Health Care Assistant-Registered Nurse dyads: A new concept of nursing team

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Abstract

Health Care Assistants (HCAs) are integral to adult nursing teams. Their role and responsibilities have been widely debated. However, it is unclear how HCAs enact their role in an adult in-patient ward environment. The aim of this study was to explore how HCAs enacted their role in an adult, in-patient environment. The objectives were to; gain an understanding how HCAs connected, interacted, and related to people at work; ascertain HCAs perceptions of the enactment of the HCA role; and to develop a construction of how HCAs enacted their role. From within a constructivist paradigm, the focused ethnographic study, consisting of 148 hours of observation and 108 interviews, was used to describe and explain the HCAs' role and their contribution to the nursing team. This data was collected from four wards in one UK hospital. Analysis found that HCAs and Registered Nurses (RN), when paired for a shift, formed a dyadic team. Within this HCA-RN dyad, the HCA joined and separated from the RN in order to ensure that all nursing tasks for the shift were complete. To contribute to the HCA-RN dyad, HCAs needed to be able to work non-dependently from, and inter-dependently with, their RN partner. Non-dependent working was achieved through carrying out the 'routine scaffolding' comprise three levels of tasks; compulsory timed tasks, mandatory flexible tasks, and RN requested tasks. The extent of the success of non-dependent working was reliant on the RN having trust in the HCA. Inter-dependent working included any tasks that required two people and relied upon the willingness of the RN to co-work. When an HCA was able to work non-dependently and inter-dependently, their contribution to the HCA-RN dyadic nursing team was considered successful and effective by both partners. Through exploration of how HCAs enact their role, the importance of the relationship with the RN has been highlighted. Completion and documentation of the nursing tasks for their bay of patients was successful when the HCA and the RN worked as both separate entities and a co-operative pair throughout the shift. The impact of the discovery of the intertwined relationship between the HCA and their RN partner is a fresh understanding of how HCAs enact their role. The newly defined model of care delivery reflects the contemporary ward environment from the perspective of the HCA.

Dedication

I wish to give my thanks to all of the Registered Nurses, healthcare team members, and especially the

Health Care Assistants

that were followed around and spoke their truth

Acknowledgements

To my Mum and Dad,

Not having personal experience of academic study has never stopped your unwavering support of me as I have travelled this path. I will be forever grateful for all the times you have listened to me, reassured me and wiped away my tears. Your belief that I could do it made all the difference.

To my Children,

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To my Husband,

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Thank you for supporting me through this process. I had no idea what a PhD entailed, and you got me to the end. Hoorah.

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Glossary of terms

Health Care Assistant (HCA) – a person who provides care to people under the direction of a Registered Nurse. Also commonly known as nursing assistants, auxiliary nurses, or support workers.

New Public Management - the process where techniques from the private sector were applied to the public sector introduced in the 1980s with the objective of making public services more efficient and business-like.

Nursing and Midwifery Council (NMC) – governing body who hold the register for nurses and midwives. Previously known as the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC).

Nursing Associate - a new role which fits between the Registered Nurse and the Health Care Assistant. Their role is to support RNs to deliver care and they are registered with the NMC.

Person-centred care (PCC) – when care is focused on the needs of the person rather than the needs of the service.

Registered Nurse (RN) – a qualified and registered first level nurse who has undertaken at least three years of training.

State Registered nurse (SEN) – a qualified second level nurse who had undertaken at least 18 months of training. This role has now been discontinued.

Unlicensed Assistive Personnel (UAP) – A term used in the United States for Health Care Assistants.

Chapter 1 Introduction

1.1 Introduction

In setting the scene for this study, I first present the reason for undertaking the research and how it derived from the EnRICH programme. The chapter will provide contextual information on the role of the Health Care Assistant (HCA). This will include demographic details, their known titles and their position within the nursing structure. A brief look at the recent evolution of the role will be provided which includes three instigators of change; the training of student nurses, the use and management of the National Health Service (NHS) and the introduction of the Working Time Directive (Directive 2003). This evolution of the HCA role was captured in the Francis (2013) report which in turn led to the Cavendish (2013) review. Relevant findings from these reports are shared. Discussion of the new professional nursing role of Nursing Associate brings the context up to date. Following this, an overview of the other chapters within the thesis are outlined.

1.2 Personal history and the EnRICH Programme

Coming from a family of electricians, I knew nothing about nursing when I applied for training. A place was available for mental health nursing at De Montfort University where they were running the second year of the newly established degree programme. During my first year of training, I had a placement on a gynaecology ward which I then returned to in my final year. It was there that I learned about the adult nursing environment; made beds with hospital corners, completed temperature, pulse and respiration charts, saw bedside handovers, understood there were many members to the hospital team, and felt the dominance of the ward sister. However, once I had qualified as a Registered Mental Health Nurse, my visits to adult nursing wards were few and far between.

In almost 20 years of NHS nursing, I had worked in many areas within mental health. When I had completed my MSc in Management and Leadership in Health and Social Care, I decided to look for a different way to utilise my nursing and leadership skills. De Montfort University were advertising for a research fellow to work on the EnRICH (Enhancing Relationships in Care in Hospital) culture change programme so I applied for the post. Funded by the Burdett

Trust for Nursing, EnRICH was a 2 year project which, with a partner NHS Trust, worked to establish the feasibility, suitability, acceptability, and sustainability of improving the experience of receiving and giving care for older people. Previous work (Patterson et al 2011) suggested that more local and focused action could result in significant change in clinical practice even in the most impoverished care environments. The research was predicated on the belief that the EnRICH change programme would provide a powerful stimulus for action, as well as a means to introduce change in the culture of care at ward level. Twelve wards were identified for the study; six participant and six comparison. Each ward was profiled using questionnaires to identify what was done well in the eyes of patients, carers and staff, as well as highlighting what could have been improved. EnRICH introduced participating wards to relationship centred care and the Senses framework (Nolan et al 2006) through workshops and action learning sets. Each participating ward was supported to plan and undertake changes suggested in the profile; later, through re-profiling, wards were helped to understand what differences to patient, carer and staff experience those changes had promoted. The aim was that study workshops would be developed as a resource for use by 'empowerment teams', nursing staff from participating wards would rollout EnRICH to comparison wards and other areas. Research methods included interviews, focus groups, questionnaires and observation.

There were two PhD scholarships associated with the EnRICH study, one of which was mine. This funded the first part of my PhD and ethical approval for my study was included in that of the Enrich Programme Research. My role within the research team involved gaining an understanding of ward work in an acute hospital. To do this, I spent time with key team members, observed people in action, attended meetings, and interviewed staff about their care of older people. The dissemination and collection of questionnaires was a central part of my work and the level of success was the result of my ward-based encouragement and support in their timely completion. Away from the ward setting, I led public and patient involvement events, co-facilitated workshops and carried out follow-up interviews with discharged patients. Through this engagement with individual staff, patients and carers, I became able to describe the similarities and differences in each of the wards' cultures. It was through this level of engagement that this study emerged.

1.3 Reason for undertaking study

"They look like they are working autonomously",
"They can't be Rachael, go back and have another look".

The above quotation was a conversation between myself and my first supervisor. As a research fellow for the EnRICH programme (Burdett Trust for Nursing 2014-2016), I spent many hours observing staff. I noticed that over time, there had been a change in how HCAs functioned on the EnRICH participating wards in comparison to those I experienced when I was a student nurse training years before. From my recollection, Registered Nurses (RNs) gave HCAs directions as and when they needed their help. Whereas I noted that these contemporary HCAs were moving around the environment with what seemed to be very little direction from the RN. If this was the case, it raised questions such as what were HCAs doing, how did they know what to do and when? It was the reflection with my supervisor that led to this ethnographic study. The aim of this study was to explore how HCAs enacted their role in an adult, in-patient environment. The objectives were to;

- gain an understanding how HCAs connected, interacted, and related to people at work
- ascertain HCAs perceptions of the enactment of the HCA role
- develop a construction of how HCAs enacted their role.

1.4 HCA demographics

It is reported that 1.2 million full-time equivalent (FTE) staff worked in the NHS in 2018 (Kings Fund 2018) and more than 400,000 of these were HCAs (Unison 2018). In the hospital setting, HCAs work alongside RNs and other health professions to provide patient care (Unison 2018). The prominence of the HCA role was emphasised by Francis (2013) who stated that when patients and the public complained about the care they received in hospital, it was often in relation to the actions, or inactions, of HCAs.

HCAs are part of the nursing team. In the NHS, at the time this study took place, staff pay was based upon the Agenda of Change pay scale and HCAs were commonly paid as a Band 2 earning up to approximately £19,000 a year. Others, with more experience, skills or qualifications were paid at Band 3 which attracted just under £21,000 a year. The RNs that HCAs most often supported began as newly qualified nurses on a Band 5, with pay of

approximately £24,000 in the first year and rising to £30,000 with time and experience. The RN had the potential to climb through the bands of the pay scale with no upper limits whilst HCAs could only ever reach a Band 4 and while RNs hold registration with the Nursing and Midwifery Council (NMC), HCAs are not regulated in any way.

The NMC is the current governing body for RNs in the UK. It has evolved from the original registration of nurses which was introduced in 1919. Registration is formalisation of nurses' authority and territory, known as their jurisdiction. However, back when the register was established, RNs did not achieve full occupational 'closure' (Kessler et al 2015). Kessler et al (2015) defined occupational closure as having two parts which are as follows. Economic closure; control over the performance of particular tasks and social closure; a widely accepted authority to exercise control over their own work. Full occupational closure would have restricted all others from doing their role and given RNs professional status. Instead, other nursing staff, not registered as nurses, were still allowed to complete aspects of the role. These staff included health care assistants and the State Enrolled Nurse (SEN). The SEN was a role which sat in between the RN and the HCA in terms of status, pay and qualifications. These three roles, plus student nurses, formed the nursing team for many years until the discontinuation of the role of the SEN in 1997.

Currently, to be registered as a nurse with the NMC, a person must have undertaken a validated course which includes 2300 practice hours and degree level academic study. Course assessments include professional, clinical and personal standards as well as academic skills. Once qualified, RNs are required to demonstrate that they have continued to learn and are safe to practice through a process of revalidation which occurs every three years. There were 716,607 nurses and midwives on the NMC register in 2019–2020 (NMC 2020). This is the only group that can use the protected title of 'registered nurse' or 'registered midwife'. The NMC Code states that RNs are accountable for patient care and any delegation of care to others (NMC 2015: 11). This delegation is the basis for the RNs relationship with the HCA and together they provide nursing care.

Because many people in the general population have the skills to deliver aspects of care (Kirkpatrick, Ackroyd and Walker 2005), caring has been seen by some as work carried out

by people of a lower social status (Traynor et al 2015). However, nursing work, which encompasses care work, also includes advanced level technical skills (Kessler et al 2010, Kitson et al 2014). Some of these skills could only be carried out by people who had successfully completed and retained their nursing registration (Traynor et al 2015, Kessler et al 2010). Nursing care, at the time this study was undertaken, could be simplistically separated in to those tasks that all staff could carry out and those that could only be undertaken by NMC registrants. This division may be clear in law but less so in the eyes of the public (Francis 2013, Kessler et al 2010). The lack of clarity highlights the close relationship that exists between the work of the HCA and the RN through the overlapping and separate tasks that they carry out. This core shared work has not always been recognised; indeed, Government reports such as The NHS Long Term Plan (NHS England 2019), The Nursing Workforce second report (House of Commons Health Committee 2018) and the independent charity, The Kings Fund (2018) discuss the nursing workforce with no reference to HCAs. A survey by Unison (2018) showed that HCAs were directly affected by the lack of clarity and acknowledgement of their contribution to nursing work; 2000 HCAs were surveyed and 60% reported that they did extra work because of unfilled RN posts. This brings to light the contrast between the invisibility of HCAs in workforce policy and acknowledgement of their role as "the backbone of the NHS" (Cavendish 2013 3.5.1).

1.5 Terminology for the Health Care Assistant

Over 60 titles were found to be used by people who provided this supportive role across health and social care (Cavendish 2013); this was felt to add to public confusion about the role (Francis 2013). The multiple titles used also made collection and analysis of statistical data for this group more difficult to achieve (Cavendish 2013). As part of her review of non-registered health and social care workers, Cavendish (2013) asked what their preferred title would be. They stated, "nursing assistant" (page 70). The report then proceeded to predominantly use the term "Health Care Assistant" alongside five other terms. In light of this confusion, I carried out literature searches based on the six terms used by Cavendish (2013) (Table 1). This helped me to identify the most prevalent term in the literature for the group of unregistered health support staff in the nursing team in adult hospital care.

Search term	CINAHL results	British Nursing Database (BND) results	Academic Search Premiere (ASP) results
“nursing aide”	36	104	33
“nursing auxiliary”	45	235	22
“health care support worker”	138	22	1
“support worker”	284	1860	322
“nursing assistant”	324	1892	342
“health care assistant”	491	2766	84

Table 1 - Terms used from Cavendish (2013) to search databases for literature

As the role of the HCA has evolved, the title has been revised to reflect this change (Cavendish 2013, Stokes and Warden 2004). For instance, early terms like “nursing aides” and “nursing auxiliaries” were later replaced by “nursing assistants” and “health care assistants”. The latter group were given a new title to reflect their position as those “trained” to carry out work previously done by student nurses (Cavendish 2013). This was evident from the higher numbers of articles found to be using the terms “nursing assistants” and “health care assistants”. There was also a difference in preference of terms used in different environments; the reduction in the number of articles found when the term “support worker” was combined with “hospital” confirmed my perception that the title “support worker” was more common in social services and community health settings than in hospital settings. As a result of this search, the term “Health Care Assistant”, abbreviated to “HCA” was chosen for use throughout my study.

1.6 Evolution of the HCA

It may be due to the multiple terms used to refer to the assistant to the nurse that has led to sparse information about the history of the HCA (Kessler et al 2012). It may also be because their role has always been interwoven with the RNs. ‘Nursing’ was recognised as an occupation during the Crimean war in the 1850s (Stokes and Warden 2004). At this time anyone could call themselves a nurse (Royal College of Nursing 2017a). Nurses were hired by families to take care of a sick relative by providing 24-hour care in their home or, as they became more popular, in hospitals. This was known as private duty nursing (Barnum 1998, Royal College of Nursing 2017a). Private duty nursing was in place until World War II when

high numbers of nurses left their usual duties to support the war effort (Barnum 1998). The demise of the private duty nurse led to more nurses in hospital settings. Until this time, the wards had been staffed by student nurses with only small numbers of nurses overseeing their work (Royal College of Nursing 2017a), but it later became usual to have nurses working in hospitals (Penn Nursing 2004). The expectations of nurse's capabilities increased as surgery, medicine and understanding of infection and its prevention improved (Royal College of Nursing 2017a). In 1919, the Health Care Act led to a standardised three-year nurse training and registration (Royal College of Nursing 2017a), thereby separating the State Registered Nurse from other carers (Kessler et al 2010). In the 1960s, a two-year course to become a State Enrolled Nurse (SEN), a high-level assistant to the RN, was developed and included registration on to the Roll of Nurses (Webb 2000), thereby dividing nursing care between four groups; the RN, the SEN, the HCA and the student. The Roll of Nurses eventually became the business of the General Nursing Council which later became the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and then the Nursing and Midwifery Council (NMC). The RNs, the SENs, the HCAs and student nurses worked together on wards to provide nursing care until the 1990s when Project 2000 was introduced (Webb 2000) and students gained supernumerary status. This overhaul of how nurses were trained was one of three instigators of change for HCAs.

1.7 Instigators of change

Changes to the role of the RN had consequential impacts on the role of the HCA. Three sets of circumstances evoked major alterations. These were: changes to the training of nurses, changes to the use and management of the NHS and changes which occurred as a result of the Working Time Directive.

1.7.1 Student nurse training and HCAs 'training'

Up until 1986, student nurses carried out their training through placements on wards where they were included in the staff numbers as a member of the team, similar to an apprenticeship (Stoke and Warden 2004, Royal College of Nursing 2017a, Allen 2009). They provided support to the registered nurse in delivering direct patient care (Stoke and Warden 2004). A review by the nurse regulator the UKCC, led to a decision that in the new training, Project 2000, pre-registered nurses would be taught in higher education institutions and

hold supernumerary status; they would no longer be counted in the ward staffing numbers (NMC 2010, Allen 2009). At the same time, the UKCC decided to stop the two-tiered nurse system by discontinuing the position of the SEN (Stoke and Warden 2004, Cavendish 2014, Allen and Hughes 2002). Supernumerary status for student nurses and loss of the SEN role left a gap in supporting the nurse in care delivery. The nursing support workers, then called Nursing Auxiliaries, were turned to, to fill the void (Allen and Hughes 2002). The UKCC (1986) acknowledged the shift in function of the nursing auxiliaries and recommended that a new type of support worker was created called the Health Care Assistant. The UKCC (1986) stipulated that this person would perform "non-nursing" duties under the direct supervision of RNs. This would allow RNs the time to provide more of the "skilled nursing care" that they had been trained to do (Stoke and Warden 2004, Traynor et al 2015).

As the role of the HCA was changing in the practice setting, the National Council for Vocational Qualifications was set up to formulate courses for people where assessment was based on experience and knowledge that had been gained in the workplace. In 1988, National Vocational Qualifications (NVQ's) were rolled out to include those working in healthcare (Roberts 1994). Based on a two-year study looking at the growth in the complexity of tasks that HCAs perform, Thornley (2000) concluded that NVQs were a sound format for formally recognising the skills of HCAs and provided a means of progress. The high uptake of this qualification by HCAs led Thornley (2000) to suggest that it was no longer appropriate to class this group as untrained or unqualified. Although this statement sounded positive for HCAs, ten years later Kessler et al (2010) reported that uptake in NVQs was restricted by a lack of opportunity to leave the ward to complete the work and a deficit in assessors. Of further concern was the finding that those who did complete the courses had gained skills which were often not utilised within their day to day work (Kessler et al 2010). Spilsbury (2004) extended the concept of non-use of the HCAs skills and this is discussed in the literature chapter.

1.7.2 Changes to the use and management of the NHS

World War II saw a move in healthcare delivery from local provision by doctors and hospitals to a more nationalised service (Kirkpatrick, Ackroyd and Walker 2005). When the National Health Service made the assurance of free medical services in 1948, this was based

upon the presumption that the population and illnesses were finite (Kirkpatrick, Ackroyd and Walker 2005); but, population demographic changes, advances in technology and pharmacology and an increase in public expectation have challenged this perception and had a negative impacted on the efficacy of the NHS (Butler-Williams et al 2010, Kirkpatrick, Ackroyd and Walker 2005, Allen and Hughes 2002). In addition, the recruitment and retention of the nursing workforce also proved problematic (Barnum 1998, Johnson et al 2004, Keeney at al 2005a). Shields and Watson (2008) declared that the decline in RNs was so great that there might be no RNs in the future and asked the Australian government to learn from the UK's mistakes. In order to address these RN shortage issues in the UK, the Department of Health (1998, 2000) made recommendations for 'cross boundary working' and creation of new roles (Butler-Williams et al 2010, Thornley 2000, Allen and Hughes 2002). At this time, the new Labour government also extended facets of the internal market system in the NHS started by the Conservatives (Roberts 1994, Kessler et al 2015, Allen and Hughes 2002). Known as New Public Management, the introduction of General Managers to the NHS, akin to those in the private sector, brought with it 'customer'/patient dominance over the traditional clinician's power as well as target-driven organisational performance (Kessler et al 2015, Kirkpatrick, Ackroyd and Walker 2005). The aims of New Public Management were to reduce public spending, to move away from government control, and to develop the use of automation for better production and dissemination of services (Hood 1991). In order to achieve this, there was a drive for explicit standards and measures of performance, and a shift in attention from procedures to results (Hood 1991). The importance of this data is conveyed by external bodies applying financial penalties when targets were not met (Evans 2014). These changes brought pressure to find more flexible and effective ways of working and, in doing so, the role of the RN, and consequently, the role of the HCA, was expected to change (Allen and Hughes 2002, Thornley 2000).

1.7.3 Working Time Directive and the development of RNs professionalisation

In 1998, the Directive 2003/88/EC (2003) known as the Working Time Directive, was implemented in the UK and this led to a review of the excessive hours worked by junior doctors. A reduction in their hours resulted in some duties being redistributed (Allen and Hughes 2002, Kessler et al 2015). Tasks such as administration of intravenous medication became the jurisdiction of RNs (Allen and Hughes 2002, Kessler et al 2015, Moseley et al

2007). Whilst some RNs embraced the opportunity to take on new tasks that would be accompanied by managerial support and resources, others felt they were adding doctors' abandoned work to their already heavy workload (Allen and Hughes 2002). This had a consequential impact on the role of the HCA and will be further explored in Chapter 2.

It is possible to see that many factors have impressed change on the role of the RN including policies, working conditions, population demographics and technological advances. In response, the role of the HCA has also been modified in order to remain complementary to the RN's responsibilities. The impact of changes to RNs' actions on the role of the HCA were not formally recognised in policy until the Francis report was published in 2013.

1.8 Formal recognition of the role change; Francis (2013)

In 2013, a report was published which had a substantial impact on the nursing community. Care and systems at Mid Staffordshire Hospital underwent two investigations by Francis between 2005 and 2008. It was during this timeframe that the hospital was deemed to be satisfactory by external bodies in aspects of managing finances and meeting targets but there were high mortality rates in comparison with similar Trusts and complaints from patients and 'those close to them' that raised interest. The first investigation highlighted a lack of basic care, acceptance of poor care, a focus on meeting targets, a lack of staff support and a lack of openness. The Trust had placed emphasis on the success of "systems not outcomes". Francis described the patient and relative stories as "harrowing". A second inquiry was granted to explore how this could happen. The Trust was not as successful as it was professed to be (Francis 2013). It was found that the Trust culture was negative; "false assurance" was extracted from good news and toleration or defensive explanation was espoused when bad news was shared (Francis 2013). It was believed that the tolerance and the lack of urgency or significance in sharing information with others allowed poor standards of care to continue (Francis 2013). In relation to the nursing team, which included HCAs, recruitment, training, staffing levels were found to be insufficient. With the addition of weak leadership, it had led to care provision that lacked governance and had a focus on meeting service standards (Francis 2013). There was recognition that the RN role had become technical in nature and it was instructed that future RN training included degree

level education (Francis 2013). In acknowledgement of this shift to more technical care, there was also an awareness that RNs may be attracted to the technical side and concentrate less on the "fundamental aspects of nursing"; this would compromise levels of compassion and patience and, ultimately, lead to RNs who were "too posh to wash" (Francis 2013 23.60). To address this, it was recommended that those wishing to train as an RN would need to have previous experience in a health care setting to gain skills in direct patient care. Francis (2013) purposefully called a chapter in the report "nursing" to capture that some nursing care is provided by team members that are not RNs. He emphasised that HCAs may be the first to observe or hear about new symptoms from patients, that their work required sensitivity and their actions could prevent hospital acquired harm.

1.8.1 "Health Care Support Workers"

The Francis Inquiry report (2013) included specific reference to the role and contribution of the HCA. It described HCAs as those who provide personal care to a vulnerable group of people. On this basis, there was concern expressed that the only form of check on this staff group was Criminal Records Bureau (CRB), now known as Disclosure and Barring Service (DBS). Francis (2013) reiterated other studies in highlighting that the absence of regulation led to other deficits; no minimum standards of competence or training, no tracking of HCA changes, no agreed job title, no system to prevent HCAs from working with a new employer after dismissal. This accumulated evidence suggested there was no patient or public protection (Francis 2013). Francis (2013) wanted registration for the regulation of HCAs to address these issues. To gather more understanding of the contemporary role of the HCA, the Cavendish review (2013) was commissioned.

1.8.2 The Cavendish Review (2013)

The points made by Francis (2013) were further explored with HCAs and those who employ them. The terms of reference for the Cavendish Review (2013) included investigation into recruitment, training, supervising and improving "public confidence" in the role of the HCA. Many of the issues that arose reiterated those found in other literature; the frustration and confusion HCAs felt around what tasks they were allowed to deliver; the lack of recognition for what they did, the problems with variable training experiences and the pressures from

senior staff resulting in HCAs carrying out tasks that they did not feel capable of undertaking (Cavendish 2013). Many nurses and doctors interviewed in the review described HCAs in body parts; “eyes and ears” and “an extra pair of hands” (Cavendish 2013), rather than as an integral whole, or a partner. HCAs interviewed reinforced the findings of Spilsbury (2004) and Kessler et al (2010) in stating that they had the primary relationship with the patient rather than the RN. HCAs felt privileged to be able to get to know patients and relatives and the importance of this patient contact, resulted in some HCAs not wanting to undertake nurse training and losing the perceived patient contact (Cavendish 2013).

Cavendish (2013) concluded that the unclear supervision and boundaries of the HCA role added to the confusion and led patients and relatives to deduce that HCAs were no different to RNs. Therefore, it was suggested that a single job title, a specified uniform and formal registration would make HCAs easier to differentiate from RNs. It was again expressed that formal registration would ensure consistency in recruitment, training and development to provide safe and quality care to a national standard (Cavendish 2013). These recommendations have not been implemented for HCAs but have been applied to the new role of Nursing Associate (NMC 2018).

Something that has come to fruition is the “Certificate of Fundamental Care”, now known as the Care Certificate. The Cavendish Review (2013) stated that the public expects HCAs to have basic knowledge in relation to their role such as how to change a dressing, but in addition, to possess interpersonal skills such as kindness and communication; characteristics of caring that were viewed as innate rather than taught (Cavendish 2013). Therefore, Cavendish (2013) stated that HCA recruitment needed to be based on peoples’ values. The Care Certificate was developed for standardised information and assessment of basic knowledge and interpersonal skills and to ensure all were aware of the importance of person-centred care (Cavendish 2013). It was implemented on a voluntary basis because regulation to make it statutory did not exist. Therefore, quality assurance was left with the employer (Cavendish 2013), again allowing learning and assessment of HCAs to be open to variation. The Cavendish Review (2013) did however, clarify responsibilities. It was the responsibility of the employer to ensure that HCAs had the skills to be able to perform the tasks they were delegated but the personal responsibility of the HCA to attend training,

receive supervision and appraisal. As well as this, there was recommendation that the Code of Conduct for Support Workers (Skills for Care and Skills for Health 2013b) should be adjusted to include a "right to withdraw" clause. Cavendish (2013) believed that together the training and the ability to refuse to carry out a task beyond their training would enable HCAs to remain within the remit of their role.

With regard to development, Cavendish (2013) agreed that there needed to be a clear pathway for HCAs to move upwards from the HCA role. Whilst HCAs have been Band 1-3 on the Agenda for Change framework, a new Assistant Practitioner role was introduced as a Band 4. The Assistant Practitioner role was created for undertaking tasks that were previously carried out by the RN in more specialist areas such as renal and endoscopy as opposed to general wards and the training is open to HCAs in these environments (Cavendish 2013). However, even though this was an opportunity to progress from a Band 2 to a Band 4, it was expected that the next leap from Band 4 Assistant Practitioner to Band 5 RN would be challenging due to RN training being at academic degree level (Cavendish 2013). The report recommended that a clear and affordable career ladder should be developed for those who want to move beyond the role of HCA (Cavendish 2013).

1.9 The Future; The Nursing Associate

Documents such as Five Year Forward View (NHS England 2014) and Leading Change, Adding Value (NHS England 2016) advised that there needed to be "workforce adaptions" to address the deficit in the nursing workforce that had been emerging over many years (Health Education England 2017). The Shape of Caring Review (Willis 2015) took an in-depth look at the role of the HCA and the RN. It confirmed that there should be competency standards and agreed job titles connected to job descriptions which were then aligned to a career framework. Added to this, Willis (2015) recommended that a new role, the Nursing Associate, be created to cover the gap between the role of the HCA and the role of the RN in light of feedback from employers that the Assistant Practitioner role was not operating well; some found that the role was expensive and they were unable to function as an RN would. After government agreement and public consultation, 11 tests sites with 1000 Nursing Associate students were set to run for two years from June 2016 (Royal College of Nursing 2017b). There was intention that the Nursing Associate would have the skills and

knowledge to support RNs in assessment, planning and evaluating care across a wide variety of settings and fields of practice (Willis 2015). Skills and knowledge were to be learned through work-based learning and university-based academic study at level 5 (Health Education England 2017). On completion of the two-year training, Nursing Associates will be qualified and registered with the NMC. They will have "a degree of autonomy and will use professional judgement to ensure that they always work within the parameters of their practice" (Health Education England 2017 p15). This remains aligned to the current situation where the RN holds overall accountability for patient care (Health Education England 2017). At the time of writing it was not possible to see the effects the introduction of the role of the Nursing Associate will have on the role of the HCA or how the extended nursing hierarchy will be enacted in practice.

This brief history of the evolution of the HCA role included the instigators for change. The importance of the Francis report (2013) was presented as a significant moment where the contribution of the HCA was recognised as important and requiring further investigation. The Cavendish (2013) review led to recommendations for change and impacted on the Willis (2015) review and creation of the Nursing Associate. Following this introduction to the HCA role, the outline for the rest of the thesis is provided.

1.10 Thesis overview

There are six chapters to this thesis. This first chapter has described how the subject of the thesis emerged from my exposure to the work of HCAs on adult wards. Statistical data has demonstrated the high number of workers in this field, thereby justifying the importance of the study and how a better understanding of this group has potential to impact on healthcare delivery. The chapter has then included explanation of the choice of Health Care Assistant terminology over many others that are used in health and social care. The evolution and instigators of change were described, and it was explained how Francis (2013) captured these changes and made recommendations as a result. Finally, there was acknowledgement that the nursing associate role was being introduced into the healthcare field but is not included in this study.

The literature pertinent to the HCA is considered in Chapter Two commencing with the review strategy and literature search. A description of the nursing tasks is presented before clarification of how such tasks were structured via models of care. Due to its importance in underpinning many national policies, ward philosophies and personal ethics in the nursing field, a description of person-centred care (PCC) is given. Next, literature highlights various factors which impact on the role of the HCA with particular attention to their relationship with the RN. The sensitising concepts of Habeeb (2017) and Menzies Lyth (1988) which were identified during data analysis, will be provided at the end of the chapter. The reason for presentation here is to allow the reader to make connections between the chapters in a pragmatic, rather than chronological order.

Chapter Three provides an explanation for my methodological decisions. Finding an appropriate perspective derived from understanding five paradigms. Reasons are given to justify the decision to use a constructivist paradigm with a focused ethnographic methodology. Following this, I share some of my experiences through prospective and retrospective reflexivity.

The methods used in the study are presented in Chapter Four beginning with the research design. The practical facets of access to the field and participant recruitment are imparted before ethical considerations are presented. The various elements of observation as a data collection method are highlighted before similar attention is paid to interviews. There is thought as to whether skills are transferrable from mental health nursing. Next the data analysis process is described. The use of qualitative data analysis software, and the role of memos is included between explanation of early analysis and focused analysis. Then theorising is defined and discussed in relation to this study.

The content of Chapter Five is the findings of the focused ethnography. Firstly, a rich description of the ward environment in which HCAs work is given and the HCA-RN dyad as a new concept of team is then introduced. The HCA-RN dyad is presented in two parts; a description of what it is (form) and then what it does (function). The form will be shown as consisting of four attributes; pre-shift preconceptions, hierarchical differences, physical isolation and concentrated relationships. It will be illustrated that the function of the HCA-

RN dyad was based on the ability to join and separate and how HCAs achieved this will be demonstrated. Through the form and the function, the HCAs contribution to the HCA-RN dyad is clarified.

The impact of the discovery of the intertwined relationship between the HCA and their RN partner as a contemporary understanding of how the HCA enacts their role is the basis for the discussion and conclusion in Chapter Six. The form of the HCA-RN dyad as a new concept of team is compared against pre-existing team style models. The team of two which is nestled within the ward nursing team is considered against the dyad literature including the sensitising concept, Habeeb (2017). The findings which highlighted the HCAs Reliance on the RN partner and Searching for Equity are compared with professionalisation of RN literature before exploration of the routine scaffolding from the viewpoint of the organisation, the HCA and the impact on person-centred care in relation to other studies. There was suggestion that HCAs were displaying signs of anxiety and these are compared with three of Menzies Lyth's (1988) defensive mechanisms. There is consideration of whether the findings imply a contradiction between the person-centred care that was espoused and the actions of the HCAs. Chapter Six also encompasses the contribution to knowledge, the contribution to the methodology and methods, limitations of the study, and the implications and recommendations for practice before the final conclusion.

Chapter 2 Literature

2.1 Introduction

Before presenting what is already known about the role of the HCA from the literature, it was necessary to contemplate what kind of work was within the remit of a nursing team on an in-patient adult ward. Based on the literature, it was possible to see that nursing tasks could be identified and categorised in to groups. Then, the categorised groups were divided between nursing team members dependent on the model of care being used on the ward. The three main models will be described; functional or task orientated; team; individualised patient allocation or primary nursing. Underpinning the nursing care is the philosophy of person-centred care and this is defined before discussion of the themes that arose from the HCA literature search. Key themes included 'RN professionalisation and the impact on the HCAs role', 'executing policy change', and 'RN and HCA relationships'. Finally, the sensitising concepts of Habeeb (2017) and Menzies Lyth (1988) which influenced the data analysis are shared. Firstly, the literature review strategy for the HCA role is presented.

2.2 Review strategy

There are differing opinions about when and how much time should be spent on looking at the literature prior to commencing data collection in ethnography. In qualitative research authors argue that findings of similar studies contribute significant information to the research journey; before, during and after the formulation of the problem, the data collection phase and throughout the analysis (Hammersley and Atkinson 2007, Gray 2009). It is seen as a way of comparing and contrasting available evidence in order to consolidate or further develop concepts (Hammersley and Atkinson 2007, Strauss and Corbin 1998) and provides opportunities for sensitising concepts to arise (Hammersley and Atkinson 2007). The important and changing role of the literature, often experienced by doctoral students (Kwan 2008), reflects my own journey of ongoing engagement. An initial, broad look at the literature was conducted at the proposal stage. First impressions were that in comparison to the high number of people carrying out the HCA role, there was a relatively small body of research. Also, the empirical data relating to HCAs was predominantly gathered from the RNs perspective and discussed the impact that the HCAs performance had on the RNs work.

There was little written from the primarily perspective of the HCA. A more structured review of the HCA literature was carried out before data collection commenced.

2.2.1 Process and inclusion criteria

The introduction chapter included information on how I came to decide on use of the term Health Care Assistant, or HCA, rather than any of the other possible 60 terms identified to describe the unregistered health/social care worker. This decision was based on three database searches using the title of the person in the role only. In order to look at the literature surrounding how HCAs enact their role, the title search was combined with other key words from this research question. These included "adult", "acute", "hospital" and "in-patient". "Nursing assistant" was the second most used term and was therefore also included in the search strategy to increase opportunities for locating relevant literature. Any articles based on the Assistant Practitioner or the Nursing Associate were discarded, as these were viewed as advanced roles and therefore different to that of the HCA.

Once search terms had been decided, appropriate databases were identified. Cumulative Index to Nursing and Allied Health Professionals Literature (CINAHL) was chosen for its wide scope of journals relating to health. The British Nursing Index (BNI) includes references from all major nursing and midwifery journals and was used for this reason. Academic Search Premiere (ASP) was recommended by the subject librarian as complementary to CINAHL and BNI for nursing relevance. The Boolean operator "AND" was used to combine terms alongside the symbol "*" to ensure incorporation of all articles that used the term in singular or plural format such as "assistant" and "assistants". The initial search for HCA literature was limited to the period between 2003 and 2015. The year 2003 was chosen as a starting point because articles which were produced prior to this date did not represent the current ward environment. This was particularly illuminated through the recommendations; suggestions for change were now either current practice or no longer applicable. 2015 was when data collection commenced. Pausing the literature search before initiating data collection provided an interlude where I could go into the setting with a background comprehension but still have room to discover how HCAs understand and enact their role currently from my own and their own perspective. I returned to the literature when attempting to understand the findings and build on theory.

When the number of articles was 60 or under, the search was stopped, and the articles were then screened by application of exclusion criteria to the abstract. The number of 60 was chosen as it appeared, at a glance, to provide a wide range of articles to represent the field. If, when all the parameters listed above were applied, the total number of articles remained at over 60, the number was further reduced by limiting to those which had "nursing assistant*" or "health care assistant*" in the title of the article. The search identified a total of 322 articles for screening across three data bases. This can be seen in Appendix 1.

2.2.2 Exclusion criteria

In order to remain focused on how HCAs do their job, it was imperative that articles contributed to understanding of the role of the HCA. On that basis, some articles were discarded as superfluous and out of scope to the study at this stage. Reading of the abstract enabled the exclusion of articles which were based on specific factors that were different to those expected in this study;

- Articles where HCAs were based in nursing specific fields such as mental health, learning disabilities, children's nursing and midwifery were excluded. This was because the patient group was different to that being studied here and may have required different skills, staffing levels, demeanour and relationships. This left only HCAs that specifically worked in the adult field of practice which matched the wards and units used in the study.

- As this research was focused on how HCAs do their job as opposed to what they do, articles concentrating on specific tasks (diabetes, pressure area care) and specialist areas (GPs, palliative care) were discarded on the basis that data was too narrow to support understanding of the HCA's role on a ward.

- Application of a restriction that research needed to be grounded in hospital settings removed articles centred on external environments such as care homes. This was felt necessary because the structure of staffing, resources and interactions with other professions could be contrasting and results may not be applicable to an acute ward environment.

- Articles about training programmes and personal needs (eg back care) were not seen as contributing to knowledge about how the HCA carries out their role and were therefore discarded.

- Opinion pieces and news reports were not included in the literature review due to their lack of research evidence.

- Articles not in English were also removed.

For each database, the articles were first filtered for duplicates. Exclusion criteria were then applied based on the information in the abstract and some articles were discarded at this stage, while those left were read in full. Any HCA articles still meeting the study criteria were used in the literature review. This process was carried out one database at a time in order to manage duplicates, starting with ASP. This process and the results can be found in table form in Appendix 1, along with those for CINAHL and BND.

2.2.3 The HCA search results

The tables in Appendix 1 demonstrate that 10 articles were drawn from ASP, a further 7 were drawn from CINAHL and another 1 was sourced from BND. This gives a total of 18 articles which provided a base for the literature on the role of the HCA. Once the databases were exhausted, hand searches were carried out. Reference lists from articles were invaluable. In this process, they supported identification of key and seminal texts such as Thornley (2000) whose work fell outside of the date parameters. Other work by the same author/s was also discovered this way and provided a breadth to my understanding. Alert mechanisms on data bases were set up for the period of the study which produced an email to highlight when new articles on HCAs were published, this helped me to remain up-to-date through the study. Documents such as the Francis (2013) report, the Cavendish (2013) Review and the Willis (2015) report were also included in the literature review as their impact was prominent in nursing at the time. This grey literature was sought through the search engines Google and Google Scholar. Ultimately, the headings and subheadings in the literature chapter reflected the key themes that arose from the HCA literature.

2.2.4 Returning to the literature

As suggested above, when data analysis was being undertaken, I returned to the literature as is a common occurrence for doctoral students (Kwan 2008). At this stage, the search for

literature was a more precise probe for data that could provide a fuller contextual background. It had become clear that person-centred care, nursing tasks and nursing models were significant to understanding the role of the HCA. Articles which provided this foundational understanding were located through a broad electronic library search which included all databases available through De Montfort University. Key articles were found and their reference lists utilised. The description of nursing tasks was by means of reviewing the HCA articles already identified in the literature search and then checking their references for more detailed accounts. Literature on models of nursing were from nursing textbooks and were found by manually searching the library shelves followed by using the library database tool for more contemporary reviews.

As well as providing better foundational understanding, there was also a return to the literature for my own comprehension due to my new theorical thoughts and empirical insights. Some aspects of the literature appeared more prominent after the data was collected due to an increased comprehension of the phenomena. For instance, the connection between task working, boundary work and New Public Management became clearer. Articles were revisited and supplementary texts were read, and these were influential when writing the discussion. Dyads was also an area that required further reading as its relevance to the study became more obvious. This was actioned through use of search engines and broad use of databases. Habeeb's (2017) work became a sensitising concept at the beginning of data analysis when I met her at a conference. At that time, I had realised that the HCA and RN were working in pairs within the broader nursing team; her theory resonated with my early connections. Menzies Lyth's (1988) nursing study became significant to my study towards the end of data analysis when I reflected that the findings did not explicitly capture the feelings of the HCAs; her theory allowed exploration of underlying anxiety that was palpable on the ward. As the transforming nature of attention to the literature has been explained, now the content of the HCA literature that resulted from the search strategy can be looked at.

2.3 The HCA literature

The review strategies for the HCA literature have been described alongside how the location of literature on nursing tasks, models of care, person-centred care was performed. The results will be presented by firstly looking at what were considered to be nursing tasks. It is then possible to contemplate how these tasks were divided between the nursing team members. Following this, person-centred care is defined. From the HCA literature, five themes were identified: RN professionalisation and the impact of the HCA role, executing policy change; tasks and boundaries, RN and HCA relationship and the difference between RNs and HCAs.

2.3.1 Describing the nursing tasks

There are many studies that list nursing tasks with regards to the role of the HCA (Keeny et al 2005a, Pender and Spilsbury 2014, Thornley 2000, Cavendish 2013, Sutton et al 2004) and these will be discussed later. The extensive study of the role of the HCA in a ward environment by Kessler et al (2010) provides a description of nursing tasks and how they were grouped and labelled, and this will be used to provide a comprehensive basis for understanding nursing work.

Kessler et al (2010) aimed to establish whether HCAs were viewed and used as a strategic resource, what backgrounds HCAs came from, the shape and nature of their role, and the consequences of their role for the three main stakeholders; HCAs themselves, nurses and patients. There were four phases to the study. Nine Trusts were included in the first phase of the study; semi-structured interviews with people in senior positions. For phase two, four cases representing regions in the UK were selected. Three months in each Trust were spent data collecting with staff and patients. This included 273 interviews, 275 observations, focus groups with 94 former patients, and in three Trusts, action research was undertaken. Phase three involved surveys with results from across the four Trusts; 746 HCAs, 689 RNs and 746 former patients.

Based on their data, Kessler et al (2010) identified and grouped the nursing tasks into categories; direct patient care, indirect care, technical and specialist tasks, pastoral support and ward level tasks. Interactions with patients such as washing, feeding, supporting with

elimination were classed as direct patient care (Kessler et al 2010). In contrast, indirect patient care incorporated tidying around the bed space, cleaning and remaking beds following a patient's discharge and offering and making drinks (Kessler et al 2015). Technical and specialist tasks were those that required some training; for instance, electrocardiograms (ECG), phlebotomy and taking clinical observations (Kessler et al 2010). Pastoral support entailed tasks that made patients more at ease; fetching something to read or listening to concerns (Kessler et al 2010). Finally, ward level tasks were those jobs carried out in the shared areas of the ward like refilling stock or disposing of bags of laundry in the sluice room.

Kessler et al (2010) were able to utilise the categorisation of tasks by next considering the breadth of the tasks and the level of technical skill involved in their delivery. Each HCA could then be placed in a cluster depending on which categories of task they enacted; the bedside technician, the ancillary, the citizen, the all-rounder or the expert. Kessler et al's (2010) study highlighted that the role of the HCA was diverse, and the boundaries were fluid. It provides a basis for discussion about the division of work not only for HCAs but within the nursing team: the division is determined by the model of care.

2.3.2 Models of nursing care

Models of care was a term used to describe how nursing work was divided between the nursing team members in the ward context (Barnum 1998). Historically, the restructuring of how nursing practice was organised could be mapped as swaying between focusing on a small number of individual patients through to looking after a large proportion or the whole ward (Barnum 1998). Private duty nursing was the first model of care (Barnum 1998) which was in place in the early 1800s. It was replaced by the functional, or task orientated model when staff resourcing became problematic.

2.3.2.1 Functional/task model of nursing

In the 1930s in accordance with industrial work at the time, the functional model of care was based upon dividing patients' care into tasks. This style of working by tasks was sometimes referred to as Fordism. Each staff member was given responsibility for a small set of tasks or functions, which they delivered to all patients on the ward (Gillies 1994, Allen 2002). A treatment nurse, a medication nurse and a pre-discharge teaching nurse were

examples of titles allocated to nursing staff on each shift (Gillies 1994, Barnum 1998). Subordinate roles like HCAs were used for completion of tasks that did not necessitate high levels of skill such as the 'bed-maker' and the 'temperature taker' (Barnum 1998). Working with sets of tasks as the focus rather than a group of individual patients was an efficient approach when resources were minimal (Gillies 1994). Application of the functional model made staff very skilled and quick at task delivery (Gillies 1994). However, a problem arose when a task that was not delegated to a staff member needed completing. It would fall through a gap and no one was accountable. There was also no single person who understood the needs of the patient as a whole or took responsibility when there were errors or omissions (Gillies 1994, Allen 2002). The model was not well accepted by those involved; patients disliked the endless number of people coming to the bedside and nurses reported that the task orientated approach felt like factory style working with no end-product (Barnum 1998). A review of the function model had become necessary and team nursing was introduced.

2.3.2.2 Team model of nursing

The introduction of team nursing provided a fresh way of looking at provision of nursing care in the 1950s (Fairbrother et al 2015). This nursing team comprised two registered nurses, (one being the leader), two lower level practical nurses (SENs), and two "aides" (HCAs) (Gillies 1994). The lead nurse for the team delegated work according to the skills and experiences of the workers and the acuteness of the patient's illness (Gillies 1994). Nursing aides made beds, supported mobile patients to wash and tested urine. With good leadership, Gillies (1994) argued that the efforts of these teams exceeded those of each individual working in isolation. There were also benefits for patients who saw a smaller number of staff who knew them better and had their needs met 'in their entirety' (Gillies 1994). RNs liked the removal of the production line feeling (Barnum 1998). However, with a leader still delegating tasks, Barnum (1998) described team nursing as simply "*superimpos[ing] the patient focus of private duty on top of the task focus of functional nursing*" (p234). In essence, Barnum (1998) argued that, a task focused approach had continued but with smaller groups of staff and more leaders. An additional problem was that team leaders were required to demonstrate leadership skills which were not included in their training and were unnecessary when working in the preceding task

orientated/functional model (Gillies 1994). Each team members' role lost the clarity it had held when concentrating on one or two tasks. Doctors were unclear who to approach for patient information exchanges where they previously approached the Sister (Gillies 1994). Another change became inevitable and the focus moved to individualised patient care.

2.3.2.3 Individual patient allocation/primary nursing

Individual patient allocation, sometimes referred to as primary nursing, was implemented in the 1970s. Each nurse looked after a small number of patients. The problems identified with team nursing brought the nurse's focus back to individual patient's needs. This model of nursing relied upon areas having a high number of RNs (Gillies 1994, Barnum 1998, Allen 2002). Based on Orlando's (1972) nursing process, the RN was responsible for assessing, planning, implementing and evaluating the health, social and care needs for four to six patients (Gillies 1994, Fairbrother et al 2015). There was an expectation that the primary nurse would be responsible for the patient's care for the entire length of the hospital stay, following discharge and on subsequent admissions (Gillies 1994, Allen 2002). In holding the key role in care delivery, Gillies (1994) suggested that RNs were able to utilise their extended nursing skills such as decision making, leadership, advocacy and patient teaching alongside their technical knowledge. In their absence, it was expected that an associate nurse would be nominated to cover the shifts and would carry out instructions handed over by the primary nurse (Gillies 1994, Allen 2002). The primary nurse was intended to be the most well informed about the patient's care and the Sister's role became about quality assessing and support (Gillies 1994). With each RN taking responsibility for a patient's care, the coordination problems seen in team nursing were eradicated and accountability issues which arose in task orientated/functional nursing were also addressed (Barnum 1998). Individual patient models were based upon one RN meeting all of the nursing needs of a small number of patients (Gillies 1994, Fairbrother et al 2015) and, due to the focus on the role of the RN as the main care giver, details of how the HCA contributed to this nursing model was not included in the descriptions (see Gillies 1994, Barnum 1998, Fairbrother et al 2015). However, articles written later about increasing the remit of HCAs demonstrate that they were present at this time and were delivering the indirect nursing tasks listed by Kessler et al (2010).

These descriptions of models of care derived from nursing textbooks dated to the 1990s. Since this time, there is no evidence that further major changes to how nursing work is divided have been made. In 2012, Fernandez et al carried out a systematic review of quantitative studies to explore which model of care was predominant. They confirmed that team nursing was the common model used in the hospital setting. Allen (2002) stated that team working was implemented as a pragmatic response to low RN staffing levels and the practicalities of the closeness of patients in the ward environment; RNs didn't exclude patients because they were not part of their allocation. Team working had strength in utilising skill mix and supporting less experienced team members (Fernandez et al 2012, Allen 2002) thereby filling some RN gaps. This finding clearly acknowledges that skill mix has become a significant factor of ward nursing. Nevertheless, Fairbrother et al (2015) challenges the concept that team working is synonymous with task-orientated care and therefore incompatible with creating a high quality nurse-patient relationship. This was reiterated by Naef et al's (2019) study which captured the RNs beliefs that primary nursing was the model that encouraged continuity and relationship-building; characteristics of person-centred care (discussed below). This said, relying predominantly on one nurse to assess, plan, implement and evaluate a patient's care during hospital admission was done inconsistently; two thirds of RNs in Naef et al's (2019) study reported that they worked in accordance with a primary nursing model when only half were observed to be doing so. Allen (2002: p36) suggested that team nursing is a "watered down version of the primary nursing ideal" but it continues to hold the value of the nurse-patient relationship. The team nursing model and task orientated ways of working was used because of its capacity for management of large workloads in stressful environments (Fairbrother et al 2015, Sharpe et al 2018). This newer research tallies with previous evidence on functional team working as quicker to learn and a quicker way to deliver care (Gillies 1994). These attributes are important as increased workloads and poor recruitment and retention of RNs are known stress factors in healthcare (Butler-Williams et al 2010).

Sharpe et al (2018), considering the role of the RN, cites relationships between peers when working in these conditions as another stressor which shapes how RNs work. They noted that RNs decisions in practice were based upon "*the system in which they work and live*" (p16); as much as RNs would like to apply their own way of working, aligning with how

others worked and ranked their priorities helped them to be socialised in to the ward team. Being seen as a team player was based upon whether the RN had completed all of their tasks, with nothing outstanding for those coming on to the next shift to pick up alongside their own pending workload (Sharpe et al 2018). This illustrates that, although individual patient allocation/primary nursing was viewed as desirable, working in a way that enabled all tasks to be completed was seen as the primary focus and overrode more holistic styles of nursing care. Even though there was a return to team working following the decline in primary nursing, the desire for nurses to make a difference to the lives of individuals remained. Person-centred care was a term coined by Tom Kitwood (1997) in an attempt to retain personhood as a focus when caring for people with dementia.

2.3.3 Person-Centred Care

Person-centred care (PCC) places the person at the centre of their own care (Kitwood 1997). In its application to a practice area, PCC is where "individuals are supported, facilitated and enabled to contribute to their care through shared decision making, equality of communication and mutual respect" (Mitchell and Agnelli 2015 p46). RNs assessed patient's personality, likes and dislikes and abilities in order to see them as an individual (Nilsson et al 2018). This understanding of the "dimensions of being" could then be used to adjust the environment, provide continuity and build trust (Nilsson et al 2018 p1254).

Person-centred care is held as symbolic of good quality care (Royal College of Nursing 2010) and therefore is an extremely common term used in health care documents including policy statements, strategic documents and organisational values (Manley and McCormac 2008, Hebblethwaite 2013). Examples include Prime Minister's Dementia Challenge for 2020 (Department of Health 2015), The Principles of Nursing Practice (RCN 2010) and most importantly in this context, The Care Certificate (Skills for Care and Skills for Health 2013a). The high level of popularity that PCC enjoys may be due to the concept being seen as an aspiration to see the world from the patient's perspective (Clissett et al 2013). Despite its popularity, PCC has also been criticised for being a poorly defined, misunderstood concept (Manley and McCormac 2008) which failed to take in to account the needs of other stakeholders in care such as family carers or other health care professionals (Nolan et al 2006). Vision statements which espoused person-centred care were frequently not

underpinned by service models that allowed for the level of diversity needed to meet care needs of individual patients (Hebblethwaite 2013).

There is evidence that PCC is not being used in practice (Moore et al 2016, Clissett et al 2013, West et al 2005). This may be due to ambiguity in policies (Clissett et al 2013) or misunderstanding of the term PCC (Ross et al 2014). Moore et al (2016) and West et al (2005) would agree that training of healthcare staff is necessary for PCC to be implemented in care environments. HCAs receive this in the Care Certificate (Skills for Care and Skills for Health 2013a). The study by Ross, Tod and Clarke (2014) looked specifically at how PCC was understood and facilitated by RNs, HCAs and student nurses. There were many personal attributes that enabled PCC to be delivered in the ward environment such as being friendly and approachable, involvement of patients, being empathetic, and believing in the PCC philosophy (Ross, Tod and Clarke 2014). There were also environmental elements such as working in a team that believed in PCC, having space to be flexible in delivering care, having a leader who role modelled PCC (Ross et al 2014). The consequence of these factors being in place was the ability to recognise patients' wishes, be able to advocate for them and be responsive in assessments (Ross et al 2014). As well as benefits for the patients, Ross et al (2014 p1229) found that the nursing team gained job satisfaction from knowing patients better and being able to do "little things" that "made a big difference". However, there are many barriers to delivering PCC.

West, Barron and Reeves (2005) gathered London-based RNs views through 2880 completed questionnaires which asked about the barriers to delivering PCC. Findings suggested that RNs could not deliver PCC. They were unable to meet patient's emotional needs, give time to discharge planning, to information giving and to give appropriate symptom relief. RNs also recognised that patient safety was compromised by their lack of time; safety call buttons were not answered and there was no time to minimise risk of fall for individuals (West, Barron and Reeves 2005). Lack of control over their ward environment to improve patient recovery such as temperature, providing privacy (Moore et al 2016) and noise reduction added to the barriers in providing PCC (West, Barron and Reeves 2005). From this study, it can be seen that the provision of nursing work was difficult for RNs resulting in interpersonal skills such as empathy, approachability and time to engage, (Ross,

Tod and Clarke 2014) being unobtainable. In order to address the deficits pinpointed in the West, Baron and Reeves (2005) study, RNs requested training which included many aspects of PCC; giving patient anxiety support, involving patients in care decisions and communication skills (West, Baron and Reeves 2005). The authors recommended a training programme to address these issues. However, Ross, Tod and Clarke (2014) suggested that PCC is primarily created and learnt through ward-based role modelling, management support for environmental changes and the ward team placing value on the delivery of PCC.

In summary, it seems that PCC is frequently written and spoken about but rarely seen in practice. McCormac and McCance (2010) instead talk of "PCC moments" rather than continual expression although Moore et al (2016) implied their disappointment when they saw clinicians were able to give PCC, only later to return to their traditional styles of interaction. Either way, PCC is a part of the narrative of nursing and therefore has an impact on the way in which role of the HCA is defined and enacted.

