

**EXPLORING THE ROLE
OF PATIENT CARE WORKERS
IN PRIVATE HOSPITALS IN THE CAPE METROPOLE**

LOUISE ANNET AYLWARD



Thesis presented in partial fulfillment of the requirements
for the degree of Master of Nursing Science
in the Faculty of Medicine and Health Sciences
Stellenbosch University

Supervisor: Mrs Talitha Crowley

Co-supervisor: Professor Ethelwynn Stellenberg

March 2015

DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Signature:

Date: 16 February 2015

Copyright © 2015 Stellenbosch University

All rights reserved

ABSTRACT

Controversy was observed regarding the opinions of nursing managers on the role of patient care workers (PCWs) in private hospitals. These opinions ranged from praise for their contribution towards patient care to serious concerns about the impact of their role on patient safety. The aim of this study was therefore to explore the role of PCWs in private hospitals in the Cape Metropole, South Africa.

A qualitative approach with a descriptive design was applied to explore the role of PCWs as perceived by unit managers, nurses and patient care workers. Purposive sampling was used to select participants from medical and surgical wards from three different private hospitals, one each from the three major private hospital groups in South Africa (n=15). Permission to conduct the study was obtained from the Health Research Ethics Committee of the Stellenbosch University, as well as from the private hospital organisations.

Fifteen semi-structured interviews were conducted, transcribed and analysed. Six themes emerged from the data. These included PCW activities, care organisation, position in the patient care team, training, reasons for employment and concerns about the PCW role. The findings indicated strong similarities with the health care assistant role as described in the literature study. The activities of PCWs are focused on direct patient care and they spend much time with patients. They are close observers of the patient's condition and report to nurses. PCWs seem to be well integrated into the patient care team and are mostly seen as nurses.

Yet, there are concerns about their evolving role despite their limited training programmes and the lack of direct supervision. The researcher recommends that the work of PCWs should be regulated, but that the nursing profession should critically evaluate the need for another nursing category in addition to that of the enrolled nurse auxiliary.

Key words: health care assistant, unlicensed assistive personnel, patient care worker, care giver, skill mix, auxiliary nurse, health care and nursing

OPSOMMING

Teenstrydigheid is waargeneem met betrekking tot die opinies van verpleegbestuurders oor die rol van pasiëntsorgwerkers (PSWs) in privaat hospitale. Hierdie opinies het variëer van waardering vir hul bydrae tot pasiëntsorg tot ernstige besorgdheid oor die impak van hulle rol op pasiënt veiligheid. Die doel van hierdie studie was dus om die rol van PSWs in privaat hospitale in die Kaapse Metropol in Suid Afrika te ondersoek.

'n Kwalitatiewe benadering met 'n beskrywende ontwerp is gevolg om die rol van PSWs, soos waargeneem deur eenheidsbestuurders, verpleegsters en PSWs self, te ondersoek. Doelgerigte steekproeftrekking is gebruik om deelnemers van mediese en chirurgiese sale uit drie verskillende privaat hospitale, een uit elk van die drie grootste privaat hospitaal organisasies in Suid Afrika, te kies (n=15). Toestemming om die studie te doen is verkry van die Etiek Komitee vir Gesondheidsorgnavorsing van die Universiteit van Stellenbosch sowel as van die privaat hospitaal organisasies.

Vyftien semi-gestruktureerde onderhoude is gevoer, woordeliks getik en ge-analiseer. Ses temas het uit die data na vore gekom. Dit sluit die aktiwiteite van PSWs, die organisering van sorg, plek in die pasiëntsorg span, opleiding, redes vir indiensneming en besorgdheid oor die rol van PSWs. Die bevindinge toon 'n sterk ooreenkoms met die rol van die gesondheidsorg assistent soos beskryf in die literatuur. PSWs fokus op direkte pasiëntsorg en spandeer baie tyd met pasiënte. Weens hulle nabyheid aan die pasiënt, kan hulle die pasiënt se toestand waarneem en bevindings rapporteer aan verpleegsters. PSWs is oënskynlik goed geïntegreer in die pasiëntsorgspan en word meesal as verpleegsters beskou. Tog is daar besorgdheid oor die uitbreiding van hulle rol ten spyte van beperkte opleidingsprogramme en 'n gebrek aan toesighouding. Die navorser stel voor dat die werk van PSWs gereguleer behoort te word, maar ook dat die verpleegprofessie die noodigheid van 'n addisionele kategorie tot die assistent verpleegster, krities moet evalueer.

Sleutelwoorde: gesondheidsorg assistent, ongelisensieerde ondersteunende personeel, pasiëntsorgwerker, versorger, mengsel van vaardighede, assistent verpleegster, gesondheidsorg en verpleging

ACKNOWLEDGEMENTS

I would like to express my sincere thanks to:

- Estelle Coustas and Mediclinic SA, for the opportunity to do the Masters degree;
- My family and friends for their interest and support;
- Freddie Aylward for language editing and fruitful debates;
- Carl Zeelie and Christine Boswell, for proof reading and final checks;
- The ethics committees and specifically the nursing managers of the three hospitals for permission to approach their employees;
- All the study participants who shared their time and experiences;
- Talitha Crowley, my supervisor, and Professor Ethelwynn Stellenberg, my co-supervisor, for their support, guidance and dedicated feedback throughout the research project.

TABLE OF CONTENTS

| | |
|---|------------|
| Declaration | i |
| Abstract | ii |
| Opsomming | iii |
| Acknowledgements | iv |
| List of tables | ix |
| List of figures | x |
| Appendices | xi |
| Abbreviations | xii |
| CHAPTER 1 FOUNDATION OF THE STUDY | 1 |
| 1.1 Introduction..... | 1 |
| 1.2 Significance of the problem | 2 |
| 1.3 Rationale | 2 |
| 1.4 Research problem | 2 |
| 1.5 Research question | 2 |
| 1.6 Research aim | 2 |
| 1.7 Research objectives | 3 |
| 1.8 Conceptual framework | 3 |
| 1.9 Research methodology | 5 |
| 1.9.1 Research design | 5 |
| 1.9.2 Study setting..... | 5 |
| 1.9.3 Population and sampling | 5 |
| 1.9.4 Data collection tool | 5 |
| 1.9.5 Pilot interview | 6 |
| 1.9.6 Trustworthiness | 6 |
| 1.9.7 Data collection | 6 |
| 1.9.8 Data analysis..... | 6 |
| 1.10 Ethical considerations | 6 |
| 1.10.1 Right to self-determination | 7 |
| 1.10.2 Right to confidentiality and anonymity | 7 |
| 1.10.3 Right to protection from discomfort and harm | 8 |
| 1.11 Definitions..... | 9 |
| 1.12 Duration of the study | 10 |
| 1.13 Chapter outline | 10 |
| 1.14 Significance of the study | 10 |

| | | |
|---|---|-----------|
| 1.15 | Summary | 11 |
| 1.16 | Conclusion..... | 11 |
| CHAPTER 2 LITERATURE REVIEW..... | | 12 |
| 2.1 | Introduction..... | 12 |
| 2.2 | Electing and reviewing the literature | 12 |
| 2.3 | Background | 13 |
| 2.4 | International context..... | 14 |
| 2.5 | South African context | 14 |
| 2.6 | Reasons for the employment of HCAs | 15 |
| 2.7 | Content of HCA's work | 16 |
| 2.7.1 | Nursing versus non-nursing tasks | 16 |
| 2.7.2 | Direct patient care | 17 |
| 2.7.3 | Indirect patient care..... | 17 |
| 2.7.4 | Misuse and non-use of HCAs..... | 18 |
| 2.8 | Care organisations | 18 |
| 2.9 | Supervision..... | 19 |
| 2.10 | Concerns | 20 |
| 2.10.1 | Letting go of nursing..... | 21 |
| 2.10.2 | Nurses divorced from the bed-side..... | 22 |
| 2.10.3 | Lack of competence | 22 |
| 2.10.4 | Insufficient communication in teams..... | 23 |
| 2.10.5 | Unclear, variable roles..... | 24 |
| 2.11. | Summary | 24 |
| 2.12. | Conclusion..... | 25 |
| CHAPTER 3 RESEARCH METHODOLOGY | | 26 |
| 3.1 | Introduction..... | 26 |
| 3.2 | Aim and objectives | 26 |
| 3.3 | Study setting..... | 26 |
| 3.4 | Research design | 27 |
| 3.5 | Population and sampling | 28 |
| 3.5.1 | Inclusion criteria | 29 |
| 3.5.2 | Exclusion criteria | 30 |
| 3.6 | Instrumentation..... | 30 |
| 3.7 | Pre-test..... | 30 |
| 3.8 | Trustworthiness | 31 |
| 3.8.1 | Credibility..... | 31 |
| 3.8.2 | Transferability..... | 31 |

| | | |
|--------|--|-----------|
| 3.8.3 | Dependability..... | 31 |
| 3.8.4 | Confirmability..... | 32 |
| 3.9 | Data collection..... | 32 |
| 3.10 | Data analysis..... | 34 |
| 3.10.1 | Familiarisation and immersion..... | 35 |
| 3.10.2 | Inducing themes..... | 36 |
| 3.10.3 | Coding..... | 36 |
| 3.10.4 | Elaboration..... | 37 |
| 3.10.5 | Interpretation and checking..... | 37 |
| 3.11 | Summary..... | 37 |
| 3.12 | Conclusion..... | 37 |
| | CHAPTER 4 FINDINGS | 39 |
| 4.1 | Introduction..... | 39 |
| 4.2 | Section A: Biographical data..... | 39 |
| 4.3 | Section B: Themes emerging from the interviews..... | 39 |
| 4.3.1 | Activities of PCWs..... | 40 |
| 4.3.2 | Care organisation..... | 46 |
| 4.3.3 | Position in the patient care team..... | 48 |
| 4.3.4 | Reasons for employment..... | 50 |
| 4.3.5 | Training..... | 51 |
| 4.3.6 | Concerns about the PCW role..... | 52 |
| 4.4 | Summary..... | 55 |
| | CHAPTER 5 DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS | 56 |
| 5.1 | Introduction..... | 56 |
| 5.2 | Discussion..... | 56 |
| 5.2.1 | Objective 1: The activities of PCWs in medical and surgical wards..... | 56 |
| 5.2.2 | Objective 2: The supervision of PCWS..... | 58 |
| 5.2.3 | Objective 3: Their position in the patient care team..... | 59 |
| 5.2.4 | Objective 4: Reasons for their employment..... | 60 |
| 5.2.5 | Objective 5: Concerns about their role..... | 61 |
| 5.3 | Limitations of the study..... | 62 |
| 5.4 | Conclusions..... | 62 |
| 5.5 | Recommendations..... | 63 |
| 5.5.1 | Regulation..... | 63 |
| 5.5.2 | Another nursing category..... | 64 |
| 5.5.3 | Educate nurses on legislation..... | 64 |
| 5.5.4 | Skill mix..... | 64 |

| | | |
|-------|------------------------|-----------|
| 5.5.5 | Future research | 65 |
| 5.5 | Dissemination | 65 |
| 5.6 | Conclusion..... | 65 |
| | References..... | 65 |
| | Appendices..... | 71 |

LIST OF TABLES

| | |
|--|----|
| Table 4.1: Themes and sub-themes | 40 |
|--|----|

LIST OF FIGURES

| | |
|---|---|
| Figure 1.1: Conceptual map: Role of HCAs in the patient care team | 4 |
|---|---|

APPENDICES

| | |
|--|----|
| Appendix 1: Ethical approval from Stellenbosch University | 71 |
| Appendix 2: Permission obtained from first hospital group | 72 |
| Appendix 3: Permission obtained from second hospital group | 74 |
| Appendix 4: Permission obtained from third hospital group | 75 |
| Appendix 5: Declaration of consent by participant and investigator | 76 |
| Appendix 6: Demographic data | 78 |
| Appendix 7: Semi-structured interview guide | 79 |
| Appendix 8: Participant information leaflet | 80 |
| Appendix 9: Confidentiality agreement with data transcriber | 82 |
| Appendix 10: Extract of transcribed interview | 83 |
| Appendix 11: Declaration by language editor | 87 |

ABBREVIATIONS

| | |
|------|-------------------------------|
| BP | Blood pressure |
| ENA | Enrolled nurse auxiliary |
| ECG | Electro cardiogram |
| EN | Enrolled nurse |
| HCA | Health care assistant |
| HB | Haemoglobin |
| HGT | Haemoglucotest |
| PSW | Pasiëntsorgwerker |
| PCW | Patient care worker |
| PN | Professional nurse |
| SANC | South African Nursing Council |
| UK | United Kingdom |

CHAPTER 1

FOUNDATION OF THE STUDY

1.1 INTRODUCTION

The realities of the twenty-first century affect the expectations from nurses in different ways, for example that nurses have to do more with less and have to ensure a good overall experience by the patient (Armstrong, Bhengu, Kotze, Nkonzo-Mtembu, Ricks, Stellenberg, Van Rooyen & Vasuthevan, 2013:44). Economic pressure, an increasing burden of disease and the continuing nursing shortage are some of these realities. Task shifting has been identified as one solution to meet expectations despite these challenges (Armstrong *et al.*, 2013:101).

Task shifting in nursing refers to the delegation of health care activities from higher to lower categories or to non-nursing staff, e.g. health care assistants (HCAs). The aim is to ease the workload of each nurse involved while simultaneously ensuring quality patient care (Callaghan, Ford & Schneider, 2010:6).

HCAs within nursing, refers to assistive personnel who do not have formal nursing training and are not regulated by a statutory nursing body (Spilsbury & Meyer, 2004:412). According to international literature, the numbers of HCAs are steadily increasing and their scope of practice is extending in response to service delivery demands (Spilsbury, Stuttard, Adamson, Atkin, Borglin, McCaughan, McKenna, Wakefield & Carr-Hill, 2009:623), resulting in less distinctive role boundaries between registered nurses and HCAs (Butler-Williams, James, Cox & Hunt, 2010:459). It therefore becomes increasingly important to define the work of HCAs, their relationship with registered nurses and the implications of their employment for the nursing workforce and patient care (Spilsbury & Meyer, 2004:417).

Patient care workers (PCWs), also known as care givers, are a specific group of HCAs, employed in South African private hospitals to assist nurses with patient care (Dorse, 2008:59). There is a tendency to increase the number of PCWs in private hospitals, although there are critical voices raised against their employment and the possible risks to patient safety. Their increased use is not based on best practice, but a strategy to address the shortage of qualified staff and of health care inflation (Dorse, 2008:3).

The role of PCWs in private hospitals remains unexplored. No scientific studies could be found to inform opinions of health care resource decision-makers about the role of PCWs in

South Africa. The aim of the proposed study is therefore to explore the role of PCWs in private hospitals.

1.2 SIGNIFICANCE OF THE PROBLEM

The researcher, who is employed in a managerial position in one of the private hospital groups, experienced that controversy exists around the acceptance and inclusion of PCWs in patient care teams in hospitals in South Africa. Nursing managers are either outspoken about their positive contribution to patient care, or concerned about their lack of standardised training, undefined scope of practice and unregulated state. Additionally, there is a gap in the literature to inform health care resource decision-makers about their role. This could lead to the nursing profession not using the benefits or effectively managing the risks of employing PCWs in hospitals.

1.3 RATIONALE

The shortage of trained nurses, health care inflation and the increasing burden of disease has been the catalyst for the employment of PCWs (Furåker, 2008:543). However, the researcher observed that there are different opinions on the inclusion of PCWs in patient care teams in hospitals in South Africa. Opinions range from embracing them and praising their contribution, to serious critique against their employment, specifically in relation to direct patient care.

No formal studies to describe their role in the Cape Metropole or in South Africa could be found. Therefore this study allowed for the opportunity to explore the role of PCWs in private hospitals and provides a starting point for further investigation.

1.4 RESEARCH PROBLEM

PCWs have been employed in private hospitals for several years, but their role remains controversial and not clearly described. This leads to uncertainty about their role and management and either resistance to their employment or potentially ineffective or unsafe use of the PCWs already employed.

1.5 RESEARCH QUESTION

What is the role of PCWs in private hospitals in the Cape Metropole?

1.6 RESEARCH AIM

The aim of this study is to explore the role of PCWs in private hospitals in the Cape Metropole.

1.7 RESEARCH OBJECTIVES

The objectives of this study are to explore the role of PCWs in private hospitals in the Cape Metropole regarding:

- the activities of PCWs in medical and surgical wards;
- the supervision of PCWs;
- their position in the patient care team;
- reasons for their employment; and
- concerns about their role.

1.8 CONCEPTUAL FRAMEWORK

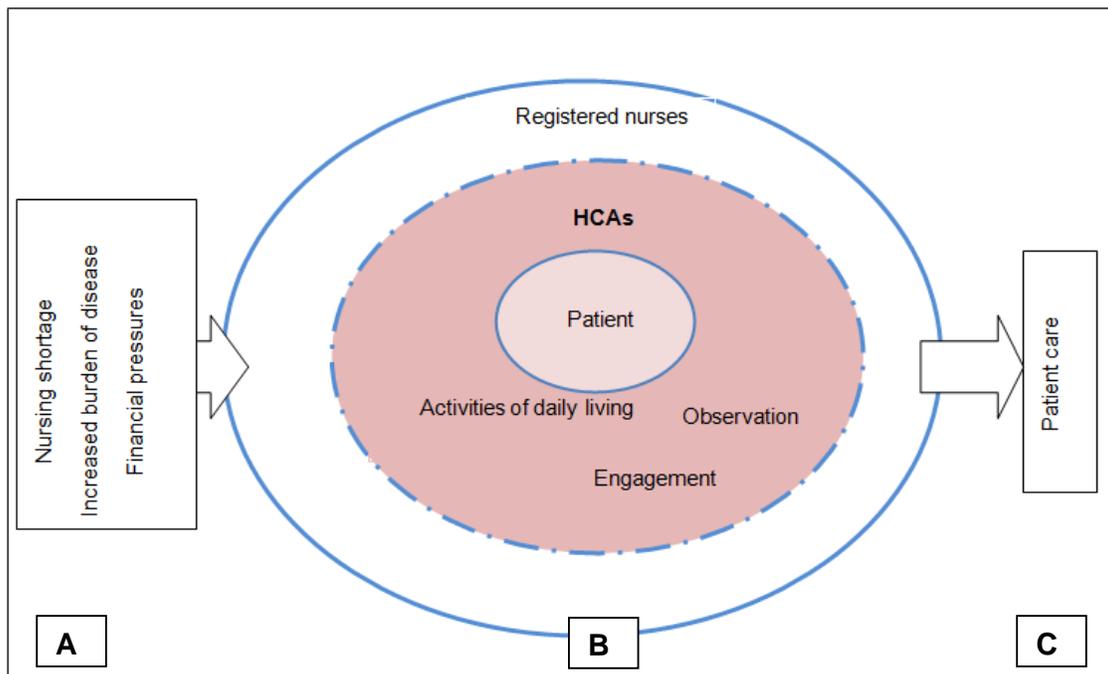
A conceptual framework is an abstract, logical structure of meaning that guides the study and enables the researcher to link the findings to the body of knowledge in nursing (Grove, Burns & Gray, 2013:116). A conceptual map is a graphic presentation of the framework and depicts the relationships between concepts and statements (Burns & Grove, 2007:179).

The researcher followed the steps described in Burns and Grove (2009:149) to develop a conceptual framework. Each of the relevant concepts identified in the literature, was written on a piece of paper. The concepts were moved around on a page, to form logical groups of interrelated concepts which were then linked by arrows to indicate relationships. This was discussed with peers and the supervisor.

The following conceptual framework, presented as a conceptual map in figure 1.1, illustrates the role and activities of HCAs in the patient care team, as described in the literature.

Figure 1.1: Conceptual map: Role of HCAs in the patient care team

(Figure by researcher)



The three labels indicate the following:

Label A: The reasons for the increased employment of HCAs in care teams are described as the nursing shortage, the increased burden of disease and financial pressure experienced by health care providers (Furåker, 2008:543).

