcomes, such as wound healing or mobilisation, could be evaluated over the course of weeks, and other outcomes over the course of months, such as the resident in the examples who went to live at home. It could also encompass outcomes at various levels, e.g. "a clean mouth" or "reduced staff turnover".

Outcome indicators used in conjunction with the framework also look to be useful. Albeit that most of the studies in the literature were conducted in acute or non-UK settings, the majority of the literature reviewed suggested that such outcome indicators can be helpful in identifying the achievement, or not, of the outcomes of care. Outcome indicators can also be useful in identifying structure or process variables, such as adverse incidents and skill mix. This could be particularly important if the numbers of RNs in care homes reduce.

#### **6.4.6: REMAINING CHALLENGES**

The study offers insights into the complex, multidimensional dynamics of processes and outcomes of care in nursing homes and the staff and residents' views on salient outcomes. As Spilsbury and Meyer (2001, p 10.) suggest, the evidence-based movement is gradually accepting the value of qualitative methods and new approaches are needed in order to 'unpack' the nature of clinical judgement and to understand better how to achieve effective change in healthcare settings. Spilsbury and Meyer (2001) recommend more rich-in-depth case studies, based on the realities of practice, that could generate a different level of findings which may be of more value and interest to practitioners.

Challenges remain, however, and this research has confirmed the contention in the literature that conceptual issues in outcomes-focused work are complex. Distinctions between process and outcomes can be difficult to disentangle and, although inferences can be made about structure, inputs, process and output elements, the staff in the study found difficulty in articulating what they brought to a situation or why they acted as they did.

As identified in all the literature on outcomes, it is not always possible to identify direct causal influences. Outcome domains/categories influence each other and so many factors contribute to outcomes that it is difficult to determine precisely what caused what. As identified in the research, influences on outcomes may be indirect, such as the influences of the RNs on the care environments for people with mental health needs. If desired outcomes are not achieved, as Peters (1989) highlighted, it may be difficult to identify what went wrong or who was responsible. Conversely outcomes can be achieved despite the care received or not received.



This study suggests that the concepts of outcome prevalent in the literature should be reworked for settings where older people receive care long-term. As recommended by Carberry (1998), broad concepts of outcome could incorporate such elements as quality of life concepts, and outcome indicators, such as infection. Some reconceptualisation of the standard outcomes would, however, likely be necessary to incorporate resident priorities, for example, one resident whose desired outcomes were:

- to be helped to move in bed, keep clean, eating, drinking, elimination
- to be relieved of her arthritis pain
- to be able to change the TV channel using her remote control

Outcomes incorporating resident perspectives are complex for a range of reasons. As identified in the work of Redfern (1993) residents may not know what they require, may know what they want but are unable to articulate it, or may want something known to be harmful, for example in this research a resident who insisted she stay in bed all day. In addition, residents will want to take risks, such as the one who was losing her sight but insisted on continuing to go out. In addition, some residents in the study did not want to think about the future or what might be the outcomes of their care but rather just to focus on each day.

The primary definers of quality with respect to nursing care should include residents and the staff directly involved in their care. As Redfern (1993, p 143) observes, the process of quality definition, however, extends beyond the patient and nurse, it is the product of the interaction, in which negotiation may play some part. Redfern concludes that quality of care is “ultimately an abstract construct based on dynamic social interactions, the outcome of 'negotiations' of various kinds between people from different social groups, each of whom holds particular expectations and values and is more or less powerful according to the context of negotiation within which each operates”.

As Qureshi (1999 p 264) concludes: “We should not expect to reach a final answer but ... the great advantage of a focus on outcomes is that it will bring us closer to the fundamental purpose and role of services, so that the central aims for individuals can be set against bureaucratic and financial imperatives and so provide a more balanced approach to understanding and assessing quality and effectiveness”.

## **SECTION 6.5: DISCUSSION OF FINDINGS:** **DISTINGUISHING BETWEEN THE OUTCOMES** **OF THE WORK OF RNs AND CAs**

### **6.5.1: THE CONTRIBUTION OF THIS RESEARCH**

The research identified important issues concerning the work of RNs and CAs with older people in care homes with nursing. It contributes to debates on the distinction between the work of RNs and CAs, the interface between them, staffing mix and subsequent effects on patient outcome identified as significant gaps in the literature (Spilsbury and Meyer 2001, p 9, Davies 2001, p 92).

For ease of reference, an overview of the literature on RNs and CAs is offered in Section 1.4.1 (page 31) with conclusions in Section 1.8 (page 80)  
Findings from this study on the outcomes of CA work are shown in Section 5.3 (page 266) and the outcomes of RN work in Section 5.4 (page 285)

### **6.5.2: CHANGING ROLES AND DEFINITIONS**

Clear throughout the research was the genuine commitment of participants to the residents and to older people. They spoke or wrote fondly of enjoying being with them, "hearing their stories" and, particularly the CAs, of sharing their day-to-day lives. There was also, in most staff, a determination to offer the best care possible to residents. The warmth, enthusiasm and dedication of the staff did not feature prominently in the literature, with the exception of Henwood's (2001) interviews, and it is reassuring for the future that there would appear to be RNs and CAs who really want to offer high quality care to older people in long-term settings, despite the challenges, and who gain immense satisfaction from this.

The work was underpinned by a strong sense of caring and, while there is limited research into CAs, caring is addressed extensively in nursing literature. Indeed



Benner and Gordon (1996, p 40) observed that, “the words ‘caring’ and ‘to care’ are some of the most heavily freighted in the English language” and Roper (1994) suggested that, as the word ‘care’ is implicit to nursing, the term ‘nursing care’ is a tautology. In fact, as the CAs in this research delivered most of the ‘hands-on’ care, much nursing literature could now be relevant to CA work.

The RN role mainly focused on leading, planning, supervising, monitoring and ‘technical’ tasks such as wound dressings. Roper (1994) observed this as a shift from the traditional ‘hands-on’ role of nursing to roles derived from other professions, mainly medicine, and indeed the residents and CAs commonly referred to the RN role as ‘anything medical’. However, as Clark (2001, p 16) argued, “while much of the nursing literature has focused on ‘doing’, i.e. if you are touching a patient you are ‘doing nursing’, this is unhelpful in distinguishing between the work of RNs and other staff”. She said: “there is no such thing as a nursing intervention in that there is no single activity that a RN does that is not in some place done by someone else, and often just as well”. Rather, she argued, we should focus on what RNs know, on clinical decision-making (deciding what to do, how to do it, when to do it) and nursing as an intellectual activity. “That is not to diminish or demean the technical, manual and caring aspects” Clark (2001, p 16) argued, “but before you can do nursing you have to get the thinking right”.

In the context of the shifts in roles and definitions that have occurred in long-term care, it is helpful to retain a focus on the inputs that different staff bring to their work. As identified in the introduction to this study, services historically defined as healthcare have gradually been redefined as social care and much traditional nursing work is now defined as personal care (Royal Commission on Long-term Care 1999, p 67). The residents in this study clearly had complex health needs and all participants stressed the importance of RN input to their care.

This study sought to identify the distinct outcomes, and potential outcomes, of the work of RNs, compared with those of CAs, for older people in nursing homes, for example in relation to health, functional capacity, wellbeing or quality of life and these have been described in the results sections. Clear from the findings is that their work profoundly influences the lives of the residents. The outcomes could be as drastic as life or death, as long-term as someone who had been “written off and left to vegetate” being able to go home to live, or as taken-for-granted as being able to enjoy each day. One factor determining whether a resident needed

the input of an RN was the complexity and stability of their health and wellbeing and this reflects some literature in the area. Roper (1994, p 460) argued that one criterion for the grade of nurse carrying out a task is the condition of the patient. Ahmed and Kitson's (1993) research identified that, with appropriate preparation, support and supervision, CAs can be delegated the major responsibility for the care of people whose conditions are relatively stable. Stability and predictability are key determinants of the need for nursing in the RCN's Nursing Older People Assessment Tool, developed by a team including the researcher (RCN 1997b). In addition, the concepts of complexity, stability/predictability and vulnerability/risk underpin the tool currently used to determine whether a person qualifies for NHS-funded nursing (the Registered Nurse Care Contribution, DH 2001c). The researcher was commissioned to devise this tool on behalf of the Department of Health and the thinking developing through this study informed that work.

The clearest way in which the outcomes of the work of RNs and CAs could be distinguished, however, is in various time frames - immediate and short-term, medium-term and long-term. Data from all groups of participants suggested that, while the CAs' work strongly influenced resident outcomes in the short-term, it was the knowledge and strategic planning of the RNs that made the significant difference in the longer-term.

### **6.5.3: OUTCOMES CONCERNING HEALTH AND FUNCTIONAL CAPACITY**

The work of CAs strongly influenced outcomes for residents from day to day, principally in the diligence with which they implemented care regimes for health and functioning, for example ensuring adequate nutrition, fluids and mobility. Skin care was particularly important.

Outcomes of RN work were those which made a significant difference in the longer-term. These were particularly influenced by, for example, the RNs' knowledge of the effects of medicines, recognition of associated problems, knowledge of the potentials for health and functioning, i.e. knowing what could be achieved and how, for example in regaining continence, and in their rehabilitative and therapeutic work.



#### **6.5.4: OUTCOMES CONCERNING WELLBEING**

As identified by some participants, and also by the physiotherapists, GP and clinical psychologist interviewed, the influence of wellbeing on health and functional abilities should not be underestimated. The work of CAs strongly influenced the residents' sense of wellbeing in all time frames, i.e. feeling they were valued and cared about.

The RNs contributed to resident wellbeing in the reassurance that residents felt knowing there was a trained and registered person available.

#### **6.5.5: OUTCOMES CONCERNING QUALITY OF LIFE**

The outcomes of CA work were that, despite ill-health, disability and multiple losses, the residents were able to enjoy their day-to-day lives and activities such as reading, listening to the radio or enjoying the garden.

Health and functional capacity strongly influenced residents' perception of quality of life and the RNs were key in achieving and maintaining this in the long-term. Quality of life was also markedly influenced by the physical environment (e.g. light and noise) and the psychological environment (e.g. whether staff were happy). Here again all the staff contributed in the day-to-day sense but the RNs were key determinants through their leadership, planning and supervision.

'The little things' also contributed to quality of life and, although diligent CAs ensured that hearing aids and glasses were worn, the RNs commonly identified when they were missing.

#### **6.5.6: EVERYDAY OUTCOMES**

Many participants suggested that, while most CAs would do their best to ensure good physical care, 'brighten the day' for residents and look after the 'tiny little things', many also said that, without RNs, standards would slip and there would be disagreements between CAs.

A few CAs, particularly those in Home 3 who had trained to NVQ Level III, were able to work at a range of levels and attend to a variety of situations at one time, as observed in RNs, but to a limited extent. Most tended to focus on single tasks. Their knowledge was largely procedure-based – ‘this is what you do’ and it focused on the ‘how’ rather than the ‘why’. Most also tended to think in the ‘here and now’ rather than longer-term and did not plan in a rehabilitative way. The CAs varied considerably in their experience, some with none at all, and their work needed supervision.

### OUTCOMES FROM ACUTE SITUATIONS

The effective RNs in the study were able to read the ‘clinical picture’ of a resident’s health and make a diagnosis. This was enhanced because the RN was able to examine and talk directly to the resident. Reaching effective diagnosis is less easy without this physical presence, even for doctors, as the case of the GP who diagnosed “just a bit of cellulite” when the RN realised the resident had a deep vein thrombosis requiring immediate hospital treatment (example in Section 5.5.4, page 322). Also some participants highlighted that, not only do CAs not assimilate and assess in the same way as RNs, but they sometimes make assumptions. Examples were given where CAs would give antacid medicine for chest pain which turned out to be a heart attack and assuming a resident had a stroke which turned out to be an arterial embolus (examples in Section 5.5.4, page 322).

Many RNs commented that their ability to diagnose comes from their broad clinical experience, for example diagnosing a fractured neck of femur from their orthopaedic experience, the severity of a nose bleed from working in Accident and Emergency and distinguishing between depression and dementia from mental health training and experience. Most CA experience was single-client and single-environment, i.e. older people in long-term care and many would never have seen a fractured femur, arterial embolus or deep vein thrombosis.

The RNs had also been trained in what action to take, when to call GP and when not, when to send to hospital and when not. This can be based on finely-balanced clinical judgement illustrated in the example where the CA wanted to send the resident to hospital because she was seemingly having a heart attack but the RN judged that the anxiety a hospital admission would likely result in



worse deterioration in her health so administered the resident's medicine and stayed with her until the pain and anxiety passed (Section 5.5.4, page 323). The good RNs also knew how to investigate a situation and observe, for example through checking blood pressure or testing urine. In some cases they also ordered investigations, for example wound swabs or blood tests for specific purposes. Investigation takes many forms, such as those illustrated in the example where the RN suspected a resident had epilepsy but there was no record of this so she sought, and found, the residents anti-seizure medication and administered this (Section 5.5.4, page 323). One RN summarised that "some things can be sorted within half an hour, others need continual treatment; CAs wouldn't know the difference". Avoiding unnecessary GP visits, ambulances and hospital admissions not only uses resources effectively, it potentially avoids additional risks for residents, for example, hospital acquired infection which affects approximately 10% of people admitted and particularly vulnerable older people. Acute situations can also be frightening for all concerned and there were examples where CAs tended to panic whereas RNs did not because they had been trained not to panic (Section 5.5.4, page 323-4).

#### CRUCIALLY 'PICKING THINGS UP' AND 'NIPPING THINGS IN THE BUD'

Many RNs emphasised how important it was that changes were 'picked up' and 'nipped in the bud'. Both RNs and CAs commented that RNs generally picked up significant changes more readily than CAs and there was an example of this in the Home 1 observations where a CA had washed and dressed a resident and sat her out of bed. When the RN came into the room she immediately noticed that the resident's toes on one foot were going blue and her urine was concentrated. Subsequently when she checked her wound this was looking red.

Residents can become ill quickly or over a period of time and there were many examples where the RNs realised this by reading the whole picture of the resident's health. Some changes were complicated to identify, examples being the effects of diuretics, antibiotics, urinary tract infection or constipation. If these were correctly diagnosed and appropriate action taken, deterioration could be prevented. Many RNs said that CAs tend to deal in the 'here and now', to take things as they are and not to tend to look for underlying causes. Even when they do recognise that something might be wrong, most RNs believed that they likely will not have the knowledge or experience to know what, or how to deal with it.

There were examples of this in the data. One CA recognised red skin on a pressure area but the RN recognised the 'marshmallow' underneath and consequent imminent skin breakdown. Another example was where a CA recognised soreness under a resident's breasts and put on talcum powder but the RN recognised fungal infection requiring antifungal cream. A third example was where a CA wanted to put a hot water bottle on a resident's cold foot but the RN recognised an arterial embolus (Section 5.5.4, page 322). One RN said: "the CAs assume a bowel action is a bowel action, the RN would need to know quantity and quality". Another said that a good RN "can spot a urinary tract infection a mile off" and that there are many "things that can't be left for a couple of days". One said: "incontinence is not just padding and making comfortable, it's solving the problem. RNs get to the bottom of things". "Nipping things in the bud" avoids health deterioration with long-term consequences for older people and their families, but also healthcare expenditure.

### ANTICIPATORY CARE

As was illustrated in the observations and interviews, and discussed in Section 6.3.4 (page 360) astute RNs were able to anticipate problems and prevent them developing. In the short-term such anticipatory care can avoid crises. In the medium and longer-term it prevents such situations escalating.

### 'TECHNICAL' AND COMPLEX NURSING CARE

With good RNs in the homes, residents can be offered 'technical' and complex care, such as subcutaneous infusions or syringe pumps. Complex medication regimes or monitoring, such as diabetic blood sugars and insulin injections on a sliding scale, can also be managed. Residents can thus receive 'acute' and palliative care in their, albeit communal, home, in familiar environments surrounded by people that they know. Examples emphasised the importance of residents being able to stay in the home, particularly when approaching death. Some RNs, particularly in Home 3, also took samples of blood, urine or faeces, and wound swabs for testing without having to bother GPs. In addition, the RNs brought knowledge not possessed by other professionals, even doctors, particularly in continence, pressure damage prevention and wound care. These are identified in the rehabilitation literature as their 'specialist role' (Waters 1994, 1996, Johnson 1995, Nolan, Nolan and Booth 1997).



## PROFESSIONAL LEADERSHIP

Many of the participants highlighted the RNs' organisational skills, professional leadership and professional accountability. To distinguish between RNs and CAs, one resident drew the analogy of the distinction between officers, who maintained an overview and led the service, and troops who did as instructed by the officers. Virtually all of the participants took the view that the homes needed someone professionally responsible and accountable and that residents gained confidence from knowing such a person was in attendance. One said that RNs know how to run homes because "they have run wards and hospitals".

## ETHICAL DECISIONS

As some CAs highlighted, RNs make ethical decisions which they would not feel competent to make. In theory RNs should be aware of ethical codes, even if not in detail, and apply these in decisions. Ethical decisions are also underpinned by the RNs' clinical knowledge, for example who and when to resuscitate and, in the context of limited resources, who receives rehabilitation input and who does not. These decisions can have far reaching consequences for residents.

### 6.5.7: LONGER-TERM OUTCOMES

#### REHABILITATIVE CARE AND HEALTH PROMOTION

As the findings and literature suggest, without health promotion and rehabilitative, re-enablement approaches to care, older residents could lose independence leading, in turn, to greater dependency and greater health and social care costs. Some RNs in the study emphasised the importance of rehabilitation and knew how to put this into everyday practice. Many CAs were not aware of the possibilities of rehabilitation and one RN said that, although "CAs have ideas about what can be done, these aren't always appropriate or practical". Some RNs also possessed the skills to recognise what is not possible. As one resident said: "the nurses know when we're really not up to it" and observations noted that RNs recognised residents looking tired, even at breakfast, and suggested rest.

Health promotion and wellbeing promotion were also integral to some care regimes, albeit that this was in subtle ways. In Home 2 the lead RN insisted that all the staff in the home, including cleaners, catering and maintenance staff, were taught about the importance of wellbeing and how to maintain this.

### MULTIPROFESSIONAL AND MULTI-AGENCY COMMUNICATION

The RNs emphasised their role in securing the services of other professionals for residents and the observations confirmed this. RNs were able to communicate in professional language with doctors, pharmacists, physiotherapists and other agencies. The importance of multiprofessional input for older people in care homes is emphasised in the literature. The Royal College of Physicians, Royal College of Nursing and British Geriatric Society taskforce (2000, para 2.9) agreed that “the transfer from hospitals to care homes has not been accompanied by significant transfers of medical resources to the community” and “care home residents have often become the medically dispossessed in spite of their complex health care needs, which may contribute to avoidable ill health and acute hospital admissions”. They concluded: “it is a paradox that older people with the greatest needs for consistent, creative and effective care now live in care homes denied the traditional essence of interdisciplinary geriatric care” (para 2.4).

All three fieldwork homes employed part-time physiotherapists, which all participants including residents believed were vital to the maintenance of their functioning. The RNs were able to continue physiotherapy regimes when physiotherapists were not available, something that the physiotherapists did not believe the CAs would be able to do. There were also instances in the examples and the observations where RNs brought in other professionals, such as McMillan Nurses to advise on pain relief in terminal illness. As there was sometimes no funding for such services, the RNs obtained them by relying on their professional contacts and knowledge of local services, of which the CAs in the study were likely unaware.

### ADVOCACY

Some RNs in the study were strong advocates in achieving care they believed the residents needed and many of their advocacy arguments were based within their clinical knowledge. Three examples in Section 5.4.3 (page 292-297)



illustrate this. Interestingly, the RNs' negotiations with the GPs were subtle and were reminiscent of 'the doctor-nurse game' described by Stein (1978) wherein the nurse overtly pays deference to the doctor's power in making decisions but achieves her/his own objectives by making suggestions, for example "do you think THIS would be a good idea doctor?", 'the clinical trials I've been reading show that THIS is effective - would you like to see the papers?', or "I really think this needs an X-ray so I've prepared the form for you to sign - here's the pen".

### AVOIDING GRADUAL DETERIORATION

Widespread in the literature is the suggestion that if older people's health problems are not identified and they do not receive adequate care, their health will deteriorate. Here, one nursing, one medical and one psychosocial model are offered.

Phair and Good (1995) illustrate the potential consequences of inadequate skilled nursing input in a flow chart. This shows how boredom can lead to lowered mood, loss of appetite and consequently reduced skin quality. It can lead to dozing in the chair and poor sleep, resulting in lack of exercise, stiffened joints, reluctance to move and risk of incontinence. All of these problems increase the risk of skin breakdown and pressure sores with consequently increased pain, discomfort, dependency, care needs and care costs.

Davies and Sinclair (1995) illustrate how disordered control mechanisms in older age can fail to allow appropriate and integrated organ response to an environmental challenge so that the person's bodily systems become overwhelmed and health breaks down.

Kuypers and Bengtson's (1984) Geriatric Breakdown Syndrome illustrates a cycle whereby vulnerability and loss can result in older people being labelled as 'incompetent'. Induction into the 'sick role' also induces dependency, atrophy of previous skills and learned helplessness. In this cycle the older person ultimately internalises the 'incompetent' label. This in turn increases loss and vulnerability.

The literature is rich in descriptions of the consequences of custodial care (Section 1.6, page 52) and the RNs in this study described such situations from their own experiences, such as units where older people sat "like zombies", were

seated on commodes in full public view during toilet rounds or where continence care comprised "being trussed up like a chicken". If the everyday issues described above are not identified and dealt with, the effect on older people's health and wellbeing would likely be deterioration. While most CAs were caring and wanted to make people comfortable, the RNs' training reinforced the importance of nursing people back to health and independence.

### OTHER OUTCOMES

A range of additional outcomes of RN work were identified. These included cost savings in the optimum use of medicines or continence products and obtaining services from outside the home, particularly multidisciplinary or specialist input.

#### 6.5.8: THE 24-HOUR RN PRESENCE

As identified in the introduction to this research, the need for RNs in care homes is being questioned (RCN 2004). There are calls for skill mix reviews (English Community Care Association, P&G Professional and Laing and Buisson 2004) and particularly with regard to the numbers of RNs needed (Blackburn 2003). A range of alternative models of RN engagement with care homes have been suggested, ranging from a high clinical intensity-based 'hands-on' practice to a peripatetic approach with a larger caseload for a lower intensity of care (RCP, RCN and BGS 2000). In addition, a range of new posts for older people nurse specialists and consultant nurses in older people's care are developing around the UK (Sturdy 2004a, b). Arguably, if there were fewer or no RNs in homes, specialist nurses could come into the homes to assess and monitor.

Addressing such models, the findings from this study suggest that RNs visiting nursing home residents, however expert, would not be as effective in dealing with acute situations as the 24-hour RN 'perceptual presence' discussed in Section 6.3.4 (page 357-8). The outcomes in most of the examples given in Section 5.5.4 (page 322-4) were contingent on the RNs being 'on the spot' to recognise and deal with problems. The findings also demonstrate the other contributions that can be made by a 24-hour RN presence and which impact on residents, the staff and the home in all time-frames (Section 6.3.4, page 358).



In addition, concerns have been expressed by district nurses visiting residential care homes about the lack of preventative or anticipatory care and the necessary teaching to underpin it when RNs are not continually present (Goodman, Woolley and Knight 2003).

The need for a 24 hour RN presence was recognised by the RCP, RCN and BGS taskforce (2000, para 6.1): "The 24 hour presence and development of registered nurses is fundamental to the assured care of high quality intensity needs of care homes residents. The working party recognises that the specially trained and experienced specialist gerontological nurse is the key professional and natural lead clinician for the identification and integration of health care support to care home residents".

#### **6.5.9: RN LEADERSHIP, SUPERVISION AND ROLE MODELLING**

As the findings of this research and some of the literature (e.g. Ahmed and Kitson 1993) demonstrates, RNs take the lead in determining the prevailing philosophy in the unit and CAs are influenced by this. Other authors conclude that the presence of RNs who maintain responsibility for directing care is crucial to act as role models and create a social environment conducive to excellent care. They suggest that this may be more important to resident care than the tasks that comprise CA work (Grau, Chandler, Burton and Kolditz 1991, Schirm, Lehman and Barton 1996).

Some RNs were better leaders, supervisors and role-models than others (Section 4.2.9, page 228) and, as highlighted in Section 6.3.3 (page 356-7), arguably RNs did not need to undertake the breadth of role they carried in the homes. What was clear from most CAs in the study, however, was that they did not want to take on more responsibility. Their motivation was to care for residents, to help them, to be with them and to enjoy their work. Many were fearful of dealing with particularly the acute situations that arose during the research. Arguably, as more CAs have NVQ, they would be able to take on more aspects of what RNs do at the moment. The numbers of NVQ III qualified CAs in the study were small, but, despite being hand-picked and trained as team leaders, they all insisted they needed the supervision of RNs.

#### **6.5.10: PREPARATION OF RNs AND CAs TO WORK IN CARE HOMES**

There are currently no requirements for RNs in nursing homes to have specific qualifications. The literature highlights that existing pre- and post-registration courses do not prepare practitioners adequately for the demands of roles in nursing homes and the quality of post-registration courses in the care of older people is variable (Davies, Laker and Ellis 1997). Courses generally tend to focus on NHS and acute care and more work needs to be done to establish the ability of courses to prepare practitioners for working in care homes (Masterson 1997). With its detailed analysis of the work of RNs and CAs in care homes, this research offers insights into what could be included in programmes to prepare staff to work in these settings.

It is interesting to note, however, that many of the staff believed the most important attribute they brought to their work was themselves. Education and training built on this, for example “the caring was always in me – that’s something I don’t think you can teach – but awareness and observation skills can be taught” and “some comes from experience but it’s mostly to do with the sort of person you are”. In considering future recruitment and training, humanity, kindness and caring would appear to be the foundation.



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# **CONCLUSIONS**

This chapter draws conclusions from the research and evaluates its contribution. It acknowledges the perspectives encompassed by the study including the characteristics of the participants overall. It also summarises the methodological achievements and shortcomings, including the 'glitches' in the research. It then evaluates the usefulness of Gadamer's philosophical hermeneutics in the study including examples of how this operated in practice. It discusses how rigour was achieved through the study and offers suggestions for further research. The chapter ends with some reflective thoughts, specifically from an older nursing home resident.

## **THE STUDY'S CONTRIBUTION**

The data encompass a breadth and diversity of perspectives and paint a rich and vivid picture of the work of RNs and CAs with older people in care homes. The chronological order in which the methods were used worked well in terms of developing the conceptual and theoretical focus of the work. The different methods of data collection and different data sources provided complementary perspectives on the work of CAs and RNs, and triangulation was achieved in terms of types of data, data sources and data collection methods. Overall, the mixed-method approach was able to access and access aspects in the work which had not been articulated in previous literature.

Analysis of the data from both phases of the research produced:

- Accounts of the outcomes of, processes within and inputs to the work of RNs and CAs with older people in nursing homes.
- Accounts of the scope and focus, role and contribution of RNs and CAs
- Models of the work of RNs and CAs
- Accounts of the similarities and distinctions between outcomes, processes and inputs to the work of RNs and CAs.
- Accounts of the contribution of the 24-hour RN presence in nursing homes
- An outcomes framework for use in nursing homes, within which the outcomes of the work for older people could be evaluated.
- An account of the influences on contemporary work in care homes



- Details of the populations living in the homes, particularly their health and care needs.
- Rich accounts of the realities of everyday life and work in care homes including environmental and cultural issues, competing priorities, the realities of communal living, perceptions on quality of life, choice and control issues, bodywork and intimacy issues, mental health issues.
- Accounts of what older people and relatives want from care in a care home; their priorities and challenges; what they want from CAs and from RNs.

In addition to its contributions to knowledge, the research contributes original products in the form of models and frameworks which offer a basis for future development through research, education, policy and practice. The grounding of these products within the realities of everyday work in care homes and the concepts, values, aspirations and priorities of CAs, RNs, other staff, older residents and relatives, enhances their potential for development.

### **AN ORIGINAL CONTRIBUTION TO KNOWLEDGE**

Originality can be defined in a range of ways. Selecting five of the 15 criteria for 'an original contribution to knowledge' identified by Phillips and Pugh (1994, p 61-62), this study offers original contributions to knowledge in terms of, for example:

#### **LOOKING AT AREAS THAT PEOPLE IN THE DISCIPLINE HAVE NOT LOOKED AT BEFORE**

The study investigated the outcomes of the work of CAs in UK independent sector care homes on which no previous research has been identified. The results are detailed in Section 5.3 (page 266)

#### **ADDING TO KNOWLEDGE IN A WAY THAT HAS NOT PREVIOUSLY BEEN DONE**

Significant examples from care home staff around the UK were collected, followed by observation, interview and documentary analysis in three care homes with different characteristics. This approach was not identified in previous research undertaken in UK Independent Sector care homes.

Also, from the data, an original framework for identifying and evaluating the outcomes of the care in long-term settings was developed. This offers a foundation for future research and practice development. The outcomes work also addressed many of the key questions raised in the literature, as detailed in Section 6.4.1 (page 368). Although, after the data analysis in this study was complete, other outcomes frameworks were identified in the literature, none of these was developed from original participant research data.

### BRINGING NEW EVIDENCE TO BEAR ON AN OLD ISSUE

While ‘the contribution of RNs’ has been discussed for decades, this study offers a rich and detailed picture of the inputs into, processes within, and potential outcomes of, the work of RNs in independent sector care homes. The findings also contribute new perspectives to the debates on the ‘invisibility of nursing’ and what nurses DO with their 24 hour presence, identified in some of the literature as their ‘distinct’ contribution (Section 6.3.4, page 357).

In addition, new models of the work of RNs and CAs in nursing homes were developed from the data. These bring new perspectives to the scope of the roles as described in the literature and their job descriptions, and specifically additional dimensions within the work that RNs and CAs undertake in care homes.

### MAKING A SYNTHESIS THAT HAS NOT BEEN DONE BEFORE

The study synthesised the perspectives of CAs, RNs, residents, relatives, documents and other staff in independent sector care homes through a range of methods. The results paint a rich and broad picture of the everyday realities of work in care homes.

### SETTING DOWN A MAJOR PIECE OF NEW INFORMATION IN WRITING FOR THE FIRST TIME

The study and its findings are synthesised and discussed within the context of UK policy. The research report acknowledges a breadth of influences specific to the work of RNs and CAs in UK Independent Sector care homes.



Phillips and Pugh (1994, p 62) suggest that, in order to make 'an original contribution to knowledge' "it is not necessary to have a whole new way of looking at the discipline or the topic. It is sufficient for the student to contribute only an incremental step in understanding".

## **THE CHARACTERISTICS OF THE RESEARCH SAMPLES**

### **THE HOMES**

The participants worked in a wide range of homes in terms of registration category, size, resident population and admission criteria, urban and rural, and under both private and voluntary sector ownership. Phase 1 examples came from around the UK. Phase 2 was conducted in three homes in different areas around England which were purposefully selected to be distinct in a range of ways (Sampling Frames are given in Appendices 2.1 and 2.2). The third home catered for people from a distinct 'culture' and applied admission criteria. (Details of the homes are in Appendix 2.10). It is important to acknowledge however that there may well be issues particular to specific settings (such as inner city homes or isolated rural homes) which the research has not captured.

### **THE RESEARCH PARTICIPANTS**

From the biographical details collected, the overall samples of staff in both phases would appear to be reasonably representative of those who work in independent sector care homes although, as identified in the Introduction, there is little aggregated information available on this.

The samples were predominantly female, which would concur with available statistics suggesting that over 90% of care home staff are female (DH 2004b, UKCC 2002, Fawcett Society 1997).

The age range of the CAs involved in the study was from under 20 to late 50s. Most were in their upper 20s to 40s. The average range of the CAs in the homes was 35-40. This would seem congruent with the findings of Thornley's survey (2000) that, although this is not always the case, CAs in care homes tend to be older and more experienced than those in the NHS. The RN samples were

slightly older than the CAs, with approximately two thirds of RNs submitting biographical details with their examples and half of the participants in the homes in their 40s. The average age of those participating in the fieldwork ranged from 39-48. Again, this would appear congruent with surveys suggesting that staff in care homes, and particularly RNs, would seem to be older than in the NHS (Buchan 1999, UKCC 2002).