2.4 RN Professionalisation and the impact on the HCA role

It has been possible to see that the working environment for HCAs and RNs has altered in response to internal and external pressures. As a reaction to demands, RN leaders have made decisions about the development of the nursing role (Allen 2000). These decisions as to whether and how to adapt to pressures were motivated by their conception of professionalisation: what they saw as their core work and their expertise. According to Kessler et al (2015), there are two rationales or logics that underpin their decisions; specialist-discard or holistic-hoard. Specialist-discard logic is based upon a judgement of what are core tasks to a nursing profession. Kessler et al's (2015) description of specialist-discard logic assumes that RNs see advanced tasks as core tasks. Once the core nursing tasks had been decided, there could be an ongoing procession of acquiring advanced level tasks and a discard of lower level, 'mundane' tasks to HCAs. It had accordance with the idea that professional status is fluid with unstable boundaries and therefore needs regular review and attention (Kessler et al 2015). In contrast, with holistic-hoard professional logic, RNs do not identify core tasks because *all* work contributes to the care of the patient (Kessler et al 2015). The professional status for this group arises from the skill of RNs to work

independently in order to provide all the integrated care (Kessler et al 2015). From these descriptions, it is perceivable that specialist- discard professional logic saw the role of the RN as delivering tasks that were given hierarchical status. This can be seen as having an association with task-orientated models of care. Alternatively, the holistic-hoard professional logic reflected the RNs commitment to a primary nursing model of care. The question of which logic has predominated has been heavily influenced by the nursing regulators (Kessler et al 2015). In countries where there is extensive closure of professional boundaries by the regulators, the tasks that could be completed by RNs or HCAs are tightly managed through registration or licence. The opposite of this tight regulation has been seen in the UK where only a few tasks are restricted to registered nurses leaving opportunities for RNs to work in a specialist-discard or a holistic-hoard logic (Kessler et al 2015). It must be acknowledged that along with loose regulation seen in the UK, there was also a convenient presence of HCAs who could act as a 'depository' for the discarded tasks and enable use of the specialist-discard logic (Kessler et al 2015 p739). These two professional logics are not only under the control of the NMC as the professional regulator, they are also under the influence of the New Public Management system.

The introduction of general managers into hospital settings, as part of New Public Management, facilitated the ability to question 'what has always been'. This included looking at the impact of poor recruitment of RNs, to pay attention to being economically sound and to implement a hospital performance strategy (Kirkpatrick, Ackroyd and Walker 2005). Under New Public Management, hospitals had more control over their own budget (Kirkpatrick, Ackroyd and Walker 2005). HCAs that had been developed through NVQs to perform at a higher level, were by this time established in the role and were functioning above that expected of a student nurse (Roberts 1994). This advanced level functioning coupled with a NVQ qualification, allowed managers to increase the number of HCAs by using money from nursing vacancies (Roberts 1994, Thornley 2000). HCAs cost less to pay, cost less to train, were easier to recruit and consequently, were seen as a threat to the role of the nurse (Thornley 2000, Kessler et al 2010, Traynor et al 2015). Terms such as "skill mix" (Roche 2015), "grade dilution" (Thornley 2000) and "substitutability" (Moseley et al 2007) were now being used in the literature to describe staffing both on wards and in the community.

The introduction of the Working Time Directive (Directive 2003) was a stimulus for RNs to review their professional logic beliefs. Agreement from RNs to take on the medically delegated tasks occurred as junior doctors' hours were cut (Traynor et al 2015, Allen 2000, Kessler et al 2010). Tasks such as administration of intravenous medication became within the jurisdiction of RNs (Traynor et al 2015). Absorption of these tasks impacted on the nurse's capacity to carry out the entirety of their role (Allen 2000, Pearcey 2008, Traynor et al 2015). However, it fitted with the 'professionalisation project' for nursing (Traynor et al 2015). Medicine had a higher status and more professional autonomy than the care work delivered by the nursing team (Traynor et al 2015, Bach, Kessler and Heron 2012). More technical tasks could also be viewed as contribution to hospital quality and efficiency, thereby influencing how RNs were valued and possibly increasing protection of their role (Kessler et al 2015). It was questioned whether RNs were being self-protective in upholding their own professional identity or driven to gather up the doctor's surplus duties to ensure that these were not passed over to another health professional group (Allen 2000). Either way, Allen's (2000) opinion was that RNs were accepting the "crumbs on the table".

As had happened when student nurses were given supernumerary status, the additional work created by the Working Time Directive (Directive 2003) led RNs to turn to HCAs for support; specialist-discard logic was being implemented. Allen (2000) described how this was done in her ethnographic study on the practices and rhetorical devices nurse managers, known as Sisters prior to New Public Management changes, used in working out boundaries between doctors, RNs and HCAs. To prevent medical staff dictating change, senior nurses led the transfer of these higher technical tasks to RNs and the subsequent delegation of less specialist tasks to HCAs. Nurse managers developed clear guidelines for the teaching and assessing of RNs to ensure they had the competencies necessary to carry out the extended skills. This contrasted with HCAs where guidelines were vague with specific details when educating HCAs in the tasks passed down from RNs (Allen 2000). They defended this by stating that the HCA role would be decided by the RN with whom they worked (Allen 2000). It was this lack of clarity that caused problems with boundaries and inconsistencies that can be seen in numerous other studies (Sutton et al 2004, Ingleton et al 2011, Johnson et al 2004). Essentially, tasks described by some as low status (Traynor et al 2015) such as "basic

care" (Pearcey 2008), "essential care" (Stokes and Warden 2004) or "fundamental care" (Kessler et al 2010) were now firmly placed within the realm of the HCA.

This shift in fundamental care towards the remit of the HCA was also seen in Canada. Experiencing the same pressures as the UK, hospital managers in Canada made changes to staffing by either reducing the number of RNs and increasing the number of licensed practical nurses (second level nurses akin to the SEN in the UK) or retaining the number of RNs and increasing the number of HCAs (Rheaume 2003). It was as a result of these actions that RNs had become supervisors and co-ordinators of care and were distanced from providing direct nursing care (Rheaume 2003). A British study confirmed that RNs spent less time giving direct care and more time carrying out other activities such as computer care planning, communicating with other professionals and providing technical care (Spilsbury 2004). In contrast to Allen's (2000) findings, RNs in Spilsbury's (2004) study expressed that they had no control over how their role was transforming in response to changes in the wider health care landscape and they continued to see their own role as including direct patient care (Spilsbury 2004). However, their words and actions were not aligned; observations highlighted that they carried out less fundamental care and did more tasks that required the use of technical skills (Spilsbury 2004). Specialist-discard (Kessler et al 2015) was displayed as the RNs actions had shifted upwards and the HCA had become the depository.

Whether delegation of new tasks by RNs to HCAs was through their choice or through "abdication" was debated (Allen 2000, Spilsbury 2004, Pearcey 2008). It is possible that changes to the NHS infrastructure encroached where previously professionals would have controlled role development (Kirkpatrick, Ackroyd and Walker 2005). Hospital statistics, audit results, benchmarks and performance measures were now available to the general public; NHS pressures had altered (Kirkpatrick, Ackroyd and Walker 2005, Bach, Kessler and Heron 2012). For RNs, debate about defining the 'core' of professionalisation (Kessler et al 2015) was stimulated. Some RNs and HCAs agreed with the view that "basic fundamental care" had been undervalued by RNs as they had moved towards providing more technical care (Spilsbury 2004, Cavendish 2013) which was a challenge to holistic, person-centred nursing care. The disagreement generated an uneven ground for increasing the skills and

use of the HCA as recommended by Department of Health in 1998 and 2000. By 2012, Bach, Kessler and Heron stated that as HCAs delivered the majority of direct patient care, RNs could no longer claim to be patient centred.

2.5 Executing policy change; tasks and boundaries

Research was undertaken as a result of practice areas introducing or extending the role of the HCA in response to changes. Studies in palliative care (Ingleton et al 2011, Herber and Johnston 2013), critical care (Sutton et al 2004) intensive care (Johnson et al 2004), GP Practices (Bosely and Dale 2008, Andrews and Vaughan 2007) and community nursing (Pender and Spilsbury 2014) all detail how HCAs were upskilled or newly introduced to the settings. Regardless of the environment and patient group, the consensus was that there were unclear boundaries and role definition for the use of HCAs and that extra education would be necessary if this role was to be successful long term (Johnson et al 2004, Sutton et al 2004, Pender and Spilsbury 2014). In an attempt to address the lack of clarity surrounding the role, there was an effort to identify the HCA's key tasks; often presented in the form of a list of tasks carried out (Keeny et al 2005a, Pender and Spilsbury 2014), lists of non-clinical work compared to nursing duties (Thornley 2000), and a list with separation of routine work from advanced skills (Cavendish 2013). Once lists had been developed, it was possible for HCAs to be assessed against them and educated as a result of gaps identified (Pender and Spilsbury 2014, Sutton et al 2004, Robinson and Griffiths 2010).

2.6 RN inconsistency

RNs could see that introducing HCAs would bring value to their team (Sutton et al 2004), but their vision for HCAs contribution and the tasks allocated to them were sometimes inconsistent. For example, staff on a critical care unit felt that the extended role of the HCA should be "patient centred" (Sutton et al 2004 p252). However, the circumstances where the majority of staff (90% of 54) considered the task to be appropriate for a HCA were not direct care tasks but support tasks. This included sending the bronchoscope for cleaning, setting up treatment trolleys and indirect patient-related tasks such as "obtaining blood results from the computer" and "checking bed spaces prior to admission" (Sutton et al 2004).

Holistic-hoarding (Kessler et al 2015) was noted in more specialist in-patient areas where primary nursing was the model of care (Johnson et al 2004). For instance, in an intensive care setting, RNs worked in a holistic, person-centred way providing all care on a one-to-one basis. When working in this way, RNs were accustomed to working alone and as such, they would know what tasks needed to be completed next. Inclusion of a colleague brought confusion to this process (Johnson et al 2004). Shearer (2013) in an open forum with 56 Australian RNs from acute care settings, and Johnson et al (2004) both stated that when RNs did delegate and supervise HCAs appropriately, it had a significant impact on their time, which reinforced their reasons not to include HCAs. It is evident that RNs held control over which parts of nursing care HCAs could be involved.

2.6.1 Supervision of HCAs

It was likely that RNs caution about allowing HCAs to be more involved in patient care included underlying concerns based upon their professional accountability (Johnson et al 2004, Sutton et al 2004, Thornley 2000). The NMC Code of Conduct (2015) states that the RN was to "make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care" (NMC 2015 11.2). The RN should also check that the person they delegated to was competent, understood the request and that the outcome of the task met their own professional standards. Although this created anxieties, seminal research revealed that HCAs on wards were already carrying out nursing duties and half of those in the study claimed that "little or none" of their work was supervised (Thornley 2000).

In a national study on the decentralisation of pay arrangements, Thornley (2000) noticed that the number of HCAs and the duties they undertook was over and above formal accounts. Plus, there was a deficit in information as to what nursing auxiliaries/assistants did and its relative impact on nursing work. At this time, the new role and title of HCA had been introduced to fill the gap left by student nurses and SENs on the wards and nursing Assistants were of a lower paid band than HCAs. This differentiation in title and role no longer exists, as discussed by Cavendish (2013). The gap in the availability of data led to two further studies funded by the union UNISON. Firstly, a national survey of HCAs and Trust

Human Resource Managers took place in 1997, followed by a second national survey of Nursing Assistants in 1998. Thornley (2000) used triangulation of questionnaires, surveys and in-depth case study interviews to gain an insight into the competencies, NVQ training and attainment, managers reasons for employment, characteristics and perceptions of the future for these two groups. Thornley's (2000) paper is often referred to as the first to raise the concept of HCAs carrying out what had previously been seen as nursing duties.

The lack of direct supervision of HCAs which was highlighted in the Thornley (2000) study was partly generated by the fact that a great deal of their patient contact was performed out of sight of the RN; behind curtains, in side rooms and in bathrooms (Spilsbury 2004). The inability to see HCA work added to the RN's issues in supervision caused by an increase in their own technical tasks and low number of RNs (Spilsbury 2004). Shearer (2013) noted that as RN's were unable to directly observe the work of the HCA, errors were sometimes only seen only by looking at HCA care records. Therefore, it appears that some RNs were not always supervising or supporting HCAs, they were not checking competency and understanding prior to allowing the HCA to work without direct supervision, and they were not following up on the outcome of the task until much later.

2.7 RN and HCA relationships

A staff group that assist nurses in their tasks have always existed in some form however, Spilsbury (2004) noticed there were few studies that considered the role of the HCA in its own right, as a separate entity rather than an adjunct to the role of the RN. Through a case study approach in one hospital, Spilsbury's (2004) doctoral study attempted to rectify this by building an understanding of how the role of the HCA was formally and informally shaped. Findings indicated that formally, the HCA role was moulded by government national policy, nursing bodies such as the NMC and RCN, and local policy towards HCAs which was evident in documents such as job descriptions. Informally, HCAs were subject to 'use, misuse and non-use' (Spilsbury 2004).

'Use of HCAs' described how the RN utilised the ability of the HCA to forge a relationship with the patient. HCAs were available to enter into conversations and develop relationships

rather than only communicating during times of activity as RNs did (Spilsbury 2004). Due to their more interactive role, HCAs were well positioned to receive and respond to patients' "demands" leaving RNs to do other work (Spilsbury 2004). When Tardivel (2012) used semi-structured interviews with eight HCAs to gain a better understanding of their role, findings suggested that a close relationship with the patient was a significant factor in job satisfaction for HCAs. Kessler et al (2010) recognised that in this role the HCA became a 'co-producer' of care with the patient. This was claimed to be because the HCA's personal profile was different to other team members and more in line with patients; and that their place in the hierarchy made HCAs more approachable to patients (Kessler et al 2010). As a consequence of this close relationship, patients and visitor's completion of the Friends and Family Test, a quality of care performance measure, was based on the input of the HCA more than any other team member. Therefore, HCA's behaviours have grown to have the most impact on this public measure of Trusts' reputations (Kessler et al 2010).

'Misuse of HCAs' described by Spilsbury (2004) occurred when HCAs were asked to undertake tasks that were outside of their expected role or for which they had not received training. This 'misuse' was most likely to happen when the ward was busy and occurred less when pressures were resolved (Spilsbury 2004). This was described by Spilsbury as another form of "hidden" work and highlighted where HCAs filled gaps left by the inexperience of new RNs or student nurses. Sometimes this work took place with no recognition by the RN (Spilsbury 2004). Findings from Tardivel's (2012) study suggested that it was during such busy periods that the HCAs relationship with the RN was strained and they found themselves unsupervised and reluctant to seek support from the RN.

The 'non-use' of HCAs (Spilsbury 2004) was seen when HCAs were prevented from using their skills in the ward environment (Spilsbury 2004). It was RNs rather than policy or regulators, that dictated the actions, or inactions of HCAs (Spilsbury 2004) and this control by RNs led HCAs to feel undervalued (Tardivel 2012). Findings suggested RNs used four sources of power to control the work of the HCA: their reserved title of Registered Nurse; their range of specialist skills; their ability to restrict the HCA from using more technical skills and, by not utilising HCA's local hospital and community intelligence (Spilsbury 2004). This power and control were reinforced by organisational systems; for example, HCAs were

unable to access or add to computerised care plans or participate in patient handover meetings (Spilsbury 2004) thus reinforcing the subordinate role and lower status of the HCA.

2.7.1 HCAs perceptions of RNs

Literature on how the HCA perceived the RN is limited; however, in their US study on missed care and delegation, Gravlin and Bittner (2010) did include the views of HCAs who recognised some significant characteristics of RNs when delegation was felt to be a positive experience. These included RN confidence, positive attitude and good communication skills. Butler-Williams et al (2010), in a survey-based investigation of how HCAs contribute care to acutely ill patients in the ward setting, found that a satisfactory relationship between the RN and the HCA was further enhanced when HCAs felt valued and respected. When HCAs felt respected, they reciprocated this; demonstrated in acts such as not challenging RNs in front of patients (Gravlin and Bittner 2010) and sharing patient information with the RN (Spilsbury and Meyer 2004). This illustrates that the HCA was not totally powerless in this relationship, and that they possessed an understated and unacknowledged power. It suggests that their perceptions of the RN impacts on the working relationship.

2.7.2 Formal and informal barriers to RNs accepting HCAs integration

It is notable that training was seen as a major element to the implementation or extension of the role of the HCA (Sutton et al 2004, Ingleton et al 2011, Herber and Johnston 2013, Johnson et al 2004). Further training of HCAs was viewed as a way to make RNs feel more confident in delegating to HCAs (Johnson et al 2004, Sutton et al 2004, Pender and Spilsbury 2014) and competency-based skills were key (Keeney et al 2005a) as these were RNs specific concerns. One way of addressing the need for extra training in the absence of national minimum standards was the introduction of development programmes for HCAs devised within individual organisations. There was delivery of “the underpinning knowledge for practice” (Hancock et al 2005 p491) both in the classroom and at the bedside before competencies were practiced and assessed. This structure was shaped and approved by RNs (Sutton et al 2004) and yet HCAs were still restricted in utilising those skills by RNs even when they were deemed competent (Hancock et al 2005). Three reasons were given for the restriction in practising the newly acquired skills; an increase in patient dependency levels making patient care more complex, lack of local decision making in identifying which tasks were most appropriate for the HCA, and concerns about accountability (Hancock et al 2005).

These were formal justifications, but the literature indicated that there were also more socially constructed reasons. There were cultural differences in what constituted "acceptable practice" (Hancock et al 2005 p495). Despite the espoused emphasis on competencies, socialisation of HCAs on to wards was also necessary. In one study (Hancock et al 2005), successful socialisation was achieved through allocating HCAs who were on the development programmes to an established team member on the ward to learn the skills, and particularly the values, that were seen as unique to each specific setting. The assessment of the HCAs competence was based on how much they complied with current ward-based practice rather than the formal assessment of knowledge and skills through the course (Hancock et al 2005); and that, before being fully accepted, RNs put HCAs through their own extra testing (Johnson et al 2004). For example, when an HCA could consistently carry out tasks to meet local cultural standards, they were more likely to have a trusting relationship with the RN (Hancock et al 2005). HCAs were not naturally accepted as team members but had to demonstrate they had earned their place (Hancock et al 2005, Tardivel 2012). RNs, rather than policy or regulators, dictated the actions or inactions of HCAs locally (Spilsbury 2004). Therefore, rather than team members making the conceptual and physical transitions necessary to accept the new/extended role of the HCA (Hancock et al 2005), the culture of the ward, shaped by the RN, was to be accepted by the HCA.

2.8 The difference between RNs and HCAs

Discussion has highlighted the intensity of RNs concern about the introduction or extension to the HCA role. However, some saw the difference between the roles as far less complex:

> *There are two main differences between the registered nurse and the HCA. Only the registered nurse can give the full range of prescription-only medication; and HCAs are under the supervision of the nurse* (Cavendish 2013 3.8).

This simplistic, yet accurate view, does not recognise the possibility that the academic understanding that underpins the RNs professional knowledge might bring a significance to their work alongside the physical actions that people see (Traynor et al 2015). It also neglects to acknowledge the fluidity (Thornley 2000) and dynamic work patterns (Spilsbury and Meyer 2004 p72) which result from the interactions between HCAs and RNs in a ward

environment. Thornley (2000) reinforced that HCAs and RNs needed to be able to work together:

> *…registered nurses should welcome a more fluid and progressive role for non-registered nurses; failing that welcome, managers will continue to 'undercut' existing registered staff with their 'cheaper' non-registered nursing team colleagues* (Thornley 2000 p457).

The mechanisms, suggested in the literature, that RNs used to protect their role may have been short-sighted according to Thornley (2000); RNs needed HCAs to accept their discarded tasks whilst they still retained accountability. After all, it seems that HCAs were working in this manner despite barriers (Spilsbury 2004). Outside of the areas such as critical care where nursing care was one-to one, the core of the HCA role was "bed-side and patient centred" (Kessler et al 2010 p68) with other aspects of their role developing in line with health care pressures.

2.9 Summary of the literature

There has been evolution in the role of the HCA as it has developed in response to changes to that of the RN. This appears to have been by inadvertent rather than via a thought through, planned progression. The majority of the literature has concentrated on the introduction or extension of the role of the HCA. Blurred boundaries, unclear job descriptions, issues with standardisation of training and concerns over delegation and accountability were common across practice areas and cited to explain the issues in the implementing of new/extended roles. Senior registered nurses and the nursing governing body could be regarded as responsible for the continued ambiguity as they did not make significant progress in defining a national HCA role despite recommendations to do so. It has been possible to understand why nurses were anxious about delegation and accountability in light of the gaps in role definition, and threat to their own role. However, HCA evolution has been due in part to RNs no longer having the capacity to fulfil their extensive and expanding remit. As the new RNs in Johnson et al's (2015 p31) study demonstrated, with increasing work pressures they have only one choice; "delegate or be late".

The literature has highlighted that often parts of the HCA role were covert, unofficial and unrecognised (Thornley 2000, Spilsbury 2004) and there was suggestion of tension between the HCA and the RN (Tardivel 2012) as the RN implicitly defended their role. It follows that if RNs were unclear about the role of the HCA, then HCAs might feel the same. But studies about the role of the HCA were frequently carried out without including the voice of the HCA (see Pender and Spilsbury 2014) or their voice was indistinguishable from the voices of others (see Johnson et al 2014). It could be said that this reflects their lower level status despite their involvement in delivering direct patient care. In light of the literature review, there is lack of understanding of how HCAs enacted their role within environments where RNs controlled their contribution and boundaries were unclear. As yet, HCAs have not had a strong voice in the literature and therefore it was not clear how they perceived their role and their relationships. Therefore, the aim of this study was to explore how HCAs enacted their role in an adult, in-patient environment. The objectives were to gain an understanding how HCAs connected, interacted and related to people whilst at work; to ascertain HCAs perceptions of the enactment of the HCA role and to develop a construction of how HCAs enacted their role.

2.10 Sensitising Concepts

During data analysis, my understanding of the role of the HCA was influenced by the work of Habeeb (2017) and Menzies Lyth (1988). These studies provided theoretical lenses through which to consider the role of the HCA in a ward setting.

2.10.1 Habeeb (2017)

Habeeb's (2017) thesis was within the field of sports psychology. She noted that cheerleading teams were scored on their overall performance and yet many aspects of the performance that they executed were in pairs. These pairs Habeeb (2017) referred to as dyads; the smallest team possible, comprising two people (Levine et al 1998). Dyads were described as unique relationships in that they had more in common with each other than with any other member of the team (Laursen 2005). In her analysis Habeeb examined and extended the work of Bandura (1977, 1997) and Lent and Lopez (2002) on efficacy beliefs.

2.10.1.1 Self-, other- and collective-efficacy beliefs

Bandura's (1977) theory was that cognitive processes, or thoughts, influence a person's ability to attain and maintain a new behaviour. He noted that through watching others do the task, a person can envisage how to do it themselves. When they then try the task, they draw on these cognitions as a base before going on to make corrections. The corrections for improvement are based upon feedback (Bandura 1977). Self-efficacy was the term used to describe how a person perceived their capability to carry out actions in a specific context (Bandura 1977, 1997). When a person applied enough effort for the outcome to be positive, they had a high level of self-efficacy. Adversely, low self-efficacy was symbolised by failure in completion of the task (Bandura 1977, 1997). Bandura (1977, 1997) explained that the difference between people of high and low self-efficacy was based on four factors within their belief systems:

- performance accomplishments – a person's perception of their past experiences
- vicarious experiences - watching others and judging yourself doing the same task
- verbal persuasion – how others encourage you, for example coach support
- emotional and physiological responses - translations of symptoms such as a fast pulse

(Bandura 1977).

This seminal work by Bandura (1977) has been applied to healthcare; for example, self-efficacy and smoking cessation (Gwaltney et al 2009), first- time mothers and post-natal depression (Leahy-warren, McCarthy and Corcoran 2011), in meta-analysis of self-efficacy and physical activity (Olander et al 2013) and health promotion (Gwaltney et al 2009). The health research shows a strong connection between self-efficacy beliefs and behaviour change (Luszczynska and Haynes 2009). Bandura (2004) himself was able to demonstrate this link by explaining that people with strong self-efficacy beliefs set higher health goals for themselves and had a firmer commitment to their achievement than people with low self-efficacy who saw obstacles which led to them giving up. From this, Bandura (2004) created a health belief model which not only predicted health habits but also included ideologies for engaging people through informing, guiding, motivating and enabling new health habits. However, self-efficacy belief application is more commonly seen in sports settings (Dunlop, Beaty and Beauchamp 2011).

Lent and Lopez (2002) built on Bandura's (1977) theory. They stated that beliefs about whether a person could be successful in carrying out a specific task were often influenced by external relationships and that this interpersonal context had an impact on their perceptions of themselves and of the other person (Lent and Lopez 2002). Other-efficacy is a term used to define the beliefs that people hold about whether another person is capable of completing the task and relation-inferred self-efficacy (RISE) describes their beliefs about how their partners perceived their abilities (Lent and Lopez 2002). RISE has been applied to the relationship between a counsellor's self-efficacy and how they perceive that their supervisor sees their efficacy (Morrison and Lent 2018). The effects of other-efficacy have been tested on pairs of people by Dunlop, Beatty and Beauchamp (2011) and found to be more influential than self-efficacy on personal performance within a relationship that required team working.

Four factors of comparison were the basis of their belief system of other's performance: what they believed to be their current partner's abilities, based upon how they performed previously; how others in the same role performed; other people's opinions of that partner's performance; and, social stereotypes (Lent and Lopez 2002). This reflection of their partner's abilities was separate to how individuals believed their own behaviours had an impact on the success of the team (Lent and Lopez 2002).

Perceptions of self-efficacy and other-efficacy concentrated on the individuals within the dyad whereas collective- efficacy described the individual's beliefs in the team performance. Bandura (1977) defined collective efficacy as "the performance capability of the social system as a whole" (p469). For example, in an educational setting, collective efficacy refers to the extent to which teachers perceived that the school had capabilities to be able to carry out actions needed to have a positive effect on students (Goddard, Hoy and Hoy 2004). These beliefs stemmed from the same factors as those for self-efficacy; group related accomplishments, vicarious experiences, verbal persuasion and reactions to emotional and physiological responses (Bandura 1977). Cohen et al (2006) were able to link Body Mass Index and collective efficacy in their cross-sectional, multi-level survey involving 807 adolescents and 3000 adults exploring the effects of collective efficacy on obesity in US neighbourhoods.

Bandura (1977, 1997) and Lent and Lopez (2002) provide a theory for how each person in the dyad developed and held beliefs about how well they would complete a task, how well their partner would complete a task and how well they would perform together. These beliefs had an impact on the actions of each individual and the dyad overall. Habeeb (2017) used this theory to explore the perceptions of efficacy of the cheerleading dyads from within the larger team. Habeeb (2017) separated out each person's perceptions scores and compared them with those of the competition examiner. Habeeb (2017) found that by increasing understanding of the dyads, a more in-depth appreciation of the whole team could lead to improvements in performance (Habeeb 2017).

A cheerleading mixed dyad was an amalgamation of one male and one female performing as pairs. The male partner was known as the "base" and the female as the "flyer". The hands of the male base were the platform from which the female flyer stood, was thrown into the air, and then caught (Habeeb 2017). The partnership relied upon each person safely executing their part for serious injury to be avoided (Jacobson, Redus and Palmer 2005). Each person had their unique role which in turn, relied upon the actions of the other. This was described as a "distinguishable" dyad; the partners were not equal or symmetrical in their tasks or responsibilities (Gaudreau et al 2010). When dyadic partners are symmetrical or equal, like in tennis, they are known as an exchangeable dyad (Gaudreau et al 2010).

Habeeb (2017) discovered a discrepancy in the level of dependence each partner had on the other; the flyer had a higher dependence on the base than the base had on the flyer. In order to address this, the female flyer controlled how she contributed to the team's overall success through close observation and appropriate adjustment to the male base's actions. The male base held the lower dependent role and focused on his own actions rather than the flyer's. It was the male base's ability to provide a good starting throw that provided the foundations from which the flyer could perform. The focus of the female flyer on the male base's ability to throw and catch her was found to echo Lent and Lopez' (2002) model of other-efficacy. The male base's concentration on his own abilities rather than the female flyer's actions corresponded with self-efficacy beliefs (Habeeb 2017).

Although Habeeb's (2017) findings corroborated self- and other-efficacy (Bandura 1997, Lent and Lopez 2002), the impact of collective-efficacy was not found to be of significance. Collective-efficacy was founded upon three out of four of the same factors as self-efficacy (vicarious experience, verbal persuasion and emotional and physiological responses) but the fourth was 'group related mastery'. Habeeb (2017) reported that the data collection period was held at the beginning of the cheerleading season and partners had not had a chance to perform together. This had a significant impact on the opportunities for partners to become aware of their group congruence and resulted in an absence of observed collective-efficacy (Habeeb 2017).

Habeeb's (2017) focus on one part of a team rather than its entirety was influential in the analysis of my data. Some terminology used for sporting pairs such as 'exchangeable' and 'distinguishable' was reflected in my findings. As well as Habeeb (2017), I was also aware of the work of Menzies Lyth (1988) which resonated with my findings.

2.10.2 Menzies Lyth (1988)

Studies at the Tavistock Institute of Human Relations were focused upon working lives and social sciences. Menzies Lyth's (1988) hospital study on the functions of RNs and student nurses was reflective of this philosophy. In 1959, RNs mostly provided supervision, administration and teaching to students rather than direct patient care. Student nurses comprised the majority of the nursing workforce but there were also nursing assistants. Menzies Lyth (1988) does not differentiate between nursing positions but refers to all as "nurses" throughout her study. This was purely terminology; in fact, the nursing hierarchy was strong. Students were themselves supervisors for the work of students that were earlier in their training and reprimanded these juniors for their mistakes. Seniors, those qualified or further in their training, were seen to be overly strict (Menzies Lyth 1988). The four-year nurse training was a rotation between wards with only six weeks per year in the nursing school. In the hospital under study, there was a staff shortage and the need to provide care for patients had halted the ward rotations of students. As data was collected, it became apparent that nurses were experiencing a high level of anxiety and tension. Consequently, they were taking short periods of sickness, frequent job changes and student nurses were

not completing their training for reasons other than failure in practice or academia (Menzies Lyth 1988).

Analysis of observations and interviews of the nursing team led Menzies Lyth (1988) to conclude that nurses' "primary task" was to provide care for sick and dying people and that they experienced high levels of anxiety as a direct consequence of providing that care. Moreover, they experienced positive and negative feelings such as compassion, pity, guilt and resentment, and were also the receiver of patients and relatives' feelings about the person being cared for in hospital. Menzies Lyth (1988) noted that nurses were expected to protect themselves from physical patient contact and development of attachment and relationships with patients as it was these aspects of nursing which they considered increased anxieties. It was deemed inappropriate for nurses to overtly demonstrate such anxieties and therefore techniques had developed within the organisation which protected against these occurring (Menzies Lyth 1988).

Acknowledging that there was overlap between them, Menzies Lyth (1988) listed ten defensive techniques used by nurses. *Splitting up the nurse-patient relationship* was the first mechanism described. Menzies Lyth (1988) noticed that the more concentrated the relationship with the patient was, the more intense the feelings of anxiety were as the nurse supported them in their illness or dying. To address this, the patient's care was divided up in to lists of tasks and each list was designated to a certain "nurse". The RN, assistant (HCA) or student nurse performed the individual task for all of the patients in the 30 bedded ward. This style of dividing up the nursing work fits with descriptions of task-orientated or functional models of care (Barnum 1998, Gillies 1994). There is debate about whether nursing work is still separated in this way (Naef et al 2012, Fairbrother et al 2015).

The second defensive mechanism was *Depersonalisation, categorisation and denial of the significance of the individual*. Menzies Lyth (1988) described an environment where as much uniformity as possible was created; times and techniques in completing tasks, reduction in the identifying characteristics of both patients and nurses and even standardisation of the ward layout. Bed numbers and disease/ diseased organ was the limited information needed. Menzies Lyth (1988) stated that this was frowned upon but continued to be used. Nurses

were depersonalised to patients and relatives by their uniform but could be identified by their place in their training by other nurses who could spot the small symbols. This was of significance: duties and privileges were given out based on their stage in training rather than their individual experiences and skills (Menzies Lyth 1988). Nurses were seen as containers of skills, resources, not as individual people (Menzies Lyth 1988). The reduction of patients to numbers and diagnosis is in opposition to person-centred care; it does not correspond with seeing the person as the centre of their own care (Kitwood 1997).

Next, Menzies Lyth (1988) describes how student nurses were moved to other wards as a technique to strengthen their abilities to be detached. *Detachment and denial of feelings* was seen as an attribute held by 'professionals'; restraint from over involvement, avoidance of manipulation and control of their feelings (Menzies Lyth 1988). Holden (1991) agreed that there was a lack of support received where naïve new nurses expected to receive as well as give kindness. In order to avoid "giving in to infantilised wishes", Holden (1991 p894) suggested that the task rather than the nurse became the subject of nurturing thereby supporting improvement of care and reduction of personal condemnation.

The attempt to eliminate decisions by ritual performance was the fourth defensive mechanism. Menzies Lyth (1988) stated that if there was a decision to be made, there was not one single action would give a guaranteed outcome. Therefore, when a nurse made a decision about their work, their anxiety increased as they were unsure if it was the correct decision; they would have to wait until later when the outcome was revealed to see if it was right. In order to reduce this anxiety, rituals were created so that all tasks were performed at a set time, in a set way thus reducing decision making. It gave a sense of importance to all tasks, even those that did not require unique nursing skills. Student nurses were actively discouraged from using their own initiative as this contradicted the removal of choice (Menzies Lyth 1988).

Rituals still exist in nursing today; they are described as aspects of mythology, part of ceremony, having their own significant meaning to individuals within that setting (Biley and Wright 1997, Holyoake 2013). They are behaviours which are enacted in formal, repeated and standardised ways and their importance is based on an individual's belief that the ritual

has the potential to heal (Biley and Wright 1997, Holyoake 2013). Biley and Wright (1997) consider that the perceived benefits of the ritual are compromised when they are subjected to positivistic scrutiny and attention to the value of rituals is limited to the performance of the act thereby losing sight of any underpinning psychological benefit. They give the example of a patient being fasted pre-operatively for more hours than necessary. This could be seen as giving the patient space to think and prepare for the changes they are about to experience; therefore, the extensive fasting has more impact than simply the physical requirement for the pending surgery; the meaning that goes beyond the actual act may not yet be fully understood (Biley and Wright 1997). Holyoake (2013) refers to rituals as the expected behaviours of people that have grown from the culture and are so ingrained that they are no longer questioned; the routine, ritualistic practices have been handed down to new staff thereby reinforcing the culture.

Reducing the weight of responsibility in decision making by checks and counter checks describes when nurses sought colleagues' opinions to reduce their anxiety about making a mistake. By carrying out checks, the nurse delayed taking action until they received reassurance that they were correct in their thinking (Menzies Lyth 1988). Double checking has been a strategy used in managing risk of medication errors in nursing (Alsulami et al 2013, Armitage 2013). Similarly to Menzies Lyth (1988), Armitage (2013) reported that double checking medication with a nursing colleague provided self-assurance and also a diminished sense of responsibility. But this sense of responsibility has since been reclaimed by RNs who have had the opportunity to stop the double-checking practice. This reflects the increased autonomy for RNs has also brought benefits of less waiting time and less interruptions (Cross et al 2017).

With *Collusive social redistribution of responsibility and irresponsibility,* Menzies Lyth (1988) stated that nurses had an intense feeling of responsibility which sometimes became overwhelming. It was found that this feeling generated thoughts that led to irresponsible actions, a conflict to their sense of responsibility (Menzies Lyth 1988). They managed these concerns by separating them from their conscious self and projecting them on to a junior nurse. They reprimanded junior nurses for their irresponsible actions regardless of whether they did the act. This was a projection of their concern that they might behave in a similar

way. Inversely, the nurse's harsh approach was justified by suggesting that they were modelling themselves on strict seniors, who they aspired to be like.

Next, Menzies Lyth (1988) names *Purposeful obscurity in the formal distribution of responsibility* whereby there was no formal system for who was responsible for which task for each patient. It was usual for nurses to have more than one task-list during the shift and sometimes there were gaps where no one was allocated (Menzies Lyth 1988). This gap enabled the projection of irresponsibility as described above. Senior nurses who held responsibility had more complex work and engagement with a larger number of people, resulting in more difficulty in knowing who was responsible for individual patient tasks (Menzies Lyth 1988). The description of a lack of a formal system for responsibility matches that of functional, task orientated nursing captured by Gillies (1994). However, Gillies (1994) did not indicate that this was purposeful avoidance of responsibility as Menzies Lyth (1988) stated; rather Gillies (1994) cited it as a reason to trial individual patient allocation/ primary nursing where a designated nurse took responsibility for a patient's care (Gillies 1994, Allen 2002).

In order to reduce anxieties, nurses were seen to "force upwards" (Menzies Lyth 1988 p59) the tasks that had a high level of responsibility attached. *The reduction of the impact of responsibility by delegation to superiors* resulted in senior nurses performing tasks that someone much lower in the hierarchy could have carried out. Menzies Lyth (1988) stated that clarity in policies and better organisation of tasks would have allowed another team member to carry these out. However, upwards delegation upheld the seniors as good role models and they were well positioned to make their decisions and undertake the tasks (Menzies Lyth 1988). As described in the earlier defence technique *Collusive social redistribution of responsibility and irresponsibility*, senior nurses saw juniors as irresponsible and incapable versions of themselves and this receipt of simpler tasks reinforced their superiority and resolved this irresponsibility issue. Reducing the impact of responsibility by delegating to superiors could be said to have ended when individual patient allocation or primary nursing was introduced. This model of care saw the involvement of senior nurses change; the primary nurse knew that patient best and liaised with other professions and the senior nurse became a source of knowledge and support (Gillies 1994). This change in

holding personal responsibility fits with holistic care and the importance of the relationship between the patient and the RN (Wolf 2013).

Another defensive strategy was *Idealisation and underestimation of personal development possibilities* (Menzies Lyth (1988). Hospitals in Menzies Lyth's (1988) study aimed to recruit student nurses who had maturity and an understanding of responsibility with the belief that these attributes could not be taught. Training was focused on ward-based practical teaching of tasks rather than addressing professional behaviours or skills in assignment writing. Maturity and personal responsibility were viewed as the foundations on which students built their nursing knowledge. As "*a considerable proportion of actual nursing tasks are extremely simple"* (Menzies Lyth 1988 p61) completion required the semi-professional skills of large numbers of student nurses to complete them. Mature, responsible students were expected to reduce their capabilities at the beginning of their training. But ideal expectations and harsh reprimand with no acknowledgement for growth, success or good work led many student nurses to leave before qualifying. Some of these elements are challenged in contemporary nursing. Rather than semi-professional skills, there is evidence that a higher level of nurse education to degree standard is a factor in reducing patient deaths thereby emphasising that academic ability is needed alongside practical skills to fulfil the RN role (Aiken et al 2011). However, in keeping with Menzies Lyth's (1988) claim that nursing tasks are simple, literature was earlier presented which suggests that some nursing task do not require that skills of a RN and have been passed over to HCAs. Nevertheless, Kitson et al (2014) and Kitson (2018) remain unwavering in their view that, what some see as simple tasks, they see as key to the role of the RN. In keeping with Menzies Lyth's (1988) defensive mechanism of underestimation of personal development possibilities, it has been confirmed that there is a lack of developmental opportunities for HCAs (Cavendish 2014). Also, Menzies Lyth's (1988) account of wishing to recruit those with a mature attitude and an understanding of responsibility is reflected in the Cavendish (2014) review. Preconditional attributes are still looked for today when recruiting to a care position; staff need to possess the "right attitude and aptitude" because it is felt that these cannot be taught (Cavendish 2013 6.11.1).

Menzies Lyth's (1988) final defence, *Avoidance of change* highlighted that if alterations were made to the current social system, the future became unpredictable for nurses and this caused anxieties. It was possible that the defensive techniques already in place would not protect against anxieties after the change and this, in itself, caused more anxieties (Menzies Lyth 1988). Avoidance of change was viewed as the answer (Menzies Lyth 1988). When changes were enforced, nursing staff were seen to hold on to the "inappropriate familiar" where flexibility would have been more effective (Menzies Lyth 1988 p63). Gosselin, Newton and O'Leary (2015) suggest that anxiety due to change is still impacting on the role of the RN. Looking at the use of technology in oncology nursing, they recognise that there is a pressure to embrace change as it has a bearing on cost, access to care, outcome measures and patient experience. It is because of these moral reasons that the healthcare team, including HCAs, need to understand the drivers for change and embrace their role in its implementation. This implies that the nursing team no longer holds on to the inappropriate familiar and instead grow resilience.

Recognising the success of Menzies Lyth's (1988) observational study, Cooper (2010) and Evans (2014) have both suggested that the NHS now has three more contemporary anxieties which may impact on HCAs. For Cooper (2010) these were rationing anxieties, performance anxieties and governance or partnership anxieties. Evans (2014) named reasons for anxieties; the internal market, the effects of cuts and the target culture. These will be looked at together. First of all, the evolution of health care in technology, pharmaceuticals, what is classed as illness and the connected costs of these has been identified as problematic (Kirkpatrick et al 2005). Cooper (2010) identified that anxieties came from whether the state could or should fund new, expensive healthcare advances and called this 'rationing anxiety'. This may affect the culture of the hospital and those who work within it providing services. Rather than the inclusion of services and its impact on cost, Evans (2014) described the deficit in funds; 'the effects of cuts'. Evans (2014) stated that RNs had to apply for their own posts at reduced pay and some were offered and accepted voluntary redundancy when funding was challenging (Evans 2014). This, he stated, placed HCAs "on the front line of clinical care while qualified nurses became more and more responsible for management" (Evans 2014 p133). This reflects the skill mix changes discussed earlier in this chapter. Next, Cooper (2010) recognised the anxieties that have arisen from the

achievement of targets introduced by New Public Management. He referred to this as 'performance anxiety' (Cooper 2010). These targets were set by external bodies and had financial penalties attached (Evans 2014). Meeting the targets was a reflection that the hospital provided a quality service with value for the taxpayers' money (Evans 2014). Evans (2014) demonstrated that clinical staff, including HCAs, felt personal anxiety for the success of their organisation and worked to ensure that these targets were met on the wards (Evans 2014). Cooper (2010) explained in his third anxiety; the effect of the internal market. This business-like way of working generated a system where teams are viewed as separate entities that competed rather than collaborated (Cooper 2010). It overlooked that services were interdependent and instead created environments of "survivors and casualties" of commissioned services (Evans 2014 p132). Cooper's (2010) final anxiety also reflected commissioning issues. 'Governance/ partnership anxiety' has been generated by a lack of overarching authority when multiple agencies worked alongside each other as commissioned services (Cooper 2010). This disparate working was not discussed in the nursing literature but would be expected to impact on the pressures of hospital work for the nursing teams including HCAs.

Menzies Lyth (1988) reflected that she could have provided clearer recommendations for change following her study. Looking through the lens of Menzies Lyth's work, Evan's (2014) not only identified new reasons for anxieties to develop, he also contemplated how they could be reduced in nurses. Evans (2014) agreed with Menzies Lyth's (1988) finding that nurses enter the profession expecting to receive care as well as provide it. Where Menzies Lyth's (1988) study highlighted that this did not occur in practice, Evans (2014) thought that nurses needed assistance with their own anxieties as they evolved from this empathetic work. As HCAs carry out nursing work, it would be expected that they too feel emotions with regards to their work.

Menzies Lyth's (1988) work has been upheld as "legendary" in its contribution to understanding anxieties in the workplace (Cooper 2010). As recently as 2015, Armstrong and Rustin produced a book based on the social defence work of Menzies Lyth (1988). Her work has been used to explore child protection social work (Lees et al 2013, Taylor et al 2007) as well as aspects of nursing (Evans et al 2014, Cooper 2010, Biley and Wright 1997,

Holden 1991). When Menzies Lyth (1988) names the nursing team, all members are included, rather than separating the role of the RN from the HCA, whereas other studies that use Menzies Lyth's (1988) work to consider contemporary issues in healthcare do not state the inclusion of the HCA role. This has been shown to be common with much of the healthcare literature. Menzies Lyth (1988) provides a concept with which to explore HCAs enacting their role in an adult ward setting; this connection will be evident in the discussion chapter alongside the work of Habeeb (2017) and other literature.

2.11 Summary

The HCA literature illustrated many aspects of the role of the HCA including development of their role and their relationship with the RN. Once this had been summarised, there was explanation of two sensitising concepts which have resonance with my findings. The work of Habeeb (2017) included a close look at cheerleading dyadic relationships and their position within a larger team. She investigated and extended comprehension of self-, other- and collective-efficacy beliefs by examination of these through the cheerleading dyads. Her work has not as yet, been used as a foundation for further research.

Where Habeeb (2017) looked at the relationship between the two team members, Menzies Lyth (1988) considered the individual worker's relationship with the patient. Menzies Lyth (1988) studied the defensive mechanisms used by nurses to separate themselves from the patient in order to reduce their anxieties. She described all of the nursing team members as nurses rather than differentiating them from students and non-registered assistants such as HCAs; all team members were exposed to anxiety provoking situations with patients. Those with a higher status had more responsibility in ensuring that there was strict application of the defence mechanisms used to manage the patient related anxieties. Menzies Lyth's (1988) work is viewed as a seminal study which still has significance today. It has been used as a platform for further research on anxieties between workers and service users in health and social work.

The inclusion of content from the contemporary study by Habeeb (2017) and classic study by Menzies Lyth (1988) will provide a backdrop for contemplation of the findings from this

study. Before the findings are presented, the methodology and methods for how the study was implemented are shared.

Chapter 3 Methodology

3.1 Introduction

In order to discover how HCAs enact their role on an adult in-patient ward, choices were made about how the exploration would be undertaken. These choices were influenced by my perspective; what I believe reality to be (ontology), what I see as truth (epistemology), what I value (axiology), and how I can find out (methodology). Before I could identify my own perspective, I needed to understand paradigms. The ontological, epistemological, axiological, and methodological assumptions of five paradigms are defined and discussed. The discussion illuminates why constructivism was felt to be the most appropriate paradigm for this study. Then, I present the meaning and brief history of ethnography and suggest why this was suitable as a methodology, before moving on to explain why the specific approach of focused ethnography was used for exploration of the HCAs role. In all, this chapter will provide the philosophical basis of the study before the methods chapter highlights the practicalities.

3.2 Finding a perspective

There are two distinct approaches to carrying out research in the social sciences; qualitative and quantitative. Silverman (2013) suggests that the language we choose to describe our research is an indicator of whether the subject requires qualitative or quantitative investigation. A quantitative model would include the language of 'variables' and looking at 'what should be' (Silverman 2013). Alternatively, in qualitative research there is a focus on how phenomena are 'experienced' or constructed in the everyday activities of people (Silverman 2013). The question of "what is going on here?", is asked in qualitative research as opposed to the creation of a hypothesis which is used in quantitative research (Silverman 2013). It was this question of, "what is going on here?" that led to using a qualitative approach for this study. There are multiple ways a qualitative exploration of HCAs can be completed, and these choices were shaped by my own philosophical assumptions (Creswell 2013). Researcher beliefs, or philosophical assumptions, arise out of exposure to what is read, conversations with supervisors and the study or work environment (Silverman 2013). It is these philosophical assumptions which lead to examination of a particular area (Silverman 2013). For me, it was a combination of the areas that Silverman (2013) listed.

Firstly, due to my new job, I was a mental health nurse spending time in adult nursing wards. My perceptions about the role of the HCA in this setting were based upon my prior experiences. Secondly, as a registered nurse, I knew that the Nursing and Midwifery Council (NMC) Code of Conduct (2015) restricted HCAs from carrying out the entirety of the nursing work, yet they seemed to be working much of their time alone. Finally, reflecting with my supervisor on the difference between my previous perception and this new observation helped me to recognise that I had identified an area for further examination.

Philosophical assumptions are made explicit through the use of theoretical and interpretive frameworks (Creswell 2013). This candidness is essential to ensuring that the researcher's philosophical assumptions are made clear as these impact on how results are interpreted (Brown and Duenas 2019). These frameworks are known as paradigms. Each paradigm consists of four areas on which philosophical assumptions are divided; ontology (the nature of reality), epistemology (what is classed as knowledge and how knowledge is defended), axiology (the position of values in the research) and methodology (the process of research) (Creswell 2013, Lincoln, Lynham and Guba 2018, Gray 2009, Wahyuni 2012). These paradigm frameworks provide 'ground rules' for how theory is used when looking at phenomena (Brown and Duenas 2019). Creswell (2013) defined the four philosophical assumptions that underpin paradigms. These are described in Table 2.

Philosophical assumption	**Description**
Ontology; the nature of reality	The belief that the researcher, participants and readers of the report all hold different realities. The researcher has the role of gathering multiple realities to create themes based on participants' words.
Epistemology; what it means to know	Knowledge is known through the subjective experiences of individuals. The views of participants are gathered as evidence from within the field of inquiry. This way the researcher can aim to know what the participants know in the context that they relate to.
Axiology; making values known	The researcher includes their values in their report. This positions the researcher in the study by explicitly discussing their predispositions.

Methodology; how we will find out?	The processes are inductive, emergent and moulded by experiences in data collection and data analysis. Taking an inductive approach allows relationships between variables to be looked for in the data rather than a deductive approach where a hypothesis is tested. Because of this inductive approach, questions and data collection plans developed before the study commenced may need alteration in order for the problem to be better understood.

Table 2 - Philosophical assumptions and descriptions in qualitative research (Creswell 2013)

The philosophical assumptions provide a way to compare paradigm types. The number and types of paradigms grow and alter over time and some researchers combine paradigms in order to get the philosophical assumptions they prefer for their study (Creswell 2013, Lincoln, Lynham and Guba 2018). While some theorists only present the extremities of paradigms (e.g. Rodwell 1998, Grix 2010), it was important for me as a new researcher, to understand how paradigms for both quantitative as well as qualitative studies differ. Therefore, the five paradigms presented by Lincoln, Lynham and Guba (2018) were contemplated alongside descriptions by Creswell (2009). Table 3 allows for a straightforward comparison between paradigm differences.

Item	Positivism	Post positivism	Critical theory	Constructivism (Interpretivism)	Participatory
Ontology - nature of reality	A single truth exists. It is there to be identified and measured by application of scientific modes.	A single reality exists but variables occur that cannot be controlled or sometimes seen.	Race, ethnicity, gender, sexual preference are examples of characteristics that can lead to oppression with the belief that human interaction is based on power.	As individuals construct their own meaning based on their interactions and experiences, there are multiple realities. Researchers need to participate to ensure that knowledge is reflective of participants reality.	Subjective- objective reality. Participation and participatory realities are the basis of world views.
Epistemology - relationship between researcher and researched	Scientific rigor is paramount with no consideration on societal impact or research participants. Objectivity is achieved through no researcher impact. Research communities judge validity not participants.	Data is viewed as incomplete as nature can only be approximated due to outside influences. Researcher interaction with participants must be minimal. Research communities judge validity not participants.	The removal of oppression through empowerment arises from changing social structures based on study outcomes.	Research findings are co-created by the researcher and the participants as they interact. The researcher's world knowledge cannot be separated from the object under study.	Critical subjectivity; understanding how we know what we know and how it achieves knowledge relations. Heron and Reason (1997) Four ways of knowing; -propositional -practical -experiential -presentational
Axiology -value theory	Propositional knowledge about the world is intrinsically valuable in itself.	The biases of the researcher are not expressed and need to be controlled to restrict impacting on the study.	Diversity of values is stressed within the position of different communities.	Values are discussed and negotiated between individuals.	Practical knowing about how to grow in a hierarchy is fundamentally valuable.
Methodology - how knowledge is gained	Based on scientific methods where disproving what is seen as the truth is the aim. Replication of results is an essential value.	Unknown variables in the research environment lead to asking more questions than positivists. Statistics help visualisation of results as the researcher aims to approximate reality.	Social revolution for oppressed groups is gained through dialogue, use of theory and acknowledgement of the researchers own power in highlighting social actions.	Hermeneutical and dialectical. Meaning emerges from the research process. The cycle occurs when actions guide data collection, which leads to interpretation of data which results in action based on the data.	People co-research and are co-subjects who work together using democratic dialogue.

Table 3 - Comparisons between five paradigms (Lincoln, Lynham and Guba 2018, Creswell 2013)

Table 3 shows how beliefs about ontology, epistemology, axiology and methodology alter from one paradigm to another. These beliefs impact on the style and direction of the research and need to be made explicit if the research is to be understandable to others (Brown and Duenas 2019). In light of this, I explain why positivism and post positivism, critical theory and participatory paradigms were inappropriate for this study and why constructivism was.

3.2.1 Positivism and post positivism

Positivism is commonly associated with quantitative research where researchers pursue law-like generalisations (Maddison 2005, Ryan 2018, Gray 2009, Wahyuni 2012). In nursing, a person's weight could be viewed as an example of a factual measurement that would be measured the same regardless of who took the measurement (Ryan 2018). The positivist's ontological stance is that reality is external and objective (Wahyuni 2012), based upon natural science facts rather than assumptions (Wahyuni 2012, Gray 2009). This belief that the world exists separately to the researcher is referred to as realism (Ryan 2018). Axiologically, the researcher takes an etic, or outsider position, thereby placing value on being separated from the research subject (Wahyuni 2012). In doing this, the impact of their presence can be excluded as a variable (Wahyuni 2012). The positivist's epistemological beliefs are that phenomena can be reduced to its simplest form by using observable, credible facts (Wahyuni 2012). These objective facts are viewed as measurements of the truth (Ryan 2018). They take the methodological approach that something is true until it is disproved (Lincoln, Lynham and Guba 2018) and this is achieved through hypothesis development, statistical testing and replication (Creswell 2009, Wahyuni 2012). Reliable and validated measurement tools are used to demonstrate scientific rigour and positivists can thereby make a claim to credible knowledge (Brown and Duenas 2019).

The post-positivist paradigm emerged from positivist foundations (Lincoln, Lynham and Guba 2018). Ontologically, rather than striving to prove a single truth or reality, as positivists do, post-positivists accept that there are unknown variables that disallow the possibility of fully understanding the single reality that exists (Lincoln, Lynham and Guba 2018). Variables are influenced by human experiences, inquiry is impacted by values and multiple

perspectives are necessary to discover the probability of cause and effect (Creswell 2009, Maddison 2005). This incomplete data set is used to make decisions and the results are validated by other research colleagues rather than participants (Lincoln, Lynham and Guba 2018). Axiologically, post positivist researchers would need to control their biases from impacting on the study as this may alter results. Like positivists, the methodology for post-positivists is based upon applying scientific methods, but in this paradigm the aim is to be as near as possible to reality (Lincoln, Lynham and Guba 2018).

Post-positivism is used as a paradigm in health care, for instance, by policy makers when they are establishing a best course of action (Houghton, Hunter and Meskell 2012). However, positivism and post-positivism were discounted as they were not the most appropriate paradigms for my study. Much of the current literature on the role of the HCA demonstrated attempts to make lists of the tasks that they carried out. These could be seen as a desire to create templates for HCAs to be measured against and a move towards finding a single reality. This does not reflect my drive which was to understand the role of the HCA, how they knew what to do and when to do it. This alternative investigation required insights into actions and more importantly, perceptions. Science-based processes and an etic, outsider axiological stance was unlikely to capture HCAs perceptions. I suspected that their role and the environment was not predictable and that there would be huge variations, thereby reducing the possibility of successful application of statistical testing and replication. Other paradigms were therefore thought to be more appropriate for this study.

3.2.2 Critical Theory

Critical Theory is a term that encompasses paradigms, for example feminist theory and race theory (Lincoln, Lynham and Guba 2018). Ontologically, it takes the standpoint that some societal groups are privileged over others and they use this position to their advantage, thereby oppressing minority groups (Ross, Rogers and Duff 2016). These more powerful, majority groups have more influence in creating social norms (Ross, Rogers and Duff 2016, Gray 2009). Critical Theorists epistemological position is that challenges and changes to social structures can redress the imbalance of empowerment and relieve oppression in the minority groups (Lincoln, Lynham and Guba 2018). Critical Theorists ask both researchers

and participants to put aside beliefs which are based on conventional social structures and take action based on new learning (Gray 2009, Ryan 2018). Methodologically, the researcher's aim is to use theory to highlight social actions through engagement and dialogue thereby creating change and allowing emancipation (Swartz 2014).

