Working in a Blurred Domain: The Health Care Assistant in Aged Residential Care

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ABSTRACT

The world population is ageing, and as the years increase so to do the consequences for the older people, with this population often experiencing longevity combined with comorbidities. Correspondingly those able to provide care are decreasing in number and it has been predicted that many countries are going to be competing for the services of the Health Care Assistant (HCA), the person who provides 90% of the direct care work in aged residential care (ARC). Researchers have explored how to attract and retain this person within the ARC environment; however, many reports focus on a narrow role, not explaining the role from the perception of the HCA. The research question for this study was '*how do health care assistants manage their work in aged residential care?'* Using social constructionist grounded theory, 16 participants were interviewed from eight ARC facilities, including rest homes, hospitals and dementia care units, located in a major city in New Zealand.

The findings explained the domain in which the HCA worked; a blurred domain, a domain with no defined boundaries, extending into the realm of the Registered Nurse and working, at times, with little supervision. Responding to this environment the HCA participants used strategies associated with protecting self, balancing the workload and engaging self, moving between the strategies depending on the conditions. Feeling responsible to fulfil needs associated with the employer, resident and self, the HCA responded to conditions associated with time and support available, with the knowledge and skill base of the HCA integral to the strategies employed.

This study has contributed an explanation of the blurred domain and the strategies employed by the HCA to manage working in this role. These finding may be used to inform practice and support legislative efforts to protect the HCA, enabling this person to work within defined parameters, no longer subject to employer discretion. Increasing the safety of the role, providing increased support, and improving employment conditions

will attract more people to work in this very complex environment, supporting New

Zealand's most vulnerable people.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ATTESTATION OF AUTHORSHIP

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning."

Signed:

Date: 24.10.2017

DEDICATION

To my mum and dad who started me on this journey, the loving never ends.

ACKNOWLEDGEMENTS

wise words, hugs and wine – I thank you for supporting me through these years. The running group and my personal trainer and friend, Karen, I needed you all and you were there all the time. Thank you.

Finally, my supervisors; Barbara McKenzie-Green and Valerie Wright-St Clair, how is it possible to say how much I owe to you both and how much I believe you have helped me grow. This has been an incredible journey that frequently had traffic jams and I smile as I remember Barb asking how long the jams would last, giving me a nudge over the bumps and onward again. It wasn't an easy journey, but I did look forward to our meetings and discussions. I look forward to more. Ladies, I cannot thank you enough for helping me achieve this goal, by joining me on this journey and at times, linking hands, helping me steer the car.

CHAPTER ONE: INTRODUCTION

But whatever we can offer, our interventions, and the risks and sacrifices they entail, are justified only if they serve the larger aims of a person's life. When we forget that, the suffering we inflict can be barbaric. When we remember it, the good we can do can be breath taking. (Atul Gawande, 2015, p. 260)

It was with huge relief, and some grief, when it became time for my parents to transition into an aged residential care (ARC) facility due to their failing health – relief, because they were now safe and grief because their known life was changing. In place of their home and independence they were entering an environment where a health care assistant (HCA) was now assisting them to meet their personal care needs. It was not until I was enmeshed in this environment that I began to understand a little of what the HCA did. This new understanding and the knowledge that New Zealand will shortly be competing, among other countries, for the services of the HCA, are two factors that prompted this research.

In this chapter, I present the introduction to the research, the reasons for undertaking this research and why it was important to me. I explain the background to the thesis, including an overview of the role of the HCA. This is placed within the context of need for this workforce; and overviews aspects of the population that most utilises the services of the HCA in ARC. I present an explanation of the dilemma that New Zealand and international communities face as they grapple with an ageing population and consider the impact of legislation, policy, funding, and the structure of the aged care sector in New Zealand**.** Following this, the working environment and the roles pertaining to direct personal care provision are examined; the Registered Nurse (RN), Enrolled Nurse (EN) and the HCA, a comparative analysis between the EN and HCA is applied. Focussing further on the HCA, I explain the demographics, explore the impact of the migrant population that supports this sector, the working conditions, remuneration, and explain the training that leads onto employment in ARC. To

conclude, I explain the HCA's role in ARC. With the background context in place, I introduce the structure of the thesis.

Introduction to the Research: The Why, What, and How of the Question

As stated, the inspiration for this research began when my parents who, like many others, lived their final few years in an ARC facility. HCAs predominantly provided their care; and I, a RN, spent many hours watching and assisting these people. I grew to understand that the ARC environment was a complex and constantly changing world and my observations and participation in my parents' care stimulated my desire to contribute to research within this area; this was the *why* of the research. The question I wanted explored and explained was '*how do health care assistants manage their work in aged residential care?'*

The *what* of the research will be explained within the literature and findings chapters. The what is about the findings of the research which included the actions of the HCA, the meanings behind these actions and the interpretation given to them. *How* this research was undertaken follows the methodology and methods of social constructionist grounded theory that will be explained in Chapter Three. Fulfilling the requirements of Doctor of Health Science, the findings are required to be applicable to practice, thus explaining the research question will both satisfy this requirement as well as my own. The Doctor of Health Science is underpinned by three papers each of 40 points. Health Systems Analysis, Practice and Philosophy, Research Practice and Methodology with the remaining 240 points for the thesis in Health Science and has a word limit of between 60 - 80 thousand words. The Health Systems Analysis paper focuses on an analysis of the legal and political influences on the New Zealand health and disability sector with reference to the student's field of study. The Research Practice and Methodology paper provides opportunities to examine and determine appropriate research approaches and

subsequently develop a management plan towards completing the DHSc. One area of personal interest was the exploration of 'self as leader'. The Practice and Philosophy paper examines the underpinning philosophy guiding various research methodologies and assists students to develop a proposed research design.

Background

Overview of the HCA role

HCA is the title used in New Zealand to describe the worker who assists the RN by undertaking direct personal care tasks (Career Force, 2017a; Dale, 2015). Similar titles given to the role of the HCA, both within New Zealand and internationally, include; community care worker, long term care worker, nurse aide, home support worker, community care assistant, personal care assistant, clinical care assistant, and clinical nurse assistant. Countries adopt many of these titles to describe workers providing essential care, however, for this thesis, I will be using the HCA, being the term commonly used in ARC.

Evidence suggest HCAs provide most of direct care in ARC (Bowers, Esmond, & Jacobson, 2003; Carlson, 2007; Dale, 2015; Thornton, 2010). The HCA role in ARC has evolved from providing essential care only, into one of complexity and challenges, whilst at the same time the demand for the HCA has grown. The increase in the numbers of older people requiring support, with corresponding co-morbidities, has meant the HCA role has become more established in the sector and that this demand will increase (Human Rights Commission, 2012).

A global ageing population

In 2001, the Department of Economic and Social Affairs (DESA) of the United Nations issued a report on ageing, in which it stated that the numbers of older people throughout the developed regions was causing concern. Fourteen years later this concern was

extended to encompass the entire globe (United Nations, Department of Economic and Social Affairs, & Population Division, 2015). The DESA 2015 report stated that there were now 901 million people in the world aged over 60 years and predicted that this would grow by 50% in the next 15 years. Whilst Europe and North America have had an ageing population for some time, with over 20% aged over 60, Latin America and the Caribbean are now experiencing significant growth with a 70% increase expected by 2030, from 70.9 million in 2015 to 121 million in 2030. Africa and Asia are close behind with a predicted 60% increase. By 2030, nearly 20% of the world population will be classified as aged (United Nations et al., 2015). New Zealand's closest neighbour, Australia, is experiencing similar growth to much of the world. In 2016, 15% of the Australian population was defined as aged, with this figure expected to increase to nearly a quarter of the population by mid-century (Australia Institute of Health and Welfare (AIHW), 2017).

The advancement in technology and medical knowledge, complemented with an improvement in general living conditions, has resulted in the fastest growing age group in the world being those aged 80 years or older (United Nations et al., 2015). In 2015, there were approximately 125 million people in this age group, a figure expected to almost double by 2030 and predicted to reach 434 million in 2050. Not all aged people require care however increasingly dementia is becoming more common. Chan (2017) reported the incidence of those living with dementia in 2016 as estimated at 47.5 million people. On current trends, the World Health Organization (WHO) predicts that the numbers of persons living with dementia will double every 20 years, with people experiencing advanced dementia nearly always needing full time care, usually provided by the HCA (Chan, 2017).

The international requirements for HCAs

Identifying a requirement to increase and strengthen the workforce associated with aged care, The WHO has recommended the development of a global strategy and action plan (WHO, Member States, & Partners Across the Sustainable Development Goals, 2016). According to The WHO, there is currently a deficit of 4.5 million HCAs worldwide (Institute of Medicine, (IOM), 2008). The increased need for this workforce is also reported with the position of the HCA within ARC now the second fastest growing occupation in the United States and the HCA working within the home care environment the next expanding occupation (IOM, 2008).

Closer to New Zealand, a recent Australian newspaper article stated, "The federal senate is holding an inquiry into the future of Australia's aged care workforce, which needs to increase from 350,000 workers to 1.3 million by 2050, according to a submission from Leading Aged Services Australia which represents providers" (Browne, 2017). Browne proceeded to argue that Australia is facing a crisis within the aged care sector. Also discussing the crisis unfolding in Tasmania, an island State of Australia, a newspaper article published in 2015 reported that currently there were about 8000 aged-care sector workers employed in Tasmania, with a predicted need of 13,000 by 2020 and 30,000 by 2050" (Beniuk, 2015). Presenting figures which indicate a lesser need, Cooke (2014), representing the Australian Aged Care Workforce Strategy 2024, stated that in 2010 there were 85,000 full time equivalent direct care workers in the ARC sector; that by 2030 this will almost double to 157,000 and will increase a further 100,000 within the next 10 years (Australian Productivity Commission, 2011). These numbers do not reflect the demands as presented by the two newspaper articles; however, the situation remains, people are ageing and require care, some of which will be within ARC facilities. New Zealand, a neighbour to Australia is also faced with changing demographics.

An ageing New Zealand population

In New Zealand, the numbers of those aged 65 years or older are expected to double in the years 2014 to 2039, from 650,000 to approximately 1.3 million people (Office for Senior Citizens, 2015b; Thornton, 2010). This will equate to over 21% of the population with the largest growth occurring between 2011 and 2037 with babies born post World War II (1943-1960) moving into this age bracket. The number of people aged 85 or older will increase significantly from 78,000 in 2014 to nearly 270,000 by 2041, and possibly 450,000 by 2068 (Office for Senior Citizens, 2015b).

Alongside an increase in the numbers of aged, there is a change in population structure. By 2025 there will be more aged people (over 65) than children under the age of 14 years, and this ratio is predicted to increase. With such a population bubble, comes the potential problem of the lack of people able to support and sustain the ageing population requiring health care (Dale, 2015; Office for Senior Citizens, 2015b; Thornton, 2010).

The population is not only ageing, it is also becoming more culturally diverse (Office for Senior Citizens, 2015a). In 2013 Europeans comprised 88% of the older population, Māori were 5.7%, Asians were 4.7% and Pasifika were 2.4%. By 2030, the proportions are expected to change significantly with Europeans only increasing by 50%; Māori increasing by 115%; Asians by 203%; and Pasifika are expected to increase by 110%. Creating a demand for multi-cultural services and assistance, the increase in ethnic diversity and associated difficulties with English as a second language, is predicted to impact on the provision of care (Office for Senior Citizens, 2015a).

Regionally New Zealand will also experience change. Auckland and Hamilton, two of the largest cities in the North Island, will continue to have the largest numbers of aged; however, it is the more rural areas in New Zealand that are now causing concern.

By 2033, except for the two major cities, every other region will have more aged than children, with many regions predicting a population decline. This decline is reflective of the decrease in births in relation to the numbers ageing. It is also due to the numbers of younger people expected to move out of the smaller cities and rural areas, reflecting employment difficulties and fewer immigrants moving to rural areas (Office for Senior Citizens, 2015a).

The changes in population age mix, diversity and distribution, as described above, indicate serious considerations required for the District Health Boards (DHBs) of New Zealand. Resourcing, including workforce and facilities required must be considered. So too, does the increased complexity of potential medical conditions, including dementia as mentioned in the *Report on the Positive Ageing Strategy* (Office for Senior Citizens, 2015a). In 2011, approximately 1% of the New Zealand population had dementia (48,000); however, within the next 35 years this is foreseen to triple, requiring an increased demand for dementia related services, including more HCAs qualified in caring for those with this condition (Office for Senior Citizens, 2015a).

The New Zealand requirements for the HCA

The Thornton Review (2010) of aged care services is the most comprehensive review in New Zealand to date. This review has predicted that between 2010 and 2026 there will be an increased demand for ARC from 12,000 to 26,000 people, and a reciprocal increase in the health care workforce of between 50% and 75% full time equivalent staff. As most of that workforce are HCAs it is projected that by 2036 New Zealand will be in deficit of close to 28,000 HCAs (Badkar, Callister, & Didham, 2009; Human Rights Commission, 2012). Conversely, a report examining trends of residential care occupancy over a 20-year period questions whether the demand, as stated above, is accurate, discussing a decline in occupancy per population basis (Broad et al., 2011).

This decline is attributed to changes in Government policy, such as the ageing in place initiatives, and the compulsory needs assessment (as explained in the next section). Ageing in place, whilst assisting people to live in their chosen environment, is changing the nature of ARC in that, when people are required to access residential care, they enter with more co-morbidities demanding a higher level of care and a corresponding shorter length of stay (Dale, 2015; Shannon & McKenzie-Green, 2016).

The current ARC workforce is also ageing, affecting the numbers and health of those HCAs available to assist with older persons. Many of the current workforce, including RNs and HCAs, are aged over 35 years and thus by 2035 over 50% of the healthcare workforce will have retired (Office for Senior Citizens, 2015a; Thornton, 2010). The implication of this is that extensive workforce and service delivery planning will be required.

Legislation and Policies Affecting Aged Care in New Zealand

Legislation has direct impact on ARC, with the major influences arising from the Health and Disability Sector (Safety) Act 2001 regulated by the New Zealand Ministry of Health. This Act introduced audit requirements for ARC facilities, with the *Standards Based Handbook* (2004) providing a prescriptive guide to the audit (New Zealand Standards Authority, 2008). More recently, standards of service to consumers and audit procedures in ARC were reviewed and then clarified in the New Zealand Health and Disability Services (General) Standards 2008 (New Zealand Standards Authority, 2008). Providing information about the quality of care provided in facilities, the results of audits are published, with findings influencing both the facility's reputation, as well as its funding. The audit, using documentation and qualitative material, focuses on the general care, safety, and wellbeing of the client, including operational procedures such as infection control and use of restraints. The assessment of the quality of care provided

also includes indicators such as provision of training and professional development, the effectiveness of communication between staff and family/whanau and extends to quality management and governance.

The effectiveness of the audit process was reviewed in 2016 (Neville, Wright-St Clair, Healee, & Davey, 2016). This review established that marked improvements had occurred within the sector; with many facilities gaining the four-year certification award, the longest period available. To evidence audit compliance requirements, a significant increase in documentation was required, impacting considerably on the work of the RN. Despite this increase in workload, the staff reported they were more accepting of the current audit process and pleased with the improved effectiveness of management that the compliance processes required (Neville et al., 2016).

In addition to the Health and Disability Sector (Safety) Act 2001 and the New Zealand Health and Disability Services (General) Standards 2008, various strategies have been designed to influence the provision and future direction of care. Providing a base to current policy is *The Health of Older People Strategy,* which was reviewed in the 2014 *Report on the Positive Ageing Strategy* (Office for Senior Citizens, 2015a). These strategies provide an overarching direction for all Government policies and complement the report *Older New Zealanders Healthy, Independent, Connected and Respected* (Office for Senior Citizens, 2013). More recently the *Healthy Ageing Strategy 2016* (Associate Minister of Health, 2016) provided a cohesiveness, connecting all previous strategies, regulations, and Acts, such as those mentioned above. This strategy provided a framework upon which policy development, service planning and provision and funding decisions are based. Prioritising healthy ageing, the strategy considers the complex care needs of the ageing population and the required responses including services offered in ARC.

Funding and the Cost of Aged Care in New Zealand

Ageing in place, which is assistance to stay living in his/her own environment/home, and residential care, are the two major ways that New Zealand supports the older person requiring care. The cost of services related to ageing in place is significant with $250 million allocated annually by the Ministry of Health. This supports the person aged 65 and over, to receive an average of 2 hours per week of home help (Dale, 2015). Ageing in place has reduced the length of stay of residents admitted to an ARC facility. Aged residential care includes the lower level of care provided by rest homes and the more intensive care provided by the private hospitals /hospices. According to Dale (2015), where once the person would live in the facility for several years, slowly deteriorating, he/she now arrives at the facility with multiple co-morbidities and lives for an average of 1.5 years. The person now being admitted into ARC requires more complex care; yet is often incorrectly assessed at being at the lower, rest home care level, attracting less subsidy and involving more time and resources than being recognised by the assessment process and subsequent funding (Dale, 2015; Thornton, 2010).

In 2013, the total real cost of ARC, including all methods of support, and acknowledging both Government and private funding, was estimated to be $1.82 billion, and is expected to increase to nearly $2.5 billion in 2022 (Dale, 2015). In 2013 the total real cost of supporting those aged 65 or over, regardless of the type of care provision, equated to a third of the overall health budget, $13 billion. The projected increase of a further $4 billion by 2022 is now known to be an underestimate. Regardless, healthcare requires the highest Government expenditure of any sector and this is disproportionate to the population number. Those aged over 65 represent 14% of the population base yet consume over a third of health resources (Dale, 2015). There is a process to assist with rationalising this expenditure, as those wishing to access residential care are needs tested which includes financial and assets as well personal

care needs (interRAI) prior to any subsidy being applied. The interRAI is a home care assessment tool that ascertains care needs/eligibility (TAS, 2017) and is explained in the next section. The needs assessment has strict criteria, meaning that some people requesting ARC may not be eligible for a subsidy and will be required to pay for residential care (Dale, 2015). Those eligible for ARC and the residential care subsidy contribute most of their New Zealand Social Security Benefit (better known as the pension), being left with less than $50 per week (Ministry of Social Development, 2017). The difference between the contribution of the resident and the amount required by the ARC organisation is paid by the regional DHB as per the Aged Related Residential Care Contracts (ARRCC). This subsidy reflects the cost differences between regions within New Zealand; for example, in Otorohanga, a small rural town, the DHB subsidy is $820 per week per person. In comparison, Auckland, a large city with a higher cost of living, attracts a weekly per person DHB subsidy of approximately $900. The subsidy increases with the level of resident dependency and/or those living with dementia (Broad et al., 2011; Dale, 2015). In 2013, the average weekly bed cost for lower level residential care, as paid by the DHB, was $83,790 and $150,500 for hospital level care, including dementia care wards or facilities. This payment by the DHB and the means tested contribution does not preclude a person from paying more to allow for an ensuite or other benefits (Dale, 2015; Thornton, 2010).

Structure of Aged Care in New Zealand

In New Zealand, the majority of ARC is provided in a mix of facilities consisting of; licensed hospitals for those requiring 24-hour nursing care, rest homes for those needing support, and dementia care units. ARC facilities may also be used for people requiring respite care and those under 65 years of age living with the results of accidents or conditions that require support or constant nursing care, for example people living with

brain injury (Broad et al., 2011; Dale, 2015). The presence of a RN on site is required for the hospitals and dementia care units, however only access to a RN is necessary in a rest home facility. The funding supporting this structure of formal care has been explained previously, however, the New Zealand Government now has a more encompassing strategy which is stated within the *Healthy Ageing Strategy* (Associate Minister of Health, 2016). This strategy describes the intention of providing a multi-faceted approach to support the older person with the primary goals being to enable maximum independence and assist older persons to be maintained within their home and community. Discussing the impact of increased longevity without a corresponding improvement in health, this document recognises the various mechanisms of support required. Substantiating this position, Dale (2015) stated that "about 40% of the additional years gained will be spent in poor health" (p. 13). Therefore, to achieve the Government policy of 'ageing in place' there are multiple support options available, designed to facilitate the older person living in his/her known environment. These include; personal and home management services, electronic monitoring devices and alarms, respite care, care giver allowances for family, subsidised aids and structural changes to dwellings, subsidised primary care, and free access to all hospital services (Dale, 2015). Regardless of how extensive this support is, as health deteriorates the person often requires admission to ARC (Broad et al., 2011).

As in other areas of the world, ARC facilities in New Zealand are predominantly privately owned and for profit, and generally use a commercially motivated business model (Human Rights Commission, 2012, p. 180). Others may be church and charity-based organisations, subsidised by other interests and running on a 'not-for-loss' principle (Thornton, 2010). Regardless of ownership, these facilities are funded by the DHB under Age Related Residential Care Contracts. As previously explained, older people undergo a needs assessment (interRAI), usually performed in the community or

by the RN within the ARC facility. The assessment informs the facility, as well as DHB, as to the level of care required, and a subsequent subsidy is applied. InterRAI stands for International Resident Assessment Instrument and has been developed in collaboration with over 30 countries (DHB Shared Services, 2017; Ministry of Health, 2017a). Using a standardised data collection system, the aim is to provide a universal means of establishing the medical, social, rehabilitation, and support needs of the client and then, using this information, develop a comprehensive care plan. Becoming mandatory throughout New Zealand in July 2015, the use of interRAI ensures consistency in reporting and establishing the level of care and thus the degree of funding appropriate for each person (Cassie, 2015; Ministry of Health, 2017a). Those assessed as requiring hospital and dementia care attract a higher rate of financial support than those assessed as rest home care level (Broad, et al., 2011; Broad, Ashton, Lumley, & Connolly, 2013). There have been challenges with the implementation and use of the interRAI. This was partly due to the lack of technology within some facilities as well as the time required to teach the RNs how to use and become proficient with the system. It is expected, however, that as more people within the community are assessed and a data base is available, that the time required for assessment in the ARC setting will lessen. As at the end of 2016 over 83,000 people representing 12.2% of those aged over 65 years had been assessed (DHB Shared Services, 2017). Using the interRAI to provide an objective and uniform approach to assessment has been deemed necessary for this sector however, there have been negative connotations reported. These reports are of difficulties especially pertaining to the role of the RN. Increasing administration and time involved implementing the assessment and adding this to the documentation and compliancy requirements associated with the quality audit, the RN role has been adversely affected, impacting the roles of the other workforce (Cassie, 2015; Shannon & McKenzie-Green, 2016).

The New Zealand Workforce for Aged Care

Interfacing and working with the New Zealand aged population are many occupations with those involved in the more formal care being the RN, EN, and the HCA (Shannon & McKenzie-Green, 2016; Thornton, 2010). The numbers of regulated New Zealand educated RNs and ENs working in ARC number 4,469 and 794 respectively (Shannon & McKenzie-Green, 2016). I will now explain the roles of the RN and EN, and then compare the role of the EN with the HCA, with the latter two being the most similar.

The Registered Nurse

There has been a shift in the RN role, from providing direct care to residents, supporting staff and providing supervision, to now being largely occupied with administration with a continuing expectation of supervision and clinical assistance (Shannon & McKenzie-Green, 2016). Tension exists between the need to enhance/maintain resident care and the intensification of compliance requirements. These factors, combined with the rapidly changing environment, expansion in technology, increased administration, the growing amounts of information and increased consumer expectations has resulted in the substantial shift in the RN's role. Much of what once was thought of as the domain of the RN, has now been passed to the EN or the HCA (Human Rights Commission, 2012; Shannon & McKenzie-Green, 2016).

The Enrolled Nurse

In 2008, the Ministry of Health New Zealand established a Nursing Advisory Committee to review and provide advice on the clinical workforce to support the RN. At this time, the EN was regarded as the 'second level' nurse responsible for providing support; however, the Committee expressed concern that the unregulated and possibly untrained HCA was increasingly assuming this role (Ministry of Health, 2009). The

Advisory Committee recognised that changes were required due to the increased requirements on those providing a supporting role in ARC, and the unclear boundaries between the regulated workforce (EN) and unregulated workforce (HCA) (Ministry of Health, 2009). As such, several recommendations were made, including expanding the scope of the EN and for Nursing Council and Career Force to work together to "make explicit the scope and competencies of the regulated and non-regulated workforce" (Ministry of Health, 2009, p. 4).

In 2010, in response to the Nursing Advisory Committee recommendations, the scope of the EN was broadened (Nursing Council of New Zealand, 2012). Originally there was a restriction of providing personal care only to clients considered stable or predictable, meaning a restriction to working in aged care. This scope was adjusted to enable the EN to work with clients deemed to be at high risk. To work in the latter scope, further education was required for those previously qualified and, as this was not compulsory, there is now an EN workforce operating within two scopes of practice, resulting in some confusion for the employer. Two other significant changes occurred with the new scope, the EN could now co-ordinate HCAs and was permitted to work under the direction of a health care professional other than a RN (Nursing Council of New Zealand, 2012). This has broadened the area within which the EN may now work and added to the responsibilities that the EN may now undertake.

Comparative analysis of HCA and the EN role

To provide a structure to this analysis, I start with explaining the regulation affecting the EN and HCA roles and then examine the supervision required for each. Training is explained, a brief overview of any similarities of the role is provided, and remuneration is compared. This section will then lead into a more in-depth explanation of the HCA role and workforce. I begin the comparative analysis, explaining regulation as it affects both the EN and HCA.

Regulation

As previously described, the EN works within the same environment as the HCA; however, the EN is a member of a regulated workforce and thus has organisational structure and accountability (Human Rights Commission, 2012). Regulation provides enrolment and therefore recognition by the legislative body; The Nursing Council of New Zealand. Regulation and enrolment also imposes requirements under the *Health Practitioners Competence Assurance Act 2003* (HPCAA, 2017). These include the requirements for on-going training and skill-based competency, and defines professional standards, limitations, disciplinary procedures, and a scope of practice decided by the Nursing Council (Ministry of Health, 2008). Regulation of the EN requires support and guidance from the Nursing Council and includes; access to legislative updates, examples of best practice, current information pertaining to the sector and access to workshops, and conferences (Nursing Council of New Zealand, 2012).

In comparison, HCAs are not regulated however, have an implied scope of practice within the qualification they obtain. The employer imposes limitations of practice for the HCA; whereas for the EN these are under the jurisdiction of the Nursing Council. Disciplinary procedures for both the EN and HCA may be employer focussed or under Duty of Care (New Zealand Police, The Health and Disability Commissioner); however, ENs also have responsibilities to their legislative body (Human Rights Commission, 2012; Standards New Zealand, 2005).

The EN is also encouraged to be a member of the union dedicated to representing nursing; the New Zealand Nurses Organisation (NZNO). In contrast, organisational support of the HCA may come from one of two unions; the NZNO or the Food and Services Workers Union now known as E Tu, meaning stand tall. Both unions

have combined efforts to support the HCA, however membership is voluntary, perceived to be expensive, and neither union has the HCA as a primary member.

Supervision

As defined by the scope of practice, supervision of the EN must occur by a registered health care professional, however, as previously discussed, the HCA does not have this as a mandated requirement. The Ministry of Health contracts allow supervision of HCAs working within the lower levels of care, such as rest home level, to be provided by a licensee who may not be a health professional (Smith, Kerse and Parsons, 2005). Therefore, the less qualified HCA has fewer supervisory requirements than the more qualified EN, making it far easier on the organisation to satisfy legislative requirements by simply employing an HCA to supervise other HCA's.

Training

Training for the EN occurs at a publicly funded tertiary organisation and is at Level 5 on the New Zealand Qualifications Authority (NZQA) framework. Whilst NZQA deems the level of competency, it is the Nursing Council that stipulates the conditions of competency, requiring the EN student to undergo 900 hours of theory and 900 hours of clinical practice of which 200 hours may be simulated (Nursing Council of New Zealand, 2014). HCAs do not come under the Nursing Council's authority, instead Career Force is the industry training organisation with the designated responsibility for HCA training. Career Force, in conjunction with NZQA, have redesigned the qualifications of the HCA and defined competencies within each level of the qualifications. New Zealand qualifications begin at Level 1 and the level closest in function to the EN is the Level 4 HCA. Training for the Level 4 HCA can also be provided in a tertiary organisation, is of 8 months duration, equating to 660 hours of classroom learning with a mandated 200 hours of clinical practice within a workplace

(Career Force, 2017a). A role definition found within the Purpose Statement of the Level 4 HCA qualification describes this worker as being able to provide advanced client-centred care and support in the home or in ARC facilities.

There are similarities in both the skills taught to the EN and HCA and in the clinical experience; yet, the underpinning knowledge differs between the two programmes with increased depth in the EN programme. It could be assumed that the depth of knowledge that both the EN and HCA has would influence the scope of practice within which they work; however, this is not the situation. Regardless of which scope of practice the EN works within, the limited or the extended one, the HCA is also performing similar skills. This is evidenced by the purpose statement of the Level 4 qualification, describing equivalent responsibilities and expectations, albeit not the same underpinning knowledge as the ENs (Career Force 2017a; Ministry of Health, 2009). Consideration should also be given to the fact that a quarter of the HCA workforce are internationally qualified RNs, having associated knowledge and skills that they are not meant to apply in the role of an HCA (Human Rights Commission, 2012)

Role

The EN with the extended qualification is now permitted to provide support to clients with complex health conditions, so too is the Level 4 HCA. Skills previously associated with a higher level of care, such as observing and responding to changes, are also an aspect of the Level 4 HCA qualification (Career Force, 2017a), which are the same skill set as for the EN, albeit without the equivalent underpinning knowledge. The EN is permitted to co-ordinate a team of HCAs; however, graduates of the Level 4 Health Care qualification are also permitted to provide supervisory skills.

Remuneration

Until April 2017, the EN was paid approximately $9,000 per annum (p.a.) more than the Level 4 HCA, which made the EN position unattractive to many employers as the HCA was perceived to provide similar skills to the EN (Human Rights Commission, 2012; Thornton, 2010). In April 2017, the New Zealand Government announced the Care and Support Worker pay equity settlement of $2 billion to those employed within the HCA role (Ministry of Health, 2017b). This meant that HCAs on Level 4 or with 12 years of experience or more, would now be on a similar pay scale as the EN, with five, yearly increments until 2022 (Ministry of Health, 2017b). The ramifications of this decision have yet to be made clear at the time of writing this thesis, although early indications will be reported within the Discussion Chapter.

The HCA Workforce and Role

In this section I provide more in-depth explanation as to the nature of the New Zealand HCA workforce and the realities of the role. I begin with explaining the demographics of the workforce and information on the contribution and issues associated with the migrant workforce. This leads into explanation of the working conditions of the HCA, the training and remuneration that is now available.

Demographics

Although dated 2010, Thornton has provided the most specific figures pertaining to HCAs working in ARC, reporting an estimated 48,000 HCAs providing care to approximately 42,000 people in over 700 aged care facilities in New Zealand. The ethnic composition of the aged care workforce, including HCAs, is 56% European, 15% Māori, 13% Asian, and 8% Pasifika (Thornton, 2010). The HCA workforce, like nursing, is ageing with over 60% of HCAs aged between 40 to 50 years and is predominantly female (90%). There has been a small increase in the number of males

employed as HCAs, stimulated during the global financial crisis and coming from the migrant workforce (Human Rights Commission, 2012). Migrants comprise 31% of HCAs and bring difficulties associated with cultural confusion, communicative difficulties, and experiencing problematic working conditions (Badkar et al., 2009; Human Rights Commission, 2012).

The migrant workforce

Migrant HCA workers rely on employment to meet visa requirements and, as such, are vulnerable and subject to exploitation (Human Rights Commission, 2012). Compounding this situation is the degree of stress that migrant workers report, associated with being under-employed and under-valued (Human Rights Commission, 2012). Migrant workers are frequently qualified as RNs within their own country of origin. However, because their qualifications are not recognised in New Zealand they can only obtain employment as an HCA, although may be working at a RN level (Human Rights Commission, 2012). Internationally qualified RNs must meet stringent criteria and invest significant finances to gain registration to practice in New Zealand (Human Rights Commission, 2012). Frequently expected by the employer to assume the duties of the RN, the migrant RN is paid at the rate of the HCA, works difficult hours and is subjected to the stress associated with needing a work visa (Human Rights Commission, 2012).

Working conditions of the HCA

The above section depicts a workforce working within difficult conditions; however, this is common for many in the HCA workforce. Under the ARRCC there are currently no mandated staffing levels and few conditions for providers to adhere to regarding staffing requirements (Human Rights Commission, 2012; New Zealand Labour, Green Party of Aotearoa New Zealand, New Zealand House of Representatives, & Grey Power

New Zealand, 2010; Standards New Zealand, 2005). Requiring the presence of the fulltime RN in areas classified as high need, management decide staffing levels, and many, but not all, will comply with the requirement to have the RN on call for the lower level care facilities. This situation may lead to the HCA being without the presence of the RN for support and, in some cases, the HCA works as the lead person (New Zealand Labour et al., 2010).

Lack of RN supervisory support for the HCA is of concern, especially with the significant increase in the dependency and complexity of care in aged care facilities, compared with that of 20 years ago (Human Rights Commission, 2012; Smith, Kerse & Parsons, 2005; Shannon & McKenzie-Green, 2016). The increase in people's longevity, improved technology, and the ability for a person to remain in his/her own home until formal care is required, has resulted in an ARC environment where 56% of occupants are classified as requiring high levels of care and 60% have some form of dementia (Dale, 2015; New Zealand Labour et al., 2010). This increase in acuity, and thus in requirements for care, has impacted the work of the HCA; yet there is little recognition of the corresponding increase in workload and the extension in the role of the HCA (Human Rights Commission, 2012; Thornton, 2010; Twaddle & Khan, 2014). This extension of the role is one of many challenges of the HCA; the low vocational and social status of the role and the compounding conditions of challenging hours, lack of training, exploitation, lack of supervision, and gender discrimination, are all major contributors to the complex conditions. In response, the employing body cites funding difficulties as the major determinant of conditions, including those of pay parity (Human Rights Commission, 2012; New Zealand Labour et al., 2010).

Remuneration

Remuneration for the ARC workforce has been low with 57% of HCAs earning $30,000 per annum or less compared with the average New Zealand annual wage of $57,158.40 (Statistics New Zealand, 2014). However, as previously stated, this changed in April 2017 with the announcement of a $2 billion pay parity increase into the sector, spread over five years. Thus, the HCA previously earning the minimum wage of $15.75, as of July 1, 2017, experienced an increase to $19 per hour and the more senior HCA will earn up to $27 per hour within the next five years (Ministry of Health, 2017b). It is yet to be seen how this increase in remuneration will affect HCAs and their working environment. This may decrease the turnover in employment, as until now this has been high, estimated between 30-60% p.a. (Human Rights Commission, 2012). Many of the workforce members are employed part time with 70% working less than 40 hours per week, forcing many HCAs to have two jobs which frequently includes split shifts (Human Rights Commission, 2012; Twaddle & Khan, 2014). The increase in pay rates may affect this situation by diminishing the need for the HCA to work these hours and in these conditions. However, the pay rate is based on the training and qualifications obtained by the HCA.

Training of the HCA

In 2012, it was identified that 46% of residential care workers had no industry related qualifications and less than 30% had tertiary qualifications. Attributing this to the workers being older, with a lack of previous access to training and limited interest, and despite 37% of workplaces providing formal training in compliance with the Age Related Residential Care Contracts, the attainment rate was very low (Human Rights Commission, 2012; New Zealand Labour et al., 2010). Compounding this situation and reflective of the under-employment of the internationally qualified migrant, was the inadequate recognition of prior knowledge and competency that the HCAs may already

have (New Zealand Labour et al., 2010). There also appeared to be a long-held belief that those working in aged care did not require qualifications as they had inherent, female, caring skills (Cavendish. 2013).

Processes to counter this situation began in 2009, when the NZQA instigated a restructuring of all New Zealand qualifications (NZQA, 2009). To comply with this, Career Force, the industry training organisation responsible for training of all non-regulated health workforce, began its restructuring. In 2014, Career Force developed the Disability, Health and Wellbeing range of qualifications, ensuring relevance to industry and suggesting a career pathway. This created an interest amongst HCAs to obtain qualifications and employers were incentivised to encourage staff to do so (Career Force, 2017a; Lawless, 2014).

HCA training starts at the NZQA Level 2 through to Level 4. Level 2, the introductory qualification is free to all learners (Australian Productivity Commission, 2008). Qualifications at Level 3 and above develop abilities in problem solving and supervision and require the learner to contribute fees, which may be a deterrent as many of this workforce are economically poor (Human Rights Commission, 2012). Nevertheless, an added value of achieving higher qualifications is the implied improvement in status and the increased ability to change employers, that is, from residential care, to working for the DHB in the acute care setting, thereby improving remuneration rates (Human Rights Commission, 2012). This increase in remuneration within a DHB setting was reported as a stimulus for the HCA to leave ARC (Thornton, 2010), although this may now have changed with the pay equity award (Ministry of Health, 2017b). One question that has not been asked, or perhaps the answer has not been broadcast, is why the Level 4 HCA is deemed to be of low status and value when the qualified trades person, who is also Level 4 on the NZQA framework, is highly valued? The Salvation Army Social Policy Unit and St Andrews Village Report (2017)

compared the Level 4 HCA to other trades and explains the Australian New Zealand Standard Classification of Occupations (ANZSCO), codes that Immigration New Zealand applies to 'value' jobs for residency application. All other Level 4 trades people are given the code of 3 whilst the HCA, despite now reaching the required pay scale, is classed as a 4. This directly affects the ability of the HCA to apply for a permanent Visa and the authors suggest that this code is historical and reflects a time when the HCA was perceived to be an unskilled or semi-skilled worker (The Salvation Army Social Policy Unit & St Andrew's Village, 2017).

The work of the HCA

The complexities inherent in providing care within ARC are multi-factorial and multi-levelled. In any one day, the HCA cares for many residents with varying degrees of dependency requiring the HCA to display a complexity of skills, attributes, and values (Carpenter & Thompson, 2008). Their use of wisdom and intuition, love, self-awareness, reflective thinking, technical expertise, negotiation, and communicative skills, are all found in a person with little training and who is under appreciated (Black & Rubenstein, 2005; Rokach, 2005). The HCA is required to balance workload, prioritise needs, be flexible in response to changing demands and have strength; physically and emotionally (Carpenter & Thompson, 2008). The HCA is expected to display attributes of care and nurturing; care as it relates to service, comfort and relationships, and exhibit values associated with unconditional love (Bowers, Fibich, & Jacobsen, 2001). Expectations on this workforce are huge, working conditions are complex and challenging and the work demands on the HCA is increasing with limited recognition of the services provided.

