

**A COMPARISON OF THE WORK OF QUALIFIED NURSES AND NURSING AUXILIARIES  
IN PRIMARY, TEAM AND FUNCTIONAL NURSING WARDS**

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## ACKNOWLEDGEMENTS

I would like to thank all the nursing staff who participated in the study for allowing me to observe their work and making me so welcome in their wards. Thanks are also due the Department of Health for funding this research via the Nursing Research Studentship Scheme.

I am especially indebted to my supervisor, Dr Senga Bond, for her support, encouragement and sound advice over the past four years, and for always finding time for me in an incredibly busy schedule. Numerous other staff at the Centre for Health Services Research have been a source of help and advice. I would particularly like to thank Dr Peter Philips for his invaluable assistance with data preparation and Dr Barbara Gregson for statistical advice.

Thanks are due to Freda Bolam and Maureen Craig for all their help and hard work in preparing tables and figures. I would also like to thank Barbara Ingman for additional help with tables, Pauline Potts for helping check references and Eric and Isabel Thomas for transcribing interviews.

Finally, I would like to thank my husband, David, for being a constant source of encouragement and support. Without him I would not have started or finished this work.

## SUMMARY

Despite the large scale utilisation of nursing auxiliaries (NAs) within the health service, there is a paucity of research evaluating their effectiveness. This study aimed to compare the contribution to patient care of NAs with that of qualified nurses (QNs) using a qualitative indicator, nurse-patient verbal interaction. Different grades were also compared in terms of activities performed and perceptions of their work environment.

The organisation of nursing work also has major implications for the roles of QNs and NAs. The study therefore also sought to evaluate the effect of three organisational modes, primary, team and functional nursing, on the work and work perceptions of both grades.

A questionnaire was developed which discriminated between organisational modes. This was used to select three wards from each mode (nine in total) for participation in the study. Within each ward, four QNs and four NAs were chosen randomly for inclusion. Data were collected by direct observation and semi-structured interviews. Each subject also completed a Work Environment Scale.

The most important differences were found across organisational mode, with QNs and NAs within modes engaging in similar patterns of work, verbal interactions with patients and regarding their work environment similarly. This suggests a culture exists within each organisational mode which permeates the work of both grades of staff. Primary wards were generally found to differ from team and functional



wards, with both QNs and NAs regarding their work more positively and working in more therapeutic ways.

The study has important implications for the debate about which grade of staff is most suited to caring for elderly patients. It is argued NAs are capable of providing therapeutic care for elderly patients within a pattern of ward organisation which facilitates sustained nursing staff-patient allocation and appropriate supervision and direction in the form of QNs working with NAs.

## ABBREVIATIONS

QN - registered general nurse or enrolled nurse  
NA - nursing auxiliary

Primary ward - ward practicing primary nursing according to author's criteria  
Team ward - ward practicing team nursing according to author's criteria  
Functional ward - ward practicing functional nursing according to author's criteria

Ward P1  
Ward P2 - Study primary nursing wards  
Ward P3

Ward T4  
Ward T5 - Study team nursing wards  
Ward T6

Ward F7  
Ward F8 - Study functional nursing wards  
Ward F9

## CHAPTER 1 LITERATURE REVIEW

### 1. INTRODUCTION

Recent studies of nurse staffing in care of the elderly wards show that nursing auxiliaries form a substantial part of the workforce. In 1982 they represented 45 per cent (Bosanquet and Gerard, 1985) and in 1986, this was 46.5 per cent (DHSS, 1986; Brocklehurst and Andrews, 1987). The 'Mix and Match' A Review of Nursing Skill Mix report (DHSS, 1986) found the percentage of nursing auxiliary hours per patient per week ranged from 35 per cent to 82 per cent. The proposals of Project 2000 that all learner nurses should be supernumerary (UKCC, 1986), demographic changes reducing the number of eighteen year olds available for nursing, together with cultural shifts in attitude towards nursing as a job are likely to exacerbate this trend to the use of unqualified nursing assistants.

The effects of the use of cheaper nursing auxiliaries compared with qualified staff on patient care are likely to come under increasing scrutiny as a result of recent management changes arising from the implementation of the Act 'Working for Patients' and its emphasis on meeting quality criteria at minimum cost (Buchan and Ball, 1991).

To date, however, despite the large scale utilisation of nursing auxiliaries within the health service, there is a paucity of research evaluating their effectiveness on any parameter. The first aim of this study, then, was to compare the differential contribution to patient care of qualified nurses and nursing auxiliaries in care of the elderly wards.

The second aim of the study was to determine the effect of three methods of nursing organisation (primary nursing, team nursing and functional nursing) on the work and work perceptions of qualified nurses and nursing auxiliaries.

In recent years, the way in which nursing work and nursing staff are organised in hospital wards has been regarded as affecting both processes of care, summarised as the quality with which care is delivered, and outcomes of care. The mode of care provision known as primary nursing has received the most attention, and attempts to demonstrate the value of primary nursing in terms of beneficial effects for patients and nursing staff have proliferated in research (e.g. Manley, 1989; Reed, 1988; Pearson et al, 1988; Armitage et al, 1991), anecdotal accounts (e.g. Marlow, 1991; Ashley, 1984) and proselytising literature (e.g. Wright, 1987; 1991; Malby, 1988; McMahon, 1989). However, no UK study compares more than two organisational modes, one of them primary nursing.

The way in which nursing work is organised also has major implications for the roles of both qualified nurses and nursing auxiliaries. The role of nursing auxiliaries and the new 'support worker' are likely to assume increasing importance due to the proposals of Project 2000 (UKCC, 1986) that nursing students become supernumerary, with qualified nurses and support workers forming the entire ward staffing complement. While many different viewpoints are expounded in the literature as to which form the role of various grades of nurse should take under different ways of organising nursing (e.g. Pearson, 1988; MacGuire, 1989a; Pembrey, 1985), these are largely anecdotal. The present study thus sought to

evaluate the effect of nursing organisation on the work of qualified nurses and nursing auxiliaries.

In this chapter, general literature on the usage of nursing auxiliaries is reviewed, followed by a section examining previous studies of nursing auxiliaries in care of the elderly. There follows a review of primary, team and functional nursing, together with literature examining the role and function of different staff grades within each organisational type.

## 2. THE NURSING AUXILIARY IN THE NATIONAL HEALTH SERVICE

### a. Defining the term 'nursing auxiliary'

Definitions of the term 'nursing auxiliary' frequently include several components. Firstly, a description of the role of the nursing auxiliary in relation to the qualified nurse; secondly in terms of qualifications and thirdly in terms of activities performed.

In the 1950s and 60s, the World Health Organisation defined nursing auxiliary personnel as:

"paid workers in a particular technical field with less than full professional qualifications in the field and who assist, and are supervised by professional workers."

(unpublished United Nations report /R170, quoted by Hockey, 1976 p.165)

In a UK context, the position of the nursing auxiliary in relation to the qualified nurse also appears in the Committee on Nursing

definitions. Here, the role of the nursing auxiliary is to "support nurses and midwives" (1972 para. 45). Also, nursing auxiliaries are identified as having

"no professional training. Patients may call them 'nurse' and they enable service to the patient to be maintained and improved, not least at night, but they are outside the profession." (1972 para.85b)

The criteria of no professional qualification further appears in the definitions given by Hardie. She defines nursing auxiliaries purely in terms of who they ARE rather than what they DO. They are:

"nursing workers without recognised qualification to nurse and who may have little or no formal training for their work." (1980)

"Nursing worker" has replaced the more nondescript "person" in her earlier definition (Hardie and Hockey, 1978a p.42), but the relationship of the nursing auxiliary to the qualified nurse is not specified.

The Royal College of Nursing defines the nursing auxiliary more in terms of what they DO, i.e. tasks, rather than who they are:

"nursing personnel able to perform specific tasks related to patient care that require considerably less use of judgement. They should be able to relate well to patients and carry out dependably, under supervision, the tasks for which they have been trained." (World Health Organisation, 1966)

This definition has several inadequacies (Johnson, 1978). For example, which tasks require less use of judgement? and what sort of judgements is a nursing auxiliary capable of making?

It is argued, however, (World Health Organisation 1982; Boylan, 1974a) that it is not possible to define a nursing auxiliary by what tasks she performs because of the varying, but often considerable,

degree of overlap in the job content of nursing auxiliaries and qualified nurses.

For the purposes of this study, Hardie's definition (1980) will be accepted. This is because it outlines nursing auxiliary status in terms of qualifications and training, but does not limit it in terms of rigid task performance. Nursing auxiliaries participating in the study were, however, chosen according to the criterion of appointed position in the ward.

**b. The role of the nursing auxiliary**

In the definitions given above, the role of the nursing auxiliary appeared as assistant to the professional nurse (unpublished United Nations report /R170, quoted by Hockey [1976]) and 'enabler' with regard to maintenance and improvement of patient care services (Report of the Committee on Nursing, 1972). How the nursing auxiliary assists or enables is not made clear.

Attempts have been made, however, to specify different roles for nursing auxiliaries according to different service needs. Hardie and Hockey (1978a) list three possible roles:

1. helper or assistant to the nurse
2. substitute nurse
3. specialist worker with a highly defined set of duties

More recently, Johnston (1987) also identified three possible nursing auxiliary roles:

1. the ward assistant role (a combination of the nursing auxiliary and domestic role)
2. a role in which the nursing auxiliary is employed to nurse specific patients under the management and guidance of a registered nurse
3. a specialised role

Hardie and Hockey do not state what the role of helper or assistant to the nurse entails, but their study (1978b) showed that where there are most nursing auxiliaries there tend to be fewer qualified nurses and vice versa. This, they argue, "would seem to militate against the role of the nursing auxiliary as assisting the nurse, unless this relationship is accepted as a chiefly theoretical one." (Hardie and Hockey, 1978b p.15). For Johnston, this role for nursing auxiliaries is suited to areas where patients need to be nursed solely by qualified nurses because "patient's nursing needs are rapidly changing and skilled nursing judgements are constantly required" (1987 p.11).

Hardie and Hockey's second role appears similar to Johnston's. Here, the nursing auxiliary 'nurses' specific patients, for example those whose needs could be met by a caring relative, allocated by a qualified nurse who retains responsibility for those patients and also manages, guides, teaches and supports the nursing auxiliary.



This role of substitute for family and friends also appears in the Royal Commission on the National Health Service:

"Nursing in the NHS may involve providing unskilled but devoted care which might otherwise be given by relatives and friends. It is carried out by nursing assistants and auxiliaries with the minimum of in-service training, under the supervision of trained nurses, and it forms a substantial part of the care given to patients." (1979 p.188)

This is contrasted with "skilled professional nursing care" given by qualified and learner nurses. Meanings of the terms 'unskilled' and 'skilled' are, however, left unexplained.

An active role for the nursing auxiliary in the nursing care of patients is also advocated by Pembrey (1985). She argues that the more important role of assistant to the patient not the professional nurse is now appropriate. While remaining under the supervision of the registered nurse, the "care assistant should be responsible for the complete nursing of a patient" (1985 p.49).

Hardie and Hockey's third role also appears akin to Johnston's. Johnston cites theatres, X-ray departments and renal units as areas in which nursing auxiliaries in this role may be found, specialising particularly in the preparation and use of equipment.

The World Health Organisation working party describes the nursing auxiliary's role in the language of the nursing process:

"If the auxiliary is not prepared in such a way as to be able to participate in the whole of the nursing process, which includes assessment of needs, planning and implementation of care and evaluation of the outcome of the care, it will be to the patient's detriment." (W.H.O., 1982 p.8)

This statement is later qualified by Hardie, who argues that nursing auxiliaries should have little input in terms of care planning:

"One may expect an auxiliary to be kind, skilful and responsible, but to exercise only very little judgement in the sense of planning the care." (Hardie, 1982 p.28).

Turning to specific duties performed by nursing auxiliaries, evidence in the literature suggests a role with potentially large parameters. Somers (1977) found sixty percent of all nursing functions to be performed by all levels of nursing personnel, and Hardie and Hockey (1978b) found the interchangeability of duties to be almost complete, with only the giving of intramuscular or intravenous injections not practiced by nursing auxiliaries anywhere.

More recently, Robinson et al (1989) found that in medical and surgical wards which employed nursing auxiliaries, they provided only 7.7 per cent of nursing care, concentrating on hygiene and elimination in direct patient care and upon housekeeping in associated care.

A major factor influencing the role of the nursing auxiliary is the debate on the professionalisation of nursing, which has resulted from nurses seeking both autonomy for their profession and a relationship of collegiality with the medical profession. Within this debate, there are two schools of thought on the role of the nurse, both of which have crucial implications for the role of the nursing auxiliary and both of which revolve around the status of 'basic care' tasks (i.e. assisting the patient with activities of daily living such as personal hygiene, toileting and ambulation).

According to the first school of thought, 'basic care' tasks are viewed as low level and repetitive, requiring little skill and judgement, just common sense and a kind heart (Proctor, 1982). Therefore, they can reasonably be handed down to the nursing auxiliary, while the professional nurse concentrates on the 'technical' aspects of her role, for example carrying out sophisticated clinical procedures delegated by medical personnel, and identifies her contribution to care in an administrative and managerial field (Bond and Bond, 1980; Bowling, 1980; Williams, 1978). Melia (1987) believes this viewpoint to be characteristic of the "rank and file" of nursing.

This view of 'basic care' is, it is argued, perpetuated in learner nurses as a result of their ward experiences. Basic nursing duties are considered menial firstly because the ward sister spends little time performing them (Boylan, 1974b). Secondly, the fact that they can apparently be carried out equally well by untrained staff, i.e. learner nurses and nursing auxiliaries, points to the requirement of no knowledge for their performance (Melia, 1987). Learners, therefore, come to describe 'basic nursing care' in terms of "anyone can do it" and to dismiss it as "just basic nursing care" (Melia, 1987 p.136) as well as viewing it as 'work' rather than as a learning activity (Fretwell, 1982). However, the activity of mobilising reluctant patients was seen as a 'high skill' area by learners in Hooper's study (1981a,b).

The second strand of thought on the professionalisation of nursing re-defines 'basic care' as not just comprising simple tasks which can be mastered by untrained staff, but as a "problem-oriented, patient

centred activity requiring considerable expertise and scientific knowledge" (Dickinson, 1982 p.63), possessed only by qualified staff. By this means, therefore, qualified staff reclaim 'basic care' as their own. This enhances nursing's claim to professional status firstly, because 'basic nursing' then forms the unique body of knowledge, one of the requirements of a profession (Freidson, 1970), and secondly because it identifies the nurse's unique contribution to patient care, thus enhancing claims for a status independent of the medical profession. MacFarlane argues this viewpoint:

"I believe it is time to stress the primacy of ... acts of caring in nursing and to give greater attention to the art and science underlying what may appear to be the simple acts we all perform for ourselves." (1976 p.190)

MacFarlane also believes nursing work should be the province of qualified staff:

"The danger is, that the one great talent of caring and helping and assisting which has been entrusted to us may be 'lodged with us useless' or worse, given to others unskilled in the art and science of caring, whilst we become technicians." (1976 p.190)

More recently, Wilson-Barnett (1988) describes 'basic care' as requiring much more than common sense. Indeed, she views it as "at the heart of nursing" and as "challenging and important work" (p.794). Wilson-Barnett also sees 'basic care' as the province of qualified nurses:

"basic care requires a comprehensive knowledge of the individual's needs, personality and situation. Although most nurses would agree with these ideals, many continue to delegate basic care to untrained or junior nurses." (1988 p.794).

Melia (1987) argues that the elevation of the status of 'basic care' is characteristic of "academic professionalisers", who are found largely in academic circles and tend to be removed from patients.

If, then, 'basic nursing care' requires a qualified nurse for its execution, the role of the nursing auxiliary must either be abolished (Bolger, 1984) or redefined. Bell suggests the former in order to enable qualified nurses to carry out research into basic care techniques and to enhance "the prestige of providing basic care." (1983 p.23)

The recent heated debate on whether to admit nursing auxiliaries into membership of the Royal College of Nursing also hinges on the issue of the professional status of nursing (Rye, 1978; Vousden, 1988; Bolger and Wright, 1989).

Arguments for the exclusion of nursing auxiliaries from patient care work, for example because this requires training and certification, run counter to the generally held belief that nurses are 'born not made'. According to this argument, personal qualities and gifts as well as knowledge and skills gained through training are essential requisites of a good nurse, and nursing auxiliaries are just as likely to be in possession of these as are qualified nurses. This viewpoint is illustrated in the recent Strategy for Nursing:

"The true quality of care...lies in the practitioner's own personal interaction and relationship with individual patients." (Department of Health, 1989 p.21)

Opinion regarding the status of 'basic care', and the grade of staff considered necessary to provide it, has important implications for the role of the nursing auxiliary in care of elderly people, where 'basic care' forms a large component of nurses' work. This is discussed further in section e.

### c. Training of nursing auxiliaries

Evidence suggests nursing auxiliaries are unprepared for a role with such potentially wide parameters. Nursing auxiliaries have no formal national training, but some are given induction courses, 'on the job' practical and/or theoretical training or both (Courtney, 1978; Catterson, 1983; Harrison, 1988; Johnston, 1987). The Report of the Committee on Nursing (1972) discovered that the duration of this training varied considerably: 13 percent of in-service training courses lasted less than 10 hours, and 16 percent over 40 hours. In only seven percent of hospitals studied did all nursing auxiliaries attend induction courses, and in only 30 percent did they attend training other than induction. Fifty percent of nursing auxiliaries had received no training at all. Hardie and Hockey (1978b) similarly found that a third of nursing auxiliaries interviewed had received no formal training, even though the hospitals concerned offered it.

Specific training in care of the elderly seems even more scarce. Hardie and Hockey (1978b) discovered only two health districts in Britain (out of a sample of 67) had training programmes in the speciality. In a random sample of nursing auxiliaries in London, Godlove et al (1980) found that 53.4% had received no training whatsoever. They found that the little training there was emphasised physical aspects of the job, such as making beds and how to lift, with very few auxiliaries taught about patients' physical and psychological problems, or how to maintain an elderly person's independence, privacy and dignity.

The World Health Organisation working group on the training and use of nursing auxiliaries (1982) suggests some reasons for the ad-hoc nature of nursing auxiliary training. Firstly, it states that in cases of economic difficulty the education of nursing auxiliaries is often considered of secondary importance to the education needs of other nursing personnel. "This [results] in poorly trained workers trying to give care beyond their competence in order to meet nursing needs identified, but not met, by others." (p.5-6). Secondly, nursing auxiliaries came into being as a short-term expedient and would not exist in an ideal world: "the lack of organized schools, qualified nurse teachers and on-going educational opportunities for auxiliaries represents an unstated but real expectation in the health professions that auxiliaries will fade away." (p.10)

There is general agreement in the literature, however, that the present situation with regard to nursing auxiliary training needs improvement. In Hockey's study (1976), staff nurses/midwives, enrolled nurses and learner nurses ranked adequate initial training of nursing auxiliaries as the most important factor in the employment of auxiliaries likely to help patient care. Nursing auxiliaries also believed adequate training to be the factor which would help most in the care of patients (Hardie, 1980).

The Report of the Committee on Nursing makes the following recommendations:

"We recommend the institution as soon as possible of a properly costed and planned scheme for the in-service training of nursing aides which will be considerably more than orientation training."

"In our view, the greater part of this training should continue to be carried out in the ward or field situation and be of a practical rather than a theoretical character." (1972 paras. 338 and 339)

Duration and frequency of this training are also stipulated. The report goes on to recommend a national syllabus devised by the Central Nursing and Midwifery Council through its education boards. Colleges of nursing and midwifery together with nursing and midwifery administration would then decide on the application of the programme, and qualified staff at ward, unit or community level would be responsible for its implementation. The award of a certificate on successful completion of the course is recommended. The recommended content of the course is not, however, specified.

While the Report of the Committee on Nursing (1972) recommends a mainly practical training for nursing auxiliaries, the World Health Organisation working party advocates an "integration of theory and practice", involving "theoretical instruction, practical demonstrations and field activities." (1982 p.11)

#### d. Future developments: Project 2000

In 1986, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting proposed a radically new form of nurse training (UKCC, 1986). The proposal having most bearing on the future role and function of unqualified staff is that learner nurses will no longer provide "pairs of hands" to meet service needs at ward level, but will be supernumerary to ward staffing requirements. A further recommendation is the establishment of a single level of nurse



training, which involves the abolition of enrolled nurse training. Therefore, first level nurses and nursing auxiliaries will form the entire staffing complement.

i. *The role of the support worker*

The UKCC also proposes a new type of unqualified worker, which it terms an 'aide'. Some attempt is made to define the role of this aide (also described as a 'helper') in relation to the 'new practitioner', i.e. the Project 2000 prepared qualified nurse. The practitioner assigns work to the helper. The helper assists the practitioner, and carries out assigned work, but the practitioner retains responsibility and accountability for patient care and monitors the helper's performance.

The UKCC proposals seem to have precipitated the need to define more clearly the 'role framework' (DHSS, 1987) of the support worker, and to identify role boundaries. Two main roles are identified for the support worker (DHSS, 1987; National Health Service Training Authority [NHSTA], not dated; NHSTA, 1988):

1. An 'environment support' role
  - a. housekeeping/contributing to the maintenance of the care environment
  - b. clerical/administrative.
  
2. A 'direct care support' role
  - a. physical, social or other support to client
  - b. assisting the practitioner.

The Strategy for Nursing also envisages two similar roles for the support worker. Firstly, in direct patient care:

"Support workers who have had appropriate training will be able to undertake, under the supervision of a qualified practitioner, a wider range of care and treatments for people whose condition is relatively stable." (Department of Health, 1989 p.21)

Secondly, the support worker can assist with tasks "which should be undertaken by ancillary, administrative or clerical staff, or by other occupational groups." (p.21)

Within these areas, the support worker may work at different levels, which have been defined by the National Council for Vocational Qualifications (the body set up by the government in 1986 to reform and rationalise the system of vocational qualifications) as follows (NHSTA, 1988; UKCC, 1990):

Level 1: Basic Level.

This involves the performance of a range of activities, primarily routine and predictable.

Level 2: Standard Level.

This is generally the same but involving more individual responsibility and accountability.

Level 3: Advanced Level.

This level requires the "ability to perform a broad range of work-related activities, including many that are complex, difficult and non-routine, appropriate to sustaining regular processes and outputs, to specified standards." (NHSTA, 1988 p.17)

Supervisory competence may be required at this level.

NHSTA identifies two boundaries to the role content of the support worker. Firstly, the support worker must have a direct link with the care of clients. Secondly, the support worker must be accountable and act on instructions from the professional practitioner.

NHSTA also considers it essential to identify boundaries to the support worker job content. These boundaries may be far wider than those of present nursing auxiliaries. For example, the report lists among the support worker's tasks preparing for and/or assisting with specific clinical procedures, taking and recording observations and specific rehabilitation activities.

Economic constraints and demographic variables (Bosanquet and Gerard, 1985) coupled with the reforms of Project 2000 may well lead to the proliferation of untrained staff in the foreseeable future (DHSS, 1987) and, in the short term, exacerbate the shortage of qualified staff. The UKCC emphasises, however, that the new nurse practitioners will be care givers, not just supervisors of untrained personnel:

"To conjure up the notion of a small cadre of registered practitioners supervising care and a larger group of helpers delivering that care, would be...in contravention of the UKCC Code of Professional Conduct. It is emphatically rejected by the project group." (UKCC, 1986 para.5.36)

ii. *Training the support worker*

A major difference between the current nursing auxiliary and the new support worker is that the support worker will, in theory, be specifically trained for the job. The UKCC (1986) recommends a "limited" (para. 5.37) form of instruction for support workers tailored to the setting in which they work. The report states that, unlike registered practitioner training, support worker training should not be the responsibility of the statutory bodies, but suggests guidelines for training should be issued by the National Boards, and training itself be arranged by employing authorities on an in-service training basis, over a period of approximately three months.

The UKCC has, however, been criticised for its "elitist and unjust" belief that while nurses need a "lifelong progression of professional learning" (UKCC, 1986 para. 6.2), support workers require only a limited form of instruction (Salvage, 1988 p.22).

e. *The nursing auxiliary in hospital care of the elderly*

The widely held assumption that 'basic nursing' requires less skill than 'technical nursing' seems to be used to justify the large number of unqualified staff on elderly care wards, as here 'basic care' occupies a large proportion of staff time. Indeed, nursing

auxiliaries may be the grade of staff in greatest contact with the patient (Davies and Snaith, 1980), providing the majority of direct patient care. Day and Klein state this graphically: looking after old people "tends to be left for much of the day and most of the night to the least trained, least skilled, and least well paid members of staff: aides, auxiliaries and domestics." (1987 p.385)

There is evidence that nursing auxiliary usage increases in direct proportion to patients' basic care needs. Hill et al (1987) found that on wards where patients had an increased need for nursing care as a result of immobility, there was an increase in the number of allocated nursing auxiliary hours and a corresponding decrease in registered and learner nurse hours.

While, then, nursing auxiliaries in care of the elderly wards spend large amounts of time performing direct patient care, several research studies indicate they do not view themselves as agents of therapeutic activity, or view this type of work as valid and valuable. Using a questionnaire designed to determine nurses' attitudes and preconceptions of care of the elderly, Armstrong-Esther and Browne (1986) discovered that nursing auxiliaries viewed medical-related work, such as dressings and giving out medications, as the most enjoyable and important jobs and the principal aim of geriatric nursing. Keeping patients socially and mentally active was viewed as least enjoyable and of least importance. Giving out meals and drinks and 'basic care' came in between these two extremes. Interestingly, no significant differences were found between qualified nurses, learner nurses and nursing auxiliaries. Armstrong-Esther and Browne argue that all staff, including nursing auxiliaries, demonstrate

allegiance to the so-called 'medical model' of care in that they view medically related tasks as of higher status than 'basic care'.

Similarly, in a USA study by Smith et al (1980), nurses' aides rated medical care activity as of more importance than psychosocial activities, patient teaching activities or physical care. Aides rated this higher than registered nurses, and also viewed psychosocial activities as of less importance than registered nurses.

Davies and Snaith (1980), investigating mealtime problems in a continuing care setting, found no nursing auxiliary viewed mealtimes as an opportunity for teaching rehabilitation skills or giving choices. However, this was common to all grades of staff. Similarly, positive and negative viewpoints on patient self-care were not linked to grade of nurse.

In an acute care of the elderly setting, nursing auxiliaries possessed the least favourable attitudes towards the elderly when compared with other grades (Armstrong-Esther et al, 1989). Armstrong-Esther et al argue this may be because nursing auxiliaries are care givers, as opposed to care prescribers, the qualified nurses. As such, nursing auxiliaries perform the lion's share of direct patient care work and as a result may view patient care delivery as "unpleasant, tiresome and often depressing" (1989 p.40).

Wells discovered that "nursing auxiliaries knew very little about causes and care of common problems in the elderly" (1980 p.47).

However, inadequate knowledge was not confined to unqualified staff: the knowledge of qualified staff was found to be "incomplete and frequently confused and questionable" (1980 p.47). Since Wells' study, no research has been conducted into the differential knowledge levels of qualified and unqualified staff.

At the level of ideology, nursing auxiliaries also frequently receive a 'bad press' in the literature. Williams (1978) argues they are distinguished by an ideology she terms "custodialism". Corollaries of this ideology are viewing elderly patients as child-like, concentrating exclusively on physical care with neglect of psycho-social aspects, and a task-oriented approach emphasising orderliness, convenience and routine (Baker, 1983; Clarke, 1978; Stannard, 1972). Stannard's study describes how this custodialism generated neglect and abuse, and Baker's study shows that while the ward sister held high rehabilitative and therapeutic ideals, these could not prevail when the ideology of other staff, particularly that of the nursing auxiliaries, was that of custodialism. This ideology is most frequently, but not exclusively, associated with nursing auxiliaries.

Although, as argued previously, all aspects of patient care, including so-called basic care, are considered by some to require the knowledge and skill possessed only by qualified staff, there is little elaboration in the literature as to exactly what knowledge and skills are required effectively to nurse elderly people. Hirschfeld (1979) suggests the knowledge base needed for enhancing optimal health in elderly patients either does not exist or is barely utilised. For the former, Hirschfeld cites the example of stroke,

where little is known about how best to utilise a patient's energy resources. For the latter, knowledge exists on sensory impairment in the elderly including intervention strategies, but these are rarely used in care of the elderly situations. MacFarlane, however, outlines general areas of knowledge which should underpin nursing action:

1. A knowledge of man and the biological and psychological basis of daily living activities
2. A knowledge of the physiological and psychological effects of the disabilities and dysfunctions affecting daily living activities related to health
3. Clinical nursing method-or methods of helping
4. Therapeutics and their relation to daily living activities." (MacFarlane, 1976 p .23)

More specifically, Redfern (1988) believes a knowledge base for care of the elderly should include a grounding in such sciences as the sociology, psychology, physiology, pharmacology and medicines of old age.

Redfern (1988) also outlines skills required for high quality nursing care. These comprise possession of interpersonal communication skills, the ability to contribute effectively to the multidisciplinary team, the ability to apply knowledge of the ageing process to patient care and recognising the importance of research based knowledge. Furthermore, Redfern argues, the skilled nurse "will enable the old person to increase or maintain her present level of independence, will prevent increasing dependence, or will help the individual cope with dependency and live a fulfilling life even when dying" (1988 p.418).



Arguments that qualified nurses provide higher quality patient care by virtue of knowledge and skills gained through training fail to acknowledge other aspects considered by some to be essential requisites of therapeutic care of elderly patients. According to this argument, inter-personal qualities and gifts as well as knowledge and skills gained through training are essential requisites of a good nurse, and nursing auxiliaries are, in theory, just as likely to be in possession of these as qualified nurses. Griffin (1983) argues nursing action cannot be described as 'caring' unless a range of personal and emotional aspects are brought into play to meet the needs of the individual. Bergman (1983) also underlines the importance of inter-personal aspects of the nurse-patient relationship by recounting the story of a lady with senile dementia who, when stressed by an unfamiliar situation, was pacified only by a comforting embrace by the nurse present.

Kitson (1987) argues that the lay and professional caring relationship share three main attributes which can be used as indicators of the quality of care. Firstly, a commitment from the carer to provide a continuous service until it is no longer required. Secondly, the possession of an adequate level of knowledge and skill to meet the patient's needs, and thirdly the upholding of the care receivers' individual integrity. Pembrey (1985) views this concept of lay caring as encompassing nursing auxiliaries, who, she argues, are also capable of offering this quality care consisting of commitment, knowledge, skill and respect for patients as individuals.

The recent Strategy for Nursing also recognises the value of aspects other than formal knowledge:

"The true quality of care...lies in the practitioner's own personal interaction and relationship with individual patients." (Department of Health, 1989 p.21)

Interpersonal aspects are particularly important in care of the elderly, for many of whom nursing staff form the sole personal contact, and it is in this sphere that nursing auxiliaries can play an important and valuable role. This capacity for developing caring relationships with patients is frequently alluded to in the literature. As early as 1950, Wilson states:

"Many, if not most, of the personal needs of the patient as an individual in an unfamiliar situation demand from the staff concerned qualities of understanding, patience, and a capacity for making and maintaining effective personal relationships rather than professional nursing skill in the sense of a knowledge of specific techniques." (1950 p.99)

Wilson envisages the nursing auxiliary meeting these needs, while the qualified nurse carries out medically related "tasks and techniques of treatment which require a trained nurse."

More recently, Young distinguishes between "caring", which it is implied can be performed by unqualified staff, and "nursing" which should be the province of qualified staff. She comments that nursing auxiliaries "show a commitment to and empathy for the old which is hard to match." (Young, 1987 p.3) Stone also identifies the positive contribution of the "home care assistant" in the community in terms of their relationships with patients:

"the home care assistants are able to generate the essential elements of care and concern without which any therapy is fruitless through the relationships they develop with the clients." (Stone, 1987 p.28)

Barney (1983) similarly believes interpersonal skills possessed by nursing auxiliaries in a nursing home setting to be an important determinant of quality care, which, he argues, "consists to an important degree in the tone of voice, the gentleness of touch, the unsolicited greeting, word of praise, act of consideration." (1983 p.46)

f. Summary

The studies by Armstrong-Esther and Browne (1986), Davies and Snaith (1980), Baker (1983) and Wells (1980) demonstrate a lack of understanding of therapeutic care by nursing auxiliaries. However, that this was not confined to the nursing auxiliaries but characteristic of nurses also suggests it is inappropriate to attribute untherapeutic patient care solely to nursing auxiliaries. There has been little research into the effect of nursing auxiliary usage on patient care, and the best composition of the ward nursing team in care of the elderly, or indeed any other setting (Royal Commission on the National Health Service, 1979; DHSS, 1986). Therefore, proof that qualified nurses give better care is hard to find (Slack, 1986). Furthermore, "no research in either long-term or acute care units has examined how the needs of geriatric long-term patients actually match with the knowledge and skills of available health workers" (Smith and Molzahn-Scott, 1986 p.321), and no study has compared how qualified and unqualified staff perform patient care activities common to both.

In this study, then, the first aim was to shed light on the similarities and differences in the way in which nursing auxiliaries and qualified nurses care for elderly patients by directly comparing these two grades of nursing staff.

An important factor influencing the work of qualified nurses and nursing auxiliaries is the organisational method used to structure nursing work. This is discussed in the next section.

### 3. THE ORGANISATION OF NURSING CARE

#### a. Introduction

In recent years, the way in which nursing work and nursing staff are organised in hospital wards has been regarded as affecting both processes of care, summarised as the quality with which care is delivered, and outcomes of care. Task allocation, generally considered the traditional nursing model in the UK (Merchant, 1985), has received increasing criticism and is now considered to have detrimental consequences for both nurses and patients. It is charged with placing completion of tasks above consideration of individual patient needs, with resultant fragmented care and unmet need. It does nothing to further the claim of nursing for professional status, as 'basic care', the sphere in which nurses can identify their unique contribution, is delegated to unqualified nursing staff.

Attention has thus focussed on other modes of nursing organisation, and attempts to demonstrate the value of these in terms of beneficial effects for patients and nursing staff have proliferated in research,

anecdotal and proselytising literature. The organisational mode known as 'primary nursing' has received the most attention. Indeed the recent Strategy for Nursing, endorsed by the Secretary of State for Health and the Chief Nursing Officer, states as one of its targets for practice that "The development of primary nursing should be encouraged" (Department of Health, 1989 p.32).

In this section, the literature concerning the organisational modes of interest in this study, namely, primary, team and functional nursing, will be reviewed. Also, the many different viewpoints expounded in the literature as to which form the role of various grades of nurse should take under different ways of organising nursing are examined.

#### **b. Functional nursing**

Task allocation or functional nursing is generally considered the traditional nursing model in Great Britain (Merchant, 1985). At least until 1972, 61% of nursing work in acute hospitals was allocated by tasks (Report of the Committee on Nursing, 1972). In the literature, three main distinguishing features of task allocation are found. Firstly, nursing work is divided into separate tasks, for example bed baths, observations and medicines (Berry and Metcalf, 1986). Secondly, these tasks are allocated to the appropriate nurse according to the perceived level of skill required to perform them (Chavasse, 1981; Kron, 1981; Pembrey, 1975) and thirdly, tasks are assigned to each nurse by the nurse in charge, usually the ward sister or deputy, who retains responsibility and accountability for the totality of patient care (Durbin, 1981).

The ward sister in functional nursing wards remains the "supreme authority" (Beswetherick, 1979), responsible for making all decisions about patient care and functioning as the centre for all communications both within and outside the ward. The role of other qualified staff becomes the completion of tasks in accordance with their grade, i.e. the supposedly more complex and demanding tasks such as medications and dressings. Tasks regarded as 'basic', such as assisting patients with activities of daily living, are delegated by the ward sister to nursing auxiliaries and junior learner nurses.

For the ward sister, functional nursing has the advantage of being relatively easy to plan and control, provides a means of utilising staff of different grade level and ensures direct accountability for tasks either done or not done, thus giving the ward sister a sense of security (Chavasse, 1981; Merchant, 1985). For other nursing staff it provides a measure of job satisfaction in that it enables a list of tasks to be completed within a span of duty (Chavasse, 1981) and provides a means of protecting nurses from anxiety caused by emotional involvement with sick patients (Menzies, 1960). Additionally, task allocation enables the ward sister to alternate heavy and light tasks in her delegation of work to a particular nurse, thus preventing physical strain on nurses (Merchant, 1985; Pembrey, 1975). For learner nurses there are additional advantages. Learners are allocated tasks according to the length of time they have been in training, and the repeated performance of tasks gives the chance to consolidate skills and gain confidence (Merchant, 1985).

Despite these reputed advantages, only 31 percent of nurses and midwives surveyed for the Report of the Committee on Nursing (1972) were found to favour the system of task allocation. Hale (1987) cites two trends which reduced its acceptability as a means of organising nursing staff. Firstly, an increased emphasis on the importance of psychosocial aspects of illness resulting in emphasis being placed on the individual needs of patients. Functional nursing is charged with placing completion of tasks above consideration of individual patient needs, thus reducing the patient to the level of "work object" (Fretwell, 1982). Furthermore, patient needs falling outside the routine of task completion and "low visibility" needs such as the need for reassurance may be omitted under functional nursing (Proctor, 1982) or assumed to be the province of the least qualified staff members (Chavasse, 1981).

Secondly, the professionalisation of nursing, with nurses asserting their right to exercise responsibility, *autonomy and discretion* in their own field of expertise, namely nursing care. A corollary of this is a re-evaluation of those activities previously described as 'basic care'. These are now viewed as requiring enormous skill and indeed as being the area in which the nurse can identify her unique contribution to patient care, rather than as simple tasks which can be accomplished by unqualified and junior nurses (e.g. MacFarlane, 1976). Functional nursing, then, is viewed as based on the mistaken principle that 'basic care' is simple (Merchant, 1985; Chavasse, 1981).

A further criticism levelled against functional nursing is that patients are subjected to constant interruptions throughout the day (Chavasse, 1981). Merchant (1985), however, suggests this need not be the case if ward routines are timed to allow patients time to rest and tasks are coordinated. Furthermore, within a functional nursing system the nurse caring for the patient may have little information about the patient's illness and his background and so may not be able to communicate with the patient about these aspects (Boekholdt and Kanters, 1978).

c. Team nursing

i. *Definitions*

Team nursing can be distinguished from task allocation in that nurses are grouped in some manner and allocated to groups of patients for variable, but usually considerable, lengths of time (Waters, 1985; Boekholdt and Kanters, 1978). Kron, one of the instigators of the concept, defines it as utilising "a heterogeneous team of nursing personnel to deliver nursing care to a group of patients" (1981 p.210). A more comprehensive definition is given by Jenkinson:

"Team nursing can be defined as a way of organizing the work in a ward by splitting the total number of patients into groups, and the total number of nurses working in the ward into teams. Then the care of each group of patients is assigned to a team of nurses, led by a State-registered nurse." (1961 p.264)

From 1950 onwards, team nursing exerted a major influence over the way in which nursing care was organised in Canada and the USA



(Beswetherick, 1979). In the UK, however, it was not much in evidence until the 1970's (Pearson, 1988). Dividing ward staff into smaller operational units is believed to accrue benefits for both patients and nursing staff.

According to Kron (1981), team nursing is based on the philosophy that "every patient has the right to receive the best care that can be provided" (1981 p.213). In terms of benefits for patients, team nursing, it is assumed, prevents the fragmentation of care associated with task allocation and improves the quality of patient care by improving nurse-patient relationships and "humanising" nursing (Jenkinson, 1961). Team nursing is also thought to provide the means by which staff of differing levels of education and skill can be deployed to ensure the patient receives care from nursing staff equipped with the skills to match his individual needs (Report of the Committee on Nursing, 1972; Kron, 1981). Patient benefits should also result from the increased supervision of unqualified and junior staff provided by the team nursing structure (Lee, 1979).

As team nursing provides the opportunity to give 'total patient care' to a smaller number of patients, it is reputed to increase the level of job satisfaction experienced by nurses (Jenkinson, 1961). It provides a vehicle which enables the ward sister to utilise all grades of nursing staff and through which qualified nursing staff, as a result of devolved decision-making, can develop leadership and managerial skills. For learner nurses, team nursing is said to promote clinical education (Jenkinson, 1961) and for junior nurses and unqualified staff to ensure adequate supervision.

## 11. *The role of the ward sister*

Kron (1981) describes the ward sister or "head nurse" as the key person in making the practice of team nursing effective and whose philosophy of nursing influences other staff grades. The role of the ward sister may undergo changes as a result of the delegation of some managerial responsibility to the team leader. This, however, "does not mean a loss of prestige; rather the need for the head nurse's particular skills, leadership, supervision, and help increases as the staff are encouraged to develop their skills and capabilities" (Kron, 1981 p.216). Kron lists the responsibilities of the ward sister in team nursing as follows:

1. Determining standards of work performance expected by staff
- 2a. Setting up personal goals and goals for the ward staff
- b. Identifying with staff standards of outcomes for patients
3. Giving team leaders the opportunity and help to develop management skills in patient care
4. Orientating new staff in the functioning of team nursing
5. Being the resource person with whom team leaders can discuss management of patient care, staff and other problems which they cannot solve unaided
6. Supervising and evaluating staff performance in the use of team nursing principles and in their delivery of patient care

7. Continuing to look for more efficient work methods
8. Encouraging staff to raise standards of nursing care by researching nursing problems
9. Maintaining channels of communication

In an anecdotal account of the introduction of team nursing, Pembrey (1975) describes how she was able to re-define the role of the ward sister by delegating the organisation and allocation of nursing work to senior staff nurses. The role now became one of "patients' assistant" and "nurses' assistant". In the former, the ward sister made herself available to patients in order to give information, teach and help with patient problems as well as checking patient progress and talking with relatives. The latter role consisted of acting as consultant for nurse problems and as active supervisor and teacher.

Jenkinson (1961) similarly regards the organisation of clinical nursing to be the role of the staff nurse in team nursing. This, in her opinion, frees the ward sister for a more active role in the education and teaching of learner nurses, accomplished partly by working with learners in the delivery of patient care.

### *iii. The role of the team leader*

The success of team nursing appears to rest largely upon the team leader (Pembrey, 1975; Kelly and Lambert, 1978). To fulfil the demands of this role, Kron believes the team leader requires "enthusiasm and desire to give good nursing care" (1981 p.217) as

well as effective leadership and management skills. Kelly and Lambert list a wide range of skills required by the team leader:

"leadership and communication skills, skills in sophisticated care planning, expertise in delivering patient care, willingness to work a flexible schedule, ability to establish rapport with staff, teaching skills, ability to accept change and to work within a changing environment". (Kelly and Lambert, 1978 p.5)

Kron (1981) provides the most comprehensive outline of team leader responsibilities.

1. Management of the team. This involves arranging all work within the team, establishing priorities in the care to be given and maintaining good working relationships with both team members and patients
2. Maintaining effective communication by giving and receiving reports and information to team members, the ward sister and other relevant personnel
3. Assessing the patient and his needs and determining nursing intervention
4. Keeping nursing care plans up to date
5. Recording and maintaining patient progress notes and recording evaluation data
6. Supervising - i.e. planning and directing patient care, observing, evaluating and teaching team members
7. Being accountable for the direction of the team and accepting responsibility for work performed by the team according to directions given by the team leader

A further role of the team leader which does not appear in Kron's

list is the provision of direct patient care. Other authors consider this to be an essential component of the role (Pembrey, 1975; Jenkinson, 1961).

iv. *The role of team members*

While other authors largely accord with Kron's outline of the team leader role (e.g. Shukla, 1981; Lee, 1979), the role of team members is rarely mentioned. The exception to this is Kron (1981), who lists the responsibilities of team members as follows:

1. Working cooperatively with their team leader and co-workers, including members of other teams and other nursing staff personnel
2. Following the nursing orders on the care plan
3. Reporting promptly and accurately about the care they give and the patients' responses to that care
4. Accepting help and supervision from the team leader

v. *The role of the nursing auxiliary*

There are only a few isolated references in the literature to the nursing auxiliary in team nursing. In one study of the introduction of team nursing (Kelly and Lambert, 1978) the nurse's aide position was eliminated totally and replaced with licensed practical nurses in order to give registered nurses more time to plan and coordinate care. Simons (1987), however, sees team nursing as a framework in which the nursing auxiliary no longer performs menial tasks for a

whole ward full of patients but gives more comprehensive care to a smaller number of patients and makes observations about their progress. Boundaries to the nursing auxiliary role are also stipulated by Simons: they should not work as team leader, nor be responsible for nursing assessment or prescription of nursing care.

#### *vi. Criticisms of team nursing*

Team nursing is heavily criticised in USA literature, usually in the context of unfavourable comparison with primary nursing. It is said to cause fragmentation of patient care, with complex tasks performed by qualified nurses and the least complex tasks delegated to the least trained members resulting in "infrequent, task-linked contacts...usually dissatisfying to patients" and fostering the "'I'm half-here' professional" (Marram van Servellen, 1983 p.51; cf. Manthey, 1980). Secondly, some authors argue, it is unclear who has responsibility for patient care (Logsdon, 1973) and who is accountable for patient outcomes (Marram van Servellen, 1983) under team nursing.

The supervisory function of the team leader role may take precedence over actual time spent with patients (Marram et al, 1974; Logsdon, 1973; Lee, 1979) with registered nurses becoming "checker-uppers of cheaper doers" (Manthey, 1980) and which may lead to a conditioning of nurses away from the bedside (Anon, 1979). Pressures of the team leader role may be too great (Lee, 1979; Urquhart, 1978) and their scope of duties too large (Marram et al, 1974). Furthermore, lack of continuity of team leaders may prevent continuity of patient care (Urquhart, 1978).

Team nursing is charged with causing complex channels of communication (Manthey, 1980) and also with failure to "promote a knowledge-based professionalism" and inhibiting the practice of the nursing process (Anon, 1979). Finally, assigning staff members to groups does not necessarily result in good team-work (Pearson, 1988).

The fault of team nursing may, however, lie not in the concept itself but in the way it is put into practice (Waters, 1985). In its ideal form, as advocated for example by Kron (1981), it is difficult to understand how these criticisms can be sustained.

#### *vii. Research studies evaluating team nursing*

Boekholdt and Kanters (1978) hypothesized that the introduction of team nursing structures would create firstly, a better work situation for nurses from which they would derive greater job satisfaction and secondly better nursing care for patients, including more attention to psychosocial problems. Findings indicated that nurses were more satisfied under team nursing, but therapeutic nurse behaviour, here defined as "giving the patient the information he needs, and stimulating him to talk about his emotional problems" (1978 p.321), did not increase. Boekholdt and Kanters suggest this may be because many of the structural features of team nursing function outside the nurse-patient relationship. For example, the communication structure only brings about direct interaction with the patient in the admission procedure. Furthermore, while the structure of team nursing may enforce regular nurse-patient contacts, there is no

guarantee that this will lead to therapeutic interaction. Boekholdt and Kanter conclude:

"team nursing provides only structural side-conditions for face-to-face interaction between nurses and patients. Team nursing as a structural model is therefore not a sufficient condition for an increase in therapeutic behaviour." (1978 p.323)

In a study presented by Kelly and Lambert (1978) the job satisfaction of nursing staff did not increase under team nursing. Patient satisfaction did, however, increase in several areas: knowledge of their illness, knowledge of discharge planning and patients' ability to identify the staff member caring for them. These changes occurred despite an increase rather than the expected decrease in the number of nurses providing care to patients and a lack of understanding of the philosophy of team nursing by all staff, including the "head nurse".

#### d. Primary nursing

##### 1. *Definitions*

The chief distinguishing feature of primary nursing appears to be the allocation of each patient to a named nurse, who is responsible for that patient for the duration of his/her need for nursing care in hospital, or extending into community care (Anderson and Choi, 1980).

Giovannetti defines primary nursing as follows:

"A mode of nursing organisation at the unit level in which one registered nurse is designated as the primary nurse for a small number of patients upon their admission and for the duration of their stay in that unit; the primary nurse takes responsibility for planning and evaluating all aspects of their nursing care." (1981 p.42)



In addition to responsibility, authority, autonomy and accountability are usually considered as prerequisites of the primary nurse role (e.g. Sellick et al, 1983) as illustrated in an early definition by Marram et al (1974). They define primary nursing as:

"the delivery of comprehensive, continuous, coordinated and individualized patient care through the primary nurse who has autonomy, accountability and authority to act as the chief nurse for her patients."

Original definitions viewed primary nursing solely in terms of an organisational framework. Manthey (1980) describes it as "a system for delivering nursing care in an in-patient facility" and "that is all it is". Manthey gives four "design elements" of primary nursing:

1. "the allocation and acceptance of individual responsibility for decision-making to one individual";
2. "assignments of daily care by case method";
3. "direct person-to-person communication";
4. "one person operationally responsible for the quality of care administered to patients on a unit twenty-four hours a day, seven days a week". (Manthey, 1980)

Other concepts of primary nursing, some of which are implicit in Manthey's statements, are that each patient has his/her own primary nurse (Spitzer, 1979; Kratz, 1979 ) who plans and evaluates care (Betz, 1982; Foglesong, 1983; Urquhart, 1978), gives direct care to her patients when on duty (Kratz, 1979; Carey, 1979; Urquhart, 1978) and has admission to discharge responsibility for those patients (Spitzer, 1979; Urquhart, 1978). Other authors also emphasise patient participation in care (Kratz, 1979) and care planning (Logsdon, 1973), and the role of the primary nurse in collaboration with other disciplines (Foglesong, 1983; Logsdon, 1973).

Some authors widen the parameters of the definition of primary nursing: it becomes "both a philosophy of care and an organisational design" (Hegyvary, 1982). Central to this philosophy is a commitment to individualised "patient-centred practice" (Hegyvary, 1982) and the development of close "therapeutic" relationships between care giver and receiver (Pearson, 1988). The organisational structures of primary nursing are now seen as facilitating philosophical underpinnings.

#### *ii. Advantages of primary nursing in the descriptive literature*

Numerous anecdotal accounts describe the benefits of organising nursing work along primary nursing lines. The principal advantage for patients appears to be that they receive care from fewer nurses, therefore care becomes more continuous and personalised (Lee, 1979; Wright, 1987; Malby, 1988; McMahon, 1989; Logsdon, 1973; Urquhart, 1978). Nurses, it is argued, gain a heightened sense of responsibility for care (Wright, 1987), increased job satisfaction (Malby, 1988), and an opportunity for self-development, use of initiative (Urquhart, 1978) and expansion of knowledge and skills (Manthey, 1973).

Primary nursing may also add credence to nursing's claim to professional status. By establishing the nurse as an autonomous practitioner, the relationship with other members of the multidisciplinary team, including medical staff, is more clearly defined (Wright, 1987) and becomes one of collaboration rather than subordination (Logsdon, 1973). As far back as 1973, Manthey implies

it may solve some, but not all, the "problems on the route to professionalism" (1973 p.87). Furthermore, primary nursing provides a framework for implementing the nursing process (Spitzer, 1979), itself seen as a tool to increase the professional status of nursing (Dickinson, 1982), as both have 'individualised patient care' as their key concept (Bowers, 1989).

### *iii. Disadvantages of primary nursing in the descriptive literature*

Primary nursing may lead to increased problems if communication channels break down as a result of the primary nurse failing to communicate her plans and goals for her patients to other nursing staff (Logsdon, 1973). Logsdon also mentions that there may be problems with the nurse-patient relationship if nurses do not feel able to develop in-depth relationships with patients. Bowers (1989) also foresees potential problems in the area of the nurse-patient relationship. Firstly, the nurse may become over-involved with one of her patients which may lead to conflict among primary nurses over care strategies. Secondly, meaningful nurse-patient relationships may prove stressful for the primary nurse. Like Logsdon, Bowers (1987) also identifies problems resulting from shortened lines of communication. Ultimately, he argues, in primary nursing "not enough is known by everybody about each patient" (1987 p.37)

### *iv. Research studies evaluating primary nursing*

Studies evaluating the effect of primary nursing on process and outcome variables are numerous. Examples of the former are studies examining the effect of primary nursing on the quality of care

received by patients (e.g. Felton, 1975; Shukla, 1981; Reed, 1988; Manley, 1989). Patient outcomes evaluated include patient satisfaction (e.g. Daeffler, 1975; Sellick et al, 1983; Pearson et al, 1988), patient stress (Hegedus, 1979; Blair et al, 1982) and length of stay (e.g. Jones, 1975; McCausland et al, 1988). Outcomes evaluated for nursing staff include job satisfaction (e.g. Brock and O'Sullivan, 1988; Alexander et al, 1981; Reed, 1988; Bond et al, 1990), staff turnover (e.g. Wilson and Dawson, 1989; Betz, 1981) and absenteeism and sickness (e.g. Wilson and Dawson, 1989; Chavigny and Lewis, 1984).

Research studies using outcome measures are examined fully in Thomas and Bond (1991). In these studies, there is no absence of definitions of primary nursing, encompassing such aspects as individual responsibility for decision making (Binnie, 1987; Hegedus, 1979) and care provision to an identified group of patients (Blair et al, 1982; Blenkarn et al, 1988; Daeffler, 1975; Jones, 1975), individual accountability (Blair et al, 1982; Chavigny and Lewis, 1984; Hegedus, 1979) and nursing autonomy (Babington, 1986). There is, however, a lack of operational definitions detailing how primary nursing is actually practiced (Giovannetti, 1986). Also, there is a paucity of descriptions of what such concepts as 'autonomy' and 'accountability' mean in practice, and how their presence or absence can be determined. Indeed, while these concepts dominate primary nursing literature, MacGuire and Botting (1990) found nurses in a primary nursing ward did not describe their work using concepts such as decision-making, autonomy and accountability, but rather in terms of the closer relationships with patients occasioned by the primary nursing structure.

As a result of lack of conceptual and operational definitions, with the research available to date it is impossible to identify which aspects of primary nursing structure and process result in which outcomes for nursing staff and patients, or to establish logically or philosophically why outcomes identified should be the product of primary nursing (Giovannetti, 1986).

v. *Primary nursing in care of the elderly*

Primary nursing is considered by many to be particularly efficacious in the care of elderly patients. As elderly patients often have prolonged lengths of stay, the continuity of care giver found in primary nursing is said to facilitate closer, more stable relationships between elderly patients and their nurses, which are considered by McMahon (1989) to be "prerequisite to therapeutic care" (1989 p.39). One such therapeutic effect, a reduction in confusion and disorientation, is described by Jones (1986) in an anecdotal report describing the introduction of primary nursing in long-term care. McMahon (1989) outlines further benefits of primary nursing in the care of elderly patients. The concept of primary nursing as a partnership between nurse and patient means that the locus of control remains with patients, enabling them to maintain their own routine as well as participating in care planning with nurses. Furthermore, the primary nurse is able to coordinate and plan discharge in a manner beneficial to the patient as a result of her detailed knowledge of, for example, the patient's social networks in the community.

While care of the elderly has been described as an ideal setting for evaluating primary nursing (MacGuire, 1989d), there is a paucity of research evidence demonstrating the benefits of primary nursing compared to other methods of organising nursing staff. Exceptions to this are studies by MacGuire (1989b,c) comparing an experimental primary nursing ward with two control wards of unspecified organisational type, and Wilson and Dawson (1989) comparing long-term care settings using primary and team nursing. MacGuire (1989d) found nurses on the experimental ward spent more time in communication and less time washing, dressing and feeding patients than their control ward counterparts. This, MacGuire argues, "suggests a shift from doing to supporting and facilitating patients in their struggle to regain independence." (1989d p.53).

Wilson and Dawson (1989) used a cross-over design to evaluate differences in the same units as they practiced team and primary nursing. In one unit, scores for the Geriatric Residents' Goals Scale (Cornbleth, 1978) showed significant differences in favour of the primary nursing system on the subscales of dressing, grooming, communication, and other behaviours, such as making purchases. In the other unit, however, the only significant result for this scale was in locomotion, again in favour of primary nursing. In one unit, there was also found to be an increase in patient's subjective well-being or less agitation under primary nursing compared to team nursing. No difference was found on the other unit. No change was found in other scales used, the Vitality Rating Scale (Reid and Zeigler, 1980) and the Personal Control Rating Scale (Zeigler and Reid, 1979). Differences between units are explained by the authors

as perhaps relating to differences in the dependency levels in the two patient populations and different designations of the units.

vii. *The role of the qualified nurse*

The role of the qualified nurse is dependent on whether the nurse is functioning in the capacity of primary or associate nurse. Commonly, a nurse will act in both roles simultaneously, caring for her group of patients as primary nurse and overseeing the care of patients belonging to absent primary nurses in an associate capacity (e.g. MacGuire, 1989c; Manley, 1989)

*The qualified nurse as primary nurse*

Three aspects of the primary nurse role are mentioned with most frequency in the literature. Firstly, the primary nurse is said to assume the responsibility for a group of patients previously vested in the ward sister (e.g. Blenkarn et al, 1988; Giovannetti, 1981; Ventura et al, 1982; Kron, 1981). Elaboration of what this means in operational terms is seldom given, however. Kron's short description of the primary nurse role is typical: "The primary nurse is responsible for the care of a patient 24 hours a day, from the time the patient is admitted to the nursing unit until the patient leaves it." (1981 p.211). While Kron gives the span of responsibility, there is no indication of what this responsibility entails.

Two attempts to operationalise the principle of 24 hour responsibility are found in the UK literature, however. MacGuire's description is the most comprehensive:

"The primary nurse will accept a 24-hour responsibility for her caseload and demonstrate this by planning care beyond her own span of duty, handing over personally to her associate nurse; seeking reports on her patient's progress from associate nurses and other staff involved in the care of that patient; making and recording all significant changes in the care plans for her patients and by being prepared to give advice, if necessary, to associate nurses when she is not on duty. In exceptional circumstances she may be called in to see a patient when she is not on duty." (1989c p.254)

Manley (1989) similarly states the responsibility of the primary nurse extends to planning and evaluating care given by the associate nurse in her absence, as well as giving clear directives to the associate nurse. In the USA, Ciske (1974) also describes the operationalisation of 24 hour responsibility in terms of the written directives of the primary nurse.

The second aspect of the primary nurse's role mentioned by numerous authors is accountability (e.g. Pearson, 1988; Ventura et al, 1982; Anderson and Choi, 1980; Logsdon, 1973). This is often found in conjunction with responsibility, as Blenkarn et al's description of the primary nurse role illustrates:

"A primary nurse is a knowledgeable, skilled professional nurse who assumes total responsibility and 24-hour accountability for the nursing care of a small group of patients." (1988 p.41).

To whom the primary nurse is accountable is seldom stated. For Pearson (1988) and Babington (1986), however, the primary nurse is accountable to the patient, while for Hegedus (1979) the nurse has a



dual accountability to the patient and the head nurse. For Manley, the primary nurse is most accountable to the patient, implying she is also accountable to some degree to "authority figures, shift, geographic location or task" (1989 p.82). Nowhere is a definition of accountability and what this entails in practice found in the literature.

The issue of who has overall responsibility and accountability for individual patients is a potentially contentious one. For example, Bowers (1987; 1989) argues, can the ward sister override a decision made by a primary nurse which she considers unsafe despite having invested this nurse with responsibility and accountability? According to Bowers, it is the ward sister who should take the final decision in this situation, and is thus the person 'in charge' of the patient's care and responsible for it. Furthermore, the ward sister is in a position of managerial authority over her registered nurses, and it is unclear how the designation of the senior ward sister as having 'continuing 24 hour responsibility' arising from the recent re-grading exercise will co-exist with the tenet of primary nursing that responsibility is vested in the primary nurse. Given these potential dilemmas, it is surprising how few authors outline what is meant by devolution of responsibility and accountability.

The third aspect of the primary nurse role found most frequently in the literature is that of assessing, planning, implementing and evaluating care for a group of patients (e.g. Deiman et al, 1984; Bowman and Thompson, 1986; Felton, 1975; Daeffler, 1975). Again, the majority of authors give no directives or indications of how this operates. Felton's description of this aspect of the primary nurse's

role is typical: she is "responsible for the planning, implementation, evaluation and coordination of the nursing care until the patient's discharge" (1975 p.27). Again, it is MacGuire who operationalises this principle:

"The primary nurse will admit her patients to the ward, carry out the nursing assessment, draw up a plan of care, evaluate the outcome of that care and modify the plan in the light of her evaluation. She will be responsible for documenting the progress of the patient." (MacGuire, 1989c p.255)

Central to the primary nurse's role is not only planning care, but "administering total care" (Pearson et al, 1989 p.270) to her patients when on duty (e.g. Ciske, 1974; Logsdon, 1973; Durbin, 1981). Furthermore, the primary nurse is generally viewed as coordinating the inputs of other disciplines to the care of her patients (e.g. Johnson, 1981; MacGuire, 1989b,c; Daeffler, 1975; Jones, 1975), or "information processing" (Shukla, 1982).

A further role for the primary nurse is that of autonomous practitioner (e.g. Reed, 1988; Anderson and Choi, 1980). Whereas definitions of responsibility and accountability are generally lacking in the literature, a definition of autonomy is given by several authors (e.g. Parker, 1984; JONA, 1988; Pearson, 1988). Pearson, for example, defines it as "the authority to determine or regulate one's own acts without outside interference" (1988 p.66), while Parker views it as being able to govern "one's own clinical judgements" (1984 p.150).

A primary nurse role seldom mentioned is that of patient advocate. Zander describes the primary nurse as "the patient's advocate in the health care system" (1977 p.20), but does not describe when or how

this operates. For MacGuire, this role is called for when the patient is either unable or unwilling to put his own case, and involves the primary nurse being prepared to "voice the interests of her patient in discussions where he is not present or where he may not feel safe enough to say what he wants to" (1989b p.247).

#### *The qualified nurse as associate nurse*

Associate nurses can be described as nurses who care for patients when the primary nurse is not present to do so. McGreevy and Coates (1980) state that associate nurses are assigned on a daily basis. MacGuire, on the other hand, argues that associate nurses should also be 'named' nurses, continuously assigned to patients, as "Continuity of care cannot be achieved by regarding any other nurse who is on an opposite shift as an associate" (1989c p.258).

It is generally agreed that the associate nurse is responsible for implementing care as planned by the primary nurse (Bowers, 1987; MacGuire, 1989b; Reed, 1988; Kron, 1981). Opinion differs, however, on the question of whether it is within the associate nurse remit to do more than merely follow the plan of care. Some view the associate nurse as contributing to the primary nurse's plan of care (Manley, 1989; Urquhart, 1978) and as being responsible for evaluating the plan of care when the primary nurse is off duty (Pearson, 1988; Manley, 1989). MacGuire (1989c), however, suggests associate nurses should only change the care plan in emergency situations and to make 'minor' changes. Definitions of emergencies and what constitutes a 'minor' change should, MacGuire argues, be agreed among nursing staff.

The position of the associate nurse with regard to responsibility and accountability is seldom mentioned in the literature. Pearson (1988), however, considers the associate nurse to be accountable both to patients for care delivered, and to the primary nurse for implementing prescribed care, while Durbin (1981) states the associate nurse is responsible for patients when the primary nurse is off duty. How this is reconciled with the 24 hour responsibility of the primary nurse is not clear.

The associate nurse is considered by some to be more than a mere deputy to the primary nurse. According to Manley, the associate nurse is "a professional colleague of equal standing who acts on her own professional judgement" (1989 p.83). Gibbs (1988) similarly suggests there should be a mutual sharing of ideas and experience between primary and associate nurses, and the relationship should be educational rather than the associate solely performing a deputizing role.

#### *viii. The role of the ward sister*

If, then, responsibility for and coordination of patient care is devolved to qualified nurses, what is the role of the ward sister? Most authors view this position as one of supporting other staff in a 'clinical specialist' or 'nurse consultant' role (e.g. Zander, 1977; Thompson, 1990). In this capacity, the ward sister serves as a "resource person" (Roberts, 1980), gives personal and professional guidance (MacGuire, 1989b; Durbin, 1981), counsels staff (Johnson, 1981) and acts as a role model (Deiman et al, 1984; Ciske, 1974).

Linked to this, the ward sister is viewed in the literature as responsible for the educational development of staff either through coordinating staff teaching (Thompson, 1990), planning an education programme (Pearson, 1988), identifying educational needs amongst staff and providing opportunities for staff development (Ciske, 1974; McCarthy and Schifalacqua, 1978; Deiman et al, 1984; Johnson, 1981). She may also act in a teaching capacity herself (Pearson, 1988; Daeffler, 1975).

A further role frequently mentioned concerns quality of care. According to Ciske (1974), the ward sister remains responsible for the quality of care delivered on the unit. The ward sister is also identified as the person who sets standards of care (Deiman et al, 1984), monitors standards (Ashley, 1984) and acts as 'quality controller' (Bowman and Thompson, 1986; Manley, 1989; Roberts, 1980). One suggested means of monitoring quality, as well as fulfilling other functions outlined above, is for the ward sister to work in the capacity of primary nurse (Ciske, 1974), associate nurse (Pearson, 1988) or either (Manley, 1989; Durbin, 1981). Alternatively, daily rounds could serve as a tool in evaluating nursing care quality (McCarthy and Schifalacqua, 1978).

While the management of patient care is largely viewed as being devolved to primary nurses, the ward sister is frequently seen as retaining managerial functions in a broader sense. For example, she is described by Pearson et al as "the day to day manager of the unit" (1988 p.18), by Hegedus as "the clinical manager and leader of the patient care unit" (1979 p.41), and by Manley as retaining overall

"administrative responsibility for nursing activities in the unit as a whole" (1989 p.81). What these managerial functions entail is, however, unclear. Some authors describe managerial activities more overtly. For example, Deiman et al (1984), list managing the unit budget and staff recruitment. A further function frequently assigned to the ward sister which could also be classed as managerial is the allocation of patients to nurses (Ciske, 1974; Johnson, 1981; Manley, 1989; Durbin, 1981).

ix. *The role of the nursing auxiliary*

Two opposing viewpoints on the role and function of the nursing auxiliary are found in the literature. According to the first school of thought, nursing auxiliaries in primary nursing should not participate in direct patient care tasks: these should be the province of qualified staff only. This viewpoint arises from a professionalising ideology which involves classifying work so that nursing care is given only by nurses with a statutory qualification (the only means, it is argued, of ensuring and regulating skill) rather than by personnel who lack this qualification, like nursing auxiliaries (Pearson, 1988; Binnie, 1987).

Proponents of this viewpoint base their argument on the status of 'basic care' and the grade of nurse considered necessary to provide this care. For Castledine, "to carry out a bed bath on an ill person requires a vast amount of nursing skills and expertise." (1985 p.22) Therefore, it should be the province of the qualified nurse.

McMahon also argues that "professional nurses" should nurse patients, and challenges the assumption that 'basic care' tasks are simple:

"Helping a patient come to terms with his illness, helping him learn to wash and dress...are caring and comforting activities that are the unique function of the nurse." (1989 p.39).

He therefore considers it "illogical" to employ unqualified staff to perform these tasks. In the past, McMahon argues, nursing auxiliaries have gained power by default of qualified staff, and, if unsupervised, do not allow patients to utilise and develop self-care abilities, but 'do for' patients rather than encouraging self-care.

In a USA study (McCarthy and Schifalacqua, 1978), qualified nurses are also credited with a more therapeutic approach to self-care. The assessment and maximisation of patients' self-care ability by the professional nurse on the primary nursing unit is compared with the unit not using primary nursing, where nurses' aides routinely 'do for' patients.