It could be argued that Critical Theory was an appropriate paradigm for exploring the role of the HCA as they can be viewed as an oppressed, minority group for a number of reasons. Their hierarchical position, reflected by their low pay, could be seen to suggest that they are of less social value than their healthcare colleagues. This is reinforced by the Royal College of Nursing restricting membership to those who hold an NVQ level 3 qualification (Kessler et al 2010) until recently. Despite their high numbers across health and social care, HCAs are not represented by another profession-specific union. In the literature chapter, it was highlighted that research on HCAs incorporated their views alongside the opinions of those they worked with, or didn't include the view of HCAs at all. This lack of voice implies oppression in itself. However, these elements highlight a perception, or a judgement drawn from information available rather than expressed feelings from HCAs. It seems a great leap to make from research with little emphasis on representing the views of HCAs, to instigating changes for emancipation on the basis of oppression. Discovering the voice of the HCA would need to precede exploration of emancipation. Therefore, Critical Theory was not chosen as the paradigm for this study.

3.2.3 Participatory

Participatory research is viewed as a way of gathering knowledge to generate action rather than simply to gain a better understanding of the phenomena (Cornwall and Jewkes 1995). This paradigm was added to Lincoln, Lynham and Guba (2018) Themes of Knowledge table after Heron and Reason (1997) challenged that there were substantial differences between constructivist and participatory styles which justified a paradigm in its own right. Ontologically, the participatory paradigm declares that our minds and the cosmos, or universe, interact. The outcome of the interaction is a sum of what the universe presents and what the mind perceives (Heron and Reason 1997). The worlds and people that we meet in the universe, are shaped by how our mind perceives them. The phenomena and

communication are joined through these interactive encounters (Heron and Reason 1997). This 'felt' experience of relation tells us about the interactive interface between a subject and what is encountered. This is known as the subjective-objective reality; subjective because it is only known through how the mind forms it and objective because the mind passes into the given universe which it shapes (Heron and Reason 1997).

Epistemologically, Heron and Reason (1997) state that there are four ways of knowing truths; experiential, presentational, propositional and practical. A participative, direct encounter with a being is the essence of experiential knowing. The knower is able to relate to the being, as well as recognise that they are separate from it (Heron and Reason 1997). Presentational knowing builds on our experiential knowledge and gives it representation in symbols such as verbal, musical and graphic art-forms. These demonstrate our resonance with the world and the meaning becomes part of our knowing. Propositional knowing is a conceptual knowledge. It occurs when the presentational sounds and visual shapes of the written or spoken word are symbolised in theories and statements. Practical knowing allows a person the capacity to demonstrate a competence, they know a skill. Heron and Reason (1997) view this as a celebratory stage where the accumulation and purpose of the preceding three knowledge forms provide the grounding for "consummation" of an accomplishment.

Methodology for participatory research is a co-operative, democratic dialogue between all those involved (Heron and Reason 1997). As part of propositional, conceptual knowing, people collaborate to decide on the question and methodology. As part of practical knowing, people as co-researchers and co-subjects, apply the methodology to the world that they are part of (Heron and Reason 1997, Cornwall and Jewkes 1995). This leads to experiential knowing as new ways of interacting with the world occur. Presentational knowledge is seen when the new knowledge is shared as meaningful patterns. This leads to adjusted propositional knowing about the original question. These four forms of knowing are cycled through many times to work through how each form is grounded in and consummates the other forms, thereby refining what is known (Heron and Reason 1997, Cornwall and Jewkes 1995).

In participatory research, the question of what, in the human condition, is valuable as an end in itself, or the axiology, Heron and Reason (1997) state is practical knowing resulting in the flourishing of humans. Hierarchy, co-operation and autonomy allow the creation of balance within and between people in a community. Hierarchy is utilised by those with a higher level of skill, experience and vision to direct others. Co-operation allows collaboration which results in support and feedback for new views and possibilities and autonomy enhances the potential of individuals through self-creation and self-transfiguring. The shift in power in the participatory paradigm generates investment, personal, professional and political viewpoints in co-researchers and co-subjects that take the study beyond the realms of other forms of research (Cornwall and Jewkes 1995). This can slow the research process but also produces a study where the question and the recommendations are local and meaningful (Cornwall and Jewkes 1995).

Participatory Action Research (PAR) is described as a methodology (De Chesnay 2014) deriving from the participatory paradigm. The value placed on recognising participants as experts and the emphasis placed on development of practical knowing as a basis for change, makes this approach appropriate for nursing (Parahoo 2014, De Chesnay 2014). However, participatory research was not selected for my study as I wanted to discover afresh how HCAs were enacting their role and the participatory paradigm was incongruent to this. It is possible to see that this paradigm may be more suitable for a subsequent study following Breda (1997). She carried out an ethnography on how mental health nurses felt about unions before she used PAR to study the professional autonomy of the same group (Breda et al 1997); the relationships and learning she developed during the ethnography provided foundations for a successful PAR study. Therefore, before empowering HCAs to ask their question, develop their methodology, and express recommendations that would be meaningful in their setting, I wanted to gain a better understanding of who they were and how they worked.

3.2.4 Constructivism

Another paradigm discussed by Lincoln, Lynham and Guba (2018) is that of constructivism. Creswell (2007 p24) used the term ‘social constructivism’ which he acknowledged was also known as interpretivism. In contrast to Creswell (2007), Williamson (2006) and Gray (2009)

stated that 'interpretivism' was the opposite to positivism. Other researchers use both terms interchangeably (Wahyuni 2012, Ryan 2018, Brown and Duenas 2019). Regardless of whether the two terms are distinct or the same, there is agreement about the philosophical assumptions. The ontological belief is that there are multiple, co-constructed views of what is reality (Lincoln, Lynham and Guba 2018, Brown and Duenas 2019).

Epistemologically, the relationship between the researcher and the researched is impacted upon as individuals develop their own subjective meanings based on their life experiences and interactions with others (Creswell 2007, Wahyuni 2012). It then follows that the axiological position would be as an emic observer, an insider, as the researcher cannot be separated from the subject (Wahyuni 2012, Williamson 2006). Methodologically, knowledge is gained through interaction; the process used to do this is hermeneutic and dialectic (Lincoln, Lynham and Guba 2018). Discussion encourages individuals to construct meanings and these meanings are then compared and contrasted through logical discussion (Silverman 2013). The aim is to develop a small number of constructions on which there is consensus. This can be achieved through observation of everyday activities and paying particular attention to communication and interactions to understand how they are created, managed and maintained (Silverman 2013, Williamson 2006). This paradigm fitted most closely with my wish to better understand the role of the HCA. Exposure to HCAs, both through observing them on the ward and reading about their role, had prompted a query as to whether their role could be better captured and understood; could multiple views of what is real be co-constructed if I took an emic, insider stance? As a person from outside of the adult ward environment, and a mental health nurse, I felt I was well positioned to take a fresh look at how meaning was constructed, managed and maintained through comparing and contrasting data in the HCAs environment.

In adhering to the practices of qualitative research discussed above, there were a variety of ways that could be used to carry out a constructivist study. Creswell (2013) comprehensively compared five possible ways of doing a qualitative research inquiry. These were narrative, phenomenology, ethnography, grounded theory and case study. Further reading of these approaches led me to the choice of ethnography.

3.2.5 Ethnography

From its anthropological beginnings, ethnography has been used to develop a description of people or culture (Denscombe 2014, Holloway and Wheeler 2010, Parahoo 2014). In the 19th century, anthropologists used interviews with missionaries and other travellers as their data set but there was criticism that this was not a systematic or rigorous approach (Hammersley 2005). Researchers then began to travel themselves to collect both physical material, such as artefacts, and non-physical such as myths and legends (Hammersley 2005). This travel to far off lands, developed into more time-consuming studies. Social anthropologists such as Bronislaw Malinowski (1922) and Margaret Mead (1943) became immersed into small, isolated tribes in order to capture detailed accounts of their ways of life before the tribes became affected by modern society or befell extinction (Denscombe 2014, Maddison 2005, Parahoo 2014). Later, studies of other cultures that were less remote demonstrated that although the immersion into isolated tribes no longer took place, the drive to look in close detail at other communities remained foremost in ethnography (Denscombe 2014, Wolcott 2010, Hammersley 2005).

Hammersley (2005) stated that the methodology of ethnography is difficult to define due in part to the overlap that it has with other research terminology such as qualitative method, case study and participant observation. He suggests that this is a reflection of some researchers' preference for attending to practice rather than theory; they view the formulations that theories are based upon as restricting. Hammersley (2005) elaborates on how ethnography is surrounded by its own philosophical assumptions and that these are important to know in order to ascertain where ethnography sits within the range of methodological approaches. It is therefore necessary to identify its features. The basic tenets of traditional ethnography are where:

- The real world, rather than experimental conditions, provides the context for collecting empirical data;
- A considerable length of time is spent in the context, or field, of the phenomena under study;
- A small setting or group, sometimes only one individual, are studied;

- A holistic approach ensures that relationships, connections, interdependency and processes are included as parts of the culture;

- Everyday events are considered worthy of study as well as special occasions;

- Observations and informal conversations are the main tools for data collection;

- There is no pre-designed plan or categories for analysis decided before the data is collected;

- In data analysis, descriptions and explanations arise from interpretation of the functions and meaning of social actions;

- The final report is a construction, rather than a description, of the culture or group under study, influenced by the ethnographer's experiences and writing skills.

(Denscombe 2003, Hammersley 2005)

It is possible to see elements of anthropology remaining in ethnography with reference to the real-world setting, the extended length of time, the small groups and the observation of everyday events. However, there is also indication that it opposes a positivistic approach in discounting pre-design and pre-decided categories. In the 1960s, the structure of quantitative research was well accepted; a hypothesis, a research design to test the hypothesis using experiments or large surveys, then an assessment of reliability (Hammersley 2005). Although contemporary realist ethnography does have elements of positivism such as objectivity, standard categories and written as a third person account (Creswell 2012), generally this approach was refuted as the only validated way to carry out research by ethnographers (Hammersley 2005). The basis of ethnographers' argument was founded on three main points; some challenged that ethnography was more suitable for finding meaning in human behaviours than the quantitative formula which did not depict real life. Others did accept the importance of the quantitative methodology, but illustrated that ethnography was the best approach in certain phases of the research process such as pilots and debriefing (Hammersley 2005). Thirdly, some ethnographers debated that ethnography had the advantage that not only could it be nomothetic, it could also be idiographic (Hammersley 2005). Nomothetic assessment is used to compare whole specific units, like teams or organisations, with other specific units in order to collect broad data (Lyon et al 2017). This new understanding supports classification and prediction to generate

general laws for large numbers of teams or organisations (Lyon et al 2017). In contrast, idiographic assessment is used to explore intra-unit differences by recognising the relationships between variables, such as time and context, that are unique to the unit under investigation (Lyon et al 2017). This strength in being both nomothetic and idiographic means that the outcome of an ethnography can be a construction as well as a description (Denscombe 2003). This addresses criticisms that capturing the ideographic intricacies of a group in context is not a useful product in itself (Denscombe 2003, Hammersley 2005). In healthcare settings in particular, ethnographic studies need to have outcomes that move results from description to ones that are of practical worth (Oliffe 2005).

Walcott's (2010) summary was helpful in my consideration of why ethnography felt appropriate for this study, with the two questions that he sees as crucial:

- "What do people in this setting have to know and do to make this system work?"
- "If culture… is mostly caught rather than taught, how do those being inducted into the group find their way in so that an adequate level of sharing is achieved?" (p74)

These questions reflected my own feelings. HCAs appeared to be working separately from the RN and the current research was very much focused on what tasks they did and how these could be separated to give clearer definition of their role in comparison with the RNs role. Exploration in the texts of the relationship between the HCA and the RN was rarely seen, it was about the RNs control over what HCAs could and couldn't do. From these studies, it was not possible to understand the impact of cultural factors such as the impact of the setting, the ratio of RNs to HCAs, how, or whether they negotiated the workload. If this was not clear in the research currently available, I wanted to ask what do HCAs need to know and do to make the system on the ward work and how do they know how to do this if it is not in the literature? The tenets of ethnography were going to allow me to find out. Next I needed to decide what type of ethnographic study this would be: critical ethnography and focused ethnography were both considered.

3.2.5.1 Critical ethnography

Critical ethnography has been used in nursing research for exploring nurses' relationships with doctors and other nurses (Manias and Street 2001) and in neuroscience nursing to

better understand the meaning of screaming for patients with dementia (Bourbonnais and Ducharme 2010). It is based upon the critical theory paradigm presented previously. As was discussed, critical theorists highlight that some groups in society use their position of being in a majority group to undermine smaller groups (Ross, Rogers and Duff 2016). Their more predominant ways of being become the dominant discourses; the right way to be, think and act in an environment (Ross, Rogers and Duff 2016, Manias and Street 2001). This becomes the unquestioned norm. Nursing work is often unconscious and familiar to those who deliver it thereby making it a dominant discourse that is difficult to identify and convey (Ross, Rogers and Duff 2016). Critical ethnographers articulate these subjective experiences and reveal the political and social constraints imposed by the dominant discourses (Ross, Rogers and Duff 2016, O'Reilly 2009). When a familiar set of behaviours are brought to the surface by researchers, it moves unconscious cultures into the conscious mind. Those acts that have been taken for granted are then questioned by participants, in the new lens of social dominance, and their perception of it can be altered (Ross, Rogers and Duff 2016).

Critical ethnography was not deemed to be suitable for this study of HCAs as it assumes some prior knowledge of the social politics of the setting. As a mental health nurse, the adult nursing environment was not my usual workplace and I had no recent experience of the dominant discourses occurring in this setting. There were indications, such as their hierarchical position, that HCAs were part of a societal group that had less power in influencing dominant discourses, however, it would have been morally wrong to assume that this was the same for the HCAs in my study before spending time in their work setting. Instead, focused ethnography was the more appropriate approach.

3.2.5.2 Focused ethnography

Changing pressures in the research field such as time and funding limits, has led to a development of a focused ethnography (Cruz and Higginbottom 2013), sometimes known as a micro ethnography (Knoblauch 2005). According to Wall (2015) focused ethnography "usually deals with a distinct problem in a specific context and is conducted within a subgroup rather than a cultural group that differs from that of the researcher". The shift from a broad look at an area to being more specific in the problem, the context and the group is what differentiates focused ethnography from tradition ethnography. Knoblauch's

(2005) views focused ethnography as an instrument in the field of ethnography rather than an entirely new approach. This more succinct style of research is successful in applied ethnographies but relies upon the researcher having some prior knowledge of the setting to know where to focus (Knoblauch 2005). It is then that smarter data collection and application to nursing practice can occur, and the key criteria of an ethnographic study remains in place (Higginbottom et al 2013, Oliffe 2005).

Knoblauch (2005) compared traditional ethnography with focused ethnography and noted that a main difference was the use of time. Traditional ethnography is based on being continually present for an extensive period in order to capture the whole picture. In contrast, focused ethnography is not continual, in that researchers are purposeful in selecting when to spend time in the study setting (Knoblauch 2005). This leads to a high level of intensity; it captures lots of rich data in a short space of time. The intensive data requires intensive analysis, which is different to the field notes gathered over substantially longer periods by traditional ethnographers (Knoblauch 2005). The ability to collect intensive data in a focused ethnography is due to improvements in technology such as voice recorders and video cameras (Knoblauch 2005). Knoblauch (2005) recognises many benefits that technically recorded data bring, such as making it accessible to other researchers on the team, thereby making analysis inter-subjective. This use of technical equipment in focused ethnography has emphasised the social value placed on what is seen and heard with researchers drawn towards where they can see activity rather than trying to catalogue every part of the setting (Knoblauch 2005). The speed of this research process is dependent on the researcher having some insights into the subculture that they would like to explore. An emic, insider viewpoint is more likely to enable a quicker assessment of both where data can be found and how to gain access to the most appropriate settings and events (Wall 2015). A common, shared knowledge with participants saves the focused ethnographer time; they already understand some language, context and behaviours of the group or phenomena under study. It is then the use of reflexivity that facilitates the search for 'otherness' in the familiar setting (Knoblauch 2005, Wall 2015).

The tenets of focused ethnography were felt to support exploration of the role of the HCA. In accordance with Walls' (2015) description, I had a distinct problem: a need to know how

HCAs know and do their work. A specific context: the adult in-patient wards. A subgroup: HCAs within the cultural group of health care workers; therefore, I decided to use a focused ethnography.

3.3 Quality and Reflexivity

Quality and reflexivity are closely linked and of high importance in qualitative research. With regards to quality, ethnographic authors such as Hammersley and Atkinson (2007), O'Reilly (2009) and Draper (2015) place emphasis on research which provides rich description of the cultural group, uses data from the context to explain analytical themes and clearly identifies the reflexivity of the researcher on the process. It is also stated that ethnographic studies are not designed or carried out in order to capture data that is generalisable or transferrable but rather to grasp social phenomenon which is usually tacit and hidden (Cruz and Higginbottom 2013). There is agreement that the settings and the purpose of ethnographic studies is so wide that any judgement criteria are going to be opinion based (Hammersley 1992). This said, a model by Lincoln and Guba (1985) is often used to assess the quality of qualitative studies. How this study met the criteria of credibility, transferability, dependability and confirmability can be found in Appendix 2. Hammersley (1992) recommended that qualitative research is evaluated by asking a more general question of: what is the goal of the research? Whether the researcher has reached this subjective standard is the opinion of the reader. In order to decide whether the research has met its goal, the reader will need information pertaining to the decisions made by the researcher. The ways that the researcher has shaped the study is known as reflexivity (Denzin and Lincoln 2011, Mays and Pope 2000, Denscombe 2014).

Reflexivity is defined as the consciousness of the researcher about how their own values and biases in their knowledge of the social world impacts on the research study (Bryman 2016, Smith 2006, Denzin and Lincoln 2011). It is the 'self-appraisal' of research, a look at how the researcher is situated within the study (Berger 2015 p220). These values and biases are based upon personal features such as age, class and gender (Smith 2006). These influence all parts of the study from the choice of subject, to what is written in the final report (Denzin and Lincoln 2011). Based on themes used by Denzin and Lincoln (2011), Table 4 was created

to illuminate how my reflexive awareness was deliberated in each part of the study and shared to enhance the reader's understanding.

Description of phase	Researcher's choices and justification
Phase 1 – **The researcher as a multicultural subject**	This study took place in an adult nurse setting and I am a mental health nurse with over 20 years of experience. I haven't worked as a HCA myself. My experiences and training gave me the freedom to ask basic questions about phenomena that is common in adult care but have the nursing knowledge to understand the answers. It was through the research fellow post on the EnRICH study that I was exposed to ward logistics. This led me to question whether HCAs were working without the direction of a nurse. Politically, I was aware that the shortage of staff in the NHS meant that HCAs had been developed to take on some nursing roles. I knew that the Francis Report (2013) was critical of nursing care in adult wards.
Phase 2 – **Theoretical Paradigms and Perspectives**	My ontological position fits with that of constructivism, where each participant constructs their own meaning of reality. For me, observing and asking HCAs and others about their actions and interactions was the most obvious way that I was going to gain a better understanding of how HCAs functioned. It was important to me to ask people directly about thoughts and feelings relating to their workplace to avoid making assumptions based on previous experiences or the literature. It was ethically right to check meaning to co-create constructions. I learnt from participants what was important to them. I wanted to do my best to represent their experiences and position.
Phase 3 – **Research Strategies**	It was expected that this study would follow in the footsteps of the overarching EnRICH study and have a constructivist grounded theory research strategy. However, it became clear that immersion in the setting to understand the ward culture was to be the starting place. My previous long exposure to HCAs on an adult ward was during my nurse training. The research strategy needed to provide an opportunity to naively start by observing the contemporary ward environment and the HCA within it. Ethnography was identified as the research strategy to enable this.
Phase 4 – **Methods of Collection and Analysis**	It was through my interviews for the EnRICH study that highlighted that HCAs were so ingrained in their role and the culture that they were not able to express what they did or why. Reflecting on this with supervisors led to a data collection of observations followed immediately by interviews. Field notes were made during non-participant observations and interviews were

	unstructured because I felt that this combination was the most open way to engage participants, to gain the greatest exposure to what was going on. Analysis was heavily influenced by my opinion of what was important. I could sense my mental health background and leadership experiences drawing out aspects such as feelings and behaviours, the HCA's support strategies and their ways of communicating. A reflective diary and supervision aided identification and challenge of influential thoughts and preconceived ideas. The computer programme N-VIVO was used to assist manual analysis of the data. Collating data under headings removed the focus from individual participants to the characteristics of groups.
Phase 5 – **The Art, Practice and Politics of Interpretation and Evaluation**	In keeping with ethnographic tradition, the final report is written in the first person where appropriate. It was during writing the findings that supervisors fed back their perceptions of my feelings about adult nurses. This allowed me an opportunity to reflect and re-evaluate my textual presentation of them. It was morally right that this study endeavoured to be as valid and relevant as possible. This was pursued through sharing my decision making and demonstrating how the finding are grounded in the data.

Table 4 - The researcher influence demonstrated through the research process (Denzin and Lincoln 2011 p12)

Table 4 illustrates how my beliefs about the social world impacted on every part of the research journey. It is with this deliberate effort to increase consciousness that I became more familiar with my own responses both in the research setting and when constructing a shared reality in the findings (Berger 2015). Berger (2015) suggests that such improvements through heightened awareness of the impact of the self allows the researcher to consider their level of involvement or detachment, and that this supports rigour. Attia and Edge (2017) argue that reflexivity should be far more than this, that it should include growth and development.

3.3.1 Prospective and retrospective reflexivity and examples from experience

Attia and Edge (2017) view reflexivity as comprising of two parts. First, rather than insights with which to contemplate the management of involvement or detachment as Berger (2015) suggests, Attia and Edge (2017) state that 'prospective reflexivity' is a researcher's increased capacity to understand the s*ignificance* of their knowledge and values on the research. The second part is retrospective reflexivity. Where prospective reflexivity is focused on how the researcher's biases and values effect the research, retrospective

reflexivity gives the researcher an opportunity to deliberate how the research has affected their biases and values. Researchers change and develop as part of the reflexive experience (Attia and Edge 2017). Examples from my research journey are presented which include prospective and retrospective reflexivity.

In Table 3, there is demonstration that I had self-awareness of my unusual position of being a mental health nurse in an adult nursing environment. I hoped that coming from a different part of the nursing world would allow me to take a fresh look at the role of the HCA. It could, however, have resulted in me being viewed as an outsider, someone to be suspicious of, when I entered their domain to collect data. My learning was that there are many people with a variety of roles that enter the ward environment, RNs and HCAs were intrigued but not surprised about my presence. They saw me as a researcher rather than a mental health nurse. I presume that this was because my visual presentation and actions suggested that of a researcher whereas participants would only know that I was a mental health nurse if I shared that information. This highlighted that my mental health nurse status had more impact on the methodology than on data collection.

Another example of prospective reflexivity occurred when I undertook a review of the literature, it influenced my view about the position of the HCA before undertaking data collection. I perceived some literature to be looking down on HCAs from the more senior perspective of the RN. The hierarchy within the nursing team appeared to be underpinning my study, subtly indicating its importance in the adult nursing world. This challenged my personal experiences of working with HCAs in mental health settings where each role was seen as making a valid contribution to the team as a whole. This brings Attia and Edge's (2017) other form of reflexivity to the fore; retrospective reflexivity. Later during the research process, I was able to look back and not only have insight, but also the ability to articulate that this may have influenced my opinion about how HCAs were viewed by RNs. As oppression of nurses is widely discussed (Dong and Temple 2011, Rooddehghan, Yekta and Nasrabadi 2015, Duchscher and Myrick 2008) it raised the question of whether this would also be found in a study of HCAs. This political insight did not alter my choice of methodology or methods. A critical theory paradigm or a critical theory ethnography would have supported exploration of emancipation, but I felt it was inappropriate for this study as

discussed earlier. It felt like a presumption, possibly based on personal bias rather than previous research. I was determined that I would stay as open as possible to understanding the function of the HCA.

Retrospective reflexivity arose from observations, interviews and early analysis when I realised that what I deemed to be important was not always the case for HCAs. As the focused ethnography needed to be narrow, I was guided by participants. For instance, in mental health nursing, death is often linked with trauma. My experience was that teams would gather to discuss how they felt about the death. With this being my part of my professional history, I was drawn to how HCAs on adult wards were supported following the death of a patient. Observations and interviews demonstrated that my experience did not transfer to this setting; death was more common and a familiar part of their role. I needed to put this line of inquiry aside, HCAs did not place emphasis on this part of their work. I learnt that what I had experienced of death of a patient was very different to theirs. This association between my experiences of nursing and those occurring on the adult ward continued; awareness of my own values and biases did not detract from what interested me in their environment. During episodes of data collection, I continued to immerse myself in their social setting. In trying to make sense of their movements and behaviours, I could not see how members of the nursing team connected with each other. My interest in leadership was a driver to look in this direction as opposed to another. My learning about their networking structure became clearer as I discussed the data and analysis with my supervisors.

It was sharing drafts with supervisors that brought to the fore my thoughts about adult RNs. Although I didn't recognise it, my supervisors felt that I did not favour adult nurses. I reflected and was able to express that this was more complex. I acknowledged that I was sometimes swayed by the HCAs negative comments about their RN partner. At times, I had observed first-hand the lack of support that they were describing during their post observation interview. When this was coupled with the HCAs expression of how this made them feel I had, what I thought, was implicit empathy. The insights instigated by my supervisors enabled me to grow and learn about myself and my identity as a mental health nurse and how this impacted on my judgment of others. The fresh insight allowed me to

review the vocabulary I had used in my account and make sure that it accurately represented the views of the participants rather than my own.

Through using examples, reflexivity in this study has been contemplated. Using Attia and Edge (2017) I have shared my learning and growth in retrospective reflexivity as well as how my values and beliefs impacted on research choices. There were different prompts for reflexivity including through self-reflection, through participants' responses and through feedback from supervisors.

3.4 Summary

The exploration of HCAs in an adult ward environment could be undertaken in many ways and this chapter has illustrated how a perspective was established. A qualitative approach was the clear option for looking at how phenomena are experienced amid the activities of people. There was explanation of how philosophical assumptions are made explicit through theoretical frameworks known as paradigms. The ontological, epistemological, axiological and methodological assumptions of each paradigm were discussed before a reason for their rejection or acceptance was made. The constructivist approach was selected as it placed value on multiple realities. This, in turn, led to an ethnographic methodology due to its attention to the culture and creation of meanings. Taking a focused ethnographic approach increased the chances for intensive, rich data being collected during the thesis time constraints. Being a research fellow on the EnRICH study provided the opportunity to utilise some previous knowledge and shared understanding. A discussion on reflexivity has highlighted the impact that my personal beliefs and biases had on the decisions that were made throughout the study. Once decisions on methodological choices had been made, the most appropriate methods for practical implementation could be instigated. The next chapter will present how the study was carried out.

Chapter 4 Methods

4.1 Introduction

The methodology chapter included how my own perspective influenced the choice of paradigm for this study. It was evidenced that constructivism was the most appropriate paradigm and focused ethnography was the methodology of choice. This next chapter will present the ethnographic research design, how access was gained to both the field and the participants and ethical considerations based on the Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research 1978). Then, details of the data collection and data analysis will be provided. There is discussion of whether there are skills that cross-over from a mental health nursing assessment to data collection and the data analysis section includes dialogue on the use of computer assisted qualitative data analysis software and memos.

4.2 The research design

As focused ethnography is used as a tool for ethnography rather than a separate methodology (Knoblauch 2005), the principles that apply to ethnographic design also apply to this study. When considering research designs of methodologies, the structure of an ethnographic study is far less rigid in comparison to others due to its exploratory nature (Hammersley and Atkinson 2007, Wolcott 2010, Creswell 2013). There are minimal recommendations for the structure of analysis, the achievement of good quality research or on how best to collate other people's perspectives on what is real to them (Hammersley and Atkinson 2007). Therefore, the more a researcher can share their decision making and influence over the data, the easier it is for others to judge whether the research is valid and relevant (Creswell 2013, Denscombe 20014).

According to Hammersley and Atkinson (2007), Wolcott (2010) and Creswell (2013), the outline of an ethnographic study is as follows: first, the researcher identifies an area for exploration and a foreshadowed problem. Secondly, time is spent in the setting gathering data by observing, questioning participants and reading related documents. Next, early analysis of this data generates categories which need further exploration. Then, the initially broad area becomes more refined and the questions being asked about the group in the

context become clearer. Ultimately, the researcher then interprets the data to illustrate functions and meaning about the social life of the group and reports this in the form of description, explanation and theory (Hammersley and Atkinson 2007). This study will follow this same outline utilising a focused ethnographic style as defined in the methodology chapter. It will also expand the outline to incorporate more specific details of this study in order to share the decision making and influences that allow readers to make judgements about validity and relevance. The first point, identification of an area and a foreshadowed problem, or aim, was discussed in the methodology chapter; how do HCAs enact their role on an adult, in-patient ward? The second point in the outline of a study, spending time gathering data, will be referred to here as data collection. Before data could be collected, access to the field was gained and participants were recruited, this process will be made explicit. Ethical considerations were required at this stage and details of this will be presented. Following a description of data collection, the techniques used for early analysis are conveyed. The categories that arose from the early analysis took the broad view, where the emphasis was placed on the day-to-day work of HCAs. This evolved into a more focused perspective, particularly on the connection between the HCAs' work and their relationship with the RN. The final presentation of the functions, meaning and theory that was interpreted from the data analysis will then follow in the findings chapter.

4.3 Access to the field

Given that an ethnographic study is exploration of how people perceive reality and attach meaning to events, it is expected that the details of the study would be unclear at the outset (Hammersley and Atkinson 2007). The feasibility of the study, such as where access can be gained and which people are recruited, contribute to the shaping of the foreshadowed problem (Hammersley and Atkinson 2007). Where other researchers experienced problems here (Ballamingie and Johnson 2011), accessing the field and participant recruitment were uncomplicated in this study.

Researchers are often working, visiting or socialising in the setting that they wish to study (Hammersley and Atkinson 2007). This is particularly true of focused ethnographies, where it is necessary for the researcher to have some prior knowledge of the setting in order to

know where to focus their attention (Knoblauch 2005). My circumstances were less usual in that I was part of a research team that had peripheral and intermittent contact with twelve ward teams. It was through these visits to the ward settings that I started to establish myself as a familiar face. A focused ethnography would not have been possible without the springboard that the EnRICH Project provided for many reasons. With regards to accessing the field and recruiting participants, it was through the EnRICH work that I knew who the gatekeepers were and how best to approach them; the best time of day, where to locate them, and to use face-to-face contact rather than via email. Gatekeepers are the key people who give local permission and are the link between the researcher and their access to potential participants, settings and events (Denscombe 2014). In this study, the gatekeepers were the ward sisters in some wards, on others it was a deputy sister. I approached them in person and spoke at length to explain my study. They were able to advise me who met the recruitment criteria. This relationship with gatekeepers was not only important, it was also ongoing and required an investment of time (Denscombe 2014, Rashid, Hodson and Luig 2019). This was because the direction of ethnographic research alters as it progresses and therefore a researcher often needs access that can rarely be predicted at the beginning of the study (Denscombe 2014, Burgess 1984). In my study, the groups of participants that I wished to recruit did not alter but gatekeepers were central for connecting me to them throughout the period of data collection. Out of the twelve wards involved in the EnRICH project, four wards were recruited for my study; two medical [M1 and M2] and two assessment [A1 and A2]. These wards were the first to have new HCAs starting when I was commencing data collection. The reason for the purposeful recruitment of new HCAs is presented below.

Once I had access to the wards for the study, the next step was to become familiar with the settings. It is recommended that the researcher “case the joint” (Hammersley and Atkinson 2007 p29) or carry out reconnaissance work (Wolcott 2010). Apart from the logistical element of the environment and identifying possible gatekeepers, this included speaking to possible participants, spending time observing and looking at significant documents (Denscombe 2014, Roper and Shapira 2000). Much of this reconnaissance work was done during the ENRICH project such as familiarity with the environment, ward events and key contact names. However, Rashid, Hodgson and Luig (2019) suggest that for focused

ethnographies to be successful, informal interactions are helpful in progressing the design and method choices. I did undertake some informal interactions with nursing team members which highlighted a possibility that HCAs may not be adept at verbally recounting what they did or how they knew what to do. This led to reflection of Wolcott's (2010) question:

> If culture, sometimes defined simply as shared knowledge, is mostly caught rather than taught, how do those being inducted into the group find their way in so that an adequate level of sharing is achieved? (Wolcott 2010 p74)

The research design became more focused because of reconnaissance work. In order to understand how HCAs were socialised into the role, how they "caught" the culture, a decision was made to recruit some new HCAs and intermittently follow them for one year. This way, their learning of the culture could be captured over time. This was to be complemented by recruitment of more established HCAs and other culture contributors. Next, sampling of participants took place.

4.4 Participant recruitment

When undertaking a focused ethnographic study, it is not possible to include all people within a setting, therefore decisions as to who most represented the group needed to be made. Hammersley and Atkinson (2007) identified three ways of sampling people which supports early and focused analysis; demographic criteria, member identified sampling and observer identified sampling. Demographic criteria such as gender, age and occupation are commonly seen as a starting point (Hammersley and Atkinson 2007). Member identified categories describe how participants were recruited based on how people in the setting categorised others. Observer identified participants are representatives of groups that the researcher has noted during their time in the field. For this study, I did not make use of demographic criteria but used member and observer identified sampling. The inclusion criteria for selecting new HCAs was set by myself and therefore was observer identified; I wanted to collect data from HCAs who were new to the role in a hospital environment and had started in post in the last three months. The aim was to recruit three new HCAs on four wards. All twelve of the new HCAs that were approached agreed to participate but these were unevenly split across the wards with M1 having only two, A1 having four and the other two (M2 and A2) having three each. The over recruitment of four on A1 was due to one HCA

leaving their post part way through the year. The new HCA who was recruited after their departure agreed to participate in the study.

Sampling of established HCAs was through two types of member identified sampling. Initially the ward sister recommended a team member, then later the new HCAs pointed out a 'buddy'; a HCA they had been paired with during their supernumerary period. Inclusion criteria for established HCAs was that they had been in post for over one year. They were recruited to be a subjective check between the new HCA's actions and those of someone more experienced. The number of established HCAs was two to three per ward, ten HCAs in total. On three occasions, I returned to an established HCA for a second time to gather more focused data in order to corroborate analysis. The recruitment of RNs was observer identified, I recognised that they had been working alongside the HCA that I had observed. Eight RNs on three wards and nine on the remaining ward agreed to be interviewed, giving a total of 33. When RNs declined to be interviewed, another RN was not invited to contribute in their place; they had not had the shared experience of that period of time with the HCA. On these four occasions, there was a gap in the data collection. A third group of participants were observer identified and recruited for enhancement of a broader, cultural overview of the ward as an organisation. The purposive recruitment criteria for each of these participants was based upon their job role and their connection with that particular ward. This group comprised a ward sister from each ward, a physiotherapist from each ward, and nursing students from three out of four wards. The fourth ward did not have a student nurse on placement whilst I was data collecting. There was also recruitment of a hospital matron whose role covered two of the participating wards and she took a lead role in employment of HCAs for the directorate. The number and type of participants recruited overall can be seen in a table in Appendix 3.

It is important to note that the relevance of recruiting new HCAs altered during data analysis. The benefits of following new HCAs when collecting data was that they were learning how to integrate into the new environment; this was the first time they had worked as a HCA in the hospital setting. They described their perceptions of people and events and their feelings in relation to these. I was able to follow how they appeared to be professionally socialised over time; how they were moulded to act by the same values and

attitudes that existed in the ward culture (Clouder 2003, Dinmohammadi et al 2013). I learnt some aspects about the setting at the same time as they did: the functions of the ward, the meaning of terminology, the expectations and influences of others on the environment. This provided a shared experience on which to base our discussions. However, when it came to analysis, the status of the HCA as a new person in the environment was not of significance when defining how HCAs enacted their role. Once they had finished the supernumerary period where the focus was on learning the role, there was no notable difference between the behaviours of new and established HCAs. Therefore, differentiating between new and established stopped after data collection and during the early analysis.

In practice, access to the field and participant recruitment was effective due to the preceding time spent in the setting building relationships (Ballamingie and Johnson 2011). As someone that had been 'seen around' whilst working on the EnRICH study, and I hope, been viewed as trustworthy and approachable, my request to engage further with staff caused little commotion. Ward sisters, as the main gatekeepers, were content with informal arrangements rather than pre-arranged appointments. They encouraged me to "drop by". This was reinforced when I noticed that my emails were not answered and they were ruled out as a form of communication. Information about whether new HCAs were due to commence was gathered from going to the ward and asking. The ward sisters introduced me to potential participants, then any further conversations were between us. This included arrangements for when I would next attend. Gatekeepers were content to see me when I arrived on the day, even though I was prepared to be sent away if the ward was not conducive to data collection. This did not happen during data collection for this study.

In retrospect, I noticed that all but one of the new HCAs that were approached agreed to participate. Even though some may have been keen to take part, for others this decision could have been influenced by the fact that the ward sister, their superior in the hierarchy, had put them forward and they felt obligated. It is also feasible that being new and unestablished within the team, they didn't feel able to refuse. Stark and Hedgecoe (2010) use the term 'institutional vulnerability' to describe when people feel obliged to participate because they rely on the researchers' host for their income, protection or wellbeing. My focus, and delight, at the success of the recruitment had distracted me from considering

these factors at the time and is a lesson for the future. This aside, the recruitment process overall was relatively untroubled. However, it was still vital that ethical issues were attended to.

4.5 Ethical considerations

When researchers carry out a study, there needs to be contemplation about how people are treated and whether there are activities that should or should not happen during the research process (Bryman 2016). Ethical codes provide professionals with principles to guide research (Bryman 2016). In healthcare, the UK Policy Framework for Health and Social Care Research (Health Research Authority 2017) presents research principles in conjunction with the responsibilities of different members of the research community. An aim of the framework is a reduction in bureaucracy, as everyone's role is made clear in the document. Alongside ethical codes for research, universities have ethical guidelines which must be adhered to. This adherence is monitored by the ethics committee and is in place to protect the reputation of the university as well as ensure that participants are treated ethically (Bryman 2016, Holloway and Wheeler 2010). The content of the ethical guidelines for the university were part of the online graduate school course, Researcher Ethics and Researcher Integrity, which I completed on 19.11.15 at De Montfort University. Faculty research ethical approval for the EnRICH study and accompanying PhDs was received on 03.09.14 and can be seen in Appendix 4. The staff information leaflet and consent form specified that the study included doctoral students. As the EnRICH study concluded, the staff information leaflet was rewritten to better reflect the progress made in the research design of my study (Appendix 5). This amendment and a request for an extension to the data collection time were applied for with the faculty research ethics committee. This was request was successful on 14.11.16 (Appendix 6). There was no resubmission made to the NHS Research Ethics Committee because the study did not involve collecting information from patients or the public. In addition to ethical approvals, I also needed formal access to the hospital. I completed a Good Clinical Practice course and was granted an honorary contract.

As well as researcher ethics, I also needed to abide by nursing ethics; the NMC code of conduct (2015). Although much of the code applied to nurse researchers carrying out data

collection in a healthcare setting, there were two sections which were particularly relevant: 'Preserve Safety' and 'Promote Professionalism and Trust'. Preserve Safety includes a clause emphasising that nurses are expected to raise and escalate concerns in relation to patient or public safety, be this in their own work environment or any other health and care setting. This highlights that adhering to the professional code of conduct as a nurse registrant remains a constant regardless of the destination or reason for attendance. This clause was applicable to me as I spent long periods of time in the adult wards. It was necessary to consider that if there was an event where a person's safety was compromised, it was possible that there would be conflict between my desire for data collection and my professional position as a registrant (Parahoo 2014). However, in reality, there was no time during the data collection phase where I felt concerned about the safety of patients. Should this have occurred, the patient or public need would have taken priority over the research need (Parahoo 2014). The second section in the NMC Code of conduct (2015) that was particularly relevant, Promote Professionalism and Trust is a mandate that as a RN I must always uphold my reputation. This leads to thoughts about how my actions can have an impact on individuals during the study. In order to safeguard the public, the researcher has a responsibility in ensuring that there is attention to, awareness of and application of research ethics throughout the whole research process (Doody and Noonan 2016). This includes how to obtain the most informed consent, when to prompt for more depth in responses, when to stop interviews, when to put patient care before data collection and how phenomena should be presented and shared (Robley 1995). In order to contemplate and address these issues, it is common to abide by the Belmont Principles (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research 1978) (Greaney et al 2012). The three principles (respect for persons, beneficence/non-maleficence and justice) were applied to this study and will be considered in relation to how this was achieved.

4.5.1 Respect for persons

An assumption that research participants are autonomous agents and are treated as such is the basis for the first principle (Greaney et al 2012). Autonomy is seen as the participant's ability to make their own choices which are respected and not influenced by the researcher (Doody and Noonan 2016, Greaney et al 2012, Holloway and Wheeler 2010). In order for

participants to be able to do this, they require three elements: all the information available, knowledge that they can withdraw at any time, and the possible benefits and risks included in participation (Doody and Noonan 2016, Holloway and Wheeler 2010). With regards to providing all information available, it is necessary to remember that the process of qualitative studies relies upon "dynamic human interaction" in order to discover and understand the phenomenon under study (Robley 1995 p46). Therefore, the direction of the study cannot be predicted prior to commencement of data collection or the turns it takes during each episode of data collection. Consequently, judging whether a potential participant is fully informed in order to consent to participation is problematic (Robley 1995). Instead, information for the purpose of consent needs to be viewed as an ongoing process which reflects the changing status of the study (Parahoo 2014). This did occur in my study. Initially, the staff information sheet was generic but as the data collection and early analysis took place, the direction of the study became more focused. The amended staff information sheet reflected this (Appendix 5). In interim periods between commencing the study and completing the data collection, I also gave additional verbal information to potential participants thereby increasing the level of informed consent to the best of my ability. When they agreed to participation, participants signed two consent forms, one they kept for themselves and the other was kept in the study file.

In most instances, at least one week passed between giving potential participants the information sheet and consent form before I returned to collect data. This allowed time for the potential participants to reconsider, withdraw or ask questions (Parahoo 2014). Some participants asked to be interviewed immediately as the time was convenient to them. This was particularly the case for those providing cultural contributions such as the physiotherapist. This was agreed on the condition that should the participant change their mind during or after the interview, they would inform me of their wish to withdraw. It was not possible to ask RNs whether they were willing to participate prior to the day due to not knowing in advance which RN the HCA would be working with on their next shift. At the beginning of the shift, the study was described to the RN and the information sheet given to them. They were asked if they would take time to consider whether they would be happy to be interviewed later in the shift, at their convenience. Following the interview of the HCA,

the RN was approached for a response and most agreed to participate. The consent form was then signed.

Whenever I returned to wards to speak again to participants, each subsequent period of observation or interview started with a verbal check that consent was still given before data collection recommenced. Only once a HCA questioned her ongoing participation. On this occasion, rather than agreeing as other participants had, HCA Monica instead asked “do I have to take part?”. I said it was her decision whether to continue to participate in the study. I asked her the reason why she was reluctant. I expected her to say that she didn’t like the experience but instead she said she was really busy. I believed that my presence when observing shouldn’t have an impact on her workload, although I would agree that the time spent being interviewed would take her away from her work. As a way forward, I asked her if it would be alright for me to make a start and she could see how she felt. She agreed. As I took up my discreet position of observer, leaning against a wall inside the entrance of the bay, I looked down at my small note pad and wondered if I had made a mistake. I was concerned that I may not have respected her right to autonomy as per the Belmont Principles. These thoughts distracted me from making notes for the first few minutes, then when I did look up, I noticed that Monica was already engaged with her work. I watched her to see if there were signs that my presence was having an impact such as distraction, self-consciousness or annoyance but none were identified. I decided to continue with the observations.

Respect for persons also came in the guise of the verbal consent that I requested from RNs for my presence in the bay where the HCA was working. This was because it was respectful, and there was a possibility that I may inadvertently intrude in the bay where they were leading the shift, and although not the focus of the study, they were part of the interactions recorded. RNs agreed for me to be present and there were no events that arose from my presence which impacted on the running of the bay highlighted. As ethical approval did not extend to interviewing patients or carers in the ward environment, the data collected where they featured was restricted; no personal details or identifiers were recorded.

This study used overt observations where the participants knew that they are being observed (Twycross and Shorten 2016). Discussed above are details of gaining consent from participants nonetheless this study was carried out in a semi-public area where a wide variety of people interacted. I verbally informed patients and relatives and any other person, of the reason for my purpose on the ward. A badge with my photograph, name and "research fellow" as my title was worn on a university embellished lanyard for identification. It is a common response to be suspicious of researchers carrying out observations (Delamont 2004). In order to try and address this, I asked the ward sister to share information widely about my reason for being present and to reassure staff as an attempt to address this. On two occasions, doctors asked who I was and the reason for my presence when they entered the bay where I was observing. I explained that my aim was to gain an understanding of the role of the HCA. They seemed satisfied with this and continued with their work. It was only this higher level of hierarchical staff that asked me directly. At other times, there was whispering when I was present on the ward.

The right to withdraw is the second element in respecting a person's autonomy (Doody and Noonan 2016, Holloway and Wheeler 2010). This was of significance to my study because I returned to some participants in order to follow their journey or to confirm early findings. A right to withdraw clause was included on the information sheet and the consent form. This is an area for contemplation when, as stated above, the direction of the study and the content of each data collection session are unpredictable; it may stir emotions that cannot be pre-empted (Parahoo 2014). Not only were participants asked if they consented to continue to be included in the study before each episode of data collection but in addition, I watched for non-verbal signs that the participant may be unhappy to continue and was prepared to stop data collection (Doody and Noonan 2013). This is a reflection that morally (Robley 1995) and professionally (NMC 2015) respect for persons was prioritised over data collection. Something that was more difficult for participants was withdrawing their contribution from previous episodes of data collection. The information sheet and the consent form advised that data collected before they withdrew consent may still be used in the study. This was due to the complexity of removing it when analysis was integral to data collection. All participants continued to participate in the study and this event did not arise.

The third element to respecting autonomy is that the potential participant should be informed of the possible benefits and risks included in participation. This coincides with the Belmont Principle (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1978) beneficence/non-maleficence.

4.5.2 Beneficence/ non-maleficence

Beneficence is defined as doing good (Parahoo 2014) and is connected to the first principle, respect for persons; if a participant is being respected, the researcher is viewed as being in the process of doing good (Gabriele 2003). The researcher needs to do all they can to ensure that the benefits of the research outweigh the risks for participants and the wider society (Holloway and Wheeler 2010, Doody and Noonan 2016, Parahoo 2014). Conversely, non-maleficence means to do no harm (Holloway and Wheeler 2010, Parahoo 2014). The two terms beneficence and non-maleficence are not always viewed as separate entities, some see that to do good means to avoid doing harm (Gabriele 2003, Cassell 2000). Others state that this is not always the case; to cause injury may sometimes be for the better good. Surgery to remove a non-functioning organ would be an example of this (Beauchamp and Childress 2019). The difference between non-maleficence and beneficence continues with recognition that non-maleficence is based upon not doing one thing, it is an intentional avoidance of actions that do harm whereas beneficence is actively helping through a combination of preventing harm, or removing harm, and doing good (Beauchamp and Childress 2019). This highlights the moral obligation of researchers in healthcare to refrain from inflicting harm and to do their duty to help (Beauchamp and Childress 2019). The discussion about separating non-maleficence from beneficence suggests that circumstances can alter which of the principles is more at the forefront (Beauchamp and Childress 2019), but morals appear to underpin decision making and judgement.

With regards to this study, it was my obligation to do all possible to ensure that the study was beneficial and would do no harm to the participants or society (Doody and Noonan 2016, Parahoo 2014). In my endeavour to do this, my awareness of potential benefits and risks needed to be shared with participants. It was not envisaged that HCAs and other participants would benefit directly from participating in the study but there was a possibility that findings could contribute to improved patient care. However, some participants do

benefit from partaking in the research through the opportunity to reflect on their work (Parahoo 2014). This could be said of the majority of participants in this study who appeared to engage with the process and were open in sharing their thoughts. The possible risks, or discomforts, of participation were the anxiety or embarrassment of being observed and the possibility that they might need to talk about issues that are sensitive. These risks were stated in the staff information sheet, along with who to contact if there was a problem. This included my own contact details, as it was my responsibility to ensure that support mechanisms were available should participants become uncomfortable or distressed (Polit and Beck 2018). In this study, there was no anticipated or actual physical, psychological or emotional harm to participants during or after data collection, that I was made aware of.

4.5.3 Justice

Attention to justice is to ensure that the dignity and autonomy of those involved in research is protected without discrimination (Gabriele 2003). It means to ensure that people are treated fairly through ensuring that preferential treatment is not given to some at the sacrifice of others (Parahoo 2014, Gabriele 2003) and that positive outcomes of the research cannot become of the benefit to some at the expense of others (Gabriele 2003).

With regards to fairness in recruitment, the application of purposive sampling led to the categories of people I wanted to participate, but the decision as to which person instead of another was not made by myself. The plan to focus on new HCAs led to their recruitment being on the basis that they were the next new HCA to commence in post on a participating ward. There were no other criteria, such as age, gender or ethnicity, which could lead to the discounting of one new team member for another. The ward sister or deputy sister identified the established HCAs initially. This appeared to be based on who was working at the time of my arrival; I did not suspect any strategic decision-making due to their spontaneity. Later, this risk was addressed as new HCAs identified their buddies. As discussed above, the recruitment of people as cultural contributors was based on there being one of their profession working on the ward and no bias could be made in their recruitment. I believe that choices were justified and were non-discriminatory.

Justice also includes consideration of fairness in the power relationship between the participant and the researcher (Parahoo 2014). Spouse (2012) suspected that people in the healthcare setting of her study made assumptions about her competence and whether they felt alliance or alienation towards her. I was aware that my physical appearance illustrated that was not in my usual place of work, or part of their world. I was not wearing a nursing uniform which could have been useful for people to ascertain my reason for being present in the setting and my position in the hierarchy, but I was wearing a name badge with the university logo on it. It was possible that people could assume that I had power as a researcher (Ballamingie and Johnson 2011).

Spouse (2012) recognised that she felt more self-conscious when collecting data for her own study rather than on behalf of the institution. My reality was that I was a novice in carrying out data collection and therefore, beholden to them for their agreement to participate and to be generous in sharing their perceptions (Ballamingie and Johnson 2011). They had the power: my reliance on them for rich data needed to be reflected by demonstrating that I was there to learn from them. This way the relationship could develop (Holloway and Wheeler 2010). When collecting data, the participant and I shared a unique experience from being in the same context at the same time. In discussing events after observations, we had opportunities to confer on ideas of understanding and clarify meaning (Holloway and Wheeler 2010). If participants were not aware of their power at the beginning, there were signs that relationships developed. There was reciprocity between us as more episodes of data collection took place. Many participants were welcoming when they saw me, kept me informed of their actions when I was observing, and were open with their views during interviews. The reciprocity that had evolved had an impact on the writing of the final report. As justice is described as attention to a person's dignity and autonomy (Gabriele 2003), I was motivated to present their reality as accurately as possible and stayed close to the meanings they expressed.

4.5.4 Confidentiality

Confidentiality is "… the respectful handling of information disclosed within a relationship of trust, especially as regards to further disclosure" (Lowrance 2012 p33). To safeguard confidentiality, the following actions were taken. All interview recordings were downloaded

from the Dictaphone as soon as possible after interviews and stored on a password protected database, as per university policy. Data was anonymised by use of a pseudonym for each participant and the list of identifiers to match the person to the pseudonym, such as ward and professional status, was kept separately. All paper data gathered is kept in a locked, fireproof filing cabinet at my place of work. Electronic copies are held on my encrypted laptop with relevant security passwords in place to avoid data being accessed by anyone else. These actions were carried out as per the university policy.

Consideration of ethical issues is essential for the researcher to be responsible for how people are treated during the research process. This account has detailed how ethical approvals were in place as part of the EnRICH Project and were subsequently altered to better reflect this study as it progressed. There was explanation of the Belmont Principles (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1978) including respect for persons, beneficence/non-maleficence and justice and how confidentiality was contemplated. These underpinned the data collection methods.

4.6 Data collection methods

Ethnography relies on the researcher as the central instrument for collecting data. It is suggested that only this tool has the sensitivities to be able to understand meaning in interactions, engage in communication, make sense of less rational actions and elicit meaning (Hammersley and Atkinson 2007, Roper and Shapira 2000, Rodwell 1988, Hammond 2018). Observing, interviewing, recording and analysing are methods used by the researcher as the human instrument, through their attention to artefacts, environments, verbal and non-verbal communication. It is this sensitivity that leads to multiple realities being gathered and understood (Roper and Shapira 2000, Rodwell 1998). The ability to achieve this relies upon both the natural and learnt skills of the researcher. For instance, the researcher is required to manage the uncertainty that arises from ethnographic studies (Campbell and Lassiter 2015, Creswell 2012) by utilising their own creativity, flexibility and communication skills (Rodwell 1998). As noted in the justice and fairness of the power relationship presented above, researchers need the self-esteem to feel safe to give up their hold on control of their own professional position in order for genuine engagement and

shared meaning to evolve (Rodwell 1998). This use of self as the instrument will be discussed in more detail below.

Data for this study was collected between August 2015 and September 2017. The number of participants and reasons for the sampling are discussed above. In total, I carried out 108 interviews and 148 hours of observations (see Appendix 3). This could be deemed as a large amount of data collected for a focused ethnography. Hammersley and Atkinson (2007) stated that a new researcher finds it difficult to know when to move away from the setting. However, rather than concern about missing data-rich encounters, I had other drivers. I was concerned that a high level of attrition may occur when following a person over the course of a year and as a result, I would not have enough data to be confident that I had gained a full understanding of the multiple realities at work. In addition, once committed to meeting new HCAs intermittently over one year, I felt compelled to finish the data collection despite reaching saturation in some areas. It seemed morally right to do as I had said but also, how could I be sure that nothing new would arise? In reality, the majority of people approached were willing to participate in the single and multiple requests on their time. The quality of their accounts was perhaps sometimes compromised by my determination to carry out less structured interviews and the increased number of data collection periods created opportunities to redress any omissions. This will be explored in relation to interviews.

Two settings had new HCAs commence at around the same time, closely followed by a third, but data collection on the fourth area began when data had been completed on the first two and was ongoing on the third. By this time, I was starting to consider whether data collection on the fourth area was going to proceed at all and deliberating whether three settings would be sufficient for the study. Just at this point, I was informed of the start date of two new HCAs. An advantage to data collecting on the fourth area at this late time was the opportunity to gain deeper understanding through taking opportunities to check my interpretation of phenomena. For example, I had gained a good understanding of the regular actions that HCAs undertook at the start of their shift by the time I started the final setting. Therefore, when data collection commenced there, I was able to compare the HCAs actions in this environment with the other three areas, and I found that there were correlations. Confidence in my research skills and in the direction of my study also

improved my ability to funnel broad context into meaningful data collection opportunities as is appropriate for a focused ethnography; I was able to shift my focus to look for differences and unusual occurrences rather than continue to write down the actions seen previously. This provided more space to watch events unfold between HCAs and others. This focus was supported by my quicker, more confident note taking including using key words (Doody and Noonan 2013) which resulted in less time looking down at the note pad.

4.6.1 The process of observations followed immediately by an interview

Sometimes research observations are used as a way of checking that people do what they say they do (Mulhall 2003, Holloway and Wheeler 2010). However, when accessing the field for this study, informal conversations prior to data collection highlighted a possibility that HCAs may not be adept at verbally describing how they enacted their role. Thus, it was decided that a combination of observations immediately followed by an interview may address this obstacle. This two-part process placed us both in the context, I watched the participant's experiences and was then able to ask about them without delay. Minton and Batten (2020) used the same technique for a case study of nurses' experiences of caring for chronically critically ill patients in an intensive care unit in New Zealand. They found the use of observations followed by voice recorded, non-structured interviews, gave high quality data. Nevertheless, in my study, this two-part process was not applied without considering some distinctions between groups.

