Northumbria Research Link

'I feel like a salesperson': the effect of multiple-source care funding on the experiences and views of nursing home nurses in England

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Abstract

The difficulties faced in the recruitment and retention of nursing staff in nursing homes for older people is an international challenge. It is therefore essential that the causes of nurses' reluctance to work in these settings are determined. This paper considers the influence that multiple-source care funding issues have on nursing home nurses' experiences and views regarding the practice and appeal of the role. The methodology for this study was hermeneutic phenomenology. Thirteen nurses from seven nursing homes in the North East of England were interviewed in a sequence of up to five interviews, and data was analysed using a literary analysis method. Findings indicate that participants are uncomfortable with the business aspects that funding issues bring to their role. The primary difficulties faced are: tensions between care issues and funding issues; challenges associated with 'selling beds'; and coping with self-funding residents' changing expectations of care. The findings of the study suggest that multiple-source care funding systems that operate in nursing homes for older people pose challenges to nursing home nurses. Some of these challenges may impact on their recruitment and retention.

Key words: nursing, health care costs, long term care, nursing homes, residential care, nursing role, phenomenology.

Introduction

In order to provide long-term care that meets the complex needs of ageing populations, there is an increasing need for registered nurses to work in nursing homes that provide services for older people (Mossialos et al. 2002; United Nations 2002; United Nations Population Fund 2012). However, nursing staff turnover and vacancy rates indicate that the recruitment and retention of nurses in these settings is problematic. For example, turnover rates are 16% in the United States of America (USA), 19% in England and 27% in Japan, while vacancy rates are 16% in the USA, and 5% in England – a rate twice as high in the nursing home sector as other health sectors (Colombo et al. 2011; National Minimum Dataset for Social Care - NMDSC 2012). As well as leading to staff resourcing problems and a lack of continuity in care provision, high staff turnover has a significant financial cost for service providers. In the USA, estimated turnover costs are $2.5 billion (Colombo et al. 2011).

In order to address recruitment and retention difficulties, it is essential to determine the factors that lead nurses to perceive nursing homes for older people as less attractive employment options. To-date, little research has explored the issues of care funding, and the consequent business aspects that funding brings to the nursing home nurse's role. Yet on-going controversies and debates regarding care funding (Mossialos et al. 2002; Chen 2003; Comas-Herrera et al. 2006; Gargett 2010; Henwood 2010) suggest that these are potentially important influencing factors. This paper explores the impact that funding and business issues have on participants' experiences and views regarding the practice and appeal of nursing home nursing in England. It also considers the implications of this impact for the recruitment and retention of nurses in these settings.

Background

In England, funding and business issues greatly influence nursing home environments. Of nursing homes in England, 73% are privately owned, and sustained by maintaining high residency rates and achieving profits (Luff, Ferreira and Meyer 2011). Healthcare in this context is provided by the National Health Service (NHS). Individuals who require residential nursing care undergo an assessment of the 'nature', 'intensity', 'complexity' and 'unpredictability' of their care needs in order to determine whether their needs are primarily health-related (Department of Health 2012). However the subjectivity of these terms of reference has led to questions about the reliability of health needs assessments, and the system has been highly contested (Clements 2010). If residents are assessed as having a 'primary health need', their care is funded solely by the NHS. People who do not meet the 'primary health need' criteria but require the support of a registered nurse receive a joint package of care, where 'health needs' are funded by the NHS, but individuals undergo means testing (assessment of financial resources) to establish private and social services contributions to the cost of personal care needs. This means that care provided in nursing homes is multiple-source funded (a mix of privately, publicly and jointly funded care).

Because of the contentious nature of health needs assessments, and the personal financial implications of means-testing, the matter of care funding is plagued by controversy. Indeed, in the United Kingdom (UK), concerns about the impact of long term care funding on older people are constantly debated in the media (for example, Triggle 2013). Studies that explore funding issues in England describe the struggle of service-users and carers to understand, negotiate and come to terms with, the financial repercussions of moving into a nursing home (Wright 2003; Henwood 2010). According to Henwood (2010) service-users'

anxieties and experiences regarding funding issues affect their attitudes to nursing care. Many service-user participants in Henwood's study (2010) reported that care providers appear more concerned with individuals' ability to pay, than with their health needs.