Remaining with USA literature, Osinski and Powals (1980) cite further reasons against utilising nursing auxiliaries in primary nursing wards. Millman's study (1978) is quoted as evidence that nursing auxiliaries spend more time unoccupied than registered nurses (27% compared with 8% per diem), have a high turnover rate due to low salary and require more in-service training and supervision, thus incurring increased costs. A further disadvantage is that qualified staff have to interrupt their work in order to assist or supervise untrained personnel. Also, Osinski and Morrison (1978) argue that because nursing auxiliaries can only have a limited area of responsibility and because the nursing process is the province of the qualified nurse, their use is negated.

If, then, the role of the nursing auxiliary as direct care giver in a primary nursing setting is considered undesirable, there are two possible options: abolition or re-definition of the nursing auxiliary role.

New roles for untrained staff in the UK literature have been outlined by Pearson (1988), MacGuire (1989a,d), McMahon (1989) and Binnie (1987). Without exception, the term 'nursing' is replaced in the new role titles, reflecting the view that nursing, however this is defined, should not be the province of the unqualified. Pearson (1988) describes a generic "care assistant" who performs a dual role. Firstly, the care assistant's primary function is stated as assistant to the nurse. This does not mean performing 'basic care' activities such as washing and bathing patients but preparing the equipment and environment for these and other procedures and providing a 'pair of hands' when necessary, for example with lifting. Secondly, the role consists of domestic non-nursing duties, for example keeping the ward clean and distributing meals, thereby freeing qualified staff for direct participation in patient care.

Binnie describes a project in which nursing auxiliaries were excluded from the ward teams in order to "provide a skill mix appropriate to primary nursing" (1987 p.37). The place of the nursing auxiliary is now taken by a "ward auxiliary" who undertakes housekeeping duties again in order to free the qualified nurse for patient care. The main difference between the ward assistant and Pearson's care assistant is that the ward assistant, in theory, participates in no nursing duties.



In her study looking at the impact of implementing primary nursing in one ward, MacGuire (1989d) describes the "redeployment" of nursing auxiliaries. Although they spend less time in activities related to direct patient care, 56% in the morning compared with 71% and 67% on the control wards (MacGuire, 1989d), they now have a "proper role with definite responsibilities" (1989a p.20) and have a new title: "ward support staff". As well as domestic duties such as making beds and keeping the ward tidy, ward support staff have taken on responsibility for physical and social aspects of the ward environment and other social aspects of patient care, for example arranging activities for patients such as keep fit exercises and reminiscence therapy.

New roles for nursing auxiliaries are outlined in a USA study by Kron (1981). Kron believes that ideally, nursing auxiliaries should be moved out of wards using primary nursing. If this is not possible, she recommends they have a dual role as "messengers and transporters" (1981 p.224) and as assistants to the primary nurse. They should not, in her opinion, give direct care.

In the opinion of some authors, the presence of nursing auxiliaries in any role is considered undesirable. Therefore, most (Anon, 1979) or all (McCarthy and Schifalacqua, 1978) nursing auxiliaries are removed from the primary nursing environment. Osinski and Morrison (1978) and Osinski and Powals (1980) also believe primary nursing requires only qualified, in their case all registered, staff.

Other authors see a part for nursing auxiliaries in providing 'hands on' patient care. In the UK literature, Pembrey argues that many "care assistants" possess the "commitment, knowledge, skill and respect for [the patient]...as an individual" (1985 p.49) which characterises good quality care and are therefore capable of performing total nursing care for patients whose condition is stable, under the supervision of the qualified nurse. For Pembrey, the use of care assistants in nursing patients in the acute rehabilitative phase of their illness is inappropriate because their nursing needs are rapidly changing. In contrast, Ross (1981) believes it is in this phase that the nursing auxiliary is able to perform a greater part of patient care, assuming she is adequately trained. Ross similarly argues that nursing auxiliaries should be allocated to specific patients, but paired with a qualified nurse.

Gibbs (1988), describing the implementation of primary nursing in a psychiatric setting, states that the "associate carer" role is capable of being filled by a nursing auxiliary as well as a registered or enrolled nurse. Furthermore, the relationship of the associate carer to the primary nurse is not merely one of subordination:

"The relationship with the primary nurse would be educational with a mutual sharing of ideas and experience, rather than a deputizing role in the absence of the primary nurse." (Gibbs, 1988 p.445)

Ashley (1984) also implies that nursing auxiliaries have a part in patient care. She states that they are allocated to qualified nurses, but does not specify their role.

Turning now to the USA literature, McGreevy and Coates state that the role of the nurses' aide changed "very little" (1980 p.10) after the implementation of primary nursing. The aide is assigned patients on a daily basis by the registered nurse and meets as many of the patients' needs as is possible within her job description. What the nurses' aide is unable to do is not specified. The aide may also assist the registered nurse in the care of patients, but does not function in an associate nurse capacity.

Jones describes how following the implementation of primary nursing the role of the nursing auxiliary within the framework of registered nurses as primary nurses and licenced practical nurses as associate nurses became "nebulous and unstable" (1986 p.89), although they continued to be involved in direct patient care. This problem was resolved by elevating properly trained nursing auxiliaries to associate nurse status. The nursing auxiliary is now assigned to a primary nurse group and as well as giving care, assists the registered nurse in planning care and evaluating outcome.

In the previous two studies, both the registered nurse and the nursing auxiliary have had a major role in direct patient care. However, in some studies the qualified nurse seems again to be moving away from 'hands on' care. This trend is nowhere in evidence in UK literature. Weeks et al (1985) describe how primary nurses felt unable to adequately assess and plan patients' nursing care because of the demands made on them by carrying out activities of daily living with their elderly patients. To resolve this, it was decided to employ more nursing auxiliaries to assist the patients with

activities of daily living thereby freeing the registered nurse and enabling her to act as "clinical coordinator" (1985 p.22).

Similarly, in a recent study by Loveridge et al (1988) the number of nursing auxiliaries is more than doubled in order to meet patients' direct care needs. The role of the "professional nurse" now changes from providing direct patient care to managing the clinical care of a caseload of patients, determining clinical outcomes and facilitating outcome attainment.

Beltran et al consider the use of nursing auxiliaries in primary nurse groups "both feasible and desirable" (1979 p.19). This is because, they argue, in many cases (which ones these are is not defined) meeting patients' physical needs does not require the skill level of a qualified nurse. By giving these activities to the nursing auxiliary, the professional nurse is free to plan and assess care, as well as teach and support patients.

#### x. *Summary*

While, then, many different viewpoints are expounded in the literature as to which form the role of qualified nurses and nursing auxiliaries should take under different methods of organising nursing work, these are without exception anecdotal. The second aim of this study, therefore, was to provide an objective assessment of the effect of different organisational modalities on the work and work perceptions of nursing auxiliaries and qualified nurses, with the emphasis on nursing auxiliaries.

#### 4. SUMMARY OF STUDY OBJECTIVES

1. To compare the differential contribution to nursing care of nursing auxiliaries and qualified nurses in care of the elderly wards using two parameters:

- i. activities performed
- ii. the quality of nurse-patient interaction

2. To determine the effect of three methods of nursing organisation (primary nursing, team nursing and functional nursing) on the work and work perceptions of qualified nurses and nursing auxiliaries.

FIGURE 2.1 Study design

	PRIMARY NURSING WARDS (n=3)	TEAM NURSING WARDS (n=3)	FUNCTIONAL NURSING WARDS (n=3)
QUALIFIED NURSES	N=12	N=12	N=12
NURSING AUXILIARIES	N=12	N=12	N=12

## CHAPTER 2 SELECTING STUDY WARDS

### 1. INTRODUCTION

This chapter outlines the design of the study, and describes the first stage, the selection of study wards. The organisation of nursing in study wards is then discussed.

### 2. STUDY DESIGN AND OVERVIEW OF METHODS

The study design was quasi-experimental, using a three group comparison format (Cook and Campbell, 1979). Figure 2.1 shows the study design. Wards were selected according to the independent variable of organisational modality, thus wards using primary, team and functional nursing comprised the study sample. Grade of staff formed the second independent variable, with qualified nurses (QNs) and nursing auxiliaries (NAs) chosen from within each ward.

The therapeutic orientation of the ward sister (Kitson, 1984), staffing levels and the behavioural ability of patients in study wards served as intervening variables. As a result of the paucity of wards found to be using each organisational type according to strict definition, therapeutic orientation could not be used as a factor (i.e. by choosing wards in each organisational type with ward sisters of high and low therapeutic orientation). It was therefore controlled by selecting only wards where therapeutic orientation was high. The latter two intervening variables were not controlled, but assessed for comparability across organisational mode.

Dependent variables in the study were activities performed and verbal interactions with patients. Perceptions of the work environment (measured by the Work Environment Scale [Insel and Moos, 1974]) served as a further dependent variable. Characteristics of staff were also assessed to determine whether other variables related to organisational mode.

### *Sample size*

Three wards from each organisational mode (nine in total) comprised the study sample. While the aim was to obtain four wards in each mode, difficulties encountered in selecting wards together with time and financial constraints meant the number achieved in each was three. Following data collection in the pilot ward, it was possible to gauge the minimum time required for collecting data in each ward (approximately 26 working days). The number of wards included in the study, then, represented the maximum possible within the time available. Also, results from the ward sister questionnaire (discussed below) indicated a paucity of available wards which met operational criteria for inclusion in the study within accessible health authorities, while financial constraints meant it was not possible to look further afield. The wealth of information generated by the study, however, compensates for sample size.

In each ward, four QNs, excluding the ward sister, and four NAs were chosen for inclusion. This figure was chosen based on the average number of nursing staff at each level available for participation in each ward, together with time and financial constraints.



Participating wards were selected by means of a ward sister questionnaire and interview. In each study ward, data were collected by direct observation and semi-structured interviews with each participating nurse. Each participating nurse and ward sister also completed a Work Environment Scale (Insel and Moos, 1974), and crude indications of subjects' workload were estimated. For reasons of clarity and because of the complexity of the study, details of the methodology and procedure used are given as each stage is described.

### 3. THE SELECTION OF STUDY WARDS

#### a. General introduction

The first stage of the study necessitated selecting a sample of wards using primary, team and functional nursing. This aim was achieved by devising a questionnaire to be completed by ward sisters followed by an interview designed to accommodate the dual parameters of method of care organisation and therapeutic orientation demonstrated by the ward sister.

This chapter describes the development and utilisation of measures to select wards according to organisational mode, while Chapter 3 describes the use of therapeutic orientation as a controlling variable.

## b. Method of care organisation

### *Introduction*

Where it is intended to use the organisational modality of hospital wards as a variable, it is necessary first to operationally distinguish those features or dimensions which characterise each mode. This is an obvious first step to matching or discriminating between wards. There is also a need to separate operation from philosophy, as "philosophic questions are not answerable through the scientific method." (Giovannetti, 1986 p.148).

With this in mind, questions were developed in which the emphasis was on the operational features of organising nursing staff, leaving aside philosophical underpinning and issues of professional nursing models (Robinson et al, 1989) or 'therapeutic nursing' (Pearson, 1988) in relation to care organisation. The questionnaire was designed to assist in identifying and discriminating between three different methods of organising nursing staff and nursing work, namely primary, team and functional nursing.

## c. Operational features of primary, team and functional nursing found in the literature

### i. *Primary Nursing*

Operational structures necessary before primary nursing can be said to be in use are scarce. Giovannetti, in her review of primary

nursing research, found that "Without exception, no investigator provided an operational definition of primary nursing" (1986 p.129). A recent example of the absence of operational definitions comes from a study comparing nurse-related behaviour, philosophy of care and job satisfaction in team and primary nursing (Reed, 1988) in which no description is given of the operational features which led to the labelling of wards as using team or primary nursing.

MacGuire, (1988), however, realises the need to express principles in operational terms if the aim is to determine if principles are being adhered to in practice. She describes, for example, how the principle of 24 hour responsibility should be operationalised: first by the primary nurse planning care beyond her span of duty, second by handing over personally to her associate nurse, and third, by being available outside her span of duty if an exceptional problem arises. Without such explicit operational definitions it becomes impossible to share meaning and understanding, or to draw conclusions from empirical investigations.

#### ii. *Team Nursing*

There is general agreement in the literature that each team within the team nursing structure should have a team leader (Kron, 1981; Boekholdt and Kanters, 1978; Waters, 1985; Giovannetti, 1981; Matthews, 1975), who may be a qualified nurse (Kron, 1981; Waters, 1985) or a senior learner nurse (Matthews, 1975) and to whom passes the responsibility for his/her patients previously invested in the ward sister.

Further operational statements, however, differ. With regard to how patient care is assigned within the team, Durbin (1981) states that the team leader assigns tasks to team members according to their competency. Merchant (1985) states that this form of work assignment may result from lack of supervision, and Kron (1981) lists this as one of the misconceptions of team nursing: "It is NOT the assignment of care on a functional basis to various team members. When only tasks are assigned to workers, functional nursing is practised, regardless of what name the method is given". (1981 p.212) Alternatively, team members are allocated patients within the team by the team leader, taking into account the stage of education and competency of each member (Waters, 1985; Boekholdt and Kanters, 1978).

Waters (1985) and Durbin (1981) also outline how other structures of team nursing operate. Here again, opinion differs. Documentation of care, for example, may be performed by team members as well as team leaders (Waters, 1985) or mostly by leaders (Durbin, 1981). Change of shift reports can be given by team members for their allocated patients (Waters, 1985) or the team leader for all the patients in the team (Durbin, 1981).

### *iii. Functional Nursing*

Merchant (1985) points to the lack of guidelines in the literature on how to implement this form of organising nursing care in basic nursing textbooks. Webb suggests this is because it is "transmitted

through practice and example in the work situation" (1981 pp.371-372). Its definition is also assumed in several research studies (e.g. Miller, 1985a; Chavasse, 1981).

Durbin (1981), however, attempts operationally to define the structures of functional nursing, albeit in the context of unfavourable comparison with team and primary nursing. For example, she argues, documentation in this form of organisation is performed by one staff member for a given number of patients, usually with no use of nursing care plans. Shift to shift reports are given by the nurse in charge, based on information given by other staff members to him/her.

#### **d. Development of questions to determine method of care organisation**

In order to define the method used in hospital wards to organise nursing staff, self-completion questions were developed for inclusion in a questionnaire designed to be completed by ward sisters. These were based on six main features which were identified in the literature as discriminating between wards using primary, team and functional nursing. These were:

1. Grouping of nursing staff and length of allocation to specific patients.
2. Allocation of nursing work.
3. Organisation of the duty rota.

FIGURE 2 2 Questions to determine method of care organisation

9. Please read through the following list and tick which ONE most accurately describes the way you organise staff on your ward.
- (F) A. The ward staff are organised as one group, and are allocated singly, in pairs or in threes, to patients or ward areas for part of their shift, and work across the whole ward for the remainder.
  - (F) B. The ward staff are organised as one group, and are allocated singly, in pairs or in threes to patients or ward areas for their entire shift.
  - (T) C. The ward staff are divided into teams with a designated leader, and allocated to a group of patients for one shift or part of a shift.
  - (T) D. The ward staff are divided into teams with a designated leader, and allocated to a group of patients for periods longer than one shift.
  - (O) E. Individual qualified nurses are given responsibility for individual patients for the duration of a shift or part of a shift.
  - (O) F. Individual qualified nurses are given responsibility for individual patients for periods longer than one shift, but less than the total duration of the patients' stay in hospital.
  - (P) G. Individual qualified nurses are given responsibility for individual patients for the duration of the patients' stay in hospital.

IF NONE OF THE ABOVE APPLY, please describe below your method of organising staff.

10. Under usual staffing conditions, who allocates work when nurses come on duty? (Please tick appropriate box)

- (F) A. Sister or nurse in charge allocates work.
- (T) B. Team leaders allocate work for their team.
- (T) C. The most senior nurse in the team allocates work.
- (p) D. Individual nurses decide what care to give their individual patients.

11. Is the Off-Duty (or Duty Rota) organised: (Please tick appropriate box)

- (F) A. For the ward as a whole?
- (T) B. Within two or more groups or teams?
- (P) C. To enable individual nurses to be responsible for individual patients?

12. Who has nursing accountability for patient care? (Please tick appropriate box)

- (F) A. It is entirely vested in the ward sister.
- (T) B. It is entirely vested in the team leader.
- (P) C. It is entirely vested in the individual nurse responsible for individual patients.
- (O) D. It is shared.

IF 'D.' APPLIES, please indicate below how accountability is shared.

13. Who is responsible for writing the nursing 'kardex' or nursing notes? (Please tick appropriate box)

- (F) A. The ward sister or nurse in charge writes the notes for most of the patients.
- (T) B. Each team leader writes the notes for the patients in his/her team.
- (P) C. Individual nurses write the notes for their individual patients.
- (O) D. The nurse/nursing auxiliary/learner who has provided care for that patient during the shift does so

IF NONE OF THE ABOVE APPLY, please describe below the method used in your ward.

14. Who liaises with the medical staff about patient care? (Please tick appropriate box)

- (F) A. The ward sister or nurse in charge.
- (T) B. The team leader, when it involves her patients.
- (P) C. The patient's individual nurse.
- (O) D. Any qualified nurse available.
- (O) E. Any nurse available.

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Key: F - Task allocation or functional nursing  
T - Team nursing  
P - Primary nursing  
O - No particular modality

4. Nursing accountability for patient care.
5. Responsibility for writing patients' nursing notes.
6. Liaison with medical/paramedical staff.

One multiple choice question was designed to relate to each feature and each option tended towards one of the three organisational modes. Figure 2.2 reproduces the format used for each question. The letters in brackets indicate to which organisational mode each response points.

Responses for each question were designed to cover the whole range of possibilities, therefore some responses do not fit exactly into any modality. For example in question nine response F ("Individual qualified nurses are given responsibility for individual patients for periods longer than one shift, but less than the total duration of the patients' stay in hospital") would not be indicative of primary nursing, where the primary nurses' responsibility would span the duration of the patients' stay in hospital, nor would it be indicative of the other two modes.

Respondents were also asked to provide additional descriptive data, namely whether there were any differences in the way in which nursing staff were organised in the morning, afternoon and evening, and whether the ward layout was influential in the way nursing staff were organised. Additional quantitative information was sought about the type of patients admitted, staffing levels and the allocation of learner nurses to the ward.

**e. Ward sister interviews**

In order to validate and supplement both the care organisation and therapeutic orientation sections of the questionnaire as well as preventing the self-completion screening questionnaire from being prohibitively long (Moser and Kalton, 1971), questionnaire data was enlarged upon by conducting ward sister interviews. Ward sisters were asked to elaborate further on the method used in their ward, covering such aspects as their role and how the method operated in practice. How interviews were used to determine therapeutic orientation is discussed in Chapter 3.

The final section of the ward sister interview contained questions relating to the role of the NA in the ward team. Ward sisters' opinions were sought about such issues as the amount of direction and supervision required by NAs and the role NAs should play in providing patient care. Findings from this final section are discussed in Chapter 10.

**f. Pilot study - ward sister questionnaire and interview**

Self-completion questionnaires were sent to ten ward sisters in one local health authority. Ward sisters on the pilot wards were asked not to return the questionnaire, but to complete and return a slip indicating whether they were willing to complete the questionnaire and consent to an interview. Reminder letters and a further copy of the questionnaire were sent after a one month period.



Six ward sisters completed the questionnaire and consented to an interview. Two ward sisters returned the slip indicating that they did not wish to participate in the study. One ward sister informed the researcher of this in person. The remaining ward sister returned neither the original slip nor a further one sent with the reminder letter.

The researcher interviewed all those ward sisters who returned the slip indicating willingness to do so.

Four ward sisters were found to be using team nursing as their method of care organisation, and two ward sisters functional nursing. Although numbers were small, the questionnaire appeared to be suitably discriminating for these two modalities, and results were further validated with data provided at interviews with ward sisters. No wards were found which described themselves as using primary nursing, so conclusions could not be drawn from the pilot study about the discriminating effect of the primary nursing options.

Using Kitson's (1984) guidelines for identifying high or low therapeutic orientation (Appendix 1), questionnaire and interview data also appeared to identify ward sisters with positive views on care of the elderly nursing. One ward sister using functional nursing held high therapeutic views, suggesting that there is no direct relationship between organisational modality and therapeutic orientation. Thus, ward sisters using functional nursing do not necessarily have low levels of therapeutic orientation, and many other factors influence the way in which the ward sister organises work. The level of staff may be one of the most significant: this

ward sister also had fewest staff on duty on the morning shift, and explained at the interview she had no option but to use functional nursing because of this constraint, although she was aware this was not in the best interests of either staff or patients.

**g. Method - ward sister questionnaire**

Using a self-completion format, questionnaires were distributed to 40 ward sisters on 31 acute and rehabilitation care of the elderly wards identified by nurse managers in 13 health authorities (Appendix 2). The questionnaire was accompanied by a letter explaining briefly the aims of the study and assuring confidentiality (Appendix 3).

In the pilot study, certain ward sisters expressed feelings of unease at receiving a questionnaire addressed to them 'out of the blue'. To combat this and hopefully to increase the response rate, nurse managers of all the wards for the main study were contacted and asked to inform ward sisters of the imminent arrival of the questionnaire and its purpose.

Since the completion and return of the questionnaire was taken as indicative of a willingness to assist in the main study, and the purpose of the questionnaire was to identify such wards rather than conduct a sample survey, only one follow-up letter was sent to non-respondents after a one month period. Twenty six questionnaires were returned from 21 wards, a response rate of 65% of ward sisters from 68% of wards. These percentages are not identical because on some wards there were two ward sisters.

#### h. Method - ward sister interview

Ward sisters were selected for interview if their responses in the self-completion questionnaire most clearly indicated adherence to primary, team or functional nursing, as well as a positive orientation to care of the elderly nursing.

In the letter accompanying the questionnaire, ward sisters were informed that the researcher *would like to conduct an interview* with selected ward sisters, and that she would contact them by telephone to arrange this. The interview consisted of a series of open-ended questions. Interviews were tape recorded. Ward sisters were asked for their consent to this, and were assured of confidentiality. No ward sister refused.

Following the interview, those ward sisters who had demonstrated closest adherence to one organisational mode and shown positive therapeutic orientation were asked if they would be willing to participate in the main study. What participation involved was fully explained. No ward sister refused participation. However, one ward sister on a team ward decided first to ask staff members if they would be willing to participate in the study before she consented. Staff on this ward felt they would not feel happy having a researcher observing them as they carried out their work, so the ward sister regretted she could not take part. This ward was therefore eliminated. A suitable month for data collection was also negotiated with each ward sister who was willing to participate.

TABLE 2.1 Findings from the Ward Sister Questionnaire - Care Organisation Section

Ward Sister Number	Question Number					
	9 Nurse Grouping	10 Work Allocation	11 Duty Rota	12 Account-ability	15 Writing Nursing Notes	16 Liaison with other Disciplines
1	F	T	F	0	P	T
2	T <sup>1</sup>	F	F	F	T	0
{ 3	T	T	F	F	P	F
{ 4	T <sup>1</sup>	T	F	0	P	F
5	P	F/P	P	F/P	0	P
6	T	F	F	F	T	F
{ 7	T	F	F	0	P	F
{ 8	T	T	F	0	T	F/T
{ 9	T	T	F	F	0	F
{ 10	T	T	F	F	F	F
{ 11	T <sup>1</sup>	T	T	0	T	F/T
{ 12	T <sup>1</sup>	T	T	0	T	F/T
13	T <sup>1</sup>	F	F	F	T	F/0
14	F	F	F	F	F	F
15	F	F	F	0	0	F
16	T	F	F	0	0	F
17	T	T	F	F	0	F
18	T	T	F	T	T	T
{ 19	T <sup>1</sup>	T	F	0	T	F/T/P/0
{ 20	T <sup>1</sup>	T	F	0	T/P	F/T/P/0
21	P	P	P	P	P	P
22	F	P	F	F	0	F
23	T	F	F	F	T	0
24	P	P	P	P	P	P
25	P	P	P	0	0	P
26	P	T	T	0	T	T

F = Task allocation or functional nursing      T = Team nursing  
P = Primary nursing      0 = No particular modality  
T<sup>1</sup> = Ward staff divided into teams for periods longer than one shift

{ Ward sisters come from the same ward

i. Findings - ward sister questionnaire, care organisation section

Table 2.1 categorises ward sisters' responses to each of the six questions.

From the results it is apparent how few ward sisters organise nursing care according to one organisational modality. Only one ward sister was found to fulfil five or more criteria out of a possible six for functional nursing (ward sister 14), two ward sisters for team nursing (ward sisters 11 and 12) and four ward sisters for primary nursing (ward sisters 5, 21, 24 and 25).

The majority of ward sisters (73%) used some aspects of team nursing. Seventeen ward sisters grouped nursing staff into teams, nine for one shift or part of a shift and eight for periods longer than one shift. Of these, 11 allowed team leaders to allocate work for their team, but only one ward sister (ward sister 18) devolved nursing accountability for patient care to the team leader. Ten ward sisters named the team leader as responsible for writing the nursing notes, and on one ward individual nurses as well as the team leader did this. On two wards only the team leader liaised with medical staff about patient care when her patients were involved. In five wards this was shared with other members of the nursing staff, usually the ward sister or her deputy.

On wards where teams were allocated to patients for periods longer than one shift, three or more 'team nursing' features were given by five ward sisters, whereas of those ward sisters who divided staff

for periods of one shift or part of a shift, only one or no other feature of team nursing was found. Length of allocation, therefore, is an important feature in defining wards using team nursing in this study.

Four ward sisters who selected option G in question nine ("Individual qualified nurses are given responsibility for individual patients for the duration of the patients' stay in hospital") also indicated primary nursing was in operation by their responses to every other question. They differed only in question 15, where ward sister 5 stated that nursing notes were written by the nurse/NA/learner who had provided care during the shift, adding "with the supervision of (the) primary nurse/facilitator" and question 12, where ward sister 25 stated that although the primary nurse was accountable on the ward, because she had not signed a contract to this effect the ward sister would be accountable in a court of law. Ward sister 26 also selected option G in question nine, but her responses to questions 10,11,15 and 16 indicated team rather than primary nursing was in operation.

While we cannot be certain that this section of the questionnaire was completed independently by ward sisters in those wards which had two sisters, there was excellent agreement within the five pairs observed.

#### **j. Selecting study wards**

Findings from this small sample demonstrate the difficulty encountered in finding a suitable number of wards representative of

each method of organising nursing care to permit comparisons between them. It also reveals how difficult it is to share meanings associated with mode of nursing organisation.

### *Primary nursing wards*

The wards of ward sisters 5 and 21 fitted perfectly into primary nursing as evidenced from questionnaire and interview data. Originally, it was intended to re-use the ward of ward sisters 19 and 20 as the third primary ward, as this ward had intended to change from team to primary nursing a few months after data collection on the ward was complete. This would also have provided an interesting 'before and after' study. Regrettably, shortly before the second period of data collection was to begin, the ward was forced to revert back to team nursing because of inadequate numbers of qualified staff and a perceived lack of support from nurse managers. A third primary ward was therefore lacking after the initial sift of questionnaires. The researcher knew of a unit outside the area which contained several care of the elderly wards purportedly using primary nursing. The nurse manager was contacted and identified three such wards (ward sisters 24, 25 and 26). Questionnaires were sent to these wards, and on the basis of these ward sister 24 was chosen to form the third primary ward sister because of her close adherence to the criteria identified as indicating primary nursing and because of her positive understanding of her therapeutic role.

### *Team nursing wards*

The ward fitting most closely the criteria for team nursing (ward sisters 11 and 12) declined participation in the main study because staff felt uneasy at the prospect of a researcher watching their interactions with patients. The criteria for inclusion in the main study thus became the allocation of nursing staff to teams for periods longer than one week. The wards of ward sisters 3 and 4 and 19 and 20 were chosen as meeting this criterion. Some time elapsed between the return of the questionnaire from ward sisters 7 and 8, and interview data revealed the ward had moved more into a team nursing mode since perusal of the questionnaire and interview data from the first sister, ward sister 8. This ward, then, formed the third team nursing ward.

### *Functional nursing wards*

The wards of ward sisters 14 and 15 were chosen to represent functional nursing as they displayed four or more features of this mode. The ward of ward sister 22 also displayed four functional nursing features, but this ward served as the pilot ward for the study as a whole and was therefore not suitable for inclusion in the main study. Ward sister 15 subsequently moved to a care of the elderly ward in a different hospital, but continued to organise nursing along task allocation lines, and agreed to participate a second time in the study and complete a further questionnaire. This ward sister now becomes ward sister 23.



Ethical approval was sought and gained from the health authorities of all participating wards.

**k. Suggested modifications to care organisation questions**

Follow-up interviews and experience of using the questionnaire indicate the following modifications would make it more useful for the purposes of describing ward organisational characteristics:

*Questions 10,12,15 and 16*

Although ward sisters were asked to tick an 'appropriate box', several ticked more than one. The wording of Question 12 should have prevented this, but Questions 10, 15 and 16 could be improved by adding the word 'usually' and making the instructions to tick ONE box more explicit.

*Question 15*

Five ward sisters ticked the 'primary nursing' option for this question, but responses given for other questions indicated otherwise. A suggested re-wording of this option could be:

"The patient's individual nurse responsible for his/her care throughout his/her stay in hospital writes his/her notes."

Further questions could be added about who usually completes a patient's initial assessment and how verbal change of shift reports are structured, since it was discovered that these items also

discriminate between methods of organising nursing staff and nursing work.

## **1. Summary**

In order to provide replicable research about the organisation of nursing care, it is essential to identify whether discrete types actually exist and to define what operational features are characteristic of each organisational method. This section of the questionnaire represents a first attempt to identify discriminating features of wards organised according to the organisational principles of primary, team and functional nursing, which could be used to select wards in each category. Results show that the organisation of nursing in few wards fulfil five or more of the criteria for inclusion in a particular mode. Reasons for this comprise an absence of a clearly planned way of working, transition between different methods of organising staff and a lack of knowledge of organisational types, as well as different ideas about how best to deploy available staff and grade mix and perceived constraints of available staffing levels.

## **4. THE ORGANISATION OF CARE IN STUDY WARDS**

In this section, the operationalisation of primary, team and functional nursing are described using questionnaire data validated by ward sister interviews.

Similarities and differences within and between team and primary nursing wards are illustrated in Figure 2.3 and 2.4.

**a. Grouping of nursing staff and length of allocation to specific patients**

On all primary wards individual QNs were given responsibility for individual patients for the duration of the patients' stay in hospital. In all team wards nursing staff were divided into teams and allocated to a group of patients for periods longer than one week. In Ward F7, ward staff were organised as one group and allocated singly or in pairs to patients or ward areas for part of their shift, and worked across the whole ward for the remainder. Ward F8 staff were also organised as one group and cared for all patients for their entire shift. Ward F9 divided nursing staff into teams and allocated these teams to patients, however the allocation only lasted for one shift or part of a shift, so met the criteria for inclusion as a ward practicing functional nursing.

**b. Allocation of nursing work**

On all primary wards, individual nurses decided what care to give their individual patients. In Ward P3 some work was also allocated by the ward sister or nurse in charge.

In all team wards team leaders allocated work for their team of nursing staff. On all functional wards this was done by the ward sister or nurse in charge.

**FIGURE 2.3 The organisation of care in primary nursing wards**

	WARD P1	WARD P2	WARD P3
<b>1. GENERAL ASPECTS</b>			
Number of primary nurse groups	3	2	4
Stability of groups	As long as group remains effective	Groups change at irregular intervals e.g. to develop other RGNs at primary nurse level	Group stability maintained as far as possible, but occasionally changes are necessary to ensure care is delivered by appropriate grade mix
Continuity of group allocation			
a: length	For the duration of the patients' stay in hospital	For the duration of the patients' stay in hospital	For the duration of the patients' stay in hospital
b: medicines	Given to each patient by his primary or associate nurse	One RGN does medicine round for all patients	Given to each patient by his primary or associate nurse wherever possible
c: meals	Breakfast: served by patients' individual nurses Other meals: served by all nurses to all patients, but if a patient has a problem the primary or associate nurse for that patient intervenes	Served by all nurses to all patients	Served by all nurses to all patients, but patients with feeding problems are helped by the nurse from their primary nurse group

## 2. PATIENTS

Number of patients in each primary nurse group	8	10	5
Criteria used for allocating patients to primary nurse groups	Patient choice	Geographical location	Geographical, location

## 3. ROLE OF PRIMARY NURSE

Grade of primary nurse	RGN, but ward sister would be happy to have an SEN with appropriate skills as primary nurse	RGN	RGN
Extent of responsibility for patients in the group	Direct responsibility for patients' care	Ward sister retains overall responsibility, but primary nurses take on responsibility for care planning, liaison with other disciplines etc.	Absolute and sole responsibility

## 4. ROLE OF ASSOCIATE NURSE

Grade of associate nurse	Ward sister (only when one group short of an associate nurse) RGNs (part-time) and SENs	RGNs and SENs, Ward sister	SENs and nursing auxiliaries, Ward Sister
Decision-making by associate nurse when primary nurse off duty	Associate nurse write care plans in primary nurse's absence. Ward sister then takes on responsibility for these. Associate nurse evaluate care under the guidance of the primary nurse	Associate nurse prioritises decisions which can and cannot wait . If decision cannot wait associate nurse makes it and discusses it with primary nurse on her return	Ideally, no major changes made to care plans by associate nurse. This only occurs if serious patient problems arise. The associate nurse is then guided by the ward sister or senior staff nurse

**FIGURE 2.4** The organisation of care in team nursing wards

	WARD T4	WARD T5	WARD T6
<b>1. GENERAL ASPECTS</b>			
Number of groups	2	2	2
Stability of groups	Constant	Constant	Change 2 weekly
Continuity of group allocation			
a: length	5 weeks	Constant	2 weeks
b: medicines	Each team gives medicines to their patients	Each team gives medicine to their patients	Person in charge plus nurse from each team give medicines to team member's patients
c: meals	All nurses serve meals to all patients, but team members advise others on their patients' dietary needs	All nurses serve meals to all patients	All nurses serve meals to all patients
<b>2. PATIENTS</b>			
Number of patients in each team	14/16	15/15	22/12
Criteria used for allocation of patients to teams	Geographical location	Dependency of patients in each team (patients not geographically allocated)	Geographical, location, sex of patient
<b>3. ROLE OF TEAM LEADER</b>			
Grade	Overall: ward sisters Day to day: most senior qualified nurse on duty in each team OR learner under supervision of qualified nurse	Overall: 1 ward sister, 1 qualified nurse Day to day: qualified nurse or 3rd year learner (not ideal)	Any nurse, including first year learners if supervised in the role
Extent of responsibility for patients in the team	Team leader "accountable" for what happens to her patients during the shift. Ward sister retains ultimate responsibility	Team leader responsible for caring for her patients, but ward sister retains ultimate responsibility	Total responsibility for span of duty

**c. Organisation of the duty rota**

In all primary wards this was organised within primary nurse groups to facilitate continuity of care and to enable individual nurses to be responsible for individual patients, as well as ensuring adequate staffing of each primary nurse group.

All team ward sisters stated at the time of completing the questionnaire that the duty rota was organised for the ward as a whole. However, by the time the researcher commenced data collection on Wards T4 and T5 the duty rota was organised within the two teams.

On all functional wards this was organised for the ward as a whole in order to permit adequate staffing for the whole ward.

**d. Nursing accountability for patient care**

In Wards P1 and P3 accountability was entirely vested in the individual nurse responsible for individual patients. In Ward P2 accountability was also vested in the ward sister.

In all team wards ward sisters held some concept of shared accountability. In Ward T4, the ward sister stated that accountability was shared between the ward sister and registered nurses on duty, but 24 hour accountability remained with the ward sister. In Ward T5 accountability was also shared between the ward sister and staff nurses on duty. In Ward T6 the ward sister stated accountability was shared "in the first instance with the team leader

but the ward sister must be fully informed and has total accountability for her ward".

In Wards F8 and F9, accountability for patient care was entirely vested in the ward sister. In Ward F7 it was shared, the ward sister commenting:

"Whoever clerks a patient on admission should draw up a care plan for that patient and evaluate it either singly or as a group if advice is required."

e. Writing nursing notes

In Wards P1 and P3 individual QNs were responsible for writing nursing notes for their individual patients. NAs were not permitted to write in patients' notes. In Ward P2 notes were written by the nurse, NA or learner nurse who had provided care to that patient during the shift with the supervision of the primary or associate nurse.

In Wards T4 and T6 each team leader wrote the nursing notes for patients in their team. Ward sister T5, however, ticked the option "Individual nurses write the notes for their individual patients". In reality, team leaders usually wrote the nursing notes for their group of patients, but this could also be done by learner nurses under supervision.

In Ward F7 the QN on each shift wrote the nursing notes for all patients, unless there was more than one QN on duty in which case writing was shared. In Ward F8 the ward sister or nurse in charge wrote the notes for most of the patients, and on Ward F9 the nursing



notes were written by the most senior nurse from each 'end' of the ward.

**f. Liaison with medical and paramedical staff**

On all primary wards this was done by the patient's individual nurse.

In Ward T4 this was performed by the ward sister or nurse in charge, the team leader, the patient's individual nurse or any QN available. In Ward T5 the ward sister or nurse in charge fulfilled this function, but wrote a note stating that all trained nurses are involved in this as appropriate. In Ward T6 liaison was performed either by the ward sister or nurse in charge or the team leader.

In Wards F7 and F8 the ward sister or nurse in charge liaised with other disciplines. In Ward F9 this was done by any QN available.

**g. Giving handover reports**

In Ward P1 nursing reports were given by the primary or associate nurse to the oncoming primary or associate nurse and NA. Thus there were no traditional ward reports where everybody on duty was present. In Ward P2, following the night nurse's report, the nurse in charge for the morning shift gave a report for all patients. At lunchtime, QNs and NAs gave the report for patients to whom they had delivered morning care to all nursing staff on the oncoming shift. In Ward P3 the lunchtime report was given by primary or associate nurses for their group of patients and for groups of patients who had been cared for by an NA to all oncoming nursing staff.

In Ward T4, following the report from the night nurse, the ward sister or nurse in charge gave information on certain patients to all nursing staff. Following this, staff divided into two teams and the team leader gave details of care needed by their patients during the morning shift. Lunchtime reports were given by morning team leaders to all staff assembled for the afternoon shift. In Wards T5 and T6 lunchtime reports were similarly given by morning team leaders to all staff on duty with the exception of NAs, who frequently remained outside the office observing patients and meeting their needs. In Ward T6 team leaders and the nurse in charge were the only ones present at the night nurse's report. Team leaders then received a second report from the nurse in charge and subsequently gave this information as they considered appropriate to their team members.

In all functional wards reports were given by the ward sister or nurse who had been in charge of the previous shift for all patients to all nursing staff on the oncoming shift.

## 5. SUMMARY AND DISCUSSION

Three wards using each type of organisational mode were selected which conformed to the empirical definitions of primary, team and functional nursing created from the literature.

In both primary and team wards the organisational method facilitated sustained allocation of both QNs and NAs to groups of patients. Length of allocation, however, varied. In all primary wards nursing staff were allocated to patients for the duration of the patients'

stay in hospital; this was also the case in Ward T5 and for ward sisters in Ward T4. In Wards T4 and T6 the perceived needs of learner nurses appeared to dictate shorter lengths of allocation. Under both primary and team nursing continuity of allocation extended to the giving of medications to patients (with the exception of one primary ward). In no ward, however, did continuity of nurse-patient allocation continue each mealtime. Indeed, it was only in Ward P1 that this occurred at all: here individual nursing staff gave breakfast to their individual patients at a time and place of the patients' choosing. Although this did not occur at subsequent mealtimes it is nevertheless significant because the way in which patients' meals, particularly breakfast, are organised and presented has been shown to be important in revealing staff values and perceptions of their work (Bond and Bond, 1989; Davies and Snaith, 1980).

Similarities are evident between the role of the primary nurse and the team leader, when this position is occupied by a ward sister (Wards T4 and T5). Ward sister team leaders were totally responsible for the patients in their team, as were all primary nurses with the exception of those on Ward P2. Generally, the concept of accountability appeared much clearer in primary than team wards. In Wards P1 and P3 it was entirely devolved to the primary nurse, whereas on all team wards it was shared in some manner between the ward sister and other registered general nurses. This was also the case in Ward P2.

The concepts of responsibility and accountability may not, of course, have held the same meaning for all ward sisters. Despite a lack of

definition, accountability is emphasised in primary nursing literature (e.g. Watts and O'Leary, 1980), and this may explain why two of the three primary ward sisters attributed accountability solely to primary nurses. Ward sister P2 appeared not to be able to totally delegate responsibility and accountability as a result of her interpretation of the staff re-grading exercise, in process during the study. Other primary ward sisters, although similarly graded 'G', did not interpret the criteria for a 'G' post as literally.

One crucial difference between wards using team and those using primary nursing as their method of care organisation was the number of patients for which the team leaders and primary nurses were responsible. All team wards had a bed complement of 30 and on each ward there were two teams, therefore the number of patients in each team ranged from 12 to 18. The number of patients in each team, here determined by the availability of trained nurses, was considered by ward sister T5 to be the major difference between her form of team nursing and primary nursing. In contrast, in primary wards the number of patients cared for by a primary nurse group ranged from five (Ward P3) to ten (Ward P2). With the exception of Ward P2, there were more than two primary nurse groups enabling primary nurses to be responsible for smaller numbers of patients.

Functional wards were characterised by a lack of sustained allocation of QNs or NAs to particular patients and, in general, no delegation of accountability from the ward sister to other QNs.

## CHAPTER 3 CHARACTERISTICS OF STUDY WARD SISTERS.

### 1. THE THERAPEUTIC ORIENTATION OF STUDY WARD SISTERS

A further variable likely to influence the work of nursing staff and which the questionnaire sought to measure was the perceptions of nursing care of elderly people held by the ward sister.

#### a. Background

The central role of the ward sister in shaping the ward environment and practices is attested in several research studies. Pembrey (1980) discovered that "individualised nursing" (a term not defined) was only achieved when the ward sister "actively managed" her ward. This involved the completion of a management cycle of assessing patients' needs, setting work objectives, delegating authority to the nursing team and monitoring progress.

More recently, Kitson (1984) examined variations in the standard of care on wards where the ward sister demonstrated high or low therapeutic function and understanding of her caring role. In the former, care was found to be qualitatively superior in that it was more patient-centred and goal directed, whereas in the latter care was characterised by routine. The ward sister therefore is the most important determinant of care in this study, over and above individual perspectives of staff, ward layout, level of paramedical support or medical policies.

Similarly, in a recent study comparing a ward using primary nursing with one purporting to be organising nursing according to the principles of team nursing (Bond et al, 1990), the primary ward sister was found to have a pivotal role in operationalising her vision of patient-centred care through other staff members. The influence of the ward sisters in the 'team nursing' ward also permeated the ward culture, but here it comprised maintenance of the status quo, routine and tradition.

In a paediatric setting, Brown (1986) found that nurse behaviour was a reflection of whether the ward sister conceptualised and practiced her work in a patient-centred or task-centred manner. These perceptions, Brown argues, are a more important influence on nurse behaviour than the pattern of work organisation in operation.

If, then, the orientation and management skill of the ward sister have an impact on how other grades of staff operate, it is likely that these would also influence both activities in which QNs and NAs spend their time and the qualitative indicator chosen to compare the work of QNs and NAs, namely the quality of nurse-patient verbal interaction (described in detail in Chapters 5 and 6). It was therefore necessary to control for this variable. Since resources did not permit increasing the sample size to use it as another factor in the design, a positive orientation to the care of elderly patients was chosen. This was because it was considered unlikely that ward sisters using primary nursing would show low levels of therapeutic orientation, while ward sisters using other methods of care organisation may view their work in a positive manner.

**b. Development of questions to determine therapeutic orientation**

In order to determine the therapeutic orientation of the ward sister, sections of Kitson's (1984) 'Therapeutic Nursing Function Indicator' (TNFI), designed to identify characteristics of nursing staff who provide patient-centred care, were used.

Kitson recognised the need to construct an operational model which could be used to guide and direct nursing practice in a therapeutic manner. Two main tenets underpin the model: (1) the acceptance of care as opposed to medically devolved activities as the primary function of nursing and (2), the adoption of a positive approach to the health and welfare problems of elderly people. To operationalise these tenets, Kitson drew on Orem's (1980) self-care model. This legitimises the nurse's caring function rather than concentrating on the curative function characteristic of the medical model. It also defines a range of caring activities which can be performed by nurses. Using this model, Kitson attempted to quantify elements which would discriminate between ward sisters for whom this theoretical framework was associated with nursing practice and those who were unaware of these elements.

Kitson identified three features which would discriminate between ward sisters with positive and negative perceptions of their role in care of the elderly nursing. Firstly, the ward sisters' definition of care of the elderly nursing. This hinges on whether the ward sister views her role as providing individualised care or as more involved with the provision of

**FIGURE 3.1** Use of Kitson's Therapeutic Nursing Function Indicator in ward sister questionnaire

CONCEPT	OPERATIONAL DEFINITION	INSTRUMENT
1. Goal content of care/perception of work	Nurses' definition of care of the elderly nursing	
2. Prescription/organising and planning nursing care	Method of organising nursing care	Questions 9-16
3. Survey list/variables which may affect nurses' activity	<ol style="list-style-type: none"> <li>1. Knowledge</li> <li>2. Skill utilisation</li> <li>3. Perception of rehabilitation role</li> </ol>	Questions 21-23 Questions 26, 18a,b Question 20



routine care to all patients. Secondly, the method chosen to organise nursing care. This has been dealt with fully above. Thirdly, other variables which affect nursing staff activity. These other variables comprise: a) knowledge - the proposition being that ward sisters who are more aware of their therapeutic function would realise the need for a comprehensive and detailed training in care of the elderly nursing for all grades of staff; b) skill utilisation - a positive response being that care of the elderly nursing requires professional as well as personal skills to perform the task competently, and finally c) the ward sister's perception of her rehabilitation role. A positive response in this context would be viewing her role as one of facilitator, maintaining patients at their individual optimal level of self-care. A less therapeutic response would be defining rehabilitation from a medical point of view.

Figure 3.1 shows the way in which the Kitson's TNFI was used in the questionnaire.

In the 'prescription' section, Kitson included questions from Pembrey (1980) to determine if an 'active management cycle' was in operation. These questions were considered inappropriate in the context of the present study as these elements are unlikely to form part of the re-defined ward sister's role in primary nursing. Furthermore, questions relating to the method of care organisation were devised in this study specifically in order to operationalise features of primary, team and functional nursing, as described above, rather than a more general management cycle.

**FIGURE 3.2 Use of Kitson's Therapeutic Nursing Function Indicator in ward sister interview**

CONCEPT	OPERATIONAL DEFINITION	INSTRUMENT
1. Goal content of care/perception of work	Nurses' definition of care of the elderly nursing	Kitson's questions Author's questions
2. Prescription/organising and planning nursing care	Method of organising nursing care	Author's questions
3. Survey list/variables which may affect nurses' activity	1. Knowledge 2. Skill utilisation 3. Perception of rehabilitation role	Kitson's questions Kitson's questions Author's questions

### *Ward sister interviews*

Therapeutic orientation sections of the questionnaire were also supplemented and validated in ward sister interviews. Further questions from Kitson's TNFI were used, and these are shown in Figure 3.2. Additional questions were added to the section designed to determine the ward sister's perception of her work. Firstly, the ward sister was asked to identify what she considered to be the most important aspects in care of the elderly nursing. This question, it was hypothesised, would point to whether the ward sister adhered to a nursing or medical model, and whether she viewed her work in task-centred or patient-centred terms. Secondly, to identify whether the ward sister viewed care of the elderly nursing as requiring special skills and knowledge respondents were asked in what ways, if any, care of the elderly nursing differed from 'general nursing'.

It was hypothesised that ward sisters with high therapeutic orientation would be able to articulate positive nursing-oriented aims of care for patients on their ward, and they were asked to do this in the questionnaire. In the interview, ward sisters were asked how these aims were achieved on the ward.

Related to both the right to choose and self-care, concepts identified by Kitson as basic to care of the elderly nursing, ward sisters were asked to outline the part played by both patients and relatives in patient care.

TABLE 3.1 Ward Sister Therapeutic Orientation Scores

	Definition of care of the elderly nursing	Knowledge required	Skill utilisation	Perception of rehabilitation role	Total Score
	(Mean %)	(Mean %)	(Mean %)	(Mean %)	(Mean %)
Primary ward sisters	100.0	82.2	91.3	100.0	92.1
Team ward sisters	95.5	91.1	94.4	100.0	94.6
Functional ward sisters	86.7	77.8	73.0	100.0	72.2

### c. Findings

Ward sisters' responses to each question were, wherever possible, assigned a score based on the system devised by Kitson. Questions not derived from Kitson were given a score based on similar criteria. The scoring system used is found in Appendix 1, and ward sisters' scores for each question in Appendix 4. Mean percentage scores are presented in Table 3.1.

#### i. *Ward sisters' definition of care of the elderly nursing*

##### **Defining care of the elderly nursing**

Functional ward sisters all described care of the elderly nursing in terms of the medical model, i.e. patient improvement and discharge. Ward sister T6 also described it in these terms but added maintaining patient independence as another crucial aspect. The remaining ward sisters gave more detailed responses describing the central role of the nurse, with several recognising the need for professional skills in fulfilling the role successfully. Holistic and individualised care was a further common theme.

Ward sister P1 illustrates all these aspects:

"nursing the elderly in an individual way is quite a challenge and once you start doing this and doing it properly it becomes very specialised and you realise that you develop skills that are quite unique to people who nurse the elderly...communication skills,...skills for lifting and handling. Nursing elderly people provides an avenue for holistic nursing."

No ward sister gave a response defining care of the elderly nursing as routine care or 'just basic nursing care', which was the criterion used by Kitson for classification as untherapeutic.

### **Most important daily jobs**

All ward sisters described their job in terms of nursing aspects rather than in terms of following medical directives. All ward sisters therefore gave positive responses to this question in line with Kitson's therapeutic model.

By describing the jobs which they performed each day ward sisters also indicated the extent to which patient care was delegated. Ward sisters in all functional wards saw 'hands on' care as important as did ward sisters T4 and T5, who were also team leaders. Ward sister T6, who was not a team leader, did not list giving patient care among her daily jobs, but 'supervising and observing patient care'. Delivering patient care was not central to the role of primary ward sisters, who saw their role more in terms of quality assurance. However, all three provided patient care in an associate nurse capacity as staffing levels dictated.

### **Extent to which care of the elderly nursing is different to general nursing**

This question was included to determine the extent to which ward sisters viewed care of the elderly as a speciality requiring special skills and expertise. As a result of time constraints, only six ward sisters were

asked this question. It was therefore not included when calculating scores.

Ward sisters F8 and T6 gave untherapeutic responses to this question. They considered care of the elderly as different only in terms of patient characteristics. Ward sisters F7 and F9 and ward sisters P2 and P3, however, recognised the specialist nature of care of the elderly nursing. Quotations illustrate the difference in perspective in response to the question "Do you think care of the elderly nursing is different to general nursing?":

Ward sister T6:

"I don't really, I only think it is heavier from a nursing point of view, much heavier, and I think that your patience gets tried a lot more on care of the elderly nursing because of the fact that you have an awful lot of poorly patients on care of the elderly...it is very frustrating, but I don't think it is any different. It is harder, much harder."

Ward sister P3:

"Yes, absolutely. I think elderly people are a speciality. I believe that. I think the ageing process and all the things associated with it make the whole job a speciality. You need certain qualities to care for these type of patients...certain expertise you have never actually put into practice on a medical ward...We do not actively treat our patients all the time so the focus is that we might be dealing with recreational needs and social needs as opposed to the actual delivery of nursing care which you would do in a busy medical ward...It is difficult for nurses on general wards to have a philosophy of care because the patients are so diverse whereas our patients, although their demands are very different and they as people are very different, at least we can get some kind of thing off the ground for the nurses to be participating [in] and by that I mean some philosophy that we can apply to all the patients on the ward."

### Aims of care

All ward sisters were able to articulate positive aims of care for patients. The most common aim cited was the return to optimum independence

and the maximisation of patient independence (ward sisters F7, F9, T4, T5, T6, P2 and P3). Achieving high standards of care (ward sister F7 and all Team ward sisters) and maintaining patient individuality (ward sisters P1 and P2) were also commonly stated aims. Furthermore, all ward sisters were able to articulate steps by which these aims were achieved.

ii. *Knowledge required to care for elderly patients (Tables 3.2 - 3.4)*

**Necessity of special training in care of the elderly**

All ward sisters believed QNs required post-basic training and NAs required special training to equip them adequately to care for elderly patients. Two functional, three team and two primary ward sisters believed NAs needed a specific training in the care of elderly patients. One functional and one primary ward sister thought a general training was sufficient, and one team ward sister believed both would be helpful. All ward sisters with the exception of ward sister F8, who did not answer this question, listed four or more topics helpful in NA training.

**Topics in care of the elderly nursing in which more training is needed (Tables 3.5 - 3.7)**

All ward sisters with the exception of ward sister F8 believed they could benefit from additional training and specified at least one area in which their knowledge was incomplete.



TABLE 3.2 Necessity of special training in care of the elderly nursing

PRIMARY WARD SISTERS			
	P1	P2	P3
Qualified nurses require post basic training	✓	✓	✓
Nursing auxiliaries require special training	✓	✓	✓
Nursing auxiliaries require a general training	-	✓	-
Nursing auxiliaries require a specific training in care of the elderly	✓	-	✓
Topics most helpful in nursing auxiliary training	<ol style="list-style-type: none"> <li>1. The ageing process</li> <li>2. Life crises</li> <li>3. Health crises</li> <li>4. Rehabilitation</li> <li>5. Health and safety</li> <li>6. Empathy</li> </ol>	<ol style="list-style-type: none"> <li>1. The ageing process</li> <li>2. The nursing process</li> <li>3. Multidisciplinary care</li> <li>4. Sensory deprivation</li> </ol>	<ol style="list-style-type: none"> <li>1. The ageing process</li> <li>2. Attitudes</li> <li>3. Communication skills</li> <li>4. Organisation skills</li> </ol>

TABLE 3.3

Necessity of special training in care of the elderly nursing

		TEAM WARD SISTERS			
		T4	T5	T6	
Qualified nurses require post basic training		✓	✓	✓	
Nursing auxiliaries require special training		✓	✓	✓	
Nursing auxiliaries require a general training		-	✓	-	
Nursing auxiliaries require a specific training in care of the elderly		✓	✓	✓	
Topics most helpful in nursing auxiliary training		<ol style="list-style-type: none"> <li>1. Handling and transferring elderly patients</li> <li>2. Communication and the elderly</li> <li>3. Role of the carer</li> <li>4. Importance of individuality</li> <li>5. An understanding of motivation</li> </ol>	<ol style="list-style-type: none"> <li>1. Attitudes towards the elderly</li> <li>2. Lifting techniques</li> <li>3. Nutrition</li> <li>4. Fire policy</li> <li>5. Reporting and awareness of assistant's limitations</li> </ol>	<ol style="list-style-type: none"> <li>1. Lifting and handling</li> <li>2. Confidentiality</li> <li>3. The ageing process</li> <li>4. Aids to continence</li> <li>5. Infection control</li> </ol>	

TABLE 3.4 Necessity of special training in care of the elderly nursing

	FUNCTIONAL WARD SISTERS		
	F7	F8	F9
Qualified nurses require post basic training	✓	✓	✓
Nursing auxiliaries require special training	✓	✓	✓
Nursing auxiliaries require a general training	-	✓	-
Nursing auxiliaries require a specific training in care of the elderly	✓	-	✓
Topics most helpful in nursing auxiliary training	<ol style="list-style-type: none"> <li>1. The ageing process</li> <li>2. Common diseases</li> <li>3. Basic psychology</li> <li>4. General introduction to workings of therapists, doctors, porters etc.</li> </ol>	NO RESPONSE	<ol style="list-style-type: none"> <li>1. Communication skills</li> <li>2. Care of the dying</li> <li>3. Sexuality in the elderly</li> <li>4. Basic physiotherapy/ occupational therapy skills</li> </ol>

TABLE 3.5 Topics in care of the elderly nursing on which more training needed

		PRIMARY WARD SISTERS		
		P1	P2	P3
<b>WARD SISTER</b>		✓	✓	✓
Topics	Time management		1. Counselling skills 2. Middle management 3. Teaching skills	1. Bereavement 2. Drugs - pharmacology
<b>QUALIFIED STAFF</b>		✓	✓	✓
Topics	1. Care planning 2. Evaluating models in nursing		1. Teaching skills 2. Management	As above
<b>NURSING AUXILIARIES</b>		✓	✓	✓
Topics	Understanding the many illnesses affecting the elderly		1. The ageing process 2. The nursing process 3. Multi-disciplinary care 4. Sensory deprivation	1. Bereavement 2. Lifting and handling

TABLE 3.6 Topics in care of the elderly nursing on which more training needed

TEAM WARD SISTERS			
	T4	T5	T6
<b>WARD SISTER</b>	✓	✓	✓
Topics	Psychiatric input and knowledge	Regular updating and refresher courses on new philosophies, models of nursing, care planning	Resource management
<b>QUALIFIED STAFF</b>	✓	✓	✓
Topics	As above	As above	<ol style="list-style-type: none"> <li>1. Standards of care</li> <li>2. Post-basic course for newly qualified RGNs</li> <li>3. Health and safety</li> <li>4. ENB998 (Teaching &amp; assessing)</li> <li>5. ENB941 (Nursing elderly people)</li> <li>6. City &amp; Guilds 730 (Teacher's certificate)</li> </ol>
<b>NURSING AUXILIARIES</b>	✓	✓	✓
Topics	Communication with the elderly	<ol style="list-style-type: none"> <li>1. Attitudes towards the elderly</li> <li>2. Lifting techniques</li> <li>3. Nutrition</li> <li>4. Fire policy</li> <li>5. Reporting and awareness of assistant's limitations</li> </ol>	<ol style="list-style-type: none"> <li>1. Lifting and handling</li> <li>2. The ageing process</li> <li>3. Health and safety</li> <li>4. Promoting continence</li> <li>5. Standards of care</li> </ol>

TABLE 3.7 Topics in care of the elderly nursing on which more training needed

FUNCTIONAL WARD SISTERS			
	F7	F8	F9
<b>WARD SISTER</b>	✓	-	✓
Topics	Update on general changes in acute field of nursing		1. Management issues 2. Social service support
<b>QUALIFIED STAFF</b>	✓	✓	✓
Topics	As above	None stated	1. Counselling 2. ENB941 - Care of the elderly 3. ENB931 - Care of the dying
<b>NURSING AUXILIARIES</b>	✓	No response	✓
Topics	General refreshers		1. Communication skills 2. Care of the dying 3. Sexuality in the elderly 4. Basic physiotherapy/ occupational therapy skills

TABLE 3.8 How ward sisters came to work with the elderly

	PRIMARY WARD SISTERS	TEAM WARD SISTERS	FUNCTIONAL WARD SISTERS
PLANNED	2	2	3
ACCIDENTAL	1	1	0

All ward sisters believed there were topics in which QNs needed more training and elaborated these, with the exception of ward sister F8 who again did not state any topics. This ward sister was also the only one who did not believe NAs could benefit from more training. Generally, NAs were perceived as requiring additional training in the most aspects of care.

### iii. *Skill utilisation*

#### **Choice of care of the elderly**

Kitson hypothesised that ward sisters who chose to work in the speciality would have higher therapeutic orientation than those arriving by accident. However, no difference was found in her study between high and low scoring ward sisters and ward choice.

Table 3.8 shows the results from this study. All ward sisters on primary wards had chosen to work with elderly patients, as had two ward sisters on both functional and team wards. Ward sisters F8 and T6 did not choose to work with elderly patients, but were deployed to their present wards as a result of hospital closure.

#### **Skills needed to care for the elderly**

All ward sisters, with the exception of ward sisters F7 and F9, listed professional skills as well as, in some cases, personal skills necessary in order to care for elderly patients competently. Ward sisters F7 and F9 seemed to view care of the elderly nursing as demanding more in terms of



TABLE 3.9 Skill Utilisation

SKILLS	PRIMARY WARD SISTERS		
	P1	P2	P3
'Basic' nursing skills	3	3	4
Rehabilitation skills	3	4	4
'Technical' nursing skills	3	2	3
Teaching skills	3	3	4
Communication skills	3	4	4
Management skills	3	4	4
Total Score	18	20	23

TABLE 3.10 Skill Utilisation

SKILLS	TEAM WARD SISTERS		
	T4	T5	T6
'Basic' nursing skills	*	4	3
Rehabilitation skills	4	4	4
'Technical' nursing skills	*	3	3
Teaching skills	4	3	3
Communication skills	4	4	4
Management skills	4	4	4
	*	22	21

\*Sister wrote note - "I disagree with splitting nursing skills into 'basic' and 'technical'".

Key: 4 Very good use  
 3 Good use  
 2 Some use  
 1 Very little use

personal qualities rather than professional skills learned through education and practice.

#### **Skill utilisation in various areas (Tables 3.9 - 3.11)**

All ward sisters considered their 'basic nursing' and rehabilitation skills were put to good or very good use. 'Technical' nursing skills were put to some use or very little use by ward sisters in functional wards, but good use in all other wards except Ward P2 and Ward T4, where the ward sister wrote a note to the effect that she disagreed with the splitting of nursing skills into 'basic' and 'technical'. Teaching skills were similarly put to least use in functional wards, as were management skills, but these were also only put to good as opposed to very good use in Ward P1. Communication skills were put to good or very good use by all ward sisters with the exception of Wards F8 and F9, where they were put to some use only.

#### **Satisfying aspects in caring for elderly patients**

Ward sisters F7 and F8 viewed 'medical model' goals of patient recovery and discharge as satisfying. Ward sister F7 also considered changing negative views held by other hospital colleagues about what a rehabilitation ward is and involves satisfying. All other ward sisters found satisfaction in aspects which are the domain of nursing, for example giving patients a high standard of care and maintaining patient individuality.

TABLE 3.11 Skill Utilisation

SKILLS	FUNCTIONAL WARD SISTERS		
	F7	F8	F9
'Basic' nursing skills	3	3	4
Rehabilitation skills	3	4	3
'Technical' nursing skills	2	1	2
Teaching skills	2	2	2
Communication skills	4	2	2
Management skills	3	3	3
Total score	17	15	16

Key: 4 Very good use  
 3 Good use  
 2 Some use  
 1 Very little use

## **Aspects considered least satisfying**

With the exception of ward sister F8, all ward sisters viewed as least satisfying constraints which hindered the delivery of high quality care to elderly patients. Ward sister F8 simply considered "office work" as least satisfying, perhaps suggesting an acceptance of the status quo and no articulated areas in which patient care could be improved.

### *iv. Ward sisters' perception of their rehabilitation role*

#### **Defining rehabilitation**

All ward sisters saw rehabilitation as maximising the potential of patients in self-care and maintaining independence and hence gave answers considered by Kitson to be therapeutic. No ward sister defined rehabilitation solely in terms of the activities of therapists, which would have constituted an untherapeutic response.

#### **The role of the nurse in rehabilitation - one (Tables 3.12 - 3.14)**

The centrality of the nurses' role in rehabilitation is reinforced in responses to this question.

TABLE 3.12 The role of the nurse in rehabilitation

	PRIMARY WARD SISTERS		
	P1	P2	P3
Primarily a job for therapists	-	✓	None of these - rehabilitation is a team approach with equal levels of input
Primarily a job for therapists with a small input by nurses	✓ This varies over the year with staff changes and annual leave	-	-
Primarily a job for nurses with a small input by therapists	✓	-	-
Primarily a job for nurses	-	✓	-

TABLE 3.13 The role of the nurse in rehabilitation

TEAM WARD SISTERS			
	T4	T5	T6
Primarily a job for therapists	None of these - rehabilitation is a shared load with nurses spending most time with patients	-	-
Primarily a job for therapists with a small input by nurses	-	-	-
Primarily a job for nurses with a small input by therapists	-	✓	✓
Primarily a job for nurses	-	-	-

TABLE 3.14 The role of the nurse in rehabilitation

	FUNCTIONAL WARD SISTERS			
	F7	F8	F9	
Primarily a job for therapists	-	-	-	
Primarily a job for therapists with a small input by nurses	-	-	-	
Primarily a job for nurses with a small input by therapists	✓	✓	✓	
Primarily a job for nurses	-	-	-	

## The role of the nurse in rehabilitation - two

In addition to the above, ward sisters were asked open-ended questions about the nurse's role in rehabilitation. Again, all ward sisters emphasised the centrality of the nurse's role, with none viewing it as merely a supplementer of medical and paramedical activity.

The role of the nurse in assessment, planning and evaluating care was stated by several ward sisters (ward sisters F7, F9, T5, T6, P1 and P2). In line with Kitson's 'high scoring' ward sisters, there is little reference to the activities of paramedical staff except in terms of collaboration and communication. Ward sister T6 explicitly outlined lack of input by therapists, who are there for "advice only". Again in line with Kitson's 'high scoring' ward sisters, all sisters in this study appeared to view rehabilitation as an integral part of their work towards the ultimate aim of maximum independence for each patient. No ward sister viewed rehabilitation merely as an additional routine to be performed on patients.

All ward sisters, regardless of organisational mode, scored the highest possible number of points for the rehabilitation role subsection.

### v. *Patient participation in care and patient choice*

On all study wards, patients were allowed to choose some aspects of their daily routine and their care, but the degree to which this was so varied.



All ward sisters considered it important that patients chose what time they arose in the morning and went to bed at night and where they chose to spend their day, for example in the dayroom or at their bedside. In some wards, (Ward T5 and Wards P1, P2 and P3) patients were allowed to assist in choosing their care depending on how they perceived their problems and goals. How this operated was well illustrated by ward sister P3:

"With the nursing process one of the greatest aims is that you are actually developing a care plan with the patient that the patient agrees with. Obviously you as a nurse have the expert knowledge to ascertain what the problems are but the patient will tell you exactly what their problems are and what they see their ultimate aims to be. Your aims as a nurse may not be exactly the same as the patient, [but] it has to be the patient that makes the decision as to what they see as the problems and what they see as the ultimate aims."

Patient participation in maintaining and improving self-care abilities was mentioned by ward sisters F8, T5 and T6. Keeping patients informed with regard to their care and treatment was also considered important by five ward sisters (ward sisters F9, T5, T6, P1 and P3).

#### vi. *Relative participation in care*

All ward sisters acknowledged the important role of relatives in patient care. With the exception of ward sister F9, all mentioned the active role of relatives in meeting patients' activities of daily living needs. Relative participation in decisions about patient care was considered important by ward sisters F9, T4, T5, P1 and P3. Relatives were seen as having a teaching role by ward sisters P1 and P3, and their contribution in terms of a source of information was mentioned by ward sister F8.

FIGURE 3.3 Work Environment Scale

---

Relationship dimensions:

1. Involvement  
The extent to which employees are concerned about and committed to their jobs
2. Peer cohesion  
The extent to which employees are friendly and supportive of one another
3. Supervisor support  
The extent to which management is supportive of employees and encourages employees to be supportive of one another

Personal growth dimensions:

4. Autonomy  
The extent to which employees are encouraged to be self-sufficient and to make their own decisions
5. Task orientation  
The degree of emphasis on good planning, efficiency and getting the job done
6. *Work pressure*  
The degree to which the press of work and time urgency dominate the job milieu

System clarity and system change dimensions:

7. Clarity  
The extent to which employees know what to expect in their daily routine and how explicitly rules and policies are communicated
  8. Control  
The extent to which management uses rules and pressures to keep employees under control
  9. Innovation  
The degree of emphasis on variety, change and new approaches
  10. Physical comfort
-

## 2. WARD SISTERS' PERCEPTIONS OF THEIR WORK ENVIRONMENT

### a. Introduction and relevant literature

In order to determine ward sisters' perceptions of their work in different organisational modalities, it was essential to use a measure which can take account of the multidimensional nature of the work and the work environment. The work of Moos and his colleagues appeared to do this in promoting the social climate perspective (Moos and Schaefer, 1987).