At the beginning of data collection, my priority was to engage with new HCAs in order to understand their experiences. The first one or two data collection periods with new HCAs was via an interview alone, without the period of observation beforehand. The reason for this decision was because participating in research was an additional burden to their new role. Being observed had the potential to cause the participant to experience embarrassment and discomfort (Allen 2010, Denscombe 2017). It was important that they didn't feel overwhelmed by pressures to meet researcher needs. It was planned that new HCAs would be interviewed during their first few weeks in order to get first impressions, uncover their expectations and start to build a relationship of trust. Although it was impactful in building trust, I soon realised that they did not have any in-depth clinical

experience at this early stage and couldn't talk about their new role. I returned approximately a month later to see how they were getting on. This longer length of time in post enabled new HCAs to draw on early insights into ward working. Based on this learning, new HCAs that were recruited later in the data collection phase had their initial interviews at approximately 12 weeks. After these initial interviews, data collection for new HCAs was in the form of a period of observation, followed immediately by an interview.

When I carried out data collection for established HCAs, they were observed and then interviewed immediately afterwards. There were two reasons for why I didn't think that they needed a stand-alone interview; first, they were more likely to have seen and spoken to me previously whilst I collected data for the EnRICH project or had been in the setting to engage with new HCAs. Second, they were more confident in their role and therefore only had the unease of being observed rather than experiencing this alongside learning their role. Generally, established HCAs appeared more comfortable with the idea of participation than some new HCAs.

As previously stated, I watched HCAs for approximately four hours. There was a natural lull in their workload mid-morning. When observing HCA Sam on A1, he asked me if we could do the interview at this time. This worked well; Sam felt he was in control of his workload and therefore more able to focus on the interview. I learnt from this request and often asked participants at around the time of the natural lull whether this would be a good opportunity to move to the interview. When it was agreed, I would quickly go to my bag in the staff area and swap my notepad and pencil for the Dictaphone. There was very little time to think about what I had seen and what I wanted to know more about. As I became more experienced, I was able to give this more thought during the observation period; for example, I would make a mental note to ask for clarification on specific interactions, the content of conversations unheard and subtle exchanges of non-verbal communication between the HCA and the RN.

Once we reached the interview room, I confirmed consent by asking whether they still agreed to participate. I asked whether they had any questions before we started. Sometimes I would be asked how long the interview would take. My response was that it

usually took about 20 minutes but I would be happy to finish the interview when they were, or "when we run out of things to say". Once, a ward sister told me that she was in agreement with being interviewed but she didn't have a lot of time. After the first ten minutes, I checked regularly whether it was alright to ask another question. She said yes and we continued until she got interrupted and I ended the interview. After the HCAs interview, we would go back to the ward and I would decipher whether it was a good time to ask the RN for an interview. This was based on whether they were occupied by a task, whether they were physically present in the bay, as opposed to in another area of the ward, and whether they responded when we arrived back in the bay. Most commonly, RNs saw our return and seemed to predict my request for an interview and were in agreement. A diagram of this process, generated from the journey of a new HCA, can be seen in Appendix 7.

The order of interviewing the HCA first and then the RN served a number of purposes. Being able to ask the HCA about their experience was vital to understanding how they enact their role. It was my priority to gather this data. I also felt that the nearer the interview was to the time of observation increased the chances that the HCA would be able to recall the events that we were to speak about. Once this primary data was collected, the interview with the RN provided an opportunity to further explore aspects that arose from the HCA interviews. The RNs often gave a different perspective or additional information that wasn't clear to me during the observation. For example, I observed an interaction between HCA Toni and RN Nikki where they discussed which of them was going to take a patients' blood pressure (field note 29.07.16). This was unusual, it was common for the HCA to undertake this task without prompting. The HCA could not explain the reason for this interaction, but the RN explained that her motivation to clarify who was responsible for the task was based on an event that happened when they worked together previously.

Sometimes observations would continue after HCA and RN the interviews. This continuation allowed me to see how events concluded. On other occasions, I would leave this setting, feeling fatigued as Allen (2010) described, and go to another to make arrangements for the next data collection period. Data collection for participants that were not HCAs or the RN they had worked on the shift with, was by interview alone and the reason for the data collection was for gathering additional information about how the HCA enacted their role.

This applied to the physiotherapist, a student nurse and the ward sister for each setting. As stated earlier, these interviews tended to be more spontaneous. Doing the interview immediately was often requested by the participant and this removed the need to make arrangements for a time in the future when they couldn't be sure about their availability.

Facets of observations with regards to its terminology, the different observer positions and how observations were applied in practice will be discussed before attention is turned to the properties and use of interviews. Prior to this, my position as outsider is portrayed.

4.6.2 Outsider position

Researchers take on a role as part of their membership with the group being studied, that of an insider or outsider (Allen 2010, Bonner and Tolhurst 2002, Holloway and Galvin 2017). An insider is someone who is part of the subculture that is being studied (Holloway and Galvin 2017, Bonner and Tolhurst 2002). This position can be beneficial in uncovering deeper insights in the setting. An insider researcher has easier access to participants because they are already part of the team. They know their colleagues and therefore rapport and trust are more likely to already be in place (Bonner and Tolhurst 2002). In addition, researchers who are insiders have familiarity with local policies, procedures and documentation (Allen 2010), they know the technical terms and abbreviations used which reduces the need to spend time finding clarification (Holloway and Galvin 2017, Bonner and Tolhurst 2002). These factors mean that insider researchers can observe and interact with participants with less disruption to activity (Allen 2010). Nevertheless, the position of insider can result in the researcher having some preconceived ideas about the phenomenon under investigation (Allen 2010). This may be accompanied by being less conscious of aspects of the setting that others may finding interesting and are less likely to check participants' meaning of terminology (Allen 2010, Bonner and Tolhurst 2002).

In contrast, being an outsider to the subculture has the advantage that the researcher doesn't know how things work around here. They can ask for clarification on any action or interaction that they have noted, some of which may have not been seen as significant to the insider (Allen 2010, Bonner and Tolhurst 2002). Making enquiries on this fundamental level relays a message to participants that the researcher has arrived with no preconceived

ideas, less bias and is not involved in ward level politics or ongoing issues (Bonner and Tolhurst 2002). Participants may feel that they can divulge their personal thoughts easier when the researcher is an outsider due to their lack of links to others within the team and the organisation (Bonner and Tolhurst 2002).

Although these positions are often presented as separate, Allen's (2010) account of her experiences as an observer implied that it was possible to move between them as data collection required. She shared how she presented her position to others, and how it was shaped as a response to the participant. With RNs, Allen (2010) showed empathy with their situation and when with HCAs, she played down her nursing registration in order to reduce the difference between their hierarchical status. My position didn't vary a lot during my time in the field, I was an outsider. In this position, I was able to observe with 'fresh eyes' the actions and interactions of HCAs as they enacted their role. I was able to look for patterns and ask for clarification for aspects of their role that they and their colleagues had taken as familiar and routine. This presentation of self was stimulated primarily by my wish to be seen as someone impartial and not a senior to HCAs, or anyone else. I wanted participants to view me as an outsider from the university who was motivated to gain an insight into the role of the HCA. I was interested in HCAs' actions and views and the perceptions of those they worked with. This reflected the description of how an outsider was less connected in the setting and had less bias than an insider, adult RN may have been. However, I did have biases. In between identifying that I wanted to look at the role of the HCA for my study and starting data collection, I read the literature. Articles were often written from the viewpoint of RNs and could be interpreted as looking 'down' on the role of the HCA, making judgements about how well they performed as their assistant. I didn't want to be linked with the sort of RN who seemed, in the main, reluctant to recognise the contribution and skill set of HCAs. Not wearing a uniform meant that my identity as a nurse and my rank within the nursing group was not on display. I hoped that this would reduce participants' pre-judgment of me and increase my opportunity to hear and see a more genuine representation of their actions and thoughts.

An additional effect of being in the position of an outsider was in relation to my clinical skills as a mental health nurse. This was exemplified when data collection started in the fourth

setting which was the double sized assessment unit, A2. Despite my growing experiences as a researcher, I found going into this area anxiety provoking. The feelings that I was experiencing were based firstly on the sheer size of the unit; I found this overwhelming. Double the number of patients, of nursing staff, and of sisters who gatekeep. This was compounded by the level of medical intervention that occurred on assessment units. Patients were more acutely unwell than on the medical units. As I walked through the main corridors, I observed patients who were dying, were very agitated, and some who were unconscious. There was often a cardiac arrest alarm going off somewhere within the vicinity. The patient acuity concerned me because it highlighted the gulf between the adult nursing skills needed here for this patient group and my own nursing skills. I was, in this instance very much an outsider, and I needed to be; I was concerned that if people knew I was a registered nurse, there may be an expectation that I would respond in a medical emergency. Although I am an experienced mental health nurse, I have limited experiences of what were regular events in this acute assessment unit.

Considering myself as an outsider in this unit also applied to my positionality as a researcher as well as a nurse. In view of the higher level of illness I observed, I was concerned that my role as a researcher may be seen by authorities as a distraction for RNs and HCAs who should be concentrating on their very sick patients. I felt that they had such an important job compared to that of a researcher and that I would be in the way should a patient deteriorate quickly; another obstacle at the bedside for staff to negotiate. However, when taking a break in the staff room of this unit, a deputy sister made polite conversation with me. When I explained the reason for my presence, she showed interested in the study. She expressed her opinion that research was important and required dedicated time. This, she believed, led to improvements in care. This made me feel more secure in my presence on the unit.

Although an outsider, it was still important to be integrated to some extent. In the adult care environment, I had noticed that the only groups that were not in Trust uniform were doctors and bed-coordinators. Where did I want to fit in this world? Ultimately, my choice of attire was based on the face I wanted to present to the clinical practice community. I saw the value in wearing my university badge that showed that I was a research fellow. This was

an immediate message that I had some official status when in the hospital grounds. I hoped that my choice of trousers, a plain t-shirt and a cardigan gave gatekeepers and participants the impression that I was trustworthy as I wanted them to share their perceptions with me. I also wanted to blend into the background when observing HCAs at work. Just as importantly, the outfits were washable, my cardigan could be easily discarded with my work bag to comply with "bare below the elbow", and my years as a mental health nurse had led me to wearing shoes in clinical areas that were covered, comfortable but suitable for running in should the need arise; some habits were hard to break. These choices were all based on meeting infection prevention standards. As much as I wanted to blend in, I also wanted to avoid creating undesired attention from senior nurses by not meeting these criteria.

My mental health nurse status had an impact on my position of outsider in relation to observations. This wasn't the only difference between my background and that of those in the study. Occasionally, terminology was also different. This included the use of the term observation.

4.6.3 Observation terminology

The term 'observation' is frequently used in the health care setting. It has many different connotations. One is as a tool used by assessors for students who are developing their clinical skills (Kogan et al 2017). There is a necessity to evidence that students are deemed as competent in practical, patient orientated aspects of their role and direct observation is the expected assessment method (Kogan et al 2017). With regards to patients, as opposed to healthcare learners, the meaning and characteristics of carrying out observation in a nursing environment is dependent on which field of practice the nursing takes place. In mental health nursing, observations are completed for checking the safety and risk of patients on the ward (Holyoake 2013). They entail nursing team members confirming the location and actions of patients at specific times during the shift, depending on the patients' level of risk (Holyoake 2013). In adult nursing, "doing the obs" describes the performance of physical measures such as pulse, temperature, respirations (Parahoo 2014 p333). The frequency of this type of observation is also carried out in accordance with the clinical need

of each patient. In research, participant observation is a data collection method which describes when a researcher observes or takes part in the activities of those under study in their naturalistic environment (DeWalt and DeWalt 2011, Delamont 2004).

4.6.4 Observations in theory

Observation allows the researcher to see the physical behaviours of participants first-hand (Creswell and Creswell 2018, Holloway and Galvin 2016). These can be understood and recorded as they occur in context and in real time (Robson and McCartan 2016, Creswell and Creswell 2018, Delamont 2004), and as such, observation can be seen as a more accurate account of peoples' actions than their verbal account provided in interviews (Oliffe 2005, Allen 2010, Holloway and Galvin 2016).

A disadvantage of observations is the Hawthorne effect which is when research participants behave differently because they are being observed (Sedgwick and Greenwood 2015). They may alter their behaviour in a way that they saw as better for answering the research question if it was known to them (Sedgwick and Greenwood 2015). More commonly, participants work harder and perform better than they usually do because they are being observed. They react to being watched because of either enjoying the attention or feeling self-conscious about their actions being scrutinised (Denscombe 2017). In their study in a mental health hospital, Oeye, Bjelland and Skorpen (2007) confirmed that participant observation was scrutiny of a participant's professional identity and needs to be considered as an ethical risk of harm. Consideration of how this could be managed would need to be included in the research design. Denscombe (2017) suggests a possible resolution is to hide that observations are being carried out by taking the position of the complete participant, but this also has ethical issues. In contrast, Mulhall (2003) proposes that the Hawthorne effect is less problematic than thought to be and that after the initial attempt to control their behaviour, most people switch their focus to concentrating on their job before long (Mulhall 2003). Holloway and Galvin (2017) advocate that there is a reduction in participant's awareness to the researcher's presence when the researcher is deeply engaged and are in the field over a long period of time and therefore alludes to the solution for this study.

As the aim of ethnography is the discovery of the meaning of everyday activities of people in their own settings, observations have the potential to reveal patterns and developments not usually seen (Holloway and Wheeler 2010, Delamont 2004). In addition, as the researcher spends more time observing, they become more immersed in the setting and develop an awareness of the tacit knowledge which can later provide a sound underpinning to the analysis and writing (DeWalt and DeWalt 2011). I chose observations to work in combination with interviews because of the richness of the data available. It fitted with my approach to gain understanding of the role of the HCA, to be immersed in their environment, to see their perspective.

4.6.5 Observer position

There is discrepancy about how research observations are defined (Savage 2000) but many authors refer to Gold (1958) who uses the level of involvement of the observer to differentiate between the types (O'Reilly 2009, Bryman 2016, Hammersley and Atkinson 2007, Allen 2010). Gold (1958) defines four types of observer: complete participant, participant as observer, observer as participant and complete observer. The complete participant describes the researcher who is fully involved in the setting and observation is hidden from participants. This form of covert research was used by Greener (2011) to explore a world of for-profit older person's residential care. His reasons for utilising this approach was to prevent the handing over of control to the 'powerful' care company group whose activities had a direct consequence for the general public. The participant as observer describes when the researcher is in the setting for another reason than purely for data collection, they already have a role there (Gold 1958). This is commonly seen in nursing environments where a RN is motivated to explore something they have been exposed to in practice (see Hales 2015, Allan, 2006). Observer as participant is the position of researchers who observe more than they participate, and the complete observer only observes and listens with no active role (Gold 1958). In a ward setting, the complete observer can watch an event unfold which would not be possible if they were in the role of complete participant (Jackson et al 2014). They can record the event and other data sooner and more accurately as a result of being overt to participants and therefore writing notes in the moment (Jackson

et al 2014). This said, it has been suggested that the position of complete observer has the same advantages and disadvantages as those of complete participant (Hammersley and Atkinson 2007). Their full integration, or absence of integration, removes the impact of their presence experienced by those researchers who use the observational positions in between as they stimulate an awareness to their presence each time they interact with participants. However, these extreme positions of complete participant or complete observer restrict the capacity to test understanding as triangulation and member checking are less possible due to their high level of involvement/remoteness (Hammersley and Atkinson 2007). The two mid points are viewed as more common positions for ethnographers to take (Hammersley and Atkinson 2007). In these positions, researchers are more able to check meaning with participants (Roberts 2009) and they avoid 'going native'; becoming so immersed in the culture that they become part of the group being studied (Robert 2009, Silverman 2013). By taking a position in between the complete participant and the complete observer, ethnographers also remove the moral dilemmas attached to deceiving groups when withholding the reasons for their presence (Hammersley and Atkinson 2007).

4.6.6 Observations in practice

A focused ethnography is more inclined to lean towards the observer rather than participant end of the continuum due to it having the benefit of being able to join and leave a setting depending on when the data collection is at its most fruitful (Higginbottom et al 2013, O'Reilly 2009). As I was already known to the staff as a research fellow, being covert as a complete participant was ruled out. The position of complete observer was also discounted on the basis that I still retained my professional status as a registered nurse and may have needed to intervene. This necessity did not arise, but I did participate in the setting in a minor way; I would help a patient with a drink, put on a blanket or pass on messages when patients requested the assistance of a 'nurse'. Complete observer and complete participant positions did not feel like a natural stance for me personally at this early stage in my research career. Observer as participant was felt to be the most comfortable and most appropriate approach for gaining rich data.

Periods of observation enable researchers to see antecedents and consequences to actions and events in the setting (Bonner and Tolhurst 2002). For this study, time spent observing participants was in four-hour episodes approximately. Allen (2010) recommends that the researcher does not exceed this period of time without good reason as field work is arduous. I discovered that this length of time allowed enough space for an event to unfold and to follow the consequences of actions but prevented depletion of concentration. As the number of data collection episodes increased, I became aware that the afternoons and evening were less beneficial times for data collection as much of the activity happened at the beginning of the day shift, so I focused on this period. This had the advantage of starting at the same time as the nursing staff and helped in following the narrative of the shift. Observations on night shift were not carried out as participants assured me that the routine was a minimised model of the day shift one with less activity.

Many morning data collection periods started in a similar way. As I made my way to the nurses' station, the ward retained the feeling of night-time: it was still and quiet and most patients were asleep. When arriving at the nurses' station, I joined the people in nursing uniforms. Those on the night shift tended to be behind the nursing station and those arriving were in front of it. I explained who I was and who I had come to observe as soon as I could catch the attention of the senior nurse. Then I spoke to all that were gathered using eye contact and a smile in the hope to demonstrate that I was warm, friendly and not a threat. People listened to what I said with a little acknowledging smile or nod, but rarely any words; I was not asked any questions at these times. They seemed to accept the information I gave and then swiftly switched back to their handover.

As the handover ensued, I looked to see the HCAs names and who they were paired with on the white board on the opposite wall. I was sometimes in time to see other nursing staff arrive and they glanced discreetly at the board. No comments were made about information on the board. However, a HCA commented in an interview that followed observations, that she was sometimes upset that she was in a "heavy" bay again whereas other HCAs didn't go into those bays. "Heavy" refers to the workload; the two middle bays out of four had the most unwell patients, many needed two people to reposition them every two or four hours. There were also patients who at times needed to be closely monitored, such as those who

didn't want to stay in bed. My understanding was that, for consistency, staff were often placed in the same bay as they had been on the previous day if their shifts were back-to-back. This was the 'understood' reason for the continual placement in these two bays rather than another HCA being given preferential treatment. However, I did not challenge her as I couldn't be certain that this didn't happen. She told me that she had raised it with the ward sister. I decided that it was my responsibility as a researcher to record the comment as part of data collection, and the responsibility of the sister to provide justification to the HCA.

Most of the HCAs I had gone to observe didn't acknowledge me at the nurses' station or in the huddle. I would follow the HCA to the bay and then ask for consent for me to stay and observe them. Then I introduced myself to the RN, gave them the consent form and information sheet and a verbal report of the reason for my presence, and asked for their permission to stay, which they granted. As previously stated, patients were informed of my reason for being in attendance when they had seen me. When I explained my role to them, I assured them that I would not be collecting data about them, that I was there to observe the HCA.

During the observations I stood or sat at the periphery of the bay and each time a HCA or their colleague spoke or carried out an action, I made an entry in my small note pad. My aim was to accurately record their vocabulary. This notetaking can be unsettling and cause reactivity from people (Holloway and Wheeler 2010, Robson and McCartan 2016). I noticed that sometimes, after I had spoken to HCA and RN in the bay, they would disappear from view for a few minutes, and I suspected that this was to discuss how they felt about me being there. I viewed that this as a natural human response, by discussing my presence, they were creating a sense of security between them. Although it is important to reassure people that I am not a "spy for the organisation" (Holloway and Galvin 2016 p114), as these questions were not asked of me, I relied on the HCA to explain and reassure the RN and others. On their return, nothing was said, and the shift work began. I took reassurance from the absence of questioning and the resuming of work. It signified that they were content to allow me to stay and not challenge my presence. Over time, participants were less concerned about my observations and note taking and they became accustomed to my presence (Robson and McCartan 2016, Holloway and Galvin 2016). As I was collecting data

from a number of participants on the same ward, I tried where I could, to return to the setting the same week to meet with another participant. For example, after I had spent a session with one HCA, I was physically there to arrange to data collect with a person who was on duty the following day. I gave them the information sheet and consent form and verbal details of the study. This next person may have been another HCA, a student nurse or the ward sister. There were two advantages to working in this way. Firstly, carrying out data collection on days close together led to me feel more immersed in the ward culture and secondly, participants appeared less aware of my presence which possibly reduced the Hawthorne effect.

As mentioned before, the decision to stop the episode of observations to move on to the interview was based on where natural breaks fell in the care delivery. This minimised interruption to the daily routine but still captured narratives about experiences near to the time when they happened. It also increased the likelihood that participants would agree and be relaxed enough to engage with the process.

There are two ways of recording observations when in the setting; structured with specific questions for systematic data collection and unstructured where notes are made of naturally occurring phenomena (Jackson et al 2014, Robson and McCartan 2016). No predisposed structure or codes were used in my study in order to ensure that I was open to new ways of interpreting phenomena. I endeavoured to write what I saw or heard as accurately as possible and didn't include my own thoughts or feelings whilst in the setting. This led to data generation rather than personal responses (Allen 2010). To capture the essence of observations as fully as possible, all field notes were typed in full within 24 hours of data collection. This short time scale was to support the quality of the data collected; I added more detail to parts where notes could not be written in full whilst it was memorable (Allen 2010). I added a column to the transcription where I could include my responses or other information including facial expressions and body language. However, recording my responses in this column wasn't fully utilised. Instead, in line with early analysis, I preferred to write memos which provided opportunities for deeper exploration of one episode of observation alongside other data.

As finding a viewpoint within the setting is recommended by Hammersley and Atkinson (2007), observations were narrowed to the actions of the specified HCA. This was key to this recording process as wards were full of activity. General experiences of the culture were absorbed when the HCAs were giving personal care in side-rooms; while I had access to this area, it felt to be an imposition on the patient's privacy and had an impact on the space available for the HCA to manoeuvre. Therefore, rather than following them into the small space, I generally stayed at the entrance of the bay. Although this may have resulted in missing data, there was also an advantage that this way, I found myself privy to other events on the ward such as how the doctor's round progressed, the housekeeper's contribution in the bay and the difference between their role and that of the domestic. This added to overall understanding of how an adult ward functioned and how the HCAs role fitted within it.

There were occasions when observations didn't go as planned. Once, I arrived on the ward and waited at the nursing station for the shift to commence and noticed that the HCA I had arranged to meet had not arrived. As I did not feel it was professional to interrupt, I waited for the huddle to finish before I asked where the HCA was. Discovering that she was sick, I hurried to another ward on the chance that another new HCA participant would be working and willing to participate at such short notice. I missed handover on this ward which meant I had less context for some of the actions of the HCA, but the new HCA agreed, and I did capture some data.

Another occasion when observations didn't go to plan highlighted how HCAs were moved around the hospital without notice. I arrived one afternoon to follow HCA Susan. The HCA and the RN were working through documentation because a patient was deceased when they arrived on the shift. This exchanging of information and learning from the RN to the HCA I found challenging. I was confused as to how it was aiding my understanding of how HCAs enacted their role. Just then, the HCA was asked by the ward sister to go to another department to provide support in a clinic. Although this did not fit with the bay-based working that I was finding to be the focus of the ethnography, the HCA was in agreement that I could continue my data collection in the alternative environment. I was able to observe her as she entered another setting and worked out what her role was there. She

was not paired with a RN but instead reported to a senior nurse. It was not impactful in my data analysis but did provide insights into the work of the HCA.

Following the observation, HCAs were invited to be interviewed immediately afterwards. This process allowed a participant to talk about what had happened. Presentation of the theory of interviews is given before the details of how these were used in this study are reported.

4.6.7 Interviews

Interviews offer an opportunity for research participants to use their own vocabulary to express their thoughts, ideas and memories of the phenomenon under study (Oliffe 2005, Holloway and Wheeler 2010). This leads to exploration of subjective meaning and interpretation across a whole group, which in turn provides multiple cultural perspectives for the researcher to engage with (Oliffe 2005). There are seen to be three types of interviews for qualitative data collection; structured, semi-structured and unstructured (Smith and Osborn 2012, Parahoo 2014, Denscombe 2007). Structured interviews have predetermined questions which are not altered in content or order (Parahoo 2014, Holloway and Wheeler 2010). This set structure has the advantage that the data can be analysed statistically (Smith and Osborn 2012, Denscombe 2007). The interviewer has control over how the interview proceeds, will ensure that the format remains the same for all interviews, and the interviewer will have minimum influence over responses (Smith and Osborn 2012). This style of interviewing is often used in quantitative studies and was not complementary to the ethnographic approach that I had identified as right for my study. The rigid structure would restrict the opportunity for wide and deep exploration of the HCA role and remove the prospect of the interviewee to share something that is important to them (Smith and Osborn 2012).

With a semi-structured interview, the researcher will have questions on a guide, but the interview will be steered by the guide rather than led by it (Smith and Osborn 2012, Robson and McCartan 2016, Charmaz 2014). This style of interviewing provides various opportunities; to establish a rapport with the interviewee, to re-order the questions in

response to answers and to ask further questions to explore interesting areas (Smith and Osborn 2012, Holloway and Wheeler 2010). Providing wide opportunity for the interviewee to speak freely gives the notion that they are the "experiential expert" (Smith and Osborn 2012 p59) which is in accordance with a constructivist approach. In comparison with structured interviews, the disadvantages of semi-structured interviews are that the researcher has less control over the data collected, they take a longer time to carry out and they are more difficult to analyse (Creswell and Creswell 2018, Denscombe 2007).

The unstructured interview is an informal interaction initiated by the interviewer asking an initial question and then allowing the participant to speak freely (Denscombe 2007, Robson and McCartan 2016, Doody and Noonan 2013). This openness allows the form of the interview to meet the needs of the participant and in doing so, generate trust that will allow the participant to express their thoughts and feelings about the phenomena (Parahoo 2014). This style can be seen as emancipatory, and therefore a possible choice for the study of HCAs. However, this is viewed as a weakness of the method; the more unstructured the interview, the more that researcher biases are difficult to rule out (Robson and McCartan 2016). The sentence structure of prompts, the direction of the interview and the vocabulary chosen in the immediacy of the situation are less controlled or consistent than in a semi-structured situation (Robson and McCartan 2016).

In light of remaining open to asking what is going on here, I did not feel that the creation of an interview guide, as expected of a semi-structured interview, was in accordance with being guided by the participants. Alternatively, the definition of an unstructured interview, having one opening question, also did not fit with the data collection process. The combination of observation followed immediately by an interview was selected in order that verbal responses could be elicited from the physical acts that had been seen. Therefore, the interviews included questions that had arisen from observations rather than from an interview schedule. Later in data collection, I also used some time during the interview for member checking. When it felt appropriate to the discussion, I asked HCAs and others to talk about phenomena that was evolving from the analysis. Minton and Batten (2020) classed their interviews as unstructured but used the same process of carrying out observations first which prompted the questions for participants. This corresponded with

Holloway and Galvin's (2017) statement that the term 'unstructured' was misleading as this style of interviewing was often complimented by an agenda, a list of topics or an aide memoire. Consequently, whether interviews were classed as semi-structured or unstructured, there was a high dross rate; not all data collected via observations was useful for the study (Holloway and Galvin (2017).

4.6.8 Interviews in practice

As a new researcher, I followed recommendations for how an interview should be carried out. Firstly, it is proposed that only one person is interviewed at a time (Denscombe 2014). The advantages are for the researcher; you can control who is speaking, capture one person's thoughts resulting in a simpler transcription (Denscombe 2014, Creswell and Creswell 2018). The venue should be where the interviewee feels most at ease and with minimum interruption (Rodwell 1998). I endeavoured to meet these recommendations.

Basic interviewer techniques were used including asking one question at a time in an easy to understand format, I listened more than I spoke, I kept opinions which may influence answers in check and was aware that I needed to appear interested (Robson and McCartan 2016, Doody and Noonan 2013). I then used open-ended questions and asked about thoughts and feelings (Denscombe 2017). This was useful in encouraging HCAs and other team members to engage with their experiences. However, as stated by Robson and McCartan (2016) there was little control or consistency over the content of the interviews. Every interview was unique, and some had a lack of meaningful content. Most significantly, insights into my biases and missed opportunities to elicit more understanding mostly came retrospectively when engaging in the transcribing of recordings that followed. I used these insights to improve my technique in further interviews. I was also able to see that the interview was not on course during it as well as afterwards. On one occasion, in the middle of an interview, I was distracted from my role as researcher and instead assumed that of a mental health nurse. A HCA was explaining her personal insecurities and how she was managing them in her new job. I was interested in the HCAs' coping strategies and wanted to offer advice. Then, I realised my diversion and refocused our discussion back to the events of the shift.

The ability to listen to the participant at the same time as think about the next question was a skill I didn't possess. I prioritised engagement with the participant's verbal and non-verbal communication and to probe for more depth for understanding as Doody and Noonan (2013) recommend. Then, I paused after the participant had finished speaking and this allowed me to consider what had been said and then compose the next question. Rather than this being an uncomfortable silence, these pauses appeared to contribute to a less formal, shared-knowledge environment. Denscombe (2017) promotes the value of silences and advises tolerance of them rather than restarting discussion immediately. However, in this experience, it was the participant that was tolerating the silence rather than it being used as a tool to encourage further disclosure.

Rodwell (1998) advocated that the venue of the interview should be where the interviewee felt most at ease and where interruption would be minimal. Unlike this recommendation, no interview took place away from the hospital environment and although choices of venues were given to interviewees, rooms were limited. Interviews most frequently took place in the relatives' room on the ward. Sometimes interviews occurred in the bay of the ward beside the patients, in storerooms and on lunch breaks in hospital cafes. Interviews were voice recorded, often with the voice recorder balancing on the arm of a chair. It was usually necessary to close the window in the room to reduce background noise of traffic and building work. Interviews were often interrupted. I stopped recording when this occurred to ensure confidentiality of the information exchange between the interviewee and the person interrupting. Once the other person had left, I restarted the recording and refocused on the subject we were discussing. If we were interrupted for a second time, I ended the interview; the work of the ward needed to take priority over data collection.

Over time, it was noted that participant's utilisation of interviews changed. In the first interview, people were nervous and appeared to want to say the right thing. In response, I was attentive by actively listening and being sensitive to the feelings of the participant (Denscombe 2017). I assured them that there were no correct answers, and the data would be anonymised, as this knowledge helps to build trust (Holloway and Galvin 2017). By the second interview, participants seemed more at ease and several were pleased to see me. Engagement and trust were being established. Some used this interview as an opportunity

to share experiences that had troubled them. Oeye et al (2007) also found that patients in the mental health hospital wanted opportunities to be listened to and to "explain their misery" (p2303). New HCA shared their feelings about how the role was different to what they were expecting, or how colleagues had treated them as a supernumerary team member. They were guiding the research to topics that were important to them (Holloway and Galvin 2017). In subsequent interviews, there was evidence of the sharing of ideas within a relationship as described by Holloway and Galvin (2017). HCAs appeared to be more empowered to speak freely, make connections and required less prompts to speak. The interviews had more flow.

It was clear that participants grew in confidence, felt more secure and were more skilled at reflection over the course of data collection. Crang and Cook (2007) describe these positive outcomes as facets of 'serial interviewing'; where a richness and depth of thoughts is brought to the fore by exploration of the phenomena within an informal interview. Increasing the number of single interviews does not generate the same level of data as serial interviewing, where participants can feel more able to disclose more contradictory or unclear thoughts because of the generation of trust over time (Crang and Cook 2007). Although my experience of serial interviewing of HCAs did match the description given by Crang and Cook (2007), there were also people that were interviewed only once who still took the opportunity to express strong feelings. Across the spectrum of RNs, HCAs and others, there were participants who used the interview as an opportunity to share their thoughts with the reason of wanting to have a voice or instigate change. Oeye et al (2007) remarked on this role of the researcher as mediator. This was particularly clear when a HCA asked me if I would return the subsequent day to carry out an interview that should have followed the observations but was cancelled by the ward sister because of work pressures. On my arrival the next day, the HCA met me at the door of the ward and asked me to accompany her to the storeroom. Here, she sat on the hard floor, surrounded by boxes, for over half an hour and proceeded to tell me on tape about how she felt about the extensive pressures on her role. Her reflections were explicit and emotional, she told me she wanted someone to know the truth. I felt honoured when people made space to provide me with insights in to their working life but also felt responsible for ensuring that the Belmont Principles (National Commission for the Protection of Human Subjects of Biomedical and

Behavioral Research 1978) were attended to and that when I told their story it was with the validity, relevance and respect that they deserved.

4.6.9 Transferable skills - Data collection and the skills of the mental health nurse

As previously stated, I was in an unusual position of being a mental health nurse who was spending hours of time in an adult nursing environment. Although I was confident in my role as a mental health nurse, this is what made me different to those around me. In the ward environments, I was both new to research and in territory that was not my own. To enhance my self-confidence when preparing to carry out data collection, I told myself I at least had some transferrable skills in paying attention to people's speech and behaviours. However, this was not a connection that was explicit in the literature. It was not possible to locate research studies that explored similarities or differences between the skills of a researcher and those of a mental health nurse even though there were comparisons to be found. Before looking at the skills of a mental health nurse specifically, the findings of Savage (2000) provide a basis for exploration.

Savage (2000) compared the researcher's role with that of a RN in an adult nurse setting to investigate whether observations could be classed as a methodology rather than a method. Both RNs and researchers spend time in the setting with the patient/participants to acquire experiential understanding of the patient/phenomena. Savage (2000) suggests that the practical activities of RNs are founded upon their epistemological beliefs about 'what is nursing knowledge' in the same vein as researchers ask the epistemological question about what it means to know from their perspective (Savage 2000). It is from this set of beliefs that RNs and 'participative' observers (those who utilise all of their senses), gather sensory data to generate the knowledge that they need to achieve their goal (Savage 2000). This knowledge of the patient, or the phenomena, allows development of empathy, as well as somatology for the RN (a study of caring for the body). Savage (2000) illustrates that there are similarities in the skills and processes used in nursing and research, but her examples ground her research in the adult nursing field.

4.6.9.1 Self as a research tool in mental health nursing

When imparting knowledge on the content of mental health assessment, Warne, McAndrew and Jones (2017) explained how mental health nurses bring their values, beliefs and pre-conceived ideas to the assessment process. These same personal characteristics are known to have an impact on the research study (see methodology chapter). In addition to the intrinsic aspects of the person, Warne, McAndrew and Jones (2017) recognise that each individual assessment may also be affected by contextual factors in the form of anticipation, probability and predictability. The significance of these influences on the assessment will depend on the mental health nurse's previous experiences, the assessment circumstances and the expected or desired conclusion. In research, the impact that personal beliefs have on the study and the expectations of how these should be addressed have been extensively explored under the subject of reflexivity however, they do not specifically attend to contextual factors that influence individual episodes of data collection. In mental health assessment, Warne, McAndrew and Jones (2017) suggest that a rebalance of these influences is through the use of Roger's (1951) three core conditions; accurate empathy, when there is an authentic appreciation of another person's perspective; unconditional positive regard, when a person listens without interruption, judgement or giving advice; and congruence, when a person is genuine in their attendance without using their professional identity to hide behind. Roger's (1951) core conditions could be viewed as incorporating aspects of the 'Respect for Persons' Belmont Principle (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1978). Therefore, both researchers and mental health nurses use the self as a tool to gain understanding from the participant/patient. For both, it seems vital that the 'self' knows what constitutes the tool, as the more control they have over the tool, the less the knowledge extracted from the other person is tainted by their biases. This is necessary if they are to gain an understanding of the world of the participant/patient.

4.6.9.2 Observations, interviews and mental health skills

Observations and interviews are associated with the use of the self as a tool in mental health nursing and in research. Where 'doing the obs' (Holyoake 2013) in mental health does not transfer to the researcher environment, the utilisation of observational skills are more akin to data collection. Mental health nurses need the skills to observe a patient's

behaviour and draw upon this information to make an assessment of their mental well-being (Fallon and G 2017). The observations inform the text entered on to the assessment documentation by the nurse (Warne, Mc Andrew and Jones 2017). When I carried out observations for this study, I felt that I was utilising my experiences as a mental health nurse in looking at peoples' actions and reactions in a setting. When it came to recording them as text, this was a new experience. Making field notes caused tension as I wanted to record data accurately, but this meant looking down to write, resulting in the possibility of missing further actions and reactions. The more observations I did, the more I was familiar with the ward routine. This resulted in less time with my eyes looking down writing about that, and more availability to concentrate on the smaller details such as body language and facial expressions. These were recollected from memory when transcribing field notes and were of importance due to how the body language and facial expressions often reflected the ambience of the shift.

In interviewing patients, the verbal and non-verbal skills of the mental health nurse are paramount if a good assessment is to be made (Lyon 2017). Lyon (2017) describes non-verbal communication as "far from simple" (p99) as mental health nurses look for messages expressed through non-verbal communication. A mental health nurse will use reassuring gestures such as head nodding, mirroring body movement and facial expression to convey interest, show sensitivity and encourage a person to continue to speak without having to interrupt them (Lyon 2017). I was able to employ these familiar skills in my newer role as a researcher. I also used opportunities to summarise and check understanding (Lyon 2017) which I found to be useful however, I was not able to fully meet the advice given to mental health nurses to ask 'good' questions. Lyon (2017) states that it is these good questions that help the interviewee to focus their thoughts, express their feelings and share circumstances and stay with a subject for longer. Some early interviews that I carried out were short and had very little analytical value. When HCAs did not know what to say, prompts about the routine of their work or their ward induction was used to start, or restart, dialogue. For instance, I attempted to re-engage HCAs by asking their feelings about completing the Care Certificate (Skills for Care and Skills for Health 2013a). This was chosen as the prompt for two reasons; for the interviewee, I presumed that it was an area that they had knowledge of but would not be particularly emotive or cause distress; for myself, it was a new document

and I was curious as to how its implementation was impacting on their ward work. As the data collection progressed and data analysis was underway, I replaced this fall-back question with more open exploration. The preceding period of observation to the interview often prompted thoughts or confirmed links with what I was seeing in early analysis. In the interview that followed this period of observation, I could ask their thoughts on my understanding. This stimulated discussion and clarity or generated further perceptions from the participant on the subject.

It can be concluded that mental health nurses and researchers do use the same skills in observations and interviews, as do the general public in their everyday lives (Warne, Mc Andrew and Jones 2017, DeWalt and DeWalt 2011). Both methods require attention to detail through listening, encouraging further exploration, being non-judgemental and creating accurate recordings that are as close to the person's account as possible. The difference between a person's everyday observations of life events and that of the researcher is the systematic recording, in the form of field notes, and the social scientific analysis (DeWalt and DeWalt 2011) and for the mental health nurse recording in the form of assessment documentation and care planning (Warne, Mc Andrew and Jones 2017). The difference between mental health nursing skills and researchers' skills is not their application, but the driver for using them. Mental health nurses aim to understand a person's experience in order to be able to help the specific individual. In research, the motivation to understand a person's experience is for wider comprehension of phenomenon and beneficence.

4.7 Data analysis process

Consistent with Hammersley and Atkinson (2007), analysis for this study did begin before the field work commenced; questions were asked about the actions of HCAs before the aims and objectives were formulated for the study. The more formal analysis was carried out in between episodes and after data collection. Starting with writing up field notes from observations and transcribing the interviews, I became familiar with the content (Hammersley and Atkinson 2007). It was difficult to find a formula in the research texts for how to analyse data within a focused ethnographic approach. This may be due to analysis

not being a distinct, separate part of the research journey (Hammersley and Atkinson 2007, Crang and Cook 2007). With no clear structure, there was a great deal of learning with regards to technique.

4.7.1 Early analysis

Early data collected was subjected to a novice style of categorisation and insights were minor. I had data from three episodes of data collection for two new HCAs both working on the same medical ward. I worked through paper prints of the relatively small amount of field notes and transcriptions highlighting any activity and labelled it in accordance with what was happening: there were 46 recorded events. Next, I noted patterns, contradictions, the common-sense explanation and participants' use of terminology (Hammersley and Atkinson 2007, Charmaz 2014). These were early attempts at generating categories by asking 'what is going on here?'. I could see that there was something about HCAs 'connecting' as an early concept. For each event identified, I drew a basic mind-map.

A mind-map is a diagram where ideas and concepts are drawn around a central key word or idea (Burgess-Allen and Owen-Smith 2010). Although my mind-maps were created from interview transcripts and field notes, they can be written during data collection, as Burgess-Allen and Owen-Smith (2010) show in capturing data during a focus group. The advantage of the immediate creation in of a map in a focus groups was that participants had ownership of process and the 'what' questions were answered (Burgess-Allen and Owen-Smith 2010). Disadvantages were that they didn't answer the 'why' questions and there was no time for reflection (Burgess-Allen and Owen-Smith 2010). My use of mind-maps were away from the study setting. It was used to capture key themes and provoke some opening thoughts in a small way, as a starting point. I was able to reflect on what happened or was said, why it happened or was said, and have some first thoughts about what it meant. For each event, in a mind-map I was able to place 'connecting' as a central key word and consider; how the event portrayed connecting, how effective the connecting was, why it demonstrated connecting, and what this meant about connecting. Figure 1 is an example of a manual mind-map.

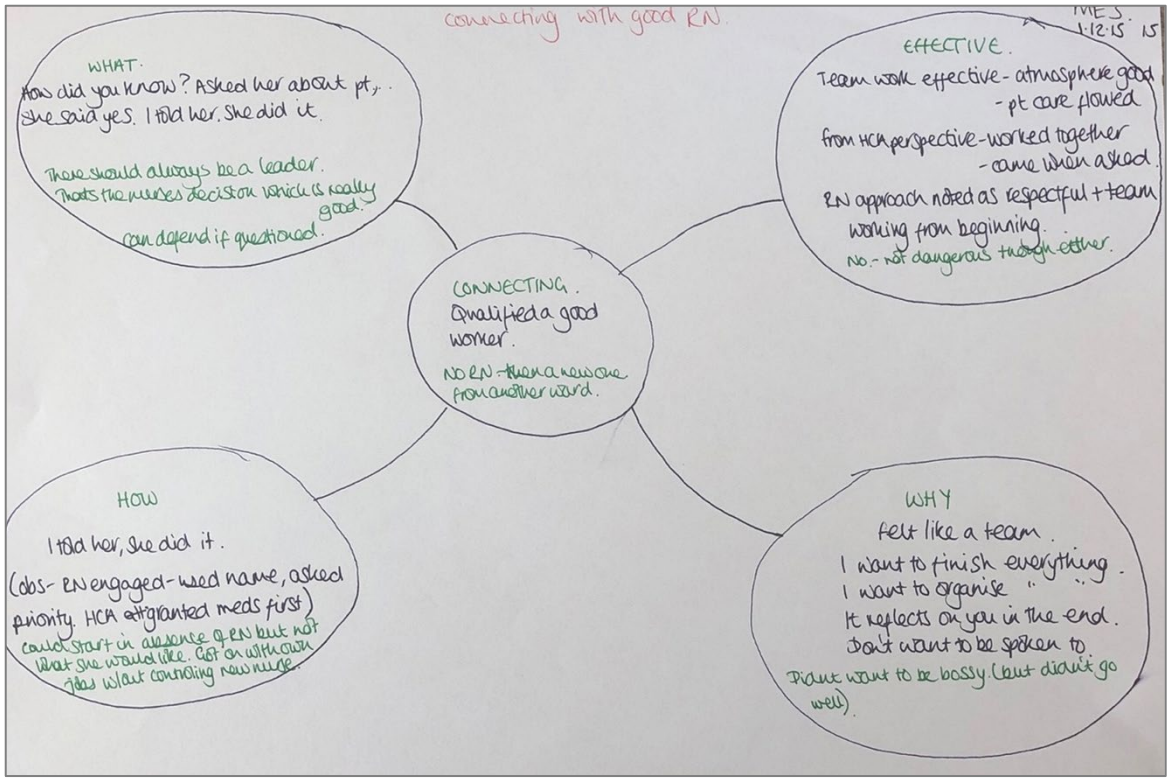
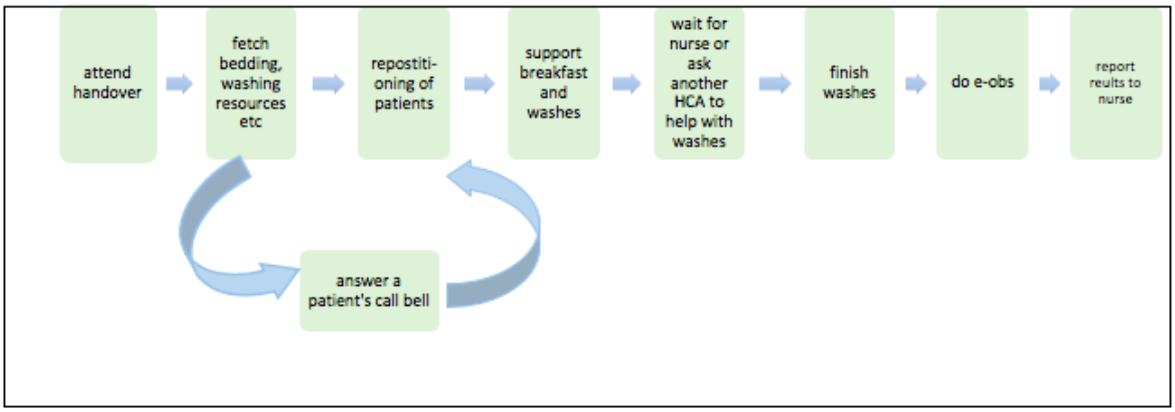


Figure 1 - early mind-map

Each paper mind-map was placed next to others to compare for contrasts and similarities. Very early ideas of categories were created using this data with the headings connecting to the culture; connecting to care; connecting patients with nurses; and connecting with others which included the multidisciplinary team, relatives and the patient's journey.

From analysing the observations, I was able to describe the daily routine of the HCA and had noted that, should they deviate from this, they would return as soon as they could (Figure 2). This first level understanding became a significant part of the final subtheme Routine Scaffolding.



Taking these 'familiar' understandings (what we assume is happening, surface level views) was preparation for delving deeper to look for the 'strange' (idiosyncrasies not previously captured in literature) and fits with studies based on anthropological traditions (Hammersley and Atkinson 2007). It allows progression from description to explanation to take place (Hammersley and Atkinson 2007, Crang and Cook 2007). This basic start gave me experience of analysing which I was able to build on and improve as data collection continued.

4.7.2 Using qualitative data analysis software

As the quantity of data increased, the use of computer assisted qualitative data analysis software (CAQDAS) package was considered and the electronic system NVivo 10 was employed. St John and Johnson (2000) provide a summary of the advantages and disadvantages of using CAQDAS rather than manual data coding and analysis. An advantage is the convenience and efficiency of using the computer to handle the text in a word processing way; cutting and pasting, marking segments to indicate sections, filing, searching for text. CAQDAS has the ability to hold a vast volume of text, pictures and sounds, which increases the amount of data that qualitative researchers can handle in comparison with a manual approach (St John and Johnson 2000). This has positive environmental and storage factors as it is not necessary to have multiple paper copies printed. With the increased volume of data, CAQDAS also has the capacity for large numbers of codes which can be merged, deleted, developed and moved as data analysis progresses (St John and Johnson 2000). In analysis, CAQDAS can be used to search for specific quotes and link ideas by creating and storing memos on the same software (St John and Johnson 2000). As for

sharing analysis, there is scope for multiple researchers to work on the data as well as utilising the graphical technology to present the analysis to wider audiences (Rademaker et al 2012, St John and Johnson 2000). It is the capacity to share data through an audit trail, that demonstrates the validity and rigour included in the analysis process. Due to the strength of holding large amounts of data in one place, examination can be more systematic and complete, and decisions are more visible to others. This combination of an audit trail and a systematic approach can prevent researchers from giving preference to findings that fit their own assumptions and world views (St John and Johnson 2000).

St John and Johnson (2000), Cope 2014 and Rademaker et al (2012) all report that there is a limited amount of research on the effectiveness of CAQDAS, particularly in the way of comparison with manual coding and analysis. This said, there is agreement in concern that using CAQDAS can distract researchers from gaining a real depth of understanding. This is because attention is given over to managing the system rather than the engagement with the data. For example, St John and Johnson (2000) recognised that using computer technology can lead to codes becoming objects, controlled by researchers as they are removed away from their context. The larger amount of data that can be handled can lead to breadth rather than depth and the loss of thick description. However, St John and Johnson (2000) argue that, regardless of whether CAQDAS is used or not, qualitative researchers participate in data reduction. There is concern that there are pressures put on researchers to comply with the use of CAQDAS, particularly in research proposals which could be compared to quantitative studies which utilise SPSS (St John and Johnson 2000) and choosing to use CAQDAS means spending time learning how to use it (St John and Johnson 2000, Cope 2014, Rademaker et al 2012).

When deciding to use NVivo 10, I had no previous experience of data software packages and this one was chosen because it was preferred by the university for qualitative data. The university provided teaching sessions on its use which I attended just prior to commencing data collection in March 2015. I gained an insight into the functions of the CAQDAS and some understanding of how to use it. When it came to its application months later, I had gaps in my knowledge. With the assistance of YouTube videos, O'Neill's (2013) NVivo toolkit and Bazeley's (2007) book I was able to carry out the basic functions and set it up to

compare data across groups; new HCAs and established HCAs, HCAs on different wards etc. However, this was not an easy process, as St John and Johnson (2000) stated, sleepless nights were the result of "encountering computer-induced emotional and time consuming trauma" (p396) until I realised that I could use NVivo10 as a container primarily, and work the rest out from that point. Importing transcriptions was easy and searching texts was useful. The ability to code text in more than one 'container' was helpful until I gained confidence in my categories and their meaning. As promoted by Rademaker et al (2012), a benefit of using CAQDAS was being able to reorganise data quickly without losing previous work.

Codes, known as nodes in NVivo, were produced from in-vivo comments (the words of the participant) such as 'gelling' and 'filling a gap'; from my own words to summarise the data, for example 'interpreting situations'; and from the sensitising concepts from the EnRICH Project as in 'purpose' and 'security'. These reflected resemblances between the handwritten mind-maps of HCAs connecting to the culture and the Senses (Nolan et al 2006). The Senses Framework (Nolan et al 2006) suggests that in a care setting, an 'enriched environment' is one where patients, family carers, health care staff and students experience the six Senses: security, belonging, continuity, purpose, achievement and significance. Each of the Senses was created as a parent node and subsequent sub-divisions, known as child nodes, helped to differentiate how the code was applied. For instance, a Sense of Purpose was used for a myriad of reasons. It was possible to sub-divide these reasons in to three child nodes; how the Sense of Purpose was created by the HCA for others, how the Sense of Purpose was created for themselves and how others created the Sense of Purpose for the HCA. Using the Senses encouraged thinking about what people experienced in the ward culture rather than simply gathering all data on a single subject area together for instance, all responses that refer to the HCAs' relationship with the RN. Some data about the relationship with the HCA was coded under Achievement and some under Belonging as well as Purpose, therefore thoughts about the content of what was being said became the focus. Where none of the Senses were appropriate, a new descriptive or in-vivo node was created; "interpreting situations", "filling a gap". There was also the node OTHER for any data that did not appear to be relevant to the research question.

A screenshot of data analysis using NVivo 10 can be seen below in Figure 3. The text in the middle of the figure is part of an interview transcription. Some of the text is highlighted. This text has been designated to a node. The parent nodes and child nodes are listed in the column to the left of the main transcription. The column to the right of the transcription indicates which code/node the text was coded to shown as a coloured bar.

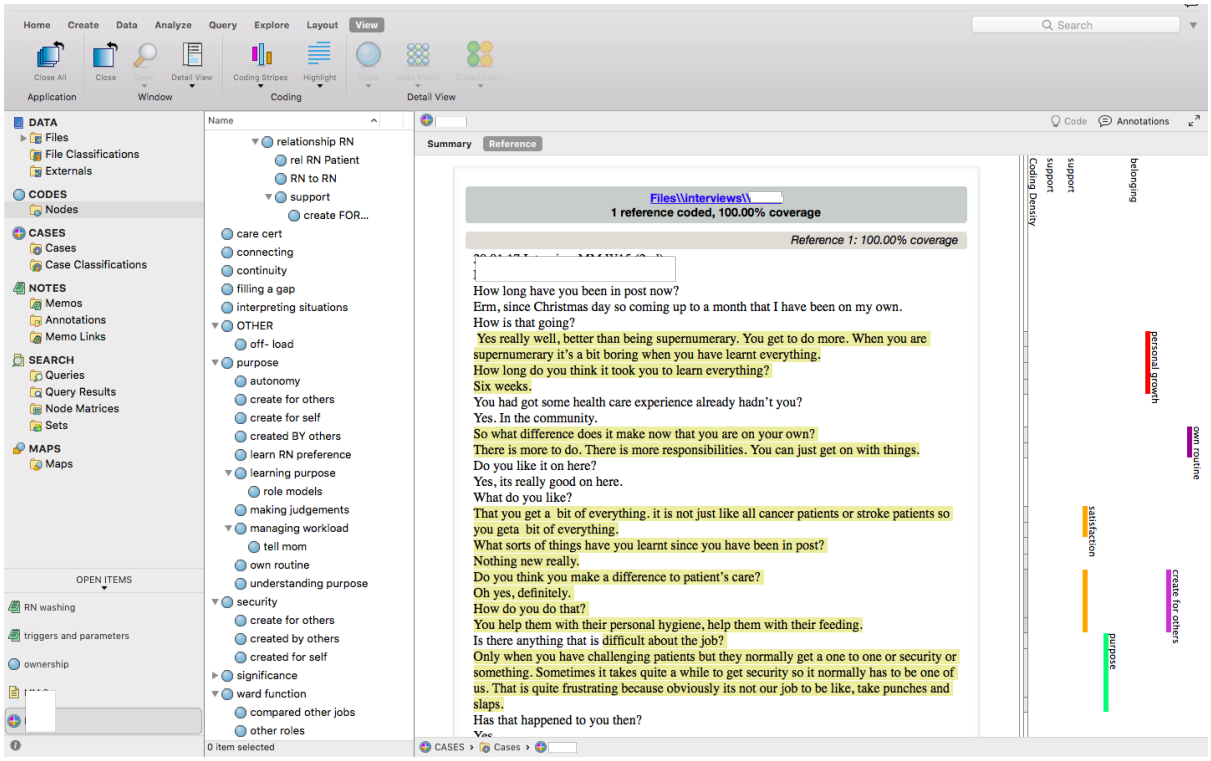


Figure 3 - screen shot of NVIVO 10

It is recommended that researchers use a code book to list and define codes which can be altered as understanding progresses (Tracy 2013). In NVivo, the nodes are listed on the left-hand side of the screen and many of them were self-explanatory. As there were no other researchers included in this study, it was not necessary to write a description of nodes where the meaning was obvious. However, there is a mechanism for attaching a description as a reminder of what I meant when I created it. For example, 'Ward Function' had an explanation attached stating that it was for contextual data, for example, the list of diagnoses that the ward covered given by a participant. There was also the possibility to write and attach memos to nodes.

4.7.3 Memos

Analytical memos are informal fragments of free writing which help researchers to make sense of the data and work out the narrative. Charmaz (2014) recommends keeping a methodological journal to document decisions and puzzles and somewhere to question assumptions. I used a notebook where I scribbled notes about my thoughts when transcribing and these later became the basis for memos where time was given to more thoughtful exploration. Memos were written to capture connections between my observations in the field and interview statements or between data sets; different HCAs, the same HCA at different times, commonalities and differences of HCAs on different wards. Using NVivo to write and store memos enabled me to link the thoughts and data in one electronic programme. It was then possible to carry out a search for memos as well as data or view all memos together to consider connections between them. Figure 4 shows a memo in NVivo. Not all memos were captured as I sifted through the data. Some memos were written 'on the hoof' as a thought entered my mind, often when getting out of bed in the morning. The benefit of memos was that I could go back, revisit and add to them. Therefore, their content could be challenged with regards to preconceived ideas and also expanded as my understanding of multiple realities developed (Charmaz 2014). It was the accumulation of memos which helped me to transition from coding to writing (Tracy 2013).