The years of CA experience varied throughout the datasets and ranged from nothing to over 20 years. The average years of experience for the CAs who participated in the fieldwork were seven years in Homes 1 and 2 and 15 in Home 3. The most outstanding feature of the sample was the length of experience of most of the RNs. The majority of RNs submitting examples had been registered as a nurse for over 20 years and the average length of nursing experience was about 23 years. About one fifth of participants had worked with older people throughout their nursing careers; most of the sample had worked with older people in continuing care or nursing homes around an average of ten years. The average years of experience for the RNs in the fieldwork was 17-21 years.

The education and training undergone by the CAs varied between the datasets. Overall, education was patchy and attitudes to its importance varied. Most did not identify education as the most significant influence on their work and many found the practical training, such as first aid or moving and handling most useful. All but one of the RNs submitting examples listed study days they had attended. Most RNs had undertaken the training required under the National Minimum Standards (DH 2001b) but additional training was highly variable among the sample and it is difficult to draw conclusions from this. The UKCC survey (2002) found also found great variation in the training undertaken by RNs in care homes with courses on moving and handling and fire procedures having been attended by around 80% of their sample but that nearly 10% had attended no courses.

Information on ethnic origin was not collected with the biographical data but the number of participants from black and minority ethnic groups was small and primarily African-Caribbean. This would appear congruent with available statistics which suggest between 5% (Fawcett Society 1997) and 9% (DH 2004b) of staff working in care homes are from black and minority ethnic groups. It may become important to consider ethnic origin in future research as more older people from minority ethnic groups reach older age.



## **POSITIVE PERSPECTIVES**

The picture painted of the work of RNs and CAs with older people in care homes is more positive than the impressions from previous literature overall and it is important to acknowledge that the predominantly positive perspectives in the data are in part a factor of my approach as the researcher, partly a factor of the samples and partly of the methods.

I began this research journey to identify the distinct contributions that RNs and CAs make to the care of older people in nursing homes. As explained in Section 1.1 (page 17) this was founded on a strong commitment to the importance of the work and also a belief that expert RNs make a valuable contribution within the staff team. I was therefore clearly seeking positive perspectives and, as can be seen in Figure 2.3 (page 105), each cycle of the interpretive process was influenced by my horizons of meaning and prejudices, informed by reflection and supervision. My beliefs and understandings were challenged early in the research and adjusted as a consequence of the experience (a full explanation is given below, Gadamer's philosophical hermeneutics in practice, Example 3, page 408)

The participants in both phases in the study were those who were keen to contribute. While the characteristics of the homes from which the Phase 1 examples came are largely unknown, from around the UK, and likely highly diverse, the RNs and CAs submitting examples were those individuals who felt sufficiently motivated and confident to take the time and trouble to write an example for the research. This suggests that they felt positively about their work and the contributions they made to older people's care.

The three participating homes in Phase 2 were also diverse in as many aspects as could be accommodated in the research. However, they were all sufficiently confident in their care to be open and welcoming of the research, accepting that this would mean an 'outsider' working in the home, talking to staff and residents, and observing practice. Crucially, these three homes had strong management, generally well motivated staff and were well-run. The three fieldwork homes therefore likely represent the better homes in a sector of services which is undoubtedly diverse.

The staff who volunteered to participate in the observations and interviews were also arguably those sufficiently confident in their practice to allow this to be observed. In addition, when being observed or interviewed they could arguably have tried to be on 'best behaviour', sometimes termed the Hawthorne effect (Mays and Pope 1996), making an effort to say and do 'the right thing' in the presence of a researcher clearly committed to the value of the work.

It could thus be argued that this research gives a positively skewed view of realities and this must be acknowledged. However, all the perspectives in the study were not positive. Although the majority of staff represented their work positively and delivered acceptable standards of care, the data revealed a broad spectrum of practice encompassing at best highly skilled care and at worst inadequate, ritualised and even unsafe practice. The homes were not without problems. One home, for example, had acute staffing problems which, due to staff working overtime, affected residents to the minimum but many of the staff were really tired and consequently not working at their best (described in Section 5.6.4, page 329, and Appendix 5.6). In another home, while the staff gave good care, there was discontentment, some of which reflected in the data (Section 5.6.7, page 330 and Appendix 5.8).

Ultimately, while a spectrum of views and practices is to be expected, it is arguable that the majority of staff in care homes do have positive intentions towards their work and do want to offer good care and this has been identified in other studies (Henwood 2001, Redfern, Hannan, Norman and Martin 2002).

## **THE 'GLITCHES' IN THE RESEARCH**

### **LOW RESPONSE RATE**

A problem in Phase 1 was the low number of RNs and CAs sending in examples compared to the numbers who originally promised to do so. As described in Section 2.4.7 (page 121) of well over 100 RNs who said they were keen to submit examples only 34 submitted them and of over 50 CAs who offered only 18 were received. The main reason seemed to be lack of time and pressure of work but a second and important reason was that they did not feel confident in writing on the form (the reasons are given on page 121). This has implications for future research in terms of how data gathering devices are designed. Participants may



be daunted by long forms. Confidence in committing thoughts to paper in writing may also be difficult for some participants and this was possibly an issue for the CAs in the study. Although some CAs wrote at length, overall their examples tended to be less detailed than those of the RNs. It would also seem that many staff, both CAs and RNs, find reflecting on their experiences to be challenging and that such activities are more effective when they are supported by skilled facilitation. Redfern et al (2002) similarly found that securing a good response rate from staff was not straightforward and that CAs preferred to respond in interview rather than taking a questionnaire away to complete alone. A particularly frustrating aspect in the research was that some of the quite remarkable achievements described by the RNs in the homes visited in Phase 1 were never sent as examples and so are not included in the research. A way of securing a broader commitment might have been to run focus groups in the home but, due to few staff being available at one time, it would likely have been difficult to gather sufficient together for enough time to contribute meaningfully unless the home and staff were committed.

#### LIMITED USEFULNESS OF DOCUMENTARY EVIDENCE

The data on the homes (facilities, services, numbers of staff and models of care) were useful in establishing the context for the fieldwork. Job descriptions proved to be very enlightening in that the roles identified in these were not always identical to the roles the staff believed they were fulfilling or what they were actually doing in practice, as identified in the observations and interviews. (Details are given in Section 3.3.5, page 1.8.4 and 4.3.7, page 249).

The remainder of the documentary data analysed, however, proved not to be useful (as described on page 140). It was difficult to establish any meaningful assessment of resident 'dependency' in that numbers of medical diagnoses or drugs prescribed could be more a consequence of how individual doctors worked than resident health or prescription need. Whether the 'dependency' tools used in the homes were valid measures of this were questionable and, perhaps more significantly, they were not completely consistently, particularly in one home where the scores for individual residents varied enormously. Records of 'adverse incidents' were also not particularly useful. As the Matron / Manager in Home 1 highlighted, falls could increase because residents were choosing to exercise their independence. In addition, most pressure sores came into the homes with

residents and could be more a reflection of their poor health and nutrition than the care given. Care plans and progress records were similarly unhelpful and entries within these seemed more a reflection of the skills of individual practitioners than of the care given. Documentary data could provide evidence to confirm, or otherwise, claims made about the care given or the outcomes of this, but only if it is completed in a timely, thorough and consistent manner.

### **METHODOLOGICAL LIMITATIONS**

The mixed-method approach with multiple data sources was useful in offering a range of perspectives on the research questions and in confirming, or not, the emerging findings. Nevertheless each of the methods individually had limitations.

The aims for Phase 1 as described in Section 2.4.2 page 116 were generally achieved but the limitations in the Phase 1 data included the lack of contextual details. Some of the situations described were complex and there was obviously a great deal more going on than was included in the examples. Also, this method relies totally on skills in articulation and therefore disadvantaged participants for whom writing was not an easy means of communication. The examples did not access all aspects of practice. As identified in the literature review, tacit knowledge, or knowledge in practice, is notoriously difficult to access, and most participants experienced difficulty in trying to articulate what knowledge and skills they brought to a situation. The examples also did not necessarily accurately recount what actually happened, rather the individual's memory of what happened. Much as this was intended to enhance the authenticity of the work, some of the claims made were questionable. For example one CA example claimed that a resident's quality of life was markedly enhanced when he began to use incontinence pads. The potential number of significant examples is enormous and it would be unrealistic to seek to obtain a complete description of the work through this method.

Phase 2 aims in terms of observations and interviews, as identified in Section 2.4.10 (page 127) were largely achieved. These methods were able to capture the everyday realities of work in care homes within the contexts in which they occur. However, as identified in the literature (e.g. Patterson 1994, Mitchell and Koch 1997, Higgins 1998), fieldwork in complex environments, such as homes



where vulnerable people live, can raise challenges. Entering and exiting the fieldwork sites was smoothed by pre- and post-fieldwork visits and by spending time getting to know the staff. Being trusted and accepted by staff and residents can be time consuming but, for the most part this was not an issue. Initially the CAs in Home 1 were not keen to work with me but they gradually warmed to the idea and, apart from a few who were wary of being tape-recorded, all ultimately said they enjoyed the experience of participating in the research. Many of the staff remarked how I “just blended in”, for example in Home 3 they spontaneously said that the handovers recorded and noted by me were no different to those when staff were alone. The welcoming, warming and “blending in” seemed to be enhanced by my willingness to help with the care of the residents. There was thus a two-way ‘payback’ in that the staff felt helped and, in turn, were happy to help. The ‘payback’ for CAs was that, with my help, they were able to finish ‘their work’ earlier and thus felt able to give some time for the interview. Some of the RNs said they valued the opportunity to talk through clinical decisions or discuss broader professional issues. The residents and relatives generally said they enjoyed the discussions and the opportunity to air their views, particularly if they were useful and contributed to the understanding about the running of the home, or to others in similar situations, or to the RNs and CAs.

Role definition and role conflict can be challenging in participative observation but my role as ‘participant as observer’ (as described in Section 2.4.14, page 130) was defined in the notice pasted in the homes and reinforced in my work with all of the staff and residents. In this way of working all the participants in the setting are aware of the research. The observation and the taking of notes is overt. The care and wellbeing of residents and staff was paramount and the work of the home always took priority over the research. Other than on the very unusual occasion when a resident might come to harm by the action of a member of staff (e.g. a wound dressing technique which risked spreading MRSA) I did not attempt to influence the care. Rather I followed staff around as they worked and, if they wanted my help, I took direction from them.

Nurse researchers who are not permitted to deliver care when the occasion arises can experience conflict, for example Patterson (1994, p 199) who reported that, with increasing time in the field, she was commonly forced to redefine her role. “many times the nurse inside me struggled not to express her opinion or thoughts about how something should be handled or done. This was particularly

difficult when my opinion was requested. I did not want to distance myself from the staff but I also recognised the necessity of maintaining my role. As a nurse, the frustration at not being able to intervene was at times overwhelming". Had I worked in a less participant role in this study I believe I would have distanced myself from the staff and thus not achieved the insights they offered me in their data.

### **EVALUATION OF THE USEFULNESS OF GADAMER'S PHILOSOPHICAL HERMENEUTICS IN THE STUDY**

Gadamer's writings both grounded and the directed the research and this worked effectively. Although initially challenging to understand, his philosophical hermeneutics helped the researcher to understand and to articulate what was happening as the research progressed. As illustrations of how the philosophical concepts both underpinned and directed the research, three examples are offered. The relevant Gadamerian concepts are shown in the square brackets. For ease of reading, these are written as accounts but each example developed over the course of time in its own distinctly spasmodic manner. The data informing the examples included observation notes, interviews recordings and transcripts, entries in my reflexive journal and notes in the audit trail. Examples 1 and 2 developed during the fieldwork in the homes. Example 3 developed during the example collection but includes reflections on the research in general.

#### **EXAMPLE 1:**

*The unit was a pleasant, airy environment, with a large lounge. Max Bygraves was singing. Residents and staff were moving around. Touring the unit, there was a variety of furniture and up-to-date clinical equipment; pictures around the walls, some locked doors; a reminiscence room circa 1940s/50s [the whole] The atmosphere felt unsettled and there was a sense of 'an incident waiting to happen'. [addressing me as important and asking me 'why'].*

*[looking at the parts within the whole] Residents had nice clothes, hairstyles and nails. Many had profound mental health needs. Some residents seem particularly anxious, restless and agitated. Staff seemed attentive to residents and busy.*

*The Charge Nurse said their main aim was reality orientation and staff were proud of their reminiscence room.*



*During this interview L (female resident) asked "when am I going home" on three occasions explaining (a) that she would miss the bus (b) that her suitcase needed to be packed but, pointing to her room, that she could not reach it on top of her wardrobe, (c) that her family needed to be told when she would arrive. She received three different answers from different members of staff: (a) that it was all arranged and she need not worry, (b) they would help with her suitcase later, (c) that she was not going home at all, at which she became distressed.*

[This was the point at which the parts offered understanding of the whole]

*The singalong selection spanned at least three decades which, for residents, could trigger vivid memories of the roaring 20s, the great depression or World War 2. The reminiscence room seemed vaguely 1940s/50s, most of the décor was contemporary but there were pictures from many different era including film stars and Winston Churchill. There was also some 'clinical' equipment.*

*Even if reality orientation had been an appropriate approach for individual residents, which I questioned, to which reality were they orientating residents?*

*Through illuminating individual 'parts' of the 'whole', it was clear how residents could become restless or anxious. But different 'parts' can be in different transcripts or observation notes and it is only through foregrounding and backgrounding, distanciation and the hermeneutic circle that coherent understanding develops. Whole and parts issues were particularly revealing during the fieldwork.*

## EXAMPLE 2

*A [female resident] always seemed to find opportunities for humour. She was adamant that she would stay in bed because her back was too painful to sit upright following a road traffic accident. She insisted she was quite happy and, although all the staff encouraged her to get up, they respected her wishes. In interview she said "I love to laugh. My family leave notes with dirty jokes for the staff and they leave jokes for my family. This morning the girls found some mint imperials in my bed. I said 'don't worry I'm ovulating'" [language and text-as-action suggested she was happy].*

*Subsequent interviews with the home manager and physiotherapist identified A as a concern to them and the home manager was being lobbied by A's relatives [the issue was being raised]*

*[distanciaton; dialogue with the data; foregrounding and backgrounding; working in the hermeneutic circle] Reviewing my observation notes, I was struck by the experience of A's colostomy bag change [the issue addressed me as important] .*

*Although the CA was very skilled and sensitive in dealing with this I wondered whether this was an issue for A. On a subsequent chat with A it emerged that she was concerned about the bag breaking in front of other people.*

*Reviewing the notes of my initial interview with A she had made a light-hearted reference to her last visit to the lounge when a male resident undressed himself. Her description of this, particularly her remarks about how the experience completed her education in life, was intended to be humorous (and unprintable), but she concluded "I don't find it funny - I find it very sad".*

*Ultimately I realised that her main reason for not wanting to go the lounge was that she did not want to see people losing their abilities, their independence and most of all their dignity, knowing she could become like this in the future.*

In Gadamer's terms, her 'language' was jovial but the 'text' was very different. This demonstrated how, although 'text' is independent of language, it can be reached through language and, as Ricoeur posited, through text-as-action. This example illustrates how a researcher can be questioned by the subject matter and develop dialogue with subject matter. Through the hermeneutic circle, engaging with the horizons of meaning offered by different research participants, and revisiting the data over and over again, each time with an increased understanding a more complete interpretive account develops. The reflexive journal and audit trail act as 'anchors' through the developing interpretation, as illustrated in Figure 2.3 (page 105).

### EXAMPLE 3:

*At the start of the research I recorded in detail my conceptions, values, beliefs and the experiences that framed these [in Gadamer's terms, my pre-understandings or 'prejudices']. I wrote of my deeply-held commitment that older people should receive the very best of care; my beliefs in what nursing could offer to this; my frustration that there was no evidence base to demonstrate nursing's contribution, and my determination to identify some evidence.*

*At the beginning of Phase 1, I visited a variety of homes to talk with RNs and CAs about their work. At one home a group of RNs offered some wonderful examples of their work with older people. I came away feeling inspired and, for the first time, confident that my research could offer what I had hoped. On my 'quest' for examples, driving home through the beautiful sunlit Lincolnshire countryside, I was reminded of the story of Don Quixote, knight in armour, on his quest to share his vision of the world and to overcome any challenge to this which, I recollected, included a joust with a windmill.*



*Two experiences shortly after this, however, really challenged my understandings. In one home, an RN explained how, while a resident was sitting on the toilet, she left the door open so that she 'keep an eye' on her but put a chair across the door so that the resident could not get out. She then described how she liked to put 'cot sides' on the beds of all new residents. In another home, a small group of RNs said they did not understand what I was trying to do. One said: "but what we do here is just basic care"; another said: "I don't know why you're bothering to do this". [horizons of meaning very different to mine]. Distanciation became a priority and I retreated into my hermeneutic circle. I worked through the research to date, reconsidered the literature and my contextual analysis, re-read the data collected, re-examined my understandings and wrote profusely in my audit trail. [distanciation in time and through physical distance; examining own prejudices; working reflexively in the hermeneutic circle; seeking alternative horizons of meaning through reflexivity, literature, peer support]*

*I also indulged in some recreational reading. Don Quixote tells of a country squire from a village in La Mancha, Spain, who "goes mad" as a result of reading chivalry books. He comes to believe that they are historically true and that he can become a knight such as they depict. Mounted on his bony horse, with spear and makeshift armour and accompanied by his squire Sancho Panza, he sets out to right the dreadful wrongs and searches the countryside for all the perpetrators, whom he challenges. In reality, those who Quixote **interpreted** as perpetrators were the commonplace objects and travellers that he met - flocks of sheep, a funeral cortege, a chain of galley slaves and, as I had recalled, some windmills. While the RN's practice to me was 'restraint', to her it was 'caring'. More fundamentally, while my concept of nursing was around 'helping to live', hers was around 'protecting from harm'. And, although I was passionate in my quest to articulate high level nursing skill, to the RNs in one home, none existed. Clearly the 'pre-understandings' and 'horizons of meaning' of those participants were very different to mine but, as more data were collected and more details added to the overall picture, these perceptions became less significant. I had gained a deeper understanding of the subject and, by examining my 'prejudices', deeper understanding of myself. The ultimate interpretative account, if viewed as a painting, was influenced by my 'quest' to paint and it encompasses, albeit in background horizons, the windmills, sheep, funeral and galley slaves.*

There are many advantages to using philosophical hermeneutics. With its assertion that there is no absolute truth Gadamer's approach frees nurse researchers to move away from the quest for a 'perfect method' to gain clear and accurate pictures of everyday realities (Hekman 1984). Rather, Gadamer supports us in being open to all that is occurring within the historical context and in exploring alternative approaches, assumptions and methods (Pascoe 1996, p 1312).

Using philosophy in research, however, is not without its challenges. Philosophers' writings can be complex and translations vary, even in how key concepts are described (for example different terminology for 'historical consciousness' is used by different translators). Interpretations of philosophical writings can be helpful but interpreters understand the philosopher's concepts in their own ways; for example some use the terms 'text' and 'language' interchangeably whereas, to Gadamer, 'text' occurs in and through language but addresses the reader as a subject in its own right.

## **RIGOUR IN THE STUDY**

### **COHERENCE, AUTHENTICITY, AGREEMENT**

The study's authenticity is demonstrated by the faithful representation of the participants' 'text' in the descriptions within the interpretive account. The account itself presents a unified 'whole' picture encompassing 'the parts', as interpreted through the hermeneutic process, including the contradictions and, as Madison (1988, p 30) suggests, making as much sense of these as the text will allow. The research has coherence in that the questions within it are those raised by the 'text' itself and the 'horizons of meaning' within the 'text' are clear in the account (i.e. there is agreement between the interpretive account and the 'text').

The report's coherence and authenticity is evidenced in that the descriptions and interpretations are recognised by the study participants, readers or other researchers who have had such experiences as an 'authentic portrait' (Miles and Huberman 1994, p 278), as addressing their own 'text' or resonating with their own 'horizons of meaning'.



This research offers coherence, authenticity and agreement through:

- Staying as close as possible to participant 'text' by retaining the participants' own language and presenting this, as much as possible, in the interpretive account. Unedited data from observation notes, interview transcripts and significant examples were retained in the interpretive account until the final edit for thesis presentation.
- Working as closely with participants as possible in the hermeneutic cycle of interpretation development.

All those reading the data and interpretative account, including participants, peer supporters and supervisors have found coherence, authenticity and agreement in the interpretation.

### TRUSTWORTHINESS, REPRESENTATION, AUDITABILITY

Trustworthiness was sought through being open and unequivocal with participants about the intentions and purpose of the research, the researcher role and what would be done with the findings.

As the researcher, my own 'prejudices' and perspectives are made explicit and it is thus clear how these likely influenced the interpretation, including:

- How I became interested in the subject matter and the significant experiences that led to the initiation of the research.
- How I view the subjects being studied (Altheide and Johnson 1994, p 293) and how this thinking developed as the study progressed.

My preconceptions and presumptions were made explicit from the beginning of the study and I worked consciously with these, particularly present during fieldwork. I also sought honest feedback on how participants were experiencing my presence and the progress of the study.

The account truthfully describes the processes in the research, including the aspects that did not run as planned, what Koch (1996) described as 'the glitches'. It aims to clearly articulate the perspectives represented (i.e. particular participants, the researcher and, through the interpretive processes, a fusion of both), so that it is clear whose voice is speaking through the account.

Auditability is a useful criterion against which to judge the rigour and consistency of qualitative findings (Guba and Lincoln 1981, Sandilowski 1986). The audit metaphor can sound forbidding in that it connotes an external, stern, obsessive expert but, as Miles and Huberman (1994) highlight, this misses the idea that researchers, with close colleagues, can look at documentation very openly, honestly and fruitfully. Auditability is specifically achieved by a description, explanation or justification of all elements of the study, and stages of the process from start to finish. The development of the research should be transparent and accessible to readers and to those who will use the research and was sought in the current study through:

- Providing sufficient detail so that study methods and procedures can be followed as an 'audit trail' (Miles and Huberman 1994).
- Explicitly communicating all elements of the work. Using criteria from Sandelowski (1986, p 34) and Miles and Huberman (1994), the key elements include the specific purpose(s) of the study, research questions, study design, how subjects or pieces of evidence came to be included in the study and how they were approached, how the data were collected, the nature of the settings in which data were collected, how the data were reduced or transformed for analysis, interpretation and presentation (Popay, Rogers and Williams 1998, Denzin 1998, p 313), how the categories developed to contain the data, specific techniques used to determine their truth value and applicability.
- Examples of raw data, quotes, sections from the researcher's reflexive journal are presented in order to demonstrate how all the elements were linked and the logic developed and the relation between the interpretation and the evidence is made explicit (Mays and Pope 1996, p 18). For example quotations are coded to link data sources, albeit anonymously.
- The auditability contributes to demonstrating the fusion of horizons - of the literature, the researcher's preconceptions and the data from multiple data sources (Koch 1996, p 179).

### COMPREHENSIVENESS, THOROUGHNESS, CONTEXTUALITY

Interpretive research is comprehensive when it communicates a sense of 'whole', i.e the contextual and historical nature of the 'text' or, in Madison's (1988, p 30) terms, the context (situatedness) and temporality of the participants. An interpretive account is thorough when it deals with all the questions posed. In



addition to some aspects discussed under the heading of coherence above, the current study sought comprehensiveness, thoroughness and contextuality through:

- Presenting descriptions which are as context-rich, 'thick' and meaningful as possible (Forchuk and Roberts 1993, Denzin and Lincoln 1994, Koch 1996, Altheide and Johnson 1994, p 293, Popay et al 1998), including unedited data from observation notes, interview transcripts and significant examples offered by participants.
- Broad sampling, in both the significant examples and nursing homes used for fieldwork.
- Triangulation, recommended by many authors (e.g. Guba and Lincoln 1981, Sandilowski 1986, p 35, Miles and Huberman 1994) was achieved through multiple data collection methods, data sources and data types.
- Findings from one database have been replicated in databases other than the one from which they arose. In fact, many of the themes held strongly throughout all datasets.

Achieving coherence in the interpretation can be satisfying. In this study, coherence was achieved in some parts before others. For example there was earlier coherence in the CA work than with the RNs, largely because of the diversity among RNs. Coherence in the overall interpretation was achieved when there was a resonance, consistency and a 'feeling of whole'.

As Miles and Huberman (1994) contend, there is no way to study something without changing it in certain respects. The findings are always influenced to some extent by the investigator and without rigour, particularly in interpretive work, there is always a risk of 'finding what the researcher expects to find'. The ultimate check for this is that the understanding offered in the interpretive account is very different from where the researcher started, i.e. they are clearly the results of the inquiry rather than merely the perspectives of the researcher (Guba and Lincoln 1981). Through the reflexivity involved in hermeneutic research, the researcher also gains greater self-understanding and is, in turn, changed through the research process. By understanding others we come to understand ourselves. The final 'whole' was very different to the one identified at the start of the research and this highlighted that, as Gadamer argues, understanding is always historical.

PENETRATION, USEFULNESS, APPLICATION, SUGGESTIVENESS,  
POTENTIAL

The account attempts to address an issue of concern, an issue that has been the subject of widespread discussion for many decades, "a central problematic" (Madison 1988, p 29). If research is to be worthwhile, the findings should also have importance and relevance to its participants, both researched and researchers, and for those who will potentially use it (Forchuk and Roberts 1993). Indeed, Miles and Huberman (1994) argue that 'pragmatic' value is an essential addition to the more traditional views of 'goodness', and specific ways in which the research could offer 'pragmatic' value are discussed in Chapter 6.

Additionally, research should have broader relevance, for example clear implications for policy and practice which, in modern health and social care services, includes a variety of stakeholders for whom it could serve as one of a range of sources to guide decision making (Popay et al 1998). Representing the Royal College of Nursing I was able to contribute the understanding emerging through the research to policies such as the single registration care home and national minimum standards for care homes. Most significantly, it contributed to Department of Health decisions on the distinction between nursing and personal care when I was invited to develop a tool to determine levels of NHS-funded nursing in care homes. The result was the Registered Nurse Care Contribution (DH 2001g).

In order for research to inform decision making, Miles and Huberman (1994) argue that researchers have a responsibility to make public what has been learned, particularly in the language used by those who contributed, and this is my intention. Set within the context of other research and theory, the account of the research suggests how the findings could, within this context, offer insights, critical discussion and possibilities that could be illuminating for current and future work in the field. It will also hopefully stimulate further research. Madison (1988, p 30) uses the term 'suggestiveness' to denote that a good understanding of an interpretive account will raise questions to stimulate further work. Ultimately, Madison (1988, p 30) suggests, the evaluation of the account "lies in the future" in that it "is capable to being extended" and there is potential for extending the research.



## **THE POTENTIAL FOR FURTHER RESEARCH**

There is potential to develop further research on the basis of this study. This could, for example:

### **INVESTIGATE THE OUTCOMES OF THE WORK OF RNS AND CAs IN CARE HOMES USING ALTERNATIVE METHODS.**

It would be enlightening to investigate direct causal links between care and outcomes and these could be identified using tools to assess, for example, pressure damage risk, continence or, as suggested by the physiotherapist in Home 1, mobility and manual dexterity. It would also be helpful to identify the cost implications of the outcomes of care, for example some RNs in the study identified cost savings in terms of fewer drugs or continence products used and less staff input required following rehabilitation.

### **EXTEND THE ANALYSIS OF THE INTERFACE BETWEEN RNS AND CAs.**

This appeared to be determined by the individual characteristics, competencies and relationships between RNs and CAs but understanding more about who makes the decisions and how these are made could help to inform determinations of skill and staffing mix. The discussions within shift-to-shift handovers produced some interesting analysis of the contributions of different grades of staff to care decisions and there is potential to analyse these further within different decision-making theories or models.

### **DEVELOP AND TEST THE OUTCOMES FRAMEWORK**

This would seem to offer potential and could be further developed as discussed in Section 6.4.

## **SUMMARY CONCLUSIONS**

The numbers of older people in the UK population, in both absolute and relative terms, are set to increase, particularly those over-85 who constitute the major group requiring long-term care. Simultaneously the numbers of adults in the groups from which RNs and CAs have traditionally been drawn are set to decline. There is a national shortage of RNs and, with an ageing workforce, many of those currently in post are set to retire within the next five years.

Care homes are under financial pressure and care home funding has been a topic of impassioned debate for the last ten years. Many homes have closed and staff costs have been a major factor in this. The roles of both RNs and CAs in care homes are currently under examination.

This research sought to illuminate and articulate the distinct contributions made to the care of older people living in nursing homes (care homes with nursing) by RNs and CAs. It asked three key questions:

- What do CAs do and how does this impact on outcomes for older people in nursing homes?
- What do RNs do and how does this impact on outcomes for older people in nursing homes?
- What are the distinct outcomes, or potential outcomes, of the work of RNs, compared with those of CAs, for older people in nursing homes (for example in relation to physical health, functional capacity, wellbeing or quality of life?)

The findings and products from the study contribute to current debates with a range of perspectives, including those of RNs, CAs, Home Managers, other professionals, relatives and, importantly, older care home residents.

### THE WORK OF CAs: RESEARCH FINDINGS

Amid suggestions that the CA role should be developed and 'professionalised' (English Community Care Association, P&G Professional, Laing and Buisson 2004), this research offers an analysis of the processes and outcomes of their work, alongside what CAs bring to their work, what motivates them and how they see their roles in the future. The CAs in the study did not want to be 'professionalised'. Even those who had been 'hand-picked' to undertake NVQ Level III and act as team leaders did not want greater responsibility and wanted RNs available to teach and support them.

The CAs in the study commonly brought a great deal of caring and humanity to their practice and worked 'from their hearts'. Despite the knowledge they had gained of individual residents, and sometimes high levels of interpersonal skills,



such inputs were widely taken for granted, dismissed as "nothing special", "just me" or "just common sense".

According to their job descriptions, CAs were employed to assist residents with physical personal care / activities of daily living and this prioritised their work in their day-to-day realities. However, what motivated and fulfilled them were the relationships they formed with residents and how these were enjoyed in their day-to-day work. Not highlighted in previous research were the close relationships and concepts of 'family' valued by CAs and many, although not all, of the residents.

The findings suggest that the outcomes of CA work are focused around resident personhood, wellbeing, daily functioning and quality of life. CAs with high levels of knowledge, skill and consciousness also influence resident outcomes of health maintenance and in preventing problems. Residents' perceptions of the outcomes of CA work prioritised help being constantly available, help with things they could not do for themselves, help to be comfortable, relationships, "caring and sharing", companionship and "the tiny little things".

### THE WORK OF CAs: RESEARCH PRODUCTS

The findings suggested an original model of CA work with older people in nursing homes (Figure 3.1, page 187 and reproduced here for ease of reference) which reveals a breadth and emphasis not identified in previous literature. This model makes a major contribution to knowledge of CA work in long-term care settings and could be used as a basis for exploring the role and contribution of CAs in other services.