This care funding controversy is not unique to England. As societies age (World Health Organisation 2011), and subsequently the costs of care mount, more and more funding systems are demanding some degree of self-funding by older people with means. Though Australia, the Republic of Ireland and France have universal benefit systems, benefits received are adjusted to reflect residents' income. Even countries regarded as operating absolute universal coverage systems, such as Scandinavian countries, Japan and Germany, nevertheless require co-payments, up-front deductible charges and service charges (Comas-Herrera et al. 2006; Colombo et al. 2011). In East Asian countries, government policies actively and overtly encourage home ownership so that housing assets can be utilised in later life (via for example, asset release schemes, sale-leaseback schemes and rent-out schemes) to generate private incomes that can be used to contribute to care costs (Doling and Ronald 2012). Thus, to a greater or lesser degree, the long-term care of older people in many countries is multiple-source funded, and as such, leads to differentials in the personal cost of care. Colombo and colleagues' report (2011) for the Organisation for Economic Co-operation and Development (OECD) states that, despite the operation of funding systems that aim to share responsibility for financing long-term care, many nursing home residents remain unprotected from 'catastrophic care costs' or significant 'out-of-pocket costs'. Consequently, service-users and their families are fearful of losing their assets, and are therefore critical of 'immoral' health and social policies that stipulate residents should pay for, or contribute to the cost of their care (Kaiser Family Foundation, 2001; Henwood, 2010).

A number of studies investigate the impact of funding issues on the experiences and attitudes of residents and families (Kaiser Family Foundation 2001; Wright 2003; Henwood 2010; Colombo et al. 2011). Previous research which considers the impact on nurses' experiences and views has primarily focused on acute and primary care settings, rather than nursing homes. In addition, these studies are located in either publicly funded settings, or privately funded settings, but not multiple-source funded settings. For example, a comparison of studies exploring the views of public funded nurses with studies examining private funded nurses' views, reveals a stark difference in perceptions of the business facets of their roles. Blackman and Cook's (2010) study, located within a publicly funded care setting, surveys UK NHS community nurses' attitudes regarding the Government's *Transforming Community Services* initiative (Department of Health 2009). The study finds that nurses are adamant that their roles should centre on care, and they are thus resistant to the Department of Health's proposal that nurses should be entrepreneurial practitioners, 'exploring business opportunities'. The study suggests that this resistance arises because business terms and processes are not embedded within nurse education and culture, so nurses struggle to recognise entrepreneurial activity as part of healthcare. On the other hand, Toffoli, Rudge and Barnes' (2011) study of private acute care nursing in Australia concludes that nurses working in the private sector are business aware, realising that care in this setting is a marketable business commodity. As such, these nurses get involved in business and marketing practices 'consciously, knowingly and actively' (345).

Research by Angelopoulo, Kangis and Babis (1998), Arasli, Ekiz and Katircioglu (2008) and Zarei et al (2012) explore patient and staff expectations of public and private hospital care services. The studies suggest that hospital staff, regardless of whether they work in public or

private settings, define quality care as emanating from staff's care skills. While publicly funded patients' definitions are in agreement with staff definitions, 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. As a result, self-funding alters patients' expectations about what constitutes quality care. Private patients' are not only concerned with staff skills, but also with tangible facilities (such as attractiveness of the care environment and the amenities on offer), and with the availability and attentiveness of staff.

As already discussed, long-term care in England is funded by both public and private resources. As a result, many nurses that work in nursing homes care for both publicly, privately and jointly funded residents within the same facility. As research into the impact of funding on the views and experiences of English nurses has not previously focused on multiple-source funding in nursing home environments, one of the objectives of this study was to explore this impact.

The overarching aim of this study was to explore the experiences and views of nursing home registered nurses regarding their role and status. This article does not represent the study's findings in entirety, but presents one aspect: nursing home nurses' experiences and views about multiple-source care funding.

