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Title: Experiences and views of nursing home nurses in England regarding occupational role and status

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Abstract

Experiences and views of nursing home nurses in England regarding occupational role and status

The aim of this paper was to explore nursing home nurses' perceptions of what influences their occupational status. A hermeneutic phenomenological approach was taken, during which 13 nurses from 7 nursing homes for older people located in England were each interviewed up to 5 times using an episodic interview technique. Findings suggested that economic policies regarding funding long-term care, and perceptions of the nature of work undertaken in nursing homes, may together negatively impact the occupational status of nurses working in these settings. This reduced occupational status is proposed as a factor which shapes nurses' perception of this role. Low occupational status may also impact on these nurses' ability to enact the role. Finally, the paper documents how nursing home nurses may attempt to manage issues of status in order to retain occupational esteem.

Key words

Nurse: nursing home: occupational role: occupational status: phenomenological study

Experiences and views of nursing home nurses in England regarding occupational role and status

Introduction

This paper explores the occupational status of registered nurses (RNs) working in nursing homes (NHs) for older people in England. It is argued that views regarding how health and social care is funded in England, and perceptions of the nature of work undertaken in NHs, may have an impact on the occupational status of nurses working in these environments. The paper proposes that reduced occupational status influences how nurses perceive the role. It also suggests that reduced occupational status may have a negative effect on NH nurses' ability to undertake the role. In addition, the paper discusses the strategies NH nurses utilise to address issues of status in their attempts to retain occupational esteem.

Background

Occupational status

There has been much debate regarding the definition and constituents of occupational status (for example, Hughes, 1951; 1958; Goode, 1978; Ashforth and Kreiner, 1999; Zhou, 2005; Jervis, 2001; Gregg and Wadsworth, 2003; Kreiner *et al*, 2006; Ashforth *et al*, 2007). These authors propose that the distinctive characteristics of occupations are interpreted and judged by society. Social or cultural consensus incorporates these judgements into a status system, resulting in an occupational hierarchy.

The researchers cited above propose that a number of occupational characteristics affect status. Zhou (2005) suggests that two types of occupational prestige exist: authority-based and knowledge-based. Zhou (2005) argues that individuals acquire higher status if their occupation is perceived to be an authoritative occupation, but acknowledges that authority does not always lend itself to status because authority figures are often required to manage social conflicts and tensions, which can destabilise their standing. For Zhou (2005), knowledge-based status depends upon the possession of knowledge, skills and qualifications. However, according to Bourdieu and colleagues (Bourdieu and Passera, 1977; Bourdieu, 1986), possession of such attributes only elevate status if these are formally recognised by the dominant socioculture, defined by Bourdieu (1986) as a hegemony through which the dominant group attains consent to its dominance by society. Bourdieu (1986) describes the acquisition of skills recognised by the dominant socioculture as the attainment of 'cultural capital'. He

proposes that possessing cultural capital elevates the social status of an individual or group, and secures him/her a legitimated 'place' within the dominant socioculture.

The above literature suggests that authority and recognised knowledge lead to high occupational status. However, Hughes (1951; 1958) and Ashforth and colleagues (Ashforth and Kreiner, 1999; 2002; Ashforth *et al*, 2007) suggest that occupations which would otherwise have authority and/or knowledge-based prestige can be undermined if society has an aversion to these groups. They propose that aversion occurs when occupations involve 'dirty work' - work that is 'physically, socially or morally tainted' (Hughes, 1958, p.122). Physical taint occurs where an occupation is 'directly associated with garbage, death, effluent' or it is 'performed under particularly noxious or dangerous conditions'. Social taint occurs where an occupation involves 'regular contact with people or groups that are themselves regarded as stigmatized, or where the worker appears to have a subservient relationship to others'. Moral taint occurs where an occupation is regarded as 'sinful or of dubious virtue' (Ashforth and Kreiner, 1999, p.415).

Aspects of this definition of 'dirty work', and its generalisability have been contested. For example, performing work in dangerous conditions, or working with stigmatised groups, can be framed as altruistic, glamorous or heroic, which may increase a role's status and appeal, both in terms of the public's perception, and as a potential career (for example, fire service personnel, armed forces, aid workers). McMurray (2012) suggests that in such circumstances, dirt is not simply to be dealt with, but 'claimed' as an entitlement and privilege.