Label B: Patients are cared for by a patient care team, consisting of nurses under leadership of the registered nurse. HCAs are members of the patient care team (Prestia & Dyess, 2012:144). They provide assistance with activities of daily living and the caring and nurturing of patients. Because they spend much of their day close to the patients, they have the opportunity to engage with patients through a caring relationship, to provide care and comfort, to teach and to be insightful observers of deterioration (Prestia & Dyess, 2012:144-146).

The patient is the centre of the care team's activities, depicting individual, patient- centered care, which is an essential approach to quality patient care (WHO, 2007:9).

The role boundary between registered nurses and HCAs is not distinctive (James *et al.*, 2010:459) and is therefore depicted as a perforated boundary in figure1.1.

Label C: This support, engagement and observation increase patient satisfaction and safety, therefore influencing patient care significantly (Prestia & Dyess, 2012:146). However, Kalish (2009:486) reports that a number of studies showed concern about the performance of HCAs' work.

The conceptual map guided the interview guide and was used to link the findings to the relevant literature.

1.9 RESEARCH METHODOLOGY

The research methodology provides a framework to ensure that the study fulfils a particular purpose (Terre Blanche, Durrheim & Painter, 2006:34). Specific aspects of the methodology are subsequently briefly described. A more detailed description will follow in chapter 3.

1.9.1 Research design

An explorative descriptive qualitative design was used in order to explore the role of PCWs as perceived by the participants. Furthermore, the data collection and analysis were guided by the conceptual framework

1.9.2 Study setting

The research was conducted in medical and surgical wards in three private hospitals in the Cape Metropole in the Western Cape, South Africa. The researcher observed that most PCWs are utilised in the medical and surgical wards of hospitals, therefore the focus on these wards in this study.

1.9.3 Population and sampling

The population consisted of unit managers, nurses and patient care workers who were permanently employed to work in either the medical or surgical wards in the three private hospitals and who had at least one year experience of working with or as PCWs. Purposive sampling was used to select one unit manager, one professional nurse, one other nurse (either an enrolled nurse or an enrolled nurse auxiliary) and two PCWs in each of the three hospitals for individual interviews.

1.9.4 Data collection tool

A semi-structured interview guide, with open questions and additional probing words, based on the literature and focused on the objectives of the study, was used to explore the role of

PCWs. Additionally, demographic data of participants was collected by the researchers prior to each interview.

1.9.5 Pilot interview

The pilot interview involved one enrolled nurse auxiliary from a target hospital. The researcher conducted the interview with the support of the supervisor, who added probing questions. During the interview, it was discovered that the nurse worked in a surgical intensive care unit and not in a surgical ward. Although the data was excluded from the study, the interview guide and process could be tested. No changes were made to the interview guide.

1.9.6 Trustworthiness

Trustworthiness was ensured through application of the principles described by Lincoln and Guba in De Vos, Strydom, Fouche and Delport (2011:346-347) and in Wahyuni (2012:77-78). The four principles, described in detail in chapter 3, are credibility, transferability, dependability and conformability and were applied to ensure the scientific rigor of the research.

1.9.7 Data collection

Interviews were conducted by the researcher and supervisor. The researcher was trained regarding the interview process by the University of Stellenbosch with further guidance from the supervisor. Interviews were conducted and audio recorded in comfortable venues in each of the three hospitals and at dates and times suitable to the participants. Each discussion started with a short summary of what the interview and study were about as advised by Terre Blanche *et al.* (2006:29). The researcher documented relevant demographic data of participants.

1.9.8 Data analysis

The researcher and an experienced transcriber transcribed the interviews verbatim. Data was analysed and interpreted according to the five steps described by Terre Blanche *et al.* (2006:322-326), as expounded in chapter 3.

1.10 ETHICAL CONSIDERATIONS

Ethical research refers to respect for the human rights of participants and the publication of accurate scientific information (Burns & Grove, 2007:197). To ensure an ethical foundation,

permission to conduct this study was obtained from the Health Research Ethics Committee of the University of Stellenbosch (Ethics Reference: S14/02/04) and the research boards of the three hospital organisations (Appendices 1 – 4).

Respect for the rights of participants was ensured throughout the study by observing the ethical principles of the right to self-determination, confidentiality and anonymity, as well as the right to be protected from discomfort and harm, as subsequently discussed.

1.10.1 Right to self-determination

The right to self-determination supports the ethical principle of respect for people. This indicates that participants should be treated as people who have the freedom to conduct their lives as they choose and without external controls (Burns & Grove, 2007:204). In this study, the participants' self-determinism was protected by the provision of information, free consent and voluntary participation in the study (Burns & Grove, 2007:209).

Information about the study, namely a summary and the research proposal, was e-mailed to the research boards of the three private hospital groups with the request for permission to conduct the study in their hospitals. This information was also shared with the nursing manager of each hospital. Potential participants were informed by means of a leaflet, including a description of the purpose of the study and the expectations from the participant (Appendix 8). Prior to the start of each individual interview the researcher confirmed the purpose of the research, the role of the participant, the expected time required and the confidentiality of information. The recording of responses was explained and permission to audio record the interview was obtained. Prior to obtaining written consent (Appendix 5), the interviewer ensured that the participants had the opportunity to clarify relevant aspects and that they understood the information. Opportunity to ask questions was provided during and after the interview.

Participants were ensured that their participation was entirely voluntary and that they were free to decline to participate. Their refusal to participate would not affect them negatively in any way. It was explained that they were free to withdraw from the study at any point and without any explanation, even if they had agreed to take part. None of the participants chose to withdraw from the study.

1.10.2 Right to confidentiality and anonymity

Confidentiality and anonymity support the participant's right to privacy of information. Privacy refers to the freedom of people to determine the time, extent and circumstances

under which their private information may be shared with others. Private information includes a person's identification, opinions and records (Burns & Grove, 2007:209).

Complete anonymity would exist if the participants' information could not, in any way, be linked to their individual responses (American Nurses Association in Burns & Grove, 2009:212). Due to the written consent and the individual interviews, the researcher knew the identity of the participants and hospitals, but ensured the participants that their identity would be kept anonymous from other people. The researchers mentioned neither the hospitals' nor the participants' names during the interviews or field notes. Pseudonyms were used during the interviews and when direct quotes from the interviews were utilised to support results. Pseudonyms were also used during audio transcriptions where participants used the actual names of colleagues or hospitals during interviews.

Confidentiality refers to the management of private information of participants by the researcher. The researcher has to refrain from sharing private information without the authorisation of the participant (Burns & Grove, 200:212). During the study participants were assured that the information they shared, would be held in confidence. The researcher also guarded against using long quotes made by participants, as those could reveal the identity of the participants. For the duration of the study, the researcher protected the recordings, transcripts, working documents and consent forms from unauthorised access by either storage in a locked cupboard or in password protected files. After completion of the study, all hard copies were scanned and will be saved electronically in password protected files for five years. Additionally, the professional data transcriber committed to confidentiality by signing a confidentiality clause (Appendix 9).

1.10.3 Right to protection from discomfort and harm

The right to be protected from discomfort and harm due to a study supports the ethical principle of beneficence, which states that one should do good and prevent harm. The participation in interviews could have caused temporary discomfort or could have been a mere inconvenience for the participants. However, the study provides information which clarifies the role of PCWs in private hospitals and could positively impact on their management and contribution to patient care. Therefore the benefit-risk ratio for this study indicates minimal risk (Burns & Grove, 2007:214). The researchers observed that the participants seemed to have a positive experience of the interviews and that no participants appeared distressed.

1.11 DEFINITIONS

The following concepts are used in this study:

Enrolled nurse auxiliary (ENA): The ENAs in this study have completed a one year training course, based on R2176 of the Nursing Act, No 33 of 2005 (SANC. Regulation 2176. November 1993, as amended).

Enrolled nurse (EN): The ENs in this study completed a two-year nursing course, based on R2175 of the Nursing Act, No 50 of 1978 (SANC. Regulation 2175. November 1993, as amended).

Nurse: A person registered in a category under section 31(1) in order to practise nursing or midwifery in terms of the Nursing Act, No 33 of 2005. In this study, 'nurse' is used as a general term, including professional, enrolled and auxiliary nurses.

Patient care worker (PCW): For the purpose of this study the patient care worker is a non-nurse without any formal training in nursing, who is not legally regulated, but involved in patient care in a hospital (Stellenberg & Dorse, 2014:2).

Private hospital: A hospital built, owned and managed by a company outside of the government healthcare sector (Hassim, Heywood & Berger, 2007:164).

Professional nurse (PN): A person registered in a category under section 31(1) in order to practise nursing or midwifery in terms of the Nursing Act, No 33 of 2005. A professional nurse is "qualified and competent to independently practise comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice" (Nursing Act, No 33 of 2005). Professional nurses obtained a comprehensive four year diploma or degree (Armstrong *et al.*, 2013:122). In this study, the term 'professional nurse' is used in the South African context. This is similar to the term 'registered nurse', which is used in the international context.

Role: Biddle (1986:67) explains 'role' as the social position of a person and the rights, obligations and expected behaviour of this person and of other persons in the particular social setting. In this study, the 'role' of PCWs refers to their position in the patient care team, their activities and supervision.

Unit manager: A registered professional nurse trained in nursing management and in charge of a nursing ward e.g. a medical ward (Booyens, 2008:121).

1.12 DURATION OF THE STUDY

Consent to conduct the study was obtained from the Health Research Ethics Committee of the University of Stellenbosch on 8 May 2014. Thereafter, permission was obtained from the ethics committees of the three hospital groups between 27 May and 7 July 2014. The nursing managers were approached and the interviews conducted from 26 June to 29 October 2014. Data transcription, analysis and interpretation of data started after the completion of the first interview and continued while the other interviews were conducted. The last interview was transcribed on 30 October 2014. Data analysis was completed on 8 November and the thesis was submitted for evaluation at the end of November 2014.

1.13 CHAPTER OUTLINE

Chapter 1: Foundation of the study

In chapter 1, the background and motivation for the study are described. A brief overview of the literature, research questions, study objectives, research methodology, definition of terms and the study lay-out are provided.

Chapter 2: Literature review

Chapter 2 provides a review and discussion of the literature relevant to PCWs in hospitals.

Chapter 3: Research methodology

Chapter 3 provides a detailed description of the research methodology utilised to explore the experience of the participants regarding the role of PCWs in private hospitals.

Chapter 4: Results

In chapter 4, the results of the data analysis are described and interpreted.

Chapter 5: Discussion, conclusions and recommendations

Chapter 5 provides a discussion of the results relevant to the study objectives. The researcher concludes the study and provides recommendations based on the scientific evidence obtained in the study.

1.14 SIGNIFICANCE OF THE STUDY

The significance of a study is related to its importance to the body of knowledge of nursing (Burns & Grove, 2007:438). Clarifying the role of PCWs should lead to a better understanding of their contribution to patient care in hospitals as well as the risks associated with their inclusion in the patient care team. The findings address the controversy around

the use of PCWs in private hospitals and may inform decisions to manage the nursing shortage and patient safety issues.

1.15 SUMMARY

This chapter contains a discussion of the background and rationale for exploring the role of PCWs in private hospitals in the Cape Metropole, Western Cape, South Africa. The significance and objectives of the study were explained. An explorative descriptive qualitative study was conducted and relevant aspects of the methodology were discussed. The study's time line and outlay were provided. The outcome of the study could support health care resource decision-makers regarding the possible benefits and risks of employing PCWs in private hospitals.

1.16 CONCLUSION

Internationally, HCAs have established their value and carried out quite demanding tasks. They are recognised as key members of the patient care team (Hand, 2012:17). South African private hospitals employ a specific type of HCA, namely PCWs. Although their numbers are increasing, there is controversy around their role and the impact thereof on patient safety. This study explored the PCW role in order to clarify their role and to address the gap in literature on this topic.

The literature review in chapter 2 provides information on the role of HCAs internationally and of PCWs and other HCAs in South Africa.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

According to Burns and Grove (2009:720), a review of the relevant literature is defined as “the analysis and synthesis of research sources to generate a picture of what is known and not known about a particular situation or research problem.”

This chapter therefore provides an analysis of sources pertaining to the role of health care assistants (HCAs), which includes patient care workers (PCWs), in hospitals. The purpose of the literature review was to:

- examine the existence of the HCA’s role internationally and in South Africa;
- determine the reasons for the employment of HCAs and for the expansion of their role;
- determine the content of their work in hospitals;
- explore aspects regarding their position in the patient care team; and
- to identify concerns about the HCA’s role.

This literature review is organised under the following headings:

- background to the HCA’s role;
- the roles, training and regulation of HCAs in the UK, Scotland and Wales, Sweden and New Zealand;
- the roles and legal aspects pertaining to enrolled nurse auxiliaries and HCAs in South Africa;
- the nursing shortage, increased burden of disease and other factors leading to the increased deployment of HCAs;
- the activities of HCAs regarding direct and indirect patient care;
- the ideology of team-nursing versus nurses’ work in practice;
- supervision of HCAs; and
- concerns of the nursing profession about the role of HCAs.

2.2 ELECTING AND REVIEWING THE LITERATURE

The review was carried out over a period of 18 months. The review commenced before the proposal for the study was started and continued throughout data analysis. Further aspects, e.g. the training of PCWs, were added to the initial literature review as a result of information shared during the interviews.

Search engines such as the Stellenbosch University Library and Information Service (SUNSearch) and Elton B Stephens Company research database (EBSCOhost) were utilized.

The majority of the material used in the review was published within the last ten years. These materials were selected from multiple databases, including the Stellenbosch University library, PubMed, websites, periodicals, journals and books. Key words included: health care assistant, unlicensed assistive personnel, patient care worker, caregiver, skill mix, health care and nursing. Both South African and international publications were reviewed.

2.3 BACKGROUND

The nursing support role can be traced back to the beginning of modern nursing, from the presence of nurses' aides during the Crimean War from 1854 to 1856, through to the auxiliary nurse role of the mid-1950s and to the HCA's role which was identified around 1990 in the United Kingdom (Hand, 2012:14). A large number of designations are assigned to unqualified nursing support workers. In the United States they have been called 'nursing assistants', 'nursing aides', 'patient care aides' and 'unlicensed assistive personnel'. In the United Kingdom (UK), their titles include 'healthcare assistant', 'clinical support worker', 'ward assistant', 'care worker' and even 'bed maker'. 'Healthcare assistant' is now the most commonly used title in the UK (McKenna, Hasson & Keeney, 2004:452). The great number of designations also indicates that there is a variety of demands, qualifications, positions and work activities related to the health care assistant role (Furåker, 2008:544).

There is no clear understanding of who these HCAs are, what they really do and what competencies they have (McKenna *et al.*, 2004:452). This implies that their role often varies depending on the country or organisation and the clinical area where the person is employed. This lack of standardisation neither helps to inform the public nor gives patients and nurses confidence to acknowledge the role of HCAs, yet they are usually recognised as an integral part of the nursing workforce (McKenna *et al.*, 2004:453).

Patient care workers (PCWs) in South Africa, are a specific category of HCA. They are non-nurses without any formal training in nursing, who are not legally regulated, but involved in patient care in hospitals (Stellenberg & Dorse, 2014:2). Although the role of HCAs internationally is fairly well described, less information is available about PCWs in South Africa.

2.4 INTERNATIONAL CONTEXT

HCA's in the UK have variable job descriptions, depending on the organisation providing employment, although their work is usually focused on patient care. The period of their training varies from two weeks to two years (Furåker, 2008:543). They are not regulated, but the current UK Coalition Government is proposing a system of voluntary regulation for healthcare support workers and is in the process of developing codes and standards as a step towards regulation (Hand, 2012:16).

In Scotland and Wales there are codes of conduct for HCA's and a code of practice for employers. Scotland also has induction standards, while Wales gives guidance regarding induction best practices. These employer-led methods of regulation were brought into practice in 2011 (Hand, 2012:16).

In Sweden, the role of HCA's is regulated through legislation since the 1950s. Their work is orientated to support the registered nurse and is focused on direct patient care and housekeeping duties (Furåker, 2008:542). They have a three year upper secondary school education in healthcare (Furåker, 2008:543).

In New Zealand, a decision document states that the HCA's role incorporates both patient support and tasks related to maintaining the physical environment. However, concerns were raised regarding the balance between direct care and housekeeping roles, the insufficiency of a three day training course and fear that the HCA's role would encroach on the enrolled nurse's scope of practice (Acute care HCA duties at Wairu Hospital, 2012:34).

International literature therefore confirms that the HCA's training, role and regulation are neither clarified nor standardised. This also seems to be the case in the South African context.

2.5 SOUTH AFRICAN CONTEXT

The nursing team in South Africa is compiled of professional and non-professional categories of nurses. The existing non-professional categories are those attained by enrolled nurse auxiliaries by completing a one year training course, enabling them to obtain a higher certificate, as well as enrolled nurses, by means of a two year course leading to a higher diploma. Professional nurses obtained a comprehensive four year diploma or degree (Armstrong *et al.*, 2013:122).

In South Africa, unlike most other countries, auxiliary nurses are regulated by the South African Nursing Council (SANC). According to the Nursing Act, No 33 of 2005, auxiliary

nurses are persons educated to provide elementary nursing care as directed and supervised by a professional nurse (PN) and the former therefore assist the PNs to provide patient care. Elementary nursing means “practical self-care and activities of daily living interventions that assist the health care users to promote and maintain their health status through the application of prescribed standards of care” (SANC. Regulation 786. October 2013).

Additionally, hospitals employ PCWs to assist nurses. They are not regulated and have no formal nursing training (Stellenberg & Dorse, 2014:1). Several training institutions in South Africa, e.g. Nido, Robin Trust and Careway provide training, ranging from three to six months to equip HCAs to provide home based care. The training program typically includes, but is not limited to, basic knowledge of the most common types of debilitating and terminal diseases, the normal process of ageing and being able to recognise when referral is needed (SAQA, 2012:np).

According to the regulations relating to the Scope of Practice of Nurses and Midwives (SANC. Regulation 786. October 2013) the PN assumes full responsibility and accountability for the safe implementation and delegation of nursing care, ensuring that nursing care is only delegated to competent practitioners or persons. However, delegating patient care to the unregulated PCWs in acute care hospitals may put patient safety at risk and may lead to PNs being confronted by ethical issues (Stellenberg & Dorse, 2014: 2).

In South Africa, there is a long history of lay health worker programs as a public health approach, particularly in resource constrained settings (Daniels, 2012:14). A lay health worker is any health worker carrying out functions related to health care delivery and who was trained in some way in the context of the intervention. They have no formal professional or para-professional certificate or tertiary education degree (Daniels, Clarke & Ringsberg, 2012:1). The contribution of lay health workers has been investigated and described by several researchers (Daniels, 2012:58), however, little information on the role of PCWs in hospitals in South Africa, could be sourced.

Several reasons for the increased use of HCAs are highlighted in literature.

2.6 REASONS FOR THE EMPLOYMENT OF HCAS

The HCA's function has grown in importance due to the continuing nursing recruitment and retention crisis (Keeney, Hasson, McKenna & Gillen, 2005:345). Additionally, the growing burden of disease and the changing profiles of patients due to an ageing population and increasing survival rates are leading to an increased demand for patient care (Furåker, 2008:543). The resulting increased patient acuity is not necessarily matched with greater

resourcing (James *et al.*, 2010:549). These factors, together with increasing demands for efficiency and productivity, affect the composition of patient care teams and the roles of the different team members (Furåker, 2008:543).

Furthermore, healthcare managers have to work within resource constraints due to financial pressure, while meeting quality patient care targets (Hunt, 2010:18). The employment of HCAs has been accepted as one approach to ensure patient satisfaction and to manage decreasing human resources in hospitals within financial constraints (Keeney *et al.*, 2005:345). Yet, the employment of HCAs in acute hospitals, with increasing patient acuities, poses risk to patient safety (Stellenberg & Dorse, 2014:8) and is further discussed in section 2.10.

Nurses involved in 'non-nursing' housekeeping, portering and secretarial duties led to a number of reports referring to the ineffective use of qualified nurses' time. It is estimated that nurses spend 50 to 70% of their time on 'low level basic tasks' that keep them away from what they have been trained to do. Therefore, one of the key arguments for the increase in the number of HCAs is that they are needed to carry out the lower level tasks and free nurses up to meet higher level patient needs (McKenna *et al.*, 2004:454). However, during the last decade, the role of registered nurses in hospitals tends to move away from direct patient care to computer work, technical duties, paper work, care planning and team co-ordination (Furåker, 2008:543).