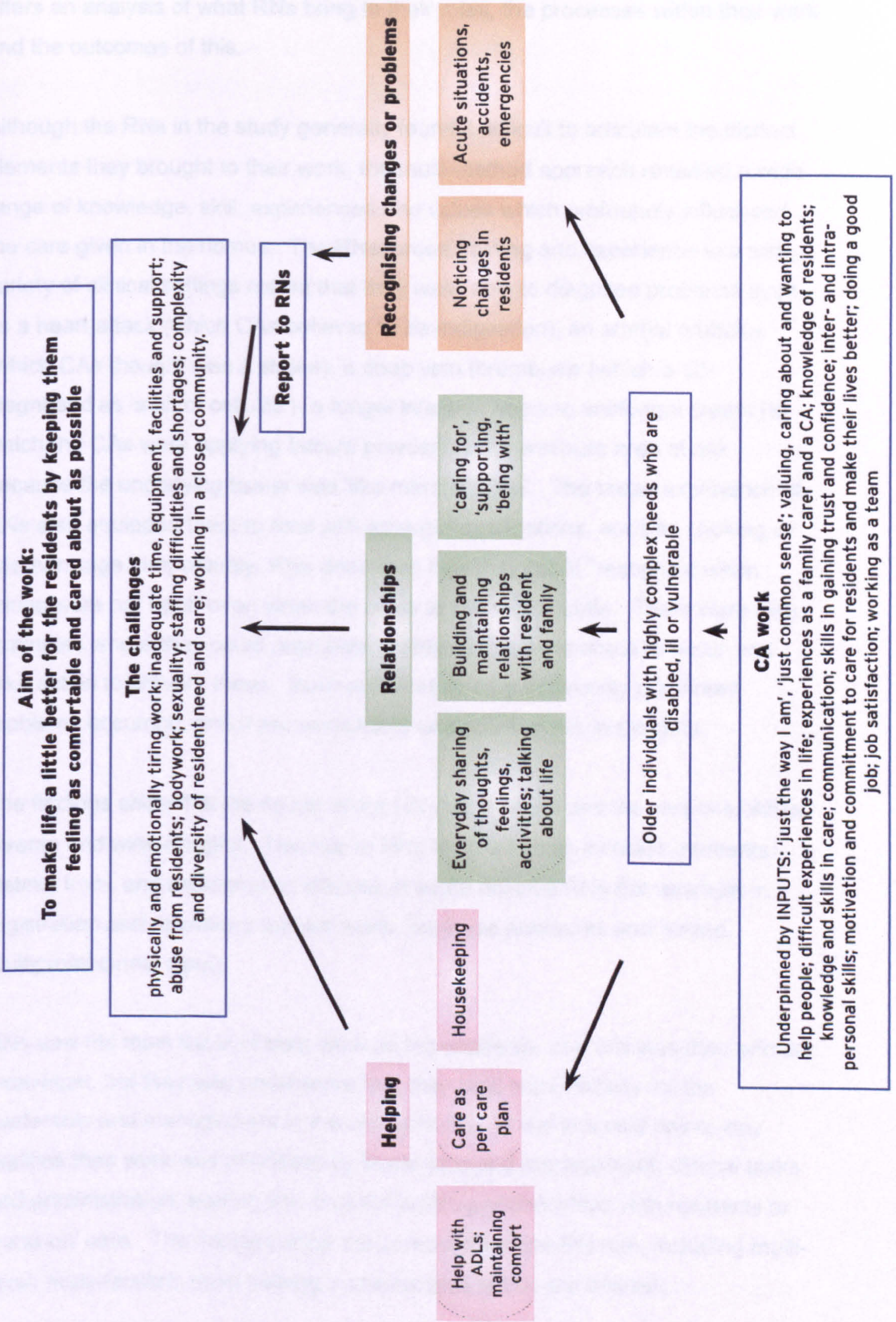
The research also produced a map of the contextual influences on the work of CAs in care homes (Figure 3.2, page 188), the like of which has not been identified in previous literature.

### THE WORK OF RNs: RESEARCH FINDINGS

The contribution of RNs has been debated for at least the last decade but has recently come under more focused scrutiny, with many questioning whether there is a future for RNs in long-term care (Blackburn 2003, RCN 2004). This research



# Model of CA work identified in the research





offers an analysis of what RNs bring to their roles, the processes within their work and the outcomes of this.

Although the RNs in the study generally found it difficult to articulate the distinct elements they brought to their work, the multi-method approach revealed a wide range of knowledge, skill, experiences and values which profoundly influenced the care given in the homes. The RNs' broad training and experience in a wide variety of clinical settings meant that they were able to diagnose problems such as a heart attack (which CAs believed to be indigestion), an arterial embolus (which CAs thought was a stroke), a deep vein thrombosis (which a GP diagnosed as 'a bit of cellulite'), a fungal infection needing antifungal cream (to which the CAs were applying talcum powder) and a pressure area at risk because the underlying tissue was 'like marshmallow'. The broad experience of RNs also equipped them to deal with emergency situations, such as choking or haemorrhage. Importantly, RNs described how they could "recognise when things were not right" even when the clues to this were subtle. There were also examples where they could anticipate problems that were about to occur and take action to prevent these. Such anticipatory care commonly prevented problems occurring, and there were many examples of this in the data.

The findings show that the scope of the RN role is broad and the responsibilities diverse and wide-ranging. The role of RNs in care homes includes elements distinct from, and additional to, the role of acute hospital RNs (for example in registration and regulatory requirements, business pressures and limited multiprofessional input).

RNs saw the main focus of their work as the residents, and this was their primary motivation, but they also understood that they held responsibility for the leadership and management in the unit or home. In the practical day-to-day realities their work was prioritised by leadership and management, clinical tasks and administration, leaving little time for building relationships with residents or 'hand-on' care. The findings show the complexity of the RN role, including multi-level, multi-faceted, multi-tasking and examples of this are offered.

The multi-method approach revealed that RNs bring dimensions to their work which are not widely acknowledged in the literature and not emphasised on their job descriptions. These include dealing with emergencies, risk assessment and

risk management, rehabilitation/re-enablement, therapeutics and health promotion. If these aspects are not recognised, other than by the RNs themselves, this raises questions as to whether such elements would exist in the care if the RNs did not bring them. Crucially, the research offers insights into what might be the consequences of removing the 24-hour presence of RNs from care homes. The contribution of RNs, particularly in non-acute services, has been notoriously challenging to articulate and there has been a lack of evidence about the effectiveness of RNs in long-term settings (Nolan and Tolson 2000).

Resident priorities for RN outcomes were that they were available to deal with health concerns, to 'keep an eye' on things and keep residents well, to care for them when ill, to sort out health and functional problems even when complicated, to do 'anything medical', to take charge, to teach and supervise CAs, to call the doctor when necessary, to keep up to date and bring new ideas and to ensure quality care. One said: "good nurses are the key to things".

#### THE WORK OF RNs: RESEARCH PRODUCTS

The findings suggested an original model of RN work with older people in nursing homes (Figure 4.1, page 253 and reproduced here for ease of reference) which reveals a breadth and complexity not identified in previous literature. This model makes a major contribution to knowledge of RN work in long-term care settings and could be used as a basis for exploring the role and contribution of RNs working in other services.

The research also produced a map of the contextual influences on the work of RNs in care homes (Figure 4.2, page 254), the like of which has not been identified in previous literature.

#### THE DISTINCT OUTCOMES OF THE WORK OF RNs AND CAs: RESEARCH FINDINGS

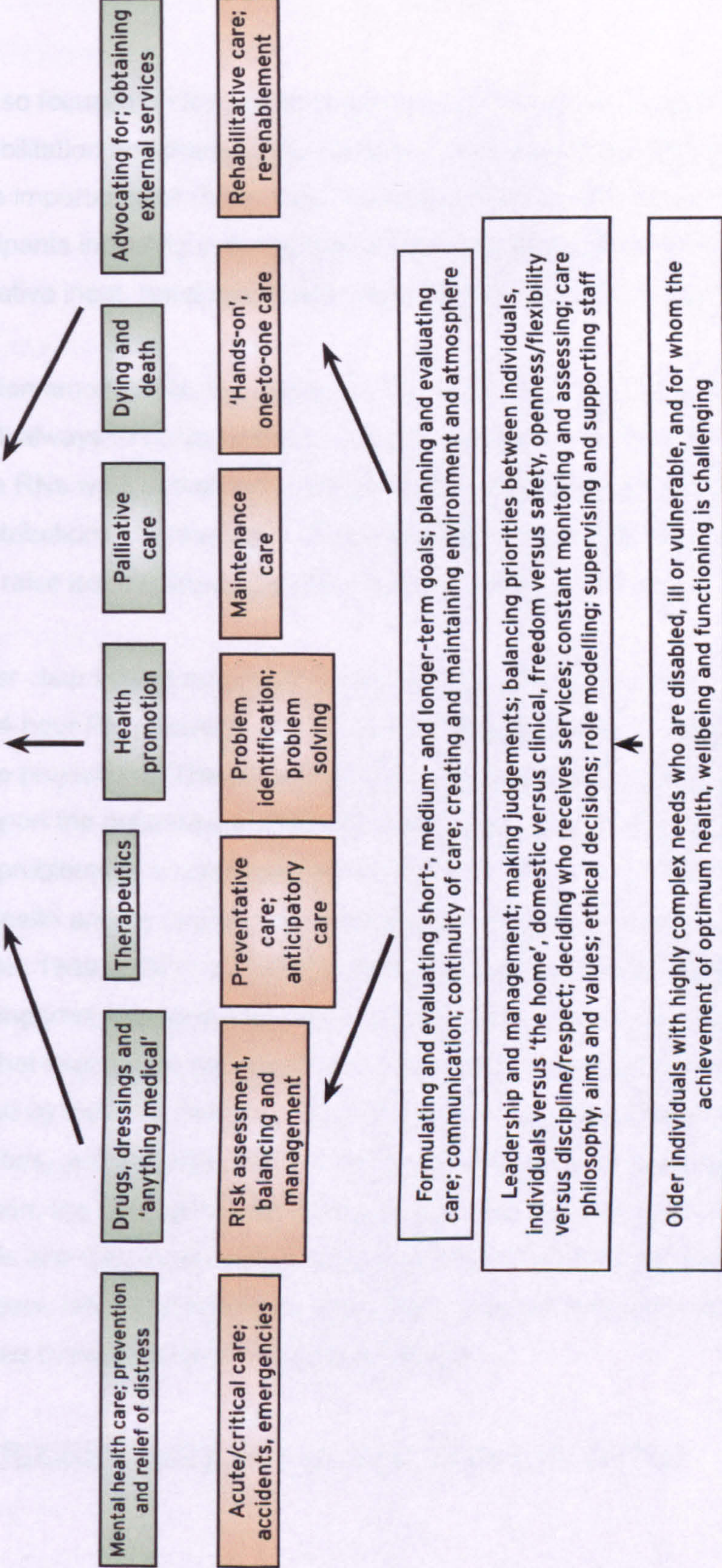
The findings suggest that the outcomes for CA work are vital in terms of resident comfort and peace of mind. The day-to-day outcomes of their work focus on personhood, wellbeing, functioning and quality of life.



# Model of RN work identified in the research

**Aim of the work: To make life as good as possible for residents; quality of life; maintaining normal life; individual health and wellbeing, functioning and fulfilment**

**The challenges**  
 Total responsibility and accountability; complexity of the RN role; pressure of the job; obtaining care for residents; limited medical and multi-professional input; limited specialist input; inadequate medical documentation; supervising a largely untrained workforce; staffing difficulties and shortages; complexity and diversity of resident need and care; working in a closed community



**RN work**  
 Underpinned by INPUTS: professional and personal knowledge, skills and experiences; knowledge of older individuals in the context of biography and family over time. RN knowledge, skills and experiences including clinical knowledge and skills; code of professional conduct; legal and ethical issues; health and safety. Leadership and management; inter-professional working; personal beliefs and motivations.



The RN 24-hour presence significantly influenced resident outcomes when acute or emergency situations arose in that they were able to anticipate and deal with these.

RN outcomes also focused on long-term health and functioning. Although such aspects as rehabilitation and therapeutics were not emphasised on the RN job descriptions, the importance of these were recognised by individual RNs. As RNs and other participants including managers and physiotherapists emphasised, without rehabilitative input, residents' health and functioning would deteriorate.

Given the variation among RNs, the outcomes that individual practitioners claim for their work will always to some extent be conjectural but, as the research suggests, where RNs work in teams the range of skills and perspectives can mitigate the contributions of individuals. The individuality of how RNs function does, however, raise issues about education for work in long-term care.

The findings offer clear indications of what might be the consequences of removing the 24-hour RN presence in nursing homes but caution is needed in making definitive projections. There are particular challenges in producing evidence to support the outcomes of the RNs' distinct contribution to anticipating and preventing problems in acute situations, and also in preventing deterioration in older people's health and functioning in the long-term. As identified in the literature (Qureshi 1999, p 261), the achievements of services which are aiming to prevent something from happening are very difficult to demonstrate because the data showing what might have happened are unavailable. Nevertheless, the examples offered by the RNs vividly illustrate the outcomes of their work in particular situations, and the observations and interviews generally supported their claims. In addition, the findings on the outcomes and potential outcomes of the work of both RNs and CAs were supported by data from a range of sources, including managers, other professionals, other staff, relatives and older residents, and data collected through different collection methods.

### STRUCTURE-PROCESS-OUTCOMES IN CARE HOMES: RESEARCH FINDINGS

Through seeking to answer the research questions, the findings from this study made additional contributions to current understanding of outcome-focused work



in care homes both in terms of two original frameworks, and also insights which contribute to broader debates about outcomes in older people's long-term care, specifically some of the conceptual, methodological and practical challenges identified in the literature.

Conceptual debates to which the findings contribute include, for example:

- what counts as an outcome
- how outcomes could be defined for individual service users
- what terminology should be used in the framing and assessment of outcomes
- who should determine the achievement of outcomes and
- when achievement should be determined.

Debates about methodological and practical issues to which this research offers insight include the inter-relationship of elements of structure, inputs, process and outputs to outcomes and how outcome indicators could be used in conjunction with an outcomes framework to determine outcome achievement.

Overall therefore the study responds to pleas from leaders in older people's research who have long highlighted "the need for more conceptual and empirical work in order to create frameworks within which the aims of the care of older people in care homes can be articulated and concepts of quality developed" (Nolan 1999, p 66).

#### STRUCTURE-PROCESS-OUTCOMES IN CARE HOMES: RESEARCH PRODUCTS

The initial original Structure (Inputs)---Process (Outputs)---Outcomes Framework developed from the literature review in this study (Figure 2.2, page 92) proved to be a useful heuristic device not only in achieving conceptual clarity through the research process but also in facilitating the collection and analysis of the data. This framework could offer such a basis in future research, education or to service or practice development initiatives exploring potentials for outcome-focused work.

Through analysis of the data, a second original Outcomes Framework (Section 5.2.2, page 264) was developed within which the outcomes of long-term care could be planned and evaluated. This is as yet rudimentary but, being based

within the concepts and realities of staff and residents in care homes, it offers considerable potential for further development.

The focus on outcomes in care homes looks set to increase, as highlighted in recent seminars of the National Care Homes Research and Development Forum (during 2005 and 2006) where senior representatives of the Commission for Social Care Inspection and senior representatives from care homes have emphasised outcomes as the focus for the future.

### **THE CONCLUSION OF THE RESEARCH JOURNEY**

The journey of this research began by recognising a context which had witnessed the gradual shift in the definition and designation, provision and funding of older people's long-term care from 'health' to 'social'. Within this overall trend many elements traditionally within the role of Registered Nurses have become redefined as 'personal care' and are now delivered by non-nurses. This study has clearly identified, however, that despite these changes in the services delivered, the needs of older long-term care service users have not shifted from 'health' to 'social'. Most of the older people living in the care homes participating in the study, including those in Phase 1, have complex health needs which require multi-professional health input. (Examples illustrating the complexity of residents' health needs are offered in Appendix 5.4). In the three fieldwork homes, General Practitioners provided the medical care; geriatricians, psycho-geriatricians or physicians with special interest in older people's care were almost totally absent. The part-time physiotherapy in the three homes was unanimously agreed to be inadequate. No occupational therapy support was identified and dietetics or speech and language therapy input was virtually non-existent.

In 2000 the Royal College of Physicians, Royal College of Nursing and British Geriatric Society taskforce agreed that "the transfer from hospitals to care homes has not been accompanied by significant transfers of medical resources to the community" and that "care home residents have often become the medically dispossessed in spite of their complex health care needs, which may contribute to avoidable ill health and acute hospital admissions" (para 2.9). They concluded: "it is a paradox that older people with the greatest needs for consistent, creative and



effective care now live in care homes denied the traditional essence of interdisciplinary geriatric care (para 2.4)".

The limited multi-professional and specialist medical input into care homes has been highlighted in subsequent research (e.g. O'Dea, Kerrison and Pollock 2000, Jacobs and Glendinning 2001, Jacobs 2003). Therapy support is particularly sparse, for example Barodawala, Kesavan and Young's (2001) survey of 400 nursing homes in England, Scotland and Wales showed that only 10% of residents received physiotherapy, mostly through private physiotherapists employed by the nursing homes, and only 3.3% of residents received occupational therapy.

If the current funding pressures on care homes continue, in the context of the diminishing numbers of Registered Nurses, skill mix dilutions resulting in fewer RNs and development in the CA role looks to be inevitable. This research, however, raises some profound cautions. Firstly, if CAs are to be 'professionalised' and assume greater responsibility for resident care, more research into their work and their contribution in care homes is clearly needed. Secondly, while there would seem to be some potential in reviewing the 'anything and everything' nature of the current RN role in care homes to focus this more precisely on the elements most in need of RN knowledge, skills and experiences, the contribution that RNs make to the health, functioning and quality of life of older people in care homes should not be under-estimated. As not only the lead clinicians in nursing homes, but also usually the sole clinician, they exert a major influence on the care that older residents receive. This study has shown not only what RN do with their 24-hour presence in nursing homes but it clearly signposts what might be the consequences if the RN presence was withdrawn.

This research has described the realities for staff working with older people in care homes – the joys as well as the challenges. Most of this takes place behind closed doors and the findings of this study are distinct from much of the literature constituting the focal theory within which it sits. Specifically, it paints a more positive picture of work in care homes than has historically been recorded, thus offering some evidence towards what Nolan and Tolson (2000, p 158) identified as "a pressing need to create a new positive image of 'institutional care' as desirable and accessible and for the work in such environments to be accorded status and value".

Working alongside RNs, CAs and older people in care homes has been a humbling experience. In a context which has historically offered them little meaningful recognition for their vital roles, most of these individuals work hard in order to offer the best service they can to some of our society's most vulnerable citizens. The humanity and commitment shown by these staff to older people was immense and the evidence that such individuals are enthusiastically wanting to care for vulnerable people to the end of their lives is reassuring for the future.

This research is offered in humility and in the hope that it will stimulate genuine interest in the work of RNs and CAs in care homes, further research and ongoing debate.

In Gadamer's terms, this interpretation, offered at a point in history, understands its own tradition in which it sits but understands it in a different way to that which existed before, with questioning, reflective and authentic openness, which offers dialectic for the future. But history will be the judge of this.

So, as Gadamer (2003, p 579) concludes: "I will stop here. It would be a poor hermeneuticist who thought [she] could have, or had to have, the last word".

Rather, the concluding words are those of a resident in Home 1:

*"The greatest thing in life my dear is to love what you're doing  
and to do it with love,  
and if you do that you'll create inside you a ball of happiness that will  
always be there. And I've known this ... since I've been a little boy.  
You can see it now that, when there's someone with education in attendance, the  
brilliant results that transpire. And it was the same in the war. If we hadn't had  
people who had the education, and if we hadn't done what we'd been trained to  
do, we wouldn't have won. And it's the same. You must have educated nurses on  
the spot when you are ill"* (Resident 510).



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# APPENDICES



## **APPENDIX 1.1: DEFINITION OF TERMS**

**Ontological issues** are concerned with what is reality; with what we believe to exist and be able to be investigated. For example what is the subject matter for nursing? Is reality existing apart from my perceptions and biases or is reality shaped by my prior understanding and assumptions (Hart 1988).

**Epistemological issues** are concerned with what procedures can be used to establish what can be accepted as reality; how we can know anything. For example is my knowledge gained solely through my senses and objectively real?; can I include intuition and personal experience or only the data in reaching my research conclusions? (Hart 1988).

**Methodology** is the theory behind method (Koch 1996). It is the philosophical framework, based on fundamental assumptions and a general orientation to life, that guides inquiry (van Manen 1990).

**Methodological issues** are concerned with what processes of research should be used in order to ensure rigour. In other words how can we validate what we claim to be knowledge. For example, should I use an inductive approach, context-based description to produce categories or theories?; am I interested in explanation or prediction? (Hart 1988).

**Data collection issues** are concerned with what techniques are the most reliable and the kinds of data most accurate for this research study (Hart 1988).

**Axiological issues** are concerned with the personal values, morality and ethics of the researcher. For example should I ignore my own feelings or work within these in my research? (Hart 1988).

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## **APPENDIX 2.1: THE SAMPLING FRAME AND INCLUSION CRITERIA FOR PHASE 1 OF THE RESEARCH**

### **AIM FOR SAMPLE**

To provide a broad database from which to identify key factors which could inform the guide data collection for Phase 2.

### **SAMPLE**

Homes registered as Nursing Homes under Part II of the 1984 Registered Homes Act, with:

- geographical spread around the UK
- both RNs and CAs employed
- residents who were predominantly older people with complex needs.

Individual RNs and CAs working in nursing homes meeting the above criteria, who expressed a willingness to participate.

### **DATA SOURCES**

Significant examples written by individual RNs and CAs.



## **APPENDIX 2.2: THE SAMPLING FRAME AND INCLUSION CRITERIA FOR PHASE 2 OF THE RESEARCH**

### **AIM FOR SAMPLE**

To provide rich, in-depth data which would answer the questions and develop the conceptual and theoretical focus of the work.

### **SAMPLE**

Three Homes registered as Nursing Homes under Part II of the 1984 Registered Homes Act, with:

- both RNs and CAs employed
- residents who were predominantly older people with complex needs.

But which differed in terms of:

- geographical location
- size of home
- type of governing or managing organisation (e.g. private company or voluntary organisation)
- focus of care (e.g. physical frailty, dementia and other mental health needs, rehabilitation)
- degree of change undergone in recent period prior to fieldwork
- type and degree of educational, training or development input

### **DATA SOURCES**

- individual RNs and CAs
- other personnel employed in the home (e.g. home manager, physiotherapist, activities organiser)
- professionals regularly visiting the homes (e.g. GP, Clinical Psychologist)
- older people living in the homes
- relatives frequently visiting the homes
- details about the homes
- documents and records kept within the homes

## **APPENDIX 2.3: ETHICAL APPROACHES AND PERMISSIONS**

Following approval for the study from the Ethics Committee of Brunel University, the following permissions were sought in order to undertake the fieldwork for Phase 2.

At the time no permission was necessary to undertake Phase 1.

### **HOME 1**

Approach for permission to undertake fieldwork in the home was made to the Company's Director of Nursing, who was pleased to support the work. Approval was also given by the Company's Long-term Care Board and the Operations Manager for the local area.

The Chair of the Brunel Research Ethics Advisory Committee suggested consulting the Local Research Ethics Committees. The [Area] Essex Local Research Ethics Committee took the view that "although [the] project is being undertaken in a private nursing homes, because the residents are of [Area] Essex, ethics research approval is required".

The researcher presented a proposal and attended a meeting of the LREC, following which the committee requested:

- written consent from the Healthcare company owning the nursing home for the project to be undertaken
- the inclusion, on the patient information sheet, of an explicit statement saying that, should the patient not wish to take part in the study, his or her treatment will not be affected,
- assurances that the audiotapes will be erased once transcribed,
- indemnity being provided through the investigator's Royal College of Nursing membership

The committee agreed that this project could be given unconditional approval by way of Chairman's action upon receipt of the above and, following the documentary adjustments and reassurances, unconditional approval was given (case reference 1228).



## **HOME 2**

Approach for permission to undertake fieldwork in the home was made through the company's Nursing and Care Management Adviser, who was pleased to support the work. After consideration of the research proposal, approval was also given by the Company's Chief Executive and its Medical Board.

The proposal was submitted to the [Area] Surrey Local Research Ethics Committee who granted ethical approval subject to the researchers responses to the following points:

1. Awareness that the results of the study could be affected by the nurse/carer ratio. This point should be addressed in the main protocol.
2. Awareness that the residents may not recognise the distinction between the nurses and carers.
3. Gender issues may affect responses from residents
4. How will issues/concerns by residents be handled?
5. Double consent must be sought for taped interviews. This involves obtaining consent to interview residents/carers/nurses prior to interview and again post interview to gain approval for using the recorded material for research purposes.
6. The patient information sheet should emphasise that patients are welcome to withdraw from the study at any time.

The researcher confirmed to the LREC that all of the points would be addressed but pointed out that Point 2 was in direct contradiction to the experience of the research so far.

The LREC subsequently gave permission for the study to be conducted (case reference PRO/51/99)

## **HOME 3**

Approach for permission to undertake fieldwork in the home was made through the Company's Director of Homes, who was pleased to support the work. Approval was also given by the Company's Chief Executive and its Executive Committee.

The proposal was submitted to the [Area] (Yorkshire) Local Research Ethics Committee who granted ethical approval subject to one amendment on the explanation to residents. The form originally said "would you mind if I talk to you for a minute?" and the committee felt this could be misleading as the researcher would likely be talking to the patient for some time. The words "for a minute" were deleted and approval to conduct the study was given (case reference LREC 99/9/1).

As the home was dual registered, the researcher also approached the Local Social Services Directorate Registration and Inspection Unit who were happy to give their support to the work. The Principal Officer wrote to say she found the study interesting and wished the researcher success (letter available).



## **APPENDIX 2.4: NOTICE PLACED ON NOTICE BOARDS IN THE NURSING HOMES TO BE USED FOR FIELDWORK**

### **THE BENEFITS OF NURSING AND CARING WORK WITH OLDER PEOPLE**

**I'm undertaking a study to highlight the value of the work of nurses and care assistants to older people living in nursing homes.**

**I'm a nurse who has worked with older people for about 12 years. I believe that this type of nursing and caring work is highly skilled, but have found that the value and skills aren't generally recognised.**

**I'd really appreciate your help with the study. The work aims to identify the good things that you are doing, in other words the actions that you take which benefit the residents.**

#### **The work is in four stages:**

##### **1. Working alongside you:**

- **I will work alongside you for about 2-4 hours as a 'pair of hands'**
- **I'll be looking to identify actions that you take in which you seem to have a purpose (e.g. asking residents a particular question, talking to them in a particular way).**
- **I'll make 'notes' of these in shorthand in a notebook.**

##### **2. The interviews**

- **At a time convenient to you but ideally later that shift, I'd like to talk to you about the actions I identified, and will ask, for example "what prompted you to ask that question, or act in that way?"**
- **There are no 'right' or 'wrong' answers in this. What I'm wanting you to tell me about is what you're trying to achieve in your work.**
- **I'll also ask you about what particular knowledge, skills or experiences you used on each occasion.**
- **The interviews will be tape-recorded, will be transcribed by my sister and will be used only by me to help with the research.**
- **Your individual identity will not be known to anyone other than me, and codings will be used on the written transcripts.**

- I will also talk to a number of residents and will take advice from you and the senior nurses or home manager on this. I'll be saying to them "when you were with ... this morning, she/he did this. What do you think were the reasons behind this ... did that action make any difference to you .....". This will help us to understand what benefits the resident gained from your actions.
- If relatives or carers are around, I would like to include them in the interviews.

3. Checking back with you

- Ideally I would like to discuss with you whether the conclusions I'm reaching ring true with you.

4. Using measurement tools

- In some of the common areas of work identified, I will look at any measurement tools that might be used to assess changes in a resident's health, functioning, or quality of life, for example, in identifying pressure area risk.

**My experience with the research so far has shown that, because it offers nurses and care assistants the opportunity to think about the knowledge and skills that they use in their everyday work and how these benefit older people, this in turn helps them to value what they're doing.**

**I'm sincerely very grateful for your help.**

**Hazel Heath  
Research Student, Brunel University**



**APPENDIX 2.5: CONSENT FORM: REGISTERED NURSE OR CARE ASSISTANT TO PARTICIPATE IN THE RESEARCH**

**The benefits of nurses and care assistants to older people in nursing homes**

**Project by Hazel Heath**

**CONSENT OF NURSE OR CARE ASSISTANT TO TAKE PART IN PROJECT**

**Hazel Heath has explained her project to me and I understand this.**

**I am happy for her to work with me, to observe me working, and to talk to her about my experiences and views.**

**I understand that she will take notes while she is observing, and that our interview will be recorded on a tape.**

**I understand that her notes and the conversation on the tape will be seen and heard only by herself and her sister, who will type them.**

**I understand that my name will only be known to her and her sister while the tape is being typed. It will not be on the typed copy.**

**I know that I can ask her questions about the research at any time, that I can change anything at any time during our conversation, and can stop this whenever I want to.**

**I am willingly offering my help and feel under no pressure to do so.**

**Signed ..... Date .....**

**Name .....**

**Job .....**

**This format was also used for interviews with other staff, e.g. physiotherapists.**

**APPENDIX 2.6: FORM FOR BIOGRAPHICAL DETAILS: RNs**

**THE BENEFITS OF NURSING AND CARING WORK WITH OLDER PEOPLE**

Registered Nurse: ...(code number inserted)...

I would be extremely grateful if you would kindly complete the following details. They are useful in helping me to identify influences on the work of individuals.

**Any details you supply will be known only to me**

All Registrations and year obtained: e.g. RGN 1979, RMN 1984

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.....

All other qualifications and courses relevant to your nursing practice:

e.g. DipN 1987, ENB 941 1990. 1-day Moving and Handling Update 1997

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Total experience as a Registered Nurse .....years.....months

Total experience working with older people .....years.....months

Total experience working in a nursing home or continuing care .....years.....months

Age group: (please tick in appropriate box)

20 or under		21-25		26-30		31-35		36-40		41-45		46-50		51-55		56-60		61-65		66 or over
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Any other details you feel to be relevant:

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**Very many thanks, Hazel Heath**

**Please return form to: [researcher's address and telephone number]**



**APPENDIX 2.7: FORM FOR BIOGRAPHICAL DETAILS: CAs**

**THE BENEFITS OF NURSING AND CARING WORK WITH OLDER PEOPLE**

Care Assistant: ...(code number inserted)...

I would be extremely grateful if you would kindly complete the following details. They are useful in helping me to identify influences on the work of individuals.

**Any details you supply will be known only to me**

**Any NVQs, levels, and year obtained:** e.g. Level 2 Health and Social Care 1995

.....  
.....

**All other courses, training or updating** relevant to your work as a care assistant:  
e.g. 1-day Moving and Handling Update 1997, 2-hour video training on Alzheimer's Disease 1998

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**Total experience as a Care Assistant** .....years.....months

**Total experience working with older people** .....years.....months

**Total experience working in a nursing home or continuing care** .....years.....months

**Age group:** (please tick in appropriate box)

20 or under		21-25		26-30		31-35		36-40		41-45		46-50		51-55		56-60		61-65		66 or over
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**Any other details you feel to be relevant:**

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**Very many thanks, Hazel Heath**  
**Please return form to: [researcher's address and telephone number]**

**APPENDIX 2.8: EXPLANATION TO RESIDENTS  
(AND ADAPTED FOR RELATIVES)**

**The benefits of nurses and care assistants to older  
people in nursing homes**

**Hazel Heath**

**Explanation to Residents**

Would you mind if I talk to you ?

I'm working in the home because I'm doing a project.  
I want to write about the work that nurses and care  
assistants are doing in nursing homes.

Particularly I want to write about what are the **benefits** of  
their work - how the things that they do **help you** - help  
you to feel better, or to be able to do things in the way  
you want...

I've been asking the nurses and care assistants how  
**they** think they help you but I'd really appreciate if I  
could talk to **you** about things that they do that  
particularly help you.

All the staff know I'm asking you and are happy with this.

You can say 'no' to talking to me about this and, if you  
don't want to, **of course** this won't affect your care or  
treatment in any way. Everything will continue just as it  
did before.

Do you have any questions about what I've said?



I want to tape the interview so that I can concentrate on what you're saying. I can just write notes if you prefer but it's easier for me to think about what you're saying if I'm not writing at the same time.

The tape will only be heard by me, and by my sister who will type it. What we have talked about will be rubbed off the tape as soon as it is typed.

The typed paper will have a code and only me and my sister will know which person has each code.

Have you any questions about what I've said ?

How do you feel about talking to me about what I've explained ?

Can I show you this piece of paper. Would you kindly read it. If you are totally happy about talking to me, would you be willing to sign the paper when we have finished talking ?

You can have as much time as you want to decide, and I'll come back to see you about it later in the week.

You can change your mind at any time. You can change what you've said, or we can stop whenever you want. Even when we've finished talking, you can say that you don't want me to use the tape and it will be erased. Then, as I said, everything will continue just as it did before - it won't affect your care in any way.

Thank you.

