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The Transition to "Patienthood," the Contribution of the Nursing Assistant: A Grounded Theory Study

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Abstract

The face of nursing is changing, as health-care organizations are looking to new assistant roles to support the registered nurse and potentially provide a source for apprenticeship toward registration. These developments are within a context of an existing assistant staff group, delivering much of the bedside care. Few studies have explored the dyadic relationship between nursing assistant and patient, despite the potential for their interactions to contribute to the patient experience. This study aimed to gain an understanding of patients' perceptions of the nursing assistant role using constructivist grounded theory. Constant comparison guided data collection and analysis, and 4 core categories emerged: expectation, observation, meaningful connections, and adaptation. Within these core categories, we suggest the assistant plays a part in how participants adapt from the known self to a self of patienthood and the overall patient experience. We conclude that there is a necessity to understand more fully the dyadic relationship between patients and nursing assistants.

Keywords

grounded theory, health-care assistant, nursing assistant, nurses, nursing, patient, patient experience

Introduction

The face of nursing is changing, as health-care organizations are looking to new assistant roles to support the registered nurse (RN) and potentially provide a source for apprenticeship toward registration. These developments are within a context of an existing assistant staff group, delivering much of the bedside care. For many years, RN activity has been supported by assistants. Within the United Kingdom, this assistant role covers multiple aspects of health care, from general housekeeping and bedside care through to more advanced roles involving a great deal of technical skill (1,2).

Internationally, the assistant nursing role is widely accepted, albeit in many different manifestations. In the United Kingdom, the nursing assistant is known as a health-care assistant (HCA), an unregistered workforce at the frontline of care delivery working across national and private health and social care sectors. Within the United Kingdom, the HCA role covers multiple aspects of health care, from general housekeeping and bedside care through to more advanced roles involving a great deal of technical skill (2). Although precise numbers are difficult to ascertain due to variations in titles, roles, and job descriptions, workforce estimations are around 1.3 million (3).

The global shortage of health-care workers, estimated to reach 12.9 million by 2035 (4), is contributing to new ways of working and workforce development. Furthermore, there are a number of challenges facing health-care providers across the globe which include the aging population (5) and the corresponding increased demand (6) with fiscal challenges realized nationally (7) and internationally (8,9). Some now argue given this backdrop, there is a greater dependence on an assistant role (10) to meet the demands of care provision. The United Kingdom has recently developed a range of new roles and ways into nursing (11), which may offer nursing assistants a potential route toward nurse registration through an apprenticeship pathway (11). Furthermore, the

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development of a new associate (NA) role adds an additional layer to the nursing workforce with 2000 NAs currently in training in the United Kingdom (12). Many of these new roles sit alongside the existing assistant workforce that continue to deliver much of the bedside care (1,3) delegated to by the RN.

Patient experience data act as an indicator of quality, safety, clinical effectiveness, and performance for healthcare systems nationally and internationally (13). However, there are differences between what is known informally from staff, patients, and carers and what is reported officially (14). This can be viewed as a communication failure where information is erased, distorted, or missed, as it travels toward and through official reporting systems. There are also differences between "official" reporting language—quantitative, predictive, and generalizing—and "local" language of explanatory narratives of a situation. There is difficulty in translating the latter into the former (15,16), which may imply that the patient voice and experience may be distorted, as it moves through the organizational communication network.

The reduction in views, perceptions, and understandings that occurs within quantitative surveys, coupled with challenges in capturing patient experience suggests the need for a deeper understanding of the complex nature of patient experience. In addition, there is a paucity of qualitative research addressing the patient's perceptions of the HCA role, providing a rationale for this study to gain understanding in greater depth from the patient's perspective.

It is widely acknowledged that much of the bedside care (1,3,17) is undertaken by a nursing assistant role. However, this existing assistant staff group is little understood (2), and given the amount of interaction the HCA has with patients, it seems pertinent to give voice to the patients experience through a qualitative approach enabling the development of an in-depth understanding.

For clarity, the term HCA will be used throughout this article, unless referred to otherwise by participants or within literature cited, the term nursing assistant will be used when more general application is required. The researcher will use the term patienthood to bring together the notion of self and the associated meaning as individuals locate themselves within secondary care.

Methodology and Methods

A grounded theory methodology congruent with a constructivist paradigm was used for this study. Drawing upon the work of Charmaz (18,19), constructivist grounded theory (CGTM) acknowledges multiple social realities and coconstruction of those realities between researcher and participant. The rationale for selecting CGTM was also underpinned by the paucity of qualitative research and theoretical exploration of the role of the HCA from the patients' perspective.