A further criticism of Ashforth and Kreiner's (1999; 2007) theories is they do not acknowledge that social identity constructs, such as those associated with gender, may, and have been found to, influence perceptions of occupational status (for example, Twigg, 2000a; 2000b; Jervis, 2001; Huppertz, 2010; Twigg *et al*, 2011). Jervis (2001) suggests that care, service, and domestic work have been customarily associated with women and femininity. The author suggests that, because women have traditionally held a lower gender status, these occupations have likewise been perceived as roles with low occupational status. However, Gregg and Wadsworth (2003) argue that de-industrialisation in the Western world during the 1980s and 1990s has resulted in men moving into care and service roles that were previously considered 'feminised'. The authors propose that, although care and service work

are still primarily undertaken by women, this work is now nevertheless increasingly accepted as gender neutral, which has had a positive impact on occupational status.

Occupational status of nursing home nurses

There has been little direct consideration of what influences the occupational status of RNs who work specifically in NHs. A number of studies that explore nurses' career preferences suggest that LTC delivered in NHs is unappealing because it is perceived as requiring little medical knowledge, or clinical and technical skills. For example, Wade and Skinner (2001) report that student nurses feel that LTC is 'basic' care, and LTC nurses are 'glorified health care assistants' who are 'missing out' on both the practice of medical and technical skills and the utilisation of medical knowledge (p.14). Likewise, Abbey *et al* (2006) found that student nurses perceive LTC to be 'inferior' to acute care because they view the utilisation of medical, scientific and technical knowledge associated with acute care as 'the core of modern nursing' (pp.16-17). Neville *et al* (2014) found that gerontology nursing in LTC is an unpopular career choice because nurses place high value on the technological interventions linked more to acute care than other forms of nursing care. Higgins *et al* (2007) demonstrate a clash of philosophies and incompatible outcome aims between acute care and LTC. The authors suggest that the prime philosophical position of acute care is to treat and return patients to optimum health status, but LTC acknowledges that cure is not always possible, so focuses on striving to improve quality of life. Higgins *et al*. (2007) suggest that consequently, acute care nurses do not value LTC skills. Raikkonen *et al* (2007) propose that such perceptions are not just externally imposed. This study found that nurses who have worked in LTC settings for long periods regard themselves as de-skilled as clinical professionals.

The idea that medical and technical skills associated with acute care are highly valued within the socioculture of nursing is not a recent idea. A number of studies of nursing history propose that Western healthcare has been dominated by a medical model, in which health is located in the arena of scientific inquiry, technological practices, and treatment and cure (for example, Carpenter, 1993; Aggleton and Chambers, 2000; Borsay, 2009; Harrison, 2010). These practices and forms of knowledge are highly valued within Western societies, and as a result, the occupational status of professions appearing to enact the medical model is heightened. As Bourdieu (1986) argues, occupations enjoy elevated professional status if they involve the possession and utilisation of

knowledge-bases that are deemed eminent by the dominant socio-culture. This suggests that the status of nurses is increased by a principle involvement with medical and technical interventions. Where skills overlap with those of doctors, nursing is associated with having, and utilising, the formal medical knowledge-base that is recognised by a healthcare socio-culture which perceives scientific knowledge as the most valuable knowledge-base. However, other caring practices, particularly those that are shared with healthcare assistants (HCAs), are devalued because they are viewed as activities enacting essential care' that address daily requirements, rather than scientific biomedical treatment.

Other authors (Twigg, 2000a; 2000b; Guy and Newman, 2004; McMurray and Pullen, 2008; Twigg et al, 2011; McMurray, 2012) also propose that performing essential care has an impact on occupational status, but their explanations take a different tack. These authors acknowledge that assumptions about gender, and the 'feminisation' of paid bodywork may influence perceptions of personal care and the occupational status of those hired to undertake it. However, echoing Ashforth and Kreiner's (1999) theory, they also suggest that personal care is viewed by society as distasteful simply because it is physically dirty. McMurray (2012) suggests that despite this, nursing claims dirt as a method of reasserting the caring role. Dirt becomes a method of demonstrating the prioritisation of others over the self, and therefore is a source of pride. Twigg (2000a; 2000b) disagrees, surmising that dirt taints the reputation and status of occupations that deliver personal care, and as a consequence, these activities are delegated away from healthcare professionals to non-professional staff.