**APPENDIX 2.9: CONSENT OF RESIDENT TO TAKE PART IN THE RESEARCH (ADAPTED FOR RELATIVES)**

**The benefits of nurses and care assistants to older people in nursing homes**

**Project by Hazel Heath**

**CONSENT OF RESIDENT  
TO TAKE PART IN PROJECT**

**Hazel Heath has explained her project to me.**

**I am happy to talk to her about my experiences and views.**

**I understand that she will record our conversation on a tape and that this will be heard only by herself and her sister, who will type it. The tape will be erased after it is typed.**

**I understand that my name will only be known to her and her sister while the tape is being typed. It will not be on the typed copy.**

**I know that I can change anything at any time during our conversation, and can stop whenever I want to.**

**I am willingly offering my help and feel under no pressure to do so.**

**Signed ..... Date .....**

**Name.....**



## **APPENDIX 2.10: DETAILS OF PARTICIPATING SITES: PHASE 2**

In order to illuminate the context in which the fieldwork took place, brief descriptions of the three homes and ten nursing units are offered. These summarise the descriptions offered by staff, particularly charge nurses and managers, and also my experiences and impressions working on the units as a researcher.

### **HOME 1**

The first fieldwork site is a 138-bed nursing home in a semi-rural area of [Area in] Essex owned by a large national private company.

Approached through a car park, this modern, purpose-built home is surrounded by shrubbery and flowerbeds and, from the back, overlooked green fields and a paddock with horses owned by the home's matron/manager.

The home is divided into four units, each with a distinct geographical layout and atmosphere.

The term 'Sister' is used to denote the Unit Manager/Charge Nurse/Sister as this is the term commonly used in the home.

The Management of the home comprises:

- Home Director, who has also Regional responsibility
- Home Manager/Matron
- Clinical Services Manager (an additional Clinical Services Manager post has recently been vacated and not re-advertised).

Additional Staff includes a Physiotherapist (20 hours a week) and two part-time Activities Organisers

### **'W' UNIT**

31 beds for physically frail older people

Staffing: AM Shift = 2 RNs + 4 CAs (Tuesday and Friday for GP rounds), remainder of week 1 RN + 5 CAs; PM Shift 1 RN = 4 CAs, Night 1 RN + 2 CAs.

Layout = central lounge and dining area; bedrooms along two corridors.

The residents have a range of complex physical health problems and two have mental health needs. Most of the residents are prescribed a range of medications, a small number need wound dressings, one resident is nourished through a PEG tube, one has a colostomy which she is unable to manage herself, and subcutaneous infusions or syringe drivers are used occasionally. Two couples live in the unit. One husband moved in to be with his wife and the other couple have met since living in the home.

On entering the home, visitors walk through a porch with various notices and the visitors' book into a large reception hall with a large desk in the far corner. This is the nurse's station for W Unit. The residents' rooms are situated either side of two of the four long corridors leading from the reception area and the residents' lounge and dining area also lead directly from the reception hall. A receptionist is available during office hours but, for most of the time, the staff of W Unit answer



the main telephone and the door, which can only be opened using the current code number.

The reception and hosting functions of the home overall thus mingle with the day-to-day functioning of W unit as the dwelling for its 31 residents. The reception function and the constant comings and goings intrude on the work of the staff but, even moreso, on the residents' home. On one occasion a party of delegates arrived for a seminar in the main lounge and residents are moved. One resident asked "who are they?". Most of the time the two functions co-exist uneasily in the same space.

One afternoon I was with a RN at the reception desk. Two visitors came to view the home for its suitability for a potential resident. They are welcomed by the Clinical Services Manager who offered them brochures on the home, seated them in armchairs and went to make coffee. During the time they are sat in the reception hall E [resident] wearing her apron asked them to move so she could dust. The RN, trying to encourage E to join the other residents, said "go and dust the small lounge E". "You work me too hard" said E. V [resident] is sitting in her usual chair by the front door crying for her husband. No-one went to comfort her. From half way down one of the corridors R [resident] is ringing his buzzer constantly. The RN went to placate him but he started shouting and swearing loudly telling her to go away. She returned to the desk where the matron/manager had come to see what the noise is about. "I'm going to kill him" said the RN. Two Care Assistants were passing through Reception. "There's a cricket bat under the desk" said one "whack him 'round the head with that". The Clinical Nurse Manager returned to the visitors with a tray of coffee "Of course the prime concern of our home is the care and welfare of our residents" she said. I wondered what were their real impressions.

The unit is busy and the staff work hard but much of the activity takes place behind closed bedroom and bathroom doors, except when residents are walked or taken in wheelchairs to and from the lounge or dining area. The unit is thus usually fairly quiet apart from the comings and goings. The atmosphere is occasionally changed and the unit filled with music during the concerts by visiting entertainers such as the Elvis Presley impersonator, or the resident who plays out-of-tune piano and takes out his teeth to sing. Staff have complained to the Matron/Manager but she says "I'm sorry, that's all I can afford". One taped interview is accompanied throughout by the strains of 'Daisy Daisy and 'Pack Up Your Troubles' because the RN wanted to be able to 'keep an eye' on the residents.

The unit has a fairly stable staffing of Care Assistants, some of whom have worked in the unit since it opened about seven years ago. RNs are mainly part-time. The senior staffing changed after the piloting of the fieldwork methods and the Sister is newly-appointed just before the main fieldwork began. Obtaining sufficient staff is an ongoing problem and comments about this feature frequently in the observation notes.

### **'M' UNIT**

49 beds for physically frail older people

Staffing: AM Shift 2 RNs + 8 CAs; PM Shift 2 RNs + 6 CAs: Night 2 RNs + 3 CAs.

Layout = small central lounge and dining area; tiny office and another desk in the corridor; resident bedrooms along four corridors.



This first-floor unit is accessed by stairs or the lifts. The windows at the front of the unit overlook local houses. Those at the back look out onto the gardens, open fields and the horses in the paddock. Despite the views from the windows, the unit has the feeling of being crowded and busy. This is probably because the lounge and central area are small and there are always residents in the lounge and going to and from the rooms in the corridors. Except during the night, the unit is rarely quiet and there are usually audible conversations.

As I wait outside the office on my first morning on the unit two residents in the lounge are shouting to each other: "where's Harold?" "Harold who?" "Harold Wilson" "Hasn't he retired?". Two other residents are sitting outside the office. One has fallen asleep. "Wake up you ..." shouts the other. Turning to me he says "wake him up!". "You don't want to wake him up if he's asleep do you?" I ask. "Why should he be asleep if I can't" is the reply.

The Sister explains that the unit is extremely busy and that the staffing levels are insufficient for the complexity of the residents' needs. The residents have a wide range of physical and mental health needs. Most are prescribed a variety of drugs, including those which need additional monitoring such as warfarin; seven residents need at least daily wound dressings; there is one PEG feed; sub-cutaneous infusions and syringe drivers are commonly in use. The unit is for physically frail older people but a considerable number of them have mental health needs, including some who have had schizophrenia for many years. The Sister explains that they can "spark each other off and become aggressive. The other day F [female resident] swiped a man around the head while she is sitting behind him in her wheelchair. She then stabbed B [male resident] with a fork".

The staff in the unit is fairly stable and the Sister is new into post. The unit seems busy and the staff, particularly the RNs, are constantly interrupted with questions from other staff or residents. As with other units in the home, staffing is a problem and messages about regular or agency staff not turning up for work are frequent in the observation notes. The week before I observe and interviewed the Sister she has worked for 70 hours.

### **'P' Unit**

#### **30 bed EMI (Elderly Mentally Ill) Unit**

**Staffing:** AM Shift 2 RNs + 4 CAs (Tuesday and Friday for GP rounds), remainder of week 1 RN, 1 Senior CA + 4 CAs; PM Shift 1 RN + 4 CAs; Night 1RN + 2 CAs.

**Layout** = lounge and dining area in centre of unit, surrounded by corridor with bedrooms, bathrooms and clinical rooms around the periphery of unit. All bedrooms have outside windows and doors onto the corridor. The corridor itself provides a continuous walkway. The office overlooks the lounge and opens onto the corridor near the entrance door.

All the residents on P unit have mental health needs, particularly various types of dementia, and also physical health needs. The unit is purpose-built. The central lounge with surrounding windows and office overlooking the lounge afford maximum observation. The corridor affords a continuous walkway for residents and is decorated by pictures, some illustrating local scenes, film stars and other famous people such as Winston Churchill. All doors to clinical and store rooms are locked. Resident bedroom doors also lock automatically but can be opened from inside. This prevents 'intruders' entering resident's bedrooms. It also means that residents can come out of their rooms but cannot re-enter without the



assistance of staff. There is access to a garden area but this is not often used, particularly when staffing levels are low.

During the day most residents stay in the lounge, particularly those who are unable to walk. Others walk around most of the day and some speak to the people with whom they wish to engage. M [female resident] is usually the first to greet visitors asking “do you know where my handbag is?” or “when am I going home?”.

The atmosphere in the unit can vary. Sometimes it feels calm but on other occasion there is a tension – as if something is about to happen. The ambience is influenced by whatever entertainment is being offered in the form of music or video. This is usually determined by the nurse in charge. During my observation shift with the Sister she paused from her work and said to a Care Assistant “please change the music – we are NOT into Capital Gold here – we are into Max Bygraves, Perry Como, Matt Munro but NOT Capital Gold – there are some CDs there – we are not to play this music”. Alternatively, during an observation session with one staff nurse (RMN), he explained that the main therapy they offered is reality orientation. Sitting in a lounge with 1990s decoration, surrounded by reminiscence materials from various eras going back to Victorian times and listening to music which, for the residents, could have evoked memories of the 1920s, 30s or 40s I wondered to which reality they were being orientated.

Finding staff for the unit is difficult. The Sister had been in post for two years but is leaving soon. The unit is staffed by some regular bank and agency staff but the home is desperate to recruit new employees. The Sister explains that, with older people with dementia, it is vital to have staff who know them and understand their needs.

### **‘U’ UNIT**

**28 bed EMI (Elderly Mentally Ill) Unit**

**Staffing: AM Shift 1 RN + 5 CAs; PM Shift 1 RN + 4 CAs; Night 1RN + 2 CAs.**

Layout = exactly the same as ‘P’ Unit, except that more of the rooms look onto the local houses rather than the fields.

The Sister explains that the unit is designed in order to afford maximum supervision of the residents, most of whom have highly complex mental and physical health needs. She describes that, of 23 residents living in the unit at the time, only three are able to eat independently, six need a great deal of help in order to eat and 14 need total help by being fed. The residents’ needs also change rapidly and some, due to their dementia, deteriorate rapidly both mentally and physically. For example, residents tend not to have their own wheelchairs as their needs can change so markedly that, by the time their wheelchair is delivered, it is no longer suitable. One resident has been admitted because her memory is deteriorating and her husband is ill. In the few months since admission she has deteriorated to the point where she has to be fed by staff and reminded to chew and swallow.

The staff also describe the residents’ needs as highly complex and relay incidents where staff have been punched, scratched or bitten by them. The sister emphasises that there must always be three staff on the unit. There is usually one RN and four CAs but, when the CAs go for breaks, the other two must be able to be vigilant of the residents in the lounge. If there is an incident, two staff



deal with this and the other is available to go for help. The RNs rarely leave the unit. The sister describes how easily incidents can arise, for example one evening where two new members of staff were on duty. They did not know the residents well and were not aware of how to calm them. One resident started to cry, another to scream, another to tell her to 'shut up' and, almost instantly, five residents were in a state of tension. She explains that, particularly if the more mobile and physically strong residents start to become aggressive, a major incident can develop in no time. Although staff try to maintain an air of calm, the unit always has an underlying tension and the sister and senior staff are constantly vigilant particularly for what the sister described as 'flashpoints'.

There is a nucleus of staff who have worked in the unit for some years but recruiting and retaining new staff is a problem, as with the other units in the home, and the sister works long hours.

### PHILOSOPHY AND MODEL OF NURSING:

The home's philosophy states that it aims to improve the quality of life for elderly people by offering excellent nursing and medical care combined with the comfort of a welcoming home. The philosophy recognises that every individual requires a different level of care and had varying needs. The staff aim to offer comfort combined with security, independence together with watchfulness and a reassuring routine that is lightened by touches of spontaneity.

The Model of Nursing is based on Roper, Logan and Tierney's Activities of Daily Living but this is used as a framework rather than a philosophy which directs the care.

### COMMUNICATION AND HANDOVERS

Between all shifts, the RN in charge of each unit gives a handover to the RN coming on duty. This usually takes no longer than 20 minutes and focuses on major concerns and tasks to be completed (e.g. a dressing to be done or medication to change with the GP). The CAs do not receive a handover unless individual RNs give instructions on their shifts. The care plans are not used during the handover.

### DOCUMENTARY DATA:

Resident dependency is assessed using the Revised Elderly Persons Dependency Scale (REPDS), which is supposed to be assessed six-monthly. Monthly audits are made of pressure sores and accidents in the home.

Entries are made daily on each resident's 'Progress and Evaluation' sheet, which are kept with the care plan.

As I originally thought the tools or measures of changes in resident health or functioning would provide insight into the outcomes of the work, I reviewed all available documentary evidence, but most proved to be of limited use in the study. The REPDS scores varied widely according to who undertook the assessment and the 6-monthly scores are often not completed.

Records of pressure sores or accidents could not be related to staffing levels or any other specific factor such as individual nurses in charge of the unit. The Matron/ Manager explained that the pressure sores in the home had generally been present when the resident is admitted, usually from hospital. Very few



actually occur in the home and the fieldwork witnessed this. Accident details were also difficult to relate to other factors. Most of the resident falls or accidents are related to them 'exercising independence'.

The Care Plans also proved unhelpful in contributing to the research. Entries by both RNs and CAs primarily record activities of daily living with which the person has received assistance, e.g. 'had a bath', or what the resident had done that day, e.g. 'up to sit in day room', "went to the hairdressers'. Occasionally the RN would write something clinical, e.g. 'wound healing well'. Other than this, I was unable to distinguish any patterns between the entries of the RNs and CAs. Progress reports were generally written hurriedly and little attempt is made to evaluate the achievement, or otherwise, of the goals on the care plan.

### Home 1: 'Signing out'

Leaving the home at the end of one fieldwork session I stopped in the porch of the nursing home to sign the visitors book. Regulations stipulate that all visitors to the home must sign in and out. These regulations, along with various health and safety notices and the home's philosophy hang in frames on the wall above the desk with the visitors book. On this occasion I met two women laughing. One was holding her head. "Are you alright?" I asked. "Yes" she said "but I'd better read all these health and safety notices again. As I bent down to sign the book this philosophy fell off the wall and hit me on the head".

## HOME 2

The second fieldwork site is a 50-bed nursing home in a residential area of Surrey, owned and run by a small voluntary sector charity. A new purpose-built single storey building, the design of which has won awards, is approached on two sides through small car parks. At the back are gardens with flower beds, patios and shelters which are used by residents, visitors and staff.

The home is organised into two main units, each of which is divided into two community living areas, each with 12 bedrooms.

The home welcomes older people with a broad spectrum of needs and specialises in offering care for people with a high level of mental health need. One main unit is for older people with dementia and the other primarily for older people with physical frailty but it is clear that most of the residents also have mental health need.

The units and communities are situated at either end of the home. Each community had its own dining, sitting and quiet rooms and there were modern assisted bathrooms, a physiotherapy room and special facilities for those with wheelchairs. At the centre of the home is a spacious lounge which is used for a range of purposes both by the home, individual residents and visitors, the staff and the active 'friends' group who organised in-house entertainment. The friends also organised visits to the home and trips for the residents to go out. Catering and other functions are located in this area. There is also a room used as a chapel. A reminiscence group Rung on Fridays and PAT (pets as therapy) dogs visited occasionally on a Monday.



The Management of the home comprises:

- A Matron / Manager
- Two Unit Managers

Additional staff include a physiotherapist (20 hours a week) and a clinical psychologist who works on specific projects. One GP looks after all the residents.

Staff wear casual dress which is uniform (i.e. all the same) rather than uniforms with clinical origin. This adds to the informality and homely feel of the environment but does not distinguish between grades of staff.

It has a very different 'feel', culture and way of operating to Home 1.

### RECENT DEVELOPMENTS

The home is keen on ongoing education and training for the staff, including a comprehensive induction programme for all staff including catering and cleaning, a dementia training programme and an internally-run leadership development programme for all qualified staff.

### V and W UNIT

24 beds primarily for physically frail older people

Staffing: One RN plus 6 CAs on an early shift, 1 plus 4 on a late shift and 1 plus 3 at night.

V Unit and W Units are separated by a spacious reception area. In all of the units the lounge and open plan kitchen are the centre of community life. There are pervading smells of food at mealtimes, coffee in the mornings, bleach when the cleaners are working and occasionally lavender or other aromatherapy oils. There is usually some background noise of conversation, general activity, a radio or the television. Residents are coming and going, usually with staff assistance as few are able to manage alone. There is a general feel of homeliness and informality.

There are bathrooms and toilets between the lounge and the bedrooms, which are along long wide corridors. Other rooms and spaces are available in the bedroom areas which are useful if residents want to sit quietly alone or entertain visitors. They are also useful for handovers and other staff meetings.

Staff prepare breakfast for residents as they arise, or take breakfast to their bedrooms. Staff also serve lunch and supper, which is prepared in the kitchen and sent to the four communities. This adds to the homeliness.

### X & Y UNIT

26 Beds for older people with mental health needs, primarily dementia

Staffing: One RN plus 6 CAs on an early shift, 1 plus 4 on a late shift and 1 plus 3 at night. Due to the national shortage of RMNs the home had agreed with the local authority a variance in the current skill mix.

X & Y Unit is the same layout as V & W and the care organisation is the same, e.g. serving meals from the open plan kitchen to residents seated in the dining area. A significant number of the residents tend to walk around most of the day and they are unrestricted in doing this. They can walk throughout the home and around a safely enclosed garden. Some other residents are severely disabled

and some commonly shout or scream. They receive responsive care from the staff. A few relatives spend many hours in the home giving care to their partners, for example one wife stays all day caring for her husband who is unable to do anything for himself and a husband visits his wife every night in order to settle her into bed. Background music is played in the unit, particularly Jim Reeves.

### PHILOSOPHY AND MODEL OF CARE

The home's philosophy emphasises improving the care and wellbeing of older people who are physically frail or suffering from dementia through a combination of continuous development of good practice in the home, seeking pre-eminence in education and training, supporting research and innovation, promoting awards for excellence and contributing to the exchange of knowledge and ideas.

The basis of the model of care is Roper, Logan and Tierney's Activities of Daily Living.

### COMMUNICATION AND HANDOVERS

The RN in charge of each unit takes a handover from the night staff and pass on any key messages to the other care staff. A 30-minute handover with all staff in the unit, and including those on early and late shifts, takes place around 2 p.m. This is used not only to report on resident health and progress but also to advise on care regimes. There is a strong emphasis on health promotion and this is integral to the daily care, e.g. prunes at breakfast to prevent constipation, encouraging mobilisation. The care plans are used during the handover.

### DOCUMENTARY DATA

The home conducts quarterly audits of falls, pressure risk, resident and staff accidents. Every six months an assessment is conducted on all residents using the Royal College of Nursing Assessment Tool.

Dementia Care Mapping is also conducted six-monthly in the dementia care unit, including one session observed by the researcher in X & Y Unit.

All available documentary evidence suggests that the care in the home is of a high standard. The Dementia Care Mapping shows that the care of the residents with dementia has improved since the previous measurement (although, unbeknown to the mappers, all available staff were allocated to the unit during the mapping sessions, leaving the other unit short-staffed).

The care plans are written by the CAs and countersigned by the RN in charge of the unit. They contain primarily notes of care given to a resident during a shift, e.g. 'had a bath', 'ate all her lunch', 'daughter visited'.

The documentary evidence is helpful in confirming the scope and focus of the work and the categories within the outcomes framework but not particularly helpful in confirming the outcomes of the work.

### HOME 3

The third participating fieldwork site is a purpose-built 67 bed dual registered (nursing and residential care) home in a residential area in Yorkshire, owned and



run by a charity which supports a specific 'cultural group' of people and their families. People with mental health need are not admitted and admission criteria reinforce this. If however a resident or patient develops mental health need the home tries to care for them for as long as possible and particularly if the person's physical needs predominate.

The home is approached through a wide drive, beside which is a garden with trees, lawns, flower beds and quiet areas in which to sit. Car parking is at the side and rear of the home. Entering the spacious reception area there is seating for visitors and guests, a small conservatory leading onto a patio with flower beds, the administrator and Home Manager offices and corridors, staircases and lifts leading to the various units and communal areas.

The home is organised into two nursing units on the first floor, each with two wings, and one residential care wing on the ground floor alongside the main facilities. The main lounge is spacious and included a bar which opened at lunchtime and early evening. There is also a large dining room, a small lounge, which is used for activities and exercise classes, and various additional seating areas. There is also a library which serves as a chapel, a conservatory and outside seating.

The management of the home comprises:

- A Matron/Manager
- A Deputy Matron
- A Head of Residential Care

Additional staff include a physiotherapist who also works as an activities organiser and also befriends the residents, for example distributing their incoming mail, if necessary reading this to them and helping them to respond. She also arranges local outings, guest speakers, games and quizzes. An occupational therapist is available once a week

There is also a voluntary House Committee, largely drawn from the local community, which supports the home, taking an interest in the welfare and happiness of residents, visiting individuals and arranging functions and outings. The House Committee runs a shop in the home once a week and a house car to make twice weekly shopping trips to the local town.

Each individual resident retained his or her own General Practitioner.

Staff wear uniforms but these are not traditional nursing uniforms. The colours are distinct for RN, CA and domestic staff and individuals choose between wearing a dress or trousers.

### RECENT DEVELOPMENTS

The staffing in the home is generally stable and staff feel supported in the education and training they need to do their jobs. NVQ progression is strongly established and there is a CA career structure in place. At least four CAs had been selected and trained to NVQ Level III. They worked as team leaders and undertook basic clinical tasks usually performed by a RN, for example wound dressings. The RNs prescribe the care. The Senior Sisters develop additional expertise in specific clinical areas, such as wound care or continence, and act as resource nurses for the home.

### A AND B NURSING UNITS

A Unit (Green Wing and White Wing) has 22 beds plus two respite beds

B Unit (Orange Wing and Red Wing) has 23 beds

Staffing on each unit:

8 a.m. - 4 p.m. 2 RNs plus 4 CAs or 1 RN plus 1 NVQ III or 2 NVQ III plus 1 supernumary RN

4 - 8.30 p.m. 1 RN plus 3 CAs or 1 RN plus 1 NVQ III plus 2 CAs

8.30 p.m. - 8 a.m. 1 RN plus 2 CAs. An extra CA is available from 8.30 p.m. to 8 a.m. and circulated depending on where the need and dependency is greatest.

Each of the nursing wings has bedrooms along long corridors. There is a lounge area in each unit, adjacent to which is a nurses' station. The lounge on one unit is used as a dining area for the residents who needed considerable help with eating. Most residents go to the main dining area for meals.

### PHILOSOPHY AND CARE

The home aims to provide a warm and homely environment in which the residents (residential unit) and patients (nursing units) can live with dignity, enjoying as full and active a life as possible. Independence is fostered and support and encouragement allowed the individual to explore his or her own potential.

In providing the highest quality of care, the home aims to plan for, provide and continually improve an environment which gave residents the highest level of satisfaction in their daily lives according to their needs, preferences, desires and expectations.

Care in the home is based on the principles of privacy, dignity, independence, choice, rights and fulfilment.

Care plans are computerised and the home has devised its own schedule of assessment. The categories are hearing, hygiene, mobility, sight, dressing, nursing procedures (e.g. dressings, eye drops, surgical stockings), tissue viability, medications, memory, eating, speech, toileting requirements, sleep, co-operation, communication and orientation. Each category has five levels of dependency/need with the exception of nursing procedures, which has six levels. Each level carries a score. Residents are assessed in every category monthly and the scores totalled. Scores are then classed as Low, Medium, High or Very High Dependency.

During the time the researcher worked in the home, **dependency** in the four nursing wings is:

<b>Unit and Wing</b>	<b>Low</b>	<b>Medium</b>	<b>High</b>	<b>Very High</b>
A: Green	1	5	5	0
A: White	1	5	2	0
B: Orange	2	6	3	1
B: Red	0	7	4	0



## COMMUNICATION AND HANDOVERS

The RN in charge of each unit takes a handover from the night staff and would pass on key messages to the other care staff. A full handover with all staff in the unit, including those in early and late shifts, takes place during the afternoon. Details of each resident's progress are passed on and there is detailed discussion, to which all staff contributed, on how the care could be improved. Care plans are not used during the handovers.

Because the handovers are so comprehensive, the researcher recorded and noted eight handovers in the nursing units. These are analysed in order to ascertain if distinctions could be drawn between the contributions of types of staff. In other words, is the contribution of RNs distinct to that of CAs?

## DOCUMENTARY DATA

In addition to the computerised dependency scores, the home measures monthly staff to patient ratios. Audits are also taken of pressure risk, falls and accidents.

The computerised care plans are detailed but user-friendly. RNs prescribed the care and all staff could add comments on progress or evaluation. There is additional documentation for continence assessment, which is thoroughly undertaken by the RNs, following which a continence promotion regime and continence products are prescribed. Moving and handling assessments are also undertaken by the physiotherapist and a RN, following which a regime is prescribed in diagrammatic form so that it could be easily implemented by all staff.

## **APPENDIX 2.11: ADDITIONAL METHODOLOGICAL ISSUES AND ADDITIONAL JUSTIFICATION FOR THE USE OF OBSERVATION AS A METHOD WITHIN THE STUDY**

Observation was an important aspect of this study. In order to answer the research questions, the researcher needed to understand the realities of life and work in care homes from the perspectives of those who experience it day-by-day, including a broad range of the staff, residents and relatives. Observation can help to identify biases inherent in personal accounts where participants want to portray themselves in a positive way. It can also help to identify discrepancies between what people say and what they actually do.

Observation was particularly relevant in the current study in that it offered the opportunity to uncover behaviours or routines of which the participants themselves might be unaware. The literature strongly suggested that some dimensions of the work, specifically the tacit dimensions and those relevant to expert practice, are only accessible, if at all, by direct observation and facilitated reflective interview (Meerabeau 1992). In addition, observation could help to develop understanding on why the examples presented in Phase 1 of the research were so diverse, and perhaps the reasons for this (e.g. do most RNs work at a range of levels within each shift, do RNs practise in very different ways, were the differences between RNs and between CAs related to skill, motivation, life experiences, education or any factor yet unified in the study?).

Observation produces especially great rigour when combined with other methods (Adler and Adler 1998, p 89) and the importance of observation within mixed-method approaches has been emphasised by many researchers in older people's long-term care settings. For example, following their extensive work, Clark and Bowling (1990) highlighted observation as an excellent means of assessing and monitoring care in a systematic and realistic way. Observation followed by interview has been found to be particularly revealing (Clark and Bowling 1989, p 143-144, Bond, Bond, Donaldson, Gregson and Atkinson 1989a). Other authors highlight the importance of researchers spending time in care homes in order to secure the trust and confidence of both staff and residents (e.g. Lee Treweek 1994a, Redfern, Hannan, Norman and Martin 2002).



I adopted the role of 'participant as observer', one of four observational roles defined by Gold (1958) and described by various writers including Adler and Adler (1998, p 84) and Mays and Pope (1996, p 21). The defining characteristics are that all actors in the setting are aware of the research and the observation is overt. The 'participant as observer' role generally poses fewer ethical dilemmas than other roles (Mays and Pope 1996), and ethical behaviour was fundamentally important in this study. Gold's alternative categories of observational researcher roles (cited in Mays and Pope 1996, p 21) were not appropriate for this study, for the following reasons:

- 'Complete participant: covert observation' was not considered ethical for this study.
- 'Observer as participant': defined by Gold as 'essentially a one shot interview with no enduring relationship based on lengthy observation'. This would not have achieved the aims of the research.
- 'Complete observer': defined by Gold as 'experimental design, no participation'. This was not selected as the role for this current study because previous nurse researchers in care homes who have not been permitted to participate in any way in the care have experienced considerable role conflict. For example Patterson (1994) reported how her role as a researcher initially seemed clear - observation, interaction and participation, not rendering direct nursing care. Nevertheless, as the length of her time in the field increased, re-clarification of that role became a common occurrence, even though she openly identified herself and her role to everyone. She wrote: "Many times the nurse inside of me struggled not to express her opinion or thoughts about how something should be handled or done. This was particularly difficult when my opinion was requested. I did not want to distance myself from the staff but I also recognised the necessity of maintaining my role. Even so often I observed or overheard interactions between staff and residents that left me uneasy. As a nurse, the frustration at not being able to intervene was at times overwhelming" (Patterson 1994, p 1990).

Through the role of 'participant as observer', the researcher participates in the activities taking place. By becoming involved in these activities, as well as observing them, the researcher attempts to minimise her/his impact on the environment and the subjects being studied. The presence of an observer can, however, influence participant behaviour, at the most basic level in encouraging self-questioning. This so-called 'Hawthorne effect' can be minimised if researchers spend sufficient time in

the fieldwork site (Miles and Huberman 1994). The Hawthorne effect was not seen as a problem in the current study. In fact the staff in all three homes commented how the researcher "just blended in" and "everything carried on just as normal". In Home 3 the Deputy Home Manager remarked how the content of the handover reports was no different when the researcher was absent to when I was present, both tape-recording the exchanges and noting these in shorthand.

### **MINIMISING OBSERVER BIAS**

'Observer bias' is a term used widely through research literature, with a common implication that such bias (e.g. "any influence that produces a distortion in the results of a study" Polit and Hungler 1991, p 640) should be 'minimised'.

In hermeneutic studies the role of the researcher in making the data is articulated.

Section 2.2: Philosophical grounding explained the philosophical concepts and constructs within which my research was grounded, i.e.

- historical consciousness,
- understanding as historical, dialectical and linguistic,
- whole and parts
- prejudice
- distance and distanciation
- foreground and background
- fusion of horizons of meaning
- the hermeneutic circle
- text as action

and how these operated within the research.

Hans Georg Gadamer highlights that "all understanding inevitably involves some prejudice" (or, in the terms of Heidegger, one of Gadamer's teachers and widely cited in nursing literature, described this as 'a fore-structure of understanding'). What is distinct about research grounded within Gadamer's concepts is that the researcher's 'prejudices' are made explicit at the start of the work (in Section 1.1).



As a hermeneutic researcher, having identified my 'prejudices', I entered a fieldwork site. In the context of the aims for my study, I looked first at the 'whole' situation. Within this, specific issues or circumstances addressed me as important and asked me questions, such as 'why' or 'how'. In this way the 'parts' of the 'whole' are identified. Through illuminating the 'whole' and the 'parts', different 'parts' become 'foregrounded' or 'backgrounded' in my consciousness as I work in the hermeneutic circle. Through this dialogue with the data, and sometimes through 'distanciation', 'horizons of meaning' emerge and 'fusion' of these 'horizons' leads to understanding at that point in time. Understanding is always historical and through engaging further with the data, further understanding is achieved by the participants and researcher.

The diagram illustrating how understanding is achieved through the hermeneutic circle was given in figure 2.3 on page 105 and the three practical examples I offered in the concluding chapter illustrate how these concepts operated in the research and I thus made explicit 'my role in making the data' (page 409-411).

This is also addressed in the sections on Rigour, e.g. in Section 2.5 and in the methodological evaluation at the end, i.e. how I achieved rigour in the study. The criteria most relevant to participant observation are emboldened.

### **SUMMARY: HOW THE RESEARCH ACHIEVED RIGOUR OR 'GOODNESS'**

#### **Coherence, appropriateness, authenticity, agreement**

The account presents a unified 'whole' picture  
 The 'parts'; within the whole are authentic to the 'text', including the contradictions  
**The questions are those raised by the text itself**  
**The authenticity means that the account and the text are in 'agreement', i.e. the same issues and perspectives are represented in both**  
**Participants in the research, and others knowledgeable in the field, could identify with the account as authentic (i.e. there is coherence as it addresses their own 'text' and horizons of meaning).**

#### **Trustworthiness, representation, auditability**

**The research was conducted in honesty and openness with participants**  
 The account truthfully articulates the processes in the research, including the 'glitches'  
**The account clearly articulates the perspectives represented (i.e. the participants, the researcher, and both through the interpretation)**

**My own prejudices are made explicit through the research**

The stages of development and decisions influencing these are auditable

**Comprehensiveness, thoroughness, contextuality**

**The account gives a sense of the 'whole' contextual and historical nature of the 'text', including the situatedness and temporality of the participants.**

The account deals with all the questions posed

**Penetration, usefulness, application, suggestiveness, potential.**

The account attempts to address an issue of concern or "a central problematic" (Madison 1988, p 29)

The work has a usefulness or application to participants, others who work in the field, scholars or researchers

The account offers insights, questions, critical discussion and possibilities that could be illuminating for future events or stimulate further research.