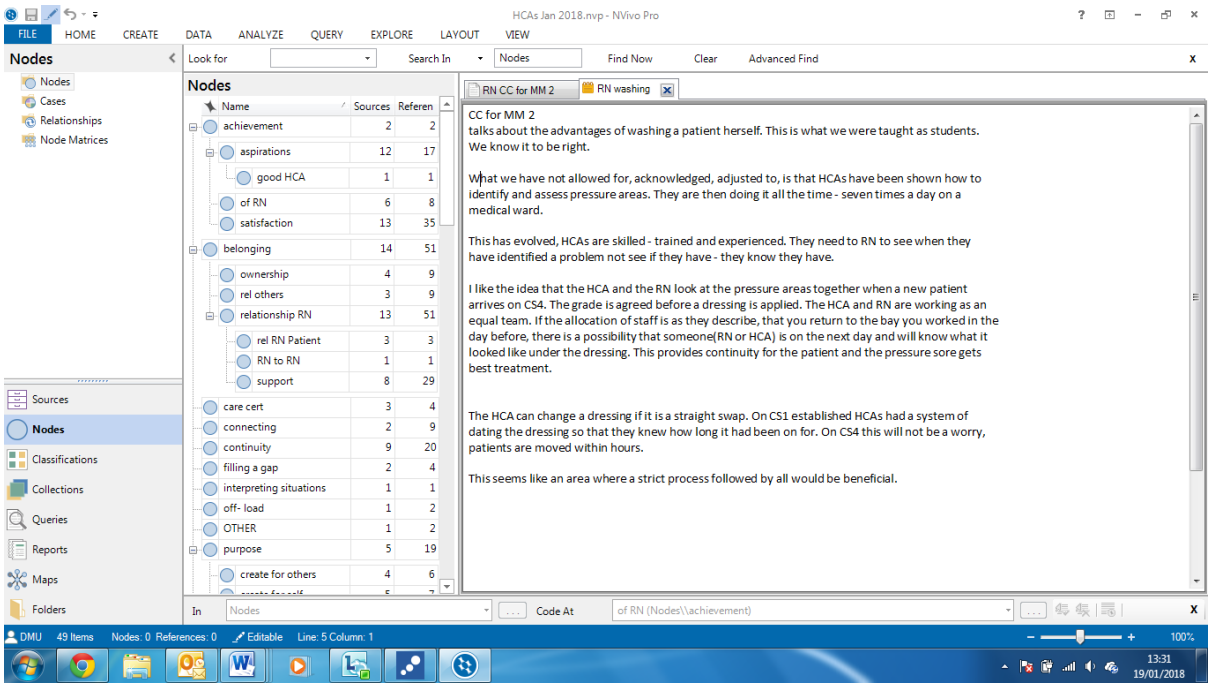


Figure 4 - Memo 18.01.18

To be able to share my early analysis at my annual review, I transferred key findings from codes/nodes on NVivo 10 to MindGenious, a mind-mapping programme. This had a clearer presentation than NVivo 10 and was convertible to PowerPoint. I could show categories reflected the different elements of what and how HCAs carried out their role by using different colour text, this can be seen in Figure 5. At this point, it was appropriate to move on to focused analysis.

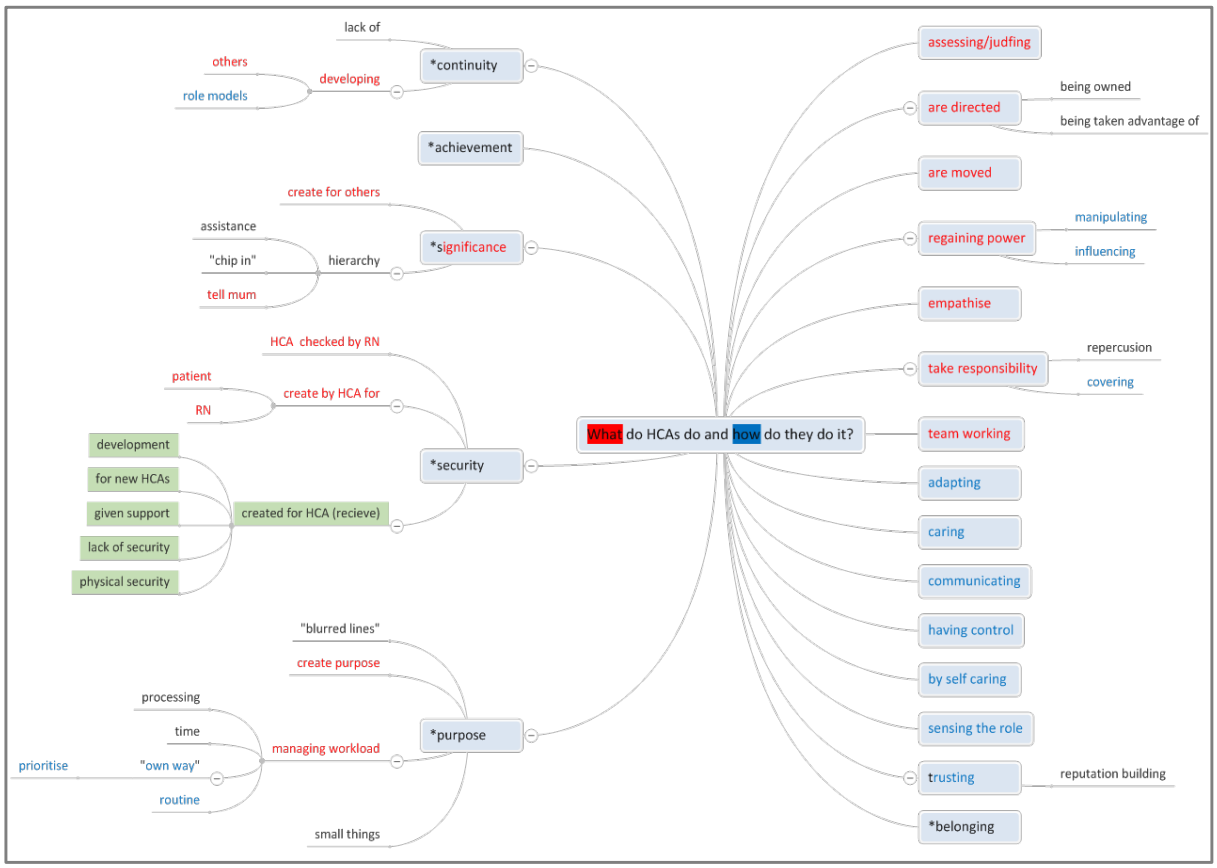


Figure 5 - Mind map for what and how HCAs do their job

4.7.4 Focused analysis

Focused analysis is when there is movement beyond description and towards explanation, interpretation, identification of patterns, rules and cause and effect (Tracy 2013). It was now appropriate to decide which categories were central to the study and those less significant (Hammersley and Atkinson 2007). As I continued to collect data as well as analyse, I had come to realise that the 'connecting' seen in the early stages of analysis was related to the RN specifically rather than the whole nursing team. At this point, it also became clear that the difference between new and established HCAs was not a significant factor and

separation of the two groups was not taken further forward. The Senses Framework (Nolan et al 2006) had likewise become less significant as the relationship between the HCA and the RN, as a partnership, had come to the fore. In directing the focus of the study on the relationship between the HCA and the RN, three themes were emerging; how the RNs were leading team effectiveness, how the HCAs were managing team effectiveness, and the elements involved in dyadic team working. These themes and subthemes can be seen in Figure 6. The next decision was to further reduce the focus of the study to explore specifically how the HCA functions within the dyadic team.

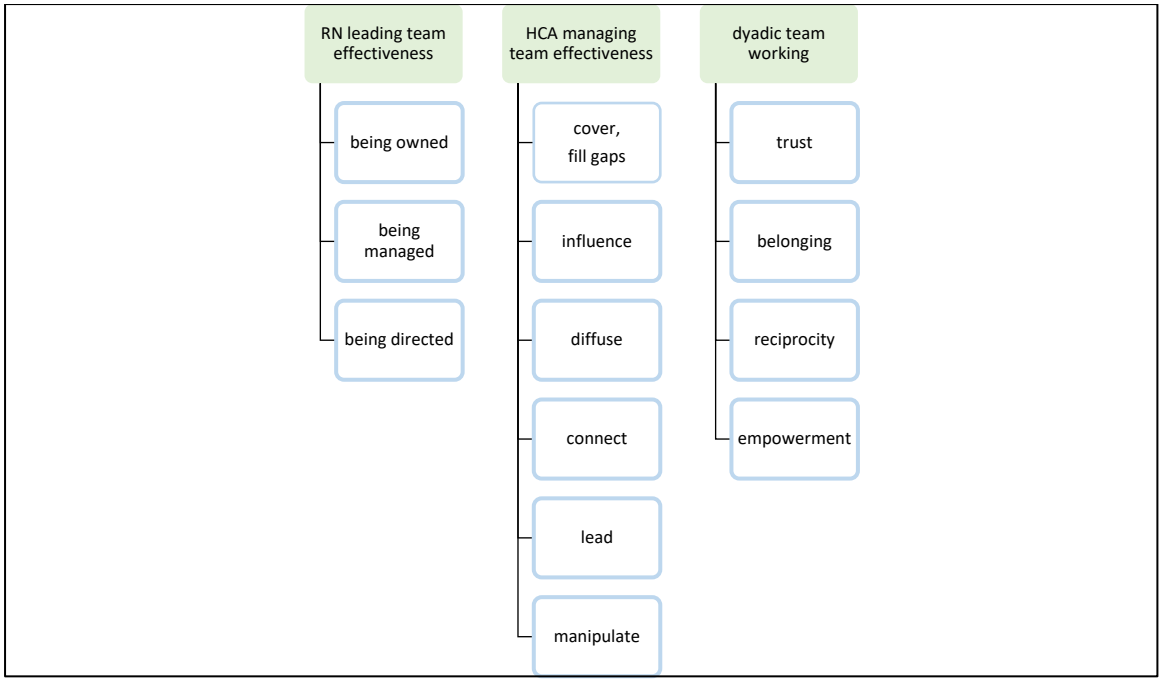


Figure 6 - focused analysis, the relationship of the HCA and the RN

With this concentrated focus, it was an opportune time to consider theoretical frameworks from the social science literature that would support understanding of the phenomena (Tracy 2013, Hammersley and Atkinson 2007).

4.7.5 Theorising

When researchers draw together data that was previously seen as unrelated, they can use a new perspective, or lens to look at the problem. This approach provides fresh insights and is known as theorising (Hammond 2018). Hammond (2018) explored the meaning of theorising with scholars and noted three commonalities in the personal undertaking that theorising requires. Theorising included problem solving, abstracting from the data and

drawing on other resources. First, theorising involved noticing a problem, or puzzle, and a gap in how it can be solved. In solving the puzzle, researchers looked for explanations for what was happening. With this explanation, they can present a story which depicts the context (Hammond 2018). This new understanding is innovative or contradictory to current thinking and requires the researcher to expose their unusual perceptions. In my study, noticing a problem came during data collection; how could the nursing team work as a team when HCAs and RNs were in bays and could not see each other? When I asked a HCA about the team, she replied "The nurse that I am working with today…". It was then that realised that my understanding of the team was different to hers. Solving of the puzzle came in the form of recognising that there was a team of two. This idea of a nursing team was contradictory to current nursing team thinking.

The second commonality in theorising was the ability to extract specific data from the vast amount gathered in order to show what was happening (Hammond 2018). It was when separate parts of data were brought together that a new way of seeing the phenomena arose, this was looking further than the data to say more, to make inferences (Hammond 2018). The scholars in Hammond's (2018) work described how, when all data seemed to fit around an overarching idea, there was a sudden feeling that the problem had been captured. For my study, it was when I was writing that I discovered I was able to demonstrate not only that the dyad was there, but the data also showed that when it wasn't, nursing work was compromised.

Thirdly, theorising involved comparison of findings with other sources (Hammond 2018). This theoretical triangulation is recommended for deliberating how other researchers' interpretation of findings aids understanding of this study's findings (Hammersley and Atkinson 2007). They highlight the key issues for consideration including the language used and specialised meanings (Hammond 2018). I was keen to investigate the relationship between two people who work within a wider team and Habeeb's (2017) work provided insights which influenced the analysis of the HCA-RN dyadic relationship. This is examined further in the discussion chapter. When I was able to articulate the HCA-RN dyadic relationship, it still left a gap in presenting the multiple realities of HCAs work on the wards. There was a discrepancy between what I felt when I was spending time with HCAs, and their

transcribed accounts and field notes from observations. As they carried out their job, there was an implicit anxiety and this needed to be expressed as part of their story. The work of Menzies Lyth (1988) incorporated the task-orientated work of the ward environment and describes mechanisms that nurses applied to manage the related anxieties. This helped to present the story depicting the context and deliver a solution to the puzzle. Hammond (2018) stated that it is clear that theorising has occurred when the researcher has reached a degree of objectivity that differentiates the writing from a narrative (Hammond 2018). For this study, judgement of whether this has been achieved can be made in the discussion chapter.

4.8 Summary

There have been many aspects considered in terms of the methods used in this study. The research design was based upon the recommendations of ethnographers including how to access the field and carry out recruitment but was expanded to elaborate on other important factors like ethical considerations and confidentiality. Data collection methods were divided by observations and interviews and these were compared to the skills of mental health nurse's during assessment. The data analysis process included detail on the use of computer assisted qualitative data analysis software, and the use of memos alongside how early and focused analysis took place. The final stage of data analysis, theorising, was then considered. The content of this chapter on methods leads to the result of this process which are presented in the findings and discussion chapters that follow.

Chapter 5 Findings

5.1 Introduction

This chapter will present findings that demonstrate that the nursing team on an adult ward comprised a number of dyads made up of a HCA and a RN who worked and focused solely on one bay and associated side rooms. These dyads worked in isolation from other dyads based in other bays on the ward. This meant that knowledge of the patient population as a whole and the overview of the work of the ward was limited to and held by the Shift Coordinator, also known as the Nurse in Charge. Within the Health Care Assistant-Registered Nurse (HCA-RN) dyad, the HCAs contribution to patient care was a substantial part of the bay work. Taken from the perspective of the HCA, the HCA-RN dyad is presented with exploration of both its form and its function.

The terminology used to describe the HCA-RN dyad was derived during the data analysis. This was influenced by elements such as 'a priori' concepts; adopted before entering the setting (Ritchie et al 2014). This is seen in the label 'hierarchical differences'. 'Exchangeable and distinguishable' were also a priori concept; vocabulary used by Habeeb (2017) when describing cheerleading dyads. The expression 'mini-meetings' was an in vivo concept (Ritchie et al 2014), drawn directly from a RNs' interview. Other terms were emergent concepts (Ritchie et al 2014) based on the vocabulary which best fitted the phenomenon like 'routine scaffolding' and 'concentrated relationships'. Terminology used by ward staff are also integrated into this chapter and are defined by speech marks when first used, for example "scoring" (page 146).

In this findings chapter, there is reference to eighteen field notes and over a hundred direct quotes from participants. The predominance of quotations over field notes was a result of the data collection method which was observations immediately followed by interviews. Rather than using field notes, which were made with best intentions in accuracy, the audio recorded words that the participants used to describe what had taken place were used where possible. The direct quotations are from eighteen different HCAs and sixteen different RNs. Some participants were key informants and are quoted more than others. There are a number of reasons for why this has occurred. For example, HCAs Mary and

Hope were two participants were recruited early in the study. They are quoted often because they were frequently the first people to explain everyday phenomena and their feelings about these. Some participants are quoted because they tell a comprehensive story about specific phenomenon, such as when HCA Jean was working with a RN for the first time. Others spoke eloquently and extensively about a subject as RN Ginny did when discussing her thoughts and experiences of trusting the HCA. Direct quotations are written in italics with the participants' pseudonym, the abbreviation "int" for interview and the number of their interview. "Field note" refers to where I used my observations, and these are referenced with the date. Entries from my reflexive diaries are drawn upon in the discussion chapter rather than the findings.

An overview of the HCA-RN dyad is provided before each element is considered in detail. Prior to this exploration, a narrative of the environment, based on my field notes, provides a rich description to allow the reader to envisage where the HCA-RN dyadic work takes place.

5.2 The ward environment

The study was undertaken on four acute wards in one NHS hospital. The two medical wards and two assessment units were housed within the same building used for the care of adults with physical illness. An introduction to each of the settings is provided before common factors of all wards are described.

The two medical wards [referred to as M1 and M2 in this study] had 30 beds for patients needing assessment, review or treatment in relation to endocrine, rheumatology, dermatology and older person's care. They were each gender specific wards which mirrored each other in their physical layout, their staffing ratios and the daily routine. Patient length of stay was approximately five days. Patients arrived via the accident and emergency department or from an assessment unit [see below]. They were usually discharged to their home address. The nursing team comprised approximately 16 RNs and 13 HCAs who worked full time and four RNs and four HCAs working part time hours. This total included one sister/charge nurse and two deputy sisters/charge nurses. The staffing ratio during the day shift was one RN and one HCA per seven to eight patients (i.e., one six bedded bay and associated individual side rooms) plus a senior nurse as shift coordinator. During the

nightshifts, the ratio changed to one RN and one HCA per 12 patients. As is common nationally, nursing staff groups were predominantly female. Services that supported the ward work such as porters and phlebotomists were provided from a central pool for the hospital as needed.

The description of the medical wards above also fitted with one of the assessment units included in the study [referred to as A2], but this was the size of two wards placed end-to-end. Like the medical wards, the assessment ward had six beds in each bay apart from one which instead had four acute care beds. This had an increased staffing level of one RN and one HCA to two patients. This bay was included in the study but only once I observed the HCA there. As with the other wards, the nursing team was managed as a whole. For instance, one of the two ward sisters completed the rota for all of the HCAs across the eight bays and the other sister completed a rota for all of the RNs. The nursing team comprised 36 RNs and 33 HCAs working full time and 9 RNs and 8 HCAs working part time. Each shift was staffed by eleven RNs and nine HCAs. This included a shift coordinator on each ward side. Patients were admitted from accident and emergency. Average length of stay was 24-48 hours, after which patients were either discharged or moved to another ward.

Although A2 was very similar in layout and staffing to M1 and M2, the size of the ward, the acuity of the patient population and high rate of patient turnover meant that it functioned in a different way. In addition to the nursing team, there were extra ward-based staff. They were dedicated to specific tasks, for example, there were porters who were based on the ward rather than called from the hospital wide team. There were Band 3 HCAs called clinical aides who undertook advanced skills such as phlebotomy and cannulation for all patients who required them. There was also a sub team of a HCA and a RN who were not allocated to a single bay but instead their responsibility was to assess and act upon their assessment in meeting the pressure area care needs of individual patients across the double ward. These dedicated roles supported the achievement of work which enabled the swift progression of patients from the accident and emergency department to receiving initial interventions on the assessment unit before being moved to longer stay wards in the hospital, such as M1 and M2.

The other assessment ward, [referred to as 'A1' in this study], was the smallest of the wards with 16 beds in bays and 6 chairs in a waiting style room. They had a nursing team of 26 staff; 10 full time and 3 part time RNs and 7 full time and 6 part time HCAs. The ratio of nursing staff to patient was the same as the other wards with one RN and one HCA per 7- 8 patients plus a senior nurse as shift coordinator. Here, patients came from the accident and emergency department when they required only 24-48 hours care before discharged either home, to a community hospital or, more rarely, to a ward.

Although there was variation in the size and specialities of the wards and assessment units in the study, there were many similarities in their physical environments. Each area had patient bays, patient side rooms, a ward manager's office, a clinic room, a sluice room and a staff room which was also used as a meeting room. There was also a nurses' station which encompassed a large desk which housed computers, telephones, folders and various bits of loose paper were strewn. It was positioned centrally on the ward and generally the patients who were most ill would be placed nearer to the nurses' station.

Apart from nursing handover twice a day, the nurses' station was occupied primarily by staff other than nurses such as physiotherapists, pharmacists, occupational therapists and a ward clerk. These were recognisable by their different coloured uniforms; bottle green trousers and matching trim on white tunics for occupational therapists, ward clerks wore black tunics and trousers. On the wall opposite the nurses' station, between the entrance to two of the bays was a large patient bed allocation whiteboard. Black tape divided the white board into boxes to represent each bed space in each bay across the whole ward. In each box, a patient's name was handwritten in a blue or red pen; the colour denoted the consultant team that the patient was allocated to. Next to the patients' white board was a smaller staff white board. On here, the first names of the nursing staff working on the day and night shift was written. There would be one HCA and one RN based in the bay for the whole shift. The names were positioned to indicate which bay they were working in and who they were working with. Where it was commonly accepted that the ward sister wrote the rota, finding out who decided who was paired with who was less known. It emerged that the senior nurse on the previous shift updated the staff white board using the names on the rota. They appeared to leave the names of staff who had worked the previous day shift in the same

place so that they worked in the same bay on consecutive days when possible. This provided continuity for patients and staff. Staff that had not worked the previous day would be slotted into the gaps. This led to HCAs and RNs working together infrequently; each shift HCAs would be working with a different RN. Break times were added to the board by the shift coordinator after the shift had begun.

All wards were entered through large, heavy wooden doors and the floors were laid with buff-coloured tiles. The lighting was stark and artificial throughout. On all of the wards and units, the walls of the main corridor were adorned with display boards of official statistics of staffing levels and patient feedback. There were also 'thank you' cards from patients secured at an angle on the walls. There was a potent smell of alcohol gel and a background humming of people talking, medical equipment bleeping and telephones ringing.

5.2.1 The bays and side rooms

As previously stated, the acute care bay in A2 had four beds, two on each opposing walls of the bay. Apart from this anomaly, the medical wards and assessment units had bays with six beds and single occupancy side rooms. These bays were laid out in the same way; three beds on each side. Although there were no written labels to be seen, each bed was known by a number starting from the first bed on the left as you entered the bay and working around to the right; bay 1 bed 1, bay 1 bed 2 etc. This labelling system was universally used across the hospital wards and allowed any member of staff to be able to communicate which bed space they were referring to. At one side of the entrance to each bay there was a table and two plastic chairs. Here RNs and HCAs would sit to write in the patient nursing folders. The table was an addition to the original design of the bay and was introduced for nursing staff to be able to complete paperwork and still remain visible to patients and vice versa. As well as the patient nursing folders, the tables were usually covered with left over supplies; packets of wipes, unused incontinence pads, hospital nightwear. Above the table, or on a nearby wall, was a white board on which was written names and some symbols relating to the patients in that bay. Symbols represented patient specific information at a glance; indicating patients who were at the end of life, were diabetic, or had discharge pending.

Each bay had two large windows, one at the end of each row of beds. They had limited opening and were dressed in long, light cotton curtains. Through the winter, the windows let in the cold and the estates staff did their best to reduce the effects by attaching plastic sheets over the gaps. In the summer, there was little staff could do to control the high levels of heat in the bays. The ceiling lights were bright and couldn't be dimmed or controlled individually. Some RNs switched all of these on at the beginning of their day shift at 07.30 regardless of whether patients were asleep or awake. There were curtains between each of the beds which were drawn when any personal care or repositioning occurred. In three settings these were made of cotton, on the fourth they were a disposable material. Behind each bed was a small white board with the patient's name, the name of the RN on duty and sometimes significant information such as "soft diet only". These were updated by HCAs at the beginning of each shift or when a patient was discharged. Members of staff such as the housekeeper, the phlebotomist and the nursing staff glanced at the name on the white board and used it when speaking to the patient, however they rarely gave their names in return. On the single gender wards or bays, almost every patient was an older person and were dressed in hospital nightwear; pink nighties for females and green pyjamas for males. The items were oversized and had buttons and ties, making removal and replacement simple.

On one side of each bed area was a cupboard for storing patient's personal belongings with a lockable cupboard on top for the storage of patient's medication. The RN in the bay held the key for the patient's medication cupboard. On the other side of the bed was an armchair and a table which could be swiveled over the bed or chair. There were no individual or shared television in the bays, only a radio which was sometimes switched on by staff. This made the areas feel stark and unhomely, which was not lost on staff:

> *… because they have got nothing to do all day, all they do is look at each other or doze off […] A lot of them love their soaps, don't they, and they don't even get to see that. It's horrible, it's horrible. (HCA Kate Int 2)*

The stimulus in the bays came from the perpetual movement of people. Patients were wheeled in and out of the bay by porters for admission, for discharge or for tests throughout the day. There were also team members entering and exiting the bays in a constant stream; phlebotomists, pharmacists, physiotherapists and medical teams. Each of

them spoke to individual patients, usually in quiet voices. Swishing of curtains opening and closing were heard as staff made efforts to construct some level of privacy for the patient. Cleaners had a discreet presence as they quietly carried out their environmental tasks whereas housekeepers were often heard joking and engaging with patients, reflecting their more patient facing tasks like giving out drinks. This movement of people created a feeling of constant bustle.

In contrast to the busyness of the bays, each ward also had a small number of individual side rooms. These ran along the opposite side of the corridor to the bays. The rooms had stark white walls and a window, often with a view of the opposite wing of the hospital building. They each had a sink with a mirror above it, a clock on the wall and a table where resources such as gloves and wipes were left. Outside of each side room was a trolley on which was placed personal protective equipment and the patient's nursing folder on. There was a white board for the patient's name next to the door and a rubbish bin for clinical waste nearby. Patients staying in side rooms were usually those who had an infectious illness or were in receipt of end of life care. In these rooms, patients were isolated from the general hum and movement in the ward and only saw team members when they entered to undertake tasks unless they used their call button.

5.2.2 The handover

Nursing staff worked through the 24-hour period on 12.5 hour shifts so there were two sets of staff in each 24-hour period. Handover of patient information between nursing staff took place at 07.30 for day staff and again at 19.30 for night staff. It started with a five-minute gathering at the nurses' station or meeting room, sometimes called a "huddle". Here, the senior nurse on the last shift would read through any important messages including what changes needed to be made to improve audit results to meet documentation targets. They also sometimes referred to significant events that had taken place that were relevant for all staff, for instance a patient's death. This short communication was followed by a bedside handover. From the names on the white board, HCAs and RNs knew which bay they were working in and who their dyadic partner was. They proceeded to their allocated bay where the RN who was finishing their shift led the arriving RN and HCA around the bay and side rooms and gave nursing information at the end of each bed.

Alongside the verbal handover, all RNs and HCAs were given a handover sheet which provided basic details about all of the patients on the ward. This included diagnosis, planned discharge date and Do Not Attempt Resuscitation status (DNAR). The handover sheet was updated by the shift coordinator and printed at handover. RNs and HCAs were seen to refer to this, taking it out of their pocket, during the shift when asked a question by another health care professional or by visitors.

5.2.3 The daily routine

The work on the wards was very routinised and varied little from day to day. After handover, the night staff left, and the newly arrived nursing staff began their work. For the RN, medication was their first task. For HCAs, helping patients eat breakfast, preparing to wash patients and making their beds was the priority. Their role also incorporated prompting RNs to help with patient repositioning, carrying out blood glucose tests as per handover request and undertaking clinical observations commonly known as "the obs" when they were due to be done. "The obs" consisted of monitoring and recording of each patient's vital signs at the specified times. Figure 13 in Appendix 8 includes the routine that HCAs undertook. Breakfast was brought into each bay on a trolley by the housekeeper and the domestic together from 07.45hrs. Patients were asked for their preference of cereal and it was delivered to their table with a juice and a yoghurt. Sometime later, the housekeeper brought around a tea trolley and offered patients a hot drink, then refreshed the jugs of water on each patient's table. Following breakfast, HCAs began to assist patients who only needed one person's support to wash.

The HCA and RN carried out their separate tasks from the beginning of the shift until the break time at approximately 11.00hrs. After each team member had taken a break, the patient washes and repositioning that needed two people to complete were carried out: known by nursing staff and others such as physiotherapists as "doubles". It was usual that by lunchtime all patients had their personal hygiene needs met, had received their medication and had their clinical observations taken and recorded.

Throughout the morning, the activity of other health professionals was interspersed between the nursing tasks. The medical teams of three or four people enclosed themselves inside of the drawn curtains of each patient, then one of them spoke softly to the patient.

In contrast, a catering staff member stood at the end of each bed and raised their voices to ask patients, some of whom were unable to hear well, what they would like to eat for lunch and dinner. Physiotherapists and occupational therapists undertook assessments of activities of daily living with patients. Phlebotomists, with their large, loaded trolleys, cross matched forms by asking patients their date of birth before swiftly taking blood samples. Visiting time brought fresh faces in from outside of the hospital from 11.00hrs; and then lunch arrived.

This tide of activity, people entering and exiting the bay continued until approximately 14.00hrs, when there was a pause and noticeably less movement. Patients were often relaxed or asleep. HCAs and RNs sat at the desk in the entrance of their bay and reviewed their progress in the delivery of their tasks and completed their documentation. Throughout the afternoon, there was a repeat of tasks such as repositioning of patients and clinical observations for HCAs and medication for RNs. Evening mealtime arrived and another set of blood glucose monitoring, clinical observations and repositioning was undertaken as the end of the shift approached. The RN and the HCA finished and checked that all work had been completed and had been documented ready for handover to the night shift.

In amongst the daily routine, the HCAs and RNs in each bay worked in pairs. As the length of the shift was 12.5 hours, full time HCAs and RNs did three or four shifts in a week and worked in combination with up to four of their colleagues within that time. In addition, there were bank and agency staff who worked ad hoc shifts and some staff worked part time. It could take many weeks for all the ward staff to engage in working with each other. Despite their inconsistent pairings, the sense of team stemmed from this bay-based relationship rather than with the whole staff group that arrived together at the nurses' station at the beginning of the shift.

5.3 The Health Care Assistant - Registered Nurse Dyad- overview

It is indicated above that HCAs were paired with a RN for a shift. HCAs understood their team to be the specific RN that they were paired with for the current shift rather than the wider nursing or multidisciplinary ward team. The paired HCA and RN worked as a team of

two, a dyad, to achieve all of the nursing tasks for their group of allocated patients. The cohesion of the dyadic relationship was central to the provision of quality care and the importance of a good dyad team was understood by nursing staff:

> *Very good shifts are when you have a very good team. If you have a very good Health Care Assistant, your shift just goes amazingly (RN Violet Int 1).*

Although both the HCA and the RN had individual tasks to complete, they also needed the support of the other to complete the work as a whole; their work was entwined and reliant one upon the other. The paired HCA and RN had a dependence on each other which was unlike the relationships they had with other team members. Each partner had complimentary and overlapping responsibilities, some tasks they executed together, and some alone. Physically, they worked in close proximity; within the confines of the bay and side rooms. They also had a cognitive investment in each other; they both needed to trust that their partner would carry out their work which, in effect, enabled them to complete their own tasks. This trust in the HCA gave the RN the scope to be able to turn their attention to their own tasks.

The aim of the dyadic team was to complete and record all of the nursing tasks on time throughout the shift. Achievement of this was based on the form and function of the HCA-RN dyad. The form was characterised by a set of attributes; pre-shift preconceptions, hierarchical differences, physical isolation and concentrated relationships. The function of the HCA-RN was enacted via the mechanism of 'joining and separating'. For the HCA, this was accomplished through 'non-dependent' and 'inter-dependent working' each with a specific set of properties (see Figure 7). These will be introduced before they are discussed in detail in the following sections. These findings are the result of analysis of data which was collected to understand the role of the HCA as opposed to considering each of the roles individually.

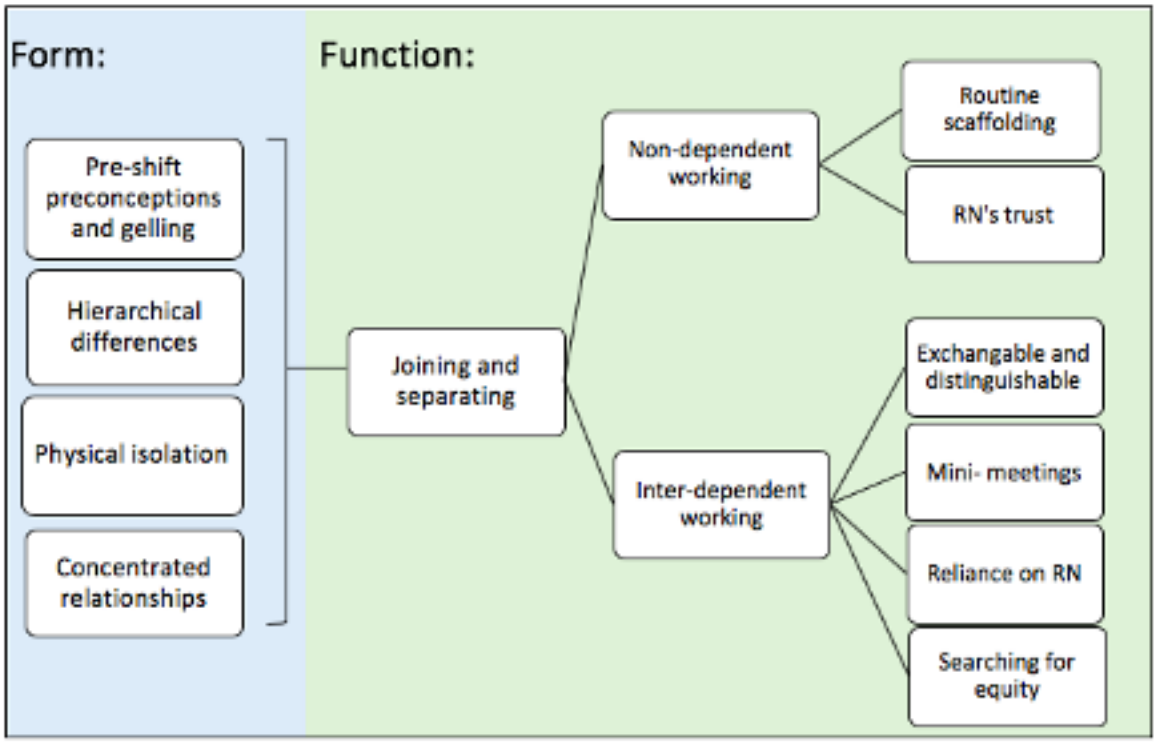


Figure 7 – The 'HCA-RN dyad' model

Understanding the form of the HCA-RN dyad began with a description of 'pre-shift preconceptions and gelling'; where HCAs and RNs made judgements about the possible quality of the dyadic working for the day, based on with whom they were partnered. This occurred before the commencement of any work on that shift. The forecast was founded on previous experiences of working with the person and whether they 'gelled', and through the partner's reputation. As HCAs and RNs could not complete all of the nursing tasks without the support of their partner, this aspect of the HCA-RN dyadic form was a precursor to how the shift might feel for each person in the dyad; it set expectations and brought to the fore possible adjustments, for instance asking for help, that may need to be made for the work to be completed.

The 'hierarchical differences' of each team member was also a significant part of the composition of the HCA-RN dyad. The HCAs lower position in the team's hierarchy was reflected in the tasks that they completed. HCAs carried out the majority of fundamental care for the allocated patients such as washing and dressing. Fundamental care was such an integral and accepted part of the daily routine that there was little acknowledgement of its

successful delivery day-to-day. This reflected on the role and recognition of HCAs and their perceived contribution to the team.

A distinctive quality of the team of two people was that they worked in 'physical isolation' from the other HCA-RN dyadic teams on the ward. They were not able to see or hear the progress of other HCA-RN dyads. This increased the focus on completing tasks for their own patients and reduced the distraction of involvement with patients in other teams. The physical isolation reinforced the HCA-RN dyadic partnership.

Physical isolation was an emergent concept which described the tangible surroundings of the team in the bay whereas the cognitive investment of members was demonstrated in the 'concentrated relationship', also an emergent concept. As the HCA and the RN were isolated from peers, their relationship with each other was inward facing and possessive. Use of the possessive pronoun "my", "my nurse", "my HCA", illustrated the intense focus on each other for completion of all tasks on time and to standard.

While the form of the HCA-RN dyad comprised pre-shift preconceptions, hierarchical differences, physical isolation and concentrated relationships, the function of the HCA-RN dyad was enacted through 'joining and separating'. For the HCA-RN dyad to be successful in completing and recording all of the nursing tasks within the shift, each partner needed to be able to spend time carrying out some tasks alone and other tasks in collaboration. The quality of their actions whilst apart and together impacted on the overall success of the team.

For HCAs to join and separate with their RN partner, they needed to be able to work 'non-dependently' and 'inter-dependently'. These are a priori terms from the dyadic relationship work by Kenny and Cook (1999). In this study 'non-dependent working' was based upon the learning and enactment of the 'routine scaffolding'. Routine scaffolding incorporated three strands; compulsory timed tasks, mandatory flexible tasks and RN requested tasks. The extent of its use was dependent upon the 'RN's trust' to allow HCAs the scope to fully perform tasks alone. Routine scaffolding, compulsory timed tasks, mandatory flexible tasks and RN requested tasks are emergent concepts.

‘Inter-dependent working’ was instigated by HCAs when they were unable to complete a task themselves. HCAs and RNs operated in ‘exchangeable and distinguishable roles’ whilst working inter-dependently. When engaged in exchangeable roles, any partner could have taken either part, whereas when they acted in distinguishable roles, there was a difference in their input in accordance with their hierarchical position and skill set. Exchangeable and distinguishable terminology are derived from the cheerleader vocabulary used by Habeeb (2017).

To be able to join and separate in a time effective manner, a technique of holding ‘mini-meetings’ was used by the team. Here the HCA and the RN spent a small amount of time together to plan, review and re-plan actions at regular intervals through the shift. This improved the overall efficiency of the team and increased satisfaction for HCAs who felt more included in the team effort.

As the senior partner, it was the RN who instigated ‘mini meetings’ as well as setting the tone for the bay. Some RNs appeared to be reluctant to help the HCA with physical tasks whereas HCAs were ‘reliant on the RN’ for their support in order to meet all of their responsibilities. When their RN partner did not provide support, the dyadic function was compromised, and the task remained outstanding. HCA’s felt responsible for resolving this and found other ways of ‘filling the gap’ left by some RNs; they utilised ‘asking a peer’, ‘escalating it’ and ‘doing it alone’. These emergent terms were chosen to best describe the HCA’s actions and verbal accounts.

A judgement was made by the HCA concerning whether the HCA-RN dyad functioned effectively. In the quest of the emergent concept of ‘searching for equity’, the perceptions of what was deemed an equitable contribution to the HCA- RN dyad was unique to each HCA. Underpinning this perception was the HCA’s desire to be respected as a partner and receive acknowledgement for their contribution.

This overview of the form and the function of the HCA-RN dyad leads to more in-depth attention to the model and the HCAs role within it.

5.4 The HCA-RN dyad: form

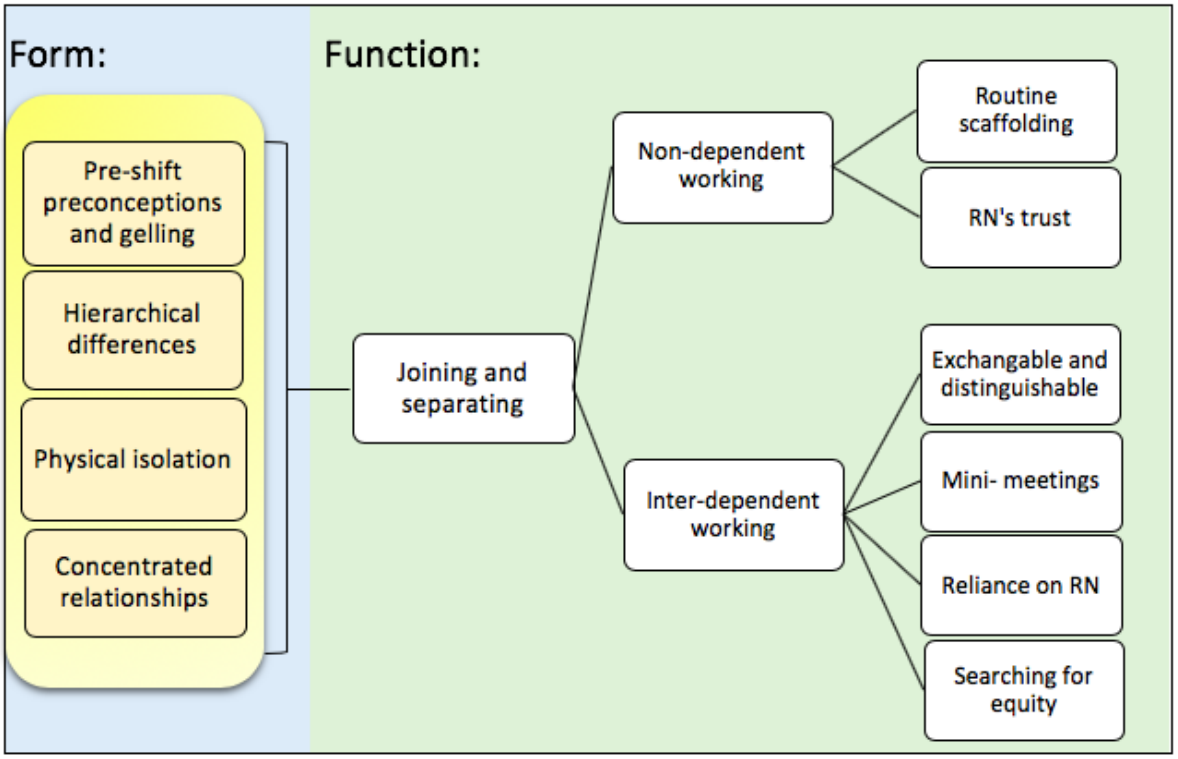


Figure 8 - The HCA-RN dyad: form

The form is a description of what the HCA-RN dyad is and is comprised of four attributes. These are: pre-shift preconceptions and gelling, hierarchical differences, physical isolation and concentrated relationships.

5.4.1 Pre-shift preconceptions and "gelling"

When the HCA works in a bay with a RN pre-shift preconceptions and gelling occurs. Pre-shift preconceptions occur at the beginning or just before the shift whereas gelling happens later. Pre-shift preconceptions are based on reflections. Giving thought to whether a shift had been "good", HCAs and RNs contemplated how well their partner had performed, as it was this performance that enabled them to do their own job. This reflection became the prediction for how the next shift together would be. Pre-shift preconceptions were the private feelings that staff held about their partner and their effectiveness based upon reputation or previous working experiences. Preconceptions encapsulated the hopes and apprehensions of HCAs and RNs; for example, HCAs were often concerned about whether the RN was going to help them and RNs held hopes that their HCA partner would be able to work with minimum prompts and require little in the way of checking their work. When the

partners found their concerns to be unfounded and their hopes met, they began to 'gel'. 'Gelling' was a term used by a HCA to describe the development of a positive relationship between themselves and a RN, firstly through the current shift and then built upon through subsequent shifts. The combination of pre-shift preconceptions and gelling provided the potential basis for a flourishing relationship.

For most people, pre-shift preconceptions were provoked when they saw who they were paired with on the shift white board at the nurse's station. This triggered a personal reaction:

> *There is a couple of people that when I come on shift it is like oh great, because you just know how the day is going to go, like people not listening to you and people talking down to you* (HCA Mary Int 1).

Other staff didn't wait to be stood at the white board before finding out their partner but looked at the rota prior to the day:

> *Before I start my shift, I like to know who is working with me, just to know. If the HCA is not a good professional, I don't like to think about it, just get on and work with her or him* (RN Daisy Int 1).

The name of the partner was symbolic of how the next shift might be; it conjured up images of what took place when they worked together on previous occasions. Knowing who they were going to work with created a level of anticipation and allowed for mental preparation.

Pre-shift preconceptions were based on either personal experience or the partner's reputation:

> *We all have a moan with each other, and we know who is hard to work with and who is not* (HCA Emma Int 2).

> *This morning when I heard who the nurse was that I was working with I was not very happy because the other day I worked with her, she didn't do anything* (HCA Hope Int 3).

The concerns for the pending shift were based on the premise that people's working behaviours did not vastly alter; if a RN viewed patient washes as primarily the role of the HCA, they were "*unlikely to change*" from that standpoint (HCA Rebecca Int 4). This made behaviours, and their consequences, feel predictable:

> *You will hear them in the staff room, such and such is on and you think hum, you are not going to have a good shift then* (RN Lily Int 1).

This pre-judgement also applied to groups of staff. When HCA Jean said that her partner was an "*agency worker*", her HCA colleagues jumped to the assumption that Jean would not be supported with some of her work and would need their help:

> *Because all I'll do, I'll go to one of my colleagues and say I've got an agency worker, oh ok then, I'll be there in a minute* (HCA Jean Int 1).

Although many staff had preconceptions, some RNs believed that "*most [HCAs] want to do a good job and that's the main thing"* (RN Lily Int 2). After that initial presumption, they "*get to know different HCAs*". This was achieved firstly through working together for the current shift and then over multiple shifts. Initially, RNs felt it was critical to quickly assess whether the HCA could contribute to the team's work. This assessment started at the beginning of their first shift together. When talking about working with a HCA they hadn't worked with before, RN Lily said "*The morning is an important time because it's, it's the busiest period. […] So that's like a real test, right first thing in the day* (Int 2). The "*real test*" of the morning's activities enabled RNs to make a judgement as to how closely they needed to monitor the work of the particular HCA.

As well as RNs assessing the HCAs physical input to the team, the social engagement between the partners was also significant to the success of the dyad. This was referred to as "*gelling*":

> *Yes, certain HCAs you tend to 'gel' better with and you can have a bit of a laugh and a joke. If you look at the board in the morning you do think oh god, I know it's going to be an uphill struggle* (RN Holly Int 1).

The relationship between the HCA and the RN was said to feel "*personal*" due to the long length and intimacy of the shift "*so it is quite important that you get on*" (HCA Emma, Int 2). This was when gelling occurred:

> *It is nice when you do get that five minutes to sit down because you get to have a chat with [RN] about other things other than what is going on in the bay. You get to know them a little bit. I have worked with loads of different nurses. I know quite a few of them now, as in, if I walked by them in Asda I would stop and have a chat. So, it is good, the relationship we have with them* (HCA Susan Int 2).

When there was gelling between the HCA and the RN, there were also additional benefits:

> *I like to work with [HCAs name] because she is a friend as well and she is a professional […]. This is a good environment to look after the patients* (RN Daisy Int 1).

The RN implied that the enhanced relationship between the RN and this particular HCA had improved the ecology in the bay, thereby benefitting patients. There was other evidence that the 'gelling' of the HCA and the RN had an effect on patients:

> *I didn't hum because I know what will happen all day. I know who is working with me […]. The workload will be on my side, so I'm not very happy* (HCA Hope Int 3).

The HCA was previously observed humming as she fed a patient, but this was not present when she was working with an RN who had a reputation of not helping HCAs with their workload. Her unhappiness was illustrated through her silence when carrying out her work. This suggested that the relationship between the HCA and the RN had an impact on the atmosphere in the bay. When they gelled, both their verbal interactions and their physical movements were relaxed, less rigid (Field note 13.11.15).

When they did not gel or they didn't have previous experience of each other, the HCAs tended to take their lead in how to behave in the bay from the RN. To demonstrate this point, HCA Jean recounted when she was paired with a newly qualified RN for the first time. She had no foundations on which to base pre-shift preconceptions, but she did hope that the RN would interact with her to complete tasks for the patients and would "*jolly us along*". The HCA described how a RN would "jolly" the bay along:

> *They'll come in and they'll be "Morning all, let's see what I can do today then", "who wants to have their first wash and who wants to do this". "Oh, I'll just give you your tablets", "oh you've not got a cup of tea there, let's go and get you a drink". And just jolly us all along […]. So that's what you expect… Well, you don't expect it, but that's what you're hoping to get from somebody else* (HCA Jean Int 1).

In contrast to this, the new RN did not speak to the HCA but instead focused her attention on giving medication (Field note 06.10.16). Left with no direction from the new RN, the HCA carried out her role as well as she could without RN input. The

impact of the RN not speaking was that the HCA did not feel able to approach her to discuss the workload in the bay:

> *That means because she's not communicating with me, every hour I have to go around and do six people's obs, every hour* (HCA Jean Int 1).

The HCA reported the results of the clinical observations to the RN but did not receive any extended interaction past affirmation (Field note 06.10.16). The RN did not offer to help with the observations despite their frequency and did not provide an opportunity for the HCA to ask for help. The HCA tried to justify the RNs style; "*It's the first time I've worked with her, so she is very quiet, I think she's still finding her feet*". The absence of 'jolliness', connectedness and lack of opportunities to communicate was seen as negatively effecting patients:

> *These poor patients are poorly, they don't want to be here, and I just feel as though the nurse don't want to be here either because there's no communication to us all* (HCA Jean Int 1).

Although she had acknowledged that the newness of the staff nurse may account for her lack of engagement, the HCA still attributed this absence of "*jolliness*" as a lack of commitment to the people in the bay, included herself. The gap between the new RNs demeanour and the HCAs hopes appeared to cause a divide that seemed to prevent development of a relationship on this shift. The importance of meeting your partner's needs, in this case for "*jolliness*", was seen as necessary for a good working relationship; "*you feed off each other's energy*" (HCA Maria Int 4). According to the HCA, the new RN had not triggered an environment of team working and the dyad had not gelled.

As there were indicators that patients benefitted from the gelling of the dyad, there were also benefits for the dyadic partners. People felt more able to ask for help when there was a personal connection:

> *I think having more of a friendship with them actually really helps because we can talk to each other. I can ask them to help me more, they can ask me. You can say no when you are friends with someone as well* (RN Laura Int 1).

It is implied that when they were not in a position to help, honesty was made more possible when the partners were friends. This may be because their relationship was more

established so their reputation more durable; there was less at risk when they had investment in each other as friends.

Where RN Laura described "*friendship*" as the basis of the stronger relationship, another RN used the term "*get on professionally*":

> *…that you can get on professionally, it's important, […] she's more likely to ask for my help, I'm more likely to ask for her help, instead of it being a bit awkward […] because, you know, she doesn't want to talk to me or something like that* (RN Lily Int 2).

In amongst the talk of "*help*", RN Lily indicated that there can be awkwardness. Awkwardness may be addressed by better interpersonal relationships, as RN Laura stated above, that people feel more able to say no. But use of the phrase "*get on professionally*" infers a different type of relationship to that of friendship; less personal but still having the characteristics that support a good working relationship, such as trust and respect.

Whether the gelling of the partners was due to 'getting on professionally' or a 'friendship', it supported the establishment of the dyadic relationship. A benefit of an established positive dyadic relationship between the HCA and the RN was that it was then carried forward to allow each partner's future pre-shift preconceptions to be more positive. When the dyad was unable to develop a positive relationship, pre-shift preconceptions were more likely to be negative and partners accepted that there was a difficult shift ahead:

> *You get a rapport with some of the people you work with better than with others. There are some people I can't stand working with, but I just shut up and put up* (HCA Kate Int 2).

The pairings made by senior nurses before commencement of the shift were generally accepted without question by nursing team members. Rapport was important in the partnership, but the absence of this was not a motive to challenge the designated pairing. The reasons for this appeared to be multi-layered. First, it was difficult to give a justifiable reason for the challenge which may itself cause 'problems':

> *I don't know if someone can say I don't want to work with this person. Then there is something wrong and if there is something wrong you have to be able to prove it. And if you can't prove it, what will happen? You will bring problems into the workplace and it can bring a barrier for the care of the patient* (HCA Grace Int 1).

The HCA felt that overtly challenging the pairing could make the already strained relationship worse and thereby create a situation where patient care may suffer as a result. Another reason for lack of challenge was that each partner was reliant upon the other for completion of nursing tasks:

> *And we don't want conflict because we work in such a close environment, you need each other's help* (RN Seema Int 1).

This point reiterated that good working relationships were central to the success of the team and avoidance of conflict was essential. HCA Maureen agreed; "*I make a point of getting on with everybody because you have to, don't you?"* As pre-shift preconceptions were based upon the reputation or previous experience of working with that partner, highlighting conflict may not change the pairing but could negatively affect their own reputation within the extended nursing group.

Finally, when a person was reported to seniors for being difficult to work with, challenge was perceived to be futile: "*so many people have bad mouthed that person … nothing gets done"* (HCA Rebecca Int 4). Senior nurses also seemed to promote a culture of avoiding conflict and to this end there was one solution; "*You have to share that person out" (LAUGH)* (HCA Rebecca Int 4). This technique ensured that no-one worked with them too frequently.

In summary, a characteristic of the HCA-RN dyad was the pre-shift preconceptions that team members held about their partners. The reputation or previous experiences of partnerships influenced how people thought their shift would evolve from the time that they saw who they were paired with. This swiftly made judgement set the initial tone for the bay and thereby made altering preconceptions difficult as they repeated the same initial reaction to each other. Shift patterns, use of bank and agency staff and high staff turnover reduced the opportunity to work regularly with the same partner, further contributing to the challenge of developing a relationship. When people did 'gel', it was based upon their perceptions of the partners' ability to carry out their work well and the quality of their personal and/or professional relationship. Chatting, laughing and joking were all seen as generating a warm

environment in which partners could ask for help or say no, and patients may have benefitted from the positive staff interactions. When pre-shift preconceptions were negative, pairings were still upheld by partners who saw the impact of challenging that partnership as disruptive to the environment, affected their scope to ask or refuse to help and impacted on their own reputation in the pre-shift preconceptions with future partners.

The concepts of "Pre-shift preconceptions" and "gelling" mark the beginning of the shift and of the relationship. However, this relationship was not based on equal terms, a hierarchy was in place.

5.4.2 Hierarchical differences

With their professional registration and overall accountability for patient care, the RN held more authority and power than the HCA. The lower hierarchical status of the HCA was reinforced by the nature of the tasks that they carried out, namely, the provision of personal care. Each RN had the ability to carry out all of the nursing tasks for the patients in their bay, from the fundamentals of care such as feeding and washing to those limited to the registered nurse such as the administration of medication. They held accountability for all of the nursing care for the patients allocated to them but did not have the time or capacity to carry out all of the duties personally. Therefore, some duties were delegated to the HCAs.

The tasks that were delegated had become so commonplace that they were almost invisible. It was expected that the HCA would focus on helping patients to wash, dress, use the toilet, eat and drink: the fundamental care. HCAs also carried out and recorded some of the baseline assessments and specific clinical observations. It was usual for the HCAs to carry out these tasks without prompting from the RN, the HCA knew they were the main part of their work; "*So they actually know what needs to be done and they will then go off and do it"* (RN Holly Int 1). However, as the accountable clinician, RNs needed to be assured that the individual HCA that they were paired with had the skills, confidence and willingness to perform the expected tasks to a good standard before they reduced checks of their work:

> *As a HCA goes on in time and they get more experienced, the less the nurse checks their notes because they can put more trust in that person* (HCA Sam Int 1).

The HCA then took ownership of these tasks and the RN concentrated on the aspects of care that required registration to perform them. The responsibility for delivery of the fundamental care in the bay had been passed 'down' the hierarchy from the role of RNs to the remit of the HCAs. Feelings of responsibility for the work were expressed by HCAs:

> *The HCAs said they've got to do their turns. Well, they're not theirs, are they? They're everybody's turns, but I suppose we've made that culture for them, haven't we? So, they've taken on those roles whereas I think that we should be more involved jointly to go and do those jobs. But, for whatever reason, we've changed it so that they are sometimes left to do those jobs on their own* (RN Tansy Int 2).

Although the accountability for patient care was the remit of the RN, the HCA felt responsible for the delivery of the patient tasks. These tasks were placed so firmly within the remit of the HCA that it had resulted in both partners referring to them as HCA owned tasks; "*the nurse won't help me with my washes*" (HCA Mary Int 3). That said, HCAs still expected RNs to support them in delivery of these fundamental care activities once their medication round was completed. The complications that arose from this expectation are discussed later.