While the issues discussed above may relate to NH nursing of older people, they do not always specifically relate to NH environments, as older patients with LTC needs may be nursed in other healthcare and community settings. Other literature explores attitudes towards the NH sector as a uniquely funded health and social care setting. Studies that explore social care funding issues describe the challenges faced by service-users and carers in comprehending, negotiating and coping with the financial ramifications of moving into a NH (Wright, 2003; Comas-Herrera *et al*, 2006; Henwood, 2010; Colombo *et al*, 2011). In England, for example, individuals who require nursing care in long-term residential settings undergo an assessment of the 'nature', 'intensity', 'complexity' and 'unpredictability' of their care needs in order to ascertain whether their needs are predominantly health-related (Department of Health, 2012). If residents are assessed as having a 'primary health need', their care is funded by the National Health Service (NHS). People who do not meet the 'primary

health need' criteria, but nevertheless require RN support, receive a joint care package. For these individuals, their 'health needs' are NHS-funded, but they undergo financial means-tests to determine private and social service contributions to the cost of their personal care needs. However, there has been widespread criticism of the health needs assessment system. In particular, payment of care often depends upon how need is conceptualised and evaluated by the subjective appraisal of assessors, rather than as the result of objective measurement (Clements 2010).

Controversies about care funding are not unique to England. As societies age across the globe, care costs mount, and as a consequence, more and more funding systems require older people with means, to self-fund to some degree (Comas-Herrera *et al* 2006; Colombo *et al* 2011; Doling and Ronald, 2012). According to Colombo *et al* (2011), although funding systems generally aim to share responsibility for financing LTC with service-users, many residents are exposed to catastrophic care costs or considerable out-of-pocket costs. Consequently, service-users can become anxious about losing their assets, and therefore may become critical of health and social policies that demand personal contributions to the cost of care (Kaiser Family Foundation, 2001; Henwood, 2010).

Henwood (2010) reports that service-users may perceive care providers as 'immoral' organisations more concerned with individuals' ability to pay than with their health needs. If so, this would be likely to negatively affect self-funding residents' perceptions of NHs. Such arguments suggest that NHs are viewed by residents as morally dirty, in that funding controversies appear to stimulate mistrust of these establishments. However, the conclusions drawn by authors discussing controversies about care funding do not directly relate to the role and status of NH nurses.

In summary, some studies suggest that the reduced status of LTC of older people is due to the perception that the skills required for the role are inferior compared to the knowledge-based prestige associated with medical and technological roles in more acute care settings. The view that personal care activities associated with LTC is a physically dirty activity, and/or a feminised activity, may also influence status. However, while these studies report that the status of NH nurses is affected by issues relating to the LTC of older people, they do not indicate whether the NH work setting itself is also an influence. Discussions of social care funding controversies suggest that these issues have damaged the image of the NH sector, but to-date there has been no empirical exploration of whether this

damaged image affects the status of the nurses who work in this sector. Furthermore, there has been little consideration of how occupational status is perceived and experienced by NH nurses themselves.

Methodology

The aim of this study was to explore NH nurses' perceptions of what influences their occupational status. It forms part of a wider study of the experiences and views of NH nurses with regard to their role and status (see Thompson, 2016). As the wider study aimed to explore the personal significance and social meaning of experience, a hermeneutic phenomenological approach was taken. The research approach was inspired by the writings of Gadamer (1976; 1979), in which understanding is considered to arise via a dialogue between the researched and the researcher. Thus, the research design aimed to facilitate a dialogue that explored participants' experiences and views through a sequence of up to five interviews.

Sample

The purposeful sampling strategy employed in the study followed Sandelowski's (1995) phenomenal variation approach. This approach targets a population with experience of the phenomenon under consideration, but scopes for diversity within that population so that breadth of experience of the phenomenon can be maximised. Utilising this approach required the inclusion criteria to be relatively unrestrictive. The inclusion criteria for NHs was that they were: registered as a NH in England; provided nursing care to some, or all, older residents; and employed RNs. The inclusion criterion for participants was that they were RNs.

The study was located in an area in North East England. 160 NHs within the location met the inclusion criteria (Carehome.co.uk, 2012), and all were invited to participate in the study. The response rate was low as only 12 NHs replied. However, this was considered to reflect judgements that potential participants made about the substantial commitment that participation would require. Responding NHs' characteristics were entered into a sampling matrix (Reed *et al*, 1996) and seven homes were chosen on the basis that they provided maximum sample diversity. Four of the selected NHs were owned and operated by large national companies, one by a local company, and two by sole proprietors. The NHs accommodated between 20 and 77 residents, and employed between 5 and 20 RNs.