Aim

There are 2 main aims for the study:

- To develop theory describing contributory factors and processes at play regarding the role of the HCA in individuals' adaption to patienthood within secondary care.
- To develop theory from patient perceptions and understanding of the HCA.

Setting

Research was conducted within a large teaching hospital in the North of England, incorporating outpatient department (OPD) and surgical inpatient areas. Only patients older than 18 and with mental capacity to consent were included.

Recruitment

Between November 2014 and October 2015, with approval from a National Health Service ethics committee (14/EE/1151), participants were recruited. Ethical approval was obtained for up to 30 interviews.

Sampling Strategy

Participant sampling was initially purposeful and then moved toward theoretical sampling, as categories and theories emerged and developed (20). Memo writing supported this activity by identifying gaps in the data, developing meaning for categories, and identifying concerns around early closure (18).

Data Collection

Face-to-face interviews were conducted from November 2014 to October 2015. Data saturation was achieved at 20 interviews, 10 from outpatients and 10 from inpatients; 10 interviewees were female with a mean age of 70, and 10 were male with a mean age of 62. The process is outlined in Figure 1.A semistructured interview guide supported inclusion of particular areas (19,22,23) while allowing participants to tell their stories, thus opening up their subjective worlds (18).

Data Coding and Analysis

Data were managed on Excel software. Interviews were analyzed through an iterative process of constant comparison (24–26) of data with data and incidents with other incidents (18). This cyclical process remains close to the data and guides the researcher (21) toward emergent theory.

Initial "lumper" coding chunked large pieces of narrative (27). Line-by-line reexamination of data followed then moved toward focused coding. Underpinned by constant comparison (24–26), this approach has the objective of

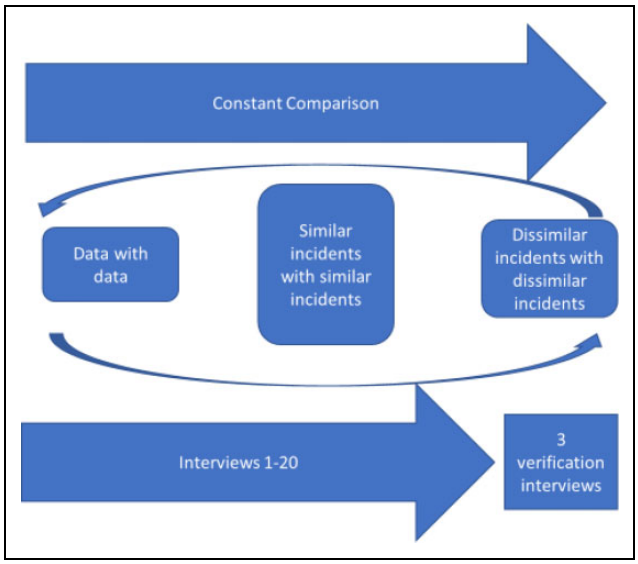

Figure 1. Stages and process of constant comparison. Adapted from Charmaz (18) and Holton (21).

developing data familiarity to support the theoretical properties of the categories generated (26). This cyclical process remains close to the data and guides the researcher (21) toward emergent theory. Data saturation was observed at 20 interviews and was around the core categories of expectation, observation, meaningful connection, and adaptation. The researcher concluded that saturation had been reached as nothing new was emerging from the data (18); in addition, there was also theoretical saturation identified during constant comparison of theory and data (21).

Quality and Rigor

To ensure rigor and quality, the researcher used a mind mapping software package to capture thoughts and decisions made. These maps provided a sequential trail of decisions and memos.

Findings

As participants entered secondary care either as an outpatient or as an inpatient, they did so with a degree of expectation, informed by their own previous experiences, knowledge, understandings, and perceptions. Participants modified these expectations through observation and the meaningful connections made with staff. The process suggests participants known self-transitioned through a process of adaptation to this new understanding, and as such participants adapted accordingly. The interactions between patient and HCA helped to shape this transition contributing to the notion of patienthood.

Expectation

As a core category, "expectation" detailed how participants narrated a positive view of a number of organizational aspects related to their knowledge or experience. Their belief in the organizational aspects was often formed prior to their admission as a patient and provided participants with a feeling of security that was often unwavering, despite more recent experiences that may have indicated otherwise. When the reality fell short of expectations, however, this often shaped their ongoing experience, resulting in either a reinforcement or a disconnect between expectation and reality.