Summary

New Zealand is facing a serious discrepancy between the numbers of ageing and those able to provide the care required (Thornton, 2010). Implied in the increase in the number of aged, frequently with a multitude of complex health problems, is the requirement to ensure that this ageing population is supported as well as possible (Office for Senior Citizens, 2015a). Providing most of the care to the ageing person, the HCA is also approaching the older age bracket, compounding an already serious workforce problem (Dale, 2015; Thornton, 2010).

The closest occupation to that of the HCA is that of the EN, a regulated and acknowledged position that is not being used to any great affect in the sector. Instead, employers prefer the lesser qualified HCA who can operate without a formal scope of practice and therefore can more easily comply with employer requests and expectations (Shannon & McKenzie-Green, 2016). The HCA may be an internationally qualified nurse, more knowledgeable and skilled than many staff, and employed because they have the background of a RN, but not provided with this recognition. These HCAs are, at times, exploited by employers who add issues of visa compliance to the complexity and uncertainty of the environment (Thornton, 2010).

Of importance, and unknown at this early date, is the impact that the increase in remuneration will have on the ARC environment. This may attract New Zealanders into the occupation and thus displace skilled migrants. Implications on training and the call for pay parity with others within this sector will have to be considered. What is known is that although the pay may have improved, other factors affecting the working day of the HCA have not; limited RN support, the increase in compliancy activity, the expectations of shareholders creating financial constraints, all continue.

Introduction to the Structure of the Thesis

Chapter One has introduced the role of the HCA within the context of providing care to an ageing population. Current and future demands for this workforce, both internationally and within New Zealand, have been explained.

In Chapter Two, the literature review chapter, I examine the HCA role more closely and place this within the New Zealand and international contexts. Whilst reviewing the scientific literature, evidence of the short and longer-term strategies the HCA employs to manage their ever-changing working day is critiqued.

Chapter Three introduces grounded theory and social constructionist grounded theory, the chosen methodology. Explanation of this methodology and the underpinning philosophy are provided. I explain the methods used throughout the research, providing examples to contextualise the research. Finally, the theory that has been constructed is revealed.

Chapter Four begins the findings chapters. I introduce the theory; ***Working in a blurred domain: The health care assistant in aged residential care***. An overview of each category is provided and an introduction to subcategories occurs.

Chapter Five explains the category of Protecting Self, the first stage of working and the stage that the HCA regresses to when needing to protect the physical, psychological, and/ or financial self.

Chapter Six explains the category of Balancing the Workload; using strategies associated with working to a system and working with others which then enables the HCA to achieve the third category of Engaging Self, explained in Chapter Seven.

Critiquing findings against extant literature is undertaken in Chapter Eight, the Discussion Chapter. This chapter also examines aspects of the participants' conversation, such as the use of familial language and reports on the strengths and

limitations of the research. Importantly, the implications and significance of the

research are discussed with ways in which the theory and other findings can be used.

CHAPTER TWO: LITERATURE REVIEW

"replaceable workers . . . at the bottom of the food chain" (Carpenter & Thompson, 2008, p. 27) with "no special talent or education . . . as caring is natural to women." (Black & Rubenstein, 2005, p. 9)

Introduction

This chapter places the literature review within the context of a grounded theory study. I explain the processes included in the literature search, the results and the methodology for analysis of the literature review and resulting themes. The themes included; working in aged care, roles within aged care, demographics and ageing, and pivoted around explaining the role of the HCA and the consequences of and to that role within the context of ARC. I also supply a definition and description of the role. The complexity and extension and stress associated with the role, and the impact of the migrant worker and associated cultural factors are explained. These lead into the satisfying aspects of the role and then the requirement of safety mechanisms for the HCA and, finally, a review of literature that examines the call for regulation of the HCA role.

Placing the Literature Review within a Grounded Theory

There is a variance of views of when a literature review should be conducted in grounded theory research (Birks & Mills, 2015). Glaser and Strauss (1967) suggested that a literature review should only occur once analysis was completed to avoid influencing the theory with the views of other researchers. Many years later, Corbin and Strauss (1990) acknowledged that the researcher usually enters a study with knowledge of relevant literature, prior discipline knowledge and experience. More recently, Birks and Mills (2015) wrote that the literature review assisted with heightening awareness and therefore could be undertaken during the research process. These authors also recognised that the literature review is a requirement of PhD candidature. Extending the discussion on the place of the literature review, Charmaz (2014) was clear on her

position that the researcher used literature to inform the argument and that a review of both the literature and argument may occur at various times during the research. The literature review for this study was undertaken to satisfy two requirements of the Doctor of Health Science; first it was used to inform a paper at the beginning of the doctoral programme and second, was undertaken again after analysis of data. As this process took three years the literature required updating and details of the argument changed. The results below reflect a combination of both occasions.

The Process of the Literature Review

Search methods

I searched for literature that provided context for the work of the HCA in ARC, providing insight into strategies that were used to manage the work and surrounding issues. Using databases available from AUT University; EBSCO Health, which includes Cinahl and Medline; I found 260 potentially relevant articles. Eliminating 162 articles due to inappropriate context, duplicate articles, and opinion pieces, I scanned 90 abstracts. I was looking for themes; the working context and the perception of the role, factors influencing the role such as regulation and training, and issues relating to the role such as stress and extension of the role. This thematic analysis also included the increasing need for the HCA workforce, changing demographics and the international and New Zealand responses to this. Except for six, all were peer reviewed, rigorous, and published in highly regarded journals. Of those not meeting these conditions, three were narratives written by qualified and experienced people providing expressions of evidenced opinion and a further three were columns or letters in journals, adding to context and included within this review. Eighty-one articles, Acts, Regulations or other Statutory Body Information results were included within this review.

In undertaking the review of literature, the following databases were searched. Table 1 (p. 30) provides a summary of databases, search terms, limiters, and results.

Table 1. Search results

Database	Search Terms	Limiters	Results
EBSCO Health	care, aged care, dying, HCA and nursing assistant, residential aged care and long-term care, managing		24 articles
Cinahl plus	aged care/nursing homes/residential care and assistants		1,763 articles
		Restricted to full text	640 articles
		Restricted to academic journal	520 articles
		Restricted to publication date 2010-2017	211 articles
Medline	referencing aged care/nursing homes/residential care and assistants		28 articles
New Zealand Government and DHB websites	health workforce demand, health care assistants, regulation, aged residential care, training		9
World Health Organization and OECD	health care roles, aged care demand		12

Although a limiter was placed on years; 2010-2017, I have used research from earlier

years, selected due to frequent citing and the relevant information they contained such as

the Schwab editorial (1975). This editorial provided information on areas of interest,

especially strategies used by HCAs to manage their working day; with most of the other

articles found being context specific, such as management of pain. I did not find any

literature that promoted a theory as to how HCAs managed their work. Embedded in

some of this literature are limited aspects of the role discussed in articles pertaining to

job satisfaction and retention. Knowing the demand for the HCA is increasing

necessitates an explanation of the role of the HCA; yet literature consistently expressed how difficult it was to define the HCA role.

In the next section, I examine a formal definition and provide descriptions of the role of the HCA as it pertains to the New Zealand context. I then review New Zealand and international literature to explore the functions of the role which vary from providing task focussed care to an all-encompassing provision that assumes much of the RN workload. Following this, the role will be examined in the context of the HCA working in the end of life and dementia care environment of ARC.

Defining the Role of the HCA

The New Zealand Nurses Organisation and the District Health Board Collective Agreement (MECA) (2015-2017) have defined HCAs as "An employee who is an auxiliary to the nursing team and is able to perform tasks in their position description relating to patient care and who works under the direction of a registered nurse or midwife" (New Zealand Nurses Organisation, 2015, p. 9). This definition is very open, relying on employer-lead directives and interpretation. Career Force (2017a) have described the HCA as being able to provide advanced client-centred care and support in the home or ARC facilities. Career Force represents the industry and is responsible for developing New Zealand qualifications leading to consistency of training; therefore, the description provided is the basis for all training. This description is important as training is regarded a method of providing working parameters in New Zealand (Thornton, 2010). There are various other descriptions of the HCA role within this review as discussed during the next section.

Understanding the role

There is a plethora of literature that explained various aspects of the role of the HCA. Introducing the role was a critique of an editorial written by Schwab (1975), a RN experienced in ARC. Schwab (1975) described the work of the HCA, an overview of the capabilities and an insight into the personal attributes required. Although the article was written over 40 years ago, it forecast the worker and environment that now exists. The HCA was described as applying measures to assist with patient comfort, rehabilitation, dignity, and independence in a compassionate and humanistic manner. Schwab further described the patients (residents) as requiring assistance to compensate for lost or deteriorating physical and cognitive abilities and who exhibited chronicity associated with illness and pathology. Schwab emphasised the HCA needing to understand the factors that affected the resident and his/her family, including the requirement for an inclusive, participatory mode of care delivery (Schwab, 1975).

Twenty-five years on, Bowers, Fibich and Jacobson (2001) reported findings that aligned with Schwab's opinions (1975). Using grounded theory dimensional analysis, 26 residents from three ARC facilities were interviewed for their perspectives of how nursing home residents defined quality of care. The resultant three categories of care were reflective of the expectations of the resident and provided a framework of the work of the HCA; care as it pertained to service, care as it pertained to relating, and care as it pertained to comfort. Care as service focussed on the more technical aspects of care and was usually expressed as a 'purchased service' with associated consumer expectations. Care as relating explained a relational sharing between the HCA, the resident, and family. Care as comfort was care that maintained or promoted comfort and frequently needed to be just 'right', with attention to detail being important to the resident. The residents also explained the importance of attending to their social, psychological, emotional, spiritual, physical, and cultural needs, extending this support to the family

and staff members (Bowers et al., 2001). These findings of the all-encompassing provision of care, focusing on the needs of the resident and extending to family, were supported by Carpenter and Thompson, (2008), Rokach, (2005), and Wenzel et al. (2011).

More recently, 1224 HCAs from 30 American ARC facilities provided information for a hierarchical survey on the activities that were involved in their work (Chamberlain, Gruneir, Hoben, Squires, Cummings, & Estabrooks, 2017). Results included activities to assist daily living such as assisting with meals for those who could not feed themselves and extended to the social and emotional support the clients required, complementing findings of the earlier reported studies. However, this survey did not include the spiritual support that was included in the research. Touhy, Brown and Smith (2005) and Yoder (2010) extended an argument for the spiritual aspect of caring, explaining it to be important in the establishment and maintenance of the intimate, personal, and psychosocial relationship between the carer and the resident.

Whilst the above research (Carpenter & Thompson, 2008; Chamberlain et al., 2017; Rokach, 2005; Wenzel et al., 2011) has indicated a breadth of role and functions, an earlier longitudinal national study of 582 facilities in the UK described a narrower more task focused role, with the HCA as "the front line providing personal care for the frailest in our society. Daily, they address patients' requests, measure vital signs, deliver, and serve food, provide baths, change beds, and assist those needing help with mobility" (Rakovski, 2010, p. 400). This research aimed to explore factors pertaining to job satisfaction; however, the parameters of the role being researched appeared restricted to the provision of essential tasks, excluding the 'caring' aspects of the work.

Another study exploring empowerment of the HCA (Kostiwa & Meeks, 2009), also described the HCA role as being task focussed, routine, and prescribed. While suggesting that empowerment might add value to the way HCAs felt about their work,

this study must be questioned as to the narrow focus that excluded the psychosocial

nature of the work that might have contributed towards feeling valued (Kostiwa &

Meeks, 2009). A systematic review of 42 articles aiming to identify factors pertinent to

job satisfaction of the HCA, further supported the limited role description. Description

was provided of care aides (HCAs) in the USA and Canada providing duties that are

primarily task focussed such as hygiene and assisting residents unable to feed

themselves (Squires, Hoben, Linklater, Carleton, Graham, & Estabrooks, 2015). The

authors qualified this with a statement saying that these tasks were essential, affecting

the quality of life of the ageing and vulnerable population (Squires et al., 2015).

Knowing the Resident

The literature reviewed thus far, suggests that the intimate and repetitive nature of the

work provided the HCA with substantial opportunity to gain knowledge of the resident.

Knowing the resident assisted the HCA with such activities as planning care,

anticipating demands, and recognising changes. Combining this knowledge with

experience and ideas gained over time also enabled the HCA to provide assessment of

the resident which was frequently described as 'just knowing' (Sandvoll, Kristoffersen,

& Solveig, 2012; Tingström, Milberg, & Sund-Levander, 2013). The ability of the HCA

to memorise a significant amount of information was the major finding by Henderson

(1994) during his 13-month ethnographic study undertaken during employment as an

HCA. The memorisation of the resident's requirements and preferences enabled the

HCA to recognise changes in the condition of the resident and was an important

component of the hands-on activities that the HCA undertook. Henderson stated that:

> 'Certified Nursing Assistants (CNAs) (HCAs), despite having no medical
> training, are potentially the most important physical healthcare agents in the
> institution. Their significance derives from their extensive contact with the
> patients. …CNAs emerge as patient caregivers who go beyond the basic duties
> commonly reported in the gerontologic literature'. (p. 22)

A small qualitative study, based on interviews using manifest content analysis (Sahlberg-Blom, Hårsmar & Österlind, 2013), supported Henderson's (1994) research, placing it in the context of end of life care. Describing the ability of the HCA to see changes occurring in the resident between entering a facility and final stages of life, this study recognised two strategies employed by the HCA to determine the transition. Explained as "the resident expresses insight" and "the resident's body changes" (Sahlberg-Blom et al., 2013, p. 23), these strategies developed as the HCA gained experience with the resident. Using the intimate knowledge gained from administering personal care and support to the resident enabled the HCA to use intuition to understand the insight expressed by the resident, and the experience of the HCA facilitated the recognition of subtle body changes (Sahlberg-Blom et al., 2013). The resident entering end of life care or living with dementia, provided the primary working load of the HCA and, at times, these conditions were combined creating a role of complexity (Black, 2015).

Complex role

Literature revealed the role of the HCA as changing from providing the basic tasks as described in previous research (Kostiwa & Meeks, 2009; Rakovski, 2010; Squires et al., 2015) to one of providing care to the increasing numbers of residents with complex conditions (Frey, Boyd, Foster, Robinson, & Gott, 2015). Such residents required extensive care, more aptly recognised as end of life or palliative care, with the associated rapid deterioration as reported in research by Black, 2015; Estabrooks, Squires, Carleton, Cummings, & Norton, 2015; Frey et al., 2015; Marshall, Clark, Sheward, & Allan, 2011; and Rokach, 2005.

In studies referenced below, HCAs reported having little training in this area, with limited understanding and confusion between the changes from curative to

palliative care, inadequate training in management of pain relief, poor access to resources, and limited understanding of the dying process (Carlson, 2007; McDonnell, McGuigan, McElhinney, McTeggar, & McClure, 2009). End of life care was reported as being further complicated when the resident also had dementia (Dean, 2011; Tyler, Leland, Lepore, & Miller, 2011). In a further study, HCAs described needing to rely on their own morals and values for guidance, expressing insecurity, doubts, and ethical and moral ambiguities (McDonnell et al., 2009).

Carlson (2007) presented an explanation of the importance of psychosocial and emotional support extended by the HCA to residents' families in a systematic review of 100 articles pertaining to end of life care in nursing homes, from the perspectives of the resident, family and staff. A dominant finding described the HCA as showing compassion, concern, sensitivity, openness, and as someone who, although busy, took time to listen and involved the families in care. These findings were congruent with the study by Kayser-Jones (2002) who conducted a longitudinal ethnographic study on dying in nursing homes. Kayser-Jones study sample included residents (n = 35), families (n = 52), nursing staff including HCA's (n = 66) and physicians (n = 36). Similarly, Black and Rubenstein (2005) described the HCA as working in a participatory way, using informal guidance, intuition, and personal values to determine what families needed, adding to the complexity of the role.

Also describing the complexity of care provided by the HCA, a systematic review reported that 48% of the residents had physical and medical conditions further complicated by dementia. Although not an inclusion criterion, this systematic review of 83 studies established that all residents required assistance with at least one activity of daily living such as bathing or feeding (Cooper, Carleton, Chamberlain, Cummings, Bambrick, & Estabrooks, 2016). Further complicating this provision of essential care was the presence of medical conditions such as ulcers and infections, psycho-social

difficulties, for example depression, and instability of motor functions with the increased risk of falls. In accord with the systematic review results was research by Knopp-Sihota, Niehaus, Squires, Norton, and Estabrooks, (2015) who undertook a cross sectional survey of 583 HCAs working in ARC in Western Canada. This research reported significant numbers of clients with dementia complicated by other health needs, resulting in the HCAs reporting that they no longer had sufficient time to provide all care that was required. A larger Canadian study involving 1,381 care aides (HCAs), reiterated and extended such findings, reporting that 60% of residents had significant care requirements, and 70% had age related dementia with associated communication difficulties (Estabrooks et al., 2015).

There is a variety of literature describing caring for people living with dementia and the effects on the HCA role. Providing care to residents living with dementia that is frequently complicated by other health issues, rapidly progressing to end of life care, has extended the role of the HCA. Requiring an increase in knowledge and in skills related to the health and psychosocial needs of the resident and family, the HCA has also had to extend self. The HCA was reported to be working in very complex and difficult circumstances, without sufficient training and beyond the envisioned scope of this role (Mansah, Coulon, Brown, Reynolds, & Kissiwaa, 2014). Dementia was described by Heaslip & Board (2012) as a disease requiring particular care needs, characterised by the unpredictability of behaviour with the seemingly unprovoked reactions of the resident. Interestingly, 70% of HCAs working with residents with dementia reported experiencing violence in the previous year and over 20% reported violence several times per week (Isaksson, Graneheim, Richter, Eisemann, & Åström, 2008). Although these figures are alarming, the authors proposed that the incidence of violence was under-reported. The study concluded that the HCA may have been using less effective or even provocative type communication due to experiencing burnout

(Isaksson et al., 2008). Other factors that contributed to the HCA experiencing violence were reported as; the heavier workload, rushing work, and the length and time of working, with day shifts and full-time workers being the most at risk (Isaksson et al., 2008). Reporting abuse rates at 34% less than the research of Isaksson et al., two United States self-report surveys linked and compared data for information relating to caring for dementia clients and subsequent consequences, such as injuries. The first study, the *2004 National Nursing Assistant Survey* interviewed 3017 nursing assistants from 582 facilities by telephone, gaining personal and employment related data; while the second linked study was the *2004 National Nursing Home Survey* which is a continuing series of surveys of US nursing homes. These were undertaken onsite whilst the managers accessed the records required to answer the questions. While the results differed from that of Isaksson's et al. (2008), it too concluded that insufficient time and rushing the resident contributed to violence (Tak, Sweeney, Alterman, Baron, & Calvert, 2010).

Regardless of the differing findings, experiencing violence and constant feelings of vulnerability affected the role of the HCA and was reported in research publications to be a contributor to the HCA exhibiting poor care and even resident abuse. Using grounded theory, Shaw (2004) interviewed nine HCAs and explained two categories of strategies that the HCA used to minimise violence and counter the feelings of vulnerability. These strategies were; resident care and self-care. Resident care included calming the resident, providing time, altering the pace of activities, and giving distance when necessary. Self-care included switching residents, working in pairs, and taking time out; it also included taking protective measures such as wearing protective shields (Shaw, 2004). Extending these strategies is further literature reporting that the HCA who knew the resident could anticipate the most appropriate method of approach and communication to use (Nicholls, Chang, Johnson, Edenborough, & Michel 2013). The use of touch was also reported as an effective communication strategy. Reducing

intrusive time with residents, establishing a relationship and respecting the resident's wishes were strategies reported to avoid or reduce unwelcome responses and lessen the stress associated with dementia care (Nicholls et al., 2013; Wilson, Rochon, Leonard & Mihailidis, 2013).

Working in a stressful role

Reporting on the HCA's day to day stress was an Australian time and motion study involving over 173 hours and noting approximately 11,000 events (Qian, Yu, Zhang, Hailey, Davy, & Nelson, 2012). Of the events observed, 70% were associated with four main activities; direct personal care (30.7%), indirect care, such as positioning tables, tidying up rooms (17.6%), infection control (6.4%) and breaks (15.2%). Verbal communication was reported as the most frequent activity, whether that be a standalone event or occurring concurrently during other activities. Of note was the number of times the HCAs changed the activity they were involved in, on an average of once per minute, with activities lasting less than a minute. The researchers commented that this indicated a very busy workload with multiple interruptions and distractions. Further, the researchers reported surprise at the findings which revealed the lack of predictability in the work flow of the HCA (Qian et al., 2012). A smaller observational study involving 7 HCAs over 387 hours reported similar findings with the interval of work without interruption, being between one and three minutes. The researchers concluded that this continual disruption of work flow and effort, involved a great deal of time wastage (Mallidou, Cummings, Schalm, & Estabrooks 2013).

Authors reported that working in this complicated, stressful and extended environment could lead to job dissatisfaction and potentially ill health/burnout. Burnout was described as a feeling of exhaustion often associated with apathetic behaviour towards the residents, leading onto depersonalisation, poor care and even abuse (Cooper

et al., 2016; Kostiwa & Meeks, 2009). Cooper et al. (2016) undertook a systemic review of literature examining contributors to burnout including; increased workload, the increased complexity of care leading to insufficient time, and a difference between the values of the HCA and the employer. There were many reports of high staff turnover, inadequate staffing levels, inadequate skills and knowledge, poor access to medical practitioners, poor resourcing and disregard for end of life wishes providing over whelming tensions (Anderson, 2008; Bowers, Esmond, & Jacobson, 2003; Carpenter & Thompson, 2008). HCAs also reported increased tensions and feeling unsafe when working with residents living with dementia (Cooper et al., 2016; Isaksson et al., 2008). Chamberlain et al. (2017) supported these findings, contributing other factors leading to burnout, such as English as a second language, the age of the HCA (being younger was more often associated with burnout), and the size of the facility (a medium sized one being less responsive to the HCA needs). Further factors included the health of the HCA and, again, there was mention of working with the dementia resident as adding to stress levels (Cooper et al., 2016; Frey et al., 2015).

Literature revealed strategies used by the HCA to counter and avoid burnout, in particular the use of depersonalisation, with this reported to be a serious issue in a quantitative survey of 136 CNAs (HCAs) (Anderson, 2008). Whilst the aim of the study was to determine that grief was a direct contributor to leaving work, this was not proven; however, the findings did add to knowledge about burnout, depersonalisation, and the effective use of distancing. HCA grief was reported as becoming more intense when the residents were viewed as 'family' and with repeated exposure the feelings accumulated (Anderson, 2008). Distancing was therefore, not necessarily negative as it was also seen as a way for the HCA to continue to work; however, depersonalisation was reported as a contributor to poor quality of care and abuse (Anderson, 2008). In contrast to the previously mentioned report, Black and Rubenstein (2005) provided data collected from

a multiyear, multisite, ethnographic study disputing that the HCA successfully created emotional distance, explaining the relationship with the resident was of such importance that this did not occur. This research, initiated in 1997 and continuing until 2005 was extensive, involving many facilities over a large region in the United States. Observation, conversations, interviews and a case study informed this report. Although over 10 years old this report is worth considering, providing an alternative view to the notion of distancing.

Regardless as to whether distancing is an effective method to cope with grief, there is significant literature that supports the view that the HCA does experience emotional disturbance. Compounded losses, with limited workplace support, came at a personal cost to the HCA and became further complicated when the carer was faced with his/her own personal loss (Tan et al., 2006). HCAs reported feeling tiredness, depression, and isolation associated with this type of stress, especially when working in this environment for a long period (Carlson, 2007; Wallace, 2009).

Contributing to this discussion, Holmberg, Flum, West, Zhang, Qamili, & Punnett, (2013) conducted a qualitative study using thematic analysis. The sample size comprised focus groups across seven facilities and interviews with 150 HCAs. This study explored the effects of the work environment supporting or impeding the provision of caring and contributed comments related to improved communication between the care givers and management. Findings proposed that care givers both identified with, and practiced as, nurturers. The study found that if this perception of nurturing was not supported in the working environment the HCA experienced stress. Being unable to nurture effectively was also explained as contributing to feelings of guilt. The feeling of guilt was also a factor when the wish to nurture conflicted with the requirement to provide procedures that caused the resident discomfort, especially when the procedure was perceived by the HCA as being unnecessary (Carpenter & Thompson, 2008; Tan et

al., 2006; Yoder, 2008). Supporting these findings was research by Geiger-Brown, Muntaner, Lipscomb, & Trinkoff (2004). Undertaken in the United States, 473 HCAs were surveyed with the conclusion that this workforce was at high risk for depression and other mental health issues, especially when the demanding hours were combined with working in dementia and end of life care. This research also revealed that the standard of care was impacted negatively with the decline in the mental health of the care giver.

Working in a regulated, highly challenging, and heavy environment such as that associated with dementia and palliative care has been reported in literature as contributing to the HCA feeling devalued. Using grounded theory and involving 18 participants and 88 hours of observation, research was designed to explain how ARC care workers could acknowledge and maintain resident's rights while providing continence care. The tension between these two concepts of rights and care, and the complex environment in which the care givers were working, revealed a stressed, undervalued and dissatisfied workforce struggling to maintain resident rights. This study also reported 'ethically compromised care' (p. 182), such as chastising the resident and neglecting to provide hygiene assistance due to workforce constraints (Ostaszkiewicz, O'Connell & Dunning, 2014). The feeling of being undervalued, with a reciprocal impact on provision of care, also came through strongly in a study by Hill et al. (2005). This action research determined to improve quality of care to end-of-life residents by instigating training and methods of self-reporting to 298 carers from 109 facilities. The resultant improvement in care was reflected in the reciprocal feelings of value as experienced by the HCA and the organisation.

Confirming and offering further findings was the New Zealand Human Rights Commission's review of equal opportunity employment in the ARC, reporting poor quality of care as usually the result of insufficient training and inadequate staffing levels.

42

This qualitative report explained that lack of adequate care was deemed of sufficient concern that families expressed disquiet at the staffing levels, perceived poor care, abuse and neglect. However, they hesitated to complain due to fear of reprisal on the resident (Human Rights Commission, 2012). A survey of 550 health care assistants working across the United States asked 67 questions related to employee and work characteristics as well as work issues. Findings indicated training and poor induction was as a factor of burnout and staff turnover (Parsons, Simmons, Penn, & Furlough, 2003), as was using a rotational shift policy (Black, 2015; Castle, 2013). The research conducted by Castle (2013) involved 3941 United States nursing homes and examined data from a direct survey of nursing homes administrators obtained from on-line survey certification, reporting data and from an area resource file. The evidence strongly supported the premise that rotational shift policy contributed to staff turnover and absenteeism (Castle, 2013). It has been well reported that knowing the resident was important in providing high quality care and using a rotating shift policy invalidated this knowledge, promoting task focussed provision and inadequate caring. Using existing staff to fill gaps, removing them from their usual residents or rotating the staff throughout the larger organisation further demoralised the HCA and evidenced the lack of support from management (Black, 2015; Castle, 2013).

There is a plethora of literature documenting the lack of support from the RN and management as leading to stress and burn out, (Stayt, 2010; Wenzel et al., 2011; Yoder, 2010). In a small participatory action research (n = 13) designed to explore the effects of troubled conscience on team work, the HCAs and the Enrolled Nurses reported having insufficient communication with the RN and lack of supervision, explaining this as impeding the provision of team work and quality care (Ericson-Lidman, & Strandberg, 2015). An earlier publication by Edge, Paule and Smith (2008) reinforced the importance of the role of the HCA and the RN in end of life care. This article described

a pilot quality improvement project, sharing the processes and results as an aged care organisation went through the Gold Standard Framework. An important outcome was how families perceived the difference between the role of the HCA and that of the RN. Findings indicated that families viewed the HCA as the person who provided the compassion, support, and reassurance; whereas the RN was approached for information, especially about medical matters. Feeling the HCA was sufficiently knowledgeable, families did not often access the RN. An example of this involved pain relief, the HCA was recognised as having skills in assessing the degree of pain the resident was experiencing and was able to provide basic pain relief measures and medications (Edge et al., 2008). Although the recognition of their abilities was acknowledged by the family, the HCA expressed frustration when his/her request to the RN for more advanced pain relief went unheard. Describing a similar frustration were 49 HCAs recruited from 12 nursing homes during an interviewed based, qualitative study. The conclusion from this study was that the HCAs' contribution to pain management was undervalued and poorly recognised, especially by the RN (Liu, 2014).

HCAs reported wanting input and recognition not only from the RN but also from management (Ericson-Lidman, & Strandberg, 2015). However, input from management could be difficult when the HCA was not 'seen' by management and ignored as a member of the team (Bowers et al., 2003). Anderson (2008) reported managers having insufficient training in dealing with stress-related matters. This deficit in knowledge and experience of management, compounded by the reality of the extreme conditions of the workplace revealed an occupation at risk of serious harm, with little acknowledgement from the RN or management (Anderson, 2008). The high workload, the intensity of the work and the complexities involved in care of the older person revealed an occupation that was going beyond the initial role of providing essential care into an unsupported extended role

Extending the role

There is extensive literature reporting on the role of the HCA working in the environment of providing end of life care, administering essential care as well as those measures focussed on providing comfort. Extending the role from one that addressed physical needs to providing spiritual and psycho-social support, encompassing the resident and family was regarded as normal practice for the HCA (Bowers et al., 2001; Carpenter & Thompson, 2008; Rokach, 2005, Wenzel et al., 2011). Further, in extending the role, the HCA was now expected to work in areas that were once considered the domain of the RN. An Australian qualitative, descriptive, exploratory study used in-depth interviews with six HCAs, and reported that due to the requirement on facilities to reduce costs, the HCA was frequently expected to work without the supervision of a RN and to assume much of the RN's duties (Holloway & McConigley, 2009; Shannon & McKenzie-Green, 2016). Reporting to have insufficient knowledge to competently undertake some of these functions, the HCA instead relied on knowing the resident, using this information as a guide (Holloway & McConigley, 2009).

Similarly, Carpenter and Thompson (2008), using a naturalistic design, observed the work of CNAs (HCAs) in three nursing homes, and conducted interviews with 11 participants. Although occurring over 10 years ago the findings are still applicable. Four common themes that have not changed over time were reported. *Transitioning between two worlds* explained the tension between the requirement to complete tasks and the wish to offer more caring to the resident. *Responding to the call* provided the answers as to why the HCA entered this occupation; they were responding to a calling and/or fulfilling a spiritual need. *Living the job* explained managing the numerous interruptions that existed in this unpredictable environment. The study also described the need to be able to have flexibility in the work, to be able to reprioritise tasks and explained the requirement for the HCA to have both physical and emotional strength. The final theme,

transcending the job, explained the feeling that HCAs wanted to do more than just complete tasks, they wanted to provide the caring the resident needed. This theme also spoke of the responsibility the HCA felt toward the resident. Underpinning these themes were reports of the HCA needing to respond quickly to the challenging and unpredictable environment and having to make decisions instantly, often without oversight of the RN, working outside of their perceived role (Carpenter & Thompson, 2008).

Supporting the above findings, Dean's (2011) discussion paper debated the extended role of the HCA and commented that while it was good that HCAs were being extended and trained in different areas, they did not have the background knowledge of the RN and as such could not be used to replace the RN. This view was supported by Heath (2012) and was based on findings from her 2006 research of the work of the RN and HCAs in UK. Heath concluded that cost cutting measures should not include replacing the RN with the HCA. Heath further explained that RNs were not simply undertaking a task; but using their knowledge to assess and anticipate a variety of factors, of which the HCA would be unaware. This report did acknowledge that some tasks previously expected of the RN, such as PeG feeding and catheter care were suitable for the HCA to perform. Heath also acknowledged that the RN was often distanced from the resident, relying on the HCA to inform him/her of changes in the condition of the resident (Heath, 2012).

The Cavendish Review (2013) also reported that the HCA was performing tasks that were once considered initially a role of the doctor and then the RN. Commissioned by the Secretary of State for Health, this report was an independent review into HCAs and support workers in the National Health System (Cavendish, 2013). It described the UK as having over 1.3 million health care workers, a rapidly ageing population,

significant advances in medicine, and a growing burden of paperwork on the RN. The cost cutting measures and the increased work load on the RN was reported as contributing to the expanding role, including extending into the domain of administering significant pain medications. The report explained that it was believed that as the HCA was working within a team environment with access to support this extension an accepted practice (Edge et al., 2008). However, at times extension led to poor care with comment made within The Cavendish Review (2012) on the difficulty of removing staff, including the HCA who was not deemed competent, allowing "poor care to go unchallenged" (p. 6).

Literature provides a further example of extension of the HCA's role. This was evidenced during an Australian participatory action research study involving HCAs to train second year nursing students in providing quality caring skills (Annear, Lea, & Robinson, 2014). Used to not only improve practical skills of the nursing students, the study was an effort to introduce the student to ARC and potentially attract the newly Registered Nurse into this growing sector. The programme was considered a success, with the student nurses acknowledging an initial bias against the HCA and an ignorance of the role of the HCA (Annear et al., 2014). Extending the role can provide HCAs with opportunities to increase their practice and knowledge; however, it also added to the already acknowledged heavy workload and stress and created confusion for the internationally qualified RN working as an HCA. These migrant workers were aware that many of the 'extended tasks' they performed should not be undertaken by an HCA, however it was an expectation, and this will now be explained.

The migrant worker and cultural factors influencing the role

There is a plethora of literature documenting the importance of the migrant worker in ARC. Khatutsky, Wiener, and Anderson (2010) linking the 2004 National Nursing Home Survey (USA) with four other surveys related to the HCA, sought factors related to the migrant workforce and contrasted these with non-migrant workers (citizens born in the U.S.) An extensive study, involving 582 nursing facilities and 3017 HCAs, the data from 2831 phone interviews with HCAs were analysed using Chi-square analysis. Findings revealed that the migrant participants were required to overcome significant cultural and language barriers with both colleagues and residents, additionally the uncertainty of employment and immigration requirements led to potential discrimination and exploitation. The study also revealed that the non-migrant worker experienced communication difficulties; and yet, it was the migrant worker who was discriminated and faced greater uncertainty over employment. The two slightly lesser concerns were; employment occurred at lower quality facilities, as the higher quality ones were selective of the ethnicities employed; and the shorter duration of employment of the migrant worker within ARC, with many using it as a stepping stone into other areas. Positive findings included the profile of the migrant worker as being more mature, educated, and able to establish a better relationship with his/her supervisor than the non-migrant worker (Khatutsky et al., 2010).

Communication and perception of equality were also reported in a Swedish based study that surveyed 6l HCAs. This research compared the tensions and similarities experienced by native born, first generation and second-generation workers. Findings strongly suggested that second generation and native-born workers experienced similar conditions of discrimination and equality issues; however, it was the first generation who were actively compromised, reporting that communication issues impacted on the trust and respect shown between co-workers and affected the quality of work (Olt, Jirwe,

48

Saboonchi, Gerrish, & Emami, 2014). These findings were similar to earlier research by Ramirez, Teresi and Holmes' (2006) studying workplace stress, and reporting racial abuse as a significant factor in job satisfaction and performance.

The literature search provided many other studies that examined the effects of ethnic and cultural differences in the workplace, with similar findings reported by Funk, Stajduhar and Cloutier-Fisher (2011), Hill, Ginsburg, Citko, and Cadogan (2005), Kayser-Jones (2002), and Tan, Low, Yap, Lee, Pang, and Wu (2006). Examining a slightly different aspect of racial tension was research reporting on the way the migrant HCA perceived quality care, with examples provided highlighting the differing attitudes to respect shown toward residents (Fisher & Wallhagen, 2008). Explaining that indebtedness and gratitude should be shown to older people, the HCAs from the Philippines reported that this was basic to their culture. The researchers described the resident as being fictive kin of the HCA and associated this with feelings of dedication and responsibility from the HCA. This grounded theory study, based in the US, had 27 participants, all were coloured and, except for three, all were immigrants. (Fisher & Wallhagen, 2008). Literature supported the findings that regardless of whether racial tension and cultural misunderstanding was experienced directly by the HCA, or whether it arose due to the practice of the HCA, it still resulted in stress. When HCAs were under stress from residents and management, and could not employ the caring that they wished, regardless of ethnicity, HCAs usually decided to leave their employment.

A satisfying role
Contrary to much of the research reported above, a search of literature provided several examples of the positive aspects of working in aged care. Opposing the beliefs of management, HCAs did not change their employer due to a dislike of their work nor to gain better pay; they did so due to a dislike of their working environment (Yoder, 2010).

HCAs described wanting to contribute to decisions, have time to provide care and to grieve, have access to training and mentoring and to be appreciated for the role that they play (Carlson 2007; Yoder, 2010). HCAs also explained that, provided with time and resources to work effectively, their level of job satisfaction would rise (Cooper et al., 2016; Frey et al., 2015). Being heard and having the opportunity to be a decision maker and being kept informed were also significant contributors reported to reduce turnover and decreasing stress. Reporting on these factors during a large survey of 550 nursing assistants examining job satisfaction, the major reason for continuing to work in this sector was identified as the relationship with the resident (Parsons et al., 2003).

This relationship was not one way. The HCA was also reported as personally benefitting from administering high quality, comfort and relationship-based care, gaining a sense of well-being, and a reciprocity; the mutual giving, taking and sharing, in this instance of caring and comfort from families (Anderson, 2008; Black & Rubenstein, 2005; Bowers et al., 2001; Carpenter & Thompson, 2008; Heliker & Hoang, 2010; Rokach, 2005). Similarly, those who worked for a religious organisation reported job satisfaction, believing they were contributing to God's work. HCAs who periodically changed their working environment also reported higher levels of satisfaction which they attributed to increased opportunities for personal growth within the new organisation (Anderson, 2008). Facilitating personal growth, as well as a feeling of responsibility, often resulted in the HCA having to extend the role beyond that of providing essential care, and as previously reported this was not supported. The next section reviews literature that evidenced this and proceeds to examine measures that may give the HCA a voice and some form of protection.