All RNs employed in the sample NHs were informed about the study, and in total, 13 consented to participate – 3 participants from each of the NHs A, B and E, and 1 participant from each of the NHs C, D, F and G. As each participant was interviewed a number of times, this was deemed to be an appropriate sample size because it offered analytical depth. Participants included two home managers, a deputy manager, a nurse manager, a palliative lead nurse, and seven staff nurses. Participants' age range was between 25 and 59 years, and the length of their NH work experience ranged between 1 and 23 years. Participants were assigned pseudonyms to preserve their anonymity. The study was approved by the Faculty of Health and Life Sciences Research Ethics Panel of Northumbria University, UK.

Data Collection

Flick's (2000; 2009) episodic interview technique informed the data collection method. During episodic interviews, the researcher prompts generalised discussions based on participants' assumptions and views about the phenomenon under review (semantic knowledge), and asks participants to describe in detail particular examples of their experiences of the phenomenon (episodic knowledge). This combination of episodic and semantic knowledge generates data that springs from different aspects of experience, as participants are located in general as well as concrete experiential contexts. The data collection method involved interviewing each participant up to five times. In total, 60 interviews were completed.

During the first interviews, background information was collected to provide contexts for the described experiences. Subsequent interview topics were informed by the aims of the study, and analyses of preceding interviews. The interview schedule was flexible rather than prescriptive, following participants' lead. However, a broad outline of interview topics was proposed:

- What are your experiences, motivators, feelings and reservations about your role and status as a NH nurse?
- What are your experiences and feelings regarding relationships with other stakeholders? Are your role and status affected by these relationships?

The purpose of the final interview with each participant was to facilitate opportunities for participants to verify and expand the researchers' interpretation of their responses.

Data Analysis

Each interview transcript initially underwent a holistic reading in order to determine its fundamental meaning. This allowed the researcher to build a frame of reference within which aspects of the text could be interpreted. Next, prominent phrases within the transcript were highlighted. This process confirmed or modified the original interpretation generated from the holistic reading. Remaining non-highlighted text was then reviewed. A detailed line-by-line examination of the transcripts was undertaken next, in order to reveal expressions that may contain hidden sub-texts. As participants were interviewed a number of times, both prominent, less prominent and sub-textual themes could be revisited in subsequent interviews. Once each transcript had undergone these three analysis stages, interview topic maps were generated. All participant topic maps were compared, and topic categories were developed. As the analysis advanced, categories were integrated and assimilated into overarching themes.

Findings

Though somewhat balanced by a sense of personal pride and challenge in the work they did, participants very frequently spoke of their occupational role as subject to unfavourable perceptions and attitudes from others. Their responses also indicated that they too viewed their own role in a negative light. They discussed their role using language that explicitly referred to low status, for example, 'stigmatised', 'second rate', 'looked down on', 'lower option'. Analysis of the data indicated that disparaging views regarding the NH nurse role arise from a variety of possible causes. The most commonly cited were the juxtaposition of care and funding issues, and perceptions of the NH nurse's role activities.

The juxtaposition of care and funding issues

Participants held that the public in England almost exclusively view healthcare as a gratis entitlement in which commercial gain should play no part. Yet NHs are generally private businesses rather than public-funded services. As a consequence, participants reported that the public assume NH providers' objective is profit attainment and not the provision of quality care. Anne explained that the public view NHs as preying on the vulnerable:

Anne: I think we should be perceived perhaps as more like the NHS, and not so much as erm, some kind of private sector who's just after the money and not interested in the care.

A significant difficulty for participants was reconciling their own negative views regarding LTC funding with their nursing role. Some suggested that, because healthcare in England is generally provided by the NHS and free-at-the-point-of-delivery, becoming a nurse in England involves supporting a health service financed by public funds. However, in the LTC setting of NHs, residents may not be deemed to have primarily healthcare needs, so their assets are means-tested to determine whether, and how much, they should contribute to their care costs. Many participants referred to this funding scheme as 'unfair', and reported feeling 'uncomfortable' about being part of a system which runs against the dominant ethical socioculture of the country. For these participants, doubt about being involved in a health sector which they view as morally questionable rather tainted their view of their own practice and role:

Alice: I do feel a little bit uncomfortable about how some patients don't have to pay a penny and the other patients do. I feel a bit, we haven't come to a good, it's just not fair basically.