> Yes . . . I was very disappointed . . . I thought there wasn't another hospital like it . . . I thought it was going to be "oh so lovely" like I remembered it when I worked there . . . but it was always the auxiliary nurses [HCA] that did what you asked them . . . (P5)

This participant's disappointment was mitigated by her relationship with the HCA that developed during her inpatient experience.

Some saw staff going beyond their expectations for other patients however not expecting this approach for themselves. The reduced personal expectation was for some explained within the context of the HCAs busy workload:

> I wouldn't expect them . . . It's a pleasant surprise if it would happen. (FS1).
>
> . . . I thought that was lovely . . . beyond their job description . . . I thought it was really nice. (FS2).
>
> Well I don't know if it's because they [HCA] had the time because they were the ones who were very, very busy, very busy . . . I didn't have any complaint whatsoever about the care and the professionalism . . . (P16).

Observation

Participants described observations that brought them an insightful perspective on the workings of the clinical area. They described how they worked out "who was who" with the roles and responsibilities of various staff, their association with tasks, and the color of their uniforms.

> Well I always knew there was a difference but just by observation really . . . The main thing is they [HCA] are not involved with the medication. (P5)

Some, however, were not concerned with "who was who" instead articulating a more generic, collective view of the clinical staff and making no differentiation between them:

> Oh I just see it as the general staff. (P17)

Many participants understood that the HCA was more available to them than the RN in terms of their visibility, roles and responsibilities, and numbers:

> that they were the people who were around. (P16).
>
> It's them that . . . seem to be more available to ask questions to. (P3)

> a lot of the sort of day to day contact and care would probably be with them rather than with somebody who was a bit, you know what I mean, higher up . . . (P18).

This availability of the HCA impacted upon the relationships the participants had with staff and connections made.

Meaningful Connections

Meaningful connections were apparent through a range of interactions that brought comfort for, and feelings of, consideration to the participants.

When some participants were uncertain about their immediate trajectory as a patient, they appreciated the HCA in helping them deal with these uncertainties. One participant was unsure whether this was due to the HCA being caring and felt that her anxiety and concern was mitigated as a result.

> Yeah . . . she was friendly, and I felt that I could talk to her. I think it was caring. I was in pain and err I didn't know what was happening and she just made me feel . . . at ease and explained what was going on. (P10)

The dyadic relationship experienced by this participant contrasted with a broader, more collective approach to interaction adopted by some HCAs. Through the observational aspect of this research, it was noted that staff sometimes popped their heads round the door to check on everyone at the same time and, by implication, managed the 6-bed area collectively. There was a positive aspect to this, with some participants seeing it as a friendly approach that built upon the community aspect of their inpatient experience. These collective moments were sometimes used for humorous interaction.

> . . . we have had a male nurse he comes on the ward "I've got a joke for you!" and everyone goes "have you?." we are all sitting here laughing about it. (P12).

Others appreciated the more intimate, dyadic moments between them and the staff.

> It means treating me . . . as if there is nobody else in the ward . . . not part of a group . . . (P11)

P2 contrasted the frequent interventions of the HCA with the more irregular contact with the RN:

> . . . the auxiliaries when they passed would always pop their head in and say, "Hello, how are you doing? Do you want this, or do you want that, or shall I make you a cup of tea?" (P2).

Another participant praised one particular HCA who made every interaction more meaningful than just attending to a mere task. The participant highlighted how she felt there were moments when the HCA checked on her even before she called or pressed the buzzer:

> she used to come in and make sure I was okay, is there anything I need? A drink or help with the toilet or whatever? And I hadn't pressed, I hadn't pressed for her. (P14)

This illustrates how the HCA anticipated the immediate and potential needs through direct observation. When this was missing, participants felt less positive. P16 was told she was likely to feel unwell after her procedure; however, as there was no one to remind or comfort her after the procedure, she reflected that it could have been a better, less fearful experience had this help been forthcoming:

> . . . that made me quite anxious because, they said, "some people do feel a bit ill after it but other people are fine," but I really felt terrible and I was really sick and . . . and just felt lousy and I don't think anybody was there who really helped with that. (P16)

Thus, it seems direct or overt observation coupled with the appropriate attention impacted significantly upon participants experience.