Based on work in a number of work environments, including health care settings, the underlying facets of social climate have been organised into three domains and the Work Environment Scale (WES) was developed to measure them (Insel and Moos, 1974; Moos, 1986). The three underlying domains deal with firstly, relationships, thus tapping the extent to which employees and supervisors are involved with and supportive of each other; secondly personal growth and goal orientation, which covers the goals towards which the work setting is orientated and finally system maintenance and system change dimensions, which assess the amount of structure, clarity and openness to change that characterise the work setting. The ten subscales which relate to each dimension are described in Figure 3.3.

The scale has had limited use in UK health care settings, but variations in the work climate associated with work discretion and work-related social support has been found to be associated with the morale and physical symptoms experienced by student nurses (Parkes, 1982). Leahy (1989) found

that when primary nurses were compared with other members of ward staff they had higher scores on every WES subscale except the extent to which they perceived managers as exerting control over their work. Hipwell et al (1989) used the WES to compare nurses working with elderly patients with nurses working in more high technology areas. They discovered nurses working in care of the elderly to be most dissatisfied with their work environment, scoring lower in their levels of autonomy, involvement and liking for their environment and higher in perceived workload.

As the WES requires a descriptive judgement of what the respondent encounters, it does not measure morale or work satisfaction, which require affective judgements (Payne et al, 1976). It does, however, address those dimensions of the work environment which contribute to them (Moos and Schaefer, 1987). Its use helps to answer the question of whether and in what dimensions ward sisters who are working in different organisational modalities regard their environment differently. The WES was also used to determine the extent to which perceptions of QNs and NAs differed in primary, team and functional wards, and also to gauge whether QNs regarded their work differently to NAs. This is discussed in Chapter 7.

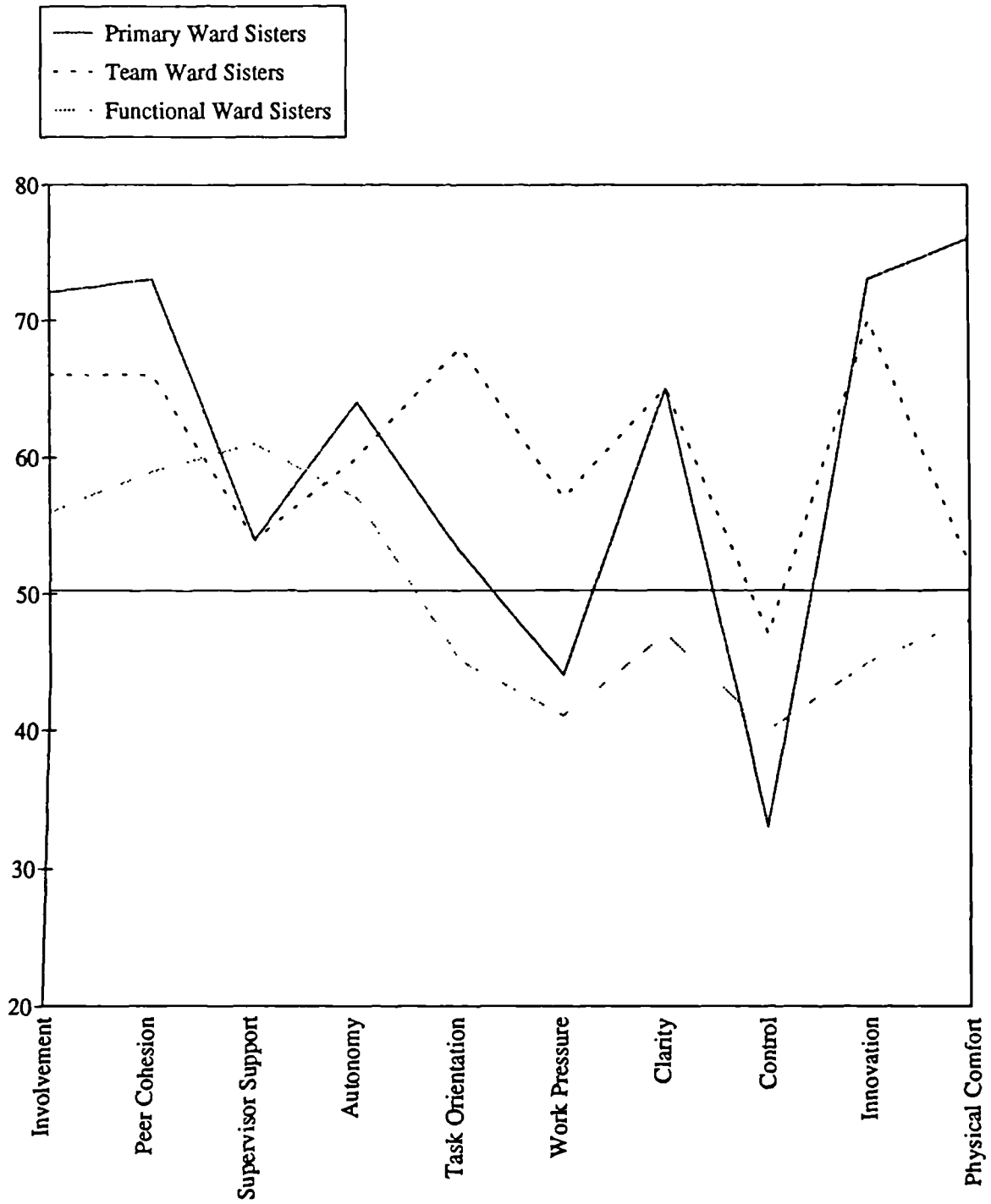
## **b. Method**

Each ward sister was asked verbally to complete a Work Environment Scale (Appendix 5) near the beginning of the data collection period on each ward. The scale was accompanied by a letter (Appendix 3) which largely reproduces Insel and Moos' (1974) instructions for the completion of the WES, but the meaning of the term 'supervisor' is given in more detail. At the end of

Table 3.15

WORK ENVIRONMENT SCALE

WARD SISTER PROFILES



the period of data collection on the ward the ward sisters were asked verbally if they had completed their questionnaires and these were then collected.

The original WES contained one question (Question 53) concerning pay bargaining which was not applicable to health service employees. A question concerning regrading was substituted as this also has financial implications and was a very topical issue throughout the fieldwork period. Questions 18 and 60 have been 'anglicised' to make them more appropriate to UK subjects.

### c. Findings

All ward sisters with the exception of ward sister T4 completed and returned the questionnaire.

Scores for the WES were obtained by summing items for each subscale for individual ward sisters and converting to standard scores using the conversion table for health care work settings (Moos, 1986). No UK norms exist for this scale. The scores for USA health workers are standardised to a mean of 50 for each subscale. Because of the skewed distribution of the data, it was not possible to use parametric analysis of variance. Instead, Kruskal Wallis tests were performed for each subscale. The level below which findings were deemed significant was set at  $p=0.05$ . Findings are presented in Table 3.15.

When primary and team ward sisters were compared, the only subscale where differences reached statistical significance was physical comfort, with primary ward sisters viewing their work environment most favourably ( $p < 0.05$ ). Comparing primary with functional ward sisters, primary ward sisters perceived significantly more involvement ( $p < 0.04$ ) and innovation ( $p < 0.03$ ) than their functional nursing counterparts. When team were compared with functional ward sisters, no significant differences were found.

### 3. DISCUSSION

Turning firstly to the therapeutic orientation of study ward sisters, overall all sisters demonstrated positive perceptions of care of the elderly nursing. Some, however, did not give uniformly therapeutic responses and untherapeutic responses were given largely, though not exclusively, by functional ward sisters. Ward sisters F8 and T6 did not recognise the specialist nature of care of the elderly nursing in their definitions but perceived it as different only in terms of patient characteristics. Ward sister F8 again only believed more training was required for QNs, not for herself or NAs, and was also not able to articulate areas which could lead to the improvement of patient care, in contrast to all other ward sisters. Skill utilisation was also lowest in functional wards, particularly 'technical', teaching, management and communication skills.

While it would have been desirable to choose wards where ward sisters answered uniformly to all questions regarding therapeutic orientation, this was not possible because of the paucity of wards which fulfilled the

criteria for each organisational mode. However, the attempt to control for this variable was largely successful in that all ward sisters gave generally therapeutic responses to the majority of questions, including one considered by Kitson to be most discriminating: understanding of the concept of rehabilitation.

Turning now to ward sisters' perceptions of their work environment, again sisters were closely matched and few significant differences were found between organisational types. This could, however, partly be the result of the small sample size. Primary ward sisters viewed their physical environment more positively than their team nursing counterparts. Two primary wards had been recently built and were specifically geared to the needs of elderly patients. The third primary ward, though situated in an old hospital building, had recently undergone major modernisation with elderly patients in mind. Team wards, on the other hand, were designed as standard hospital wards and possessed no features geared towards elderly care.

Primary ward sisters perceived greater involvement in their work than functional ward sisters, suggesting a greater concern for and commitment to their job. Furthermore, primary ward sisters achieved a higher score for innovation, suggesting a greater emphasis on variety, change and trying new approaches. From supplementary interview data, a dynamic, constantly evolving environment was outlined to a greater extent by primary ward



sisters. A quotation from ward sister P3, outlining a list of changes made since becoming ward sister, illustrates this:

"one of the most important things is that the staff now know that there are things that they can do to change and improve patient care while they are in hospital, and I think if you are in the habit of making changes, and being able to adapt to those changes, when they are of benefit to the patients - and I don't just mean change for changes sake - then that is a very good thing."

While two functional ward sisters believed they had made changes in their ward, these tended to be less wide-ranging, for example creating a more friendly atmosphere (ward sister F7). On Ward F8, an atmosphere of status quo appeared to prevail. When asked if she had made any changes since becoming sister, ward sister F8 replied:

"No, not really, but things will change now with twenty four hour responsibility, because its always been the day staff and the night staff - we had nothing to do with the night staff, we couldn't tell them if you had any qualms about a night nurse, you had to go through the correct channels or to night sister, but now you will be able to change policies and things."

Changes for this ward sister, then appeared to be imposed from outside rather than being generated from within the ward.

In summary, while ward sisters did not match perfectly, and differed in their responses on the involvement and innovation subscales and in their perceptions of their physical environment, they were not radically different and concurred on the majority of subscales.

## CHAPTER 4 OTHER INTERVENING VARIABLES

### 1. INTRODUCTION

While organisational mode, staff grade and the therapeutic orientation of the ward sister were treated as independent and controlling variables respectively, there are other factors which, if not treated as such, need to be taken into account. These include location of wards, the physical environment in which staff provide care, staffing characteristics and patient dependency. How these variables were assessed for comparability between organisational modes is described in this chapter.

### 2. LOCATION OF STUDY WARDS

Ward P1 was situated in a community hospital consisting of one care of the elderly ward, one medical ward, an accident and emergency and a maternity department. Ward P2 was located within the same health authority as Ward T5, but was in a small hospital specialising in elderly care and to which patients were admitted from Ward T5. Ward P3 was in what had once served as the general hospital for a large city, but which was due to close in two years time and now catered almost exclusively for elderly patients whose need for acute medical intervention had passed.

Wards F7 and F8 were situated in the same hospital. This used to function as a general hospital for a small town but now consisted almost exclusively of a mixture of rehabilitation, continuing care

and psychogeriatric care of the elderly wards. Ward F9 was situated in a large inner city teaching hospital.

Ward T4 was similarly situated in a large inner city teaching hospital and was the only elderly care ward in the hospital. Wards T5 and T6 were located in general hospitals servicing smaller towns and both formed part of an elderly care unit comprising several wards.

### 3. LAYOUT OF STUDY WARDS

Ward P1 consisted of four five-bedded rooms and four single rooms. Similarly, Ward P3 comprised five four-bedded rooms and three single cubicles. Ward P2 was of 'racetrack' design, with two four-bedded, two five-bedded and two single rooms.

Wards T4 and T5 were divided into bays, and consisted of four six-bedded rooms and six cubicles. Ward T6 was divided into two ends. All functional wards were also divided into two parts. In two wards (Wards F7 and F9) these parts were separated geographically by a corridor, whereas in Ward F8 they were separated by a partition.

#### *Influence of ward layout on the organisation of care*

In no primary ward did ward layout affect the way in which care was organised according to questionnaire data.

At the time of questionnaire completion, ward layout affected care organisation on all team wards. In Wards T4 and T6 two teams of

nursing staff cared for patients in distinct geographical areas. This had previously been the system in operation on Ward T5. By the time data collection began on this ward this had been changed because one team had significantly more 'heavy' patients than the other. Now, each team had patients in each bay and the cubicles, located at one end of the ward, similarly contained patients from each team.

In Ward F8 the ward layout had no effect on the organisation of nursing staff. Ward F7 consisted of two sides. The ward sister stated that because of this it was impossible to work in groups because with the usual three nursing staff members on duty individuals were constantly running from one side to another. It was only when there were four nursing staff on duty that division into two groups was possible. Ward F9 was similarly divided geographically into two ends, so when numbers allowed nursing staff were divided into two teams. When numbers were insufficient nursing staff worked throughout the whole ward.

#### **4. WARD STAFFING LEVELS**

##### **a. Method**

In order to give a crude indication of workload in study wards, the number and grade of nursing staff on duty together with the number of patients on the ward were recorded for every session in which subjects were observed providing care. The total number of sessions for which staffing figures were calculated was as follows:

TABLE 4.1 Staffing levels

TYPE OF WARD	MORNING SESSION				
	Qualified nurse/patient ratio	Nursing auxiliary/patient ratio	Learner/patient ratio	Total unqualified/patient ratio	Total staff/patient ratio
Primary nursing wards	.17	.14	.05	.19	.35
Team nursing wards	.11	.06	.09	.15	.26
Functional nursing wards	.10	.12	.02	.13	.24
	AFTERNOON SESSION				
Primary nursing wards	.13	.14	.08	.21	.34
Team nursing wards	.14	.07	.11	.18	.32
Functional nursing wards	.12	.13	.02	.15	.26
	EVENING SESSION				
Primary nursing wards	.11	.13	.02	.14	.25
Team nursing wards	.08	.04	.04	.07	.15
Functional nursing wards	.08	.10	.01	.11	.19
	ALL SESSIONS COMBINED				
Primary nursing wards	.15	.14	.05	.19	.34
Team nursing wards	.11	.06	.08	.13	.25
Functional nursing wards	.10	.12	.02	.14	.23

Note: Mean values are reported  
'Qualified nurse' includes ward sister

Morning sessions	- 144
Afternoon sessions	- 33
Evening sessions	- 39
Total sessions	- 216

Table 4.1 shows mean staff to patient ratios. To determine whether there were any differences in staffing levels between wards using different organisational modes, a one-way analysis of variance using Scheffe's test was used with the significance level set at  $p < 0.01$ .

**b. Findings (Tables 4.2 - 4.4)**

*Morning sessions*

In primary wards there were significantly more QNs per patient than in either team or functional wards. In primary and functional wards there were significantly more NAs per patient than in team wards. When NAs and learner nurses were combined, primary wards had significantly more unqualified staff than either team or functional wards. Primary wards also had significantly more nursing staff per patient when all nurse grades were combined. Team wards had a significantly higher learner nurse to patient ratio than either functional or primary wards.

*Afternoon sessions*

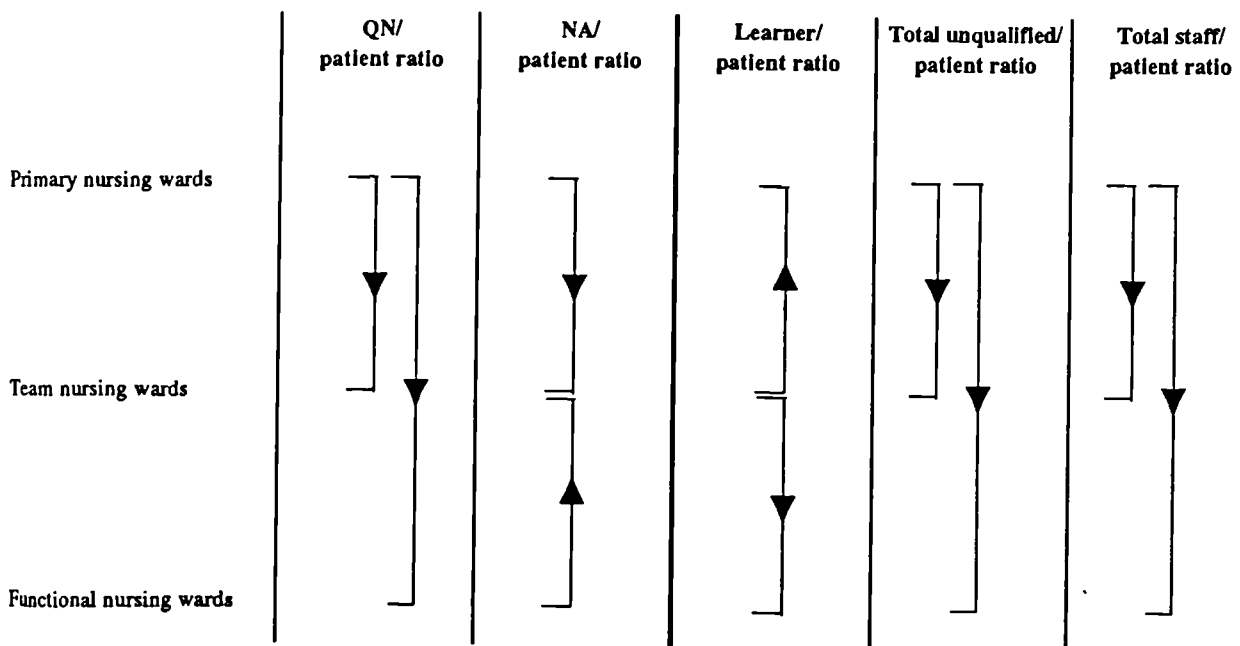
There were no significant differences between ward types.

*Evening sessions*

There was no significant difference found in the QN to patient ratio between ward types. Functional and primary wards were found to have significantly more NAs per patient than team wards, and when NAs and

**TABLE 4.2: STAFFING LEVELS SIGNIFICANT FINDINGS**

**MORNING SESSION**




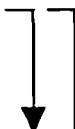
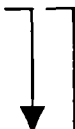






All differences significant at  $p < 0.01$  level

'Qualified nurse' includes ward sister

Arrows indicate greater score

**TABLE 4.3: STAFFING LEVELS SIGNIFICANT FINDINGS**

**EVENING SESSION**

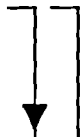


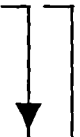
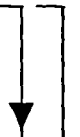










	QN/ patient ratio	NA/ patient ratio	Learner/ patient ratio	Total unqualified/ patient ratio	Total staff/ patient ratio
Primary nursing wards					
Team nursing wards					
Functional nursing wards					

All differences significant at  $p < 0.01$  level  
 'Qualified nurse' includes ward sister  
 Arrows indicate greater score



**TABLE 4.4: STAFFING LEVELS SIGNIFICANT FINDINGS**

**ALL SESSIONS COMBINED**

	<b>QN/ patient ratio</b>	<b>NA/ patient ratio</b>	<b>Learner/ patient ratio</b>	<b>Total unqualified/ patient ratio</b>	<b>Total staff patient ratio</b>
Primary nursing wards					
Team nursing wards					
Functional nursing wards					

All differences significant at  $p < 0.01$  level

'Qualified nurse' includes ward sister

Arrows indicate greater score

learner nurses were combined primary wards continued to have more unqualified nurses per patient than team wards. Primary wards also had a higher total number of nursing staff per patient than either team or functional wards.

#### *All sessions*

When all sessions were combined, primary wards were found to have significantly more QNs and unqualified staff per patient and also more nursing staff when all grades were combined than either team or functional wards. Primary and functional wards had significantly more NAs per patient than team wards, but team wards had a higher ratio of learners to patients than either primary or functional wards. The ratio of learner nurses to patients was also greater on primary than on functional wards.

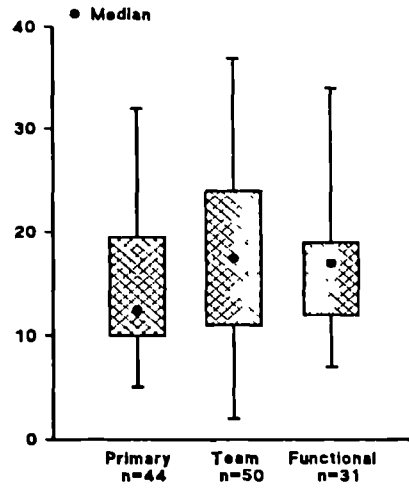
## **5. BEHAVIOURAL ABILITY OF PATIENTS ON STUDY WARDS**

### **a. Method**

In order to compare patient characteristics in study wards, the Modified Crichton Royal Behavioural Rating Scale (CRBRS, Wilkin and Jolley, 1979; Appendix 6) was administered to each participating subject for each patient to whom she had delivered morning care. The modified CRBRS consists of ten items, five of which measure physical dependency (mobility, feeding, dressing, bathing and continence) and five showing mental disturbance (memory, orientation, communication, cooperation and restlessness). This instrument was chosen because its reliability has been tested in several research studies (e.g. Wilkin and Jolley, 1979; Bond et al, 1989) and because of its quick

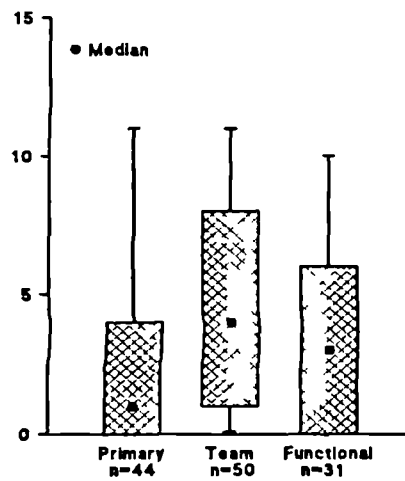
**Table 4.5**

**Crichton Royal Behavioural Rating Scores for patients in primary, team and functional nursing wards**



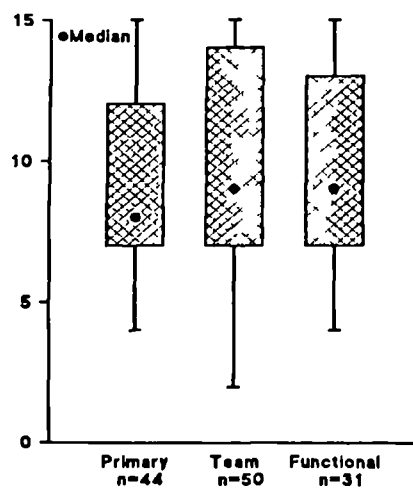
**Table 4.6**

**Crichton Royal Confusion Rating Scores for patients in primary, team and functional nursing wards**



**Table 4.7**

**Crichton Royal Functional Status Scores for patients in primary, team and functional nursing wards**



completion time (circa three minutes per patient). The scores range from 1 to 38 with higher scores indicative of greater frailty.

## **b. Findings**

Table 4.5 shows box-and-whisker plots of the modified CRBRS in all locations. The top and bottom of the rectangle represent upper and lower quartiles of the data, the circle within the rectangle representing the median. Lines extend from the ends of the box to the upper and lower values.

Kruskal-Wallis one way analysis of variance was performed to determine whether there were any differences in patient characteristics between types of ward. No significant differences were found between types of ward in total scale scores or the 'functional ability' subscale. There were similarly no differences between team and functional wards or primary and functional wards in the 'confusion' subscale, but team wards were found to have a significantly higher score for this subscale than primary wards ( $p < 0.01$ ).

## **6. SUMMARY AND DISCUSSION**

Ward profiles obtained thus far are presented in Figures 4.1 and 4.2.

Ideally, all variables other than method of organising nursing staff would have been controlled. The paucity of wards meeting stated criteria meant that it was not possible to control for variables such as ward size, ratio of unqualified to qualified staff and staffing

FIGURE 4.1

WARD CHARACTERISTICS - 1

	PRIMARY NURSING WARDS			TEAM NURSING WARDS			FUNCTIONAL NURSING WARDS		
	WARD P1	WARD P2	WARD P3	WARD T4	WARD T5	WARD T6	WARD F7	WARD F8	WARD F9
Number of male beds	Mixed	4	5	10	9	11	7	6	10
Number of female beds	Mixed	16	17	20	21	19	15	15	8
Total number of beds	24	20	22	30	30	30	22	21	18
Number of acute patients	6	0	0	0	17	10	1	0	5
Number of rehabilitation/ assessment patients	9	14	17	30	10	15	18	20	11
Number of respite/shared care patients	6	4	3	0	0	0	3	1	2
Number of continuing care patients	3	2	2	0	3	5	0	0	0
Allocation of learner nurses	✓	✓	0	✓	✓	✓	0	0	✓
Average number of learners	1	3	0	6	4	3	0	0	3
Number of consultants	1	2	1	2	2	1	5	1	2

**FIGURE 4.2**

**WARD CHARACTERISTICS - 2**

	PRIMARY NURSING WARDS			TEAM NURSING WARDS			FUNCTIONAL NURSING WARDS		
	WARD P1	WARD P2	WARD P3	WARD T4	WARD T5	WARD T6	WARD T7	WARD T8	WARD T9
Qualified nurse: patient ratio	0.17	0.15	0.1	0.12	0.1	0.12	0.08	0.09	0.12
Unqualified nurse: patient ratio	0.17	0.27	0.11	0.16	0.11	0.12	0.12	0.1	0.19
Total nurse: patient ratio	0.34	0.43	0.21	0.28	0.2	0.24	0.2	0.18	0.31
CRBRS Scores (Mean)	14	12	14	16	17	19.5	17.5	17	13.5
Ward sister TNF Score	71	74	76	77	78	72	66	57	67
Ward layout	Bays	Racetrack	Bays	Bays	Bays	Bays	2 ends	2 ends	2 ends

levels. It will therefore be necessary to take these intervening variables into account when interpreting study findings.

According to questionnaire data, geographical layout was a factor in determining ward organisation in two functional and two team wards, but according to primary ward sisters this assumed far less importance in primary wards. In practice, however, in only one primary ward (Ward P1) were patients with the same primary nurse not placed geographically together. In this respect, Ward P1 was similar to Ward T5, as here also patients from each team were spread throughout the ward.

Examination of staffing figures revealed a higher ratio of QNs to patients on primary wards on morning and evening shifts, a higher unqualified nurse to patient ratio than on all other wards in the morning and a higher unqualified nurse to patient ratio than team wards in the evening. Furthermore, on primary wards there was a greater overall number of nursing staff per patient when all grades were combined on morning and evening shifts. These results, however, mask differences between primary wards. Ward P1 largely achieved the aim of one QN and one NA per primary nurse group per shift (with the exception of the night shift). Similarly, in Ward P2 there was at least one QN and one NA for each group of patients to facilitate supervision and direction. On Ward P3, however, there were insufficient qualified staff to have one QN on duty for each group at all times of the day, generally considered to be the ideal of primary nursing. On the majority of shifts there was only one staff member on duty for each primary nurse group and usually the number of NAs exceeded that of QNs. This meant several groups of patients were

cared for solely by their NA, with QN(s) on duty acting as associate nurse(s) for these groups. At the time of data collection, this ward was four QNs below complement as a result of recruitment problems due to plans to close the hospital in two years time.

Team wards were found to have significantly more learner nurses on morning and evening shifts than either primary or functional wards. All team wards were training areas for learner nurses, but this was so in only one functional (Ward F9) and two primary wards (Wards P1 and P2). In primary and functional wards there were more NAs per patient than in team wards on morning and evening shifts. This accords with Hardie's (1980) finding that NAs and learners are interchangeable in terms of making up numbers to provide patient care.

As a result of small numbers, the dependency level of patients in study wards can be viewed only as a general indication of the dependency level of the total ward population. Overall, behavioural abilities of patients in all wards was found to be the same, and this is a crude indication that all wards comprised patients who generated the same level of work and possessed similar nursing requirements. However, patients on team wards were found to have significantly higher 'confusion' sub-scale scores than primary wards, which may have had implications for nursing care.



In this chapter, a collection of variables which were taken into account in the study have been examined. The next three chapters go on to describe the dependent variables: the activities performed by different grades of nursing staff (Chapter 5), the quality of nurse-patient verbal interaction (Chapter 6) and nursing staff perceptions of their work environment (Chapter 7).

## CHAPTER 5 THE FIRST DEPENDENT VARIABLE: ACTIVITIES PERFORMED BY QUALIFIED NURSES AND NURSING AUXILIARIES IN PRIMARY, TEAM AND FUNCTIONAL NURSING WARDS

### 1. CHOICE OF MEASURES TO COMPARE THE WORK OF QUALIFIED NURSES AND NURSING AUXILIARIES

Typically, previous work study methods have concentrated on categorising nursing care into a series of units or tasks capable of being timed, followed by a report of the time spent by different grades in each task (e.g. "The Aberdeen Formula", Scottish Home and Health Department, 1969). This approach has been criticised by Gault (1982) on technical, methodological and philosophical grounds. As it inevitably leads to a definition of nursing as merely a series of tasks, it is unable to accommodate features of quality or competence with which care is given.

More recently, manpower systems devised by Ball et al (1984) have attempted to control for the quality of care by relating measures of patient dependency to standardised indicators of quality. However, as Proctor (1982) points out, even with this system, the care given is not assessed for its suitability in meeting individual patients' needs. Furthermore, any assessment of its effectiveness is lacking and the fundamental assumption that 'correct' nurse performance equals effective treatment is questionable (Openshaw et al, 1988). A further issue is whose definition of 'correct' (e.g. patients' or nurses') is given most credence.

Others have attempted to measure quality by specifying the overall purpose of care and defining patient outcome in terms of this, then determining the extent to which patient or client outcomes have been achieved by examining appropriate nurse and patient activities (Felce et al, 1983; Kitson, 1984). Felce et al compared small community homes for mentally handicapped adults with existing institutions and large community units. The purpose of care was defined as fostering the development of individual potential, and the outcome of this was specified as engagement in meaningful activity. Clearly defined patient and staff behaviours were identified related to this outcome, and quality of care was judged by assessing to what extent the client performed purposeful activity and the extent to which staff were observed directing their behaviour towards it.

Kitson (1984) defined the purpose of care for hospitalised elderly patients as the achievement of optimal self-care (following Orem, 1980). Nurse activities were then judged therapeutic or untherapeutic according to how far they achieved this goal. Kitson's approach, however, is criticised by Openshaw et al (1988) as not necessarily reflecting what care actually achieves in terms of patient outcomes: action is measured against what Kitson believes will be effective, but this is not validated by examining actual patient outcomes.

Openshaw et al (1988) attempted to devise a method by which the effectiveness of nursing care in terms of patient outcomes could be measured against goals of treatment for surgical patients. The desired outcome in this study was patient recovery, and Openshaw et al concluded from their results that it was possible to set

standards of "optimal patient well-being" for each stage of the recovery process which could then serve as goals to guide and direct meaningful nursing action.

In the present study, the aim was to use an identifiable and measurable indicator of quality in order to compare the work of different grades of nursing staff organised in different ways. The focus was nursing staff and nursing behaviour, and it was beyond the scope of the study to examine the effect of each nurse's interaction on individual patient outcomes. A qualitative indicator was therefore chosen to meet the following criteria:

- i. particular relevance to the care of elderly patients, but with relevance to the whole of nursing.
- ii. amenable to strict definition - to ensure intra-rater reliability and replicability of the indicator.
- iii. capable of measurement - to enable statistical analysis
- iv. feasible - to enable a single researcher to collect the required amount of data in the available time.

The indicator chosen to meet these criteria was the quality of nurse-patient verbal interaction.

In addition, the activities in which QNs and NAs spent their time was recorded simultaneously. The next section details how data for these two dependent variables were collected. The remainder of the chapter

presents findings from activity data, and findings from the qualitative indicator are presented in Chapter 6.

## **2. METHOD USED IN OBSERVATION STUDIES**

### **a. Selection of the study sample**

Since both registered and enrolled nurses contribute to the qualified staff complement, it was intended to include two registered nurses and two enrolled nurses, together with four NAs from each study ward. To facilitate nursing staff availability for observation, a decision was taken to include only full-time staff wherever possible. Where this was not possible, part-time staff working the largest number of hours per week were selected.

Names were chosen randomly from the duty list. Each person was asked verbally if she was willing to participate in the study and given a letter outlining its aims and what participation entailed (Appendix 3). Only one NA refused participation, and was replaced by another NA also chosen randomly.

### **b. Observation of the work of nursing staff**

Non-participant observation using a computerised event recorder was used to collect two types of data: the activities carried out by both grades of nursing staff and their verbal interactions with patients. Pilot studies were carried out in typical wards for elderly patients to develop categories of activities and verbal interactions. A further testing of the research method and

validation of the categories was carried out over a one month period in an acute care of the elderly ward practicing functional nursing. Findings from this are reported fully in Bond et al, (1990). Both sets of categories were programmed into a portable Epson HX 20 computer using the 'Ethogram' software package (Browne et al, 1984; Clark et al, 1987), which was also used to collect the real-time data. The 'Ethogram' package has also been used in a nursing study of the post-operative care of surgical patients (Openshaw et al, 1988).

Two drawbacks of this method were taken into account. Firstly, to control for observer drift, the researcher observed and coded a videotape of nursing work entitled 'Talking to the Geriatric Patient'. This was performed before commencing work in the pilot ward, before commencing data collection for the main study, at the end of data collection in the third and sixth study ward and at the end of data collection. Agreement was monitored by calculating the percentage of activities and verbal interactions coded identically between sessions using a hard copy of the data. Reliability was greater than 95 per cent between all occasions.

Secondly, an attempt was made to control for observer effects on the data. Before beginning the main observation work on each ward, the researcher spent several hours in the ward both informally and formally observing each subject, with the intention that subjects would become used to both the researcher's and the computer's presence.

FIGURE 5.1 Categories of nursing staff activities

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Fundamental patient care:	Performing and assisting with patient hygiene including gathering and returning equipment Physical activity/mobility including gathering and returning equipment Activities associated with evacuation Activities associated with nutrition
Supplementary patient care:	Nursing observations Patient inspection Activities associated with medication Nursing procedures including collecting and returning equipment Assisting medical staff
Communication:	Ward report Communication about patients Teaching others not including patients
Administration:	Administration Activities associated with ordering or storing equipment and supplies
Domestic work:	Domestic work
Sociable:	Social and recreational interaction with patients
Staff time:	Staff time for meals etc. and apparently unoccupied time
Other:	Unable to observe Other activities not included above

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In order not to unduly influence verbal interactions with patients, subjects were not told explicitly that these were coded. A general explanation provided was that the study was about the sort of work NAs do compared with QNs.

The type of data to be collected necessitated staying close to the subject being observed even when events occurred behind curtains. Because of the ethical implications of including patients, each patient was given the right to refuse participation. There were no refusals.

Each nurse was observed for two three-hour periods (presented as 360 minutes of observed time), one in the morning and another in the afternoon or evening. Categories of the activities are presented in summary in Figure 5.1 and in detail in Appendix 7. Morning and evening periods observed were arranged to coincide with the start of the morning shift and the end of the evening shift. Thus the observations covered the whole of the day worked by day nursing staff.

To enable the recording of supplementary qualitative information about the context in which patient care was taking place, to flesh out details of quantitative data collection and to prevent observer fatigue when doing real-time observation, each hour of observation was followed by a one hour 'resting' and note-writing period.

Data, expressed as percentage observed time in each activity, were analysed using the Statistical Package for the Social Sciences (SPSSX; Spss Inc., 1988). Following tests demonstrating the normal



TABLE 5.1 All sessions: percentage time spent with patients

Staff Grade	Organisational Modality		
	Primary	Team	Functional
	Mean %	Mean %	Mean %
Qualified nurses	36.3	36.1	32.0
Nursing auxiliaries	41.7	44.6	42.6
Both grades	39.3	40.4	37.4

distribution of the data, two-way analysis of variance was used with time in activities as the dependent variable and organisational mode and staff grade as the independent variables. Time spent in the eight different types of activity were individually subjected to analysis. Analysis of variance tables for all sessions combined are presented in Appendix 9.

### 3. FINDINGS: COMPARISON OF ACTIVITIES PERFORMED BY QUALIFIED NURSES AND NURSING AUXILIARIES IN THREE ORGANISATIONAL MODES

#### a. All sessions

Total time spent with patients (Table 5.1)

##### *Main effects*

##### *i. organisational mode*

No significant difference was found.

##### *ii. staff grade*

A highly significant difference was found when QNs and NAs were compared within organisational types ( $p=0.001$ ). NAs spent a greater proportion of their time with patients than QNs in all three organisational modes. This difference was most apparent in functional wards, with NAs spending more than ten percent more time with patients.

##### *Interaction effects*

There were no interaction effects.

Time spent in each activity (Table 5.2 and Appendix 8a)

*Main effects* (Table 5.3)

*i. Organisational mode*

The only activity which differed significantly between organisational modes was supplementary patient care. Both QNs and NAs in primary wards spent just over half the percentage time in this activity than their team and functional counterparts ( $p=0.008$ ).

*ii. Staff grade*

NAs in all modes performed more fundamental patient care than QNs ( $p<0.001$ ), despite the highest percentage of time being spent in this activity by QNs also. NAs also spent a greater proportion of their time in domestic work, staff/unoccupied time, which includes meal breaks, and 'other' activities ( $p<0.001$ ,  $p<0.01$  and  $p<0.05$  respectively), while qualified staff spent a larger percentage of their time in administrative work ( $p<0.001$ ), communication ( $p<0.001$ ) and supplementary patient care ( $p<0.001$ ).

*Interaction effects*

An interaction effect was found in supplementary patient care, with QNs and NAs differing across locations. Primary NAs spent only 6% of the time spent by QNs in this activity, whereas for team and functional NAs this was 8.2% and 9.9% respectively.



**TABLE 5.3**  
**All sessions**  
**Percentage time spent in activities by qualified nurses and nursing auxiliaries**

Type of activity	PRIMARY NURSING WARDS		TEAM NURSING WARDS		FUNCTIONAL NURSING WARDS		ORGANISATIONAL MODE		GRADE OF NURSE	
	QUALIFIED NURSES	NURSING AUXILIARIES	QUALIFIED NURSES	NURSING AUXILIARIES	QUALIFIED NURSES	NURSING AUXILIARIES	F	Sig of F	F	Sig of F
	Mean % time	Mean % time	Mean % time	Mean % time	Mean % time	Mean % time				
Fundamental patient care	30.9	40.0	28.5	42.8	22.0	37.7	3.4	0.55	39.9	<.001
Supplementary patient care	10.0	0.6	16.7	1.4	17.2	1.7	6.4	0.008	165.6	<.001
Communication	13.0	5.4	11.3	3.3	12.7	4.1	0.8	0.46	40.6	<.001
Administration	11.0	3.7	11.0	3.5	10.7	3.7	0.01	0.99	53.9	<.001
Domestic	2.2	7.9	3.8	7.4	2.8	9.9	0.6	0.56	32.3	<.001
Sociale	4.8	5.6	3.5	4.4	3.5	5.4	1.5	0.25	4.0	0.06
Staff time/unoccupied	18	22.7	15.9	26.0	22.5	26.9	1.9	0.17	11.0	0.004
Other	3.9	6.8	4.4	5.5	4.6	4.8	0.4	0.7	4.8	0.043

Time spent in each activity with patients (Table 5.4 and Appendix 8b)

*Main effects* (Table 5.5)

*i. Organisational mode*

Significant differences were found across organisational types in fundamental patient care activities ( $p=0.05$ ), administration ( $p=0.03$ ), and 'other' activities ( $p=0.05$ ) and a highly significant difference in supplementary patient care ( $p=0.001$ ) and domestic activities ( $p=0.01$ ). Subjects on primary wards spent the largest time with patients in fundamental patient care (62%), and staff from functional wards the least (54.5%). Functional nursing staff, however, spent larger amounts of time while with patients in administrative activities (3.7%, compared with 1.8% in primary and 2.2% in team wards). Nursing staff on functional wards spent less time in 'other' activities, but percentage time spent in this category was small. Subjects in primary wards spent the least time with patients performing supplementary patient care, such as dressings and observations (6.1%, cf. 10.5% and 12.4% in team and functional wards respectively).

*ii. Staff grade*

When QNs and NAs were compared, a significant difference was found in percentage time spent in staff time ( $p=0.03$ ) and highly significant differences in fundamental patient care ( $p<0.001$ ), supplementary patient care ( $p<0.001$ ) and domestic activities ( $p=0.004$ ). NAs spent more time than QNs performing fundamental patient care while with patients, however differences were less marked on primary wards, with NAs spending approximately 6% more time in this activity compared with approximately 15% by team and functional NAs. NAs also spent

TABLE 5.4 All sessions: time spent in activities with patients by qualified nurses and nursing auxiliaries

Type of activity	PRIMARY NURSING WARDS		TEAM NURSING WARDS		FUNCTIONAL NURSING WARDS	
	QNs Time in minutes	NAs Time in minutes	QNs Time in minutes	NAs Time in minutes	QNs Time in minutes	NAs Time in minutes
Fundamental patient care	1162	1479	980	1539	763	1364
Supplementary patient care	214	25	343	41	370	50
Communication	3	0	2	0	0	0
Administration	26	48	52	36	70	49
Domestic	17	71	81	157	51	181
Sociable	220	261	159	197	158	248
Staff time/ unoccupied	25	52	17	63	26	60
Other	4	4	7	10	4	3
<b>Total time</b>	<b>1671</b>	<b>1938</b>	<b>1641</b>	<b>2043</b>	<b>1441</b>	<b>1955</b>

**TABLE 5.5**  
**All sessions**  
**Percentage time spent in activities with patients by qualified nurses and nursing auxiliaries**

Type of activity	PRIMARY NURSING WARDS				TEAM NURSING WARDS				FUNCTIONAL NURSING WARDS				ORGANISATIONAL MODE		GRADE OF NURSE	
	QUALIFIED NURSES		NURSING AUXILIARIES		QUALIFIED NURSES		NURSING AUXILIARIES		QUALIFIED NURSES		NURSING AUXILIARIES		F	Sig of F	F	Sig of F
	Mean % time with pts	Mean % time with pts	Mean % time with pts	Mean % time with pts	Mean % time with pts	Mean % time with pts	Mean % time with pts	Mean % time with pts	Mean % time with pts	Mean % time with pts	Mean % time with pts	Mean % time with pts				
Fundamental patient care	58.9	25.3	65.1	31.8	51.7	21.5	66.8	33.6	46.9	16.9	62.1	29.7	3.7	0.047	28.1	<.001
Supplementary patient care	11.1	4.6	1.1	0.5	19.2	7.6	1.7	0.9	22.7	8.2	2.2	1.1	10.6	0.001	191.6	<.001
Communication	0.6	0.3	0	0	0.2	0.1	0	0	0	0	0	0	-	-	-	-
Administration	1.4	0.6	2.2	1.0	2.8	1.1	1.6	0.8	4.3	1.6	2.8	1.4	4.2	0.03	1.1	0.32
Domestic	0.9	0.4	3.1	1.5	4.2	1.8	6.7	3.4	3.2	1.1	7.8	3.9	5.8	0.01	11.0	0.004
Sociable	11.3	4.8	11.5	5.6	8.6	3.5	8.5	4.3	9.7	3.5	10.9	5.4	1.9	0.18	0.1	0.73
Staff time/unoccupied	1.2	0.5	2.3	1.1	0.8	0.4	2.8	1.4	1.6	0.6	2.6	1.3	0.1	0.88	6.0	0.03
Other	0.2	0.1	0.2	0.1	0.4	0.2	0.4	0.2	0.3	0.1	0.2	0.1	3.7	0.05	0.04	0.85



larger proportions of time in domestic work while with patients, while QNs spent more time in supplementary patient care activities. NAs also spent a greater percentage of time in staff activities, for example unoccupied time and social interaction with anyone other than patients.

### *Interaction effects*

A highly significant interaction effect was found in supplementary patient care ( $p=0.005$ ), indicating differences between QNs and NAs across locations. QNs on primary wards spent just over half the time spent by team QNs in supplementary patient care (11.1%, cf. 19.2%) and less than half the time spent by functional QNs (22.7%). The same trend is evident for NAs, with primary NAs spending least time in this activity (1.1%, cf. 1.7% and 2.2% by team and functional NAs respectively).

Time spent in each activity away from patients (Table 5.6 and Appendix 8c)

### *Main effects (Table 5.7)*

#### *i. Organisational mode*

Significant differences were found in the category of fundamental patient care ( $p=0.04$ ) and highly significant differences in the categories of staff time ( $p=0.003$ ) and 'other' activities ( $p=0.008$ ). Functional nursing staff spent less time than their primary and team counterparts in fundamental patient care while not with patients, and also spent a smaller percentage of their time in 'other' activities, for example walking between activities. They did, however, spend a far greater percentage of time in staff activities, including meal

TABLE 5.6 All sessions: time spent in activities away from patients by qualified nurses and nursing auxiliaries

Type of activity	PRIMARY NURSING WARDS		TEAM NURSING WARDS		FUNCTIONAL NURSING WARDS	
	QNs	NAs	QNs	NAs	QNs	NAs
	Time in minutes	Time in minutes	Time in minutes	Time in minutes	Time in minutes	Time in minutes
Fundamental patient care	248	357	275	382	223	355
Supplementary patient care	214	3	380	22	379	27
Communication	264	106	192	71	288	69
Administration	482	111	443	126	407	110
Domestic	83	293	89	183	76	273
Sociable Staff time/unoccupied	2	1	1	4	1	0
Other	303	419	270	361	638	744
	177	222	190	239	197	218
<b>Total time</b>	<b>1773</b>	<b>1512</b>	<b>1840</b>	<b>1388</b>	<b>2209</b>	<b>1795</b>

**TABLE 5.7**  
All sessions

Percentage time spent in activities away from patients by qualified nurses and nursing auxiliaries

Type of activity	PRIMARY NURSING WARDS				TEAM NURSING WARDS				FUNCTIONAL NURSING WARDS				ORGANISATIONAL MODE		GRADE OF NURSE	
	QUALIFIED NURSES		NURSING AUXILIARIES		QUALIFIED NURSES		NURSING AUXILIARIES		QUALIFIED NURSES		NURSING AUXILIARIES		F	Sig of F	F	Sig of F
	Mean % time away from pts	Mean % time away from pts	Mean % total time	Mean % total time	Mean % time away from pts	Mean % time away from pts	Mean % total time	Mean % total time	Mean % time away from pts	Mean % time away from pts	Mean % total time	Mean % total time				
Fundamental patient care	14.5	5.6	23.6	8.2	15.3	7.0	27.7	9.2	10.4	5.1	19.6	7.9	4.0	0.04	29.3	<001
Supplementary patient care	12.2	5.3	0.3	0.1	20.6	9.2	1.6	0.5	17.1	8.9	2.1	0.8	2.8	0.09	73.1	<001
Communication	14.6	12.9	6.9	5.4	10.3	11.2	5.3	3.3	13.0	12.7	3.9	4.1	2.3	0.13	36.8	<001
Administration	27.0	10.5	7.4	2.7	23.9	9.8	8.9	2.8	18.4	9.1	6.3	2.7	2.1	0.16	56.7	<001
Domestic	4.7	1.8	19.4	6.4	4.9	2.0	13.6	4.0	3.6	1.7	15.8	5.9	0.9	0.43	41.1	<001
Sociable	0.2	0.1	0.1	0.03	0.1	0.03	0.6	0.2	0.1	0.04	0.1	0.02	1.0	0.42	0.8	0.40
Staff time/unoccupied	16.8	17.4	27.6	21.6	14.7	15.5	25.4	24.6	28.3	21.9	40.7	25.6	7.9	0.003	12.3	0.003
Other	10.1	3.9	14.8	6.7	10.3	4.2	17.2	5.3	9.0	4.5	12.2	4.8	6.4	0.008	46.0	<001

breaks (34.5%, compared with 22.2% and 20% in primary and team wards respectively).

*ii. Staff grade*

When QNs and NAs were compared within organisational types, highly significant differences were apparent in fundamental patient care, supplementary patient care, communication, administration, domestic, 'other' activities ( $p < 0.001$ ) and staff time ( $p = 0.003$ ). In all organisational modes NAs spent a greater percentage of time in fundamental patient care than QNs. Differences were most marked in team wards, where QNs spent approximately 13% less time in this activity, compared with approximately 9% and 10% in functional and primary wards respectively. As in activities with patients, NAs spent more time in domestic work away from patients than QNs, for example 19.4% compared with 4.7% in primary wards. NAs also spent a greater proportion of their time in staff and 'other' activities, with NAs in primary and team wards spending approximately 10% more time in the former activity than their qualified colleagues. QNs, on the other hand, were more occupied in administrative work and communication while not with patients.

*Interaction effects*

No interaction effects were found.

TABLE 5.8 Morning session: percentage time spent with patients

	Organisational Modality		
Staff Grade	Primary	Team	Functional
	Mean %	Mean %	Mean %
Qualified nurses	40.5	39.9	33.3
Nursing auxiliaries	42.4	49.4	42.5
Both grades	41.5	44.8	39.1

**b. Morning session**

**Total time spent with patients (Table 5.8)**

*Main effects*

*i. Organisational mode*

No significant differences were found.

*ii. Staff grade*

A highly significant difference was found when QNs and NAs were compared within locations ( $p=0.01$ ). NAs spent a larger percentage of time in the presence of patients than their QN counterparts. This difference was, however, most marked in team and functional wards, where NAs spent approximately ten percent more time with patients, compared with only two percent in primary wards.

*Interaction effects*

No interaction effects were found.

**Time spent in each activity (Table 5.9 and Appendix 8d)**

*Main effects (Table 5.10)*

*i. Organisational mode*

The only significant difference found was in the category of fundamental patient care. Nursing staff in primary and team wards engaged in similar percentages of this activity (40.2% and 39.7% respectively). This is in contrast to functional wards, where approximately 10% less time was spent in this (30.4%).

TABLE 5.9 Morning session: time spent in activities by qualified nurses and nursing auxiliaries

Type of activity	PRIMARY NURSING WARDS		TEAM NURSING WARDS		FUNCTIONAL NURSING WARDS	
	QNs	NAs	QNs	NAs	QNs	NAs
	Time in minutes	Time in minutes	Time in minutes	Time in minutes	Time in minutes	Time in minutes
Fundamental patient care	842	1029	757	1072	524	860
Supplementary patient care	272	17	374	37	410	29
Communication	229	90	282	62	315	113
Administration	180	81	213	100	201	29
Domestic	79	156	116	257	83	363
Sociable Staff time/unoccupied	87	87	72	78	60	100
Other	373	498	255	450	469	579
	99	201	91	104	98	88
Total time	2160	2160	2160	2160	2159	2160

**TABLE 5.10**  
**Morning sessions**  
**Percentage time spent in activities by qualified nurses and nursing auxiliaries**

Type of activity	PRIMARY NURSING WARDS		TEAM NURSING WARDS		FUNCTIONAL NURSING WARDS		ORGANISATIONAL MODE		GRADE OF NURSE	
	QUALIFIED NURSES	NURSING AUXILIARIES	QUALIFIED NURSES	NURSING AUXILIARIES	QUALIFIED NURSES	NURSING AUXILIARIES	F	Sig of F	F	Sig of F
	Mean % time	Mean % time	Mean % time	Mean % time	Mean % time	Mean % time				
Fundamental patient care	36.4	43.9	32.9	46.5	23.3	37.5	5.6	0.01	19.2	<.001
Supplementary patient care	11.7	0.7	16.4	1.6	18.2	1.7	1.7	0.22	60.7	<.001
Communication	9.9	3.9	12.4	2.7	14.0	5.0	0.8	0.47	21.6	<.001
Administration	7.7	3.5	9.3	4.4	9.0	1.3	0.5	0.59	16.2	0.001
Domestic	3.4	6.7	5.0	11.2	3.7	15.8	2.7	0.1	18.0	<.001
Sociable	3.7	3.7	3.1	3.4	2.7	4.4	0.3	0.75	1.6	0.22
Staff time/unoccupied	16.1	21.3	11.1	19.5	20.9	25.3	3.3	0.06	5.9	0.03
Other	4.3	8.7	4.0	4.5	4.4	3.8	1.4	0.28	1.3	0.27



### *ii. Staff grade*

Comparing QNs and NAs within organisational modes, highly significant differences were found in the categories of fundamental patient care, supplementary patient care, communication, administration, and domestic work ( $p < 0.01$ ) and a significant difference in staff time ( $p = 0.03$ ). NAs again were found to spend greater amounts of time in fundamental patient care, but differences were less marked in primary wards, where NAs spent approximately 8% more time in this activity (cf. approximately 14% and 15% by team and functional NAs respectively). NAs spent more than double the amount of time in domestic work than QNs. Here, the difference was particularly marked in functional wards, with NAs spending 15.8% of their time in this activity, compared with 3.7% by QNs. NAs also spent more time in the morning shift in staff activities. On the other hand, QNs were occupied to a greater extent with supplementary patient care, administration and communication.

### *Interaction effects*

There were no interaction effects.

Time spent in each activity with patients (Table 5.11 and Appendix 8e)

*Main effects* (Table 5.12)

### *i. Organisational mode*

Significant differences were identified in the categories of fundamental patient care ( $p = 0.04$ ), supplementary patient care ( $p = 0.04$ ) and domestic work ( $p = 0.02$ ). The largest amount of time spent in fundamental patient care was in primary wards (65.1%),

TABLE 5.11 Morning session: time spent in activities with patients by qualified nurses and nursing auxiliaries

Type of activity	PRIMARY NURSING WARDS		TEAM NURSING WARDS		FUNCTIONAL NURSING WARDS	
	QNs	NAs Time in minutes	QNs	NAs Time in minutes	QNs	NAs Time in minutes
Fundamental patient care	684	796	579	850	398	674
Supplementary patient care	125	15	152	28	202	14
Communication	0	0	1	0	0	0
Administration	15	22	33	25	30	3
Domestic	14	58	68	137	45	163
Sociable	87	87	72	76	60	100
Staff time/ unoccupied	10	14	7	19	14	21
Other	2	1	4	5	2	2
<b>Total time</b>	<b>937</b>	<b>993</b>	<b>916</b>	<b>1140</b>	<b>750</b>	<b>975</b>

**TABLE 5.12**  
**Morning session**  
**Percentage time spent in activities with patients by qualified nurses and nursing auxiliaries**

	PRIMARY NURSING WARDS				TEAM NURSING WARDS				FUNCTIONAL NURSING WARDS				ORGANISATIONAL MODE		GRADE OF NURSE	
	QUALIFIED NURSES		NURSING AUXILIARIES		QUALIFIED NURSES		NURSING AUXILIARIES		QUALIFIED NURSES		NURSING AUXILIARIES		F	Sig of F	F	Sig of F
	Mean % time with pts	Mean % total time	Mean % time with pts	Mean % total time	Mean % time with pts	Mean % total time	Mean % time with pts	Mean % total time	Mean % time with pts	Mean % total time	Mean % time with pts	Mean % total time				
Type of activity	62.1	29.6	68.1	34.0	54.3	25.2	66.4	36.9	47.0	17.7	62.2	29.4	3.9	0.04	13.1	0.002
Fundamental patient care	11.6	5.4	1.3	0.7	15.8	6.7	2.1	1.2	23.8	9.0	1.5	0.8	4.0	0.04	61.3	<.001
Supplementary patient care	0	0	0	0	0.2	0.1	0	0	0	0	0	0	-	-	-	-
Communication	1.4	0.7	1.8	0.9	3.2	1.5	2.2	1.1	5.0	1.8	0.5	0.3	1.8	0.2	3.6	0.08
Administration	1.3	0.6	4.9	2.5	6.1	2.9	10.6	6.0	5.4	2.0	13.8	7.1	4.7	0.02	9.1	0.01
Domestic	8.0	3.7	7.4	3.7	6.9	3.1	5.9	3.3	7.3	2.7	8.9	4.3	1.2	0.33	0.003	0.96
Sociable	1.2	0.6	1.2	0.6	0.7	0.3	1.4	0.8	1.7	0.6	1.7	0.9	0.5	0.63	0.2	0.69
Staff time/unoccupied	0.2	0.1	0.1	0.1	0.4	0.2	0.4	0.2	0.2	0.1	0.2	0.1	3.0	0.08	0.01	0.92

followed by team wards (60.4%). In functional wards this activity still accounted for over half of nursing staff time, but time spent in it was approximately ten percent less than in primary wards. Functional nursing staff spent a greater percentage of time in supplementary patient care, more than double that in primary wards (14.3% compared with 6.5%). Team were more akin to primary nursing staff, spending 8.9% of time in supplementary patient care. Subjects in primary wards spent less time in domestic work in the morning shift (3.1% cf. 8.3% and 9.6% in team and functional wards respectively).

#### *ii. Staff grade*

When QNs and NAs were compared, significant differences were found in the same activities as organisational mode, but findings approached a higher level of significance ( $p < 0.01$ ). NAs spent a larger percentage of their time in fundamental patient care. Again, this difference was more apparent in team and functional compared with primary wards. Domestic work also occupied more NA than QN time. QNs were more occupied with supplementary patient care, with NAs in each organisational mode spending less than 2.5% of their time in this activity.

#### *Interaction effects*

An interaction effect was found in the category of administration ( $p = 0.04$ ), indicating a difference between QNs and NAs across organisational types. While the percentage time spent in this activity by QNs and NAs in primary wards was similar (1.4% and 1.8% respectively), in team wards QNs performed more administrative work with patients (3.3% compared with 2.2%). In functional wards the

amount of time spent by NAs in this activity was negligible (0.5% compared with 5%).

Time spent in each activity away from patients (Table 5.13 and Appendix 8f)

*Main effects* (Table 5.14)

*i. Organisational mode*

Highly significant differences were found in the categories of fundamental patient care ( $p=0.01$ ), 'other' activities ( $p=0.001$ ) and staff time ( $p=0.01$ ). Primary and team nursing staff were found to spend similar percentages of time in fundamental patient care (25.5% and 24.3% respectively), but functional nursing staff spent only 16.3% of their time in this while away from patients. 'Other' activities also featured less prominently in functional wards (9.4% cf. 14.8% and 12.3% in primary and team wards respectively). Nursing staff in functional wards did, however, spend more of their time away from patients in staff activities, with this accounting for more than double the time spent in team wards, and approximately ten percent more than in primary wards.

*ii. Staff grade*

Highly significant differences were found in the categories of fundamental patient care, supplementary patient care, communication, administration, domestic work and 'other' activities ( $p<0.01$ ), and significant differences in time spent in staff activities ( $p=0.05$ ). A larger proportion of NA time was again spent in fundamental patient care, with NAs being occupied in this activity between approximately 8% and 11% longer than qualified staff. NAs also spent more time in 'other' activities and domestic work. In the former, the difference

TABLE 5.13 Morning session: time spent in activities away from patients by qualified nurses and nursing auxiliaries

Type of activity	PRIMARY NURSING WARDS		TEAM NURSING WARDS		FUNCTIONAL NURSING WARDS	
	QNs	NAs Time in minutes	QNs	NAs Time in minutes	QNs	NAs Time in minutes
Fundamental patient care	154	217	156	196	124	179
Supplementary patient care	115	2	185	9	185	15
Communication	89	40	78	37	139	33
Administration	164	50	179	75	169	25
Domestic	64	98	48	120	38	200
Sociable	0	0	1	2	0	0
Staff time/ unoccupied	130	180	97	148	324	336
Other	97	118	85	97	94	86
<b>Total time</b>	<b>813</b>	<b>705</b>	<b>828</b>	<b>683</b>	<b>1073</b>	<b>875</b>

**TABLE 5.14**  
**Morning session**  
**Percentage time spent in activities away from patients by qualified nurses and nursing auxiliaries**

Type of activity	PRIMARY NURSING WARDS				TEAM NURSING WARDS				FUNCTIONAL NURSING WARDS				ORGANISATIONAL MODE		GRADE OF NURSE	
	QUALIFIED NURSES		NURSING AUXILIARIES		QUALIFIED NURSES		NURSING AUXILIARIES		QUALIFIED NURSES		NURSING AUXILIARIES		F	Sig of F	F	Sig of F
	Mean % time away from pts	Mean % total time	Mean % time away from pts	Mean % total time	Mean % time away from pts	Mean % total time	Mean % time away from pts	Mean % total time	Mean % time away from pts	Mean % total time	Mean % time away from pts	Mean % total time				
Fundamental patient care	19.9	6.8	31.1	10.0	19.2	7.7	29.5	9.7	12.1	5.6	20.6	8.1	5.6	0.01	16.9	0.001
Supplementary patient care	14.1	6.3	0.6	0.2	21.6	9.7	1.9	0.5	17.3	9.3	3.8	1.3	0.7	0.5	19.5	0.001
Communication	11.0	9.9	5.7	3.9	9.3	12.4	5.6	2.7	13.2	14.0	3.7	5.0	0.3	0.77	26.7	< .001
Administration	18.6	7.1	7.0	2.5	21.7	7.8	10.3	3.3	15.7	7.6	4.0	1.5	1.4	0.29	14.5	0.001
Domestic	8.7	2.8	14.0	4.2	5.9	2.1	18.0	5.2	3.5	1.7	24.1	8.7	0.3	0.75	21.5	< .001
Sociable	0	0	0.2	0.1	0.3	0.1	0.4	0.1	0	0	0.1	0.03	0.2	0.82	0.1	0.84
Staff time/unoccupied	15.0	15.7	25.1	20.7	11.8	10.8	20.8	18.7	29.5	20.2	36.7	24.4	5.8	0.01	4.3	0.05
Other	12.6	4.2	16.9	8.6	10.4	3.8	14.3	4.3	8.8	4.3	10.0	3.7	9.6	0.001	9.9	0.01

TABLE 5.15 Afternoon session: percentage time spent with patients

Staff Grade	Organisational Modality		
	Primary	Team	Functional
	Mean %	Mean %	Mean %
Qualified nurses	35.4	29.7	31.7
Nursing auxiliaries	41.7	36.5	37.9
Both grades	41.6	35.8	35.5



between grades of nurse was less marked in functional than team and primary wards. In the latter, primary QNs and NAs demonstrated a larger degree of similarity (8.7% cf. 14%) than either team (5.9% cf. 18%) or functional (3.5% cf. 24.1%) QNs and NAs. QNs in all methods of organising nursing spent a larger proportion of time in supplementary patient care, administration and communication.

#### *Interaction effects*

There were no interaction effects.

#### **c. Afternoon session**

**Total time spent with patients (Table 5.15)**

##### *Main effects*

##### *i. Organisational mode*

No significant differences were found.

##### *ii. Staff grade*

NAs again spent a greater percentage of time with patients, but this did not reach statistical significance.

#### *Interaction effects*

There were no interaction effects.

**Time spent in each activity (Table 5.16 and Appendix 8g)**

##### *Main effects (Table 5.17)*

##### *i. Organisational mode*

A significant difference was found in the communication category ( $p=0.04$ ) and a highly significant difference in staff time ( $p=0.005$ ).

TABLE 5.16 Afternoon session: time spent in activities by qualified nurses and nursing auxiliaries

Type of activity	PRIMARY NURSING WARDS		TEAM NURSING WARDS		FUNCTIONAL NURSING WARDS	
	QNs Time in minutes	NAs Time in minutes	QNs Time in minutes	NAs Time in minutes	QNs Time in minutes	NAs Time in minutes
Fundamental patient care	285	356	265	245	247	312
Supplementary patient care	148	2	178	7	198	24
Communication	247	139	121	62	96	22
Administration	114	51	111	18	136	69
Domestic	14	131	31	21	24	41
Sociable	63	90	41	52	50	48
Staff time/unoccupied	171	247	280	276	293	325
Other	38	64	54	39	37	60
<b>Total time</b>	<b>1080</b>	<b>1080</b>	<b>1080</b>	<b>720</b>	<b>1080</b>	<b>900</b>

**TABLE 5.17**  
**Afternoon sessions**  
**Percentage time spent in activities by qualified nurses and nursing auxiliaries**

Type of activity	PRIMARY NURSING WARDS		TEAM NURSING WARDS		FUNCTIONAL NURSING WARDS		ORGANISATIONAL MODE		GRADE OF NURSE	
	QUALIFIED NURSES	NURSING AUXILIARIES	QUALIFIED NURSES	NURSING AUXILIARIES	QUALIFIED NURSES	NURSING AUXILIARIES	F	Sig of F	F	Sig of F
	Mean % time	Mean % time	Mean % time	Mean % time	Mean % time	Mean % time				
Fundamental patient care	25.7	36.0	22.4	32.1	21.5	31.9	0.4	0.71	5.2	0.04
Supplementary patient care	12.9	0.2	15.9	1.7	17.0	2.7	0.5	0.63	19.5	0.001
Communication	22.1	11.8	13.6	8.1	9.2	2.1	3.9	0.04	5.5	0.03
Administration	10.5	3.6	9.7	2.3	13.3	8.3	1.9	0.18	10.1	0.01
Domestic	1.3	10.5	2.2	2.7	2.3	5.2	2.2	0.14	7.2	0.02
Sociable	5.5	7.6	3.4	6.9	3.7	4.4	0.6	0.56	1.4	0.26
Staff time/unoccupied	12.9	17.9	24.3	36.0	26.9	33.3	7.3	0.01	4.5	0.05
Other	3.4	5.4	4.9	5.1	2.9	6.0	0.3	0.78	3.9	0.07

Both QNs and NAs in primary wards spent a much larger percentage of time communicating with others, for example medical and paramedical staff, than their team or functional counterparts (16.9% cf. 10.9% in team and 6.2% in functional wards). Whereas primary NAs spent 11.8% of their time in this activity, for functional NAs this occupied only 2.1% of their time. Primary nursing staff, however, spent a much smaller proportion of time in staff activities (15.4% cf. 30.1% in team and 29.6% in functional wards).

#### *ii. Staff grade*

Comparing QNs and NAs within organisational modes, highly significant differences were found in the categories of supplementary patient care ( $p=0.001$ ) and administration ( $p=0.01$ ), and significant differences in fundamental patient care ( $p=0.04$ ), communication ( $p=0.03$ ), domestic work ( $p=0.02$ ) and staff time ( $p=0.05$ ). NAs spent a larger proportion of their time in fundamental patient care, with this accounting for approximately ten extra percent in all methods of organising nursing. NAs also engaged in more domestic work than QNs, particularly in primary wards, and staff time. QNs, on the other hand, spent more time in supplementary patient care, administrative work and communication.

#### *Interaction effects*

There were no interaction effects.

Time spent in each activity with patients (Table 5.18 and Appendix 8h)

*Main effects* (Table 5.19)

*i. Organisational mode*

No significant differences were found.

*ii. Staff grade*

A highly significant difference was found in the category of supplementary patient care ( $p < 0.001$ ) and a significant difference in staff time ( $p = 0.03$ ). QNs again spent more time in supplementary patient care, while NAs spent a larger percentage of time in staff activities, with the exception of functional wards where percentages were approximately equivalent.