Providing a Mechanism for Safety

The above studies have revealed a conflicted workforce. Literature described a workforce under stress and duress, capable of great service and caring, but also of inflicting abuse, whether that be from burnout, over work or ignorance. In this section I review literature and regulatory documents that supports ways to try to ensure safety of the resident and the HCA, which includes both non-regulatory and regulatory methods. Non-regulatory methods included using training and qualifications as a guide, operational directives, and codes of conducts. Regulatory methods are described as licensing or regulation. The difference between non-regulation and regulation, using New Zealand as an example, will be explained.

The Human Rights Commission (2012) defined the regulated and unregulated workforce as:

> 'the regulated workforce is subject to regulatory requirements under health legislation such as the Health Practitioners Competence Assurance Act 2003. This act mandates registration, on-going competence requirements, professional standards, limitations and disciplinary procedures. The regulated workforce is subject to scopes of practice. Other workers, including carers, are part of the unregulated workforce'. (p. 14)

The HPCAA (2003) (Ministry of Health New Zealand, 2012), provided four reasons a role may not be regulated: low level of risk, supervision being provided by a regulated profession, employment arrangements acting as a form of regulation, and self-regulation. Examining these reasons, it could be argued that the working environment and the complex nature of HCAs' work promotes a high risk of harm to the client as well as to the HCA. Furthermore, the HCA may not be directly supervised by a professional, employment arrangements may not be in the interest of the HCA, and little self-regulation occurs (Holloway & McConigley, 2009; Thornton, 2010). Non-regulated bodies can apply for regulation under the HPCAA, "the principle purpose of which is to protect the health and safety of members of the public by providing mechanisms to

ensure that health practitioners are competent and fit to practice their professions" (Ministry of Health Guidelines, 2012, p.1).

New Zealand has opted for the default system of using training and the purpose statement of the qualification as the guide to practice (Career Force, 2017b). It also relies on employment contracts and job descriptions to define the role of the HCA (Thornton, 2010). These mechanisms, seen by many as an inadequate means of providing a structure and definition to a role, contribute to the debate about regulation in New Zealand (Cassie, 2014). In a *Nursing Review* article, Cassie (2014) concluded with the Nursing Council of New Zealand stating that this unregulated workforce was not their responsibility at this time. The comment further suggested that the HCA would shortly have access to a standardised qualification and now only required a Code of Conduct and a system that could manage any breeches of the Code. Perhaps this 'shadow regulation' is an alternative to be considered; however, there are compelling arguments supporting regulation rather than the partial implementation of a management system (Cassie, 2014).

Since the Cassie (2014) article, New Zealand has not proceeded with the Code of Conduct, however, the Nursing Council of New Zealand (2011) issued a guideline for the RN who delegates care to the HCA. This guideline was specific about the responsibilities of the employer and provided very clear instructions for RNs to maintain their safety of practice. Many of these guidelines are difficult at best to implement in ARC. For example, the RN must be directly involved with the care of the client who is less predictable. Considering the complexity of health changes and unpredictability of conditions this directive is difficult to achieve. These guidelines also explain that the RN should understand the role of the HCA to ensure that the HCA does not operate outside his/her abilities (Nursing Council of New Zealand, 2011). There is however, significant literature explaining that understanding this role is not easy. A report from Estabrooks et

al. (2015) described the progress that Canada was making toward regulation of health care assistants and explained progress at provincial level. Reporting progress as slow, Estabrooks et al. (2015) explained that obtaining basic details such as the numbers and characteristics of workers involved, tasks they do, and their qualifications was difficult and that the lack of uniformity across the country was hindering progress in providing a nationwide approach. Also querying the nature of the role of the HCA was a descriptive, exploratory study undertaken in Australia which questioned the practical and legal implications of the work of the HCA (Holloway & McConigley, 2009). Findings from this study explained the need for a defined scope of practice, especially considering the extended HCA role. Holloway and McConigley (2009) called for improved governance and guidelines for the provision of safe care, a clearer scope of practice, and consideration of regulation.

Literature provides an example of an alternative to regulation coming from Australia. The Australian Government does not have regulatory processes in place; however, the Government of Western Australia (2013) has an operational directive that provides a guide to HCA competencies. Added to this guide is the premise that this work must always be under supervision of the RN. The directive further stipulated a level of qualification (Certificate 111) that, once obtained, enabled the HCA to offer all outlined skill sets. The tasks or skills listed were basic and prescriptive (Federal Government of Western Australia, 2013).

The International Call for Regulation

Evidencing the call for some form of regulation is provided in literature from both professional organisations and HCAs. A survey undertaken by The Royal College of Nurses in 2009 gave substantive voice to the HCAs, reporting that 85% of the HCAs in the UK wanted regulation and 98% were prepared to pay towards this measure

(Vaughan, 2009). Supporting this call was an independent review of HCAs and support workers in the UK National Health Service which was underpinned by 14 weeks of interviews and observations within the ARC sector (Cavendish, 2013). The Cavendish Review was commissioned after many deficiencies of care and the resultant reports, including the Francis (2013) Report. The Francis Report was significant in the findings of extremely poor care involving an acute hospital under the National Health Setting; however, it also commented on the HCA. One recommendation was for regulation; another was to provide a national identity for the HCA (Francis, 2013). Endorsed by the UK Health Select Committee, the Willis Commission (2012) further supported this call, reporting that it was unacceptable to have unregulated staff caring for a vulnerable population. The Willis Commission discussed a default system of relying on qualifications as not providing satisfactory rigour of quality assurance and added a concluding comment that most European countries had mandatory regulation of the HCA workforce (Willis, 2012).

Providing more information, an in-depth review of three major reports (Development and co-ordination of a network of nurse educators and regulators 2010-2013, Francis, 2013 and Cavendish Review, 2013) and several projects were instigated to assess the commonality of training, roles, transportability, and regulation of the HCA (Wöpking, 2016). The purpose was to achieve comparability and compatibility of HCA training throughout the European Union. Recognising that the demand for the HCA position was increasing quickly, the review provided the reader with knowledge aimed at assessing the status of the HCA as it pertained to the country of training. A measure for the review was the availability or not of regulation. In 2016, the countries offering regulation were; Belgium, France, Austria, Netherlands, Italy, Romania, Denmark, Slovenia, Czech Republic, Poland, Germany, and Northern Ireland. Finland had Licenced Practitioners as well as the unregulated care assistant. Wales and Scotland had

Codes of Conduct for employers and HCAs. There was no regulation for HCAs in Spain, Sweden, and Switzerland; however, there were compulsory levels of training. The UK has a nationwide Code of Conduct and, as previously stated, a national organisation calling for regulation (Wöpking, 2016). In 1987 the Congress of the United States passed a federal law requiring all care assistants to be regulated and to achieve certification. From this law, a nurse aide training and competency evaluation programme was developed that listed minimum requirements of skills that must be achieved to obtain and maintain certification (Hegner, Acello, & Caldwell, 2010).

Closer to home, literature revealed a cohesion existing between Australian organisations exploring the question of regulation. National professional bodies were supportive of this premise. The Australian Nursing and Midwifery Federation (ANMF) stated that as it was their responsibility to provide the public with protection, as it related to the practice of nurses and midwives, thus it should be extended to include the assistants who work with them and for whom the RN assumed responsibility (ANMF, 2015). This position was very clear that the standards of practice and ethical practice should not be the responsibility of the employer and proceeded to list requirements that would be met under regulation (ANMF, 2015). These requirements were similar to those provided by the Australian Nursing Federation (ANF); minimum levels of training, a standard of minimum care and competency requirements, and an identified scope of practice. Regulation would provide a mechanism for accountability with mandated consequences and a means to protect and inform the public. The RN, as the supervisor of the HCA, would also be supported through regulation; and, very importantly, there was the provision of voice for the HCA with representation on the regulatory board (ANF, 2011).

It is interesting that a search of literature has revealed no documented discussion of opposition to regulation, other than the occasional line in literature which suggested

that funding the improved status of a regulated HCA would impact heavily on the employer. A modelling exercise commissioned by the Human Rights Commission (2012) New Zealand had estimated that regulation would cost less than 1% of the health budget.

The Gap in Knowledge

When undertaking this literature review I was searching for research to assist with answering the research question '*how do health care assistants manage their work in aged residential care'.* My findings revealed older research as evidencing the wider range of caring skills associated with the HCA working in ARC, with the more current research focussing on questions of a more specific nature, such as management of pain. It was disappointing to find research exploring job satisfaction or retention that pertained to a narrowed role offering task focussed care, neglecting the psychosocial support and complexity of care offered by the HCA in a constantly changing environment. There are significant gaps in current research, both in New Zealand and internationally, examining the more encompassing and complex role that the HCA is now undertaking.

Summary

The role of the HCA is difficult to define with research reporting a richness in variety of knowledge, skills, and attributes that are at times obvious and other times go unnoticed (Bowers et al., 2001; Carpenter & Thompson, 2008; Chamberlain et al., 2017; Rakovski et al., 2010; Rokach, 2005, Schwab, 1975; Wenzel et al., 2011). What is obvious is the change in nature of the work, from gently supporting the aged over a period of years, to now providing end of life and/or dementia care in an environment that is time pressured, complex, unpredictable, and often unsupported (Carlson, 2007; Cooper et al., 2016; Frey et al., 2015; Henderson, 1994).

Literature clearly demonstrated the demand for the services of the HCA increasing exponentially as the world population ages, and those countries with too few carers will shortly be contesting for this workforce (Badkar et al., 2009; Human Rights Commission, 2012). Such competition is already occurring with many countries targeting the migrant workforce; however, few are addressing the issues that such a workforce face (Khatutsky et al., 2010; Thornton, 2010). Depression, isolation, and burnout occur too frequently, resulting in multiple loss to the HCA, high turnover for the employer, and potentially poor quality of care for the resident (Carlson, 2007; Cooper et al., 2016; Kostiwa & Meeks, 2009; Wallace, 2009). The safety of the resident is paramount for all, and so too should be the concern and support for the HCA; thus, a call for some form of regulation has been heard by many countries (Estabrooks et al., 2015; Hegner et al., 2010; Wöpking, 2016). In other countries, where regulation has not occurred, such as in New Zealand, there are attempts at introducing consistency of provision of care and guidance with training and increased employer regulation (Human Rights Commission, 2012). Ultimately two groups of people pay the price for the rapidly occurring change in aged care provision; the resident and the HCA. The ramifications of this, and strategies that are enacted to assist will be further explicated as this thesis progresses.

CHAPTER THREE: METHODOLOGY & METHODS

The methodology used for this research is constructivist grounded theory, a qualitative methodology with pragmatist philosophical foundations. Beginning this chapter, I explain the methodology within the historical context of the development of grounded theory by Glaser and Strauss (1967) and examine the philosophical underpinnings of grounded theory. I then introduce social constructionist grounded theory developed by Kathy Charmaz. Within this discussion I explain the two terms; constructionism and constructivism, both of which are used interchangeably when describing this methodology (Charmaz, 2012).

The explanation of the research extends to include; the research design, methods, and the quality and ethical assurances I applied when conducting the research. Introductions to this study continue with information pertaining to the methods of participant inclusion and exclusion, followed by an introduction to the participants, details of data gathering and the processes of data analysis. Following the explanation of the methods, I present the constructed theory.

Overview of Grounded Theory

Grounded theory is a qualitative methodology developed in the mid-1960s by Barney Glaser and Anselm Strauss, originating from a research project undertaken together when they were employed to teach nurses at the University of California San Francisco (UCSF) (Corbin & Strauss, 1990). During this project, the men realised that the analytical processes they were using were unique, combining strengths of both quantitative and qualitative methods of research. Strauss, from the Chicago School of Sociology, contributed the philosophical foundation of pragmatism; and Glaser, from Columbia University, contributed the more positivist empirical methods of data collection and analysis.

Glaser's approach led to the inclusion of coding and constant comparative analysis, methods that were to become key processes of grounded theory (Bryant & Charmaz, 2007; Morse, Stern, Corbin, Bowers, Charmaz, & Clarke, 2009). The talents and passion of these two scholars contributed to the publication of *The Discovery of Grounded Theory* in 1967, which introduced grounded theory to the world, providing guiding principles for fellow researchers, and in particular, their students. Nurse practitioners especially, expressed great interest in using this methodology as it meant they could study the intricacies of behaviour in a social context which previously used quantitative methodologies. At the same time, this methodology provided the systematic, empirical, and rigorous attributes of quantitative methodologies preferred by the scientific community (Corbin & Strauss, 1990). Grounded theory is therefore an excellent methodology to explain the research question of my study "*How do health care assistants manage their work in aged residential care?*" Over the following years many of these students, including Charmaz, developed variances in the methods used; however, the basic processes remained (Bryant & Charmaz, 2007; Charmaz, 2012; Stern & Porr, 2011) and it is the variant of Charmaz that I have used for my methodology.

Charmaz described herself as bringing a *social constructivist* view to her research. The constructivist view differs slightly from that of the classical grounded theory approach in that it acknowledges a more active participation of the researcher. Suggesting a co-construction of data occurs in the development of the theory, Charmaz recognised the contributions of both the participant and the researcher. Initially occurring during the interview process from the participants' stories and in combination with the analysis and conceptualisation applied by the researcher, Charmaz (2014) attributed a more active role of the researcher in the development of the theory. In contrast, Corbin and Strauss (2015) explained the theory as emerging or being

discovered (Bryant & Charmaz, 2007). It is interesting to note, however, that more recently Corbin has used the phrase 'construction of theory' and acknowledges the work of Charmaz, saying that over the years, methodologies develop and change (Corbin & Strauss, 2015; Stern & Porr, 2011).

As Corbin has acknowledged the change in methodologies over time, I too have noticed a change in terminology used by Charmaz. In early writings, Charmaz usually referred to constructivism, to clearly differentiate the methodology that she had developed from that of the classical grounded theory (Charmaz, 2006) and from the social constructionist methodology that Charmaz (2014) believed did not acknowledge the researcher. However, today the terms *constructivist* or *constructivism* appear to be interchangeable with *constructionism*. This interchangeability can create confusion as has been written about in literature (Andrews, 2012; Young & Collin, 2004) and evidenced within the members of a grounded theory group to which I belong. I will clarify my understanding of the difference between the two and assume a methodological position.

Constructivist grounded theory was the original name given to the methodology developed by Charmaz. This methodology is of the interpretivist paradigm and ontologically is relativist with subjectivist epistemological views (Mills, Bonner, & Francis, 2006). In other words, this methodology reflects the interpretivist view that there are multiple realities, and the nature of that reality is relative to the person's perceptions at that time. Therefore, constructivist grounded theory acknowledges that the researcher brings with him/her "beliefs and feelings about the world and how it should be understood and studied" (Denzin & Lincoln, 2005, p. 22). Thus, constructivist grounded theory recognises that the researcher cannot be divorced from, nor objective about, the data and instead is an active participant, shaping questions, interpreting responses and 'bringing his/her being' into the analysis and the ultimate construction of

the theory (Bryant & Charmaz, 2007; Charmaz, 2012; Morse et al., 2009). When we explain the participants actions and reactions we are sharing our construction of what we see and hear in that social context (Crotty, 2015).

The confusion associated with using the term constructivist occurs when we examine the nature of the philosophical perspective of constructivism. Constructivism is focussed on the individual, explaining that knowledge is individually constructed through experience (Sutherland, 1992). This allows for the unique interpretation each of us brings to that experience (Crotty, 2015). This term is, therefore, not totally conducive to grounded theory which is used to develop a theory pertaining to the action resulting from meaning given within social occurrences (Andrews, 2012).

Differing from constructivism, social constructionism addresses the societal nature of relationships, including that of the researcher with the participants. It explores interaction resulting from the relationships and is especially focussed on the importance of language (Andrews, 2012; Berger & Luckmann, 1991). Social constructionism acknowledges that the participants are constructing meaning whilst interacting together, that the meaning is influenced by culture and that each person has his/her own realities (Crotty, 2015. Crotty (2015) explains the difference between the two terms; "reserve the term Constructivism for epistemological considerations focussing exclusively on 'the meaning-making activity of the individual mind' and to use constructionism where the focus includes 'the collective generation and transmission of meaning' (p. 58).

Charmaz (2014) also explained the interchangeability between the two terms; referring to the name constructivist grounded theory as being the initial name for her research methodology and clarifying that both constructionism and constructivism is appropriate terminology, describing the same methodology. Addressing the interchangeability of these terms, and to avoid confusion, I have used the terminology social constructionism, acknowledging the societal aspects of this research, the

importance of discourse in relation to action, and the contribution of the researcher. I will also address the contribution of construction and co-construction pertaining to the development of the theory.

Co-construction is acknowledging the place of the researcher, who, using the participants' data and recognising their contribution 'co-constructs' during analysis (Charmaz, 2012). Co-construction occurs within the analytical methods used, including member checking which is checking back with the participants to ensure relevance and fit; however, the construction of the theory is ultimately the work of the researcher.

Pragmatism

Underpinning the grounded theory methodology is the philosophy of pragmatism, providing the framework for the processes and language used (Charmaz, 2012; Morse et al., 2009). As explained above, the social constructionist acknowledges multiple realities, understanding that the nature of that reality is relative to the person's perceptions at that time. This is a logical and reasonable way of thinking; it is pragmatic. The pragmatist gives prominence to what is important to him/her, at that time and then applies this thinking within that context (Denzin & Lincoln, 2005). Truth is a fundamental tenant of this philosophy; and truth to the pragmatist is what the person deems to be real in his/her world at that moment in time.

There are three dominant contributors to the development and acceptance of the philosophy of pragmatism; C.S. Peirce (1839-1914) considered the father of pragmatism, William James (1842-1910) who developed the philosophy of pragmatism, and John Dewey (1859-1914) an ardent proponent of the philosophy (Bryant & Charmaz, 2007; Stern & Porr, 2011). Having an in-depth interest in logic and truth, Peirce provided the foundations for pragmatism and contributed theories on induction, deduction, and abductive reasoning that were to become pivotal processes in grounded

theory. Peirce considered that truth reflects the best argument that fits the current evidence and that truth must be able to be applied in action; therefore, be of a practical nature (Stern & Porr, 2011). However, it was James who extended the work on pragmatism and subsequently developed the philosophy of pragmatism; theorising that pragmatism was a reasonable or logical way of doing things or thinking about specific problems. Therefore, what is true for one may not be true for another, "reality is not out there but rather continually in the making on the part of active beings" (Bryant & Charmaz, 2007, p. 583). When the continual making of reality stops, interpretation of action ceases, this then becomes a fact (Crotty, 2015). The philosophy of pragmatism was supported by John Dewey (1925/1981), and later by Herbert Mead (1932, 1934) and George Blumer (1969). Blumer clarified Mead's original ideas and was the first person to use the phrase Symbolic Interactionism (Charmaz, 2012). Symbolic interactionism is a sociological perspective explaining actions humans take based on meanings gained from social interactions and modified by interpretation of the individual (Blumer, 1969). Symbolic interactionism is described by Crotty (2015) as 'pragmatism in sociological attire' (p.62).

Using pragmatism as the foundation of grounded theory research was explained by Charmaz (2012) as assisting the researcher with the interpretative nature of the study by providing a focus on the language, meaning, and action within a grounded theory study. Pragmatism, therefore provides a methodological principle for the analysis and explanation of meanings that can be given to actions occurring in ordinary situations.

Personal Philosophical and Methodological Perspectives

Birks and Mills (2015) wrote of the importance of having a clear philosophical position, enabling the researcher to choose a methodology that best suits him/her and therefore providing an effective and transparent platform for research. Upon consideration of this

logical view, I explored why I felt so comfortable with a pragmatist philosophy. In my roles within business and community, as a leader, manager, and mentor, I assume the pragmatist philosophy believing that truth is as seen by the person. I am also continually questioning whether something is logical and reasonable. This has held me in good stead and provided an ethical, and I believe a 'fair', basis for considerations and decisions made. The pragmatist philosophy therefore makes grounded theory very attractive. Further, I believe that my training as a nurse, providing what was then described as holistic care, has led me to acknowledge that I am never alone in what I do, that someone else is always a part of that, and together we construct what I perceive to be my reality and that I affect others' realities through social interaction and actions. This belief complements the fundamental premise of social constructionist grounded theory where the co-construction of concepts, leading to a theory, seems logical and exciting to me. Adding to this, the training and experiences I gained as a RN has promoted the skills of reflection, analytical, and comparative abilities all of which are essential to constructionist grounded theory.

As previously explained, I bring to this research my background as a RN and as a daughter of parents who lived and died within ARC. HCAs predominantly provided the care they received, in an environment similar to that of many of the participants. Although observation is not a method used in this research, I do have memories of watching and assisting the HCAs during the three years that my parents were in care; and these memories undoubtedly, although not deliberately, contributed to the co-construction of concepts and construction of the theory. Using grounded theory, with the constant comparative analysis, memoing, presupposition interview, supportive supervisors and a grounded theory working group to access and challenge my conceptualising, contributed to ensuring that my perceptions did not detract from the participants' perspectives and the meaning and actions arising from these.

Research Methods

Design of the study and the nature of the research question

The research question for this study was, "*How do health care assistants manage their work in aged residential care?*" As previously explained within Chapter One, the HCA role is complex, as is the environment within which the HCA is employed. By examining these complexities and the resulting actions, and using social constructionist grounded theory methodology, I intended to construct a theory grounded from the data, to answer the research question. The underpinning principle of grounded theory is that the main theory is constructed after data collection, in-depth analysis and conceptualising, resulting in an original theory which provides explanation for thoughts and actions within a social context (Morse et al., 2009).

Recruitment and Data Collection

Researcher involvement

I proposed the original question which arose while watching the interactions of the HCAs assisting my parents in ARC. My interest in this area was further generated when I was on an advisory group exploring the development of generic New Zealand qualifications for the HCA. The question was asked during this time, 'what does the HCA actually do and what should he/she be doing'? Answers were varied and consensus difficult, thus reinforcing my desire to answer the initial question and use the outcome to influence the latter.

As the researcher, I developed the research, information for the participants, the questions, undertook the interviews, organised transcription, coded the data, wrote memos, analysed the data and constantly compared the codes and concepts that were arising, eventually developing the theory. As the theory was developing, I went back to six of the participants to ask if the theory resonated with them and fitted with how they

saw their working role. This sharing was an aspect of co-construction, ensuring that the participants actively contributed at all stages; and indeed, sharing did result in changes, including changing categories and ultimately the theory, as I explain in the section on theoretical sampling.

Inclusion and exclusion criteria

The inclusion criteria for this study were persons with at least four months working as a HCA, currently employed as a health care assistant in an aged residential care service, who had conversational English, and were located within two geographic regions of Auckland. The respective rationale for the inclusion criteria, were that the approach required participants to have sufficient employment experience within the ARC environment to be able to reflect upon and answer questions. I decided that 4 months of working as an HCA would be the minimum time required and I needed the participant to be able to converse in English, as I am not adept at other languages.

HCAs who were previous students or stakeholders of mine were excluded from participating. I had a training establishment based in the south of this city and thus I avoided this region for recruitment as I did not wish potential participants to feel any undue pressure.

Recruitment

Purposive recruitment began with an email to all ARC facilities within the western region of Auckland City. This email introduced myself, outlined the research proposal and requested a meeting to discuss possible participant recruitment. Of the 30 or so emails sent out there were 10 positive responses, to which I organised to meet with either the human resources or clinical nurse management. The purpose of the research and requirements I had were explained at this meeting held in each facility; to interview HCAs who met the criteria for the purpose of my research. I left information sheets

(Appendix C) and posters (see Appendix E) with the organisations to be placed in staff rooms and, once permission had been gained from the organisation, meetings were held in the staff tea rooms with any HCA staff members expressing interest. At these 15-30-minute meetings, I provided information about the proposed study and recruitment details, including their freedom of choice to participate and option to have a support person. HCAs who met the inclusion criteria and were interested in participating were asked to contact me by text messaging or email, and interviews were arranged at a venue of the person's choice. These venues were usually coffee shops or libraries, close to the person's home. When a greater number of participants were sought the process was repeated, however the emails were sent to organisations in the eastern region of Auckland City, with a further 6 positive responses and the same recruitment process was followed.

Informed consent

Information about this research study was provided on a poster and left at a pre-organised staff information session. When a potential participant enquired, I sent a copy of the participant information sheet and consent form to the person, in the preferred format, either email or hand delivered. A meeting was subsequently organised.

Upon meeting with the potential participant, and prior to interview, I ensured that the person was fully informed of the research and of the consent process, and the consent form was signed/resigned prior to interview. A copy of the signed form was returned to the participant and the original stored securely at AUT.

Maintaining confidentiality

Interviews were not conducted within the participants' work settings unless participants particularly requested this. Participant confidentiality was maintained through replacing all names of individuals with pseudonyms. I kept a log of the pseudonyms and stored it

in a locked filing cabinet to which only I have access. All electronic data were password protected. I have ensured that any potentially identifying details have been changed in transcripts, as well as in the thesis, and any subsequent publications, presentations, or reports arising from this research. All material pertaining to the research, including transcripts of interviews, have been stored in a locked filing cabinet and the signed consent forms have been retained by my primary supervisor, as well as the audio tapes of the interviews, as per AUTEC policy. The audio tapes were transcribed by a contracted transcriptionist who consented to keep strictly within ethical and confidential boundaries (see Appendix D).

The participants in this study

Sixteen HCAs participated in the study from seven facilities. The recruitment methods provided a richness of ethnicities in staff as well as a comprehensive range of facility types; for example, rest homes and hospitals, for profit and not for profit and dementia care.

The following table (see Table 2, p. 69) depicts research participant information. It is reasonably representative of the normal composition of New Zealand HCAs, with the minor representation of males (Thornton, 2010). Of the 16 HCAs recruited, one was male. That said, the Thornton Review ranks 56% of the healthcare workers as New Zealand European, and 13% Asian, reflecting the HCA demographics; whereas in this study Asian, in particular, those from the Philippines, is the dominant ethnicity. This affirms my experience, although is not supported by literature, with the reason most probably being that demographics within the Auckland region change reasonably quickly.

Each participant was interviewed for one hour, and six participants had a further 20-minute interview as a part of the member checking process. The latter six participants were involved in theoretical sampling.

Data Collection

Birks and Mills (2015) emphasised not confining the research to interviews or observations; rather the necessity to obtain a diverse range of data through accessing a variety of information sources that could assist with sensitivity to the subject, such as blogs, YouTube, and auto-biographies. I read widely and accessed YouTube; however, of great assistance were the memories of the care that my parents received whilst in an ARC facility and then later in the hospital. Reflecting on the above provided me with an understanding of the working environment and assisted in sensitising me to nuances I may have missed otherwise, such as the comment made 'it's all on us' which is explained on page 155.

Table 2: Participant demographics

Country of origin	Length of experience as HCA (in years)	Previous occupation
Fiji	4	Admin
Fiji	4	Graphic artist
India	12	Health care
New Zealand	10	Housemaid
New Zealand	2	Unknown
New Zealand	4	Unknown
New Zealand	40	Midwifery training
New Zealand	40	Nurse training
Philippines	3	Admin
Philippines	10	Artist
Philippines	12	Office
Philippines	9	Registered nurse
Philippines	9	Registered nurse
Philippines	8	Registered nurse
Samoa	10	Hotel worker
South African	16	Health care

During this time of data collection and analysis, memo writing, and conceptualisation was occurring. Memos are described as an analytical conversation which begins at the data coding process and progresses to becoming advanced memos as the level of abstraction and conceptualisation occurs (Charmaz, 2012; Morse et al., 2009). Strauss and Corbin (1998) explained memos as growing more complex and accurate as the process proceeds with memos becoming modified as this progression occurs, which certainly occurred within this research. Eventually these processes lead to theoretical saturation and the generation of the theory (Charmaz, 2012; Birks & Mills, 2015). The coding, memo writing, and theorising were iterative, going backwards and forwards constantly, and it was reflexive. The reflexive nature of this work, the inherent involvement of myself within these processes, was unavoidable and supports the choice of the methodology. All processes will be now explained.

The interview

The participants chose the interview venues including; quiet cafes, libraries, and in one instance a chapel and quiet room at the place of work. Using grounded theory methodology, I encouraged the participants to share the meanings they gave to situations, their thoughts and actions; therefore, the questions used were open ended such as "tell me about your job' or "tell me about how you manage your job" with participants responding as they wished. If it became apparent that there was confusion in the question I rephrased it. For example, the question "how do you cope with disruptions to your planned work?" was rephrased as "for example; you have a resident who has a fall and you need to spend considerable time with them, how do you fit in everything else you have to do that day?"

I needed rich data that explored participants' thinking and actions. Hence, questions were designed to encourage sharing and to avoid imposing possible

preconceptions that I might have, and indeed that the participant may have. The participants were aware of my nursing background and may have omitted to discuss aspects of their role that they assumed I knew. It was important to remain aware of this possibility, thus I actively encouraged full explanations of events and actions. This resulted in some very rich data; descriptions of green wounds, crying clients in the shower, difficulties in medicating clients, and violence that was considered the norm. Eliciting this depth of information, the communication skills I used included; active listening, prompting by repeating the last few words, rephrasing and providing the participant with my undivided attention. Supplementary notes were written only once the person had left, usually when I was in my car leaving the interview, and this included background information on the ethnicity, age, place of work or some significant remark made when not on audio tape. Notes also included body language witnessed as well as questions or ideas to follow up on. An example of a supplementary note:

> 12.12.16. Interview 15 stated that the Eden Alternative was proving a much more difficult concept to put into practice than what the bosses first thought. Research Eden Alternative and read Being Mortal, mentioned by [name].

Remaining active during the interview process was important, encouraging in-depth revelations and remaining alert to areas of further interest. At times, I was engrossed in the sharing by the participant and missed areas that I would have wished to explore further; however, I was able to pick up on these alerts whilst reading the transcription and thus used these as a basis of further questioning (theoretical sampling) with other participants (Charmaz, 2012). Charmaz (2012) wrote that during the interview the researcher "endeavours to view the world through the participant's eyes" and that as "we attempt to bring meaning to and interpret their views we must also not bring bias to this process" (p. 19). I aimed to avoid bias by using the iterative measures of constant comparative analysis, looking for similarity and the 'out of the norm'

expressions and codes, and then reflecting on these. A part of the reflection included, what am I seeing here, what is the meaning of this, whose point of view is this? I believe I also avoided bias by attending two groups at AUT; the DHSc Group and the Grounded Theory Group, sharing, explaining and justifying concepts and theory with the members.

All interview transcripts were recorded and transcribed verbatim by an independent transcriber. During the interview process two of the participants became emotionally overwhelmed and acknowledging and respecting this I ceased interviewing and instead focussed on the person and the pain he/she was expressing. Although the audio recording continued (moving to turn it off would have disrupted the moment), the transcriber was asked to blank this time, thus no transcription occurred. The participants concerned were offered counselling from AUT which they declined explaining that they were well supported by their employer.

Analysis and Generation of the Grounded Theory

After the recording and transcription of each interview, line by line coding occurred. I was looking for expressions – statements that stood out – and thus the iterative and reflexive process of analysis and constant comparative analysis had begun. Following line by line coding a more focussed coding began, where similar codes were grouped together, at times becoming sub-categories and leading to categories (see Figure 1, p. 73), while others remained stand alone. Each of these steps will be detailed below.
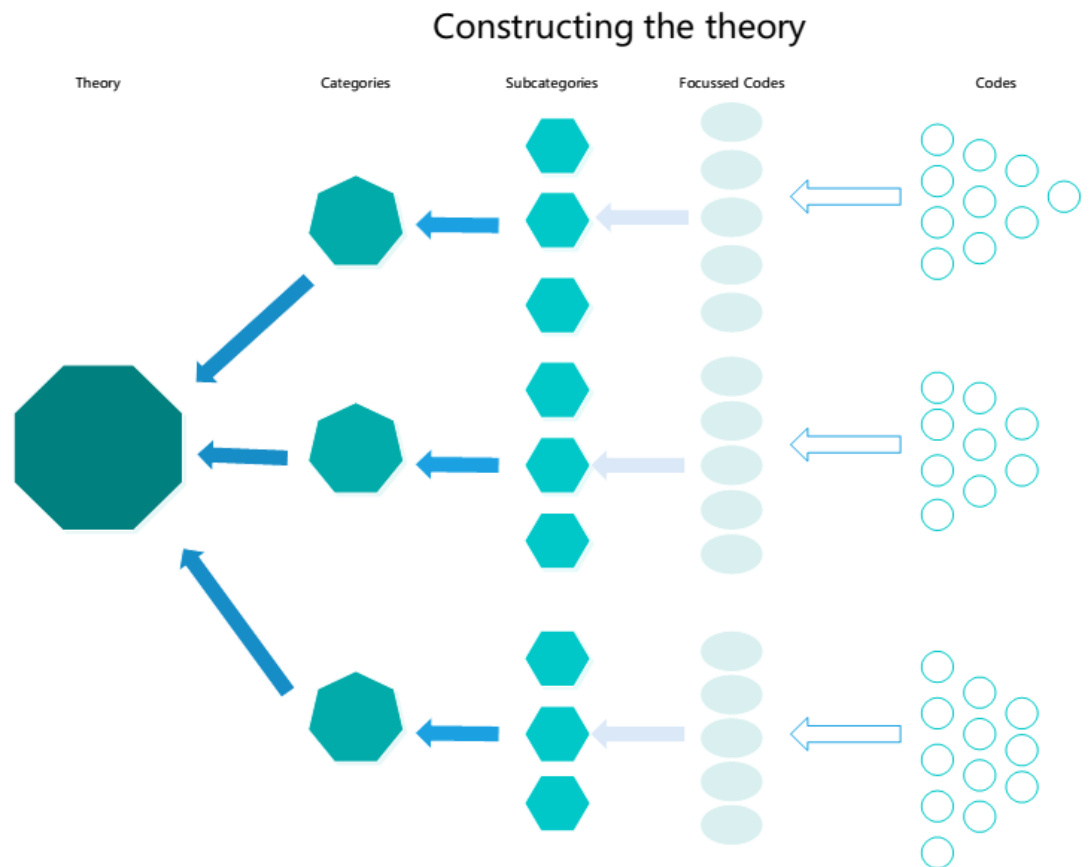
Figure 1: Constructing the theory

Initial coding

Analysis began by reading each line of the initial transcription for incidents, facts, anything at all that seemed relevant. This was the beginning process of data analysis and using inductive reasoning a code was applied (Bryant & Charmaz, 2007; Charmaz, 2012; Stern & Porr, 2011).

Coding is the process of applying a name or label for that piece of data, preferably using a gerund, an 'action' word (Charmaz, 2012). The language used for codes was important with gerunds giving energy and action to the words; hence, words having an 'ing' were applied thus: 'wasn't happy' became 'feeling unhappy', 'I love the oldies' became 'loving the residents' (Birks & Mills, 2015; Charmaz, 2012). 'Working within fear' was used to explain actions such as hiding from the RN and working when ill due to threats to employment, both actions pertaining to the perception that

73

employment was threatened. 'Bypassing the RN' was also used multiple times, explaining actions taken to avoid working with a particular RN or excluding the input of the RN altogether and usually due to the perception of unreliability or indifference on the part of the RN. An example of codes arising from line by line analysis are provided below;

> *"on a work permit we don't feel we have any rights. Whatever the boss says we have to listen to and we can't talk back."* (Ann)

This statement resulted in several codes; feeling intimidated, feeling vulnerable, having no rights, choosing to stay quiet, and protecting the job.

Codes that were directly representative of wording used by the participant are called 'invivo' codes (Birks & Mills, 2015; Bryant & Charmaz, 2007; Charmaz, 2012; Stern & Porr, 2011). An example of an invivo code from the above excerpt is 'having no rights'. Another one was '*it's on us*', explaining the responsibility that many of the participants felt for the care of their clients and, at times, extending that responsibility to the facility. '*Nagging the RN*' arose from a frequent comment that the HCA 'nagged the RN'. Upon further analysis, this comment could have been referring to the need to continually remind the RN to provide assistance and, therefore, the HCA is not able to rely on the RN to follow through (*not relying on the RN*). Alternatively, it may also have implied that the RN was too busy and must be reminded, which may be seen as a helpful activity (*assisting the RN*). These examples demonstrated that it was important to remain open and to review the codes many times, looking at them from different perspectives and within context and ensuring the 'best fit' underpins the grounded theory (Birks & Mills, 2015; Coyne & Cowley, 2006).

Focussed coding

Memo writing, and constant comparative analysis assisted me to take these initial codes to the more abstracted level of focussed coding. An example of focussed coding is

'*protecting the job*'. This focussed code occurred using deductive reasoning; comparing, contrasting, and examining codes to see which ones fitted together or alternatively to identify ones different to the others or where gaps were. Other codes that fitted well within the *protecting the job* included; choosing to stay quiet, using documentation, and collecting evidence. '*Lacking respect from the RN*' was the focussed code that represented; being ignored, feeling belittled, feeling undervalued. A gap that was revealed at this stage was what did it look like to receive praise from the RN, did this actually occur? Subsequently this became a question used during theoretical sampling, to be explained shortly.

Another example of taking the initial code to a deeper level occurred with the invivo code mentioned above of '*nagging the RN*'. This code contributed to a more focussed code of *protecting the job* which eventually contributed to a category of *protecting self.* In this situation, the HCA was *nagging the RN* to see her resident who was unwell. Eventually the HCA stepped in and supplied the care required but very carefully documented the difficulty she had with the RN and the resultant lack of action from the RN, thus the focussed code of *protecting the job*. The HCA, although looking after her client, protected the job and ultimately was seen to be *protecting self* for two reasons; had she not cared adequately for her client she would not be satisfied with the care provided, thus these actions were intrinsically driven. The second reason was that she needed the job, both for the security it gave to her family and the self-fulfilment obtained.

Focussed coding formed the basis of the construction of the sub categories and categories, using the processes of constant comparative analysis, reasoning, theorising and memoing. The processes of constant comparative analysis and reasoning will now be explained, and an example provided.

Constant comparative analysis

The processes of coding, focussed coding, developing sub categories, categories and eventually the theory, requires the method of constant comparative analysis. There are three forms of reasoning used within this analysis, inductive, deductive, and abductive. Inductive reasoning occurred within the initial coding process, taking the larger picture and breaking it down into smaller sections. From the transcript to the line by line coding.