Methodology

As the study is an exploration of the social meaning and personal significance of experiences, 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. With this in mind, the research design explicitly aimed to facilitate exploration of the participants' experiences and views through a sequence of up to five interviews.

Sample

The purposeful sampling strategy followed Sandelowski's (1995) phenomenal variation approach. This approach targets a population with experience of the phenomenon under consideration, but scopes for diversity and comparison. The inclusion criteria for the nursing homes in this study was relatively unrestrictive and included sites that employed registered nurses providing nursing care to older people. The inclusion criterion for participants was that they were registered nurses who were currently working within nursing homes for older people.

The study was located in North East England. The total number of nursing homes in the chosen areas that met the inclusion criteria was 160 (Carehome.co.uk 2012). All homes were invited to participate in the study, and 12 interested parties replied. The response rate to the invitation to participate in the study was low, but was deemed to reflect the 'real life' judgements that managers made about the significant commitment that was required for participation. Characteristics of responding homes were entered into a sampling matrix (Reed, Proctor and Murray 1996) and seven homes were selected on the basis that they provided maximum diversity of sample. Of the selected homes, five were located in urban areas, and two in rural areas. Four were owned and operated by large national companies, one by a local company, and two by sole proprietors. The homes provided services for between 20 and 77 residents, and employed between 5 and 20 registered nurses.

All registered nurses working in the sample nursing homes were informed about the study. In total 13 nurses consented to participate. As each participant was interviewed up to five times, this was considered to be an appropriate sample size because it achieved insightful explorations without forfeiting analytical depth. Participants included two home managers, one deputy manager, one nurse manager, one palliative lead nurse, and seven staff nurses. The age range of participants was between 25 and 59 years, and their length of experience in nursing homes ranged between one and 23 years. Each participant was allocated a pseudonym in order to preserve anonymity. The study was approved by the Faculty of Health and Life Sciences Research Ethics Panel of Northumbria University, UK.

Data Collection

The data collection method was based upon Flick's episodic interview technique (Flick 2000, 2009). During episodic interviews, the researcher prompts generalised discussions based on participants' assumptions and views regarding the phenomenon in question (semantic knowledge), and asks participants to describe specific examples of their experiences of the phenomenon (episodic knowledge). This combination of episodic and semantic knowledge generates data that arises from general, as well as concrete experiential contexts. The data collection method involved interviewing each participant up to five times. After each interview, the audio-recording was transcribed verbatim and initial analysis was performed. In total, 60 interviews were completed.

The purpose of the first interview was to collect background information with a view to developing contexts for the described experiences, and to allow participants to initiate discussions about topics that were significant to them. Subsequent interview topics were informed by the study's aims and analyses of the preceding interviews of the participants.

The purpose of the final interviews was to allow participants to verify the researchers' interpretation of the accounts of their experiences, views and feelings. This exercise supported the trustworthiness of interpretation. The researchers verbally summarised the main aspects of interviews with individual participants and invited the participant to comment.

This multiple interview technique had a number of advantages. For example, it facilitated identification of topics for subsequent interviews (Dumay, 2010), and it supported clarification of inconsistencies in individual interviewees' responses because topics could be revisited in later interviews (Cohen, Khan and Steeves 2000). The method also enabled participants to reflect on their ideas between interviews, a process that Cohen et al (2000) argue leads to the generation of richer data.

Data Analysis

Van Manen (1997) has proposed that the creativity and fluidity involved in literary analysis are better suited to the exploration of complex phenomena than more systematic research approaches, or approaches that utilise software. Therefore, a literary approach, based upon the methods of Iser (1978) and Van Manen (1997), was employed in this study. Each interview transcript initially underwent a holistic reading in order to determine the fundamental meaning of the text. The second stage of analysis involved highlighting prominent phrases within the transcript. This process served to confirm, modify or contest the original inferences generated from the holistic reading. The remaining non-highlighted text was then re-read. This reading ensured that topics of potential prominence, as well as actual prominence were identified. Because data collection involved multiple interviewing, these potential topics could be monitored, or revisited in later interviews. The third stage of

analysis entailed a line-by-line examination of the text. Strowick (2005) explains that expressions used in texts and speech may have hidden sub-texts. Such expressions themselves do not directly constitute meaning, but they can be indirect clues to underlying issues. Line-by-line analysis also emphasised the relationships and links between separate phrases. Iser (1978) believes it is important to both perceive phrases in isolation, and within context, so that the standpoint of each individual sentence can be confirmed or altered by its association with the others within the text.