In Gadamer's terms, the interpretation, offered at a point in history, understands its own tradition in which it sits. It understands in a different way to that which existed before, with questioning, reflective and authentic openness, which offers dialectic for the future.



## **APPENDIX 2.12: ADDITIONAL INFORMATION ON THE NUMBER OF PARTICIPANTS IN THE STUDY**

The number of significant examples collected in Phase 1 is given on pages 121-2. Of over 100 RNs who offered examples only 34 submitted them and, of over 50 CAs who offered, 18 were received. Reflections on this are described in the conclusions section on 'glitches' in the study and the implications for future research are discussed.

As shown on page 137, the total number of interviews achieved was 77, and there were approximately 73 observations, although these varied in length from approximately two hours to full shifts.

To identify the number invited to participate in the fieldwork is not straightforward as the participation developed through my presence in the homes. In each of the homes I issued an invitation through a notice on the staff notice board some weeks before I arrived. In each of the units in Homes 1 and 2, I began by working with the senior nurses on duty, and staff who were interested generally approached me to express their willingness to participate in the research. In Home 3 the Deputy Home Manager had identified a range of staff who were interested and had drawn up a rota. The CAs generally enjoyed the participation as they had help with their work and a chance to talk about this. The RNs generally enjoyed the participation as they found my presence supportive - another professional with whom to discuss professional issues.

The only multidisciplinary team members working in the homes were the part-time physiotherapists and each of them was happy to participate. In Home 2 there was a part-time Clinical Psychologist and GP who spent time in the home as all the residents were his patients. They both happily participated. In Home 1 the GP was in and out so quickly the residents used to joke that "he's gone before he arrives" so I did not ask him. In Home 3 each of the residents had his or her own GP so each rarely visited and it did not seem appropriate to ask them.

With the residents, I took advice from the staff on who might be happy to participate and, of all those I invited, none refused. In Home 3, residents volunteered when they heard about the research and they were the ones I interviewed. There were three residents in Homes 1 and 2 with whom I chatted about, for example, their family or their life in the home, but, as they seemed vulnerable, I did not ask them to participate in case this might cause distress.

## **APPENDIX 2.13: ADDITIONAL REFLECTIONS ON THE EXPERIENCE OF INTERVIEWING OLDER CARE HOME RESIDENTS**

The residents interviewed were from diverse backgrounds and had experienced a broad range of careers, for example as a nurse, headmaster, teacher, missionary, factory worker, gardener and many years in the Royal Navy. The conversations were also wide-ranging from one who explained that he had virtually no education to another, a retired schools inspector, who enquired about the philosophical framework for my research.

Residents in all the homes had complex needs and the interviews highlighted their vulnerability which arose from their ill-health, disabilities and dependence on others. Loss of health, abilities and independence was particularly hard for some residents.

*"I want to be independent but I try not to look ahead. I've been rather dependent on this thing [frame]. I can't go far now because of my sight. Now a lovely garden doesn't mean the same because I can only see certain colours"* (Resident 950).

*"I've had arthritis for donkey's years. Now I can't make the effort - no push to try. I can't do much but I like the television. I can't reach the knobs but it's on. I've got a thing [remote control] but it's no good because the arthritis is all over me"* (Resident 507)

Particularly traumatic for many had been the loss of their home.

*"My house is gone. The people that bought it knocked it down. They wanted something bigger. The really awful part, once I knew I couldn't look after myself, was trying to wind up 50 years of family life. Everything had to go and there was a limit to what the family wanted because they had things of their own"* (Resident 950).

Bringing their own possessions into the home helped.

*"It's nice to have your own bits and pieces and I have my own bureau and bookshelf and chair and table - that makes a difference "* (Resident 950)

*"It was difficult deciding what to bring in - all my drawers are full up"* (Resident 956).

There was a sense of resignation to being in their current situation as they emphasised there was little they could do to change this.



*"It's so frustrating not being able to do things for yourself, but I have to put up with that" (Resident 957).*

*"I'm reasonably satisfied - I can't be anything else but, because I'm here for the rest of my life - so ...!" (Resident 504)*

*[does this feel like your home?] "I've back-peddled on that and don't even think about it. I have to think 'I'm here for the rest of my life and my family's life is at peace' and that's my main concern. Their main concern is me but my main concern is not - it's them" (Resident 506).*

The residents' vulnerability and dependency was generally recognised by the RNs in their interviews.

*"This work can be sat at times but I feel it's the last good thing that we can do for these people. They're not going home. B says 'I'd rather be dead' and he says that quite often, and I really feel for him. If I thought he would do something to end his life that would be different but he just feels hopeless. Although he can't reason why he's here, he knows he's not at home doing what he likes to be doing" (IV RN 501).*

*"There is discontent with some of the residents - some who are brave enough to complain. But they're so dependent on us and it's difficult for them". (IV RN 505).*

The vulnerability of the residents identified during the fieldwork emphasises the vital importance of the ethical measures described in Section 2.3. Nevertheless they said they enjoyed participating in the research, particularly the opportunity to have a long uninterrupted chat and the thought that their views might help to enhance care for others in the future.

Interviewing the residents was an enjoyable yet humbling experience. One entry in the Research Journal read:

*"I feel privileged that these people have taken me into their lives and given me insight into what it is like to be in their situation. I am buoyed onward to complete my study in the home by the hope that the findings will make a positive impact on the way in which care is provided in nursing home settings"*

## **APPENDIX 3.1: THE FOCUS OF THE CAs' SIGNIFICANT EXAMPLES**

The significant examples submitted by the CAs for Phase 1 of the research focused on the following topics. These are arranged into themes.

### **CAs BUILDING RELATIONSHIPS WITH RESIDENTS**

Building a relationship with a resident who had been "aggressive", "wouldn't talk to anybody" and told people to leave her alone. Resident will now talk and joke with staff (1.1).

Built relationship with resident who was "very aggressive", "tearful and confused" and would "bash out the fists". Is now more gentle, interacts with other residents and staff. His grandchildren visit more often now (1.2).

Bringing a smile, laughing, joking and singing, particularly to one resident who becomes sad and cries. Resident always asks for CA and tells her relatives [she's] "kind and strong and understands me" (2.3).

Trying to cheer up residents, talking to them, using activity books and cards. Life is a little better for them and they know that someone cares (2.4)

A resident was ringing the bell for help "for nothing in particular ... every five minutes". CA felt she needed reassurance and built relationship with her. Resident now feels "safe and secure ... liked and loved" and no longer rings frequently for help (8.3).

CA escorted resident with dementia, for whom she was keyworker, and his wife to hospital for investigation of a sore on his mouth. The sore was diagnosed as cancer needing urgent removal but resulting in disfigurement and difficulty in eating. CA supported throughout and resident and wife expressed gratitude. CA felt that, without her support, the resident may not have consented to treatment (10.2). Resident's health had deteriorated and he was nursed in bed on a pressure mattress. CA reported that he was frequently aggressive when CAs tried to wash him. CA learned how to approach him, to gain his confidence, to be "pleasant and patient", to "sit and talk to him" and to respond to his expressions. CAs are able to wash and shave resident (102.1).

Resident had been "abusive and bitter". CA felt this was due to his incontinence and encouraged him to wear an incontinence pad. Resident is now "happier and calmer about life" (104.2)\*\*\*

CA described how team worked with resident over time. Resident was very ill when admitted, not eating, drinking heavily, incontinent of urine and wanting to stay in bed. Through gradual support and input, the resident was going to live at home with a social care package (105.4)

When resident came to live in the home she was very unhappy, refused to get up, eat or drink. Resident would not mix with others and would "shout and scream" at care staff attending her. Was "sectioned" to "psychiatric ward" for six weeks. On return to the home staff set a programme of goals and resident's



health improved such that she was able to visit her sister, a personal goal for her (105.5)

### CAs NOTICING A CHANGE IN A RESIDENT

CA discovered that, after catheter removal, a resident was losing blood. Called the nurse and stayed with him on his transfer to hospital. Resident survived. Had the CA not noticed his change in condition and sought help, the CA believed he would have died (8.1).

CA noticed that resident with cancer, to whom CA is "very close", did not seem well and did not seem to be sleeping well. Resident had told CA that if she could not walk she would "lose the fight to live". CA asked RN to assess and Dr was called. Pain relief was increased and resident was able to walk again (100.2).

CA noticed that resident seemed unwell and was coughing. Reported to RN and monitored resident's condition. Decided that a cold was developing and resident was kept in bed and given medications. Resident recovered by then CA noticed she was not walking as before. The team decided she was not getting sufficient exercise and "the girls" walked resident, with her agreement, more frequently. Resident did not contract chest infection and her mobility improved (100.3).

### CARE AROUND DEATH

CA became particularly close to a resident and they frequently spent time "chatting". When resident was dying, CA took pride in the good care that was given. CA was not on duty when resident died but resident was asking for her. Some years later, CA still remembered resident with great fondness and shed "a little tear" (102.4).

CA knew that dying resident wanted her family to be with her when she died. One day, because the CA knew the resident so well, CA felt she was deteriorating, called RN and called in family. Resident died early the following morning "with dignity and her family around her as they all had wished" (200.2)

### OTHER EXAMPLES

A newly-admitted resident with 'confusion and disorientation' was urinating in "inappropriate places". CA frequently showed him the layout of the unit and eventually he could remember some areas. Ultimately, with prompting, he was able to use the toilet and no longer incontinent. The resident's embarrassment was reduced, comfort increased. The relatives were "less stressed" and staff had a sense of achievement (10.3)

Staff took residents on a trip to Buckingham Palace shortly after the death of Diana Princess of Wales. Residents gained enjoyment and had enjoyed talking about this among themselves and to their relatives (2.1).

CA applied makeup on residents. Residents felt more confident, enjoyed being pampered and the opportunity to talk (2.2)

\*\*\* dubious claims and dubious practice?

## **APPENDIX 3.2: COMPARISON BETWEEN THE CAs IN THE THREE HOMES: OBSERVATIONS AND INTERVIEWS**

The main themes held strongly throughout the data sets. There were, however, some distinctions between the homes. Because the themes were strong, these distinctions did not alter the overall results but they do demonstrate how the themes emerged.

Themes are listed with the strongest first and the least strong last.

Detail within the themes is given after this table.

### **OBSERVATIONS**

<b><u>HOME 1</u></b>	<b><u>HOME 2</u></b>	<b><u>HOME 3</u></b>
The challenging nature of the work	Enjoyment of working with residents	Enjoyment of working with residents and within the team
Working closely with residents and knowing them well	Working closely with residents and knowing them well	Working closely with residents and getting to know them over the course of time
Enjoying working with residents and other CAs	The challenging nature of the work	The potentially challenging nature of the work
Family concepts	Family concepts	Family concepts

#### **The challenging nature of the work**

- The work could be physically and emotionally tiring (particularly in Home 1)
- Residents were highly diverse and their needs complex (particularly in Homes 1 and 2). Residents in Home 3, which had selection criteria, were generally discerning, which presented different types of challenges.
- Residents not uncommonly spoke abruptly, complained, were abusive or demonstrated behaviour which was potentially challenging for staff (particularly in Homes 1 and 2)
- Bodywork, dealing with bodily functioning and sexuality expression were commonly-encountered issues, including bodily exposure, intimate touch and embarrassment, dealing with bodily fluids and excreta and expression of sexuality or sexual need
- Equipment was unavailable or unsuitable (often in Home 1, occasionally in Homes 2 and 3).

#### **Working closely with residents and knowing them well**

- Residents were totally reliant on CAs for help and to report problems or changes
- CAs learned to understand residents as individuals
- Most CAs formed close relationships with residents (Homes 1 and 2 particularly)
- Through knowing the residents, CAs knew how to bring out the more positive aspects of the residents (Homes 1 and 2 particularly)
- The CAs used humour with the residents, with each other and to 'let off steam', in all homes.



Enjoyment of working with residents

- Enjoyment of spending time with residents (Homes 1 and 2 particularly)
- Fulfilment in helping residents (Homes 1 and 2 particularly)

Enjoyment of working with residents and within the team (particularly in Home 3)

- Enjoyment of working within the strong team structure
- Fulfilment and satisfaction in giving good care to residents

Family concepts

- The CAs did not treat the residents as children but, in comments made during the observations, commonly conceptually linked their caring work with family caring roles.

The residents in Homes 1 and 2 had particularly complex needs. Home 3 had the strongest team structure.

INTERVIEWS

<u>HOME 1</u>	<u>HOME 2</u>	<u>HOME 3</u>
Liking older people, enjoying being with them	Liking older people, enjoying being with them	Liking older people, enjoying being with them
Caring about residents and working hard to help them	Caring about residents and enjoying helping them	Caring about residents and doing their best to help
Closeness to the residents	Closeness to the residents	Closeness to the residents
Humour and reciprocity	Humour and reciprocity	Humour and reciprocity
Family concepts	Family concepts	Family concepts

Liking older people and enjoying being with them

- The CAs talked about how they liked older people, liked the residents and enjoyed being with them

Caring about the residents

- The CAs cared about, and showed concern for, the residents
- The CAs persevered in caring for the residents even in difficult situations

Closeness to the residents

- The CAs knew the residents well and formed close relationships with them (the closest relationships were formed in Homes 1 and 2)
- There was reciprocity in the relationships between CAs and residents in all homes
- Humour was a strong feature of the working all homes
- The CAs would pick up when things were wrong with the residents because they knew them so well

Family concepts (particularly in Homes 1 and 2)

- The majority of CAs conceptualised their work in terms of their own family caring roles
- Some CAs saw the residents as extended family and themselves as extended family to the residents
- Most CAs formed close relationships with residents' families

## **APPENDIX 3.3: SUMMARY OF INPUTS TO CA WORK IDENTIFIED IN ALL DATASETS**

The following sections summarise the inputs identified by the CAs in all the datasets and the participants' own words are reproduced here. The additional inputs identified in the observation sessions are discussed in Section 3.2.

### **PERSONAL VALUES, BELIEFS, QUALITIES**

"Just the way I am"  
 "Just common sense"  
 Valuing people, valuing older people, valuing the residents  
 Liking people, particularly older people and specifically the residents  
 Caring about people, older people and the residents  
 Wanting to help people, older people and the residents  
 The belief that the residents deserved the best care possible  
 Instinct, intuition or 'gut feeling'.

### **PERSONAL AND WORK EXPERIENCES**

Difficult experiences in their lives  
 Experiences as a family carer  
 Experiences of being with, relating to and working with people, for example in previous posts  
 Experiences as a care assistant

### **KNOWLEDGE AND SKILLS**

Knowledge of residents as individuals through getting to know them, working closely and intimately with them  
 Knowledge to deliver care  
 Knowledge varied between individuals  
 Personal communication skills  
 Skills in working with and caring for people  
 Skills to gain trust and confidence  
 Interpersonal skills in delivering care  
 Intrapersonal skills  
 Practical skills in delivering care  
 Skills used in their work seemed to be undervalued by CAs or taken-for-granted  
 Education and training were generally not highly valued

### **MOTIVATION AND COMMITMENT**

Motivation and commitment to look after the residents and make their lives better  
 Motivation and commitment to doing a good job  
 Motivation from the enjoyment they gained from doing their work  
 Motivation from the job satisfaction they felt  
 Motivation from working in a good team



## **APPENDIX 3.4: CA JOB DESCRIPTIONS**

### **AN AMALGAMATION OF THE JOB DESCRIPTIONS FOR CAs IN THE THREE FIELDWORK NURSING HOMES**

**Providing practical care and assistance to residents in their daily lives: helping with dressing, undressing, bathing and toilet.**

**Promote the well-being and quality of life of residents, respecting their independence and right of choice**

**Monitor resident health and welfare and report any significant matter**

Helping residents with mobility problems and other physical disabilities such as incontinence; help in the use and care of aids and personal equipment

Provide emergency procedures appropriate to residents

Help in the promotion of mental and physical activity of residents through talking to them, taking them out and sharing with them in activities such as reading, writing, hobbies and recreations

Ensure the whereabouts of all residents is known.

Inspect residents' clothing and make arrangements for laundry and mending

Serve meals, assist residents at mealtimes if required, wash up utensils

Answer emergency bells, the door, the telephone, greet visitors

Read and write reports in case notes

Take part in staff meetings and training activities

Report any faults with the services to the buildings and any repairs needed to fixtures and fittings

Ensure that the security of the buildings and their contents is maintained

Ensure safe working practices are followed and any deficiencies are reported

Any other reasonable duties as may be required from time to time by the matron.

#### **Keyworkers, or Key Carers had additional responsibilities such as:**

Monthly weights

Labelling residents' clothes

Ensuring resident had required supplies of soap etc.

Tidying of drawers and wardrobes

Cutting of fingernails, checking toenails, removing facial hair

## **APPENDIX 4.1: THE FOCUS OF THE RNS' SIGNIFICANT EXAMPLES**

The significant examples submitted by the RNs for Phase 1 of the research focused on the following topics. These are arranged into themes.

### **'TOTAL CARE' SITUATIONS: IMPLEMENTING ORGANISATIONAL CHANGE IN THE HOME AND IMPROVING THE HEALTH AND WELLBEING OF A GROUP OF RESIDENTS OVER TIME**

RN described the changes made on taking over a unit. Before intervention all residents stayed in bedrooms; there was no music and no activities; concentration and mental activity was dulled by drugs; relatives were complaining of residents deterioration. RN brought residents out of the room, reduced the drugs, tried to build relationships and understand them, encouraged activities, watching television, conversation. The residents "are like different people now". (1.3c) \*

RN took up a new post in a unit where CAs were working on a "conveyor belt" system, everyone received the same approach and little time was spent on interaction with residents. Staff sickness rates were high. RN described how she changed the care in the unit by educating the staff, getting to know the residents, ensuring they had choice and changing working patterns.

The RN described the changes in four different residents, including:

- Better rapport between residents and staff, reduced aggression, greater acceptance of help and more singing and laughing. (9.1a) \*
- A resident who showed greater interest in life and especially in maintaining the houseplants. (9.1b) \*
- A resident with hearing impairment. Once her hearing had been assessed and her care improved, staff realised that she had been suffering from depression not dementia. Resident is now happy and appreciative of the home. (9.1c) \*
- One resident who spent all day slumped in the chair, being fed, changed and lifted. With improved care she became alert and mobile. (9.1d) \*

RN described in great detail her actions following taking over the ownership and management of a nursing home including changing institutionalised approach, offering greater choice, empowerment, stimulation, motivation to residents in terms of care and daily activity, reducing withdrawal, depression and dependency. Outcomes were supported by evidence such as improved staff retention and recruitment, positive feedback on staff appraisal, positive feedback from residents and relatives at quality reviews, improved care plans as identified on audit, increased occupancy levels, improved inspection reports and successful rehabilitation of residents including one discharge back to the community when all staff had been prepared for her to spend the rest of her life in a nursing home. (101.1) \*

After over six years as Senior Sister in a nursing home, the RN took leadership responsibility for a project to develop training and improve skill mix. The RN describes in detail how this improved quality of care, reduced complaints from residents and staff and resulted in evidence-based rather than ritualistic care.



Improvements were to be identified in individual staff performance reviews, a relatives questionnaire, complaints records and various audits. (103.1) \*

#### 'TOTAL CARE' SITUATIONS: DAY-TO-DAY MANAGEMENT OF THE HOME

RN described how, one morning, for 38 very frail residents, the only staff were two RNs (one only two days in the post), 1 full-time CA and two agencies. RN described how she prioritised, engendered team spirit, praised and encouraged staff and reassured residents. Disaster averted. (268)

RN described the challenges in managing a community of people with mental health needs and the staff. She described how she sometimes knows when things are not right in the home even when in the office doing paperwork. She emphasised the importance of reading body language, of listening to everyone's point of view and skilful management of episodes where residents are aggressive. (100b)

Two residents struck up a relationship and, because they had mental health needs, this was ethically complex to manage. Some staff felt the relationship to be inappropriate and said that the couple should be separated. RN described how she managed the situation "who am I to stop a relationship developing ... all I can do is ensure that both the parties are comfortable with it ... it's very much a balance of what everyone is wanting. (100c)

#### TOTAL CARE OF A RESIDENT AND FAMILY OVER TIME

A resident spent all day in her room, not communicating, living on Ensure at risk of pressure area damage and mental deterioration. RN "got to know her better", got to know her background, made an audiology appointment, improved her diet, gradually encouraged her to mix. Resident now enjoys life, is able to hear and make conversation, is more outgoing, enjoys reading, is more continent, is no longer aggressive, is able to express herself and has some quality of life. (1.3a). \*

RN noticed that a resident, who was usually "unhappy, frustrated and aggressive", filled in the last word when the RN sang (although she said she could not sing well). Staff and resident's brother brought in music. Resident is now less aggressive and "more content in her world". (100.1) \*\*

RN realised that a resident's pressure sore was not healing and instituted care regimes including teaching CAs, more frequent position change, improved moving and handling, continence care, infection prevention, improving fluids and dietary intake. Sore healed completely within four weeks. (101.2)

RN describes how she saw the potential for rehabilitation in a resident admitted, "unable to do anything for herself" following a stroke. The care given and progress made is described in detail. RN hoped her example would demonstrate that, if staff see beyond older people coming into nursing homes to be "looked after", there is potential for them to enjoy their lives. The resident described now lives at home with her family "contributing to everyday life instead of being looked after". (101.3)

A resident was admitted to the home from hospital following a fall and in very poor health, including a range of illnesses, long-standing leg ulcers and chronic sensitivity



to various treatments. She had been labelled as unco-operative. Following a regime of getting to know the resident, trying to understand her situation and wishes, improving pain control, consulting the leg ulcer specialist, achieving appropriate treatment, physiotherapy and helping her to gain confidence in mobilising, the resident's health and wellbeing have improved and the family are very happy to "have their mum back". (102.2)

RN described the care of a devoted husband (with Parkinson's Disease) and wife (with dementia) over the course of some years including helping them to maintain maximum independence, their way of life and their intimacy. This included dealing with abuse within the relationship, an episode of choking, resuscitation, the death of the wife and support of the husband until his death. (105.1)

RN described the care of a resident with late term Parkinson's Disease and his wife over 18 months until his death, particularly how she helped him to maintain maximum dignity, health, independence and enjoyment of life, for example by staff reading to him and watching films on aeroplanes. (105.2)

#### NOTICING A PROBLEM AND TAKING REMEDIAL ACTION

On first meeting with a resident the RN noticed a "funny smell" about a man and realised that his pressure sore was "really bad". Called the sister from the other unit and then the doctor. Resident was treated but died two weeks later. Without RN intervention resident would have died more quickly and in more pain (1.3b) \*

RN put "cot sides" on resident so that she could hear when the resident was trying to get up during the night. (2.5) \*\*

RN described how the health of a resident newly-admitted to the home suddenly deteriorated. He was admitted to hospital and returned in poor health and with a pressure sore. RN described in detail the care given and his health improved. One day the RN noticed his abdomen was distended, took remedial action which involved considerable negotiation with other professionals, including the GP who wanted to send the man to hospital to be catheterised and the district nurse who was reluctant to catheterise. Example also demonstrates how the RN worked with the next of kin and avoided what could have become a very difficult situation. (261)

CA reported to RN that a resident was having a stroke. RN recognised that it was an arterial embolus, resident was taken to hospital, underwent immediate embolectomy and fully recovered. Had RN not taken this action the resident could have lost a limb or died in pain (262).

A resident had a stroke and was taken to hospital. She returned to the care home for terminal care with a diagnosis of septicaemia and a morphine pump. The RN and team gave "total care" but the situation did not make sense to the RN ("morphine for septicaemia?"). She sought advice from GP who was reluctant to challenge diagnosis so RN encouraged next of kin to seek a second medical opinion. Consultant agreed with RN. Resident gradually weaned off morphine, given "total care" and "came back from the brink". "Two years later she is still alive and looking forward to her 93<sup>rd</sup> birthday on Sunday". (263)



RN noticed that resident had cancelled his daily paper and went to ask him way. (The CA had concluded the resident was being "grumpy"). Resident explained that his sight had deteriorated. The RN obtained medical assessment and detached retina was diagnosed. (264)

RN noticed that a resident began to "wander". She observed and realised that, on recent redecoration, the door next to the resident's usual chair had been re-hung and this had changed the view from the chair. The resident was sitting in the chair but becoming disorientated and getting up again. Support was given and the resident has now settled. (265)

A night duty RN reported that a resident had not been well and, when the day duty RN investigated, she found the resident in heart failure. She rang the doctor immediately, requesting that he bring the emergency box and intravenous diuretics. The RN requested oxygen in the home but the GP would not prescribe. The RN gave "total care", periodically requesting that the doctor visit to give intravenous diuretics and antibiotics. The doctor refused to be called again so the RN sought another doctor who came to prescribe. The resident "has made a full recovery" but RN claimed that, without her intervention, the resident "would have died". (266) \*

CAs reported to RN that they thought a resident needed an enema. RN assessed and thought resident was in urinary retention, probably with urinary tract infection. RN called GP and set up catheterisation equipment. GP visited and ordered catheterisation and antibiotics. Resident recovered. (4.1).

RN described how she sought advice from a Continence Advisor and, following the fitting of a urinary surgical appliance, a resident's pride and independence was restored. He was subsequently able to live his life more normally and to spend what turned out to be his last Christmas at home with his family. (104.1)

RN noticed that a resident had abdominal distension, informed the GP, catheterised the resident and urinary retention was relieved. The CA working with the RN had not noticed the problem. (106.1)

### DEATH, PALLIATIVE CARE, PAIN CONTROL AND SUPPORTING THE RESIDENT AND FAMILY

RN assessed that resident's self-administered pain relief for carcinoma was not effective as resident tended to forget what she had taken. She talked with the resident, sought palliative care advice from local hospice and RNs delivered analgesia to good effect. Distressing side-effects were also reduced. (8.2)

RN (EN) described how she worked with a resident unable to care for herself from admission to the home until death including reassurance, keeping her safe while trying to help her to be independent particularly in walking, physical care, enjoyment of some activities and caring for her family. The EN emphasised that, because she was able to recognise change in the resident, she was able to obtain appropriate care and palliation. (102.3)

RN on night duty described the care given to a resident from the time of admission with a brain tumour until her death. Particular care was given to pain control,

positioning for comfort and pressure relief, psychological support and the care and support of her daughter. (105.3)

RN described the care of a resident with a range of complex problems from his admission until his death. Care included promoting his functioning, comfort and personal care and particularly ensuring that his major wish, not to die alone, was realised. (107.1)

Two residents with advanced dementia had become particularly close and, when one died, the other was constantly searching for her. The RN explained gently to the resident that her friend had been ill and had passed away and the resident said "I knew it". The RN asked if she would like to see her friend and the resident said "yes". On seeing the body of her friend the resident tucked her in, stroked her face and said "gone to sleep now". Although the resident still asked for her friend the staff were able to remind her that she had passed on and the resident accepted this. Without seeing the body, staff felt she would have continued to search for her friend (700)

\* Example refers to inadequate care given previously or in other units.

\*\* Example includes questionable practice.



## **APPENDIX 4.2: COMPARISON BETWEEN THE RNs IN THE THREE HOMES: OBSERVATIONS AND INTERVIEWS**

The main themes held strongly throughout the data sets. There were, however, some distinctions between the homes. Because the themes were strong, these distinctions did not alter the overall results but they do demonstrate how the themes emerged.

Themes are listed with the strongest first and the least strong last.

Detail within the themes is given after this table.

### **OBSERVATIONS**

<b><u>HOME 1</u></b>	<b><u>HOME 2</u></b>	<b><u>HOME 3</u></b>
Responsibility and accountability	Promoting person-centred care; Knowing the residents well	Leadership, teamwork, responsibility and accountability, community-building
Having to balance priorities	Normal life / quality of life focus to the work	Complexity of residents' needs
Complexity of residents' physical and mental health needs	Leadership, responsibility and accountability, community-building and teamwork	Comprehensive care
Considerable challenges in the work	Complexity of residents' physical and mental health needs	Challenges in the work
Staffing challenges	Comprehensive care	Knowing the residents well
The variations among RNs	Challenges in balancing priorities	Emergencies, challenging episodes, dilemmas
Knowing the residents well	Challenges in the work	
Emergencies, challenging episodes, dilemmas	Staffing challenges	
	Emergencies, challenging episodes, dilemmas	

#### **Leadership, responsibility and accountability**

- Nursing homes are nurse-led units; the RN determines, and often has responsibility for, everything that goes on in the home
- The work is professionally isolated (the support of other nurses, doctors and other professionals is not readily available)
- There are added dimensions to the nursing home RN's role compared with NHS RN roles
- RNs have responsibility for supervising a largely untrained workforce
- The RN had responsibility and accountability for continuing monitoring and assessment
- RNs are decision-makers and problem-solvers

Teamwork (particularly in Home 3)

- Teamwork was a key to effective working; RNs lead teams
- With strong systems, quality became intrinsic to the care

Community-building (particularly in Homes 2 and 3)

- RNs could lead in building communities between residents, between staff and between residents and staff.

The enormous responsibility and accountability of RNs for everything that went on in the homes was particularly apparent in Home 1. Home 2 had a more coherent leadership and supervision structure which took some of the responsibility away from RNs working 'on the floor'. Home 3 had a strong leadership and teamwork structure.

Promoting person-centred care (Home 2)

- Knowing residents well
- Genuine respect for residents
- Resident freedom and choice
- Resident self-expression
- Resident power

Normal life / quality of life focus to the work (Home 2).

Home 2 had a strong homely, 'normal life' and person-centred focus to the environment and the care. Residents with dementia walked freely throughout the home and the emphasis was on their wellbeing, choice and self-expression. This was not apparent in the other homes, even the dementia units in Home 1.

Knowing residents well (all Homes)

- Understanding them as individuals
- Understanding their health and clinical needs
- Ability to prioritise through knowing the residents well
- Ability to recognise change through knowing them well
- Advocating for residents, particularly with GP, because they know residents well
- Working with residents' families, whom they also get to know well

Complexity of residents' needs

- Advanced age
- Varied needs
- Residents who are ill or disabled
- Combination of needs in each resident, most residents' were complex
- Residents had a high dependency on others for help
- Residents' health was often unstable and unpredictable
- Constant and ongoing assessment was needed
- Assessment was complicated
- Goal planning was complex
- Staff needed to understand the perspectives of different generations
- Residents with mental health needs as well as physical needs were particularly complex and required highly-skilled care (There were residents with a range of mental health needs in Homes 1 and 2).



### Comprehensive care

Integral to the work is consideration of:

- Risk, risk assessment and risk management
- Therapeutic approaches
- Health maintenance and health promotion
- Rehabilitation / re-enablement

### Challenges in the work (particularly in Home 1)

- The work can be physically and mentally demanding
- There are frequently inadequate support systems
- There is usually pressure of time
- Balancing priorities (residents, relatives and staff, how time and resources should be used etc)
- Multi-level, multi-faceted working
- Constant interruptions
- There is often an ever-present risk of 'challenging behaviour' or abuse
- Working towards goals in various time-frames
- Making any impact in the long-term presents challenges

### Particular challenges in Home 3:

- Meeting resident expectations for lifestyle and health improvement (i.e. residents had high expectations)
- Maintaining residents' lifestyles before entering the home
- Meeting resident expectations for level and availability of services
- Staff were not always treated with respect by the residents

### Staffing challenges

- Staff shortages, absence and sickness (particularly acute in Home 1)
- Bank and agency staff (particularly Home 1 and, to a small extent, Home 2)
- Variable quality of staff (particularly in Home 1; not really an issue in Home 3 because of engrained hierarchy and tightness of teamwork)

Variability among RNs (particularly in Home 1 where some RNs offered an exceptionally high standard of care while others offered substandard and inadequate care)

- Variation in approach and ways of working
- Variation in knowledge-base
- Variation in care focus and priorities in RN role

Emergencies, challenging episodes and dilemmas featured constantly throughout the RN observations in all homes.