2.7 CONTENT OF HCA'S WORK

Various authors described the content of the HCA's work day, referring to non-nursing tasks, direct and indirect patient care and how HCAs are used and mis-used in health care organisations. These are subsequently discussed.

2.7.1 Nursing versus non-nursing tasks

Traditionally, nursing practice has been defined in terms of roles and tasks. However, such a definition becomes debatable due to the shifting context of healthcare delivery and the blurring of role boundaries. One argument is that, rather than being restricted to a list of tasks, nursing should be described from a tradition of caring, based on skills and values, for example the coordinating role and the development and maintenance of programs of care (Hancock & Campbell, 2006:36).

Yet, authors continue to list non-nursing activities with the notion that these tasks could be allocated to non-nursing or support staff. Non-nursing activities performed by nurses are

listed by Estabrooks, Midodzi, Cummings, Ricker and Giovannetti (2011:78) as: delivering and fetching food trays, ordering of stock, coordinating or carrying out ancillary services, arranging discharge referrals and transportation, performing electro cardiograms, routine phlebotomy, transportation of patients and housekeeping duties. Furåker (2008:546-548) continued to divide the daily work tasks of HCAs between direct and indirect patient care.

2.7.2 Direct patient care

Direct patient care describes the time that HCAs spend with patients. Furåker (2008:546-548) described the work and every day activities of HCAs in acute hospital care in Sweden. She recorded the following aspects of direct patient care which took up an average of 50% of the HCA's workday:

- basic care, which refers to personal hygiene, toilet visits, making beds, food distribution and 'going around visiting patients'. This compiled about 25% of their workday;
- controls and treatments include the monitoring of vital signs and wound care, which made up 10% of their workday;
- conversations include supportive talks, discussions with patients in the day-room or while being accompanied and these make up 10% of the workday and
- answering patient calls that comprised about 5% of working time.

Hancock & Campbell (2006:40) report that patients are of the opinion that HCAs are more involved in direct patient care, that they look after patients and that patients have more of a relationship with HCAs than with nurses. HCAs therefore spend much time with patients and are taking on direct patient care which traditionally comprised a significant part of the nursing role. The close proximity of HCAs to patients has led them to be described as 'insightful observers' and well positioned to identify early warning signs of deterioration (James *et al.*, 2010:549).

2.7.3 Indirect patient care

Indirect patient care includes housekeeping (e.g. preparation and serving of meals and cleaning of the ward), administration duties (including documentation, checking mail and making phone calls), the fetching and delivering of items, opening and closing of doors, supervision and education of students and pauses, for example meal breaks. Indirect care makes up half of the working hours of HCAs (Furåker, 2008:548-550).

2.7.4 Misuse and non-use of HCAs

Spilsbury and Meyer (2004:415) describe the misuse of HCAs as situations in practice where HCAs are used beyond formal policies. This happens when nurses delegate activities, which are seen as nursing activities, to HCAs. These additional activities are taken on when circumstances in the nursing unit cause pressure on nurses, e.g. in situations of increased workload or insufficient staffing. Another area of additional work of HCAs is providing advice and guidance to junior staff and filling the gaps in care left by inexperienced, higher category nursing staff.

Additionally, Spilsbury and Meyer (2004:415) noted that the roles of HCAs are sometimes limited by nurses through not involving HCAs in discussions concerning patient care and discharge. Although their role as the 'eyes and ears' of the nurse is recognised, the passing on of their observations is not actively sought and valued by nurses (Spilsbury & Meyer, 2004:415).

The HCA's role is further impacted by the way that care is organised in hospitals, as explained in the following section.

2.8 CARE ORGANISATION

Care organisation refers to the way patient care is organised and tasks are distributed among all categories of health care workers (Furåker, 2008:546). Furåker (2008:546) and Kalisch (2009:485) found that the team-nursing model was most commonly used where teams of healthcare staff (e.g. a registered nurse with one or two HCAs) are allocated to care for a group of patients (e.g. seven to eight patients). A team is described as two or more individuals who are co-dependent and who share a common purpose (Kalisch, 2009:485).

While nurses and HCAs should be functioning together as teams to care for patients, the common practice is that nurses are responsible for certain tasks and HCAs for other tasks (Kalisch, 2009:488). In a study by Kalisch (2009:490) the lack of several components of team-work, leading to missed care, have been described. These are closed-loop communication, mutual trust, team leadership, team orientation and shared goals. The findings of this study show unmistakably the need to intervene to improve the quality of team-work between nurses and HCAs in support of a higher quality patient care (Kalisch, 2009:491). Kalisch (2009:491-492) further recommended the following to enhance team-work:

- that registered nurses must communicate clearly and plan carefully at the start of every shift with debriefings during the shift to report care provided or changes in care plans;
- training of all staff in how to be an effective team member, including methods of giving effective feedback and delegating appropriately; and
- actions that will enhance communication, team orientation and a shared purpose.

The division of tasks among hospital staff is influenced by several factors, such as regulations, work policies, education, leadership, supervision and interpersonal relationships (Furåker, 2008:543). Additionally, the roles of individual HCAs vary and are affected by patient needs, colleagues, staffing levels, local decisions and lack of clarity about the HCA's role (Hancock & Campbell, 2006:38). Registered nurses in charge of the nursing units have great influence on task allocation as they make decisions about the division of labour and define the need for knowledge and skills of employees (Furåker, 2008:552).

Kalish (2009:486) recorded that a number of studies have examined the working relationship between nurses and HCAs. There are mixed findings as to the opinion of nurses on the quality of work of the HCAs. Few studies show a positive view. Most studies report concern about the performance and training of HCAs. Nurses fear delegating to HCAs as they do not trust the competency levels of HCAs, especially regarding the identification of patient problems (Kalisch, 2009:487). The communication of patient problems to the nurses relies on the relationship which exists between the individual nurse and the HCA. A poor relationship could therefore lead to missed care and unsafe patient situations.

Furthermore, an Australian interview study revealed that the ideals of a holistic patient care approach as expressed by nurses and taught by nurse educators, are not demonstrated in actual nursing practice. Although nurses expressed that they believed in team work to support this ideal, nursing work appeared task orientated, routinised and therefore fragmented (Fitzgerald, Pearson, Walsh, Long & Heinrich, 2003:331). This view is supported in a study by Furåker (2008:275), which indicates a discrepancy between the philosophy underlying the goals and contents of nursing programs and the content of nurses' work in practice. This leads to the question whether to what extent team nursing, which supports the humanistic and holistic perspective taught in nursing education, can be used in practice (Furåker, 2009:269).

2.9 SUPERVISION

Effective employment of HCAs requires that their work is directed and supervised by registered nurses who remain accountable for the care that has been delegated (Keeney *et*

al., 2005:347). The responsibility of the registered nurse to provide supervision at the bedside should therefore be assured (James *et al.*, 2010:553). This delegation is rarely formal. However, it is expected that HCAs should be working within a protocol. They should contact the registered nurse for advice or support if they have any concerns or queries requiring a clinical judgement (Hand, 2012:15).

Nurses are concerned about their legal responsibilities when supervising and delegating to HCAs, especially when HCAs undertake tasks outside of their remit. This situation has the potential to exacerbate legal and litigation difficulties of the supervising nurses (Keeney *et al.*, 2005:347). Furthermore, it is not possible to ensure that delegation is appropriate if roles are not clearly defined and when training is adhoc. Qualified staff need to have a clear understanding of their role and the role of the HCA in order to delegate appropriately and safely (McKenna *et al.*, 2004:456).

According to Snell in McKenna *et al.* (2004:454) 53% of HCAs reported that little or none of their work was supervised. Nurses, who are under pressure, may allow HCAs to carry out unsupervised activities they would not otherwise consider, which could compromise safety with regards to patients. Therefore, according to McKenna (2004:456), delegating care processes to HCAs is loaded with ethical and legal difficulties and their inclusion in direct patient care is of grave concern to nurses (Stellenberg & Dorse, 2014:3).

Many healthcare organisations and educational institutions do not prepare registered nurses to work with and to supervise HCAs. This leaves them ill-prepared to lead highly differentiated teams in the workplace (Keeney *et al.*, 2005:347). The expectation is that registered nurses will lead patient care teams, but where leadership is perceived to be lacking, care deteriorates (Duffield, Dier, O'Brien-Pallas, Aisbett, Roche, King & Aisbett, 2011:252).

Therefore the benefits of employing HCAs must be considered along with the increasing amount of registered nurse time used to induct, train and supervise the increasing number of HCAs. Research studies confirm the shifting of nurses' work towards more indirect care activities, such as co-ordination and supervision and away from direct patient care (Keeney *et al.*, 2005:347). McKenna (2004:454) mentions that the introduction of HCAs to free up nurses' time for patient care, might actually be eating up nursing time.

2.10 CONCERNS

Concerns about the increasing use of HCAs revolve around the following issues: nurses moving away from core nursing tasks, the amount of direct patient care delivered by less

competent staff, the lack of effective communication in nursing teams and the variable roles of HCAs. These are explained and supported by literature in the following paragraphs.

2.10.1 Letting go of nursing

HCAs are usually taking on more challenging activities that were previously carried out by nurses (Furåker, 2008:544), leaving the nursing profession with the concern that HCAs will be used to replace nurses as the former are cheaper to employ (Keeney *et al.*, 2005:346).

Carr-Hill and Jenkins-Clarke in McKenna *et al.* (2004:454) found that HCAs carry out routine nursing tasks that were traditionally within the domain of student and junior nurses. This caused calls from nurses not to 'let go' of nursing. A considerable portion of what many people would view as nursing care is being undertaken by HCAs. HCAs and nurses were interchangeable in many hospitals. Studies in the UK revealed the extent to which the role of the HCA goes beyond its original scope; not always to the benefit of the patient (McKenna *et al.*, 2004:454). As the distinction between a nurse and a HCA becomes increasingly vague, the challenge for nurses may be to define and control their operational practices before they lose their claim to the core skills related to nursing (McKenna *et al.*, 2004:457).

During the previous three decades, key studies have been published supporting that the registered nurse to patient ratio is related to patient outcomes such as mortality, morbidity, length of stay, failure to rescue and patient satisfaction (Aiken, Clarke, Sloane, Sochlaski & Siber, 2002:6; Duffield *et al.*, 2011:253; Estabrooks *et al.*, 2005:75). In addition, a study by Hunt (2010:19) confirmed that ratios also influence important organisational and nurse outcomes such as sickness, absence and job satisfaction. The registered nurse provides surveillance of patients and the resulting early recognition of and rescue from complications are vital in improving patient outcomes. The effectiveness of nurse surveillance is influenced by the number of registered nurses available to assess patients continuously and to be present specifically at the bed-side (Aiken *et al.*, 2002:6). Using fewer skilled workers therefore does not support safe patient care. The association with better patient outcomes visible in the literature, supports the opinion that policy should maximise the registered nurse workforce to improve skill mix (Twigg, Duffield, Bremner, Rapley & Finn, 2012:2716).

The concept 'economic value of professional nursing' refers to the financial judgment of the value of work provided by nurses. Dall, Chen, Seifert, Maddox and Hogan (2009:97) explain that more registered nurses at the bed-side, leads to improved patient care and the early identification and management of complications, e.g. nosocomial infections. Less complications lead to faster recovery and subsequent decreased medical costs. This means

that the higher cost of registered nurse employment can be offset against the cost of patient complications and a higher staff turnover.

Chang (1995:73) expressed concern that nurses need to study critically the reasons for, and implications of, adopting support workers. This does not mean that nurses are necessarily advocating an all registered nurse staff mix, but rather that nurses should be actively involved in decisions made about the mix of qualified and assisting staff, rather than leaving the decisions to employers and non-nursing managers (Chang, 1995:73).

As nurses relinquish bed-side care, they seem to move further away from and become less available to patients.

2.10.2 Nurses divorced from the bed-side

In a study by Furåker (2008: 548), HCAs in Swedish hospitals reported that they spend an average of 50% of their workday on direct patient care activities. In a subsequent study by Furåker (2009:272), registered nurses in hospitals in Sweden reported that only 38% of their everyday activities is related to direct patient care. Patients could also identify a range of direct care activities undertaken by HCAs (Keeney *et al.*, 2005:3520). This provides evidence that the bed-side nursing care delivered by registered nurses has steadily decreased and that subsequently many of the core skills of nursing have been handed over to HCAs (McKenna *et al.*, 2004:454).

Patients also perceived that HCAs were more available than registered nurses. Some patients, on the one side, mentioned concerns about the disconnection of registered nurses from patient care, yet, on the other side, referred to the quality of care provided by the HCAs (Hancock & Campbell, 2006:41). These two points seem to contradict the notion that HCAs are being employed to do non-nursing tasks and to free nurses' time for direct patient care (Keeney *et al.*, 2005:352).

Although many aspects of bed-side care are being handed over to HCAs, nurses are concerned about their competence to provide safe patient care, as subsequently described.

2.10.3 Lack of competence

Amidst the increasing range of patient care, growing concern about the competence of HCAs and the impact on quality and safety of patient care prevails. This is fuelled by the variations in the role and education, as well as the lack of regulation of HCAs (Furåker, 2008:544). However, authors seem to have various opinions of what competence is.

Baldwin (1999:195) argues that competence should be defined in context and that competence could be viewed and allocated according to what is seen as competent in a particular setting, rather than according to a particular definition of competence. However, Howe (2011:np) highlights that competence is confirmed by the consistent display of appropriate behaviours and judgements in practice, therefore integrating skills and knowledge. The Lancet commission further described that competence earns trust, if combined with service orientation, ethical commitment and social accountability, which forms the essence of professional practice (Frenk, Chen, Buttha, Cohen, Crisp *et al.*, 2010:1954).

HCA's being able to do specific tasks, might be seen as competent, although this does not mean that they have the knowledge and judgement to detect abnormalities and early warning signs. Registered nurses bring additional knowledge and expertise to apparently simple tasks, for example, they detect abnormalities and provide health education while bathing a patient (Hunt, 2010:29). The Lancet commission further states that professional education will be a crucial element to address the modern health challenges (Frenk *et al.*, 2010:1954).

Modern healthcare is complex and patients who are hospitalised are often in the acute stage of their illness. Patient throughput has increased and new interventions and technologies have brought with them their own risks and complexities. As a result, many nurses express concern about the competence of HCA's and the impact of a lower skill mix on patient safety and quality of care, especially in acute care hospitals (McKenna *et al.*, 2004:455). A study done in private hospitals in South Africa indicated similar concerns by PNs about the introduction of unregulated caregivers in the clinical field to provide direct care (Stellenberg & Dorse, 2014:2). The study revealed gaps in the knowledge of caregivers, who are not trained nurses, but practising nursing (Stellenberg & Dorse, 2014:8).

2.10.4 Insufficient communication in teams

Kalisch (2009:490) identified the lack of closed-loop communication as a component of nurse team-work that is lacking. Communication of patient problems to nurses relies on the relationship that exists between the individual nurse and the HCA. Although Spilsbury and Meyer (2004:74) describe the HCA as the 'eyes and ears' of the ward, HCA's felt that neither their reporting of observations nor their knowledge, was acknowledged. This was perceived as an obstacle to efficient communication (Butler-Williams, James, Cox & Hunt, 2010:790). A poor relationship can therefore lead to missed communication and unsafe patient situations (Kalisch, 2009:487).

Furthermore, Furåker (2008:551) found that HCAs neither document care nor participate in ward rounds, which implies that documentation and communication of information is either lacking or based on second-hand information. This raises concerns about the quality of patient care. Allowing the HCA to write on documents and including them in ward rounds, would show respect to the person delivering the care, avoid secondary completion of patient records and allow the registered nurse to evaluate care provided while spending less time to document care (Hancock & Campbell, 2006:36).

2.10.5 Unclear, variable roles

There is a lack of consensus regarding the role, training requirements and titles of HCAs and yet HCAs are being used increasingly as part of the patient care team (Spilsbury & Meyer, 2004:412). Specified qualifications are not prerequisites to employment and many HCAs are employed with no recognised training (Keeney *et al.*, 2005:346). This leads to registered nurses having varied perceptions of the HCA's role which account for further role variability (Hancock & Campbell, 2006:39). Additionally, HCAs continue to report variation in their role, including amongst and within clinical areas (Hancock & Campbell, 2006:40). Hancock and Campbell (2006:40) state that clarity about the role of HCAs, their accountability and the lines of responsibility are vital to their successful contribution to safe patient care.

The Royal College of Nursing is of the opinion that all HCAs should be regulated in the interest of public safety as statutory regulation brings with it a code of conduct, standards for education and training, a clear career pathway and definition of the role. HCAs themselves seem to support statutory regulation (Hand, 2012:16).

Nursing in South Africa is regulated by the Nursing Act (No 33 of 2005), which prohibits the employment of people who perform nursing functions if they do not hold the necessary qualifications or are not registered in terms of the Nursing Act. Stellenberg and Dorse (2014:8) therefore recommend that regulation of caregivers in South Africa should be considered, as their current use is illegal and may place the safety of patients at risk. The Nursing Act (No 33 of 2005) further states that the Minister may register other categories to practice nursing as is considered necessary in the public interest.

2.11. SUMMARY

This chapter described an analysis of the literature pertaining to the role of HCAs, which includes PCWs, in hospitals. The HCA's role, internationally and in South Africa, was examined, including their activities in hospitals and the reasons for their employment. Their

position in the patient care team as well as concerns that nurses have about PCWs' role, were presented.

2.12. CONCLUSION

The role of HCAs in hospitals internationally is acknowledged and their numbers are increasing. Yet, concerns regarding lower skill mixes and the reduced quality of patient care have been expressed. The roles of HCAs in specific organisations are blurred and their competence to contribute to safe patient care, questioned. Furthermore, nurse leaders have to explore the management of HCAs in nursing teams and clarify the registered nurses' responsibility to supervise, communicate effectively and to be team leaders.

Similar to the international scenario, increasing numbers of PCWs are employed in private hospitals in South Africa. Their training and role descriptions are not regulated by a professional organisation, but determined by the employer. Their contribution to patient care, as well as associated risks, are therefore not clear.

Chapter 3 presents the methodology used to explore the role of PCWs in private hospitals in the Cape Metropole.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The previous chapters provided a description of the background to the study, including a literature review regarding health care assistants (HCAs) in general and patient care workers (PCWs) in particular. The goal of this chapter is to describe the research methodology that was applied to explore the role of PCWs in private hospitals as perceived by unit managers, nurses and PCWs.

Research methodology refers to the research process employed by the researcher to answer the research question (Mouton, 2009:56). Therefore the study aim and objectives, setting, research design, population and sampling, instrumentation, pilot test, trustworthiness and data gathering and analysis are described in this chapter.

3.2 AIM AND OBJECTIVES

The aim of this study was to explore the role of PCWs in private hospitals in the Cape Metropole regarding:

- the activities of PCWs in medical and surgical wards;
- the supervision of PCWs;
- their position in the patient care team;
- reasons for their employment; and
- concerns about their role.

3.3 STUDY SETTING

The research was conducted in three private hospitals in the Cape Metropole in the Western Cape, South Africa. Staff employed to work in the medical and surgical wards participated. The researcher observed that most of the PCWs were employed in the medical and surgical wards. Limiting the study to these wards, scoped the study and provided a starting point to explore the PCW's role.

The particular hospitals were selected based on the following criteria:

- three hospitals in the Cape Metropole; one each from the three largest private hospital organisations in South Africa;
- hospitals with more than two medical and / or surgical wards;
- PCWs were employed in either a medical or surgical ward for at least one year; and

- willingness of management and staff to participate in the study.

Further information of the study setting was obtained from the nursing managers and is provided to support transferability of study findings by the reader. The wards included were general surgical and medical wards, orthopaedic, neurology, oncology, cardiology, transplant and day care. The permanent nursing and PCW staff per ward included unit managers, professional nurses, enrolled nurses, enrolled nurse auxiliaries and patient care workers. All the hospitals used additional agency staff.