Deductive reasoning, as mentioned within focussed coding, was the process I used in taking many small items or, in this case, codes and clustering them into larger groups. I grouped together similar codes and gave them a more defining name, placing them into a table format (see Figure 2).
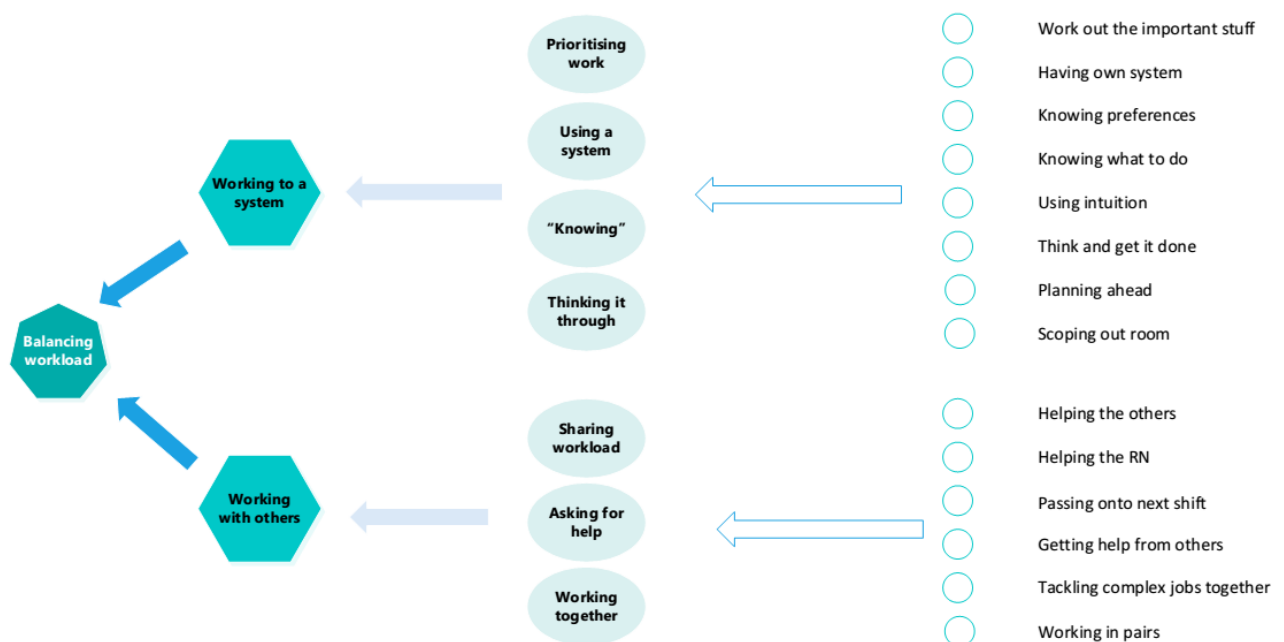
Figure 2: Coding of one category

As I read the transcripts and applied the coding I added to the table. Abductive reasoning is exciting, it examines the deductive data, especially the surprising codes, and applies intense conceptualisation to arise at a plausible theoretical explanation. Grouping together the tables I again looked-for similarities and using conceptualisation

developed categories, leading onto the development of the theory. Figure 3 shows an example of how my abductive reasoning led to the development of the category *engaging self*, which was constructed initially from the codes of loving the work, loving the old people.

Reasoning

Note: When conditions change investing self may be withdrawn

Its all about how I love them, I love working with old people (Beth)

What is meant by loving?

Data

Inductive Reasoning

"Satisfaction from working with old people. Loving the work/job?

Loving the work
Working with old people

Codes

Inductive Reasoning

Other data included: using own time, providing loving cares, taking the job home, grieving.
All aspects of investing self

Explore further existing data for evidence of investing

Feeling the work / job
Gaining intrinsic reward

Focussed Codes

Deductive Reasoning

Note:
Explore work "The Job"

Investing self and gaining reward

Sub Category

Abductive Reasoning

When investing self doesn't occur the converse is withholding self

Engaging self

Category

Figure 3: An example of inductive, deductive and abductive reasoning

Theoretical sensitivity

Remaining sensitive to the data was important throughout the process of analysis; from the beginning of the interviews to the construction of the theory, this process is called theoretical sensitivity. Theoretical sensitivity can be achieved through a variety of means and for me these included my supplementary notes written after the interview, YouTube clips, and novels based around aged care such as *Being Mortal* by Atul Gawande (2015) and Timothy Diamond's (1992) *Making Gray Gold*. My memories, discussions with fellow grounded theorists, my supervisors, and clinical nurse managers

of ARC facilities, blogs on line, and many newspaper articles about care within the aged care environment provided further material to consider and helped with the analytical and conceptual processes. Theoretical sensitivity is about using all of one's being, seeing possibilities and Charmaz (2014) discussed using memos as assisting this process.

Memo writing

Memos were important and personal, becoming an extension of my thoughts and leading to intensive conceptual exploration and assisting to construct the various levels of the theory. Memos originated whilst reading the transcribed data, coding and constructing the categories. Something would grab my attention and demand more in-depth thought. Often it would be a simple word or phrase the participant had spoken. For example, the phrase '*it's on us*', had many implications, such as being held or feeling responsible for everything. This required further exploration and a memo. The memo started with defining the language used, exploring the various connotations of the words and meanings, subsequently enabling further conceptualisation and welcoming other codes to merge into the memo. Writing the memo helped with focussing codes and constructing a category and '*it's on us*' became '*assuming responsibility*' which eventually became feeling responsible; a subcategory of *Engaging Self*. It was exciting to integrate the participants' words and expressions into the memo and to reference these for possible further development and comparison. The memos '*It's on us*' and '*assuming responsibility*' are appended as examples of the method (see Appendix F).

Analysis never stopped and reflecting on the memo, '*assuming responsibility*', led me to understand that although at times the HCA did feel responsible it was because he/she perceived a gap in care and felt that he/she needed to step in to fill the gap. '*Stepping in and filling the gap*' were important concepts that underpinned 'feeling responsible' and became a sub-category of *Engaging Self,* one of the three major

categories. Memos also provoked diagrams and word maps to aid in clarifying the conceptualisation. The memo and subsequent diagram (Figure 4) informed the construction of all three major categories; *Protecting Self, Balancing the Workload* and *Engaging Self*.

Responding to pressures

Working within self

Deciding to ignore
Extending into own time
Rushing and cutting corners
Working to task
Protecting the job

Working Smarter

Thinking it through
Prioritising and using a system
Responding to challenges
Extending the role

Working with others

Asking for help
Sharing the load
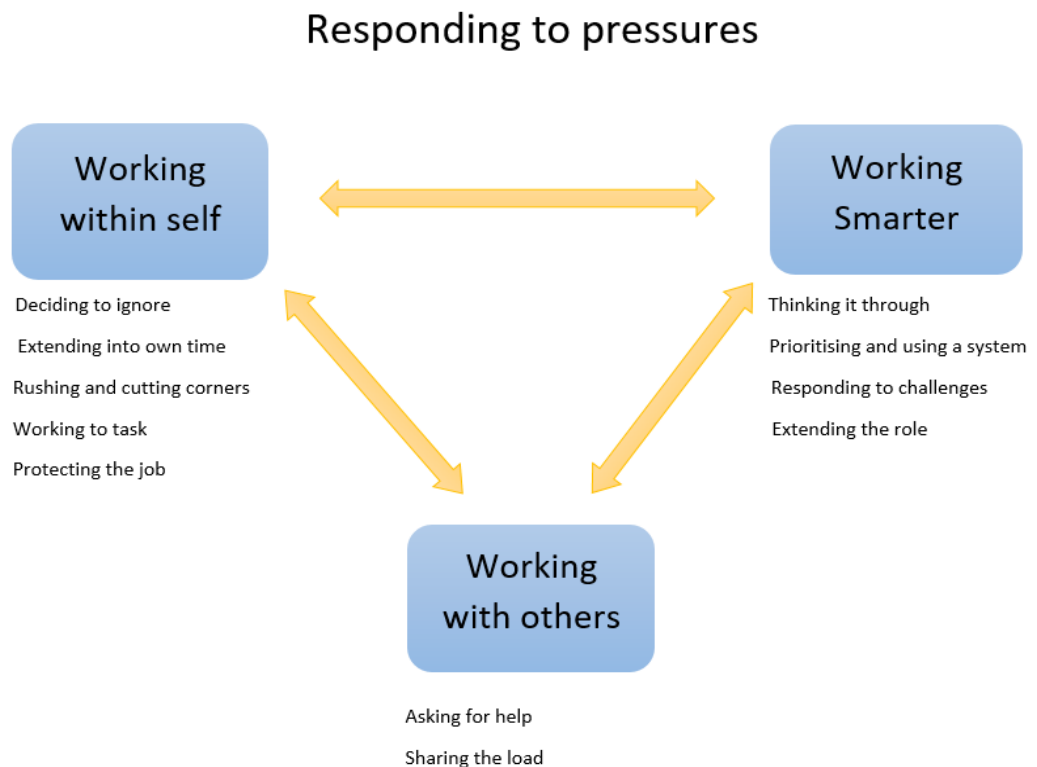
Figure 4: The diagram; initial conceptual analysis: responding to pressures

Theoretical sampling

Theoretical sampling is an integral part of the analysis process and is used to test or refine a category or to further explore developing concepts. It occurs during the data gathering process and can involve examining a concept further to gain a deeper understanding and add depth to the developing concept. This may be undertaken with a previous participant or be part of an initial interview conducted further into the study (Coyne & Cowley, 2006). An example of theoretical sampling; this participant

mentions having a good day so what does a good day look like? And thus, I asked the next participant. The following participant replied, "a good day is one where I have finished my work, my residents are happy and the RN thanks me".

Another participant used the term "nagging the RN" which became an invivo code and was further explored by asking the next participant if she too reminded the RN at times, to which the answer was yes, she 'nagged their RN'. Theoretical sampling also occurred once a category was constructed, to test that the underpinning findings were supportive of the category and that, indeed, the category did 'fit' as perceived by the participants.

An example of this *member checking* occurred as I sought assistance from two earlier participants, sharing with them the category of 'navigating' as a strategy of the HCA. A section of the memo: *Navigating*

Navigating through the perplexity of providing care.

For a long time, I have been pondering on the actions that the HCAs take in response to various stimuli, whether these be confirmation from a client that a shower is wanted, a request by the RN that help is required, a resident becoming unsteady, assistance required with a meal or a call bell sounding. I have tried using such descriptions as the HCA reacting or responding to a situation, manipulating and manoeuvring around events, shifting focus and stepping in to fill gaps, however none of these seemed adequate, they were not sufficiently inclusive to describe the full range of activities. I also needed a word that would represent these activities and have previously used such terms as 'complexity of care', however that too seemed inadequate. Then the light dawned. I was watching a movie called 'The fundamentals of caring' (2016), based on a novel by Jonathan Evison. The opening scene is a tutor instructing a class of potential care givers. She describes this occupation as being all about navigation and that intrigued me. On exploring the definition of navigation, I discovered that the tutor was correct, as navigation describes the ability to move around, direct, manage, find ones' way, plot, to progress through in a logical sequence. This fitted in so well with the activities that the HCAs have shared with me; the ways of moving around people and situations and knowing where you are and how to return. "when you get interrupted by an emergency you write it down as to where you were stopped, deal with the emergency – phone the ambulance, phone the family, write the reports and paper work and then go back to what you were doing". Nell

Both participants could see the relevance of navigating; however, during the interviews both participants suggested that navigating occurred in response to the HCA *adapting*

various other strategies first and then using navigation as a further strategy. The category of navigating had originally arisen from memos about the way the HCA responded to pressures.

Adapting became a core category and was considered as a potential theory; however, as occurs with grounded theory, further analysis, theoretical sampling, and memo writing suggested that another strategy was applied prior to adapting; *weighing up needs*. Weighing up needs did not become a category, but the process underpinned every strategy used by the HCA and thus was acknowledged as being important to managing work. Theoretical sampling also supported that 'weighing up' was basic to all strategies. This conceptualisation and abductive reasoning constructed the final three categories as no new data were required, theoretical saturation had occurred, and the theory was constructed (Coyne & Cowley, 2006). Figure 5 (p. 82) demonstrates the codes, focussed codes, sub-categories and categories constructed pertaining to *'the job'*, which underpinned the conceptualisation of all categories, as explaining how the job was managed was the essence of the research.

Data	Initial coding	Focussed coding	Sub-category	Category
2.212.on hand over we get room numbers, names, conditions, and how many cares they need to be assisted with	Being told what is needed, preparing for work.	Doing the job	Using a system	Balancing the workload
2.215. The verbal hand over is one by one. What happened, what time and what is needed. We usually write down notes too	Handing over the shift. Documenting	Doing the job	Using a system	Balancing the workload
2.173 I'm too busy to finish the job, but I go back after work and finish	Completing the task after work	Using own time	Investing self	Engaging self
2.173 I always make time to finish the job.	Making time	Making time	Using a system Investing self	Balancing the workload
2.179 finish all the tasks then go back (morning tea) and spend some time with them, have a laugh with them	Completing the task then enjoying the company	Using own time.	Investing self	Engaging self
2.192 I make sure the client is safe I check after the breaks.	Checking the clients	Checking the clients	Using a system	Balancing the workload
2.218 finding something each client responds to, making a fool of myself and watching them laugh	Instigating laughter using self	Using self	Investing self	Engaging self

Figure 5: From data to categories

Constructing the theory

The methods used, as explained above, resulted in the construction of three major categories, supported by a number of sub-categories and concepts. Originally the three major categories were; *prioritising self, balancing self* and *committing self* and the theory was '*weighing up, how the HCA manages in ARC'*. However, as with most grounded theory studies, with analysis and conceptualisation the categories and the theory changed, to **Working in a blurred domain: The Health Care Assistant in Aged Residential Care** with the three major categories being: *protecting self, balancing the workload* and *engaging self*. I will explain how this occurred.

Previously I had shared the temporary theory of adaptation; that the HCA is continually adapting to the constantly changing environment and, as I explained, after

sharing this with participants and upon further reflection I realised that a strategy came before the adaption which was, that the HCA was continually weighing things up. This theory was then shared with the participants (member checking), ensuring that my perceptions and the further theorising was in fact accurate, supporting the methodology, and acknowledging the contributions of both myself as researcher and the participants. I also shared the theory with the Grounded Theory Group at AUT who challenged and who supported the ultimate theory. All member checking verified my conceptualisation; that the HCA did use weighing up as a major strategy. Weighing up was the *basic strategy* that the HCA used to manage their work, and this led to protecting self, for, as the HCA weighed up conditions he/she may decide that actions were required to protect self, or as conditions permitted, the HCA might shift into balancing the workload, and/or engaging self. Two things had changed from the proposed theory; weighing up was no longer a part of the title of the theory as I now considered it inherent in all actions and thus I gave dominance to the three categories, and the names of two of the categories had changed. This change was a result of constant abductive reasoning, conceptualisation, memoing and, as previously mentioned, acknowledging that the language used is important, thus I changed prioritising self to protecting self, and committing self, became engaging self. However, during this conceptualisation I also realised that the dominant and most important theory was that the HCA works in a *blurred domain*.

A grounded theory is described as providing explanation for actions that we have observed many times but have not previously examined or named. It explains actions and interactions that have become integrated into everyday life and should be able to be transferable to other similar situations. Murray and Chamberlain's (1999) descriptive summation of the grounded theory process likens it to making a gourmet meal, consisting of many items that come together to create something special and this

is exactly how I found social constructionist grounded theory to be, with order being achieved through the systematic method of constant comparative analysis. Once the theory was decided and supported I needed to ensure that it followed the guides of quality research; that the theory and my research had rigour, validity, credibility, and transferability.

Rigour, Validity, Credibility, and Transferability

Suggesting that there are several ways to ensure validity and rigour of a grounded theory study Chiovitti and Piran (2003) include such factors as; clarity in the participant selection criteria and scope of the study and encouraging the participants in guiding the interview and checking the theory. Encompassing these factors also requires the acknowledgement of the researcher and what he/she brings and adds to the study (Chiovitti & Piran, 2003). These criteria were adhered to as this methodology/methods chapter evidences. Participation selection criteria were clear, and participants lead the way within the interview, were involved in theoretical sampling, member checking, and in seeing the fit of the final theory.

Other measures of validity, as explained by Glaser and Strauss (1967), included; the validity of the analysis, whether the study 'grabs or speaks' to the reader, providing an answer to the question, and whether the answer could be modified as new data appeared. Keeping these measures in mind I shared the theory with six participants and several people interested in the research, such as the Grounded Theory Group at AUT. All people responded that the processes involved in constructing the theory were valid and yes, the theory did speak to them, with comments such as "that makes so much sense" being very common. The question of how HCAs manage their very complex day was explained; however, the theory of managing the blurred domain was agreed to as

being more significant to this workforce. As to 'can this theory be adjusted as new data appears', that is in the future, and being of the pragmatist philosophy I believe so.

Cheryl Beck (2009) identified criteria to ascertain the credibility of qualitative research which included; trustworthiness, dependability, authenticity, and transferability, as the major factors to verify. Trustworthiness of the research is evidenced by the honesty in which the research was undertaken and the total commitment of both participants and myself. Many participants provided over an hour of their time for the interview and considerable time travelling. They then made themselves available for member checking. As to the trustworthiness of my research process; I adhered to the tenets of the methodology and employed the criteria of quality and ethics as pertaining to AUTEC requirements. Dependability and trustworthiness are similar and again the answer is evidenced by the honesty with which the participants answered my questions, at times revealing a depth of information that was unexpected. The participants consented to being available for theoretical sampling as well as member checking, assisting with the co-construction of the data underpinning the theory. Dependability is also demonstrated by the data/analysis and theory being fully explained and fitting with the audience.

Authenticity is about how legitimate and valid the research is, and, in my reality, this is a unique study providing a theory that is logical and fits within this and other contexts. Transferability is an interesting concept to assess and the most appropriate question to ascertain this is "if I apply this theory to a similar situation would it work, does it allow me to interpret, understand and predict phenomena?" If the answer is yes, then it can be seen as being reliable" (Chenitz & Swanson, 1986, p. 3). I believe the answer is yes, I can think of other occupations that work within a world of constant change such as ambulance officers, police, hospitality workers, and politicians, where

they are constantly working beyond the 'norm', and so too did the Grounded Theory Group, when presented with the theory.

The theory that has been constructed, together with the participants, meets the above criteria for validity, rigour, credibility, and transferability; with the major judge being the participants and the reader. Does this research explain to you how the HCA manages their working day? Do you agree that the HCA is continually weighing things up and then acting in response? Can this theory be applied to other situations? My participants answered yes. However more importantly, do you believe that the HCA works in a blurred domain? The participants' answered 'yes'. Is this a significant finding? My answer is yes.

Ethics approval

Ethical approval was granted by the Auckland University of Technology Ethics Committee (AUTEC) in September 2015 in fulfilment of the requirements to commence Doctor of Health Science. Reference number 15/309 (see Appendix A).

Ethics is both a requirement of the research organisation, in this instance AUTEC, and is implied within the methodology. Corbin and Strauss (2008) wrote that using pragmatism as a philosophical stance provides "the viewpoint that the individual is a thoughtful, purposeful, interacting being … and therefore points to the importance of treating participants and the data they provide with value, dignity, respect and confidentiality" (p. 28).

Treaty of Waitangi

The Treaty of Waitangi (1840) is the founding document of New Zealand as a nation and underpins all legislation, policies, and activities of New Zealand. Therefore, the three principles of the Treaty of Waitangi; partnership, participation, and protection are acknowledged and addressed within this research.

The Principle of Partnership was honoured and practiced throughout the research process and was evidenced by acknowledging the rights of the participants; for example, the right to be treated with courtesy, integrity and honesty, the right to withdraw, and the right to confidentiality.

The Principle of Participation was evidenced by the design and practice of this research being dependent on the participants feeling able to share experiences, views, and knowledge with myself, as the researcher, in an open and honest manner. I asked participants to converse with me for between 60-90 minutes in an environment perceived as safe to both the participant and myself. The participants provided consent for the interview to be digitally audio taped and were aware that they could stop the taping at any time, therefore having control of the process. I did not ask participants to inform or influence the nature of the research, its aims, or its methodology; however, participants were aware that I might return to them to ensure that my perception of the data collected was as the participant intended, which did occur. The final theory was also shared with all participants. The major role of the participants was the sharing of their knowledge and experience with the final role of providing feedback on the theory, called member checking.

The Principle of Protection of the participants was evidenced by ensuring that all information was provided in a language that was fully understood, and that there was opportunity to ask questions and voice concerns before committing to signing the consent form (see Appendix B). Any questions and concerns were answered and discussed with honesty and integrity. Confidentiality was important; as was the safety of the participant being able to choose the venue and the ability to opt into and out of the interview process.

The study was designed to pose minimal risks to the participants; however, there was the possibility that during the interview participants might become disturbed by

something they revealed. This possibility clearly explained along with information on where to go for assistance as part of the participant information sheet (see Appendix C).

Summary

Grounded theory is a popular methodology for explaining human behaviour in context, especially within nursing, because it is used to develop theories grounded from data collected from the substantive field. Grounded theory is, therefore, a valuable means of explaining behaviour as it pertains to health issues, environmental and situational challenges and changes (Munhall, 2012). As the question pertaining to this research involved explanation and was conducted within the defined context of ARC, grounded theory was an appropriate methodology to apply.

The use of grounded theory from a social constructionist paradigm, which acknowledges the 'wholeness' of the researcher, is very appropriate. I am a RN who has an intense interest in the care provided in aged care facilities. This interest stems from business, professional, and personal influences. The business involvement was associated with training of HCAs undertaken by my organisation, the professional aspect is concerned with the quality of care evidenced by HCAs, and the personal is witnessing the 'good deaths' of both parents in aged care facilities. The social constructionist methodology recognises the researcher's contribution, providing checks and balances ensuring that the researcher's perspective does not dominate nor influence the theory; however, it acknowledges the contribution of the researcher in an honest and transparent context.

The iterative nature of the analytical comparison, reflexivity, and member checking assisted the theory to develop from a robust methodology; and the support from the Grounded Theory Group of AUT has assisted in challenging my perceptions and the conceptual interpretations that I have developed. This group provided a check

on any undue subjectivity that I may have applied and assisted with developing the methodological skills that I required to develop the theory as to how the HCAs manage their work in ARC. More importantly, the support and constant conceptualisation assisted me to recognise that grounded theory allowed for construction of a more important category; 'working in a blurred domain' encouraging this to become the dominant theory and is introduced in the next chapter.

Chapter Four: Introducing the Theory

Introduction

> *"Even 10 years ago there wasn't this much paper work, we should leave it to the people who want to do the paperwork like the RNs and ENs and then we look after our residents."* (Lima)

This chapter introduces the theory of:

Working in a blurred domain: The health care assistant in aged residential care.

Working in the dynamic, complex environment of ARC, the participants in this study struggled to define their role and position. The role was reported as ill-defined, extending into the realm of the RN with the responsibilities blurring, dependant on employer and self-requirements. Compounding working in this blurred domain, was the need to respond to the resident who had multiple co-existing conditions and required palliative and/or dementia care. The environment was one of unpredictability due to the complex resident conditions, time, and resources. The HCA was at times cautious, protecting his/her own needs and working to task, learning how to balance the workload, and ultimately engaging self; learning to love the job and the residents. However, to enable the HCAs to manage the blurred domain, they were required to weigh up needs. The needs related to the residents, self, staff, the organisational expectations and were conditional on: time, support available, and the health of the resident.

I begin this chapter by providing an overview for the theory, introducing the concept of the *blurred domain* and explaining the environment in which the HCA worked. Next, I introduce the major strategy of *weighing up needs*, before overviewing the three categories of *protecting self, balancing the workload* and *engaging self* and the related subcategories of; protecting self physically, emotionally, financially, and

working to a system, working with others and providing caring, feeling responsible and being guided (as seen in Figure 6). I also introduce the three main conditions affecting the complexity of the HCAs' work: time, support and the residents' current conditions.
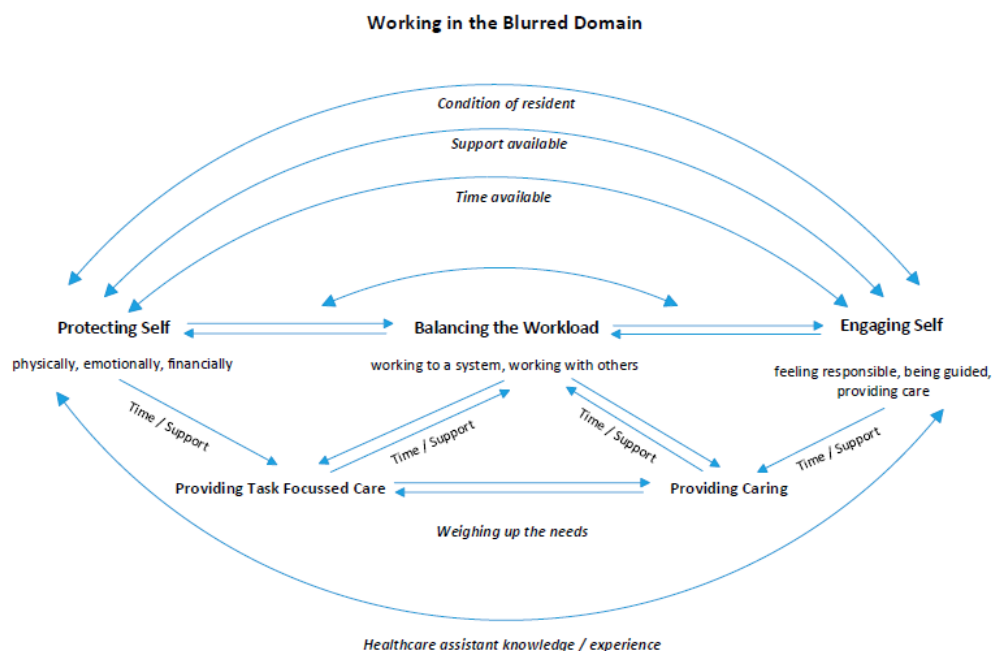
Figure 6: The theory of working in a blurred domain: The health care assistant in aged residential care

Overview of the Theory

Findings from this study explain the HCA moving between the three categories of protecting self, balancing the workload and engaging self, depending on the experience level of the HCA and on conditions at the time. The inexperienced HCA will stay within protecting self which encompasses the self physically, emotionally, and financially. The type of care offered here is task focussed with the HCA maintaining a relational distance from the resident whilst learning the new role. Once the HCA is reasonably comfortable in the role she/he will progress onto working out how to balance the workload and ultimately into a role where the self is engaging with, and providing caring for the resident, as well as engaging with other key people. At any time, the experienced HCA may move between these stages, with this movement being affected

by time and resources available, the residents' conditions and the HCAs' perception of where they need to be in relation to weighing up needs at that moment. Weighing up needs frequently results in HCAs extending their core role of providing essential care into areas outside of their job description and into the perceived work of the RN. I now introduce the blurred domain.

The blurred domain

The blurred domain was a concept that explained the confused boundaries within which the HCAs worked, often outside their job description and in response to a perceived need. The acknowledged role of the HCA had a core of required tasks and expectations, based around the provision of essential personal care to the resident, supporting his/her efforts in living and dying. However, the parameters of the role were constantly changing, with the HCA frequently extending into the domain of the RN, such as dressing complex wounds and providing medications (see Figure 7, p. 93). Choosing to do this, some HCAs regarded it as a way to further knowledge and qualifications, or they needed to protect the job because of employer expectations or they wanted to help the resident in the best way possible. The blurred domain has a poorly defined periphery and becomes even more confusing for the unregistered internationally qualified RN working as an HCA. These workers were already aware of the requirements of the RN role and easily moved into the periphery, knowing that they should not.

Narcotic administration

Physical assessment   Medical assessment   Cognitive assessment

'In charge'   Spritual support   Advocacy

Cleaning   Laundry   Kitchen   Petcare/Feeding

Staff delegation   Documentation   Staff training

Safety / Protection

Intravenous fluids   *Essential Care;*
                         nutritional,
                         continence,   Staff discipline
Dementia management   *Ambulatory,*
                         hygiene and
                         comfort   Meal preparation

Medication

Family support

Ostomy care   Laying out   Rehabilitation

Dressings   Exercises   Dialysis

Oxygen therapy   Emergency response

Indwelling catheter insertion and
care

Figure 7: The blurred domain

Regardless of being a migrant RN or not, HCAs reported that extension of the core role
was in response to both employer expectations and the HCA feeling a responsibility to
fill a perceived need. Extending and then retreating, moving in and out quietly or
obviously, depending on his/her interpretation of need for this movement, the HCA
worked in an environment that was unpredictable, chaotic, and at times unsafe.

> *"On the floor is total chaos at times. On morning shift it's really busy and the*
> *amount of residents each HCA gets is huge, 15 or 16. I'm worried about getting*
> *into trouble, I'm not that qualified, I'm doing ok but I've only got 3 years'*
> *experience but still really careful. Being in-charge, your mind is just*
> *everywhere, on what you are doing and what needs to be done."* (Mona)

Mona spoke of the in-charge role, the role given to a senior HCA replacing the RN when one was not available, or unable to assist. Although this was a recognised position within the facility, the role developed in response to work demands, with no supporting qualification, further blurring expectations. However, training and/or experience in areas such as medications and wound care enabled the HCA to extend the role, delivering a service previously allocated to the RN, stepping into the RN domain.

> *"If it's a good day for the RN then she will go and have a look, but if not, they will say they will follow it up later, tomorrow. But the dressing is green and, so I ask another RN to do it on the afternoon or if we have a HCA who is wound care competent then we will just do it."* (Liz)

Working in this complex situation, Liz weighed up needs associated with the green wound indicating infection, with the associated impact on the resident and the response of the RN. The RN had been approached and had not assisted; therefore, the HCA had to decide her response; whether to seek another RN or a competent HCA and just 'do it'. Responding to the conditions, the HCA used a strategy of by-passing the RN after weighing up the needs of the resident, and the probable RN response. Extending the role into the blurred domain, the HCA responded and fulfilled a need, complicating the already busy and complex working day. Extending the role, introduced further pressure on the HCA, physically, emotionally and at times placed the HCA at risk in other ways.

In the excerpt below Liz spoke of pressure to perform in an extended capacity, within the blurred domain, which resulted in the need to shortcut in other areas,

> *… "since they introduced that we can do medications and dressings it has put a lot of pressure on us – to perform to the expectations of management. They say you should be competent enough to do but it's not easy to learn. They think you should be able to do it well, but not really as you have the residents who refuse and the one who takes time and at the back of your mind you know you have residents to go back to. You are trying to do it the best you can, so this is the routine, so there are short cuts that we do to catch up on the care.*" (Liz)

Liz responded to pressure from management and thus an expectation of her job. She explained using a system that was now disrupted and having to instigate strategies to catch-up. The extended competencies were now considered a part of the job, with Liz working to protect self by doing as required, trying to rebalance the workload. Fitting the extended expectations into the existing workload led to shortcutting and rushing to complete resident needs.

Weighing up needs

Working in this complex and changing environment the HCA was required to weigh up needs and to consider such aspects as; consequences, possibilities, outcomes, interactions, as well as the relationships that were needed to fulfil the needs. The HCA would instigate strategies to protect self, balance workload or find time to provide caring. During the weighing up process HCAs were aiming to work to their own scope of practice, fulfilling needs in the best way possible to suit themselves, and consequently the resident.

Weighing up needs, the HCA evaluated conditions such as time and support available and considered the possible outcomes of the resultant actions, such as risk to the job. Weighing up needs was multi-faceted. The needs of the HCA and his/her family, the resident, other staff, and the organisation expectations, all came under consideration. The needs of the HCA and his/her family would ultimately take priority over any other needs, with the HCA devising strategies to ensure that consequences to the HCA and thus the family would be minimal.

> … *"sometimes I have to mentor new staff. I always make it clear that we are not supposed to wear gloves when showering or cleaning dentures, but I wear them I want to protect my family. So, if I get caught I will take responsibility and consequences. I had to make sure she understood and teach her right."* (Honey)

Remaining fearful for her job, Honey weighed up needs of self, family and the job, considering the possibility of taking infections home to her family. Responding to these considerations, Honey prioritised her family's safety over job security, deciding to hide when using gloves and going against the organisation's directives. Weighing up multiple conditions to ensure job security (protection of self financially), to protecting the health of self and family, Honey was also responsible for teaching the new staff member the requirements of the employer, regardless of the acceptability of the policy and the conflict this imposed. The explanation provided by Honey indicated that weighing up needs involved a range of considerations.

Knowing their residents, HCAs planned their day; however, in a working environment, pivoting around supporting vulnerable and frequently fragile people, nothing could be predetermined. The HCA would use the strategies of weighing up needs rapidly, accepting change was required and then responding quickly,

> *"I placed Mrs S on the shower seat, she is such a big lady. I had to shower Mrs T too and had to get Mrs R up as well. I had only just put Mrs S in the shower and she say she needs to go back to the toilet again, so I wrapped her up warm and took her back to the toilet. She's ok sitting there so I went and got Mrs T's clothes ready for her and spoke with Mrs R about her getting up. I handed her a nice warm cloth too because she likes having her face washed before she gets up and she enjoys a quick chat. Then I rushed back to Mrs S and she was finished, and I took her back to the shower again. She can wash most of herself, so I left her to do this while I went back and made her bed nice and found the necklace I knew she would want to wear today. I told Mrs T that we would be going soon and to think about anything else she wants done and asked her if she wanted to go to the toilet too? Mrs R wanted some hand cream and that was easy."* (Ann)

Ann knew she was working under time pressure and working to a system had strategies in place should a disruption occurred, which it did. This was common and quickly weighing up the conditions of time available and condition of the residents enabled Ann to complete multiple tasks, whilst providing caring; providing warm cloths, having the chat, anticipating personal preferences, going the extra mile.

'Working to a system' is a subcategory and explained a process of working methodically which evolved with experience.

"I work methodically so when a resident is done there is no need to go back into the room. They are washed, glasses cleaned, hearing aids out and washed, dentures are clean, they are in bed, warm, table close, rubbish bin emptied, it's done, then go onto the next one. Work smart then you don't rush them, but you get it done." (Lima)

As explained above, weighing up the needs of the resident was facilitated by knowing the resident and this often fostered a feeling of responsibility.

"We are looking after them and we are the ones to actually see what's going on. See their mood, behaviour, we notice if someone is quiet today and we enquire what's wrong and investigate." (Liz)

In this situation Liz explained how feeling responsible for the resident involved using her knowledge and intuition to assess the resident and then initiate a response. There was a sense of frustration, almost a justification, but also pride, that she, the HCA, was the one who facilitated this caring.

Weighing up needs included knowing when to ask for support from other staff. Usually the allocation of work enabled the HCA to work independently but there were times when the HCA required assistance. Should that assistance not be available, the HCA employed other strategies such as shortcutting and reverting to old practice or delaying the procedure. In the excerpt below Chris explained using shortcuts. Weighing up the conditions of time, resources and the needs of the resident, factoring in the requirement to protect self and the job, shortcuts were deemed necessary;

"Everybody must take shortcuts and that is wrong, it can hurt them and us, but we do it because we are stressed and must keep the job." (Chris)

I now overview the three major categories of the theory; *protecting self, balancing the workload* and *engaging self.* To manage the blurred domain the HCA reported using strategies to firstly protect self and, by inference protect the family, physically, emotionally and to protect finances, thus employment. Resulting from this protective

action was the provision of task focussed care instead of the caring that most HCAs would prefer to deliver. The new employee usually used protecting self; however, at times, the experienced one would also revert to this practice, conditional on perceived threats, time, and support available. Once the strategies of protection were learned, the HCA endeavoured to balance the workload, which promoted a harmony to working methodically and enabled the provision of caring rather than task focussed work providing caring.

Balancing the workload, participants used the strategies of working to a system and working with others. Achieving this was difficult for the workload was constantly changing; responses involved moving in and out of the blurred domain, however once achieving balance, the HCA was able to engage self, providing the caring that most HCAs aspired to. There were times during the working day when the HCA might move amongst all three categories; protecting self, balancing workload and engaging self (see Figure 6, p. 91). This movement is explained, beginning with protecting self.

Protecting self

Protecting self was the process by which HCAs weighed up needs, ultimately deciding to prioritise self. Self, in this instance, included family and considered risks pertaining to the physical, emotional, and financial aspects of self. Using strategies such as hiding or standing up for self, protecting self, included strategies such as working with others and shifting blame or focus onto another. Protecting self was the initial mode the new HCA entered, when focussed on learning the job and doing tasks correctly, thereby staying employed. Working within a blurred domain was not as common in this mode as the new HCA was not usually stepping beyond the core role unless they had some previous knowledge or experience; however, there were times when the experienced HCA did and because of this, needed to invoke protective strategies. Protecting self, had

one major consequence; providing task focused care which was in response to the perception of risk to self. I now explain protecting self physically, emotionally and financially before explaining providing task focussed care.

Protecting self physically

Working in the unpredictable ARC environment, the potential risk of harm to self was considered as high. This was in response to resident behaviour, especially when associated with dementia, or time constraints, limited staffing, and resourcing difficulties, as reported by Honey;

> *"We work in pairs when we need to use the hoist, but we will shortcut if we need to and use the old lifting. We are in a hurry, but risk losing the job. But there is cost cutting and not enough hoists, so really, we are helping management."*
> (Honey)

Using hoists was time consuming and labour intensive, both factors the HCA found difficult to manage. Wishing to avoid personal injury from moving the resident, the HCA weighed up time constraints, available support, and the resident mobility or current health and emotional status. Weighing up also considered; delaying the move, negotiating equipment, time taken to find assistance, using manual lifting techniques, risking injury, and assessing management responses. Strategies when support was not available, (equipment or personnel), were to go against policy and use manual lifting, while running the risk of having their employment terminated and injuring self, or delaying the move. Honey acted on the perception of being indirectly supported by management and thus not risking the job and self financially and choosing to ignore the risks to the physical self, reverted to manual techniques.

Such actions were not uncommon; however, some HCAs did report adhering to policy for fear of losing their jobs as explained by Fay;

> *… "we stick to the polices and won't get into trouble. Policies are your guide, they are used to protect you and residents."* (Fay)

Providing a guide to behaviour, policies were used to assist the HCA to weigh up risks with the HCA deciding to obey or ignore them. Honey ignored them; however, Fay did not, believing that adhering to policy was a protective strategy. Dilemmas such as these were reported to create stress in an environment rich with stressors. The unpredictable conditions of many of the residents and the grief associated with providing palliative care that was also the reality of this work, all contributed to a need to protect self emotionally.