After each interview had been subject to these three analysis stages, interview topic maps were generated which were then assimilated into individual participant topic maps. Next, all participant topic maps were compared, then topic categories were created. After re-reviewing the topic maps, it was possible to categorise associated topics under unifying headings. As the analysis advanced, categories were integrated and assimilated into themes.

Findings

Findings suggest that participants are uncomfortable with the business aspects that funding issues bring to their role. The primary difficulties faced are: tensions between care and funding; challenges associated with 'selling beds'; and coping with self-funding residents' changing expectations of care.

Tensions between care and funding: 'culture shock'

Cath proposed that healthcare education in England is geared towards producing professionals to work in the 'free at the point of care' NHS. She suggested that education does not prepare nurses to understand, accept or endorse the concept of self-funding care. She stated that the 'culture shock' which results from the tension between nurses'

expectations regarding 'free' care and the reality of means-tested payment of care costs, contributes to the attrition of the nursing home nurse workforce:

> That's total culture shock [when you come to work in a nursing home], because you don't realise how much you've got to depend on these residents' money to give them the care that they need. We're not told that … that little bit of pressure can sometimes knock people over the edge (Cath).
>
> Over the edge? You mean put people off working here? (Researcher).
>
> Yeah. A lot of people just can't do it (Cath).

Other participants agreed. They referred to self-funding as 'immoral' and 'unfair', and they said they feel 'uncomfortable' about being part of a seemingly inequitable system:

> I do feel a little bit uncomfortable about how some patients don't have to pay a penny and the other patients do (Alice).
>
> I think it's shocking. I really, really do. And the people who pay five hundred pounds a week get exactly the same care as the people who don't pay anything… I wouldn't treat one person first class and the next person, 'Oh well, the government's paying for you, I'm not changing your leg dressing today' (Emma).

Participants' responses inferred that they have devised coping strategies in order to manage their discomfort. For instance, Faye claimed powerlessness excuses her from any responsibility regarding unsavoury commercial aspects of nursing home nursing:

There's a difference in the fees, and I think it's unfair, but that's government level. You know, when they have to sell their own property, it's uncomfortable, but that's government level and I can't change that (Faye).

Beth, on the other hand, attempted to reject the perceived immoral business side of their role, and emphasised the morally acceptable nursing aspect of their role:

To be honest I absolutely hate the business side of things. I don't really see that as my role. My role is to care for people (Beth).

Ellen and Georgia transformed the business aspect of the role into a type of mission, in which services for residents are protected, and job security for both themselves and the rest of the staff is assured:

We need to keep the home going because it is a business. For the resident's sake, we don't want the home to close, and for them to be moved on (Ellen).

I mean everybody has to be aware that basically it's keeping us employed. And without bums on beds, you wouldn't have a job (Georgia).

Selling beds: 'I feel like a salesperson'

Participants reported that they are often required to show potential residents around nursing homes, an aspect of the role they regard as 'selling' to customers. Indeed, many of the participants used sales language when discussing this activity (for example,

'salesperson', 'selling beds', estate agent'). Some of the participants stated that they are so repelled by the idea of 'selling beds' that they avoid, or redirect, the activity:

> 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 because I almost feel like my job role changes immediately, and I become you know like a salesperson, and I really don't like it, and I try and separate myself from it (Beth).

> I think its management's job. I feel that it's the owner's business, and it's their, it's their business that they need to be showing people round and the facilities. Yes. I prefer to separate it, erm, I feel very strongly that I'm a nurse here (Diane).