3.4 RESEARCH DESIGN

The research design is a framework to guide a study. The design ensures that the study fulfils a particular purpose and that the research can be completed with the available resources (Terre Blanche *et al.*, 2006:34).

An explorative descriptive qualitative design was used in order to explore the role of PCWs as perceived by the participants. The research question was explored with the intent to describe and to promote understanding (Grove *et al.*, 2013:27). Descriptive studies aim to describe phenomena accurately through narrative-type descriptions (Terre Blanche *et al.*, 2006:44) and to gain a clear picture of a situation as it naturally occurs. A descriptive design also identifies problems with current practice, justifies current practice, makes judgements and determines what other practitioners do in similar situations (Burns & Grove, 2007:240).

Qualitative research is used to explore phenomena inductively and to provide a 'thick' description of phenomena (Terre Blanche *et al.*, 2006:48). Induction refers to the immersion in both the details and specifics of the data in order to discover categories, dimensions and interrelationships, and to start exploring genuinely open questions (Terre Blanche *et al.*, 2006:48). Skinner in Ehrlich and Joubert (2007:318) explains that qualitative methods provide opportunities to obtain and interpret in-depth information from the participants. This allows researchers to understand how participants perceive their role within a specific context. Burns and Grove (2009:529) confirm that the application of a descriptive qualitative approach enables researchers to distance themselves from pre-conceived ideas regarding a research question under study; allowing them to gain insight in the perceptions of the participants.

Blumer, in Joniak (2002:11-14), describes a specific theory of qualitative research: symbolic interactionism, which guided the methodology of this study. Symbolic interactionism describes how meaning is produced by agents through their interaction with symbols. It sees meaning as arising in the process of interaction between people. This theory was

applied to guide the aim of the research, which was to explore the role of PCWs from the perspective of different role players. The researcher aimed to explore the meaning ascribed to interactions with PCWs by individual participants in the private hospital context.

Blumer further explains symbolic interactionism as resting on three premises:

1. Human beings act upon things based on the meanings that those things have for them. For the purpose of this study, these 'things' could include people, e.g. PCWs.
2. The meaning of things arises from the social interactions one has with one's social systems, e.g. 'work,' as a social system, can shape how nurses interact with PCWs.
3. These meanings are handled in, and modified through, an interpretative process used by the persons in dealing with the things they encounter. The process of creating meaning is a continuous one.

These premises guided the researcher during data collection and analysis.

3.5 POPULATION AND SAMPLING

A population is the total set of persons with whom the research question is concerned. The individuals for the study are selected from the population (De Vos, Strydom, Fouche & Delport, 2005:194). The researcher selected one hospital from each of the three major private hospital groups in the Cape Metropole. Hospitals were selected based on accessibility and on the sample characteristics needed as described in the study setting (section 3.2) (Grove *et al.*, 2013:44).

The target population for this study consisted of all unit managers, nurses and PCWs who were permanently employed to work in the medical or surgical wards in the three private hospitals and who had at least one year experience of working with PCWs or as a PCW. This included a total of 18 unit managers, 54 professional nurses, 90 nurses (enrolled and auxiliary) and 36 PCWs.

The sample is a sub-set of the population and comprises of the individuals actually included in the study. The main reason for sampling is feasibility as the researcher has to use limited time and resources to complete a study. The sample is studied in an effort to understand the population from which the sample was drawn. However, in qualitative research, the reader has to decide whether the outcomes of a study could be transferred to another setting (De Vos *et al.*, 2005:194), therefore a rich description of the context is provided in section 3.2.

Skinner in Ehrlich & Joubert (2007:26) explains that the depth of the data gathered, rather than the number of participants interviewed, is the primary goal of sampling. Yet, time and resource constraints also needed to be considered. The researcher aimed to select a sample that represented all the important sub-groups in the population. In this study, purposive sampling was used to select one unit manager, one professional nurse, one enrolled nurse or enrolled auxiliary nurse and two PCWs from the medical and surgical wards in each of the three hospitals for individual interviews.

Purposive sampling is a type of non-probability sampling as the odds of selecting a particular individual are not known (De Vos *et al.*, 2005:201). Munhall in Grove *et al.* (2013:365) describes purposive sampling as a method used in qualitative research to gain insight into a new area of study or to obtain in-depth understanding of an experience. The researcher endeavoured to select a sample composed of the individuals who met the sample criteria, who could provide different perspectives on the research question (De Vos *et al.*, 2005:202) and who were particularly suitable to share their opinions on the role of PCWs (LoBiondo-Wood & Haber, 2010:90). This provided a sufficient number of participants to reflect the sites and the range of participants who made up the population and allowed other nurses and PCWs outside the sample to connect to experiences of those in the sample (De Vos *et al.*, 2005:294).

In qualitative research, the focus is on the quality of the information obtained from the participants and not on the size of the sample (Grove *et al.*, 2013:371). Samples are usually fairly small because of the vast amount of text that needs to be analysed (LoBiondo-Wood & Haber, 2010:92). The sample for this study comprised of 15 participants and included three unit managers, three professional nurses, two enrolled nurses, one enrolled nurse auxiliary and six PCWs. A point of data saturation was reached by the 12th interview, as the researcher heard the same information being reported repeatedly and no new information was shared (De Vos *et al.*, 2005:294). Yet, the researcher decided to complete the 15 interviews planned in order to cover the three hospitals and all categories of staff.

3.5.1 Inclusion criteria

Unit managers, professional nurses, enrolled nurses, enrolled nurse auxiliaries and PCWs who were permanently employed in medical or surgical wards in private hospitals in the Cape Metropole, Western Cape and who had more than one year experience of working with or as a PCW, were included in the study.

3.5.2 Exclusion criteria

Employees who worked in intensive care units and other non-medical or non-surgical wards and who were placed by temporary employment services were excluded from the study.

3.6 INSTRUMENTATION

The researcher used semi-structured, face-to-face, individual interviews to gather data. Interviews involved verbal communication during which the participants were encouraged to provide information to the researcher. This is the most common measurement strategy used in qualitative and descriptive studies (Grove *et al.*, 2013:422). Interviews allowed the researcher to use her interpersonal skills to encourage the participant to co-operate and to elicit rich data (LoBiondo-Wood & Haber, 2010:424). This resulted in the exploration of the PCW's role and relevant issues that emerged during the discussions. The participants were seen as the experts on the role of PCWs and were allowed maximum opportunity to share their perceptions (De Vos *et al.*, 2011:296).

A semi-structured interview guide (Appendix 7) was compiled by the researcher and used to direct the interviews. The guide comprised of open-ended questions and additional probing words that were based on the literature. Questions focused on the objectives of the study, e.g. "Tell me about the activities of PCWs in your ward?" Probing words such as "patient care", "secretarial functions" and "housekeeping," were used to elicit data. The researcher ensured that the questions were non-judgemental and unbiased (De Vos *et al.*, 2005:297).

3.7 PRE-TEST

The interview guide was evaluated by the researcher's peers and supervisor to ensure that no questions were biased or could lead to predetermined answers (Wahyuni, 2012:74). Pre-testing provided the opportunity to determine whether the participants would understand the open-ended questions posed to them and to identify potential question vagueness (Brink, van der Walt & van Rensburg, 2008:151-152). Additionally the duration of the interview and the procedure for the recording of responses were tested (LoBiondo-Wood & Haber, 2010:424).

The pilot test was conducted by the researcher and the supervisor who interviewed one PCW from the target group. This PCW was identified by the nursing manager. During the interview, the researcher discovered that the PCW was allocated to work in a surgical intensive care unit and therefore did not meet the selection criteria for the study. The researcher thereafter changed the terminology and in further communication referred to medical and surgical wards instead of units, as units referred to intensive care units. The

researcher also checked that participants met the selection criteria before starting with subsequent interviews. No problems with the interview guide or audio recording procedure were identified. The data from this interview was not included in the data analysis.

3.8 TRUSTWORTHINESS

Trustworthiness is concerned with the accuracy and truthfulness of scientific findings (Brink, *et al.*, 2008:118). Lincoln and Guba in De Vos *et al.* (2011:346-347) and in Wahyuni (2012:77-78) describe trustworthiness as the 'truth value' of the study's findings or how accurately the researcher interpretes the communication by participants. Four criteria were developed to describe the trustworthiness and to support the rigor of qualitative research, namely credibility, transferability, dependability and conformability. These criteria were applied in the study as described in the following paragraphs.

3.8.1 Credibility

Credibility deals with the accuracy with which the data reflects the phenomenon of interest. In this study the researcher and supervisor checked transcriptions of audio recordings for accuracy. The supervisor also assisted with the interviews and evaluated consistency of data coding. She independently coded one interview and compared the results to the coding of the same interview by the researcher. Similarities and discrepancies had been discussed and the outcomes agreed upon. Rich data, including selected quotes from the interviews, was used in the report for validation by the reader. All findings, including discrepant information which contradicts the themes, are presented in chapter 4.

3.8.2 Transferability

Transferability refers to the applicability of findings to other settings. The decision to transfer findings rests with the reader. However, the researcher provided a thick description of the setting and the research process that was followed. Additionally, multiple perspectives were used to illuminate the role of PCWs, including the perspectives of unit managers, nurses and PCWs from three different private hospital groups.

3.8.3 Dependability

Dependability corresponds to the reliability and repeatability of a study. Dependability was enhanced by providing a detailed description of the research design, process and interview questions to enable future researchers to follow a similar research approach.

3.8.4 Confirmability

Confirmability relates to objectivity and refers to the extent to which the reader can confirm that the findings reflect the perceptions of the participants, rather than the researcher's own preferences. The researcher ensures that documentation and audio recordings of data and the research process are carefully kept to provide an audit trail. This enables examination of both the research process and research outputs. A partial transcription of one interview is attached to support confirmability (Appendix 10).

3.9 DATA COLLECTION

Data refers to the spoken words and the non-verbal communication during the interview (Grove *et al.*, 2013:271). Data collection is the systematic gathering of information relevant to the research purpose, objectives and questions (Grove *et al.*, 2013:45). Although meticulous planning guided the data collection process, the researcher had to be flexible to accommodate the hospitals and participants.

Semi-structured, face-to-face individual interviews were conducted to collect data for this study. Semi-structured interviews are organised around a set of open-ended questions. According to Marshall and Rossman in Grove *et al.* (2013:271), these can also be called guided or topical interviews.

Additionally, demographic data of participants was collected by the researcher prior to each interview (Appendix 6). The demographic questionnaire contained six questions. The researcher completed the questionnaire by obtaining the answers through observation and direct questioning of the participant, e.g. "In what ward do you work?" and "For how many years have you been working with PCWs?".

While meeting with the nursing managers, the researcher also gathered information regarding the type of wards and staffing in order to provide a rich description of the context of the study.

Interviews were conducted by the researcher and study supervisor. The researcher is employed in a managerial position in one of the private hospital groups, therefore the supervisor collected data in the hospital of the specific group. The researcher conducted the ten interviews in the other two hospitals. She was trained regarding the interview process by the University of Stellenbosch with further guidance by the supervisor. Preparing the interviewer was critical as the interviewing skills of the researchers directly affect the quality of the data produced (Marshall & Rossman in Grove *et al.*, 2013:272).

Initial recruitment contact was made with the nursing managers of the three hospitals once permission had been obtained to access the hospitals. The researcher scheduled individual meetings with the three nursing managers to discuss the purpose, proposed process and interview criteria. In two of the hospitals, the researcher could also discuss this information with the unit managers of the surgical and medical wards. Pamphlets describing the study were left with the nursing and unit managers.

The researcher and nursing manager agreed on the days of the week and the times for the interviews. In most cases, Saturdays after 14h00 were identified as a suitable time. The researcher also asked permission to interview the employees while on duty and to use venues in the hospitals. A private office or empty patient room in the hospitals was offered for the interviews. The researcher could arrange the seating in order to create a relaxed environment and to face the participant.

The nursing manager, with the involved unit managers or the manager on duty during weekends, presented participants who met the selection criteria and who were available for interviews. Each interview lasted between 45 and 60 minutes. The language preference for interviews was determined by the participants. One interview was conducted in Afrikaans while the other fourteen interviews were conducted in English. Interview skills such as summarising and reflection were used to ensure that the responses were correctly understood.

After introductory pleasantries, the researcher confirmed that the participant met the selection criteria. The purpose of the research, the role of the participant, the expected time required and the confidentiality of information were discussed. The recording of responses was explained and permission to audio record the interview was obtained. A pamphlet, containing this information as well as the cell phone number of the researcher, was discussed with the participant. The signing of the consent forms was finalised and the participants were again informed that they were free to withdraw at any time, should they wish to do so (De Vos *et al.*, 2005:295).

For the purpose of describing the participants and to ease the participants into the interview, demographic details were gathered first (Grove, *et al.*, 2013:273). This was followed by a broad question: "Tell me about the role of the care worker in your ward?" Additional probing questions were asked to encourage the participant to elaborate further on specific aspects of the role of PCWs (Grove *et al.*, 2013:272).

In closing, the researcher again assured the participants of the confidentiality of the information. The participants were encouraged to contact the researcher should they have any additional data or should they wish to withdraw their information from the study. Participants were neither emotionally upset nor did they require psychological support during the interviews.

Two voice recorders were used (the second one as a back-up). Seven of the recordings were transcribed by the researcher and eight by an experienced data transcriber.

3.10 DATA ANALYSIS

Creswell (2013:180) describes the general process that researchers use to analyse qualitative data as consisting of “preparing and organising the data for analysis, then reducing the data into themes through a process of coding and condensing the codes and finally representing the data in figures, tables, or a discussion.” Qualitative data analysis is “a process of examining and interpreting data in order to elicit meaning, gain understanding and develop empirical knowledge” (Corbin & Strauss in Grove, Burns & Gray, 2013:279).

The researcher listened to all the recordings. Interviews were transcribed verbatim in Excel. Each sentence or meaningful section of the recording was captured in a separate row. A unique identifier and columns to add notes were used to aid analysis of data.

The researcher applied inductive thinking to the words of the participants to move to more abstract concepts and themes (Grove *et al.*, 2013:264). The goal of data analysis was to find commonalities and differences between interviews and then to group these broader categories in themes that represent most of the data (LoBiondo-Wood & Haber, 2010:93).

Data analysis in qualitative research occurs concurrently with data collection. The researcher found that analysis of an interview’s data resulted in the asking of additional questions in subsequent interviews, e.g. “Can you think of any activities that PCWs should not do?” and “How does the PCW’s role differ from the role of the enrolled nurse auxiliary?” Furthermore, the process of interpretation took place in the mind of the researcher and therefore already started during data collection (Terre Blanche *et al.*, 2006:321).

The researcher was immersed in the data by personally conducting most of the interviews (ten) and transcribing some of the recordings (seven) (Grove *et al.*, 2013:278). The researcher and supervisor met regularly to discuss their experiences and observations during interviews. The researcher endeavored to stay close to the data and to interpret from a position of empathetic understanding (Terre Blanche *et al.*, 2006:321).

While getting immersed in the data and during analysis and interpretation, the researcher was consciously aware of the need to apply the principle of 'bracketing'.

'Bracketing' is being aware of one's own beliefs and setting these aside during the research process (Grove *et al.*, 2013:60). It means "temporarily forgetting about everything we know and feel about the phenomenon and simply listening to what the phenomenon is telling us now" (Terre Blanche *et al.*, 2006:322). Bracketing was particularly necessary, as the researcher is involved in the management of staffing of a private hospital group and therefore in decisions regarding PCWs. The researcher made a concerted effort to remain neutral and to set aside her perceptions, previous knowledge and experiences regarding the role of PCWs. She endeavoured not to judge what she heard, but to remain open to the perceptions of the participants (Brink *et al.*, 2008:113).

LoBiondo-Wood and Haber (2010:105) refer to several techniques that are available for data analysis, yet there is a general pattern to move from the participants' descriptions of their experiences to the synthesis of all participants' descriptions. The researcher applied interpretative data analysis as described in five steps by Terre Blanche *et al.* (2006:322-323). This is not an inflexible process as the analysis of data did not proceed in such an orderly and rigid step by step method, but the researcher was guided to become immersed in and to reflect on the data. The five steps of interpretative data analysis and the application thereof in this study, are described in the following paragraphs.

3.10.1 Familiarisation and immersion

The first step refers to the researcher immersing herself in and familiarising herself with the data. The researcher already formed a preliminary understanding of the data during contact with the nursing managers and during data collection. The researcher listened to the audio recordings and recalled observations and experiences. Personally transcribing seven voice recordings supported immersion in the data. Immersion was further deepened by reading and re-reading the interview transcripts in their entirety in an attempt to get a sense of the interviews as a whole, before breaking it into parts (Creswell, 2013:182). The researcher made notes, drew diagrams and brainstormed ideas till the data was well known (Terre Blanche *et al.*, 2006:323). Eventually recurring patterns and emerging themes of parts within the whole started to surface (Grove *et al.*, 2013:281). As the researcher became immersed in the data, ideas and insights occurred at odd times, e.g. while the researcher was travelling or while at work. Notes were made of these ideas as they emerged, as advised by Grove *et al.* (2013:283).

3.10.2 Inducing themes

Themes (also known as categories) are broad units of information that consist of several codes aggregated to form a common idea (Creswell, 2013:186). Inducing themes infers a bottom-up approach during which the researcher studied the data and determined the general rules, classes and organising principles underlying the data. Terre Blanche *et al.* (2006:323) suggest that themes should arise naturally from the data yet, at the same time, support the research questions. The researcher moved beyond merely summarising the content, by thinking in terms of processes, tensions, functions and contradictions.

The researcher strived to find the optimal level of complexity, by six themes with several sub-themes. Creswell (2013:186) uses the analogy of a family of themes (five to six) with children (sub-themes) and grandchildren (segments of data). Different kinds of themes were tried out before the researcher settled on the specific themes, keeping in mind that the aim of the study was to explore the role of PCWs in medical and surgical wards in private hospitals (Terre Blanche *et al.*, 2006:323-324).

3.10.3 Coding

Initial efforts at analysis focused on reducing the huge volume of data. The reduction of data occurred as the researcher attached meaning to elements of data and documented that meaning with a word, known as a code. Coding therefore means labeling or naming (Grove *et al.*, 2013:281). The code names originated from the words used by the participants and from names the researcher composed that seemed best to describe the information (Creswell, 2013:185). During coding, the researcher took the data apart into labeled, meaningful bits with the aim later to cluster the bits of coded data together under headings and subsequently to link the headings together (Terre Blanche *et al.*, 2006:324-326).

As data analysis and insight in the data progressed, a framework within which to organise the data, emerged in the mind of the researcher. The framework with themes, sub-themes and categories was used to develop drop-down menus which made systematic labeling of data segments in Excel possible. The framework and drop-down menus were expanded as more data was analysed and insight grew. After coding, similar data segments could be sorted. As the researcher progressed with coding, new understanding emerged.

The researcher and supervisor regularly discussed the content and experience of the interviews, the data analysis process, findings and conclusions. The first interview was coded independently, where after the codes were compared. No significant dissimilarities were found.

3.10.4 Elaboration

Elaboration pertains to the close exploration of themes to bring differences between seemingly related extracts of data and sub-themes to light. The purpose is to capture the finer nuances of meaning not captured in the original themes, sub-themes and categories and to revise the coding system. The researcher kept on coding, elaborating and reflecting until no significant new meanings emerged (Terre Blanche *et al.*, 2006:326).

3.10.5 Interpretation and checking

The interpretation is presented in chapter 4 as a written account of findings, using the themes and sub-themes as headings. The data analysis was checked for weaknesses, e.g. over- or under-interpretation or prejudices, by the researcher and supervisor. The opportunity was also used to reflect on the researcher's role during data collection and interpretation in order to provide an indication of how these could be coloured by her personal involvement with PCWs in private hospitals (Terre Blanche *et al.*, 2006:326). According to Terre Blanche *et al.*, (2006:326) it is important to talk to people who are familiar with the topic as well as with those who are not, as the latter may be able to provide fresh perspectives on the topic. Therefore the researcher discussed the findings with two colleagues, a family member and a friend.