Protecting self emotionally

Feeling stressed and over whelmed by the job was reported by many participants who used various strategies to protect self. At times the HCA was not permitted by the employer to work through his/her feelings, especially if those feelings were associated with grief. Those allowed to, were able to balance their working life more easily than those who were instructed to accept the death and get on with the next resident. This was not possible for the engaged HCA, with Beth explaining that she allowed concern for the resident to intrude into her own time;

> *"It worries me if someone doesn't eat – I go home and wonder if the person will be gone the next day."* (Beth)

Anticipating loss was a protective strategy, used by the HCA to prepare for imminent grief, however others turned off their emotions, blocking feeling. This strategy was used by those close to becoming unwell, or by those who did not wish to engage with the resident, as Olga reported;

> *"When I leave here I don't want to hear anything or think of anything. I have to turn it off, if I don't I get ill."* (Olga)

Protecting her emotional self, Olga compartmentalised work life from home life, having learned that she needed this division. Being able to withdraw self from the emotions of the job assisted the HCA to continue to work. At times this meant that the HCA was

providing essential tasks, rather than caring and this continued until the HCA felt he/she could re-engage, or they would leave. Most HCAs who reported the need to withdraw, to disengage perhaps, even episodically, did so to protect the emotional self but also to protect the job and thus the self financially.

Protecting self financially

At least half of the participants reported needing to protect self financially, and thereby doing anything required to keep their job. Striving to keep the job involved working difficult hours, sometimes two shifts in a day, working when ill if they could not find their own replacement, and using the strategies previously explained to protect self, including hiding, keeping quiet, and shifting focus onto another. Olga explained the pressure she experienced and aspects she considered during her weighing up;

> *"How can I go home and tell my family that I can't work there anymore? What would we do? So, I do as I am told. It is worse for the girls wanting the visa. They have it much worse*." (Olga)

Needing financial security, many of the participants reported accepting poor working conditions, and the additional stressors this brought to the day, rather than leaving work. Relying on the protection of working to a defined role within an employment contract was not a strategy normally applied by the HCAs, especially those who relied on the employer to endorse a Working Visa. The HCAs spoke of needing to please the employer, regardless of the request. They explained they were not able to change employers as they had no faith that another would employ them and thus they tolerated abuse and the associated fear, as explained by Ann and Honey:

> *"I was threatened that I would not get a job anywhere else and then they fired me."* (Ann)

> *"So, I'm afraid. I am still on work permit so I'm like being careful."* (Honey)

Being afraid was reported as a common emotion for all HCAs needing a Visa renewal; hence, thus those who needed to protect self financially would elevate this need above

the need to protect the emotional self. They would swallow the anger and fear and apply coping strategies previously discussed, especially hiding. When it was considered necessary, the HCA would extend the hiding and withdrawal strategies, attempting to protect self emotionally and offer essential care only, providing task focussed care.

Providing task focussed care

Protecting self, included restricting the self from engaging in caring such as when the HCA experienced emotional fatigue. In this situation, the HCA offered the resident task focussed care, often referred to as quantity care, rather than the more quality and caring focussed service, providing an opportunity to recover and eventually re-engage. Providing task focussed care also enabled the HCA to fulfil employer expectations thus protecting self by working to a level sufficient to ensure employment. Providing this type of care also kept the boundaries of the role from unintentionally extending as the HCA was not looking to fill gaps or offer extended nor engaged care;

> *"Some HCAs only work for the money, only do what they have to do, they give no passion, no love or care 'it hurts'."* (Inna)

Inna did not approve of the HCA delivering this restricted and task focussed care. Trying to resolve this situation, Inna reported instigating strategies to improve the quality of work of the HCA who provided the task focussed care. These strategies would vary from a frank personal discussion, raising the issue at team meetings, or trying to mentor the HCA. The results of this type of intervention usually lasted a short time, with the errant HCA soon reverting, withdrawing from providing the 'caring' component of the job, and shifting back into providing task focussed care as Inna explained*; "We talk to these HCAs which works for a short time and then they revert back. We try using praise, we keep encouraging but it doesn't last, they stop showing the caring."*

Inna said; 'They stopped showing the caring', which meant they were providing task focussed care, evidencing the work of the HCA not engaged with the resident. However, at times, it also became the working mode of those who had once been engaged. The retreating from and the withdrawing of caring was explained as a form of protection, particularly for those who had previously engaged a great deal of self and were now experiencing fatigue, as reported by Des;

> *"Some of us just give everything. Sometimes it is just too much. Then we need to rest and just do what we can. We need to just keep on going but not give so much love for a while. After a while we will give more, or we will leave and that will really hurt."* (Des)

Withdrawal was explained as a form of protection and remedial action. Using withdrawal as a protective strategy involved the HCA having to suppress wanting to care for, and provide love to the residents, hiding from involvement and even leaving their work.

Being engaged; giving of self emotionally and at times spiritually, the HCA was opening him/herself to experiencing harm. The most common harm spoken of was associated with the grief experienced with the passing of a resident that the HCA had grown to care about. Three participants spoke of the resident as substituting for a member of their family and thus intensifying the grief, see the example provided by Inna;

> *"It's like our dad or mum we are treating them like this other person. The resident I saw die wanted to be held and comforted. We all grieve, we all grieve that's why we're here, because we care."* (Inna)

Expressing the depth of caring of the engaged HCA, Inna was at risk of emotional harm which was the very opposite of the HCA who was there to simply do a job, and who did not see the resident as anything other than a means to an end. As Des stated, "*I had family pressures and had to do any job I could get.*" Eventually Des developed a passion for the work and people and changed from providing task focussed care to one

of being engaged and providing caring. This was explained as quite normal for those first entering this work as they concentrated on learning the job and protecting self.

Once comfortable, the HCA would evolve into entering the blurred domain, endeavouring to provide a balanced workload and providing caring.

> *"This is a hard job and I found it really hard to get my head around everything. I didn't really like the old people very much when I first started, I was scared. Now I love them, I love hugging them and looking after them, but it took me a while, but I needed this job anyway."* (Kate)

Being scared, as reported by Kate, triggered strategies associated with protection of self-focussing on the financial aspect of self. Once Kate gained sufficient experience she progressed into the more balanced mode of working and onto providing caring.

Balancing the workload

Balancing the workload includes working to a system and working with others; and provides further opportunities for the HCA to extend into the blurred domain. Balancing the workload enabled participants to provide the caring to which they aspired. The HCA was able to employ strategies suitable to working in the conditions that were present, especially in conditions poor in time and support. These strategies weighed up needs in relation to the constantly changing environment and the residents with complex conditions and were usually being considered in response to the processes of work. By weighing up these conditions, using the processes of work and knowing the residents, the HCA could work effectively, as explained by Penny;

> *"First thing in the morning we go around and ask some of the residents whether they want any help and if they say 'yes' we take them to the shower then bring them into the room and dress them, tidy up the room and make the bed. You need to look at the people you are going to look after, and you think about which one you are going to do first. Some are showered in the afternoon or if they have soiled. You need to be flexible and know how to operate the system."* (Penny)

Balancing the workload enabled the HCA to provide the caring to which he/she aspired.

It also aided the HCA to manage the blurred domain more effectively, assisting the

HCA to fulfil needs and extend the role as required; however, this required knowledge

of how to work to a system and that of working with others.

Working to a system

Working to a system was a strategy that evolved over time and explained the use of a

system or routine to help balance workload. This was most effective when the HCA

knew the resident, although this was not a necessity. The following excerpt explained

one system used by Penny.

> *"I want to finish all my work and I've got a piece of paper that I can put a tick
> with everything that I have done."* (Penny)

The checklist system was a manual form of ensuring tasks were completed. When the

checklist sequence was interrupted, the HCA could effectively return to the list and

carry on. An alternative system was based on knowing the residents and the work

involved, resulting in a system of practice achieved over time;

> *"I know the people who want to get up, have breakfast in the lounge, so I go to
> them first. Then, who wants to get up, then sit up the others, get them ready,
> trays in front. Then into dining room and deliver breakfasts, feed, tidy and then
> continue the care, try to do everyone by lunch time."* (Beth)

Knowing the routine well and having sufficient knowledge of her residents enabled

Beth to plan the initial morning's work. The rest of her system was based on the

conditions surrounding her residents and the response to these; they did not affect the

system but were built into it. If a situation developed that disrupted the plan, such as a

change in status of a resident, Beth would initiate other strategies, such as asking other

staff for help. Working with others was essential to balance the workload.

Working with others

Working with others was a combination of strategies used to assist balancing the workload and was often an important aspect of working to a system, one dependant on the other. Working in this dynamic, and at times physically challenging environment, the HCA relied on other HCAs and the RN to assist when the work could not or should not be carried out by one person. The HCA usually accessed the help of another HCA, who, although also overwhelmed with work, usually responded;

> *"We set a time to work together on the hard resident. There is compassion in the HCA, they are eager to help. The one who helps is the one you go to."* (Inna)

At times, the HCA needed the assistance of the RN who, for a number of reasons, was not always available. Alternatively, the HCA deliberately chose which RN to work with, as explained by Liz

> *"I chose to go to RNs I have rapport with, the ones we engage with. Others I won't go to as I think their work ethic is below professional standard."* (Liz)

This attitude arose from the HCA having assumed responsibility for and engaging in the care of the resident, thus enlisting the help of the RN was important. If there were difficulties with the RN, the HCA weighed up the options and instigated strategies. For example, selecting the most responsive RN, nagging the RN until the required response was obtained or bypassing the RN entirely, preferring to seek help from a senior HCA and, finally, just getting on with it. Working with others enabled the HCA to work to a system more effectively, assisting to balance the workload and therefore provide more opportunity for providing caring, the result of engaging self.

Engaging self

Engaging self, represented the third stage of working. The HCA could not achieve this until he/she had progressed beyond the need to continually protect self, had learnt how to balance the workload and could now find the means to provide the caring of the

experienced HCA. Engaging self was not limited to the experienced HCA, for the newer

HCA was able to move into this area for small periods of time. Engaging self was,

however, the chosen method of working for most participants, when conditions such as

time and resources permitted.

Engaging self explains the processes used by the HCA to achieve the 'caring' to

which the HCA aspired in his/her job. Engaging self, encapsulated the HCA who put

heart and soul into the work and who often referred to the resident using a familial term,

such as mum or dad. HCAs spoke of loving the resident and provided care that reflected

a genuine relationship.

> *"It's like your parents you know. So, I do get attached to them, I try not to but it's never easy to try to keep your work separate from just seeing them as something instead of seeing them as the people they are. They are living human beings, not furniture where you just come and wipe them and put them away, you look after them like your own family."* (Liz)

Getting attached to the resident, as reported by Liz, was an example of the HCA

engaging a part of self, trying not too but failing. Looking after the resident like 'your

own family' and the sense of outrage about others providing less than this type of caring

exemplified Liz as being an engaged HCA. Liz also spoke of residents being regarded

as furniture which was an example of an HCA who was not engaged, and who would

'wipe them and put them away'.

Feeling attached to the residents and providing caring epitomised the engaged

HCA. Such caring often extended into their own time and many participants reported

taking the job home.

> *"When I go home I go through my head and tick off each room. I might have forgotten to do something and will ring the night staff and tell them. Then I can go to sleep."* (Lima)

Engaging self includes: feeling responsible, being guided, and providing caring. The

HCAs sense of responsibility encompassed the resident, family, other staff, and the

organisation. This wide focus will be explained in Chapter 6; however, I will now introduce feeling responsible, as pertaining to the resident.

Feeling responsible

The HCA, whilst feeling responsible, could not assume responsibility as they knew this was the role of the RN and management. It was knowing this that often generated the anger and disappointment expressed by the HCA and provoked the HCA stepping into the RN role because he/she perceived a responsibility. Many HCAs spoke of feeling responsible both for the care of the resident (meeting physical needs) and caring about the resident (meeting emotional needs of both the resident and HCA).

They spoke of working into their own time, experiencing exhaustion, and thinking about the residents when at home. They did so because they felt responsible, because they believed this to be a part of their job;

> … *"I will catch up on the paper work, I have to stay back later because I made that choice to look after and find my client, but paper work is a legal requirement. I would hate for something to happen to my resident and I haven't completed the paper work. I couldn't rest easy.*" (Grant)

> … *"because that is my job, I look deep into my heart. They don't know what they are doing sometimes because they have dementia. I can't say I'm too tired, because once I take the job that is my responsibility, my passion to finish, I then thank God."* (Des)

Feeling a responsibility towards his client, Grant chose to stay into his own time, finishing the documentation required and thus fulfilling the responsibility. Des displayed strategies, such as a determination to respond, regardless of tiredness based upon a profound belief system and a responsibility to the resident. Des also spoke of thanking God; a common refrain, especially amongst the migrant HCAs. Invoking God explained a way of being guided.

Being guided

Being guided was a subcategory of engaging self and provided a strategy enabling the HCA to 'see the way' by following an intrinsic sense of direction. Engaging self, required a commitment of emotion, and 'heart' which some HCAs referred to as soul, this being especially so when the HCA had a spiritual basis to their life. Reporting a strong reliance on conscience and God, on karma and values, this spiritual investment was made easier if the HCA felt supported, as evidenced in the following excerpt from Fay.

> *"I go to work each day wondering who is still with us and I pray to my God and ask him to help me. He is my strength. I could not go against what I think is right. That would be going against my God."* (Fay)

HCAs also talked about using intuition, a sense of knowing, and experience; as highlighted by Beth:

> *"Before I do anything, I assess the condition of my resident, I might need to stop and watch and allow them time to settle. I speak to them and calm them, I know them and can tell when something is not right. I just know."* (Beth)

Being guided was an important concept that provided a form of reassurance to the HCA, especially when working in the blurred domain. At times, the employer/manager expected the HCA to step beyond the perceived boundaries of the HCA role, or the HCA would feel a responsibility to do so. In these instances, being guided was reported as being very important, and provided the support they required especially when aspiring to provide caring.

Providing caring

Providing caring went beyond fulfilling the daily tasks required by the resident, such as providing essential hygiene and nutritional care, and revealed how the HCA engaged with the resident. The engagement of self, included holding the resident's hand, gently touching, showing compassion, and genuinely sympathising and empathising with a

resident demonstrated caring. As the following quote reveals, providing caring entailed being engaged with the resident.

> *"It's really us the HCA who is doing the caring, who is engaged with the resident every day, we work here 6 times a week, we know them really well, better than the RN does."* (Inna) and
> *"We hold them, comfort them, wipe away their tears. It is us they rely on and us that knows them."* (Des)

Knowing the resident can only be achieved by being with that person for considerable time and in an intimate manner, and it was this knowledge that assisted the HCA in providing caring. Inna explained that knowing went beyond the capacity of the RN who, for many reasons, was distanced from the residents. However providing caring often consumed more time than simply completing tasks and required the HCA to balance the working day, factor in the conditions affecting the situations and strategise the opportunities to provide the level of caring that he/she desired. Providing caring depended on responding to various conditions including time and support available in relation to the condition of the resident.

Conditions

Caring was directly related to how the HCA managed the blurred domain, weighing up needs that were influenced by various conditions. Depending on these conditions the strategies employed would change as would the demeanour of the HCA. The HCA may become assertive, or the response may be subtle; manipulative or appearing submissive. Three major conditions influencing HCAs' strategies were time, support, and condition of the resident.

Time

Time affected the amount and quality caring able to be provided by the HCA, and this was influenced by other conditions such as the workload, availability of resources and

support, interruptions, values and guidance of the HCA, and the health of the HCA.

Describing the workload as being heavy, the HCA was allocated and responsible for large numbers of residents, many of whom were living with co-morbidities requiring intensive and extensive care. Having this workload required significant time as the residents needed a variety of support mechanisms as well as caring. Weighing up time required consideration of both the availability and accessibility of resources, as well as the support required to use them. For example, a hoist may be available, however located in another ward therefore requiring significant time to obtain it.

> *"Cost cutting meant insufficient amount of equipment promoting huge time wastage as staff went from floor to floor looking for it (hoists) and then we argue over who is going to use it. Then we need to get someone to help us, it's not easy to organise the hoist.*" (Kate)

As Kate revealed, using a hoist required time both for obtaining the equipment and then the negotiating skills and experience to recruit others' assistance.

Participants also spoke of using their own time to provide the caring that their values decreed:

> *"If no one is there I can do it by myself, but God is watching you know. We need to wait and be patient and calm and support the patient. I might need to stay in my tea break but that is okay."* (Des)

Time was a crucial variable for the HCA and waiting for assistance, Des used time to keep the resident calm. Using a shortcut was an option, however extending into own time was the chosen strategy and a common practice amongst the engaged HCAs. The above incident required support from another person, coordinating support and resources sufficient to meet the needs of the resident. These situations were reported to be challenging for the HCA.

Support

Reflecting the accessibility of resources, equipment and staff to help, obtaining support was reported to be time consuming and problematic. Having a colleague available to assist the HCA with a heavy physical task such as moving a resident was essential, and so too was having staff for the HCA to access when he/she was concerned about an issue;

> … "not all RNs are the same. I will go to the one I am most comfortable with when I have a problem, but if it's important, I go to the one most available. I try to look at in a professional manner if it has to be addressed now and not tomorrow. But if there's no response then I go higher." (Fay)

Choosing whom to approach was a commonly used strategy. When the RN was not responsive or was unsatisfactory the HCA would go higher or seek another RN; when neither was available the HCA would approach the in-charge or competent HCA. When this peer support was not available the HCA might go against policy and manage alone or wait until such times as support was available.

At times, and when feeling supported by the organisation, loyalty for that organisation would be offered by the HCA. Four participants spoke of assistance they had received from their organisation which went beyond the 'activity of working' including support for personal and family issues, as expressed by Fay and Honey;

> "The organisation is very supportive of the staff, we are lucky to be working here. They are even supportive of our families". (Fay) and

> "The organisation helped me with immigration, I owe everything to it. My dad was dying, and I really wanted to go home, and I was scared that immigration wouldn't let me back in, but my manager helped me. I owe them so much, but I was told no need to repay, they said; 'you come here every day to work and are doing a good job and that's enough for us'. I am so thankful to my organisation and I am loyal. Loyalty is in our culture." (Honey)

Support included emotional assistance as explained above; however, it more frequently involved access to equipment, with many of the participants reporting the lack of

equipment and the difficulty of access. Employing strategies of scheduling, bargaining for, and even commandeering equipment were explained as common practice;

> *"Cost cutting meant we didn't have enough equipment and we wasted huge time going from floor to floor looking for it (hoist). We used to steal it and then hide it, but the boss made us timetable the hoist, but when the client has to go to the toilet they have to go."* (Kate)

Timetabling the use of equipment implied that the resident needs were predictable which was not the situation at all. As Kate mentioned 'when the client has to go....'. This leads to the third major condition affecting the work of the HCA; the condition of the resident.

Condition of the resident

The residents' condition contributed significantly to the issues and needs the HCA was required to weigh up. Considering the resident's level of dependence on others was a major factor in managing workload with some being self-sufficient, requiring a little support, totally dependent, or needing extensive care. The residents cognitive abilities, whether they had dementia and/or were requiring end of life caring, were also factors of significance. Many participants spoke of the need for extra care when working with people living with dementia, care both for the resident and themselves:

> *... "you may be dealing with a challenging client, there is just not sufficient recognition in my organisation. They don't recognise the challenges that HCAs go through when dealing with mental and physical abuse because we are so concerned with resident's rights, but not ours. No advocacy for the HCAs at all."* (Grant)

Explaining many of the conditions the HCA must weigh up, Grant spoke of acknowledging the rights of the residents over the rights of the HCA, the physical and mental abuse the HCA would receive from the resident, and the lack of support provided to the HCA.

> *"It's not just the emotions we feel when we lose somebody but also when we are abused, hurt – we do the incident report, write up the challenging behaviours but we have swollen arms, busted shoulders and no one cares."* (Grant)

Despite the above, the HCA continued to manage his/her role whilst balancing a multitude of factors. Most HCA participants were constantly weighing up time, support, and resident needs, whilst endeavouring to provide the caring ultimately desired by all.

Summary

Working within an environment of complexity and change and in a poorly defined, blurred domain, the HCAs responded as they believed was appropriate, which included extending into the realm of the RN. This action was a result of the HCA feeling responsible, whether that feeling was inspired by the self or the organisation. Regardless, the HCA responded, weighing up needs and considering conditions such as time, support available and the condition of the resident. At times this response was aided by being guided by other HCAs or their own inherent belief system such as referencing God or Karma.

Feeling responsible to fulfil needs, the HCA at times protected self, a strategy used when the HCA was new to the workplace and still learning, wanting to protect the job and thus the finances. Protecting self was also used when threats to both physical and emotional safety were perceived. This was a category that the HCA would move in and out of each day, depending on conditions and responses required. Once the HCA achieved a feeling of safety, he/she endeavoured to balance the workload, working to a system and working with others when necessary. Working in a balanced mode also enabled engaging self, showing love and providing caring to the residents who most HCAs spoke of as family. At other times the HCA reported withdrawal from engaging self, feeling unbalanced and moving into protecting self. The HCA may also need to prioritise self, such as wearing gloves, whilst continuing to provide a balanced working

load and still being able to engage self, demonstrating a movement between all three categories. Protecting self is the first of the three categories and is more fully explained in Chapter Five.

CHAPTER FIVE: PROTECTING SELF

"I wanted to answer her back "it's your job…" but I can't. I don't have the right to say that. Like if only I could answer back, but I know if I answer back they will pick on me." (Honey)

Evoking images of a protective field around the person, hiding, waiting, and merging into the background or of taking up weapons to defend the self, *protecting self* was significant for all HCA participants. The participants in this study used strategies to protect self, albeit in differing ways. Initiated when danger or threat was perceived, protecting self was associated with physical, emotional, or financial harm. By inference the harm or threat may also have extended to the HCA's family, for if the HCA was exposed to this, so too might the members of the family. When evoking strategies for protecting self, the provision of providing caring to the resident was often withdrawn as the HCA usually focussed on task completion, no longer able to fully engage the self with the resident.

Protecting self was a strategy used throughout the day in response to various conditions and was also a strategy commonly used by the HCA entering employment. This was a time of learning and developing the knowledge and skills to feel safe, thus a time of working in a state of protective anxiety and watching for risk to self. It would take time to shift from a focus of protection, to one including balance of workload and engaging with the resident. Protecting self was not a strategy reserved only for the newly employed, experienced HCAs also reported using this strategy when he/she perceived risk. This risk may have been in the form of threat to self physically, emotionally, or financially. After weighing up the needs, the experienced HCA would shift to protecting self as required and once the threat was over, strive to regain a working balance, re-engage with the resident and manage the work as effectively as possible. Refer to Figure 8 (p. 117) for a depiction of the process *protecting self*.

Working in the Blurred Domain
Protecting self

Condition of resident

Support available

Time available

Protecting Self — Balancing the Workload — Engaging Self

physically, emotionally, financially

working to a system, working with others

feeling responsible, being guided, providing care

Time / Support

Time / Support

Time / Support

Time / Support

Providing Task Focussed Care — Providing Caring

Weighing up needs

Healthcare assistant knowledge / experience

Figure 8: Protecting self

This chapter explains protecting self; the response to the process of weighing up needs which includes managing risk and the strategies required to protect the self. Underpinning this category is the subcategory of providing task focussed care, a consequence of using protective strategies. Providing task focussed care was the act of completing essential tasks, such as showering; however, neglecting to imbue the tasks with the demonstration of caring. Completing these tasks, even on a basic level, the HCA ensured that the work was sufficient to maintain employment. I will now explain the category of protecting self with focus on the risks pertaining to the physical, emotional, and financial aspects of self.

Protecting Self from Physical Risk

Physical risk could occur at any time and included both direct harm to the body, and indirect such as that caused by a work-related infection, for example norovirus. In

addition, many of the participants explained physical abuse as being an accepted part of the job, as spoken of by Grant; "*we are abused, hurt, we do the incident report, write up the challenging behaviours but we have swollen arms, busted shoulders and no one care*". Documenting the incident was a policy requirement of the organisation and a form of protection for the HCA, ensuring the occasion and responses were clearly detailed. However, Grant's comment implied many incidents and many injuries, and significantly, the words 'no one care' indicated that the participant's perception was that management took these episodes as a normal aspect of the job. The HCAs, when working with distressed residents reported weighing up their own and the residents' needs, applying one or a combination of three strategies; work with another and distract the resident, calm the resident using something meaningful to them such as music, or withdraw from the situation and provide the resident time to become calm.

Lima explained her strategy for diffusing a tense situation;

"Over the years you gain experience and know what works best for you, being cheerful and using a sense of humour can make a difficult situation not so difficult." (Lima)

Requiring knowledge of the resident, as well as a confidence to implement it, this strategy had developed with experience. It was a not a strategy reported as being used by the newer and more inexperienced HCA, as it was a strategy employed in a high-risk situation and the newer HCA had not acquired the knowledge and skills required to implement it. In the following excerpt Inna expressed a possible retaliation on the resident; "*if they are hitting you, you cannot hit them back. You must be respectful to the older people because it is our culture. It is not acceptable to be aggressive in any way*". Of concern in this excerpt was the phrase 'not hitting back', with physical retaliation being an unacceptable strategy, implied as being occasionally used by others to protect self. Responding in a safe and a culturally respectful manner,

employing protective strategies such as the use of music, withdrawing self and diverting attention away from an issue were also reported.

Physical harm occurred in ways other than directly by the resident as Kate explained;

> *"The facility was backward, there was no equipment, no hoist. We had to use manual handling and there were too few staff. I got a painful back and ended up leaving."* (Kate).

Limited staff and resources were frequently reported as perceived consequences of cost cutting, with another example provided by Honey who explained a threat to herself that extended to her family;

> *"The place is cost cutting so we are told to only wear gloves when touching body fluids, so we wear them anyway and hide when we are cleaning the dentures. We have to protect ourselves and our families.... If it's a new resident, we don't know if they are safe or not and we still aren't meant to wear the gloves. So, we hide then too.*" (Honey)

Honey spoke of physically hiding when wearing gloves, who having weighed up needs and prioritising self, employed a protective strategy. Hiding, blending with others, being busy and not available were strategies frequently used.

Choosing whom to work with was another strategy that assisted with balancing workload but also as a form of protection. HCAs needed to be able to depend on each other for support, both physically and emotionally, as will be explained in Chapter 7. They also reported the need to trust the availability and reliability of their partner which was usually in response to the conditions of time and support, as reported by Chris;

> *"Staff are niggling over who to work with. It's in the culture. I choose my partner carefully, I need to trust them to have my back and they will be there.*" (Chris)

Choosing the partner, acknowledging a requirement for trust and a need to 'have my back', were strategies to protect the self from physical harm as well as the risk to emotional wellbeing.

Protecting Self from Emotional Harm

Emotional harm was reported as occurring in three ways; exposure to grief as related to the residents, bullying from colleagues, and extending the role into the blurred domain, creating stress within the job. Strategies to protect self were similar to those used above; withdrawal and hiding, and also included compromising values and initiating different response modes;

> "*We need to be strong mentally and physically, because suppose the patients die, we feel bad for a whole month.*" (Des).

Feeling bad increases with repetitive exposure to grief situations. It was reported by participants that few organisations provided opportunity to grieve effectively, with many of the HCAs relying on each other for support and on their personal coping mechanisms such as prayer.

Whilst death was an accepted aspect of working in ARC another stressor reported as being common was that of bullying. Protecting the emotional self was important for wellbeing and as this became compromised the HCA reported withdrawing into self, hiding, and staying quiet, contributing to providing task focussed care. The two examples below evidenced the strategies commonly used in response to bullying, in the ARC environment;

> "*We have a culture of bullying staff, happens everywhere. I come to work with a smile and I know it's going to go because they [the RN] will get to you. I will just keep to myself as much as possible.*" (Honey)

> "*In the beginning, I loved it but the constant barraging at you and people putting you down and telling you off in front of people. I put myself first now. I do what I need to do and keep my head down. I don't stand up for anyone, I stay quiet and I hide when I can.*" (Chris)

Putting the head down, being submissive, accepting humiliation and intimidation to protect the job were not strategies that promoted emotional wellbeing; however, one

was sacrificed for the other. In the excerpt below, Kate explains weighing up the areas of priority for her. Feeling undervalued, a feeling strong enough for her to consider ceasing work and leaving New Zealand, Kate prioritised her family needs over her emotional wellbeing;

> *"I feel so undervalued that I just want to go home, but I can't because my family is here. I struggled for years and then I changed jobs, but my family came first.*" (Kate)

As explained previously, hiding and withdrawal were common protective strategies effectively used when confrontation was not an option. Preferring to retreat, most HCAs did not have the confidence to stand up for their beliefs or position. There were also those who felt sufficiently valued and protected by the organisation that they felt confident to be more assertive, and at times confrontational:

> *"I asked the RN why do you get your pay? Why do you come here? I told the RN I was a senior care giver and I train other staff and I have never seen it done like that before. He told the boss to sack me, but I am senior, and they won't. I have been here a long time and I know what I am doing. I am more valuable than him, he doesn't know what he is doing.*" (Ann)

> *"It's harder for my team mates, for myself I am able to say to the RN, "I need you to do this right now." Many times, I've even had to say, "just listen to us and be quiet," but I need to do it because we know best and I just can't stand putting up with them looking down and being wrong."* (Grant)

In both incidents, the HCA explained a threat to safety of self; Ann had employment threatened and for Grant it was self-value; needing an urgent response that was not forthcoming. Both HCAs decided to speak out and no longer worked in the submissive manner; protecting self. This was a successful strategy for Ann and Grant, however confidence to confront and to turn down the employer/RN's request was uncommon, as Beth commented;

> *"They [RN] are requesting us to do medication, I refuse. That's the RN's job. One care giver is doing it, she pushed herself, she had too, but she's not trained, it's not fair."* (Beth)

Beth explained that although she refused to undertake a task, another HCA complied and, pushing herself, added further stress into the very complex day. Extending into the realm of the RN further blurred the HCA role and in this situation the HCA had not acquired the extra training to assist. Feeling pressure to extend the role was explained as being a common occurrence, with the HCA obliging the RN, protecting her job and therefore protecting the self financially.

Protecting Self Financially

At the time the data for this study were gathered, participants were not well remunerated, with several reporting working two jobs or enduring split shifts, agreeing to these conditions to ensure some degree of financial security. Therefore, knowing how to protect self financially was important, usually occurring in response to a perception of risk to employment. Originating from various sources including the RN, management and the residents, these perceived risks requiring the HCA to be constantly vigilant to anything that might possibly threaten financial security;

> *"The client has the right to complain so they do that on paper, every day we do them we must respect their rights, or they complain, and you get into trouble yourself."* (Ann)

> *"There is a resident's meeting once per month and they can complain about you."* (Chris)

Endeavouring to protect the self financially from the consequences of resident complaints, the HCA employed strategies that were a little different from those previously explained.

Not always needing to hide or acquiesce Lima explained that she worked carefully, choosing to do things she knew pleased the resident, albeit restricted by the condition of time. In the following excerpt Lima also spoke of another strategy, 'enticing' the resident, working to negate a situation;

"We try really hard to please them, but sometimes we just can't do it. If I have really upset one of them I go back when I can and might take a little hand cream or a nice biscuit with a cup of tea. I don't need a complaint against me." (Lima)

Complaints from the resident were reported as less frequent than those from colleagues. To protect their job and thus finances from the attention of the RN or management, the HCAs employed other strategies such as choosing whom to work with, and at times even ensuring a witness was present. The participants also reported trying to choose the role they worked in, either the senior in-charge role or lesser HCA role, obeying authority regardless of doubts, staying within policy, keeping quiet and documenting work to ensure protection. Depending on the context the HCA would, at times, employ more than one of these strategies such as using documentation and providing evidence (photo) which were obvious actions; yet, conversely, keeping verbally quiet. Employing another subtler strategy, involved shifting focus onto another person and a more obvious strategy, used as a last resort by the HCA was to enlist help from the union or the employment courts. I will explain these strategies in more detail.

Choosing who to work with was explained on page 119 within the context of protecting self from harm. It was also a strategy used to protect the self financially. Knowing that the HCA could rely on his/her partner if the RN was required and could not be accessed effectively necessitated a range of strategies to ensure financial security of the job. At times, the partner (HCA) would turn a blind eye to an activity, such as shortcutting a procedure or wearing gloves when the HCA was told not to. The partner supported the HCA to maintain his/her job, understanding that conditions such as time and resources impacted on the job.

Needing to work with the RN, was at times reported to be stressful. However, when the resident's condition required the RN's clinical expertise and knowledge and the HCA was required to 'obey', the HCA implemented strategies to add protection;

"I am happy to help the RN but sometimes she asks me to do things that I shouldn't, so I insist on supervision, like a witness that I am doing it right." (Ann)

Being asked to work outside of the norm contributed to working in the blurred domain and Joy helped to negate and clarify this by requesting supervision. Working in the blurred domain promoted stress if the HCA was not prepared or willing to accept it and the HCA was required to weigh up how far he/she wished to extend into this area. Working as a senior HCA and feeling unprepared for this responsibility was reported as a risk to the job and thus threat to financial security, with some participants explaining a preference to assume the lesser HCA role;

… "the team leaders are panicking in case they make a mistake. If they do they get spoken to and they are afraid they will lose their job. So, they get frantic and then they don't want to do those jobs anymore and don't want to work. It's a cycle. They would rather just do the care for the resident. They want to choose their job." (Liz)

In the above excerpt Liz spoke of panic which has an impact on the emotional wellbeing of the HCA, potentially affecting the financial security of the job. Prioritising protecting the finances could have a detrimental impact on protecting the emotional self and the HCA was required to weigh up the consequences of choice. Most participants explained that they chose financial security by putting strategies in place to decrease emotional risk, such as asking for support from another HCA. Many HCAs reported experiencing conflict between the two strategies of protecting self and protecting finances.

A similar example was provided by Kate who spoke of choosing to protect herself financially to the detriment of protecting her physical self. The primary strategy chosen was to obey direction;

"I was sick, and they told me to come into work and I was the only one medication competent. We are responsible for finding our own cover and it must be the same level, but they don't give us the phone numbers for the others. We work on work visa, so we can't complain, or we lose the job. … The migrant worker has no rights, we are not citizens, we just listen to the boss and do what the boss says." (Kate)

Kate spoke as a migrant worker; feeling pressured and treated unfairly, of needing a work permit and thus opting to stay quiet and doing as she was told to ensure financial protection. Not all workers were immigrants; however, many HCAs reported responding in the same way as Kate. Feeling intimidated and vulnerable, the HCA chose to protect financial security, responding by swallowing anger and just doing as told:

> … *"I had to complete the incident form on the spot. The admin staff are bullies. I had to just do what they said or lose the job."* (Chris)

> *"The RN demanded I stop what I was doing. I had already missed my lunch and I said, "I won't be long, I am rushing" but the RN demanded I stop and do her work because she wanted to finish for the day and go home."* (Nell)

> *"If the RN says, 'get them out of bed' then we have to do it to protect our job. We must do exactly what they say. We have to even when we know the resident and know it's wrong."* (Ann)

The first two excerpts directly affected the HCA and the response was one of acceptance, whereas Ann spoke of a situation that adversely impacted on the resident. Being in a difficult position and wanting to advocate for her resident, Ann weighed up needs, prioritising the job and protecting financial security over her values, doing as she was told.

Choosing to stay quiet was a commonly used strategy employed in a range of difficult situations;

> *"The RN is meant to do her job and I do mine, but she gave me a list to do of her work and I had to do it. I missed my breaks, but I had to do it and I can't complain because I need my job."* (Nell)

Being afraid of risking financial security the HCA chose to obey and act submissively. Acting submissively could been seen in the physical activity of the HCA, where he/she tried to blend in and become invisible as Honey reported, *"The RN will tell the other*

RNs and they will try to find something that I have done wrong and I will get fired. I am

afraid, so I stay small."

Working in conditions that promoted the HCA 'losing themselves', blending,

becoming small, is a further example of prioritising financial security over the

emotional wellbeing of the self and evidenced the HCA using a strategy that was easy to

apply. At other times, the HCA would choose to look externally for the solution and

access policy as protection. An example was provided by Nell who spoke of seeking

protection for her job by ensuring she did not blur her role and act outside of her scope,

staying within her competencies;

> *"I know my limits. Because I am not a RN I cannot administer medication not on their charts, give them an injection. I tell the RN, no."* (Nell)

Knowing how to use documentation was also a powerful strategy frequently

used by the participants;

> *"I have seen it when I have made a report and another HCA says that she has already reported it a few days ago. It's just too long. If you tell the RN on Monday have a look on Monday, don't wait until Thursday because it's too long and sometimes they are seriously ill by then you need to take action and I document it all."* (Liz)

> *"I often take the wound care chart to the RN and say, "this has been treated for 5 days and there is no RN signature on there." I fear this is dangerous for the HCA as our manager will say we are trained, but we aren't the RN. But I take this documentation to the RN and say, "go and look," but all she does is sign it. I am protected but my resident is not."* (Grant)

Trying unsuccessfully to advocate for the resident, Liz and Grant voiced concerns to the

RN who, in turn, ignored them. In each situation, the HCAs believed the resident was at

risk and questions may be asked of them and their role. Documentation was the only

protection.

Frequently the HCA would use an incident form, or, in some instances, forms

specifically used to keep a check on issues that might escalate, as reported by Grant.

> *"So, if I have a concern about the resident who is showing signs of infection I will do the dipstick, send off a sample. We have a form called a XXXX Form. We*

> *just tick off the boxes what our concerns are. It might be 3 days before the RN will go and look at the form, but we have done our bit. We are safe.*" (Grant)

Such forms were meant to be reviewed on a regular basis and provided evidence in a situation of misadventure, thereby protecting the HCA. However, forms also acted as a memory prompt, improving the situation and thereby used by the HCA in a constructive manner.

There were other ways of protecting finances, a subtler process which involved shifting focus from the HCA and reporting another colleague, usually the RN. Strategies reported included; ignoring, bypassing, intimidating and at times even 'dobbing in' the RN. Examples have been provided below from Kate and Nell who have protected their job and thus financial security by evidencing against another person.