**INTERVIEWS**

<b><u>HOME 1</u></b>	<b><u>HOME 2</u></b>	<b><u>HOME 3</u></b>
Commitment to their work and the residents	Commitment to their work and the residents	Commitment to their work and the residents; recognition of specific client group needs
Undervaluing the knowledge and skills they use in their work	Complex needs of residents and relatives	The home as a close community
Variations among RNs	Undervaluing the knowledge and skills they use in their work	Undervaluing the knowledge and skills they use in their work
Challenges in the role	Variations among RNs	Humour and 'fun'
Complex needs of residents and relatives	Home as a close community	Teaching and supervising
Care delivery is not straightforward	Family concepts in the work	Family concepts in the work
Striking balances	Challenges in the role	"Better than the NHS"
Working with untrained staff	Striking balances	Challenges in the work
"Better than the NHS"	Working with untrained staff	Specific challenges at night
Specific challenges at night	Care delivery is not straightforward	
	Specific challenges at night	

**Commitment to their work and the residents** (in all Homes)

- Liking older people and the residents
- Getting to know the residents as individuals
- Commitment to giving good care
- Commitment to creating a good home for residents

**Variations among RNs** (particularly in Home 1)

- Different approaches to the work
- Different priorities in the work
- Different styles of leadership

**Challenges in the role** (Home 1)

- Responsibility and accountability, particularly for resident care
- Responsibility on the nursing team to maintain continuity in the context of staff shortages and often inadequate staff
- Added dimensions to the role, compared to hospital settings, with inadequate facilities (rooms), equipment not suitable or broken (lift, bed, hoist) or supplies not available (infection control measures, linen, refuse bags)
- The responsibility to make recommendations to other professionals
- Working with an untrained workforce
- The professional isolation



- Inadequate time
- Making decisions on priorities (e.g. who receives care)
- Working with a diversity of residents with complex needs
- Working with people who are vulnerable
- The challenges of not being able to see immediate results from the work

#### Challenges in the role (Home 2)

- Responsibility for everything on most, except morning, shifts (building, roof, washing machine, administration, fire)
- Total responsibility for the care and wellbeing of residents and staff throughout the building
- Total clinical responsibility (particularly as doctors not easily available)

#### Challenges in the role (Home 3)

- Achieving balances and making compromises (resident expectations with realities of what could be provided; resident choices with what might be in their 'best interests' health-wise)
- High need for nursing care
- Responsibility and accountability; total responsibility during evening and night shifts
- Professional isolation
- Negative views of nursing home work
- Nursing home work nursing as second-class
- Added dimensions to nursing home work

#### Working in a close community (Home 2)

- Diverse and potentially conflicting needs of residents (the rights of residents with mental health needs to walk throughout the home versus the rights of residents with physical disabilities to live without intrusion)
- Working in a home where the environment is planned as a home and staff are guests, then staff do not get along with each other.

#### Complex needs of residents and relatives

- As above, and particularly those with communication difficulties or 'challenging behaviour'

#### Undervaluing the skills they use in their work

- Virtually all RNs tended to see their skills and knowledge as "just part of the job"
- When asked to list their skills and knowledge, the lists were short
- When given the opportunity to reflect on the skills they had used during the observations most admitted that they tend to undervalue their expertise

#### Family concepts in the work

- The home seen as a family
- Residents seen as extended family
- Own family members came into the home to visit residents (grandparents, partners, children)

#### Striking balances

- Between open, informal cultures and maintaining order
- Supporting residents but not controlling them
- Balances between what different residents wanted

Care was not straightforward

- "You can't work to the book", largely because residents' individual needs were so complex
- RNs were required to find innovative ways of dealing with problems

Working with untrained staff

- And training them in caring skills
- Training them in the complex needs of residents
- Acting as a role model for untrained staff
- Agency staff
- Male staff (particularly in Home 2)
- Staffing levels (particularly in Home 1)

Specific challenges at night

- Emergencies occur, particularly people becoming ill or falling
- Things can seem worse or become exaggerated
- Environmental issues need careful consideration (e.g. lighting levels for different residents, locked doors to balance safety/security with freedom to move around, fire doors)

Humour and 'fun' (Home 3)

- The RNs referred to the humour and fun they share with residents, and the residents agreed with this.
- This became an issue probably because the period of fieldwork preceded Christmas and both staff and residents were making detailed preparations for their celebrations.

Teaching and supervising (Home 3)

- This was seen as a key aspect of the role of the RNs in Home 3, less so in the other two homes.
- Home 3 had a strong hierarchy of teaching and supervision from the Matron/Manager, Deputy Matron through the RNs to the CAs.

"Better than the NHS"

- Despite the challenges, RNs felt there were more resources in the independent, and particularly charitable, sector and it was easier to obtain resources through fund-raising
- Care for older people can be better than the NHS
- Nursing home nurses have their own skills and areas of expertise



## **APPENDIX 4.3: SUMMARY OF INPUTS TO RN WORK IDENTIFIED IN ALL DATASETS**

The following sections summarise the inputs identified by the RNs in all the datasets and the participants' own words are reproduced here. The additional inputs identified in the observation sessions are discussed in Section 4.2.

### **LEADERSHIP AND MANAGEMENT: KNOWLEDGE, SKILLS AND EXPERIENCES**

#### **RUNNING THE HOME**

Maintaining the overall picture  
 Overseeing all functions of the home - the home as a home and the home as a business  
 Attending to the diversity of needs and priorities within the home - the residents, staff and relatives, how they are interacting  
 Promoting a positive atmosphere - calm and cheerful, picking up the vibes  
 The importance of an air of normality in residents' lives and needs  
 Maintaining good relationships throughout, communicating well throughout the home  
 Reassuring  
 Prioritising  
 Managing crises  
 Leading, organising, co-ordinating and overseeing all care  
 Maintaining high quality care  
 Recognising institutionalised care and its effect on residents and staff  
 How to review literature to ascertain evidence-base for care  
 Quality assurance and audit requirements  
 Understanding, and working within, legislative, professional and ethical guidelines  
 Forming policies, procedures and protocols  
 Budget management

#### **LEADING, SUPERVISING AND WORKING WITH STAFF**

Leading, directing, encouraging and motivating all staff  
 Knowing how to build on self esteem praise, be positive and communicative.  
 Knowing how to support all care from auxiliary and qualified staff  
 Supervising, teaching and developing staff.  
 Understanding the importance of team spirit, a united approach.  
 Working as part of a team  
 Being an example to other staff  
 Good communication  
 Personal staff management  
 Organising staff and teams, an organised approach  
 Facilitative skills in setting up groups, working parties  
 Awareness of the effectiveness of staff having ownership  
 Teaching skills and passing on information to carers  
 Being able to teach all care, including physiotherapy techniques, taking into account particular needs of client group  
 Education - of carers in all aspects of care, e.g. pressure area prevention  
 Training skills

**INTERPROFESSIONAL WORKING**

Understanding of where and when to seek outside assistance, what services are available and how to obtain them

Understanding funding regulations/arrangements

Engaging and working with other professions

Motivating other professionals, particularly GPs

Dealing with other professionals, particularly medical personnel, in a professional manner

Advocacy: speaking for residents to obtain the treatment and care they need.

**CLINICAL CARE AND MANAGEMENT****CLINICAL, NURSING-RELATED KNOWLEDGE**

Grounding in anatomy and physiology

Knowledge underpinning all clinical work, e.g. medicines, dressings

Preventing and recognising deterioration (such as pressure area breakdown).

'Medical' knowledge - differential diagnoses, clinical features of illness and the likely consequences e.g. in stroke, Parkinsons' Disease

Treatments and interventions, particularly what is urgent, what needs to be referred to GP, telling GP what to bring (e.g. intravenous diuretics)

The progress of diseases and likely outcomes

Drugs, effects and side effects, drug interactions

Types of pain and the drugs most suitable

Types of aperients and those most suitable

The use of diagnostic tests and tools

Clinical issues identified using a quality impact analysis tools

**CLINICAL SKILLS**

All nursing and clinical skills, techniques and procedures, e.g. to promote and maintain pain relief and to provide support to leg ulcer nurse and practice correct procedures

Taking observations, pulse, temperature etc.

Using all equipment, including mobility equipment

Giving medicines by different routes

Manual handling

Techniques to carry out physiotherapy exercises and assist in mobilising as instructed by physiotherapist

Giving prescribed medication, giving intramuscular injection, resiting butterfly needles

Redressing wounds and aseptic techniques, e.g. setting up the aseptic trolley with correct equipment for catheterisation

Infection control procedures, e.g. barrier nursing, MRSA protection and management

Particular specialities developed, including:

Taking blood samples

Sub-cutaneous infusions

PEG feeding



Skills in reminiscence therapy, e.g. using the photographs, videos and working with residents reactions, e.g. distress  
 Music and movement, art therapy  
 Palliative care knowledge and skills, e.g. use of syringe driver  
 Knowledge and skills from working in other specialties, e.g. ophthalmology  
 Rehabilitation, e.g. assessing who will benefit from rehabilitation input, using rehabilitation equipment  
 Makaton communication

**ASSESSING, PLANNING, DELIVERING AND EVALUATING CARE**

**Assessment**

Assessment of physical, psychological, social, emotional, spiritual dimensions of resident's lives

Assessing for total care

Assessment of 'medical' needs

Personal needs

Family concerns

What resident liked to eat and drink and not

How far resident could walk

Assessing change - noticing the difference in someone

Assessment skills to recognise what someone is feeling

Assessing when to help and when to leave them to help themselves or each other

Assessment of total health and social care

**Observation**

Observation to detect need or change

Observation of illness and for signs of deterioration

Examining the person for unusual signs, e.g. distended abdomen

**Planning care**

Care planning, assessment and goal setting

Reporting and documenting

Organising staff to deliver care

**Care implementation and evaluation**

Care implementation

Achieving a balance in care implementation between 'doing for' and helping resident to do as much as she can for herself

Organisation skills to assure staff follow care plans

How to evaluate progress and whether goals of care have been met

**CLINICAL EXPERIENCES**

**Experience in leadership roles**

Managing clinical areas, managing patient care, managing challenging situations

Negative experiences of staff shortages as well as more positive experiences

Knowing leadership role so well

**Specific clinical situations:**

Experience of a wide variety of clinical situations to recognise what is happening and take action, e.g. experience of patients having strokes in nursing homes, nursing strokes in acute hospitals, following up at home.

Years of experience nursing older people to understand how they and their family could be feeling

## PERSONAL SKILLS, KNOWLEDGE, EXPERIENCES AND QUALITIES

### PERSONAL KNOWLEDGE

Not to make assumptions but look at signs and look beyond the obvious  
 The importance of focusing on the positive  
 Knowledge of human behaviour  
 Self-awareness - a person who is aware of oneself is usually sensitive to the needs of others  
 The importance of focusing on the positive  
 Knowledge of human behaviour to be more emphatic  
 Knowledge of coping with difficult and upsetting situations

### INTERPERSONAL SKILLS

Skills of working with people  
 Showing caring, interest, empathy  
 Giving reassurance and support  
 Instilling confidence  
 Being approachable  
 Counselling skills  
 Communication skills  
 Coping with difficult or distressing situations  
 Tact and diplomacy  
 Handling conflict  
 Assertiveness  
 Courage  
 Patience and persistence  
 Determination and perseverance  
 Listening and hearing  
 Giving an air of confidence

### INTRAPERSONAL SKILLS

Self-awareness  
 Using your intuition  
 Using your humanity  
 Learning from others  
 Being adaptable  
 Being open, up front and honest  
 Being prepared to try things and do anything  
 Remaining optimistic  
 Will, determination, staying power and stamina  
 Speed - the ability to work quickly  
 Time management  
 Personally being positive, proactive, dynamic



**PERSONAL EXPERIENCES**

Good role models  
Experiencing a close family

**INDIVIDUAL VALUES, BELIEFS AND MOTIVATIONS****COMMITMENT TO RESIDENTS**

Caring commitment to people, older people and residents  
Determination to give good care

**RESIDENTS' RIGHTS TO GOOD CARE**

Belief that older people have the right to good care  
Belief that older people should not suffer

**CARE FOR OLDER PEOPLE MUST BE IMPROVED**

Previous experiences of inhumane, abusive, ritualistic, ill-informed and institutionalised care  
The belief that care for older people must be better than it has been in the past  
Determination to work to improve care and obtain the best possible standard for older people currently in their care

**INTUITION, INSTINCT OR 'GUT' FEELING**

Some RNs believed intuition does exist  
Others believed that intuition results from highly developed observational skills  
Some believed intuition was a combination of instinct and observational skills

**Some additional elements were listed by Registered Mental Nurses (RMNs). These are given in the following box.**

**ADDITIONAL ELEMENTS LISTED BY RMNs**

Knowledge  
Mental health in older age, its manifestations  
Mental Health legislation  
Drugs, particular considerations with people with mental health needs - how to assess dosages, recognise drug reactions, restrictions with medications  
Registration requirements (UKCC)  
Company policies and guidelines  
Particular ethical issues concerning older people with mental health needs

Skills

Very acute observational skills that come from being a mental nurse

Highly attuned communication skills

Skills in working with mental health needs in groups

Conversational skills, listening, responding

Patience skills, watching what they do and listening to what they say

Questioning practice

Leadership skills, motivational skills, how to keep up morale and motivation in challenging work situations

Calmness, authority

Experience

Learning what works with older people with mental health needs and what doesn't,

Learning from 'getting a slap'



## **APPENDIX 4.4: RN JOB DESCRIPTIONS**

### **AN AMALGAMATION OF THE JOB DESCRIPTIONS FOR RNs IN THE THREE FIELDWORK NURSING HOMES**

#### **Managing unit or whole home**

Managing all aspects of the delivery of care to residents within the Home, or defined part of the Home

Working with all staff including administration, housekeeping, catering and maintenance.

Planning, organising and managing the units and all resources therein

Deputising for matron in her absence

Reporting any faults with the buildings and grounds, and any repairs needed to fixtures and fittings, furniture or equipment, or services thereto

Ensuring that the security of the buildings and their contents is maintained

Promoting the organization

#### **Managing service quality**

Planning, organising and auditing professional standards.

Identifying, developing and implementing quality initiatives.

Monitoring and auditing all aspects of care delivery.

Ensuring all documentation is completed and satisfactory.

Receiving and investigating complaints.

Ensuring compliance with Health and Safety legislation and rules.

Communicating fully with staff, managers and external health care professionals and educationalists.

#### **Leading and managing staff**

Providing professional leadership to all nursing and care staff.

Managing subordinate staff, maintaining high levels of morale, sound professional practices and good motivation

Assessing staffing requirements and preparing rotas to meet needs.

Monitoring staffing and recording attendance, absence and relief/agency cover

Supervising staff in all respects.

Participating in appraisal.

Taking part in staff meetings.

Reporting problems as appropriate.

#### **Leading staff development and training**

Training, developing and facilitating learning by staff and students.

Encouraging staff to maintain up-to-date professional knowledge.

Ensuring staff comply with all legislative and policy requirements.

Developing processes for clinical supervising.

Developing and implementing training.

**Creating and maintaining resident-focused care**

Ensuring individualised care is given to all residents and that staff contribute to the best of their ability to the efficient running of the home and the creation of the right atmosphere

Receiving, or supervising the reception of, new residents ensuring that all appropriate documentation is completed and that the resident is orientated to the surroundings and neighbours.

Ensuring the whereabouts of all residents is known

Assessing the care needed to address the resident's physical, psychological and social needs and draw up a care profile.

Ensuring the maintenance of high standards of nursing care while promoting an environment which enables residents to live as independently as possible

Ensuring that individual residents' dignity is maintained at all times.

Visiting each resident daily to assess needs.

Helping residents to understand how ageing is affecting their health and lifestyle.

Assisting residents to adjust lifestyle to maximise comfort, dignity and independence.

Ensuring good communications are maintained with residents and relatives.

Promoting a non-institutionalised approach.

Promoting the welfare of older people generally

**Leading, managing and supervising care**

Providing and supervising the delivery of, high standards of nursing care to residents in accordance with up-to-date, evidence-based, professional practice and organisational policies.

Continuously evaluating care needs, assessing status of resident, e.g. nutrition, and updating care plans. Ensuring that care plans and records are evaluated, up-to-date and accurate.

Planning, implementing and evaluating nursing care in accordance with residents' needs.

Supervising all nursing activities.

Leading the shift team, supervising staff in all respects including orientation, training, development or care staff, organisation and co-ordinating their duties; guiding, supporting, monitoring and evaluating staff performance.

Ensuring accurate information on residents' conditions is given to nurse in charge

**Specific nursing responsibilities**

Carrying out all treatments as prescribed, including administering medicines, and in accordance with good nursing practice.

Ensuring that he/she complies with the Code of Conduct at all times including the safe ordering, custody, storing and administration of all medication. Accepts responsibility for the safety of medicines in store and during dispensing rounds.

Managing stocks of all supplies effectively and economically and ensuring the timely ordering of replenishment stocks.

Being responsible for correct use and care of medical equipment, reporting defects.

Proactively seeking and using opportunities to develop own professional and clinical skills and knowledge

Regularly updating in lifting and handling and fire safety

**For RMNs:** Maintaining detailed and up-to-date knowledge of the Mental Health Act.



## APPENDIX 4.5: DISTINCT INDIVIDUAL 'MODELS' OF WORKING AMONG RNs

	<b>Approach and ways of working</b>	<b>Knowledge -base</b>	<b>Care Focus and RN role</b>	<b>Potential Results for Residents</b>	<b>Description of Model</b>
<b>RN1 (RMN)</b>	Highly competent; knew residents well and directly engaged with them	Good re clinical care, mental health legislation; specialist in mental health	Resident-centred; leader, supervisor, teacher, role model; advocate	They were safe; cared-about; needs met and dignity preserved	Therapeutic; Person-centred with strong leadership and highly skilled observation
<b>RN2</b>	Under pressure; staff absence; constant interruption and problems Acknowledged residents but did not engage unless necessary. Very caring and kind.	Seemed safe. Confident. Checked eg medicines when unsure; special - communication -Makaton	Task-focused. Getting through the work but ?how would be in less fraught circumstances. RN role – drugs, dressings and dealing with disorganisation; advocate	They were safe. Inappropriate care prevented. If way of working continued potentially highly detrimental to residents as needs would not be met.	'trying to cope under pressure' Results – inadequate care. Mistakes, things missed.
<b>RN4</b>	Highly competent. Detailed knowledge of residents and individual engagement. 'hands-on'	Very good. Discussed new research with GP; reads journals; teaches; specialist wound care	Person-centred, individualised. Leader, supervisor, teacher, role-model; advocate	Liked and respected by residents. They had confidence and mentioned her name often	Therapeutic; promoting autonomy and independence; quality care; best quality of life.
<b>RN5</b>	Under pressure (Dr's round, meds order). Efficient. Acknowledged residents while going around	Safe; asked when in doubt; specialist in neurology	Organisational, focus on completing jobs and continuity of care; little time for supervision; advocate	They were safe; inappropriate care prevented but problems may not be picked up as CAs giving care;	Organisational efficiency; but little longer-term planning and inadequate supervision
<b>RN7(E N)</b>	Kindly; direct engagement with residents but little assessment or problem anticipation	Unsound and inadequate re drugs, dressings and fire drill	Doing things for residents; hands-on; little supervision of CAs	Potentially unsafe care; resident needs /problems not identified.	Kindly task-focus; no longer-term planning
<b>RN11 (RMN)</b>	Exceptionally caring/loving, close, knowledgeable re residents; but maintains over-view of whole unit	Very sound and detailed; specialist in mental health care	Supervision of residents+++ and staff++; hand-on when appropriate; monitoring and planning; strong advocate	Safe; felt cared about and loved; needs met and physical and mental health preserved as much as possible	Person-centred; loving; attention to detail
<b>RN12</b>	Engagement with individual residents; detailed knowledge of needs; assessment, monitoring; problem prevention	Very good in clinical and managerial aspects; queries with clinical supervisor; specialist in surgical and rehab	Detailed attention eg to nails and skin; rehabilitation focus; strong emphasis on supervision of all staff including other RNs; advocate	Safe; basic needs met; dignity preserved; health maintained; problems identified /prevented	Therapeutic; rehabilitative ?resident QoL because of mix on unit ?long-term effects of staff working long hours
<b>RN13</b>	Interest in, and engagement with, residents as individuals;	Very good and specialist in rehab; palliative care and ophthalmology	Assessment and supervision while working; rehab and hobbies focus; facilitator and enabler	Health maintenance /enhancement, enjoyment and fulfilment	Facilitative; therapeutic; rehabilitative; QoL, but compromised by environment and low staffing

## **APPENDIX 5.1: KEY OUTCOMES OF THE WORK OF CAs EXPRESSED WITHIN THE OUTCOMES FRAMEWORK**

The following table lists the outcomes of CA work as identified by the CAs themselves in their examples and interviews and, mostly, confirmed in the observations.

The participants' own words are used.

The statements in the square brackets were made by the CAs in their examples and interviews but, because they took place over the course of some time, were difficult to confirm in the observations.

### **QUALITY OF LIFE**

#### **Quality of Life**

Residents felt they had some quality of life, despite ill-health, disability and other losses.

#### **Enjoyment / recreation**

Residents were encouraged to be as active as possible and engage in activities of personal choice; encouraged to continue activities enjoyed while at home (e.g. reading the newspaper, listening to the radio); encouraged to join in activities within the home (e.g. games, quizzes); enjoying life; taken out on occasions.

#### **Safety and security**

Residents felt safe and secure in the home; felt safe that needs would be met; had a call-bell or means of summoning help when needed. Were reassured that everything was OK and that the resident was safe; side-rails (bed rails, cot sides) on mechanical bed to prevent falling out of bed.

#### **Environment**

Room and personal surroundings kept clean and tidy but as per personal choice; equipment needed was within easy reach; personal things were in the desired place; lighting levels were appropriate for individual needs and preferences; noise levels were not intrusive; rubbish was removed;

#### **'The little things'**

Little things were attended to, such as winding the clock, applying a wrist watch;

#### **Comfort**

Physical comfort was ensured as far as possible.

### **PERSONHOOD**

#### **Being recognised and treated as a person**

Residents felt human; felt like a person who had worth despite having lost health, independence, valued abilities and one's home.

[following input over time the real person and the personality emerged].



**Being understood as an individual**

Residents' individuality was appreciated, including idiosyncracies and 'the little things'; individual needs were recognised and understood. 'Everything just as they like it'.

**Receiving attention**

Residents knew that someone was always there to help in case of need; they received attention to additional aspects of needs or wants, even when not asking for such (e.g. putting on wristwatch, winding the clock, putting on radio, bringing in magazines or items of individual interest).

**Feeling cared about**

Residents received time and affection, sometimes more-so than at other times in life; felt no longer neglected; felt pampered and 'fussed over'; reassured that one is not a nuisance; felt liked and loved; 'life is a little better knowing someone cares'

**Biography and life experiences acknowledged and valued**

Residents were able to talk about their past to younger people who had genuine interest; they could share memories and photographs; were able to pass on lessons learned in life.

**Autonomy**

Residents felt in control in life, subject to the restrictions of living in a care home and as a consequence of ill-health or disability; received explanations of whatever is happening or going to happen; felt able to ask for help;

Residents were offered as much choice as possible, within limitations of living in a care home and imposed by ill-health or disability.

[increased self confidence; no longer refusing help; 'getting what they want']

**Privacy and dignity**

Privacy was preserved but with restrictions imposed by living in a care home, individual needs for care or inconsiderate practice.

**Well-being**

Residents had greater peace of mind; reduced mental confusion; increased enthusiasm for life; felt reassured; less stress ; were thinking positively rather than negatively;

[reduced aggression; no aggressive; less agitation; less anger; less frustration; reduced fear; reduced apprehension; reduced anxiety; reduced fretfulness; reduced embarrassment; greater calmness and relaxation; cessation of screaming, reduced destructiveness; less crying]

**Humour /Happiness**

Residents were able to enjoy a joke; share funny stories; laugh with CAs at funny situations; greet others with a smile

**Relationships**

Chosen relationships were encouraged; visitors were encouraged; relationships with the home were encouraged

**With family**

Contact with family was facilitated and maintained; family welcomed when visiting. [Family and grandchildren visited more often once problems were alleviated].

**With other people/generally**

Residents enjoyed being with people and near to people; enjoyed closeness; enjoyed sitting and chatting with staff and other residents; had someone to listen and were able to feel that they had something to say; enhanced socialisation within the home.

[improved communication and enhanced rapport with staff and residents]

**With staff**

Residents were able to enjoy relationships with staff; enjoy close relationships with some staff; sharing trust with the staff;  
Enjoyment of physical affection and touch with staff; wanting and receiving cuddles;

[increased ability to recognise staff; enhanced rapport with staff; increased trust in the staff; enhanced co-operation with staff; enjoying cuddles when previously was unable to do this; reduced abusiveness towards the staff]

**The will to live**

Maintaining or even regaining the will to live, rather than feeling 'unwanted, unable to do anything, outlived all usefulness, no reason to live'.

**Death**

Being able to prepare for death and dying according to own wishes, knowing one is cared about and receiving physical care and comfort; complications prevented through regular attention.

**DAILY FUNCTIONING****Independence**

Independence was encouraged in all aspects

[Through this encouragement, independence was achieved over the course of time, e.g. the resident 'is active again'; 'quite independent with supervision'; 'calls for help much less often'; is able to stand and walk with a frame'; 'has improved walking'; 'is able to sit at the table and feed self'; 'reduced incontinence'; 'now clean, dry and comfortable']

**Washing, grooming and dressing**

Residents received help to wash; skin was kept in condition; helped to apply deodorant, perfume, aftershave and makeup.

Hair was brushed, washed, set and cut.

Dressed according to individual choice;

Clothes were washed/cleaned and returned; help was given to mend and replace clothes as necessary.

When unable or reluctant to clean self due to mental health needs staff awaited an opportunity to do this and employed a range of strategies to do so with minimum distress to the resident

**Mobility**

Residents were moved and 'handled' safely with explanations of procedures and the necessity for them.

Helped to move around as appropriate. Encouraged to move around as appropriate

**Sensory functioning**

Hearing aids and glasses were applied as appropriate.



**HEALTH****Elimination**

Effective and regular elimination was maintained

Residents were helped to go to the toilet / bedpan / urinal / commode as appropriate.

Taken to the toilet if appropriate.

Reminded to go to the toilet if appropriate.

Continence aids were changed and body kept clean and dry.

**Nutrition and fluid intake**

Nutrition and hydration were maintained

Residents were helped to eat and drink; have meals brought into room if necessary or are served at dining table; receive sufficient fluids; receive reminders of weight change.

[Eating well and 'filling out' when had been very frail]

**Sleep**

Sleep was improved due to pain reduction

**Oral health**

Teeth or dentures were cleaned; encouraged to seek dental advice and to wear dentures as prescribed;

**PROBLEMS AVOIDED**

Changes were recognised and reported to the RN in charge

Deterioration (and possibly death) was prevented

Residents were helped to take medications left by the RN

Pain was reduced through attention to comfort.

Pressure area problems were avoided through the administration of regular prescribed care.

Acute problems were recognised, reported to RN and dealt with (e.g. bleeding, cold/chest infection)

Infection was prevented through the adoption of appropriate infection control practices

Ineffective or malfunctioning equipment was reported;

**GENERAL**

General improvement over the course of time  
 ['has really improved'; 'she's really changed'; feel better in themselves through the care and attention received; reduced frailty; greater comfort; life is made as comfortable as possible; increased self-confidence; feeling able to undergo treatment due to the support received; fully recovered and able to go home]

**OUTCOMES FOR STAFF**

Staff enjoyed good teamwork;  
 Staff gained a sense of satisfaction and a feeling of achievement from giving good care;  
 Staff gained satisfaction from their relationships with the residents, families and each other;  
 Workload reduced as resident's independence improved, particularly in mobility (e.g. no longer have to use a hoist).  
 [Staff were no longer scared of residents; no longer have to answer the bell every five minutes;]

**OUTCOMES FOR RELATIVES**

Family felt reassured and comforted by the care given;  
 Family expressed appreciation for good care;  
 Family enjoyed visiting;  
 Family felt less distress, apprehension, fear, stress knowing resident has good care;  
 Family could be involved in resident's dying and death and felt supported in this;  
 Family felt better knowing resident did not suffer  
 [Family became much closer; family enjoyed visiting more due to improvements in resident's condition]



## **APPENDIX 5.2: KEY OUTCOMES OF THE WORK OF RNs EXPRESSED WITHIN THE OUTCOMES FRAMEWORK**

The following table lists the outcomes of RN work as identified by the RNs themselves in their examples and interviews. Many of these were confirmed in the observations.

The participants own words are used.

The statements in square brackets were made by the RNs in their examples and interviews but, because they took place over the course of some time, were difficult to confirm in the observations.

### **QUALITY OF LIFE**

#### **Quality of life**

Residents enjoyed better quality of life through:

- Being reassured that they were able to maintain optimum health and well-being through the care they received
- Knowing that there were qualified staff available to help when they needed this
- Living in an environment where they felt safe and could live their lives with an optimum of choice and enjoyment.

#### **Enjoyment of life (personal and social activities music, outings)**

Enjoyment of life to the optimum

Aspects listed by RNs and observed included

- reading, music, activities, exercise classes, reminiscence, art therapy.
- enjoying the view from a window, wildlife, watching people move around, instructing CAs on watering plants, enjoying singing and laughing along with staff.
- watching films.
- for residents with sensory impairment, large print or talking books, staff reading to residents on favourite subjects, e.g. aeroplanes.
- celebrating birthdays and anniversaries with cake. Enjoying treats, e.g. chocolate.
- events organised in the homes such as coffee mornings, entertainers, staff putting on a Christmas show for residents.

#### **Knowledge and understanding**

Residents' understanding the reasons for their health changes and options in terms of treatment, lifestyle change etc. For example:

- understanding deterioration, e.g. reasons for sight loss and why this was irreversible.
- resident understanding why she had been disorientated, receiving reassurance, slowly realising that 'things are OK' and adjusting to a change of view.
- understanding and eventually accepting a diagnosis, being supported emotionally in this.
- understanding medications being prescribed.
- understanding lifestyle changes important for health, e.g. moving around more.

#### **Safety and Security**

Being in a safe environment

Potential hazards and risks recognised, minimised and managed

Health changes identified, investigated and treated.

### **Location of choice**

#### **Being able to stay in the nursing home**

Being able to stay in the home where resident is happy, rather than be forcibly moved.

Being able to stay in the home rather than be taken to hospital.

Being able to die in the home rather than in hospital

#### **Being able to go home:**

Returning to live in own home through rehabilitation in a nursing home despite, in some cases, being told this would never be able to happen.

### **Environmental improvement**

Living in an improved environment, e.g. smaller and more homely.

Living in a better environment – physically and psychologically

Levels of noise, light and activity were controlled

## **PERSONHOOD**

### **Personhood**

Being viewed and treated as a person

Individual strengths were recognised and worked with; people with mental health needs offered understanding of their individual ways of behaving and communicating

The individual was recognised within the community, particularly for people with mental health needs.

Staff took time to get to know residents, to listen and try to understand, to take an interest in lives and viewpoints, really trying to understand priorities

### **Biography**

Residents enjoyed talking about life history and life experiences.

Staff compiled biographies through resident writing, staff reporting what resident has said, or through family photographs

### **Spirituality/religion**

Residents were able to follow faith and religious rituals through daily practices, ministers visiting or going out to church.

### **Relationships and sexuality**

#### **With family**

Through enhanced health and well-being, more able to enjoy family and relatives

Relatives felt welcome in the home

Able to go to relatives' homes, e.g. for Christmas

Residents were helped to stay in touch with families, e.g. RN 'phoned hospital to enquire about the brother of resident B (who was unable to speak).

#### **Husband and wife and couples**

Couples were able to stay together

Facilitated to continue to care for each other

Supported by staff to spend time together and be apart when necessary

Received support from staff when necessary.