For some participants, discomfort about business/funding led to disengagement from associated activities. For example, Beth refused to engage in showing potential residents around the home, as she felt this was tantamount to 'selling' beds:

Beth: I don't really see that as my role. I don't like it when someone says to me, 'How much would it be to live here, if my husband, wife, mother wanted to move here, how much would it be?' I really don't like it, or getting involved with it. I try and separate myself from it... I just don't like the salesperson that you become.

Three participants appeared to have less problem reconciling care and business concerns. These participants had worked in more commercial-orientated occupations prior to entering the nursing profession, and this may have influenced their views. In addition, two of these participants, as the only NH managers included in the sample, were accustomed to dealing with company funding, budgets

and finances. One of these, Anne, explained that she viewed the relationship between high occupancy, profit, and service-improvement as a cyclical business process. She saw profit as a means of generating re-investment income for the residents' benefit, but she also recognised that investing in better services and facilities attracts and retains custom. In effect, Anne amalgamated the concepts of resident and turnover/profit unit into a unified entity – 'customer care':

Anne: Customer care is a very important part of what we do...What we're looking at, at the end of the day is the patient as customer. I don't see a conflict at all, because we're serving the patient [It's] maintaining the home's occupancy level, because that impacts on the whole of the profitability and survivability of the home.

Anne was personally able to reconcile business and care aspects of her role. However, her earlier quote demonstrates her concern that the public do not perceive possible synergies, and instead regard NHs are 'just after the money and not interested in the care'.

As a result of the means-testing system, different residents within the same NH establishment have different funding arrangements, so that while some do not contribute to care costs at all, others wholly fund their own care. Participants indicated that, as a consequence of this, some self-funding residents and their families are very concerned about staff availability and attentiveness, and expect priority care:

Elaine: We've had a few people who are privately funded and they have been like that. They expect you there all the time. And you get, 'I'm paying for this'.

Faye: And I hear it all the time, you know, 'My mother pays x price, and I expect....', and that's alright, but just because she pays for it, it doesn't mean to say that the people who are social service funded don't deserve the same care. Of course they do.

Participants suggested that self-funding not only influences residents' expectations regarding care, but that these expectations impact on resident/nurse relationships. Some participants stated that, due to

care expectations, self-funding residents can be more demanding, or may develop a condescending attitude towards staff:

Cath: And then you get residents that treat you as a servant...So a lot of the barriers about that is from the residents, and what they perceive they should expect for their money.

Perceptions of nursing home nurses' role activities

Many participants reported that the public and other healthcare professionals assume that NH nursing is primarily concerned with the provision of personal care. Some specified that personal care is viewed as a physically dirty activity that primarily involves the cleaning up of bodily fluids and waste:

Beth: I can't stand it [emphasises by raising voice] when you tell people that you work in a nursing home and their first thing is something about you know like, personal care, 'Is that all you do?' And I hear that a lot, more than anything else. 'Is that what you spend your day doing? Wiping people's bottoms?'

Others suggested that this support is often perceived as being associated with the HCA role, so that the distinction between the nurse's role and the HCA's role lies on 'woolly ground' (Ellen). These participants proposed that the public assume that NH nurses are in fact, not RNs, but a type of HCA:

Emma: One of the ladies, one of her [mother's] friends said to me, 'What do you do then [in the nursing home]?' I said, 'I'm a nurse'. She went, 'Are you a nurse, or are you a carer? Because there's a difference, and carers call themselves nurses.' 'No', I said, 'I'm a proper registered nurse'.

These participants reported that such assumptions lead the public and indeed other nurses working in more acute environments to doubt NH nurses' clinical ability, and consequently to regard NH nursing disparagingly:

Alice: I think we're definitely looked down upon. I think they [public] think we don't have any skills...the hospital nurses just think that we're not as skilled as they are.

Some participants agreed that they are not required to perform a great deal of acute clinical interventions. For example, despite Beth's indignation regarding the perception of the role as primarily about personal care, she suggested that LTC residents require less acute clinical interventions than other types of patients because their conditions are relatively stable:

Beth: You kind of don't have the same day-to-day role, because often the people you're looking after are quite stable and not needing any acute treatment.

Alice made a similar comment:

Alice (3): I mean medical needs, if they had stronger medical needs, they wouldn't be here. They're stabilised more or less.