> *"I write in the progress notes that I informed the RN because I did my part, so the RN will get into trouble not me."* (Kate)

> *"If the RN has left medication on the table I will pick it up and take it back and write up an incident form and report it. If the client is not too well later it won't be my fault."* (Nell)

Sometimes reporting another became a more thorough process than simply completing documentation and included producing hard evidence such as taking a photograph. Two HCAs reported using this as a means to protect their job, as Lima explained;

> *"I already took a photo of the drug the RN left on the table. She will get into trouble not me."* (Lima)

On a more serious occasion the HCA, already disturbed by actions and requirements from the RN, decided to weigh up consequences and became more strategic in her response. Unable to openly confront the RN, Honey opted to report a slightly lesser offence, decreasing the threat to her job, however still reporting an offence and minimising ramifications on herself;

> *"The RN will not ask for help from the nurse manager, she wants the HCA to sign out the control drugs all at once. Says it is better for time, but we know it's wrong, but we can't say anything. She can get away with it with us because we*

can't say anything because we are on visa. So, I reported the RN for leaving the
medication on the table." (Honey)

Reporting another member of staff was serious, with possible consequences on the HCA requiring support from outside agencies such as the union. This was a strategy of last resort, used when the HCA was in dire need to protect self and finances. It was a strategy used by three of the participants, with two examples provided below;

"I was threatened by the employers that I would not get a job anywhere else, so I took them to court. They damaged my name." (Ann)

"I was put on a personal improvement plan and the union came in for me." (Chris)

Both Ann and Chris reported occasions of what may have been perceived as providing poor care. They both had decided to withdraw or could not invest emotion or too much energy into the work involved and focussed only on the task.

"I get too tired now. I had a moon boot on and I still came to work, but I can't do the care. It's not my fault I can't do the care. I do what I can." (Ann)

This was called providing task focussed care.

Providing Task Focussed Care

Providing task focussed care involved undertaking essential care, such as showering, feeding, or helping the resident walk. There was no emotion involved, no sharing of the self. Providing task focussed care was conditional on time pressures and support available. It was also explained as the process of work that the new person entering into the role of HCA would employ, as reported by Ann.

... "they don't know anything yet. They are still learning and there's a lot to learn and to do and not a lot of time. No holding of the hand by the RN like there used to be. It's best they just get the job right and don't worry about the extra stuff yet. The nice stuff will come, if they want it to." (Ann)

Ann spoke of 'lots to learn' and limited time. However, providing the very basic care was also work that the experienced and engaged, caring HCA would sometimes resort

to, usually in response to time pressures. Thus, depending on conditions any HCA may have been reduced to providing essential care. Time was the major condition affecting the delivery of care and when time was limited or pressured the HCA reported rushing, cutting corners and reducing the caring to solely completing tasks.

> "*We have to cut costs, so we rush and cut corners and have no time to do the nice care. We just do the easiest way, the old way. We don't have time to do more. We do what has to be done.*" (Chris)

> "*Some HCAs are quantity orientated so they do as much as possible in a short time. They might revert to old ways and they take short cuts, no caring.*" (Fay)

Chris reported the pressure to perform, rather than encouraging the provision of 'nice care'. This pressure came from a senior person and emphasised task completion rather than caring. Chris and Fay both reported taking short cuts and reverting to old ways. The old ways were in place before equipment became commonly available and involved such processes as manually lifting the resident rather than using a hoist, which could be time consuming. Using old ways often involved going against policy and thus, in the excerpt below, Honey spoke of this as being a concern. However, she weighed up needs including time pressure, ramifications on employment due to ignoring policy and not meeting expectations of task completion.

> "*We work in pairs when we need to e.g. the hoist, but we do shortcut and don't do all the care because we are in a hurry. But we do risk losing the job, but we have to finish the tasks.*" (Honey)

In the weighing up on this occasion there was no mention of the needs of the resident. Working to this type of pressure and providing task focussed care meant residents' needs were not always the priority;

> "*It feels like we work in a time frame to finish the work, not thinking about the person only the work.*" (Liz)

> "*Sometimes they force the resident, so they can complete on time.*" (Joy)

Forcing the resident was reported to include rushing the resident to complete a task and may have involved physically moving them, pulling, or lifting them;

> *"I saw her forcing her arm into the cardigan. She twisted it and hurt her. She just needed to tell the old dear what she wanted to do, but no, she just pushed at her, always in a hurry."* (Beth)

Both Joy and Beth spoke of the disengaged HCA, who provided task focussed care; however, when engaged the HCA would do his/her best to respond to the condition of limited time. They worked to put strategies in place to allow for the delivery of more caring, albeit less than they would wish and still quite task orientated. These strategies would involve prioritising and grouping tasks, sometimes returning to the resident later.

> *"We have to divide tasks into time slots and we ask the resident what they want and prioritise the tasks and come back when we can."* (Joy)

> *… "sometimes we take short cuts in dressing the ladies, we don't put their makeup on, the finishing touches, and this saddens me. But we do not shortcut on the essential care. We do still think of them as mum and dad, we can't do everything, but I tried."* (Kate)

Wanting to use the more caring approach, Kate recognised that some services could not be offered, such as the makeup which she perceived to be significant to the resident. However, weighing up needs in relation to time pressures meant that task focussed care was prioritised. Acknowledging that there was a variance in time for the resident and the priorities of the HCA, Joy would try to find time to return to the resident to address this. In the excerpts below, both HCA's spoke of insufficient time to engage more fully with the resident;

> *"We do what we have too. No time to laugh and joke."* (Ann)

> *"We are always rushing in response to everyone and everything, bells and requests and time and so we try to prioritise and just work to keep people safe. There's just no time for the nice stuff."* (Liz)

Support made a significant difference to the type of care provided, making work easier for all. Without support and with little caring, the task focussed care from the HCA when prioritising self, could place the resident in danger of harm, as reported by Ann;

> *"We sometimes don't have a partner and I saw the other HCA just dragging the resident. She didn't care she hurt her, she is just for quantity, no care."* (Ann)

Summary

Many participants explained that they 'do what they need to do' which involved using strategies to protect self; physically and emotionally and/or to protect finances; and, in doing so, almost certainly provided task focussed care. This was not a satisfactory method of working for the majority of the HCAs involved in this research; however, at times retreating to this method of working was required. Strategies used by the HCA to counter factors that impinged on self compounded the feeling of vulnerability, such as the hiding and withdrawing into self and accepting intimidation. These were not the ways of the caring, engaged HCA; yet depending on circumstances the HCAs would move in and out of engaging self and providing caring, to providing task focussed care and using protective strategies. This movement was primarily in response to conditions of time and support as well as the HCA being inexperienced. Even the very new person, struggling to learn what was needed, could move into providing caring at times, albeit at a lesser degree than the experienced HCA. There were times when the very experienced, engaged HCA would initiate strategies of protection, however may still have had the capacity and capability to continue to provide engaged care.

Protecting self was about survival of the self, which included paying attention to emotional wellbeing, family, and financial protection. The conditions experienced by the HCA and the requirement to weigh up needs and protect self had the potential to influence responses to resident needs. To counter the resulting provision of task focussed work, the HCA needed to have sufficient confidence in his/her experience and

value to the organisation to enable him/her to stand up for self, advocating for both self and resident. These promoted conditions in which the HCA could find opportunity to provide caring, removing the need for imminent strategies of protection. It also enabled the HCA to work in a manner that, although, always keeping vigilant for the need to employ protective strategies, enabled the HCA to deliver a balanced workload and provide the caring to which he/she aspired. In the following chapter, the category of *balancing the workload* is explained.

CHAPTER SIX: BALANCING THE WORKLOAD

It is so hard sometimes. I try to stay calm and I have a plan I use and that helps me. I don't know how the others manage to get through it all, but then they don't seem to care much about the oldies. (Des)

Participants in this study strove to balance their workload, strategising to get their work done while maintaining a caring approach. To facilitate balancing the workload, the HCA used two dominant strategies; working to a system and working with others. Working to a system explains how the experienced HCA managed their work, preferably in a caring manner. Working with others was reported by participants as essential to assist with the physical and emotional demands of working in this environment, especially when the support of the RN was absent. Where once balancing the workload may have been as the result of the RN's direction, ensuring that all tasks were carried out correctly and appropriately, the data revealed that the RN behaviour was variable and thus the response by the HCA involved a combination of strategies. Liz commented,

> … *"several years ago, we did have a good RN. I just find if you have a good one who over looks [oversees] some things and allocates work, guides and steps in sometimes to help, it really makes the work flow. She would know if something was being neglected and would say it directly to the ones concerned. She would see the staff aren't slacking off and was there to support you if you were struggling."* (Liz)

In the absence of the RN leadership, having awareness of the needs of all, providing direction, stepping in to help, and ensuring the work flowed, were strategies put in place by most participants of this study. Getting through the day, working in a balanced manner was a result of working to a system, and occurred from the experience and knowledge of the HCA.

Balancing the workload (as depicted in Figure 9, p. 134) was more effectively achieved when the HCA had knowledge of the residents' condition and requirements, enabling an efficiency and quickness in weighing up needs and decision making.

Experience in the vocation, leading to an understanding of the most efficient use of skills, resources and time management strategies, assisted the HCA to balance the workload. Combining the two, knowing the resident and knowing the work, assisted the HCA to plan and respond to situations, ensuring that the important aspects of providing caring were not sacrificed in responding to the conditions of time and support. Unfortunately, there were occasions when these conditions impacted sufficiently that maintaining any semblance of balance to the workload required the HCA to minimise some aspects of providing caring, and even shifting into using protective strategies.
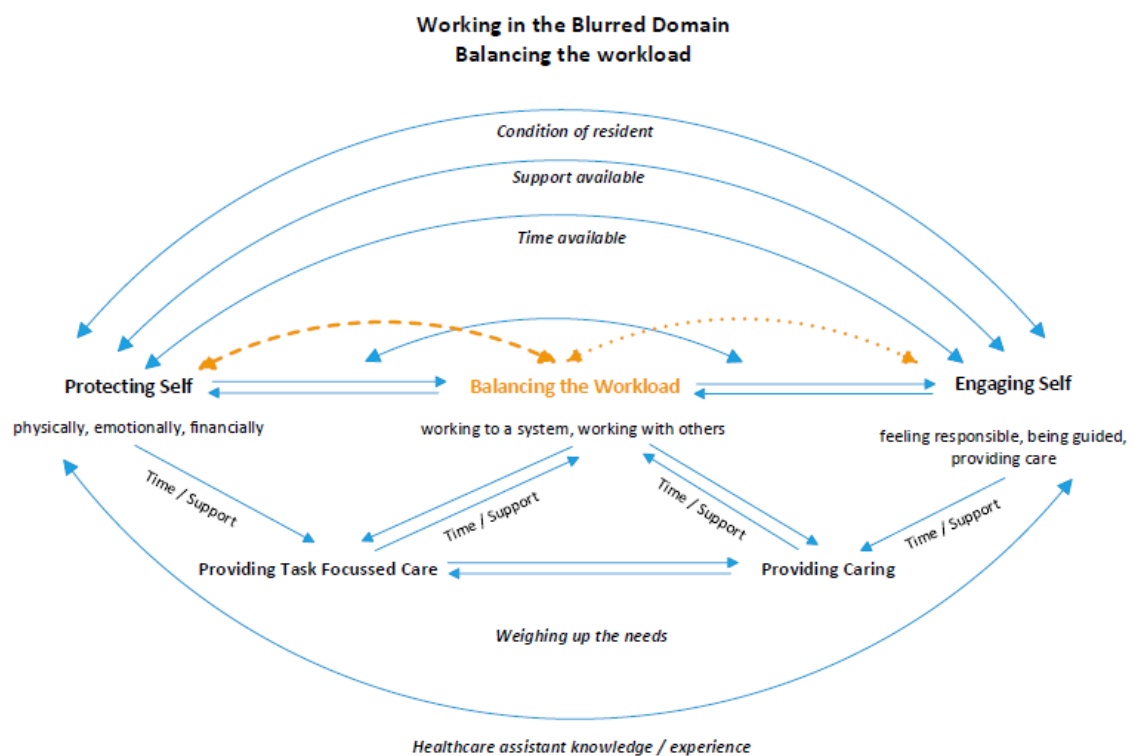
Figure 9: Balancing the workload

Participants also reported using a strategy of shifting their work plan and completing the caring that had been sacrificed earlier by working into their own time and working towards a more engaged mode of service; … "*sometimes I don't have a break and I need to make sure the residents are finished before I go home.*" (Penny)

Strategising to shift the work around enabled the HCA to feel balanced in his/her work approach and realise that anything minimised or not completed could be achieved at a later time. This ability to organise the workload also meant that achieving a complete balance was not necessary and, at times, would be very difficult to accomplish within the environment. Understanding the complexity of the working day, from the participants' perception, will now be explained in more depth.

Working one of three 8-hour shifts within a rest home, hospital or a dementia care unit was the normal and legal time period, albeit this did not always occur, as reported by Kate; … "*in the weekends we get paid time and half and if we do double shifts we get an extra allowance. But other places don't do this at all they pay just normal pay.*" The hours were important, impacting significantly on the working conditions and the responses from the HCA; however, so too was the nature of the work, for example rest home or the higher level of dementia care.

The rest home environment which meant for those residents with some independence, would also at times accommodate those who required more extensive care associated with hospital or dementia care. This confusion of resident allocation complicated the work required on all shifts, with certain care being specific to each resident 'type'. Regardless of the resident care requirements, participants reported morning shift to be noisy, with many people involved in a multitude of interactions. Predominantly health related these workers included; language therapists, physiotherapists, podiatrists, diversional therapists, the GP, and at times x-ray and laboratory personnel. Participants reported other people on site to include the administration and management personnel, as well as family and friends visiting. Representatives from the local church and community organisations provided more distractions to an already complex working day. Interactions amongst the staff were

135

explained as busy and time consuming, with HCAs interfacing with many of these people, as well as occasionally escorting residents offsite to various appointments.

Morning shift was reported as a time that included housekeeping, laundry, meals, maintenance, gardening, and the hairdresser. During the following two shifts decline in personnel, distractions, and noise was explained by Lima, who stated "*we get to do our own thing without interruptions, without heaps of people around and it probably suits the residents better – less noise and movement than on morning shift.*" Morning shift would normally have a RN on site; however, if it was a rest home, the RN may only be contactable via phone. Participants reported afternoon and night shifts rarely having a RN; being replaced with an experienced HCA.

Regardless of the time of day, the shifts began with a handover where the outgoing staff informed the oncoming of residents' conditions, as well as care that was required and anything else of interest. During handover HCAs were assigned residents and any extra tasks. Following discussion with their partner, the HCAs would plan the care required. Allocating the rooms, identifying the residents who required two people to assist, and how they were going to get through the shift the best way possible, was explained by Beth:

> "*I work my way from handover, talking through the rooms one by one with my partner, then we decide who's doing what, when we need to work in pairs.*"
> (Beth)

HCAs reported their resident allocation as being heavy, five to eight residents on a busy morning shift, regardless of the category of care required, and up to 12 residents on the afternoon shift. Providing an explanation of the start of a typical morning shift was Chris;

> "*Handover is from 0700-0715, we split into hospital a and b with five caregivers to 30 patients. These are split into 3 teams with the most patients you get being 8. Two members of the team do the breakfast, go into the kitchen and bring the hot trolleys, the trays are set up on them already by night staff. Second*

136

team sit the patients up, put feeders on, and then we start to hand out the food and start the feeds." (Chris)

Invoking a system well established to balancing workload; sharing of duties, working in teams, and coordinating tasks, including those not related to direct resident care, the HCA progressed through the work, providing caring to multiple residents.

Unlike the morning shift, the night shift involved fewer interactions and disturbances and thus there would often be one HCA to 20 or more residents, with access to an HCA in another unit. Participants reported difficulties working under the assumption that disturbances would be fewer on the night shift, for when they did occur there were insufficient HCAs to enable a safe and effective response. At these times the balance of the workload was adversely affected, and the HCAs explained weighing up needs, shifting their plan and cutting out work. Being asked to assist outside their unit the HCAs reported discomfort, of not knowing the residents and concern over resident safety. Working out of balance was common in this complex environment, as was responding to a multitude of influences. Achieving or working towards a balanced workload required strategies and robust processes to be in place and these are represented in the two subcategories underpinning the category of balancing the workload. These two subcategories and dominant strategies, as reported earlier are; *working to a system* and *working with others* and are now explained.

Working to a System

Enabling the HCA to balance the workload required strategies which will be explained throughout this chapter. Working to a system was one of the strategies used to balance the workload and enable the HCA to provide care to several frail and end-of-life residents whilst responding to multiple contingencies effectively and efficiently as possible. Learning the ropes was the first stage of working to a system, leading onto

working with others, preplanning, thinking it through, delegating tasks, and reflecting on the working day.

Using checklists, making notes as memory joggers, and drawing on experience to inform one's work assisted working to a system. Using their personal system, the experienced HCA would think things through and, at the same time, adapt to changing conditions;

> *"When you get interrupted by an emergency you write it down where you were stopped, deal with the emergency; phone the ambulance, phone the family, write the report and paper work etc., and then go back to what you were doing."*
> (Nell)

Reporting how many HCAs explained managing their work, Nell spoke of adapting to multiple stimuli and employing many processes including the overarching strategies of 'thinking it through' and working to a system. In this instance working to a system included recording the interrupted activity, completing tasks associated with the emergency, and resuming the preceding work when able. Dealing with the emergency involved the processes of decision making, communication, team work, delegation, documentation, and time management. The HCA's flexibility to respond effectively to an unexpected situation came from experience of the facility, knowledge of the resident, ability to work with others and efficient use of time and resources. As Liz commented,

> *"Everyone knows what their workload is and know how the routines go and know their residents well – help they need with care, so they share workload when things get a bit hard and help their partner and level the load."*

When placed in a new area the experienced HCA had sufficient general knowledge of work place skills to help compensate for not knowing the resident.

Knowing the resident did, however, facilitate an ease into the workload as the HCA was able to pre-empt some requirements and plan more thoroughly. Easing into the workload helped promote a calmness both for the HCA and resident, assisting the

HCA to implement the system more effectively and maintaining the balance that the calmness had generated, as shared by Lima;

> *"I just gently go in and fold the bed down and say hi sweetie I'm back today, that's my way of working into the room."* (Lima)

Lima was an experienced HCA, knowing how to put strategies in place to effectively begin the working day. This was not so for the beginner HCA.

Learning the ropes was the first step in developing the skill the beginner needed to balance the workload, as explained by Beth;

> *"At the beginning, I didn't even know where to start, where I was going, who I should do? I had no idea, no method, no experience. I looked for the easy ones and tried to not do the hard ones. So, then I set a goal, I don't look for the easy ones anymore, I just had to go there and do what I had to do – my goal was like a plan. I learnt about the work and now I can do it, my plan is better."* (Beth)

Speaking of her experience and unease of working as a new HCA, Beth explained her confusion and the initial decision to 'do the easy ones'. With a little more confidence Beth revised this decision and spoke of gaining more experience, developing a system, accepting any level of resident needs, and working through their requirements.

Balancing the workload was difficult to realise until the HCA had sufficient experience to develop his/her own working system as explained by Grant:

> *"You need to know the floor plan, where everything is kept, who your allocated people are, where they are, what's wrong with them, how mobile they are, what do they need like the hoist. You need to know all the rules and the paper work is just dreadful. Even knowing what they should eat is hard let alone how they like their cup of tea. There are so many to do too, it's hard to remember them all. I have to work out who to do first and when I need help and then my partner is always busy. You can't win until you have worked for a long while and then you start to get a plan."* (Grant)

Learning the ropes was not easy; participants spoke of needing to know the organisation including the layout, resources, and policy, of knowing the residents and their preferences, of struggling to remember and trying to make order of what seemed insurmountable information. Feelings of almost despair were reported by the

participants, including Grant as above, and this did not resolve until sufficient experience was gained to enable the development of a system, providing direction to the day. The development of a system evolved, promoting a little more time for providing the caring to which the participants aspired.

For some HCAs, working to the system included planning prior to entering the workplace. The HCA who knew the clients and workload, and worked using a system, would have already formulated a plan; adapting it after the initial checking of the residents;

> *"I enter the room and say, 'hello my lovely, how are you?' And I can gauge immediately who has had a bad night and who needs that extra time. I do this in each room, opening the curtains and checking each one and then I know who I need to start with and who needs more time in bed. My routine is much the same, it's just who gets done when, and who needs that bit more time that changes. Every now and then during the day something will happen, someone will fall, you know, but we cope."* (Ann)

Varying mainly by the requirements of the resident, participants reported a routine that responded to who wanted what, when and to what degree. Time was allocated within the system to ensure that all residents would receive the caring required. In the above excerpt Ann spoke in her role as an HCA; however, when HCAs worked as senior or in-charge their day was different.

> *"I start the day with a plan, after night shift handover I discuss this with the RN as to what to do first. Usually for me it is the controlled drugs because they need medication before breakfast, stuff like that."* (Nell)

Planning before work was reported as common amongst the senior/experienced HCAs, with discussion occurring to construct the best working system. The tasks that Nell completed as a senior were at a higher level than the other HCAs, more in line with assisting the RN, rather than working closely with the residents. Distancing from the resident, as explained by Mona in the following excerpt, produced conflicting emotions;

pride in the level of work involving more clinical tasks, but guilt in the perceived lack of opportunity to provide caring for the resident.

> *"It feels good being in-charge – you are a level up. In other ways being a caregiver and helping a resident feels much better. If you are in-charge and a resident needs something and you don't have time then you feel guilty."* (Mona)

Being task focussed the senior HCA established a system associated with the completion of tasks, with interruptions to this system being minimised as it was accepted practice that the HCA would assist the senior HCA;

> *"The senior is a level away from the resident, they do the important tasks. We help them when they are busy, and they try to help us."* (Olga)

Accepting delegation from one of their own, the HCAs would revise their working system to fit the requirements, responding to the change of time now available to complete their own work. They simply rebalanced their load by weighing up needs; omitting some tasks, withholding aspects of caring that required time, working faster and smarter, working into their own time, and asking others to help. Rebalancing by initiating these strategies would mean providing more task focussed care until balance was attained and engaged caring could once more take place. Amongst these strategies, working with others was essential and a pivotal aspect of working to a system.

Working with Others

Working with others included; cooperation, a mutual understanding of requirements or, at the very least, the ability of another to respond to direction and provide assistance. In an environment where working with others was crucial to facilitate certain aspects of work, lack of assistance meant that various tasks would not be completed safely, if at all. Under the conditions of time and resource constraints, working with others was a strategy to complement working to a system and thus balance the workload.

Working with others, as explained in Chapter Four, meant selecting the person the HCA worked with, which in turn was influenced by the needs of the situation; for example, was it an activity that the HCA could assist with or did it require the RN? The situation often dictated from whom the HCA sought assistance and there were times when the clinical needs outweighed personal choice.

> *"Not all RNs are the same. I will go to the one I am most comfortable with, but if it's important I go to the one most available – I try to look at in a professional manner if it has to be addressed now and not tomorrow but if no response then I go higher."* (Fay)

> *"I go to someone I know will take action, who doesn't muck around. They do it in a subtle way without actually advertising themselves or making a big show of it. I think you know the nurses who can do it and you build a good rapport with them."* (Liz)

Trusting that the RN would respond, and do so quickly and professionally, the HCA did report having other strategies in place should this not be so. Both Fay and Liz were mindful that there were RNs who would either not respond or would create tension when doing so, thus choosing the RN, reporting the RN and bypassing the RN to work with another HCA were strategies employed. Deciding whether to access the RN or, alternatively, work with the HCA was often based on experience, as Fay suggested in this comparison between the RN and HCA;

> ... *"RNs are more on the clinical part of the care. So that is they are inside the box. So, everything is specific, done according to how it should be done. An HCA is more about the quality of care. So that is where conflict comes. The RN's view is different to the HCA's. Because they are so much on the clinical part and the HCA is on the wellbeing of the client. I wanted to be the first RN with the perspective of the HCA (did 1-year RN training)."* (Fay)

Needing to work with the RN when clinical needs arose, participants reported the perception that a higher standard of caring would be provided by the HCA. Supporting Fay's explanation, Grant explained how the RN prioritised clinical, and at times administrative needs before the wellbeing of the resident:

... "the HCAs know when to ask the RN for help and when to do it ourselves –
we look at the situation of the RN and if they are really busy (with paper work or
drugs) then the HCA will do that responsibility." (Grant)

Providing the clinical tasks, or even a clinical assessment that was once thought of

solely as the domain of the RN, the participants reported seeking the assistance of

another HCA, bypassing the RN. Explaining this as common practice is the excerpt

from Inna; *"we really try to manage by ourselves with the other HCAs, we try to not ask*

for help from the RN". Liz reported the HCA as replacing or standing in for the RN;

"sometimes the senior HCA doing the RN work will come and help out and balance the

workload, if you got a good team it works well, if not – well oh okay. Carry on and do

your best."

Achieving a workload balance, using a system, and working together were

strategies of the work process with many aspects of these involving the RN. Working

with the RN, the HCA stood beside and assisted, sometimes mentoring her/him and at

times stepping into the place of the RN, sharing the load;

"I can help the nurse sort out the medication. I found the nurse is always busy
all the time." (Joy)

"I will give it [enema] I want to help the nurse with her workload but bear in
mind it's not my job. Helping so that everyone gets to finish and relax a bit."
(Chris)

Working against the RN occurred when the HCA felt that the RN would not or could

not supply the assistance required, could not be relied upon, or there was a difference in

personalities. Invariably using documentation, the deficiencies of the RN's practice

were evidenced. When the decision was made to avoid or bypass the RN other HCAs

were required for assistance, thus affecting their workload balance. Responding to this,

the other HCAs employed strategies to mitigate issues and adjusted their working

system. Shortcutting procedures, which was not the preferred option, working harder

and faster, working into their own time, and sharing the load with another HCA who,

perhaps, was able to adapt their working system to help, were strategies used to once again strive towards achieving balance;

… "choosing what to do because you are so exhausted from rushing and passing the rest on." (Nell)

Requiring help, working with another HCA was the preferred option with the HCAs reporting feeling more comfortable working together and more confident of receiving assistance. However, asking for help, even from HCAs, could not always be taken for granted and relationships needed to be established.

> *… "as long as the HCAs have a good relationship it's okay, they help each other willingly."* (Inna)

Not all HCAs were happy working with others, begrudging time away from their own tasks and forgetting or ignoring the fact that they too would require the assistance of another at some time. These HCAs were usually the ones reported as being withdrawn and protecting self, as explained in Chapter Five. Their focus was on ensuring tasks were finished rather than trying to find time to provide caring. Balancing the workload for these HCAs was only required to ensure that the day's allocation of tasks was completed, as explained by Inna;

> *… "and helping each other to catch up. Some staff don't care as long as they finish their job, they will not volunteer to help, but others will."* (Inna)

Being aware of those who would not help, the HCAs would endeavour to avoid working with them, or try to encourage them to help, as explained by Beth;

> *"We share our load, working individually and then come together to work on the more difficult resident. If one of us gets behind, then the other tries to help. Sometimes we have the HCA who does not want to help, we try to work with them, give them the residents who won't need help, or we talk to them and encourage them to help. Sometimes it is just no good and, so we ignore them [HCA]."* (Beth)

Responding in similar ways as they do to the unresponsive RN, the HCAs had strategies in place to cope with the HCA who did not contribute. Such strategies included the decision to ignore, bypass, or at times encourage them to change:

"If we look at the reason we are here to work and how we can work together for everyone whether it's residents, medications, care, even ourselves, work out our relationship so we don't always have these niggles." (Liz)

Encouraging change or working on 'niggles', promoting a more effective working environment and enabling working together, demonstrated a feeling of responsibility for the cohesiveness of all concerned. At times, the HCA was simply overwhelmed;

"If my partner is not managing well then that's when I help; help them think it through and work with them, let's do it together." (Ann)

Identifying a situation or responding to a request for help, Ann worked alongside her colleague, supporting the HCA physically, emotionally, and sharing her system of working. Working with and training the new migrant RNs was also reported.

… "with the influx of new migrants there a whole change in the way the work ethics were. Pretty much needed to be told what to do as they didn't know. A lot had never worked with elderly and where they came from there was no such thing as residential care, or home care. They didn't know about or had been with dying, didn't know what to do. Maybe it's no part of their culture. Whole lot of things they needed to learn and understand, and we help and they like us." (Liz)

Discussing working with the migrant RNs, the HCA was explaining the perceived deficiencies of the RN; the lack of experience, lack of awareness. Helping to integrate the new RN into the ARC environment benefitted the HCA as the RN then worked alongside the HCA, not knowing any other system. Working with the HCA ensured a reciprocity, with the RN receiving assistance and support from the HCA resulting in both of them being able to balance their workloads;

… "the RN can't do everything by herself, she is very busy, so as a HCA I need to stand beside her and I need to help her, especially when she helps me too. Such as doing a dressing, I hold the patient and help her to finish the task and

when she is struggling with the drugs I can help her. When I ask her to check things then I know she will come. I don't do this for all of them though." (Des)

The support of the RN frequently relied on the HCA believing there was cooperation between the two roles. If not, the HCA would withdraw from assistance, hide when able and becoming obstructive, and even documenting questionable behaviour of the RN.

"Sometimes we just can't stand it anymore and we refuse to help anymore and document the RN, she is just lazy." (Liz)

Instructing others to not comply was another strategy; "*Sometimes with the agency staff they leave the medication on the tray and I tell the HCA not to give* it." (Honey)

At other times the HCA would seek to assist the RN, perceiving this as an aspect of his/her role; however, this was reported as being misinterpreted by the RN and thus working together became a challenge, as explained by Inna;

… "sometimes the RN is newly graduated and the HCA who was a RN may be seen as a challenge. The HCA who offers advice may have this taken negatively, because they are just HCAs." (Inna)

Feeling conflicted about the role, the HCA who was an international qualified RN but unable to register in New Zealand often held a senior HCA role and reported feeling unsure both about the role and how to work with others. Frequently being allocated the role of senior HCA on the shift and at times replacing the RN, meant assuming a responsibility very closely aligned to that of the RN role for which they were not officially recognised. They were required to plan, delegate, support, and work closely with others whilst providing clinical care. Having previously been a RN and working in a senior role, offering support to the new RN and having this received negatively added confusion and complexity to the working relationship.

Working with the RN may have meant simply responding to feedback, taking direction and completing instructions the RN had provided, as reported below;

"Sometimes RNs just do the medication, so if a patient is complaining of pain I will inform the RN. They will come and check the patient, give them pain relief,

check vitals, tell me what to do and just go away. I am responsible to check they are feeling more comfortable, if the medication has worked, that is my task." (Des)

… "*some RNs will assess the resident and then come back and talk with the HCA tell the plan of action and the HCA carries it out.*" (Liz)

Working together as perceived by most HCAs meant standing beside, supporting and consulting each other, rather than working in the more submissive role of 'doing as told'. Preferring to act collaboratively, offering support, and physically working together was considered a normal function of the HCA, regardless of the level of the role. In the excerpt below Liz spoke of an HCA helping a senior HCA:

"*If a team leader isn't concentrating too well, I said do what you need to do, and we will do this. They do panic a lot of them. Just concentrate on the medications and we will do the rest.*" (Liz)

Stepping in to provide support, reassurance and organising the rest, enabled the team leader a chance to catch up, rebalance him/herself and his/her load. Helping was regarded as expected practice, especially in times of difficulties; "*if things don't go well you just have to carry on and others will help to balance the load*" (Nell) and Ann commented, "*if we have an incident that needs more than one of us we work together and then go back to our own work.*"

Stepping in to help was reported as essential when staffing numbers were low and risk to others was high. It was also necessary when there were new staff. As previously explained, the ARC environment was bewildering for the person with no prior knowledge.

"*Being new or in a new area, or with a new resident is hard. I have to ask colleagues what to do. Sometimes I need them to help out a bit.*" (Joy)

Asking for help was often a very considered strategy as the HCA was aware that this request would disrupt another's ability of working to his/her system. Fortunately, as disruptions of this nature were common, the HCA had strategies built into the system to

assist, such as delegating some of his/her workload, reprioritising tasks, taking short cuts and working into own time. An example of this was provided by Joy who explained that when "*running short of time, the HCA will ask the RN to pass the work onto the next shift. We are a 24hour organisation.*" The culture of the organisation determined whether this strategy was effective. If the culture was not conducive to supporting each other this strategy was reported as promoting resentment;

> *"The others don't like it when we haven't done all our work. They think we should be able to get it done. We aren't lazy. I don't think they understand what our shift is like. But sometimes they need to pass it on too, it's just how it sometimes needs to work."* (Ann)

Being perceived as 'lazy', Ann spoke of the reluctance of some HCAs in taking on another's work. Some HCAs asked for help consistently, causing animosity amongst the other HCAs who believed that they should learn to work more independently;

> *"Some HCAs love getting help from other staff including the RNs but there are some who are really good at managing their time and situation, so they can answer their bells and not need help."* (Fay)

> *… "if someone has left me heaps to do I go to management and they deal with it, they have let me down."* (Lima).

Not working to a system and relying on others assisted these HCAs to get through their day. Other HCAs did not see the need to work with others; they simply ignored the tasks requiring assistance and assumed the work would be picked up at another time. Being unwilling to respond to bells or assist in emergencies, these HCAs were not engaged in providing caring however they had a working system in place, providing task focussed care. They balanced their working load by restricting the view of the work required, only seeing the tasks they could and would provide;

> *… "younger ones neglect the detail to finish the work more quickly to just get the work done." (Mona)*

… "some HCAs are quantity orientated so do as much as possible in a short time. Some are quality orientated and take their time and use best practice for the safety and best for the resident." (Fay)

Opposite to the above, some HCAs spoke of not wishing to share their residents with others, feeling that no one else would provide the same quality of caring. Being particularly engaged in their work, these HCAs usually reported they had an efficient working system in place, working around the need for help, and timing this need to accommodate all concerned.

Summary

Balancing the workload was a core category, promoting strategies essential for the HCA to provide the caring aspired to by most participants, effectively and efficiently. Achieving this occurred most successfully when the HCA worked to a system and, acknowledging that working with others was necessary, offered reciprocity. Achieving workload balance enabled the HCA to provide caring through finding the time and opportunity to engage self. Being able to facilitate the provision of caring was explained as occurring through experience and knowing how to work efficiently, working to a system and working with others.

Balancing the workload and providing caring required the HCA to be sufficiently experienced to have developed a system that could be adapted when required. The HCA worked with others and knew when to access this assistance, whom to go to and when. Expected to reciprocate and be prepared to share of themselves, HCAs learned how to adjust their workload accordingly, rebalancing when able.

Balancing the workload within this dynamic and complex environment required the HCA to weigh up needs, considering the condition of the resident, time, and resources available, and how these impacted on the requirement to work with others. Being a major category, balancing the workload acknowledges the pivotal nature of this

149

overarching strategy – weighing up needs – and the requirement for HCAs to achieve this strategy, thus enabling them to work more effectively in their blurred domain. Strategies associated with the balancing would add to working in the blurred domain, as the HCAs stepped beyond their core role to work with others. It was at these times that the HCAs would initiate other strategies such as reprioritising and delegating tasks, enabling them to rebalance. Ultimately the HCA was working towards engaging self and providing caring, as is explained in Chapter Seven.

CHAPTER SEVEN: ENGAGING SELF

"I watch them, feel for them. I see them even in my sleep." (Ann)

In this chapter, *engaging self* includes; feeling responsible, being guided, and providing caring. Engaging self (as depicted in Figure 10), encapsulated the processes employed by the HCAs to work closely with others; the resident, families and staff, and in doing so share a part of themselves whilst maintaining a balanced workload and at times, shifting briefly into protecting self.
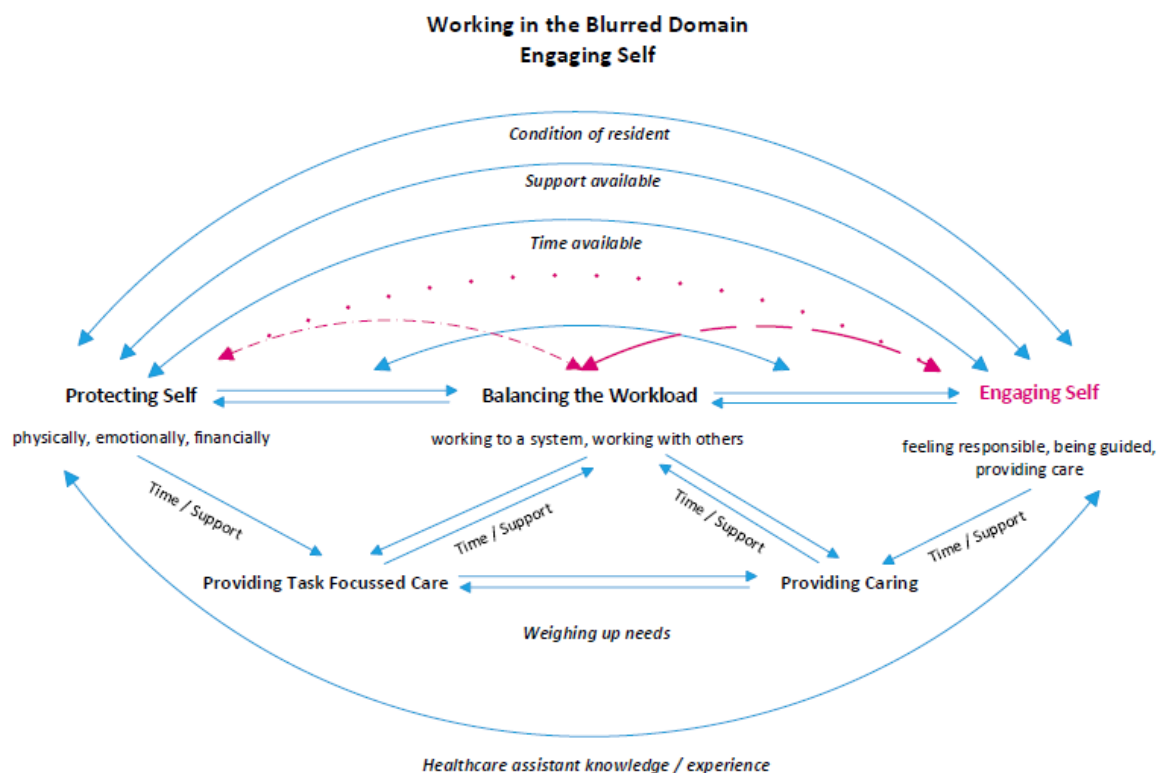

Figure 10: Engaging self

Engaging self was reported as a process of becoming emotionally and physically committed to caring for the resident. It also epitomised a connection between the HCA and the resident which at times extended to include family and other staff. Through engaging self, the HCA was committed to caring for all, trusting that the opportunity to

do this was sufficient to enable the values and desires of the HCA. The process of engaging self developed from having a love of the residents, a love that came from the feeling of responsibility such as that experienced by the parent to the child. Love was explained as being an all-encompassing feeling of fulfilment in providing service, a way of giving meaning to the work and for one participant, validating the existence of the HCA.