Additionally, the biographical data collected prior to each interview, was analysed and presented in chapter 4.

The purpose of data analysis was therefore to provide a thick description of the characteristics of the phenomenon being studied as well as a presentation of the researcher's role in arriving at this description (Terre Blanche *et al.*, 2006:321).

3.11 SUMMARY

In chapter 3, a detailed description of the research methodology and research process was presented. This allows the reader to form an opinion of the trustworthiness of the study and the transferability of the findings.

3.12 CONCLUSION

An explorative descriptive qualitative design guided the exploration of the opinions of participants of the role of PCWs. The design further guided the analysis of data and the presentation of a clear picture of the PCW's role.

The fourth chapter contains a presentation of the data analysis and the interpretation of the research findings.

CHAPTER 4

FINDINGS

4.1 INTRODUCTION

This chapter contains a presentation and discussion of the findings of the study. Interviews were transcribed verbatim and analysed to describe the role of PCWs in medical and surgical wards in private hospitals as reported by unit managers, nurses and PCWs. A partial transcription of one interview is attached (Appendix 10) and several quotations are used to support and to authenticate the trustworthiness of the findings.

Data was analysed using the approach proposed by Terre Blanche *et al.* (2006:322) as described in chapter 3, section 9. The researcher used inductive reasoning to build generalisations from specific observations. Six key themes emerged as the participants verbalised their opinions on the role of PCWs. These themes were related to their activities, the organisation of care, the position of PCWs in the patient care team, reasons for employment, training and concerns regarding their role.

The data is presented in two sections. Section A provides biographical data which was gathered at the start of each interview while section B provides the themes that emerged during analysis of the interviews and transcriptions.

4.2 SECTION A: BIOGRAPHICAL DATA

The sample consisted of fifteen participants, including three unit managers, three professional nurses (PNs), two enrolled nurses (ENs), one enrolled nurse auxiliary (ENA) and six PCWs. Nine participants were employed in medical wards and six in surgical wards. The average duration of employment as a nurse or PCW, was 12 years while the average duration of working with PCWs, was eight years. The average age of participants was 40 years. Fourteen of the fifteen participants were female.

4.3 SECTION B: THEMES EMERGING FROM THE INTERVIEWS

The following themes and sub-themes emerged from the interviews and were used as a framework within which to present the findings (Table 4.1).

Table 4.1: Themes and sub-themes

| Themes | Sub-themes |
|--|--|
| Activities of PCWs | Direct patient care Indirect patient care |
| Care organisation | Supervision Allocation of work Reporting |
| Position in the patient care team | Value Seen as nurses Not seen as nurses Compared to ENAs |
| Reasons for employment | Preventing falls Helping nurses Preventing complaints Financial constraints |
| Training | Basic care worker training Learning in the hospital Career aspirations |
| Concerns about the PCW role | Limited appreciation Lack of career development opportunities Variety of basic training courses Doing more Lack of insight Other concerns |

4.3.1 Activities of PCWs

Participants described that PCWs in their wards focused on keeping patients clean, comfortable and safe. The biggest part of the PCWs day is dedicated to direct patient care, while the 'specialling' of patients was frequently mentioned. Both direct and indirect patient care activities are subsequently described.

4.3.1.1 Direct patient care

Direct patient care describes the time that PCWs spend near to and often touching patients. Several aspects related to direct care emerged.

4.3.1.1.1 Basic care

Basic care comprises those activities that relate to the hygiene, comfort and feeding of patients. It was clear that all categories of participants agreed that the PCW is responsible to provide basic care to patients. A PCW reported: "*The care worker actually sees that the*

patient is clean; that their surroundings are clean and yes, makes the patient comfortable. That's actually the care worker's role." (Participant 4)

The basic care activities mentioned included full wash or assisting with bathing, nappy change, pressure care, mouth hygiene, catheter care and emptying of catheter bags, washing of hair, shaving, care of nails, feeding per mouth and assisting to mobilise, especially to the bathroom. The aim is to keep the patient clean, dry and comfortable. Assisting patients to mobilise was frequently mentioned as a precaution to prevent falls.

Although these activities are described as basic care, participants mentioned the intimate nature thereof. Most participants expressed that these are nursing activities and that the PCWs are actually nursing and nurturing the patients.

4.3.1.1.2 Helping patients

PCWs mentioned that they helped patients, in every way, with the small things that patients could normally do themselves, e.g. fetching a newspaper and getting something from the handbag. A PCW related the words of a patient to her: *"I can't use my cell phone. Can you maybe perhaps make a call for me and hold the phone at my ear?"* (Participant 4)

4.3.1.1.3 Responding to the patient call system

Participants often referred to the bells or patient call system. PCWs are primarily assigned to answer bells. An ENA explained: *"Like if the patient is in pain, the patient will ring the bell. The person who walks to; who answers the bell is the carer."* (Participant 6) A PN explained the relief brought by having PCWs in the ward: *"So, as I say, you don't hear the bells when there's a carer."* (Participant 12) PCWs also mentioned that nurses will sometimes not answer bells, even if they have nothing else to do, as it is expected that this is the duty of the PCW.

4.3.1.1.4 Closeness to the patient

All categories of staff mentioned that the PCW is close to the patient; they are around the patient most of the time, spend time with the patient and know what the patient needs. They are in the patients' rooms and sometimes, in the case of patients being confused, sit on a chair next to the patient's bed. A unit manager referred to the intimacy experienced with the patient while doing a bed bath, even though a bed bath is seen as basic care. *"It is when you are most intimate with a patient."* (Participant 8)

Simultaneously, the distance between patients and nurses was confirmed, as verbalised by the following PN: *"And you know who they compliment? The carers, when they go home,*

because they are the people who interact with them. Because we don't really interact with the patients." (Participant 12)

4.3.1.1.5 Observers

Being close to the patient provides the opportunity for observation of aspects that the nurses do not see or know of, e.g. skin lesions, bleeding, that patients are skipping meals, find it difficult to swallow or have dietary preferences. A unit manager mentions that, while doing a bed bath, *"you can literally pick up the blankets and look at your patient physically, bums and scrapes and bruises and moles and ugliness and all the rest of it."* (Participant 8) Participants often remarked that PCWs observe when a patient's condition is changing: *"They are the ones that most of the time they can tell us if there is something changing on the patient's condition."* (Participant 11) Although most participants reported that PCWs are excellent observers, some expressed concern that they do not have the knowledge and insight to interpret what they observe.

4.3.1.1.6 Record-keeping of direct care

The same expectations regarding record-keeping, applies to all patient care staff, including PCWs. All activities and findings have to be recorded. Specific documents where PCWs are expected to write, were mentioned, e.g. the intake and output record, the nursing activity document for documentation of pressure care and the progress report for all other record-keeping. The specifics expected from PCWs during record-keeping, e.g. exactly what and how much a patient ate and whether the patient was wet or dry during a nappy check, were discussed by participants. The discipline of record-keeping was described by a PCW: *"Yes, we also write in the patient's record. What's not written is not done. Whatever you do you write down; even if you give a glass of water you write down; if you change a nappy you write down."* (Participant 7)

4.3.1.1.7 Communication

PCWs report that patients talk to and confide in them, as they spend time with the patients and understand the patients' needs. They try to encourage and *"uplift patients spiritually."* (Participant 4) They are friendly with patients, but know not to discuss the illnesses of patients with them. More than one participant mentioned that PCWs are often thanked by name when written feedback is received from patients. Both PCWs and PNs mentioned that PNs do not have time to interact with patients. This is supported by a PCW saying: *"The sisters just see the patients coming in but the patients confide in you and talk about that*

they're scared for this operation. Then you talk to the patient and comfort the patient." (Participant 7)

PCWs further communicate to the family of patients, sharing information about eating and sleeping, but were clear that they refer questions about medications and illness to the nurses. Families are usually looking for someone who is working in the room of the patient and request information on everything that has been done for the patient during that day. However, one unit manager shared her concern that PCWs sometimes discuss patients and staff with families, *"and you realise that they don't know that there is patient confidentiality."* (Participant 3) Families will share with PCWs how the patient was when younger, while PCWs try to encourage and comfort families when the patient is dying. They will also ask family members to bring items for the patient, e.g. soap and nappies.

4.3.1.1.8 *Specialising a patient*

The phrase 'to special a patient' was frequently used when a PCW is assigned to care for one specific patient. Three types of patients being 'specialised' were discussed:

- The confused patients who need close observation in order to be kept from falling and hurting themselves. The PCW addresses their basic needs, keeps the environment tidy and often sits next to the bed while ensuring that the patient is under constant observation. A PN explained: *"We don't call that carer. She has to stay with that patient the whole time...just to keep her safe the whole time."* (Participant 12)
- The elderly or totally dependent patient who needs 'full care'. Everything has to be done for the patient. These patients are typically grouped together, e.g. in a four bedded room, with a PCW allocated to the room.
- The patient who requires a constant companion or do not want to be left alone. This is typically a patient who has a care worker at home or who is anxious to be alone in hospital. A PN mentioned: *"When he comes into hospital, he wants his care worker with him. And then the carer must give him his tablets, must wash him, must do everything for him."* (Participant 12) The family sometimes requests that a carer is allocated to such a patient.

4.3.1.1.9 *Difference between medical and surgical ward activities*

Although most functions overlapped in medical and surgical wards, the care of dependent, elderly and confused patients was focused on in medical wards. Participants from medical

wards, mentioned that *“it’s better for us if we have a care worker that’s actually coming from an old-age home although they have to be taught the hospital way.”* (Participant 1)

In surgical wards, the expectations of the PCW to assist with the workload created by multiple admissions and theatre cases were evident. These included: the preparation of the bed space, orientation of the patient in the ward, assistance with the changing of clothes, the packing away of possessions and providing a urine glass for a urine sample. Some PCWs are allowed to measure the height and weight of patients at admission. An EN further explained what the PCWs in the surgical ward do: *“If the patients are from theatre...give water to the patients...make sure that the patient has been ordered food for...do fixing like if the patient has wet the bed.”* (Participant 3) However, a unit manager of a surgical ward, explained: *“But when the ward is full and pumping, I don’t see a place for the care worker because then I need the skilled hands.”* (Participant 15)

4.3.1.1.10 What they should not do

Participants were fairly clear about what PCWs are allowed and not allowed to do, e.g. they are not allowed to do the following: admissions, take patients to and receive patients back from theatre, perform haemoglucotests (HGT) and haemoglobin (HB) tests, give nasogastric feeds and change drips. Consensus lacked on the monitoring of vital signs. While this seemed to be prohibited in one hospital, it had been a general expectation in another hospital. Yet, even if not allowed to do vital signs, a PCW reported: *“I will do it if I must.”* (Participant 4)

Urine testing was not allowed in most instances, although some participants reported that a ‘dipstix’ is done by PCWs. Some PCWs who have been trained to do HGTs and HBs, will perform these tests as well.

All unit managers were concerned that PCWs might do more than they should do. However, all PNs reported that PCWs actually did more than they should have done. Yet, they did not express concern about this, as illustrated by a PN: *“You will use, if you have, an extra care worker to go and do the observations, but they do help us; they can do it, because everything is machine wise.”* (Participant 1) Furthermore, an EN was of the opinion that PCWs were *“undermined”* by them not being *“allowed to show their skills.”* (Participant 11)

Exploring the direct patient care activities of PCWs therefore revealed that PCWs spend most of their time close to patients. This allows them to observe and to report abnormalities and changes as well as to interact with patients and families. They specifically keep

confused and elderly patients safe and respond to the patient call system. Their involvement in indirect patient care activities is subsequently described.

4.3.1.2 Indirect patient care

Indirect patient care includes administration duties, stock management, housekeeping and portering or running functions. PCWs are also involved in the orientation of new staff.

4.3.1.2.1 Administration duties

A PCW who is competent will stand in for a secretary when absent due to sick or vacation leave. Duties include answering the phone, bed bookings, taking files down to the administration department, preparation of admission files and other clerical tasks. Both PCWs and unit managers saw the allocation of administrative duties e.g. answering the phone or compiling files, as a challenge to stretch the PCW. Nurses expressed concern as the PCW is usually not replaced for patient care when having to stand in for the secretary.

4.3.1.2.2 Stock management

PCWs, similar to nurses, have to charge all stock used by them. They help the stock controller with stock take and to unpack stock. Three participants mentioned that a PCW had been appointed to do stock: *“It’s a care worker that is appointed to help with stock. Sometimes if he has finished the stock taking, he helps in the ward.”* (Participant 11) As a routine, they will do daily checks to ensure that the emergency cupboards at the patients’ bed-side and drip trolleys are stocked, that the equipment such as suction and oxygen is in working condition and that stock items have not expired.

4.3.1.2.3 Housekeeping

PCWs are responsible to keep the patient environment clean and tidy, as explained by a PCW: *“We have to clean around the patients...see that the family member doesn’t come in a dirty place.”* (Participant 2) The cleaners clean the rooms, but the PCW will see that the rooms are clean and call a cleaner if necessary. In the morning, they check that the patients have clean towels and water. The PCW will make a cup of tea for a patient if needed.

4.3.1.2.4 Portering and running

PCWs take patients to x-rays or the doctor’s rooms, or escort the patients, depending on the condition of the patient. When a porter is not available, PCWs will push a patient to theatre while a nurse is accompanying the patient. They are sent to fetch medication from the pharmacy and the emergency cupboard, to make copies of documents and to fetch items from other wards or doctors’ rooms, as illustrated by the following PCW: *“You need the*

medication now for the next patient; the carers must go down quickly. The carers must go and make a copy quickly...you need a copy for the doctor.” (Participant 7)

4.3.1.2.5 Other indirect patient care activities

One participant mentioned that the PCW is responsible to put up signage and to provide the protective equipment at the door of a room in which a patient is isolated.

PCWs look after clothes and valuables of patients, as explained by a PCW: *“Mostly the carers are looking good after the patients’ valuables. When they go to another ward you know, oh, that slippers belong to the patient. I will take it up to where the patient is.”* (Participant 7)

PCWs mentioned that they spent time to orientate new staff and students: *“We show them where things are and how things work.”* (Participant 9)

Although PCWs spend most of their time on direct patient care, they are further involved in indirect patient care activities, especially to stand in when the secretary is absent and to act as stock controller. A variety of other indirect tasks are allocated to them.

The PCW’s role is further described in relation to the way that care is organised in the patient care team.

4.3.2 Care organisation

Care organisation in this study, refers to the supervision of PCWs in the patient care team, how tasks are allocated and to whom they report.

4.3.2.1 Supervision

It was mentioned of PCWs that *“they are not allowed to basically be alone with a patient”* (Participant 3) and that they are supposed to do basic care under supervision of a PN. However, participants also mentioned that PCWs often work on their own and will ask help from nurses or another PCW as needed. Although nurses are working with the PCWs in the ward, they are not present with the PCW during basic care activities, as stated by a unit manager: *“Now, in essence, they are under supervision because there is a sister or two sisters and me and ENAs and ENs and whatever. But they are not there when they take them out of the bed and put them into the chair.”* (Participant 8)

Direct supervision was further mentioned by a PN, but was associated with the checking of patient records: *“The only thing that we really do is to come and check the file; is the patient's chart up to date.”* (Participant 12)

It therefore seems that nurses are aware that supervision is needed, but acknowledge that PCWs most often work on their own.

4.3.2.2 Allocation of work

All participants reported that PCWs were included in handover meetings during which they will receive instructions or hear information of importance to them. Direct instructions to the PCW were elaborated on by an EN: *“If the care worker stands during the handing over during the morning, so there is no need of you telling her, you can just make sure, ask her, ‘did you hear that this patient is not supposed to eat now?’ ”* (Participant 11) The EN further explained why the PCWs were included in the handover meeting: *“The reason why everybody must be part of the handover, because they are part of the patient's care.”* (Participant 11) Further instructions from the PN after doctor's rounds or during the day, were also mentioned.

The PCW will be allocated to a group of patients (e.g. bed number 1 – 8) or to a specific patient to 'special' the patient. Patient and task allocation are indicated in an allocation book.

Yet, *“most of the time they know what to do and they follow a routine.”* (Participant 11) Three PCWs gave a vivid description of their daily routine, while a fourth PCW explained: *“So start sommer on my own doing my thing that I know. Going around seeing that everybody is comfortable, were they washed, is there water, is their surroundings clean, that person must be fed...”* (Participant 4)

Other routines included *“hourly wet-dry nappy checks”* (Participant 11) and two-hourly rounds during the night to *“check if the patients are breathing, if they are OK.”* (Participant 9) Daily routines included checking that patients had been identified with ID bands, checking expiry dates of equipment and whether waste bins contained the correct items according to waste segregation rules.

4.3.2.3 Reporting

Reporting to the 'sister' (PN) was often mentioned, although reporting to the nearest nurse or the nurse responsible for either the patients or for medication was also mentioned. A PCW explained: *“I firstly report to that person who is responsible for that patient. If that person is not there then I go to a senior sister or the unit manager.”* (Participant 4)

PCWs often referred to their responsibility to report abnormalities or concerns to nurses, e.g. pain, red skin or bruises, poor eating or drinking and urinary incontinence or general deterioration of a patient's condition. Nurses rely on this reporting and mentioned that PCWs were good at reporting. However, some nurses raised a concern that PCWs might not have enough knowledge to identify abnormalities. One PN mentioned that she insisted to be called to see for herself when an abnormality, e.g. skin lesion, had been identified: *"Every time she works with the patient she has to call me, 'Sister, come and see for yourself'"*. (Participant 10)

The findings above indicate that PCWs mostly follow routines and work without direct supervision and on their own. Yet nurses rely on them to report and PCWs seem to be good at reporting. Findings regarding their position in the patient care team are subsequently described.

4.3.3 Position in the patient care team

This theme relates to how PCWs fit into the patient care team. The opinions of participants regarding the importance of their role and how this compares to nursing are included.

4.3.3.1 Value

All participants agreed that PCWs added value in the ward. Several terms to express this were used, including: *"the care workers are really important"* and they are *"a very, very big help."* A PN remarked: *"So I can't think, I can't imagine a ward without the carer."* (Participant 12)

4.3.3.2 Seen as nurses

Most participants, nurses and PCWs, were clear that they see PCWs as nurses and what they do, as nursing care. A PN explained: *"You will call them nurses all over because they are such a part of the whole team and nursing, because how can you care for a patient and not do nursing? Everything you do for 24 hours a day is nursing, even giving water and helping the patient to drink. That's nursing."* (Participant 1) However, a unit manager explained that, in a legal investigation, she *"has to explain the role of each and every person. Then we have paper work for each category, but when it comes to the care worker, no, ok, this and this and this was the role."* (Participant 3)

PCWs further reported that patients did not address PCWs as if they are not nurses. A PCW elaborated: *"And the patients...because they don't know which category I am, they just call you a nurse. They don't know, because we call each other by names here."* (Participant 13) However, a unit manager explained her discomfort when having to rectify a patient's

misperception: *“Implications for me would be a patient being unhappy with something that's being done and me having to tell the patient that that person is actually not a nurse.”* (Participant 3)

Two unit managers were of the opinion that PCWs should be regulated by the South African Nursing Council, to acknowledge them as part of the nursing team and also to standardise their training and scope of practice.

4.3.3.3 Not seen as nurses

Very few participants did not regard PCWs as nurses. One unit manager was clear that PCWs are not nurses and expressed her concern that nurses see PCWs as nurses and therefore allocate nursing tasks to them. The exclusion of PCWs from Nurses' Day in two hospitals, gave the message to participants that management did not see and recognise PCWs as nurses. This is further described in section 4.3.6: Concerns about the PCW role.

A few participants mentioned that PCWs were being looked down upon by ENAs, as indicated by the opinion of the following PN: *“Sometimes the carers are being looked at, they are always looked down by the immediate, the ENA.”* (Participant 10) However, most participants described that they experienced that staff in the patient care team had worked well together.