*Interaction effects*

There were no interaction effects.

Time spent in each activity away from patients (Table 5.20 and Appendix 8i)

*Main effects* (Table 5.21)

*i. Organisational mode*

Significant differences were found in the categories of communication ( $p = 0.03$ ) and staff time ( $p = 0.02$ ). Nursing staff in primary wards spent a larger amount of time communicating with each other and with other professional groups. The contrast was greatest between primary and functional wards (17.4% cf. 8.9%). Both QNs and NAs spent a greater percentage of time in this activity, and the difference between primary and functional NAs was particularly apparent (10% cf.

TABLE 5.18 Afternoon session: time spent in activities with patients by qualified nurses and nursing auxiliaries

Type of activity	PRIMARY NURSING WARDS		TEAM NURSING WARDS		FUNCTIONAL NURSING WARDS	
	QNs Time in minutes	NAs Time in minutes	QNs Time in minutes	NAs Time in minutes	QNs Time in minutes	NAs Time in minutes
Fundamental patient care	239	282	197	198	183	246
Supplementary patient care	79	2	86	3	99	14
Communication	3	0	2	0	0	0
Administration	7	25	10	3	29	38
Domestic	2	11	10	7	5	8
Sociable	63	89	40	50	50	48
Staff time/unoccupied	3	24	8	18	7	8
Other	2	2	1	1	1	0
<b>Total time</b>	<b>397</b>	<b>436</b>	<b>353</b>	<b>279</b>	<b>372</b>	<b>361</b>

**TABLE 5.19**  
**Afternoon session**  
**Percentage time spent in activities with patients by qualified nurses and nursing auxiliaries**

Type of activity	PRIMARY NURSING WARDS				TEAM NURSING WARDS				FUNCTIONAL NURSING WARDS				ORGANISATIONAL MODE		GRADE OF NURSE	
	QUALIFIED NURSES		NURSING AUXILIARIES		QUALIFIED NURSES		NURSING AUXILIARIES		QUALIFIED NURSES		NURSING AUXILIARIES		P	Sig of P	F	Sig of P
	Mean % time with pts	Mean % total time	Mean % time with pts	Mean % total time	Mean % time with pts	Mean % total time	Mean % time with pts	Mean % total time	Mean % time with pts	Mean % total time	Mean % time with pts	Mean % total time				
Fundamental patient care	50.6	21.5	56.6	29.2	51.3	16.7	60.9	25.9	45.2	15.9	57.3	25.3	0.3	0.75	3.0	0.10
Supplementary patient care	16.7	7.0	0.6	0.2	20.2	7.1	1.9	0.7	23.4	8.0	3.6	1.6	0.7	0.53	21.7	<.001
Communication	2.1	0.8	0	0	4.5	0.9	0	0	0	0	0	0	-	-	-	-
Administration	3.0	1.5	6.3	2.2	2.7	1.0	0.9	0.5	9.1	3.2	17.5	7.9	2.4	0.14	0.5	0.48
Domestic	0.6	0.2	2.8	1.1	2.2	0.9	3.7	1.7	1.3	0.6	2.4	1.0	0.9	0.43	3.3	0.10
Sociable	14.3	5.5	16.0	7.6	10.2	3.4	14.9	6.6	9.3	3.7	10.0	4.4	0.6	0.57	0.4	0.54
Staff time/unoccupied	0.7	0.3	4.4	2.1	1.7	0.7	5.4	2.3	1.8	0.6	1.8	0.8	1.0	0.38	6.2	0.03
Other	0.4	0.2	0.8	0.3	0.2	0.1	0.5	0.2	0.3	0.1	0	0	1.1	0.37	2.9	0.12

TABLE 5.20 Afternoon session: time spent in activities away from patients by qualified nurses and nursing auxiliaries

Type of activity	PRIMARY NURSING WARDS		TEAM NURSING WARDS		FUNCTIONAL NURSING WARDS	
	QNs Time in minutes	NAs Time in minutes	QNs Time in minutes	NAs Time in minutes	QNs Time in minutes	NAs Time in minutes
Fundamental patient care	40	70	56	47	64	66
Supplementary patient care	69	0	91	4	99	8
Communication	104	43	62	13	71	13
Administration	107	24	100	15	106	20
Domestic	13	115	20	14	19	33
Sociable	0	1	0	2	0	0
Staff time/unoccupied	44	88	59	41	130	228
Other	36	55	53	38	36	60
<b>Total time</b>	<b>412</b>	<b>395</b>	<b>440</b>	<b>173</b>	<b>525</b>	<b>428</b>



**TABLE 5.21**  
**Afternoon session**  
**Percentage time spent in activities away from patients by qualified nurses and nursing auxiliaries**

Type of activity	PRIMARY NURSING WARDS				TEAM NURSING WARDS				FUNCTIONAL NURSING WARDS				ORGANISATIONAL MODE		GRADE OF NURSE	
	QUALIFIED NURSES		NURSING AUXILIARIES		QUALIFIED NURSES		NURSING AUXILIARIES		QUALIFIED NURSES		NURSING AUXILIARIES		F	Sig of F	F	Sig of F
	Mean % time away from job	Mean % time away from job	Mean % total time	Mean % total time	Mean % time away from job	Mean % time away from job	Mean % total time	Mean % total time	Mean % time away from job	Mean % time away from job	Mean % total time	Mean % total time				
Fundamental patient care	10.6	4.2	20.0	6.7	12.1	5.7	29.2	6.1	11.9	5.7	15.0	6.6	1.1	0.36	6.8	0.02
Supplementary patient care	17.0	5.9	0	0	21.8	8.8	8.6	2.0	19.7	8.9	3.8	1.7	0.2	0.84	2.9	0.12
Communication	24.7	21.9	10.0	11.8	16.2	13.4	8.4	8.1	13.6	9.2	2.6	2.1	4.2	0.03	18.3	0.001
Administration	25.9	9.8	4.9	1.9	22.0	8.9	8.0	2.0	20.3	10.1	5.1	3.1	0.3	0.75	28.1	<.001
Domestic	6.3	1.7	28.5	9.7	6.8	2.7	7.5	1.9	5.0	1.9	12.3	4.5	2.7	0.11	3.6	0.08
Sociable	0.2	0.1	0.4	0.1	0.1	0.03	6.4	1.0	0	0	0	0	-	-	-	-
Staff time/unoccupied	8.9	12.7	21.1	15.8	11.6	23.7	22.1	33.7	24.4	26.3	48.7	38.6	5.1	0.02	6.9	0.02
Other	9.7	3.2	15.4	5.2	12.9	4.8	21.0	5.0	6.4	2.9	13.7	6.0	2.4	0.12	7.5	0.01

TABLE 5.22 Evening session: percentage time spent with patients

Staff Grade	Organisational Modality		
	Primary	Team	Functional
	Mean %	Mean %	Mean %
Qualified nurses	31.0	32.6	27.9
Nursing auxiliaries	48.5	41.1	45.4
Both grades	40.2	37.4	38.1

2.6%). Time spent in staff activities also varied across locations, with functional nursing staff spending double the amount of time in this than their primary or team counterparts (34.8% cf. 15% and 17% respectively).

*ii. Staff grade*

Highly significant differences were found in the categories of communication ( $p=0.001$ ), administration ( $p<0.001$ ) and 'other' activities ( $p=0.01$ ) and significant differences in fundamental patient care ( $p=0.02$ ) and staff time ( $p=0.02$ ). Fundamental patient care occupied a greater percentage of NA time while away from patients, and this difference was most marked in team wards (29.2% cf. 12.1%) and least marked in functional wards (15% cf. 11.9%). NAs also spent more time in 'other' activities and staff time than QNs, in the latter approximately double. QNs again were occupied to a greater extent with administrative and communication activities.

*Interaction effects*

There were no interaction effects.

**d. Evening session**

Total time spent with patients (Table 5.22)

*Main effects*

*i. Organisational mode*

No significant differences were found.

*ii. Staff grade*

When QNs and NAs were compared within organisational mode, a highly significant difference was found ( $p=0.01$ ). In all locations, NAs spent a larger percentage of their time with patients. This difference was most obvious in primary and functional wards, where NAs spent more than 17% more time with patients, compared with only circa. 8% in team wards.

*Interaction effects*

There were no interaction effects.

Time spent in each activity (Table 5.23 and Appendix 8j)

*Main effects* (Table 5.24)

*i. Organisational mode*

A highly significant difference was found in the category of 'other' activities ( $p=0.01$ ) and a significant difference in supplementary patient care ( $p=0.05$ ). In primary wards, nursing staff spent the least time in supplementary patient care (1.9% cf. 8.5% and 10.4% in team and functional wards respectively). The difference was most marked among QNs, with QNs in team and functional wards spending approximately ten percent more of their time in this. Nursing staff in primary wards also spent the least amount of time in 'other' activities.

*ii. Staff grade*

Comparing QNs and NAs, highly significant differences were found in the categories of fundamental patient care ( $p=0.002$ ), supplementary patient care ( $p=0.001$ ) and communication ( $p<0.001$ ), and a significant

TABLE 5.23 Evening session: time spent in activities by qualified nurses and nursing auxiliaries

Type of activity	PRIMARY NURSING WARDS		TEAM NURSING WARDS		FUNCTIONAL NURSING WARDS	
	QNs Time in minutes	NAs Time in minutes	QNs Time in minutes	NAs Time in minutes	QNs Time in minutes	NAs Time in minutes
Fundamental patient care	294	477	276	644	219	556
Supplementary patient care	41	9	209	20	165	26
Communication	124	23	109	25	161	52
Administration	215	42	174	44	144	73
Domestic	8	82	25	63	21	51
Sociable	72	85	47	71	49	101
Staff time/unoccupied	283	312	186	465	251	327
Other	44	50	54	108	71	74
<b>Total time</b>	<b>1080</b>	<b>1080</b>	<b>1080</b>	<b>1440</b>	<b>1080</b>	<b>1260</b>

**TABLE 5.24**  
**Evening session**  
**Percentage time spent in activities by qualified nurses and nursing auxiliaries**

Type of activity	PRIMARY NURSING WARDS		TEAM NURSING WARDS		FUNCTIONAL NURSING WARDS		ORGANISATIONAL MODE		GRADE OF NURSE	
	QUALIFIED NURSES	NURSING AUXILIARIES	QUALIFIED NURSES	NURSING AUXILIARIES	QUALIFIED NURSES	NURSING AUXILIARIES	F	Sig of F	F	Sig of F
	Mean % time	Mean % time	Mean % time	Mean % time	Mean % time	Mean % time				
Fundamental patient care	27.7	46.2	26.7	42.5	20.70	43.3	0.3	0.76	12.4	0.002
Supplementary patient care	3.1	0.8	15.7	1.3	13.1	2.1	3.5	0.05	17.3	0.001
Communication	11.9	1.8	9.1	1.7	14.8	3.2	2.1	0.15	45.7	<.001
Administration	19.5	4.9	12.3	2.9	11.1	6.4	0.6	0.56	5.7	0.03
Domestic	1.9	6.0	2.2	4.1	2.3	3.7	0.4	0.67	2.3	0.15
Sociable	5.5	7.3	4.0	4.7	4.2	5.7	1.00	0.38	1.2	0.28
Staff time/unoccupied	22.9	23.6	20.2	30.8	23.3	26.8	0.1	0.92	1.1	0.31
Other	3.7	4.6	5.1	7.1	6.2	5.3	5.5	0.01	1.5	0.24

difference in the category of administration ( $p=0.03$ ). QNs spent more time in supplementary patient care, but differences were greatest in team and functional wards. QNs also spent larger proportions of time in communication and administration. NAs spent more time in fundamental patient care, ranging from approximately 16% more in team wards to approximately 22% more in functional wards.

### *Interaction effects*

No interaction effects were found.

Time spent in each activity with patients (Table 5.25 and Appendix 8k)

### *Main effects (Table 5.26)*

#### *i. Organisational mode*

The only category to demonstrate a significant difference was 'other' activities ( $p=0.02$ ). Nursing staff in all organisational modes spent very small percentages of time in this activity, but nursing staff in team wards spent more time in it than their functional and primary counterparts (0.8% compared with 0.4% and 0.1% respectively).

#### *ii. Staff grade*

Comparing QNs and NAs within organisational types, highly significant differences were found in the categories of fundamental patient care ( $p=0.004$ ) and supplementary patient care ( $p=0.002$ ), and significant differences in administration ( $p=0.05$ ) and 'other' activities ( $p=0.03$ ). More time was spent in fundamental patient care by NAs, however time spent in this by QNs in primary wards most closely approximated to that of NAs (a difference of approximately 9% cf. approximately 19% and 15% in team and functional wards respectively).

TABLE 5.25 Evening session: time spent in activities with patients by qualified nurses and nursing auxiliaries

Type of activity	PRIMARY NURSING WARDS		TEAM NURSING WARDS		FUNCTIONAL NURSING WARDS	
	QNs	NAs	QNs	NAs	QNs	NAs
	Time in minutes	Time in minutes	Time in minutes	Time in minutes	Time in minutes	Time in minutes
Fundamental patient care	239	401	204	490	182	445
Supplementary patient care	10	8	106	11	69	23
Administration	3	1	9	8	11	8
Domestic	1	2	4	14	2	11
Sociable	70	85	47	71	48	101
Staff time/unoccupied	12	13	2	27	5	31
Other	0	0	2	4	2	1
<b>Total time</b>	<b>336</b>	<b>510</b>	<b>373</b>	<b>624</b>	<b>319</b>	<b>619</b>



**TABLE 5.26**  
**Evening session**  
**Percentage time spent in activities with patients by qualified nurses and nursing auxiliaries**

Type of activity	PRIMARY NURSING WARDS				TEAM NURSING WARDS				FUNCTIONAL NURSING WARDS				ORGANISATIONAL MODE		GRADE OF NURSE	
	QUALIFIED NURSES		NURSING AUXILIARIES		QUALIFIED NURSES		NURSING AUXILIARIES		QUALIFIED NURSES		NURSING AUXILIARIES		F	Sig of F	F	Sig of F
	Mean % time with pts	Mean % time with pts	Mean % total time	Mean % total time	Mean % time with pts	Mean % total time	Mean % time with pts	Mean % total time	Mean % time with pts	Mean % total time	Mean % time with pts	Mean % total time				
Fundamental patient care	60.9	22.9	70.2	39.3	51.4	19.2	69.8	32.3	51.8	16.8	67.4	33.8	0.7	0.5	11.1	0.004
Supplementary patient care	5.1	1.1	1.4	0.7	21.1	7.9	1.3	0.7	17.3	5.5	3.9	1.9	1.8	0.2	13.6	0.002
Administration	4.3	0.9	0.3	0.1	1.8	0.7	1.2	0.5	4.3	1.5	2.5	1.4	2.8	0.12	5.3	0.05
Domestic	0.6	0.3	0.4	0.2	1.5	0.6	2.2	0.9	0.9	0.3	2.7	1.4	1.1	0.38	0.8	0.40
Sociable	16.1	5.4	13.6	7.3	10.7	4.0	10.3	4.7	13.2	4.2	10.8	5.7	1.2	0.32	0.6	0.46
Staff time/unoccupied	2.5	1.5	2.8	1.1	0.8	0.3	4.0	1.8	1.8	0.6	5.3	2.6	0.3	0.78	2.3	0.15
Other	0.1	0.03	0	0	1.2	0.4	0.6	0.3	0.6	0.2	0.2	0.1	6.6	0.02	6.3	0.03

QNs spent greater proportions of time in supplementary patient care, where again differences were least marked in primary wards, administration and 'other' activities, although time spent in the latter was small for both grades of nurse.

*Interaction effects*

There were no interaction effects.

Time spent in each activity away from patients (Table 5.27 and Appendix 81)

*Main effects* (Table 5.28)

*i. Organisational mode*

No significant differences were found.

*ii. Staff grade*

Highly significant differences were found in the categories of supplementary patient care ( $p=0.01$ ), communication ( $p=0.002$ ) and 'other' activities ( $p=0.01$ ), and a significant difference in fundamental patient care ( $p=0.04$ ). NAs were occupied more in fundamental patient care, with differences least marked in primary wards, and 'other' activities. QNs spent more time in supplementary patient care, with differences most apparent in team and functional wards, and more than double the percentage time of NAs in communication.

*Interaction effects*

There were no interaction effects.

TABLE 5.27 Evening session: time spent in activities away from patients by qualified nurses and nursing auxiliaries

Type of activity	PRIMARY NURSING WARDS		TEAM NURSING WARDS		FUNCTIONAL NURSING WARDS	
	QNs Time in minutes	NAs Time in minutes	QNs Time in minutes	NAs Time in minutes	QNs Time in minutes	NAs Time in minutes
Fundamental patient care	55	71	63	140	35	110
Supplementary patient care	30	1	104	9	95	3
Communication	72	23	52	21	78	23
Administration	212	36	165	36	132	64
Domestic	7	80	21	49	19	40
Sociable	2	0	0	0	1	0
Staff time/unoccupied	129	151	115	173	184	179
Other	44	50	52	104	67	73
<b>Total time</b>	<b>549</b>	<b>412</b>	<b>571</b>	<b>532</b>	<b>611</b>	<b>493</b>

**TABLE 5.28**  
**Evening session**  
**Percentage time spent in activities away from patients by qualified nurses and nursing auxiliaries**

Type of activity	PRIMARY NURSING WARDS			TEAM NURSING WARDS			FUNCTIONAL NURSING WARDS			ORGANISATIONAL MODE		GRADE OF NURSE				
	QUALIFIED NURSES		NURSING AUXILIARIES	QUALIFIED NURSES		NURSING AUXILIARIES	QUALIFIED NURSES		NURSING AUXILIARIES	$\bar{Y}$	Sig of F	F	Sig of F			
	Mean % time away from pts	Mean % time total	Mean % time away from pts	Mean % time away from pts	Mean % time total	Mean % time away from pts	Mean % time away from pts	Mean % time away from pts	Mean % time total							
Fundamental patient care	13.6	4.8	19.8	7.0	16.6	7.5	27.2	10.2	7.6	4.0	26.6	9.5	0.4	0.66	5.2	0.04
Supplementary patient care	4.7	2.2	2.1	0.7	15.0	7.8	2.5	0.8	13.9	7.6	2.2	0.9	3.1	0.09	10.2	0.01
Communication	13.8	11.9	5.0	1.8	8.6	9.1	4.1	1.7	12.2	14.8	3.8	3.2	0.8	0.47	13.2	0.002
Administration	34.5	19.3	17.6	7.3	22.6	11.6	8.0	3.2	19.2	10.4	16.8	6.0	1.0	0.39	2.4	0.14
Domestic	3.3	1.7	15.9	5.8	3.7	1.8	9.9	3.2	4.3	2.2	7.8	2.7	0.9	0.42	3.6	0.08
Sociable	0.7	0.4	0	0	0	0	0.3	0.1	0.3	0.1	0.3	0.1	-	-	-	-
Staff time/unoccupied	23.8	21.4	36.5	22.6	23.0	20.1	30.2	29.0	31.2	22.9	33.8	24.2	0.4	0.68	1.9	0.18
Other	8.6	3.7	13.5	4.6	10.6	4.9	20.7	6.9	11.7	6.1	14.8	5.2	1.9	0.18	9.7	0.01

TABLE 5.29 Percentage time spent in activities: significant findings

	ALL SESSIONS		MORNING SESSION		AFTERNOON SESSION		EVENING SESSION	
	OM	Grade	OM	Grade	OM	Grade	OM	Grade
<b>ALL ACTIVITIES</b>								
Direct patient care	.	**	**	**	.	.	.	**
Supplementary patient care	**	**	.	**	.	**	.	**
Communication	.	**	.	**	.	**	.	**
Administration	.	**	.	**	.	**	.	.
Domestic	.	**	.	**	.	.	.	.
Other	.	.	.	.	.	.	**	.
Staff time	.	**	.	.	**	.	.	.
Sociable	.	.	.	.	.	.	.	.
<b>ACTIVITIES WITH PATIENTS</b>								
Direct patient care	.	**	.	**	.	.	.	**
Supplementary patient care	**	**	.	**	.	**	.	**
Communication	.	.	.	.	.	.	.	.
Administration	.	.	.	.	.	.	.	.
Domestic	**	**	.	**	.	.	.	.
Other	.	.	.	.	.	.	.	.
Staff time	.	.	.	.	.	.	.	.
Sociable	.	.	.	.	.	.	.	.
<b>ACTIVITIES AWAY FROM PATIENTS</b>								
Direct patient care	.	**	**	**	.	.	.	.
Supplementary patient care	.	**	.	**	.	.	.	**
Communication	.	**	.	**	.	**	.	**
Administration	.	**	.	**	.	**	.	.
Domestic	.	**	.	**	.	.	.	.
Other	**	**	**	**	.	**	.	**
Staff time	**	**	**	.	.	.	.	.
Sociable	.	.	.	.	.	.	.	.

\* p<0.05  
 \*\* p<0.01

OM = Organisational modality

#### 4. DISCUSSION

Findings from the observation of nursing staff activities are summarised in Table 5.29.

Regardless of organisational modality, the majority of staff time in all sessions was spent in nursing work associated with activities of daily living. Nursing staff in primary wards were, however, found to spend a significantly larger percentage of time in fundamental patient care than those in team and functional wards. This difference was particularly apparent when QNs were compared, with primary QNs spending 58.9% of their total time with patients in fundamental care, compared with 51.7% by team and 46.9% by functional QNs. One of the intended features of primary nursing is to bring QNs into greater contact with patients and increase their involvement in providing care of the type which is often regarded as 'basic' and thus delegated to unqualified staff. The data presented here show that patients in primary wards were receiving a larger proportion of this kind of care from individual QNs. This difference is exacerbated when the larger number of QNs available to provide patient care in primary wards is taken into account.

The majority of differences between organisational modes occurred in the morning shift. The observation of morning care has been selected by several researchers (e.g. Sandman et al, 1986; Barton et al, 1980) as being representative of, for example, ward culture, nursing staff priorities and the milieu in which care is given. In this study also, the way in which morning care was organised and delivered

was more likely to demonstrate differences between primary, team and functional wards, while fewest differences were apparent in the evening shift.

Time spent in fundamental patient care in the morning was similar in team and primary wards, but very much lower in functional wards, particularly for QNs. This can be explained in part by the division of work between day and night staff which existed in two functional wards. When day staff arrived on duty, the majority of patients were already washed, dressed, and sitting in their chairs ready for breakfast. Only the most physically dependent patients remained in bed, and had their morning care performed by day nursing staff. A similar pattern occurred in the evening, where day nursing staff ensured that the majority of patients were in bed before the night staff arrived on duty. According to the stated objectives of the wards, patients could choose whether or not to stay in bed in the morning or stay up in the evening. However in practice, if a large number of patients were still in bed when day staff came on duty, this engendered negative comments about night staff. A functional NA commented to a registered nurse:

"Are you putting Joe to bed? We're putting all the heavies to bed and when we come back in the morning the night staff will have left them all in bed."

This ambivalent attitude to patient choice is illustrated by a functional enrolled nurse:

"Some [patients] are kept up because they don't sleep at night, like Tom, he'll ask to go to bed, but we just ignore it. Last night two ladies, Mrs. Smith and Mrs. Jones were watching the television, so they stayed up, and there was Tom, [so that makes] four...The night staff are under no compulsion to get them up - it depends who's on. Sometimes they only get a few up who can do themselves. It depends how they feel."

The tension between meeting the deadline of day staff arriving on duty and not imposing too early rising times on elderly patients had potentially detrimental effects on patients' self-care abilities, as a functional night nurse illustrates:

"[patients get up] about 7, and they have a cup of tea before that. They put their top clothes on if they can, we put their bottom clothes on. They might be able to do that later in the day, but first thing they are a bit wobbly, so we do it for them."

In team and primary wards and the remaining functional ward, on the other hand, day nursing staff were almost exclusively responsible for carrying out morning care with patients, and viewed the performance of morning care as an activity contributing to patient rehabilitation, as the following examples illustrate:

1. Primary NA to recently admitted patient:

"Do you want to take your nightie off first? Do you manage to take your nightie off? [NA left patient to try and do it by herself, but remained with her.] I'm just seeing if you can manage. It would be easy for me to do it for you, but I won't be there when you go home will I?...Who does it at home?"

Patient:

"Me."

NA:

"I'll make your bed while you have a go. [Started making the bed] Go on, Janet, have a go. [NA gave her some time, then assisted her, while teaching her ways to take off her nightdress] Put your hand on the outside...try to take it over your head...that's the easiest way to do it."

2. QN:

"You use your good arm and wash what you can, then we'll come and help you. We're going to be partners in care, so you keep the abilities you've got, we're *not* going to take over and do everything for you. You do what you can, then we'll help you with the rest."

Also in the morning, time spent in supplementary patient care with patients, which included activities such as assisting medical staff



and performing more elaborate procedures, was significantly less in primary than in team and functional wards. Resulting from the structure of primary nursing, each QN, under normal staffing conditions, was responsible for between five and ten patients only, and therefore performed activities such as giving out medications and dressings solely for her patients. In contrast, the usual number of patients cared for by QNs in team wards was 15, and in functional wards it was the whole ward complement. While the amount of supplementary patient care needed by patients is not necessarily in direct proportion to patient numbers, it is likely that the increased amount in team and functional wards was occasioned by the larger group of patients within each QN's remit.

NAs in primary wards were, however, also occupied less with this activity than their team and functional counterparts. This is likely to be directly related to the amount performed by QNs, as the NA role in this activity frequently involved assisting the QN in the performance of the procedure.

As supplementary patient care was largely found to be the remit of QNs, the smaller amount of time spent in this type of work in primary wards may also be due to the significantly larger number of QNs per patient compared with team and functional wards. Primary wards were also markedly different in this respect in the evening session.

Again in the morning session, both grades of staff in team and functional wards spent more of their time in domestic work while with patients than nursing staff in primary wards. The most common domestic work carried out in the presence of patients was bed-making.

In primary wards, it was common practice to ensure patients' needs, both physical and psycho-social, were met before bed-making took place. As a result, patients were frequently away from the bed area when beds were made, either in the dayroom or participating in other activities of their choosing. In team and functional wards, however, bed-making formed part of the morning routine, and sometimes preceded caring for patients, as one team NA illustrates:

"On Ward 16 they dress the patients first [after breakfast], but on here we make the beds".

A further illuminating finding which separates primary from team and functional nursing is the greater amount of time spent in communication, particularly in the afternoon session. This was not limited to QNs, but extended to NAs also.

Perhaps as a direct consequence of the small group of patients cared for by each primary nurse group, in primary wards there was constant discussion between both QNs and their peers and QNs and NAs within primary nurse groups. The latter is illustrated in the following examples. The first is a dialogue between an enrolled nurse and her NA, the second an extract from field notes:

1. EN "He's OK when he has something to do. He likes listening to the wireless."  
NA "Playing cards are the best thing for him"  
EN "He washed and dressed himself, and ate his breakfast. I don't know what we're going to do with him."  
NA "Is he standing and transferring at all?"  
EN "He can stand with the zimmer, and took himself off the commode into the chair."  
NA "Have they checked his potassium?"  
EN "No, because the doctor didn't want anything doing because they had just been done. I think doctors should sit down and discuss things with him."

2. "Lucy [NA] was collecting the things for Susie's breakfast. She told me she was looking for a special spoon for her, and found one with a special handle. She put Susie's porridge on a rubber mat and put the spoon in her hand. Verity (Lucy's associate nurse) came up and said the speech therapist didn't want Susie to have that type of spoon, but a teaspoon, because it was her swallowing reflex that was defective. Lucy said that yesterday when she had given her something she had swallowed very well, but it kept falling off the spoon, and that was why she had given her this one."

QNs and NAs in primary wards not only discussed their patients with each other, but also regularly sought the advice of paramedical staff. This extract from field notes is an example of an NA consulting a physiotherapist:

Maureen [NA] went to look for Hugh [the physiotherapist], and asked him how Jane was doing with her walking. Hugh said she could walk with the frame. Maureen asked Hugh if he wanted her to help walk Jane. He said yes.

The following example illustrates a discussion between a qualified associate nurse and a physiotherapist:

QN "What would you suggest as a mobility goal for Alice?"

PT "She walked with me from the bedroom to the dayroom."

QN "I'll tell her primary nurse."

On certain occasions, therapists demonstrated handling of patients to both QNs and NAs, as this extract illustrates:

"Later, Freda was in the dayroom with Tom. Muriel [the physiotherapist] said she was going to demonstrate transferring Tom from chair to chair. Freda said she would fetch Josephine, 'the nursing auxiliary who looks after him'. Muriel demonstrated transferring him, and Freda, Josephine and Muriel discussed how they would manage in the toilet with pulling his trousers down etc. Muriel said they could call her when they were taking him to the toilet, and she would advise them."

In team and functional wards there was far less discussion with regard to optimal ways in which to care for individual patients. Conversations between QNs and NAs tended to be either instruction-

giving or NAs asking about tasks to be performed. This extract from a functional QN and NA illustrates the latter:

"Anne [NA] discussed with Belinda [QN] what to do next, and asked if any baths had been done in the morning. Belinda said none had because of the doctor's round. Anne said she would go and do some with [NA] Pam."

Nursing staff in functional wards spent a larger amount of time with patients in administrative activities, such as filling in menu cards and eliciting information from patients in order to complete nursing notes and care plans. In all primary and two team wards an administrative assistant was employed to assist in this type of work. No functional ward had this assistance, however, and the work was therefore performed by nursing staff.

Nursing staff in functional wards also spent a smaller amount of time in 'other' activities, such as walking about with an intention unknown to the researcher. This finding could be due to ward layout: functional wards differed from team and primary in that they comprised two ends and were not divided into bays, with a corresponding decrease in the amount of walking needed by nursing staff.

Functional nursing staff spent more time in staff activities, particularly in the afternoon session. As a result of the earlier time at which nursing staff in two functional wards were sent for their lunch break, this fell within the morning period of observation. This did not occur in other wards, and partially explains the larger percentage time spent in this activity by functional nursing staff when all sessions were combined.

In the afternoon session, however, time spent in this activity in primary wards was half that in team and functional wards. This suggests that nursing staff in primary wards were more likely to give up break time to meet the needs of their patient group. For example, if a new patient arrived on the ward while the designated primary or associate nurse was having her break, she would forego this in order to introduce herself to the patient and meet his immediate needs. In contrast, in team and functional wards this role would usually be performed by a nurse already present on the ward.

We would expect the work of qualified and unqualified staff to be different in a number of respects related to their different responsibilities and skills, and this was the case in all organisational types. Generally, and as expected, QNs were found to spend more time in supplementary patient care, communication and administrative activities, while NAs were more involved in care associated with activities of daily living and domestic work.

Not so obviously interpreted is the finding that NAs spent a larger percentage of time in staff activities. *In all organisational modes*, all grades of nurse spent some, if not all, their breaks on the ward. While this was usually in a room away from patients, in one functional ward all breaks with the exception of lunch were spent sitting in the ward away from, but in view of, patients. QNs were, however, more likely than NAs to have their breaks disturbed by happenings on the ward which required their attention.

TABLE 5.30 Effect of staffing levels on percentage time spent in activities

Session	Qualified/ patient ratio	Unqualified/ patient ratio	Total staff/patient ratio
<b>ALL SESSIONS</b>			
All activities	Sociable*	-	-
Activities with patients	Supplementary patient care*	Sociable*	Sociable*
Activities away from patients	Sociable *	-	-
<b>MORNING SESSION</b>			
All activities	-	-	-
Activities with patients	-	-	-
Activities away from patients	-	-	-
<b>AFTERNOON SESSION</b>			
All activities	-	-	-
Activities with patients	-	-	-
Activities away from patients	-	-	-
<b>EVENING SESSION</b>			
All activities	-	-	-
Activities with patients	Supplementary patient care *	Supplementary patient care *	Supplementary patient care *
Activities away from patients	-	-	-

\* p<0.05

## 5. THE EFFECT OF STAFFING LEVELS ON ACTIVITIES PERFORMED BY QUALIFIED NURSES AND NURSING AUXILIARIES

### a. Introduction

As discussed above, times spent in activities varied depending on whether primary, team or functional nursing was practiced. However, findings from staffing data indicate primary wards had more staff available to provide patient care than team and functional wards. In order to determine whether differences could be attributable to staffing levels, analysis of covariance was performed with qualified to patient, unqualified (including learner nurses) to patient and total nurse to patient ratios serving as covariates. Analysis of covariance tables for significant findings are presented in Appendix 10.

### b. Findings

Table 5.30 shows that only two activities, sociable interaction and supplementary patient care, were affected by variations in staffing levels. In the former, this occurred only when all sessions were combined, and not when morning, afternoon and evening sessions were considered in isolation. Time spent in sociable activity was not significantly different either across or within organisational mode when staffing ratios were not incorporated into the analysis.

Variations in staffing ratios affected time spent in supplementary patient care while with patients in the evening session and when all sessions were combined. When staffing ratios were not incorporated,

significant differences were found in this activity across organisational modes both when all sessions were combined and in the evening session.

It can be concluded, therefore, that staffing ratios could contribute to differences in time spent in supplementary patient care between organisational modes, particularly in the evening. Other differences found cannot, however, be attributed to differences in staffing levels.



## CHAPTER 6 THE SECOND DEPENDENT VARIABLE: THE QUALITY OF NURSE-PATIENT VERBAL INTERACTION

### 1. Choice of nurse-patient verbal interaction as a qualitative indicator

#### a. General literature

Since the beginning of the 1960s, increasing attention has been paid to both nurse-patient interaction and nurse-patient relationships in nursing theory, education and research (May, 1990). Communication is now regarded as the means of achieving 'the purpose of nursing' (Travelbee, 1971 p.108), as being central to all practice (MacLeod Clark, 1988) and, if used therapeutically, as a vehicle through which nurses can demonstrate caring (Burnard, 1987).

Studies investigating nurse-patient interaction, however, demonstrate the limited use made by nurses of this therapeutic tool. In general, regardless of speciality in which the research was conducted, nurses' interactions with patients typically are found to be of short duration, infrequent, task-oriented and governed by the necessity of nursing contact for purposes of physically oriented care. For example, Bond (1978) and Stockwell (1972) found nurses' communication with patients to be infrequent and of short duration. Moulton et al (1978) discovered that where conversation was not linked to another nursing activity the average length was 0.75 minutes. Where conversation occurred during a nursing task duration ranged from 0.5 to 9.5 minutes. Similarly, MacLeod Clark (1983) found mean duration

of interaction between patients and learner nurses to be 2.01 minutes and that between patients and qualified nurses to be 1.36 minutes.

Moreover, nurses have been found to use tactics which discourage effective communication with patients. In a radiotherapy setting, Bond (1978) found nurses avoided openness about patients' illness by minimising private interactions and managing conversations in order to avoid expressions of feelings or concern. In a surgical setting, MacLeod Clark found the predominant behaviour used by nurses to be 'discouraging'. This comprised repeated closed questions, leading questions and negative responses to direct questions or cues. By so doing, MacLeod Clark argues, nurses do not "benefit patients in terms of meeting their needs for information and support" (1983 p.52).

Several reasons are suggested in the literature for the limited and untherapeutic nature of nurse-patient interaction. Firstly, many nurses only believe they are practicing 'nursing' when they are meeting patients' physical needs. Stockwell (1972) discovered that after completing tasks for patients, nurses disappeared out of the patient area. This suggests nurses would rather 'hide' than participate in activities *not seen as proper work, for example* talking to patients. Clarke (1978) also found that although nurses may agree with individualised care in theory, they were reluctant to spend time talking to patients in case this was construed as "not really working", or in other words expending physical energy.

Other authors view nurse-patient interaction within the framework of ward organisation. Implicit in this literature is the idea that sustained periods of allocation of nurses to patients will be more

conducive to the development of nurse-patient relationships, a visible sign of which is nurse-patient communication. Moulton et al (1978) describe nurse-patient communication as "a patient outcome of the organisational system of the ward" (1978 p.107). They hypothesised that the prevalence of nurse-patient communication would be greater under a system of patient allocation than one of task allocation. Results indicated that while nurses spent slightly more time in conversation with patients in patient allocation wards, overall nurses in the study spent very little time talking with patients.

Knight and Field (1981) present a study showing how a task-orientated and routinised form of nursing organisation led to routinised verbal communication with cancer patients despite the development of close relationships between junior nurses and patients. This was, however, also due to the medical policy on the ward of not informing patients of their diagnosis, thus keeping patients in a state of "closed" or "suspicion" awareness. A further consequence of the task-oriented system was the division of labour whereby qualified staff occupied themselves with administrative and ward management tasks while unqualified and junior nursing staff performed the majority of direct patient care (cf. Seers, 1986, discussed below), and thus found themselves on the receiving end of patient anxiety about their condition. While maintaining friendly relationships with these patients, ward organisation facilitated evasion tactics by junior nurses in order to avoid patients' questions. It was possible for nurses to work elsewhere, thus avoiding contact with a particular patient, and/or the nurse could indicate by her actions that she had no time to talk. Wells (1980) and Armstrong-Esther and Browne (1986)

similarly cite task allocation as mitigating against nurse-patient interaction. These studies are described in the next section.

Field (1984), however, describes the effect of a totally different ward organisation and management structure on nurse-patient interaction, again in relation to cancer patients. Here, the ward was run along team nursing lines with patient allocation within the team. Nurses accepted individual responsibility for patients and authority was widely delegated from the ward sister to trained nursing staff. An "open disclosure" policy existed on this ward with regard to the sharing of information with patients. Within this structure, nurses were able to develop close relationships with patients and did not consider this level of involvement to be problematic. Indeed, emotional involvement was considered an essential predisposition to provide "total nursing care" for the "whole person" (1984 p.67).

Perälä (not dated) presents a study investigating the effect of primary nursing on nurse-patient communication. Differences were found in the content of interaction following the implementation of primary nursing: the frequency of ritual expressions decreased and there was an increase in the expression of feelings and opinions. Furthermore, nurse-patient interaction in the absence of nursing intervention increased. Patients initiated more interactions following the introduction of primary nursing (22% compared to 12%), but this figure remains low and indicates the patient's role remains one of waiting for instructions and answering questions while the nurse acts as questioner and instructor.

Thirdly, limited nurse-patient verbal interaction may be a means of preventing the development of nurse-patient relationships thus minimising a potentially anxiety creating situation (Menzies, 1960). Task allocation, Menzies argues, facilitates this defence against anxiety. By performing tasks for a large number of patients, the nurse is not brought into contact with "the totality of any one patient" (1960 p.101) and his illness, and this offers protection.

b. The special relevance of communication in care of the elderly

Nurse-patient communication is a crucial issue in care of the elderly nursing for a myriad of reasons. Most importantly, it is relevant because it serves as a pointer to the quality of the nurse-patient relationship (Wells, 1980; Bond and Bond, 1989). While the concept of a meaningful nurse-patient relationship is important in every nursing speciality, it takes on added relevance in elderly care for several reasons. Firstly, for many elderly patients nurses form the sole human contact. Therefore if patients' need for love and reassurance are not met by nursing staff, they may remain unmet (Fielding, 1979).

Secondly, without the development of therapeutic nurse-patient relationships through the medium of communication effective nursing care is impossible, as "effective and meaningful nursing care of the elderly rests on effective and meaningful nurse-patient relationships" (Wells, 1980 p.123). Wells illustrates this by giving the example of patient incontinence. She argues the solving of this problem can only be achieved within a nurse-patient relationship

which facilitates gaining the patient's views on, for example, what his problem means to him and what he perceives will be helpful in treatment. Castledine (1987) similarly views meaningful nurse-patient communication to be an essential component of the nurse-patient relationship, but believes only qualified staff to be capable of forming this relationship.

Communication in the form of giving knowledge to patients is vital in elderly care nursing because it enables the exertion of "legitimate power" and control by patients over their daily lives (Carlse, 1987). Lanceley (1985) describes how nurses use language in order to reinforce their position of control and power over the patient, with possible negative consequences for patients' self-concept and rehabilitation prospects. Several examples given by Lanceley are, however, questionable, for example whether, as Lanceley argues, the term 'just' can be described as "a half apologetic gesture for the naked exercise of control" (1985 p.131).

Thirdly, effective communication with elderly patients is an essential precursor to the provision of individualised care. Communication skills are necessary to enable nurses to gather relevant information about individual patients, for example during the taking of a nursing history, to plan and administer appropriate care and to evaluate the effectiveness of care with patients. Wells puts this succinctly:

"nurse-patient communication is important because it is a measure of the effectiveness of nursing care, i.e., the patient's need is defined, appropriate help provided, and the effectiveness of care evaluated." (1980 p.123)

Again, while the need to gain detailed patient knowledge in order to plan, give and evaluate care is not confined to nursing elderly patients, they frequently have multiple nursing and medical problems as well as an increased need for social and domestic support and, frequently, health education (Syred, 1981).

Finally, elderly patients often have special communication needs as a result of, for example, memory (Armstrong-Esther and Browne, 1986) or speech and sensory problems (Walton and MacLeod Clark, 1986).

**c. Research studies investigating nurse-patient communication in care of the elderly wards**

Studies of nurse-patient communication in elderly care wards present a uniformly depressing picture of nurses largely unaware of patients' needs, ill-equipped to meet these needs or both.

As part of a descriptive study, Wells (1980) investigated nurse-patient communication in one female rehabilitation ward. Wells divided the content of communication into three sections: procedural communication, that concerned with the performance of a task; personal communication, that concerned with a specific patient in a personal way and mixed procedural/personal communication, which contained both types. As most nurse-patient interactions (50 - 80%) were found to be of less than 25 seconds duration, Wells selected "sustained interaction" (interaction of a duration longer than 25 seconds) as her unit of analysis. Wells found the average length of "sustained interaction" with patients to be a mere one minute 28 seconds. 54.1% of these concerned physical care tasks and were not

focussed on the patient. Furthermore, even where there were personal interactions these were found to be superficial and not patient-oriented. When interacting with patients, nurses were most often performing physical care tasks (in 75.3% of interactions), and interacted socially with patients in only 5.3% of interactions. The vast majority of interactions (72.5%) were initiated by nurses and nurses were most likely to communicate with patients who were most confused. This led Wells to conclude that "sustained nurse-patient verbal communication in a geriatric ward was infrequent and of limited quality" (1980 p.121) and failed to meet the needs of patients.

Armstrong-Esther and Browne (1986), observing nurse-patient interaction with confused patients, similarly found physical care and completion of ward routines took priority over psycho-social care. Carrying out medical treatment such as dressings and giving medications was considered by all nursing staff, irrespective of grade, as the principal aim of care. Talking to patients and keeping them socially and mentally active were not only considered the least enjoyable but also the least important aims. According to Armstrong-Esther and Browne these views demonstrate allegiance to the medical model in that subjects only believed they were practicing 'nursing' when they were engaged in physical care activities. Nursing staff were found to spend only 10.7% of their time interacting with patients, who consequently spent 88.5% of their time inactively, either staring into space or dozing in their chairs.

In contrast to Wells' findings, nursing staff in this study interacted more with lucid than confused patients, those arguably in



need of the most stimulation and with the most psycho-social needs. In keeping with Wells' findings subjects initiated interaction with patients more frequently than they responded to patients' interactions.

Nursing staff dominance was also exhibited by the type of communication used: interaction was largely in the form of statements and instructions rather than questions. This type of interaction is inappropriate, according to the authors, because it is ineffective in eliciting a response from the patient, is not conducive to promoting independence and finally does nothing to encourage social interaction.

Walton and MacLeod Clark (1986), like Wells, found most nurse-patient interactions in their study of communication with two dysphasic patients to be of less than three minutes duration. Again, nurses were found to be preoccupied with the physical task rather than therapeutic conversation and again verbal behaviour (largely consisting of orders or multiple questioning) was inappropriate to the client group. Furthermore, nurses were unaware of the nature of patients' speech problems, and their description of patients' speech disorders rarely equated with that of the speech therapist.

In line with the above findings, Seers (1986), using categories of communication developed by Wells (1980), found the majority of nurses' communication with patients to be task-initiated (64%) and nurse initiated (81%). Seers compared learner nurse interaction with that of qualified nurses, and found that patients received 14% more interaction from learner nurses, but learners engaged in more task-

initiated conversation (62%) than qualified nurses (56%). Learners also spent only 2% of their total interaction time in personal interactions, compared with a figure of 34% for qualified staff. Patient characteristics were also found to influence the amount and content of interactions. A patient who required a considerable amount of nursing time due to a physical need and sustained conversation with nursing staff and a further patient known as a "chatterbox" received the most frequent and sustained interactions. On the other hand, a quiet patient and an 'unpopular' patient were recipients of shorter, less frequent interactions and these were largely task-initiated and procedural in nature. These latter findings accord with those of Armstrong-Esther and Browne (1986), who found nurses communicated most with those patients who provided feedback.

In summary, then, all studies of nurse-patient communication in care of the elderly hospital wards demonstrate a failure of nurses to perform therapeutically in this area. Generally, nurses were found to communicate with patients when primarily completing tasks and most conversation was task-orientated in nature. Patient characteristics were also found to affect the amount and nature of nurse-patient conversation, with those arguably in need of most stimulation, for example confused patients, often receiving the least, and patients with speech problems receiving interaction inappropriate to their needs. While Seers (1986) compared learner nurse interaction with that of qualified nurses, no study has compared how the amount and content of nursing auxiliary interaction compares with that of qualified nurses. The present study sought to remedy this.

FIGURE 6.1 Categories of verbal interactions with patients

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Giving choice:	Offering choice to patients
Questions:	Asking patients questions
Commands:	Giving patients instructions
Explanation - simple:	Routine explanations and remarks
Explanation - detailed:	More detailed explanations of procedures or care
Encouragement of self-care:	Verbal remarks associated with encouraging self-care
Teaching:	Imparting knowledge associated with changing behaviour
Reassurance:	Using reassuring words or phrases, attempting to relieve worries
Sociable:	Conversation not associated with routine activities or the patients' condition or care
Inaudible/other:	Verbal interactions which could not be classified within those described above

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## 2. METHOD

Nurse-patient verbal interaction was recorded simultaneously with activities performed by nursing staff (described in Chapter 5), according to the same method. Analysis was also performed according to the procedure described in Chapter 5. Verbal interaction categories are presented in outline in Figure 6.1 and in detail in Appendix 11. Analysis of variance tables for all sessions combined are presented in Appendix 13.

## 3. FINDINGS: VERBAL INTERACTION WITH PATIENTS

### a. All sessions

Total percentage time spent in verbal interaction (Table 6.1)

The percentage of observed time in verbal interaction was calculated by summing all interaction types.

#### *Main effects*

##### *i. Organisational mode*

Significant differences were found ( $p=0.02$ ). Nursing staff in primary wards spent the largest and those in functional wards the smallest amount of time communicating with patients.

##### *ii. Staff grade*

NAs spent significantly larger percentages of time in verbal interaction with patients than their QN counterparts ( $p=0.03$ ).

TABLE 6.1 All sessions: percentage time spent in verbal interaction with patients

Staff Grade	Organisational Modality		
	Primary	Team	Functional
	Mean %	Mean %	Mean %
Qualified nurses	6.3	5.0	4.2
Nursing auxiliaries	7.1	5.8	5.9
Both grades	6.7	5.4	5.1

### *Interaction effects*

There were no interaction effects.

Time spent in verbal interaction as a percentage of total observed time (Table 6.2 and Appendix 12a)

*Main effects* (Table 6.3)

#### *i. Organisational mode*

A significant difference was found in the category of giving choice ( $p=0.03$ ) and a highly significant difference in the category of routine explanation ( $p=0.003$ ). Subjects in primary wards spent a greater percentage of time offering choice (0.8% compared with 0.6% in team and functional wards) and giving general explanations about care to patients (1.9% cf. 1.5% and 1.4% in team and functional wards respectively).

#### *ii. Staff grade*

Comparing QNs and NAs within organisational types, highly significant differences were found in the categories of giving commands ( $p=0.01$ ), routine explanations ( $p=0.003$ ) and social interaction ( $p=0.01$ ) and a significant difference in the category of giving choice ( $p=0.02$ ). In every method of organising nursing, NAs spent more time giving patients commands, routine explanations of their care and choice. In the latter the difference was least apparent in primary wards. NAs also spent a larger percentage of time than QNs talking socially with patients.

### *Interaction effects*

A significant interaction effect was found in the self-care category ( $p=0.05$ ), indicating a difference between QNs and NAs across

TABLE 6.2 All sessions: time spent in each type of verbal interaction by qualified nurses and nursing auxiliaries

Type of verbal interaction	PRIMARY NURSING WARDS		TEAM NURSING WARDS		FUNCTIONAL NURSING WARDS	
	QNs Time in minutes	NAs Time in minutes	QNs Time in minutes	NAs Time in minutes	QNs Time in minutes	NAs Time in minutes
Command/instruction	31	44	30	44	25	38
Giving choice	36	39	23	33	16	33
Questions	51	52	41	42	36	43
Explanation - simple	80	92	60	74	55	75
Explanation - detailed	53	32	39	28	25	30
Encouragement of self-care	6	5	7	4	3	6
Teaching	1	1	0	0	2	0
Reassurance	1	4	2	2	0	2
Sociable	31	63	26	37	24	42
Inaudible/other	1	1	1	1	1	1
Total time	291	332	229	264	188	271

TABLE 6.3

All sessions

Percentage time spent in each type of verbal interaction by qualified nurses and nursing auxiliaries

	PRIMARY NURSING WARDS				TEAM NURSING WARDS				FUNCTIONAL NURSING WARDS				ORGANISATIONAL MODE		GRADE OF NURSE	
	QUALIFIED NURSES		NURSING AUXILIARIES		QUALIFIED NURSES		NURSING AUXILIARIES		QUALIFIED NURSES		NURSING AUXILIARIES		F	Sig of F	F	Sig of F
	Mean % time in verbal interaction	Mean % time in verbal interaction	Mean % time in verbal interaction	Mean % total time	Mean % time verbal interaction	Mean % time verbal interaction	Mean % time verbal interaction	Mean % total time	Mean % time verbal interaction	Mean % time verbal interaction	Mean % time verbal interaction	Mean % total time				
Type of verbal interaction																
Command/Instruction	10.8	0.7	13.1	0.9	13.2	0.7	16.6	1.0	13.5	0.6	14.2	0.8	0.6	0.57	8.4	0.01
Giving choice	12.2	0.8	11.9	0.8	10.1	0.5	12.5	0.7	8.7	0.4	12.9	0.7	4.1	0.03	7.0	0.02
Question	17.5	1.1	15.6	1.1	17.8	0.9	15.7	0.9	19.1	0.8	15.9	0.9	2.6	0.1	0.4	0.52
Explanation - simple	28.3	1.7	28.5	2.0	26.2	1.3	28.5	1.6	29.6	1.2	28.3	1.6	8.4	0.003	11.5	0.003
Explanation - detailed	17.8	1.2	9.6	0.7	17.2	0.9	10.4	0.6	13.3	0.6	10.8	0.7	2.4	0.12	3.1	0.10
Encouragement of self-care	2.1	0.1	1.7	0.1	3.1	0.2	1.7	0.1	1.6	0.07	2.2	0.1	0.9	0.41	0.1	0.84
Teaching	0.2	0.01	0.3	0.03	0.2	0.01	0.1	0.01	1.6	0.07	0.3	0.02	-	-	-	-
Reassurance	0.5	0.03	1.1	0.08	0.8	0.04	0.7	0.04	0.2	0.01	0.6	0.04	-	-	-	-
Sociable	10.4	0.7	18.2	1.4	11.3	0.6	13.6	0.8	12.9	0.5	14.8	0.9	1.9	0.18	8.4	0.01
Inaudible/other	0.3	0.02	0.3	0.02	0.3	0.01	0.4	0.02	0.4	0.02	0.3	0.02	-	-	-	-



locations. Time spent in this type of verbal interaction was small. However, while time spent in primary wards by QNs and NAs encouraging self-care was similar, in team wards it was QNs and in functional wards NAs who spent more time in this category. Overall, time spent encouraging self-care was similar in primary and team wards and lowest in functional wards.

Time spent in verbal interaction as a percentage of time spent with patients.

#### *Main effects*

##### *i. Organisational mode*

A highly significant difference was found in the category of routine explanation ( $p=0.002$ ) and a significant difference in giving choice ( $p=0.03$ ). Subjects in primary wards spent more time than their team and functional counterparts giving patients choice (1.8% cf. 1.3% in team and functional wards), and also giving patients general explanations about their care (4.1% cf. 3.2% and 3.4% in team and functional wards respectively).

##### *ii. Staff grade*

A highly significant difference was found only in the category of detailed explanation ( $p=0.01$ ), with QNs spending more time in this. Differences were least marked among functional QNs and NAs.

#### *Interaction effects*

There were no interaction effects.

TABLE 6.4 Morning session: percentage time spent in verbal interaction with patients

Staff Grade	Organisational Modality		
	Primary	Team	Functional
	Mean %	Mean %	Mean %
Qualified nurses	6.9	5.8	4.0
Nursing auxiliaries	7.7	6.2	5.8
Both grades	7.5	6.1	5.0

**b. Morning session**

Total percentage time spent in verbal interaction (Table 6.4)

*Main effects*

*i. Organisational mode*

A significant difference was found ( $p=0.02$ ). Nursing staff in primary wards spent the most and subjects in functional wards the least amount of time in verbal interaction (7.3% in primary wards, cf. 6% in team and 4.9% in functional wards).

*ii. Staff grade*

No significant differences were found.

*Interaction effects*

There were no interaction effects.

Time spent in verbal interaction as a percentage of total observed time (Table 6.5 and Appendix 12b)

*Main effects (Table 6.6)*

*i. Organisational mode*

A highly significant difference was found in the category of routine explanation ( $p=0.01$ ) and a significant difference in giving choice ( $p=0.02$ ). Nursing staff in primary wards spent the largest (0.9%) and subjects in functional wards the smallest (0.5%) amount of time giving choice to patients, with nursing staff in team wards inbetween the two (0.7%). This order was replicated in the time spent in routine explanations (2.2%, 1.8% and 1.5% in primary, team and functional wards respectively).

TABLE 6.5 Morning session: time spent in each type of verbal interaction by qualified nurses and nursing auxiliaries

Type of verbal interaction	PRIMARY NURSING WARDS		TEAM NURSING WARDS		FUNCTIONAL NURSING WARDS	
	QNs Time in minutes	NAs Time in minutes	QNs Time in minutes	NAs Time in minutes	QNs Time in minutes	NAs Time in minutes
Command/instruction	15	26	18	18	12	19
Giving choice	21	20	14	17	9	13
Questions	27	26	23	25	16	24
Explanation - simple	45	56	39	44	27	41
Explanation - detailed	29	16	19	17	13	14
Encouragement of self-care	4	3	6	3	2	3
Teaching	0	1	0	0	0	0
Reassurance	0	2	1	1	0	1
Sociable	18	31	14	18	11	17
Inaudible/other	1	0	0	1	1	1
Total time	159	181	133	144	91	133

**TABLE 6.6**  
**Morning session**  
**Percentage time spent in each type of verbal interaction by qualified nurses and nursing auxiliaries**

	PRIMARY NURSING WARDS			TEAM NURSING WARDS			FUNCTIONAL NURSING WARDS			ORGANISATIONAL MODE		GRADE OF NURSE				
	QUALIFIED NURSES		NURSING AUXILIARIES	QUALIFIED NURSES		NURSING AUXILIARIES	QUALIFIED NURSES		NURSING AUXILIARIES	F	Sig of F	F	Sig of F			
	Mean % time in verbal interaction	Mean % time in verbal interaction	Mean % time in verbal interaction	Mean % time verbal interaction	Mean % time verbal interaction	Mean % time verbal interaction	Mean % time verbal interaction	Mean % time verbal interaction	Mean % time verbal interaction							
Type of verbal interaction																
Command/instruction	9.6	0.7	14.1	1.1	13.8	0.8	13.5	0.8	13.5	0.5	14.1	0.8	1.2	0.33	5.6	0.03
Giving choice	12.8	0.9	11.5	0.9	10.5	0.6	11.7	0.8	9.5	0.4	10.3	0.6	5.0	0.02	0.8	0.38
Question	16.8	1.2	14.5	1.1	17.4	1.1	16.9	1.1	18.0	0.7	17.8	1.0	1.2	0.32	0.6	0.43
Explanation - simple	29.3	1.9	32.1	2.4	28.8	1.7	31.8	1.9	29.9	1.2	31.4	1.8	6.7	0.01	8.1	0.01
Explanation - detailed	17.8	1.3	8.4	0.7	14.9	0.8	11.7	0.7	14.7	0.6	9.5	0.6	2.4	0.12	2.6	0.13
Encouragement of self-care	2.6	0.2	2.0	0.1	3.9	0.2	2.3	0.1	1.5	0.06	2.7	0.1	1.7	0.22	0.5	0.51
Teaching	0	0	0.8	0.08	0.3	0.02	0	0	0.8	0.04	0.2	0.01	-	-	-	-
Reassurance	0.3	0.02	1.0	0.08	0.5	0.03	0.7	0.05	0.2	0.01	0.7	0.05	-	-	-	-
Sociable	10.7	0.8	16.2	1.3	9.9	0.6	11.1	0.8	12.1	0.05	12.8	0.8	2.3	0.13	3.8	0.07
Inaudible/other	0.4	0.02	0.2	0.02	0.3	0.02	0.4	0.03	0.5	0.02	0.5	0.03	-	-	-	-

*ii. Staff grade*

A highly significant difference was found in the category of routine explanation ( $p=0.01$ ), and a significant difference in giving commands ( $p=0.03$ ). NAs spent more time in both forms of verbal interaction. In the former the difference was most apparent in primary wards.

*Interaction effects*

There were no interaction effects.

Time spent in verbal interaction as a percentage of time with patients

*Main effects*

*i. Organisational mode*

A highly significant difference was found in the category of routine explanation ( $p=0.01$ ) and a significant difference in giving choice ( $p=0.02$ ). Nursing staff in primary wards spent more time giving choice to patients (1.8% cf. 1.3% and 1.1% in team and functional wards respectively), and the same trend was apparent in the category of routine information giving (4.4%, 3.6% and 3.4% by primary, team and functional subjects respectively).

*ii. Staff grade*

Comparing QNs and NAs, a significant difference was found only in the category of detailed information giving ( $p=0.02$ ). QNs in all organisational types spent more time in this than NAs, with differences being most obvious in primary wards.

TABLE 6.7 Afternoon session: percentage time spent in verbal interaction with patients

Staff Grade	Organisational Modality		
	Primary	Team	Functional
	Mean %	Mean %	Mean %
Qualified nurses	6.1	3.7	3.9
Nursing auxiliaries	7.1	6.0	6.2
Both grades	6.9	5.0	5.0

### *Interaction effects*

There were no interaction effects.

### **c. Afternoon session**

**Total percentage time spent in verbal interaction (Table 6.7)**

#### *Main effects*

##### *i. Organisational mode*

A significant difference was found ( $p=0.05$ ). Nursing staff in primary wards spent most time communicating with patients (6.6%), while times spent by subjects in team and functional wards were equal (4.9%).

##### *ii. Staff grade*

Comparing QNs and NAs within locations, a highly significant difference was found ( $p=0.01$ ). NAs in each method of organising nursing spent more time communicating with patients. The difference was, however, least marked in primary and most apparent in team and functional wards, where NAs spent more than 2% more time in verbal interaction.

### *Interaction effects*

There were no interaction effects.



Time spent in verbal interaction as a percentage of total observed time (Table 6.8 and Appendix 12c)

*Main effects* (Table 6.9)

*i. Organisational mode*

A highly significant difference was found in the category of routine explanation ( $p=0.01$ ) and a significant difference in asking questions ( $p=0.02$ ). Again, nursing staff in primary wards spent more time asking questions and giving patients routine explanations than subjects in team and functional wards. Nursing staff in team wards spent least time in these verbal interaction types.

*ii. Staff grade*

A highly significant difference was found only in the category of giving choice ( $p=0.01$ ). NAs spent more time giving patients choice, and this difference was particularly obvious in functional wards.

*Interaction effects*

There were no interaction effects.

Time spent in verbal interaction as a percentage of time with patients

*Main effects*

*i. Organisational mode*

No significant differences were found.

*ii. Staff grade*

A significant difference was found in the category of giving choice ( $p=0.02$ ). NAs in all organisational types spent more time giving

TABLE 6.8 Afternoon session: time spent in each type of verbal interaction by qualified nurses and nursing auxiliaries

Type of verbal interaction	PRIMARY NURSING WARDS		TEAM NURSING WARDS		FUNCTIONAL NURSING WARDS	
	QNs Time in minutes	NAs Time in minutes	QNs Time in minutes	NAs Time in minutes	QNs Time in minutes	NAs Time in minutes
Command/instruction	9	9	5	14	7	7
Giving choice	8	11	5	5	5	13
Questions	13	14	7	5	10	7
Explanation - simple	20	19	10	10	14	15
Explanation - detailed	14	7	8	3	5	8
Encouragement of self-care	1	1	1	1	1	0
Teaching	0	0	0	0	0	0
Reassurance	1	0	0	0	0	0
Sociable	6	22	6	9	7	8
Inaudible/other	0	0	0	0	0	0
Total time	71	84	42	46	48	60

**TABLE 6.9**

Afternoon session

Percentage time spent in each type of verbal interaction by qualified nurses and nursing auxiliaries

Type of verbal interaction	PRIMARY NURSING WARDS			TEAM NURSING WARDS			FUNCTIONAL NURSING WARDS			ORGANISATIONAL MODE		GRADE OF NURSE				
	QUALIFIED NURSES		NURSING AUXILIARIES	QUALIFIED NURSES		NURSING AUXILIARIES	QUALIFIED NURSES		NURSING AUXILIARIES	F	Sig of F	F	Sig of F			
	Mean % time in verbal interaction	Mean % time in verbal interaction	Mean % time in verbal interaction	Mean % time in verbal interaction	Mean % time in verbal interaction	Mean % time in verbal interaction	Mean % time in verbal interaction	Mean % time in verbal interaction	Mean % time in verbal interaction							
Command/instruction	12.6	0.8	12.4	0.8	14.7	0.5	25.7	1.8	17.6	0.6	11.9	0.7	0.4	0.68	1.3	0.27
Giving choice	10.2	0.6	12.9	0.9	9.8	0.4	10.9	0.6	10.2	0.4	25.4	1.5	2.1	0.16	8.7	0.01
Question	17.1	1.1	16.3	1.2	14.6	0.6	10.6	0.6	19.6	0.8	12.5	0.8	5.3	0.02	0.1	0.80
Explanation - simple	29.5	1.8	26.1	1.7	24.2	0.8	23.5	1.3	31.4	1.1	24.1	1.5	6.5	0.01	2.6	0.13
Explanation - detailed	19.7	1.2	8.9	0.7	18.5	0.7	7.1	0.4	8.4	0.4	12.3	0.8	2.7	0.09	0.7	0.41
Encouragement of self-care	1.4	0.1	1.5	0.1	1.3	0.1	1.1	0.1	2.0	0.1	0.7	0.04	-	-	-	-
Teaching	0.8	0.05	0	0	1.6	0.04	0.7	0.04	0	0	0.6	0.04	-	-	-	-
Reassurance	1.2	0.08	0.6	0.05	1.2	0.04	0.7	0.04	0.9	0.04	0.7	0.04	-	-	-	-
Sociable	7.8	0.5	21.6	1.7	15.6	0.6	20.2	1.1	11.1	0.5	12.1	0.8	0.5	0.64	3.8	0.07
Inaudible/other	0.4	0.03	0.2	0.01	0.3	0.01	0.2	0.01	0.6	0.03	0	0	-	-	-	-

TABLE 6.10 Evening session: percentage time spent in verbal interaction with patients

Staff Grade	Organisational Modality		
	Primary	Team	Functional
	Mean %	Mean %	Mean %
Qualified nurses	5.3	4.8	4.2
Nursing auxiliaries	6.1	4.9	5.1
Both grades	5.7	4.9	4.7

choice to patients, and this difference was most apparent in functional and least apparent in team wards.

*Interaction effects*

There were no interaction effects.

**d. Evening session**

Total percentage time spent in verbal interaction (Table 6.10)

No significant main effects or interaction effects were found.

Time spent in verbal interaction as a percentage of total observed time (Tables 6.11, 6.12 and Appendix 12d)

No significant main effects or interaction effects were found.

Time spent in each type of verbal interaction as a percentage of time with patients

*Main effects*

*i. Organisational mode*

No significant differences were found.

*ii. Staff grade*

Highly significant differences were found in the categories of asking questions ( $p=0.01$ ) and giving detailed explanations ( $p=0.01$ ). QNs spent more time than NAs asking questions as well as giving detailed explanations to patients.

*Interaction effects*

There were no interaction effects.

TABLE 6.11 Evening session: time spent in each type of verbal interaction by qualified nurses and nursing auxiliaries

Type of verbal interaction	PRIMARY NURSING WARDS		TEAM NURSING WARDS		FUNCTIONAL NURSING WARDS	
	QNs	NAs	QNs	NAs	QNs	NAs
	Time in minutes	Time in minutes	Time in minutes	Time in minutes	Time in minutes	Time in minutes
Command/instruction	7	9	6	12	6	12
Giving choice	8	8	4	11	3	7
Questions	11	12	11	13	9	12
Explanation - simple	16	17	12	20	14	20
Explanation - detailed	10	9	12	8	7	9
Encouragement of self-care	1	1	1	1	1	2
Teaching	0	0	0	0	1	0
Reassurance	0	2	1	1	0	0
Sociable	7	10	6	10	7	16
Inaudible/other	0	0	0	0	0	0
Total time	60	69	54	75	48	79

**TABLE 6.12**

**Evening session**

**Percentage time spent in each type of verbal interaction by qualified nurses and nursing auxiliaries**

Type of verbal interaction	PRIMARY NURSING WARDS				TEAM NURSING WARDS				FUNCTIONAL NURSING WARDS				ORGANISATIONAL MODE		GRADE OF NURSE	
	QUALIFIED NURSES		NURSING AUXILIARIES		QUALIFIED NURSES		NURSING AUXILIARIES		QUALIFIED NURSES		NURSING AUXILIARIES		F	Sig of F	F	Sig of F
	Mean % time in verbal interaction	Mean % time in verbal interaction	Mean % time in verbal interaction	Mean % total time	Mean % time verbal interaction	Mean % time verbal interaction	Mean % time verbal interaction	Mean % total time	Mean % time verbal interaction	Mean % time verbal interaction	Mean % time verbal interaction	Mean % total time				
Command/Instruction	12.2	0.8	13.5	0.8	12.9	0.6	16.0	0.8	12.3	0.5	20.4	0.9	0.1	0.93	1.2	0.29
Giving choice	11.3	0.6	11.8	0.7	8.2	0.4	14.0	0.7	7.3	0.3	9.0	0.5	2.0	0.16	2.1	0.17
Question	20.4	0.9	16.1	1.0	20.9	1.0	16.7	0.8	16.9	0.7	16.1	0.8	0.8	0.46	0.01	0.92
Explanation - simple	24.8	1.4	26.4	1.6	21.1	1.1	26.4	1.3	29.0	1.2	29.9	1.4	0.6	0.59	0.6	0.43
Explanation - detailed	16.1	0.9	12.7	0.8	20.7	1.0	10.2	0.5	17.3	0.7	7.1	0.4	0.7	0.53	2.2	0.16
Encouragement of self-care	2.5	0.1	2.0	0.1	2.8	0.2	1.4	0.1	2.3	0.1	3.5	0.2	-	-	-	-
Teaching	0.3	0.02	0.4	0.02	0	0	0	0	3.7	0.2	0.1	0.01	-	-	-	-
Reassurance	0.4	0.03	2.3	0.2	1.8	0.09	1.0	0.05	0.3	0.01	0.4	0.02	-	-	-	-
Sociable	12.2	0.6	15.3	0.9	13.2	0.6	13.8	0.7	12.6	0.5	14.5	0.9	0.1	0.88	1.9	0.18
Inaudible/other	0.7	0.02	0.5	0.03	0.5	0.03	0.6	0.03	0.3	0.02	0.6	0.02	-	-	-	-

TABLE 6.13 Percentage time spent in verbal interaction with patients: significant findings

	ALL SESSIONS		MORNING SESSION		AFTERNOON SESSION		EVENING SESSION	
	OM	Grade	OM	Grade	OM	Grade	OM	Grade
<b>VERBAL INTERACTION AS A PERCENTAGE OF TOTAL TIME</b>								
Command	-	**	-	*	-	*	-	-
Giving choice	*	*	*	-	*	-	*	-
Questions	-	**	-	**	-	**	-	-
Explanation - simple	-	-	-	-	-	-	-	-
Explanation - detailed	-	-	-	-	-	-	-	-
Self-care	-	-	-	-	-	-	-	-
Teaching	-	-	-	-	-	-	-	-
Reassurance	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-
Sociable	-	**	-	-	-	-	-	-
<b>VERBAL INTERACTION AS A PERCENTAGE OF TIME WITH PATIENTS</b>								
Command	-	-	-	-	-	-	-	-
Giving choice	-	*	-	-	*	-	-	**
Questions	-	-	-	-	-	-	-	-
Explanation - simple	**	-	**	*	-	-	-	**
Explanation - detailed	-	-	-	-	-	-	-	-
Self-care	-	-	-	-	-	-	-	-
Teaching	-	-	-	-	-	-	-	-
Reassurance	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-
Sociable	-	-	-	-	-	-	-	-

OM = Organisational modality

\* p<0.05  
\*\* p<0.01



#### 4. DISCUSSION

Findings summarised in Table 6.13.