Despite the distress that the prospect of 'selling beds' causes, other participants articulated that they reluctantly acquiesce to fulfilling this aspect of their role, because by doing so, they are informing, advocating for, and protecting, residents. While these participants stated that they are uncomfortable with the concept of selling, they felt that administration/non-nursing management staff are unfamiliar with the practicalities and ethics of care. Participants expressed concern that non-nursing staff are at risk of selling beds to potential residents on the bases of unrealistic assurances motivated by income rather than individuals' care needs. Participants stated that for these reasons, they agree to undertake the selling of beds themselves. They felt that, by assuming the role of salesperson, they are giving potential residents an honest, realistic, full and balanced account of the service on offer:

Because I've had a bad experience in the past with that. Where a previous manager was showing someone round and promising them all this. Obviously when they choose this place and come in, they're like, 'Well, why isn't he going out today?' 'I'm really sorry but we can't manage to take him out every day'… It's really hard, and then they say 'I was told that this is going to happen', and it makes our job really hard, so you have to be honest (Elaine).

The participants all deemed advocacy to be fundamental to their dealings with potential residents, demonstrating that their strong ethical nursing culture pervades their sales behaviours. Thus, when Alice and Ellen worked in nursing homes where they felt quality care was lacking, selling beds was a troubling experience:

I secretly didn't like the place. It wasn't, I wouldn't want people to come here, and I wouldn't want to be giving a misrepresentation of the place (Alice).

I feel a bit better here, but in [home] I wasn't very happy showing people around because I didn't really want to recommend it. I felt awkward when people I knew came. I thought, 'I don't want them to think it's a good home just because I'm here' (Ellen).

In both cases, the participants attempted to improve care delivery in these nursing homes, but the prospect of selling poor quality services proved too uncomfortable, and consequently, both participants left to work in other settings.

Self-funding residents' changing expectations: 'I'm paying for this!'

Participants suggested that there is a disparity between the expectations of self-funding residents and those of healthcare professionals regarding what constitutes quality care. While participants value a service based on care, they felt that self-funding residents look for more tangible signs of quality:

> They want different care. They want, not better care, but they want it there and then, and they want a 42 inch plasma screen on the wall, kind of thing (Beth).

> Like these days, erm, I think the competition is how nice is the home, like you know, the environment, the state-of-the-art, you know, and as you can see, we haven't got that here, we have the care (Bella).

Participants also suggested that self-funding residents and their families are preoccupied with staff availability and attentiveness:

> Actually there were patients who, if they don't get attention straight away would say, they'd be shouting and say, 'I've paid for you, I'm paying for you'. And then some relatives who would come in, you can see and you can feel that, 'My mum needs attention now. This is what we pay. We pay a lot' (Andrea).

> They expect better quality of care, so they want you in the room twenty-four-seven sometimes. 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' (Elaine).

Participants proposed that private-funding not only influences residents' expectations, but that these expectations have an impact on the nurse/resident relationship. Some participants reported that, due to different expectations, self-funding residents can become more demanding and develop a supercilious attitude towards staff:

> And then you get other residents that treat you as a servant, who want you to pick up a piece of paper, and think the nurse has to do it. So they go from one extreme to the other. So a lot of the barriers about that is from the residents, and what they perceive they should expect for their money (Cath).

Anne attributed difficulties in relationships to residents' disclosure regarding funding. Although funding details are confidential, Anne explained that some residents choose to disclose funding issues to staff and other residents. To comply with the requirements of ethical practice, the participants stressed the importance of treating all residents with equal consideration, regardless of funding arrangements. However, they felt that this can lead self-funding residents and families to feel resentful and frustrated because of a perceived lack of priority care, despite their self-funding status:

> I mean, it's the patient themselves that say, 'I'm paying for this', and what have you. But I mean, in theory it's confidential. And as far as we're concerned the delivery of the care is the same regardless. But I mean, I have had people come to me and say, erm...if there was a complaint about the food, 'My mother's paying all this money. Why can't she have a steak for her tea', you know what I mean. But my answer is always actually, 'I accept that you're paying for your care,

but that isn't the home's decision, and in fact as far as we're concerned, all our residents are treated the same' (Anne).

I think the families have definitely got different conceptions. 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 (Faye).