Partners supported in grieving; staff go to funerals.

### Sexuality

Residents' sexual needs were treated with sensitivity and understanding  
New relationships were viewed and treated with sensitivity

### Generally

Isolation was avoided

Residents were able to share conversations, enjoyment etc, with others, as well as be alone when they wish

Residents were able to form friendships or relationships.

### With staff

Residents showed appreciation to the staff for care given, thank staff for their help and the trouble they have taken.

Improved rapport between residents and staff

Residents able to be more receptive to, and confident in, the help being offered.

### Autonomy - choice and control

Residents had choice in daily care and activity

Residents felt they had control over how they spent their time

In view of resident disabilities, staff offered ideas for alternative activities and interests

Residents were asked for their views and these were listened to.

Staff welcomed resident's ideas.

### Privacy and dignity

Residents had privacy, could stay in their rooms when they wished, had privacy when taking meals if desired.

Dignity enhanced through improved health and functioning, e.g. becoming continent again

## FUNCTIONAL STATUS

### Independence - general

Some residents regained abilities and functioning they had lost

[Residents were successfully rehabilitated]

[Residents were helped to become more independent to the point where they could live at home, despite predictions that this would never be possible.]

Residents come out of their rooms, rather than remaining within and deteriorating

### Sensory Functioning

Residents were able to 'get their hearing sorted out', their vision and other sensory functioning assessed.

Speech improved through therapy, so that communication is easier.

Communication aids were obtained.

Specialist assessment was obtained.

Aids were maintained.

Aids were used appropriately (e.g. when V, who had dementia, lost her glasses it was important to find them quickly not only for her own orientation but also because staff might forget she wore them)

**Communication, responsiveness**

Residents were able to make conversations with others when previously they were not  
 Residents were able to express themselves  
 [Depression was prevented, detected or prevented from becoming worse]

**Personal Care activities, e.g. dressing**

Personal needs were cared for  
 RNs checked that washing, bathing etc was carried out appropriately  
 Encouraging to go to the hairdresser  
 Helped to purchase clothes through catalogues

**Mobility**

Optimum mobility achieved within individual limitations  
 Residents were helped to be able to walk again  
 Resident potential for mobility was preserved through appropriate moving and handling techniques  
 Residents received explanations about changes in manual handling.

**Continence**

Continence was preserved, maintained or improved  
 Specialist assessment was obtained when appropriate

**HEALTH STATUS****General health**

'They're all much healthier now'  
 'Going from strength to strength'  
 General health, independence and activity levels enhanced

**Well-being**

Enhanced well-being / reduced illbeing  
 Enhanced calmness  
 Reduced aggression  
 Reduced distress  
 Enhanced orientation  
 Reduced unhappiness, frustration, aggression  
 Less likely to distress other residents  
 Enhanced stimulation and motivation  
 Reduced depression, withdrawal and dependency  
 Less likely to be labelled as confused or dementing.  
 Dementia care mapping helped identify well-being and illbeing on an ongoing basis

**Mental Health**

Less risk of mental health deterioration due to lack of stimulation  
 Improved general mental state  
 Improved mental alertness  
 Enhanced orientation  
 Enhanced memory  
 Diagnosis of dementia removed (residents had been diagnosed with dementia but, after RN intervention, it was realised that residents did not have dementia)



**Nutrition and Fluids**

Residents were able to eat proper food and enjoy food

No longer needed thickened fluids

Dehydration was prevented, e.g. despite swallowing difficulties

Special diets and supplements were obtained

Good nutritional status was maintained

RN sat with resident who is having feeding difficulty in order to assess and obtain appropriate help,

Residents were encouraged to eat

**Oral health**

Dental assessment undertaken and/or new dentures obtained

Resident's mouths were cared for, kept clean and moist, despite major or terminal illness

Dental appointments were made

**Urine output**

Healthy urine output was maintained

Urinary retention was prevented, or detected and treated

Problems were identified

**Bowel function**

Constipation was prevented, detected or treated

Bowel function was maintained, e.g. by osmotic aperient

Normal bowel function was re-established, even in people with disorders such as multiple sclerosis

**Sleep**

Adequate and restful sleep was facilitated

**PREVENTING PROBLEMS****Breakdown of skin**

Skin breakdown was prevented

Pressure sore deterioration was prevented, appropriate treatment was given

Infection was prevented or treated

Pressure sores healed completely

Discomfort resulting from pressure sores was prevented

Death resulting from pressure sores was prevented

**Wound Healing**

Leg ulcers healed

Wounds healed

Because changes were recognised and skilled assessment undertaken (e.g. RN recognised that under this apparent healthy skin was 'marshmallow' which could lead to breakdown).

**Infections (reduced or prevented)**

RNs instituted infection control procedures, ensured staff followed these and taught staff the reasons for them.

**Falls or accidents (reduced or prevented)**

Falls and accidents prevented by RNs assessing risks and preventing these where possible.

Falls protocols in place in two homes.

**Detrimental complications (reduced or prevented)**

Complications prevented

Deterioration prevented by RN recognising change and taking preventative actions

Examples included dehydration, pressure sores, chest infections, death

**Pain (reduced or avoided)**

Pain prevented, avoided or reduced.

Residents remained pain-free

Residents died pain-free

Medication was changed to meet resident need

Correct medication and other measures were given.

**Acute situations (with positive outcome)**

Acute situations were recognised by RNs and immediate action taken. Without this, residents could have had to be admitted to hospital, lost limbs, choked or died.

Examples include recognition of urinary retention, abdominal distension, detached retina, deep vein thrombosis, heart attack, fractured neck of femur and epileptic fit.

Appropriate action was taken in the case of choking, cerebral bleeding and cardiac arrest.

Abuse was recognised and steps taken to stop this.

Examples are given in Section 5.5.4

**Death (postponed or avoided, or process enhanced)**

Through good care, residents lived for longer

Through good communication with the family and GP etc, the outcome was a comfortable, peaceful death with family attending.

Resident's last Christmas spent happily with family around.

Through 'not taking things at face value', investigating further, seeking second opinion and working with the family, resident's life was preserved

Through recognising acute situations, as above, residents' lives were saved

**OTHER OUTCOMES****Other services obtained****General Practitioner**

GP services were obtained by RNs liaising, being assertive, being persistent, repeatedly telephoning, insisting on a visit, making suggestions on the diagnosis, challenging a doctor's diagnosis, making suggestions for treatment, 'praising the doctor for being so caring'.

**Specialist Medical Consultants**

RNs sought opinions from specialist geriatricians and psychogeriatricians



Specialist Nurses

Services of specialist nurses in palliative care, continence, wound care were obtained

District Nurse

Specifically through RNs insisting that residents are in the community

Other services

Audiology, dentistry, speech therapy

Total culture change in the home

Institutionalised approach to care could be changed

Improved quality of care. Evidence-based care and preceptorship.

A climate to ask questions of trained staff and each other, further promoting improved care

Improved nursing documentation, as indicated in care plan audits

Improved care plans which were used to record progress and inform staff - toileting regimes, continence plans, and charts used to record teaching sessions on urine output and continence and walking exercises

Other outcomes

drugs were reduced, specifically antidepressants

use of incontinence pads and other aids reduced through good care

OUTCOMES FOR RELATIVES

With good RNs the relatives said they were happy that the health of their loved ones improved and that they received good care

Relatives felt welcomed in the home and involved in the care (e.g. bringing in books and taped music)

Relative contact was maintained by staff, even when they were unable to visit the home

Potentially difficult situations were avoided because RN understood relatives' feelings and proactively approached the problem.

Relatives trusted staff because care needs were met, e.g. pain and discomfort approaching death was avoided.

Relative distress was avoided

Relatives appreciated improved environments

Relatives were happy to welcome loved one home once health had improved through good care.

[Fewer complaints from residents]

OUTCOMES FOR OTHER STAFF

Through good RN leadership and management:

Happy workers - Greater job satisfaction. Low sickness/absenteeism level. High

morale/avoiding low morale leading to high sickness/absenteeism level. Avoiding deteriorating relationships with staff. Avoiding rapid turnover.  
 Staff felt empowered  
 Poor quality, institutionalised and ritualised care was reduced  
 Improved teamwork  
 Expansion of activities in the home to include art, music, singing, with consequent improvement in residents' enjoyment of life

Through implementing preceptorship, a career structure and evidence-based care:  
 Staff could see a plan for their development and felt supported in this, boredom was prevented, staff motivation and retention improved and consequent disruption to residents avoided  
 Improved record-keeping leading to improved inspection reports  
 Progress could be monitored

Abuse of staff avoided

### OUTCOMES FOR THE HOME

#### Other residents

Maybe avoiding elder abuse due to frustrations in inadequately run home  
 Relationships among residents improve in well-run home

#### The Home

Situations of staffing shortage managed and atmosphere maintained.  
 Without good management, good reputation of home is lost, increased complaints, poor inspection reports or investigation by health authority, reduced occupancy, job losses, home generally goes down.



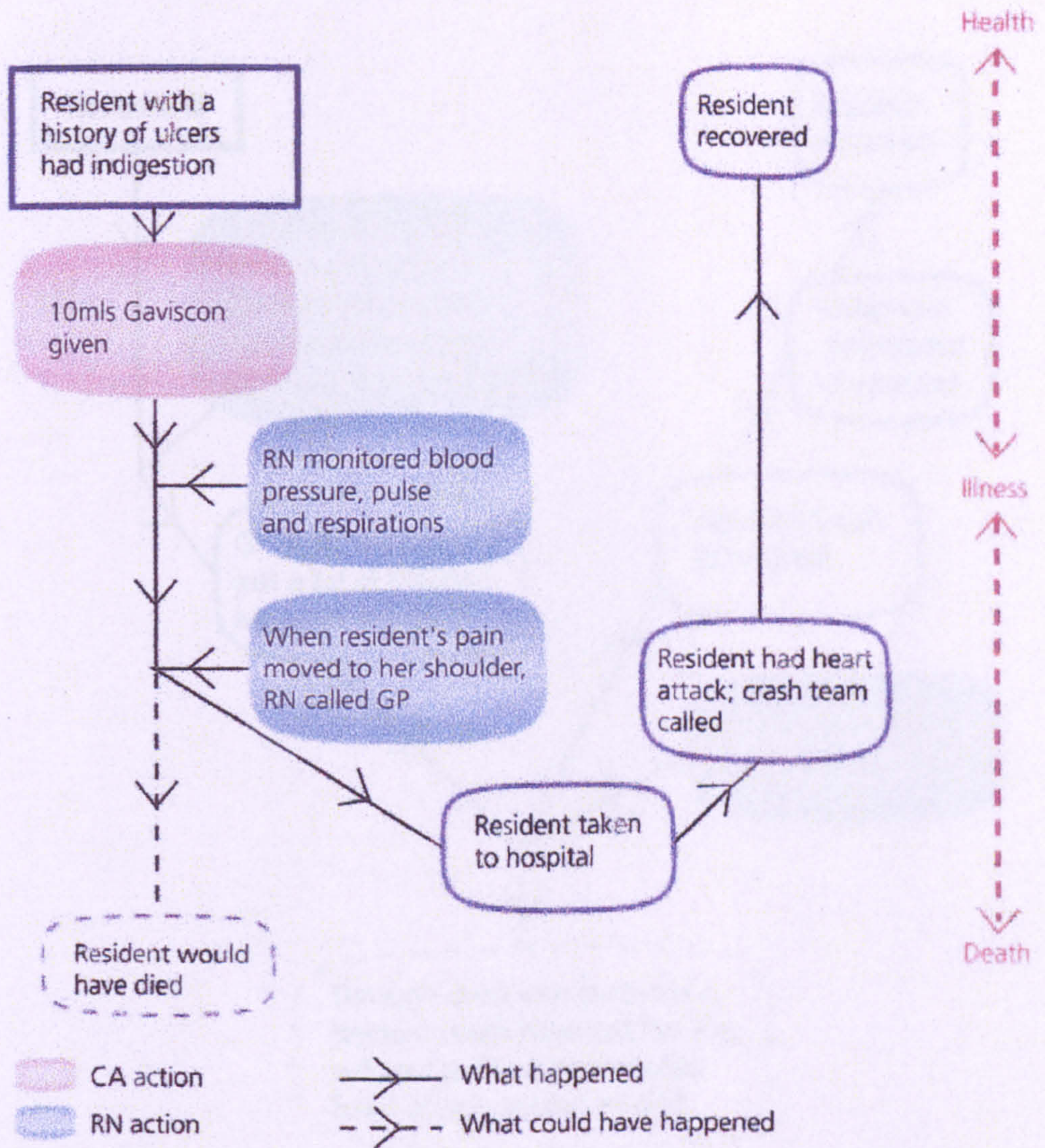
## **APPENDIX 5.3: EXAMPLES HIGHLIGHTING POTENTIAL OUTCOMES WITHOUT RNs**

This appendix contains visual representation of five of the examples given in Section 5.5.4 which illustrate potential outcomes if RNs had not been present in the homes or had not taken the actions they did.

These are numbered Figures 5.2 to 5.5.

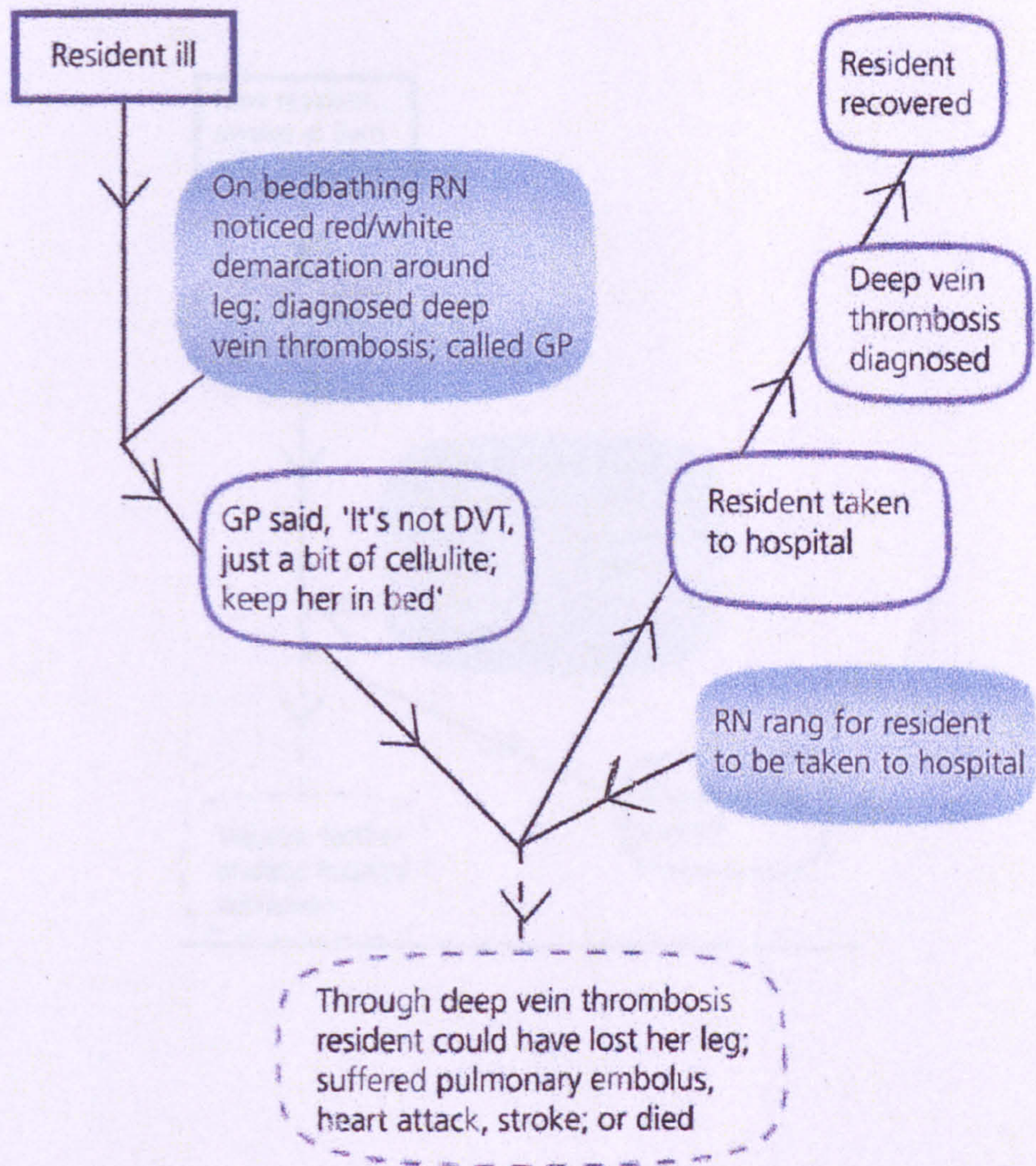


**FIGURE 5.2: EXAMPLE OF RN ACTION: 'INDIGESTION'**





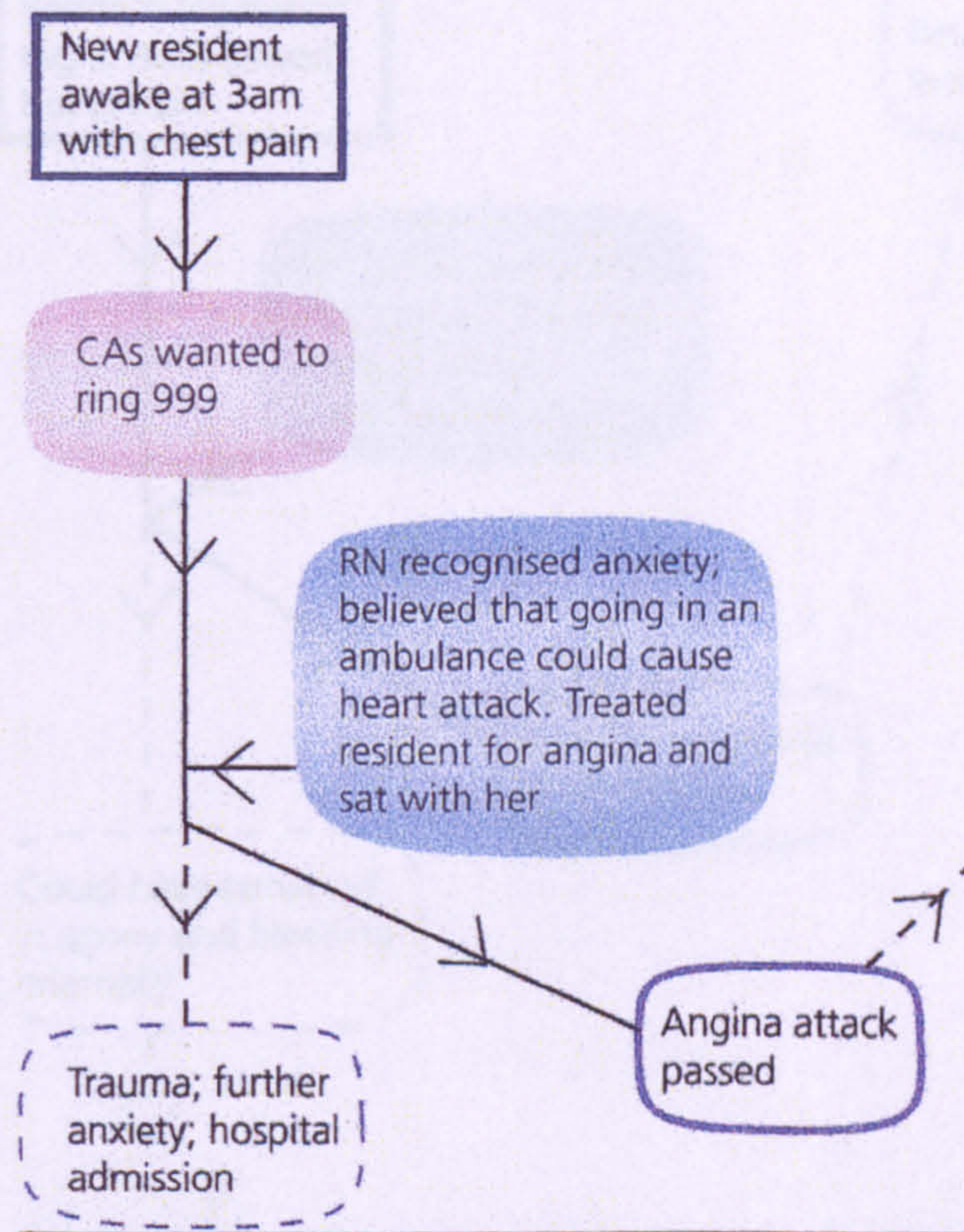
**FIGURE 5.3: EXAMPLE OF RN ACTION: 'CELLULITE'**





**FIGURE 5.4: EXAMPLE OF RN ACTION: 'CHEST PAIN'**

FIGURE 5.4: EXAMPLE OF RN ACTION: 'CHEST PAIN'





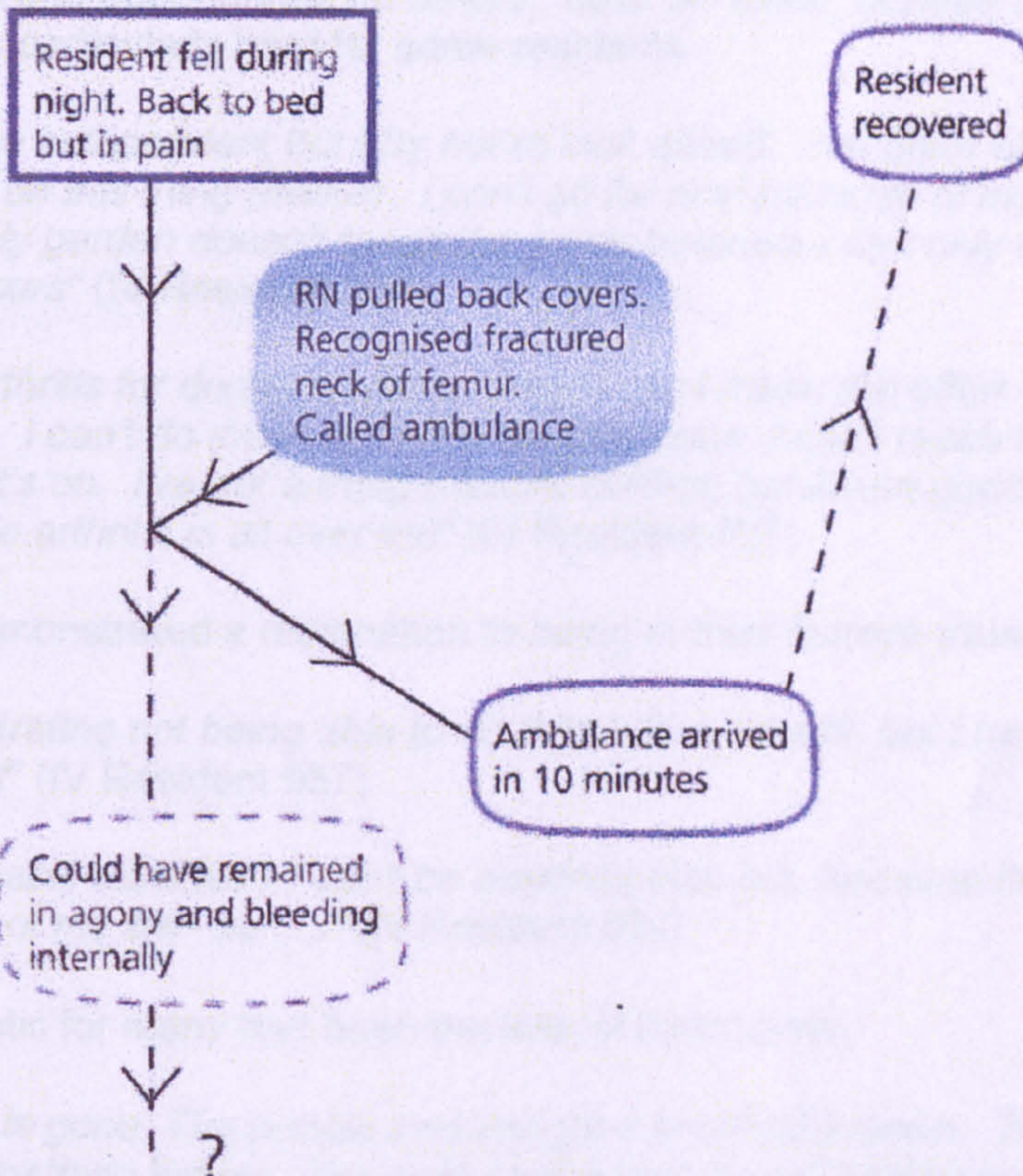
## APPENDIX 5.4: THE COMPLEXITY OF RESIDENTS' HEALTH AND CARE NEEDS

**FIGURE 5.5: EXAMPLE OF RN ACTION: 'FRACTURED NECK OF FEMUR'**

RESIDENT

The majority of residents in all the homes are frail and dependent. In the examples had highly complex needs.

The resident interviews highlighted the vulnerability of residents whose cognitive function, disabilities, frailty, and dependence on others meant that their independence was



Many residents described their lives as being in a state of constant fear. It's so frustrating of being stuck up with that TV. I'm really for the rest. Particularly traumatic. My house is not what I wanted. I had to go and I had things of their own.

Bringing their own possessions was important. It's nice to have your own things. I had a chair and a table. It was difficult deciding what to take. Resident AOK.

For some residents, family had played a role. I got to the stage where I needed more help when I wanted to go home. My family were very helpful.



## **APPENDIX 5.4: THE COMPLEXITY OF RESIDENTS' HEALTH AND CARE NEEDS**

### **RESIDENT VULNERABILITY**

The majority of residents in all the homes and those described in the examples, had highly complex needs.

The resident interviews highlighted the vulnerability which arose from their illhealth, disabilities and dependence on others. Loss of health, abilities and independence was particularly hard for some residents.

*"I want to be independent but I try not to look ahead. I've been rather dependent on this thing (frame). I can't go far now because of my sight. Now a lovely garden doesn't mean the same because I can only see certain colours" (IV Resident 950)*

*"I've had arthritis for donkey's years. Now I can't make the effort - no push to try. I can't do much but I like the television. I can't reach the knobs but it's on. I've got a thing (remote control) but it's no good because the arthritis is all over me" (IV Resident 507)*

Many residents demonstrated a resignation to being in their current situation.

*"It's so frustrating not being able to do things for yourself, but I have to put up with that" (IV Resident 957)*

*"I'm reasonably satisfied - I can't be anything else but, because I'm here for the rest of my life - so ...!" (IV Resident 504)*

Particularly traumatic for many had been the loss of their home.

*"My house is gone. The people that bought it knocked it down. They wanted something bigger. The really awful part, once I knew I couldn't look after myself, was trying to wind up 50 years of family life. Everything had to go and there was a limit to what the family wanted because they had things of their own" (IV Resident 950)*

Bringing their own possessions into the home helped.

*"It's nice to have your own bits and pieces and I have my own bureau and bookshelf and chair and table - that makes a difference" (IV Resident 950)*

*"It was difficult deciding what to bring in - all my drawers are full up" (IV Resident 956)*

For some residents, family had played a role in their decision to go into the home.

*"I got to the stage where I had to go somewhere where I knew I could get more help when I needed. That meant traumatic things like losing the house. My family wanted to feel that I was secure" (IV Resident 950)*



*[does this feel like your home?] "I've back-peddled on that and don't even think of it. I have to think 'I'm here for the rest of my life and my family's life is at peace' and that's my main concern. Their main concern is me but my main concern is not, it's them" (IV Resident 506)*

Most RNs highlighted that the residents with whom they work are vulnerable, not only in physical, psychological and emotional ways, but because of their life situations.

*"There is discontent with some of the residents and I can see ... those who are brave enough to complain of their discontent. They're so dependent on us and its difficult for them. It's almost a lottery who you get to care for you because you might get somebody whose very cheerful but equally you might get some miserable puss who doesn't lighten your life". (IV RN 505)*

### **COMPLEX PHYSICAL AND MENTAL HEALTH NEEDS**

Most of the residents in the homes had complex needs. The people living on the units for people with physical frailty had a range of complex needs and some mental health needs. The residents on the mental health units had highly complex mental health needs, including various types of dementia, schizophrenia, Korsakoff's syndrome, as well as the same types of physical needs as the other residents.

Overall, this means that the RNs are carrying responsibility for the safety, health and wellbeing of groups of older people who are frail, vulnerable and dependent.

Residents' needs were complex due to:

#### **ADVANCED AGE**

Most residents were of advanced age. In one home the average age was over 90 and in another 22% of residents were over 90, 63% 80-89 and 15% over 70. Residents therefore had a range of age-related disabilities affecting particularly hearing, sight and mobility.

#### **MULTIPLE PATHOLOGIES**

Most residents had a number of medical conditions requiring treatment. Drugs prescribed for one condition could be detrimental to other conditions and treatment regimes were therefore complex and required ongoing monitoring. They experience *"all the pathologies of older age plus the mental health needs and communication difficulties"* (IV RN 511)

#### **NEEDS CAN BE COMPLICATED**

Particularly for residents with mental health needs, physical and mental needs could interact, for example their mental health needs may cause them to want to walk around but their cardiac and respiratory problems make this difficult. In addition, the RNs explained that people with dementia can be additionally sensitive to medications and exhibit drug intolerance.

Some cases were particularly complex, for example a woman who was insulin-dependent diabetic with mental health needs and behavioural problems. Despite the RN's attempts to keep her carbohydrate levels constant her BM ranged from 1.8-22. Her mental state was described as poor. The psychiatrist had reviewed medication but her behaviour was very unpredictable. RN 511 said: *"She can smile and look or claw you to death"*.

Some residents may be unable to speak due to a stroke or Parkinson's Disease, or may communicate in individual ways that staff have to learn, for example people with dementia.

Some residents behave in ways which are challenging for staff, such as showing distress, frustration, anger, aggression or screaming, hitting out, biting.

### RESIDENTS ARE ILL

The RNs identified that the residents now being admitted to nursing homes were generally more ill and that their illnesses were now at a more advanced stage.

### SPECIAL AIDS OR EQUIPMENT MAY BE NEEDED

A variety of specialised equipment was observed in the homes, such as PEG (percutaneous endoscopic gastrostomy) feeding, a keyboard and speech therapy equipment for a person that could not speak.

### HIGH DEPENDENCY ON OTHERS FOR HELP

Many of the residents were highly dependent on the staff for help. Some with dementia, for example, could forget to chew and swallow food, have insatiable appetites or not be able to retain fluids.

Some residents with dementia were unable to maintain their own body temperature because they were unable to recognise when they were cold.

### HIGH NEED FOR NURSING CARE

Most residents had a high need for nursing care in order to prevent deterioration. For example many had high pressure-risk scores (e.g. on Waterlow charts).

*"We have quite a lot of people who very rarely get out of bed and they require a lot of passive movements and care and that in itself is very time consuming"* (IV RN513)

### HEALTH IS UNSTABLE / UNPREDICTABLE

The health of residents could change and deteriorate rapidly. The deterioration could also be unpredictable over time.

*"They can plateau and then go down rapidly"* (IV RN 511).

Some resident's behaviour was unpredictable.

*"They can have physical and verbal outbursts"* (IV RN 511)

### CONSTANT AND ONGOING ASSESSMENT IS NEEDED

They need constant and ongoing assessment in order to identify causes of distress



*e.g. 'V screaming and distressed. Try to 'settle her down'. Behaviour chart, discovered doesn't like cold drinks so now give copious amounts of tea because she needs copious fluids. Very wet so changed regularly. Sometimes, if all else fails, responds to paracetamol ? she has physical pain. Insatiable appetite with no significant weight gain. Wanders. Meals and supplements. ? has a bad tooth. ? cerebral irritation'. (Researcher fieldnotes)*

*"We've had a few that we've had to send to hospital - four in the few weeks I've been here. One had to be catheterised and had quite severe trauma, quite pronounced hysteria. We sent him in and he passed away with very severe chest infection two days later – so we didn't get to the bottom of that. The normal sort of thing.*

*A gentleman fell quite badly had quite a sore back and we thought he'd broken one of his fingers and with bruising that came out immediately on his head because he fell out of his bed. We thought it best that he went and had X-rays especially the skull to see if there were fractures there or not. All the X-rays came back clear and they sent him straight back which I was cross about because we haven't got the facilities here. We can do the basic neuro obs and we can use our experience but we haven't got the facilities if anything went wrong quickly we could do nothing. But I still think they should have kept him in overnight for at least observation. His whole side was black.*

*When C fell out of bed she had 14 X-rays but they actually kept her in because of her age for a couple of days. But the other one they should have kept in and they didn't. And so it goes" (IV RN512)*

### ASSESSMENT IS COMPLICATED

It could be complicated to assess the health of residents because the influencing factors, due to age-related change, multiple pathology etc, could be complex.