Giving patients the right to choose formed a much larger part of conversations with patients in primary compared with team and functional wards. Indeed, patient choice was a fundamental tenet in the operationalisation of individualised patient care. As such, it featured prominently in interviews with primary ward sisters, as ward sister P3 illustrates:

"I think one of the most important things is that they [patients] are treated as individuals, to me that is of paramount importance, and there are so many ways in which nursing staff can demonstrate that they see each of these elderly people as individuals. It could be something as very simple as which name they prefer,...or other things like wearing their own individual clothing to knowing the other members of their family and treating the family as a whole and this kind of thing."

Ward sister P2 similarly described patient choice within the context of individualised care, and viewed choice as patient involvement in planning and evaluating care:

"They [patients] are involved in their care planning and they are also involved in their evaluations, so that they can plan goals that they want to do in the next week, in the next day, in three months, so they can be involved in what happens to them."

In primary wards, then, giving patients the right to choose meant that wards ran, to greater or lesser extents, to meet the needs of patients rather than nurses. Patients were, therefore, given a say in their care and treatment. This was exemplified on one occasion in Ward P1, when visitors arrived from the English National Board to determine whether or not the ward was suitable as a learning area for

learner nurses. The visitors mentioned to the ward sister the smell of urine in every bay. The ward sister, commenting on this to the researcher, said:

"What do you do, though? You could catheterise everyone and the problem would be solved, but when I asked Thomas what he would most like, apart from being able to go home, and he said 'to have this tube out'. To not let him have this would be an infringement of his right to choose, his rights."

This patient compared with nurse-centred approach was further illustrated in the approach to routine in primary wards. The aim was for each patient to be able to choose their daily routine according to their wishes or their routine at home. Therefore, patients could choose, for example, times for rising and going to bed and time, type and extent of personal hygiene. The following field note extract illustrates the latter:

Lucinda (NA) asked William how he wanted to get washed today. She suggested a bowl on the table by his bedside may be easier for him than moving him in the wheelchair to the sink. William said he wanted whatever was best for Lucinda, but Lucinda said: "No, William, we want to do whatever you want." William said he would have a bowl by his bed.

Patients were also asked in which order they wanted to perform morning care. For example, a QN was observed asking a patient whether he wanted to have a shave or brush his teeth first, and further if he wanted to brush his teeth at the sink or over a bowl. Similarly, an NA was observed asking a patient: "would you like a cup of tea first or a wash?".

Both primary QNs and NAs, then, realised the importance of patient choice within the context of the ward philosophy.

Ward P1, however, appeared further along the continuum of patient choice than wards P2 and P3, where choice was sometimes tempered and on occasions none was given. The following conversation between a QN and a patient in ward P2 illustrates the latter:

QN: "You're going down in the room with the other ladies."  
Patient: "Oh no!...I hate that room."  
QN: "You've got to stop feeling sorry for yourself. You'll get all depressed if you sit in the bay all by yourself."

Patient choice was also viewed as an important concept by both QNs and NAs in team and functional wards. Patients were frequently given a choice, for example with regard to clothes and food preferences, as the following examples illustrate:

1. [team QN, talking to researcher]  
"If all the patients wanted to stay up, that's the way it would be. The night staff wouldn't like it, but they would have to accept it. They haven't quite got the idea of 'patient centred care'."
2. [conversation between a functional NA and newly admitted patient]  
NA: "What's your name? You're new to me."  
Patient: "Rosanna."  
NA: "What do you like to be called? Rose?"  
Patient: "Rose is fine, Rosanna's too long."

In these two organisational modes, however, while giving choice was observed, there were more occasions than in primary wards when a nurse-centred approach, characterised by routine and restriction of choice, prevailed. For example, in functional wards those patients still in bed generally had no choice but to get up out of bed when day nursing staff arrived on duty, as this conversation between a patient and an NA shows:

NA: "Are you going to get up and sit in the chair?"  
Patient: "I don't want to get up."  
NA: "I didn't want to, but I had to!"

Once out of bed, in two functional wards patients were often compelled to sit at dining tables in the centre of the ward to eat breakfast:

QN: "We're going to take you down to the table for breakfast."

Patient: "I usually stay here."

QN: "Yes, I know, but there's three people who need feeding and only three of us."

Following breakfast, patients were strongly encouraged to spend the remainder of the day, with the exception of mealtimes, in the dayroom. In two functional wards (F7 and F8), bath lists were still in existence, and ensured patients received one bath per week, usually at a time of the nurses' choosing, as this conversation between two NAs demonstrates:

Alice said to Mo they would go off and do some baths. They discussed who to bath in the office, working out from the 'bath book' who had not had a bath.

Alice asked Mo if she wanted to do men or women. Mo replied:

"We'll do Carol tonight, then she can go straight to bed."

They decided between themselves to 'do' Carol and Josie.

In ward F9 also, baths were performed according to a rule other than to comply with patients' wishes, as this extract from a report session shows:

June [QN] said Sue had been in the bath. NA Flo said Sue had been in the bath yesterday. June said she hadn't known that, so was starting the baths at one end and working round. Kate [QN] said "that's the problem with bowel charts and bath charts, there isn't anything on them except the date".

Both QNs and NAs in primary wards spent more of their total time and their time with patients giving patients general explanations about their care. These differences were particularly marked in the morning and afternoon sessions. Explaining what is happening or is about to happen to patients is one means of both recognising the presence of patients and acknowledging patients' right to know what

is happening to them. These aspects were recognised as important to a greater extent by both NAs and QNs in primary wards, and manifest as general explanations to patients of nurses' actions. Below are some examples:

1. Primary QN to patient:  
"I'll take you into the toilet to the mirror to do your hair."
2. Primary NA to patient:  
"I'm going to put some soap on a flannel so you can wash your face."

While nursing staff in team and functional wards did explain their actions to patients, this occurred to a lesser extent and with less consistency. General explanations were sometimes minimal, as this extract, recorded while two functional NAs were bathing a patient, illustrates:

[NA to patient] "Right, Lucy, we'll put you in the bath pet, up you come."

Two NAs walked with Lucy down to the bathroom. Took her clothes off and bathed her, while discussing knitting patterns and the benefits of 'pep pills' between themselves. NAs dried and dressed Lucy, with very little conversation with her throughout. Also, the bath was a very quick procedure - one NA stated she wanted to finish the baths by two o'clock, then they would have a cup of tea.

On this occasion, then, apart from being informed she was going to be given a bath the patient was given no further explanation of the NAs' actions. A lack of general information giving was not, however, limited to NAs. In one team ward, for example, a QN was observed getting a patient up, washed and dressed without once explaining what she was doing.

In the afternoon session, nursing staff in primary wards spent more time seeking verbal feedback from patients in the form of asking questions. Linked with giving choice, one purpose of asking

questions was to determine patients' individual likes and dislikes, as this example shows:

Primary QN:

"What do you usually have for breakfast, Lydia?"

A further purpose was to elicit information necessary to care for the patient effectively:

1. Primary NA to patient:  
"Have you got your hearing aid in? [Patient said no.] Where is it, then?...In the middle bit? [NA looked in patient's handbag and found it there] Can you put it in? [Patient said no, so NA put it in] Can you hear me?"
2. Primary NA to patient:  
"Have you been walking at all, Julie? With the physiotherapist?"

Questions further served to seek patient endorsement for the appropriateness of nursing actions:

1. Primary QN, after making patient comfortable in bed:  
"Are you comfortable there?"
2. Primary QN:  
"Does that boot fit you alright, Bill?"

Finally, questions served as general enquiries about patients' well-being:

1. Primary NA:  
"Hello, Tom, how are you feeling?"
2. Primary QN:  
"Are you alright, Teresa?"

While QNs and NAs in team and functional wards sought verbal feedback from patients, again this occurred with less frequency than in primary wards.

In both morning and afternoon sessions, QNs in all organisational modes spent more time giving detailed explanations about care to

patients than NAs. Included in this category of verbal interaction were explanations indicating a knowledge of patients. For example:

1. Functional QN:  
"I've put it in a feeder because you prefer a feeder."
2. Primary QN:  
"Its not your bedtime yet is it. Half past ten, they tell me...I know all your little secrets. I've been in touch with the nursing home, The Poplars, just to find out a little bit about you."

This form of explanation was not, however, limited to QNs, as the following examples illustrate:

1. Functional NA:  
["Do you want grapefruit, pet?...]I know, but you're on a diet now, just like me. I know exactly how you feel, pet."
2. Primary NA [to a newly admitted patient]:  
"Its a year since you were in, but I remembered you were a diabetic."

Overall, findings indicate that patients in all three organisational modes received a larger amount of verbal contact from NAs than QNs, particularly in the form of offering choice, giving commands and simple explanations about care. NAs also spent a larger percentage of time in social interaction with patients. When verbal interaction is taken as a percentage of time spent with patients, however, with the exception of the category of detailed explanation (explained above), the majority of differences disappear. This suggests that findings are due to the larger percentage time spent with patients by NAs both overall and in morning and evening sessions, with the consequence of increased opportunity for verbal contact.

A significant interaction effect was found in the category of encouraging self-care when all sessions were combined, indicating

differences between QNs and NAs across organisational modes. In primary wards, time spent in this type of verbal interaction by QNs and NAs was largely similar, indicating a shared self-care philosophy. As one NA said:

"We ask the patients to do whatever they can for themselves, because if you lose the will to do things for yourself then you've lost a lot."

In team wards, however, QNs spent a larger percentage of time encouraging patients to use self-care abilities than NAs. The ward sister in one team ward believed NAs needed a qualified presence to ensure patients were allowed to fulfil self-care potential:

"Nursing auxiliaries are a lot better than they used to be, when I came on here they were the worst for doing things for quickness, but I think they have realised now and they do really follow the same trend as everybody else, by encouraging the patients. But I think you have got to watch them and work with them...getting them to look at the care plans...all of the time."

From observation, there did appear to be more occasions in which NAs, compared with QNs, prevented the exercise of patient self-care in team wards. One team NA described her views on this in the context of explaining why she had not enjoyed working in a rehabilitation unit with an active self-care philosophy:

"[There], you're not supposed to do anything for them, you're supposed to let them do it themselves. I couldn't adjust to that, with being used to doing things so quickly in the mornings, I found it difficult to hold back, and found I would stand back for a while, but then get in and do things."

In functional wards, on the other hand, NAs spent more time encouraging patients to use self-care abilities than QNs. This may



TABLE 6.14 Effect of staffing levels on percentage time spent in verbal interaction

Session	Qualified/ patient ratio	Unqualified/ patient ratio	Total staff/patient ratio
<b>ALL SESSIONS</b> All activities Activities with patients	-  Giving choice *	-  Giving choice *	-  Giving choice *
<b>MORNING SESSION</b> All activities Activities with patients	-  -	-  -	-  -
<b>AFTERNOON SESSION</b> All activities Activities with patients	Asking questions **  Asking questions **	Asking questions **  Asking questions **	Giving choice * Asking questions **  Asking questions**
<b>EVENING SESSION</b> All activities Activities with patients	-  -	-  -	-  -

\* p<0.05

\*\* p<0.01

be explained by the fact that there was a much larger differential in time spent in direct patient care between QNs and NAs in functional compared with team and primary wards. As one would expect the majority of self-care conversations to arise in this context, the much larger time spent by NAs compared with QNs in direct care activities may explain this finding.

## **5. THE EFFECT OF STAFFING LEVELS ON NURSES' VERBAL INTERACTION WITH PATIENTS**

### **a. Introduction**

Time spent in verbal interactions with patients varied depending on whether primary, team or functional nursing was practiced. However, findings from staffing data indicate primary wards had more staff available to provide patient care than team and functional wards. In order to determine whether differences could be attributable to staffing levels, analysis of covariance was performed on verbal interaction data with qualified to patient, unqualified (including learner nurses) to patient and total nurse to patient ratios serving as covariates. Analysis of covariance tables for significant findings are presented in Appendix 14.

### **b. Findings**

Table 6.14 shows that two types of verbal interaction, giving choice and asking questions, were affected by staff to patient ratios. When staffing levels were not included in the analysis, giving choice was found to be significantly different across organisational modes when all sessions were combined. However, the amount of choice given to patients in the morning session, significantly different when

staffing ratios are not incorporated, is not explained by staff to patient ratios.

Percentage time spent asking patients questions, however, is significantly different across organisational modes when staffing levels are not incorporated. Ratios of staff, both qualified and unqualified, to patients may, therefore, contribute to the explanation of this finding. Time spent by QNs and NAs explaining aspects of care to patients is not affected by staffing ratios.

## CHAPTER 7 QUALIFIED NURSE AND NURSING AUXILIARY PERCEPTIONS OF THEIR WORK ENVIRONMENT

### 1. INTRODUCTION

In this chapter, findings from the Work Environment Scale are reported for QNs and NAs. Each participating subject was asked to complete the scale near the beginning of the data collection period on each ward. At the end of the period of data collection on the ward (approximately four weeks) those who had not returned questionnaires were asked to do so. Details of the scale, together with information regarding scoring and analysis, have been discussed fully in Chapter 3.

### 2. FINDINGS

#### a. Combined nursing staff types

Table 7.1 shows the profile of scores obtained for combined nursing staff types in primary, team and functional wards, and Table 7.4 shows significant findings. Comparing primary and team wards, highly significant differences were found on the involvement, peer cohesion, supervisor support, autonomy, work pressure, clarity, innovation and physical comfort subscales ( $p < 0.01$ ). Nursing staff on primary wards perceived greater involvement, peer cohesion, supervisor support, autonomy, clarity, innovation and physical comfort than their team nursing counterparts, but less work pressure. Primary nursing staff also perceived significantly greater task orientation but less control exerted by management over their work ( $p < 0.05$ ).

**WORK ENVIRONMENT SCALE TABLES**  
**COMPARISONS BETWEEN PRIMARY,**  
**TEAM AND FUNCTIONAL NURSING WARDS**

Table 7.1: All Staff

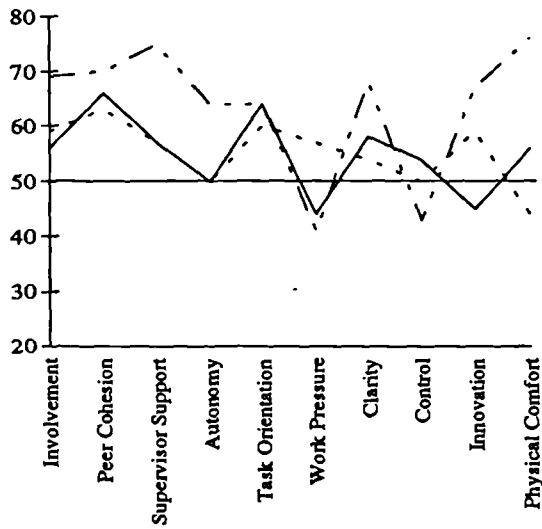


Table 7.2: Qualified Nurses

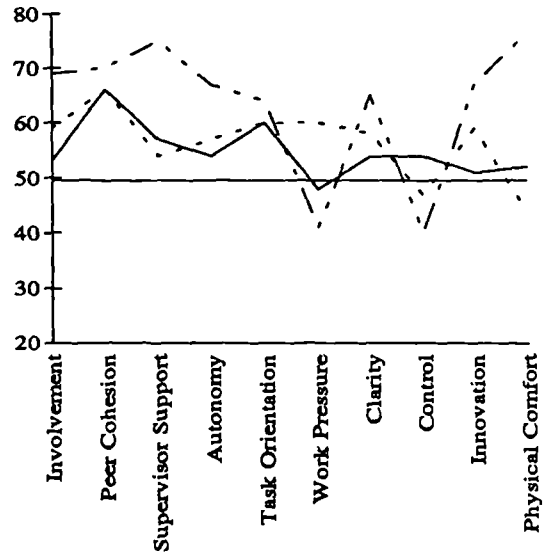
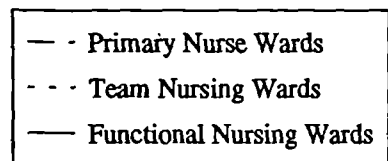
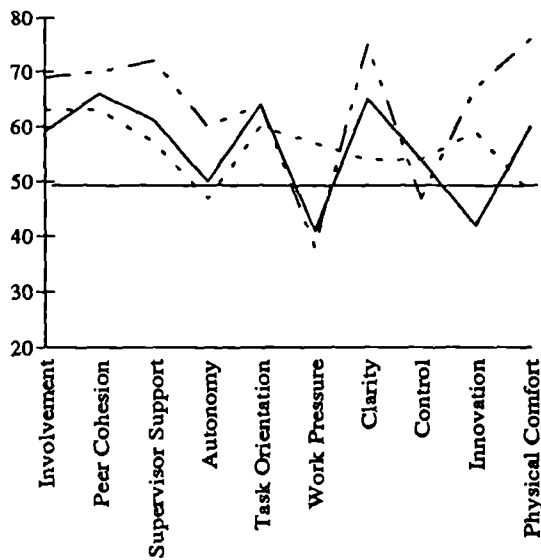


Table 7.3: Nursing Auxiliaries



**TABLE 7.4**  
**WORK ENVIRONMENT SCALE - SIGNIFICANT FINDINGS**  
**Qualified Nurses and Nursing auxiliaries combined**

	Primary nursing wards	Team nursing wards	Functional nursing wards
Involvement	***	**	
Peer cohesion	**		
Supervisor support	***	***	
Autonomy	***	***	
Task orientation	*		
Work Pressure	***	**	
Clarity	**	**	
Control	*	**	
Innovation	**	***	***
Physical comfort	***	***	*

\* p < 0.05  
 \*\* p < 0.01  
 \*\*\* p < 0.001

**TABLE 7.5**  
**WORK ENVIRONMENT SCALE - SIGNIFICANT FINDINGS**  
**Qualified Nurses**

	Primary nursing wards	Team nursing wards	Functional nursing wards
Involvement	**		
Peer cohesion			
Supervisor support	**		
Autonomy	*		
Task orientation			
Work Pressure	**		
Clarity			
Control	**		
Innovation	***		
Physical comfort	***		

\*  $p < 0.05$   
 \*\*  $p < 0.01$   
 \*\*\*  $p < 0.001$

Comparing primary and functional wards, highly significant differences were found on the involvement, supervisor support, autonomy, clarity, control, innovation and physical comfort subscales ( $p < 0.01$ ). Primary nursing staff perceived greater involvement, supervisor support, autonomy, clarity, innovation and physical comfort than nursing staff on functional wards, but perceived less control by management over their work.

When team and functional nursing staff were compared, highly significant differences were found on the work pressure and innovation subscales ( $p < 0.01$ ) and a significant difference on the physical comfort subscale ( $p < 0.05$ ). Nursing staff on team wards perceived greater work pressure and innovation, but less physical comfort than their functional nursing counterparts.

#### **b. Qualified nurses**

Table 7.2 shows the profile of scores obtained for QNs in primary, team and functional wards, and Table 7.5 shows significant findings. Comparing QNs on primary and team wards, highly significant differences were found on the supervisor support, work pressure and physical comfort subscales ( $p < 0.01$ ) and a significant difference on the autonomy subscale ( $p < 0.05$ ). Primary QNs perceived greater supervisor support, physical comfort and autonomy but less work pressure than team QNs.

Comparing QNs on primary and functional wards, highly significant differences were found on the involvement, supervisor support, autonomy, control, innovation and physical comfort subscales



**TABLE 7.6**  
**WORK ENVIRONMENT SCALE - SIGNIFICANT FINDINGS**  
 Nursing auxiliaries

	Primary nursing wards	Team nursing wards	Functional nursing wards
Involvement	***		
Peer cohesion	*		
Supervisor support	***		
Autonomy	***		
Task orientation			
Work Pressure	***	*	
Clarity	***		
Control			
Innovation	*		***
Physical comfort	***		*

\* p < 0.05  
 \*\* p < 0.01  
 \*\*\* p < 0.001

( $p < 0.01$ ). Primary QNs achieved higher scores on all these subscales with the exception of managerial control, where they perceived less than their functional counterparts.

When team and functional QNs were compared, no significant differences were found.

### c. Nursing auxiliaries

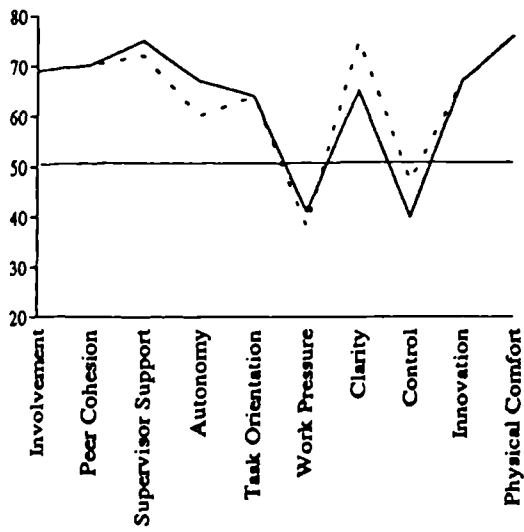
Table 7.3 shows the profile of scores obtained for NAs in primary, team and functional wards, and Table 7.6 shows significant findings. Comparing primary and team NAs, highly significant differences were found on the involvement, supervisor support, autonomy, work pressure, clarity and physical comfort subscales ( $p < 0.01$ ) and significant differences on the peer cohesion and innovation subscales ( $p < 0.05$ ). Primary NAs perceived greater involvement, peer cohesion, supervisor support, autonomy, clarity, innovation and physical comfort than their team counterparts, but less work pressure.

When primary and functional NAs were compared, highly significant differences were found on the clarity, innovation and physical comfort subscales ( $p < 0.01$ ) and significant differences on the supervisor support and autonomy subscales ( $p < 0.05$ ). Primary NAs perceived greater supervisor support, autonomy, clarity, and innovation than their functional counterparts, as well as viewing their physical environment more positively.

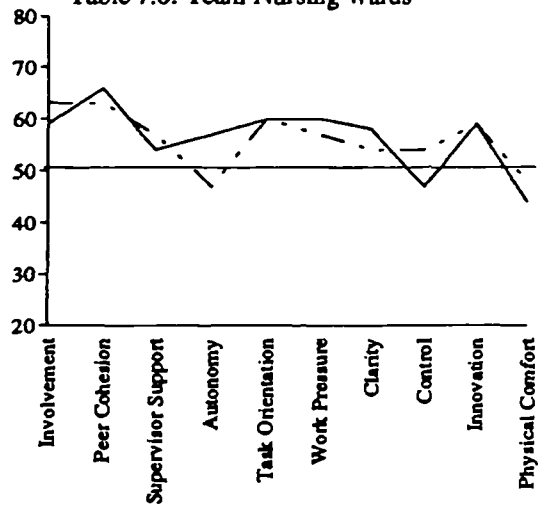
When team and functional NAs were compared, a highly significant difference was found on the innovation subscale ( $p < 0.01$ ) and significant differences on the work pressure and physical comfort

**WORK ENVIRONMENT SCALE TABLES**  
**COMPARISON WITHIN PRIMARY, TEAM**  
**AND FUNCTIONAL NURSING WARDS**

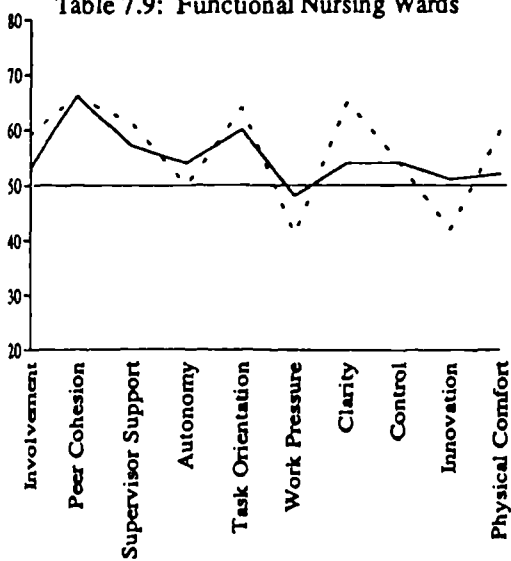
**Table 7.7: Primary Nursing Wards**



**Table 7.8: Team Nursing Wards**



**Table 7.9: Functional Nursing Wards**



— Qualified Nurses  
 - - - Nursing Auxiliaries

subscales ( $p < 0.05$ ). Team NAs experienced greater work pressure and perceived greater innovation than their functional counterparts, but functional NAs viewed their work environment more positively.

**d. Qualified nurses and nursing auxiliaries within organisational types (Tables 7.7 - 7.9)**

When QNs and NAs were compared within organisational mode, no significant differences were found.

### **3. DISCUSSION**

#### *Autonomy and supervisor support*

QNs on primary wards perceived themselves as more autonomous than QNs in either team or functional wards. This is in keeping with the criteria of devolution of responsibility and autonomy from the ward sister to primary nurses found in the literature. For example, in one primary ward the ward sister considered each primary nurse to be employed by the health authority with direct responsibility for the care of her patients. Each primary nurse was responsible for her actions and could be made accountable for these. For this ward sister, responsibility meant not only responsibility to the patients, but also to peers and for communication within her group of nursing staff. Primary nurses were also responsible for care delivered in their absence by associate nurses provided it was documented in the care plan. However, associate nurses as well as primary nurses were included in the sample, and findings suggest associate nurses were not deprived of autonomy. In contrast, in team and functional wards the ward sister retained overall responsibility for patient care, with a reduced level of autonomy given to other staff members.

Autonomous practitioners in primary wards did, however, receive a greater level of supervisor support than either their team or functional nursing counterparts to enable them to fulfil this role effectively. For example, in one primary ward well-developed structures in the form of weekly meetings for primary nurses and monthly meetings for all nursing staff existed to serve this purpose.

Primary NAs, like primary QNs, also perceived greater autonomy and greater supervisor support than team and functional NAs. While primary NAs worked closely with their primary and associate nurses, as a result of their intimate knowledge not only of their patients but of the preferences of their primary nurse, NAs were allowed to carry out patient care without direct supervision and to use their initiative, as the following quotations illustrate:

1. "We've always been taught by Irene [ward sister] to use our initiative and be part of the team, that's probably why I like working on this ward because we're expected to use our initiative to a large extent...Its just part and parcel because we've got this good working relationship whereby you do it automatically and you've got into the habit, you know how each of [the primary nurses] work. I know what Melissa likes to do and I know what she likes me to do."
2. "Primary nursing gives me everything I want - that's the whole point, isn't it, you are able to use your own initiative."

In these primary wards, then, there was no reduction in the amount of autonomy and decision-making given to NAs, as recommended by some proponents of the 'professional model'.

In contrast, team and functional NAs believed they received less

encouragement to be self-sufficient and make their own decisions.

The following quotation from a team NA illustrates this:

"when you are working with the patients...you are running backwards and forwards asking the staff nurse 'do you think I should do this or do that' instead of [it] being explained, so you have to go feeling your way about from patient to patient. You are never sure what you should be doing and what you shouldn't."

### *Physical comfort*

Both QNs and NAs in primary wards perceived their physical environment more positively than their team and functional nursing counterparts. As discussed previously, all primary wards were specifically geared to the needs of elderly patients. Team wards, on the other hand, were designed as standard hospital wards, and possessed no features geared towards elderly patients. Functional wards also were standard hospital wards, and two of these were situated in areas of hospitals which used to be the 'workhouse'.

Functional NAs were also found to view their physical environment more positively than team NAs. Reasons for this are unclear, given that the standard of team wards in terms of space and light was higher than functional wards. This finding could, however, be explained by the problems of excessive heat and poor ventilation found in team wards.

### *Work pressure*

Interestingly, primary QNs and NAs perceived LESS work pressure than team QNs and NAs, in contrast to other studies (e.g. Leahy, 1989). One reason for this may be the finding that when all shifts were combined, primary wards were found to have significantly more

qualified and unqualified staff per patient and also more nursing staff when all grades were combined than team wards. Furthermore, while in team wards each team cared for 15 patients and in functional wards nursing staff cared for all patients, in primary wards the number of patients cared for by a primary nurse group ranged from five to ten only.

Differences in work pressure cannot, however, be attributable to staffing figures alone, as there were also significantly more qualified and unqualified staff per patient and more nursing staff when all grades were combined in primary compared with functional wards, yet functional QNs did not perceive significantly greater work pressure than primary QNs. As all team wards were placement areas for learner nurses (compared with one functional and one primary ward, and a further primary ward in a limited capacity), it is possible that greater work pressure for team QNs was occasioned by the need to supervise and direct learners. Furthermore, a larger number of QNs in team wards had been in post less than six months, and for five (cf. 3 in primary and functional wards) it was their first post since qualifying.

In addition, in team wards a strong "getting through the work" mentality appeared to exist, perhaps contributing to a feeling of being under pressure. This is illustrated by a comment from an enrolled nurse to the researcher:

"We've only got the obs [observations] and dressings to do, so that's not bad."

For NAs, whereas in primary wards QNs paired with NAs in order to provide care, in team wards NAs were frequently left to care for patients unaided while qualified staff were occupied in duties associated with ward management, and this could serve as a source of work pressure. A team QN said:

"They [NAs] are expected to do much more than they're officially supposed to...They're expected to organise their own workload and get on with it and do it and have everything done by the end of the day."

The "getting through the work" mentality described above in relation to QNs also permeated the work of team NAs, and perhaps contributed to a feeling of being under pressure, as illustrated in a comment from an NA to another NA who was being observed by the researcher:

"I hope you're working hard in here, when I was in this bay I had everything done by now!"

This source of work pressure was not in evidence to such a large extent in either primary or functional wards. A primary NA illustrates a different viewpoint:

"It may seem as if I'm going slow, but I like to spend time with them because they don't get much company, some of them. Like Mr. Smith, they said in the report that he had been ringing his bell a lot during the night, well that was probably only because he was lonely".

An emphasis on 'getting through the work' could also explain why NAs in team wards perceived more work pressure than those in functional wards.



### *Involvement*

Primary QNs perceived greater involvement in their work than functional QNs, while primary NAs scored significantly higher on this subscale than team NAs. This may be a consequence of devolved responsibility for a small group of patients characteristic of primary nursing, with its corollary of a more detailed knowledge of this patient group. In the case of primary nurses, knowing that they are accountable for the outcomes of their patients may also serve to increase concern for and commitment to the job. In contrast, functional QNs were responsible for the total population of patients in the ward, and this only when the ward sister was not on duty. Furthermore, the change in role of functional QNs depending on the presence or absence of the ward sister served as source of frustration and mitigated against involvement in the job, as illustrated by a comment from an enrolled nurse:

"you see, you are either the highest of the high or the lowest of the low. You are either acting sister, where you have to keep on the ball, or a glorified nursing auxiliary."

Only one functional QN, compared with five primary and eight team QNs, had chosen to work with elderly patients, which could also explain the smaller degree of involvement.

For NAs also, a greater concern for and commitment to their job could be the result of caring for a small group of patients, and the subsequent intimate knowledge of and involvement with them. Apart from involvement in patient care, NAs in primary wards were also active participants in the decision-making process not only with

regard to patient care but in other aspects of ward life. For example, in one primary ward an NA was present at and participated in the process of interviewing potential new NAs.

### *Innovation*

Both grades of staff in primary wards perceived a greater sense of innovation than their functional nursing counterparts, and NAs further perceived a greater sense of innovation than team NAs. As discussed previously, the dynamic, constantly evolving environment which existed in primary wards was also in evidence in interviews with primary ward sisters. This was in contrast to functional wards, where changes tended to be less wide-ranging or imposed from external sources. This lack of dynamism by functional ward sisters appeared to permeate QNs also, as a functional QN illustrates:

"It is quite a depressing working atmosphere. You are often short staffed - I know they are trying to rectify this, but there is no doubt about it the patients are neglected - the depressing atmosphere is partly our fault, we should try to be dynamic."

Findings show that NAs were by no means excluded from this the dynamism inherent in primary wards. Their opinions with regard to patient care were highly valued in all primary wards, as one ward sister illustrates:

"I don't believe you just have to be the trained nurse to make changes that are of benefit to the patients - a lot of small changes have been implemented by the auxiliaries, whose ideas are excellent because they actually have the chance to voice their opinions."

This is further illustrated in a quotation from an NA describing events before the commencement of morning care:

"We [primary nurse and NA] always have a discussion. After we've had the report, you must have heard us, we always have a discussion as to what we're going to do, what's got to be done that morning, if anybody's got to have enemas or x-rays or anybody going home, we always have a discussion before we start what we're doing with the patients."

Team NAs perceived a greater sense of innovation than their functional nursing counterparts. Again, this can be explained by looking at ward sisters' approach to change. All team ward sisters were involved in a continuously evolving process of change in their wards, the overall purpose of which was improving patient care and of which team nursing formed a part. This in turn affected the work of NAs. In functional wards, as discussed previously, changes were less far-reaching.

In some cases, subscales which were significantly different for QNs across organisational modes were different to those which were significantly different for NAs.

### *Control*

Primary QNs perceived management as exerting less control over their work than functional QNs. Again, this relates to the devolution of responsibility for patient care from the ward sister to primary nurses characteristic of primary nursing. QNs in primary wards were, to a large extent, free to plan and implement care for their patients on a daily basis without receiving directives from the ward sister. In functional wards, on the other hand, the ward sister made the

rules and gave the directions. In one functional ward particularly there was an emphasis on doing things "as sister likes". For example, when asked about informal teaching she had given to QNs, a QN gave as one of these "the routine, and how sister likes it".

### *Clarity*

Primary NAs perceived more clarity in their work than their team and functional counterparts. This may be because their role was not viewed by ward sisters merely in terms of tasks to be performed, but within the context of the total ward philosophy. For example, one primary ward sister stated the importance of NAs being "attuned to the way in which you want care to be given". If this was not so, the NA could undo good work done with patients. In contrast, in team and functional wards the work of NAs did appear to be defined in terms of tasks. In both these settings NAs were very aware that so-called 'technical' tasks, which they valued highly and had previously been allowed to perform, were now the province of QNs only, as a functional NA explains:

"I used to give NG feeds, I can't now. Its not that much of a responsibility but it makes you think more, use your brain. It also makes the job more interesting when you have things to do other than basic washing and dressing."

Team and functional NAs viewed 'technical' aspects of care as constituting major responsibilities, as a team NA illustrates:

"Sister gives you little responsibilities but makes you feel like you've got a big responsibility, for example making dates for the trip. Big responsibilities are doing care plans and drugs, but that's not in our league."

### *Peer cohesion*

Primary NAs believed there to be significantly greater peer cohesion than their counterparts in team wards. This feeling may have been generated by the close working relationship between QNs and NAs found in primary wards, as discussed earlier. Also, structures in operation in primary wards, such as monthly meetings for all nursing staff in one ward and weekly multidisciplinary meetings for all staff including NAs in another, may have facilitated group cohesion.

Two factors mitigated against NA and QN peer cohesion in team wards. Firstly, NAs viewed themselves as responsible for doing "the work", i.e. direct patient care, while QNs did, in the NAs' eyes, the more exciting jobs such as administration and 'technical' tasks. As one NA said while being observed,

"This is where the staff nurse disappears and the auxiliary does all the work."

Secondly, five team NAs were not present at ward reports about patients, and this prevented the generation of team spirit. One NA said:

"The idea is that everybody works as a team and the patient benefits from it, and I feel that because we are shut out from the report that we are not part of the team."

### *Comparisons within organisational modes*

When QNs were compared with NAs within organisational types, no significant differences were found. Differences in the way nursing staff perceive their work in primary, team and functional wards can

therefore be said to transcend staff grade. This suggests a culture exists within each organisational mode which permeates the work of all grades of staff.

In this chapter, it has been argued that primary wards differed from team and functional wards due to the structures and processes which characterised primary nursing and which affected staff perceptions of their work and the role and function of QNs and NAs. These themes are expanded Chapter 11.

## CHAPTER 8 QUALIFIED NURSE CHARACTERISTICS AND PERCEPTIONS OF THEIR WORK

### 1. INTRODUCTION

In previous chapters, it was seen how nursing staff in the various organisational modes differed both in the activities they performed and in the pattern of their verbal interactions with patients. To summarise the most important findings thus far, nursing staff in primary wards were found to spent <sup>a</sup> a greater amount of time in direct patient care and communication, together with less time in supplementary patient care and staff activities (the latter particularly in the afternoon session) than their team and functional counterparts. Team and functional nursing staff, on the other hand, spent more time with patients in domestic and administrative activities.

Turning to verbal interaction with patients, both QNs and NAs in primary wards spent more time giving patients choice and offering general explanations about care, the latter particularly in the morning and afternoon observation sessions. In the afternoon session, more time was spent seeking verbal feedback from patients in primary wards. QNs in all organisational modes were found to give more detailed explanations about care to patients than NAs. Overall, however, patients participated in more verbal interaction with NAs.

Both QNs and NAs in primary wards were found to view their work environment differently to their team and functional counterparts,

but QNs and NAs within each organisational mode perceived their work environment similarly.

In the next three chapters, an attempt is made to open the 'black box' and examine whether staff characteristics can be used to explain findings. The characteristics of QNs (Chapter 8) and NAs (Chapter 9) will be discussed, followed by a description of how these different grades viewed their work with elderly people. Chapter 10 provides a more specific discussion on the role and function of the NA within each organisational mode, as perceived by the ward sister, QNs and NAs themselves.

## 2. METHOD

Each participating QN and NA participated in a semi-structured interview (Appendix 15 and 16). This consisted of a series of structured questions covering issues such as demographic data and previous experience and qualifications, followed by more open-ended questions about perceptions of the role of the NA and therapeutic orientation. As with ward sister interviews, selected questions from Kitson's TNFI were used to structure the latter, and scoring was carried out using Kitson's guidelines (Appendix 1). Where questions were designed for the purposes of this study, responses were also scored according to Kitson's rationale. Open-ended questions were coded into categories, which were then summed according to organisational mode rather than by respondent. As each subject may have given more than one response for any category, the number of responses may exceed that of respondents.



TABLE 8.1 Length of time qualified nurses in present post

Time in post	Primary qualified nurses (n=12)	Team qualified nurses (n=12)	Functional qualified nurses (n=12)
1 month < 6 months	1	4	-
6 months < 1 year	1	3	3
1 year < 2 years	2	2	5
2 years < 5 years	8	2	4
5 years < 10 years	-	1	-

One team NA was not interviewed. This was because her part-time hours covered the busiest periods of the day, and at no point was there time available to conduct the interview.

Interviews were usually performed during a quiet period of the afternoon shift at the discretion of the ward sister or other QNs. They were tape recorded. All participating staff were asked for their consent to this, and were assured of confidentiality. Only one QN interviewed refused to be tape recorded. Staff interviews were piloted in the same ward used to test all other research instruments.

### 3. CHARACTERISTICS OF QUALIFIED NURSES

Table 8.1 shows time in post of study QNs. A larger number of primary QNs had occupied their present post between two and five years. The greatest number of nurses who had been in post less than six months were found in team wards, as was the QN who had been in post longest.

While the intention was to recruit only full-time nurses, only eight primary, 11 team and seven functional QNs worked full-time. Part-time nurse hours ranged from 20 to 37 per week. The mean age of functional QNs was slightly higher (33 years, cf. 28 years for team and primary QNs).

For three primary, five team and three functional QNs the study ward was their first nursing post. Team and functional QNs had held posts on a larger number of ward types than primary QNs. Mean numbers of

TABLE 8.2 Basic nursing qualification possessed by qualified nurses

Qualification	Primary qualified nurses (n=12)	Team qualified nurses (n=12)	Functional qualified nurses (n=12)
Registered General Nurse	7	8	7
Enrolled Nurse	5	4	5

ward types worked on were 1.2 (primary QNs) and 2 (team and functional QNs).

#### **4. THE TRAINING AND TEACHING OF QUALIFIED NURSES**

##### **a. Basic nursing qualification (Table 8.2)**

While the original intention was to choose equal numbers of level 1 and level 2 nurses on each ward, on Wards P2 and F7 there was only one level 2 nurse available for participation. In Ward T5 there was a policy in operation which excluded enrolled nurses from employment, therefore all participating QNs on this ward were registered nurses.

##### **b. Other nursing qualifications**

One QN from each organisational type possessed an additional nursing qualification. A primary QN had a diploma in orthopaedic nursing as well as an enrolled nurse qualification. One team QN also possessed the latter. One functional QN possessed the orthopaedic nursing certificate.

##### **c. JBCNS or ENB courses**

Five functional, three primary and two team QNs had undertaken English National Board courses. For one primary and two functional QNs this was the short care of the elderly course (ENB 940 or 941). The majority of QNs in all organisational types had not attended any ENB course.

##### **d. Other nursing courses**

Eight primary and ten functional QNs had attended other nursing courses, in contrast to only four team QNs. The most common course

TABLE 8.3 Duration of practical care of the elderly experience in nurse training

Duration	Primary qualified nurses (n=12)	Team qualified nurses (n=12)	Functional qualified nurses (n=12)
None	1	-	1
5 weeks < 10 weeks	4	3	2
10 weeks < 15 weeks	5	6	5
15 weeks < 20 weeks	2	1	1
More than 20 weeks	-	2	3

TABLE 8.4 Duration of theoretical care of the elderly component in nurse training

Duration	Primary qualified nurses (n=12)	Team qualified nurses (n=12)	Functional qualified nurses (n=12)
None	3	-	2
Less than 1 week	3	2	2
1 week < 2 weeks	1	5	1
2 weeks < 3 weeks	3	4	3
More than 3 weeks	1	-	4
Other	1	1	-

completed or being taken by functional QNs was the Open University Systematic Approach to Nursing Care course (P553; 8 nurses, cf. 1 primary and 2 team QNs), whereas three primary QNs had completed the Open University course 'Caring for Older People' (P654).

**e. Experience of care of the elderly nursing during training**

All nurses, with the exception of one primary and one functional QN, had worked on elderly care wards during their training. Duration is shown in Table 8.3. For all nurses, with the exception of three primary and two functional QNs, a theoretical component in care of the elderly formed part of their training. Length of this is given in Table 8.4.

**5. TEACHING GIVEN AND RECEIVED BY QUALIFIED NURSES IN PRESENT POST**

**a. Formal teaching received by qualified nurses on the ward**

Nine team and ten functional QNs had received no formal teaching on the ward since taking up post. This was in sharp contrast to primary wards, where only four QNs had received none. Mean numbers of formal teaching sessions on primary, team and functional wards were 2.7, 0.4 and 0.2 respectively.

**b. Formal teaching received by qualified nurses off the ward**

The same trend is found in the number of teaching sessions attended off the ward, although differences are less marked. Two primary QNs had attended no formal teaching sessions off the ward, in contrast to four team and six functional QNs. Mean numbers of sessions off the ward on primary, team and functional wards were 2.8, 1.9 and 0.9 respectively.

TABLE 8.5 Frequency of formal teaching received by qualified nurses

Frequency	Primary qualified nurses n=12)	Team qualified nurses (n=12)	Functional qualified nurses (n=12)
Once or twice a month	5	1	-
Once or twice every 6 months	6	4	-
Once or twice a year or less	-	4	6
Not applicable	1	3	6

TABLE 8.6 Frequency of informal teaching received by qualified nurses

Frequency	Primary qualified nurses n=12)	Team qualified nurses (n=12)	Functional qualified nurses (n=12)
Once or twice a week	5	3	1
Once or twice a month	3	1	1
Once or twice every 6 months	3	1	-
Once or twice a year or less	-	3	5
Other	-	-	1
Not applicable	1	4	4

**c. Frequency of formal teaching for qualified nurses (Table 8.5)**

QNs in primary wards were more likely to receive teaching every month or every six months than team or functional QNs. Indeed, functional QNs received formal teaching either once or twice a year or not at all.

**d. Formal teaching given by qualified nurses**

In all types of ward, the majority of nurses had given no formal teaching sessions (9 primary, 8 team and 8 functional QNs). Two primary QNs had given five sessions and one seven (mean value 1.4). The number of sessions given by team and functional QNs ranged from one to 12 (mean value 1.8) and two to five (mean value 1.0) respectively.

**e. Grade of nursing staff present at formal teaching given by qualified nurses**

Regardless of method of care organisation, learner nurses were the most frequent recipients of formal teaching, with only one NA on one team and one functional ward reported as being present. QNs were also rarely present.

**f. Informal teaching given to qualified nurses on the ward**

Again, QNs on primary wards were found to have been recipients of the most informal teaching. Only one had received none in contrast to four team and four functional QNs. Mean numbers of informal teaching sessions in primary, team and functional wards were 2.3, 1.3 and 1.5 respectively.



TABLE 8.7 Most frequent teacher in informal sessions for qualified nurses

Teacher	Primary qualified nurses (n=12)	Team qualified nurses (n=12)	Functional qualified nurses (n=12)
Ward sister	2	3	1
Other qualified nurse	1	1	3
Therapists	6	1	-
Other	2	3	4
Not applicable	1	4	4

TABLE 8.8 Grade of nurse present at informal teaching given by qualified nurses

Grade of nurse	Primary qualified nurse responses	Team qualified nurse responses	Functional qualified nurse responses
Qualified nurses	3	5	4
Nursing auxiliaries	7	3	12
Learner nurses	5	11	4
Other	1	-	1

**g. Frequency of informal teaching for qualified nurses (Table 8.6)**

As with formal teaching, informal teaching occurred most frequently in primary and least frequently in functional wards.

**h. Most frequent teacher in informal sessions for qualified nurses (Table 8.7)**

Therapists were found to play a much larger role in informal teaching in primary wards.

**i. Informal teaching given by qualified nurses on the ward**

Findings indicate functional QNs were most active in giving informal teaching (median=4 sessions, cf. primary and team median=3). Mean numbers of informal teaching sessions in primary, team and functional wards were 2.8, 3.7 and 4.4 respectively.

**j. Grade of nursing staff present at informal teaching sessions given by qualified nurses (Table 8.8)**

A clear distinction can be seen between primary and functional wards and team wards. Whereas on the former NAs were the most frequent recipients of informal teaching, in the latter this was most frequently directed at learner nurses.

## **6. THE THERAPEUTIC ORIENTATION OF QUALIFIED NURSES**

As in the ward sister questionnaire and interview, questions for this section were taken from Kitson's TNFI (1984). The criteria used by Kitson, and illustrated in Appendix 1, were used to assign numerical values to responses. Scores are given in Appendix 17. One-way

TABLE 8.9 Is care of the elderly nursing different to general nursing?

	Primary qualified nurses (n=12)	Team qualified nurses (n=12)	Functional qualified nurses (n=12)
Yes	12	10	10
No	-	2	2

analysis of variance was used to compare scores across organisational modes for each subscale and for total scores.

**a. Defining care of the elderly nursing**

Regardless of organisational mode, the majority of QNs viewed care of the elderly nursing as different to general nursing (Table 8.9).

*Ways in which care of the elderly nursing is different to general nursing*

One functional, three primary and five team QNs viewed care of the elderly nursing as a speciality, requiring specialist nursing skills.

One team and one primary QN illustrate this:

**Team QN:**

"Very much so. You really have to turn your whole thinking on its head. You have to get away from ritualistic care and getting things done where you have a set routine in the morning of getting the patients up, giving them their breakfast, giving them their medicines, sitting them prettily beside their beds waiting for the doctor to do his round and then feeling as if you've achieved something. On care of the elderly it is completely different. Each patient is different: some of them like to get up early, some of them don't;...sometimes they don't get out of bed till half past twelve in the afternoon, that's fine, and sometimes the ward looks like a tornado's been through it because the beds aren't made, but that's also fine....Also you spend a lot of time counselling and listening and also counselling the families, so it really turns everything round."

Primary QN:

"I think its more difficult for them to stand up for themselves. I think you've got to be able to try and find out from them what they would like to do and work at it for them, whereas in general nursing most people can actually stand up for their own rights. [Also] I think it is harder because you have to know a lot about a lot of things: a little bit about a lot of different specialities because they still get other things, other diseases. You have to know more about contra-indications of things like medication and about the importance of things like drinking as far as electrolytes are concerned."

The majority of primary QNs (8, cf. 3 team and 4 functional QNs) stated that care of the elderly nursing was different because of elderly patients' medical and nursing needs and favourable patient characteristics. A primary QN illustrates the latter:

"Patients come from a different era, they have a lot they can pass on to you about when they were brought up - you've got that interest there, and they can tell you what life used to be like... whereas in general nursing you don't know them, you're not on the ward long enough to get to know them, they just come in for an operation and go out again, and you don't have that atmosphere of personal interest."

The majority of functional QNs (7, cf. 4 team and 1 primary QN) argued care of the elderly nursing was either no different to general nursing or different only in terms of negative characteristics of elderly patients and negative aspects of working with them. A functional QN illustrates this type of response:

"You need more patience with these old people, a lot of them are deaf, a lot of them can't see, a lot of them are senile and you don't often get that mix on a general ward, here we have a concentrated ward full. The workload is different, a lot heavier because a lot of them are immobile,...just in basic care it is very demanding."

### *Aims of care*

All nurses with the exception of one team and one primary QN listed aims unique to nursing in their response to this question. The most common aim, particularly in primary and functional wards (28 primary and 23 functional cf. 10 team responses) was the provision of a high standard of physical and psychological care to patients. Two primary QNs illustrate this:

"To give [patients] a good standard of care relating to what they see as their needs; to work with them, not over or above them".

"The aim of care is for individuality and a dignified approach in treating the person as a whole, that is a holistic approach."

Patient choice formed a further aim of care frequently mentioned (3 primary, 4 team and 4 functional responses), as illustrated by a team QN:

"My aims are their aims, what they want to achieve, their objectives of care, whether they want to get better or whether they want to die peacefully, or their aim may be to be discharged home. So I aim towards their aims, what they want to achieve."

Patient recovery in terms of increasing patients' level of functioning was mentioned as an aim in all organisational types (10 primary, 8 team and 5 functional responses). Only one primary and one team respondent, however, gave this response in isolation without also listing other distinctly nursing aspects.

### *Most important aspects in the care of patients*

Nurses from all organisational modes (with the exception of 2 primary and 3 functional QNs) viewed as most important aspects other than the solely physical care of patients or medical aspects of care. Meeting patients' psychological needs formed the largest group of responses (14 primary, 19 team and 12 functional). Some examples are given below:

#### Team QN:

"Trying to keep the patients from getting depressed, that's very important I think. I suppose you try and make them keep thinking of the best all the time...and if they're not doing so well, keep encouraging them so they don't lose heart."

#### Primary QN:

"I think forming quite a good relationship with [the patient] so that they know that you're trying to see how they see it from their point of view; empathy, being sympathetic or empathy."

Giving patients a say in their care and maintaining patient individuality was mentioned as most important by several respondents, as the following examples illustrate:

#### Functional QN:

"Try and assess what the patient would like and try and make sure you can still carry out good care but include some of the things the patient would like. We get patients in here and their only companion may be a tiny dog at home; if they want to see that dog we make sure that somebody can bring it in and let them see it. [You have to be] flexible, without endangering other people, of course."

#### Team QN:

"Talk to [the patient] a lot about how they feel, what would make them happier, how they would like to change things."

TABLE 8.10 Necessity of special training in care of the elderly nursing

	Primary qualified nurses (n=12)	Team qualified nurses (n=12)	Functional qualified nurses (n=12)
Qualified nurses require post-basic training	9	9	7
Qualified nurses do not require post- basic training	3	3	5
Nursing auxiliaries require special training	11	9	10
Nursing auxiliaries do not require special training	1	3	2



Two primary and three functional nurses listed as most important aspects concerning the physical and medical care of patients only. Examples of this type of response are given below:

Functional QN:

"Make sure [the patients] are clean, well dressed and dry."

Primary QN:

"Physical needs initially, maintaining a safe environment and ensuring adequate food and diet."

Mean percentage scores for defining care of the elderly nursing for primary, team and functional QNs were 86.1, 86.7 and 76.7 respectively. There was no significant difference between organisational modes for this subscale.

#### **b. Knowledge required to care for elderly patients**

*Necessity of post-basic training for qualified nurses (Table 8.10)*

The majority of QNs on primary and team wards believed QNs required post-basic training to care for elderly patients. A larger number of functional QNs, however, thought general training was sufficient to care for elderly patients effectively.

When asked to explain their response, several nurses gave general statements why post-basic training was required. For example, it was thought to keep nurses motivated and prevent stagnation if nurses had been in post some time (team QN), give care of the elderly the

prestige accorded more 'technical' specialities (team QN) and provide an opportunity to learn about research (primary QN).

Further responses, particularly from primary and team QNs (3 and 7 responses respectively), argued post-basic training was essential because of the nature of care of the elderly nursing. For example, its specialist nature was stated. Post-basic training was further thought to lend weight to the argument that elderly care be recognised as a speciality. Some respondents believed elderly patients' needs to be different or more, thus necessitating specialist knowledge (3 primary, 3 team and 4 functional responses). A further group of responses (5 primary, 7 team and 3 functional) stated post-basic training was necessary to give knowledge of elderly care nursing, for example of services available to elderly people in the community, the workings of the multidisciplinary team and rehabilitation. Post-basic training was also thought to be beneficial in teaching psychosocial skills (2 primary and 3 functional responses), as illustrated by a primary QN:

"it [post-basic training] helps you to think about how the patients feel, look at things from their point of view. How you want to help them may not be how they want to be helped, because they were brought up in a different era, so it does help to know what they are thinking as well as what you want to do for them."

Ten functional (cf. 4 primary and 4 team) responses outlined reasons why post-basic training was not necessary for QNs. The most common reason given was that in care of the elderly wards patients required only "basic nursing", which was learned during nurse training, picked up while working on the ward or both.

*Necessity of specific training in care of the elderly for nursing auxiliaries (Table 8.10)*

Most nurses in all organisational types believed NAs required special training in care of the elderly. Only one primary, three team and two functional QNs thought no special training was required.

In explaining their answers several respondents, particularly in team wards (9 team and 2 primary responses), thought NAs required a special training in order to understand the special needs of the elderly, for example the need for rehabilitation and the need to encourage self-care. A further group of responses, particularly from primary QNs (5 primary, 1 team and 1 functional response), believed NAs needed training in order to be able to appreciate conditions affecting the elderly, such as diabetes and dementia.

Four team and two functional responses argued a specific training was required for NAs because of the nature of elderly care nursing. A team QN illustrates this:

"I think it is a field of nursing that requires a lot of patience, a lot of hard work and you have to have a lot of insight, more so on here than on a normal, say surgical, ward."

Several respondents cited areas in which training was required for NAs. Two most frequently mentioned areas were "basic care" and lifting and handling, but nurse-patient communication and training in attitudes towards the elderly were also listed.

TABLE 8.11 Necessity of further training in care of the elderly nursing

	Primary qualified nurses (n=12)	Team qualified nurses (n=12)	Functional qualified nurses (n=12)
Qualified nurses require more training	10	10	10
Qualified nurses do not require more- training	2	2	2
Nursing auxiliaries require more training	11	10	10
Nursing auxiliaries do not require more training	1	2	2

Reasons why a special training for NAs was not required were given in two primary, four team and four functional responses. The most frequent reason was that NAs just do "basic nursing care" and thus require a basic training only. Other respondents believed an "on the job" training was more suited to the needs of NAs, and another believed careful choice of NAs obviated the need for special training. The latter two reasons are well illustrated by a functional QN:

"You need to choose auxiliaries carefully. You don't want immature or flighty ones, they must have their mind on the job. We are lucky because ours do care. They get training on the ward and each ward is different. They learn from the staff they are with."

*Topics on which qualified nurses require more training*

In all organisational modes, most QNs perceived the need for more training in care of the elderly (Table 8.11). Average numbers of topics in which more training was considered necessary did not differ greatly between ward types. Means for primary, team and functional wards were 2.1, 2.7 and 2.0 respectively.

*Topics on which nursing auxiliaries require more training.*

Again, the majority of QNs in all organisational types believed there were areas in which NAs required more training (Table 8.11). Primary QNs, however, listed more topics on average in which training was required. Mean numbers of topics listed by primary, team and functional QNs were 2.3, 1.7 and 1.7 respectively.

TABLE 8.12 How qualified nurses came to work with the elderly

	Primary qualified nurses (n=12)	Team qualified nurses (n=12)	Functional qualified nurses (n=12)
Planned	5	8	1
Accidental	6	3	9
Not sure	1	1	2

TABLE 8.13 Necessity of particular skills in caring for the elderly

	Primary qualified nurses (n=12)	Team qualified nurses (n=12)	Functional qualified nurses (n=12)
Particular skills required	11	11	7
Particular skills not required	1	1	5

Mean percentage scores for the knowledge subscale in primary, team and functional wards were 87.5, 79.8 and 77.8 respectively. No significant difference was found.

### c. Skill utilisation

#### *Choice of care of the elderly nursing*

More primary and team than functional QNs had actively chosen to work with elderly patients (Table 8.12). The majority of functional QNs had come to the speciality by chance. For other respondents it was not possible to determine whether elderly care was their chosen speciality or if they had arrived by accident.

#### *Skills needed to care for the elderly*

All QNs in primary and team wards with the exception of one in each ward type believed particular skills were required to care for elderly patients (Table 8.13). Five functional QNs, however, stated no special skills were required. When asked to detail which skills were required, the largest number of responses in each type of ward listed personal qualities such as patience, compassion and a sense of humour.

Skills specific to care of the elderly were outlined in ten primary and eight functional (cf. 5 team) responses. An example of the

skills of understanding and respect are given by a primary QN:

"you have to understand how they [elderly people] feel, they are not just another old person to be pushed in a corner. They have a life and you should respect that when they move from home to a residential place...even tidying a patient's locker, you should not do this because the locker belongs to the patient and that is how they want it to be."

Communicating effectively with patients is mentioned as a skill by several respondents, particularly from team wards (14 responses cf. 4 primary and 7 functional responses). A team QN illustrates this:

"You have to learn to communicate in a different way...A lot of old people are in a totally different frame of mind and you have to learn to get into that frame of mind to communicate with them properly. [You have to] know how to be calm when talking to a confused, agitated person, and how to relate to a person like that."

Communication skills with others, for example relatives, medical staff and other colleagues, were mentioned in one primary and four functional responses. Other professional skills were given rarely in all organisational types. For example, basic nursing skills were listed by only one team and one functional respondent. Four primary and four team responses did, however, list specific areas of knowledge required to care for elderly patients. These ranged from a sound knowledge of the ageing process and the pathology of illness to an understanding of bereavement.

The majority of primary and team QNs believed professional as well as personal skills were required to care for elderly patients (9 and 10 nurses respectively). Two primary and two team QNs listed personal skills only, while one primary QN thought no skills were required. In contrast, only five functional QNs listed professional as well as



Table 8.14 Skill Utilisation

SKILLS	PRIMARY QUALIFIED NURSES n = 12				TEAM QUALIFIED NURSES n = 12				FUNCTIONAL QUALIFIED NURSES n = 12			
	very little use	some use	good use	very good use	very little use	some use	good use	very good use	very little use	some use	good use	very good use
'Basic' nursing skills	-	1	7	4	-	-	1	11	-	1	2	9
Rehabilitation skills	-	1	5	6	-	3	3	6	-	-	2	10
'Technical' nursing skills	1	5	3	3	2	2	8	-	1	5	4	2
Communication skills	-	-	3	9	-	-	1	11	-	-	2	10
Management skills	-	4	3	5	1	3	2	6	-	4	4	4

personal skills. Five listed personal skills only and the remaining two believed no special skills were required.

#### *Skill utilisation (Table 8.14)*

The majority of team and functional QNs believed their basic nursing skills were put to very good use in their work on the ward. Most primary QNs, however, considered these skills to be put to good use only. Rehabilitation skills were put to very good use by the majority of functional QNs, but only six team and primary QNs. Overall, 'technical' nursing skills were considered to be put to less use, while communication skills were put to very good use regardless of ward type. Management skills responses in primary and functional wards were spread evenly over three categories. Six team QNs, however, considered their management skills to be put to very good use.

#### *Satisfying aspects in caring for elderly patients*

For many respondents, particularly in team and primary wards (10 primary, 12 team cf. 7 functional responses), aspects of nurse-patient relationships formed an important source of satisfaction. A team QN illustrates this:

"[the patients] give a lot back to you, you give them a lot and they often give you it back, they are very affectionate and very appreciative. I respect them quite a lot, they teach me my job. They are all different...I like all the stories they tell you from years ago when they were in the war; I look upon them as my elders and respect them for that."

A further two areas from which nurses derived satisfaction were patient recovery and improvement (14 primary, 14 team and 18 functional responses) and discharge home (10 primary, 5 team and 15 functional responses).

Nurses also derived satisfaction from dealing with relatives, for example advising and talking to relatives and family pleasure at patients' improvement.

#### *Aspects considered least satisfying*

The nature of nurses' work in elderly care was stated as an aspect liked least, particularly in team and functional wards (8 team and 5 functional cf. 1 primary response). The heavy, demanding nature of the work was cited, in addition to mental stress and strained patience. Certain specific tasks were also mentioned, for example making beds and performing Last Offices. Other team respondents mentioned the routine nature of the work and lack of unexpected drama, together with the unrelenting business of the ward throughout the day. Not surprisingly, several respondents cited lack of staff as an area in which much could be improved, and these responses were particularly prevalent in team wards (9 responses cf. 5 primary and 2 functional responses).

A further group of responses indicated a lack of satisfaction with the organisational structure of the hospital (particularly functional wards) and the ward (particularly team wards). A functional QN

illustrates the former and a team QN the latter:

Functional QN:

"There are far too many chiefs and not enough Indians. It is supposed to be patient orientated but it is not patient orientated because the people who are working with the patients are so thin on the ground you can't do what you want to do with them, but you go over there [management block] and there are two people doing one person's job many a time....Everything is so financially orientated. On this ward, take for example the toilets - you are teaching somebody to be independent and the best you can aim for is for them to be wheelchair independent, they can't be wheelchair independent when the toilets and door frames don't allow them to be."

Team QN:

"You are treated like school kids - you are told when to go for breakfast, you are told when to go to dinner - its like being at school isn't it? And the way certain people sit in the office the whole shift and don't get out with the patients."

Negative attitudes towards elderly care nursing and a lack of resources allocated to the speciality formed two further aspects disliked by nurses, particularly in team wards (11 team cf. 2 primary and 1 functional response). Both of these are well illustrated by a team QN:

"we don't have resources, we don't have a social worker to come onto the ward although we have asked four hundred times, we don't have an occupational therapist - the one we had frightened the patients, she was only a student. We do not have enough time to do rehabilitation skills, which I would love to be able to do; we never have either of the consultants on the ward, the full time one couldn't care less and the part-time one is too soon in and out to think of the patients; you never have a multidisciplinary team report which I think you desperately need on this type of ward. So much could be done. [Management] don't think of us as a specialised unit, we have no equipment, they will not buy us any whereas other units just get it....It is just other peoples' attitude, I wish they would respect us at times."

To summarise, in all locations most QNs derived satisfaction from areas which are the domain of nursing, for example relationships with patients and relatives (11 primary, 11 team and 9 functional QNs). One primary, one team and three functional QNs, however, mentioned solely aspects encompassed by the medical model, such as patient discharge, as satisfying.

Turning to aspects considered least satisfying, again the majority of nurses in all organisational types viewed as least satisfying aspects which hindered the delivery of quality care to elderly patients (10 team, 8 primary and 7 functional QNs). A further three primary, two team and five functional QNs either stated there was nothing they did not like or mentioned the physical side of the work as least satisfying. One primary QN listed negative patient characteristics only in response to this question.

Mean percentage scores for skill utilisation in primary, team and functional wards were 82.5, 87.3 and 79.6 respectively. A significant difference was found between organisational modes for this subscale ( $p=0.04$ ).

#### **d. The role of the nurse in rehabilitation**

All functional, ten primary and six team QNs viewed the role of the nurse in rehabilitation as complementary to the therapists' role, were able to articulate the role of the nurse and considered rehabilitation an integral part of their work, not as an additional routine to be performed on patients. A myriad of nursing roles in rehabilitation were given. These included the encouragement of

self-care in activities of daily living, patient teaching and the provision of psychosocial support to patients. Using the nursing process as a means of structuring a rehabilitation programme featured prominently (7 responses from each organisational type). Examples of responses indicating the most positive level of therapeutic orientation and illustrating these aspects are given below:

Primary QN:

"Therapists carry out the care which I prescribe by liaison with the doctor. This is done by writing down the problem on the care plan, setting an objective which you hope the patient will achieve and then planning the nursing action: the nursing care which you would like to be carried out in the hope of reaching success. Quite often the care we prescribe may be enhanced by the therapist, it might be that the therapist has better ideas about how to reach the goal."

Functional QN:

"In the beginning nurses play a big part, and this lessens as patients grow more competent with what they are trying to do for themselves. For example, when a new stroke patient is admitted they need total help to wash, dress and perhaps feed. As the patient gets better you have to do less and less, but as it gets less the patient needs more encouragement to feel she is still doing well.

The nurse has a more social role [than the therapist], we get to know patients better, talk to them more and have a more familiar relationship with them. The nurse has overall responsibility for the patient. The physiotherapist just has mobility and the occupational therapist washing and dressing. The nurse does all those things but cares for the social aspect as well."

Six team and two primary QNs gave less therapeutic responses. Here, the role of the nurse was regarded as one of supplementing activities normally performed by paramedical staff and rehabilitation was viewed

as an additional routine to be performed on patients. Examples are given below:

Team QN:

"[The role of the nurse is to] extend the physio's role when she is not here or at weekends or if she can't do somebody - ...just really an extension of their [therapists] roles. I wouldn't think our role was as important really. They're the ones who can assess better whether somebody's walking better or not. I just think they are two different roles...- their job is to get somebody walking or dressing themselves, our job is..I don't know, just an extension, to carry on doing the work that they do."