Other participants attributed residents' altered attitudes to 'funding transitions'. For many self-funding nursing home residents in England, the shift from 'free' healthcare to paid care, is both unexpected and unwelcome (Wright 2003; Henwood 2010). Participants suggested that this 'funding transition' prompts some residents and families to alter their expectations and attitudes towards care home staff:

I feel uncomfortable once I realise they're coming off the NHS floor. And that's when it hits them, that whatever the assessment team decide, how much money is coming out of their pocket. And that's when they decide to stop being a bit, you notice they become a bit more critical about the home. Because it was all free before (Alice).

Although the altered expectations and attitudes of self-funded residents can pose a challenge for participants, they nevertheless appreciated why these attitudes occur:

If we're paying for a service out of our own purses, it's understandable. That's why I try not to judge them, because I can still understand where they're coming from, you know (Faye).

It's quite understandable. You save for a rainy day and you get

penalised for it (Georgia).

Difficulties arise when residents' expectations and attitudes detrimentally affect their own

motivation to maintain independence. For example, Barbara and Georgia reported that

although some residents have the ability to undertake certain physical tasks themselves,

because they are paying for care, they insist on staff intervention. These residents are

potentially foregoing rehabilitation opportunities:

We've got a lady. She's in hospital at the moment, and we, she came,

she's privately funded. She needs intermittent catheterisation. She

said, 'Are you not going to pull my trousers up?' I said, 'Well no, you

can do that yourself'. 'But I'm paying you to do it' (Georgia).

Discussion

The position of nursing home nurses in England is unique within the country's healthcare

system. Unlike public sector nursing, where competition, and business and sales skills are

not so much of an issue, nursing home nurses are thrust into the arena of funding,

marketing and profit. Some participants described this experience as a 'culture shock'.

Culture shock arises when individuals find themselves in a situation which requires them to

adjust to a new culture distinctly different from their own (Preston, 1985). Berry and

colleagues' analyses of cross-cultural psychology describe this process as 'acculturation'

(Berry, 1974; 2001; Berry et al, 2011). These authors argue that as a consequence of

acculturation, individuals respond with strategies that are dependent upon the importance

and value that they place upon two issues: their own cultural heritage, and their willingness

to embrace the new culture. If individuals value the new culture, but not their original, they assimilate the new. If they value their own culture, but not the new, they separate themselves from the new. If they value both cultures, then they integrate the two. None of the participants in this study are 'assimilators'. However, the 'separator' outcome was displayed by some. Frustrated and critical regarding the commercial aspect of nursing homes, these participants stated that they avoid becoming involved in business and sales. Cath inferred that for some nurses, this 'culture shock' becomes too much, and they reject the new culture altogether by leaving the nursing home setting. The other participants could be described as 'integrators' because they adapt to some elements of business and sales culture while retaining the care aspects of the culture of nursing. However, because their adaptation of business/sales practices is more a reluctant acquiescence rather than a positive undertaking, they are not truly integrating.

These difficulties result from three acculturation challenges. Firstly, participants stated they are uncomfortable with being involved in a care system, which is funded in a way that they feel to be unfair and immoral, and which is alien to the care culture in which they are embedded. Participants felt that they became like 'sales persons', although selling and business is an aspect of their role that they are averse to. This aversion appears to be because participants view the commercial aspect of their role as morally 'tainting' their work as nurses. According to Ashforth and Kreiner's (1999) study regarding the nature of 'dirty work', occupational 'moral taint' occurs when occupations are regarded by the dominant culture as 'defying the norms of civility' (415). It is possible that because the participants' view the 'immoral' manner in which care is funded in this way, they perceive the business aspects of their own roles as morally reprehensible. Ashforth and Kreiner

(1999) and Lagerway (2010) suggest that the presence of moral discomfort is indicated by behaviours such as denial of responsibility, refocusing on more morally acceptable facets of the role, and reframing the role in order to instil it with positive value. Many participants in this study used these strategies, which further reinforces that they are ill at ease with the monetary and selling aspects of their role.