Some RN tasks did not involve direct patient contact. Locating medication, checking other RNs medication, mixing intravenous fluids and liaising with other MDT members often took place away from the bay. In contrast, the work of the HCA was within the bay and side rooms and many tasks included direct physical patient contact. This made the HCA central to the bays' ecology. A benefit of their consistent presence was that they were tuned in to any changes in patient presentations:

> *If a patient is okay one minute and something wrong the next, we would be able to identify how they were previously more than what the nurse would* (HCA Rebecca Int 4).

This is a higher-level task above that of fundamental care. The HCAs ability to recognise changes in patients was due to performing patient facing tasks multiple times over the length of the shift thereby becoming more familiar with the patient. By escalating their insights, they formed a credible link between the accountable RN and the patient. This in-

depth patient knowledge added a layer of unique HCA contribution to the dyad that was in addition to fundamental care and clinical observations.

Although their attendance brought many benefits to the patient and the RN, there were indicators that the contribution of the HCA was less valued in comparison with that of their RN partner. This was seen in both content of formal communication mechanisms and physical presence. In relation to communication, HCAs were included in exchanges between RNs in formal forums but there was a far greater emphasis on ensuring that the accountable RN received the information that they needed than the lower positioned HCA. For instance, sharing the audit results for the management of controlled medication at the huddle was not relevant to any of the HCAs in attendance (Field note 19.09.16). The bedside handovers that followed the huddle were also biased towards meeting the needs of the RN, "*it was all about what the IV drips are"* (HCA Emma Int 2) rather than fundamental aspects of care like patient mobility which indicated the support level required for personal care.

The RNs physical presence was also more significant. Their arrival at the bay prompted the beginning of the bedside handover, even when HCAs were still in transit from the huddle to the entrance of the bay:

> *Handover has started between the RNs.*
> *HCA Jean – can you start again please?*
> *Night RN carries on* (Field note 06.10.16)

The request by the HCA for the RN to recommence handover was not acknowledged and continued without pause. On more than one occasion, the bedside handover was seen to start with only half of the dyadic team present; "*And you couldn't do that if it was the nurse [missing] because they are obviously talking about medication"* (HCA Emma Int 2). This HCA felt overlooked with both to the content of the handover and the demeanour of the departing RN delivering it; "*Some will just have their back to you"* (HCA Emma Int 2). These physical actions of commencing handover in their absence and in not addressing the HCA either physically or verbally suggested that the HCAs were seen as the less significant partner in the dyadic team.

While some RNs were only concerned with handing over to another RN, others were more inclusive of the incoming HCA:

> *Night RN to HCA Monica – that frame at Bed 3 is now for him. He is self- caring. Bed 4 is self-caring and Bed 6 is self-caring* (Field notes 12.04.17)

As a result of the information given by the departing RN, the HCA was more informed about the needs of the patients in her bay. Another HCA used an alternative approach:

> *Night RN hands over bay 2 bed 1.*
> *HCA Kate – Is she staying in bed?*
> *Night RN – Yes*
> *HCA Kate – Is she two hourly?*
> *Night RN - Yes*
> (Field notes 16.09.16)

This HCA was more proactive in seeking out the information that she needed from the handover forum but an interruption of a RN by a HCA was not common practice. It challenged the expected hierarchy by bypassing her RN senior partner.

Finding out basic information about a patient's level of functioning removed the necessity for HCAs to guess their abilities at the bedside immediately before performing an activity. If this knowledge was not retrieved from handover, other resources were used:

> *Well, I look on their BEST SHOTS paperwork because it will tell me whether they transferred and whether they sit out and things like that. If that don't help me, I will look at the medical notes or ask another HCA whether they were in yesterday* (HCA Emma Int 2)

The HCA drew upon assessment tools, written entries in notes and informal verbal communication in order to glean the patient information. This commitment to finding out the information highlighted the impact it had on their work.

Once this information had been discovered, utilised and added to, some HCAs were keen to personally hand over the knowledge that they had gained at the end of their shift (Field note 20.01.17). A RN had noticed this:

> *They'll do like a little, HCA sort of, handover. So sometimes I might not ask all the questions of the nurse, in terms of mobility and stuff so much […] Because, if I*

> *can expect [HCA] to do that, and I know she will do that, […] I don't have to worry; and I know that she'll get that information, and then later on she'll tell me what I need to know (RN Lily Int 2).*

This quotation implies that this RN did not see "*mobility and stuff"* as her core business and did not feel compelled to ask about it on behalf of the team. She saw the HCA as capable in using other strategies to discover the information and then by stating "*and then later on she'll tell me what I need to know"* infers a presumption that the HCA will filter the information to only that which was essential to the RN's role. This reiterated that the tasks of the HCA were not the usual remit of the RN and they didn't need to be privy to the associated information. By the RN not prompting for this information, the work of the HCA was intensified; they had to seek out the information, decide what the RN needed to know and then pass it over at a convenient time.

HCAs reported the accumulative score of assessments. Early Warning Scores (EWS) were the most frequently reported:

> *HCA Susan to RN Fern - bed 1 is scoring 3; 2 for oxygen and 1 for heart rate. Bed 6 is scoring 3; 2 for oxygen and 1 for blood pressure. It was 2, it was 107/55 so I left her on 2 hourly obs. Bed 2 has gone for a scan* (Field note 18.09.17)

When a patient's observations were outside of pre-set parameters, they "scored". These scores were indicators of illness or harm, rather than care delivered. When HCA Rebecca was new to the role, she noted that she was assessed on her competency of physical skills such as removing cannulas and wrote entries in the Care Certificate to demonstrate understanding of person-centred care but a central part of her role was not appraised; *"nobody watches you wash them" (Int 2)*. A RN agreed that the emphasis on the quality of personal care had been compromised:

> *I think our patient care has deteriorated really, […] I think we now wash them with a few chemicals in a papier-mâché bowl and it's all very speedy […], and it's almost as if we're getting it out of the way because we've got so much else to do* (RN Tansy Int 3)

The RN saw the shift in focus away from the patient and towards documentation:

> *I don't know whether we're troubleshooting or avoiding litigation, or we're avoiding trouble from the matrons because we haven't filled this piece of paper in or we haven't done that, […]. I'm not sure that's a good thing at all, it's not what I trained to be a nurse for really* (RN Tansy Int 3)

Collectively, the HCA and the RN established that the washing of patients was not seen as important as understanding Person-Centred Care or clinical skills which both were assessed. When it was delivered, the wash was of a compromised quality because it had become a task restricted by policies, time and resources. This was reinforced by a HCA who used the quality of washes done by others as an example of how she worked differently:

> *It's just the way you wash some people and some people like, really squeeze the water out the washcloths and I think, you are going to change the sheet anyway, just drench them, so they have a proper wash. I wouldn't want a bed bath with hardly any water. So, it's just little different things, nothing major, it's making it your own routine* (HCA Monica Int 4)

Another HCA reiterated this in regard to one specific RN:

> *The nurse I am working with today, when we did the washes, they don't get a wash, they get a flick of water, the pads are changed and if their knickers are dry, they are put back on. I like to change my knickers every day whether they are wet or not. So should they. Just little things I think* (HCA Debbie Int 1)

She continued to explain more gaps in provision of fundamental care:

> *We don't have time to sit with someone to clean their nails any more, or wash their hair […] If you have had your hair washed on here, that is a luxury. It is not an everyday occurrence, or weekly occurrence.*
> ***And how do you feel about that?***
> *I think it's disgusting. Personal hygiene needs to be done* (HCA Debbie Int 1)

Both HCAs considered the washing technique of their colleagues to be of a poor standard and both described these as "little things" that were different to their own standards. This apparent lack of attention to fundamental care contrasts with the importance placed on compulsory timed tasks. HCA Debbie was observed smoothing the sheets as she made the beds (Field note 13.10.16), an attention to patient comfort that was not seen carried out by other HCAs. Yet later in the same shift, field notes (13.10.16) captured the HCA being told by the RN that a patients' two-hourly repositioning was late. The HCA had at the time, been with another patient in the

toilet. The RN came to find her and they walked from the toilet back to the bay together. In the interview that followed, the HCA expressed her frustration with the RNs rebuke because she had been busy rather than avoiding completing the task. Being behind with the compulsory timed tasks seemed to cause problems. I asked if there were consequences to being behind:

> *Well its, if you are behind on paperwork and turns and everything, the fact that you are busy isn't a good reason on this ward. If you are short staffed that is not a good reason on this ward. They still expect everything done, whatever event happens in the day, it doesn't matter as long as everything is cross your Ts and dot your I's, whatever it is they say. Because that is what it is all about now, paperwork. If you go to coroners, as long as the paperwork is done, its ok. So, people do the paperwork but don't always do what they say they have done. But it is written down, so therefore it is done* (HCA Debbie Int 1)

The HCA clarified that there were no excuses for incompletion of compulsory timed tasks. The importance placed on measurable actions portrayed that documentation and avoidance of litigation was a higher priority than personal care. This was to the extremities that the HCA implied that there may be staff who have recorded the outcome without actually carrying out the action. This level of importance was evidenced by the "*trouble*" created by matrons and reinforced by RNs checking the HCAs recording of tasks: there appeared to be emphasis on proof of actions rather than quality of actions.

Suggestion that the quality of fundamental care was secondary to other tasks was underpinned by the lack of any apparent measurement of washes. Where audit tools were used to record when a patient was repositioned, there appeared to be an absence of process with which to measure the quality or the time spent on washing or feeding someone or support of their elimination; fundamental care was given no formal recognition in the overall treatment of patients. Integrated into the main workload of the HCA and carried out in between compulsory timed tasks, only its progress rather than its occurrence was spoken of. It could therefore be considered as unrecognised and undervalued work.

In contrast to the implications of varied hierarchical positions, HCAs reported that patients were unaware that there were two levels of nursing staff in the bay: "*I think the patients that we get on this ward, they only know nurses and doctors"* (HCA Maria Int 4). Patients' awareness that this was not the case arose when a patient requested support that required an RN's input:

> *I say I will just get the nurse to disconnect you from the drip. "Well, what are you then"? I am just the nursing assistant* (HCA Monica Int 4).

It is highlighted by the HCA that patients and family carers did not identify with the role of the HCA as a separate contributor of care but as a central performer in the bay. This suggests that their role in provision of fundamental care was given a value by patients and family carers. However, the response of HCAs added contention; when describing her role to the patient, she used the word *"just"*. This suggested that she saw herself as secondary to the RN and positioned herself as such; "*In a way I am a nurse, but I am just not qualified one*". This naive description enabled others to build on their own preconceptions of the role of the RN by introducing the idea that there were distinctive levels of nurse. According to the HCA, the difference between them was whether they held a qualification.

The dyadic team of two had a hierarchy which was based on qualifications, accountability and reflected through pay. It was reinforced through the mechanisms used for communication on the ward. The HCA role encompassed support of the very basics of human need, and this placed the HCA at the bottom of the hierarchy but in the heart of the bay. They provided a link between patients and RNs through reporting clinical observation outcomes and their ability to notice change over time. When the RN left the bay to attend to higher level tasks, HCAs remained as the constant. It was this bay space that was home to the HCA for the shift. It provided the context for the dyadic team and the physical characteristics of this environment had an impact on the form and function of the HCA-RN dyad.

5.4.3 Physical isolation

The HCA-RN dyads were allocated to a bay and side rooms where they worked together for the length of the shift. The designated side rooms were most often directly across the main ward corridor opposite to the allocated bay. After the huddle, each dyadic team went to

their bay for the bedside handover. This is where their work was focused for the rest of the shift.

Each of the dyadic teams was segregated from the others by the brick walls which defined the parameters of the bay areas. Peers were on each side of the adjacent walls carrying out their mirrored duties. This physical barrier prevented individuals from being able to see other HCA-RN dyadic teams at work. Without visual comparison, individuals could only know about the workload in another bay if someone, such as the HCA based in there or the nurse in charge who had an overview of the ward as a whole, came in to their bay and told them.

Each pair may have worked together before, but there was a uniqueness to every shift. This arose from the needs of the patients that were within their bay and side rooms. Even when one partner had worked in that bay on the previous day, the patients' needs varied; "*one lady can take half an hour one day and take you 45 minutes the next"* (HCA Kate Int 1). This resulted in HCAs and RNs adapting the ways that they worked together to accommodate for changes in the needs of the patients. Therefore, the HCA-RN dyad was unique to that specific pair on that specific shift: no two shifts were the same.

An outcome of the dyads being isolated by the walls was consistency in staff presence and the continuity of care for patients across the 12.5 hours:

> *It [dyad] encourages team work in the fact that you have got a nurse and a HCA working together for the full day, they know what is happening in their bay, they have got their group of patients and that's it* (Senior RN Sarah Int 1)

The physical walls excluded others, this included other patients and colleagues. The boundaries stopped HCAs and RNs from doing tasks in other bays and leaving their bay with no nursing staff. Sometimes nursing staff did support each other with a task that required more than two people, such as repositioning a patient who was obese, [Field note 26.10.16] but that was rare. Working only in their own bay and side rooms also kept workload somewhat equitable with the same number of patients divided equally between the HCA-RN dyadic teams. Senior RN Sarah stated that extreme differences in workload were addressed by the nurse in charge.

Physical isolation has highlighted how the walled boundaries of the bay separated the HCA-RN dyadic teams from each other. It was because of the physical lack of sight of the other teams that the dyads became cognitively inward facing, turning foremost to their partner for support. This created an intense, concentrated relationship.

5.4.4 Concentrated relationship

The HCA and the RN worked more closely with each other than they did with anyone else. The tasks for patients that were completed by other people complemented their work, but they were not dependent on its delivery for the success of their dyadic team. For instance, the assessment of a patient by the physiotherapist helped the HCA and the RN to understand the mobility needs of a patient but if the physiotherapist was delayed in carrying out their assessments, they could continue to work in their absence. Whereas, if the HCA was late in completing blood glucose monitoring, the RN would need to act, before the mealtime, to ensure that patients were adequately cared for. In working closely together, there was an investment made by each partner into the dyad over the 12.5-hour shift. The intensity of the relationship was demonstrated through the language they used to define each other. HCAs and RNs used vocabulary pertaining to ownership as may usually be applied to an object rather than a person and a RN compared the connection between a mother and daughter to describe her relationship with HCAs.

The concentration on the HCA-RN dyadic relationship was generated by each partners' need for the other person to support them in carrying out their work. They invested in to the team because this was where mutual support was found. For many HCAs, the commitment to completing their work was driven by their sense of responsibility and avoidance of "*hear[ing] something from the matron or the manager that oh, this is not been done"* (HCA Hope Int 3).

The intensity of the HCA-RN dyadic relationship was expressed in the possessive language they used when referring to their partner:

> *They took my nurse off me in the bay and sent her to another ward* (HCA Mary Int 3).

The investment into the relationship of the HCA and her RN partner had grown during the time they had spent in the bay together on that shift. The unusual change to the dyadic structure part way through the shift led to the HCA's astonishment. Her use of the possessive pronouns "*my*" and "*me*" indicated that she had personal investment in the relationship and that moving the RN meant that the completion of their joint working was impeded, effecting the success of the overall shift. The HCA-RN relationship had stretched beyond the physical reliance upon each other, there was a cognitive investment.

Possessive reference to dyadic partners in this way was often overheard and commonly related to perceived fairness and equity:

> *The RN said why are you going to help them, you are my nursing assistant, not theirs. I said they needed a few of us to turn someone (Field Note 26.10.16).*

The RN was temporarily left with no partner whilst the HCA helped with repositioning of a patient. The suggestion of possession in the use of *"my nursing assistant"* highlighted the RNs authority and was a reminder to the HCA of where her first team priority was.

Confirming ownership of "*my*" HCA/RN partner was when it was inverted; "*Your nurse*" was used when a HCA asked an RN for help in the absence of her own partner:

> *But it always falls when the nurses are on break. There are people wanting pain relief and they are "why do you always come and ask me, why don't you ever ask your nurse?". I wouldn't if I didn't have to* (HCA Monica Int 4).

This negative response upheld that RNs questioned the fairness of covering for someone in another team. However, the frequency of this interaction was reduced over time. Through experience, some HCAs had gained an understanding of what RNs needed to respond to immediately and in which circumstances the information exchange could wait for their return:

> *As well now, like when [RN] was on break, that lady was scoring 3 and I thought we will just leave her on hourly where before I would go searching to find another nurse* (HCA Susan Int 4)

Being able to make a judgement about the immediacy reduced the need to interrupt a RN outside of their own dyad. Consequently, the details of events taking place within the walled parameters of each bay were kept to only the people inside of it. They became a confederate:

> *When you are in a bay together you know that's who you are working with, you are going to have "they are mine". I think you can do it in a joking way and then it is like, yeah, I need my nurse to come and deal with this rather than any nurse* (Senior RN Sarah Int 1).

The two aspects of ownership were the superficial, joking level which highlighted that 'gelling' had taken place between them, and the deeper value that was exclusive to your shift partner; to inform your own RN of changes was likely to have been quicker and safer than explaining the context to a person who was part of another dyadic team.

In addition to the use of "my" to demonstrate the investment in the HCA-RN dyad, analogy was also made to the relationship between a parent and a child:

> *If you come down to the level of the daughter, sometimes daughters can tell you things but if you are up there, they keep things to themselves. So, I think it is the same thing with work and relationship as well. If you are respectful to the role and listen to them, what they say, they tend to liaise with you better* (RN Rosemary Int 1).

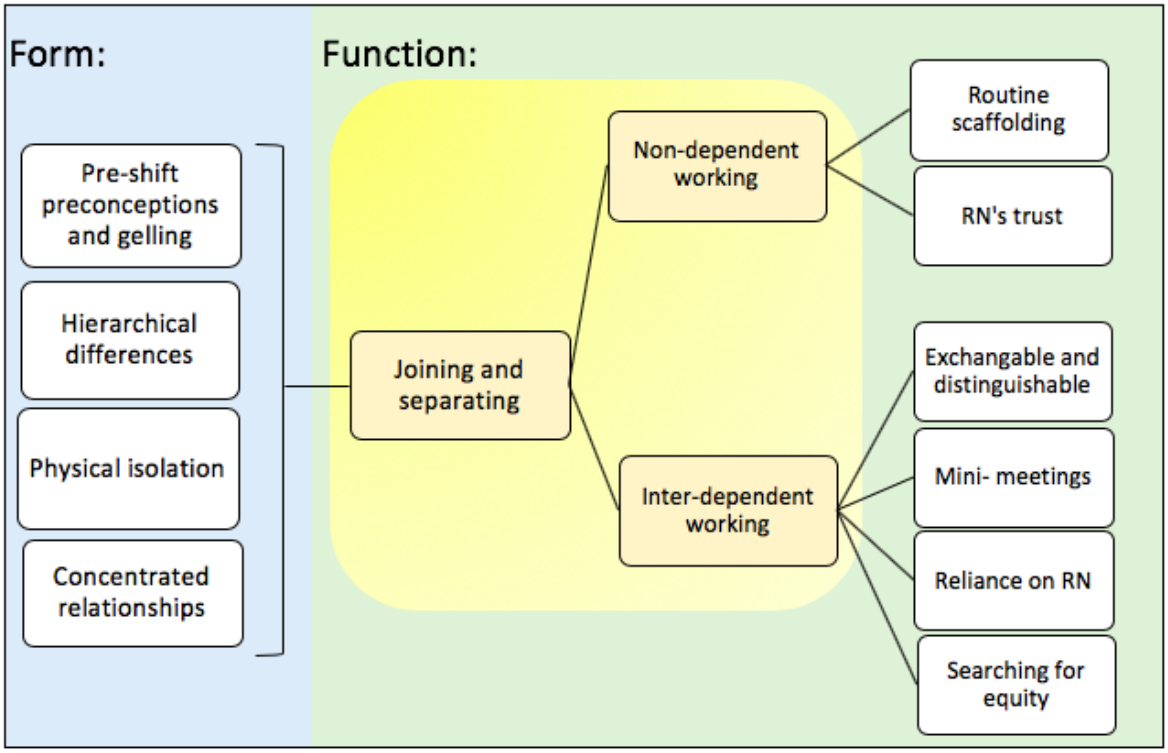
Affirming that the HCA held knowledge of different aspects of the bay work, the RN compared an open, flattened, family hierarchy with best management of HCAs. The RN also implied that being respectful to her HCA partner was a choice she made to gain the advantage of better engagement; the appreciative, concentrated relationship supported better communication and confirmed to the HCA that they had a significant contribution to make to the dyad work.

The relationship between the HCA and the RN in the bay became concentrated because they only had each other. This lack of alternative affiliations made the relationship between the HCA and the RN appear to be possessive in nature with reference to each other with the pronoun "my" and comparison with family relationships.

5.5 Summary of HCA-RN Dyad form

HCAs and RNs generated thoughts about how their shift was going to go, how the difference in their status affected their relationship, how lack of physical sight of other dyads led to a concentration on their own partnership. Now that the HCA-RN dyad has been examined, the function of the team can be considered.

5.6 HCA-RN Dyad; Function



5.6.1 Joining and Separating

The function of the HCA-RN dyad was based upon the mechanics of joining and separating. When the team functioned well, there was clarity in the periods when the HCA and the RN were working together and when they were working apart. This is demonstrated in Figure 12, Appendix 8. Joining and separating was an observable act; the HCA and the RN joined to receive handover, then parted to carry out non-dependent tasks. They re-joined later to exchange information; HCAs reported to the RNs what patients were "*scoring*" (a measure of how ill they were) and the RNs advised the HCAs which tasks needed to be given priority. Then they separated again to complete the outcomes of the discussion. At times, they

joined to complete tasks together rather than to exchange information: this pattern reoccurred throughout the shift.

To allow the act of joining and separating to take place at optimal times, spatial and temporal strategies were applied. Although the dyadic partners moved around the bay as individual entities, there were visual and audible symbols which indicated the progress of their partner's work. Often, both the HCA and the RN commenced their separate tasks in a methodical manner; the first patient on the left was a logical place to start delivering a task that was common to all bays, like offering help with eating and drinking, then move onwards to the second patient on the left. If a HCA deviated from this expected starting point, the reason was usually shared with the RN. For example, a HCA informed the RN that they intended to start the wash of the patient in Bed 4 because the patient required repositioning at that time (Field note 06.11.15).

The awareness of the other persons actions often arose without apparent consciousness; each partner glanced at the position of the other when the opportunity surfaced such as when finishing a task; a view of closed curtains around a bed and quiet verbal exchanges would suggest that the HCA was providing personal care to that particular patient. From these predictable behaviours, the visual symbols and the time of day, the RN could establish the probable advancement of the HCAs workload (Field note 14.09.16). This level of awareness enabled each member of the dyad to understand when to approach the other for information, or for planning the next actions, or to make a request for help. This was the working mechanics for when the HCA and RN sought to join and separate through the shift.

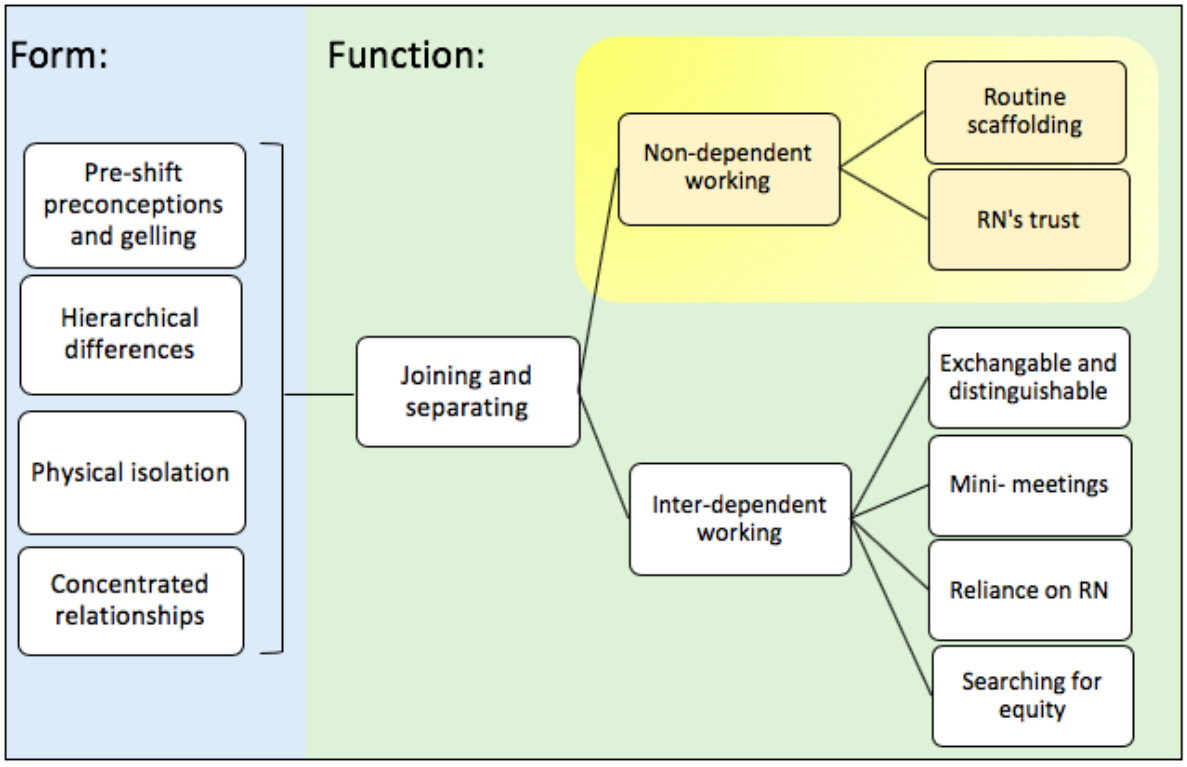
Joining and separating brought harmony to the dyadic team. When this was succinct and coordinated, observations highlighted that a smoother, slicker style of team working was generated. When asked to describe how it felt when the HCA and RN worked well as a team HCA Mary (Int 1) stated, "Everything just goes to plan". Both HCAs and RNs reported increased satisfaction when their partner knew their own role and enacted their movements without needing direction:

> *She knows what she is doing so you don't need to tell her to, drag her just to give you a hand* (HCA Hope Int 2).

The HCA knew the RN was a "*good worker*" based on her ability to quickly focus on her tasks on arrival. However, there was also a respectful interaction that preceded this; the RN asked the HCA if there was anything that urgently needed her attention before she turned to the administration of medication (Field notes 30.10.15). Regardless, the HCA felt reassured by the positive behaviour of the newly arrived RN which facilitated the HCA to concentrate on her own tasks in the confidence that the RN had a "join and separate" ethic.

To be able to join and separate with the RN, HCAs required the ability to make a non-dependent and inter-dependent contribution to the HCA-RN dyad.

5.6.2 Non-dependent Working



For the team to be successful, the HCA needed to be able to contribute when the dyad was in its 'separated' phase:

> *If she wasn't there, my patients would not eat on time, they wouldn't be washed on time, people wouldn't be changed on time, because I am focusing on tablets* (Senior RN Ruby Int 1).

In everyday practice, the HCA's actions counterbalanced the RN's intense focus on each patient in turn by ensuring that other tasks were completed. HCAs performed movements which coordinated with the RN's work. The HCA's role in the dyadic team was as a complementary entity rather than an appendage to the RN.

5.6.2.1 Non-dependent rather than independent contribution

'Non-dependent working' describes how HCAs performed tasks separately to the RN as contribution to the success of the team. The word 'independent' is typically used to describe the behaviours of a person who are not influenced by others, does not require others' support and worked autonomously. In relation to this definition, HCAs did feel able to make decisions about managing their workload:

> *Certain people might do certain things differently like make the beds first then do washes, but some people do washes and then beds first so it's about learning your own technique (HCA Rosie Int 2).*

HCAs had the scope to decide the order of some of the delivery of their work; who they chose to wash first, when they completed their "writing" in the patients' notes and small variations in washing and dressing order. Although on the surface, this appeared to be independent working, it was not truly reflective of the HCA role. They were part of a close team, where the actions of one person affected the actions of the other. Their actions were monitored, closely or from a distance, by the accountable RN. Their performance was a response to the working style of each RN that they were paired with; "*Obviously, all the nurses like different things done in a different way*" (HCA Monica Int 2). The RNs had nuances and preferences in the same way as they did in their own work:

> *You have to be very flexible, […] the different people you work with, you might change the way you work. And it's not because their way is worse, it's just maybe, it's different, so you adapt to it (RN Lily Int 2).*

For the HCA-RN dyad to function at its best, it needed to be "flexible", to accommodate the personal preferences of the individuals within it.

Whilst accepting that HCAs carried out tasks without the physical help of the RN, they did not function as an entirely separate entity. Their behaviours were inter-woven with the RNs

actions and preferences. Non-dependent working, as opposed to independent working, was a preferable term to describe the behaviours of the HCA when carrying out the routine scaffolding.

5.6.3 Routine scaffolding

The HCA's ability to work non-dependently stemmed from implementation of the routine scaffolding. This was a framework which ensured that all tasks were carried out with no omissions and met pre-set time frames: it was carried out like a ritual. By working in this way, the dyadic partners were able to separate, and the RN was released to carry out tasks that were exclusive to their role. The routine scaffolding comprised three levels of tasks; compulsory timed tasks, mandatory flexible tasks, and RN requested tasks. This is captured in Figure 13 in Appendix 8. Compulsory timed tasks described the first level tasks. From the accumulated hours of observation and confirmed in interviews demonstrated in quotations below, it was established that these tasks had to be met within a stipulated time and took priority over any other actions. These tasks were the repositioning of patients who were unable to roll over in bed themselves and sets of clinical observations.

Repositioning of patients, referred to by HCAs and RNs as "turns", were carried out every two or four hours depending on the patient's assessed risk of pressure ulcers. The act of repositioning was handwritten on a paper chart. Clinical observations comprised a set of measurements including temperature, respiration rate and blood pressure. HCAs entered the results of clinical observations onto the Early Warning System (EWS) programme via an electronic device referred to as "e-obs". The frequency of the clinical observations was dictated by the previous score:

> *And if they are scoring 1 its every 4 hours, well, if it's a new score, we have to repeat it in an hour and if they score the same, it's every four hours*. (HCA Lisa Int 3)

If the results were outside of set parameters, the patient was given a "score" on the EWS. When a patient "scored" the frequency of the observations became more regular. The time that the observations were next due to be completed could be found on the e-obs programme on the i-pad and i-phone devices. RN Ruby acknowledged that the completion

of some tasks that were previously delegated by RNs to HCAs had now become usual practice, but she believed that the new i-pads and i-phones would allow both HCAs and RNs to see where there was work outstanding:

> *I think the E- obs device has had quite a lot of impact on that as well because everybody has got access to that and it's there and it tells you when the observations are due as well. So, someone can just go OK and off they go to do that (RN Ruby Int 2)*

The RN was hopeful that through this new device, there would be a more equitable approach to the delivery of some tasks (RN Ruby Int 2). This was not yet apparent during researcher observations.

When HCAs had completed the physical checks, they verbally alerted their RN partner if the "*patient is scoring*". This prompted the RN to acknowledge the score on their e-obs device and make an entry for any further actions. When the time was reached for the observations to be repeated, a red clock face symbol appeared on the e-obs device. Therefore, it was clear when observations were overdue.

HCAs were aware that the times that the clinical observations were carried out were audited and that the results were fed back to the ward sister. The ward sister's reinforcement that audit results were important had made an impression on HCAs:

> *Obs come first* (HCA Debbie, HCA Lisa Int 4).

This phrased was used by two HCAs based on different wards. Repeated like a mantra, the onus placed on the times of the "obs" completion was suggestive of a ward level pressure descending from higher organisation groups.

The e-obs system provided easy access to accurate and current audit results which could result in early detection of a life- threatening illness. In comparison, the recording of repositioning was manual and therefore, there was an absence of the visual "red clocks" to prompt the HCAs workload and the RNs checking. The paper records for repositioning were instead checked by RNs and will be discussed later in the section 'RN's Trust'. Clinical observations and repositioning were time-related tasks and therefore provided the initial

structural framework within which other tasks were fitted. Figure 13 in Appendix 8 shows the thick black vertical lines which represent how other activity stopped for compulsory timed tasks to be completed. This could be a delay in starting the next wash (Field note 13.02.17) or continuing with the observations even when medical staff indicated that they should not.

HCA Lisa was observed going to take a patient's observations but seemed unhappy with pulse oximeter. In the interview, she stated that it was only measuring 89% saturation. She didn't think that this was right and was observed to fetch another pulse oximeter to try again. Whilst she was doing this, a medical team arrived. The HCA continued to carry out the observations in their presence. In the interview that followed, she explained why she persevered when the doctor commented that the results were fine, implying that she leaves:

> *It is because we are constantly getting, I don't know what is the right word, under a lot of pressure with obs being on time. His obs were already overdue, I think by 5 minutes or 7 minutes or something but if I had left it until after the doctors had finished it could have been like 20 minutes, half an hour later and we get in trouble because we have not been on it with the obs. We have been told that obs come before everything* (HCA Lisa Int 3)

Due to the pressure felt, the HCA believed that it was correct to continue with her task and not retreat for the benefit of the doctor. The length of the delay appeared to be significant to the trouble she would be in.

The second level of tasks was related to care rather than clinical measurements. Mandatory flexible tasks were those that were necessary to complete but did not have time constrictors. These included supporting patients with washing, elimination, food and fluid intake and recording actions undertaken in patient's notes. They were fitted in between the compulsory timed tasks. Not only were they secondary to the electronically recorded and audited timed tasks, but they were also impacted on by unpredictable human factors such as: the time the breakfast trolley reached the bay, the number of patients that needed two people to support them to wash, the amount of time needed for the RN to finish the medication round, the timings of staff breaks.

The unpredictability of the mandatory flexible tasks was problematic for HCAs. One HCA felt less in control of her workload; *"and then they will bring the meals and you just end up falling behind with everything"* (HCA Mary Int 3). Another HCA had the foresight to pre-empt a problem and altered her pattern of behaviour to allow for the forthcoming obstacle:

> *I thought I will get my trolley loaded up and get everything prepped ready because I knew that there was going to be a problem with giving out breakfasts* (HCA Freya Int 3).

The rigidity of the compulsory timed tasks and the unpredictability of the mandatory flexible tasks was managed through the small scope of movement given to them to rearrange the order of their own work. This enabled them to increase the probability of remaining on track for the next set of observations/repositioning and fit in all other work by the end of the shift.

These two levels of tasks (compulsory timed and mandatory flexible) shaped the routine scaffolding by providing the framework by which there could be assurance that tasks were less likely to be missed and progress would be made throughout the shift. It was not a concrete procedure that could be enacted without thought or adaptation; each shift was unique in its amount of patient care and the frequency and times of tasks. But the routine scaffolding was carried out by all HCAs, in some format, on each shift.

The third and final level of tasks were those that were requested by the RN. RNs had requests such as undertaking an electrocardiogram (ECG) for a patient. In comparison with the first and second level tasks, RNs requests were infrequent and were unique to the shift. Completion of these tasks were fitted in between the compulsory timed tasks and the mandatory flexible tasks as required:

> *If anything needs doing my nurse will tell me what I need to do in the bay that I look after but you kind of go off and do your own thing because you know what you have got to do* (HCA Rebecca Int 3a).

The structure of the routine scaffolding reassured HCAs and RNs that the fundamental care and audited observations would be completed and documented. The non-dependent working of the HCA was structured and was monitored by the leading RN partner; they did not work independently, but non-dependently.

A benefit of implementing the routine scaffolding was that HCAs often knew what their next task was going to be:

> *I know what is going on with each patient that I have got. I know what needs doing now and what needs doing in ten minutes time, what paperwork needs filling out etc.* (HCA Freya Int 3).

Being the primary person for the implementation of the routine scaffolding had the advantage of predicting the work. This was further extended when HCAs were aware of the consequential action to take when a patient "scored":

> *The results to the obs dictate what I do next. If the blood pressure is low, I prompt them to have a drink. If it is very low, I will see the nurse. They may want to give some IV fluids (*HCA Rebecca Int 3b).

The HCA was able to take an initial action based on the clinical observation results. To behave in this way gave further breadth to the HCA's capacity to work separately to the RN.

Evidence that the routine scaffolding had evolved as the best way of working was that HCAs on different wards followed the same formula. The extent of how much the HCA was able to contribute to the overall success of the dyadic team was dependent on the RN trusting them enough to give them the space in which to perform it.

5.6.4 RNs trust of HCAs

To work separately from the RN, HCAs had to demonstrate that they were capable and trustworthy to deliver their role:

> *We work together quite a lot so she just lets me get on with my job. I only need to go to her when I need any assistance or when patients need anything* (HCA Sam Int 1).

RNs wanted to be able to trust HCAs to complete the routine scaffolding without direction and then report anything that was atypical:

> *They can lead patients with personal care, primary care, and they will not ask for us to confirm what they are doing. They just let me know, anyway we did this, okay, thank you* (RN Nadia Int 1).

Through the experience of working together, the RN gave the HCA endorsement that they were meeting her standards. The confidence that tasks were completed and recorded was essential due to the RN's accountability for patient care:

> *I do find it frustrating that if there was a big issue then it would come back to us and [HCAs] would have no responsibility. […] they might not have told you, you might not be aware and then it's all on you* (RN Ginny Int 1).

Although HCAs expressed feelings of responsibility, the NMC registration of the RN meant that they held overall accountability regardless of whether they or the HCA carried out the task. As HCAs received a lower level of training than RNs, it was possible that they might not have appreciated the importance of an issue and might not know to report it to the RN. The HCA was also not be answerable to a professional registered group, leaving the impact of the issue with the senior dyadic partner. The RN took measures to manage this:

> *Well at first, I was just literally checking paperwork all the time like, has that person been turned, is that done. And eventually you work out who is better at some jobs than others* (RN Ginny Int 1).

The RN had become aware of the behaviours of HCAs. She also recognised the nuances of individual styles; *"some people will leave all their writing until after they have turned them a couple of times"*. This knowledge reduced anxieties that arose from finding gaps in patients' charts. In knowing the HCAs ways of working, the RN identified individuals' strengths and weaknesses. This enabled her to concentrate on checking the gaps rather than their whole performance; *"you get to work out who needs prompting at some jobs and who needs others"*. From this in-depth insight of her partner's behaviours, teamwork could be bolstered and success more likely; *"[HCA] and I are both bad at checking blood sugars. […] We know that's our little thing, so we remind each other"*.

Alongside the increased awareness of the HCAs strengths and flaws, the RN realised that she built trust through her own actions and observations within the environment:

> *I would like to think I have seen what has been going on and most of the time [HCA] will report it. You just say things in passing, don't you, or I was helping them to do that* (RN Ginny Int 1).

This broad overview of the bay added to her scrutiny of the skills of the HCA and provided further reassurance that she could trust the HCA.

Once HCAs were able to demonstrate that they were able to deliver the routine scaffolding, non-dependent working could be extended:

> *I think a good team is when you can rely on that other person to get what they need to do done, not necessarily for you to have to think about their work as well all the time* (RN Ginny Int 1).

Rather than managing both roles, the increased trust in the HCA resulted in a reduced focus upon them, thereby releasing time and concentration for enactment of their own role.

It was through time spent working shifts together that RNs learned the capabilities of HCAs but there was an initial shift where the dyadic team members had no prior knowledge of each other's ways of working:

> *If they have never worked on here before, you are having to go around and double check everything they are doing. It makes your job a lot harder because you have not got that trusting relationship there with them (RN Asha Int 1).*

As a consequence, RNs often spent additional time confirming that the HCA had carried out the tasks on time and had met their standards:

> *You can sometimes build that [trust] through the day but equally it's like 'have you done the BEST SHOT?' it's like 'Okay, I am going to have a quick look'* (Senior RN Daisy Int 1).

BEST SHOT is an acronym and the name of a paper document for assessment of pressure areas. Reassurance that the tasks had been completed was done by checking the documentation, in this case, a paper chart.

Contradictory to other RNs who were very focused on whether tasks had been completed on time and recorded, one RN was less concerned about the HCAs' skills:

> *Not sounding like my job is more important than theirs but they are not going to make a drug error, they are not going to, I don't know, they can't really go wrong* (RN Ivy Int 1).

Fundamental care and clinical observations were seen as lower risk of harm to patients than giving medication if it did not go to plan. This reassurance in the ease of tasks, rather than the skills of the HCAs, increased the RN's capacity to allow HCAs to work non-dependently.

Accepting that views differed as to the risks and impact of HCAs performing tasks non-dependently, when trust was present, partnerships became more intuitive in nature:

> *I know that I don't need to tell her that you need to fill in the score sheet, you have forgot to do this and forgot to do that, she will do it without me telling her, she knows* (RN Bertha Int 1).

The RN had developed an understanding of the individual HCAs through their predictable behaviours and conveyance of the RN's expectations. This working relationship accumulated into less verbal interaction:

> *You are working together, and you don't have to ask each other do that or can you do that. It's just everybody come in in the morning, we take the handover, straight away we each have our position and what roles we are playing* (RN Sky Int 1).

"Roles we are playing", suggests an act or performance: the dyadic partners had patterns of actions which increased predictability and therefore, trust. With the elements of predictable actions and trust in behaviours, non-dependent working could be extended. The commencement of the shift triggered the routine scaffolding of each dyadic partner and directed their separate priorities and initial actions.

Trust in the HCA was of importance when the RN had an increased pressure in their own workload:

> *Even if the shift is going really difficult or some things are happening like today, everything seems to run a lot smoother because you don't have to communicate so often what you really want to do (RN Violet Int 1).*

The RN took reassurance when they were paired with HCAs who had demonstrated consistency in performing their role during a "difficult" shift. The HCAs were trusted to carry on with their routine scaffolding tasks which ensured that the foundations of the bay work were still tended to. By HCAs performing the routine scaffolding, patient deterioration would be identified, pressure areas would not be neglected, and patients would have their personal care attended to.

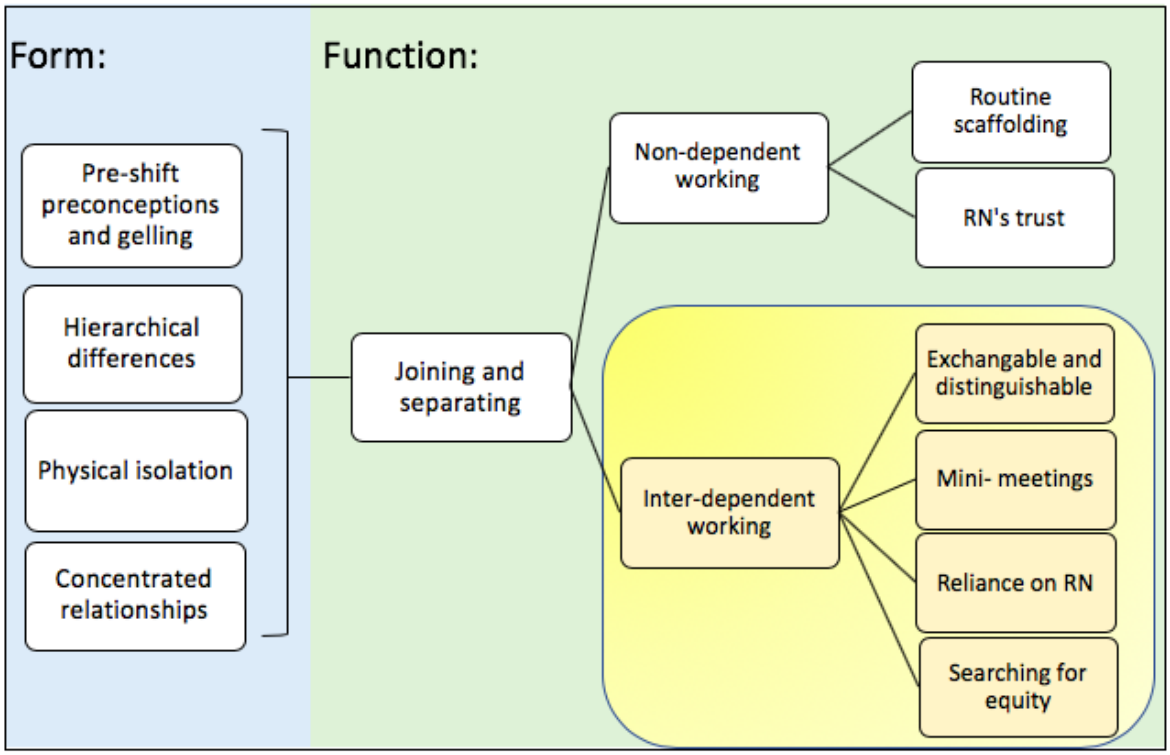
In order for RNs to be able to trust their HCA partner, they gathered knowledge about their ways of working and capabilities in applying the routine scaffolding. This provided a basis for deciding the amount of checking and prompting necessary to feel reassured. Once trust was in place, RNs benefitted from the non-dependent working of the HCA and HCAs were able to contribute for longer periods of time thereby making their contribution to the HCA-RN dyad more meaningful.

5.6.5 Summary – Non-dependent working

As RNs did not have the capacity to complete all of the nursing work that they were accountable for alone, it was essential that they worked closely with their HCA partner. The performance of the HCA was in alignment to the RNs but not dependent upon it. They added to the success of the team through their separate acts which included repeated tasks and consistent presence in the bay. The strength of their non-dependent contribution was embedded in their capabilities of applying the routine scaffolding. RNs checked HCAs' work until they felt confident in their skills and reliability. Then, the HCA's predictable behaviours reduced the need for communication in prompting and checking actions. This consequently increased the amount of time that they could function for when separated.

The HCA's ability to work separately contributed to the success of the HCA-RN dyad, but at times, there were tasks that HCAs could not carry out without help. It was necessary to join with their RN partner for inter-dependent working.

5.7 Inter-dependent working



Reinforcing that the nursing team was the relationship which occurred between a HCA and a RN for their current shift, there was assumption that any nursing work that required two people would be supplied by the two people based in the bay. Through episodes of joining, inter-dependent work was performed. Working together, the HCA and the RN carried out actions that did not mirror each other and were therefore described as asymmetrical. Their movements could be further divided into exchangeable and distinguishable dyadic activities. Where the dyadic team performed well, these asymmetrical, inter-dependent activities were planned and reviewed through mini-meetings. However, the HCA was beholden to the RN for inter-dependent working to be successful. When the RN did contribute in an equitable way, the HCA felt respected.

Each associated subtheme of inter-dependent working will now be discussed in more detail. Although inter-dependent working incorporates both partners, the primary focus for data collection was to look at how the HCA enacts their role.

5.7.1 Exchangeable and distinguishable roles

There were two reasons for tasks to require inter-dependent working; tasks that merely required two people and those where the specific skills and knowledge of the RN were requested by the HCA. Therefore, the dyadic work of the HCA and RN was divided by whether they were functioning as exchangeable or distinguishable asymmetric partners.

In exchangeable interactions, the HCA and the RN carried out the same movements but at different times. For example, one partner supported the patient in laying on their side whilst the other partner changed the sheet underneath. The patient was then rolled towards the other partner and the sheet pulled into place. In this instance, both partners in the HCA-RN dyad used commonly possessed skills to complete the task of changing the sheet on the patient's bed; there were no disparities between the roles they played, their actions were exchangeable.

In general, the HCA prompted an exchangeable interaction for support with patients whose mobility was in a reduced state. As HCAs carried out tasks for the same group of patients at set intervals, they knew how the patient previously managed and when the task was due to be repeated. HCAs made a judgement about whether they could proceed with the task alone. If not, the dyadic partner, in an exchangeable role, was requisitioned and informed of what needed to be done. The RN then led the interaction with the patient and the HCA:

> *RN – when you get up you need to turn a bit.*
> *Patient – alright*
> *HCA – shall we try again?*
> *RN – now turn*
> *HCA – well done.*
> (Field notes 12.04.17)

The HCA and RN worked together with the patient to get him onto the commode. The partners' movements were not a mirror image of each other and therefore the dyad was asymmetrical. It was not the intention of the HCA to request the help of the RN for his higher-level skills, only as a support person, and so the partners had exchangeable roles.

In contrast, when working in distinguishable roles, the RNs interposed their specialist skills into the interaction. The HCA's role was then to provide physical support and some verbal reassurance to the patient:

> *The RN irrigated and dressed the pressure area wound whilst the HCA held the patient securely on her side and gave her reassurance* (Field Notes 09.09.16)

The hierarchical differences were more noticeable when the interaction was based upon partners performing distinguishable roles. The care of the patient had reached beyond the scope of the HCA. Their movements were different, with the HCA taking the supporting role.

5.7.2 Mini-meetings

Intermittent meetings to plan, review progress and re-plan work increased productivity for both partners and enhanced the success of inter-dependent working. A short time gathered together to discuss their separate work plans increased the probability that the routine scaffolding that each partner implemented would, at times, coincide. Through spatial and temporal awareness of the visual and audible symbols representing their partner's movements, HCAs had a clearer understanding of when to interrupt the RN and the RN was more aware of when a request for support from the HCA was pending. An example of this was when a partner returned from their break. They seemed to walk straight to where the HCA or RN could be found in order to receive a quickly-delivered update on the activities in the bay (Field note 18.09.17). As a consequence of knowing where each other were, the HCA spent less time waiting to complete inter-dependent tasks than when working in teams where there was no planning. On an occasion where the dyad had not held a mini-meeting, the patient, the HCA and the relative waited for the RN to help move the patient from the commode to the bed:

> *HCA calls RN by name for a second time*
> *HCA - Are you ready?*
> *RN – I am coming*
> *Daughter – you said two minutes, not that we were counting.*
> (Field notes 13.11.15)

The frustration of waiting for support became palpable when the HCA was overheard to say to herself "it drives me nuts" (Field note 13.11.15). Mini-meetings enhanced the flow of the

movements of both partners as unproductive intervals were minimised and patients spent less time in undignified and uncomfortable states. In teams where the RN instigated mini-meetings, the initial gathering took place after handover and comprised the RNs explaining what they would like the HCA to do:

> *0745hrs - RN – She declined everything orally yesterday. [HCAs name], you need to push fluids (Field notes 14.09.16).*

It was also used to share information if one of the partners worked in the bay on the previous shift:

> *0750hrs - RN asks HCA who is 'a double' and who she can do alone. HCA told her what she knew from her night shift. She looked towards each bed "he walked to the toilet, he walked to the toilet"… "I will call you". RN laughs and they continue with their separate tasks* (Field notes 11.04.16).

The term 'double' referred to those patients who needed two people to provide their wash or repositioning. The knowledge of how many patients were 'a double' gave the RN an indication of how much inter-dependent work was pending and how much could be done by the HCA alone; doubles were a restrictor of the HCA non-dependent working capacity. A plan for inter-dependent working could be generated.

At a mutually convenient point such as a natural break in work, or at the discretion of the RN leader, the team reunited:

> *After she gave out the medication, she has been communicating with me, asking me who's scoring, asking what's going on, asking who needs a hand* (HCA Maria Int 3).

Mini-meetings to achieve continuity in inter-dependent working occurred as frequently as necessary throughout the shift. The team then re-joined towards the end of the shift for the RN to check all patient related information with the HCA before writing in the patients' notes.

Both the HCA and RN felt the benefits of the mini-meetings. It helped to have an up-to-date overview of the bay space and side rooms and was believed to reduce omissions and repetition of tasks (RN Daisy Int 1). It made it easier to request joining for inter-dependent

working because each person knew the plan of their partner and could use this information alongside their physical location.

As the team leader, it was the RN who chose whether to hold mini-meetings:

> *Some don't really plan, they just go straight into their medication and don't consider that there are other things that we have to work together as a team, for example, the washes, the feeds* (HCA Maria Int 3).

The HCA saw the joint planning as an indicator of investment into team working. However, for mini-meetings to work, the RN needed to be willing to interrupt their own priorities.

5.7.3 Reliance on the RN partner

It has already been recognised that the RNs possessed the whole gamut of skills necessary to provide care for patients but that they were not physically able to carry out all of the tasks personally. Despite the necessity for working with a HCA partner, some HCAs perceived that RNs did not see the inter-dependence between their role and that of the HCA. Therefore, they did not invest in the dyadic relationship:

> *I think it's all about hierarchy really, sadly. Because they are up here, they can do everything we can't do. And they will be like, oh, we are busy […]. I think there are a lot of nurses that don't want to help* (HCA Rosie Int 4).

Being *"busy"* excluded some RNs from involvement in the provision of fundamental care of their allocated patients alongside their dyadic partner. The hierarchical structure placed RNs in a position where they could make choices and control elements of their workload:

> *A lot of the newly qualified and international nurses don't see [personal care] as their role anymore* (Senior RN Ruby Int 1).

Some RNs used their senior position of authority to choose not to include personal care of their patients in their day-to-day activities.

Rather than being aware of an explicit expression of withdrawal, HCAs were suspicious that some RNs extended the time spent on RN-exclusive tasks as an avoidance strategy:

> *They're self-caring, they've not done anything with them, but they'll still write this big, full long sheet of paper, which is very annoying on our part because*

> *they'll be sitting there for about half an hour and all we want to do is get on with the next person* (HCA Jean Int 1).

Some HCAs felt that certain RNs took longer than seemed necessary to give out medication to avoid *"helping with washes" and* were scathing about this; *"Two and a half hours for a medication round to do seven patients"* This was referred to as *"Holding on to the drugs trolley"* by a HCA:

> *They will hold on to their drugs trolley, they will wander off and disappear for God knows how long and they will make no end of different excuses to why they can't come and help you wash people* (HCA Hope Int 4).

As the access to the drugs trolley was restricted to the RN, it could be seen as a status symbol; an object, held like a physical barrier, reiterating the power of their senior role. "*Wandering off*" and "*disappearing*" was in direct connection to the medication round and therefore RNs did not explain their absence to their partner as it was not related to the HCAs tasks.

As much as HCAs suspected that certain RNs were avoiding involvement in washing people, they were making judgements about tasks that were outside of their own remit. Also, the HCAs did not have the power to influence RNs to attend to inter-dependent working tasks more quickly. Whilst RNs appeared to be avoiding the lower-level tasks by stretching out RN-specific tasks, there was no signs of recognition by the RNs that their delays had a negative impact on the progress of the HCAs. From observation, it could be seen that the routine scaffolding tasks were more difficult to achieve without RN support, but HCAs still felt a responsibility for its completion. For this reason, HCAs found ways to fill the gap left by the absence of the RN. They used three techniques to achieve this; asking a peer to help, escalating it to a senior nurse or doing the task alone. The decision as to which technique was used was dependent on a variety of factors such as personal preference, ward culture and the resources available.

Sometimes HCAs sought out their HCA peers help to fill the gap. A HCA confirmed that "*It is much easier to go to the next bay and borrow the HCA from there and say can we pair up*" (HCA Catherine Int 1). Confrontation with the RN was avoided and 'saved' for other

forthcoming challenges, "*then you can pick your battles through the day*" (HCA Catherine Int 1). The team of two people in a bay, one HCA and one RN, was not always achieved on wards due to staffing shortages. The HCA-RN dyad was then compromised as each team member was allocated patients in more than one bay or had more than one team member to work with. It was in these circumstances that HCAs were seen asking other HCAs for help. As a consequence, the qualities of the HCA-RN dyad were diminished; the concentration on the partner was lost and the boundary wall was no longer a physical barrier defining HCA-RN dyadic teams.

Although HCAs were now working across bays in this circumstance, it was still difficult to find another HCA to help:

> *Obviously, they have got more to do as well. So, asking them for help is adding on to their task list when they are already running behind* (HCA Lisa Int 3).

The depleted team turned to each other for support despite knowing the challenges of their workload. This style of working also relied upon both HCAs being available at the same time and some level of trust that they would reciprocate the help:

> *There is always that one person who says let's work together, let's work across the two but then they take you in to their bay and it's like right, we will do everything in here first and then you find that your bay gets left til last and then you are running behind and they don't want to know* (HCA Mary Int 4).