4.3.3.4 Compared to ENAs

Most of the participants, including PCWs and ENAs, do not see much difference between the role of the PCW and the ENA, as indicated by a PN: *“And the care workers in this ward are almost like the ENAs.”* (Participant 1) However, participants mentioned that this differs according to individuals, *“because there are some individuals who are equal to ENAs.”* (Participant 12) A PCW is sometimes allocated to an ENA and they perform all tasks together. However, the monitoring of vital signs is typically seen as the duty of ENAs, as depicted by this PN: *“An ENA...takes the BP machine and do the vital signs. And I think that is all that the ENAs are doing.”* (Participant 12) However, PCWs are allowed to do vital signs in some wards and not in other wards. Other duties typically assigned to ENAs and not to PCWs are admissions, discharges and accompanying patients to and from theatre.

The findings therefore indicate that the PCW role is regarded as important by both nurses and PCWs. They are most often seen as nurses, performing nursing tasks, similar to that of ENAs.

4.3.4 Reasons for employment

Participants discussed several reasons for the employment of PCWs, including the prevention of falls, assistance to nurses handling a heavy workload, prevention of complaints and financial constraints.

4.3.4.1 Preventing falls

Initially, PCWs were used primarily to keep the confused and elderly patients safe. This is still a major task allocated to PCWs. Unit managers, nurses and PCWs indicated that PCWs were tasked to prevent falls and injuries, especially of elderly and confused patients. A unit manager explained: *“We are definitely more focused on patient safety; so the moment the nurses realise that mr. X in room three is a risk for falling, he can definitely not get up and go to the bathroom on his own, they will definitely need a care worker.”* (Participant 3) Additional PCWs are being hired through the agency when there are confused patients in the ward. The importance and outcome of this intervention were noted by a PN: *“You know why the carers are also important lately? Because there are less falls now also.”* (Participant 12)

4.3.4.2 Helping nurses

All PCWs described the reason for PCW employment as relating to *“do those types of things that they won’t be able to get to.”* (Participant 2) PCWs are of the opinion that *“nurses can’t do everything and they need someone who is going to help them.”* (Participant 13) ENAs are described as being busy with monitoring vital signs and admissions while ENs are occupied with the administration of medication and PNs with doctors’ rounds, while PCWs *“know everything the patient needs.”* (Participant 7) *“We play a very important role because we are with the patient 12 hours. Sometimes the sister doesn’t get time to get to the patient during the day; she is so busy, but we are there and we keep them comfortable.”* (Participant 9)

4.3.4.3 Preventing complaints

PCWs further assist nurses to do the small things that nurses won’t necessarily do for patients and that causes families to complain if not done. A unit manager described *“all those little things that the nurses cannot get to sometimes”* as *“that caring, the conversation with the patient, that the nurses sometimes don’t have time to do nowadays. The caring of like offering her something to wipe her hands after she has eaten, giving her the extra cup of tea when she wants it.”* (Participant 15)

A PN explained the reason for employment of PCWs as *“the complaints also that we get from the family.”* (Participant 12) A unit manager further described how PCWs are responsible to do hourly wet and dry checks and to record their findings per hour, as family members were complaining that their parents were not being kept clean and dry. She could use the record as evidence when complaints were lodged. The PN further indicated that PCWs help to decrease complaints by families: *“Before the care workers, they were complaining about the little things that you don't even want to think of.”* (Participant 12)

4.3.4.4 Financial constraints

Three participants referred to financial reasons for the employment of PCWs. An ENs opinion is: *“I think it's financial, otherwise they would just employ ENAs.”* (Participant 5) A unit manager further referred to budgetary constraints being considered when deciding to hire PCWs, but that she would not use a PCW when *“a skilled hand is needed.”* (Participant 15) PCWs earn much less than ENAs, yet do almost the same work. One unit manager called this *“cheap labour.”* (Participant 8) Participants did not explicitly say that PCWs are used instead of nurses, yet this was implied. One example is the following quotation: *“So I will not book a care worker unnecessarily. I will rather up the game in my unit with four ENAs than having two ENAs and two care workers.”* (Participant 15)

Participants further were of the opinion that the reasons for employment of PCWs have changed from 'then' to 'now'. A unit manager explained: *“Initially they were just there to assist us with the confused patients.”* (Participant 3) However, PCWs are now also employed to assist nurses with nursing activities and for financial reasons.

Although the subject of training was not an objective of this study, the information offered by participants adds to the understanding of the PCW role. Related findings are subsequently presented.

4.3.5 Training

Three aspects of training emerged from the interviews. These were basic PCW training, further in-service training in the hospital and career aspirations.

4.3.5.1 Basic care worker training

PCWs completed basic care worker courses with a duration of three to six months. Nurses realize that the training is not standardised, but are not sure what the duration and content of this training are. Practical learning is often done in old age homes. Although the hospital environment is very different from the old age homes, the work is basically the same, as explained by a PCW: *“They just do the washing and feeding and also see that the room is*

clean." (Participant 13) Yet, one PCW reported: *"The first time I came here I didn't know nothing."* (Participant 13) A unit manager further suggested that PCWs need a bridging course when starting to work in a private hospital as she was concerned about the content and variety of courses completed by the PCWs applying at her hospital. (Participant 3) Specific differences between the training and hospital environments were discussed. Hospitals have more infection prevention and control measures, x-rays and more movement (admissions and discharges) of patients, as well as more patient visitors. PCWs have to learn what the expected standards in a private hospital are, e.g. regarding patient confidentiality.

4.3.5.2 Learning in the hospital

Further in-service training takes place in the hospitals. Participants mentioned that PCWs learnt from the other nurses and they knew how to do things, e.g. blood pressures and HGTs, but that they were not allowed to do it. They also attend training presented in the hospital, e.g. prevention of slips and falls, prevention of pressure sores, basic life support and catheter care as well as topics related to life skills, such as money matters. An EN mentioned that, when a new device is introduced, all staff, including PCWs, are called to learn about the device. Nurses report that they identify quick learners and teach them to do more, e.g. HGTs, ECGs and to support with admissions. This was confirmed by a PCW, who mentioned: *"There was this sister. She was always helping, calling me every time she does something, because she was willing to teach me. And I was also willing to learn."* (Participant 13)

4.3.5.3 Career aspirations

Most PCWs aspire to become nurses by starting with the ENA course. However, they reported not having a senior certificate and financial constraints being barriers to their career development. Some participants expected from their employers to support PCWs to enhance their careers. A PCW mentioned: *"Help the carer; she doesn't have matric. Send her to do her training."* (Participant 7)

4.3.6 Concerns about the PCW role

4.3.6.1 Limited appreciation

Participants mentioned that PCWs were not appreciated enough and were seen as cheap labour. They *"must definitely be paid more"* (Participant 12) for their valuable contribution to patient care. A PN voiced her opinion: *"Appreciation through raising their income. That's what I want, nothing else."* (Participant 12) Even if they stand in for the secretary for long periods, they do not get paid more.

PCWs, unit managers and nurses mentioned that PCWs are not sufficiently recognised by management for their contribution to patient care, yet they experience that appreciation is expressed by nurses and patients. Their exclusion from Nurses' Day in two of the three hospitals caused emotional upset with some participants. This is illustrated by a PNs experience of Nurses' Day: *"Every year the 11th or 12th of May we have a National Nursing Day and they are not invited, because they are not nurses and with that we have got a problem. So what we do we go on the day and we go and if we have sweeties or so, your whole pocket is full of sweeties. You bring it back because you feel terrible because they are nurses; in our eyes they're nurses."* (Participant 1) It is said that, although their colleagues give recognition to PCWs, the same is not true of management. In the hospital where PCWs are included in Nurses' Day, a participant explained that *"there is no discrimination"* and *"we are all treated equally."* (Participant 11)

4.3.6.2 Lack of career development opportunities

PCWs mentioned that they were 'stuck' in that they could not enhance their career if they did not have a senior certificate. A PN confirmed this: *"They just stay care workers, that's all; not even nursing care workers."* (Participant 1)

Yet, a few participants mentioned with much appreciation that they were working with nursing students or qualified nurses who started their career as PCWs. However, a unit manager voiced her concern that PCWs working in the hospital have the expectancy to do a nursing course although they do not have the ability to do what is expected of ENAs.

4.3.6.3 Variety of basic training courses

A unit manager explained her concern about the variety of courses completed by the PCWs who apply for positions in her ward and that *"the training is not the same."* (Participant 3) She therefore suggested a bridging course for PCWs, including topics on how to work in a private setting and on ethics as well as to standardise their basic training. Some participants proposed regulation, *"to know what is expected from the care worker."* (Participant 3)

4.3.6.4 Doing more

Although there seemed to be a fair amount of clarity about the PCW role, all unit managers and PNs indicated that PCWs were doing more than they were allowed to do. This was elaborated on by a unit manager: *"The other thing is you, you can easily be pressurised, that when the ward is getting busy, you can easily be pressurised into allocating a different task to that care worker. So you can easily trust her and say okay, carry on with the observations, and that is where the problem lies."* (Participant 15) Another unit manager indicated that nurses see the PCWs as nurses, therefore expecting nursing tasks from them.

However, although unit managers seemed concerned about this, PNs apparently accept that the PCW role is expanding. A PN mentioned: *“Then we tell them, in this ward, if we are really short they help us with everything.”* (Participant 1)

In one hospital, the PCWs wear name badges indicating that they are hospitality attendants. Yet, all participants referred to them as carers. Although one participant indicated that their job description did not stipulate basic patient care and record-keeping, she further described that, in reality, they were involved in those activities. Concern was expressed that PCWs might be able to do the tasks, but lack insight to understand the possible consequences of not doing what is expected of them. *“I don’t think they’re always aware of the consequences if they don’t do their job the way they should do it.”* (Participant 8)

Three reasons for the expanding role of PCWs emerged. Firstly, PCWs are pressurised by nurses to ‘do more’, either because the wards are busy and nurses cannot get around to doing everything they have to do, or because nurses expect that PCWs should be able to do more, e.g. vital signs. Secondly, PCWs learn how to do things and use the opportunity to use their new skills. Thirdly, being allowed to ‘do more’ is seen as recognition that the PCWs are not ‘stupid’ and that they are indeed nurses.

4.3.6.5 Lack of insight

One unit manager expressed concern about the poor language proficiency and lack of insight of PCWs. She mentioned that PCWs were initially employed to do basic things, e.g. giving water to a patient and answering patient calls. However, they are now expected to be ‘scientific’ in their approach, e.g. to identify that the sacral area is red, to record that and to evaluate progress. She added that, although a bed bath was seen as a basic task, it was actually a very important and intimate skill that needed to be developed. Nurses seem to expect that PCWs should have the knowledge to handle an expanding role efficiently, as depicted by an EN: *“So if someone is a care worker and she doesn’t have, you know, basic knowledge, basic skills of nursing, then it’s a matter of concern.”* (Participant 11)

She contemplated whether PCWs were actually employed as additional nurses, while a unit manager mentioned that she was giving up ENA positions to employ PCWs in an effort to stay within budget.

4.3.6.6 Other concerns

Concern was expressed about the possibility of injury to PCWs as they are mostly working with heavy patients and the nurses are not available to help them.

One PCW was concerned that too few PCWs are hired, especially in cases where elderly patients need constant supervision to prevent injuries. The increasing number of elderly patients in wards was mentioned as a reason why more PCWs are needed than in the past.

Poor support of PCWs was expressed in that nurses do not answer patient calls, even while they are not busy, because it is seen as the PCW's duty. A PCW remarked: *"Some of the staff are very lame. I will say if they hear the bell ring they wait, where is the carer now?"* (Participant 7) Yet, most participants reported that good relationships existed between nurses and PCWs.

Prominent concerns about the PCW role were therefore the lack of recognition, especially by management, through exclusion from Nurses' Day celebrations and poor salaries. Doing more than what PCWs are allowed to do was reported by unit managers as a concern.

4.4 SUMMARY

Chapter 4 contains a discussion of the findings of the study, including the biographical data of the participants and the information obtained during the interviews.

The findings revealed that PCWs spend most of their day with patients while providing direct patient care, often 'specialling' confused or elderly patients. They are further involved in administration, stock control and housekeeping duties. They mostly work without direct supervision and follow routines to accomplish their tasks. They assist nurses and prevent falls and complaints. Nurses are unsure about PCWs' training, however, they teach PCWs to function in private hospitals. Participants discussed concerns about the PCW role, of which limited recognition of their contribution to patient care seemed to be prominent. Their expanding role, while lacking the insight and knowledge to understand the consequences of their actions, was additionally discussed.

Chapter 5 contains a discussion of the findings of the study and provide conclusions and recommendations related to these findings.

CHAPTER 5

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The previous chapters contain a description of the rationale for this study and a literature review regarding the role of health care assistants (HCAs) in general and patient care workers (PCWs) in particular. A description was further provided of the research methodology and data analysis applied for this study. Six themes emerged from the data. These are the activities of PCWs, care organisation, position in the patient care team, reasons for employment, training and concerns about the PCW's role.

Chapter 5 contains a discussion of the findings, conclusions drawn from the analysis and recommendations.

5.2 DISCUSSION

Creswell (2013:187) describes the interpretation of data as moving beyond codes and themes to the wider meaning of data. Meaning of the data is obtained by linking the findings to the larger research literature as depicted by the conceptual map in chapter 1, figure 1.1.

The aim of the study was to explore the role of PCWs in private hospitals in the Cape Metropole. The discussion of the findings of the study in relation to each study objective is subsequently provided.

5.2.1 Objective 1: The activities of PCWs in medical and surgical wards

All participants were clear that PCWs are primarily tasked to provide direct care to patients, therefore spending most of their day close to patients. Most participants also mentioned that PCWs do more than what they are allowed to do, which was a point of concern to unit managers, as further discussed in section 5.2.5.

Their tasks involve all aspects of hygiene and comfort, similar to the activities of daily living, or physiological aspects of care, referred to by both Henderson (George, 2002:86-87) and Orem (George, 2002:128) in their theories of nursing. This supports the notion by McKenna *et al.* (2004:454) that many of the core skills of nursing have been handed over to PCWs. Even though unit managers made an initial effort to explain that PCWs do not do nursing by labeling their work as 'non-nursing tasks' and 'non-scientific nursing', most participants, including unit managers, professional and other nurses as well as PCWs, eventually

concluded that PCWs are seen as nurses and that they are actually performing basic nursing tasks. Their activities therefore overlap with those of ENAs, although their training is not standardised and they are not regulated in terms of the Nursing Act. No 33 of 2005. According to Stellenberg and Dorse (2014:2) the practice of PCWs in hospitals may put patient safety at risk and may lead to PNs being confronted by ethical issues.

Participants also explained the intimate nature of these activities and that PCWs spend much time close to patients. Their closeness to patients allows PCWs to observe the patients' conditions. It is evident that the expectancy is that they will report abnormalities and the progress or the worsening of a patient's condition to nurses. Most nurses responded that PCWs are good observers, although concern about the lack of insight was also expressed. These findings correlate with the writings of James *et al.* (2010:549) that the close proximity of HCAs to patients has led them to be described as 'insightful observers' and that they are well positioned to identify early warning signs of deterioration.

Simultaneously, the growing distance of PNs from patients and their decreasing involvement in direct patient care in the medical and surgical wards were revealed by participants, as described by a PCW: *"Somtyds kry die suster nie miskien kans om by die pasiënt uit te kom daardie dag nie; sy is so besig."* (Participant 9) Translated: *"Sometimes the sister doesn't get time to get to the patient during that day; she is so busy."* This aligns with the findings of Furåker (2008:543) and Keeney *et al.* (2005:347) that nurses' work is shifting towards more indirect care activities such as co-ordination, supervision and paper work and subsequently shifting away from direct care. A study by Fitzgerald *et al.* (2003:347) further described that nursing work appears task orientated, routinised and therefore fragmented, although nurses' ideal is a holistic approach to patient care which should be realised through team work. This was supported by the findings of this study, as participants linked specific tasks to different categories of nurses, e.g. the PNs to doctors' rounds, ENs to medication administration and ENAs to vital sign observations and admissions. However, PCWs are constantly around patients while providing care and comfort to patients, as expressed by a PCW: *"Ons is 12 ure by hulle, aan hulle bed-side, elke dag."* (Participant 9) Translated: *"We are with them 12 hours, at their bed-side, every day."*

These findings illustrate that patients have more contact with PCWs who provide direct care, while patients' contact with trained nurses is less, so that it seems that trained nurses are distant from patients. The 'Future of Nursing Report' (Institute of Medicine, 2011:7-8) states that nurses must achieve higher levels of education and training to meet the changing needs of patients. Having informally trained health care workers delivering direct care, does therefore not support this recommendation.

PCWs are further involved in indirect care, especially to stand in for unit administrators and stock controllers. They also support nurses by doing errands, thus allowing nurses to stay in the wards. Although Furåker (2008:548-550) reported that indirect care comprised half of the working hours of HCAs, participants reported that PCWs spend less time on indirect activities in comparison to direct care activities. Administrative, stock control and house-keeping activities seem not to be the focus of PCWs, but of other types of support staff.

5.2.2 Objective 2: The supervision of PCWS

The supervision of PCWs relates to one aspect of care organisation in the ward. Two other aspects, namely task allocation and reporting, emerged during the data analysis and are therefore included in this section.

Keeney *et al.* (2005:347) stated that effective employment of HCAs requires that their work is directed and supervised by registered nurses. James *et al.* (2010:553) further stated that the responsibility of the registered nurse to provide supervision at the bed-side should be assured. Yet, although the researcher found that nurses and unit managers are aware that supervision of PCWs is needed, both nurses and unit managers acknowledged that PCWs most often work on their own. This corresponds with the findings of Snell in McKenna *et al.* (2004:454-56), indicating that 53% of HCAs reported that little or none of their work was supervised. Poor supervision of HCAs' work, expose both nurses and employers to legal and ethical risks.

Tasks are allocated to PCWs by PNs, although delegation by ENs and ENAs was also mentioned. Yet, most PCWs reported that they 'know what to do' and follow routines through which the hygiene and comfort needs of patients are addressed. All participants further reported that PCWs are included in hand-over meetings during which they gather information and receive instructions about patients. This finding does not align to the notation of Spilsbury and Meyer (2004:415) that the roles of HCAs are sometimes limited by nurses by not involving them in discussions concerning patient care.

Nurses often acknowledged that PCWs are good at reporting and indicated that they rely on them to report abnormalities and signs of progress or deterioration. PCWs, similar to all nurses, record their activities and observations on patient records. However, Spilsbury and Meyer (2004:415) found that the passing on of HCAs' observations is not actively sought and valued or acknowledged by nurses. Yet, the findings of this study illustrate that nurses acknowledge, value and rely on the ability of PCWs to report abnormalities and that they document observations, e.g. skin lesions and activities on patient documents. According to

Hancock and Campbell (2006:36), the inclusion of PCWs in documentation and patient care meetings, conveys respect to them.

5.2.3 Objective 3: Their position in the patient care team

All participants explained that PCWs contribute significantly towards patient care and that they are well integrated in the nursing team. This is in contrast to the report by Kalish (2009:486) that there are mixed findings regarding the opinion of nurses on the quality of work of the HCAs and that few studies show a positive view. However, although nurses had a positive experience of PCWs' work, the impact of their activities on the quality of patient care, was not an objective of this study. Their integration into the nursing team could also be explained in that the average duration of participants working with or as PCWs, was eight years.

Most participants further expressed that they see PCWs as nurses and that they are actually rendering nursing care. Yet, they are legally not acknowledged as nurses, as they are not registered according to the Nursing Act, No 33 of 2005. Nurses therefore do not seem to understand the legal regulation of their practice or the implications thereof for nursing practice.

PCWs seeing themselves as nurses, further seem to align with the social identity theory of Henry Tajfel (McLeod, 2008:np), who defined social identity as a person's sense of who he or she is based on group membership. PCWs adopt their identity from the nursing group they associate themselves with and therefore see themselves as nurses and act as nurses accordingly. PCWs develop an emotional attachment to the nursing group and their self-esteem becomes intertwined with that of the nursing group's self-image.

Some participants also indicated that the relationship between ENAs and PCWs can be strained, as shared by a PN: *"Sometimes the carers are being looked at, they are always looked down by the immediate, the ENA."* (Participant 10) This could further be explained by the social identity theory (McLeod, 2008:np) which states that the in-group (ENAs) will discriminate against the out-group (PCWs) to enhance the in-group's self-image.