Strategies invoked by the HCA to engage with the resident included going the extra mile; offering to do a service not normally expected, anticipating a small need and providing it, and finding time. Showing empathy; weeping with the resident or family and providing comfort to a colleague, were also frequent strategies. Borrowing or substituting for family was dominant and evidenced by the language spoken by the participants, commonly expressing love for the grandparent or parent. Wanting to share this love with the resident may have been inherent in the HCA or, as reported in Chapter Four, may have evolved over time.

> *"I believe I was born to do this job. When I was little I would run up to old people and say 'nana, nana,' I could not imagine doing anything else. They actually give so much to me. I come here to do the basics and I leave work every night tired but never down – they fill me up. They are amazing."* (Lima)

Lima loved looking after her 'old people' and felt that this was a partnership in caring. Engaging with the residents resulted in finishing the day with a feeling of completeness; receiving from the resident as much as was given.

Beth, in the excerpt below, also spoke of a love for the work and the residents, referring to them using familial terms, evidencing the strategy of borrowing or substituting for family;

> *"It's all about how I love for them, I want to know how to look after them, care for them like your own grandparent or own parent. I just loving working for the old people. It is in my heart that what I love and what I learned has connected together."* (Beth)

Being able to combine knowledge and skills with a passion for working with the residents provided the participants with a sense of fulfilment, and a reason to work. In the excerpt below Olga explained why she worked, which also included the feelings of love and of responsibility;

> *"I've got to be there to make sure she's well enough, cares are done, toileting is done. Her wellbeing, her physical being, everything is right. If she's not right in her mind, her eyes, her face, if she's sleeping too much I've got to find out why. It's my responsibility, my love for her. It's a lot of work, from head to toe, you've got a lot to do, but God watches."* (Olga)

Explaining her perception of her role, Olga spoke of a responsibility stemming from a love for the resident, a work ethic encapsulating values, and a belief system supported by her faith in God. Epitomizing the engaged HCA; Olga spoke of being able to combine the strategies associated with the clinical needs of the resident, such as observation and assessment with the strategies of engaging and providing caring.

Providing caring to this degree frequently necessitated the HCAs using strategies such as; working into their own time, finding time and opportunity to 'go the extra mile', using their breaks for work tasks rather than self-care and engaging emotions, as explained below;

> *"It's my choice to stay with my resident, how can I go to a break when she is that bad? I stay, and I hold her hand and I cuddle her. I will make up time later. I need to be with her, I feel her pain."* (Ann)

Using personal time during the normal working day was reported as very common; with Fay speaking of an unusual example;

> *"I took her to church. I know it was outside the organisation and I forgot to ask the family, but they were happy. It meant a lot to her, but in the back of my mind I knew I wasn't meant to, but I put the client first. I might have got into trouble, but I didn't.*" (Fay)

Taking the resident to church was an act of sharing a personal event, time, and assuming responsibility for the resident away from the organisation. By not following the rules,

such as seeking family permission, Fay was putting her job at risk. However, Fay weighing up the needs of the resident and prioritising those over her own needs, engaged self in a process that involved more than just time and caring.

Thinking or worrying about the resident was another way in which the HCA demonstrated an engagement of self, frequently bringing work into personal time.

> *"We take the job home in our heads, if we forget to do something we phone in or can't sleep. We must do our work properly, the best we can for our resident."* (Inna)

This consideration of the resident went beyond the normal job description of simply fulfilling tasks and extended to the HCA engaging emotionally, conceptually and financially, as reported by Inna;

> *"We bring in our own supplies for our residents. Sometimes they run out of shampoo and stuff and there is no family, so we bring it in. It's our obligation to look after them, we treat them as family."* (Inna)

The feeling of responsibility was reported as generated by an awareness of the needs of the resident, resulting in the response of the strategy of substituting for family and engaging self.

Knowing the residents, their needs and preferences enabled engaging self. Knowing the right cream to use, temperature of the shower preferred, staying in bed to have breakfast, that pills were preferred to be crushed and placed in jam, required an investment of time and interest in knowing the resident;

> *"Knowing that she likes her lipstick on as she gets up is important to her and to me."* (Beth)

Engaging self; time, emotions, and heart provided a platform of caring. The resident frequently responded, valuing the sharing that the HCA demonstrated, returning that sharing. Sometimes the reply was simply a smile, a calming of behaviour or a hug, and

154

it was this response that provided the HCA with the inspiration to continue to engage self;

> … *"when I came here one resident looked like my father in law and I felt honoured, he requested my care and he really liked me."* (Honey)

Engaging self includes; feeling responsible, being guided and providing caring, which will now be explained.

Feeling Responsible

Evidencing the process of engaging self was the feeling of responsibility reported by the HCAs, to put the resident first and fulfil the resident's needs ahead of their own. This feeling was spoken of frequently amongst the participants, with many believing that they were alone in caring for the resident;

> … *"the unit would not run without us. Because it is us who are really looking after them. It's all on us."* (Ann)

"It's all on us" was a refrain heard from many of the HCAs participants, implying a commitment, a feeling of responsibility, an obligation on the HCA. Primarily the focus was on the resident, with the HCA feeling a total responsibility for a variety of reasons, including an understanding that the family could not provide the care required, the RN could not and, at times, would not contribute to the care, and the perception that at times the organisation did not have the welfare of the resident at heart. The HCAs reported many aspects of feeling responsible which included providing care for the resident, family, other HCAs, the RN, and the organisation.

For the resident

> … *"if it wasn't for the HCA this unit would not run, it can't run without us. Who's really looking after the resident, the nurse can't do everything?"* (Penny)

Penny explained the position of responsibility felt by the HCA, especially when the RN was not available, with the total onus of care transferred onto the HCA. HCAs responded to the obligation on both a personal and professional level, as reported by Grant.

> *"It's just the profound responsibility I feel towards the client. I don't look at them like it's my job and although the organisation is paying me, if I need to go against the organisation on behalf of my client I will.* (Grant)

Acknowledging the role of the organisation as the overarching power; Grant prioritised his client ahead of the organisational requirements. Feeling 'profoundly responsible' Grant initiated a strategy, deflecting management from knowing of his activities, such as hiding what he was doing, or had strategies in place to protect himself, for example, diverting attention from himself onto someone else. Regardless of strategies needed and used, the decision had been made, the resident was the priority.

Creating a feeling of ownership, HCAs reported not wishing to share their resident nor burden others with looking after them:

> *… "don't want to rely on the float, just want to do my thing with my residents. It's my responsibility to look after them. I don't want to pass my responsibility to the PM shift."* (Penny)

The float was the HCA who had fewer residents to care for and thus was available to assist other HCAs. Wanting to fulfil her responsibility by herself, Penny explained another strategy that was sometimes employed, that of passing uncompleted work onto the next shift, explaining that this was not her preference. Most HCAs who were engaged reporting similar feelings to Penny, preferring to finish their work, extending into their personal time. However, in the quote below the HCA had requested help from the RN, which did not occur;

> *"How can I sleep if I know I didn't do my job properly, if I know he has a cut and it hasn't been treated properly? I can't go home, I have to deal with it. [RN not doing wound care]."* (Nell)

Feeling responsible for the resident, the working day continued until the resident had been sufficiently cared for. This involved one of many strategies such as asking another RN to look at the wound, seeking help from another HCA, or providing the care required. This attention would be documented, providing both a form of job protection and advocating for the resident. Explaining her feeling of commitment to the resident, of not being able to sleep if she had not acted appropriately Nell acted in response to her values.

This sense of commitment extended to substituting for family, with familial transference expressed by many of the participants.

> *"It's like our dad or mum we are treating them like this other person. The resident I saw die just wanted to be held and comforted. We all grieve, we all grieve that's why we're here, because we care."* (Inna)

> *"My job is to look after the residents because when you come here this is like family. This is your family."* (Penny).

Many of the HCAs were migrants and did not have family in New Zealand. Explaining strong family values, the participants reported a sense of missing their own parents, gaining happiness in the substitution of residents;

> *"If something happens it's us who gets emotional, attachment is stronger if we have no family here. We are looking after them every day we take the place of family."* (Inna)

Inna spoke of 'it's us' and used the word 'we' indicating a connection with the resident, mentioning the extra bond felt when the HCA did not have family in New Zealand. Although the HCA reported taking the place of family, many participants also explained a perception of responsibility to support the families of the residents.

For the family

> *"We form a close attachment to the residents and their families too. We have to help them too."* (Honey)

157

> *"We love the residents and we get to love the families too. When our resident dies we miss the families. It's just another loss."* (Penny)

The above excerpts described a commitment to the families and the feeling of compounding loss when the association ended. In this complex environment, closely associated with grief, the HCAs reported having to support families and other staff, providing little time for themselves;

> *"It's so tough when a resident is going to die. We are sad and so is the family and they don't know what to do or say sometimes. We need to be there for them, but we have so much to do. And who looks after us? Sometimes we are not allowed to cry. We have to grieve too, but we can't. We comfort each other."* (Olga)

Voicing several issues and strategies regarded as important by the HCA, Olga spoke of supporting the dying person, comforting and helping the family engage with their dying member. Reporting grief and the sense of loss, Olga expressed these feelings as being compounded by the lack of organisational support and in some instances a refusal by the organisation to acknowledge the grief being experienced. In these situations, the HCA turned to other staff for support.

For other staff

The feeling of responsibility extended to their colleagues, especially the other HCAs. Supporting each other became important to enable all to get through their workload.

> *"I think the work can get done if you have a team that has good rapport with each other, who understand the residents and will cover. It's always nice to have someone there to help because you are always on your feet. It's never ending."* (Liz)

Involving many strategies, this support was explained as including providing physical assistance, comfort, guidance, and training. At times, these strategies, in response to conditions of time and resources available, would include cutting corners; so, although

the HCA was engaging with other staff he/she had reverted to providing task focussed care for the resident. Examples of each are provided below;

> *"We help each other with the hoist and when we don't have the hoist we just help lift. We aren't meant to but sometimes it's faster and with the two of us it's okay. We know how we work together."* (Chris)

> *… "hold each other and cry and remember them and then go onto the next one."* (Ann)

> *"I was new once. I remember the fear and the worries and the anxiety and everything that goes with it. Somebody has to tell you what to do and make you feel supported. The new staff has to learn to open up and trust that other staff will help them."* (Fay)

The above excerpts reported varying strategies that responded to a feeling of responsibility and explained an engagement of self, especially providing the emotional support that this work required.

However, it was not solely emotional support required. This was work that had two levels to the role, with one level assuming more responsibility than the other; the in-charge. It was reported that all HCAs felt obliged to support the in-charge and did so willingly.

> *… "will step into help the in-charge when needed if I can, it's everyone's responsibility."* (Liz)

Working as the in-charge, the HCA would step into the RN role when the RN was not available and at other times the in-charge would work alongside the RN providing him/her support. The role was reported as being difficult for apart from providing the usual resident focussed activities, the in-charge had similar obligations as the RN, which included responding to emergencies and extended to disciplining other staff.

> *… "being in-charge has increased responsibility it's really hard and you are the one who is reliable for everything."* (Mona)

> *"The in-charge ensures that they tell off the colleague in a private and nice way, but has to do this or are not doing their own job well."* (Joy)

159

> *"The in-charge not only looks after the residents in the facility but also in the village, if their [village resident] bell goes off you are supposed to answer within 10 minutes."* (Mona)

Stepping up and assuming more responsibility, the HCA assisted the in-charge. This was reported as resulting in the HCA extending the role, moving from working at the 'normal' level to moving up to the level of the in-charge, who had stepped up to the RN level. This also evidenced the HCAs feeling responsible to provide support to each other.

> *… "the in-charge does dressings but if your resident has a skin care you tell the in-charge, but you deal with it if she's busy."* (Lima)

> *"I learnt from the old ones, one has been here 25 years. Then there are the new policies and changes you have to adapt to and colleagues will look at you and ask you what you think about something and I say ask the RN, but the other HCAs have huge expectations of me and expect me to teach them."* (Liz)

Believing that teaching was a role of the RN, Liz expressed frustration at being asked to undertake this; however also spoke of the implied responsibility to do so. The reality was that many of the HCAs enacted the strategy of bypassing the RN preferring to obtain support from each other. However, not all HCAs had antipathy towards the RN with some HCAs reporting a feeling of responsibility for the behaviour of the RN and a need to offer assistance.

For the RN

Working with the RN was reported in contradictory ways. At times the HCA supported the RN; at other times strategies of bypassing, ignoring, or intimidating the RN were employed. Inna spoke of removing a RN from a potentially dangerous situation which involved a client exhibiting confused behaviour, *"we have to step in and take the RN away and then it is us"* (Inna).

160

Assuming the responsibility for the situation and thus the safety of the RN involved strategies of protecting others and included stepping into a lead role. The following excerpt demonstrated caring for and assisting the RN;

> … *"sometimes she used to forget things, so we write in the progress notes and she checks it the next day, so we reminded her."* (Kate)

Employing the strategies of ignoring, bypassing or intimidating the RN were undertaken when the HCA was weighing up various needs and conditions and perceptions of negativity from the RN were received. Requiring support from a RN that was not forthcoming the HCA might bypass, choosing another RN, or may decide to do the work alone. The HCA commonly reported the RN support or lack of, as pivotal to strategies used to protect themselves. The excerpt from Kate revealed that by helping the RN to complete her work the HCA was effectively safeguarding her position. Inna also protected the RN, this time from physical harm. By supporting the RN and being responsible for the actions and safety of the RN, the HCA was contributing towards the organisation.

It was also reported that the HCA doubted the knowledge and competency of the RN, to the extent of believing that it was the responsibility of the HCA to train the RN.

> *"It's a true lack of knowledge you know, you really want to rely on the RN because we can't do it all, but no… you really have to train the RNs you know."* (Ann)

Training the RN was not a recognised role of the HCA; however, it was one the HCA accepted to ensure he/she could work with the RN, bringing the RN into line. Training of the RN was also reported as a response to the awareness that RNs were not easy to employ and retain, thus HCAs again expressed a feeling of responsibility on behalf of the organisation,

> *"So, if the RN left then it's sometimes weeks before they are replaced. It's hard on all of us. We just have to put up with her and do the best we can with her."* (Olga)

Putting up with the RN, training the RN, stepping into gaps created by the RN, bypassing the RN and choosing the RN with whom to work, were all strategies used when, weighing up needs the HCA perceived a gap. At times filling this gap required the HCA to assume responsibility for the safety and wellbeing of the RN as previously explained and it also included supporting the RN to maintain employment. In the excerpt above the HCA tolerated and worked around the RN until the organisation could find a replacement, further evidencing a responsibility to work on behalf of the organisation.

For the organisation

Feeling responsible for the organisation encompassed strategies responding to feelings of responsibility as well as loyalty; and to conditions such as occupancy and funding of the organisation. Participants reported trying to ensure employment for all and 'making do' in cost cutting situations whilst working for an organisation that they liked. Perceiving a responsibility toward the organisation was therefore reported as common amongst the participants.

> … *"we are the eyes and ears of the whole organisation; our wages suck but we still work for the organisation."* (Grant)

> *"I have so much loyalty. It is our role to keep the organisation safe because we are charged with people's lives, it is not just the manager's role/owner's role. We play an important part in keeping that home safe."* (Grant)

Expressing loyalty, Grant reported the need to share the responsibility for the resident and organisation. Not all HCAs would extend the feeling of responsibility to this level however most contributed to activities such as representing the organisation in marketing the facilities. Arising from a condition of requiring occupancy of the facility, extending to a feeling of obligation to ensure beds were full, the HCA was aware that cost cutting, potentially resulting in redundancies, would occur if vacancies existed.

"I don't mind stopping my lunch to show people through the facility. It's part of my job they are asking me to do it. I am quite happy the organisation is getting money because I am employed by them." (Nell)

… "on the face of it, it looked like the residents were treated well, family did not know, we put on a show. We had to look happy or someone would tell management." (Kate)

"We begin to give our residents the basics you know, we put our heads down and carry on because we like the place and the people, and they are doing the best they can." (Ann)

Contributing towards filling the beds included 'acting' to protect the job and therefore misleading the public on behalf of the organisation. However, all HCAs were aware of the consequences of cost cutting which would affect the resident and working conditions. Thus, the subterfuge that Kate reported was for a multitude of reasons, as was 'carrying on' regardless of conditions.

At times however, when the values of the HCA were compromised the HCA would not support the organisation

… "staff used to hide pads (incontinent) under their clothes because of insufficient amounts and would have to wake residents up 2 hourly at night to toilet them instead of using pads. Residents got agitated and nasty due to lack of sleep and management found out about the hoarding of pads. They said it had to stop and now we 'borrow' from other areas. The pads are not freely supplied so we negotiate for them. Management thought the HCA was lazy not wanting to toilet the client 2 hourly at night and did not listen as to what would happen. We asked the RN to intervene with management, but it was ineffective. I had to listen to my conscience and steal the pads." (Kate)

Feeling responsible for the welfare of the resident, the HCA went against the organisational requirements. The above excerpt explained strategies invoked to help the resident; deception, hiding, negotiation, and pleading. Being expected to waken tired and confused residents to toilet them, the HCA used his/her knowledge of the resident to apply the most effective measures to calm the resident during this process, ensuring the safety of both the resident and him/herself. Weighing up needs, including consequences, feeling a responsibility to the resident and, acting against organisational

requirements, the HCA stole and used pads, enabling the resident to sleep. The contradictory feelings experienced by the HCA were complex, the sense of responsibility toward the resident, self, others, and the organisation requirements. In this process of weighing up needs and deciding on the best course of action, HCAs were assisted by being guided.

Being Guided

Being guided reveals the support processes used by many of the participants to assist them to balance the work load and be engaged. Whether the guidance was from a higher level; God, conscience, intuition, morals, or a more formal level; policies and training, experience; or a more basic requirement of fulfilling financial or Visa commitments, the HCA operated using some form of direction or a mixture of all. Those who predominantly relied on the higher-level appeared to apply a high moral standard and reported offering an engaged provision of caring, gaining an intrinsic reward in providing care that elicited a smile or similar response from the resident.

> *"He reached out for my hand and smiled at me and I thanked God that I could help him.*" (Des)

Other participants spoke of policy, procedures, and training as the major guide to their work. This was not to say that those who explained using a higher level did not also abide by policy; however, those who used the higher guides would also reflect on the requirements and effects of policy, and weighing up needs and conditions may decide to ignore policy;

> *"I know the policy is important but if need to go against the organisation on behalf of my client and for my God I will."* (Grant)

Those who spoke of being guided strongly by policy and training did not appear to be as motivated by the 'smile response' of the resident and described a good day as one where

all tasks were completed or communication between staff went well. It was also reported that the HCA who used policy and training as his/her main guide would be more task and time focussed, applying strategies that did not support engaging self;

> … *"stick to the polices and you won't get into trouble, polices are your guide, used to protect you and residents. Keep the policies at the centre of your work, be flexible but you can work around them*. (Fay)

Working to protect self, Fay also reported working around policies. This flexibility was dependant on the conditions present at the time, such as support available, and at the stage HCA was working within; protecting self, balancing workload or engaging self.

The participants explained adhering to and going against policy when working in all three stages, however being guided by a higher level was reported by those balancing the workload and working towards engaging self. In the excerpt below Des provided an example of being guided at a higher level, explaining that although he was quite capable of moving a person on his own, he prioritised his beliefs;

> *"It's very dangerous you know, and I can do it [move an older person] by myself if no one is there, but God is watching you know."* (Des)

Grant also used God as his guide to protect self;

> *"I couldn't do this job so well if I didn't have my God helping me. It hurts me sometimes to see my residents like this. I need to talk to my God and he helps me get through."* (Grant)

Other participants explained using prayer as a strategy, providing comfort and a sense of direction for the HCA;

> *"I feel like I was really hurt and then I just pray for their souls and I ask my mum back home to pray too*." (Honey)

> *"You just carry on and do your best and pray that no one has a fall or gets really ill because you will call the RN and you pray she will come, so you just pray*." (Liz)

Using prayer helped the HCA progress through a time of difficulty, as Honey and Liz reported.

Other participants, including both the migrant and domestic HCAs referred to Karma, believing that what they did now would come back to them later, thus using Karma as a form of protecting self as well as a guide. Believing in Karma strongly influenced decisions, with the HCAs not altering practice despite conditions such as time;

> ... *"we treat them as ourselves or it will come back to us. I used to be cared for by my grandparents so caring for the residents is like returning that."* (Joy)

> ... *"we are all getting old. I want to look after the residents as best as I can or it will come back to me, it's karma."* (Olga)

Conscience was another aspect of guidance frequently mentioned, as exemplified by Des who stated, *"if I did anything wrong I have a conscience, we are accountable."* Beth commented on *"not being able to rest after work "if I have not completed my work,"* indicating that feeling guilty acted as a measure of conscience. Abiding by conscience provided a meaning for and was a strong influencer of actions.

In the excerpts below Des and Ann reported that empathy and 'being in the same shoes' were other guides that supported providing caring. These guides invoked such strategies as acknowledging the dignity of the resident, adjusting self to resident needs and engaging self.

> ... *"they have the pain, because they are older people we don't know what they are going through, pain and difficulties, they can't walk like me, I can't expect them to walk fast like me – no."* (Des)

> *"I like to think and get things done, like how I dress myself, how I wash my kids, how I want to be treated. If they can't tell me how they like it I look at the photos, hair is parted, so I part the hair."* (Ann)

Consideration by the HCA of how he/she would like members of his/her family treated was a common guide to ensuring a standard of quality and engaged caring:

> *"I always say, imagine this person as your mother, how would you like your mother cared for, dressed?"* (Grant)

Speaking of how he trained the newer HCAs, Grant shared strategies of transference and reflection to assist guiding them.

Using intuition was one further strategy reported; "*I can sense when they are off, when they don't like something and when they might hit at me. I just know when I walk into their room*" (Ann). Sensing when something was wrong or 'a bit off' was frequently spoken of by the HCA as a guide to modifying actions, timing, and even changing noise levels. Some HCAs spoke of using music and singing to calm a situation, being guided in the knowing that it was enjoyed by the resident. Knowing the resident was reported as a condition that supported providing caring.

Providing Caring

Providing caring was explained as the process involved with giving something of the self to the resident, interwoven with providing tasks. It related to providing a service surrounded by love and consideration, and frequently involved using personal guides and values to provide the degree of caring to which the HCA aspired. Providing caring was achieved by the HCA sufficiently experienced to be working towards balancing the workload, fulfilling the conditions of time and resources and enabling engagement of self. When conditions such as support, time, and resources were not available the HCA's ability to provide care was affected, resulting in strategies to get through the work such as undertaking short cuts. However, aspiring to work by engaging self and providing caring, the HCA would also counter these strategies by using other means, such as working into own time, delivering the caring they were required to restrict earlier.

Providing caring was the demonstration of caring amongst the provision of tasks, the holding the hand and gently wiping of tears, perhaps crying with the resident. Providing caring was the working process used when the HCA was engaged.

> *... "and I wrapped her up warm and held her and rocked her and told her she was in the best place. My heart was breaking for her."* (Grant)

Grant spoke of his heart breaking for the resident, of taking the time and surrounding her with comfort, providing caring. In this instance the caring was empathetic and emotional support, support frequently reported as generating something of value in the HCA as explained in the following excerpt:

> *... "she gave me a chocolate to thank me and the feeling, you know, the wages do not compare for what you do, but the feeling inside – I feel like I am helping my mum."* (Nell)

The 'feeling,' as described by Nell was often reported by the HCAs. Sometimes there were no words for it, as with Nell; others explaining a happiness or a sense of achievement. Another participant, Lima explained the effect as a feeling of completeness, *"they fill me up. They are amazing."* Such feelings were often reported as being in response to the HCA doing something little but of value to the resident. This was evidenced in the excerpt below, Mona reported managing the condition of time, providing a service that elicited a response from the resident and a corresponding feeling of pride; a smile for a smile.

> *... "feel real proud if you have done a little thing for someone and that made them smile – gives a good feeling that you have actually taken time out and done that for that person."* (Mona)

Providing caring, as explained above included the HCA doing the extra little things, managing to do so even when time was a condition;

> *... "when you shower them, you have to check and clean nails, what they want to wear, help them move and you still need to ask them what they want to wear even if you are in a hurry."* (Nell)

It also included showing the resident respect and consideration, such as informing them of activity, as reported by Liz:

> *... "talk with them and say I'm going to wash your back so they know someone's going to the back, I'm going to wash your hair instead of giving them a fright,*

things like that. I think that's something a lot of them lack over here, they go and do it and the resident doesn't know." (Liz)

As explained by Liz, there were some HCAs who did not provide caring, had not achieved this ability or had withdrawn from providing such care. This HCA had closed off or removed emotion from his/her work. The engaged HCAs gave of themselves in many ways, especially emotionally. This became very apparent when the resident was removed from the HCA's care, ceasing the relationship, and creating grief and confusion:

> *"When they get to palliative care or high risk for mobility they go into a private hospital and I find that emotionally draining. They [management] cut the cord and hand them on and I can't get my head around that system. It's like – she's gone - get on with the next one*." (Grant)

'Getting on with the next one', was the perceived response from the organisation to the grief of the engaged, caring HCA. Des explained his perception of the cycle involved with caring within the 'end of life' environment which was 'get on with the next one as another one will be coming'. This, however, did not stop Des from providing caring to the resident;

> *"I had a patient I became very close to, we shared personal stories, my patient always smiled, and we sang hymns together, she was a Christian. She passed, and I felt very sad for days, couldn't immediately forget her and her smile, then after a while others come and the cycle goes on."* (Des)

Summary

Engaging self was the process of working in an engaged manner. Reported as a feeling coming from within, a belief that this was meant to be or as a development over time, engaging self, epitomised the caring HCA. Stemming from a feeling of responsibility, the HCA explained weighing up the needs of everyone within the working environment and responding to those needs. This may have included the needs of the residents and their families, other staff including the RN, and the organisation. Feeling responsible for

the RN included working with the RN and at times stepping into the role of the RN. Working in ARC, the HCA predominantly relied on other HCAs for support in preference to the RN. The HCA reported feeling responsible to assist other HCAs with the physical workload and the emotional; and it was working at the emotional level that enabled the HCA to engage self.

Engaging self, required an ability to weigh up many frequently complex and intertwined needs and conditions. To respond appropriately the engaged HCA usually referred to his/her personal belief systems for guidance. This guidance was reported to be at a higher level than abiding by policy, with policy being a more formal form of guidance used by the HCA who provided task focussed care. The higher level was reported as being more intrinsic and included being guided by God, Karma, conscience, and intuition. At times, the engaged HCA would be guided by more than one form, depending on the conditions at the time, such as the need to protect self or others.

Engaging self, was evidenced by the HCA providing caring. Caring was more than completing tasks as it involved the weaving of emotions including the feeling of love throughout the work. Caring included sharing and receiving, creating a relationship that gave purpose to the working day of the HCA. However, providing caring did not cease at the end of the day as the HCA reported thinking about and worrying for the resident during personal time. Engaging self, feeling responsible, and providing caring were aspects of the self that, once realised, only shifted when the HCA perceived that protecting self, and/or balancing workload, became necessary. This movement between categories will be further explained within the next chapter, the discussion.

CHAPTER EIGHT: DISCUSSION

*"We wrap the clients and hold them, comfort them, "why are we still living?"
And I said, 'you know sweetheart, it's not about how long you live, but it's about
the quality of life you can have while you are living, and I would like to think
that that is what we are giving you and your husband.' So sometimes I just wish
we could have some emotional support too, or someplace we could have a
voice."* (Grant)

Introduction

I begin this chapter with describing the context within which the HCAs in this study
worked. Next, I critique the findings; weighing up needs and the theory of working in a
blurred domain employing the three categories of; protecting self, balancing the
workload, and engaging self, referencing them against relevant literature. I discuss a
common finding throughout this study, the language used to pertain to ageism,
transference, and objectifying people and actions. The implications of working in a
blurred domain will be explained, as will the contribution to knowledge that this study
provides. The recent ramifications of the pay equity award are discussed and finally, the
strengths and limitations of the study, contribution to knowledge along with
recommendations for further research are explained.

Situating Findings in Literature

With 20% of the world's population predicted to be aged by 2030, the demand for the
HCA working within ARC is increasing, nationally and internationally (United Nations,
2015). The UN findings complemented mine, revealing a workforce working within
constant change and in an environment of uncertainty and complexity. My findings are
also in agreement with research describing the role of the HCA as pivoting around
providing direct personal care needs to residents who have entered ARC. This role is
complicated by the residents entering this environment with complex co-morbidities

and requiring palliative and/or dementia care (Office for Senior Citizens, 2015a; Thornton, 2010). Not only is direct personal care provided, but my findings also support those of Bowers, Esmond, & Jacobson, (2003); Carlson, (2007); and Thornton, (2010), that the HCA offers so much more and agree that the HCA provides the majority of direct care. Furthermore, my findings also support research reporting the HCA working in a poorly defined role with the extension of that role into the realm of the RN (Shannon & McKenzie-Green, 2016). I also support other research, finding the role of the RN as having changed, focussing on legislated compliance requirements thus reducing direct resident care time and availability to supervise the unregulated workforce; the HCAs (Shannon & McKenzie-Green, 2016). To mitigate the current lack of supervision, researchers have suggested that the RN role be restructured, providing less task focussed responsibilities and more time to support the people; the resident, families and staff (Choi & Johantgen, 2011; McGilton, Bowers, McKenzie-Green, Boscart, & Brown, 2009).

HCAs perceive the significance and difficulties of being unregulated when their role is constantly changing, with their only guides being training, job descriptions and their values (Human Rights Commission, 2012). These factors allow for employer interpretation of the role. Findings of this study indicate a workforce focussing on resident needs and when conditions enable, delivering high quality care. The findings presented in this thesis shares participants reports of employers valuing, caring for and about, and emotionally supporting the HCA, even at times assisting financially. Amongst these positive reports are those concerning the perceptions of employer expectations of the migrant HCA who is concerned with maintaining a Visa to work (Human Rights Commission, 2012). These reports reveal a workforce subject to exploitation, abuse, and neglect.

Critique of Findings

In this section, I explain the HCA weighing up needs as an integral process to establishing the responses required for either task focussed care or providing caring. Weighing up needs encapsulated a variety of conditions and produced actions grouped under the three categories of; protecting self, balancing the workload, and engaging self. However, during this research the participants used certain language that was reoccurring. Thus, I include a discussion pertaining to some of this language.

Weighing up needs

Weighing up needs promoted the actioning of task focused care or, providing caring. At times, the HCA shifted between the two. Affecting this shift and deciding what actions to take was the process of weighing up needs and the influencing conditions of time, support, and condition of the resident. Studies by Thornton (2010) and Cooper et al. (2016) identified similar conditions which clearly describe the influence of limited time and support in association with resident status. Taking short cuts, reverting to old practice, and providing task focussed care were all strategies explained by participants in response to adverse conditions and by those HCAs who, albeit having knowledge and skills, chose to limit caring. Those HCAs who did have knowledge and skills, under the conditions of increased time or the condition of the resident offered engaged care. Offering, or aspiring to offer engaged caring was the aim of most participants, however they reported confusion about the role, with unclear expectations as to the level and provision of care expected.

The blurred domain

The perception of the HCA's role appeared to vary considerably depending on who was explaining it. Certainly, the role of the HCA, as I initially perceived it, was very different from what the participants were reporting. My perceptions were of a role with

defined tasks, time to undertake these tasks with supervision and support undertaken robustly by the RN. I was aware that during a night shift and depending on the facility, the RN was on call; however, I had believed that a call would be responded to immediately. In this study, based on the participants perspectives, my perceptions were inaccurate.

Having a clearly defined role was not evident for participants in this study; a role has an expected set of behaviours, rather what was present were patterns of work responses. The role was at times confused, responding to need and extending into areas of other workers, especially that of the RN (Shannon & McKenzie-Green, 2016). Extension occurred when the HCA became educated or knowledgeable about a certain procedure, for example medication administration and/or wound care. In this instance the extension became a normal part of the role of the HCA and was usually accepted. However, confusion, or blurring occurred when a gap in care was apparent, and thus the HCA left his/her core area of work and, filling the gap, shifted towards the periphery of the poorly defined role, with little or no perceived boundaries. Filling the gap of the RN occurred "*because the nurse is not coming, and you have to do the medications and manage the care of your residents*" (Liz) and "*in the morning we do the controlled drugs, medications, dressings, weights and blood pressures then go onto lunch*" (Nell).

An example of the confusion and blurring of the role is reported by Ann speaking of having a resident on dialysis. Working a night shift Ann was expected to connect the resident to the dialysis machine, however if a RN was present then "*I don't do the task, because it's beyond my job, but I have a little learning how to remove and put on dialysis.*" Confusion reigned, when it was necessary the task became part of the role; at other times it was 'beyond' the expected provision of tasks. Providing tasks beyond the scope of the HCA was reported by Sandvol et al. (2012) as becoming a concern, especially when this was related to administration of drugs. When there was no

other staff, such a task extended well beyond the commonly perceived role of the HCA however it was undertaken as there was no one else. In this instance the HCA was expected to undertake work of the RN.

The concept of a central, task focused role was explained in literature (Human Rights Commission, 2012; Thornton, 2010; Twaddle & Khan, 2014), as was acknowledgement of an extending role (Human Rights Commission, 2012; Smith, Kerse, & Parsons, 2005; Shannon & McKenzie-Green, 2016). Working in this blurred domain was reported in this study as promoting stress and distress, with some of the HCAs preferring to stay within the core of essential tasks. Others, however, perceived it as a way of keeping their internationally recognised RN skills up to date and extending their knowledge, albeit their workload. A common complaint reported by HCAs in this study was increasing workload due to inadequate staffing, which they perceived was a direct result of DHB insufficient funding. HCAs reported inadequate staffing as contributing to working under stress and consequently employing a strategy of protection, with this finding supported by Thornton (2010).

Protecting self
Protecting self, included the protection of the self physically, emotionally, and financially. Supported in literature (Nicholls et al., 2013; Shaw, 2004), protecting self, involved a range of strategies from wearing protective equipment to knowing how to defuse a situation. Interestingly, the participants' strategies of hiding, diverting focus by using other people or even music, and taking time away from the resident were revealed in other research (Nicholls et al., 2013; Shaw, 2004). Protecting self physically was particularly important in the care of residents with dementia, requiring an understanding of the resident's condition and a knowing of him/her as a person. Knowing the resident enabled the experienced HCA to anticipate and employ strategies to defuse potentially

alarming situations, a finding reported by other researchers (Nicholls et al., 2013; Wilson, Rochon, Leonard, & Mihailidis, 2013).

Participants reported protecting self emotionally by using strategies such as withdrawal and hiding, acting to prevent ill-health and limit exposure to stressful situations, as also reported by Anderson (2008). Occurring from constant exposure to stress, Anderson posited that ill-health and possibly burnout, was frequently associated with loss, and thus was a regular occurrence in the ARC environment. Being allowed to grieve was noted as important; however, many of the HCAs spoke of not being permitted to express their grief as reported by Olga, "*Sometimes we are not allowed to cry. We have to grieve too, but we can't. We comfort each other.*" Strategies for coping with grief and constant change were associated with the organisation, centred around supporting each other and relying on personal belief systems, such as prayer. Some HCAs reported exhibiting grief and displaying emotion as a perceived threat to employment and thus invoked strategies to protect self financially, such as withholding emotion, withdrawing self, and hiding self, anything to divert attention from themselves. It took a strong and experienced HCA to advocate for self, speaking out against a perceived risk to self. Evidencing resilience, the experienced HCA would initiate strategies required to cope with the stressful situations and mitigate burnout, as reported in a study by Frey et al. (2015). Frey et al., undertook research establishing factors leading to the encouragement of ARC staff to undertake training in palliative care. Employing strategies, as reported in my findings, and supported by Frey, the HCA would weigh up needs; consider conditions, and engage those strategies most effective and efficient to assist the HCA move from protecting self emotionally to balancing the workload.

Balancing the workload

Balancing the workload was the second major theoretical category. Balancing explains the processes of work the HCA employed to manage the day. These processes included working with others and working to a system, enabling the HCA to undertake expected tasks, respond to the unexpected, and still provide caring most of the time. Carpenter and Thompson (2008) described balancing as transitioning between two worlds, the world of providing tasks as required by the institution and the world of providing individualised care, responding to specific needs of the resident. Their study also revealed the flexibility required of the HCA in managing the day and the difficulties associated with balancing when moving beyond the task focussed provision and into an extended role (Carpenter & Thompson, 2008).

Requiring the HCA to have knowledge of the resident as well as skills associated with the blurred domain; it was the experienced HCA who usually perceived the gap in needs and responded, thus balancing the workload with need. In the following excerpt Liz explained three common strategies used: knowing the workload, knowing the resident, and working with others:

> … *"everyone knows what their workload is and know how the routines go and know their residents well. They know help they need with care, so they share workload when things get a bit hard and help their partner and level the load."*

Knowing the resident was reported by Holloway and McConigley (2009) as providing the HCA with the ability to perceive and assess change, in particular that associated with pain management. Knowing the resident was a necessary component of working with residents declining in their communicative and cognitive abilities, as reported by Wilson, Leonard, Rochon, and Mihailidis (2012). The latter study described having knowledge of the resident as providing an effective base when anticipating needs and employing strategies such as negotiation and is supported by Sandvol et al.'s (2012) research describing knowing as pertaining to the HCA with experience and using this to

deliver the perceptive caring that I found in my study. However, providing this level of

caring depended on the conditions at the time, especially time and support available.