When HCAs worked with other HCAs in the absence of RN support, the HCAs 'default position' was still to complete all of the routine scaffolding in their own bay by the end of the shift. This HCA reinforced that when working with a HCA peer rather than the RN partner, this driver was still predominant and resulted in an inequity in commitment to the workload of both HCAs.

Rather than turn to peers, some HCAs chose to escalate the need for support to the deputy sister in charge of the shift:

> *I wanted to fetch (Deputy Sister) so I could just get it done, get the lady sorted* (HCA Kate Int 1).

The RN partner was already occupied when the HCA asked the deputy sister for her opinion on the pressure area of a new patient. The HCA expressed awareness that she had by-passed usual protocols but justified this with meeting patient comfort.

On one ward it was commonplace for HCAs to report their need for more support to the senior nurse:

> *I went and spoke to the nurse in charge and said I can't cope. She got somebody to come and help me. I said it's not fair that everything has been left down to me whereas she's not doing anything to help anybody (HCA Rosie Int 2).*

This suggests that the quality of this particular HCA-RN dyad was not strong. The HCA wanted to demonstrate the weakness of the RN support to a higher authority. The strategy risked making the HCA look inadequate but exposed the RNs lack of *"fairness"* in contribution to the team to a person higher in the hierarchy. The technique of escalating the gap was successful. The deputy sister resolved the immediate issue through deployment of a HCA from a bay where workload was light, which reconciled the situation.

Working alone was another way of filling the gap when the RN was unable to help; *"If you can't help, then I will do it on my own, which is taking the risk"* (HCA Hope Int 3). Tasks that required two people were often moving and handling manoeuvres. "*Taking the risk*" referred to putting the HCAs own physical health at stake in order to complete a task alone that required two persons. This choice of action was executed when HCAs felt a pressure to continue to work at a pace that would allow them to complete all of the routine scaffolding on time:

> *If somebody can roll but needs to be held, that is where I try it on my own but normally that is classed as a double […]. If I have got a patient that should be a double I will say I am on my own today so you are really going to have to help me, okay? (HCA Freya Int 2)*

The HCA did not possess mobility information from the bedside handover but instead assessed the patient's capabilities when she approached their bed. Once she approached the bed, she considered what the patient would be "classed" as, but the difference in the decision of whether she could complete the wash alone was not only reliant on the patient's physical abilities but also related to whether they had the cognitive understanding to act on

her instructions. Asking patients to "help" her placed the onus of success on the patient's ability and willingness to support her rather than accepting their physical limitations at face value. From this perspective, filling the gap left by the RN by doing the work alone led to the patient fulfilling the exchangeable partner's role in the dyadic team.

When the patient was able to roll so that some of the wash was done, the RN was called for to complete the task, for example, for supporting the patient in sitting forward so that pyjamas could be put on. The HCA believed that only asking the RN to support the end of the wash rather than the entire wash improved the RN's response time when it was requested:

> *I will do as much as I can on my own and at the point where I need help, it is because I do need help and it is putting people's safety at risk. So now they have got to know me [RNs] realise if I ask for help it is because I do genuinely need help* (HCA Freya Int 2).

Through working in this way, the HCA had extended her non-dependent working time and decreased the need for inter-dependent working with the RN partner. As a result, the RN was not called as often or for as long: she felt that trust had been built. The HCA and the patient spent less time waiting inactive and the HCA had more control of her own workload.

Asking a peer, escalating the gap to a senior nurse or performing more of the 'double' activity alone were strategies implemented by HCAs to ensure that application of the routine scaffolding continued in the absence of a RN partner. It exposed the way in which the form of the HCA-RN dyad had been compromised. The extent of the HCA's efforts to fill the gap highlighted how the absence of the RN was not viewed as a reason to halt provision of the routine scaffolding. However, working with a RN who was invested in their role as a dyadic partner was easier for the HCA. The impact of inter-dependent working on achievement of the routine scaffolding implementation led to HCAs having a sensitivity to the contribution of the RN to the workload. This led to questioning whether they were being taken advantage of in the distribution of work.

5.7.4 Searching for equity

The HCAs had two interlinked concerns with regards to equitable working with their dyadic partner. They asked themselves whether the RN was contributing fairly and whether the RN was taking advantage of them or *"taking the mick" (HCA Rebecca Int 4).*

The equity of the contribution between the partners was a personal perception held by the HCA. This was based upon how they defined their own role parameters and which tasks they consider not to be shared tasks. HCAs at one end of the spectrum saw their role as predominantly completion of as much of the work as possible that did not require NMC registration:

> *It's about having that support for them so they can go on and do other jobs that they need to do, whether it is documenting or medications or dressings (HCA Lisa Int 4).*

Assisting the RN, by relieving them of any tasks that they could, created space for the RN to concentrate on higher level tasks. This depicted a clear hierarchical split: those tasks that were carried out by RNs only and any other tasks. Other HCAs saw this as an opening to being taken advantage of:

> *I think some nurses think because you are the HCA you do all the rubbishy jobs and they don't do that, that's not in their job description* (HCA Alana Int 3)

Some HCAs tried to limit this opening for being taken advantage of:

> I *don't do no washes until they have done the meds. If you start them, they will think "she will carry on so if I just take my time, I won't have to help her" (HCA Monica Int 4).*

Through the knowledge that each partner was aware of the other's movements, the HCA was mindful that her actions and progression in washing patients would be noticed and interpreted by the RN. There was manipulation of the work towards gaining the best response from the RN. She chose to give a different non-verbal message to her partner; "*I just wait for them now, it's both our responsibilities, I ain't straining my back"* (HCA Monica Int 4).

At one end of the spectrum of equity was HCAs completing as many of the non-registered nurse tasks as possible, at the other end was the belief that the success of the HCA-RN dyadic team occurred when RNs did half of the fundamental care tasks:

> *Today went really well because [RN name] fed one patient, I fed another, […] so that was an equal balance* (HCA Maria Int 3).

Fundamental care tasks such as washing and feeding patients was viewed as sitting within the remit of the HCA. Although the HCA saw a literal, numerical split of the task as suggestive of a well-performing dyad, this was *"equal balance"* of delivery of a HCA led task, not an inter-dependent task.

A RN debated whether this way of dividing work was fair; RNs had tasks that HCAs could not deliver. She expressed that the importance of her role was overlooked by those HCAs who insisted on equity in carrying out washes:

> *It is difficult for them to understand, sometimes I think it shouldn't be, because when you have poorly patients you have to be on-hand and you have to do everything you can for that patient. If something happens you can't say oh, I had to wash a patient* (RN Tansy Int 1).

The RN saw that HCAs had a lack of insight into the RN role despite their close partnership working. Where distinguishable movements were earlier discussed in relation to specific interactions during task delivery, this time the HCA and RN were distinguishable in the more general context of the bay. The RN reiterated that there was a hierarchy of tasks and washing and feeding patients did not take priority over tending to *"poorly patients".*

There was confirmation that the HCAs did not have a full understanding of the extensive role of the RN. A HCA reported that they saw RNs administering medication but they did not know what RNs did for periods in between (HCA Laura Int 1). As the HCA rarely left the bay, their judgement about the workload of the RN was based on what they could see them doing.

The RNs absence from the bay had a negative effect that stretched beyond the lack of understanding of their role. Through not being present, the RN was less aware of the

proceedings in the bay, they lacked insight into the HCA workload and did not share the work:

> *She was in the office and then she came out about seven o'clock when we were due to nearly finish and she said I have not seen you do any turns today. And I said you have been in the office so don't come out and ask me what I have done and what I ain't done because you have had no part in it at all* (HCA Emma Int 2).

The HCA expressed hostility towards the RN for not performing her part in the HCA-RN dyad. Their physical lack of presence in the bay meant that her reflection was interpreted as criticism which infuriated the HCA who had worked without leadership or support. In the mind of the HCA, the RN had lost their entitlement to challenge the actions of their partner through lack of equitable contribution to the team work.

This interaction underlined the dichotomy of the RN's accountability for patient care and the choices they made in ensuring its delivery; the RN had trusted that the HCA would perform as per expected practice. There was no consideration of equity of work and the RN had assumed it was reasonable to leave the HCA to carry out tasks alone in the bay. This was seen by other HCAs:

> *I have done the Best Shots and I PAT- slided them, I have got them changed, washed and dressed and I go to write, and they say I have already done that while you were in there changing them. I say yes, but you didn't do it and your name is at the side of it. Although nobody is ever bothered, but I think, I have done all that* (HCA Toni Int 1).

There was inequity between the HCA who completed the tasks and the RN who did not participate but was seen to take the credit as she had signed the written entry in the patient's notes. Stating *"although nobody is ever bothered"* suggested that it was usual practice for tasks contribution to go unnoticed; the importance was placed on whether the task was recorded rather than who delivered it.

Equitable working was a demonstration of respect for the contribution that the HCA made to the success of the team:

> *We work in a team, so I don't say no, I am a nurse and I need to speak with the doctor. I know you are a professional carer, you can do it* (RN Daisy Int 1).

Encouraging the HCA to communicate with the doctor had the advantage of continuity of care in the absence of the RN and demonstrated that the RN trusted the HCA: their contribution to the team was valid.

When respect was present, the impact of the hierarchy was reduced:

> *Even though she is higher than me, we are acting like we are at the same level and she does include me in the decisions that she makes in the bay as well. It makes me feel like I am part of the team and that we are not working on our own* (HCA Rosie Int 2).

The HCA was led to believe that her input in the care of patients was of value because her opinion was sought. With this act of inclusion, the RN was acknowledging that the HCA had a significant contribution to make to the team, an equal to the RN.

In searching for equity, HCAs tried to shield against being taken advantage of. They strived for equity in work and respect for their contribution. They judged whether the RNs contribution was fair and used techniques to protect against having "the micky" taken out of them. But what was classed as equitable working was debated with opposing views in play. This said, an equitable dyad was an aspiration for HCAs at the beginning of each shift, regardless of where on the spectrum they saw the correct level of support to be.

5.8 Summary – Inter-dependent working

As HCAs carried out their routine scaffolding, tasks arose that required the support of their RN partner. By partaking in exchangeable and distinguishable asymmetric roles, HCAs and RNs provided care together. It was seen that mini-meetings between the dyadic partners enhanced the success of inter-dependent working by increasing the probability of routines coinciding which reduced disruption and waiting time. But, in the lower hierarchical position, the HCA was reliant upon the RN for inter-dependent working to be successful. When the RN was not able to support the HCA, they asked peers, escalated issues to a deputy sister or did the tasks alone. Reflecting on the success of the HCA-RN dyad, HCAs opinions varied in how much support was felt to be equitable. When HCAs felt the relationship was more equitable, they had a more positive experience of the HCA-RN dyadic team working.

5.9 Summary

Exploration of the relationship between the HCA and the RN who work in a bay for a shift has been presented as a new concept of a nursing team. Defining the form of the HCA-RN relationship was through acknowledgement of pre-shift preconceptions and gelling, hierarchical differences, physical isolation and concentrated relationships. The HCA-RN dyad functioned by joining and separating through the shift. HCAs needed to be able to work non-dependently and inter-dependently to contribute to the HCA-RN dyadic team. Non-dependent working was enacted through application of the routine scaffolding and came to fruition when they had the trust of their RN partner. When working inter-dependently HCAs and RNs partook in exchangeable and distinguishable roles. Mini-meetings were a tool with which to plan and review their team working to ensure that there was effective use of their time. The RN's commitment to working as a pair was crucial and the HCA's definition of "equity" influenced whether they felt the RNs were fair in their contributions.

Where successful non-dependent working required the trust of the RN, for inter-dependent working to be successful, HCAs needed the RN's support. HCAs searched for equity and protection against being taken advantage of. However, the HCA's contribution to the success of the HCA-RN dyadic team was intertwined with the RNs contribution: neither partner could function without the other. These findings will next be discussed in relation to the literature.

Chapter 6 Discussion and conclusion

6.1 Introduction

The aim of this study was to explore how HCAs enacted their role in an adult, in-patient environment. The objectives were: to gain an understanding how HCAs connected, interacted, and related to people whilst at work; to ascertain HCAs perceptions of the enactment of the HCA role; and to develop a construction of how HCAs enacted their role. A focused ethnographic approach generated data which provided a new understanding of how HCAs worked with RNs. It was identified that the HCA and the RN worked as a dyadic team to provide care for patients in a bay and associated side rooms. The HCA-RN dyad, as a new concept of team, was defined in both its form and function.

This chapter will discuss and conclude the findings of the study. The description of the HCA-RN dyad, or the form, is considered in light of efficacy beliefs discussed in Habeeb (2017) and a US study which brings new insights to physical isolation and concentrated relationships. After discussing the form, the joining and separating of HCAs and RNs is considered in relation to the literature. This includes audit culture and boundary work, red clocks and the role of senior nurses, task based work and its effect on person-centred care and the conflict of New Public Management and person-centred care philosophies for the organisation. There is a summary of the discussion before presenting the contribution to knowledge, the contribution to methodology and methods, the limitations and the implications and recommendations for practice.

6.2 HCA-RN Dyad – form

The concept that has emerged from this study is that of the HCA-RN dyad as the primary nursing care model in the adult ward setting. This close partnership working is different to descriptions of nursing models seen in the past. Previously, nursing work delivery has either been by a team orientated approach or by individualised patient approach (Gillies 1994, Barnum 1998). Neither of these accurately described the current nursing care in the acute hospital ward environment found in this study. The findings have highlighted that the HCA role exceeds that of assistant, and that it is integral to the achievement of nursing duties.

The HCA-RN dyad is a different form of team working that is newly identified in nursing. HCAs have adapted in order to work non-dependently and inter-dependently, moving towards and apart from their RN partner as the work unfolds. The individual HCAs and RNs have learnt to manage each other's strengths and deficits in order to achieve their total workload. This new way of working has evolved as a reaction to imposed changes in the environment such as RN vacancies, financial pressures, skill mix changes, patient safety measures and the layout of the physical setting.

The HCA-RN dyadic team discovery has shown that my motivation for the study, whether HCAs were working autonomously, was too simplistic in its assumption. HCAs did work separately from the RN as I had seen before commencing the research, but this perception did not account for the complexities that were within this separate working. These snippets of observations prior to data collection had picked up on how the HCAs were in the bay and the RN was less visible and not providing constant direction. However, this research provided indication of their reliance, responsiveness and reactions to the RN with whom they were paired with. It captured the subtle interactions between the partners which often occurred in whispers, in visually reading each other's progress, in assessing their partner's skillsets. It reflects a fundamental aspect of dyads; each of the partners had a closeness to the other that was not replicated with other members outside of the dyad (Kenny and Cook 1999).

Kenny and Cook (1999) looked broadly at dyads within interpersonal relationships. They used examples from studies on romantic couples and siblings to illustrate their model. Their work has been used to explore areas including shared decision making between patients and general practitioners (Melbourne et al 2011) and cheerleading pairs (Habeeb 2017). Kenny and Cook (1999) stated that there can be four different combinations of how the two people in the dyad, the actor and the partner, affected each other in the relationship; actor-orientated, partner-orientated, couple-orientated and social comparison. Their definition of actor-orientated research described the standpoint that I took for this study. I viewed HCAs as a group whose role had changed in a way that was not reflected in the literature and chose to focus on them. Subsequently, I thought of the work and relationship of RNs and others only from the HCA's perspective. In hindsight, my initial curiosity surrounded how

HCAs were *not* working under close direction from the RN and yet I did not deliberate whether and how their roles could be 'separate'. I discovered that there were partner effects which corroborated an interdependence between the two people (Kenny and Cook 1999). Also, in keeping with Kenny and Cook (1999), it was noted that the greater the interdependence, the greater the partner effect had on the individual. This was illustrated in the anxieties HCAs expressed about their RN partner's performance, particularly in pre-shift preconceptions.

The findings of this study exhibited that each HCA-RN dyadic team contributed to the accumulated whole ward nursing team. This reflected Habeeb's (2017) description of dyads being small teams nestled within a wider team of cheer leaders. The wider team was given a score for the performance rather than scoring the smaller teams that it was comprised of (Habeeb 2017). This is also reflected in the feedback from audit reports on wards. The whole nursing team is viewed as the public face of the ward. There was no breakdown of activities even though dyads within the whole nursing team could be performing at very different levels. This may alter in the future as the extraction of data from electronic observation devices becomes more sophisticated. The current, generic style of feedback did not evaluate dyadic working, or even personal contribution, thereby reducing opportunities for individuals to reflect on their own performance in meeting the goals of the whole team.

How nursing teams function has previously been explored via the movements of the RN before all else. Then, from this starting point, attention moves to the contribution, or impact, of other healthcare workers (see Barnum 1998, Gillies 1994). This implies that other healthcare workers have been viewed as having secondary status, working on the peripheries of nursing care, rather than significant contributors (Francis 2013). This importance placed on nurses doing nursing work is reinforced by documents such as the Houses of Commons Health Committee report 2017-2019 (2018) which looked at the recruitment and retention of the nursing workforce. It doesn't mention HCAs but does recognise nursing associates, presumably because they are also registrants. This study challenges this view by illustrating that the role of the HCA is more central than previously acknowledged. It has shown the RNs cannot complete their workload on an in-patient adult ward without the support of their HCA partner.

There is evidence that dyadic relationships have been studied in the field of health. Examples are studies on patients and caregivers (Ellis et al 2017), a parent and their child (Venkatesh et al 2019), people with dementia and their relative (Martin et al 2009), doctors and patients (Von Friedriches-Fitzwater and Gilgun 2001), and dentists and dental nurses (Hakenen, Perhoniemi and Bakker 2013). These accounts included how the actions of one partner affected the responses of another through looking at specific events. For example, Hakenen, Perhoniemi and Bakker (2013) considered whether there was a crossover of exhaustion between dentists and dental nurses. Crossover is defined as the process by which the stresses of one person are transferred to another person within the same vicinity (Westman 2011). The asymmetrical roles, the variance in hierarchy, the importance placed on the interpersonal interactions in this working relationship has many similarities with the HCA-RN dyad. Although not specified in the article, it is known that the dentist and dental nurse work mainly within the confines of one room as did the HCA-RN dyads. As with my study, Hakenen, Perhoniemi and Bakker (2013) focused on the interdependent dyad without inclusion of the patient's presence. This implies that the ongoing attendance and departure of patients occurred alongside the phenomena being researched. A difference between the dentist and dental nurse and the HCA-RN dyad is that the former is a more recognisable, more established dyadic team. The majority of their work is done in partnership, often with the same person, in one room with little interruption from supporting colleagues such as the receptionist and hygienist. However, in my study the recognition of a dyad which sits within a known, wider, nursing team is a new concept for nursing.

There has been acknowledgement in the literature that the RN and the HCA worked together to provide care, as presented by Spilsbury (2004), Kessler et al (2010) and Thornley (2000), but the complex, inter-relational working identified in this study has not previously been articulated. The term 'dyad' has also been used in regard to HCAs and RNs working together. Kalisch and colleagues looked at the relationship between the HCA and the RN in acute care hospitals in the US where HCAs were called Unlicensed Assistive Personnel (UAP) (Kalisch, Weaver and Salas 2009, Kalisch 2011, Kalisch and Lee 2012). In 2011, Kalisch used the term "RN-UAP dyad" (p 20) when listing seven barriers to nursing team working. These

included: lack of role clarity; inability to deal with conflict; and the UAP not included in decision making. Although the term dyad was used, it was not as has been presented here. For instance, in Kalisch (2011), there was a higher number of RNs than HCAs on a shift and therefore they were not the dyadic pairs that worked in close proximity, and to the exclusion of all others, as the HCA-RN dyads in my study were. Indeed, it is believed that many of the seven barriers to RN-UAP teamwork identified by Kalisch (2011) would be addressed if the HCA-RN dyad was successfully implemented.

Further exploration of the physical form of an HCA-RN dyad can be illustrated through additional comparison with cheerleading dyads as presented by Habeeb (2017). The HCAs in my study presented as steady, reliable and predictable in the enactment of their role. This was verified in the stringent application of the routine scaffolding. They spent much of their time in the bay and as a consequence, could see changes in patients which they reported back to their RN partner. This consistent behaviour and bay-based presence provided a solid ground for nursing care. The position of the HCA was representative of Habeeb's (2017) base role in the cheerleading dyads. The base was strong and provided a secure foundation for the flyer. Their performance was consistent and did not change with different partners. They brought stability to the team. The RNs role resembled that of Habeeb's (2017) description of the cheerleading flyer. The flyers were thrown into the air, carried out a move and were then caught by the base. Flyers reacted and altered their performance in response to the bases' starting throw. This reaction can be seen as a parallel with the RNs response to the feedback or changes brought to their attention by their HCA partner; their movement is in response to the feedback given to them by their dyadic partner. They were dependent on this solid base. With the HCA consistently situated in the bay, with their feet firmly on the floor, the RN entered and exited in accordance with what was necessary to fulfil their duties. The physical gap created when the flyer was air-bound positively correlated with how the HCA and the RN were physically separate when the RN left the bay. The HCA was able to hold their position until the RN returned and then provided them with the information they needed for an 'aerial' understanding for the bay that they were accountable for, it was a part of joining and separating.

Habeeb (2017) found the base to be self-efficacy focused; they assessed their team performance on their own achievement as a consistent thrower and catcher (Habeeb 2017). The flyer, in contrast, was not primarily focused on their self-efficacy. Instead, the flyer reinforced the base's belief by also directing her efficacy beliefs on the performance of the base and being other-efficacy focused. This means that both partners believed that the success of the team was built on the performance of the base. However, for the HCA-RN dyad, both partners saw the other partner as the key to whether their shift was going to be successful or not. This other-efficacy focus was seen in the HCAs need of the RN for physical support and their anxieties about whether the RN would provide it willingly or would need to be prompted. RNs were concerned about the capabilities of the HCA before the shift, as they were dependent on HCAs for completion of lower-level tasks in order to release them to do higher level tasks; they too were other-efficacy focused. This emphasised the extent of the intertwined relationship; it was not possible to separate out the success of one person without looking at the contribution of the other. Efficacy beliefs discussed in Habeeb (2017) were also evident in other parts of the HCA-RN dyadic form.

6.2.1 Pre-shift preconceptions and gelling

HCAs held preconceived ideas about how the shift would progress based on with whom they were paired. As stated above, HCAs were generating other-efficacy beliefs; an individuals' beliefs in their partner's capabilities (Lent and Lopez 2002). The other-efficacy beliefs were founded upon four perceptions as seen in Habeeb's (2017) work: 'partner's previous performance,' 'beliefs about similar others', 'third-party views' and 'social stereotypes'. Data from this study has highlighted that HCAs based these perceptions on interactions which were away from the current shift both in time and in physical space. Previous shifts together were the basis for perceptions of the 'partner's previous performance', conversations in staff rooms between two or more HCAs demonstrated both 'third-party views' and 'beliefs about similar others', and speculation that agency workers would not support them in delivering their tasks was illustration of 'social stereotype' perceptions. This shows the link between pre-shift preconceptions and other-efficacy beliefs thereby emphasising the importance and impact of this phenomena. This was compounded by the knowledge that other-efficacy beliefs have an impact on self-efficacy beliefs (Lent

and Lopez 2002) which is a vital element of personal success (Bandura 1997). Therefore, if HCAs believe in their RN partner's abilities to complete the work, then their belief in their own success will also increase. HCAs who experienced this phenomenon appeared more relaxed during their shift and teamwork was completed. In effect, Kalisch's (2009) finding may be reflected here; improved teamwork between HCAs and RNs will lead to higher quality patient care. This would require further investigation.

"Gelling" occurred during a shift when the HCA and RN had time to exchange more personal information. Other research in developing an inter-personal relationship between a HCA and RN during a shift wasn't found but Kalisch and Begeny (2005) discussed strategies for improving nursing unit team work where 'familiarity of team members' was a theme. Here they linked the capacity to become acquainted with another team member's strengths, idiosyncrasies and vulnerabilities to the number of people in the nursing team: fewer people meant more frequent shifts together and quicker learning about each other. This upholds my findings; recognising that knowing the strengths and weaknesses of team members had significance in provision of quality care. However, Kalisch and Begeny (2005) omitted contemplation of how the length of the shift could have an impact on relationships rather than solely the number of shifts; whereas HCAs and RNs in this study believed that the length of time spent together meant that gelling could make a difference to how quickly the time passed.

The values HCAs attached to getting to know someone personally, due to the long shift, was not seen in the literature. Rather, previous studies show the HCAs can learn and have proof of their skills, but professional socialisation was key to acceptance by the RN (Hancock et al 2005). The emphasis, in the literature, placed on cultural integration suggests that HCAs needed to be seen as 'one of us' before the relationship could proceed. This could be viewed as an antecedent step towards gelling. The acceptance of new HCAs, or an increase in the involvement of HCAs, is an example that RNs were perhaps applying other-efficacy, by pre-judging HCAs in a negative light, based on 'social stereotypes' and previous experiences. It happened before the performance with a specific HCA had taken place. Previous literature did not acknowledge that this relationship-building was a two-way process, whereas this study has shown that HCAs also needed to know that a RN was going to support them. This

need sometimes caused emotional responses. Menzies Lyth (1988) recognised that often nurses entered the profession expecting to receive care as well as provide it, but she was referring to the relationship with the patient. More recently, Evans (2014) agreed that RNs needed help with their own anxieties as they evolved from the empathetic care work. As this study has highlighted that the primary relationship for the HCA is with the RN, it implies that RNs rather than patients, were positioned to guide HCAs to manage their work-related emotions. Where gelling took place in this study, there was investment from each partner illustrated through the sharing of some personal information, but there was no literature found stating this. This is possibly due to the focus on the perspective of RNs and omission of the perceptions of the HCA in studies about nursing team relationships.

Collective-efficacy beliefs, as observed in cheerleading dyads by Habeeb (2017), provided some insight into how gelling occurred. Collective-efficacy was defined as the individual's beliefs in their joint performance and was based on group related accomplishments, vicarious experiences (judging how well you could do an action based on seeing someone else doing it), verbal persuasion and reactions to emotional and physiological responses, like anxiety (Bandura 1997). Habeeb (2017) recognised that it was not possible to formulate collective-efficacy beliefs for cheerleading partners at the beginning of the sporting season. There had not been enough time for team members to have performed together and experienced group accomplishments, to have learnt through watching how others have performed, to have received encouragement from coaches, or to understand their emotional and physiological responses to the situation. The infrequently paired HCAs and RNs upheld Habeeb's (2017) proposition that collective-efficacy improved over time. When HCAs and RNs did work together more frequently, they reported more gelling and more equitable team working. However, the desire to gel with their partner during the shift was not an indicator that the hierarchical status did not still hold significance in their relationship.

6.2.2 Physical isolation and concentrated relationships

In this study, the physical environment had a significant impact on the generation of HCA-RN dyads. Dividing the human resource of nursing staff to fit with the bays and side rooms created an inward facing, concentrated relationship. No other nursing literature was found

which looked at this and only one American study could be found that described an intense bond between healthcare staff. These were emergency medical staff (EMS) (Patterson et al 2016). Patterson et al (2016) looked at shift records and injury logs to see if there was a connection between teammate familiarity and risk of injury. Like HCAs and RNs and cheerleading dyads, there was no regular pattern to EMS clinician's pairing, and it was common to have limited prior experience of working with a shift partner (Patterson et al 2016). Patterson et al (2016) found that there was a lower risk of injury when partners had more shared experiences together; and also noted that the chances of injury were reduced with a relatively small increase in the number of shifts worked together which they attributed to EMS team members' ability to quickly develop team working behaviours. Although not aligned to staff injury, it is possible to see other similarities between the EMS clinicians and the HCA-RN dyad. The development of a relationship had benefits for the HCA-RN dyadic partners. More familiarity meant that HCAs were more able to ask for help and to feel empowered in the relationship; this is the "right to refuse" clause that was important to Cavendish (2013) when making recommendations for the Code of Conduct for health care support workers. It would allow HCAs to refuse to carry out roles where they have not been trained or don't feel confident in doing safely (Cavendish 2013). It is not possible to ascertain a definite time frame for establishing a long-term relationship from my data in order to compare with Patterson et al (2016) but it is known that RNs were able to quickly assess the skills of a HCA in order to release them to work non-dependently at the beginning of a shift. HCAs also hastily judged whether a RN was going to be supportive and collaborative. Therefore, the RN and the HCA did have to develop relationships quickly in order to achieve all of their tasks within the 12.5-hour shift. If Patterson et al's (2016) finding, that individuals had to quickly develop team working behaviours, is placed alongside Habeeb's (2017) observation that collective-efficacy requires longitudinal working, it highlights that there were two sorts of relationships emerging. The short, in-shift assessment enabled the HCA-RN dyad to achieve the tasks. The longer-term building of a relationship, which used the in-shift experience as a basis for pre-shift preconception, resulted in a companionship that grew as the dyad worked together on sequential shifts.

6.3 HCA-RN Dyad – function; joining and separating

The working mechanics of the HCA-RN dyad was through the joining and separating of the partners. HCAs and RNs had methodical, predictable movements within the bay space that occurred throughout the shift. This increased the time spent working non-dependently and created more mutually convenient times for information exchanges and inter-dependent working thereby generating slicker team working. The dearth of other literature suggests that joining and separating in this way is a new observation of the movements of HCAs and RNs. It was the ability of the HCA to work non-dependently and inter-dependently which enabled full contribution for the success of the dyadic team. When working in a 'separated' phase, HCAs performed tasks that complemented the actions and preferences of their RN partner. This was possible through implementation of the routine scaffolding. It is suggested that task based working and the routine scaffolding were central to how HCAs enacted their role. There was evidence that they were structured to support the organisation's audit culture which had stemmed from the New Public Management way of working. 'Red clocks' and senior nurses reinforced to HCAs the urgency that surrounded task based working but it was shown that in order to achieve all of their tasks, they needed the support of their RN dyadic partner. It is proposed that this has moved the HCA's primary relationship from the patient to the RN partner. These changes, probably stimulated by meeting New Public Management requirements, has had a negative impact on person-centred care. These areas will now be discussed, with the HCA-RN dyad hierarchy and boundary work first.

6.3.1 The HCA-RN dyad hierarchy and boundary work

The findings 'Hierarchical differences', 'Reliance on the RN partner' and 'Searching for equity' were all reflective of the professionalisation project of RNs. This is when a professional group competes for reward and positioning (Kessler et al 2015). Two possible professional logics for enactment have been proposed as routes for RNs; specialist-discard and holistic-hoard (Kessler et al 2015). Specialist-discard logic described when RNs viewed advanced nursing tasks as the centre of nursing and alluded to work being task orientated. Alternatively, holistic-hoard was when all nursing tasks were considered to be core and was reflective of a more holistic style of nursing (Kessler et al 2015). It was evident in this study that specialist-discard rather than holistic-hoard professional logic (Kessler et al 2015) was

the rationale on which RNs based their professionalisation work. Regardless of whether this route was chosen with RNs, as put forward by Allen (2000), or forced upon them, as suggested by Spilsbury (2004), it has been demonstrated that nursing work was clearly divided in to tasks. Such tasks were separated into those that only RNs could do, as specified by law and through training, and then all other nursing tasks. Before discussing professionalisation specifically, it is necessary to look at the differences between the roles.

There was evidence in this study to confirm the idea that the only difference between the role of the HCA and the RN was a qualification when a HCA stated this to be their perception. This clear-cut description was similar to Cavendish (2013) who stated that the distinguishing tasks between the two groups were medication and delegation. These opinions were substantiated by the HCA literature and the tangible pay scale, leaving no debate that HCAs held a lower hierarchical position to their RN partner. However, with regards to qualifications, Thornley (2000) gave HCAs more credit when justifying that they were qualified, in the form of undertaking NVQs. It was this that allowed the development of the HCA role, according to New Public Management history. Despite NVQs and other development, such as the Care Certificate (Skills for Care and Skills for Health 2013a), HCAs in this study did not always feel their extended training and subsequent increased contribution, was respected. An example of this was when HCAs felt less valued than their RN partner during the bedside handover. This communication mechanism was orchestrated to meet the needs of the RN. There was evidence to suggest that HCAs felt marginalised by the lack of significant content that related to their role. At times, this feeling was reinforced by the disrespectful physical behaviours of some RNs. In her study of UAPs, the US equivalent to HCAs, Kalisch (2011) found that lack of involvement in handover led HCAs to feel less ownership in meeting the team's goals. However, this study revealed that handover was not the only communication mechanism in use. Mini-meetings had evolved as an information exchange and HCAs were central to it. The application of such meetings allowed HCAs to feel that the team's goals could be achieved with less stress when performed in partnership. Development and formalisation of this communication mechanism would be beneficial to the team working of HCAs and RNs.

Confirming findings by Thornley (2000) and Spilsbury (2004), fundamental care tasks were fully embedded into the HCA's role. This study has highlighted progress in that RNs were applying strategies which enabled them to feel more comfortable with HCAs involvement in care delivery. This point contrasts with the literature which described the problems with RN accepting HCA's support (Sutton et al 2004, Shearer 2013, Johnson et al 2004). For example, Johnson et al (2004) recognised that when there was confusion about who was accountable when a HCA carried out a task, it led to RNs being reluctant to fully utilise HCAs and they continued to do the work themselves. In my study, the acceptance that HCAs were capable of carrying out tasks had reached the point where they were in command of their own role, once they had been deemed trustworthy by the RN. Moreover, HCAs were now taking the lead with these tasks and were prompting RNs to ensure that inter-dependent work was completed on time. This could be viewed as having reached an 'autonomous' state that was desired by HCAs in Bach, Kessler and Heron's (2012) study. HCAs in their study rebuffed any suggestion that they were the RN's aide; they worked alone or with another HCA when delivering fundamental care. They founded their self-worth on the strong relationship with the patient; a positive outcome of being the main provider of fundamental care. However, the HCAs in Bach, Kessler and Heron (2012) still required help with tasks like "making beds and lifting patients" (p214) and, akin to the HCAs in my study, their judgement of an RN's "teamworking" commitment was based on the extent that they helped with these tasks. Therefore, even though HCAs in Bach, Kessler and Heron's (2012) study were described as striving for autonomous working, they still required the support of the RN and still referred to them as their team. This challenges the concept that HCAs function autonomously and confirms that inter-dependent working was necessary and, that the RN was the obvious partner. The HCA could not complete their work in isolation. Therefore, the term 'non-dependent', rather than 'autonomous', used for this study was most appropriate when clarifying that their actions were influenced by their personal interpretation of how much they assisted the RN or strived for equal balance. They were also bound by the routine that was going to ensure that all work was completed on time. Therefore, although there has been forward movement in acknowledging, accepting and progressing the contribution of HCAs, it has not resulted in autonomous working. Hierarchy remains, due to RN accountability, but is better managed; checking documentation and progress through the shift, alongside building trust, has allowed RNs to manage their anxieties about being

accountable whilst not directly supervising the actions of their HCA partner. As acceptance of joining and separating has developed, the discussion about role boundaries appears to have subsided. This study has demonstrated that the non-dependent and inter-dependent actions of the HCA were the basis of a successful HCA-RN dyadic team.

The hierarchical differences between the HCA and the RN, the professionalisation and boundary work of RNs were seen in this study. As professionalisation status is fluid rather than stable, work to manage the boundaries was always necessary (Kessler et al 2015, Allen 2000). There was evidence of varied levels of boundary work carried out by RNs with HCAs in this study. First, the absence of registration for HCAs and the accountability of the RN for patients' nursing care led RNs to check HCAs' documentation until they were assured that the HCA could be trusted to complete it correctly. As the RN became reassured that the HCA was capable and trustworthy, the checking of documentation reduced in the short term as the shift progressed, and also in the long term, when the RN and the HCA worked on multiple shifts together over time. This development of trust resulted in HCAs functioning non-dependently which was beneficial to RNs in management of the nursing workload. The behaviour of checking by RNs may have been partly stimulated by the culture of risk management and avoidance of litigation as it was they who held accountability. However, Bach, Kessler and Heron (2012) verified that when RNs reminded HCAs that they were registered, accountable and could lose their PIN because of the HCAs actions, it was reinforcement of the differences in their roles and part of protecting their status.

A RN stated that the HCAs could be trusted to work non-dependently because they "can't really go wrong". This was also a viewpoint expressed by doctors about nurses when negotiating changes due to the introduction of the working time directive (Allen 2000, Ernst 2020). It was common for doctors to reduce the importance of role of RNs by suggesting that the tasks being devolved were low risk, repetitive and of a practical rather than theoretical nature (Allen 2000, Ernst 2020). This was confirmed by RNs who discovered that when they were given tasks that were previously within the realms of junior doctors, the tasks lost their superior value (Jones 2003). But HCAs in the Clark and Thompson (2015) study disagreed; the tasks that had been handed over from RNs to HCAs they believed, were wrongly devalued. Rather, the tasks retained their status, but they were seen as additions

which 'intensified' the HCA's workload as RNs were unwilling or unable to do them regardless of the level of skill involved (Clark and Thompson 2015). As was seen with the RN stating that HCAs can't really go wrong, it is probable that some RNs in this study did carry out boundary work by reducing the importance of tasks devolved to HCAs thereby reinforcing the boundaries between the groups.

The proposition that RNs were carrying out boundary work was reinforced by the perceptions of HCAs about some of their RN colleagues. HCAs felt that some RNs used their hierarchical position to choose which parts of the nursing workload they were going to be involved with. They were seen as too busy or gave the impression that they didn't view personal care as part of their role. The RNs in Bach, Kessler and Heron's (2012) study justified this by insisting that they possessed better technical skills which allowed them to distance themselves from the "dirty work" (p217). Their finding implied that RNs were honest and explicit about their decision to withdraw from some tasks. In my study, a senior nurse confirmed that newly qualified and international RNs did sometimes hold the opinion that lower-level tasks were not within their remit. However, it was the RNs' behaviours which HCAs interpreted as demonstration of their reluctance; they viewed 'holding on to the drugs trolley' and 'disappearing' from the bay as strategies used to avoid involvement in what some HCAs saw as 'their share' of the patient washes. This was in accordance with the literature. Allen (2002) advised that RNs should continue to be involved in 'mundane work' and to achieve this by integrating it with more complex nursing tasks. According to the HCAs in this study, RNs were not acting this way. This conceivable lack of support caused HCAs to feel anxious that they would not be supported in tasks that required two people. It was this support that enabled them to achieve their part of the nursing work. A RN envisaged that the e-obs devices would lead to more equity in the delivery of these tasks as the device allowed both of the dyadic partners to see which patient was due to have clinical observations completed next and at what time. However, HCAs knew what needed to be done next because they had carried out the previous set of observations. There was an understanding that these tasks were integral to their role. Therefore, the introduction of the machines had not yet, led to more equity in delivering clinical observations. Nevertheless, it is possible to imagine

that some RNs could have been completing some 'mundane', or fundamental tasks when in the vicinity of the patient. With HCAs concentrating on delivering the routine scaffolding, often behind curtains and in side rooms, they might not have been present when RNs carried out this integrated work as part of their care of patients. This presumption fits with HCA's confessions that they did not know what RNs were doing when not in the bay; it is possible that they also were not fully aware of their actions within the bay. This said, Allen's (2002) example of integrating mundane work with more complex tasks was to have "an interactional encounter which builds rapport" rather than asking direct questions about a patient's wellbeing (Allen 2002 p46). Based on this, it is suspected that the mundane work that Allen (2002) suggests would not be of the same intensity as providing patients with washes, as the HCAs were wanting.

It is worthy of note that HCAs in this study were not passive to RN's boundary work. Some HCAs controlled the flow of the work to avoid what they viewed as being taken advantage of. This manipulation of workload by HCAs adds to the existing literature of withholding patient information (Spilsbury and Meyer 2004), and challenging RNs in front of patients (Gravlin and Bittner 2010) and illustrates that the HCA's perception of the RN can influence how smoothly nursing work is delivered. It has highlighted that RNs asserting their senior position, either explicitly as seen in Bach, Kessler and Heron (2012) or implicitly as in this study, does not lead to total RN control and clarifies that their roles were intertwined. This said, Bach, Kessler and Heron (2012) would argue that the true extent of the HCAs influence is limited, as recognised by the physical reality of their pay scale.

The findings exhibited that RNs sometimes engaged in boundary work in order to protect their professional status. They reminded HCAs of their accountability and there was a possibility that they devalued tasks that were handed down. As their senior position in the hierarchy allowed them more scope to choose whether to engage in these more fundamental, less specialist, nursing tasks, RNs at times appeared unsupportive of HCAs in delivering tasks that needed two people. These interactions were all taking place under the organisation's implementation of New Public Management.

6.3.2 Audit culture and New Public Management

New Public Management was still deemed to be current at the time of this study and was the basis on which hospitals decided their priorities (Lapuente and van de Walle 2020, Wallis et al 2016). The term New Public Management' refers to the application of management techniques, more usually found in private companies rather than in public sector settings such as the NHS (Lapuente and Van de Walle 2020). It is argued that the techniques, such as audits, provided more systematic and less biased evaluations of hospital trusts regarding their business operations and finances (Shore and Wright 2015, Rudge 2011, Cook 2006). This was achieved by using an explicit approach to measuring performance and a focus on results rather than procedures (Hood 1991). Target-driven organisational systems and consumer priority over clinician's power were applied to increase quality and efficiency in healthcare (Kirkpatrick, Ackroyd and Walker 2005). More recently, New Public Management has naturally developed into the area of risk management as litigation and hospital reputation have become major concerns for hospital trusts (Hillman et al 2013, Willis et al 2016). This move to a more structured way of monitoring and managing risk has been supported by the improvement in technology and enabled development of audit systems which provide accurate and available data for hospital management to track the actions, delays and omissions of the staff responsible for care measurements and delivery in real time (Wallis et al 2016) as manifest in the appearance of 'red clocks' and the presence of senior nurses who enforce the computer led routine, discussed in Section 6.6.

This study has demonstrated that the use of audits in these four adult in-patient environments, was extensive and institutionalised, thereby confirming the shift from 'government to governance' (Shore and Wright 2015). That is, rather than being directly controlled by the government, hospitals in general have become more self-managed organisations that demonstrate their quality and effectiveness by meeting performance targets. These targets have been set by external bodies and have financial penalties attached (Evans 2014). Willis et al (2016) provide an explanation of how clinical staff and the New Public Management system functioned to manage risk. Based on this, a cycle could be identified: a patient-related incident prompts an investigation; the outcomes lead to a tightening of protocols and creation of standardised processes; and audits developed for

quantitative data to be extracted to demonstrate compliance. A consequence of this was that the clinician's freedom to use professional judgement and initiative was reduced as they instead adhered to the standardised processes and complied with the measurements otherwise, they risked being held responsible should another incident take place (Ernst 2020). In this study, this was apparent through the predictable behaviours of both the HCAs and the RNs which were triggered by the clinical observation outcomes.

This attention to measurement by organisations and governing bodies may be misguided. In relation to social care, Cooper (2010) stated that social work has learnt to respond to findings of failure, of risks and damage which create social and political anxieties. When an event such as an unexpected death has occurred, tools such as regulation, risk management and audit have been used to illustrate that a concerted effort is being made to prevent such events from reoccurring (Cooper 2010). This sends a message to the public that 'we will not let this happen again', new procedures will be written and actioned to ensure this and checks of implementation will form new rituals in order to reassure the public (Cooper 2010). This description of how events lead to new procedures emulates that of hospital care, as seen in Francis (2013) where 290 recommendations were made. These have not all been implemented and although there will be many reasons for this, it is known that making changes to clinical practice is challenging when the activity is regularly carried out in the same context, as happens in nursing (Bodansky et al 2017). In addition, it is also difficult to change behaviours that conform to cultural expectations even when an individual believes they can act in a manner of their choosing (Sharp et al 2018). For instance, spending time on aspects of care not captured by the audits, like offering patients choices about where they have their wash, become more difficult to do when it is not how most other HCAs behave. This is further complicated by the issue that how people say they act and how they actually act can be different. It has been highlighted in this study that HCAs did conform to cultural expectations; they reacted to the sense of urgency surrounding completion of compulsory timed tasks and they adhered to the expectation that all their tasks would be completed by the end of their shift. Whilst focusing on the measurements, their attention to those less quantifiable forms of patient care, such as tending to patient comfort, was reduced in alignment with the organisational culture. This links with Darbyshire and Ion's (2018) editorial on the Gosport War Memorial Hospital panel report where they expressed concern

that nurses had not changed their ways since the findings of the Francis (2013) report and lacked the capacity to refocus on the care of the patient. It exudes their frustration that more lives were shortened since, and despite Francis (2013), and nursing care again was found to be below expected standards. Criticism included failure to provide individualised care and to make patients their centre of attention (Darbyshire and Ion 2018). This is indication that processes, audits and policies do not always prevent events from happening. They instead provide evidence that people carried out the policy (Taylor et al 2007). This leads to the HCAs role within the hospital culture of audit and New Public Management.

6.3.3 The HCA role – delivering tasks within the routine scaffolding

Kessler et al (2010) had grouped activities that the nursing team did into categories thereby providing terminology for the groups. Using this terminology, my study found that the HCA's role included 'direct patient care' like washing and feeding, 'indirect patient care' for instance remaking beds, and some 'technical/specialist tasks' such as taking clinical observations (Kessler et al 2010). It has been shown in this study that these tasks were contained in the routine scaffolding for the HCAs. Using the metaphor of a physical scaffolding, with time as the horizontal poles, the compulsory timed tasks would be the vertical poles that created stop-points. This has been illustrated in Figure 13 in Appendix 8. The routine scaffolding was a mechanism of control. It had developed as a result of an accumulation of pressures. Its application addressed anxieties for many people in the setting.

The compulsory timed tasks, those that fitted with Kessler et al's (2010) description of technical/specialist tasks, had to be carried out at specific times. They were given a high value, or status, due to pressures placed on their completion. They were audited and used as evidence for meeting governance criteria, as described in Section 6.4. The mandatory flexible tasks incorporated those Kessler et al (2010) classed as direct patient care. They received little attention with regard to discussion, recording or auditing. This implies, for instance, that washes were less important than taking blood pressure measurements. However, some would argue that these tasks were the core of nursing (Kitson et al 2014, Kessler et al 2015, Kitson 2018). In my study, it was rarely questioned as to whether

personal care was going to be given, or to whom; in the four areas observed in the study, there was high physical dependency, and it was accepted that all patients would receive help with washing, usually in bed, and on a daily basis. There was no need to report that it was going to be done or how it went, only that it had been done in order to make sure that every patient had been washed. It could be argued that this is because washes were not recognised as requiring risk management. This contrasted with compulsory timed tasks.

Viewing the work of HCAs as sets of tasks could be described as Fordist method of working. Clark and Thompson (2015) suggested that organisations benefitted from this method with its assembly line techniques, enabling mass production of objects. For this to work, the HCAs role was re-formed in to a set of instructions and labels (Clark and Thompson 2015). There was no space for unplanned or unexpected work, such as being present with a patient, unless these were labelled as a task and included in the HCA role (Clark and Thompson 2015). Allocation of time to be with patients wasn't evident in this study; HCAs moved through the structure of tangible tasks.

Seeing the HCA's role as a set of instructions and labels fitted with the New Public Management's aim of organisations being efficient, effective and value for money (Rudge 2011, Evans 2014). This could be said to have led to their work being 'automated' for better production; a descriptor used to define the effect of New Public Management by Hood (1991). A step further would be to confirm Menzies Lyth (1988) claim that these HCAs, like her 'nurses', were containers of skills and resources to be utilised, not thought of as individual people, just as patients were not seen as individual people. Holden (1991) viewed the depersonalisation that Menzies Lyth (1988) described as a positive. He suggested that the task, rather than the nurse, became the subject of nurturing thereby supporting improvement of care and reduction of personal criticism. This was demonstrated in this study. Some of the tasks were nurtured by HCAs, reinforced by the RNs and the ward sisters in order to monitor deterioration. This suggests that the people behind the tasks, both nursing staff and patients, have become devalued.

The routine scaffolding could be described as a 'ritual performance'; clearly defined tasks, delivered at set times, to provide predictable behaviours and results (Menzies Lyth 1988).

HCAs applied the routine scaffolding regardless of all other events in the bay. If they were diverted from it, they returned to it as soon as possible. This compares favourably to Holyoake (2013) in his study of what the myth of 'doing the observations' means in mental health nursing culture. He noted that policies, procedures and checklists had been combined to generate a systematic framework, or scaffolding, which was a logical way to keep patients safe (Holyoake 2013). It had become ritualistic and prioritised in the work of the ward (Holyoake 2013). This way of working reproduced one of Menzies Lyth's (1988) defence mechanism 'the attempt to eliminate decisions by ritual performance'. However, it is necessary to note that although the routine scaffolding met Menzies Lyth's (1988) definition of a ritual performance, the HCAs in this study had a limited amount of capacity to flex, or bend, in order to accommodate for unforeseen problems. These minor alterations that HCAs made to their routine scaffolding compensated for diversions such as the late arrival of meals. This reflected the understanding that in order to meet targets, the organisation required nursing team members to have some level of innovation and self-management (Shore and Wright 2015). The vocabulary of 'innovation' and 'self-management' may be strong descriptors for the actions of HCAs, although low level alteration was captured in this study. The innovative practices of HCAs were seen when they used three techniques to fill the gap left by the absence of the RN partner in order to ensure accomplishment of their tasks. Evidence of self-management was apparent when HCAs sought out information to help them to complete their work when it wasn't handed over to them. These skills were a necessity; lack of partner support and lack of information were not excuses for non- completion of tasks and their endeavour to complete their work raised HCA's anxieties. This anxiety corresponded with symptoms of burnout, stress, and disengagement which were listed as palpable consequences for those whose work was based on audited tasks (Shore and Wright 2015). A positive side of this limited flexibility was that HCAs expressed enjoyment in having the power to decide the order of the delivery of some of their work. This enabled them to continue to progress with the routine scaffolding which in turn gave them a sense of reassurance. Moreover, the organisation also benefitted from the HCA's scope to adjust the routine scaffolding as the HCA then retained responsibility for their work and subsequently absorbed the impact of uncontrollable diversions and still met expected standards for audited tasks.

6.3.4 Red clocks and the role of senior nurses

HCAs knew that the compulsory timed tasks were important, not because of concern that it was linked to a patient's health, but because of the reaction by senior nurses. It has been established in this study that RN's and ward sister's responses to audited information, or its deficit, reinforced the importance of the compulsory timed tasks to HCAs. RNs demonstrated this through their checking of the paper documents or electronic devices to make sure that tasks were being recorded. The appearance of the red clock on the electronic device brought the ward sister to the bay to find out why this information hadn't been gathered and entered on to the system earlier. There was a sense of urgency that had been created in relation to meeting audit deadlines which was demonstrated in the anxieties of senior nursing staff. Rudge (2011) stated that the audited practices that regulated nurse's clinical work were shaped by this sense of urgency and the need for order otherwise there would be chaos in the healthcare setting. The, almost frantic, way of working that was frequently felt in the settings in my study. It didn't seem to allow space for reflection or questioning by senior nurses of why there was this pressure or whether it was the best way of delivering nursing care. However, its impact could be seen on tasks that were not audited; washing a patient had become a task restricted by resources, policy and time, fitted in quickly between tasks that were measurable, and essential to proving the organisations good governance. These impacted tasks were the person-centred tasks. The consequences of this are discussed later in the section 'Task based work and its effect on person-centred care'. This matches the claim that the sense of urgency diverted attention towards areas where it was possible to account for what was happening and making this evident (Rudge 2011). There was an urgency to complete the unmeasured washes so as to attend to the 'obs' on time. Shore and Wright (2015) suggested that this diversion has led to replacement of professional judgement with measurable standardised processes.

6.3.5 Standardised processes and recording of measurements

From the HCAs perspective, there was a process for compulsory timed tasks; they carried out and recorded the measurements at the correct time; when a patient's clinical observation results were outside of set parameters, they 'scored,' and it led to an action. This was either delivery of an initial task or informing the RN and awaiting further

instruction. The process was not individualised or part of a holistic assessment. Looking at the patient who was scoring was not part of the process. The only deliberation necessary for HCAs was whether the measuring tool was working and positioned in the right place on the patient's body. The interaction with patients during this time was solely to obtain the measurement. This implies that clinical observations were objective, evidence based, single tasks. HCAs actions were disconnected from the patient as a person and this mirrors the detachment that the external bodies who required the audit results in that they were far away from the tasks and the context (Shore and Wright 2015). It was a standardised process, part of the routine scaffolding. Therefore, regarding audited tasks, the process for the HCA-RN dyad was to perform measurements, record measurements, report measurements and respond to measurements in order to capture and manage a deterioration in health. There was nothing to indicate that this process was person centred or involved any 'care'.

It is proposed here that the notion put forward by (Shore and Wright 2015), that measurable performance standards have replaced professional judgement, is accurate but does not capture the extent to which the concentration on measurable tasks dominated over everything else that the HCA did. In addition, it appeared that it was the recording of the measurements that was of most importance. For HCAs, it was these that kept them out of trouble and avoid being summoned by the ward sister. For RNs, it was these that ensured they were in control of their professional accountability for patient care and avoidance of litigation. The recording of measurements was the primary concern, and the results of those measurements were of secondary importance. When the HCA waited for the RN's response to each of the changes in the patient's score, the RN checked the measurements on the e-obs device and did not appear to confirm them by going to the patient in the bed. Then, the RN responded in accordance with which measurement was outside the parameter. These responses seemed to be a standardised procedure as HCAs often knew what the RN was going to do or advise.

The audit system efficiently measured intervention not interaction, and although this was not misdirected in situations like patient repositioning, it was the urgency placed on prioritising these tasks that impacted on the philosophy of person-centred care and brought

to question the participating Trust's value of "making sure patients and colleagues feel valued". It is possible that both staff and patients felt undervalued by the audit culture. Hillman et al (2013) suggested that the improvement in technology to capture data had resulted in a value system which was based on bureaucratic practices. It was also significant to note that as with other studies (Holyoake 2013), neither the patients nor the staff members had a choice but to comply with audited processes. This acceptance of being audited, to the degree that this is no longer questioned, demonstrates how this has become a normal part of being an employee or receiver of a service (Shore and Wright 2015).

6.3.6 HCAs primary relationships

When looking at the delivery of the standardised processes, it was clear that the HCA and the RN interacted. From here, it is possible to see that the level of success in the application of the routine scaffolding was reliant on working with their RN partner. This relationship was in contrast with the work of Menzies Lyth (1988). The defensive mechanisms had developed to protect the nurse from having a relationship with the patient (Menzies Lyth 1988). This infers that the primary relationship for the 'nurses', including the HCA, was with the patient, which in turn, corresponded with the nurse's principal task; to care for sick and dying people (Menzies Lyth 1988). Although the patient voice was not heard in this study, some of these mechanisms such as 'splitting up the nurse-patient relationship' were seen in this study and could be said to be successful in undermining the nurse patient relationship; now the primary relationship for the HCA was not with the patient, but instead with the RN that they were paired with for that specific shift. This was evidenced in how the HCA's relationship with the patient was not prominent in the data collection, and consequently, not pronounced in the findings chapter. The change in primary relationship from the patient to the RN was due to the effect that completing, or not completing tasks had on this relationship, rather than a relationship with the patients. This was dissimilar to HCAs in Bach, Kessler and Heron (2012) who appreciated that they, the HCAs, had a distinctive relationship with patients. Alternatively, in this study, the HCAs intertwined working with the RN relied on this relationship being good to give them job satisfaction, rather than the relationship with the patient. They needed the approval of the RN to be able to fully deliver their part of the HCA-RN dyad. HCAs needed the RN partner to trust that they were capable

of completing their non-dependent work in order to be released to do this. In inter-dependent tasks, they were reliant upon the RN for physical support, and this was more readily available if the RN valued their contribution to the team as well as valuing the task. Again, this was different to Bach, Kessler and Heron (2012) where HCAs chose to work alone or with another HCA rather than an RN. Overall, in my study, HCAs were invested in this relationship and needed the RN to also invest if the dyadic team was to be successful. This switch from a patient focused relationship to RN focused relationship may have been an added factor in HCAs being disconnected from patients. This disconnection was a sign that person-centred care was not the prominent in the work of the HCA.