Adaptation

The core category of "adaptation" described how participants began to understand their new environment, including the techniques they used to help with the adjustment. Participants described being ready to learn, using observations to aid their knowledge of being a patient:

> Well it feels strange, it feels new . . . Well there is a lot you have to get used to that you don't know anything about. Like pressing the buzzer, where is the buzzer? Things you pick up and learn for yourself you know. (P8)

P11 recognized the learning curve she experienced as a new patient but, in contrast to P8 comment's, felt that this was unnecessary. In her view, staff should have supported her adaptation to her new patient role:

> you have got to sit and try and work out what you are supposed to do. Well you shouldn't have to do that it is their job . . . You are just the patient . . . it is their job. (P11)

Adaptation also incorporates narratives related to how negative personal or observed experiences led to a state of vigilance, which raised their awareness of what was going on around them and led them to question and lose confidence in staff. This therefore sometimes impacted upon them "asking for help," as they navigated their way through their new environment. When speaking about both her own experiences and those of others, one participant suggested patients were frightened of making a nuisance when requiring help or assistance from the RN or HCA:

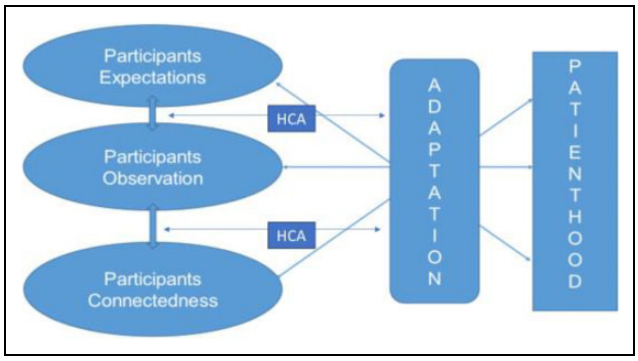

Figure 2. Model depicting the relationship between elements contributing to the patient experience through the process of adaptation.

> Yes frightened, yes a lot are frightened coz a lot of them think if I make a nuisance I won't be looked after. A lot of people feel that. (P11)

The use of the word "frightened" indicated the depth of feeling for this participant, although her concerns were not isolated. Another was less forceful in his language but, all the same, alluded to patients appearing compliant and accepting of their situation:

> Erm . . . (sigh) I think most of them don't want to question you know, don't want to cause any trouble. (P1)

While another told of how she managed her dependency in terms of asking for help *from the RN or HCA*:

> I only bother them if I have to. (P14)

Discussion

Figure 2 depicts a model illustrating the conceptual elements contributing to patients transitioning from the known self to patienthood, a process that influences the overall patient experience.

Transitioning to Patienthood: A Theoretical Model

Expectations. For some participants, nostalgia played a part in shaping expectations and navigating the present. Howard (28) suggested there is consensus among disciplines that nostalgia is defined by the difference between a more positive past and a less positive present (29,30). He further suggested that selective memory may also have a part to play in idealizing the past, which may help understand why a positive view was recalled from the participant's perspective. This may partly explain the disconnect between past perception and current experience as described by some.

Thus, being cognizant of the existence and impact of nostalgia, the RN and HCA must be able to assist the patient in repositioning their past experiences within the context of their current experience, if appropriate to do so. It also provides an insight into the way in which seeds of future nostalgic recollections can be sown through positive patient experiences in the present.

Observation. Association of uniform with task illustrates the symbolic representation of uniforms in assisting participants' understanding of what to expect in terms of behavior and professional status. However, it has been suggested that with the increasing numbers of uniforms, there is potential for confusion (31), with more recent studies confirming such difficulties (1).

The observer of the uniformed wearer may note professional identity and gain reassurance (31), as the uniform offers a visual legitimacy to the vocational or professional group membership. Internationally, health-care organizations may seek a standardized uniform that has the potential to bring professions together, described by Ritzer (32) as "McDonaldization," where there is a public image of predictability and corporate identity. There is however a paucity of recent analytical literature on the role of uniforms within health care informing on such developments. With no central policy within the UK hospital setting (33), there remains a complex array of uniform colors and types that challenges the notion of predictability and the corporate identity.

Furthermore, it is interesting to note that Kessler et al (1) suggest that it is important for the patient to be able to distinguish between the HCA and other members of staff, emphasizing the importance of explaining these differing roles to the patient so that they know who to ask for what. This contingent emphasis toward the patient knowing who is who places additional "responsibility" on the patient who may be adjusting to a new social world at a time that may not be in line with their patienthood trajectory and capacity to do so.