Primary QN:

"[Our role is to] try and follow up what the physio and OT say, and the instructions they give us...it is not much of a role - we don't have any contact in the department, we don't go on home visits, although we should do. We tend to see more to washing, dressing, feeding and are more observant with regard to infection. We always seem to be preparing the patient for the physio or OT to take over."

Using the criteria given by Kitson, mean percentage scores for rehabilitation role for primary, team and functional QNs were 93.4, 80 and 100 respectively. This difference was highly significant ( $p=0.01$ ).

When all subscales were summed to form a total score, mean percentage scores for primary, team and functional QNs were 84.9, 85.4 and 80.1 respectively. Differences were not statistically significant.

## 7. SUMMARY AND DISCUSSION

### a. Characteristics of qualified nurses

Overall, a larger number of primary QNs had been in post for a longer time period than team and functional QNs.

TABLE 8.15 Qualified nurse therapeutic orientation scores

	Definition of care of the elderly nursing (Mean %)	Knowledge required (Mean %)	Skill utilisation (Mean %)	Perception of rehabilitation role (Mean %)	Total score (Mean %)
Primary qualified nurses	86.1	87.5	82.5	93.4	84.9
Team qualified nurses	86.7	79.8	87.3	80.0	85.4
Functional qualified nurses	76.7	77.8	79.6	100.0	80.1



**b. Training and teaching**

Primary and functional QNs were more likely to have attended courses other than those run by the ENB or JBCNS. While the majority of team and functional QNs had received no formal teaching on the ward, only four primary QNs had received none. Primary QNs were, furthermore, more likely to have received formal teaching away from the ward, more frequent formal teaching and to have been recipients of a larger amount of and more frequent informal teaching. Therapists had a larger role in informal teaching in primary wards.

In primary wards NAs were more likely to be recipients of informal teaching, whereas in team wards this was more likely to be directed at learner nurses.

**c. Therapeutic orientation**

Scores are summarised in Table 8.15.

*Defining care of the elderly nursing*

Primary and team QNs scored higher in this section than functional QNs, but not to a degree reaching statistical significance. Functional QNs were less likely to view care of the elderly nursing as a speciality requiring specialist skills, and the majority believed care of the elderly nursing to be no different to general nursing, or different only in terms of negative patient characteristics.

### *Knowledge required to care for elderly patients*

Primary QNs scored highest in this section, believing that comprehensive and detailed training in care of the elderly nursing is essential for all grades of nursing staff. Functional QNs scored lowest, with a larger number indicating a general training was sufficient for QNs.

### *Skill utilisation*

Primary and team QNs scored highest in this section, with functional QNs again scoring the lowest. These differences were statistically significant. Only one functional QN had chosen to work with elderly patients, and functional QNs were more likely to believe no special skills were required. Furthermore, functional QNs were less likely to consider professional as well as personal skills to be requisite to elderly care nursing.

### *The role of the nurse in rehabilitation*

In this section functional QNs scored the highest possible number of points. Team QNs were more likely to give untherapeutic responses, for example regarding the nurses' role as one of supplementing activities normally performed by paramedical staff only. These differences were highly significant.

While functional QNs scored lower than primary and team QNs on the skill utilisation subscale, they scored highest in perceptions of their rehabilitation role. Despite these differences in subscales, total scores from different organisational modes were not found to

differ significantly. Overall, then, QNs in primary, team and functional wards did not differ significantly in their therapeutic orientation as measured by Kitson's TNFI.

TABLE 9.1 Length of time nursing auxiliaries in present post

Time in post	Primary nursing auxiliaries (n=12)	Team nursing auxiliaries (n=11)	Functional nursing auxiliaries (n=12)
1 month <6 months	1	1	1
6 months < 1 year	1	-	-
1 year < 2 years	1	1	9
2 years < 5 years	6	8	2
5 years < 10 years	3	1	-

## CHAPTER 9 NURSING AUXILIARY CHARACTERISTICS AND PERCEPTIONS OF THEIR WORK

### 1. NURSING AUXILIARY CHARACTERISTICS

Table 9.1 shows time in post of study NAs. Primary and team NAs had most frequently been in their present post between two and five years, in contrast to functional NAs, for whom time in post was commonly between one and two years. The number of part-time primary and functional NAs exceeded that of full-time NAs. In contrast, only four team NAs worked part-time. Part-time NA hours ranged from 20 to 32 hours per week. *Team NAs were younger than primary and functional NAs, with a mean age of 33 years compared with a mean of 38 years for primary and functional NAs.*

Functional NAs had worked in a larger number of other ward types; a mean of three compared to one for team and primary NAs.

### 2. THE TRAINING AND TEACHING OF NURSING AUXILIARIES

#### a. Introductory course to nursing auxiliary work

Nine primary (cf. 6 team and 5 functional) NAs had attended an introductory course to NA work. Furthermore, two thirds attended a course specifically for NAs working in elderly care. One team NA attended a specialised course, but all functional NAs who attended one at all attended a general course. Primary NAs, however, were less likely than team NAs to have attended the introductory course before they commenced work on the ward. Indeed, two primary NAs (and

TABLE 9.2 Extent to which introductory course prepared nursing auxiliaries for their work on the ward

Extent course prepared nursing auxiliary	Primary nursing auxiliaries (n=12)	Team nursing auxiliaries (n=11)	Functional nursing auxiliaries (n=12)
Not very well	1	1	-
Quite well	3	2	4
Very well	3	3	1
Other	2	-	-
Not applicable	3	5	7

1 team NA) had been working as an NA for more than a year before attending the course.

Table 9.2 shows the extent to which NAs felt their introductory course prepared them for their work on the ward. Giving reasons for their responses, three primary, one team and one functional response outlined inadequacies in the course. These included not enough practical experience and the course being too basic.

Benefits of the course were mentioned in seven primary, four team and two functional responses. Examples of these are given below:

**Functional NA:**

"It gave you a basic outline of what was expected of you. You knew that if an admission came in you had to do urinalysis. If you hadn't been in school you wouldn't have known - nobody would have told you."

**Primary NA:**

"It gave an understanding of what health care of the elderly is all about, what you are up against. *We are here to help nurses* - if the nurse asks you to fetch something you know exactly what, and if helping with dressing you know exactly what to do."

**b. Formal teaching given to nursing auxiliaries on the ward**

Only two primary NAs had received no formal teaching on the ward. This is in sharp contrast to nine team and eight functional NAs. Mean numbers of sessions attended by NAs on primary, team and functional wards were 2.3, 0.6 and 0.6 respectively.

**c. Formal teaching given to nursing auxiliaries off the ward**

Five primary, six team and eight functional NAs had received no formal teaching off the ward. Mean numbers of formal teaching

TABLE 9.3 Frequency of formal teaching received by nursing auxiliaries

Frequency	Primary nursing auxiliaries (n=12)	Team nursing auxiliaries (n=11)	Functional nursing auxiliaries (n=12)
Once or twice a week	1	-	-
Once or twice a month	-	-	-
Once or twice every 6 months	2	-	-
Once or twice a year or less	5	5	4
Other	2	1	-
Not applicable	2	5	8



sessions attended by primary, team and functional NAs were 1.6, 0.6 and 0.5 respectively.

**d. Frequency of formal teaching given to nursing auxiliaries (Table 9.3)**

Most NAs in each organisational type who had attended formal teaching sessions stated they received formal teaching once or twice a year or less. For three primary NAs, however, this was more frequent.

**e. Informal teaching**

The majority of NAs in all organisational modes had received informal teaching since beginning work on the ward. Only two primary and team and three functional NAs had received none. Primary NAs appear to have received a smaller number of informal teaching sessions: mean numbers on primary, team and functional wards were 1.4, 2 and 2.2 respectively. However, seven primary (cf. 3 team and no functional) responses stated informal teaching was an ongoing process. This is attested further in responses regarding the frequency of informal teaching (Table 9.4). Seven primary (cf. 2 team and 2 functional) NAs stated they received informal teaching once or twice a week. No primary NA said she received informal teaching once or twice a year or less, but three team and three functional NAs gave this option.

**f. Provider of informal teaching to nursing auxiliaries (Table 9.5)**

Primary NAs were more likely to name the ward sister as the person who most frequently gave informal teaching, while team NAs were more likely to name therapists.

TABLE 9.4 Frequency of informal teaching received by nursing auxiliaries

Frequency	Primary nursing auxiliaries (n=12)	Team nursing auxiliaries (n=11)	Functional nursing auxiliaries (n=12)
Once or twice a week	7	2	2
Once or twice a month	1	2	2
Once or twice every 6 months	1	-	1
Once or twice a year or less	-	3	3
Other	1	2	1
Not applicable	2	2	3

TABLE 9.5 Most frequent provider of informal teaching to nursing auxiliaries

Teacher	Primary nursing auxiliaries (n=12)	Team nursing auxiliaries (n=11)	Functional nursing auxiliaries (n=12)
Ward sister	3	-	1
Other qualified nurse	4	4	3
Therapist	1	3	-
Nursing auxiliary	-	-	1
Other	2	2	4
Not applicable	2	2	3

### 3. THE THERAPEUTIC ORIENTATION OF NURSING AUXILIARIES

NAs were asked selected questions only, concerning the definition of care of the elderly nursing and skill utilisation. A broader range of questions was asked in pilot interviews with NAs. However, as several NAs found answering some questions problematic, these were omitted from the main study. Scores are given in Appendix 18.

#### a. Defining care of the elderly nursing: Most important aspects in caring for elderly patients

Meeting patients' psychological and social needs was considered important by several respondents, particularly in functional wards (32 responses, cf. 17 primary and 16 team responses). Talking and listening to patients was mentioned most frequently (3 primary, 5 team and 10 functional responses), but further examples are given below:

##### Team NA:

"Firstly it is to win their confidence, to get them to relax and to know we are here to help them and that they shouldn't be afraid, because a lot of patients are really frightened when they come into hospital, even more so elderly patients."

##### Functional NA:

"The patient understanding their condition and what is asked of them - they have to know what is going on and what is expected of them. And for them to be able to trust care."

##### Primary NA:

"The most important thing is tender loving care, and coming on duty with a sense of not just coming for the money (who would be in nursing for the money!) but that you're here because you love them. You're here because you care about them."

TABLE 9.6 How nursing auxiliaries came to work with the elderly

	Primary nursing auxiliaries (n=12)	Team nursing auxiliaries (n=11)	Functional nursing auxiliaries (n=12)
Planned	3	2	2
Accidental	5	7	7
Not sure	4	2	3

A further group of responses, particularly in primary and functional wards, concerned patient choice and individuality (9 primary, 5 team and 10 functional responses), for example obtaining the patient's point of view and ensuring patient satisfaction with care.

The provision of patient care was mentioned most frequently as an important aspect by team NAs (17 responses cf. 12 primary and 14 functional responses). Attending to patients' hygiene and dietary needs and making patients comfortable were two aspects frequently mentioned.

Mean percentage scores for definition of care of the elderly nursing for primary, team and functional NAs were 96.6, 96.4 and 100 respectively. Differences were not statistically significant.

#### **b. Skill utilisation**

##### *Choice of care of the elderly nursing*

Regardless of organisational mode, a minority of NAs had chosen to work with elderly patients (Table 9.6). For some it was not possible to determine whether they had chosen the speciality or arrived by accident.

The majority of NAs in all organisational types believed particular skills were required to care for elderly patients (Table 9.7). Listing skills considered necessary, the majority of respondents in all ward types outlined personal qualities. However, eight functional (cf. 4 primary and 5 team) responses mentioned skills of particular relevance to the speciality, for example an understanding

TABLE 9.7 Necessity of particular skills in caring for the elderly

	Primary nursing auxiliaries (n=12)	Team nursing auxiliaries (n=11)	Functional nursing auxiliaries (n=12)
Particular skills required	9	8	9
Particular skills not required	3	3	3

of elderly people and their needs. Six primary (cf. 2 team and 3 functional) responses stated the importance of communication skills with patients.

*Most satisfying aspects in caring for elderly patients*

16 primary and 15 functional (cf. 11 team) responses mentioned aspects of the nurse-patient relationship as giving satisfaction. For example:

Primary NA:

"when a patient doesn't particularly want to go home, because they are happy here. I think we've probably done too good a job then, because although we are striving to get them home, the thing is you know they are going home and probably sitting in a warden controlled flat and the only person they'll see to talk to is the milkman or something like that. And I feel very sorry for them."

Functional NA:

"Being able to become friendly with the visitors and family and the patients themselves. We're not supposed to have favourite patients, but I find that you do."

Patient recovery as a source of satisfaction formed a further large group of responses, particularly from primary NAs (16 responses cf. 9 team and 10 functional responses). For example:

Primary NA:

"When patients haven't been able to walk and they make a few steps, that is nice, to see them walk or even starting to dress themselves, just when they start going on the mend is the best time, getting better."



Functional NA:

"Seeing a patient coming into hospital really ill and seeing them progress. Especially if they have had a stroke and are able to do nothing for themselves and then as the days and weeks and months go on you see them really gaining their confidence, being able to do a lot for themselves and finally being able to go home or able to reach their goal or target, and knowing that you've played a part in getting them back to full strength again."

*Aspects liked least*

Four functional (cf. 1 team and no primary) responses listed negative characteristics of patients as giving least satisfaction, for example incontinence and aggression. More primary than team or functional responses (6, cf. 4 team and 3 functional) mentioned the nature of care of the elderly nursing in response to this question. The majority of responses concerned specific tasks disliked by NAs, such as making beds and escort duty. Team NAs were more likely to mention the position of the NA within the organisational structure at ward level (6 responses, cf. 3 primary and 1 functional). For example:

Team NA:

"You clean all the muck up after everybody else! You seem as though you're tidying round after everybody else. You're left to tidy round."

Primary NAs were most likely and team NAs least likely to give positive comments in response to this question (9 primary, 5 functional and 1 team response). For these respondents, there was nothing about their job they disliked.

Mean percentage scores for primary, team and functional NAs for the skill utilisation subscale were 70.4, 75.8 and 77.8 respectively. Differences were not statistically significant.

#### 4. SUMMARY

Overall, the mean age of NAs was greater than that of QNs in all organisational modes, and NAs were more likely than QNs to be part-time, particularly in primary and functional wards.

For NAs as well as QNs, primary wards placed a larger investment in training and teaching. This included introductory courses to NA work, particularly specialist courses for NAs working with elderly patients, formal and informal teaching. Primary ward sisters were more involved in the latter than ward sisters in the other organisational modes.

The majority of NAs, regardless of organisational mode, named the most important aspects of their job as those illustrating the primacy of nursing interpersonal skill, as compared with physical care of patients or medical aspects only, and therefore gave a therapeutic response.

While few NAs had chosen to work with the elderly, the majority, regardless of organisational mode, believed skills were required to care for elderly patients effectively. Six primary, five functional and four team NAs believed professional as well as personal skills were required. While functional NAs were more likely to enumerate

professional skills, primary NAs were more likely to cite communication skills.

The majority of NAs listed as those aspects considered most satisfying ones which are the domain of nursing, thus giving a therapeutic response. Team and functional NAs were most likely to give aspects hindering the delivery of high quality care to patients as least satisfying, whereas primary NAs were more likely to state there was nothing they did not like.

As with QNs, then, NAs in primary, team and functional wards were similar on the parameter of therapeutic orientation as measured using Kitson's criteria (1984).

## CHAPTER 10 THE ROLE AND FUNCTION OF NURSING AUXILIARIES IN PRIMARY, TEAM AND FUNCTIONAL NURSING WARDS

### 1. WARD SISTER PERSPECTIVES

#### a. The preparation and training of new nursing auxiliaries

In order to determine the preparation NAs were given for their role ward sisters were asked what training was provided when a new NA arrived on the ward.

In Wards F7 and F8 (located within the same hospital), a hospital induction scheme was in operation lasting one week. This comprised new NAs spending some time on each elderly care ward and each ward sister giving a lecture covering the "basic principles of auxiliary nursing" (ward sister F7). Topics mentioned were lifting and handling, hospital and ward policies. Apart from this, training was at the discretion of the ward sister. On Ward F9 no set training scheme existed.

Training given in Wards T4 and T6 appeared to be more comprehensive. In Ward T4 NAs received a one week induction course run by the nurse education department and covering "all the basics" such as making beds and activities of daily living. The ward sister, however, considered this training inadequate:

"I think they need a lot of education in attitudes, in dealing with patients and relatives and also the elderly mentally infirm...The fact that the patient is the most important person and that we are here for the patients and...it is up to us to respect the patient as an individual and meet their needs. A lot of auxiliaries come into nursing and think the nurse is here to tell people what to do and that is just not appropriate."

Ward sister T4 considered a much more formal training should take place on the ward over and above NAs working alongside qualified staff.

In Ward T6 a course for NAs was provided by the teaching unit, but not necessarily at the beginning of the NAs' appointment. Training on the ward was "ongoing all the time" with the physiotherapists and the ward sister teaching, for example, lifting and handling and how to feed patients. In Ward T5 there was no induction course available. There had only been one new NA since the ward sister had taken up post, who learned largely by working with QNs. While the ward sister said she would like to see seminars given for NAs as they were for learner nurses, this was a problem because all NAs with the exception of one worked part-time.

The most comprehensive training was provided in primary wards. Ward sister P1 had recently become responsible for in-service training for the unit. Training provided by her included lifting and handling and nursing hygiene as well as medical conditions and nursing problems. Furthermore, NAs were taught the importance of correct attitudes towards elderly patients and the philosophy of the ward. In addition to this programme, which was conducted on the ward, NAs also spent two weeks in another care of the elderly area and were encouraged to attend courses and study days.

In Ward P2 a one-week district induction course was provided for new NAs. A further three-day course existed covering, for example, the

nursing process and counselling, and giving "the theory behind the practice". On the ward, learner nurses took precedence with regard to teaching, but NAs sometimes attended seminars given for learners. Otherwise, "they just pick it up as they go along and learn as they go along".

On Ward P3 there was similarly a week long training course held at a nearby hospital. NAs were not routinely sent on this course before commencing work on the ward. The ward sister considered it her responsibility to ensure NAs were competent in certain "basic" things, for example lifting and handling. She also felt it important to spend time with NAs to determine their training needs.

**b. Part played by nursing auxiliaries in providing patient care**

Ward sister F7 divided her response to this question into what NAs were "officially" allowed to do and what in her opinion they were capable of. Officially, the role of the NA was to assist patients in activities of daily living. These activities were:

"those...that don't need medical or trained nursing input - the likes of bathing, helping them with dressing, somebody sitting down and talking to them and listening to their problems, feeding and the general maintenance of the ward e.g. bed making."

In performing these duties only, the ward sister considered NAs to be under-utilised. In her opinion, following correct training, NAs were capable of "minor nursing duties" such as taking blood pressures and of having more say in the formulation of patients' care. Ward sister F9 similarly made a distinction between what NAs were officially allowed to do and what they did in practice. According to hospital

guidelines, "they are here purely to assist the first and second level nurses to bath, to make beds, [and] to generally clean". In practice, the ward sister described their role as follows:

"[They are] a valued member of the team, very good at gaining patient's confidences, very good at recognising signs and symptoms that I certainly miss; their expertise, at least of two of the girls who have worked here a long time cannot be underestimated."

Ward sister F8 was asked this question following data collection because she was unable to complete the interview at one sitting. She refused to answer this question, stating that the role of the NA was as the researcher had witnessed it.

In contrast to functional ward sisters, ward sisters T4 and T5 believed the role of the NA should not be expanded, but should be kept within tighter parameters. Ward sister T5 believed NAs should not care for acutely ill patients unless there was a QN present. Their role was to care for patients who did not need much "nursing intervention", i.e. 'social problem' patients or those patients who only needed help with activities of daily living, not those patients who did need "nursing intervention", such as patients who were unconscious and needed catheter care. NAs were praised for their rapport with patients, and the ward sister believed an important role for them could be in providing social activities. In her opinion, however, this was not possible because the majority of NAs worked part-time.

Ward sister T4 believed helping patients with activities of daily living to be very much a "nursing task" and did not consider it ideal

that NAs did this. She believed "every patient has the right to be looked after by a trained nurse", and cited two reasons why it was preferable for a QN to provide so-called basic care. Firstly, NAs are not trained in patient observation and therefore might miss something which would not be missed by a QN. Secondly, NAs may not realise the therapeutic opportunity arising from performing activities of daily living:

"going back to attitudes again, actually being able to draw the patient out, because this is what happens when you are washing and dressing patients..., by talking to them and listening to them you get information and find out about how they feel about what is happening to them and that is something that comes with experience and should come with training."

According to ward sister T4, NAs should be more geared to the patients' area, for example keeping this tidy. In reality, however, NAs were relied upon to perform "nursing tasks" because there were insufficient qualified staff to preclude this.

In contrast, ward sister T6 considered NAs, with in-service training, to be "excellent bedside nurses, under supervision". It was their role to meet patients' activities of daily living needs and participate in "rehabilitation", as well as talking to patients and providing reassurance.

Ward sister P1 considered the role of the NA to be one of "supporting" primary and associate nurses. In doing this, NAs were involved in "rehabilitation care" and performed "nursing interventions" in the form of activities of daily living. Ward



sister P1 stated the importance of NAs being "attuned to the way in which you want care to be given". If this was not so, NAs, like QNs, could undo good work done with patients.

Ward sister P3 similarly viewed the NA role as one of supporter to primary and associate nurses: NAs gave care "compiled by the primary nurse in conjunction with the associate nurse". Apart from patient care, the NAs' role was to provide "social, recreational and spiritual care..., giving the patient a sense of belonging and a feeling of being with friends and family".

In Ward P2 NAs similarly delivered patient care under the supervision of a QN. NAs were allocated patients on a daily basis from their primary nurse group, and the ward sister stated that they used their observational skills and worked from the care plan in caring for these patients. NAs also built up a good rapport with patients and provided an important source of information:

"you sometimes get valuable information relayed back to the primary or associate nurse that patients might not care to tell a trained member of staff."

A further part of NAs' role was performing housekeeping functions, such as doing the laundry.

c. Extent to which nursing auxiliaries require supervision when caring for patients

All functional ward sisters did not consider NAs to need what they termed "direct" supervision, i.e. a QN constantly watching their

actions. All considered it sufficient to have a QN on the ward at all times to which NAs could come for advice and guidance.

In contrast, ward sister T6 viewed NAs as requiring more supervision: "they [NAs] are on a team and the team leader will be directing them and watching them at all times". Ward sister T5 believed the amount of supervision required depended on the individual NA, together with the demands of the patient for whom they were caring. Some NAs could be relied on to allow patients to use self-care skills, whereas others would, if left unsupervised, do everything for the patient in order to "get finished quick" and because of a lack of understanding of the benefits of self-care to patients. In Ward T4, like functional wards, NAs were supervised by having a qualified team member working within the team.

Ward sister P1 believed NAs should not be supervised constantly because this would inhibit their development, but should nevertheless work "under" a qualified member of staff. What was meant by this in terms of supervision was unclear. Ward sister P2, like functional ward sisters and ward sister T4, believed NAs needed only a QN presence, in this case within the primary nurse group. Ward sister P3 believed NAs required supervision in the form of a QN overseeing her actions when delivering patient care. This did not, however, involve the QN working with the NA.

**d. Extent to which nursing auxiliaries require direction when caring for patients**

Ward sister F7 believed NAs required very little direction, provided

they had been working on the ward for a few months, because "on a ward like this 90% of patients have similar conditions", so NAs "appreciate the principles of nursing stroke patients and patients who come in with immobility" and are able to provide appropriate nursing care. According to this ward sister, NAs probably knew more than QNs about how to nurse these patients, although they did not go into the "deeper medical aspects" such as physiology.

Ward sister F8 believed the amount of direction required depended on the individual NA. Those now working on the ward were "quite capable of carrying out the duties that they should be doing" without direction, but if an NA was employed who had no previous experience she would need a large amount. Ward sister F9 similarly believed NAs, provided they had worked on the ward some time, to require "very little" direction.

Team ward sisters viewed NAs as requiring more direction. Ward sister T4 stated that the amount needed depended on the individual NA:

"some use their initiative, but they always come and ask 'shall I go and do this' or 'would it be a good idea if', and they often have really good ideas. Other ones like to be directed all the time and if you don't ask them to do something they won't do anything."

Ward sister T6 similarly stated that NAs were directed all the time by their team leader. According to ward sister T5, the amount of direction given to NAs depended on the patient they were caring for. If the patient had been on the ward for some time, NAs knew the appropriate amount of assistance needed by the patient. With other

patients NAs needed direction as to the capabilities of the patient, i.e. what to allow the patient to do for himself and what to do for him. This, the ward sister argued, precluded the tendency of NAs to 'act for' a patient when he was able to perform activities for himself.

Primary wards had a more structured approach to NA direction. Ward sister P2 stated that direction was given by primary or associate nurses going through care plans with NAs for those patients to whom NAs were going to deliver care. NAs then gave care to patients and talked through reports of care with QNs. According to ward sister P3, direction was given by the primary or associate nurse sitting down with her team members and explaining about the patients and their needs for the day.

#### e. Summary of ward sister perspectives

Ward sister opinion in team and functional wards regarding the role of the NA related to the status of 'basic care'. Generally, in functional wards assisting patients with activities of daily living was considered work not requiring a QN, and therefore capable of being performed by NAs. Furthermore, functional ward sisters considered an expansion of the NA role to include "minor nursing duties", for example measuring blood pressure, to be appropriate.

Two team ward sisters, on the other hand, considered it necessary to restrict the NA role to within tighter parameters. For ward sister T5 this meant not allowing NAs to perform "nursing interventions", such as catheter care, while for ward sister T4 helping patients with

TABLE 10.1 General statements on the part played by nursing auxiliaries in providing patient care

Statement	Primary		Team		Functional	
	Qualified Nurses	Nursing Auxiliaries	Qualified Nurses	Nursing Auxiliaries	Qualified Nurses	Nursing Auxiliaries
A big part	3	3	2	4	2	1
We depend on them a lot	-	-	2	-	-	-
We couldn't manage without them	-	-	1	-	1	-
NAs are part of the team	1	2	-	1	1	-
NAs do job well	1	-	-	-	1	-
NAs are the backbone of the ward	-	-	1	-	2	-
NAs are an extra pair of hands	-	-	-	-	1	-
NAs are relied on too heavily	-	-	1	-	1	-
NAs do not do a lot	-	-	-	-	-	1

activities of daily living was a "nursing task", and as such should ideally be carried out by QNs only.

Primary ward sisters appeared to take a broader view of the NA role, and defined it in global terms rather than in terms of specific tasks considered suitable or otherwise.

Functional ward sisters believed direction required by NAs to be minimal. Team ward sisters, on the other hand, considered direction to be necessary, and the degree to be dependent on such factors as the competence of the individual NA or the condition of the patient being cared for. Primary ward sisters, however, had a much more structured conception of what NA direction entailed.

All functional ward sisters believed indirect supervision in the form of a QN to whom the NA could come for advice to be sufficient. Similarly, primary ward sisters believed supervision in the form of QN and NA working together at all times to be unwarranted. Team ward sisters, however, considered closer supervision to be required, although as with direction this was to some extent determined by the competence of the individual NA and the needs of the patient for whom they were caring.

## 2. QUALIFIED NURSE PERSPECTIVES

### a. The role of the nursing auxiliary in the ward team

Several QNs prefaced their answers to this question with a general statement summing up the contribution of the NA. These are summarised in Table 10.1.

In all organisational modes, several responses outlined the role of the NA in relation to that of the QN. Five functional (cf. 2 primary and 1 team) responses described the NA role as one of helper, assistant or supporter to the QN. Another commonly mentioned role, particularly in primary responses, was that of intermediary, passing on information and giving feedback from patients to QNs (4 primary, cf. 3 team and 1 functional response).

The role of the NA in relation to patients was mentioned frequently by primary and functional QNs (16 primary and 12 functional cf. 4 team responses). Talking and listening to patients was considered an important role in all organisational types (4 primary, 3 team and 3 functional responses). Several primary and functional QNs also believed NAs had superior relationships with patients than QNs:

Functional QN:

"with them [NAs] having more patient contact, we sometimes don't get out of the office at all, they can communicate effectively because they get to know the patients better. It means that they can become more familiar. I think the patients are more comfortable talking to an auxiliary, I think the patients would sometimes tell an auxiliary more than they'll tell somebody in a blue dress."

Specific patient care duties performed by the NA formed another large group of responses (13 primary, 8 team and 11 functional responses). Most commonly stated was the giving of 'basic care', for example meeting patients' hygiene, dietary and elimination needs. Other duties frequently mentioned were enhancing the patients' social environment and domestic duties such as bedmaking and cleaning (4 team and 1 functional response).

Other responses (4 primary, 3 team) viewed the role of the NA as being one of freeing QNs for administrative and managerial work by carrying out patient care which QNs would otherwise have to perform.

For example:

Primary QN:

"They [NAs] play a major part in attending to the smaller things especially when we are concerned with the administration side of the ward; we depend on the auxiliaries for providing the comfort to the patients, i.e. looking after their teeth."

No primary respondent stated that NAs should be allowed to perform more duties, however two team and two functional QNs argued NAs should, for example, be permitted to do small dressings and observations.

#### **b. Responsibility which should be given to nursing auxiliaries**

Several nurses began their response with a general statement about NA responsibility. While primary and functional responses emphasised NA responsibility in carrying out care prescribed by QNs, three team responses argued that NA responsibility should be limited because of lack of training and knowledge.

More primary responses (14, cf. 9 team and 9 functional) mentioned NA responsibilities in patient care. The most commonly stated area was 'basic nursing', for example meeting patients' needs in activities of daily living. Other responses expanded NAs' area of responsibility to include "total care of the patient" (team QN) and the "personal welfare of patients" (primary QN).



TABLE 10.2 Opinions on the amount of responsibility given to nursing auxiliaries

Amount of responsibility	Primary		Team		Functional	
	Qualified Nurses (n=12)	Nursing Auxiliaries (n=12)	Qualified Nurses (n=12)	Nursing Auxiliaries (n=11)	Qualified Nurses (n=12)	Nursing Auxiliaries (n=12)
Too little	1	-	2	4	4	4
Just enough	10	11	7	6	6	7
Too much	1	-	3	-	2	1
Other	-	1	-	1	-	-

In all organisational modes, additional responsibilities in relation to patient care work were outlined. Reporting patient information to QNs and acting as go-between between QNs and patients were mentioned (5 primary and 2 functional responses), as was psychological and social care of patients (3 primary and 4 team responses).

NA responsibility in domestic duties, for example keeping the ward tidy, featured prominently in all organisational types (9 primary, 6 team and 8 functional responses).

A large number of responses, particularly from functional QNs, indicated NAs should be given a wider range of responsibilities (17, cf. 9 primary and 6 team responses). Most frequently, these were so-called 'technical' responsibilities, such as doing observations and dressings. A smaller number of responses (4 primary, 2 team and 4 functional) cited areas in which NAs should have no responsibility, for example patient care. A further three responses from functional QNs argued NAs should be given no responsibility because they are not trained or experienced enough to be given any.

**c. Qualified nurse opinion concerning the level of responsibility given to nursing auxiliaries (Table 10.2)**

Giving reasons for their response, the majority of respondents gave general statements outlining the satisfactory nature of the present situation regarding NA responsibility. For example:

Team QN:

"they [NAs] do what they are capable of - although they are supposed to do much less, they do actually take on as much as they can, so they are working within their capabilities. They won't do what they're not happy with."

Some responses (2 primary and 3 team) implied a wide remit for NAs:

Team QN:

"a lot of them [NAs] are left to their own devices, to make their own decisions."

Team and functional responses (5 team and 6 functional, cf. 1 primary) were more likely to indicate NAs were given too little responsibility:

Team QN:

"They [NAs] are not supposed to even bandage a leg. Bathing and the more mundane jobs are what they seem to get...They don't get invited to talks or seminars, yet care of the elderly is getting updated all the time. Even the computer [part of resource management project], they didn't get told about the computer, they just didn't get brought into it."

Functional QN:

"They [NAs] are not used as effectively as they could be...I think patient care could be more effective if nursing auxiliaries were given more responsibilities. I think they're just as capable as we are at looking after patients effectively."

In contrast, five team responses suggested NAs were given too much responsibility (cf. 3 primary and 3 team responses). Usually, this was seen as a result of an insufficient number of QNs. For example:

Team QN:

"Often I find you are so short staffed that you are relying upon them [NAs] to do work that they shouldn't have to do...the staff leave two auxiliaries to care for an unconscious patient in a side ward, which I don't think is right at all: it is not fair on them and it is not fair on the patient."

TABLE 10.3 Amount of direction required by and given to nursing auxiliaries

Amount of Direction	Primary		Team		Functional	
	Qualified Nurses	Nursing Auxiliaries	Qualified Nurses	Nursing Auxiliaries	Qualified Nurses	Nursing Auxiliaries
None	-	1	-	-	2	2
Small amount	4	4	6	6	6	7
Medium amount	5	6	5	2	4	3
Large amount	2	-	1	3	-	-
Other	1	1	-	-	-	-

d. Amount of direction perceived necessary for nursing auxiliaries  
(Table 10.3)

Giving reasons for their answers, many respondents gave positive statements about NA ability (5 primary, 8 team and 5 functional responses), experience and knowledge (3 primary, 5 team and 5 functional responses). NAs were described as being capable and good at their work, as doing their job properly and as being reliable in giving feedback to QNs. Their length of service was also recognised (4 team and 3 functional responses).

Primary QNs were more likely to outline ways in which direction was given (10 primary cf. 3 team and 5 functional responses). Common ways mentioned were QNs informing NAs about patients' needs and NAs consulting care plans and asking advice. The latter two are illustrated by a primary QN:

"I think they need very little prompting actually. In the morning I'll say if there is anything specific I'm looking at or they should take care of or be aware of, and there's the care plan to follow. But basically they get on and use their brain about it."

A further group of responses concerned why NAs needed direction (3 primary, 3 team and 5 functional responses). It was considered necessary to ensure NAs were providing good care, for example maintaining the patient's dignity. Other responses indicated NAs

TABLE 10.4 Necessity of supervision for nursing auxiliaries

	Primary qualified nurses (n=12)	Team qualified nurses (n=12)	Functional qualified nurses (n=12)
Supervision required	4	4	5
Supervision not required	8	8	7

required directing because they were not qualified:

Team QN:

"they [NAs] are not qualified to assess a patient...I think by just asking someone to go and help someone wash you are asking them to assess every minute that they are capable of washing themselves, [and] that their physical state hasn't suddenly changed".

#### e. Supervision

*Amount of supervision required by nursing auxiliaries (Table 10.4)*

In explaining their responses, general reasons why supervision was needed were given most frequently by primary QNs (6 responses cf. 1 team and 3 functional responses). For example, supervision was considered necessary to ensure NAs were doing their job competently. Three responses from each organisational type gave reasons why NAs needed supervision related to patient care. For example, it was required to ensure NAs were providing care needed by patients, including identifying psychological and physical needs and taking account of patients' self-care ability. The latter is illustrated by a primary QN:

"its to do with trying to slow them down a bit...they're so used to the old system where you had to be finished by lunchtime...I think sometimes they are rushing around - I don't find you get there any quicker by running around, in the end anyway, you have to slow down. Especially with bathing, you find that people are whipped in and out in the wink of an eye and then they can tend to take over *dressing a person while the patient is sitting on the wet bath seat on the hoist instead of getting the person into a comfortable chair and drying them first.*"

Six team responses (cf. 1 primary and 1 functional) outlined the detrimental effects constant supervision would have upon NAs. For example, respondents argued it would make NAs feel anxious,

intimidated and insulted, together with undermining their confidence and making them feel useless.

By far the majority of responses to this question concerned why NAs did not need supervision. These were divided into general statements (12 primary, 8 team and 11 functional responses) and statements related to patient care (3 primary, 4 team and 6 functional responses). With regard to general statements, several responses, particularly from primary and functional wards, indicated supervision was not necessary because NAs were competent to work alone. In relation to patient care, many responses stated NAs did not need supervising while performing 'basic care' duties:

Functional QN:

"If they are giving basic care you know they are doing it well."

Team QN:

"Competent nursing auxiliaries carry out basic nursing care in some cases better than qualified nurses. They have more pride in what they do and put more thought into it...Very little could go wrong with basic care tasks, there is little chance of causing harm or injury to the patient [while performing basic care]".

Three functional responses argued that supervision needed was dependent on the patient being cared for. Acute patients or patients whose condition was deteriorating required assessment, implementation and evaluation of care by a QN. The NA could, however, care for "non-acute" patients unsupervised.



TABLE 10.5 Qualified nurses' opinion on the level of supervision given to nursing auxiliaries

	Primary qualified nurses (n=12)	Team qualified nurses (n=12)	Functional qualified nurses (n=12)
Too little	1	4	3
Just about right	10	7	9
Too much	-	1	-
Other	1	-	-

*Qualified nurse opinion on the level of supervision given to nursing auxiliaries (Table 10.5)*

In giving reasons for their responses, nurses in primary and functional wards were more likely to mention NA ability and competence (8 primary, 9 functional cf. 4 team) than team QNs, but in all ward types NA experience was recognised (4 primary, 3 team and 3 functional responses).

Many more team responses suggested NAs required more supervision (9, cf. 2 primary and 5 functional responses). A shortage of QNs was cited as one reason why supervision was insufficient, but more paperwork for QNs, for example in planning and evaluating care, formed another reason why NAs were left to give direct care unsupervised.

**f. Nursing auxiliary presence at ward reports (Table 10.6)**

Whereas in primary and functional wards all QNs stated NAs were usually present at ward reports, only seven team QNs gave this response. All QNs in all organisational types believed NAs should be present. Reasons given fell into three main categories. NAs, it was argued, should be present to learn about patients, for example their condition and care needed. Functional QNs gave the most responses in this category (21 cf. 12 primary and 12 team responses). Secondly, NAs should be present to contribute to the report. Here, primary QNs gave the most responses (12 cf. 8 team and 6 functional). Below are

TABLE 10.6 Nursing auxiliary presence at ward reports

	Primary		Team		Functional	
	Qualified Nurses (n=12)	Nursing Auxiliaries (n=12)	Qualified Nurses (n=12)	Nursing Auxiliaries (n=11)	Qualified Nurses (n=12)	Nursing Auxiliaries (n=12)
Present	12	11	7	6	12	12
Not present	-	1	5	5	-	-

two examples:

Primary QN:

"[NAs] could bring up some topics or aspects of discussion which might benefit the care of the patient that we hadn't realised,...they can also suggest various approaches which we might not have thought of."

Team QN:

"Ward reports are discussions as well as anything else...[NAs] can often add a lot to the report, if they've been with the patient all morning. If they've had contact with the patient often the patient has told them things that we haven't heard."

The final category of responses concerned the positive effect of NA inclusion on team spirit and NA morale. This was frequently mentioned in all organisational types (6 primary, 8 team and 8 functional responses).

#### g. Summary - qualified nurse perspectives

The role of the NA as intermediary and as supporter or assistant to the QN appears mainly in primary and functional responses respectively. Furthermore, the function of the auxiliary in relation to patients is elaborated prominently by primary and functional but very little by team QNs. While no primary QN argued that NAs should have their duties expanded, two team and two functional QNs stated that the role should be extended to incorporate 'technical' tasks. While this viewpoint is in line with that of functional ward sisters, it is at odds with the majority of ward sisters from team wards.

When asked what responsibility should be given to NAs, while primary QNs emphasised patient care, functional responses were more likely to indicate a wider range of responsibilities which should be given and

team QNs to argue for a more limited NA role. This accords with the views of team and functional ward sisters. Following the same trend, the majority of primary QNs believed NAs were given the right amount of responsibility, whereas four functional QNs believed they received too little and three team QNs too much.

Like primary ward sisters, primary QNs were more likely than their team or functional counterparts to outline ways in which NAs were directed.

The majority of QNs in all organisational modes believed NAs did not require supervision while providing patient care. Those who indicated it was required stated that intermittent supervision was sufficient. As with direction, primary QNs were more likely to give reasons why supervision was required, while team QNs were more likely to outline the detrimental effects constant supervision would have. Primary and functional QNs indicated most frequently that NAs were competent in their work.

The majority of QNs regardless of organisational type believed the level of supervision given to NAs to be just about right. However, team and functional QNs were more likely to argue NAs did not receive enough supervision. Team QNs were also more likely to outline reasons why NAs did not receive the level of supervision perceived as required.

To further determine the status and function NAs within the ward team, QNs were asked about the presence and function of NAs in the ward report. QNs from all organisational modes considered it

necessary for NAs to be present. While functional QNs emphasised this was so that NAs could learn about patients, primary QNs stressed the contribution NAs could make to the report. QNs from all forms of nursing organisation viewed NA presence as contributing to 'team spirit' and NA morale.

### 3. NURSING AUXILIARY PERSPECTIVES

#### a. Part played by nursing auxiliaries in providing patient care

Several NAs prefaced their answers with a general statement summing up their role. These are summarised in Table 10.1. Primary and team NAs were more likely to state that they played a big part in patient care and an integral role in the ward team.

In line with QN responses, NAs in all organisational modes outlined their role in relation to that of the QN. NAs most commonly described their role as an assistant, helper or supporter to QNs (4 primary, 4 team and 2 functional responses), but two primary and one functional NA also mentioned an intermediary role in passing information from patients to QNs. This second role is described as important because it is the NA who provides much of the 'hands on' care:

#### Primary NA:

"When you are washing somebody and you see little bruises appear and shouldn't, little things, a rash or...which your trained member of staff would see if she was doing the job, but you're doing it so she needs you to pass everything on that you can, even if it is irrelevant".

Many more NAs described their role in terms of patients, particularly their relationships with them (13 primary, 12 team and 30 functional responses). Most commonly mentioned was helping patients wherever possible and meeting their needs. Talking and listening to patients and making sure they were happy and/or comfortable were also frequent responses, the latter particularly in functional wards. Functional NAs also saw their role as being a friend to patients:

"The patients look at you as a nurse anyway, as a friend and as a confidant...Few of the patients have any visitors and you've got to be able to give them individual care...just being there when you're needed, for whatever you're needed".

Some NAs (2 primary and 1 functional) regarded themselves as having better relationships with patients than QNs:

"we have more personal dealings with [patients]. We talk to them more. They even confide in the auxiliaries more than the trained staff...They just see the trained [staff] as more important people and us as, you know,... we're sort of inbetween them and the patients,...so they trust us more I should think, because we spend much more time with them, and build up a big relationship with some of them".

Specific patient care duties were mentioned as part of the NAs' role in a large number of responses (8 primary, 11 team and 10 functional responses). Most frequently mentioned was 'basic care', for example meeting patients' hygiene, elimination and dietary needs. Two NAs in each organisational mode stated that domestic work, such as cleaning, formed part of their work.

**b. Ways in which nursing auxiliaries' job the same as qualified nurses' job**

Primary and team NAs were more likely to give general statements indicating shared aims and goals of patient care (5 primary and 6 team cf. 2 functional responses). For example, one team NA stated: "we are all there for the good of the patient. Our aims are all the same". Primary NAs were also more likely to indicate similarities in the areas of assisting patients with activities of daily living (12 responses, cf. 5 team and 8 functional), administration and 'technical' nursing.

**c. Ways in which nursing auxiliaries' job different to qualified nurses' job**

In all organisational modes the most commonly mentioned differences were in 'technical' aspects, for example medications and observations, and administrative and managerial aspects, such as writing care plans and running the ward. As a result of this, QNs were seen by some team NAs as doing "all the interesting work", leaving NAs to "just see to the patients" and do all the "hard" and "dirty" work. Contact with relatives was seen as the sole province of QNs, particularly by functional NAs. As one NA said, "if someone dies, you just make the tea".



#### d. Responsibility

##### *Responsibility given to nursing auxiliaries in the ward*

Team and functional NAs were more likely to state that they were given none or not a lot of responsibility (5 team and 6 functional, cf. 2 primary responses). More primary than team or functional responses indicated that NAs saw patient care and well-being as their responsibility (13 responses, cf 4 team and 9 functional responses).

The following are examples from primary NAs:

"you've got people's quality of life in your hands,...and if you don't notice something then somebody could be in pain or suffering because of your lack of notice."

"we are responsible for looking after our own patients...[including] making sure their care gets passed on when you go off duty."

NAs in primary and functional wards were more likely to view patients' activities of daily living as their responsibility (18 and 16 responses respectively, cf. 6 team responses). This included not only dressing, feeding, walking and toileting patients, but also, for example, making sure patients were well dressed and knowing what patients were capable of with regard to self-care.

Three primary and six functional responses mentioned the responsibility of the NA in the psychological well-being of patients, as the following quotations illustrate. No team NA mentioned this.

Primary NA:

"I believe in physical love, cuddling love, you know, to put my arms around them and hold them, physical contact, I think its important. They need that assurance that you're there to help and assist, and you'll always be there."

Functional NA:

"[I am responsible for] making someone feel at home and as happy as I can".

Team NAs were more likely to mention domestic and environmental work as their responsibility (12 responses cf. 5 primary and 6 functional responses), for example keeping the sluice tidy and putting away laundry.

*Nursing auxiliary views on level of responsibility (Table 10.2)*

Giving reasons for their answers, team and functional responses were more likely to indicate that NAs would like more responsibility (8 team and 6 functional cf. 1 primary). The majority of responses stated that more responsibility was requested in so-called 'technical' aspects of care, such as dressings and observations. Writing in the 'kardex' and care plans was also mentioned. NAs frequently argued that these constituted major responsibilities. For example:

Team NA:

"Sister gives you little responsibilities but makes you feel like you've got a big responsibility, for example making dates for the trip. Big responsibilities are doing care plans and drugs, but that's not in our league."

TABLE 10.7 Nursing auxiliary satisfaction with level of direction

Satisfaction level	Primary nursing auxiliaries (n=12)	Team nursing auxiliaries (n=11)	Functional nursing auxiliaries (n=12)
Very satisfied	4	1	4
Satisfied	8	7	7
Neutral	-	-	-
Dissatisfied	-	1	1
Very dissatisfied	-	-	-

Ten primary and eight functional responses indicated primary NAs would not like more responsibility, in contrast to only four team responses.

**e. Direction**

*Level of direction given*

Table 10.3 shows level of direction given, and Table 10.7 satisfaction with direction given.

Primary and functional NAs gave more positive statements than team NAs (9 primary and 6 functional cf. 2 team responses). Several primary NAs stated they were happy with a medium or small amount of direction because they cared for the same patients every day. Functional NAs indicated their satisfaction in statements such as "they [QNs] tell you what you need to know" and "it is there if you need it".

Three team responses stated that NAs would like more direction. Only one primary NA gave this response, and argued that she only required more direction when not working with patients belonging to her primary nurse group. Team responses indicated a more fundamental problem:

"when you are working with the patients...you are running backwards and forwards asking the staff nurse 'do you think I should do this or do that' instead of it being explained, so you have got to go feeling your way about from patient to patient. You are never sure what you should be doing and what you shouldn't."

TABLE 10.8 Amount of supervision received by nursing auxiliaries

Amount of supervision	Primary nursing auxiliaries (n=12)	Team nursing auxiliaries (n=11)	Functional nursing auxiliaries (n=12)
None	5	6	8
Small amount	6	3	4
Medium amount	-	2	-
Large amount	-	-	-
Other	1	-	-

TABLE 10.9 Nursing auxiliary level of satisfaction with supervision

Satisfaction level	Primary nursing auxiliaries (n=12)	Team nursing auxiliaries (n=11)	Functional nursing auxiliaries (n=12)
Very satisfied	8	2	7
Satisfied	4	5	5
Neutral	-	2	-
Dissatisfied	-	-	-
Very dissatisfied	-	2	-

Several responses, particularly from functional NAs (13 cf. 8 primary and 4 team responses) suggested a lot of direction was not required because of NAs' competence and experience. Examples are given below:

**Functional NA:**

"they [qualified staff] realise I know what I am doing now...I feel I don't need any real direction. If I did it would be given."

**Primary NA:**

"they [qualified staff] know you can do whatever, you know the patients' needs...they can just give that responsibility and know that you will be able to cope with it."

Primary NAs were more likely (17 responses cf. 5 team and 7 functional responses) to mention ways in which direction was given. Examples were asking QNs for instructions and reading patient care plans.

**f. Supervision**

*Amount of supervision given when carrying out patient care and satisfaction with it (Findings are shown in Table 10.8 and 10.9 respectively)*

Primary and functional NAs were more likely to give positive statements in explaining their level of satisfaction (9 primary and 6 functional, cf. 2 team responses) Commonly, respondents said QNs were always there to ask if they needed advice, but did not watch them constantly.

NAs from all organisational types (3 team, 2 functional and 1 primary response) argued there was no need for QN supervision during the

performance of 'basic care' tasks. One reason is illustrated below:

Primary NA:

"I'd rather get on myself, I can do things better myself. When I've looked after the group on my own in the morning I've got them up and dressed them all a lot quicker than having someone else with me."

Other responses (3 primary, 1 team and 2 functional) gave reasons why NAs did not want supervision in the form of QNs being constantly with them. NAs believed this would offend them and imply they were not trusted or capable of working alone. One primary and three functional responses gave reasons why two people present would be detrimental to patient care: it would be too impersonal for the patient, prevent the encouragement of self-care and mitigate against the development of nursing staff-patient relationships:

Functional NA:

"I like to be on a one to one basis, and it gives the patient more confidence, they feel more secure."

As with direction, several NAs, particularly from functional wards (13 responses cf. 8 primary and 4 team), stated not much or no supervision was required because of NA experience and competence. Two team NAs, however, indicated more would be a positive advantage. One viewed the ideal situation to be QNs and NAs working together, while the other believed NAs to be sometimes neglected, and "just expected to get on with it".

TABLE 10.10 Amount of information given to nursing auxiliaries about patients' physical condition

Amount of information	Primary nursing auxiliaries (n=12)	Team nursing auxiliaries (n=11)	Functional nursing auxiliaries (n=12)
None	-	-	-
Small amount	-	5	1
Medium amount	4	4	6
Large amount	8	2	5

TABLE 10.11 Nursing auxiliary satisfaction with information given about patients' physical condition

<i>Satisfaction level</i>	Primary nursing auxiliaries (n=12)	Team nursing auxiliaries (n=11)	Functional nursing auxiliaries (n=12)
Very satisfied	5	-	2
Satisfied	6	5	9
Neutral	1	2	1
Dissatisfied	-	4	-
Very dissatisfied	-	-	-



**g. Sharing information with nursing auxiliaries**

*i. Ways in which nursing staff share information*

The most common means of information transfer cited was the ward report. Also frequently mentioned were informal conversations about patients and NAs requesting information from QNs. Consulting patients' nursing notes was mentioned in six primary and eight team but only three functional responses

*ii. Presence at ward reports (Table 10.6)*

All functional and 11 primary NAs stated they were present at ward reports, compared with seven team NAs. All NAs with the exception of one team NA believed they should be present. For the majority, this was to learn about patients. Very few responses (2 team and 2 functional) mentioned the reason for NA attendance in terms of contributing to reports. Five team responses (cf. 1 primary and 1 functional) argued that inclusion of NAs fostered good team spirit.

*iii. Amount of information given to nursing auxiliaries about patients' physical condition and satisfaction with it (Findings are presented in Tables 10.10 and 10.11 respectively)*

When giving reasons for their level of satisfaction, the largest number of positive statements were given by primary NAs (7 responses cf. 4 team and 5 functional). Examples are:

Team NA:

"I get as much as I need."

TABLE 10.12 Amount of information given to nursing auxiliaries about nursing care needed by patients for their physical needs

Amount of information	Primary nursing auxiliaries (n=12)	Team nursing auxiliaries (n=11)	Functional nursing auxiliaries (n=12)
None	-	-	-
Small amount	-	4	2
Medium amount	2	4	6
Large amount	10	2	4
Other	-	1	-

TABLE 10.13 Satisfaction with amount of information given to nursing auxiliaries about nursing care needed by patients to meet their physical needs

Satisfaction level	Primary nursing auxiliaries (n=12)	Team nursing auxiliaries (n=11)	Functional nursing auxiliaries (n=12)
Very satisfied	6	1	2
Satisfied	6	5	9
Neutral	-	1	1
Dissatisfied	-	3	-
Very dissatisfied	-	1	-

Primary NA:

"they give you all the information you want - when a new patient comes on the ward you want to know about them before so you can give them the best care."

Six team responses (cf. 3 primary and 3 functional) indicated NAs would like more information about the patients' physical condition.

Some team NAs held strong views on this:

"[if we were told], say if a patient was really deaf or had had a stroke, we wouldn't think the patient was lazy and would understand why they couldn't do things for themselves. [Not knowing] makes us quite ignorant in a way."

Several NAs, particularly in primary wards (11 responses cf. 3 team and 6 functional), believed it was also up to NAs to find out information, for example by reading care plans and medical notes.

*iv. Amount of information given about nursing care needed by patients for their physical needs and satisfaction with it (Findings are presented in Tables 10.12 and 10.13 respectively)*

In explaining their answers, positive statements were more likely to be given by primary and functional NAs (8 primary and 9 functional responses). Again, more team responses indicated NAs wanted more information about patients' nursing care needs:

Team NA:

"they [qualified staff] never seem to have the time, I don't know why. We have to ask all the time."

TABLE 10.14 Amount of information given to nursing auxiliaries about patients' psychological needs

Amount of information	Primary nursing auxiliaries (n=12)	Team nursing auxiliaries (n=11)	Functional nursing auxiliaries (n=12)
None	1	2	-
Small amount	3	6	5
Medium amount	2	3	6
Large amount	6	-	1

TABLE 10.15 Nursing auxiliary satisfaction with information given about nursing care needed by patients to meet their psychological needs

Satisfaction level	Primary nursing auxiliaries (n=12)	Team nursing auxiliaries (n=11)	Functional nursing auxiliaries (n=12)
Very satisfied	4	-	1
Satisfied	6	3	6
Neutral	1	-	5
Dissatisfied	-	7	-
Very dissatisfied	-	1	-
Other	1	-	-

NAs frequently mentioned finding out about nursing care needs for themselves, for example by asking QNs and reading patient care plans.

Patients were a further source of information:

Functional NA:

"If you get a new patient you leave them to do as much as they can rather than do them, see what they can do, then pass on that information for the next report."

*v. Amount of information given about patients' psychological needs and satisfaction with it (Findings are presented in Tables 10.14 and 10.15 respectively)*

In explaining their answers, again most positive statements were given by primary NAs (6 responses cf. 3 team and 4 functional). One primary NA mentioned the continuity of patient allocation found in primary nursing, which, in her view, facilitated knowledge of patients' psychological needs. Seven team responses (cf. 0 from primary and functional NAs) stated more information was required. Five team responses (cf. 1 primary and 1 functional) described the benefits of knowledge about this aspect of patient care, for example being able to approach patients in an appropriate manner:

Team NA:

"[qualified staff] sometimes forget that the patient's wife might have just died and you don't know it and you just go barging in...and get talking to him and saying 'are you married and have you got any family' and his wife's just died a couple of weeks ago."

Again, NAs on primary and functional wards particularly said they found this information out for themselves by, for example, asking QNs and assessing patients' mental state as they cared for them.

TABLE 10.16 Staff member who most frequently advised nursing auxiliaries concerning "basic care" problems

Staff member	Primary nursing auxiliaries (n=12)	Team nursing auxiliaries (n=11)	Functional nursing auxiliaries (n=12)
Ward sister or nurse in charge	4	4	11
Other qualified nurse	7	2	1
Other	1	5	-

**h. Staff interactions**

*i. Staff member who most frequently advised nursing auxiliaries concerning basic care problems (Table 10.16)*

The 'Other' option applied for five team NAs. Of these, three said they most frequently asked advice from their team leader; one asked advice from the person she was working with and for the final NA who she consulted was determined by the problem.

*ii. Grade of staff most frequently working with nursing auxiliaries (Table 10.17)*

Those choosing the 'Other' option explained that work partner depended on the time of day. For example, one team NA stated that during the day she worked with either a QN or a learner but in the evenings the QN stayed in the office so she then worked with a learner.

*iii. Grade of staff nursing auxiliaries would prefer to work with (Table 10.18)*

A variety of reasons were given by NAs in all types of ward why they preferred working with a QN. For example, NAs could ask questions about their work and QNs would ensure NAs were giving patients correct care.

Five team responses outlined why an NA was the ideal work partner. One reason was that NAs perform the same tasks. Other responses

TABLE 10.17 Grade of staff most frequently worked with by nursing auxiliaries

Grade of staff	Primary nursing auxiliaries (n=12)	Team nursing auxiliaries (n=11)	Functional nursing auxiliaries (n=12)
Nursing auxiliary works alone	9	7	3
With qualified nurses	3	-	-
With nursing auxiliary	-	2	6
Other	-	2	3

TABLE 10.18 Grade of staff nursing auxiliaries would prefer to work with

Grade of staff	Primary nursing auxiliaries (n=12)	Team nursing auxiliaries (n=11)	Functional nursing auxiliaries (n=12)
Ward sister	2	-	-
Other qualified nurse	4	6	5
Nursing auxiliary	-	4	1
No preference	6	1	6



suggested two NAs were more efficient at 'getting through the work':

"We work together well, get on with the work and get it done. You don't feel any minute you're going to be on your own because they're not going to get called off to do medicines etc."

Two team NAs viewed the enrolled nurse as the preferred partner because she was "one step up from a NA", and did not look down on them, as did staff nurses. Two primary NAs, on the other hand, most preferred working with the ward sister.

#### I. Summary - nursing auxiliary perspectives

Primary and team NAs were more likely than functional NAs to preface a description of their role by stating the large part they play in patient care and their integral role in the ward team. Like QNs, NAs described their role in terms of assisting and supporting QNs, and, to a lesser extent, as one of intermediary. Again as with QN responses, NAs in all organisational types frequently described their role in relation to patients, particularly their relationships with them. Functional NAs gave most responses in this area, and team NAs articulated their role in relation to patients to a far greater extent than team QNs. Both QNs and NAs in all organisational types mentioned 'basic care' most frequently as a patient care duty performed by NAs.

Primary and team NAs were more likely to describe similarities in role with that of QNs and indicate shared aims and goals of care. Primary NAs described more similarities with regard to activities of daily living, and also mentioned more similarities in administrative and 'technical' nursing fields. While NAs in all organisational

modes viewed QNs as more involved with 'technical', administrative and managerial work, team NAs were more likely to interpret this in a negative manner.

Approximately half the sample of NAs in team and functional wards believed they were given none or not a lot of responsibility. This was in contrast to primary NAs, only two of whom gave this response. Mirroring QN responses, primary NAs were more likely to view patient care and well-being as being their responsibility. Few team responses indicated this was the case. Similarly, NAs in primary and functional wards were more likely to argue that assisting patients in activities of daily living was their responsibility, and to emphasise the NAs' role in patients' psychological well-being. Team NAs, on the other hand, were more likely to mention maintaining the environment and domestic work. Both team and functional NAs argued most frequently that they would like more responsibility, particularly in 'technical' and administrative fields. In contrast, all primary NAs believed the level of responsibility they were given was sufficient.

In their views on direction, primary and functional NAs are again similar, and team NAs dissimilar. Primary NAs more frequently recorded a medium amount of direction in contrast to the small amount received by the majority of team and functional NAs. However, primary and functional NAs were more likely to be satisfied with their level of direction and express positive statements to this effect. Again, NA responses echoed those of the ward sister. More team responses indicated more direction was desired, whereas functional NAs were more likely to argue against the need for

direction because of their competence and experience. Primary NAs gave more examples of ways in which direction was given.

A larger number of NAs from functional wards said they received no supervision at all. Two team NAs stated they received a medium amount, but no primary or functional NA believed they were supervised to this extent. Again, differences are apparent between primary and functional NAs on one hand and team NAs on the other. The majority of primary and functional NAs were very satisfied with the level of supervision, whereas team NAs were more likely to consider themselves neutral or very dissatisfied, and to give reasons why a greater level of supervision would be advantageous. Again, NA responses were akin to those given by ward sisters and QNs in each organisational mode.

While all NAs with the exception of one believed they ought to be present at the ward report, five team NAs stated they were not. The majority believed they should be present to learn about patients. In contrast to QN responses, very few NAs mentioned NAs as contributors. Of these responses, none were from primary NAs. Team NAs were more likely to mention the generation of team spirit as a function of the report.

NAs were asked about the information they were given about patients to equip them to care for them. With regard to information given about patients' physical condition and nursing care needed by patients to meet their physical and psychological needs, primary NAs stated they received the most information, and were the most satisfied. Team NAs received the least information and were the least satisfied, particularly with information given about patients'

FIGURE 10.1 The role of the nursing auxiliary

	Primary		Team		Functional	
	Qualified Nurses	Nursing Auxiliaries	Qualified Nurses	Nursing Auxiliaries	Qualified Nurses	Nursing Auxiliaries
Role of Nursing Auxiliaries in ward team	Described in relation to patients	Described in relation to patients Specific patient care duties		Described in relation to patients Specific patient care duties	Described in relation to patients	Described in relation to patients Specific patient care duties
Ways in which Nursing Auxiliaries' job same as Qualified Nurses' job		1. Shared aims and goals patient care 2. Assisting patients with activities of daily living 3. Administration 4. "Technical Nursing"		Shared aims and goals of patient care		
Ways in which Nursing Auxiliaries' job different		"Technical Nursing"		"Technical Nursing"		"Technical Nursing"
Responsibility which should be/is given to Nursing Auxiliaries	1. Following qualified staff instructions 2. Patient care 3. Psychological and social care of patients 4. Domestic duties	1. Patient and well-being 2. Activities of daily living 3. Psychological well-being of patients	1. Nursing Auxiliary responsibility should be more limited 2. Psychological and social care of patients 3. Domestic duties	1. Given none or not a lot of responsibility 2. Domestic and environmental work	1. Following qualified staff instructions 2. Domestic duties 3. Nursing Auxiliaries should be given wider range of responsibilities	1. Given none or not a lot of responsibility 2. Activities of daily living 3. Psychological well-being of patients
Opinion regarding current level of nursing auxiliaries responsibility			More likely to suggest Nursing Auxiliaries given too much responsibility	Would like more responsibility		Would like more responsibility
Direction	1. Positive statements about Nursing Auxiliaries' ability 2. Ways in which direction given outline	1. Positive statements about direction given. 2. Ways in which direction given outlined	Positive statements about Nursing Auxiliaries' abilities	More likely to state more direction required	Positive statements about Nursing Auxiliaries' ability	1. Possible statements about direction given 2. Not much direction needed because of Nursing Auxiliaries' competence.
Supervision	1. More likely to give reasons why Nursing Auxiliaries need supervision 2. More likely to mention Nursing Auxiliaries' ability and competence	More likely to give positive statements about supervision given	1. More likely to outline detrimental effects of constant supervision 2. More likely to state Nursing Auxiliaries require more supervision		More likely to mention Nursing Auxiliaries' ability and competence	1. More likely to give positive statements about supervision given 2. More likely to mention Nursing Auxiliaries' ability and competence
Presence at ward reports	1. More likely to state Nursing Auxiliaries should be present to contribute to report. 2. Important for "team spirit"	Presence necessary to learn about patients	Important for "team spirit"	1. Presence necessary to learn about patients 2. Important for "team spirit"	1. More likely to state Nursing Auxiliaries should be present to learn about patients. 2. Important for "team spirit"	Presence necessary to learn about patients

psychological needs. Functional NAs fell inbetween the two. Furthermore, primary NAs were more likely to consider it important to find out information for themselves about patients' physical condition.

In order to tap grade formations and structures when completing nursing work, NAs were asked who they worked with most often and also who they would prefer to work with. NAs from primary and team wards responded most commonly that they worked alone. Functional NAs, on the other hand, named another NA as the most common partner. When asked who they would like to work with, half the NAs on primary and functional wards did not express a preference. Of team NAs, however, only one gave this response, and half named a QN as the ideal partner.

#### 4. DISCUSSION

Findings are summarised in Figure 10.1. The role and function of NAs, as perceived by ward sisters, QNs and NAs themselves, was found to vary considerably depending on whether primary, team or functional nursing was practiced.

Findings from interview data show opinion regarding team NAs to differ from that of primary and functional NAs in several respects. Specifically, team NAs appeared to be regarded by ward sisters and QNs as present only because an all-qualified staff was impossible given staff budgets. As a corollary, their contribution appeared not to be greatly valued. While team NAs considered themselves to have

an important role in relation to patients, very few team QNs endorsed this. Also, while several primary and functional NAs believed assisting patients with activities of daily living to be their responsibility, as well as providing psychological care, team NAs were more likely to list domestic and environmental work as within their remit.

Other examples from interview findings illustrate the status of NAs in team wards. While in primary and functional wards QNs largely believed NAs were competent to work alone, in team wards they were generally considered to require a greater level of supervision and direction. Team NAs were frequently not present at ward reports, and consequently were the most dissatisfied both with information received about patients and 'team spirit', which they felt was negated by their exclusion.

While viewpoints on the role and function of primary and functional NAs were similar in many respects, it is argued this is due to quite different underlying philosophies. In functional wards, activities which took up the majority of NAs' time, so-called 'basic care', were considered simple tasks not requiring skill. This was evidenced, for example, in functional QNs' belief that post-basic training was not necessary in care of the elderly, as patients require only 'basic' nursing. As such, 'basic care' tasks were considered well within the remit of the competent NA, who could complete them with the minimum of instruction, supervision or direction. Indeed, NAs were considered by the majority of qualified staff, as well as by NAs themselves, as capable of extending their role to tasks generally labelled 'technical'.

In primary wards, on the other hand, so-called 'basic' care was considered an integral part of patients' total care and was viewed as valuable and requiring skill. While primary QNs were more likely to outline NA responsibilities in patient care, this was considered appropriate and important work, rather than work undertaken by NAs by default (as in team wards) or simple work most suited to the least skilled, i.e. NA, grade (as in functional wards). Furthermore, the NAs' role was not defined in terms of tasks, but within the context of the ward philosophy and in relation to other staff members comprising the ward team. The structures of primary nursing, then, appeared to facilitate appropriate supervision and direction, and indeed primary QNs were more likely to outline how the latter operated. Perhaps as a result of the value placed on NA work as an integral part of the primary nursing team, neither primary QNs or NAs believed NAs should have their role extended.

These findings are discussed more extensively in Chapter 11.

## CHAPTER 11 CONCLUSION AND RECOMMENDATIONS

The aim of this chapter is to draw together the main findings of the study, consider them in the light of methodological shortcomings and discuss the implications of these for further research and practice.

### 1. Describing the organisation of nursing care

The way in which nursing staff are organised to provide patient care has assumed increasing importance in recent years. The mode of care provision known as primary nursing has received the most attention. Forming part of the professionalising ideology of the 'new nursing' (Salvage, 1990), primary nursing is seen as providing the means for nurses to demonstrate the value of specifically nursing practice in terms of its effects on patients and nursing staff. However, while there is a wealth of USA studies comparing primary nursing with other forms of nursing organisation, and similar studies are beginning to proliferate in the UK (e.g. Pearson et al, 1988; Manley, 1989; Bond et al, 1990), studies are characterised by a lack of operational definitions detailing how primary nursing is actually practiced. As this represents a first step in matching and discriminating between organisational modes, to date it is impossible to identify which aspects of nursing structure and process result in which outcomes for nursing staff or patients, or to establish logically or philosophically which outcomes identified are the product of a particular organisational mode (Giovannetti, 1986).