Against negative images of their occupational role, many participants argued that their role is important in that they provide continuity of care, and individualised care that contributes to enhancing residents' quality of life:

Andrea: We make it a homely environment for them. The staff are like the family members already because they know them. They knew them already, they know their voices, they know their faces.

Diane: We always give the residents more choice I think, have more er, I feel as if they're able to make their own decisions.

Bella: For our permanent residents here, I think it's more of like making their life, like there's still quality...They still manage to see the beauty of life, you know. It's not just because you live in a NH that will stop you from going out, or like, good things which you have done, especially if you have been a very active person, like you have had an active life. So of course we'd be looking to that.

However, they conceded that providing continuity and consistency of care within a LTC facility tended to render the practice of these skills repetitive, routine and unchallenging:

Andrea: Because, in the hospital it's a new experience every day. They come and go. Different situations. But in the nursing home you get to know your residents, you get to know the diagnoses, and their problems, then it will become a routine.

Bella indicated that she did not perceive the role as affording opportunities for learning and development. This was a significant contributory factor in her decision to seek employment in the acute sector. During her final interview, Bella explained that she had accepted a position in a local hospital:

Bella (5): It's like an everyday learning for you...In the hospital, you know, like different ones, it's like a different condition, different situation, and so, I kind of want to get involved with that.

Due to their view that their work is repetitious, routine and unchallenging, and lacking in development opportunities, some participants labelled their role as a 'job' not a 'career:'

Alice: I definitely don't think of it as a career. No I just see it as a job right now.

Participants indicated that they manage the inference that the role is low status, repetitive and unchallenging, in a number of ways. Alice, Andrea, Bella, Diane and Emma aspired to leave the NH setting to work in more acute settings. Another common strategy was to avert discussion about their role. Some explained that they found fielding questions about their role activities uncomfortable and embarrassing. For example, Anne, Georgia and Bella said that when people ask about their jobs, they disclose that they are nurses, but remain vague about their work setting:

Anne (1): You might actually try to hide the fact that you're actually in a NH. You sort of like, say you're a nurse and then maybe change the subject.

Diane's and Emma reported that they inform those who ask about their employment that although they work in NHs now, they have worked for the NHS in the past. Similarly, Alice and Beth both work in NHs that accommodate NHS contracted units. They respond to questions about their occupations by

stressing the NHS commission, in order to suggest they are strongly affiliated, or even employed by, the NHS:

Alice (1): When asked what I do, I kind of, I say I'm a nurse, and then when they, when somebody pushes, 'Where do you work?' I say, 'I work at [home] nursing home, but on the NHS unit'. That's what I say. I feel then that I'm not having to defend myself, you know.

Some participants' responses indicated that they react against disparaging perceptions of their role by criticising the work of those with whom they feel negatively compared, primarily acute care nurses:

Diane: I feel really the NHS - people are being told bad diagnoses, erm, and there is always a pressure on time really.

Discussion

Many participants suggested that their role significantly contributes to the enhancement of residents' well-being and quality of life, and they expressed a sense of pride in this. Nevertheless, participants were frequently concerned about disparaging views regarding the NH nurse role. Analysis of their responses indicated that such views result in a lowering of the occupational status of the role. Findings suggested that disparaging views arise from a variety of possible causes. The most commonly cited were the juxtaposition of care and funding issues, and perceptions of the NH nurse's care activities.

Funding issues

Most participants said that because the majority of NHs in England are private businesses, rather than public-funded services, the public generally assume that the overriding objective of NHs is profit attainment rather than care. Participants proposed that, as a result, NHs are often viewed as immoral organisations that prey upon the vulnerable. Although the funding system for healthcare in England is distinctive in that it is publicly funded by the NHS, social care funding controversies are not unique to England. Colombo *et al's* (2011) global study found that, because residents and families often struggle to understand and negotiate the financial implications of living in NHs, they become fearful of losing their assets, and are therefore critical of iniquitous health and social policies that stipulate residents should pay for, or contribute to the cost of their care. Participants in this study inferred that because NH staff become necessarily involved with the funding and business aspects of social care,

some residents/families' low opinion of the care funding system influences attitudes to NHs and NH staff as well. In other words, participants' responses inferred that some residents perceive the funding/business aspects of the NH nurse's role as morally tainted, as defined by Ashforth and colleagues (Ashforth and Kreiner, 1999; 2002; Ashforth *et al*, 2007).