Meaningful connections. Participants described care received in terms in which interactions were often punctuated with moments of connectedness contributing to the patient–HCA dyad. The "nurse–patient" dyad is recognized as a fundamental component of a positive patient experience in the United States (34,35) and Philippines (36). These articles however often researched from the perspective of RN and patient (34–36) without mention or recognition of the nursing assistant. This suggests further research into the concept, impact, and potentiality of the assistant–patient dyad may be necessary, particularly from the perspective of the patient adding to greater depth of understanding of the patients' dyadic relationships.

Foucault's (37) work on surveillance helps illuminate some behaviors demonstrated by HCAs in the observation of patients. Direct observation was overt as the HCA performed much of the clinical observation and monitoring of vital signs, while collective observation could be covert or overt. In theorizing the expression of forms of power, Foucault (37) makes a distinction between indiscreet (overt) and discreet (covert) observation which are proposed as

mechanisms of "governmentality." Governmentality is an expression of power—not externally held and imposed but manifest in all routine activity and often involving forms of surveillance and "self-policing." For governmentality to work, individuals need to be aware of its presence, that is, the visible presence of staff. Therefore, the collective approach of HCAs to observing groups of patients from a distance provided the patient with a level of awareness of the staff (and of surveillance), as they went about their day-to-day business.

Foucault (33p135) argues that once patients are aware of the gaze, they turn themselves into "docile subjects" or "docile bodies" compliant with the medical treatment. The patient as a "docile body" may therefore not want to make a nuisance of themselves in asking for help from within the position of a collective audience. This may serve to reduce the potential demands on staff which suggests this may be an illustration of a form of self-policing that acts to sustain the disciplinary power of the staff. Forbat et al (38) by way of contrast suggest that the medical gaze can be comforting if perceived as monitoring well-being and the things they are worried about. It could be argued however that the attendance to those things that are of concern to the patients are not attended to by a collective surveillance technique.

Adaptation. Adaptation illustrates how participants adjusted their known self, learning new behaviors with the assistance of the HCA, and incorporated into their social identity as part of the world of patienthood.

Participants described having varying degrees of willingness in asking for help. The subjugation of care needs in preference of presenting an agreeable persona may in part be explained and understood from the work of Stockwell and Schwartz (39) They studied the patient from the perspective of the RN and proposed that nurses label patients as "popular" or "unpopular." The binary notion of the concepts "good" and "bad" and "popular" and "unpopular" may suggest the patient being "liked" or "disliked."

The labeling concept suggests those with power are able to construct a reality that has the potential to disadvantage those with less power. It could be proposed that the assistant dialogue has such power, potentially hidden (40), with limited interprofessional inclusion (41) which in turn may impact upon patient safety (42). Earlier work has however described the RNs' awareness of these labels and the effort required to manage them so as not to subject the patient to inequity of care and treatment (43). Therefore, it is further evidence of bringing a greater focus on the assistant–patient relationship in addition to the RN ensuring the patient can and will ask for help where appropriate to ensure equity.

Limitations

The research design included patients and not the nurse assistant, which may be viewed as rendering the analysis incomplete. Although the inclusion of the nurse assistant would have provided a different perspective on the patient–assistant dyad, the aim of this study was to give precedence and voice to the patients' perspective, as this is often omitted. It is suggested that in-depth research into the assistants' perspective would be a useful follow-on from this study and enable contrasting and comparing of the 2 perspectives to be undertaken based on 2 separate focused sets of analysis.

In addition, data were collected prior to the introduction of the nursing assistant and apprenticeship roles and thus did not account for patients' perceptions and understandings of these newer roles.

Conclusion

Until recently, there has been little or no reference within the literature to the relationship between nurse assistant and patient. This observation suggests that further research is needed from the perspective of the dyadic assistant–patient relationship but should also incorporate relationships between the nurse assistant and the RN. This triadic understanding would help to build upon what is known in terms of interprofessional working and inclusion of the assistant into the nursing family as the nursing profession meets the challenges of additional assistant roles. Such research would be expected to add to the existing breadth and depth of knowledge of the patient experience.

The process of interpreting and reframing the patients' narratives around their experiences and observations provides opportunities for service and role development and service provision that go beyond a merely hierarchical and jurisdictional view of staff within health care. This would open up the debate for rethinking the patient experience in terms of their needs, rather than the needs of staff and professions.

A Foucauldian lens may help future research reframe some of the practices of observation and surveillance that have the potential to impact upon the patient–nurse assistant dyad and implications for the RN. This refocus may also help bring greater insight into the reluctance of some to ask for help or assistance.

Authors' Note

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