This study used organisational mode as the independent variable. Previous attempts to assess the effect of staff organisation on dependent variables are found in the UK literature. Berry and Metcalf (1986), for example, compared task with patient allocation, Hawthorn (1984) task-oriented and patient-oriented nursing and Miller (1985b) compared individualised and routinised care. However, these studies do not adequately define the independent variable and are confined to single wards in a before-after design, thus limiting their generalisability. To increase methodological rigour, the present study selected wards according to pre-defined organisational criteria. To this end, a questionnaire was developed which represents a first attempt to identify wards organised according to the principles of primary, team and functional nursing. The questionnaire was largely concerned with the operational features of organising nursing staff. It was able to discriminate between wards using different methods of organising nursing, and was validated using ward sister interview data and observation of the work of nursing staff.

The first major finding obtained from the small sample in this study is the difficulty encountered in matching wards to a specified set of criteria depicting different types of organisation and consequently finding a suitable number of wards representative of each method to permit comparisons to be made between them. The variation in responses, indicative of the absence of discrete types, also suggests the adoption of research methods which can take account of this variety.

## 2. Comparing the work of qualified nurses and nursing auxiliaries in primary, team and functional nursing wards

Regardless of dependent variable, the most important differences were found across organisational modality, with QNs and NAs within organisational modalities engaging in similar patterns of work, verbal interactions with patients and regarding their work environment similarly.

### Summary of major findings

Nursing staff in primary wards were found to spend a greater amount of time in fundamental patient care and communication, together with less time in supplementary patient care and staff activities (the latter particularly in the afternoon session) than their team and functional counterparts. Team and functional subjects, on the other hand, spent more time with patients in domestic and administrative activities. With the exception of time spent in supplementary patient care, differences were not attributable to staffing levels.

Turning to verbal interaction with patients, both QNs and NAs in primary wards spent more time giving patients choice and offering general explanations about care, the latter particularly in the morning and afternoon observation sessions. In the afternoon session, a larger proportion of time was spent seeking verbal feedback from patients in primary wards. Staffing levels were found to affect the amount of time spent asking patients questions and giving choice, but did not affect the latter in the morning session.

QNs were found to give more detailed explanations about care to patients than NAs in all organisational modes. However, overall patients received a greater amount of verbal interaction from NAs, occasioned by the greater amount of time spent with patients by this staff grade.

Both QNs and NAs in primary wards were found to view their work environment differently to their team and functional counterparts, but QNs and NAs within each organisational mode perceived their work environment similarly.

Overall, neither QNs nor NAs across organisational modes differed significantly in their therapeutic orientation as measured by Kitson's TNFI. In primary wards, however, there was a greater investment in training and teaching for both QNs and NAs.

These findings suggests a culture exists within each organisational mode which permeates the work of both grades of staff. Primary wards were generally found to differ from team and functional wards, with the latter two organisational types exhibiting greater similarities than differences. The following are tentative explanations for these findings.

## Implications of organisational mode

### a. *For nursing practice*

In primary wards, a well-articulated philosophy of care underpinned work practices. The predominant philosophy, as described by ward sisters, was one of providing "holistic and individualised care" through continuity of nurse-patient allocation. As one primary ward sister said, the aim was "to give individualised care in partnership with the patient". A further primary ward sister described nursing the elderly as providing "an avenue for holistic nursing". Because of this emphasis, patients were viewed as whole people, rather than as objects on whom a whole series of tasks had to be performed.

While terms such as 'holistic' and 'individualised' care could be meaningless jargon bearing no relationship to reality, in primary wards their interpretation was in evidence in the work practices and viewpoints of both grades of staff. One example of this was a lack of distinction between 'basic' and 'technical' tasks. Hence both QNs and NAs gave care to their group of patients in order to meet their individual needs, rather than dividing work into 'basic' and 'technical', and these being performed by NAs and QNs respectively. As so-called 'basic' care was an integral part of the patients' total care, it was viewed in primary wards as valuable and requiring skill.

### b. *For nursing auxiliaries*

The 'holistic' view of the patient and resultant opinions regarding the status of 'basic care' found in primary wards had important

implications for the work and work perceptions of NAs. The NA role was defined by ward sisters within the context of organisational mode and ward philosophy. With regard to the former, NAs were there to "support" primary and associate nurses. In terms of ward philosophy, in the opinion of one primary ward sister, NAs were

"very valuable,...because they understand the philosophy and the multidisciplinary team approach."

A further ward sister emphasised the importance of NAs being "attuned to the way in which you want care to be given". Perhaps as a result of this role definition and integration into the 'team', NAs perceived greater clarity in their work than their team and functional counterparts.

As a consequence of the definition of the NA role in terms of ward philosophy and organisation rather than in terms of tasks, no primary QN believed NAs should be given more 'technical' tasks, in contrast to team and functional QNs. Again, while team and functional QNs largely believed NAs should be given more responsibility (usually in the form of 'technical' tasks) and NAs concurred with this viewpoint, as both grades in primary wards believed fundamental patient care constituted an important responsibility, no grade believed more was required.

From observational data, QNs in primary wards were found to spend more time with patients in fundamental patient care than their team or functional counterparts. This served not only to emphasise the value of 'basic care', but also provided a role model for NAs and

often served as a teaching exercise. The latter is illustrated in the following fieldnote extract:

[NA Julie asked primary nurse Fiona if she had noticed the legs of the patient whom they were helping with morning care.]

Fiona: Its cellulitis she's got, which is fluid on her legs. We can't put stockings on her because the fluid may then overload her heart.

Primary NAs were correspondingly more likely than their team and functional counterparts to list activities of daily living as an area in which their job was the same as QNs. Fundamental patient care was viewed by primary NAs not as work to be 'got through', but as valuable work and as a means of meeting individual patients' needs. As one NA said:

"It is important to do every bit right and care for them [patients]. Everything is important, no matter what you're doing, if its taking them to the toilet or giving them their teeth in the morning, its all important to them as people."

In team and functional wards, on the other hand, both QNs and NAs were very conscious of the distinction between 'basic' and 'technical' work. NAs were delegated the former, and as a corollary it was viewed by them as of low status. As one functional NA said,

"I don't think we should have been regraded, we don't do anything, just basic care."

This view was shared by QNs also, as a conversation between a functional QN and a NA shows:

QN: "It wasn't so bad when you were on surgery, but on here you don't need to use your brain."

NA: "Its pretty mindless work, really."

Thus, despite stating they were responsible for activities of daily living, most functional NAs believed they were not given a lot of responsibility.

A second corollary was viewing patients as work-objects on whom a series of tasks had to be performed, at a time dictated by routine. Some examples are given by NAs:

[one NA to another, functional nursing ward] "Shall we start shoving them to the tables for lunch?"

[Team ward. On return from break, learner nurse asked NA what was left "to do"]  
NA: "Just the shaves".

The following are suggestions why fundamental patient care was viewed as of low status. In functional wards, ward sisters considered 'basic care' tasks not to require, in the words of one ward sister, "trained nursing input". All functional ward sisters further believed that limiting NAs to these tasks meant they were under-utilised. Secondly, if qualified staff demonstrated which tasks they considered important by what they spent their time doing, functional QNs spent the least time in fundamental patient care and the most time performing 'technical' nursing tasks when compared with their primary and team counterparts. Thus, functional QNs were least likely to serve as a role model in fundamental patient care or work with NAs in order to teach skills involved in meeting patients' basic needs. Indeed, NAs were most likely to work with another NA. Not surprisingly, then, NAs in functional nursing wards viewed their job as least like a QN's job, as indeed this was the case.

Team, unlike functional, ward sisters viewed fundamental patient care as requiring skill, and in the opinion of one ward sister this ideally should not be within the remit of NAs. While both team ward sisters and QNs held more positive views regarding the status of 'basic care', this was reflected to a lesser extent than in primary wards in what QNs spent their time doing. As in functional wards, then, team QNs infrequently served as a role-model for NAs in the arena of fundamental patient care.

Thus, while team QNs recognised the importance of fundamental patient care, this viewpoint did not filter down to NAs, who viewed 'technical' aspects of care as constituting highly valued and 'major' responsibilities.

Furthermore, team NAs appeared the least satisfied with their role and status within the ward structure, in particular with the information they were given to enable them to care for patients. This finding reflects the ward sisters' view of NAs as there simply because the budget did not extent to an all-qualified staff. NAs were frequently excluded from ward reports, which, in their view, not only served as a barrier to finding out about patients but as negating the development of 'team spirit'. Benefits commonly associated with team nursing, such as in-depth knowledge of a smaller number of patients, did not, therefore, extend to NAs. Indeed, the structure of team nursing appeared to generate an element of competition between NAs, revolving around the speed with which they completed their 'work'. This is illustrated in the following



fieldnote extract:

While making Thelma's bed, Laura [NA] discussed with Theresa [nursing student] what was "still left to do. We're a bit behind today, mind you the other team's still got four [left to do]".

This could explain the greater work pressure experienced by team NAs compared with their primary and functional counterparts. Functional NAs, on the other hand, while viewed by the ward sisters as there to perform 'low level' tasks, were valued for their ability to do this.

*c. For nursing auxiliary training*

Perhaps because NAs were considered to have an important role and because fundamental patient care, the activity occupying the majority of NA time, was believed to require skill, there was a greater investment in NA training in primary compared with team and functional wards both on a formal and an informal basis. In one primary ward, both QNs and NAs attended an Open University care of the elderly course, run by the ward sister. This covered such aspects as patients' rights, how to establish relationships with patients unable to speak and methods of finding out patients' likes and dislikes.

The status given to 'basic care' also had implications for the training of functional NAs. Only five functional NAs had attended an introductory course, and in no case was this a specialised course in nursing elderly patients. Formal teaching was sparse and infrequent, and while all functional NAs had received informal teaching, this did not appear to be an ongoing process. In team wards, nursing

students, not NAs, were also first priority as recipients of teaching.

*d. For the quality of nurse-patient verbal interaction*

It was argued previously that the quality of verbal interaction with patients is indicative of the quality of care provided. As discussed in Chapter 6, regardless of staff grade, subjects in primary wards gave patients more choice, general explanations about their care and, in the afternoon session, spent more time seeking verbal feedback from patients about their care. While giving patients choice and seeking feedback from patients was found to be affected by ratios of staff to patients, neither the amount of choice given in the morning session nor explanations given to patients were affected by staffing levels. A more likely explanation, therefore, is the view of each patient as an individual with interrelated rather than 'basic' and 'technical' needs which operated in primary wards and which permeated the work of both QNs and NAs. The structure of sustained nursing staff allocation to a small group of patients characteristic of primary nursing facilitated this, as an NA illustrates:

"The good thing about primary nursing is that you always look after the same patients so you know their needs, whereas before when you got back from your days off you didn't know the patients. Plus patients get to know you - someone like Holly hates strangers."

Furthermore, interview data revealed that primary NAs were more likely to list communication skills as essential in caring for elderly patients.

Psychosocial care was valued highly by primary ward sisters, and this was reflected in the investment in both qualified and NA training. For example, the Open University course covered how to establish relationships through effective communication with aphasic patients. Ways in which communication could be facilitated with patients with special problems was also discussed while caring for patients. For example, a primary nurse said to an NA concerning a deaf patient:

"She's quite good at lip-reading if you stand in front of her and project your voice to the right".

While interview data suggest both QNs and NAs in team and functional wards recognised the importance of forming relationships and communicating with patients, neither the structures of team nor functional nursing facilitated this. In the former, this can be related to the perceived need to "get through the work" with maximum speed, and perhaps in the case of NAs to lack of knowledge about patients' individual needs. In the latter, it can be explained by lack of sustained allocation of nursing staff to patients.

#### **Study implications for the employment of nursing auxiliaries and the new support workers in care of the elderly wards**

This finding of a greater amount of therapeutic communication in primary wards regardless of staff grade has important implications for the debate about which grade of staff is most suited to caring for elderly patients. Based on the findings of this study, it is argued that NAs are capable of providing therapeutic care for elderly patients within an overall therapeutic ward philosophy and with appropriate QN role models. In this study, the latter is facilitated

by the structure of primary nursing, whereby QNs and NAs provide care together continuously for a small number of patients for the duration of the patients' stay in hospital. The study therefore shows the need for grade mixes which enable qualified staff sufficient time to work with, supervise and support NAs and the new breed of support worker.

This would, it is hoped, prevent further replication of the findings of Davies and Snaith (1980), who discovered NAs to be totally untrained and having little communication with other grades of staff or those of Bond and Bond (1992), who found NAs in hospital to have little educational input directed towards patients in their care.

The finding that there is a culture in each organisational mode which transcends staff grade has important implications, particularly in the light of the proposals of Project 2000. It argues against the professionalising ideology which proposes classifying work so that nursing is given only by nurses with a statutory qualification rather than other personnel who lack this qualification, such as NAs. Rather, it shows firstly, that NAs perceive their work in the same manner as the qualified staff with whom they work and by whom they are supervised.

This accords with the findings of other research studies. Armstrong-Esther and Browne (1986) found allegiance to the 'medical model' of care and opinions of basic care spanned both QNs and NAs. Similarly, Davies and Snaith (1980) found staff behaviour at mealtimes and viewpoints on patient self-care not to be linked to grade of nurse. Baker's (1983) study also illustrates shared perceptions of care held

by QNs and NAs. She discovered how all ward staff (with the exception of the ward sister) viewed their patients as of low status, childlike, manipulative and attention-seeking; in need of control and discipline rather than care. This resulted in depersonalised, task-orientated patterns of care being delivered by both grades, with total neglect of patients' self-care needs. Bond and Bond (1992) similarly found that NAs and qualified staff in both long-stay wards and NHS nursing homes perceived the care they gave similarly within settings but found large differences between settings.

Secondly, it indicates that the perceptions of both QNs and NAs are coloured by ward philosophy and work practices, regardless of method of care organisation in operation. The influence of the ward sister on these factors is attested in several research studies. For example, in elderly care Kitson (1984) found the overall care orientation of the ward depended on the ward sister's orientation to the care of patients rather than the individual perspectives of staff or ward layout, level of paramedical support or medical policies. More recently, Wilkinson (1991) found the influence of the ward sister over the ward environment predicted the quality of verbal behaviour with cancer patients. Wards in which ward sisters participated in 'hands on' patient care and delegated responsibility in the form of patient allocation were characterised by facilitating verbal behaviour. On wards where ward sisters operated in an autocratic style with little involvement in fundamental patient care blocking verbal behaviours predominated. In these wards, a system approaching task orientation existed.

In the present study, all primary ward sisters, like Wilkinson's 'democratic' ward sisters, delegated responsibility to primary nurses, who consequently viewed themselves as more autonomous than their team and functional counterparts. Primary ward sisters did, however, continue to act as a role model by being actively involved in delivering patient care. For two ward sisters, this was as a permanent associate nurse. While two team ward sisters similarly were active in patient care as team leaders, responsibility for other patients was not fully delegated. For example, a directive in the 'ward profile' of one team ward stated that team leaders must "discuss any changes in planned care with the ward sister...before changing care". Functional ward sisters, on the other hand, tended towards the style of Wilkinson's 'autocratic' ward sisters. Duties associated with ward management, such as administrative tasks, were performed largely by the ward sister, with little delegation and consequently little time remaining for providing patient care, unless dictated by low staffing levels.

### **Methodological issues**

The intention of the study had been to control for the ward sister's therapeutic orientation. This was successful in that there was little variability in TNFI scores between ward sisters in different organisational modes. However, other elements of the ward sister's orientation not covered in the TNFI were found to influence ward practices. It is therefore suggested that factors other than the orientation of ward sisters to elderly care nursing influence the ward environment, which are not covered in Kitson's TNFI. These

factors include the readiness of the ward sister to innovate and introduce change.

Moreover, while all ward sisters held therapeutic views regarding care of the elderly nursing, for functional ward sisters this did not extend to facilitating continuity of patient care through more sustained nurse-patient allocation. Of course, if the way in which ward sisters organised nursing work had been included in the scoring for the TNFI, it is likely primary and team ward sisters would have scored higher than functional ward sisters. However, as this served as the main independent variable and questions were designed to meet the study criteria for ward organisation rather than using Kitson's care organisation questions for this section, this was not possible.

A possible methodological weakness of the study was that the researcher was aware of both organisational mode and grade of nursing staff while carrying out observation, with the resultant possibility of bias. To preclude this, it would have been necessary to employ observers 'blind' to organisational mode and staff grade, which was not possible within financial constraints. Given that there are external signs of both grade of staff and, in some cases, organisational mode (e.g. primary nurse allocation boards), it is doubtful whether 'blind' observation would be possible without disruption of normal practices. It is hoped bias was avoided both by using clearly defined activity and verbal interaction categories and performing regular intra-rater reliability tests.

### 3. RECOMMENDATIONS

#### a. For practice

##### *Nursing auxiliaries and the new 'support worker'*

In acute and rehabilitation elderly care wards, the ratio of NAs to QNs should not exceed 1:1, to enable adequate supervision and direction

#### b. For the organisation of nursing care

To facilitate therapeutic nursing staff-patient relationships, QNs and NAs should be allocated continuously to named patients for the duration of the patients' stay in hospital.

To facilitate appropriate direction and supervision of NAs, as well as foster 'teamwork' and provide a role model, one QN and one NA should work together to provide care for a group of patients for each span of duty.

#### c. For training

##### *For nursing auxiliaries/support workers*

A specific training before beginning work on a ward in the care of elderly patients, including the techniques and value of 'basic' care and therapeutic nursing staff-patient communication.

An on-going training in the above at both a formal and informal level. The organisational structure of QN and NA working together (see section b) should facilitate the latter.



*For qualified nurses*

A specific training in the care of elderly patients, including the techniques and value of 'basic' care and therapeutic nurse-patient communication.

On-going training in the the care of elderly patients, including relevant research findings.

Training in techniques of supervision, direction and teaching of NAs and support workers

*For ward sisters*

Training in managing nursing staff in order to foster effective teamwork

Training in the principles, benefits and operationalisation of 'democratic' leadership in order to facilitate professional development of nursing staff, regardless of grade.

**d. For research**

*The organisation of nursing care*

Progression from organisational features of the nursing service in hospitals to describing other dimensions of the provision of nursing care, and a consideration of the association between them would provide an interesting avenue for future study.

*The employment of nursing auxiliaries and grade-mix*

Research is needed which looks at the effect of NA employment, and various ratios of NA to QN, on patient outcomes.

*Determining therapeutic orientation*

Revisions to Kitson's TNFI are necessary in order to accommodate both developments in nursing organisation and other factors which may affect ward practices, for example ward sisters' openness to change.

This study has gone some way towards shedding light on the quantitative and qualitative contribution of nursing auxiliaries to patient care, and the effect of organisational modes on these parameters. It is hoped the recommendations arising from it will be taken up in debates on the role of nursing auxiliaries and the new 'support workers', with the ultimate objective of improving the care of elderly people in hospital.

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APPENDIX 1

SCORING SYSTEM FOR QUESTIONS TO DETERMINE THERAPEUTIC ORIENTATION

<b>1. DEFINING CARE OF THE ELDERLY NURSING</b>		
<b>a. definition of care of the elderly nursing (ward sister only)</b>		
Maintenance /rehabilitation therapy Total patient care  5	Medical model orientation   3	Routine care Just 'basic nursing care'   1
<b>b. ways in which care of the elderly nursing different to general nursing</b>		
It is a speciality requiring specialist nursing skills   5	It is different only in medical terms, and/or because patients possess positive characteristics   3	It is no different. It is different because patients and/or ward possess negative characteristics   1
<b>c. aims of care</b>		
Aims unique to nursing   5	Medical aims of patient recovery and discharge only   3	Inability to articulate aims   1
<b>d. most important daily jobs (ward sisters only)</b>		
Jobs unique to nursing   5	Following medical directives   3	Inability to articulate most important jobs   1
<b>e. most important aspects in the care of elderly patients (qualified nurses and nursing auxiliaries only)</b>		
Aspects illustrating the primacy of nursing skill   5	Physical care of patients medical aspects   3	Inability to articulate most important aspects   1

<b>2. KNOWLEDGE</b>		
a. agree: qualified nurses need post-basic training 3	2	disagree: qualified nurses do not need post-basic training 1
b. agree: nursing auxiliaries require special training in care of the elderly 3	nursing auxiliaries require a general training only 2	disagree: nursing auxiliaries do not require training 1
c. three or more than three areas identified where more education and training required 3	Less than three areas identified 2	No extra training required 1
<b>3. SKILL UTILISATION</b>		
<b>a. Choice of care of the elderly</b>		
Chose to work with the elderly 3	2	did not choose to work with the elderly 1
<b>b. Skills need to care for elderly patients</b>		
Includes professional skills 5	Personal skills only listed 3	No skills required 1
<b>c. Skill utilisation</b> (please see qualified nurse interview schedule)		
<b>d. Satisfying aspects in caring for elderly patients</b>		
Nursing related aspects 5	Medically orientated aspects (eg patient recovery and discharge) only 3	1

**e. Aspects liked least in caring for elderly patients**

Aspects hindering delivery of high quality nursing care Positive comments about patients  5	Nothing not liked Physical side of work  3	Negative comments about patients  1
--	---	---

**4. REHABILITATION ROLE**

**a. Responsibility for rehabilitation role**

Rehabilitation primarily a job for nurses  3	2	Rehabilitation primarily a job for therapists  1
--	---	--

**b. Perception of rehabilitation role**

Nurses' role complementary to therapists' role Nurses' role articulated  Rehabilitation = integral part of nurses' work  5	Nurses' role = supplementer of activities normally performed by therapists  Rehabilitation = additional routine to be performed on patients  3	Therapists' role in rehabilitation greater than nurses' role  1
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**A COMPARISON OF THE CONTRIBUTION  
 TO CARE OF QUALIFIED NURSES  
 AND NURSING AUXILIARIES**

**S E L F - C O M P L E T I O N   Q U E S T I O N N A I R E**

Please answer the following questions and record your answers in the numbered boxes on the right (unless otherwise indicated). Thank you.

1. How many MALE beds are there on your ward? *(Please fill in two boxes, eg 5 to be filled in 

--	--

)*

		1-2
--	--	-----

2. How many FEMALE beds are there on your ward? *(Please fill in two boxes, eg 5 to be filled in 

--	--

)*

		3-4
--	--	-----

3. How many patients do you have, on average, in the following categories? *(Please fill in two boxes, eg 5 to be filled in 

--	--

)*

- A. acute .....
- B. rehabilitation/assessment .....
- C. respite/shared care .....
- D. continuing care/long-stay .....

		5-6
		7-8
		9-10
		11-12

4. This question asks about staffing on your ward.  
 (Please answer by filling in the numbers for each grade in the appropriate boxes below.)

	How many staff are currently in post FULL TIME?	How many staff are currently in post PART TIME?	In total, how many hours per week do PART TIME staff work?
A. ward sisters			
B. staff nurses			
C. enrolled nurses			
D. nursing auxiliaries			
E. ward clerk			

<input type="text"/>	<input type="text"/>	<input type="text"/>	13-
<input type="text"/>	<input type="text"/>	<input type="text"/>	16-
<input type="text"/>	<input type="text"/>	<input type="text"/>	19-
<input type="text"/>	<input type="text"/>	<input type="text"/>	22-
<input type="text"/>	<input type="text"/>	<input type="text"/>	25-

5. How many staff do you usually have on a MORNING shift? (Please fill in two boxes, eg 5 to be filled in  )

<input type="text"/>	<input type="text"/>	28-
----------------------	----------------------	-----

6. How many staff do you usually have on an EVENING shift? (Please fill in two boxes, eg 5 to be filled in  )

<input type="text"/>	<input type="text"/>	30-3
----------------------	----------------------	------

7. Are learner nurses allocated to the ward? (Please tick 'Yes' or 'No')

Yes (1)	No (2)	
<input type="checkbox"/>	<input type="checkbox"/>	32

IF YES

How many on average? (Please fill in two boxes, eg 5 to be filled in  )

<input type="text"/>	<input type="text"/>	33
----------------------	----------------------	----

From which courses are learner nurses allocated? (Please tick appropriate box.)

A. Registered General Nurse .....

<input type="checkbox"/>	34
--------------------------	----

B. Enrolled Nurse .....

<input type="checkbox"/>	35
--------------------------	----

C. Other (please specify) \_\_\_\_\_

<input type="checkbox"/>	36
--------------------------	----

8. How many consultants have patients on your ward? (Please fill in the number in the box.)

<input type="text"/>	37
----------------------	----

9. Please read through the following list and tick which ONE most accurately describes the way you organise staff on your ward.

A. The ward staff are organised as one group, and are allocated singly, in pairs or in threes, to patients or ward areas for part of their shift, and work across the whole ward for the remainder.

38

B. The ward staff are organised as one group, and are allocated singly, in pairs or in threes to patients or ward areas for their entire shift.

39

C. The ward staff are divided into teams with a designated leader, and allocated to a group of patients for one shift or part of a shift.

40

D. The ward staff are divided into teams with a designated leader, and allocated to a group of patients for periods longer than one shift.

41

E. Individual qualified nurses are given responsibility for individual patients for the duration of a shift or part of a shift.

42

F. Individual qualified nurses are given responsibility for individual patients for periods longer than one shift, but less than the total duration of the patients' stay in hospital.

43

G. Individual qualified nurses are given responsibility for individual patients for the duration of the patients' stay in hospital.

44

IF NONE OF THE ABOVE APPLY, please describe below your method of organising staff.

10. Under usual staffing conditions, who allocates work when nurses come on duty?

*(Please tick appropriate box.)*

- |   |                          |    |
|---|--------------------------|----|
| A. Sister or nurse in charge allocates work. ....                             | <input type="checkbox"/> | 45 |
| B. Team leaders allocate work for their team. ....                            | <input type="checkbox"/> | 46 |
| C. The most senior nurse in the team allocates work .....                     | <input type="checkbox"/> | 47 |
| D. Individual nurses decide what care to give their individual patients. .... | <input type="checkbox"/> | 48 |

11. Is the Off-Duty (or Duty Rota) organised:

*(Please tick appropriate box.)*

- |  |                          |    |
|--|--------------------------|----|
| A. For the ward as a whole. ....   | <input type="checkbox"/> | 49 |
| B. Within two or more groups or teams. ....                                    | <input type="checkbox"/> | 50 |
| C. To enable individual nurses to be responsible for individual patients. .... | <input type="checkbox"/> | 51 |

12. Who has nursing accountability for patient care?

*(Please tick appropriate box.)*

- |  |                          |    |
|--|--------------------------|----|
| A. It is entirely vested in the ward sister. ....  | <input type="checkbox"/> | 52 |
| B. It is entirely vested in the team leader. ....  | <input type="checkbox"/> | 53 |
| C. It is entirely vested in the individual nurse responsible for individual patients. .... | <input type="checkbox"/> | 54 |
| D. It is shared. ....  | <input type="checkbox"/> | 55 |

IF 'D.' APPLIES, please indicate below how accountability is shared.

13. Are there differences in the way in which nurses are organised in the morning, afternoon and evening?

Yes (1)	No (2)	
<input type="checkbox"/>	<input type="checkbox"/>	56

*(Please tick 'Yes' or 'No'.)*

IF YES APPLIES, please explain these differences below.

14. Does the layout of the ward influence how you organise your nurses?

Yes (1)	No (2)	
<input type="checkbox"/>	<input type="checkbox"/>	57

*(Please tick 'Yes' or 'No'.)*

IF YES APPLIES, please explain below in what way.



15. Who is responsible for writing the nursing 'kardex' or nursing notes?

(Please tick appropriate box.)

- A. The ward sister or nurse in charge writes the notes for most of the patients. ....  58
- B. Each team leader writes the notes for the patients in his/her team. ....  59
- C. Individual nurses write the notes for their individual patients. ....  60
- D. The nurse/nursing auxiliary/learner who has provided care for that patient during the shift does so. ....  61

IF NONE OF THE ABOVE APPLY, please describe below the method used in your ward.

16. Who liaises with the medical staff about patient care?

(Please tick appropriate box.)

- A. The ward sister or nurse in charge. ....  62
- B. The team leader, when it involves her patients. ....  63
- C. The patient's individual nurse. ....  64
- D. Any qualified nurse available. ....  65
- E. Any nurse available. ....  66

PLEASE ANSWER QUESTIONS 17-19 AS FULLY AS POSSIBLE.  
(Continue on a separate sheet of paper if necessary.)

17a. What do you consider the MOST important daily jobs  
for you to do? Please give reasons for your choice.

17b. Which of the above jobs would you be most unHaPPY to  
leave out, and why?

18a. What do you find particularly satisfying about your job?

18b. What do you like least about it?

19. How would you describe the aims of care for patients on your ward?

20. On your ward, is rehabilitation:

*(Please tick appropriate box below)*

1. Primarily a job for therapists	2. Primarily a job for therapists with a small input by nurses	3. Primarily a job for nurses with a small input by therapists	4. Primarily a job for nurses
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

67

21. Do you think qualified nurses working on a care of the elderly ward require any special post-basic training to provide care?

*(Please tick 'Yes', 'No' or 'Don't know'.)*

Yes (1)    No (2)    Don't know (3)  
            68

22. Do you think nursing auxiliaries working on a care of the elderly ward require any special training to provide care?

*(Please tick 'Yes', 'No' or 'Don't know'.)*

Yes (1)    No (2)    Don't know (3)  
            69

IF YES APPLIES, do they require:  
*(Please tick appropriate box.)*

A. A general training.

70

B. A specific training in care of the elderly.

71

Please list below which topics you think would be most helpful in nursing auxiliary training.

23. Do you think there are any topics in care of the elderly nursing on which more training is needed for:

*(Please tick appropriate box[es] below.)*

	You	Your qualified staff	Your nursing auxiliaries
Yes			
No			
Don't know			

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

72-7

75-7

78-8

IF YES APPLIES, which topics would be most useful for:

- A. You.
- B. Your Qualified Nurses.
- C. Your Nursing Auxiliaries.

24. Is any continuing education or in-service training provided for you and/or your staff?

*(Please tick appropriate boxes below.)*

	1. Provided by District/ Region	2. Provided by hospital	3. Provided on the ward	4. None of these
You				
Staff nurses				
Enrolled nurses				
Nursing auxiliaries				
Learner nurses				

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

81-8

85-8

89-9

93-9

97-1

25. Have you had the opportunity to organise any teaching sessions for your staff within the last six months?

*(Please tick 'Yes' or 'No'.)*

Yes (1)	No (2)
<input type="checkbox"/>	<input type="checkbox"/>

1C

IF YES APPLIES, on what topics?

Which grades of staff were involved?

*(Please tick appropriate box[es].)*

- A. Qualified nurses .....
- B. Nursing auxiliaries .....
- C. Learner nurses .....


102

103

104

26. In this post, what use do you feel is being made of your skills?

*(For each skill, please tick the appropriate box below.)*

	Very little use	Some use	Good use	Very good use
'Basic' nursing skills				
Rehabilitation skills				
'Technical' nursing skills				
Teaching skills				
Communication skills				
Management skills				

105

106

107

108

109

110

27. On your ward, which patients are assessed by the physiotherapist? (*Please ring below all that apply, eg 'Some acute' 2 .*)

All rehabilitation	1	Some rehabilitation	2
All acute	1	Some acute	2
All long-stay	1	Some long-stay	2
All respite	1	Some respite	2

<input type="checkbox"/>	111
<input type="checkbox"/>	112
<input type="checkbox"/>	113
<input type="checkbox"/>	114

28. On your ward, which patients are assessed by the occupational therapist? (*Please ring below all that apply, eg 'All acute' 1 .*)

All rehabilitation	1	Some rehabilitation	2
All acute	1	Some acute	2
All long-stay	1	Some long-stay	2
All respite	1	Some respite	2

<input type="checkbox"/>	115
<input type="checkbox"/>	116
<input type="checkbox"/>	117
<input type="checkbox"/>	118



29. Please could you tick below the qualifications you possess and the year these were obtained.

	1. Yes	2. No	3. Year obtained
Registered General Nurse			
Enrolled Nurse			
Registered Mental Nurse			
Registered Nurse for the Mentally Subnormal (RMNS/RMND/RMNH)			
Registered Sick Children's Nurse (RSCN)			
State Certified Midwife			
Health Visitors Certificate (HV Cert/RHV)			
District Nursing Certificate			
Registered Clinical Teacher			
Midwives Teachers Diploma			
Nursing degree			
Diploma in Nursing			
ENB (JBCNS) long course in the care of elderly people (JBCNS 297)			
ENB (JBCNS) short course in nursing elderly people (ENB 941)			

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	119
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	122
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	125
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	128
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	131
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	134
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	137
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	140
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	143
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	146-
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	149-
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	152-
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	155-
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	158-

30. Which ONE of your qualifications do you think provided the best preparation for your current job?

161

31. In the next 12 months are you:

*(Please tick appropriate box.)*

A. Planning to stay in your present job? .....

163

B. Considering moving to another post? .....

164

C. Definitely moving to another post? .....

165

32. Is there more than one Ward Sister/Charge Nurse on your ward?

Yes (1)      No (2)

166

*(Please tick 'Yes' or 'No'.)*

IF YES APPLIES, are you:

*(Please tick appropriate box)*

A. Of equal status with the other sister. ....

167

B. The junior sister. ....

168

C. The senior sister. ....

169

THANK YOU VERY MUCH FOR COMPLETING THIS QUESTIONNAIRE.

## APPENDIX 3

### LETTERS

- a. Letter accompanying ward sister questionnaire
- b. Letter accompanying Work Environment Scale
- c. Explanatory letter to participating nursing staff

# THE UNIVERSITY OF NEWCASTLE UPON TYNE

Health Care Research Unit  
21 Claremont Place Newcastle upon Tyne NE2 4AA

A

Director:

Telephone: 222 6000 (STD Code 091) Ext  
Facsimile: 222 6043 (STD Code 091)

Sister A.N. Other  
Ward 00  
[Address]

Dear Sister Other

I am carrying out a research study comparing the contribution to patient care of qualified nurses and nursing auxiliaries in acute and rehabilitation care of the elderly wards. The study is funded for three years by the Department of Health and Social Security, and my supervisor is Dr. Senga Bond.

The aims of the study are twofold:

1. To compare the type of nursing work performed by qualified nurses with that of nursing auxiliaries.
2. To determine the effect of method of care organisation used in the ward on the work of qualified nurses and nursing auxiliaries.

The proposals of Project 2000 suggest that all learner nurses become supernumerary to ward staffing requirements. This will mean all wards will be staffed by qualified nurses and nursing auxiliaries only. It is therefore very topical and timely to examine the whole question of staffing levels, grade mix and the role of the nursing auxiliary compared with that of qualified staff, particularly in care of the elderly *where nursing auxiliaries often form an important part of the workforce.*

If you are willing to participate, please complete the enclosed questionnaire and return it to me in the pre-paid envelope. I will then conduct an informal interview with a number of respondents whose wards best fit the criteria of my study. This will last approximately one hour, and will expand on some of the topics covered in the questionnaire. If your ward is selected, I will contact you on receiving your questionnaire to arrange an interview date convenient for you.

All information given will be treated in the strictest confidence and no individual or ward will be identifiable in the final report.

Thank you very much for your help.

Yours sincerely

(Mrs.) Lois Thomas BA (Hons), RGN.

# THE UNIVERSITY OF NEWCASTLE UPON TYNE

Health Care Research Unit  
21 Claremont Place Newcastle upon Tyne NE2 4AA

Director:

Telephone: 222 6000 (STD Code 091) Ext  
Facsimile: 222 6043 (STD Code 091)

Dear Nurse,

Overleaf are 90 statements about the place in which you work.

Please decide which statements are true of your work environment and which are false.

If you think a statement is TRUE, or mostly TRUE of your work environment, please tick the box labelled TRUE.

If you think the statement is FALSE, or mostly FALSE of your work environment, please tick the box labelled FALSE.

Note: The term "supervisor" is intended to refer to the person or persons who is or are in charge of you.

Please answer every statement.

All information given will be treated in the strictest confidence.

Thank you.

Yours faithfully,

(Mrs) Lois Thomas B.A. (Hons) R.G.N.

# THE UNIVERSITY OF NEWCASTLE UPON TYNE

Health Care Research Unit  
21 Claremont Place Newcastle upon Tyne NE2 4AA

Director:  
LT/FB

Telephone: 232 8511 (STD Code 091) Ext 6186

Dear Nurse,

As you may have heard from Sister/Charge Nurse, your ward has been chosen to participate in a research study comparing the contribution to patient care of qualified nurses and nursing auxiliaries in acute and rehabilitation care of the elderly wards. I am funded for three years by the Department of Health and Social Security to carry out this study and am a Registered General Nurse.

The aims of the study are twofold:

1. To compare the type of nursing work performed by qualified nurses with that of nursing auxiliaries.
2. To determine the effect of the method of care organisation used in the ward on the work of qualified nurses and nursing auxiliaries.

The proposals of Project 2000 suggest that all learner nurses become supernumerary to ward staffing requirements. This will mean all wards will be staffed by qualified nurses and nursing auxiliaries only. It is therefore very topical and timely to examine the whole question of staffing levels, grade mix and the role of the auxiliary compared with that of qualified staff. I am particularly interested in Care of the Elderly, where nursing auxiliaries form an important part of the workforce.

By a process of random selection, you have been chosen to participate in the study and I very much hope you will be willing to do this.

Participation will involve the following:

1. Allowing me to observe you as you carry out your normal nursing duties.
2. Answering some simple questions about your work.
3. Completing a questionnaire about the patients you have been caring for.
4. Consenting to an informal interview about how you view your work as a nurse on a care of the elderly ward.

All information gathered will be treated in the strictest confidence and no individual will be identifiable in the final report.

I very much hope you will agree to participate in the study.

Yours sincerely,

(Mrs.) Lois Thomas, BA (Hons) RGN.

**APPENDIX 4 WARD SISTERS' THERAPEUTIC ORIENTATION SCORES**

WARD SISTER	DEFINING CARE OF THE ELDERLY NURSING				KNOWLEDGE					
	Defining care of the elderly nursing	Most important daily jobs	Aims of care	Necessity of special training for qualified nurses	Necessity of special training for nursing auxiliaries	Topics in which more training needed for ward sister	Topics in which more training needed for qualified nurses	Topics in which more training needed for nursing auxiliaries		
P1	5	5	5	3	3	2	2	2		
P2	5	5	5	3	2	3	2	3		
P3	5	5	5	3	3	2	2	2		
T4	5	5	5	3	3	2	2	2		
T5	5	5	5	3	3	3	3	3		
T6	3	5	5	3	3	2	3	3		
F7	3	5	5	3	3	2	2	2		
F8	3	5	5	3	2	1	2	1		
F9	3	5	5	3	3	2	3	3		

SKILL UTILISATION										REHABILITATION ROLE			
WARD SISTER	Choice of care of the elderly nursing	Skills needed to care for elderly patients	Skill utilisation	Satisfying aspects	Aspects liked least	Responsibility for rehabilitation role	Definition of rehabilitation	Total Score					
P1	3	5	18	5	5	3	5	71					
P2	3	5	20	5	5	3	5	74					
P3	3	5	23	5	5	3	5	76					
T4	3	5	24	5	5	3	5	77					
T5	3	5	22	5	5	3	5	78					
T6	1	5	21	5	5	3	5	72					
F7	3	3	17	5	5	3	5	166					
F8	1	5	15	3	3	3	5	57					
F9	3	3	16	5	5	3	5	67					



	TRUE	FALSE		TRUE	FALSE		TRUE	FALSE
	1	2		1	2		1	2
1. The work is really challenging.	<input type="checkbox"/>	<input type="checkbox"/>	13. Supervisors usually compliment an employee who does something well.	<input type="checkbox"/>	<input type="checkbox"/>	23. Supervisors tend to discourage criticism from employees.	<input type="checkbox"/>	<input type="checkbox"/>
2. People go out of their way to help a new employee feel comfortable.	<input type="checkbox"/>	<input type="checkbox"/>	14. Employees have a great deal of freedom to do as they like.	<input type="checkbox"/>	<input type="checkbox"/>	24. Employees are encouraged to make their own decisions.	<input type="checkbox"/>	<input type="checkbox"/>
3. Supervisors tend to talk down to employees.	<input type="checkbox"/>	<input type="checkbox"/>	15. There's a lot of time wasted because of inefficiencies.	<input type="checkbox"/>	<input type="checkbox"/>	25. Things rarely get 'put off till tomorrow'.	<input type="checkbox"/>	<input type="checkbox"/>
4. Few employees have any important responsibilities.	<input type="checkbox"/>	<input type="checkbox"/>	16. There always seems to be an urgency about everything.	<input type="checkbox"/>	<input type="checkbox"/>	26. People cannot afford to relax.	<input type="checkbox"/>	<input type="checkbox"/>
5. People pay a lot of attention to getting work done.	<input type="checkbox"/>	<input type="checkbox"/>	17. Activities are well-planned.	<input type="checkbox"/>	<input type="checkbox"/>	27. Rules and regulations are somewhat vague and ambiguous.	<input type="checkbox"/>	<input type="checkbox"/>
6. There is constant pressure to keep working.	<input type="checkbox"/>	<input type="checkbox"/>	18. People can wear wild-looking clothes while at work if they want.	<input type="checkbox"/>	<input type="checkbox"/>	28. People are expected to follow set rules in doing their work.	<input type="checkbox"/>	<input type="checkbox"/>
7. Things are sometimes pretty disorganised.	<input type="checkbox"/>	<input type="checkbox"/>	19. New and different ideas are always being tried out.	<input type="checkbox"/>	<input type="checkbox"/>	29. This place would be one of the first to try out a new idea.	<input type="checkbox"/>	<input type="checkbox"/>
8. There's a strict emphasis on following policies and regulations.	<input type="checkbox"/>	<input type="checkbox"/>	20. The lighting is extremely good.	<input type="checkbox"/>	<input type="checkbox"/>	30. Work space is awfully crowded.	<input type="checkbox"/>	<input type="checkbox"/>
9. Doing things in a different way is valued.	<input type="checkbox"/>	<input type="checkbox"/>	21. A lot of people seem to be just putting in time.	<input type="checkbox"/>	<input type="checkbox"/>	31. People seem to take pride in the organisation.	<input type="checkbox"/>	<input type="checkbox"/>
10. It sometimes gets too hot.	<input type="checkbox"/>	<input type="checkbox"/>	22. People take a personal interest in each other.	<input type="checkbox"/>	<input type="checkbox"/>	32. Employees rarely do things together after work.	<input type="checkbox"/>	<input type="checkbox"/>

	TRUE	FALSE		TRUE	FALSE
	1	2		1	2
33. Supervisors usually give full credit to ideas contributed by employees.	<input type="checkbox"/>	<input type="checkbox"/>	46. There is no time pressure.	<input type="checkbox"/>	<input type="checkbox"/>
34. People can use their own initiative to do things.	<input type="checkbox"/>	<input type="checkbox"/>	47. The details of assigned jobs are generally explained to employees.	<input type="checkbox"/>	<input type="checkbox"/>
35. This is a highly efficient, work-oriented place.	<input type="checkbox"/>	<input type="checkbox"/>	48. Rules and regulations are pretty well enforced.	<input type="checkbox"/>	<input type="checkbox"/>
36. Nobody works too hard.	<input type="checkbox"/>	<input type="checkbox"/>	49. The same methods have been used for quite a long time.	<input type="checkbox"/>	<input type="checkbox"/>
37. The responsibilities of supervisors are clearly defined.	<input type="checkbox"/>	<input type="checkbox"/>	50. This place could stand some new interior decorations.	<input type="checkbox"/>	<input type="checkbox"/>
38. Supervisors keep a rather close watch on employees.	<input type="checkbox"/>	<input type="checkbox"/>	51. Few people ever volunteer.	<input type="checkbox"/>	<input type="checkbox"/>
39. Variety and change are not particularly important.	<input type="checkbox"/>	<input type="checkbox"/>	52. Employees often eat lunch together.	<input type="checkbox"/>	<input type="checkbox"/>
40. This place has a stylish and modern appearance.	<input type="checkbox"/>	<input type="checkbox"/>	53. Employees feel free to discuss regrading with their supervisor.	<input type="checkbox"/>	<input type="checkbox"/>
41. People put quite a lot of effort into what they do.	<input type="checkbox"/>	<input type="checkbox"/>	54. Employees generally do not try to be unique and different.	<input type="checkbox"/>	<input type="checkbox"/>
42. People are generally frank about how they feel.	<input type="checkbox"/>	<input type="checkbox"/>	55. There's an emphasis on 'work before play'.	<input type="checkbox"/>	<input type="checkbox"/>
43. Supervisors often criticise employees over minor things.	<input type="checkbox"/>	<input type="checkbox"/>	56. It is very hard to keep up with your workload.	<input type="checkbox"/>	<input type="checkbox"/>
44. Supervisors encourage employees to rely on themselves when a problem arises.	<input type="checkbox"/>	<input type="checkbox"/>			
45. Getting a lot of work done is important to people.	<input type="checkbox"/>	<input type="checkbox"/>			
			57. Employees are often confused about exactly what they are supposed to do.	<input type="checkbox"/>	<input type="checkbox"/>
			58. Supervisors are always checking on employees and supervise them very closely.	<input type="checkbox"/>	<input type="checkbox"/>
			59. New approaches to things are rarely tried.	<input type="checkbox"/>	<input type="checkbox"/>
			60. The colour scheme and decorations make the place warm and cheerful to work in.	<input type="checkbox"/>	<input type="checkbox"/>
			61. It is quite a lively place.	<input type="checkbox"/>	<input type="checkbox"/>
			62. Employees who differ from the others in the organisation don't get on well.	<input type="checkbox"/>	<input type="checkbox"/>
			63. Supervisors expect far too much from employees.	<input type="checkbox"/>	<input type="checkbox"/>
			64. Employees are encouraged to learn things even if they are not directly related to the job.	<input type="checkbox"/>	<input type="checkbox"/>
			65. Employees work very hard.	<input type="checkbox"/>	<input type="checkbox"/>

TRUE FALSE  
1 2

66. You can take it easy and still get your work done.
67. Fringe benefits are fully explained to employees.
68. Supervisors do not often give in to employee pressure.
69. Things tend to stay just about the same.
70. It is rather draughty at times.
71. It's hard to get people to do any extra work.
72. Employees often talk to each other about their personal problems.
73. Employees discuss their personal problems with supervisors.
74. Employees function fairly independently of supervisors.
75. People seem to be quite inefficient.
76. There are always deadlines to be met.
77. Rules and policies are constantly changing.
78. Employees are expected to conform rather strictly to rules and customs.

TRUE FALSE  
1 2

79. There is a fresh, novel atmosphere about the place.
80. The furniture is usually well arranged.
81. The work is usually very interesting.
82. Often people make trouble behind others' backs.
83. Supervisors really stand up for their people.
84. Supervisors meet with employees regularly to discuss their future work goals.
85. There is a tendency for people to come to work late.
86. People often have to work overtime to get their work done.
87. Supervisors encourage employees to be neat and orderly.
88. If an employee comes in late, he/she can make it up by staying late.
89. Things always seem to be changing.

TRUE FALSE  
1 2

90. The rooms are well ventilated.

THANK YOU VERY MUCH FOR COMPLETING THIS QUESTIONNAIRE.

PLEASE RETURN IT TO ME IN THE ENVELOPE PROVIDED.



FEEDING

7. Can she/he feed her/himself correctly unaided without the need for food to be cut up?	Yes 1 No A	23 <input type="checkbox"/>
---	---------------	-----------------------------

IF NO (A) (b) What level of help does he/she require with feeding?

READ OUT

minimum supervision - requires food cutting up	2
continual supervision - needs to be sat with, can feed self	3
full assistance - physically fed	4

INTERVIEWER TO ESTABLISH ELDERLY PERSON'S FEEDING ABILITY

8. <i>Correct unaided</i>	0	24 <input type="checkbox"/>
<i>Adequate with minimum of supervision</i>	1	
<i>Inadequate unless continually supervised</i>	2	
<i>Requires feeding</i>	3	

DRESSING

9. When dressing does she/he require assistance with buttons and fastenings?	Yes 1 No 2	25 <input type="checkbox"/>
---	---------------	-----------------------------

10. Is she/he able to dress adequately independently?	Yes 1 No A
---	---------------

IF NO (A) (a) What level of help does she/he require with dressing?

READ OUT

minimum supervision - clothes laid out in order perhaps help with one or two items	2	26 <input type="checkbox"/>
continual supervision - may need considerable physical assistance attempts to put some items on	3	
full assistance	4	

11. Does she/he regularly attempt to remove clothing during the day?	Yes 1 No 2	27 <input type="checkbox"/>
---	---------------	-----------------------------

INTERVIEWER TO ESTABLISH ELDERLY PERSON'S DRESSING ABILITY

12. <i>Correct</i>	0	28 <input type="checkbox"/>
<i>Imperfect but adequate</i>	1	
<i>Adequate with minimum supervision</i>	2	
<i>Inadequate unless continually supervised</i>	3	
<i>Unable to dress</i>	4	
<i>Unable to retain clothing</i>	5	

BATHING

13. Does she/he require someone in the room when taking a bath? Yes 1 No 2

29

14. Does she/he require assistance:

READ OUT

getting in and out of bath  
washing all over  
washing hands and face

Yes	No
1	2
1	2
1	2

30   
31   
32

INTERVIEWER TO ESTABLISH ELDERLY PERSON'S BATHING ABILITY

15. Washes and bathes without assistance 0  
Minimal supervision with bathing 1  
Close supervision with bathing 2  
Inadequate unless continually supervised 3  
Requires washing and bathing 4

33

CONTINENCE

16. Is she/he incontinent of urine or does she/he have a catheter or other appliance? Yes 1 No 2  
Catheter or other appliance 3

34

IF YES (1) (a) is she/he incontinent most days or less often? Less often 1 Most days 2 Not applicable 8

35

READ OUT

(b) Does this happen irregularly 1  
only during the day 2  
only during the night 3  
or both day and night 4  
Not applicable 8

36

17. Is she/he incontinent of faeces? Yes A No 2

37

IF YES (A) Is that occasionally or regularly? Occasionally 3 Regularly 4

18. Does she/he have to be regularly taken to the toilet or reminded to go by herself/himself? Yes A No 2

38

IF YES (A) Is that Day only 3 Night only 4 Both day and night 5  
READ OUT

19. Does she/he wear an incontinence pad or pants? Yes 1 No 2

39

INTERVIEWER TO ESTABLISH ELDERLY PERSON'S CONTINENCE

- |     |   |   |    |                          |
|-----|---|---|----|--------------------------|
| 20. | <i>Full control</i>                                       | 0 | 40 | <input type="checkbox"/> |
|     | <i>Occasional accidents</i>                               | 1 |    |                          |
|     | <i>Continent by day if regularly toiletted</i>            | 2 |    |                          |
|     | <i>Urinary incontinence in spite of regular toileting</i> | 3 |    |                          |
|     | <i>Regular or frequent double incontinence</i>            | 4 |    |                          |

(I would now like to ask you questions concerning the mental state of Mrs/Mr. \_\_\_\_\_)

MEMORY

- |     |  |                             |    |                          |
|-----|--|-----------------------------|----|--------------------------|
| 21. | Does she/he forget where things have been left or forget when she/he has done something? | <i>Yes</i> 1<br><i>No</i> 2 | 41 | <input type="checkbox"/> |
| 22. | Does she/he remember what happened yesterday or last week?                               | <i>Yes</i> 1<br><i>No</i> 2 | 42 | <input type="checkbox"/> |
| 23. | Does she/he remember events of the more distant past and talk sensibly about them?       | <i>Yes</i> 1<br><i>No</i> 2 | 43 | <input type="checkbox"/> |
| 24. | Would you say her memory is complete for her age or not?                                 | <i>Yes</i> 1<br><i>No</i> 2 | 44 | <input type="checkbox"/> |

INTERVIEWER TO ESTABLISH ELDERLY PERSON'S MEMORY

- |     |                                 |   |    |                          |
|-----|---------------------------------|---|----|--------------------------|
| 25. | <i>Complete</i>                 | 0 | 45 | <input type="checkbox"/> |
|     | <i>Occasionally forgetful</i>   | 1 |    |                          |
|     | <i>Short term loss</i>          | 2 |    |                          |
|     | <i>Short and long-term loss</i> | 3 |    |                          |

ORIENTATION

26. Is she/he fully orientated in the hospital, by that I mean is she/he aware of the layout of the immediate surroundings? Yes 1 No 2 46
27. Would she/he have a fairly good idea of where she/he is outside, e.g. knows where she/he is on outings? Yes 1 No 2 47
28. Is she/he aware that she/he is in a hospital? Yes 1 No 2 48
29. Is she/he able to recognise and name people with whom she/he has regular dealings? (e.g. able to differentiate members of staff) Yes 1 No 2 49
30. Can she/he find her/his way to bed? IF CHAIRFAST - Is she/he aware of where her/his bed is? Yes 1 No 2 50
31. Can she/he find her/his way to the toilet? IF CHAIRFAST - Is she/he aware of where the toilet is? Yes 1 No 2 51

INTERVIEWER TO ESTABLISH ELDERLY PERSON'S ORIENTATION

32. Complete 0  
 Orientated in ward, identifies people correctly 1  
 Misidentifies but can find way about 2 52   
 Cannot find way to bed or toilet without assistance 3  
 Completely lost 4



COMMUNICATION

33. Can you have a normal conversation with her/him, without the need to simplify? Yes 1  
No 2 53

IF NO (2) (a) Is this because she/he is deaf or has a speech defect or is it for some other reason?

*because deaf* 1  
*because speech defect* 2  
*other reason (specify)* 3  
*not applicable* 8

(b) Is she/he able to understand a simplified conversation and respond appropriately? Yes 1  
No 2  
Not applicable 8 55

(c) Is she/he able to indicate her/his needs? Yes 1  
No 2  
Not applicable 8 56

(d) Will she/he respond appropriately when spoken to? e.g. will say hello when greeted Yes 1  
No 2  
Not applicable 8 57

INTERVIEWER TO ESTABLISH ELDERLY PERSON'S COMMUNICATION ABILITY

34. *Always clear, retains information* 0  
*Can indicate needs, understand simple verbal directions, can deal with simple information* 1  
*Cannot understand simple verbal information or cannot indicate needs* 2  
*Cannot understand simple verbal information and cannot indicate needs, retains some expressive ability* 3  
*No effective contact* 4

58

CO-OPERATION

35. Do you find it difficult to get her/him to do as you ask? Yes 1  
No 2 59

IF YES (1) (a) Is she/he unco-operative over one or two activities or is it more general 3  
4  
8 60   
*one or two activities*  
*more general*  
*not applicable*

(b) How often is she/he unco-operative 3  
4  
8 61   
*less often*  
*most days*  
*not applicable*

(c) Does she/he frequently need to be encouraged and persuaded before doing as you ask? Yes 1  
No 2  
not applicable 8 62

IF NO (2) (a) Is she/he helpful when assisted or does she/he just allow things to be done for her/him? 3  
4  
8 63   
*Helpful*  
*Allows things to be done for her/him*  
*Not applicable*

IF ALLOWS THINGS TO BE DONE (4)

(b) Does she respond in any way when physically helped or not respond at all e.g. like dressing a doll? 3  
4  
8 64   
*Responds*  
*No response*  
*Not applicable*

36. Does she/he regularly reject attempts that are made to assist her/him to carry out a task? Yes A  
No 2 65

IF YES (A) When this happens, does she/he try to do whatever it is by herself/himself, even though she/he may not do it very well? 3  
*Performs task independently*  
OR Does she/he resist attempts to help, and not try to do it herself/himself? 4  
*Does not perform task at all*

INTERVIEWER TO ESTABLISH ELDERLY PERSON'S CO-OPERATION

37. *Actively co-operative* 0  
*Passively co-operative or occasionally unco-operative* 1 66   
*Requires frequent encouragement and persuasion* 2  
*Rejects assistance, shows independent, ill-directed activity* 3  
*Completely resistive or withdrawn* 4

RESTLESSNESS

38. Is she/he ever noisy? Does she/he shout or sing loudly? Yes A 67   
No 2

IF YES (A) (a) Does this happen:  
READ OUT Nearly every day 3  
More than once a week 4  
Less often 5

(b) Does this create a disturbance which annoys other people or not? Yes 1  
No 2 68   
Not applicable 8

39. Does she/he wander around in the middle of the night causing a disturbance or waking others up? Yes A 69   
No 2

IF CHAIRFAST - Does she/he cause a disturbance during the night and wake others up?

IF YES (A) (a) Does this happen:  
READ OUT Nearly every day 3  
More than once a week 4  
Less often 5

40. How often is she/he restless?  
READ OUT Never 1  
Intermittently 2 70   
Persistent day or night 3  
Persistent day and night 4  
Constant - may sleep 1/2 hr at a time but no more 5

IF RESTLESS (a) In what ways is she/he restless?  
SPECIFY \_\_\_\_\_  
\_\_\_\_\_

INTERVIEWER TO ESTABLISH ELDERLY PERSON'S RESTLESSNESS

41. None 0  
Intermittently 1 71   
Persistent by day or night 2  
Persistent by day and night 3  
Constant 4

## APPENDIX 7

### BEHAVIOURAL CATALOGUE WITH DEFINITIONS

#### 1. PATIENT HYGIENE

##### a. Performing patient hygiene

Bathing/bed bathing/showering patients (including lifting patients into and out of bath)  
Washing and cleaning incontinent patients  
Care of patient's hair and nails  
Mouth toilet, teeth and denture care  
Shaving patients  
Dressing/undressing patients (including removing and applying anti-embolic stockings)  
Making patients comfortable in bed/chair, e.g. arranging bedclothes  
Tidying occupied beds  
Stripping and making occupied beds

##### b. Assisting with personal hygiene

Supervising/assisting patients with personal hygiene activity  
Assisting another person/persons with patient hygiene activity

##### c. Gathering/returning equipment

Collecting and returning equipment required for the performance of personal care  
Preparing equipment required e.g. running patient's bath water  
Tidying up following personal care e.g. cleaning and tidying bathroom/shower room.

#### 2. PHYSICAL ACTIVITY/MOBILITY

##### a. Moving patients

Moving patients out of/into bed/chair/wheelchair/bath chair  
assisting or supervising walking  
Transporting patients in wheelchair/bath chair  
Turning and repositioning patients  
Performing active or passive range of motion exercises

##### b. Gathering/returning equipment

Collecting and returning equipment required for physical activity

### 3. EVACUATION

Use of bedpan/urinal/commode/toilet  
Collecting/returning bedpan/urinal/commode  
Emptying catheter bags  
Measuring and disposing of patient output

(Note: This category includes pulling clothes up/down, lifting or assisting patient on/off toilet and hand-washing following evacuation)

### 4. NURSING OBSERVATIONS

Weighing patients  
Measuring temperature, pulse, blood pressure and respirations  
Neurological observations

### 5. INSPECTING

Observing patients' condition (includes observation as part of a 'round' of patients)  
Checking asleep or unconscious patients  
Inspecting areas of the patient e.g. pressure sores

### 6. MEDICATION

Giving medications to patients  
Setting up/maintaining/discontinuing intravenous therapy  
Preparing intravenous therapy  
Preparing injections  
Giving enemas and suppositories  
Checking medicine trolley  
Filling in medicine kardex

(Note: This category includes giving patients fluids with which to swallow tablets etc.)

### 7. NURSING PROCEDURES

Performing dressings  
Treating pressure sores  
Specimen gathering and testing  
Catheterisation  
Setting up/maintaining/discontinuing oxygen therapy  
Nasogastric tube insertion/aspiration/removal  
Last Offices

(Note: This category includes preparing for and clearing away after above procedures)

## 8. ADMINISTRATION

- Filling in patients' charts
- Filling in menu cards (includes assisting the patient to do this)
- Filling in specimen forms
- Filling in admission and discharge forms
- Writing the nursing kardex
- Checking and recording patients' clothes and valuables
- Other paper work NOT related to ordering supplies or giving medications

## 9. NUTRITION

- Preparing meals, snacks and drinks for patients
- Setting tables
- Serving meals
- Clearing away after meals
- Cutting up food for patients
- Supervising or assisting patients with food or fluids
- Feeding patients
- Pouring drinks for patients
- Distributing water jugs/drinks

## 10. ASSISTING MEDICAL STAFF

- Accompanying medical staff to visit patients
- Assisting medical staff carry out procedures with patients  
e.g. taking blood
- Accompanying medical staff on ward rounds
- Attending multidisciplinary meetings and case conferences

## 11. DOMESTIC WORK

- Washing locker tops and bed-tables
- Distributing patients' clothes
- Unpacking and packing patients' belongings
- Distributing linen
- Sorting and folding linen
- Emptying linen bags
- Washing patients' 'smalls'
- Replenishing stocks
- Cleaning the sluice and toilets
- Making unoccupied beds
- Cleaning unoccupied beds
- Tidying the ward
- Care of plants and flowers
- Moving beds, lockers and chairs
- Changing and disposing of rubbish bags

## 12. WARD REPORT

- Giving ward report
- Listening to ward report

**13. EQUIPMENT AND SUPPLIES**

Checking and ordering supplies of drugs, dressings etc.  
Unpacking and putting away supplies  
Checking equipment e.g. cardiac arrest trolley

**14. RECREATION**

Participating in recreational activity with patients, e.g. playing games

(Note: This category includes watching television with patients IF there is interaction between nurse and patient. If there is no interaction, code UNOCCUPIED)

**15. SOCIABLE INTERACTION**

Engaging in social intercourse with patients in the absence of any other activity.

**16. COMMUNICATION**

Talking about aspects related to patient care with anyone other than the patient in the absence of any other activity  
Talking on the telephone

**17. COLLECTING/RETURNING EQUIPMENT**

Walking around or walking between activities, not obviously collecting/returning equipment for any categories other than those specified above.

**18. UNOCCUPIED TIME**

Social interaction with anyone other than patients  
Unoccupied time  
Unofficial tea-breaks

**19. STAFF TIME**

Staff tea and meal breaks  
Hand washing  
Going to the toilet

**20. TEACHING/LEARNING**

Giving or receiving teaching, includes formal teaching sessions and demonstrations at patients' bedsides

**21. UNABLE TO SEE**

Researcher unable to see what activity the nurse is involved in

**22. OTHER**

Any activity not covered by the above definitions.