For some participants however, the taint is more than an external imposition upon the participants because they *agree* that the funding system is morally wrong. In this sense, the perception of moral taint can be regarded as a consequence of interpellation, the process by which a social situation produces an individual's sense of their own identity, value or status (Althusser, 1971). For these participants, becoming a nurse in England is about contributing to a health service that is predominantly financed by public funds. However, NH care includes personal care elements and accommodation costs which are not publicly funded. Some participants referred to this method of funding as 'unfair', and the moral taint that emanates from funding issues appeared to be a part of their experience of themselves, as well as their sense of the perceptions of others. Some participants coped with the 'taint' of business/funding by separating themselves from, or avoiding, these aspects of the role. However, such rejection of business/sales in an environment in which these aspects are inextricable meant omitting a potentially important nursing activity of supporting service-users in times of transition. It has been argued that showing potential residents around NHs, and discussing their requirements and the NH's ability to meet their needs is an essential part of supporting the decision-making process (Reed, Cook, Sullivan, & BurrIDGE 2003; Davies 2005; Toles, Young and Ouslander 2012).

One the other hand, some participants reported amalgamating the concepts of care and business into a unified entity. They felt that business could be utilised to ensure high quality services for residents, and that high quality services in turn could help sustain competitive advantage. It appeared that these participants' integration of business and nursing within their NH nurse role occurred because they had experience of business/sales. They were habituated into accepting business issues are part of their role. This helped them view these activities as integral to supporting the position of LTC facilities operating in an uncertain political and financial market.

Participants indicated that funding issues may also result in social dirt. Previous research that explores patient and staff expectations of public and private hospital care services suggests that

publicly funded patients define quality care as emanating from staff's care skills (Angelopoulou *et al*, 1998; Arasli *et al*, 2008; and Zarei *et al*, 2012). However, private-paying patients assume that such care skills and knowledge are automatically provided for all service users, so paying should afford services over and above what are perceived as the norm. Participants in the current study indicated that self-funding residents become supercilious in their behaviours towards NH nurses because they are paying for care. According to Ashforth and Kreiner (1999), social dirt arising from subservience lowers occupational status, while Zhou (2005) found that when members of a community perceive other members as having less authority than themselves, then authority-based status is diminished. In this instance, social dirt and the absence of authority-based status may shape participants' relationships with residents: residents may not recognise and value NH nurses as healthcare professionals attempting to provide nursing and rehabilitation care, but instead view them as service industry staff.

Care activities

Participants proposed that the public and other healthcare professionals perceive the NH nurse role as predominantly involving personal care activities. As discussed in the literature review, Jervis (2001) and Huppatz (2010) propose that care, service, and domestic work have been customarily regarded as 'feminised' activities, which may limit the roles' status potential. However, Gregg and Wadsworth (2003) argue that de-industrialisation in the Western world resulted in men moving into care and service roles so that these roles are increasingly accepted as gender neutral. None of the participants referred to gender when discussing role and status. If the ideas of Jervis (2001) and Huppatz (2010) are applied, it could be argued that gender and role/status associations are implicit, concealed in participants' social values, but this seems unlikely considering the lack of allusion to the topic was absolute. However, if Gregg and Wadsworth's (2003) stance is applied (i.e that in recent years, care work has become gender neutral), it is plausible to conclude that participants lack of explicit reference to gender demonstrates that they view the causes of their low occupational status to be independent of the fact that they are women.

Some participants indicated that the public and other healthcare professionals' lack of understanding of the NH nurse role has led to the RN role being confused with that of HCAs. This is similar to the findings of other studies that propose student nurses and acute care nurses perceive LTC nursing as

inferior to acute care nursing because it does not necessitate the practice of high-status medical and technical skills (Wade & Skinner, 2001; Abbey et al., 2006). According to Zhou (2005) and Bourdieu (1986) the perception of a weak or unvalued knowledge-base significantly reduces occupational status, which may explain why an association with personal care and HCA work diminishes NH nurses' status.

Some participants' discourses, however, suggested that a more significant factor in shaping perceptions of core activities as low status was that personal care is 'physically dirty'. For instance, Beth (2) stated that personal care is perceived to be imbued with physical dirt because it involves contact with the body and human effluent. Such findings are not aligned with McMurray's (2012) view that dirt can be a source of pride for workers. Rather, the study gives weight to Twigg's (2000) work which suggests that personal care is viewed by society as distasteful, tainting the repute and lowering the status of occupations that deliver this care.