6.3.7 Task based work and its effect on person-centred care

The combination of the primary relationship being with the RN and task based working dominating the practices of HCAs suggested that the work of the HCA was incompatible with person-centred care even when the role of the HCA in this study theoretically lent itself well to providing person-centred care both through their verbal and physical behaviours. Verbally, HCAs were speaking to patients to gain consent, informing the patient of their intended actions and giving the patient instructions. Previous literature demonstrated that these interactions between HCAs and patients were openings to develop better connections than their RN partner was able to achieve (Spilsbury 2004, Kessler at al 2010). These were opportunities for HCAs to become the expert on individual patients and to discover their preferences and needs, as these factors are known to provide the foundation for person-centred care (Nilsson, Edvardsson and Rushton 2018). However, HCAs in this study did not often interact with patients beyond giving instructions such as 'roll over', or requests such as if they could take their temperature. They directed patients in order to achieve a task rather than to co-produce an action. Daykin and Clarke (2000 p356) used the term "announcements" to define this form of communication. The use of announcements reinforced Daykin and Clarke's (2000) observation that "there was no real evidence of patients being involved in decisions about their care" (p356). There was no indication from those higher in the ward hierarchy that any more patients interaction was necessary or desired.

In relation to the physical behaviours of the HCA and the provision of person-centred care, HCAs had the mandate to enter a patients' personal space. They touched them to take clinical observations, they washed their skin and cleaned their most intimate body parts. They were in a position to create or diminish a patient's dignity and privacy each time they provided personal care. However, as described above, the drive and obligation to complete audited physical care such as repositioning and Early Warning Scores, or "obs", impacted on the time available for unaudited tasks such as washing and feeding patients. HCAs manipulated their workload in order for mandatory flexible tasks to be manageable despite unpredictable human factors having an impact. There were specific examples of where short cuts to patients' personal care were made. Some HCAs decided that what they described as the little things, such as changing underwear on a daily basis, was important to them, but realised it was not always important to their colleagues. They utilised the small amount of flexibility they had in their work routine to personalise the way in which they achieved the task required. However, this strategy had its risks. It was evident that when HCAs took more time to deliver mandatory flexible tasks, it introduced the possibility that they may be delayed in carrying out compulsory timed tasks and it was clear that there was no acceptable reason for not completing compulsory timed tasks.

The HCAs management of time pressures through working in a task orientated way corresponded with findings that the requirement to prioritise measurable tasks had resulted in a different type of work intensity and possibly tougher working conditions (Willis et al 2016). It has been suggested that as a result of this intensity, the 'rationing' of care that had always been done by RNs in their prioritising of work, had now developed in to missed care; when there wasn't enough time for care to be completed (Willis et al 2016). It has been illustrated that HCAs in this study worked intensely. They needed to keep moving forward with completion of their tasks if they were all to be achieved and recorded on time and by the end of the shift. To attain this, they adhered to what they regarded as their personal, finely tuned, routine scaffolding. They had tested its reliability and were assured that it was a formula for success.

To continue to compare the findings with those of Willis et al's (2016), contemplation of rationing care brings a different perspective. it could be said that some parts of fundamental

care were rationed. The 'flexible' in the term 'mandatory flexible tasks' was used to illustrate how this group of activities were not carried out at a stipulated time but were fitted in between compulsory timed tasks, there was flexibility in when they were completed. However, the possible actions that were carried out within the group of mandatory flexible tasks might be deemed as restricted rather than flexible. They did not include what some would consider to be all aspects of fundamental care; hair washing was viewed as a luxury rather than a necessity for example. To limit the type of mandatory flexible tasks to a standardised set ensured that a certain level of fundamental care was reached for all patients, for example, every patient got a wash every day, unless they refused. However, it may be asked whether this limitation was also a strategy to ensure that the length of time HCAs spent with individual patients did not impose of the audited tasks required.

As already acknowledged, this study did not include the views of patients and it was not possible to know whether or how this task based working impacted on patients. This said, there was indication that working by delivery of tasks led to depersonalisation of patients (Menzies Lyth 1988). The patient's role was to give their consent and make available the body part needed for measurement, such as an ear for taking their temperature. HCAs in my study rarely knew a patient's diagnosis. The task-orientated care delivery made the patient's illness insignificant. The HCA's conduct towards patients was based on their mobility, their capacity to feed themselves and the frequency specified for their clinical observations. It was this information that informed the routine scaffolding whereas the diagnosis of the patient had little bearing on the tasks that were delivered. This reflects the defensive mechanism 'depersonalisation, categorisation and denial of the significance of the individual' (Menzies Lyth 1988). The patient had been reduced to the smallest levels of information needed. Clark and Thompson (2015 p217) stated that HCAs had "unitise(d) patients as occupants of bays or bed numbers" as a protective factor from the stresses of work intensification.

The defence mechanism 'splitting up the nurse-patient relationship' (Menzies Lyth 1988) was used to question the HCA's relationships, but it also further elucidates the depersonalisation or unitisation of patients. It was acknowledged that giving a patient a

wash had become a task to be completed rather than a person-centred experience. Kitson et al (2014) suggested that this lack of application of person-centred care was due to an absence of a universally agreed way of approaching nursing practice that preserves the integrity of the whole person as opposed to 'depersonalised' (p334) tasks. However, this study indicates that it was not lack of universal agreement that diminished application of person-centred care but almost the opposite; in order to ensure fundamental care was delivered to all patients every day within the environment where compulsory timed tasks were prioritised, there needed to be some pace to their work.

The HCA and the patient were clearly 'split' in this study as this had benefits for the HCAs. Engaging with patients beyond those announcements brought with it a risk of being delayed and this could have impeded on the completion and recording of nursing tasks. HCAs in Clark and Thompson (2015) described this as "putting a block-hole on chat" (p217) which meant not slowing down their actions to make time for conversations with patients. The 'splitting up the nurse-patient relationship' mechanism was successful; the HCA was no longer the person who soaked up the patients' and relatives' feelings about the hospital admission, and consequently they were not exposed to the guilt, pity, compassion and resentment that nurses felt in Menzies Lyth's (1988) study. HCAs did not engage with patients on a level where empathy and compassion were activated. It was not necessary to know a patient on a personal level in order to be able to complete their work. This finding is in conflict with the philosophy of person-centred care.

6.3.8 The conflict of New Public Management and person-centred care philosophies for the organisation

Placing the person at the centre of their own care is the aspiration of nurses (Royal College of Nursing 2010). Person-centred care requires physical and human resources which enable patient choices (Ross et al 2014). It needs the support of leaders and the organisation to provide these resources and to assess how these fit with quality measures (Kitson 2018). The organisation in this study did not appear to be providing these essentials and could even be said to be discouraging these behaviours by prioritising compulsory timed tasks.

The onus placed on measured tasks contradicted elements of the Trust values which include "taking time to care", and "finding out what matters most to patients…" (Trust website).

This lack of attention and consideration of the importance and requirement of time to carry out mandatory flexible tasks and other 'softer' gestures was surprising given the high media profile of the Francis (2013) report. It placed great emphasis on the importance of fundamental care. The Francis (2013) report highlighted that Mid Staffordshire Hospital Trust was compliant with regulators at the time of the investigation but despite this, patient care was lacking compassion. Yet in this study, the pressures to exhibit audit results were still being given precedence. For example, the weight given to the recommendation that HCAs were to be "recruit(ed) for values" (Cavendish 2013 p44) appeared to have been lost in the day-to-day work of HCAs as they concentrated on task delivery, and these did not reflect whether values had been demonstrated by HCAs at interview.

In this study, the lack of time given to person-centred care was exemplified by a HCA who used the patient as the assistant. When there was a gap left by the RN in helping a HCA to carry out a wash, her patient became the exchangeable partner in the dyadic team rather than wholly the recipient of care. The pressure of time, and the anxiety that it caused, was transferred from the HCA to the patient. Defined as a 'time debt', this pressure of how HCAs spent their limited time in the in-patient acute environment, was recognised by Rushton, Nilsson and Edvardsson (2016). It was found that nursing staff interacted with more patients and for a shorter duration because of pressures of throughput in the current healthcare system and referred to this as 'fast care' (Rushton, Nilsson and Edvardsson 2016). 'Clock time', as denoted by the succession of time, and fast care were prioritised over 'slow care' and 'process time' (Rushton, Nilsson and Edvardsson 2016). Process time was defined as the product of human interactions which were fluid or continuous, or grounded in shared events (Rushton, Nilsson and Edvardsson 2016). The concept that is predominant is an indicator of how the organisation associates the time used by staff in relation to what they view as good care (Rushton, Nilsson and Edvardsson 2016). Their study found that the RNs choice to interact fast mirrored the organisation's priorities rather than the patient's (Rushton, Nilsson and Edvardsson 2016). The findings from my study uphold that HCAs were also enacting their role within an environment of clock time and fast care. The individualised

and non-standardised care that was necessary for person-centred care was in conflict with the culture in these acute care settings.

It could be argued that New Public Management and person-centred care were philosophically opposed. Tasks were used as a form of controlling actions, as Menzies Lyth (1988) asserts, but it was now in the form of non-clinical managers responding to government mandates and avoiding litigation (Clark and Thompson 2015). As New Public Management was aligned to demonstrating governance in safe, efficient and cost effective care, and had financial penalties if not achieved, it was obvious why there was pressure to tend to this before all else; 'obs' needed to come first. As this took priority, the capacity to support and enable patients to participate in shared decision making about their care did not seem to be available. The organisation in this study had developed a culture that had a compromised link between policy and practice. To continue to promote person-centred care in this climate suggests a lack of depth of understanding of the meaning and extent of the philosophy: attempts if there are any, become tokenistic.

A way forward may be person-centred care moments (McCormac and McCance 2010) rather than enactment of the entire philosophy. This is when members of the nursing team have instances when their thoughtful actions had satisfying outcomes for the people they cared for (McCormac and McCance 2010). 'Pastoral care' (Kessler et al 2015) could be interpreted as the acts of kindness that are innate to nursing and some take very little time to deliver. Providing comfort, taking time when feeding, increasing fluid intake in the form of a well-timed cup of tea are caring gestures, not full person-centred care philosophy. They need slow care and process time. It is sorrowful to discover that Kitson et al (2014) needed to include the value of "being nice" in their nursing pledge to patients' model (p335). The importance of these human touches had been lost or possibly 'discarded', as HCAs absorbed and prioritised measured tasks. It is clear that task delivery is not synonymous with 'care'. By revealing and discussing this contradiction between policy and reality, remodelling can take place.

A review of the function of NHS in-patient hospital nursing care may halt this 'push and pull' of person-centred care philosophies versus audit culture realities. Recognition of this

inability to provide both to a high level could lead to overtly abandoning policies and talk of providing person-centred care. This is not to suggest that members of the nursing team should not provide pastoral care. However, these have not been acknowledged as part of professionalisation or boundary work of RNs and they have not been allocated any time in the HCAs remit, it could be said that they fall in to a gap outside of the scope of each partner's role.

Although this discussion has highlighted the opposing philosophies present in the ward environments, and explains why New Public Management strategies take priority, it does not reflect that the NHS is an organisation of national pride and features greatly in political debate. The question is raised of how important the cost effectiveness, efficiency and patient safety that is derived from New Public Management is for members of the public when it is in direct competition with person-centred care which requires the opposite; rather than the cost effective strategy of constant, forward movement, it needs slow time, and space for staff to feel that they can be in the moment. The question of whether this is now the time we acknowledge, that while patients centredness is an ideal we all aspire to, that it is unrealistic in modern health care settings. There were examples which suggested that the lack of person-centred care was not the fault of the HCAs. They had become a product of their environment; when they performed more person-centred care, they fell behind with the mandatory timed tasks. However, if it was wide public knowledge that individualised and person-centred opportunities were not prioritised, it may have a negative impact on how people viewed the nursing team. In reality, patients and relatives may already be finding that being given a cup of tea is forsaken for pressure area repositioning to be carried out on time. There doesn't appear to be enough resource to provide both.

This study has identified the clash of work principles taking place in the ward environments. The nursing philosophy of person-centred care was in direct conflict with the New Public Management business philosophy. HCAs were not able to meet both sets of criteria to the same high level and the traditional, softer aspects of nursing care were being overrun by the priority of meeting targets that quantitatively demonstrated performance, safe care, efficiency and financial security. The hospital could not continue to exist without meeting these, hence the pressure to measure and demonstrate performance. It has been shown

person-centred care can not exist in an environment such as this and new conversations need to take place.

6.4 Summary

The findings of this study have been discussed in the light of existing literature in the field. It was argued that the form of the HCA-RN dyad did not fit previous descriptions of nursing teams due to its unique, inter-dependent working style. In order to understand this new concept of team, the work of Habeeb (2017) and cheerleaders was used. This provided a novel way to look at the HCA as a partner through execution of their role and through efficacy beliefs. The intertwined relationship between the two people in a ward environment and further thought about how gelling improves the personal understanding of the partner was better understood through comparison with the work of Kalish and Begeny (2005). It has been possible to see that fundamental care has become ingrained into the HCA's role that it was no longer discussed and had developed in to non-dependent working including leading RNs to ensure tasks requiring two people were completed.

In joining and separating, there has been discussion about the hierarchy and the boundary work that took place between the RN and the HCA. This relationship functioned within environments where audit culture and New Public Management was strong. The enactment of the HCA role was through carrying out tasks within the routine scaffolding framework. This ensured that red clocks and senior nurses were averted. There was discussion of how the predominance of task working prevented enactment of the philosophy of person-centred care; the two systems were opposing and the necessity to satisfy higher public bodies prospered.

6.5 Contribution to knowledge

The relationship between the HCA and the RN has previously been acknowledged as important but this study has impressed that each role cannot be successful without the other. This is the first study to propose that the HCA and the RN function as an intertwined team of two that are reactive to each other's movements. The discovery of HCAs working with RNs as cohesive dyads was evidenced and shown to be strong. It is also the first time

HCAs have been compared to cheerleaders. This provided imagery for describing the HCA-RN dyad form. Using efficacy beliefs to understand the perceptions of HCAs, as has often been done in the field of sport, had not been contemplated in healthcare before and provided new insights in to their world.

Previously, the nursing team has been viewed as encompassing the whole ward whereas this study has found that when the HCA-RN dyad was in place, the actions of other nursing team members were inconsequential. The more cohesive the form of the HCA-RN dyad was, the more the function was productive in completing and recording all nursing work within the timeframe of the shift.

In earlier studies, HCAs work was considered in relation to the role of the RN, but boundary work and the difficulties this brought for both parties were dominant. This was evidenced in literature which aimed to clarify the tasks within each person's scope of practice. This study has demonstrated that the work was not about who did which tasks but rather about how task-delivery fitted together; about how partners joined and separated, about their ability to switch from being an exchangeable partner to a distinguishable one, about using mini-meetings to clarify progress and create a new plan. It was about team cohesion rather than work division. This resulted in more perceived equity, with each partner making a contribution to the success of the team. This was based less on hierarchical status and founded more on skills and role. The ability to work in these ways originated in good dyadic form; positive previous experiences where gelling occurred, having a respect for each other's position as a contributing partner, of clear physical boundaries and the capability to maintain the concentrated relationship.

This study has clarified that there were opposing philosophies impacting on the work environment of the HCA-RN dyad. There were the criteria of New Public Management, necessary for demonstrating compliance and then person-centred care, seen as symbolic of high quality nursing care. Working in this environment created anxieties for HCAs whose workload was a group of tasks delivered within a framework which required the support of their partner if it was to be achieved. It has been highlighted that the environment was not

constructed to allow for person-centred care and thought and action is needed for this conflict of philosophies to be resolved.

6.6 Reflections of and contribution to methodology and methods

A strength of this study was that constructivism and focused ethnography were appropriate for exploration of the role of the HCA. They provided the perspective to capture multiple views from HCAs, RNs and other team members which assisted in finding consensus on constructions that were presented in the findings chapter. These contemporary insights add to the somewhat dated literature which sometimes did not give weight to the discourse of HCAs.

Epistemologically, I found the differences between my subjective meanings and those of others stimulating. I wanted to know other peoples' perceptions in order to co-construct what was perceived as real in their setting, and constructivism allowed for this. Being a mental health nurse led me to ask 'what is going on here?' but from an emic, insider angle that had not otherwise been seen in research on HCAs. I was able to approach, with 'fresh eyes', a role that had become ingrained in the setting that it had not been explored in depth in the last ten years.

Methodologically, taking a longitudinal approach and a focused ethnographic paradigm had not before been used to contemplate the HCA role specifically. The benefits of this combination were that I was able to build relationships and trust over time whilst choosing the more productive data collection times. It is these trusting relationships, along with HCAs now having first-hand experience of research, that will enable participatory action research (PAR) to occur in a post-doctoral study. As PAR recognises participants as experts and emphasises practical knowing as a basis for change, it would be an appropriate next step for continuing to build understanding of the role of HCAs. Building on the foundations of this study, it would be possible to empower HCAs to ask their questions, develop their methodology, and express recommendations that would be meaningful in their setting as the PAR approach entails.

With regards to methods, I discovered that I could draw on my mental health nursing skills when carrying out observations and interviews which hasn't been explored in the research methods literature. However, the greatest decision was the combination of methods. To be able to observe HCAs, then immediately interview them was an effective strategy. It enabled HCAs to demonstrate and then articulate their role, this was not a strategy used before in the HCA literature. While there was contribution to the methodology and method, there were also limitations to the study that need to be contemplated.

6.7 Limitations of the study

There were three limitations to this study. Firstly, as the data emerged to demonstrate the significance of the inter-dependent dyadic relationship between the HCA and the RN, the focus on the HCA became a limiting factor. The RNs were interviewed to add another layer of understanding about the actions of the HCA, whereas the findings illuminated the high significance of their impact on the HCA's role. An opportunity to gain understanding of the HCA-RN dyad from the viewpoint of the RN was missed. A second limitation was the absence of the patient voice. The impact of the finding that care was task-orientated and not person-centred could not be fully explored due to the lack of inclusion of patients. Thirdly, as with many ethnographic studies, the generalisability of the findings to environments outside of the wards used in this study cannot be assumed. This said, there was consistency across the four wards and with previous HCA literature. In effort to support transferability, contextual information in the methodology and the findings of this study have been presented allowing readers scope to consider the connections with their own environment.

6.8 Implications and recommendations for healthcare practice

Since commencement of this study, awareness of the hard work of the nursing team has become heightened in the public arena due to the COVID-19 pandemic. "Nurses" has been used as a catch-all term confirming that the public do not differentiate between RNs and HCAs. It is suggestive that the public are not making judgements about care delivery based on qualifications or hierarchy, but on being well looked after. This provides an opportunity to ensure that we advance nursing care from the basis of contribution rather than

hierarchical position. This was an attribute of the HCA-RN dyad when it worked well. Sharing the findings of how HCAs work non-dependently and inter-dependently, and the facilitators and barriers to working in this way, has the capacity to improve working relationships and consequently, care for patients who are admitted to care environments with bays. This said, it is also right to recommend that national institutions such as the House of Commons, refrain from viewing RNs as the only nursing human resource. This study has confirmed that the success of the RN is dependent on the relationship they have with the HCAs.

Identification of the non-dependent and inter-dependent facets of the HCA role and how RNs assess their trustworthiness needs to be shared on a national and local level. Nationally, placing value on the contribution that HCAs make to the healthcare team would enhance how they are valued by others and may reach the public who cannot differentiate between the two groups.

HCAs take their role and responsibilities seriously despite lack of formal recognition through registration. Their involvement in patient care has been shown as crucial. It is recommended that documents which only refer to the HCA in regard to having opportunities to 'step up' to a higher band be reconsidered in relation to their implicit message that being a Band 2 HCA is not an adequate contribution in itself. These documents reiterate the HCAs' less visible contribution to care and undermines the work that they do.

The work of HCAs needs to be more valued at local Trust level also. This study has connected the HCAs role with anxieties, created by task completion or pleasing the RN, which have descended from higher levels. It was recognised by Kessler et al (2010) and Spilsbury (2004), that organisations shape the role of the HCA, and thus attention from them to this intertwined relationship would be advisable. This could be achieved in a number of practical ways. Firstly, Trust inductions and in-house training would benefit from inclusion of information pertaining to the function of HCA-RN dyadic working with the aim of increasing, improving and valuing its use. This would incorporate the description and operationalisation of mini-meetings as a planning and communication tool. This is necessary for emphasising collaborative rather than hierarchical working. Next, RNs and other multidisciplinary team members would benefit from gaining a comprehensive and

consistent message about the preparation and skill-set that HCAs hold. Trusts should show that they support this way of working; that this is safe delegation. RNs could then improve their 'bedside' assessment of the HCAs skills and reduce their own anxieties about the capabilities and trustworthiness of the HCA partner at the beginning of the shift. Also, formalising the HCA-RN dyad would need to be bolstered by general managers and senior sisters ensuring that minimum ward staffing levels included the appropriate number and skill mix for the HCA-RN dyad to be fully implemented in each bay and associated side rooms.

Finally, there is a complex conflict that crosses between national and local policy and practice that requires attention; the nursing philosophy of person-centred care and the reality of task-orientated working. In our contemporary health care climate, there is emphasis placed upon safe care and evidence of results. Whilst the importance of this cannot be denied, anxieties may be reduced for all in the ward environment if there was acknowledgement of the conflicting ethics and then agreement in which of these is prioritised. It may be beneficial to start with exploration of what value patients place on person-centred care in an acute ward environment and move forwards from there. Policies and practices need to be aligned.

6.9 Recommendations for further research

The findings of the HCA-RN dyad and the HCAs role within it is a new construction of the nursing team. Therefore, there are many aspects of this research that could be further examined. As suggested in the limitations, I placed importance on prioritising the meaning that HCA's ascribed to their social world because the voice of HCAs as participants was rarely given gravity in final reports. But as the research journey took unpredicted turns, the juxtaposition of the HCA with the RN was undeniable. Therefore, a further study which gives equity to the voice of each dyadic partner may provide deeper understanding of the self-, other- and collective-efficacy beliefs and their influence on partnership development. There is suggestion that what happens between dyads can be more than a sum of each individual's part (Kenny and Cook 1999). There would be a prospect of investigating whether this was the case for HCA-RN dyads and an opportunity to use PAR or critical ethnography. These

methods, which were felt to be inappropriate before, could now be utilised to build on the knowledge of HCAs that was discovered in this study.

This depth of understanding of the HCA-RN dyad would provide a base for other comparisons. For example, paramedics work as a dyad. In the HCA-RN dyad, the boundary walls of the bays played a significant part in providing a clarity to what was their workload and a concentrated relationship emerged as a consequence. In contrast, there are no physical walls to mark the paramedics' work, yet they are also isolated from other dyadic paramedic peers. Exploration of this dyadic relationship doesn't appear to have been explored in the UK and, as they have historically worked in this type of team, there may be transferrable learning to the HCA-RN dyad.

During the process of undertaking this research, the role of the Nursing Associate was introduced which has brought the nursing team back to three hierarchical levels and pay bands as was seen before with the role of the State Enrolled Nurse (SEN). Whilst the number of Nursing Associates is low and they are establishing their role, the bearing on the HCA-RN dyad may currently be small. However, the impact of this structure long term could be derived from other countries such as Australia and New Zealand where the SEN role was not terminated. More research is advisable.

In a culture where measurements are valued, a mixed methods study which looks at correlations between time spent planning in mini-meetings, in working non-dependently and inter-dependently and the impact that these elements had on patient care is needed. An exploration of the HCA-RN dyad through a social capital framework would provide a different measure of success.

Finally, it is recommended that further research takes place to clarify the patient's perception of what is a priority when being cared for on an adult ward. This will provide information with which to improve the policy and practice synthesis.

6.10 Conclusion

How HCAs enact their role has been constructed to increase understanding of their contribution to the nursing team and their relationship with the RN to an intensity that has not been seen before. It has been demonstrated through the data that HCAs work in a task-orientated way, where their actions are reactions to the RN that they are working with on that particular shift. It has been shown that the HCA is one half of the dyadic team which has more importance than the whole ward nursing team. The HCA's movements were at times non-dependent, still reflecting the RN's preference, and at others inter-dependent where they worked with and led RNs to ensure that low level measured tasks were completed on time. It is known that the capacity to work non-dependently was based on application of the routine scaffolding which provided reassurance of staying on track to complete everything within the shift. It was clear that the RN retained the senior position and confirmed the capability and trustworthiness of the HCA in carrying out the routine scaffolding. It has been shown that inter-dependent working necessitated HCAs and RNs to take on exchangeable and distinguishable roles in response to circumstances that arose. Mini-meetings had developed as a tool to effectively review and progress work. This is a summary of what was occurring on two medical wards and two assessment units. It updates the literature on the role of the HCA in the hospital environment.

Importantly, this research has depicted that the task-orientated culture does not seem to be able to also incorporate person-centred care. It is not advocated that this position is correct, rather that there was consensus in the constructions of perceived reality captured through many of the 148 hours of observation and 108 interviews. Acknowledgement that this describes the current situation provides opportunities for reassessment of the reality. There have been recommendations for practice made above but in essence, the HCA-RN dyad is successful in meeting government mandates and achieving the workload, particularly when it adheres to the functions described. Recognising the elements that comprise the form of the HCA-RN dyad offers openings for improving this style of nursing team working. This is based on the assumption that the onus on measures of performance continues to be the priority in the hospital culture.

This research has thoroughly explored the HCA's role and described how it fits within the HCA-RN dyad. This is an exciting development which, if nurtured, could improve the care environment for all.

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Appendices

Appendix 1 – The HCA literature search results

Table 5- The search strategy for HCA literature based on terms identified and Boolean operators.

Search number	Search term	ASP	CINAHL	BND
1	"nursing assistant*"	1,144	4,631	2,801
2	"nursing assistant*" AND role	191	880	726
	TI ("nursing assistant*") AND role	19 (screened)	52 (screened)	8 (screened)
3	"nursing assistant*" AND hospital	406	796	740
	TI ("nursing assistant*") AND hospital	20 (screened)	22 (screened)	3 (screened)
4	"nursing assistant*" AND "acute care"	28 (screened)	97	394
	TI ("nursing assistant*") AND "acute care"	-	2 (screened)	1 (screened)
5	"Health care assistant*"	281	186	2758
	"Health care assistant*" AND role	84	82	255
	TI ("Health care assistant*") AND role	27 (screened)	45 (screened)	9 (screened)
6	"Health care assistant*" AND hospital	81	35 (screened)	176
	TI ("Health care assistant*") AND hospital	12 (screened)	-	4 (screened)
7	"Health care assistant*" AND "acute care"	4 (screened)	4 (screened)	27 (screened)
Total	Total number of articles ("nursing assistant* + "health care assistant*")	1,425	4,817	5,559
	Number of articles screened by abstract	110	160	52

Table 6- Table to show number of HCA articles screened and number and reason articles were discarded for ASP.

ASP Articles for Screening	 110	 Total 110
Duplicates	8	Total 102
Excluded after reading abstract	87	Total 15
Excluded after reading full text	5	**Total 10**
Reason for exclusion		
Not hospital	40	
Not adult field of practice	8	
Not health care assistant (eg nurse, teamwork)	14	
Not written in English	2	
Task/role specific (eg pressure area care, diabetes)	13	
Opinion piece	8	
Personal/health/development	7	

Table 7 - Number of HCA articles screened, and number and reason articles were discarded for CINAHL.

CINAHL Articles for screening	 160	 Total 160
Duplicates within CINAHL search	9	Total 151
Excluded	130	Total 21
Duplicates with ASP	13	Total 8
Excluded after reading full article	1	**Total 7**
Reason for exclusion		
Not hospital	46	
Not adult field of practice	8	
Not health care assistant (eg nurse, teamwork)	7	
Not written in English	3	
Task/role specific (eg pressure area care, diabetes)	34	
Opinion piece/news	16	
Personal/health/development	17	

Table 8 - number of HCA articles screened, and number and reason articles were discarded for BND.

BND Articles for screening	52	Total 52
Duplicates within BND search	4	Total 48
Excluded	40	Total 8
Duplicates with ASP and CINAHL	3	Total 5
Excluded after reading full article	4	**Total 1**
Reason for exclusion		
Not hospital	11	
Not adult field of practice	3	
Not health care assistant (eg nurse, teamwork)	9	
Not written in English	0	
Task/role specific (eg pressure area care, diabetes)	11	
Opinion piece/news	5	
Personal/health/development	8	

Appendix 2 –Table showing Trustworthiness

Based on Lincoln and Guba (1985)

Criteria	Criteria/description	Examples/explanation
Credibility	Prolonged engagement	I started to establish myself as a research fellow with the EnRICH project before commencing my own data collection. Focused, intermittent data collection took place between 24.08.15 and 06.10.17
	Persistent observation	There was 148 hours of observations and 108 interviews. This assisted with looking at phenomena at various times, with 28 different participants, in four different settings. This demonstrates that there was in-depth exploration of elements of interest that arose from prolonged engagement.
	Member checking	Example from 18.09.17 - Interview 4 with HCA Susan from A2 **R - I was just telling you a bit about what I had found with the processes and the routines. To say that person-centred care exists on the ward, I would say, is possibly not the case anymore. What are your thoughts on that?** Susan - I think on a ward where you have got patients there for longer, you can do, because you can get to know them better. On here, I am with these patients for the 12 hours but then come tomorrow, I will be in that bay again and not one of them could be there. So, all what I have learnt from what they have had today, it doesn't matter anyway because you are not going to see them tomorrow. Not that you shouldn't find out what they like but you are not with them long enough to find out what they are like. Does that make sense?
	Triangulation	Observations were compared with interviews for each participant. Data collected from each participant was also compared - Over the period of one year through cross reference with their previous interviews - With other participants in the same environment - With participants in the other three environments
Transferability	When the applicability of the findings and interpretations is detailed enough for	Thick description was provided for readers to consider the transferability to their own setting through - the methods chapter that explained the research design, access to the field, participant recruitment, ethical considerations, data collection methods and the data analysis process - the exemplar based on HCA Monica where real aspects of data collection are depicted

	others to apply to their setting.	- the findings chapter which provided description of the environments, the composition of the form and function of the HCA-RN dyad - the discussion and conclusion which gave added context by comparing the findings of this study with other studies. This said, this study was only conducted within one hospital and this limits the transferability of the results.
Dependability and confirmability	Consistency of findings Analysis process in keeping with accepted standard	A handwritten field journal was kept of who was recruited, when data was collected, when observations and interviews were transcribed and then entered on to Nvivo. The process of how codes were developed were captured by Nvivo and the results shared in Chapter 4.7- Data Analysis Process. Decision making and reflections were also recorded in the field journal. They were discussed with supervisors monthly and with other researchers at annual reviews. These are referred to in Chapter 3.3 - Quality and Reflexivity.

Appendix 3 - Table of interviews and observations undertaken

M1 - medical ward - female

	When- week /month number	Other data gathered	Other information
New HCA Mary			
Interview 1	24.08.15 week 4	none	No observations at early meetings
Interview 2	12.10.15 week 10	none	
Interview 3	06.11.15 week 14	Observations RN Geeta interviewed	Agency RN – regular shifts
Interview 4	04.03.16 month 8	Observations	RN Asha invited to interview but refused
Interview 5	07.09.16 month 12	observations RN Robyn interviewed	
New HCA Hope			
Interview 1	24.08.15 week 1	none	No observations at early meetings
Interview 2	09.10.15 week 8	none	
Interview 3	30.10.15 week 11	Observations RN Holly interviewed New S/N Dawn interviewed	New S/N on induction.
Interview 4	10.03.16 month 7	Observations	RN Asha invited to interview but refused
Interview 5	06.09.16 month 12	observations RN Jane interviewed	Left post this week for a new job in theatres
Established HCA Kate			
Interview 1	13.11.15	Observations RN Carol interviewed	
Interview 2	16.09.16	observations RN George interviewed	
Established HCA Grace			
Interview 1	14.09.16	Observations RN Helen interviewed	
Cultural contributor interviews			
Ward sister	14.09.16		
Physiotherapist	14.09.16		
Student nurse	14.09.16		
Established HCA Debbie	16.09.16		Worked with HCA Kate

M2 medical ward - male

	When – week /month number	Other data gathered	Other information
New HCA Maria			
Interview 1a	21.05.15 week 4	none	The ward moved environments last week, so another interview arranged
Interview 1b	29.06.15 week 10	none	
Interview 2	01.09.15 month 4	none	
Interview 3	11.04.16 month 11	Observation RN Daisy Interviewed	
Interview 4	30.09.16 month 16	Observation RN Jerry interviewed	
New HCA Freya			
Interview 1	27.10.16 week	Buddy interview – Maria	HCA Maria had participated in this study as a new HCA. She was now the buddy for a new HCA.
Interview 2	13.02.17 month 4	Observation RN Dot interviewed	Observations were for a short time due to opportunity for interview
Interview 3	18.05.17 month 7	Observation	No RN interview
Interview 4	-	-	HCA Sick
New HCA Lisa			
Interview 1	01.11.16 week 4		No observation at early meeting
Interview 2	12.01.17 month 4	Observation RN Aliya interviewed	Lisa hadn't been allocated a buddy
			20.03.17 – sick
Interview 3	26.04.17 month 7	Observation RN Sky interviewed	
Interview 4	06.10.17 month 12	Observation RN Bertha interviewed	
Established HCA Emma			
Interview 1	29.06.15		
Interview 2	19.09.16	Observation RN Ginny interviewed	
Established HCA Alicia			
Interview 1	20.09.16	Observation RN Tansy interviewed	

Cultural contributor interviews			
Ward sister	20.04.16	interviewed	
Student Nurse	12.01.17	Observed and interviewed.	3rd day 1st year, 1st placement. Working with HCA Lisa and RN Tansy
Physiotherapist	13.02.17	interviewed	

A1 assessment unit

	When/week	Other data gathered	Other information
New HCA Rebecca			
Interview 1	13.05.15 week 1	none	No observations at early meetings
Interview 2	24.06.15 week 6	none	
Interview 3a Interview 3b	18.12.15 month 8 14.01.16 month 9	Observations Observations and interviewed (handwritten, not recorded)	18.12.15 circumstances were that observations were not useful. Ceiling collapsed – beds closed. Interview carried out still. Returned 14.01 to carry out obs. RN not available to request an interview
Interview 4	30.06.16 month 15	Observations RN Seema interviewed	RN interview short
New HCA Kim			
Interview 1	11.03.16 week 12	none	No observations at early meetings
Interview 2	18.04.16 week 19	Observations RN interviewed Deputy Andrea interviewed	
Interview 3	04.07.16 month 7	Observations RN Nadia interviewed	
Interview 4	09.11.16 month 11	Observations RN Laura interviewed	RN Laura also discussed HCA Toni
New HCA Alice			
Interview 1	22.06.15 week 12	none	No observations at early meetings
Interview 2	07.08.15 week 16	none	
Interview 3	06.10.15 month 8	Observations RN Ida interviewed	
Interview 4	07.01.16 month 10	Observations RN Jasmine interviewed	
New HCA Alana			

Interview 1	21.05.15 week 5	none	No observations at early meetings
Interview 2	20.07.15 week 13	none	
Interview 3	18.12.15 month 10	Interview only – last day in post	Left health care
Established HCA Sam			
Interview 1	17.12.15	Observations RN Chris interviewed	
Interview 2	04.07.16	Observations RN Ivy interviewed	
Established HCA Toni			
Interview 1	29.07.16	Observations RN Nikki interviewed	
Interview 2	11.11.16	Observation RN Laura interviewed	
Cultural contributor interviews			
Ward sister	23.04.15 17.12.15 05.09.16		05.09.16 –In relation to a specific incident
Matron	13.05.15		
Deputy sister	23.04.15		
Physiotherapist	14.04.15		
Staff nurse	23.04.15		
Student nurse	21.04.15		

A2 - assessment unit

	When/week	Other data gathered	Other information
New HCA Rosie			
Interview 1	13.10.16 week 4	none	No observations on first meetings
Interview 2	09.01.17 month 4	Observations RN Lily interviewed	
Interview 3	28.03.17 month 7	Observations	No RN interview - unavailable
Interview 4	08.09.17 month 12	Observations RN Gill interviewed	
New HCA Monica			
Interview 1	26.10.16 week 3	none	No observations on first meeting
Interview 2	20.01.17 month 4	Observations RN Clara interviewed	

Interview 3	12.04.17 month 7	Observations RN Lily interviewed	
Interview 4	25.07.17 month 10	Observations Senior RN Ruby interviewed	
New HCA Susan			
Interview 1	20.01.17 week 7	none	Now new HCAs supernumerary until week 8, not week 12 as previously.
Interview 2	21.03.17 month 5	Observations RN Violet interviewed	
Interview 3	27.06.17 month 8	Observations	
Interview 4	18.09.17 month 11	Observations RN Fern interviewed	
Estab HCA Jean			
Interview 1	06.10.16	Observations RN Summer interviewed	
Estab HCA Catherine			
Interview 1	20.01.17	Observations RN Rosemary interviewed	Buddy to Susan
Estab HCA Maureen			
Interview 1	20.01.17	Observations	Buddy to Rosie
Cultural contributor interviews			
Ward sister Sarah	08.09.17		
Physiotherapist	28.03.17		
Student nurse	25.07.17		

Appendix 4 – Faculty research ethical approval form

DE MONTFORT UNIVERSITY LEICESTER

HLS FREC Ref: 1410

3rd September 2014

Professor Jayne Brown
Nursing & Midwifery

Dear Jayne,

Re: Ethics application – EnRICH (Enhancing Relationships in Care in Hospital) Culture Change Programme (ref: 1410)

I am writing regarding your application for ethical approval for a research project titled to the above project. This project has been reviewed in accordance with the Operational Procedures for De Montfort University Faculty of Health and Life Sciences Research Ethics Committee. These procedures are available from the Faculty Research and Commercial Office upon your request.

I am pleased to inform you that ethical approval has been granted by Chair's Action for your application. This will be reported at the next Faculty Research Committee, which is being held on 16th October 2014.

Should there be any amendments to the research methods or persons involved with this project you must notify the Chair of the Faculty Research Ethics Committee immediately in writing. Serious or adverse events related to the conduct of the study need to be reported immediately to your Supervisor and the Chair of this Committee.

The Faculty Research Ethics Committee should be notified by e-mail to hlsfro@dmu.ac.uk when your research project has been completed.

Yours sincerely,

Professor Martin Grootveld
Chair
Faculty Research Ethics Committee
Faculty of Health & Life Sciences
De Montfort University

Email: hlsfro@dmu.ac.uk
Web: http://www.dmu.ac.uk/research/ethics-and-governance/faculty-specific-procedures/health-and-life-sciences-ethics-procedures.aspx

Faculty of Health and Life Sciences, Edith Murphy House, The Gateway, Leicester LE1 9BH.
T: (0116) 255 1551 **F:** (0116) 257 7135

Appendix 5 – Staff information sheet -revised

STAFF PARTICIPANT INFORMATION LEAFLET

Title of Project: What factors influence creation of an enriched environment for and by Health Care Assistants?

Name of Investigator: Rachael Carroll

You have been invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and decide if you want to take part. Talk to others about the study if you wish. This information leaflet tells you the purpose of the study, what will happen to you if you take part and gives detailed information about the conduct of the study. If anything is not clear or if you would like some more information, please contact Rachael Carroll. Telephone (0116) 201XXXX or email Rachael.carroll@dmu.ac.uk

What is the purpose of the study?
Health Care Assistants provide a vital contribution to patient care. The current focus on the role of the Health Care Assistants is in relation to their job description, their training and the lack of legislation. There has been little interest in how they do their job and what makes a difference to how they achieve it. This study would like to address this.

This doctoral study is being carried out under the umbrella of a larger project called the EnRICH Project (Enhancing Relationships In Care in Hospitals). The EnRICH project has been funded by the Burdett Trust for Nurses and has been undertaken at De Montfort University with grant holders at University of Sheffield and University Hospitals of Leicester. This doctoral study shares common elements with the EnRICH project; it will use some of the same wards, it will use similar ways of collecting information and it will look at the culture on the ward. However, where the EnRICH Project focused on the experience of older people, this study will look at the role of the Health Care Assistant.

What does the study involve?
A small number of Health Care Assistants and other professionals have been identified by the researcher as possible participants for the study. The information that the researcher wishes to gather is different, depending on whether you are a Health Care Assistant or another member of the ward team. Below is a description of what is involved if you agree to participate.

For Health Care Assistants:

- Health Care Assistants will be observed carrying out their work on the ward. The researcher will write down what she sees and hears. This will happen for periods of four hours or more.
-
- Immediately after the period of observation, the Health Care Assistant will be interviewed. The interview will take place in a room near to or on the ward and will

be voice recorded. The researcher will ask the Health Care Assistant to talk about how he/she did their job using what she saw or heard to prompt the participant. The researcher will then ask the Health Care Assistant to talk about how they see their role and what makes it easier or more difficult to undertake.

For other team members:
Although the focus of this study is the role of the Health Care Assistants, to be able to understand how they carry out their role it is necessary to see how they interact with other team members, patients and carers.

- After the Health Care Assistant has been observed and interviewed, the nurse who has been working alongside the Health Care Assistant will be interviewed. They will be asked about what was observed and how they see the role of the Health Care Assistant.

- Other people may also be part of the observations that take place on the ward and therefore also invited to interview. This may include people in roles such as Occupational Therapists, Physiotherapists, Student Nurses, Discharge coordinators and Doctors.

- There are also groups of professionals that the researcher believes would contribute information to the study because of their specialist knowledge or position within the hospital. They will also be invited to interview.

As the study looks at the role of the Health Care Assistant over time, you may be asked to participate on more than one occasion. If you agree to the first instance, you at not obliged to agree to any others that follow. Consent will be sought each time you are observed or invited to interview.

Who is organising and funding the research?
Two years, full time fees of the doctoral study are funded by the Burdette Trust for Nursing under the EnRICH study umbrella. The EnRICH study is now coming to a close but this doctoral study will continue. This study will be undertaken by Rachael Carroll, a student at De Montfort University.

Why have I been chosen?
You have been invited to participate because you are a staff member on a ward which took part in the EnRICH study at the University Hospitals Leicester. Your opinions on the role of the Health Care Assistant are valued and I would like to learn from your experience.

Do I have to take part?
No – taking part is entirely voluntary. If you would prefer not to take part, you need do nothing and you do not have to give any reason.

What are the possible benefits of taking part?
There are no direct benefits to you. It is hoped the information gathered might help improve the experience of giving and receiving care on the ward and throughout the hospital in the

future. Sharing your experiences during the interview can be helpful; some people enjoy the opportunity to reflect that research participation sometimes offers.

What are the possible disadvantages and risks of taking part?
Being observed at work can sometimes feel uncomfortable. Also, the study includes being interviewed, sometimes on more than one occasion. This will involve taking time to talk to the researcher which can be difficult.

Expenses and Payments
Participants will not be paid to participate in the study.

Will my taking part in the study be kept confidential?
Quotes from the interviews will be used in the doctoral study, articles and presentations at professional and educational meetings and conferences. However, your name or details that will identify you or any other person will not be used in any report of the findings. No-one else will be informed that you have taken part in the research. Procedures for handling, processing, storage and destruction of study data meet the requirements of the Data Protection Act 1998.

Ethical and legal practice guidelines will be followed and all information about you will be handled in confidence. If you join the study, the data collected for the study will be looked at by the researcher and authorised persons from De Montfort University or the UHL Research and Develop team who will check that the study is being carried out correctly; all have a duty of confidentiality to you. All information which is collected about you during the course of the research will be kept strictly confidential, stored in a secure and locked office, and on a password protected database.

Any personal information (address, telephone number) will be kept for 6 months after the end of the study so that we are able to contact you about the findings of the study (unless you advise us that you do not wish to be contacted). All other information (the transcribed anonymous interviews) will be kept securely for 10 years. After this time your data will be disposed of securely. The audio recording of the interview will be password protected before being stored on computer by the doctoral student at De Montfort University, Leicester. The content of the interview will then be transcribed to assist with analysis. The audio files will be destroyed at the end of the study and the transcriptions will be securely stored for 10 years.

What happens if I don't want to carry on with the study?
Your participation is voluntary, and you are free to withdraw at any time, without giving any reason. If you withdraw before the interviews are analysed, then the information collected from you will be withdrawn from the study.

What will happen to the results of the research study?
Quotes from the interviews will be used in the final doctoral study, articles and presentations at professional and educational meetings and conferences. These publications and presentations will contain verbatim quotations from interviews so although

you will not be identified you may if reading these papers recognise something you have said.

Who has reviewed the study?
This study was given a favourable ethical opinion for conduct in the NHS through the Integrated Research Ethics Committee Research Ethics Committee 14/WS/1130 Approval Number: 150281

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researcher Rachael Carroll who will do her best to answer your questions. Please contact on (0116) 201XXXX, email Rachael.carroll@dmu.ac.uk , by post De Montfort University, Edith Murphy Building, Room 7.09 The Gateway, Leicester LE1 9BH.

If this is not satisfactory then please contact Jayne Brown who is the supervisor by telephone on (0116) 201XXXX, mobile 07XXXX by email jbrown@dmu.ac.uk by post De Montfort University, Edith Murphy Building, Room 3.30 The Gateway, Leicester LE1 9BH.

If you are still unsatisfied you should contact Professor Martin Grootveld who is Chair of the Ethics Committee at De Montfort University by telephone on (0116) 250XXXX, by email mgrootveld@dmu.ac.uk by post De Montfort University, The Gateway, Leicester, LE1 9BH

What if I have any queries or concerns after reading this information sheet?
Please feel free to contact the researcher Rachael Carroll. Telephone direct dial:- 0116 201 3815, email Rachael.carroll@dmu.ac.uk or you can write to: Rachael Carroll, Doctoral Student, De Montfort University, Edith Murphy Building, The Gateway. Leicester LE1 9BH

Thank you for reading this information sheet

Appendix 6 – faculty research ethical approval committee amendment agreement

19 June 2020

Mrs Rachael Carroll & Professor Jayne Brown Edith Murphy House
De Montfort University
The Gateway, Leicester LE1 9BH

Dear Rachael & Jayne
Re: Ethics Amended Application – EnRICH - Enhancing Care in Relationships in Hospitals

Ref: 1410

I am writing regarding your amended application for ethical approval for a research project titled to the above project. This project was reviewed in accordance with the Operational Procedures for De Montfort University Faculty of Health and Life Sciences Research Ethics Committee. These procedures are available from the Faculty Research and Commercial Office upon your request.

I am pleased to inform you that your amended application received a favourable opinion on 14th November 2016.

Should there be any further amendments to the research methods or persons involved with this project you must notify the Chair of the Faculty Research Ethics Committee immediately in writing. Serious or adverse events related to the conduct of the study need to be reported immediately to your Supervisor and the Faculty Head of Research Ethics.

The Faculty Research Ethics Committee should be notified by e-mail to hlsfro@dmu.ac.uk when your research project has been completed.

Yours sincerely,

Dr Douglas Gray

Faculty Head of Research Ethics Faculty of Health & Life Sciences De Montfort University

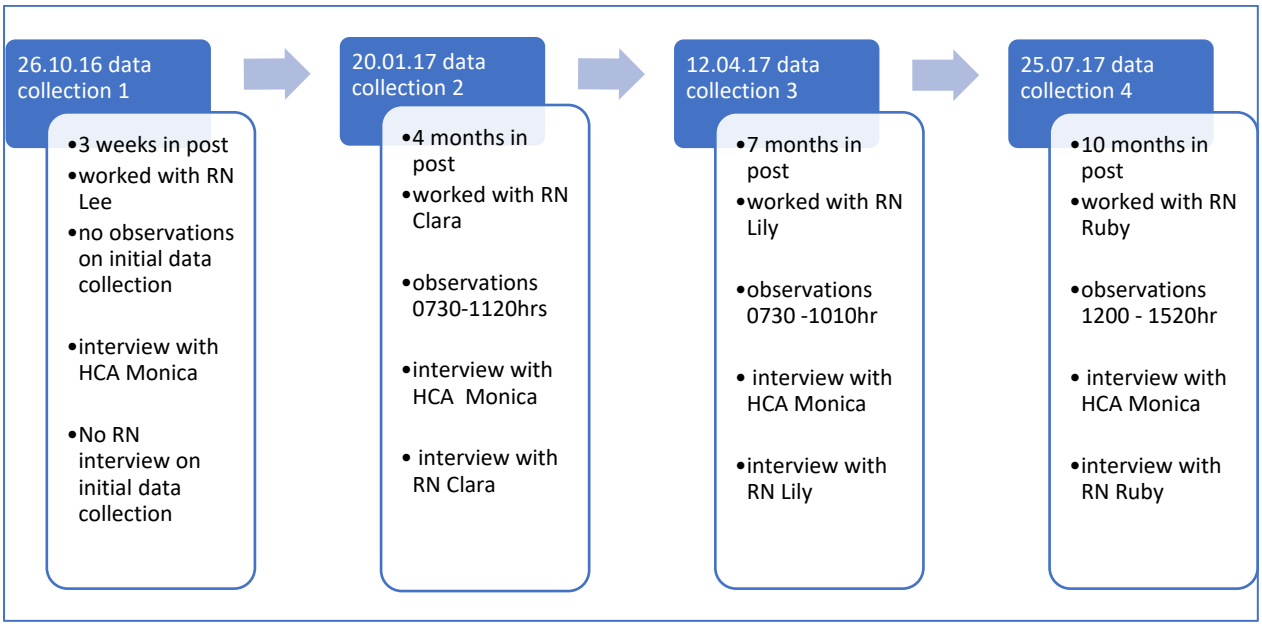
http://www.dmu.ac.uk/research/ethics-and-governance/faculty-specific-procedures/health-and-life-sciences-ethics-procedures.aspx

Faculty of Health & Life Sciences, Faculty Research Ethics Committee, Edith Murphy House, The Gateway, Leicester LE1 9BH, hlsfro@dmu.ac.uk

HLS FREC Ref: 1410

Appendix 7 - Diagram to show process of observations and interviews for one new HCA over the course of one year

This diagram illustrates the process of observations and interviews for one new HCA over the course of one year. It has been generated from the journey that HCA Monica took on A2 which was the double sized assessment unit but is representative of how data was collected for all new HCAs. The diagram includes the dates of the four data collection periods, how long the new HCA had been in post, who the HCA worked with on that shift, the length of observations and that the RN partner was interviewed. It shows that the initial episode of data collection for a new HCA was interview only. It also illustrates that HCAs worked with a different RN on each shift.



Appendix 8 – Joining and separating and routine scaffolding

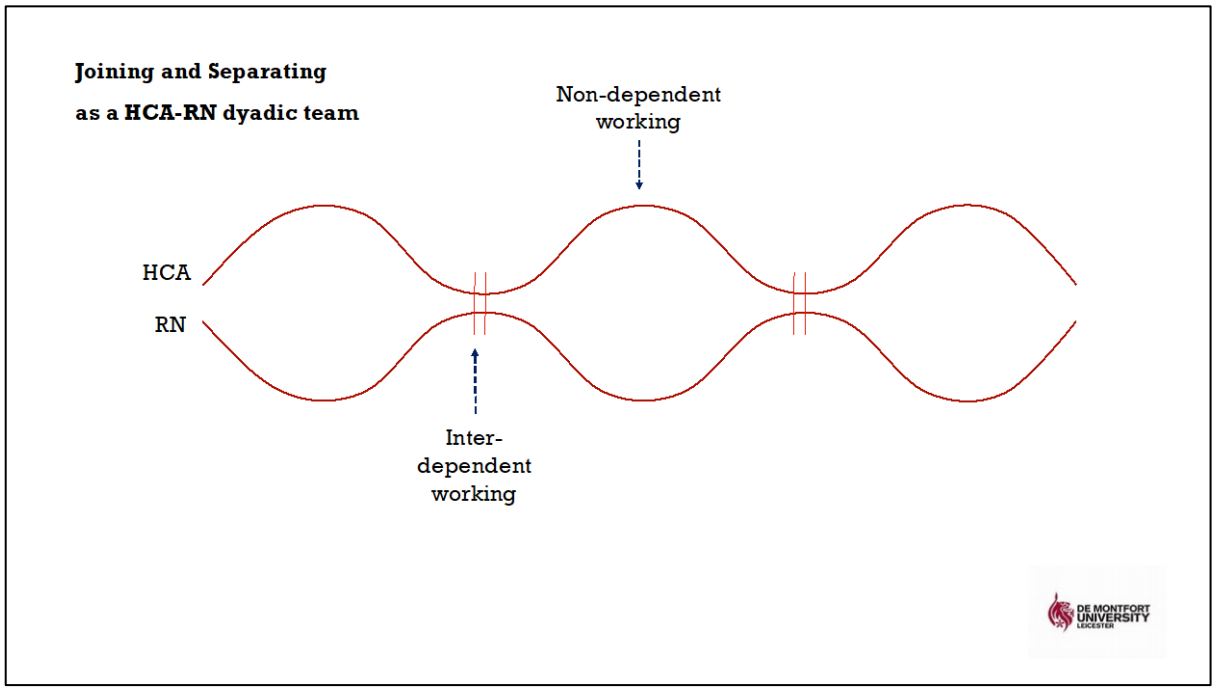


Figure 12 - Joining and separating

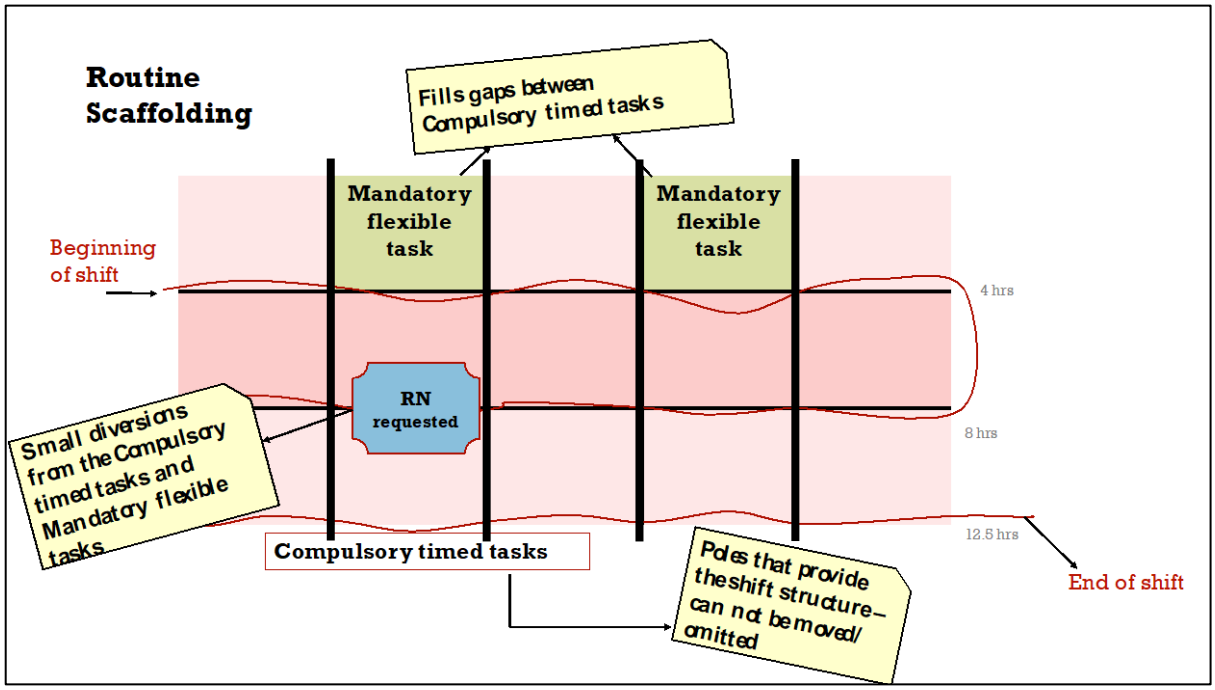


Figure 13 - Routine Scaffolding