APPENDIX 8a

ALL SESSIONS Time spent in activities by all nurses

Type of activity	PRIMARY NURSING WARDS		TEAM NURSING WARDS		FUNCTIONAL NURSING WARDS	
	Time in mins	Mean % time	Time in mins	Mean % time	Time in mins	Mean % time
Fundamental patient care	3283	35.4	3260	35.7	2719	29.8
Supplementary patient care	488	5.3	823	9.1	851	9.4
Communication	852	9.2	661	7.3	758	8.4
Administration	682	7.4	659	7.2	651	7.2
Domestic	470	5.1	512	5.6	581	6.3
Sociable	484	5.2	361	4.0	407	4.5
Staff time/unoccupied	1884	20.4	1913	20.9	2244	24.7
Other	496	5.4	451	4.9	427	4.7
Total time	8639		8639		8639	

APPENDIX 8b

ALL SESSIONS Time spent in activities with patients by all nurses

Type of activity	PRIMARY NURSING WARDS			TEAM NURSING WARDS			FUNCTIONAL NURSING WARDS		
	Time in mins	Mean % time with patients	Mean % total time	Time in mins	Mean % time with patients	Mean % total time	Time in mins	Mean % time with patients	Mean % total time
Fundamental patient care	2641	62.0	28.5	2518	59.2	27.5	2127	54.5	23.3
Supplementary patient care	239	6.1	2.6	384	10.5	4.2	420	12.4	4.7
Communication	3	0.6	0.3	2	0.2	0.1	0	0	0
Administration	73	1.8	0.8	88	2.2	1.0	119	3.7	1.5
Domestic	88	2.0	1.0	239	5.4	2.6	232	5.5	2.5
Sociable	481	11.4	5.2	357	8.5	3.9	406	10.3	4.4
Staff time/unoccupied	77	1.8	0.8	78	1.8	0.9	85	2.1	0.9
Other	7	0.2	0.1	17	0.4	0.2	8	0.2	0.1
Total time	3609			3684			3396		

ALL SESSIONS Time spent in activities away from patients by all nurses

Type of activity	PRIMARY NURSING WARDS			TEAM NURSING WARDS			FUNCTIONAL NURSING WARDS		
	Time in mins	Mean % time away from patients	Mean % total time	Time in mins	Mean % time away from patients	Mean % total time	Time in mins	Mean % time away from patients	Mean % total time
Fundamental patient care	605	19.1	6.9	657	21.5	8.1	578	15.0	6.5
Supplementary patient care	217	7.1	3.1	402	11.1	4.8	406	10.7	5.5
Communication	370	10.8	9.2	263	7.8	7.2	357	8.5	8.4
Administration	593	17.2	6.6	569	16.4	6.3	516	12.4	5.9
Domestic	376	12.1	4.1	273	9.3	3.0	349	9.7	3.8
Sociable	3	0.1	0.1	5	0.3	0.1	1	0.1	0.03
Staff time/unoccupied	722	22.2	19.5	632	20.0	20.1	1382	34.5	23.7
Other	399	12.5	5.3	428	13.8	4.8	415	10.6	4.6
Total time	3285			3228			4004		

## MORNING SESSION Time spent in activities by all nurses

Type of activity	PRIMARY NURSING WARDS			TEAM NURSING WARDS			FUNCTIONAL NURSING WARDS		
	Time in mins	Mean % time	Time in mins	Mean % time	Time in mins	Mean % time	Time in mins	Mean % time	
Fundamental patient care	1871	40.2	1830	39.7	1384	30.4			
Supplementary patient care	289	6.2	410	9.0	439	11.1			
Communication	319	6.9	344	7.5	428	9.5			
Administration	261	5.6	313	6.8	230	5.1			
Domestic	235	5.0	373	8.1	445	9.7			
Sociable	174	3.7	150	3.3	160	3.5			
Staff time/unoccupied	871	18.7	705	15.3	1048	23.1			
Other	300	6.5	195	4.2	186	4.1			
Total time	4319		4319		4319				

APPENDIX 8e

MORNING SESSION Time spent in activities with patients by all nurses

Type of activity	PRIMARY NURSING WARDS			TEAM NURSING WARDS			FUNCTIONAL NURSING WARDS		
	Time in mins	Mean % time with patients	Mean % total time	Time in mins	Mean % time with patients	Mean % total time	Time in mins	Mean % time with patients	Mean % total time
Fundamental patient care	1480	65.1	31.8	1430	60.4	31.0	1072	54.6	23.5
Supplementary patient care	140	6.5	3.0	179	8.9	3.9	215	14.3	5.5
Communication	0	0	0	1	0.2	0.1	0	0	0
Administration	37	1.6	0.8	58	2.7	1.3	33	3.2	1.2
Domestic	72	3.1	1.5	205	8.3	4.5	208	9.6	4.5
Sociable	174	7.7	3.7	148	6.4	3.2	159	8.1	3.5
Staff time/unoccupied	24	1.2	0.6	26	1.1	0.6	35	1.7	0.8
Other	3	0.2	0.1	10	0.4	0.2	4	0.2	0.1
Total time	1930			2056			1726		

APPENDIX 8f

MORNING SESSION Time spent in activities away from patients by all nurses

Type of activity	PRIMARY NURSING WARDS			TEAM NURSING WARDS			FUNCTIONAL NURSING WARDS		
	Time in mins	Mean % time away from patients	Mean % total time	Time in mins	Mean % time away from patients	Mean % total time	Time in mins	Mean % time away from patients	Mean % total time
Fundamental patient care	370	25.5	8.4	351	24.3	8.7	303	16.3	6.9
Supplementary patient care	117	9.6	4.3	194	13.1	5.6	200	12.6	6.6
Communication	129	8.3	6.9	115	7.5	7.5	172	8.4	9.5
Administration	214	12.8	4.8	253	16.0	5.6	194	10.7	5.0
Domestic	162	11.3	3.5	168	12.0	3.7	238	13.8	5.2
Sociable	0	0.2	0.1	2	0.4	0.1	0	0.1	0.03
Staff time/unoccupied	310	20.1	18.2	245	16.3	14.8	660	33.1	22.3
Other	215	14.8	6.4	183	12.3	4.0	180	9.4	4.0
Total time	1517			1511			1948		

## AFTERNOON SESSION Time spent in activities by all nurses

Type of activity	PRIMARY NURSING WARDS		TEAM NURSING WARDS		FUNCTIONAL NURSING WARDS	
	Time in mins	Mean % time	Time in mins	Mean % time	Time in mins	Mean % time
Fundamental patient care	641	30.8	510	27.2	560	26.0
Supplementary patient care	150	8.7	184	11.2	222	10.9
Communication	385	16.9	183	10.9	118	6.2
Administration	165	7.0	129	6.0	205	11.1
Domestic	145	6.6	51	2.5	64	3.7
Sociable	153	6.6	93	5.1	97	4.0
Staff time/unoccupied	418	15.4	556	30.1	618	29.6
Other	103	4.4	94	5.0	97	4.2
Total time	2160		1800		1980	

APPENDIX 8H

AFTERNOON SESSION Time spent in activities with patients by all nurses

Type of activity	PRIMARY NURSING WARDS			TEAM NURSING WARDS			FUNCTIONAL NURSING WARDS		
	Time in mins	Mean % time with patients	Mean % total time	Time in mins	Mean % time with patients	Mean % total time	Time in mins	Mean % time with patients	Mean % total time
Fundamental patient care	522	53.6	25.4	395	56.1	21.3	428	50.4	19.9
Supplementary patient care	80	11.3	4.7	89	14.1	5.0	113	14.9	5.3
Communication	3	2.1	0.8	2	4.5	0.9	0	0	0
Administration	32	5.0	1.9	13	1.8	0.7	66	11.9	4.7
Domestic	13	1.9	0.7	17	2.7	1.1	13	1.8	0.8
Sociable	152	15.1	6.6	91	12.5	5.0	97	9.6	4.0
Staff time/unoccupied	27	2.8	1.3	26	3.9	1.7	14	1.8	0.7
Other	4	0.6	0.2	2	0.3	0.1	1	0.3	0.1
Total time	833			632			733		



AFTERNOON SESSION Time spent in activities away from patients by all nurses

Type of activity	PRIMARY NURSING WARDS			TEAM NURSING WARDS			FUNCTIONAL NURSING WARDS		
	Time in mins	Mean % time away from patients	Mean % total time	Time in mins	Mean % time away from patients	Mean % total time	Time in mins	Mean % time away from patients	Mean % total time
Fundamental patient care	109	15.3	5.5	103	20.6	5.9	129	13.3	6.1
Supplementary patient care	69	17.0	5.9	95	19.1	7.4	107	14.4	6.5
Communication	147	17.4	16.8	75	12.3	10.7	84	8.9	6.2
Administration	131	15.4	5.8	115	15.0	5.4	127	13.8	7.1
Domestic	128	21.1	7.1	35	7.3	2.2	52	8.7	3.2
Sociable	1	0.3	0.1	2	3.3	0.5	0	0	0
Staff time/unoccupied	132	15.0	14.3	99	16.9	28.7	358	34.8	29.0
Other	91	12.5	4.2	90	17.0	4.9	96	9.5	4.2
Total time	807			613			953		

## EVENING SESSION Time spent in activities by all nurses

Type of activity	PRIMARY NURSING WARDS		TEAM NURSING WARDS		FUNCTIONAL NURSING WARDS	
	Time in mins	Mean % time	Time in mins	Mean % time	Time in mins	Mean % time
Fundamental patient care	771	36.9	920	34.6	776	32.0
Supplementary patient care	49	1.9	229	8.5	190	7.6
Communication	148	6.9	134	5.4	213	9.0
Administration	257	13.3	218	7.6	216	9.1
Domestic	90	5.1	87	3.2	72	3.0
Sociable	157	6.4	118	4.4	151	5.0
Staff time/unoccupied	595	23.3	652	25.5	578	25.1
Other	94	4.1	162	6.1	145	5.8
Total time	2160		2520		2340	

## EVENING SESSION Time spent in activities with patients by all nurses

Type of activity	PRIMARY NURSING WARDS			TEAM NURSING WARDS			FUNCTIONAL NURSING WARDS		
	Time in mins	Mean % time with patients	Mean % total time	Time in mins	Mean % time with patients	Mean % total time	Time in mins	Mean % time with patients	Mean % total time
Fundamental patient care	640	65.6	31.1	694	60.6	25.8	627	59.6	25.3
Supplementary patient care	18	3.0	0.9	116	11.2	4.3	92	10.6	3.7
Administration	4	1.6	0.4	17	1.5	0.6	19	3.7	1.5
Domestic	3	0.5	0.2	17	1.9	0.8	12	2.0	0.9
Sociable	156	14.9	6.3	118	10.5	4.3	149	12.0	4.9
Staff time/unoccupied	26	2.6	1.3	29	2.9	1.3	36	3.8	1.7
Other	0	0.1	0.03	6	0.8	0.3	3	0.4	0.1
Total time	846			997			938		

## EVENING SESSION Time spent in activities away from patients by all nurses

Type of activity	PRIMARY NURSING WARDS			TEAM NURSING WARDS			FUNCTIONAL NURSING WARDS		
	Time in mins	Mean % time away from patients	Mean % total time	Time in mins	Mean % time away from patients	Mean % total time	Time in mins	Mean % time away from patients	Mean % total time
Fundamental patient care	126	16.7	5.9	203	21.9	8.8	146	17.1	6.8
Supplementary patient care	31	4.2	1.9	113	9.6	4.8	99	11.5	6.2
Communication	95	9.4	6.9	74	6.4	5.4	100	8.0	9.0
Administration	248	28.9	15.3	201	16.3	8.0	196	18.2	8.5
Domestic	87	13.4	5.0	70	6.8	2.5	60	6.0	2.4
Sociable	2	0.7	0.4	0	0.3	0.1	1	0.3	0.1
Staff time/unoccupied	280	30.2	22.0	287	26.6	24.5	364	32.5	23.5
Other	93	11.0	4.1	155	15.6	5.9	140	13.3	5.6
Total time	961			1103			1104		

**APPENDIX 9a**

**ANALYSIS OF VARIANCE TABLE: ACTIVITIES**

All sessions

All activities

**1. Fundamental patient care**

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	1193.7	3	397.9	15.6	.00
Nursing staff grade	174.6	2	87.3	3.4	.06
	1019.1	1	1019.1	39.9	.00
<b>2 way interactions</b>					
Explained	47.0	2	23.5	0.9	.42
Residual	1240.6	5	248.1	9.7	.00
<b>Total</b>	459.6	18	25.5		
	1700.2	23	73.9		

APPENDIX 9b

ANALYSIS OF VARIANCE TABLE: ACTIVITIES

All sessions

All activities

2. Supplementary patient care

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	1160.8	3	386.9	59.5	.00
Nursing staff grade	83.7	2	41.9	6.4	.01
	1077.1	1	1077.1	165.6	.00
<b>2 way interactions</b>					
Explained	48.4	2	24.2	3.7	.04
Residual	1209.2	5	241.8	37.2	.00
<b>Total</b>	117.1	18	6.5		
	1326.3	23	57.7		

**APPENDIX 9c**

**ANALYSIS OF VARIANCE TABLE: ACTIVITIES**

All sessions

All activities

**3. Communication**

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>	405.2	3	135.1	14.1	.00
Organisational mode	15.4	2	7.7	0.8	.46
Nursing staff grade	389.8	1	389.8	40.6	.00
<b>2 way interactions</b>	1.1	2	0.5	0.1	.95
Explained	406.3	5	81.3	8.5	.00
Residual	172.9	18	9.6		
<b>Total</b>	<b>579.2</b>	<b>23</b>	<b>25.2</b>		

APPENDIX 9d

ANALYSIS OF VARIANCE TABLE: ACTIVITIES

All sessions

All activities

4. Administration

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	312.3	3	104.1	18.0	.00
Nursing staff grade	0.2	2	0.1	0.0	.99
	312.1	1	312.1	53.9	.00
<b>2 way interactions</b>					
Explained	0.2	2	0.1	0.0	.98
Residual	312.5	5	62.5	10.8	.00
<b>Total</b>	104.2	18	5.8		
	416.7	23	18.1		



APPENDIX 9e

ANALYSIS OF VARIANCE TABLE: ACTIVITIES

All sessions

All activities

5. Domestic

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>	187.6	3	62.5	11.2	.00
Organisational mode	6.7	2	3.4	0.6	.56
Nursing staff grade	180.9	1	180.9	32.3	.00
<b>2 way interactions</b>	11.5	2	5.7	1.0	.38
Explained	199.0	5	39.8	7.1	.00
Residual	100.7	18	5.6		
<b>Total</b>	299.7	23	13.0		

**APPENDIX 9f**

**ANALYSIS OF VARIANCE TABLE: ACTIVITIES**

All sessions

All activities

6. Other

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	14.0	3	4.7	1.8	.18
Nursing staff grade	1.8	2	0.9	0.4	.70
	12.1	1	12.1	4.8	.04
<b>2 way interactions</b>					
Explained	7.0	2	3.5	1.4	.28
Residual	20.9	5	4.2	1.6	.20
<b>Total</b>	46.0	18	2.6		
	66.9	23	2.9		

APPENDIX 9g

ANALYSIS OF VARIANCE TABLE: ACTIVITIES

All sessions

All activities

7. Staff time/unoccupied

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	336.0	3	112.0	4.9	.01
Nursing staff grade	87.6	2	43.8	1.9	.17
	248.5	1	248.5	11.0	.00
<b>2 way interactions</b>					
Explained	41.3	2	20.7	0.9	.42
Residual	377.4	5	75.5	3.3	.03
<b>Total</b>	408.6	18	22.7		
	785.9	23	34.2		

**APPENDIX 9h**

**ANALYSIS OF VARIANCE TABLE: ACTIVITIES**

All sessions

All activities

8. Sociable

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>	15.0	3	5.0	2.3	.11
Organisational mode	6.4	2	3.2	1.5	.25
Nursing staff grade	8.6	1	8.6	4.0	.06
<b>2 way interactions</b>	1.4	2	0.7	0.3	.72
Explained	16.4	5	3.3	1.5	.23
Residual	38.3	18	2.1		
<b>Total</b>	54.7	23	2.4		

## ANALYSIS OF VARIANCE TABLE: ACTIVITIES

All sessions

Activities with patients

## 1. Fundamental patient care

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	1116.6	3	372.2	11.8	.00
Nursing staff grade	230.0	2	115.0	3.7	.05
	886.6	1	886.6	28.1	.00
<b>2 way interactions</b>					
Explained	107.7	2	53.9	1.7	.21
Residual	1224.3	5	244.9	7.8	.00
<b>Total</b>	567.2	18	31.5		
	1791.5	23	77.9		

APPENDIX 9j

ANALYSIS OF VARIANCE TABLE: ACTIVITIES

All sessions  
 Activities with patients  
 2. Supplementary patient care

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	1694.3	3	564.8	70.9	.00
Nursing staff grade	168.5	2	84.3	10.6	.00
	1525.8	1	1525.8	191.6	.00
<b>2 way interactions</b>					
Explained	115.3	2	57.7	7.2	.01
Residual	1809.6	5	361.9	45.4	.00
<b>Total</b>	143.4	18	8.0		
	1953.0	23	84.9		

**APPENDIX 9k**

**ANALYSIS OF VARIANCE TABLE: ACTIVITIES**

All sessions

Activities with patients

**3. Administration**

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	16.5	3	5.5	3.3	.05
Nursing staff grade	14.1	2	7.0	4.2	.03
	1.8	1	1.8	1.1	.32
<b>2 way interactions</b>					
Explained	5.7	2	2.9	1.7	.21
Residual	22.2	5	4.5	2.6	.06
<b>Total</b>	28.7	17	1.7		
	50.9	22	2.3		

## ANALYSIS OF VARIANCE TABLE: ACTIVITIES

All sessions

Activities with patients

## 4. Domestic

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	122.5	3	40.8	7.5	.00
Nursing staff grade	63.0	2	31.5	5.8	.01
	59.5	1	59.5	11.0	.00
<b>2 way interactions</b>					
Explained	7.0	2	3.5	0.7	.54
Residual	129.5	5	25.9	4.8	.01
<b>Total</b>	97.6	18	5.4		
	227.1	23	9.9		



**APPENDIX 9m**

**ANALYSIS OF VARIANCE TABLE: ACTIVITIES**

All sessions

Activities with patients

5. Other

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	0.2	3	0.1	2.5	.10
Nursing staff grade	0.2	2	0.1	3.7	.05
	0.0	1	0.0	0.0	.85
<b>2 way interactions</b>					
Explained	0.1	2	0.0	1.0	.38
Residual	0.2	5	0.1	1.9	.15
<b>Total</b>	0.4	17	0.0		
	0.7	22	0.0		

**APPENDIX 9n**

**ANALYSIS OF VARIANCE TABLE: ACTIVITIES**

All sessions

Activities with patients

**6. Staff time/unoccupied**

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	12.0	3	4.0	2.1	.14
Nursing staff grade	0.5	2	0.3	0.1	.88
	11.5	1	11.5	6.0	.03
<b>2 way interactions</b>					
Explained	1.0	2	0.5	0.3	.77
Residual	13.0	5	2.6	1.4	.29
<b>Total</b>	34.7	18	1.9		
	47.7	23	2.1		

## ANALYSIS OF VARIANCE TABLE: ACTIVITIES

All sessions

Activities with patients

7. Sociable

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	34.3	3	11.4	1.3	.30
Nursing staff grade	33.2	2	16.6	1.9	.18
	1.1	1	1.1	0.1	.73
<b>2 way interactions</b>					
Explained	2.1	2	1.0	0.1	.89
Residual	36.3	5	7.3	0.8	.54
<b>Total</b>	157.3	18	8.7		
	193.7	23	8.4		

**APPENDIX 9p**

**ANALYSIS OF VARIANCE TABLE: ACTIVITIES**

All sessions

Activities away from patients

**1. Fundamental patient care**

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	800.2	3	266.7	12.4	.00
Nursing staff grade	171.1	2	85.5	4.0	.04
	629.2	1	629.2	29.3	.00
<b>2 way interactions</b>					
Explained	14.3	2	7.1	0.3	.72
Residual	814.5	5	162.9	7.6	.00
<b>Total</b>	386.1	18	21.5		
	1200.6	23	52.2		

APPENDIX 9q

ANALYSIS OF VARIANCE TABLE: ACTIVITIES

All sessions  
 Activities away from patients  
 2. Supplementary patient care

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	1373.3	3	457.8	25.7	.00
Nursing staff grade	101.3	2	50.7	2.8	.09
	1303.1	1	1303.1	73.1	.00
<b>2 way interactions</b>					
Explained	45.6	2	22.8	1.3	.31
Residual	1418.9	5	283.8	15.9	.00
<b>Total</b>	285.3	16	17.8		
	1704.3	21	81.2		

APPENDIX 9r

ANALYSIS OF VARIANCE TABLE: ACTIVITIES

All sessions  
 Activities away from patients  
 3. Communication

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	358.2	3	119.4	13.8	.00
Nursing staff grade	39.2	2	19.6	2.3	.13
	319.1	1	319.1	36.8	.00
<b>2 way interactions</b>					
Explained	18.6	2	9.3	1.1	.36
Residual	376.8	5	75.4	8.7	.00
<b>Total</b>	156.0	18	8.7		
	532.8	23	23.2		

**APPENDIX 9s**

**ANALYSIS OF VARIANCE TABLE: ACTIVITIES**

All sessions  
 Activities away from patients  
 4. Administration

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	1563.3	3	521.1	20.3	.00
Nursing staff grade	106.7	2	53.3	2.1	.16
	1456.7	1	1456.7	56.7	.00
<b>2 way interactions</b>					
Explained	57.2	2	28.6	1.1	.35
Residual	1620.5	5	324.1	12.6	.00
<b>Total</b>	462.8	18	25.7		
	2083.3	23	90.6		

APPENDIX 9t

ANALYSIS OF VARIANCE TABLE: ACTIVITIES

All sessions  
 Activities away from patients  
 5. Domestic

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	881.7	3	293.9	14.3	.00
Nursing staff grade	36.0	2	18.0	0.9	.43
	845.7	1	845.7	41.1	.00
<b>2 way interactions</b>					
Explained	37.4	2	18.7	0.9	.42
Residual	919.1	5	183.8	8.9	.00
<b>Total</b>	370.6	18	20.6		
	1289.7	23	56.1		



**APPENDIX 9u**

**ANALYSIS OF VARIANCE TABLE: ACTIVITIES**

All sessions  
 Activities away from patients  
 6. Other

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	186.1	3	62.0	19.6	.00
Nursing staff grade	40.4	2	20.2	6.4	.01
	145.7	1	145.7	46.0	.00
<b>2 way interactions</b>					
Explained	13.9	2	6.9	2.2	.14
Residual	200.0	5	40.0	12.6	.00
<b>Total</b>	57.0	18	3.2		
	257.0	23	11.2		

APPENDIX 9v

ANALYSIS OF VARIANCE TABLE: ACTIVITIES

All sessions  
 Activities away from patients  
 7. Staff time/unoccupied

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>	1735.5	3	578.5	9.4	.00
Organisational mode	975.9	2	488.0	7.9	.00
Nursing staff grade	759.6	1	759.6	12.3	.00
<b>2 way interactions</b>	3.7	2	1.8	0.0	.97
Explained	1739.2	5	347.8	5.6	.00
Residual	1110.1	18	61.7		
<b>Total</b>	2849.3	23	123.9		

APPENDIX 9W

ANALYSIS OF VARIANCE TABLE: ACTIVITIES

All sessions  
 Activities away from patients  
 8. Sociable

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	0.2	3	0.1	0.9	.51
Nursing staff grade	0.2	2	0.1	1.0	.42
	0.1	1	0.1	0.8	.40
<b>2 way interactions</b>					
Explained	0.2	2	0.1	1.4	.33
Residual	0.5	5	0.1	1.1	.46
<b>Total</b>	0.4	5	0.1		
	0.9	10	0.1		

APPENDIX 10a

ANALYSIS OF COVARIANCE TABLE: ACTIVITIES

All sessions

All activities

1. Sociable

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
Covariates	1.8	3	0.6	1.5	.22
Qualified staff/patient ratio	1.6	1	1.6	4.1	.05
Unqualified staff/patient ratio	1.5	1	1.5	3.7	.06
Total staff/patient ratio	1.5	1	1.5	3.8	.06
Main effects	2.4	3	0.8	2.0	.12
Organisational mode	0.6	2	0.3	0.8	.47
Nursing staff grade	1.8	1	1.8	4.5	.04
2 way interactions	0.3	2	0.2	0.4	.67
Explained	4.5	8	0.6	1.4	.20
Residual	47.2	118	0.4		
Total	51.7	126	0.4		

**APPENDIX 10b**

**ANALYSIS OF COVARIANCE TABLE: ACTIVITIES**

All sessions

Activities with patients

**2. Supplementary patient care**

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Covariates</b>	82.9	3	27.6	5.3	.00
Qualified staff/patient ratio	21.1	1	21.1	4.1	.05
Unqualified staff/patient ratio	16.3	1	16.3	3.1	.08
Total staff/patient ratio	16.3	1	16.3	3.1	.08
<b>Main effects</b>	270.1	3	90.0	17.3	.00
Organisational mode	22.9	2	11.5	2.2	.12
Nursing staff grade	251.1	1	251.1	48.4	.00
<b>2 way interactions</b>	20.2	2	10.1	2.0	.15
Explained	373.2	8	46.6	9.0	.00
Residual	519.4	100	5.2		
<b>Total</b>	892.6	108	8.3		

APPENDIX 10c

ANALYSIS OF COVARIANCE TABLE: ACTIVITIES

All sessions

Activities with patients

3. Sociable

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Covariates</b>	9.1	3	3.0	1.7	.17
Qualified staff/patient ratio	7.9	1	7.9	4.5	.04
Unqualified staff/patient ratio	7.0	1	7.0	3.9	.05
Total staff/patient ratio	7.3	1	7.3	4.1	.05
<b>Main effects</b>	4.6	3	1.5	0.9	.46
Organisational mode	4.3	2	2.1	1.2	.31
Nursing staff grade	0.4	1	0.4	0.2	.65
<b>2 way interactions</b>	0.4	2	0.2	0.1	.90
Explained	14.1	8	1.8	1.0	.45
Residual	210.0	118	1.8		
<b>Total</b>	224.1	126	1.8		

APPENDIX 10d

ANALYSIS OF COVARIANCE TABLE: ACTIVITIES

Evening sessions

Activities with patients

4. Supplementary patient care

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Covariates</b>	197.6	3	65.9	2.6	.07
Qualified staff/patient ratio	165.5	1	165.5	6.6	.02
Unqualified staff/patient ratio	136.1	1	136.1	5.4	.03
Total staff/patient ratio	139.5	1	139.5	5.6	.03
<b>Main effects</b>	808.8	3	269.6	10.7	.00
Organisational mode	122.4	2	61.2	2.4	.11
Nursing staff grade	645.4	1	645.4	25.7	.00
<b>2 way interactions</b>	178.4	2	89.2	3.6	.04
Explained	1184.8	8	148.1	5.9	.00
Residual	654.0	26	25.2		
<b>Total</b>	1838.8	34	54.1		

## APPENDIX 11

### VERBAL INTERACTION CATALOGUE WITH DEFINITIONS

#### 1. Giving choice

Nurse gives the patient positive choice between two or more alternatives e.g. 'which bed would you like?'

#### 2. Asking questions

Other requests intending to result in verbal feedback from the patient e.g. 'is the bath water too hot?'

#### 3. Giving commands

Instruction to the patient to perform activity e.g. 'please sit down'

#### 4. Explanation - simple

Routine remark or explanation e.g. 'here's your dinner'

#### 5. Explanation - detailed

Giving reasons WHY, for example, procedures are being performed, drugs are being administered  
Explanations showing knowledge of individual patients' needs e.g. 'I've made your tea black because I know that's how you like it.'  
Discussing aspects of his care with the patient

#### 6. Encouraging towards self-care

Using words or phrases with the intention of giving the patient confidence to regain, maintain or improve self-care abilities

#### 7. Teaching

Imparting knowledge with the aim of changing behaviour

#### 8. Comforting/reassuring

Using reassuring words or phrases  
Attempting to relieve a patient's need or worry by providing answers to/explanations for his problems

#### 9. Sociable interaction

Conversation not related to the patient's condition or care

#### 10. Other

Any other communication related to the patient's condition or care not covered by the above categories, including interactions which the researcher is unable to hear.



## ALL SESSIONS Time spent in each type of verbal interaction by all nurses

Type of verbal interaction	PRIMARY NURSING WARDS			TEAM NURSING WARDS			FUNCTIONAL NURSING WARDS		
	Time in mins	Mean % time in verbal interaction	Mean % total time	Time in mins	Mean % time in verbal interaction	Mean % total time	Time in mins	Mean % time in verbal interaction	Mean % total time
Command/instruction	75	11.9	0.8	74	14.9	0.8	64	13.9	0.7
Giving choice	75	12.1	0.8	56	11.3	0.6	50	10.8	0.6
Question	103	16.5	1.1	83	16.8	0.9	79	17.5	0.9
Explanation - simple	172	28.4	1.9	134	27.4	1.5	131	29.0	1.4
Explanation - detailed	85	13.7	0.9	67	13.8	0.7	55	12.0	0.6
Encouragement of self-care	11	1.9	0.1	11	2.4	0.1	9	1.9	0.1
Teaching	1	0.3	0.02	0	0.2	0.01	2	0.9	0.04
Reassurance	5	0.8	0.06	4	0.7	0.04	2	0.4	0.03
Sociable	94	14.3	1.0	63	12.5	0.7	66	13.8	0.7
Inaudible/other	1	0.3	0.02	2	0.3	0.02	2	0.3	0.02
Total time	623			493			458		

## MORNING SESSION Time spent in each type of verbal interaction by all nurses

Type of verbal interaction	PRIMARY NURSING WARDS			TEAM NURSING WARDS			FUNCTIONAL NURSING WARDS		
	Time in mins	Mean % time in verbal interaction	Mean % total time	Time in mins	Mean % time in verbal interaction	Mean % total time	Time in mins	Mean % time in verbal interaction	Mean % total time
Command/ instruction	41	11.8	0.9	37	13.7	0.8	31	13.8	0.7
Giving choice	41	12.1	0.9	31	11.1	0.7	22	9.9	0.5
Question	53	15.6	1.1	48	17.2	1.0	40	17.9	0.9
Explanation - simple	100	30.7	2.2	83	30.3	1.8	68	30.6	1.5
Explanation - detailed	45	13.1	1.0	36	13.3	0.8	27	12.1	0.6
Encouragement of self-care	7	2.3	0.2	9	3.1	0.2	5	2.1	0.1
Teaching	1	0.8	0.1	0	0.3	0.02	1	0.5	0.03
Reassurance	2	0.7	0.05	1	0.6	0.04	1	0.6	0.04
Sociable	48	13.4	1.03	31	10.5	0.7	28	12.4	0.6
Inaudible/other	1	0.3	0.02	1	0.4	0.02	1	0.5	0.02
Total time	339			277			223		

## AFTERNOON SESSION Time spent in each type of verbal interaction by all nurses

Type of verbal interaction	PRIMARY NURSING WARDS			TEAM NURSING WARDS			FUNCTIONAL NURSING WARDS		
	Time in mins	Mean % time in verbal interaction	Mean % total time	Time in mins	Mean % time in verbal interaction	Mean % total time	Time in mins	Mean % time in verbal interaction	Mean % total time
Command/instruction	18	12.5	0.8	20	20.2	1.2	14	15.2	0.7
Giving choice	18	11.5	0.8	10	10.4	0.5	18	16.7	0.9
Question	27	16.7	1.1	11	12.6	0.6	18	16.6	0.8
Explanation - simple	39	27.8	1.8	20	23.8	1.1	29	28.3	1.3
Explanation - detailed	21	14.3	1.0	11	12.8	0.5	13	10.1	0.5
Encouragement of self-care	2	1.5	0.1	1	1.2	0.1	1	1.2	0.06
Teaching	0	0.8	0.1	0	1.2	0.04	0	0.6	0.04
Reassurance	1	0.9	0.07	1	0.9	0.04	1	0.8	0.04
Sociable	28	14.7	1.08	15	17.9	0.9	14	11.5	0.6
Inaudible/other	0	0.3	0.02	0	0.3	0.01	0	0.6	0.03
Total time	155			88			108		

## EVENING SESSION Time spent in each type of verbal interaction by all nurses

Type of verbal interaction	PRIMARY NURSING WARDS			TEAM NURSING WARDS			FUNCTIONAL NURSING WARDS		
	Time in mins	Mean % time in verbal interaction	Mean % total time	Time in mins	Mean % time in verbal interaction	Mean % total time	Time in mins	Mean % time in verbal interaction	Mean % total time
Command/ Instruction	16	12.9	0.8	18	14.4	0.7	18	16.3	0.7
Giving choice	16	11.5	0.7	15	11.1	0.6	10	8.1	0.4
Question	23	18.2	1.0	24	18.8	0.9	21	16.5	0.8
Explanation - simple	33	25.6	1.5	32	23.7	1.2	34	29.5	1.3
Explanation - detailed	19	14.4	0.8	20	15.5	0.7	16	12.2	0.6
Encouragement of self-care	2	2.3	0.1	2	1.9	0.1	3	2.8	0.1
Teaching	0	0.4	0.02	0	0	0	1	2.5	0.1
Reassurance	2	1.4	0.1	2	1.3	0.07	1	0.3	0.02
Sociable	17	13.7	0.7	17	13.5	0.6	23	13.5	0.7
Inaudible/other	0	0.6	0.02	1	0.6	0.03	0	0.4	0.02
Total time	129			128			127		

APPENDIX 13a

ANALYSIS OF VARIANCE TABLE: VERBAL INTERACTION

All sessions

All activities

1. Command/instruction

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	0.5	3	0.2	3.2	.05
Nursing staff grade	0.1	2	0.0	0.6	.57
<b>2 way interactions</b>					
Explained	0.5	5	0.1	1.9	.14
Residual	1.0	18	0.1		
<b>Total</b>	<b>1.5</b>	<b>23</b>	<b>0.1</b>		

APPENDIX 13b

ANALYSIS OF VARIANCE TABLE: VERBAL INTERACTION

All sessions

All activities

2. Giving choice

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	0.6	3	0.2	5.1	.01
Nursing staff grade	0.3	2	0.2	4.1	.03
	0.3	1	0.3	7.0	.02
<b>2 way interactions</b>					
Explained	0.1	2	0.1	1.3	.30
Residual	0.7	5	0.1	3.6	.02
<b>Total</b>	1.3	18	0.0		
		23	0.1		

APPENDIX 13c

ANALYSIS OF VARIANCE TABLE: VERBAL INTERACTION

All sessions

All activities

3. Questions

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	0.3	3	0.1	1.9	.17
Nursing staff grade	0.3	2	0.1	2.6	.10
	0.0	1	0.0	0.4	.52
<b>2 way interactions</b>					
Explained	0.0	2	0.0	0.2	.80
Residual	0.3	5	0.1	1.2	.34
<b>Total</b>	1.0	18	0.1		
	1.3	23	0.1		

APPENDIX 13d

ANALYSIS OF VARIANCE TABLE: VERBAL INTERACTION

All sessions

All activities

4. Explanation - simple

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	1.5	3	0.5	9.5	.00
Nursing staff grade	0.9	2	0.5	8.4	.00
<b>2 way interactions</b>					
Explained	0.6	1	0.6	11.5	.00
Residual	0.0	2	0.0	0.3	.73
<b>Total</b>	1.5	5	0.3	5.8	.00
	1.0	18	0.1		
	2.5	23	0.1		



**APPENDIX 13e**

**ANALYSIS OF VARIANCE TABLE: VERBAL INTERACTION**

All sessions

All activities

**5. Explanation - detailed**

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	0.7	3	0.2	2.6	.08
Nursing staff grade	0.4	2	0.2	2.4	.12
	0.3	1	0.3	3.1	.10
<b>2 way interactions</b>					
Explained	0.3	2	0.2	1.9	.17
Residual	1.0	5	0.2	2.3	.08
<b>Total</b>	1.5	18	0.1		
	2.5	23	0.1		

APPENDIX 13f

ANALYSIS OF VARIANCE TABLE: VERBAL INTERACTION

All sessions

All activities

6. Sociable

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Main effects</b>					
Organisational mode	1.6	3	0.5	4.1	.02
Nursing staff grade	0.5	2	0.2	1.9	.18
<b>2 way interactions</b>					
Explained	1.1	1	1.1	8.4	.01
Residual	0.2	2	0.1	0.9	.43
<b>Total</b>	1.8	5	0.4	2.8	.05
	2.3	18	0.1		
	4.1	23	0.2		

APPENDIX 14a

ANALYSIS OF COVARIANCE TABLE: VERBAL INTERACTION

All sessions

Activities with patients

1. Giving choice

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Covariates</b>					
Qualified staff/patient ratio	0.2	3	0.1	2.0	.12
Unqualified staff/patient ratio	0.2	1	0.2	4.2	.04
Total staff/patient ratio	0.2	1	0.2	4.1	.05
<b>Main effects</b>					
Organisational mode	0.2	1	0.2	4.3	.04
Nursing staff grade	0.2	3	0.1	2.0	.13
<b>2 way interactions</b>					
Explained	0.0	2	0.1	2.4	.10
Residual	0.1	1	0.0	1.1	.30
<b>Total</b>					
	0.5	2	0.0	1.1	.35
	4.5	8	0.1	1.8	.09
	5.0	118	0.0		
		126	0.0		

APPENDIX 14b

ANALYSIS OF COVARIANCE TABLE: VERBAL INTERACTION

Afternoon sessions

All activities

2. Giving choice

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Covariates</b>					
Qualified staff/patient ratio	0.9	3	0.3	1.4	.26
Unqualified staff/patient ratio	0.8	1	0.8	4.0	.06
Total staff/patient ratio	0.8	1	0.8	4.1	.06
	0.8	1	0.8	4.1	.05
<b>Main effects</b>					
Organisational mode	1.1	3	0.4	1.9	.16
Nursing staff grade	0.0	2	0.0	0.1	.94
<b>2 way interactions</b>					
Explained	1.1	1	1.1	5.4	.03
Residual	0.4	2	0.2	0.9	.41
<b>Total</b>	2.4	8	0.3	1.5	.22
	4.8	24	0.2		
	7.2	32	0.2		

APPENDIX 14c

ANALYSIS OF COVARIANCE TABLE: VERBAL INTERACTION

Afernoon sessions

All activities

3. Questions

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
Covariates	1.0	3	0.3	4.0	.02
Qualified staff/patient ratio	0.9	1	0.9	10.0	.00
Unqualified staff/patient ratio	0.8	1	0.8	8.9	.01
Total staff/patient ratio	0.8	1	0.8	9.3	.01
Main effects	0.4	3	0.1	1.6	.22
Organisational mode	0.4	2	0.2	2.4	.12
Nursing staff grade	0.0	1	0.0	0.0	.90
2 way interactions	0.1	2	0.0	0.3	.72
Explained	1.5	8	0.2	2.2	.07
Residual	2.1	24	.09		
Total	3.5	32	0.1		

## ANALYSIS OF COVARIANCE TABLE: VERBAL INTERACTION

Afternoon sessions  
 Activities with patients  
 4. Questions

	Sum of squares	Degrees of Freedom	Mean Square	F	Sig of F
<b>Covariates</b>					
Qualified staff/patient ratio	5.9	3	2.0	4.1	.02
Unqualified staff/patient ratio	4.4	1	4.4	9.2	.01
Total staff/patient ratio	3.8	1	3.8	7.8	.01
<b>Main effects</b>					
Organisational mode	3.9	1	3.9	8.2	.01
Nursing staff grade	1.9	3	0.6	1.3	.29
<b>2 way interactions</b>					
Explained	1.4	2	0.7	1.4	.26
Residual	0.6	1	0.6	1.3	.27
<b>Total</b>	0.3	2	0.1	0.3	.74
	8.1	8	1.0	2.1	.08
	11.5	24	0.5		
	19.6	32	0.6		

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CONFIDENTIAL

**A COMPARISON OF THE CONTRIBUTION TO PATIENT CARE OF  
 QUALIFIED NURSES AND NURSING AUXILIARIES**

**QUALIFIED STAFF INTERVIEW SCHEDULE**

Survey number

1      1

First, I would like to ask you some personal details.

1. Do you work FULL TIME or PART TIME?

Full time 1  
 Part time 2

6

IF PART TIME,

How many hours do you work per week?

7

2. How old were you on your last birthday?

11

3. What is your basic professional qualification?

Registered General Nurse 1  
 Enrolled nurse 2  
 Other (Specify) 3

13

4. Do you have any other NURSING qualifications?

Yes 1  
 No 2

14

IF YES, what?

Registered Mental Nurse 01  
 Registered Nurse for the Mentally  
 Subnormal (RMNS/RMND/RMNH) 02  
 Registered Sick Children's Nurse 03  
 State Certified Midwife 04  
 Health Visitor's Certificate  
 (HV Cert/RHV) 05  
 District Nursing Certificate 06  
 Nursing Degree 07  
 Nursing Diploma 08  
 Other (specify) 09  
 Not applicable 98

15    
 ..    
 17    
 ..    
 19    
 ..

5. Have you attended any Joint Board or English National Board courses?

Yes 1  
No 2

21   
..

IF YES, which?

JBCNS/ENB long course in the care of elderly people (JBCNS 297) 1  
JBCNS/ENB short course in nursing elderly people (JBCNS/ENB 940 or 941) 2  
Other JBCNS/ENB long course 3  
Other JBCNS/ENB short course 4  
Not applicable 8

22   
..   
23   
..   
24   
..

6. Have you attended any other nursing course?

Yes 1  
No 2

25   
..

IF YES, SPECIFY.

26    
..    
28    
..    
30    
..

7. Which ONE nursing qualification do you think prepared you best for your present post?

32   
..

8. Do you have any NON-NURSING qualifications?

Yes 1  
No 2

33   
..

IF YES, what?

University or Polytechnic degree 1  
Other professional qualification 2  
Other non-professional qualification 3  
Not applicable 8

34   
..   
35   
..

9. What year did you first qualify as a nurse?

36    
..



10. What nursing posts have you held since qualifying?  
(SPECIFY TYPE OF WARD, DATES IN POST)

TYPE OF WARD

DATES IN POST

38	<input type="checkbox"/>	<input type="checkbox"/>	48	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>
40	<input type="checkbox"/>	<input type="checkbox"/>	49	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>
42	<input type="checkbox"/>	<input type="checkbox"/>	50	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>
44	<input type="checkbox"/>	<input type="checkbox"/>	51	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>
46	<input type="checkbox"/>	<input type="checkbox"/>	52	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>

11. Since leaving full-time education, have you held any non-nursing posts?

Yes 1  
No 2

53   
..

IF YES,

(SPECIFY TYPE OF POST, DATES IN POST)

TYPE OF POST

DATES IN POST

54	<input type="checkbox"/>	<input type="checkbox"/>	62	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>
56	<input type="checkbox"/>	<input type="checkbox"/>	63	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>
58	<input type="checkbox"/>	<input type="checkbox"/>	64	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>
60	<input type="checkbox"/>	<input type="checkbox"/>	65	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>

12. How long have you been in your present post?

Less than 1 month 1  
1 month < 6 months 2  
6 months < 1 year 3  
1 year < 2 years 4  
2 years < 5 years 5  
5 years < 10 years 6  
More than 10 years 7

66   
..

13. During your nurse training, did you spend any time working on care of the elderly wards?

Yes	1	67	<input type="checkbox"/>
No	2	..	<input type="checkbox"/>

IF YES,

How many weeks?

68   
..

What type of ward?

	Yes	No	
Acute	1	2	69 <input type="checkbox"/>
Rehabilitation/assessment	1	2	.. <input type="checkbox"/>
Continuing care/long-stay	1	2	70 <input type="checkbox"/>
Psychogeriatric	1	2	.. <input type="checkbox"/>
Not applicable	8		71 <input type="checkbox"/>
			.. <input type="checkbox"/>
			72 <input type="checkbox"/>
			.. <input type="checkbox"/>

14. During your nurse training, did you spend any time in the classroom learning about the theoretical side of care of the elderly?

Yes	1	73	<input type="checkbox"/>
No	2	..	<input type="checkbox"/>

IF YES,

a) How many weeks?

74   
..

b) How helpful did you find this theory in preparing you for your present post?

Of no help at all	1	75	<input type="checkbox"/>
Of some help	2	..	<input type="checkbox"/>
A lot of help	3		
Not applicable	8		

15. Do you think qualified nurses working on a care of the elderly ward require any post-basic training to provide care or is basic training sufficient?

Yes	1	76	<input type="checkbox"/>
No	2	..	<input type="checkbox"/>
Don't know	3		

1     2

Why do you say that?

6	<input type="checkbox"/>	<input type="checkbox"/>
.		
8	<input type="checkbox"/>	<input type="checkbox"/>
.		
10	<input type="checkbox"/>	<input type="checkbox"/>
..		
12	<input type="checkbox"/>	<input type="checkbox"/>
..		

16. Do you think nursing auxiliaries working on a care of the elderly ward require any special training to provide care?

Yes	1
No	2
Don't know	3

14	<input type="checkbox"/>
..	

Why do you say that?

15	<input type="checkbox"/>	<input type="checkbox"/>
..		
17	<input type="checkbox"/>	<input type="checkbox"/>
..		
19	<input type="checkbox"/>	<input type="checkbox"/>
..		
21	<input type="checkbox"/>	<input type="checkbox"/>
..		

17. Do you think there are any topics in care of the elderly nursing on which you feel you would like more training?

Yes	1
No	2
Don't know	3

23	<input type="checkbox"/>
..	

IF YES, which topics?

24	<input type="checkbox"/>	<input type="checkbox"/>
..		
26	<input type="checkbox"/>	<input type="checkbox"/>
..		
28	<input type="checkbox"/>	<input type="checkbox"/>
..		
30	<input type="checkbox"/>	<input type="checkbox"/>
..		

18. Do you think there are any topics in care of the elderly nursing on which more training is needed for nursing auxiliaries?

Yes	1
No	2
Don't know	3

32	<input type="checkbox"/>
..	

IF YES, which topics?

33	<input type="checkbox"/>	<input type="checkbox"/>
..		
35	<input type="checkbox"/>	<input type="checkbox"/>
..		
37	<input type="checkbox"/>	<input type="checkbox"/>
..		
39	<input type="checkbox"/>	<input type="checkbox"/>
..		

19. Since starting work on this ward, have you had any FORMAL teaching sessions on the ward?

Yes 1  
No 2

41   
..

IF YES,

a) What topics did they cover?

42   
..   
44   
..   
46   
..

48   
..   
50   
..   
52   
..

b) Who were they given by?

54   
..   
56   
..   
58   
..

60   
..   
62   
..   
64   
..

20. Since starting work on this ward, have you had any FORMAL teaching sessions off the ward?

Yes 1  
No 2

66   
..

IF YES,

a) What topics did they cover?

67   
..   
69   
..   
71   
..

73   
..   
75   
..   
77   
..

1  3  
..

b) Who were they given by?

6   
..   
8   
..   
10   
..

12   
..   
14   
..   
16   
..

c) Where were they given?

18	<input type="checkbox"/>	<input type="checkbox"/>	24	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>
20	<input type="checkbox"/>	<input type="checkbox"/>	26	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>
22	<input type="checkbox"/>	<input type="checkbox"/>	28	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>

d) How often usually do you have FORMAL teaching sessions?

- Once or twice a week 1
- Once or twice a month 2
- Once or twice every 6 months 3
- Once or twice a year or less 4
- Other 5
- Not applicable 8

30

..

21. Since starting work on this ward, have you had the opportunity to organise any formal teaching sessions yourself?

- Yes 1
- No 2

31

..

IF YES,

a) On what topics?

32	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
34	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
36	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
38	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>

b) Who was present?

- |                     | Yes | No |
|---------------------|-----|----|
| Qualified staff     | 1   | 2  |
| Nursing auxiliaries | 1   | 2  |
| Learner nurses      | 1   | 2  |
| Other               | 1   | 2  |
| Not applicable      | 8   |    |

40

..

41

..

42

..

43

..

22. Since starting work on this ward, have you had any INFORMAL teaching sessions? (e.g. during the ward report, or demonstrations by the patient's bedside)

- Yes 1
- No 2

44

..

IF YES,

a) Can you give me some examples of informal teaching sessions?

45

..

47

..

b) Who would you say does MOST of this informal teaching?

- Ward sister(s) or Charge nurse(s) 1
- Other qualified nurses 2
- Therapists 3
- Nursing auxiliaries 4
- Nurse Learners) 5
- Others (specify) 6
- Not applicable 8

51

..

c) How often, usually, do you have informal teaching sessions on your ward?

- Once or twice a week 1
- Once or twice a month 2
- Once or twice every six months 3
- Once or twice a year or less 4
- Other 5
- Not applicable 8

52

..

23. Have you had the opportunity to give any informal teaching sessions yourself?

- Yes 1
- No 2

53

..

IF YES,

a) On what topics?

54

..

56

..

58

..

60

..

b) Who was present?

- Qualified staff Yes 1 No 2
- Nursing auxiliaries 1 2
- Nurse learners 1 2
- Other 1 2
- Not applicable 8

62

..

63

..

64

..

65

..

Now, I would like to ask you some more questions about nursing auxiliaries.

24. What part do you see for nursing auxiliaries in providing patient care?

66	<input type="checkbox"/>	<input type="checkbox"/>	72	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>
68	<input type="checkbox"/>	<input type="checkbox"/>	74	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>
70	<input type="checkbox"/>	<input type="checkbox"/>	76	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>

1      4

25 a) What responsibilities should be given to nursing auxiliaries?

6	<input type="checkbox"/>	<input type="checkbox"/>	12	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>
8	<input type="checkbox"/>	<input type="checkbox"/>	14	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>
10	<input type="checkbox"/>	<input type="checkbox"/>	16	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>

b) Do you feel the responsibility that nursing auxiliaries are given is:

- |                  |   |
|------------------|---|
| Too little       | 1 |
| Just about right | 2 |
| Too much         | 3 |
| Other            | 4 |

18

Why do you say that?

19	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
21	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
23	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
25	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>

26. In your view, how much direction do nursing auxiliaries require when caring for patients?

- |                 |   |
|-----------------|---|
| None            | 1 |
| A small amount  | 2 |
| A medium amount | 3 |
| A large amount  | 4 |
| Other           | 5 |

27

Why do you say that?

28	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
30	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
32	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
34	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>

27. In your view, do nursing auxiliaries once they are competent require supervision when providing 'basic' care for patients?

Yes 1  
No 2

36   
..

IF YES

28. Do they require:

Constant supervision 1  
Intermittent supervision 2  
Other 3  
Not applicable 8

37   
..

Why do you say that?

38    
..    
40    
..    
42    
..    
44    
..

29. What do you feel about the amount of supervision given to nursing auxiliaries on this ward?  
Is it:

Too little 1  
Too much 2  
Just about right 3  
Other 4

46   
..

Why do you say that?

47    
..    
49    
..    
51    
..    
53    
..

30. How are nursing auxiliaries supervised on your ward?

55    
..    
57    
..    
59    
..    
61    
..



31 a) Are nursing auxiliaries usually present at ward reports about patients?

Yes 1  
 No 2  
 Not applicable 8

63   
 ..

b) Do you agree with this?

Yes 1  
 No 2  
 Not applicable 8

64   
 ..

c) Why?

65    
 ..    
 67    
 ..    
 69    
 ..    
 71    
 ..

I would now like to ask you some questions about your work with elderly people.

1      5

32. How did you come to work with elderly people?

6    
 .    
 8    
 .    
 10    
 ..

33 a) Do you think care of the elderly nursing is different to general nursing?

Yes 1  
 No 2  
 Don't know 3

12   
 ..

IF YES,

b) In what ways?

13   19    
 ..   ..    
 15   21    
 ..   ..    
 17   23    
 ..   ..

34 a) What are your aims of care when caring for your patients?

25	<input type="checkbox"/>	<input type="checkbox"/>	31	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>
27	<input type="checkbox"/>	<input type="checkbox"/>	33	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>
29	<input type="checkbox"/>	<input type="checkbox"/>	35	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>

b) How do you achieve these?

37	<input type="checkbox"/>	<input type="checkbox"/>	43	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>
39	<input type="checkbox"/>	<input type="checkbox"/>	45	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>
41	<input type="checkbox"/>	<input type="checkbox"/>	47	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>

35. Can you tell me what you consider to be most important aspects in the care of your patients

49	<input type="checkbox"/>	<input type="checkbox"/>	55	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>
51	<input type="checkbox"/>	<input type="checkbox"/>	57	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>
53	<input type="checkbox"/>	<input type="checkbox"/>	59	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>

36 a) Do you think particular skills are needed to care for elderly patients?

Yes	1
No	2
Don't know	3

61	<input type="checkbox"/>
..	<input type="checkbox"/>

IF YES

b) What do you think these skills are?

62	<input type="checkbox"/>	<input type="checkbox"/>	68	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>
64	<input type="checkbox"/>	<input type="checkbox"/>	70	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>
66	<input type="checkbox"/>	<input type="checkbox"/>	72	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>

37. How well do you think your skills in the following areas are used?

	Very little use	Some use	Good use	Very good use
'Basic' nursing skills	1	2	3	4
Rehabilitation skills	1	2	3	4
'Technical' nursing skills	1	2	3	4
Communication skills	1	2	3	4
Management skills	1	2	3	4

74   
..

75   
..

76   
..

77   
..

78   
..

1      6

38. What do you think you need to know to care for the elderly?

6 <input type="checkbox"/> <input type="checkbox"/>	12 <input type="checkbox"/> <input type="checkbox"/>
8 <input type="checkbox"/> <input type="checkbox"/>	14 <input type="checkbox"/> <input type="checkbox"/>
10 <input type="checkbox"/> <input type="checkbox"/>	16 <input type="checkbox"/> <input type="checkbox"/>

39 a) Is there anything you find particularly satisfying about caring for the elderly?

18 <input type="checkbox"/> <input type="checkbox"/>	24 <input type="checkbox"/> <input type="checkbox"/>
20 <input type="checkbox"/> <input type="checkbox"/>	26 <input type="checkbox"/> <input type="checkbox"/>
22 <input type="checkbox"/> <input type="checkbox"/>	28 <input type="checkbox"/> <input type="checkbox"/>

b) What do you like least about it?

30 <input type="checkbox"/> <input type="checkbox"/>
32 <input type="checkbox"/> <input type="checkbox"/>
34 <input type="checkbox"/> <input type="checkbox"/>

These final questions are about your view of rehabilitation.

40. How would you define rehabilitation?

36	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
38	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
40	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
42	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>

41. What part does the nurse play in the rehabilitation of patients on this ward?

44	<input type="checkbox"/>	<input type="checkbox"/>	50	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>
46	<input type="checkbox"/>	<input type="checkbox"/>	52	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>
48	<input type="checkbox"/>	<input type="checkbox"/>	54	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>

42. How would you describe your role in rehabilitation compared to the therapist's role?

56	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
58	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
60	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
62	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>

43. If you were given a free hand, is there anything you would do to make things better for old people in hospital

64	<input type="checkbox"/>	<input type="checkbox"/>	70	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>
66	<input type="checkbox"/>	<input type="checkbox"/>	72	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>
68	<input type="checkbox"/>	<input type="checkbox"/>	74	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>	<input type="checkbox"/>

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A COMPARISON OF THE CONTRIBUTION TO PATIENT CARE OF  
 QUALIFIED NURSES AND NURSING AUXILIARIES

NURSING AUXILIARY INTERVIEW SCHEDULE

Survey number

1      1

1. How long have you been working as a nursing auxiliary on this ward?

- Less than 1 month 1
- 1 month < 6 months 2
- 6 months < 1 year 3
- 1 year < 2 years 4
- 2 years < 5 years 5
- 5 years < 10 years 6
- More than 10 years 7

6

2. Do you work FULL TIME or PART TIME?

- Full time 1
- Part time 2

7

IF PART TIME

How many hours do you work per week?

8

3. How old were you on your last birthday?

12

4. Is this your first nursing auxiliary post?

- Yes 1
- No 2

14

IF NO, please could you tell me:

a) type of ward on which you held your previous posts

15

..

17

..

19

..

21

..

23

..

4 b) length of time in each post

TYPE OF WARD

DATES IN POST

25

..

26

..

27

..

28

..

29

..

5. Since leaving full-time education, what else have you been doing? (excluding working as a nursing auxiliary)  
e.g. any caring or voluntary work

Length

30   38

..   ..

32   39

..   ..

34   40

..   ..

36   41

..   ..

6. Do you have any non-nursing qualifications?

Yes 1  
No 2

42

..

IF YES, SPECIFY

43

..

44

..

7. Have you attended an introductory course to nursing auxiliary work?

Yes 1  
No 2

45

..

IF NO, GO TO Q. 8

IF YES

a) Did you attend the course BEFORE you started working as a nursing auxiliary?

Yes 1  
No 2  
Not applicable 8

46

..

IF NO

7 b) How long had you been working as a nursing auxiliary before being sent on the course?

47

c) Where was the course held?

48

d) Was the course ONLY for nursing auxiliaries working in the Care of the Elderly speciality?

Yes 1  
No 2  
Not applicable 8

50

e) Which topics did the course cover?

51   59   
..   ..   
53   61   
..   ..   
55   63   
..   ..   
57   65   
..   ..

f) Are there any topics which were not covered but which you think would have helped you in your work on the ward?

67    
..    
69    
..    
71    
..    
73    
..

g) How well do you think the course prepared you for your work on the ward?

Not very well at all 1  
Quite well 2  
Very well 3  
Other 4  
Not applicable 8

75

g) Why do you say that?

1					2
..					

6		
..		
8		
..		
10		
..		
12		
..		

8. Since starting work on this ward have you had any FORMAL teaching sessions on the ward?

Yes	1
No	2

14	
..	

IF YES

a) What topics did they cover?

15			21	
..			..	
17			23	
..			..	
19			25	
..			..	

b) Who were they given by?

27			33	
..			..	
29			35	
..			..	
31			37	
..			..	

9. Since starting work on this ward have you had any FORMAL teaching sessions off the ward?

Yes	1
No	2

39	
..	



IF YES

a) What topics did they cover?

40	<input type="checkbox"/>	<input type="checkbox"/>	46	[
..	<input type="checkbox"/>	<input type="checkbox"/>	..	[
42	<input type="checkbox"/>	<input type="checkbox"/>	48	[
..	<input type="checkbox"/>	<input type="checkbox"/>	..	[
44	<input type="checkbox"/>	<input type="checkbox"/>	50	[
..	<input type="checkbox"/>	<input type="checkbox"/>	..	[

b) Who were they given by?

52	<input type="checkbox"/>	<input type="checkbox"/>	58	[
..	<input type="checkbox"/>	<input type="checkbox"/>	..	[
54	<input type="checkbox"/>	<input type="checkbox"/>	60	[
..	<input type="checkbox"/>	<input type="checkbox"/>	..	[
56	<input type="checkbox"/>	<input type="checkbox"/>	62	[
..	<input type="checkbox"/>	<input type="checkbox"/>	..	[

9 c) Where were they given?

64	<input type="checkbox"/>	<input type="checkbox"/>	70	[
..	<input type="checkbox"/>	<input type="checkbox"/>	..	[
66	<input type="checkbox"/>	<input type="checkbox"/>	72	[
..	<input type="checkbox"/>	<input type="checkbox"/>	..	[
68	<input type="checkbox"/>	<input type="checkbox"/>	74	[
..	<input type="checkbox"/>	<input type="checkbox"/>	..	[

d) How often, usually, do you have formal teaching sessions?

- Once or twice a week 1
- Once or twice a month 2
- Once or twice every six months 3
- Once or twice a year or less 4
- Other 5
- Not applicable 8

76	<input type="checkbox"/>
..	<input type="checkbox"/>

10. Since starting work on this ward, have you had any INFORMAL teaching sessions, e.g. during the ward report, or demonstrations at the patient's bedside?

- Yes 1
- No 2

77	<input type="checkbox"/>
..	<input type="checkbox"/>

1     3

IF YES

a) Can you give me some examples of informal teaching sessions?

6    
8    
10    
..

b) Who would you say does MOST of this informal teaching?

- Ward sister(s) and/or charge nurse(s) 1
- Other qualified nurses 2
- Therapists 3
- Other nursing auxiliaries 4
- Nurse learners 5
- Other 6
- Not applicable 8

12   
..

10 c) How often, usually, do you have informal teaching sessions on your ward?

- Once or twice a week 1
- Once or twice a month 2
- Once or twice every six months 3
- Once or twice a year or less 4
- Other 5
- Not applicable 8

13   
..

I would now like you to think about the information you are given about the patients you care for.

11 a) On your ward, how do nurses share information about patients?

14    
..    
16    
..    
18    
..    
20    
..

b) Are you usually present at the ward reports about patients?

Yes	1	22	<input type="checkbox"/>
No	2	..	<input type="checkbox"/>
Not applicable	8		

c) Do you agree with this?

Yes	1	23	<input type="checkbox"/>
No	2	..	<input type="checkbox"/>
Not applicable	8		

d) Why?

24	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
26	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
28	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
30	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>

12 a) How much information are you given about the patients' physical condition?

None	1	32	<input type="checkbox"/>
A small amount	2	..	<input type="checkbox"/>
A medium amount	3		
A large amount	4		
Other	5		

b) How satisfied are you with the amount of information you are given about the patients' physical condition?

Very satisfied	1	33	<input type="checkbox"/>
Satisfied	2	..	<input type="checkbox"/>
Neutral	3		
Dissatisfied	4		
Very dissatisfied	5		
Not applicable	8		

d) Why do you say that?

34	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
36	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
38	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>

13 a) How much information are you given about the nursing care needed by the patients for their physical needs?

None	1
A small amount	2
A medium amount	3
A large amount	4
Other	5

40

..

13 b) How satisfied are you with the amount of information you are given about the nursing care needed by the patients for their physical needs?

Very satisfied	1
Satisfied	2
Neutral	3
Dissatisfied	4
Very dissatisfied	5
Not applicable	8

41

..

c) Why do you say that?

42

..

44

..

46

..

14 a) How much information are you given about the patients' psychological needs?

None	1
A small amount	2
A medium amount	3
A large amount	4
Other	5

48

..

b) How satisfied are you with the amount of information you are given about the nursing care needed by the patients to meet their psychological needs?

Very satisfied	1
Satisfied	2
Neutral	3
Dissatisfied	4
Very dissatisfied	5
Not applicable	8

49

..

c) Why do you say that?

50	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
52	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
54	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>

15 a) How much direction are you given when caring for patients?

None	1
A small amount	2
A medium amount	3
A large amount	4
Other	5

56	<input type="checkbox"/>
..	

b) How satisfied are you with the amount of direction you receive when caring for patients?

Very satisfied	1
Satisfied	2
Neutral	3
Dissatisfied	4
Very dissatisfied	5
Not applicable	8

57	<input type="checkbox"/>
..	

c) Why do you say that?

58	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
60	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
62	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>

16 a) How much supervision do you receive when you are carrying out basic care tasks for the patients? (e.g. washing and dressing patients)

None	1
A small amount	2
A medium amount	3
A large amount	4
Other	5

64	<input type="checkbox"/>
..	

b) How satisfied are you with the amount of supervision you receive when carrying out basic care tasks?

Very satisfied	1	65	<input type="checkbox"/>
Satisfied	2	..	<input type="checkbox"/>
Neutral	3		
Dissatisfied	4		
Very dissatisfied	5		
Not applicable	8		

16 c) Why do you say that?

66	<input type="checkbox"/>	<input type="checkbox"/>
..		
68	<input type="checkbox"/>	<input type="checkbox"/>
..		
70	<input type="checkbox"/>	<input type="checkbox"/>
..		

17. If you come across a problem while carrying out a basic care task for a patient, who do you USUALLY go to to ask advice?

Ward sister/charge nurse/nurse in charge	1	72	<input type="checkbox"/>
Other qualified nurse	2	..	<input type="checkbox"/>
Other nursing auxiliaries	3		
Nurse learners	4		
Other (specify)	5		

18 a) Who do you work with most often? Do you usually work:

On your own	1	73	<input type="checkbox"/>
With a qualified nurse	2	..	<input type="checkbox"/>
With a nursing auxiliary	3		
With a nurse learner	4		
Other (specify)	5		

b) Which grade would you prefer to work with?

Ward sister or charge nurse	1	74	<input type="checkbox"/>
Other qualified nurse	2	..	<input type="checkbox"/>
Nursing auxiliary	3		
Nurse learner	4		
Other (specify)	5		

c) Why?

75    
 ..    
 77    
 ..    
 79    
 ..

1     4  
 ..

19. What kind of responsibility are you given in the ward?

6   12   
 ..   ..   
 8   14   
 ..   ..   
 10   16   
 ..   ..

20 a) What do you think about the responsibility you are given in this job? Are you given:

- Too little responsibility 1
- Just enough responsibility 2
- Too much responsibility 3
- Other 4

18   
 ..

b) Why do you say that?

19    
 ..    
 21    
 ..    
 23    
 ..    
 25    
 ..

21 a) In what ways do you think your job is the same as that of qualified nurses?

27   33   
 ..   ..   
 29   35   
 ..   ..   
 31   37   
 ..   ..

b) In what ways do you think your job is different to that of qualified nurses?

39	<input type="checkbox"/>	<input type="checkbox"/>	45	<input type="checkbox"/>
..			..	
41	<input type="checkbox"/>	<input type="checkbox"/>	47	<input type="checkbox"/>
..			..	
43	<input type="checkbox"/>	<input type="checkbox"/>	49	<input type="checkbox"/>
..			..	

I would now like to ask you some questions about your work with elderly people.

22. How did you first come to work with elderly people?

51	<input type="checkbox"/>	<input type="checkbox"/>
..		
53	<input type="checkbox"/>	<input type="checkbox"/>
..		
55	<input type="checkbox"/>	<input type="checkbox"/>
..		

23 a) Do you think particular skills are needed to work as a nursing auxiliary with elderly people?

- |            |   |
|------------|---|
| Yes        | 1 |
| No         | 2 |
| Don't know | 3 |

57	<input type="checkbox"/>
..	

IF YES

b) What do you think these skills are?

58	<input type="checkbox"/>	<input type="checkbox"/>	64	<input type="checkbox"/>
..			..	
60	<input type="checkbox"/>	<input type="checkbox"/>	66	<input type="checkbox"/>
..			..	
62	<input type="checkbox"/>	<input type="checkbox"/>	68	<input type="checkbox"/>
..			..	

24. In this post, what use do you feel is being made of your skills?

70	<input type="checkbox"/>	<input type="checkbox"/>
..		
72	<input type="checkbox"/>	<input type="checkbox"/>
..		
74	<input type="checkbox"/>	<input type="checkbox"/>
..		
76	<input type="checkbox"/>	<input type="checkbox"/>
..		



1      5

25. What do you think you need to know to care for elderly people?

6	<input type="text"/>	<input type="text"/>	12	<input type="text"/>
.	<input type="text"/>	<input type="text"/>	..	<input type="text"/>
8	<input type="text"/>	<input type="text"/>	14	<input type="text"/>
.	<input type="text"/>	<input type="text"/>	..	<input type="text"/>
10	<input type="text"/>	<input type="text"/>	16	<input type="text"/>
..	<input type="text"/>	<input type="text"/>	..	<input type="text"/>

26. What do you think your part is as a nursing auxiliary in providing patient care?

18	<input type="text"/>	<input type="text"/>	24	<input type="text"/>
..	<input type="text"/>	<input type="text"/>	..	<input type="text"/>
20	<input type="text"/>	<input type="text"/>	26	<input type="text"/>
..	<input type="text"/>	<input type="text"/>	..	<input type="text"/>
22	<input type="text"/>	<input type="text"/>	28	<input type="text"/>
..	<input type="text"/>	<input type="text"/>	..	<input type="text"/>

27. Can you tell me what you consider to be the most important aspects in the care of your patients?

30	<input type="text"/>	<input type="text"/>	36	<input type="text"/>
..	<input type="text"/>	<input type="text"/>	..	<input type="text"/>
32	<input type="text"/>	<input type="text"/>	38	<input type="text"/>
..	<input type="text"/>	<input type="text"/>	..	<input type="text"/>
34	<input type="text"/>	<input type="text"/>	40	<input type="text"/>
..	<input type="text"/>	<input type="text"/>	..	<input type="text"/>

28 a) Is there anything that you find particularly satisfying about caring for elderly people?

42	<input type="text"/>	<input type="text"/>	48	<input type="text"/>
..	<input type="text"/>	<input type="text"/>	..	<input type="text"/>
44	<input type="text"/>	<input type="text"/>	50	<input type="text"/>
..	<input type="text"/>	<input type="text"/>	..	<input type="text"/>
46	<input type="text"/>	<input type="text"/>	52	<input type="text"/>
..	<input type="text"/>	<input type="text"/>	..	<input type="text"/>

28 b) What do you like least about it?

54	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
56	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>
58	<input type="checkbox"/>	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>

29. If you were given a free hand, is there anything you would do to make things better for old people in hospital?

60	<input type="checkbox"/>	<input type="checkbox"/>	66	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>
62	<input type="checkbox"/>	<input type="checkbox"/>	68	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>
64	<input type="checkbox"/>	<input type="checkbox"/>	70	<input type="checkbox"/>
..	<input type="checkbox"/>	<input type="checkbox"/>	..	<input type="checkbox"/>

APPENDIX 17a Qualified nurses' therapeutic orientation scores

1. PRIMARY NURSING WARDS

Nurse number	Ways care of the elderly nursing different	Aims of care	Most important aspects	Role of nurse in rehab-ilitation
1	3	5	5	5
2	5	5	5	5
3	3	3	5	5
4	3	5	5	5
5	5	5	5	5
6	3	5	5	5
7	3	5	5	5
8	3	5	3	5
9	5	5	5	5
10	3	5	5	3
11	1	5	5	3
12	3	5	3	5

APPENDIX 17b Qualified nurses' therapeutic orientation scores

2. TEAM NURSING WARDS

Nurse number	Ways care of the elderly nursing different	Aims of care	Most important aspects	Role of nurse in rehabilitation
1	5	5	5	5
2	5	5	5	5
3	3	5	5	3
4	1	5	5	5
5	5	5	5	5
6	5	5	5	3
7	1	5	5	3
8	5	5	5	3
9	3	5	5	5
10	1	5	5	3
11	3	5	5	3
12	1	3	5	5

APPENDIX 17c Qualified nurses' therapeutic orientation scores

3. FUNCTIONAL NURSING WARDS

Nurse number	Ways care of the elderly nursing different	Aims of care	Most important aspect	Role of nurse in rehabilitation
1	3	5	5	5
2	1	5	5	5
3	3	5	5	5
4	1	5	3	5
5	3	5	5	5
6	1	5	3	5
7	1	5	5	5
8	3	5	5	5
9	1	5	5	5
10	5	5	5	5
11	1	5	3	5
12	1	5	5	5

APPENDIX 18a Nursing auxiliary therapeutic orientation scores

1. PRIMARY NURSING AUXILIARIES

Nurse number	Choice of care of the elderly	Skills required	Satisfying aspects	Aspects least satisfying	Most important aspects
1	1	3	5	3	5
2	3	5	3	3	5
3	1	5	3	3	3
4	1	5	5	3	5
5	1	3	3	3	5
6	1	5	5	3	5
7	1	5	5	3	5
8	1	3	5	3	5
9	1	1	5	3	5
10	3	5	5	3	5
11	3	3	5	3	5
12	1	1	5	3	5

APPENDIX 18b Nursing auxiliary therapeutic orientation scores

2. TEAM NURSING AUXILIARIES

Nurse number	Choice of care of the elderly	Skills required	Satisfying aspects	Aspects least satisfying	Most important aspects
1	3	3	5	3	5
2	3	3	3	3	5
3	1	5	5	5	5
4	1	5	3	5	5
5	1	3	3	5	5
6	1	3	5	5	5
7	1	3	5	3	3
8	1	5	5	5	5
9	1	3	5	3	5
10	1	3	5	3	5
11	1	5	5	5	5

APPENDIX 18c Nursing auxiliary therapeutic orientation scores

3. FUNCTIONAL NURSING AUXILIARIES

Nurse number	Choice of care of the elderly	Skills required	Satisfying aspects	Aspects least satisfying	Most important aspects
1	1	3	5	3	5
2	1	5	5	5	5
3	3	3	5	5	5
4	1	3	5	5	5
5	1	5	5	5	5
6	3	5	5	5	5
7	1	3	5	3	5
8	1	3	5	3	5
9	1	5	5	5	5
10	1	3	5	3	5
11	1	3	3	1	5
12	1	5	5	5	5