Yet, most participants were of the opinion that there is little difference between the ENA's and the PCW's roles. Most of the direct care activities mentioned by participants as set out in chapter 4, section 4.3.1, seem similar to the definition of elementary nursing, which falls within the domain of the ENA. Elementary nursing is defined by SANC as "practical self-care and activities of daily living interventions that assist the health care users to promote and maintain their health status through the application of prescribed standards of care"

(SANC. Regulation 786. October 2013). The ENA's one year training program and practice as a nurse is regulated (SANC. Regulation 176. November 1993, as amended). The activities of PCWs thus overlap with those of ENAs for reasons discussed in section 4.3.6.4, although their training courses are shorter and not standardised. The role boundary between nurses and PCWs therefore does not appear distinctive as illustrated in the conceptual model (chapter 1, figure 1.1).

5.2.4 Objective 4: Reasons for their employment

Several authors stressed financial pressure as a reason for the employment of HCAs (Hunt, 2010:18; Armstrong *et al.*, 2013:101; Keeney *et al.*, 2005:345). However, only some participants offered financial restrictions as a reason for the employment of PCWs. It was mentioned that there is pressure on staff to stay within budget and that PCWs are seen as 'cheap labour' or 'cheaper' to hire than ENAs. The World Medical Association (WMA) general assembly for task shifting from the medical profession, poses a warning that task shifting should not be viewed solely as a cost saving measure since the economic benefits of task shifting have not been substantiated and that such cost-driven methods are unlikely to produce quality results that will serve the best interests of patients. The resolution further states that the aspiration should be to train more skilled professionals, rather than shifting tasks to lesser skilled workers (WMA Assembly, 2009:3).

Although a unit manager implied that nurses are replaced by PCWs, this was not explicitly mentioned in the interviews. However, Keeney *et al.* (2005:346) describe the nursing profession's concern that HCAs will replace nurses, as HCAs are taking over traditional nursing tasks while they are cheaper to employ. This is a particular concern in hospitals, where patient care is growing in complexity (Stellenberg & Dorse, 2014:8). It is further concerning that participants mentioned that the basic care needed by patients in the medical and surgical ward setting is similar to that of care in old age homes, yet a PCW revealed, "*The first time I came here I didn't know nothing.*" (Participant 13) PCWs might lack the insight to understand the complexity of the care needed by patients in acute care hospitals.

Furthermore, the literature is quite pertinent that the HCA's function has grown in importance due to the continuing nursing recruitment and retention crisis (Keeney *et al.*, 2005:345). However, 'nursing shortage' as such, was never mentioned by participants. Yet, participants often explained that PCWs do those things "*that the nurses cannot get to sometimes*", the "*little things*" (Participant 15) that keep patients happy and prevent complaints, e.g. ensuring that there is always fresh water at the bed-side. It seems that specific tasks, related to direct care, are shifted from nurses to PCWs to ease the workload of nurses. The concept of task

shifting refers to the delegation of health care activities from nurses to lower categories and non-nursing staff, as described by Callaghan, Ford and Schneider (2010:6). The World Health organisation states that task shifting should be implemented within systems that contain adequate control and evaluation checks to protect both health workers and patients (WHO, 2007:7-8).

Most participants mentioned that PCWs were initially hired to watch over confused patients. This is still a task primarily allocated to PCWs. The PCWs' responsibility to prevent falls, especially of elderly patients, was often discussed and is growing in importance as the patient population becomes older. Furåker (2008:543) similarly describes the changing profiles of patients due to an ageing population and increasing survival rates which, in turn, leads to an increased demand for patient care. Participants commented that an increased focus on patient safety, contributes to the hiring of PCWs.

5.2.5 Objective 5: Concerns about their role

Participants explained that most nurses and patients acknowledge PCWs for their contribution towards patient care. However, participants are of the opinion that the same does not apply to management. This was evident with PCWs' being excluded from Nurses' Day in two hospitals and their low salaries despite their hard work. Consequently, it caused ambivalent emotions on Nurses' Day and evoked sympathy towards PCWs. Yet, including PCWs on Nurses' Day, would indicate that management acknowledges PCWs as nurses, which is in conflict with the Nursing Act, No 33 of 2005.

Most participants mentioned that PCWs do more than they are allowed to do, similar to the findings by Spilsbury *et al.* (2009:616) who validate that HCAs' responsibility for patient care is increasing. Although this was a point of concern to unit managers, PNs seemed to be comfortable that the duties of PCWs go beyond basic patient care. Unit managers' concern about the expanding role is possibly fuelled by them not knowing what the PCWs' training entails and that they are not regulated, as confirmed by a unit manager: *"I don't know what happens in their training."* (Participant 15) and, *"the training that they give is not the same."* (Participant 3) They are therefore concerned that, although PCWs might be able to do the tasks, they lack the knowledge and insight to understand the possible consequences of some of their actions. Kalish (2009:487) similarly describes the concern of nurses about the training and performance of HCAs and that nurses are hesitant to delegate to HCAs as they do not trust their competency levels. Regulation or credentialling is advised to enable and to regulate task shifting as well as to ensure that the new type of health workers are appropriately qualified for the tasks that they will undertake (WHO, 2007:7-8).

Nevertheless, PCWs learn from nurses and are trained by nurses to do more. Nurses are clear that they identify PCWs who have the ability to learn quickly and teach them to do more. The additional tasks, e.g. doing HGTs and HBs, then become part of the PCW's role or are delegated to the PCW when the nurses are under pressure in a busy ward. However, this training is informal and with no standardised assessment of competency, which, in turn, poses risk to the health care team and patients.

A further reason for PCWs 'doing more', might be their lack of career development opportunities. Financial constraints and not possessing a senior certificate were mentioned as reasons for being 'stuck' as a PCW. Having the cognitive ability and desire to progress, but not meeting the criteria to study nursing, could encourage them to learn from nurses and also to apply new skills.

5.3 LIMITATIONS OF THE STUDY

The study was conducted in medical and surgical wards of private hospitals in the Western Cape Metropole and excluded other units, e.g. critical care units and paediatric wards, as well as the wider population of public hospitals. Data was collected from three private hospitals, each representing one of the three largest hospital groups in South Africa. However, nurses might have different experiences of the role of PCWs in other units and in public hospitals.

The sensitivity of the research topic could lead to participants holding back on their experiences of PCWs in their wards. This is supported by the perception of the researcher that unit managers made an effort to explain that PCWs are not nurses and have to work under direct supervision, yet, as the interview progressed, they shared that PCWs do nursing work and that they usually work on their own.

5.4 CONCLUSIONS

This study was guided by the research question: "What is the role of PCWs in private hospitals in the Cape Metropole?" The findings reveal that PCWs are well integrated into patient care teams while most of their time is spent on direct patient care. Their activities seem similar to elementary care, which is the domain of the ENA and therefore overlap with the ENA's scope of practice. Yet, PCWs are not regulated and therefore their training programs and activities in hospitals vary. They are also not legally entitled to practice nursing. Their competency to care for patients in the hospital setting and their insight to observe and report on the patient's condition are questioned, although nurses rely on PCWs to report abnormalities and expressed that PCW are good observers.

The findings also demonstrated that nurses are moving further away from the bed-side while handing over more of their core nursing tasks to PCWs. Yet, PCWs are the least trained and lowest paid members of the patient care team and mostly not recognised as nurses by hospital management or by the nursing profession. However, the participants acknowledged their contribution to patient care. Most participants see PCWs as nurses and what they do, as nursing, even though this contravenes the legal requirements as stipulated in the Nursing Act, No 33 of 2005. They are further not adequately supervised and mostly work on their own.

The initial role of PCWs was to keep confused patients safe, but their role has evolved to and even beyond the rendering of basic patient care. Unit managers are concerned about the risks to patient care posed by the expanding role of PCWs and their functioning beyond their competency levels. Unit managers additionally find it difficult to explain to patients that a person rendering direct patient care is not a nurse. It is equally difficult to explain their role during legal investigations. Yet, PCWs have been part of patient care teams in hospitals for several years. It is therefore crucial to critically evaluate their role as their participation in nursing care cannot be ignored.

Furthermore, budget restrictions were mentioned as a reason for the employment of PCWs. Yet, the WMA warns that task shifting should not be viewed solely as a cost saving exercise as the economic benefits of task shifting have not been substantiated and that the benefits to patients are unlikely (WMA Assembly, 2009:3).

The findings therefore confirm that the research question has been answered and that the objectives of the study have been met, as discussed in section 5.2. However, further areas for research emerged and are listed in section 5.5.5.

5.5 RECOMMENDATIONS

The recommendations are based on the scientific evidence obtained in this study as well as on the literature studied. The findings of the study indicate that PCWs are integrated into the nursing team and are regarded as nurses and that they perform direct patient care. Therefore various recommendations are proposed.

5.5.1 Regulation

According to Spilsbury *et al.* (2009:616) regulation of PCWs would help to standardise their role, while also providing recognition, confidence and career progression to PCWs (WHO, 2007:8). PNs would then find it easier to delegate appropriately to PCWs, as confirmed by

participant 3: “*Regulation, so that we know what to expect of them.*” Stellenberg and Dorse (2014:8) further stress the importance of regulation to align formal training to the Nursing Act, No 33 of 2005, and to protect the public. The importance of regulation to ensure patient safety is also described by Hand (2012:16), in that regulation will introduce a code of conduct and definition of the role. An appropriate legislative framework will further protect nurses, as nurses who delegate functions to PCWs will remain accountable should adverse events happen. The researcher therefore recommends that the work of PCWs should be regulated.

5.5.2 Another nursing category

Nurse leaders should investigate the reasons for the employment of PCWs in hospitals (WMA Assembly, 2009:3) and critically debate the need for another category of non-professional worker involved in direct patient care in hospitals (Chang, 1995:73). Participants mentioned that the PCW's and ENA's roles are similar, although PCWs have less training than ENAs. The findings further revealed that some participants were concerned about the lack of insight of PCWs to identify abnormalities and to understand the consequences of their actions. ENAs have a longer and formal training and are regulated. They should therefore be better equipped to care for patients in hospitals than PCWs. The researcher therefore recommends that the provision of bridging opportunities for PCWs by SANC should be investigated.

5.5.3 Educate nurses on legislation

Nurses seem to be unclear on the legislation governing the nursing profession. The researcher observed that they struggle to explain the practical implications of relevant legislation correctly. Nurses should regularly be updated on relevant legislation while new regulations, after publication, should be included in nurses' continuous development program.

5.5.4 Skill mix

Nurses should be actively involved in decisions made about the skill mix of the patient care team (Chang, 1995:73) and the competency of staff rendering care at the bed-side. Several studies describe the positive impact of a higher skill mix on patient, nursing and organisational outcomes (Aiken *et al.*, 2002:6; Duffield *et al.*, 2011:253; Estabrooks *et al.*, 2005:75). The WMA (2009:4) further advocates that a thorough study should be made of the needs, costs and benefits of task shifting and that task shifting should not be used solely as a reaction on other developments in hospitals. The researcher recommends that lower

skill mixes should be cautiously considered in the light of scientific evidence, the effects thereof monitored and the risks determined and managed.

5.5.5 Future research

The following areas for future research are proposed:

- the experience of patients of the role of PCWs;
- the role of PCWs in other types of units, e.g. critical care units, in public hospitals and in other care facilities, e.g. homes for the aged;
- the employment effect of PCWs on the quality of patient care;
- a comparison between ENAs and PCWs regarding their training and roles;
- the effect of supportive staff on the supervisory function of the professional nurse; and
- the knowledge and practical application by PNs of legal aspects pertaining to nursing practice.

5.5 DISSEMINATION

The researcher plans to publish the findings in an accredited, peer-reviewed health care journal as well as to present the findings at a National Nursing Leadership conference. The researcher will request an opportunity to present the findings at a meeting of the Forum for Professional Nurse Leaders, Western Cape chapter, in order to share the findings with the hospitals involved in the study.

5.6 CONCLUSION

In this chapter the findings of the study were discussed in relation to the study objectives. The objectives were reached through the exploration of the role of PCWs in private hospitals in the Cape Metropole.

The findings indicate that, for several years, PCWs have been involved in direct patient care and that they are well integrated into the patient care team. Therefore urgent attention needs to be given to their regulation and the clarification of their role in acute care settings, since their employment contravenes national and international recommendations to employ higher qualified staff. The involvement of non-regulated staff in direct patient care may also put hospitals at risk of litigation.

REFERENCES

- Acute care HCA duties at Wairu hospital. 2012. *Kai Tiaki Nursing New Zealand*, 18(7):34.
- Aiken, L.H., Clarke, S.P., Sloane, D.M., Sochlaski, J. & Siber, J.H. 2002. Hospital nurse staffing and patient mortality, nurse burnout and job dissatisfaction. *Journal of the American Medical Association*, 288(16):1987-1993.
- Armstrong, S., Bhengu, B., Kotze, W., Nkongo-Mtembu, L., Ricks, E., Stellenberg, E.L., van Rooyen, D. & Vasuthevan, S. 2013. *A new approach to Professional Practice*. 1st ed. Claremont: Juta & Company Ltd.
- Baldwin, D. 1999. Community-based experiences and cultural competence. *Journal of Nursing Education*, 38(5):195-196.
- Biddle, B.J. 1986. Recent Developments in Role Theory. *Annual Review of Sociology*, 12:67–92. [Online]. Available: <http://www.jstor.org/stable/2083195> [2014 November 11].
- Booyens, S., W. 2008. *Introduction to health service management*. 3rd ed. Cape Town: Juta & Company Ltd.
- Brink, H., Van der Walt, C. & Van Rensburg, G. 2008. *Fundamentals of Research Methodology for Health Care Professionals*. 2nd ed. Cape Town: Juta & Company Ltd.
- Burns, N. & Grove, S.K. 2007. *Understanding Nursing Research: Building An Evidence-Based Practice*. 4th ed. St Louis: Saunders Elsevier Publishers.
- Burns, N. & Grove, S.K. 2009. *The Practice of Nursing Research: Appraisal, synthesis and generation of evidence*. 6th ed. St Louis: Saunders Elsevier Publishers.
- Butler-Williams, C., James, J., Cox, H. & Hunt, J. 2010. The hidden contribution of the health care assistant: A survey-based exploration of support to their role in caring for the acutely ill patient in the general ward setting. *Journal of Nursing Management*, 18:789-795.

- Callaghan, M., Ford, N. & Schneider, H. 2010. *A systematic review of task shifting for HIV treatment and care in Africa*. [Online]. Available: <http://www.human-resources-health.com/content/8/1/8> [2014 October 15].
- Chang, A.M. 1995. Perceived functions and usefulness of health support workers. *Journal of Nursing Administration*, 21:64-74.
- Creswell, J.W. 2013. *Qualitative inquiry and research design: Choosing among five approaches*. London: SAGE Publications Inc.
- Dall, T.M., Chen, Y.J., Seifert, R.F., Maddox, P.J. & Hogan, P.F. 2009. The economic value of professional nursing. *Med Care*, 47(1):97-104.
- Daniels, K. 2012. Lay Health Worker Programmes as a Public Health Approach in South Africa: Doctoral thesis at the Nordic School of Public Health NHV. Sweden: Ineko.
- Daniels, K., Clarke, M. & Ringsberg, K.C. 2012. Developing lay health worker policy in South Africa: a qualitative study. *Health Research Policy and Systems*, 10(8):1-11.
- De Vos, A.S., Strydom, H., Fouche, C.B. & Delpont, C.S.L. 2005. *Research at grass roots for the social sciences and human service professions*. 3rd ed. Pretoria: Van Schaik Publishers.
- De Vos, A.S., Strydom, H., Fouche, C.B. & Delpont, C.S.L. 2011. *Research at grass roots for the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik Publishers.
- Dorse, A. J. 2008. Legal and ethical aspects of nursing practice in selected private hospitals in the Western Cape Metropolitan area. [Online]. Available: <http://scholar.sun.ac.za/handle/10019.1/3337>. [2011, 19 July].
- Duffield, C., Dier, D., O'Brien-Pallas, L., Aisbett, C., Roche, M., King, M. & Aisbett, K. 2011. Nursing staffing, nursing workload, the work environment and patient outcomes. *Applied Nursing Research*, 24(4):244-255.
- Ehrlich, R. & Joubert, G. 2007. *Epidemiology: A Manual for South Africa*. Cape Town: Oxford University Press.
- Estabrooks, C.A., Midodzi, W.K., Cummings, G.G., Ricker, K.L. & Giovannetti, P. 2011. The Impact of Hospital Nursing Characteristics on 30-day Mortality. *Journal of Nursing Administration*, 41(7/8):58-68.

- Fitzgerald, M., Pearson, A., Walsh, K., Long, L. & Heinrich, N. 2003. Patterns of nursing: A review in a large metropolitan hospital. *Journal of Clinical Nursing*, 12:326-333.
- Frenk, J., Chen, L., Buttha, Z.A., Cohen, J., Crisp, N., Evans, T., Fineberg, H., Gracia, P., Ke, Y., Kelley, P., Kistnasamy, B., Meleis, A., Maylor, D., Pablos-Mendez, A., Reddy, S., Scrimshaw, S., Sepulveda, J. & Serweda, D. 2010. Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world. *The Lancet*, 376:1923-1958. [Online]. Available: <http://www.thelancet.com> [2014 November 15].
- Furåker, C. 2008. Health care assistants' and mental attendants' daily work tasks in acute hospital care. *Journal of Nursing Research*, 13:542-553.
- Furåker, C. 2009. Nurses' everyday activities in hospital care. *Journal of Nursing Management*, 17:269-277.
- George, J.B. 2002. *Nursing Theories: The Base for Professional Nursing Practice*. 5th ed. New Jersey: Prentice Hall.
- Grove, S. K., Burns, N. & Gray, J. R. 2013. *The Practice of Nursing Research: Appraisal, Synthesis, and Generation of Evidence*. 7th ed. St. Louis: Elsevier Saunders.
- Hancock, H. & Campbell, S. 2006. Developing the role of the health care assistant. *Nursing Standard*, 20(49):35-41.
- Hand, T. 2012. The developing role of the HCA in general practice. *Practice Nurse*, 42(19):14-17.
- Hassim, A., Heywood, M. & Berger, J. 2007. *Health and democracy. A guide to human rights, health law and policy in post-apartheid South Africa*. Cape Town: Cred Communications (Pty) Ltd.
- Howe, L. 2011. What is competence in health care? [Online]. Available: <http://blog.healthstream.com/blog/bid/77623/What-is-Competence-in-Healthcare-Part-I> [2014 November 15].
- Hunt, J. 2010. Building a case with hard facts. *Nursing Standard*, 24(51):18-20.
- Institute of Medicine. 2011. *The Future of Nursing: Leading Change, Advancing Health*. National Academy of Sciences. Washington DC: National Academic Press.

- Kalisch, B. 2009. Nurse and Nurse Assistant Perceptions of Missed Nursing Care. What Does It Tell Us About Teamwork? *The Journal of Nursing Administration*, 39(11):485-493.
- Keeney, S., Hasson, F., McKenna, H. & Gillen, P. 2005. Nurses', midwives' and patients' perceptions of trained health care assistants. *Journal of Advanced Nursing*, 50(4):345-355.
- LoBiondo-Wood, G. & Haber, J. 2010. *Nursing Research: Methods and Critical Appraisal for Evidence-Based Practice*. 7th ed. Missouri: Mosby Elsevier.
- Mckenna, H.P., Hasson, F. & Keeney, S. 2004. Patient safety and quality care: The role of the health care assistant. *Journal of Nursing Management*, 12:452-459.
- McLeod, S.A. 2008. *Social Identity theory*. [Online]. Available: <http://www.simplypsychology.org/social-identity-theory.html> [2014 September 19].
- Mouton, J. 2009. *How to succeed in your Master's and Doctoral studies. A South African guide and resource book*. Pretoria: Van Schaik Publishers.
- Prestia, A. & Dyess, S. 2012. Maximising caring relationships between nursing assistants and patients. *Journal of Nursing Administration*, 42(3):144-147.
- Republic of South Africa. 1993. *Regulations Relating to the Course Leading to Enrolment as a Nurse, R2175 of 1993*. Pretoria: Government Printer.
- Republic of South Africa. 1993. *Regulations Relating to the Course Leading to Enrolment as a Nursing Auxiliary, R2176 of 1993*. Pretoria: Government Printer.
- Republic of South Africa. 2013. *Regulations Relating to the Scope of Practice of Nurses and Midwives, R786 of 2013*. Pretoria: Government Printer.
- Republic of South Africa. 2005. *Nursing Act 33 of 2005*. Pretoria: Government Printer.
- SAQA. 2012. *SAQA US ID: 260463: Assist the client and significant others to manage home based health care*. [Online]. Available: <http://regqs.saqa.org.za/showUnitStandard.php?id=260463> [2013 August 31].
- Spilsbury, K. & Meyer, J. 2004. Use, misuse and non-use of health care assistants: Understanding the work of health care assistants in a hospital setting. *Journal of Nursing Management*, 12:411-418.