Participants explained knowing the workload and working using a system as

being integral to balancing as reported by Liz, "*everyone knows what their workload is*

and know how the routines go and know their residents well." Supporting this concept

was research describing the HCA as just knowing and no longer having to refer to lists

or notes, thus exhibiting the experience required to establish working patterns and

knowing how to work with each other (Sandvol et al., 2012). Balancing the workload

also entailed being able to react to the unexpected and usually required the cooperation

and support of others. Thus, being able to rely on colleagues, including the RN, was

important. Unfortunately, many of the participants reported an uneasy relationship with

the RN, which is also supported in literature (Carpenter & Thompson, 2008), and

explained using strategies to bypass or substitute for the RN. Very few HCAs reported

being able to rely on the RN. Instead they explained being selective in which RN they

approached and when they would do this, preferring to delay the approach to work with

the chosen person. Balancing the workload enabled the HCAs to provide the caring to

which they aspired, described by Carpenter and Thompson (2008) as transcending the

job, moving beyond the daily tasks and establishing "cherished relationships and

integrating caring into routine" (p. 28), which required the HCA to engage self, the third

category of this theory.

Engaging self

Engaging self, originated from the invivo code 'it's all on us' and represents the

strategies underpinning feeling responsible for the resident, family, and other staff. This

ultimate sense of responsibility added to the perception of needing to step towards the

periphery of the role, filling the gaps in care. This was the category that explained the

sharing of emotion, the gentle touch, the cradling someone as he/she wept. It also explained hiding pads for the resident, bringing in creams from home, working into their own time, helping the RN, comforting family, and supporting each other. This category revealed strategies that when responding to the conditions of time, support, and the resident, might entail leaving the engaging self for a short period of time, perhaps shifting into a mode of protecting self, and returning once again when work was becoming balanced. Engaging self was complex, involving the use of personal guides to assist the HCAs to follow their values in providing the caring they desired. Being guided by God, Karma, conscience, were concepts frequently explained as important in the weighing up process, helping to decide on the most appropriate strategies to invoke, enabling providing caring. Using conscience was also reported to have a negative impact on performance, with the 'troubled conscience' explained as adding to workplace confusion and stress (Ericson-Lidman & Strandberg, 2014).

Providing caring has many connotations. Many of the participants spoke of providing caring as a mother/parent; "*when you work with older people some are like babies, children, some we need to have compassion towards them*" (Des). Noddings (2013b) described natural caring as the "I want to care", coming from a memory of a mothers caring and a 'want' to help another. Noddings goes so far as to state "caring is the language of the mother" (p. xiii). Thus, this language may be seen to be expressing natural caring, rather than being the language of ageism and therefore derogatory. It is the actions resulting from the feeling of caring, be it demonstrating the relational and responsive actions of the natural caring or the 'I must' care, reflecting the 'ethical caring', that would be the indicators of whether the use of "babies" is expressing natural caring or ageism.

Ethical caring (Noddings, 2013b) stems from caring provided out of a sense of duty, the 'I must care', rather than 'I want to care', and it is this type of caring that

would be involved with providing the task focussed care explained in this research. As reported in this study, providing task focussed care/ethical caring can lead onto the provision of engaged/natural caring. An example of this is provided by Des; "*I give them everything, I care for them like my own mum and dad.*" Des continued; "*they will come near me, hug me, appreciate me and I receive a lot of blessings from them.*" Des spoke of a giving and receiving, a foundation for engaging self in caring. Reciprocity, the giving and receiving, is one of the main motivators sustaining the provision of engaged/natural caring as reported by these participants. Noddings (2013a) also discussed the reciprocity of natural caring, the relationship of providing attention, receiving a response, and establishing a connection. Noddings (2013b) described caring as being motivated by love and the inclination to provide it, supporting the study of Carpenter and Thompson (2008).

Adams and Sharp (2013) discussed motivation of the HCA to work in this environment and cited Nancy Folbre, who reported that there are three facets to motivation; reciprocity, altruism, and responsibility. Reciprocity is further segmented into three types; positive, negative and generalised reciprocity. Positive reciprocity is the returning of a kindness previously given; negative is retribution for wrong doing; and generalised is similar to paying it forward or helping someone who in turn will help another. Providing engaged caring towards the resident and staff demonstrated positive reciprocity, whilst generalised reciprocity was more likely to be in relation to the residents' family. Professional reciprocity can also be defined as "deliberate and skilled relational work of paid care workers that results in shared meaning with their care recipients and a mutuality or interdependence in which both achieve goals" (Adam & Sharp, 2013, p. 107). Whilst much of this definition fits with the HCA, it would not be correct to generalise that the relationship established between the HCA and resident was

deliberately achieved; rather, a more accurate summation would be that this occurred because of an innate, natural caring.

Understanding why the HCA continues to work in this complex and blurred domain requires consideration of the dynamics and factors providing the motivation to do so. Once these are understood the employer can encourage these factors to sustain the workforce. Previous studies examining psychological conditions required to retain and recruit the HCA have reported the necessity for enabling the caring aspect of work, acknowledging the emotional commitment and altruism (Frey et al., 2016; Rakovski & Price-Glynn, 2010). Whereas Black (2015), supporting the latter, also prioritised the heavy workload with corresponding lack of support as being primary indicators of intention to leave. Also reporting a further negative impact on leaving, Black explained increased responsibility exerted on the HCA as being increasingly significant. Countering this is the recommendation from Choi and Johantgen (2011), of the importance of supervision of this workforce. From these findings, there is one other major contributor to encouraging the HCA to remain in the workforce; that is, knowing and understanding the role enabling the HCA to no longer work within a blurred domain.

Examining the language

Language used by the participants exhibited many contradictory messages and this will now be discussed.

Language used by the HCA was perceived by them as reflecting caring yet was often denigrating or demeaning to the resident. Words such as 'wearing a nappy', instead of using incontinence products; 'feeding them', instead of assisting with nutritional needs; calling them 'mum' and 'pops', instead of by their name were reported in this study to be normal practice. This language was created, reinforced, and

habituative in the workplace because it was easily understood and, while it was not intended to be disrespectful, could be perceived as being expedient (Nussbaum, Pitts, Huber, Krieger, & Ohs, 2005). Unfortunately, whilst the participants were using a commonly practiced language, it also implied a dependency and reduction in status of the resident. Similarly, a study examining ageism and language, including that occurring in ARC, found residents perceived an increased feeling of incompetence and lowering of self-esteem predominantly due to the modification of language used by the HCA to address decreased cognitive and, at times, physical ability (Nussbaum et al., 2005).

In trying to establish an improved level of communication, the HCA explained using speech associated with earlier years would be easier for the resident to understand. An example provided was 'putting on the nappy' is easier than using the term incontinence product, with this explanation being supported in research (Nussbaum et al., 2005). Participants in this study also spoke in a way that belied their meaning, appearing to objectify the residents by 'doing them' which was in directly opposite to the emotion relayed by the participant. Ann commented; "*Hold each other and cry and remember them and then go onto the next one.*" Her message is of caring and grieving; yet the resident is reduced to the 'next one' which appears derogatory and in contradiction to the context. However, I believe the use of such language was expressing the participant's subjective reality; the notion was easily shared and understood by colleagues and indeed anyone in the environment, with my view supported by Berger and Luckmann (1991).

A similar situation existed with the use of familial terms such as referring to the resident as mum or dad or a grandparent: "*It's like our dad or mum we are treating them like this other person. The resident I saw die just wanted to be held and comforted*" (Inna). Researchers suggest use of such ageist language reflects a patronising and

condescending relationship, demonstrated especially in the language used to the older person (Kane, 2002; Nussbaum et al., 2005). Although using these terms may be explained as examples of ageism, findings from my research suggests that some participants expressed it is a demonstration of respect common to their culture, as explained by an HCA from the Philippines: "*maybe because we are family orientated we are brought up to be really close to family*" (Inna). Using the term mum or dad or expressing caring for the resident as the HCA would to a grandparent, was an endearment, it meant respect and was perceived by the HCA to be an integral aspect of the job, as stated by Penny: "*my job is to look after the residents because when you come here this is like family. This is your family, this is how I see my family.*" Interestingly, Fischer and Wallhagen (2008) used the term 'fictive kin' to describe how the HCA replaces his/her family with the family of the residents, providing them with the respect and love. Fischer and Wallhagen reported the use of honorifics in addressing the resident as common, and this was a finding of the current study.

Language indicating a denigration of respect would be that associated with caring for a child, referring to the resident as a baby, using nappies, or explaining that the resident behaved as a child and was frequently reported with residents suffering dementia. This language was commonly used alongside actions associated with providing task focussed care and, in two reported instances, care that demonstrated a lack of understanding of the disease. "*She's a dementia patient, there's no point in talking with her. I fit her in and do her care, put the nappy on and put her in the lounge. I don't spend as much time or detail on them as they don't understand*" (Kate). Using baby talk/elderspeak, was reported as promoting the resident's withdrawal in communication and adversely affected relationships surrounding the resident, with others perceiving this form of communication as being the most appropriate and affecting the culture of the organisation (Johnston & Womack, 2015). Using elderspeak

183

was also reported as affecting resident behaviour with Williams et al. (2012) examining emotional tones used in association with this language and the corresponding reaction of residents with dementia. Responding poorly to the condescending language, the resident was twice as likely to resist care. Verifying this finding are reports from my study, with many of the participants providing examples of elderspeak and speaking of receiving abuse from residents. If the findings from studies such as Williams et al. (2012) were acknowledged and training in appropriate methods of speaking to residents were introduced, perhaps the incidences of violence would lesson.

Communication with the residents is important and examples of inappropriate language such as 'love the oldies' and 'they don't understand' have previously been provided. This language is described as ageist; language and behaviour reflecting discrimination against older persons, reinforcing stereotypical attitudes such as all elderly are; senile, frail, and deaf (Nussbaum et al., 2005). Ageism affects the attitudes of staff in ARC with this being evident in the excerpt above where Kate spoke of a resident with dementia being left alone and another HCA spoke of 'doing them'. 'Doing them' is a derogatory statement, implying control, a common feature amongst the participants' language.

Not all language used by the participants of my research was derogatory. In fact, many of the HCAs believed the language they were using was appropriate and respectful; for example, in many of the participants' narratives, residents accepted and enjoyed being a substitute family for the HCA. A common finding of this research involved the migrant participants, all of whom had left their family 'back home' transferring their affection onto the resident, effectively substituting the resident for family, as reflected in their actions and language; "*I feel like I am helping my mum*" (Nell). Fisher and Wallhagen (2008) described transferring emotion from the family onto the resident, supporting this finding. The Theory of Transference was originally provided by Freud to explain

184

transferring of emotion from one person to another and is described as being of value in providing caring in the health environment (Gattuso & Bevan, 2000).

> *"I get quite emotional about seeing them here and caring for them, no one else is here for them so we are here, on behalf of the families. I have left my family back home and they are now like my mum and my dad."* (Liz)

Transference is therefore, not necessarily a negative process and can frequently enhance the caring experience for both the HCA and the resident. For the migrant HCAs it helped lessen the feeling of loss associated with home, as explained in the above excerpt and reported by Gattuso and Bevan (2008). Transference, the demonstration of affection and caring, enriched the HCAs' and residents' experience. The majority of participants reported the give and take of emotions, the sharing of affection, respect, and caring. Many spoke of the love they had for their grandmother and then shifted this onto the resident. Participants shared the grief they felt at leaving family back home and now substituted the resident for family, even to the extent of taking them out, bringing in supplies and kissing them good night. They had transferred their affection from one family to another and received a feeling of being valued and loved in return. Reciprocity, as introduced on page 50 and explained on page 180, was important to the continued feeling of wellbeing for the HCA. Sharing emotions, giving and receiving between the HCA and resident has been identified as an important aspect of the HCA work, both from the resident view as reported by Bowers et al. (2001) and from that of the HCA (Carpenter, 2008; Frey et al., 2015; Rakovski & Price, 2010). The latter two studies explored criteria of job satisfaction pertaining to the HCA, with reciprocity one of the most dominant and being able to provide caring to another. However, my findings do support that transference and reciprocity contributed to working in the blurred domain, with the participants stepping in and up to provide the caring they perceived was required for the residents.

Implications of the Study

Policy implications

Findings from this study indicate several policy reviews are required, however my recommendations pertain to three significant areas explicitly involving a national and societal level of awareness; these are, protection for the HCA; fairer treatment of the migrant HCA by both employers and the New Zealand Government, especially in relation to Visa applications; and policies to increase the value that society places on this workforce.

Protection for the HCA

The potential benefits for regulatory changes are implied from this study. Perceptions of this workforce reveal the HCA working in a blurred and, at times, unsupported role, and amongst a vulnerable population in a constantly changing environment. The findings report consequential conditions affecting the role of the HCA in ARC, requiring complex weighing up/decision making and a range of strategies depending on the conditions in operation at the time. This research has provided opportunity to theorise the strategies of management within this blurred domain, with the findings highlighting the situation, providing a basis to inform policy and support solutions. The findings of; exploitation, intimidation and, at times, poor practice, demonstrated a workforce under immense pressure. These findings are supported in literature, with examples cited of HCAs enduring long hours, split shifts, insufficient resources, lack of supervision, unexplained termination of employment and under payment (Human Rights Commission, 2012; Thornton, 2010). Reporting on a workforce requiring support and protection, which once came from the RN, this study reports the perception that this is no longer occurring, leaving a workforce feeling alone and unsupported. I believe that this function should once again be an active role of the RN and with a little structural change within ARC this could occur. Whist the HCA is not regulated by the Nursing Council of New Zealand, the RN is and as previously explained, is seen by the Nursing

Council to have a role in providing supervision. In fact, Nursing Council has provided a Guide for the RN (Nursing Council of New Zealand, 2011) explaining their supervisory requirements which, in this aged care environment have been described anecdotally as being unrealistic and adding stress to the RN workforce. Ultimately, regulation of the HCA role would provide the safety and security that the HCA requires. It is the professional and moral responsibility of the New Zealand Government to ensure that the parameters within which HCAs work are clearly defined and that the support that they desire is provided. From my findings, I recommend regulation of the HCA role, redefining the role of the RN and mandating a staff to resident ratio.

Protection for the migrant HCA

Findings indicate a workforce in serious need of protection, especially the migrant HCA. Two out of every three HCAs in this study were international migrants. Of these, half of them had qualified as nurses in their countries of origin. Many of these participants explained that they believed they were expected to perform as a pseudo RN, administering medications and providing care that should have been the responsibility of the employed RN. These HCAs described feeling insufficiently recognised for their work financially and were often placed under pressure to perform with the reported constant threat to their Visa status. Two participants expressed prolonged grief, missing their families especially in times of the stress associated with the deteriorating health of an elderly parent. However, concern over their Visa viability prevented them returning home. Many of those I interviewed demonstrated this concern, having to apply for a Visa yearly and, in some cases, every six months. These HCAs reported working in New Zealand for over 6 years, one for 12 years; becoming established and contributing to the community. Unfortunately, the role of the HCA is not seen to be of sufficient

value to Immigration New Zealand to enable the migrant HCA to apply for permanent residence (The Salvation Army Social Policy Unit & St Andrew's Village, 2017) and while New Zealand employers recognise the need for qualified and experienced HCAs it is reported by the participants that immigration policies are placing these people in precarious situations and these policies need to be reviewed. This concern has also been expressed in other research (Humans Rights Commission, 2012; Thornton, 2010).

Recognition of value

The study reveals a workforce deserving far more recognition than presently occurring. Society, as well as industry, perceives the role of the HCA to be of low value (Human Rights Commission, 2012), albeit the financial aspect is being remedied with the pay equity award increasing remuneration (Ministry of Health, 2017b). However, it is not only financial recognition that this HCA workforce deserves, it is also the increase in social and vocational status; the 'value' placed on the role. The HCA obtaining a Level 4 qualification on the New Zealand Qualifications Framework has achieved the same as a qualified tradesperson, a builder, a plumber, and an electrician. Yet, the perception of the HCA is one of far less worth (Human Rights Commission, 2012; Thornton, 2010; Twaddle & Khan, 2014). This study provided explanation as to the problem solving, analytical and decision-making expectations placed on the role, establishing the role as at least equivalent to a qualified tradesperson. These findings can be used to support a review of the role and enhanced recognition by society.

Implications for training of the HCA

This study's findings imply that the HCA effectiveness in managing their roles in ARC would be improved by additional facility specific training. An example; affecting the culture of the organisation which includes the behaviour of the resident, is the language

used. Recognition of the importance of language and associated behaviour of all, and the provision of training in the importance of respectful communication would benefit most of the organisations that the participants worked in. Not only would the behaviour towards and from the resident improve, but so too would language and behaviour between colleagues and management.

Further training is also required in understanding dementia. The occurrence of dementia is increasing, and it was apparent from these findings that there is a concerning lack of knowledge, attributing to poor care. My findings indicate that this is unintentional, stemming from ignorance. Poor care also occurs in response to conditions such as time, with HCAs prioritising the residents they perceive as understanding the care being provided and able to reciprocate with an appropriate response.

Needing training about rights and appropriate responsive behaviour are the migrant HCAs. Findings indicate a lack of understanding, an acceptance of intimidation and exploitation, and needing to hide and swallow anger due to fears about Visa status. These reports demonstrate a lack of awareness of the laws and policies of immigration in New Zealand.

Confusion is also reported about the role of the RN, with HCAs perceiving a variety of expectations and employing a range of strategies in response. Reviewing the structure of the workforce in ARC, including the role of the RN would seem inevitable with the changes occurring in response to the pay parity award; however, when this occurs it will be vital for the HCA to have training to establish a clear understanding of roles and boundaries and support available. This training will be essential for all staff, including the RN.

My recommendations for training would therefore be to; increase training on understanding societal and organisational culture in New Zealand as it pertains to aged care and increase the knowledge the RN role and the HCA the rights and

responsibilities. However, of immediate concern, is the lack of knowledge about dementia and the subsequent poor care that is being offered, with training being urgently required.

Pay equity award

I include discussion about the ramifications of the pay equity award as this affected conceptualisation of some reports by the participants, as well as affecting the ARC sector. The pay equity award occurred during the final stages of analysis of this study and thus, when considering comments such as "I don't come here for the pay" and "we deserve more", I decided to consider these in the context of the interview, rather than conceptualise around the specifics of these statements. The media resulting from the award made no impact on my findings, other than to provide an awareness that to balance the findings I needed to report on the consequences to date. Whilst the initial reaction of the pay equity award was one of jubilation for the sector (Broughton, 2017), the ramifications of the award were quickly seen and felt by all. The same month that the award was actualised, the increased cost to the employer was being passed onto the resident fees (Gee, 2017). Rest homes were restructuring staff, with some HCAs told to reapply for a 'home assistant' role, a role with little resident contact and paid below the original level of the HCA (Eder, 2017). The RN was not excluded either, with anecdotal evidence of discussions occurring which were considering replacing more RNs with HCAs, especially as the RNs were now asking for parity with the acute care sector and thus an increase in their remuneration. At the time of writing, the pay equity award has recognised an underpaid and undervalued workforce but the unintended ramifications will continue to be felt for some time (Eder, 2017).

Implications for further research

The results of this study pertain to perceptions of HCAs, the meanings that they give to their everyday experience in providing care to a vulnerable population, in a very complex environment. The findings indicate a requirement to change the structure of the workforce and define the role of the HCA. To support a more cohesive change further research examining the residents' perceptions of care as provided by the HCA is recommended; better informing provision with the resident as central to these decisions.

There have been interesting reactions to the pay parity decision in New Zealand, with some employers already restructuring the roles of the workforce. Resulting from this research, I believe that revision of roles is necessary, particularly, that of the RN and the HCA; however, this should occur on evidence-based recommendations and not as a reaction to funding. I recommend that this is an area requiring further and immediate research. There is little research as to how RNs perceive their work with the HCA and vice versa. Results would better inform training of both the RN and HCA. Further, there are few studies on the migrant HCA within New Zealand. As there are now many migrants working both as RNs and HCAs, this study would be invaluable to increase cultural awareness and would again, inform training as well as workforce policy.

Language and the implications of use within the ARC environment was significant, especially the use of familial terms and the suggestion of transference. I was unable to find any recent studies and suggest research that examined transference, especially as it related to various cultures, would provide a wealth of awareness and add to earlier research.

Finally, during this research I explain stages of 'learning the job' which initiated with working in a protective mode, progressing to balancing the workload and, finally, providing engaged caring. I could find no studies that supported these findings. I have

since had these stages confirmed during discussions with other health related colleagues and I believe that these stages would be transferrable to many occupations, however further research is recommended. Should this be verified it would provide a valuable theory explaining the progression of learning to work, underpinning both employer and educationalists' practice.

Original Contribution to Knowledge

Managing the blurred domain is a significant contribution to knowledge. Achieving the ability to manage included; weighing up conditions and situations and responding by using variations and degrees of the three major strategies of protecting self, balancing the workload, and engaging self. These are explained as three stages of learning the job, a further contribution to knowledge. The complex environment that the HCA is working in has been explained to reveal a depth of complexity that has not previously been examined. This finding corresponds with the explanation of the blurred domain which, although research has reported the work of the HCA extending into the realm of the RN, no current research explains the blurred role that has the associated feelings of responsibility as perceived by the HCA, nor explanation of actions taken.

Strengths and Limitations

Strengths

There were two dominant strengths of this research; the participants and the methodology. Being unable to find other research explaining how the HCAs managed their role in ARC, using grounded theory provided a methodology enabling construction of a theory to answer this question. Essential to grounded theory is obtaining data rich in meaning and this can only originate from participants. All participants were eager to offer their stories, sharing time, emotion, and energy. Grounded theory enabled me to share the participants' words, conceptualise meaning and answer the question and, more

importantly, the emergent nature of this methodology provided explanation of the blurred domain of the HCA. Undertaking this research as a requirement of a Doctor of Health Science was also a strength as the fundamental premise is a requirement to make a difference applicable to practice. As previously explained, this study contributes in many areas; policy, education/ practice, and further research. Transferability of findings is applicable and therefore the above contributions will affect other workforces.

Limitations

Whilst all participants shared generously, of the 16 there were only two who expressed disengagement. This may have affected findings; however, I do not believe so as all participants related their perceptions of working with non-engaged or disengaged people. There was only one male participant, however as less than 10% of HCAs are male this was not significant. I did not engage in observations thus was unable to observe the HCAs' process of managing in action. I did however, read widely, increasing sensitivity and drew upon my extensive personal experience of being within this environment.

Conclusion

This study revealed an ingenious, skilled, and concerned workforce providing care, whether that care be task focussed, or the more engaged caring that the vulnerable population within ARC require. This work was delivered in an environment of constant change, responding to residents with complex co-morbidities, further complicated by requiring palliative and/or dementia care. Working in this environment, the HCA was often required to weigh up needs quickly, before instigating appropriate strategies. These strategies were conditional on; the experience on the HCA, support, time and resources available, and the status of the resident. The inexperienced HCA erred on the side of caution, using strategies to protect self and providing task focussed care, whilst

the HCA with more experience had learned how to balance workload and progressed to utilising strategies that included engaging self and providing caring. No matter how experienced the HCA, or how comfortable he/she felt in this environment, the most dominant condition affecting all strategies was that of time.

Time, whether it was the lack of, or better use of time, was a major condition which, upon weighing up, prompted the implementation of strategies such as cutting corners and offering task focussed care. Conversely, the more experienced HCA explained making time to provide caring and instigating strategies such as; using a system, working with others, and working into own time. Knowing which resources were available and where they were located influenced time and promoted strategies such as seeking and hiding resources, negotiating and substituting for them, and allocating time to use them. Having resources available influenced the strategies used, with some HCAs reporting bringing in supplies from home and reverting to old practice when equipment and resources were unavailable. Deciding on the most appropriate strategies was reflective of the experience of the HCA and depending on this, the HCA may work in one of the three stages.

The beginner HCA was focussed on learning skills and would use various strategies of protection. During this time, the HCA was providing task focussed care; however, as he/she became more confident in the work, the strategies associated with balancing workload, such as working with others, working to a system became more common. Working in this area was reported as enabling the provision of caring, the final stage, and extended beyond the provision of caring to the residents, to include residents' families and colleagues. These three categories of working were not separate from each other, nor were they constant, with the HCA reporting moving between all three depending on weighing up needs and the conditions in place at the time. These categories answered the original question of this study '*how do health care assistants manage their*

work in aged residential care?' Weighing up needs, they protect self, balance their workload, and engage self.

However, the primary finding of this study related to working in the blurred domain, created due to a perception of being unsupported and working in a poorly defined role. Participants reported lack of direction or role description and increased employer expectation, with corresponding feelings of confusion, stress and at times, fear. This was particularly so for the many internationally qualified RNs employed as an HCA yet expected to work as a pseudo-RN. Working in this blurred domain was not restricted to the migrant HCA, with all participants explaining expectations and a professed obligation to step in and/or up, to fill perceived gaps in care. Creating the gap was usually an inaction or incorrect reaction of the RN who no longer offered the services that were once common. The RN was reported to be focussed on compliance issues and had insufficient time to provide the essential tasks of the role, such as issuing medications. Where once the RN was the participatory leader of the HCA workforce in ARC, this was explained as no longer being so, frequently resulting in the HCA feeling unsupported and assuming a responsibility that should not have been necessary. Responding to needs, be it their own, residents' or colleagues', the Health Care Assistant working in ARC is operating within the *blurred domain*, an environment of high risk and vulnerability, needing the safety and protection obtained from regulated boundaries.

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APPENDICES

Appendix A: AUTEC Approval

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

25 September 2015

Barbara McKenzie-Green
Faculty of Health and Environmental Sciences

Dear Barbara

Re Ethics Application: **15/309 The work of the health care assistant in aged residential care.**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 24 September 2018.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 24 September 2018;

- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 24 September 2018 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Chritine Clark christine@corpgroup.co.nz, Valerie Wright-St Clair

Appendix B: Consent Form

Consent Form

Project title: *The work of the health care assistant in aged residential care*

Project Supervisor: *Dr Barbara McKenzie-Green and Dr Valerie Wright-St Clare*

Researcher: *Christine Clark*

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 17.08.2015.

- ○ I have had an opportunity to ask questions and to have them answered.

- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.

- ○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

- ○ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.

- ○ I agree to take part in this research.

- ○ I wish to receive a copy of the report from the research (please tick one): Yes○ No○

Participant's signature: ....

Participant's name: ....

Participant's Contact Details (if appropriate):

....

....

....

....

Date:

Approved by the Auckland University of Technology Ethics Committee on September 24th 2015 AUTEC Reference number 15/309

Note: The Participant should retain a copy of this form.

Appendix C: Participant Information Sheet

Participant Information Sheet

Date Information Sheet Produced:

17.08.2015

Project Title

The work of the health care assistant in aged residential care.

An Invitation

My name is Christine Clark and I am a Registered Nurse and post-graduate student at AUT University with a special interest in how health care assistants manage their work in aged residential care. I am doing this study for my Doctor of Health Science thesis. My supervisors Dr Barbara McKenzie-Green and Dr Valerie Wright-St Clair have a special interest in the provision of aged care services and believe that understanding the role of the health care assistant is very important.

You are invited to participate in this study which will explore what the typical day is like for you and how you manage these activities. Your participation in this research project is voluntary and you may withdraw from the study at any time. I have no involvement in any aged care facility therefore you will not be advantaged or disadvantaged in any way if you choose to participate or not.

What is the purpose of this research?

I want to understand what the role of the health care assistant actually entails. How you manage all of the tasks and emotions involved in your role. This will involve one or two interviews with you.

How was I identified and why am I being invited to participate in this research?

You will have either responded to an advertisement about the study on a noticeboard at your place of work, or have attended a meeting at your place of work. You are eligible to volunteer if you have worked as a health care assistant in aged residential care for more than four months and have conversational English. If you are directly affiliated with any of the researchers, or have been a past student of Corporate Academy Group or know of a past student then we will not be able to accept you into the study.

What will happen in this research?

If you wish to participate, please contact me. I will first check you are eligible to volunteer for this study, that you don't know me or of my organisation and that you have worked in aged care for over 4 months. We will then discuss a time and place to meet for the first interview which would be approximately one hour and I will ask you to sign the Consent Form. The interview could happen at the local library, Church meeting room, or any other private place similar that you are comfortable in. With your consent the interview will be audio taped and typed so that I can think about your responses. I may find after listening and reading your comments that another interview with you would be very helpful but this would be approximately 30 minutes. This will be in total confidence, your employer will not know. At the end of my research I would value the opportunity to share the results with you and if you too would like this then we could organise a short time to meet and discuss these.

What are the discomforts and risks?

It is not anticipated that you will experience any significant discomfort or embarrassment and it is not my intention to ask questions that may cause you any discomfort. It is possible, however, that you may experience minor emotional distress during the discussion.

How will these discomforts and risks be alleviated?

I will be watching for any signs of your discomfort or embarrassment. You may choose at any time to not answer a question, or if you become uncomfortable at any point you can choose to not talk about the subject and may leave the interview. If we discuss something that has upset you then you are able to see the AUT Health and Counselling for three free visits and I can provide you will that information at any time.

What are the benefits?

In other studies with health care workers talking about familiar and important everyday activities, people have reported they gain new and beneficial understandings about themselves and their lives. By participating in this study, you may experience personal benefits from sharing what you do every day as a health care assistant. As this study is

the first of its type in New Zealand, the findings may help other staff, employers and the Government understand as to what the health care assistant role actually is.

How will my privacy be protected?

Maintaining your confidentiality is very important to me. A pseudonym (fictitious name) will be used when the interviews are typed (transcribed) and when referring to any information from the study in research reports or published articles. No material which could personally identify you will be used in any reports on this study. If necessary, confidentiality will be maintained by changing any identifying details in the transcripts and in any reports, presentations, or publications arising from the research.

All material pertaining to the study, including your contact details and the interview transcript will be stored in a locked filing cabinet at my business for six years, then destroyed. During the study, only myself and my supervisors will have access to the information.

I will meet with you away from your working environment and I will not be informing your employers of your help. If I see you when I come into your facility for further recruitment I will be very discreet in anything I say or do so that no one will know that you are assisting in this research.

What are the costs of participating in this research?

There will be no financial cost to you for participating in this study. Participating will take up to 2 hours of your time, however I may contact you again to check something out. I will also like to share my findings with you, which may take up to 30 minutes.

What opportunity do I have to consider this invitation?

If you would like to assist me with this research I would like to hear from you within the next two weeks please.

How do I agree to participate in this research?

If you choose to participate in this research, you just need to contact me at the email or phone number given at the end of this form. You will be asked to sign the consent form (attached) when you come in for your first appointment time. I will check that you understand what we are going to talk about and then I will ask you to sign the form. We will have discussed and agreed upon the place that the first interview will take place in.

Will I receive feedback on the results of this research?

Yes, you will get a summary of the results of this research. I will have a summary for you to read and I would like the chance to discuss it with you, which would take no more than 30 minutes.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Barbara McKenzie-Green, email: barbara.mckenzie-green@aut.ac.nz, Ph: 9219999 ext 7352

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Should you wish to use the three free counselling sessions due to issues that have arisen from the interview you are very welcome to contact either the AUT City Campus on Phone 9219992 or drop into WB219 or AS104 or on the North Shore phone 9219998 to make an appointment. You will need to let the receptionist know that you are a research participant assisting me and give them my name and details please. You will be very welcome and can find out more about these Counsellors at the website;

http://www.aut.ac.nz/students/students_services/health_counselling_and_wellbeing

Researcher Contact Details:

Christine Clark Christine@corpgroup.co.nz mobile 0274990142

Project Supervisor Contact Details:

Dr Barbara McKenzie-Green, email: barbara.mckenzie-green@aut.ac.nz, Ph: 9219999 ext 7352

I would like to thank you for considering assisting in this research.

Appendix D: Confidentiality Form

Confidentiality Agreement

For someone transcribing data, e.g. audio-tapes of interviews.

Project title: *The work of the Health Care Assistant in Aged Residential Care Project*
Supervisor: **Dr Barbara McKenzie-Green**

Researcher: **Christine Clark**

☑   I understand that all the material I will be asked to transcribe is confidential.

☑   I understand that the contents of the tapes or recordings can only be discussed with the researchers.

☑   I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: ....

Transcriber'sname: .....Shoba Nayar...

Transcriber's Contact Details (if appropriate):

...email: snayar19@gmail.com..

....

....

....

Date: 9th November 2015

Project Supervisor's Contact Details (if appropriate):

....

....

....

....

Approved by the Auckland University of Technology Ethics Committee on September 24th 2015 Reference number 15/309

Appendix E: Poster

Health Care Assistants Needed

Health Care Assistants are needed to help with a research project.

- Have you been a Health Care Assistant longer than 4 months?
- Can you hold a conversation in English?

If so, would you be prepared to give approximately one to two hours of your time for an interview by the researcher?

If you would like to ask any questions or receive some information about the study, please do not hesitate to contact:

Christine Clark

 (AUT University student)

Phone or text: 0274990142

Email Christine@corpgroup.co.nz

Appendix F: Memo

Concept: assuming responsibility.
This comes from the memo of "it's on us' (1.21.e) a feeling of responsibility.
Initially I played with words such as accepting, taking, assuming and wanting, all in relationship to some aspect of ownership of responsibility for 'the job' especially areas related to providing care.

Accepting implies that the responsibility has been offered, handed over, and that the responsibility is wanted, however although the HCA might believe that this is an aspect of the job there does not appear to be any direct 'offering' of responsibility from management, there is however delegation of certain aspects of the job by middle management to the HCA such as writing care reports which are important in the day to day running of the facility as well as for audit purposes.

Taking implies a more physical or positive mode of action, acknowledging and accepting the choices made by the HCA and the consequences of those actions. Although this may occur at times on an individual basis for a specific incidence it is not the norm. An example is when the HCA responds in an emergency and does not get the support from the RN that is expected. Although in many instances the HCA is not mandated to provide the required care it is felt by the HCA that they must fulfil their duty in the interest of the client.

Assuming implies an almost insidious acceptance of responsibility in that the care giver feels a duty or an obligation. The two words duty and obligation are often seen as interchangeable however duty is influenced by morality whereas obligation is a feature of maintaining order, abiding by rules. Morality is the characteristic that we associate most with the HCA, the loving, caring, 'maternal' person providing care to the vulnerable. Many HCA's speak of this as the most important aspect of their work. They describe loving the clients and caring for them as though they were their own children or parents. This aspect of the work provides the fulfilment which is important to them and keeps them in this type of employment. Maintaining order, abiding by rules suggests supporting the employer. By fulfilling an unspoken or at times spoken obligation to provide care which makes the place more attractive and thereby more 'marketable' the HCA is assisting the employer to fill beds and thus employment may be more secure. There is also the understanding that by abiding by rules of the organisation the care of the client should be better. However due to the very strong pull of the moral aspect of assuming responsibility there is at times a conflict between the duty and obligation roles. An example is when there is a lack of time or equipment and a client needs to be moved, the HCA may abide by the rules and wait for a hoist or may revert to old practice, manually moving the client. The client is not waiting and is now more comfortable, the task is completed and the duty of providing care has been provided, however the rules have been bent or broken. Bending and breaking the rules is a direct threat to employment and many HCAs are anxious over disciplinary and employment issues.

Assuming responsibility also suggests an authority over or control over something or someone and thereby an autonomy.

Authority over the client is unspoken and unacknowledged however exists in all facets of living in an aged care environment. The expectation that incontinent products will be worn even when not needed; the time tabling of meals and showers are all evidence of

control over the client. Some HCA's will 'allow' the client some say in when some care are provided, however due to rules and task completions this may vary. The HCA speaks of not trusting the RN anymore and manipulating the day to bypass the need to be involved with the RN. They speak of relying on each other and appear to have a hierarchy amongst themselves which may not be acknowledged by management. There is also discussion about lack of recognition for service, effort and leadership by management but there is a quiet satisfaction in being seen as a leader by the other staff. This also impatience when this 'leadership' is not acknowledged correctly, especially by the 'young ones'.

The memo.
 "It's on us" implies commitment, a feeling of responsibility, an obligation. A feeling of responsibility implies obligation to fulfil a duty or duties and in doing so a feeling of success or satisfaction is obtained. By achieving the role of main care giver and taking ownership of the residents the HCA is promoting an intrinsic reward for the care provided. The residents show respect and appreciation that may be lacking from the management of the organisation.

There are many aspects to the HCA's feeling of responsibility
.
Responsibility of providing care, as a 'parent'. Many HCA's speak of loving their work, loving their residents, treating them as their own parents. However, in reality much of the work involved such as helping the resident remember to toilet (1.113.e) reduces the resident to requiring care reflective of the state of childhood. The perception may be that the HCA feels a responsibility of care as the parent does to the child. Are the HCA's getting the same intrinsic reward that the parent gets, along with the feeling of responsibility? Is the hug from the resident similar promoting feelings similar to that of the hug from the child?

The responsibility of ownership which is implied within 'It's on us', also reflects a feeling of distrust in the care and support provided by the Registered Nurse. The RN cannot be relied upon to assist in an emergency (1.227.e), is no longer involved in training the new HCA's as they once were, and in fact requires extensive training themselves (1.284.d.l). The R.N's are predominantly from overseas and do not appear to 'feel the pain' as the HCA does (1.311. e). The HCA feels that as the RN is no longer a person to be relied on that they must now step up. This feeling of distrust harbours an anger towards the RN and comment is made frequently about the RN exhibiting a power (1.356.d.l) that is not deserved as the HCA does the work (1.410.e) however the HCA is worried about their employment (1.154.e) and ramifications if they say too much. How does this concern for the resident, the feeling of responsibility towards them mesh with the lack of recognition by management in and the recognised responsibility of the inadequate RN who holds a huge amount of power over the HCA?? How does the HCA reconcile their feeling of obligation and responsibility / ownership when they disagree with what is happening?

The HCA also reports a feeling of responsibility that implies an ownership in the organisation that that in reality should not exist at this level of employment. Responsibility that goes beyond the personal care provided and into the area of management such as budgeting and recruiting of clients which is an unusual factor in the HCA world. This interviewee states many times of her concerns regarding funding, budgets, and client numbers. The HCA expresses a liking for the organisation but not to the extent that you would think that the HCA would assume this level of responsibility,

however if the HCA were to see this as a threat to continued employment then the contribution to cost cutting, saving and recruitment could be seen as insurance measures.

The HCA is concerned at continued employment, at the lack of support from the RN and expresses lack of recognition for what they do. They have assumed responsibility and ownership in all levels of the organisation which go unrecognised. Ownership and responsibility carries with it reward. In some cases, continual employment in a job that evokes feelings of fulfilment in caring for a dependant in the face of adversity (the RN) may be sufficient.