However, for some participants, low occupational status only appeared to become a personal problem when combined with dissatisfaction with providing care which they perceive to be routine and unchallenging. Judge, Bono and Locke (2000) offer the concept of 'skill complexity', which has bearing here. These authors define complexity as the level of variation, magnitude and challenge involved in a role. They propose that complexity of tasks involved in an occupational role strongly correlates with job satisfaction. This is because complex roles are more likely to require and encourage skill improvement, interest and innovation - aspects which promote feelings of fulfilment, self-esteem and positive concept of one's own status. It can be argued that where participants perceive LTC as not requiring the practice of varied and complex skills, and not a stimulating or challenging environment, they are likely to feel unfulfilled by the role, internalise perceptions of low status, and be anxious about the development and maintenance of knowledge and skills. It appeared that the perceived routine nature of participants' skills practice hindered some from deriving satisfaction and pride from the way that their nursing skills as important clinical interventions for the management and stabilisation of residents' complex multi-morbidities.

Hippel et al. (2005) suggest that workers who are perceived, and perceive themselves, as having low occupational status may attempt to attain occupational esteem by implementing strategies to validate their work. In this study, participants appeared acutely aware of their low occupational status, and used a variety of strategies to manage this circumstance. Some aspired to leave the NH setting to work in more acute settings, where they felt work will be more varied and challenging, lending itself to more development opportunities. However, others attempted to sustain occupational esteem within the NH environment. Some refocused attention away from the tainted aspects of the role towards acceptable aspects, and away from the NH context to their status as RN. Other participants challenged the legitimacy of critical others' qualities, thus enabling them to reject their condemners' perceptions.

Limitations

This study's findings are based upon the responses of a small number of participants located in one region of England. It could be argued that the study's transferability on an international scale is problematic because of the distinctiveness of England's health and social care funding system. However, the care funding controversy discussed is not unique to England. Many countries in the developed world operate care funding systems that result in differentials in the personal cost of care and where controversies have ensued. Whilst these controversies will differ depending on the political and economic environment, they may nonetheless be expected to have implications for the status of NH nurses. However, before transferability is assumed, the insights offered by this study would benefit from further consideration by studies examining other international contexts.

This study focuses solely on the perspectives of NH nurses. During the study, participants referred to their perceptions of the views and behaviours of other stakeholders regarding the role and status of NH nurses. As these perceptions do not report the actual views and experiences of other stakeholders, further research is required which explores this topic from the perspective of other stakeholders, for example, residents/families, other nurses and healthcare professionals, and NH service providers.

Participants did not express positive feelings about their role to any great extent. It is unlikely that their rather negative stance reflects the entirety of their feelings, experiences and views of the role. It may be that enquiring about role and status together influenced the manner in which participants perceived

both concepts. Since the participants perceived their status to be low, their discussions focused away from the positive aspects of their role. They spoke instead predominantly about aspects of the role which might lead to low status, and on the challenges that low status brings to the role.

Conclusion

This study proposes that participants perceive their role to have low occupational status. Findings suggest that reduced occupational status arises from LTC funding policies. Participants indicated that being perceived by residents as associated with inequitable care funding systems and profit-making, damages their moral standing. They also inferred that the payment structure of care in England influences self-funding attitudes towards staff, which may undermine the development and maintenance of nurse/resident therapeutic relationships. Participants most able to manage the threat of moral dirt were those habituated into the concept of customer care. This suggests that workforce development and education initiatives should include business/funding topics, to support NH nurses to understand and manage these aspects of their role – aspects that are unavoidable in NHs, and increasing in significance in many other areas of nursing practice.

Findings suggest that perceptions of NH nurses' care activities influence occupational status. Participants did not appear to perceive gender to be an influencing factor, but their responses indicated that status may be affected by the views that NH nurses have a low knowledge-base, that their work is primarily physically dirty, and that their work is routine. Furthermore, the perception that their work is routine suggests that skills involved in managing multi-morbidities are not recognised as high level clinical skills. Participants devise strategies to manage their occupational status, which suggests they are acutely aware of their predicament. A common strategy is to leave the sector, which devalues the role further, and contributes to staffing shortages. Perhaps efforts to re-frame long-term care and the management of multi-morbidities as requiring specialised, skilled knowledge-bases need to be strengthened.

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