*"Another gentleman his bloods were all up the shute ... he was a walking time bomb basically - his levels were such that he could have had a massive heart attack at any time. His Us and Es were all up the shute so we took him in the hospital kept him for 10 days. They sorted the blood levels out and he's back but unfortunately he's going back the same now as he was but when he came back he looked brilliant. He does retain quite a lot of fluid anyway. He's got quite a nasty dressing on his legs that ooze – he's quite difficult to see to". (IV RN 512)*

It could be particularly difficult to assess health changes in people with mental health needs such as dementia.

*"They don't communicate in the usual sense, so you have to learn to communicate with them as individuals. So when someone isn't as they usually are or is distressed you have to find out - is it physical or what. A lady we have has an irritable skin and low haemoglobin and we don't know what's causing it. If someone has a headache is it due to noise or lights or something within them?" (IV RN511)*

### GOAL PLANNING IS MORE COMPLEX

The RNs explained that it could be difficult to plan goals for care because individuals can respond so differently and their health can change at any time.



*"You don't know how people will respond ... sometimes it's about seeing the possibilities and finding solutions through exploring a range of possibilities" (IV RN511)*

### STAFF NEED TO UNDERSTAND THE PERSPECTIVES OF DIFFERENT GENERATIONS

The data highlighted how the staff needed to be aware of the experiences and values of older generations, for example residents commonly wanting to pay for food or care. For example the observation of RN 511 recognising that a resident was concerned that her brother had settled.

### VARIED NEEDS AND A DIVERSITY OF RESIDENTS WITHIN THE HOME

The residents had a range of needs. Most had physical needs resulting from ageing and pathologies. Many had mental health needs. Those in the mental health units generally had advanced mental health needs along with physical disabilities. This resulted in each unit containing a wide variety of needs. Some catered for respite care and some for younger people with disabilities resulting from diseases such as multiple sclerosis.

Not only were the residents' needs complex, the residents themselves were diverse.

*"We have got a very diverse group of residents up here we've got 54 to 104. We've got a few residents that are in all honesty wrongly placed – we've got one who's waiting to go downstairs. He's a lovely man he can be aggressive and a couple of them can when aggressive thrown things, stumble around themselves, they can fall quite safely and they don't care where they fall and we have got some elderly frail mobiles and one day one of the elderly frail mobiles will just be in the way of a linen basket being thrown or a tea cup being thrown. So one of them the problem has been addressed anyway and we're waiting for a place for him down stairs" (IV RN 512).*

*"Its quite a mixed variety of residents – we have wheelchair bound and I've worked in the young chronic sick unit. I've got some idea of the problems they have – if they feel they need certain drug, they've been in their wheelchair longer than I have and they're very often right. They know they need a bladder wash out twice a week" (IV RN 505)*

*"I do use my RMN skills but I don't use them to the extent that I could use them if I had people with the same needs. I used to work in the day hospital and we would have those people from the beginning, and we would do activities with all of them such as making cakes, doing the crossword everyday things we take for granted so I don't do as much because we've got such a varied client group. So I could do it and I do do it. We've got a video of Max Bygraves he's going through the war and you get all the sights and sounds. And that does evoke quite strong memories from quite a few of them. And then you lead that into a conversation then they go off at a tangent so we can do it but its so limited. You've got so much going on and we have got other facilities but not necessarily quiet areas." (IV RN501)*



## RESIDENTS ABUSING EACH OTHER AND STAFF

Because of the complexity of residents' needs the work could be challenging and there was an ever-present risk of abuse. A considerable number of staff reported being abused by residents, for example a CA was bitten, a sister had water thrown over her, many CAs and RNs had been punched or scratched. Such situations were noted throughout the observations and mentioned in the interviews and some in the significant examples.

Residents could have disagreements and confront or even attack other residents.

*"Sister explains that some residents can be very aggressive and throw things - a linen basket or a tea cup. They can spark each other off - the other day F [female resident] swiped a man around the head while she was sitting behind him in her wheelchair. She then stabbed B [male resident] with a fork" (Observation RN512)*

The observations highlighted numerous potentially difficult situations in which residents spoke sharply to staff or were, less commonly, abusive.

For example Observation of RN 5 Home 1: *"resident shouting loudly at her and telling her to \*\*\*\* off. This was audible all over the unit".*

Even seemingly unchallenging approaches could elicit aggressive responses, e.g. *RN 512 Home 1 went to see resident to say "good morning". Resident said "don't you come in and say that to me any more".*

*A CA asked Sister to help. She was trying to clean up after a resident who had been sick in the toilet and he was hitting her. Sister went to investigate. (Obs notes RN 501).*

In most instances the staff dealt with these situations in a 'matter-of-fact' way as 'just part of the work'. This was particularly so when the behaviour of the resident could be attributed to his or her condition.

*G [resident] was very upset and would not allow anyone near her. She was accusing C [CA] of hitting her and was shouting "I'm going to tell the council of you, you wicked old cow". The CA was trying to be calming and reassuring "it's alright G, there's nothing to worry about". When G had stopped shouting and the CA was able to get close to her she cuddled G and said softly "Are you not feeling well today? Are you in pain. Are you fed up? Your son will be in later. Would you like some chocolate?". G calmed down.*

*V was reluctant to be touched and was hitting the CA. The CA was trying to calm her. Said to me "It's a punch and scratch day today" (Observation CA506).*

## THE CHALLENGE OF MAKING ANY IMPACT IN THE LONG-TERM

Although the RNs generally remained positive about the future for their residents, some commented that, particularly with the residents with dementia, it could be difficult to feel that their work had any impact in the long-term.

*"Therapy groups wouldn't achieve anything for the long-term but for the short-term I'm giving them time, I'm showing them that they're cared about". (IV RN501)*

*'I've always liked this type of work ... it can be sad as well at times. But I feel it's the last good thing that we as people can do for these people. They're not going home. B says I'd rather be dead, and he says that quite often, and I really feel for him. But I'm not going to get into that. If I thought he would do something to end his life that would be different but he just feels hopeless. Although he can't reason why he's here, he knows he's not at home doing what he likes to be doing'* (IV RN501)

It can be challenging for the staff to remain positive, particularly in the face of the additional challenges listed above but, when they could, most really enjoyed their work. *"The job's very rewarding"* (IV RN 511)

### THE CHALLENGES OF NOT BEING ABLE TO SEE IMMEDIATE RESULTS FROM THE WORK

Some RNs commented that, with the people resident in nursing homes, dramatic and immediate results from the care they give would be rare. Some older people would respond in the intermediate or long-term future but some would likely not show any improvement.

Such challenges were also highlighted by a physiotherapist.

*"B has been here a matter of months and it's very difficult in the early days that situation of just chipping away at things that you may not perceive as hugely dynamic – not exactly cutting edge of technical input of clinical intervention. However over a period of time it has a very real effect on her.* (Physiotherapist Home 1)

Goals were adapted for individuals and stated within varying time frames. Sometimes the RNs recognised that the resident's individual goals would never be achieved but that maybe showing caring might help in the meantime:

*"It can be sad at times. But I feel it's the last good thing that we as people can do for these people. They are not going home. B says I'd rather be dead and he says that quite often, and I really feel for him. But I'm not going to get into that. If I thought he would do something to end his life that would be different, but he just feels hopeless. Also, although he can't reason why he's here; he knows he's not at home doing what he likes to be doing"* (IV RN501).

### THE CHALLENGE THAT THE WORK NEEDS TO BE CONSTANTLY RESPONSIVE

It can be difficult for staff to work to any definitive pre-prepared plan as the work and care needs to be responsive to residents, relatives, staff and others. Frequent interruptions in the work of RNs was the norm and even the best organised found it difficult to complete all they wished within each shift.

The challenge of not being able to work in a planned way and the need to be responsive.



**EXAMPLES OF THE COMPLEXITY OF THE NEEDS OF RESIDENTS ON THE MENTAL HEALTH UNITS WITHIN THE OUTCOMES FRAMEWORK**

**PERSONHOOD**

**Promoting personhood**

Staff aim to work with residents as individuals and, in order to do this, get to know them over a period of time.

One strategy that staff employ is helping residents to feel cared about: *"you're here because we love you"*

**Maintenance of wellbeing**

Maintained in the atmosphere created in the unit. If not maintained, wellbeing can deteriorate. *"in hospital they maintain them physically but can't maintain their wellbeing in the same kind of way and in 5-6 weeks they will have deteriorated"* (RN511).

Although strongly influenced by the environment and atmosphere, wellbeing can seemingly change minute-by-minute because recognition and lucidity change minute by minute, (RN511), although the emotion can linger longer, even if residents do not remember what caused the emotion.

Staff work to preserve residents' dignity on their behalf. E.g. M frequently removed her clothes so RN asked her sister to bring her in dresses. M still fiddles with the waist band but remains dressed.

**QUALITY OF LIFE**

Maintaining choice and control can be challenging, particularly in identifying what residents need and want. *"we try to offer as much choice as possible"* (RN 501) and choice is offered in every interaction - *"are you ready for medicine now"*.

Helping residents to express themselves and do what they want to do, e.g. walk around, helps maintain wellbeing but staff have to strike a balance between the needs of individuals (to walk freely) and the needs of other residents (who do not want someone walking into their rooms) (RN 702).

Maintaining a calm, homely and therapeutic atmosphere in the unit is very difficult, particularly as residents can shout, cry or scream. *"one can start, the noise levels increase and the tensions can increase"* (RN511)

Maintaining their happiness and enjoyment of life is difficult with large numbers of residents and few staff.

Entertainment and mental stimulation are important - residents can become frustrated and aggressive because they are bored.

It can be minute-by-minute balancing the needs of different residents (e.g. one wanted to watch the news but that can create difficulty with other residents who don't want it on or want something different. Sometimes if staff turn off the television they forget).

Safety - there can be outbursts, incidents e.g. fighting between residents, residents walking off the unit.

Organising outings can be very difficult. *"We try to organise outings, particularly if it's nice weather ... some are distressed by noise and can go for a ride to the forest and walk around the car park or to the farm up the road. We can't go too far a distance because if their sleep pattern is disturbed they can become restless. It also depends on their health on that day. And of the people who are willing to go how many will be mobile and who will react one with the other. It takes hours of planning. And you can't even say the evening before - you have to decide on the day because they may not be able to at that time, either because they're being aggressive, or have had a bad night, or have a chest infection ..."* (RN511).

## DAILY FUNCTIONING

RNs and CAs are trying to help maintain functioning in all activities of living and all aspects of functioning.

Breathing: Attention needs to be paid to all aspects of functioning even breathing. If residents are sitting in slumped positions and not breathing adequately they are at risk of a chest infection (RN511).

Maintaining mobility - can be challenging. Some residents want to walk around but may be at risk of falling or endangering themselves. Some residents need encouragement to move otherwise they can become fixed and disabled. A safe environment is essential so that residents are free to move without hurting themselves. Floor covering is also important, e.g. for people with Parkinson's Disease who may have difficulty crossing boundaries in the flooring.

Sensory functioning - It can be difficult to judge what residents need if they are unable to communicate. Staff have to pay particular attention to explaining e.g. food and medication

Examples observed included V, whose glasses were lost. Staff were diligent in trying to find them *"otherwise people could forget she wears glasses and she can't remind us"* (RN505); difficulty with a false eye because resident wouldn't wear it, the socket was shrinking, but staff were trying to put it in for when relatives came.

Continence - complexities in maintaining continence. Residents with mental health needs may forget where the toilet is, may not recognise it as a toilet or use other equipment as a toilet, may not recognise that they want to go, may not be able to tell staff that they want to go, may resist having clothes changed etc. Staff work with their abilities *"Some can use the toilet if you point them in the right direction"* (RN702)



## HEALTH

Health can be very unstable and unpredictable because of their complexity of needs.

Nutrition - Can be complex to maintain, e.g. may have insatiable appetite with no weight gain, may need food and supplements and copious fluids. Weight loss is often significant when residents go into hospital - up to one stone. (RN511)

In the home RNs have to watch what is eaten and watch what CAs are giving, e.g. diabetic juice for people with diabetes.

Maintenance of body temperature - is more complex because residents cannot express their needs. Staff have to monitor types of clothing to ensure they stay at an appropriate temperature. Clothes also sometimes have to be changed to accommodate special needs e.g. if they take them off in public.

Sleeping patterns - Can be more complex and needs can vary from day to day. Staff try to assess exactly the right time to offer to take residents to bed by gauging when they are ready. Residents can become very tired, e.g. through walking all day.

Working towards APPROPRIATE medication.

RNs are vigilant on medicines. Residents are mostly unable to verbally communicate when something is wrong. RNs recognise when the pharmacy has sent the wrong dose and assess the need for medication e.g. *"I like to see how each person is. Sometimes it's striking a balance with physical symptoms of Parkinson's Disease and congestive cardiac failure. I know them well enough to pick up the early signs"* (RN511)

RNs try to cut down on drugs *"GPs go through four patients at one session and I try to get them to do it properly because their time is so limited"* (RN505)

## ANTICIPATING, PREVENTING AND DEALING WITH PROBLEMS

There were many examples of where RN observation prevented accidents or incidents, e.g. where RN spotted resident going for another with a knife, spotted a resident about to hit another, noticed someone about to fall.

Some residents require very close monitoring, e.g. resident with diabetes, insatiable appetites and potentially violent behaviour, RNs monitor blood sugar.

## **APPENDIX 5.5: OPERATING IN THE INDEPENDENT SECTOR**

### **OPERATING AS A BUSINESS**

For all the Home Managers, including those who offered significant examples, the need to maintain the integrity of the home as a business was overriding. At the end of the day the homes needed to make a profit in order for the service to be able to continue. The need to maintain a profit could, on occasions, conflict with the homes' aim to provide high quality care.

The Managers explained that they needed to meet their budgets and targets. In order to do this, it was vital to ensure that their beds were always filled. Social services were dropping their fees and, if this continued, homes would be unable to provide adequate care for the fee levels paid by social services. Some beds in one home were contracted to the local Health Authority but, again, fee levels were not high. Homes were increasingly seeking residents who had sufficient funds to pay their own fees ('self-funders') but, even then, problems arose if the resident's funding became exhausted.

Local competition for residents could be fierce and this was particularly so for Homes 1 and 3. Home 2 was able to cater for people with high levels of need, including dementia, and there was less competition locally offering such a service.

### **OPERATING IN THE CHARITABLE SECTOR**

The issues for the homes operated by charities were distinct in some respects from those for the home operated by the corporate company. The charitable homes reported fewer problems with funding.

*"I've never worked for a charity before and there's lots of fundraising goes on so it's nice because if someone really needs something more often than not I can usually get it by one means or another and that's really important - it makes a lot of difference" (IV Matron/Manager Home 2)*

*"On the whole we're lucky here from my experiences in other homes and the NHS. We tend to fundraise more for the nice things. We've recently changed our hoist because what we had wasn't adequate. We've purchased a very nice dynamic air cushion for a lady who had the need. We've had some Alpha Excel mattresses recently too. I think resources-wise we do very well" (RN 701 Head of Care Home 2).*

*"Finances are not a challenge. We can make a case for anything we need. We've recently looked into mattresses and lots of moving and handling equipment and if there's a case for anything else we can have it. Generally we're very lucky" (Deputy Matron/Manager Home 3).*

*"Here they are very good on the funding so we don't have to cut corners. It must be soul destroying if you do, wherever you work, if you can't have the linen or the lifting aids when you know that's the way it should be done" (IV RN 908 Senior Sister Night Duty Home 3)*



## **OPERATING IN THE PRIVATE SECTOR**

The pressures on funding in the private home seemed to be considerably greater. The company insisted that the beds remain full and the Home Manager felt this placed her in a difficult position.

*"Sometimes head office don't think about the residents as people they just think of bums in beds and that annoys me because they are people. They go on about census and get angry because you have a death but what can you do. You try your best – you can't go out on the street and drag people in. Here we do take a lot of residents that other homes can't take because of the skills we've got in the home, like terminally ill for hospice care, sub-cut fluids, supra-pubic catheters. But some homes take people they can't really care for just to fill the beds" (Matron/Manager Home 1)*

The Home Manager explained that, if the home was unable to meet its budgets, the company would not allow money for refurbishment. The home then began to look less pristine and it was more difficult to attract residents.

*"... a continuous circle. We've just got to plod along and try and fill our best as best as possible and still keep the reputation of being the best nursing home in the area".*

The pressures on finance resulted in less than ideal equipment and staffing ratios. The effects of these were experienced daily 'on the floor' of the home and comments were made by the staff, including the Care Assistants.

*"It's all down to greed – money - the units are too big" (IV CA503)*

*"I don't think its ever going to change because it all comes down to money" (IV CA510)*

## **ATTRACTING POTENTIAL RESIDENTS**

The importance of attracting potential residents to fill the beds was mentioned by all home managers and those managers offering significant examples.

Most of the homes were maintaining what they saw as their 'core business', i.e. older people, or older people with mental health needs, or older people from a particular cultural background. A minority, however, were looking to *"plug the gaps in other parts of the market, such as young chronic sick, young people with behavioural problems"*.

## **MAINTAINING THE HOME'S REPUTATION**

Maintaining the good reputation of homes was a priority for all home managers, including those who offered significant examples (8.1, 10.1, 101.1).

*"We avoided damaging our reputation, which we survive on" (Example 266)*

If homes lose their good reputations, all managers identified that they would be unable to fill beds, their occupancy levels would drop and staff could lose their jobs.

## **APPENDIX 5.6: STAFFING ISSUES**

The challenges of attracting suitable staff were highlighted throughout the data and particularly in the fieldwork homes. The shortage of RNs, and particularly of RMNs, was a recurring theme in the data.

### **COMPETITION WITH NHS FOR NURSES**

Independent sector homes had to compete with the NHS for available staff and, when NHS staff were awarded pay increases, independent sector homes had to match these in order to attract suitable staff and maintain the levels necessary to meet registration and inspection requirements and to provide adequate care for the residents.

*Money-wise I think its going to be a problem in the future because when the government pay the NHS nurse more so they will have to up their wages I think because we'll be fighting for the nurses. (Matron / Manager Home 1)*

### **STAFFING SHORTAGES AND SICKNESS:**

Heavy workload and time pressures on the staff were evident in all of the homes visited during Phase 1 and also during the fieldwork. One entry in the researcher's diary during Phase 1 read *"Due to workload in the home it wasn't possible to talk with more than one person at a time. Only able to talk to four care assistants as the home has staffing problems – all afternoon staff are agency. There was a RN around but obviously very busy and the home manager didn't offer for her to speak with me"*.

On another occasion *"I feel awkward taking their time, particularly when they're busy, but they were all very willing to help – helped me to feel better"*.

Pressures of work and other aspects of life appeared to be the main reason for the low response rate in Phase 1, much as many potential informants commented on the importance of the research, it was not a priority in their busy lives.

Home 1 was particularly short-staffed during the fieldwork. One researcher diary entry read: *"Sister obviously under pressure - says there's insufficient time for the care she wants to give. Says care plans are a mess - they aren't good. Time pressures were considerable. There really is very little opportunity for therapeutic intervention as opposed to maintenance"*.

Many units, particularly in Home 1, had staffing vacancies and, because staffing levels were so tight, the absence or sickness of even one staff member could cause immense problems for the remainder of the staff. During Observation with RN502, the RN spent a considerable time on and off during the morning telephoning agencies for staff to cover shifts. The Home's Matron / Manager explained the situation in her interview at 2 p.m. on the day of this observation:

*"A classic is this morning – even for myself ..."*



*C [Sister on the unit] got a call at half five this morning to ask her to come and do an early instead of a late, that's just made the whole day out because we're now short this afternoon now.*

*C and I have spent most of the morning trying to cover shifts – shifts that were already covered but due to sickness – J [resident who pays for a CA to be with him all the time] – we have a night carer who's still here and I want to get him off the unit as soon as possible because he's looking after J till somebody comes on because S's [CA] off sick. We've got someone's car broken down – she's not turned in yet. It's been a case of ringing the agencies to cover the shifts, which means the drugs were late getting done; it means that the nurse does not supervise what's happening on the floor from a care point of view; she hasn't supervised meals; the whole thing – everything has had to take a step back because you're having to do things you wouldn't normally do – there are lots of things that I should be doing, but I can't get done because I'm helping cover shifts.*

*Then this afternoon we've a problem because we're one qualified nurse down with sickness, so again – all I've done this morning, and the same for her, is actually phoning 'round agencies and trying to cover the shift. I haven't managed to cover it so its meant shuffling 'round staff – so that's been a bad day".*

When even one staff member was absent, this affected the work, not only are the 'tasks' (drugs, dressings etc) were delayed but also 'maintenance' needs may be missed e.g. checking whether J has taken enough fluid or opened his bowels. The Matron / Manager explained:

*"You can provide continuous care but the whole day just falls back because things that would be done in the morning by the team – if you have an agency carer in there things just fall behind, then in the afternoon things that haven't been done in the morning so the afternoon staff fall behind then it falls on the night staff so it builds up. Then on other days things will run smoothly and then the nurse in charge is going to be doing her job and supervising care on the floor; supervising meals and just making sure that things like dressings are done".*

*"For the number of hours you're working and the number of people you're looking after it is almost impossible to give adequate physiotherapy and exercise or rehabilitation of any kind - it's not feasibly possible ... the physio helps but he's not here enough to benefit the number of people here" (IV RN513)*

*"its nice when you've got time to have a good conversation with the different residents. Unfortunately you very often haven't got time for more than five minutes here and there and you pick up little bits and pieces" (IV RN512).*

Staff shortages also affected the mental health units.

*"mental health care isn't catered for as well as it could be because of staff shortage and we often get challenging behaviour because the residents aren't stimulated enough" (IV RN501)*



## **AGENCY AND BANK STAFF**

Agency and bank staff were brought in but this was not ideal if these nurses did not know the residents or understand their needs.

*"from a continuity point of view the residents suffer because they're seeing different nurses and the agency nurses don't know the system – the residents don't get the little extras they expect from the care staff done because they don't know them - and that where it falls down". (Matron / Manager Home 2)*

In addition, agency staff were more costly to the homes than if their own staff worked longer shifts and Home Managers were under pressure to reduce the numbers of agency staff engaged.

*"But then Head Office saying to me – try and cut down on the agency – try and get your staff to pick up. Some of the staff are super and they will just stay on and work. But I've got to send staff home some days because they're picking up shifts and are exhausted but they're picking up because they feel sorry for the residents. The staff just get run down. You've got to keep your eye on that as well especially with the working directive you have to really watch what they are actually working. (Matron / Manager Home 1)*

Many of the staff in the units with particular staffing problems were working 'long days' (i.e. 7.30 a.m. to 9 p.m.). Staff commented how tired they felt. Some were becoming 'run down' and the sickness rates in the units affected were increasing.

Many of the staff commented that staffing issues were common throughout the independent sector.

*"Staffing is a problem - not as bad as other places. You're still need bank staff or agency staff to cover sick leave and holidays but you get that everywhere" (IV RN512).*

*"Every home's in the same position. It just varies, and you just have to get on with it". (Matron / Manager Home 1)*

## **VARIABLE QUALITY OF STAFF**

Most of the staff worked well and were caring but, as highlighted in Chapters 3 and 4, there were exceptions, particularly in Home 1 and to a small extent in home 2.

*"It's the quality of the carers you're working with as well, some shifts you've got no support . Some have knowledge and patience. Some are more mature than others but mature people don't always make better carers. Some people don't seem to notice the way their body language affects the residents and the way they're dealing with it but I can see it. If they're sharp and loud and demanding the resident to do something, they get aggressive and agitated and uptight and they can't do it then the carer gets worse and it escalates. It's tone of voice and mannerisms, being too rough or short tempered" (IV CA706)*



**INADEQUATE SUPPORT SYSTEMS**

Inadequate or inappropriate support services also put additional pressures on the staff, particularly in Homes 1 and 2.

Maintenance staff were felt not to be helpful in Homes 1 and 2. During one observation, the RN felt the maintenance man was being unhelpful because he would not alter the height of a bed in order to accommodate a hoist. Eventually she snapped *"Don't bother then I'll do it myself"* (Observation notes RN502).

In Home 2 an RN complained that the maintenance man would disturb residents in the morning by throwing the newspaper into their rooms (Observation notes RN703).

There was little administrative support in Home 1 and this seemed to result in some jobs not being able to be completed by the RNs. While the RNs were ringing for agency staff or sorting out problems with equipment they were unable to complete their own work, such as dispensing the medicines, seeing the residents or renewing wound dressings. This led to a lack of continuity in care.

In Home 2 there were also complaints of inadequate administrative support.

## **APPENDIX 5.7: FACILITIES, EQUIPMENT AND SUPPLIES**

### **FACILITIES IN THE HOMES**

The facilities in the homes were not always suitable for the residents' needs and the type of care the staff wanted to offer.

For example in units for people with advanced mental health needs:

*"We have no quiet areas" (RN501)*

In units for residents with physical and mental health needs:

*"Especially with people on the second floor because we don't have the grounds so freely available, but trying to get people interested in birds and gardening downstairs because we can have bird tables and things outside and get them to do things like that or draw pictures and flowers - there's quite a few budding artists. Up here it's more of a challenge - we don't have space so we're very limited with what we can do for people unfortunately and even to create things and do things from home so that they can continue with things that they've been doing in the past. It can be a problem to store all these things." (IV RN513)*

*"It's very idealistic sometimes because trying to put [hobbies and activities] into practice is very difficult. Some interests are easier than others. If they can be confined to small parts of the home or unit then that's good. If it involves quite a lot of outside work, like posting things outside so they can get post in or books in, it can be a little more complicated. We do try our best. Sometimes it works out really well and other times we have to rethink and possibly introduce them to something different but probably in the same line" (IV RN513).*

Some RNs wanted more facilities in order to provide more comprehensive care to residents:

*"I think a lot of the time they see nursing home – oh there will be trained staff there – they can manage. Yes we do manage but we haven't got the facilities if anything needs to be done in a rush and it could come back on us. That worries me sometimes ... We've got oxygen obviously and we just do our ordinary CPR until the ambulance came but we can't stitch and that was quite alien to me because I can stitch I've worked in resus – but its home policy here that we're not allowed to stitch – we can put steristrips on but sometimes there's occasions where if we had the facilities we would be able to do more but home policy is that we can't and they have to go to hospital. In residential its even worse because there's no trained staff – they're not supposed to have nursing needs but a lot of them do" (IV RN512).*

### **SUFFICIENT AND APPROPRIATE EQUIPMENT AND SUPPLIES**

Sufficient and appropriate supplies and equipment was vital for the effective delivery of care to residents. Home Managers and RNs aimed to have available



all the equipment needed by residents but, because of the diversity of resident needs and the vast range of equipment available on the market, this could be challenging.

Equipment and supplies budgets were identified in all of the homes but those run by voluntary organisations said they could fund-raise for what they needed. The private sector home had more difficulty, particularly in purchasing the right hoists, air mattresses and other pressure relieving devices. The Matron / Manager explained that having appropriate equipment could be cost-effective.

*"The company is now aware of the legal implications of people getting pressure sore. We spend a fortune on dressings but you need air mattresses to prevent the pressure sores in the first place, and if you don't have the proper mattresses, sores aren't going to heal, so you will save money because if the sore heals quickly then you don't use as many dressings and are not spending as much money, so the air mattress saves money. We need the equipment to nurse the residents".*

The diversity of equipment needed in the care of residents was considerable and there were occasions throughout the observations in all three homes when particular items were not available.

One unit in Home 1 was particularly short of equipment and this impacted significantly on the CAs. In the observations on this unit shortages were noted in gloves, aprons, wipes, Hibiscrub, green incopads, plasters, pillow cases, flannels, yellow plastic bags (for clinical waste - potentially contaminated). There were also no rubbish bin liners and one CA suggested going to the local Tesco to steal some plastic carrier bags.

On the same unit, unsuitable equipment included low beds which CAs (and the researcher) had to stoop to make; hoists which were not suitable for all residents, in use in another area of the home or in need of repair; wheelchairs with footplates missing.

The lack of appropriate equipment caused additional work for the CAs and much additional energy expenditure making trips to linen cupboards, store cupboards or other wings of the home to find equipment. It also potentially put them at risk. Two particular examples of this were

- when protective gloves and aprons were not available and residents with infections, including MRSA, needed care
- when lifting/moving/handling equipment was not available or the beds were too low for safe working.

Lack of suitable equipment also impacted on the RNs:

*"I'm trying to achieve a smooth running unit, even though I'm not the boss – a lot of the hassle with the carers are we don't have certain equipment – we don't have enough pads, gloves – its ridiculous really that I'm being asked because we don't have enough gloves" (IV RN505)*

## **APPENDIX 5.8: WORKING IN A CLOSED COMMUNITY**

The data identified a range of issues concerning working in the closed community of the homes.

### **STAFF AND RESIDENTS KNOWING EACH OTHER WELL**

Throughout the examples, observations and interviews it was clear that staff and residents grew to know each other well and relationships were close. Most RNs and CAs worked hard to understand the residents and displayed:

- Understanding of the residents individuals (to varying extents between staff)
- Understanding of their health and clinical needs
- Were able to prioritise because know residents well
- Were able to recognise change because know residents well
- Advocate for residents, particularly with GP, because they knew them
- Work with the residents families, whom they also got to know well

### **BEING TOGETHER EVERY DAY**

The staff and residents saw each other virtually every day over the course of years and many staff and residents commented that the home could become like a family. Working in such a closed community can, however, bring its own challenges.

### **DISLIKE AMONG RESIDENTS**

Not uncommonly, residents did not get on with one another and did not want to spend time together.

*"I sometimes talk to the other residents but we don't have much in common. One was a schoolmaster and I'm not interested in school - I left years ago. And most of them are old women. I suppose I am an old man but I don't feel like it. There's one woman who packs the food in her mouth. Company doesn't bother me - I'm used to being on my own". (IV Resident 953)*

*"I don't go up to the lounge. I'm not really keen on people. Intellectually there's nothing to talk about. They don't know me. I'm used to being on my own. I can watch the TV programmes I like" (IV Resident 507)*

*"Like any people living together, there's often friction. It works both ways - they often sit and talk to each other and keep each other company and things like that, so they do socialise quite well most of the time. They you get one starts shouting and it escalates - several start shouting and then they get physical, the ladies are much more physical than the men. They lash out much more readily than the men do. We have a couple of ladies here who lash out a lot with their hands. They will hit the people around them on both sides of them and anybody in front they will lash out and kick out. Things upset them at certain times and once they're in this type of mood it all goes" (IV RN513)*



*"Some days you go home totally exasperated where they've all been arguing - it's like family life, they'll all get on with each other or they all wind each other up and that's like family life. This is their home. Some of the gentlemen haven't got anyone at all, we are his family and for them especially their emotional side is important. Me being a part of their extended family - them being part of mine ... they do live like a huge family, so if one's a bit low it brings the others down" (IV RN512)*

*"I know all the residents very well and every day they're different characters. One day they can be wonderful, another day they could be very aggressive" (IV RN510).*

### **FRICTION BETWEEN STAFF**

Several of the staff interviewed commented how nursing homes, as closed communities, can lead to the formation of cliques of staff and can easily become breeding grounds for gossip.

*"You see the same people every day. Some get on better with some than others and little cliques can develop. If I walk in a room and they are gossiping they stop talking. You have to know who you are talking to and how to quell gossip. Wherever you have a lot of women working that happens" (IV RN703).*

*"Things can get out of hand with a lot of women together. And sometimes there's personality clashes but as long as they are not upsetting the clients or their care I let them sort it out" (IV RN916)*