Secondly, participants' comments implied that their discomfort regarding funding systems influences their understandings regarding the purpose of showing potential residents around homes. According to Meleis' transition theory, whilst undergoing transitions within health care systems, individuals' psychological health is at risk because transition involves the acquisition of new knowledge, modification of behaviours, and periods of uncertainty. Nurses' knowledge and position within these systems makes them ideally placed to assist people with transitions (Schumacher and Meleis 1994; Meleis et al. 2000). Because nursing home nurses understand nursing home life, it is apposite that they support residents to make decisions regarding the transition to residential nursing care. Showing potential residents around the home, and discussing their requirements and the home's ability to meet their needs is an essential part of supporting the decision-making process (Reed et al. 2003; Davies 2005; Toles, Young and Ouslander 2012). However, some participants stated that they engage in this activity reluctantly, because by doing so, they are involved in business and 'sales', concepts with which they are uncomfortable. Participants said that they find 'sales' activities particularly uncomfortable in situations where care quality requires improvement. For Alice and Ellen, 'selling' in such circumstances resulted in an ethical dilemma which led them to leave their work settings, rather than stay to initiate improvements. These findings appear to support Blackman and Cook's (2010) suggestion

that nurses in the UK are resistant to involvement in entrepreneurial activity because business is not widely incorporated into UK education programmes or nursing organisational culture, meaning that nurses do not view it as part of their remit.

Thirdly, participants asserted that negotiating residents' expectations and frustrations that result from funding issues, is difficult. This is because they perceive a tension between the culture of nursing which is based upon the provision of an equitable care service that promotes residents' independence, and the expectation of residents to be provided with a tariff-related hospitality service. This confirms the findings of Angelopoulo and colleagues (1998), Arasli and colleagues (2008) and Zarei and colleagues (2012) which conclude that there is a disparity between the expectations of private patients and healthcare professionals regarding what constitutes quality care. Private patients' value high quality tangible facilities and expect staff to be on hand and attentive. However, in addition, participants in this study suggested that personal cost differentials between residents within the same facility, and 'funding transitions' that occur as service-users move through health and social care systems, can lead self-funding care home residents to become supercilious in their behaviour to staff. The resultant difference in the relationship between nurse and resident also adversely affect residents' motivation to maintain independence.

Despite differences in the way long-term care is funded, many countries' funding systems, to a greater or lesser degree, are multiple-sourced. Currently, self-funding as a proportion of total long-term care funding stands at 45% in England, 35% in the USA, 27% in Canada, and 20% in Australia (Colombo et al 2011). These statistics illustrate that differentials in the personal cost of care are widespread. As discussed earlier, studies located in Europe and East Asia suggest that care funding and self-funding contributions to care costs are common

concerns which can lead to changes in service-users' perceptions and attitudes regarding care. This infers that nurses working in nursing homes in these countries may face similar challenges to those working in England.

Study Limitations

This study's findings are based upon the responses of a small number of participants located in one region of England. Although multiple-source funding of care is a widespread phenomenon, funding policies of individual countries and regions may influence nursing home nurses' experiences and views in differing ways. The insights and new perspectives offered by this study should therefore be considered by further studies in other contexts.

This study suggests that nursing home nurses' perception of care funding is a mediating variable between multiple-source care funding issues and recruitment and retention difficulties. To investigate this further, new studies should be undertaken using quantitative or mixed methodologies.

Conclusion

While the debate about how best to fund the residential nursing care of ageing populations remains a prominent political, social and economic theme, the impact that funding issues have on the experiences and views of nursing home nurses has not been adequately acknowledged. By exploring this impact, this paper extends understanding of factors that may influence recruitment and retention. The study suggests that multiple-source funding systems prescribed by political and economic agendas can have a negative effect on working environments for nursing home nurses. This is because nurses become involved in systems which they perceive as unfair, and which involve selling – an activity with which some are

uncomfortable. This discomfort arises because business processes are not part of nurse education and culture. The systems also contribute to residents' altered expectations of care, and this poses an extra challenge to nursing home nurses as they strive to provide ethical, equitable care for residents. The study implies that unless these challenges are addressed by nurse education and nursing home service providers, then multiple-source funding systems may continue to contribute to attrition of the nursing home nurse workforce and deter potential recruits.

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