- Spilsbury, K., Stuttard, L., Adamson, J., Atkin, K., Borglin, G., McCaughan, D., McKenna, H., Wakefield, A. & Carr-Hill, R. 2009. Mapping the introduction of Assistant Practitioner roles in Acute NHS (Hospital) Trusts in England. *Journal of Nursing Management*, 17:615-626.
- Stellenberg, E. L. & Dorse, A. 2014. Ethical issues that confront nurses in private hospitals in the Western Cape Metropolitan area. *Curationis*, 37(1):1- 9.
- Terre Blanche, M., Durrheim, K. & Painter, D. 2006. *Research in Practice: Applied Methods for the Social Science*. Cape Town: University of Cape Town Press.
- Twigg, D., Duffield, C., Bremner, A., Rapley, P. & Finn, J. 2012. Impact of skill mix variations on patient outcomes following implementation of nursing hours per patient day staffing: A retrospective study. *Journal of Advanced Nursing*, 68(12):2710-2718.
- Wahyuni, D. 2012. The research design maze: Understanding paradigms, cases, methods and methodologies. *JAMAR*, 10:169-80.
- WMA General Assembly. 2009. *WMA Resolution on task shifting from the medical profession*. [Online]. Available: <http://www.wma.net/en/30publications/10policies/t4/> [2014 November 17].
- World Health Organization. 2007. *Task shifting to tackle health worker shortages*. [Online]. Available: http://www.who.int/healthsystems/task_shifting_booklet.pdf [2014 November 17].

APPENDICES

APPENDIX 1: ETHICAL APPROVAL FROM STELLENBOSCH UNIVERSITY



UNIVERSITEIT-STELENBOSCH-UNIVERSITY
jou kennisvenoot - your knowledge partner

Approval Notice New Application

08-May-2014
Aylward, Louise LA

Ethics Reference #: S14/02/043

Title: Exploring nurses' perceptions of the role of patient care workers in private hospitals in the Cape Metropole.

Dear Ms Louise Aylward,

The New Application received on 27-Feb-2014, was reviewed by members of Health Research Ethics Committee I via Minimal Risk Review procedures on 08-May-2014 and was approved.

Please note the following information about your approved research protocol:

Protocol Approval Period: 08-May-2014 -08-May-2015

Please remember to use your protocol number (S14/02/043) on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:

Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

Translation of the consent document to the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372

Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.

For standard HREC forms and documents please visit: www.sun.ac.za/rds

If you have any questions or need further assistance, please contact the HREC office at 0219389657.

Included Documents:

Investigator CV

Supervisor CV

HREC Checklist

Synopsis

APPENDIX 2: PERMISSION OBTAINED FROM FIRST HOSPITAL GROUP

RESEARCH OPERATIONAL COMMITTEE FINAL APPROVAL OF RESEARCH

Ms L Aylward

Approval number: UNIV-2014-0027

E mail: Louise.Aylward@Mediclinic.co.za

Dear Ms Aylward

RE: EXPLORING THE ROLE OF PATIENT CARE WORKERS IN PRIVATE HOSPITALS IN THE CAPE METROPOLE

The above-mentioned research was reviewed by the Research Operational Committee's delegated members and it is with pleasure that we inform you that your application to conduct this research at Private Hospital, has been approved, subject to the following:

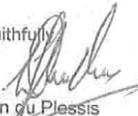
- i) Research may now commence with this FINAL APPROVAL from the Committee.
- ii) All information with regards to Company will be treated as confidential.
- iii) Company's name will not be mentioned without written consent from the Committee.
- iv) All legal requirements with regards to patient rights and confidentiality will be complied with.
- v) Insurance will be provided and maintained for the duration of the research. This cover provided to the researcher must also protect both the staff and the hospital facility from potential liability
- vi) In accordance with MCC approval, that medicine will be administered by or under direction of the authorised Trialist
- vii) The research will be conducted in compliance with the GUIDELINES FOR GOOD PRACTICE IN THE CONDUCT OF CLINICAL TRIALS IN HUMAN PARTICIPANTS IN SOUTH AFRICA (2000)
- viii) Company must be furnished with a STATUS REPORT on the progress of the study at least annually on 30th September irrespective of the date of approval from as well as a FINAL REPORT with reference to intention to publish and probable journals for publication, on completion of the study.



- ix) A copy of the research report will be provided to Company once it is finally approved by the tertiary institution, or once complete.
- x) Company has the right to implement any Best Practice recommendations from the research.
- xi) Company reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental to the subjects/Netcare or should the researcher not comply with the conditions of approval.
- xii) APPROVAL IS VALID FOR A PERIOD OF 36 MONTHS FROM DATE OF THIS LETTER.

We wish you success in your research.

Yours faithfully,


Prof Dion du Plessis
Full member: Research Operational Committee & Medical Practitioner evaluating research applications as per Company Policy


Shannon Nell
Chairperson: Research Operational Committee

Date: 30/6/2014

This letter has been anonymised to ensure confidentiality in the research report.
The original letter is available with author of research

APPENDIX 3: PERMISSION OBTAINED FROM SECOND HOSPITAL GROUP



Life Healthcare Head Office
Oxford Manor, 21 Chaplin Road, Illovo 2196
Private Bag X13, Northlands 2116, South Africa
Telephone: +27 11 210 9000
Telefax: +27 11 210 9001
www.lifehealthcare.co.za

13 June 2014

ATTENTION: LOUISE AYLWARD

APPROVAL FOR RESEARCH STUDY

TITLE: Exploring the role of patient care workers in private hospitals in the Cape Metropole.

Our previous correspondence refers.

The Research Committee of Life Healthcare has granted permission for your study to be conducted within the company's facilities. Please present this letter to the Hospital Manager of each institution when seeking permission to use facilities.

We look forward to seeing the results of your research once it is completed.

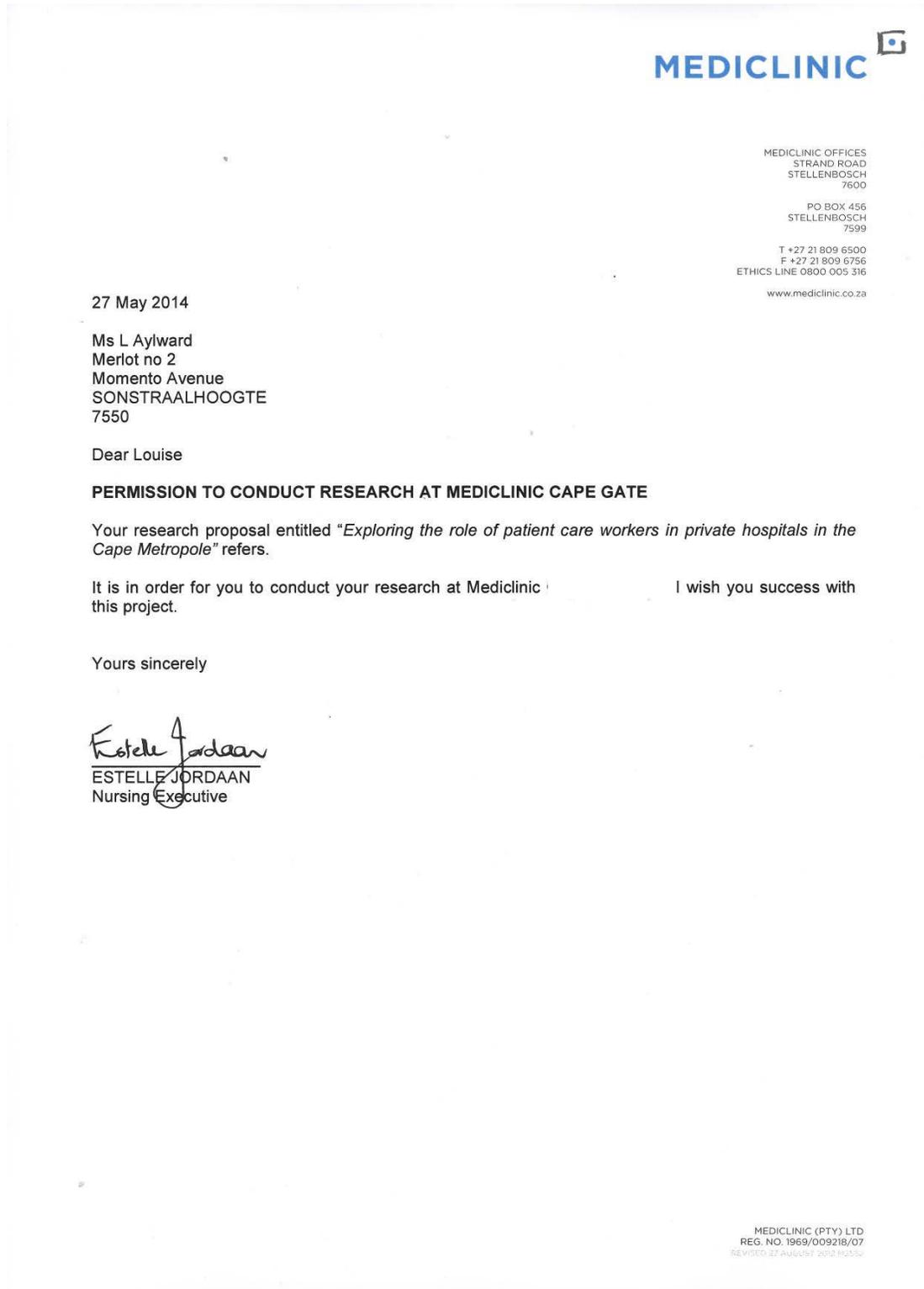
Yours sincerely

A handwritten signature in black ink, appearing to read "Arloodt".

Anne Roodt
Education Specialist



APPENDIX 4: PERMISSION OBTAINED FROM THIRD HOSPITAL GROUP



APPENDIX 5: DECLARATION OF CONSENT BY PARTICIPANT AND INVESTIGATOR

Declaration by participant

By signing below, I agree to take part in a research study entitled "Exploring the role of patient care workers in private hospitals in the Cape Metropole."

I declare that:

- I have read the attached information leaflet and that it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is voluntary and that I have not been pressurised to take part.
- I may choose to leave the study at any time and that I will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interest, or if I do not follow the study plan as agreed to.

Signed at (place) on (date) 2014.

Signature of participant

Declaration by investigator

I, Louise Aylward, declare that:

- I explained the information in this document to
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did not use a interpreter

Signed at (*place*)on (*date*) 2014.

.....

.....

Signature of investigator

Signature of witness

APPENDIX 6: DEMOGRAPHIC DATA

Please answer the following questions by marking the box with your answer.

In what type of ward are you employed?

| | | |
|---------|----------|---------------------------|
| Medical | Surgical | Mixed Medical/Surgical |
|---------|----------|---------------------------|

What is your position in the ward?

| | | | | |
|-----------------|-----------------------|-------------------|--------------------|-------|
| Unit manager | Professional nurse | Enrolled nurse | Auxiliary nurse | Other |
|-----------------|-----------------------|-------------------|--------------------|-------|

How many years of nursing experience do you have?

For how many years have you been working with or as a patient care worker?

What is your age in years?

What is your gender?

| | |
|------|--------|
| Male | Female |
|------|--------|

APPENDIX 7: SEMI-STRUCTURED INTERVIEW GUIDE

Exploring the role of patient care workers in private hospitals in the Cape Metropole

The interviews were guided by the following open-ended questions:

4. Tell me about the role of PCWs in your ward.
Probing words: their current activities, patient care, documentation of patient care, housekeeping, cleaning, catering, ward administration, training, stock control, night shift, day shift, what they should do and should not do, non-nursing duties, work profile
5. Why are PCWs employed in your ward?
Probing words: nursing shortage, financial reasons, assist nurses, patient satisfaction, safe patient care
6. How do you see the position of PCWs in the patient care team?
Probing words: assisting nurses, enrolled nurse auxiliary functions, work independently, trust
7. How does the PCW role differ from other roles in the patient care team?
8. What are the similarities with other roles?
9. What is your experience of the supervision of PCWs?
Probing words: reporting structure, communication, delegation, feedback
10. Do you have any concerns about the use of PCWs in your ward? Please explain.
Probing words: Training, competencies, supervision, nursing posts, nursing tasks, role clarity, role variability, regulation, risks

APPENDIX 8: PARTICIPANT INFORMATION LEAFLET

TITLE OF THE RESEARCH PROJECT: Exploring the role of patient care workers in private hospitals in the Cape Metropole.”

REFERENCE NUMBER: S14/02/043

PRINCIPAL INVESTIGATOR: Louise Aylward

ADDRESS: Faculty of Medicine and Health Sciences: Division Nursing
Francie van Zijl Drive
Tygerberg 7500
South Africa

CONTACT NUMBER: 084 584 8239

Dear Colleague

My name is Louise Aylward and I would like to invite you to participate in a research project that aims to investigate the perceptions of unit managers, nurses and patient care workers (care givers) about the role of patient care workers in private hospitals.

Please read the information presented here, which will explain the details of this project and contact me if you require further explanation or clarification of any aspect of the study. Your participation is entirely voluntary and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point and without any explanation, even if you do agree to take part.

This study has been approved by the Health Research Ethics Committee (HREC) at Stellenbosch University and will be conducted according to accepted and applicable national and international ethical guidelines and principles, including those of the International Declaration of Helsinki, October 2008.

The researcher aims to conduct individual interviews with a total of fifteen participants, including unit managers, nurses and care givers from three different private hospitals. Each interview should not take longer than one hour and will be conducted in a private venue in your hospital or a venue of your choice. The interviewer will explain the process to be followed and you will be asked to complete a short questionnaire.

The purpose of the interview will be to understand your view of the role of care givers in your ward. Nursing and patient care should benefit from the results of the study in that a clearer

understanding of the role of care givers can lead to the better use of scarce nursing and support staff.

You will not be paid for participating in the study, but can be refunded for personal expenses related to the study, e.g. transport costs. You will have no further responsibilities after the interview and there is no foreseeable risk or discomfort to participants.

Your confidentiality will be protected in that your name or the name of your hospital will not be recorded and no comments will be linked to individuals or specific hospitals.

Yours sincerely

Louise Aylward

Principal Investigator

APPENDIX 9: CONFIDENTIALITY AGREEMENT WITH DATA TRANSCRIBER

CONFIDENTIALITY AGREEMENT

), the undersigned WEIGH STOKER

1. herewith undertake that all information disclosed or submitted, either orally, in writing or in other tangible or intangible form by Louise Aylward to me, or made available to me, or details of Louise Aylward's business or interest of which I may become aware of in respect of transcriptions being done by myself for Louise Aylward, to keep confidential and not to divulge to anyone for which Louise Aylward did not give written consent;
2. guarantee that I will apply the information, detail or knowledge in **clause 1** only for the purpose of the intended research;
3. indemnify Louise Aylward against any claims that may be instituted against Louise Aylward, amounts that may be claimed or losses that Louise Aylward may suffer in consequence of a violation by me of any provision included in this agreement.

SIGNED at Cape Town on 27 October 2014

BOAMPHEE

Witnessed by:

Boamphee

APPENDIX 10: EXTRACT OF TRANSCRIBED INTERVIEW

Date of interview: 29 August 2014

The participant was a 29 year old female enrolled nurse, working in a medical ward. She worked for two years as a PCW before commencing the pupil enrolled nurse course and had just completed the course.

The interview was conducted in an office in the hospital where the participant was employed and while she was on duty.

The participant was selected as she met the selection criteria (full time employed for at least one year in a medical ward where PCWs are employed in the private hospital). She was available and willing to partake in the interview.

Interviewer So if you think of the care workers that you've been working with in the medical ward specifically, what are the things that they are doing?

Participant They are doing a lot of things. Like they promote the patient's hygiene, preventing complications like pressure sores by turning the patients, rubbing the patients and sometimes you will find out in our scope of practice, it also includes a staff nurse, ENA and a registered nurse to promote the patient's hygiene and to prevent complications.

But now in private hospital it differs because you will find that the EN is giving medication most of the time and the sisters are doing doctor's rounds, and the ENAs will do admissions, and the care workers are the ones that are most of the time there for the patient.

We are also there for the patient, but talking about things like pressure care, when they wash the patient, they pick up, like if the patient's skin is getting red.

So they report those kind of things, and we also help them.

So they report all those kind of things. They are knowledgeable. They know how to differentiate from normal and abnormal.

So they are valuable to us because they can tell you this patient, the skin is getting red, I think we must order the Allevyn dressing, what do you think?

So I will say okay, let me check, and then we order that.

Then we write the date and we check again after three days, they always give a report on those kinds of things.

Like if the patient is coming in, some of the patients are looked at at home.

They come in; the minute they come in they are willing to help, like to promote hygiene of the patient.

We wash the patient, and if there are scars, maybe bruises, or the patient is developing pressure sores, they will always suffer for it because sometimes you find you don't have time to do everything.

Like the patient comes in, you must phone the doctor, you must do the orders, drip and all those things, and then while you are busy with doctor's orders, they are doing something else, like to wash the patient, to change the clothes.

While they are changing the clothes, they get to see the condition of the skin of the patient, things like that.

Talking about nutrition, they are the ones that help to feed the patient.

In most cases they are the ones that tell us Mr Smith, I will make an example, is not eating well, or he is aspirating, he is choking, come and see.

So they are a big value to us.

They are the ones that most of the time they can tell us if there is something changing on the patient's condition.

We are also there to see that, but most of the time they are there.

Interviewer I listen to you and it sounds as if they are very much involved with the basic needs, the basic hygiene.

Participant Yes, hygiene.

Interviewer Physical care.

Participant Yes, and sometimes, you know what? The people from other companies like HGT Company when they come to demonstrate how to use that particular blood sugar testing machine, they call everybody.

So they also go and listen, and when they are demonstrating, they can see how to do all those kind of things.

So they help here and there, although it is not in their scope of practice, but sometimes they can differentiate between the normal and abnormal.

Like blood pressures, things like that, if the blood pressure is high, they will report.

Interviewer So it sounds to me as if you say that they also learn other things.

Participant They learn other things under that supervision.

Interviewer Okay, and they do other things, like they do the HGT?

Participant Under supervision.

Interviewer They do the vital signs?

Participant Yes.

Interviewer And blood pressure?

Participant And most important they know whatever observation, whatever things they do to the patients, whatever procedures, they must report.

They report whether it's normal or abnormal so that we can know the condition of the patient.

Interviewer All right. So I can hear that you say they do a lot of patient care activities. Are there other things that they do, like secretarial functions or stock control functions or cleaning functions, things like that?

Participant The cleaning functions, yes, they are involved in terms of isolations.

You know mos we have got different kinds of precautions, all those kind of things.

They know that in the room when the patient has been discharged, everything must be cleaned with a specific Medisure that is mixed by housekeeping.

They also help us to do all those things.

They help us in ensuring that the ward, like in the taps, there is hygiene, all the hygiene tools like Hibiscrub, alcohol, gel, the gloves.

APPENDIX 11: DECLARATION BY LANGUAGE EDITOR

2 Merlot
Momento Drive
Sonstraal Heights
7580
18 November 2014

TO WHOM IT MAY CONCERN

This letter confirms that I, Freddie Aylward, was responsible for the language editing of the thesis for submission to the University of Stellenbosch of Louise Aylward.

Sincerely



Freddie Aylward
BA, HED (UNISA)