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**AN EXPLORATION OF THE ROLE
AND STATUS OF NURSES WORKING
IN NURSING HOMES FOR OLDER
PEOPLE: A HERMENEUTIC
PHENOMENOLOGICAL STUDY**

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PhD

2015

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AND STATUS OF NURSES WORKING
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PEOPLE: A HERMENEUTIC
PHENOMENOLOGICAL STUDY**

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the requirements of the University of
Northumbria at Newcastle for the degree
of Doctor of Philosophy

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Health and Life Sciences

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Abstract

Older people residing in nursing homes have complex needs requiring the input of nurses skilled in managing multi-morbidities and psychosocial issues. However, in England, nursing homes have proven to be unappealing work settings for potential staff, while nurses who do work in these settings are often afforded low status. Such contradictions pervade current understanding of the nature of work in nursing homes. To-date, few studies have investigated the views and experiences of nursing home nurses themselves regarding the contradictions that arise from role and status issues.

This study explores English nursing home nurses' views regarding status and role. The aims of the study were constructed as follows:

- To explore the experiences and views of nursing home nurses working with older people regarding their status and role.
- To generate an understanding of how and why these experiences and views occur.
- To explore whether emerging insights regarding nursing home nursing can inform workforce development processes.

The methodology utilised was hermeneutic phenomenology, based upon the philosophies of Gadamer and Iser. Thirteen nurses from seven nursing homes were each interviewed five times using an episodic interview technique. Data analysis methods were adapted from Van Manen's hermeneutic phenomenological approach, and Iser's literary reception theory methods.

Four categories emerged from the data - nursing 'residents' rather than 'patients', business role, stigma, and isolation and exclusion. From these categories, three themes were ascertained - uncertainty about role identity, unpreparedness for the demands of the role, and low occupational status.

Participants feel uncertain, unprepared and stigmatised because they are positioned at the intersection of health and social care – a location where health and social care funding issues cross, and healthcare and social care work overlaps. Understanding generated from this study can inform workforce development processes.

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Author's Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work.

Any ethical clearance for the research presented in this thesis has been approved. Approval has been sought and granted by the Faculty Ethics Committee on 24 July 2012.

I declare that the word count of this thesis is 84,501 words.

Juliana Thompson

Date:

1 Introduction and Background to the Thesis

The first chapter of this thesis introduces the study, and provides an introductory discussion of its terms of reference. It also explains how my research interest in nursing home (NuH) nursing came about, and how this interest led to the focus of the study. The background and current contexts of English NuHs are then described. The chapter concludes with an outline of the thesis structure.

1.1 Introduction

The primary purpose of NuHs in England is the provision of care for older people who are unable to manage their activities of daily living independently within their own homes, and who require continual nursing care delivered by registered nurses (RNs) (see 1.2 for terms used in this thesis). NuHs are different to most other healthcare facilities in that service-users are residents who dwell in these care facilities – the NuH becomes their home, and their personal care and social activity needs, as well as their health needs, are addressed by staff. The inclusion of accommodation, and personal and social needs in care provision impacts upon how care in NuHs is funded. While the National Health Service (NHS) funds the health-related elements of care, needs assessed as non-health are either privately funded or funded by social services, depending on the outcome of means tests. Thus, NuHs are set apart from other health services because they are situated at the intersection of health and social care.

The residents of NuHs are some of the most vulnerable people in society in that they present with severe disabilities and complex multi-morbidities. In order that these conditions are properly managed, nurses working with NuH residents are required to undertake a highly specialised, skilled role. However, NuHs have proven to be unappealing work settings for potential staff, while nurses who do work in NuHs are often afforded low status. This contradiction pervades current understanding of the nature of work in NuHs. This thesis explores the experiences and views of NuH nurses regarding role and status from within the NuH setting, and in this way, understanding of their role and status will be developed.

1.2 Terms of reference

According to Howe, Jones and Tilse's (2013) comparison of international terms for older people's housing services, the lack of consistent terminology can lead to difficulties for policy makers and service managers responsible for defining and planning services. Furthermore, these authors propose that research can also be adversely affected when inconsistencies in terminology lead to mis-analysis of service provision, and inaccuracies

and lack of clarity in comparative studies. Whilst undertaking the literature review for this study, the pertinence of Howe et al.'s (2013) analysis became apparent. The review revealed an array of terms and meanings relating to residential nursing care of older people. Two difficulties arose from this. Firstly, the same terms were often used for different care services. For example, in England, the term 'care home' is a generic term for any type of residential care setting, regardless of what levels of care, or for which resident groups, facilities are registered to provide (National Minimum Data Set for Social Care (NMDS-SC), 2014a). Secondly, different terms were at times used for similar services. For example, residential nursing care of older people occurs in 'long-term care homes' in Canada, 'skilled nursing facilities' in the United States of America (USA) and 'high care residential aged care homes' in Australia (Howe et al., 2013). Due to this lack of consistent terminology, there is a risk that the terms I have chosen to use for particular services do not match readers' understanding of those terms. Thus, in order to reduce the risk of misunderstanding, a brief and introductory definition of terms and their meanings in the context of this thesis is provided below. These terms are based upon most common usage internationally, so may not necessarily reflect usage in individual countries or regions.

Care home (CH) – generic term for residential care facilities for older people. This includes settings which do, and do not, provide nursing care.

Nursing home (NuH) – provision of RN care for older people in a residential or institutional setting on a long-term basis.

Nursing home nurse (NuH nurse) – RN providing long-term nursing care to residents in a NuH as defined above.

Residential home (RH) - provision of care support by healthcare assistants (HCAs) for older people in a residential or institutional setting on a long-term basis.

Long-term nursing care (LTNC) – nursing care provided in any long-term care setting. Although long-term care nursing is a fundamental aspect of NuH nursing, it is not exclusive to the NuH setting, but may occur on long-term care wards in hospitals and within the domestic setting. It may also relate to mental health or learning disability settings for younger people. In the context of this thesis, the term is used to denote the long-term care of older people with disabilities or multi-morbidities who require 24 hour nursing care. As such it is a nursing activity, rather than a care setting.

Gerontological nursing – nursing care provided for older people. Although gerontological nursing is a fundamental aspect of NuH nursing, it is not exclusive to the NuH setting, but may occur in hospitals, within the community setting, or may be a specialist practitioner role. In the context of this thesis, the term is used to denote the nursing care of older people. As such it is a nursing activity, rather than a care setting.

1.3 My research interest in nursing home nursing

My research interest in NuH nursing and, in particular, the issues of role and status, emerged from my own experiences of working in this setting. I entered the nursing profession late, after completing an adult nursing degree as a mature student. My previous education and career had been very different. I initially studied English literature to Master's level and then worked in the field of accountancy, both in private practice and private industry, for many years before changing career.

During my nursing studies, I found that I preferred working with older people, supporting rehabilitation and the management of long-term chronic conditions. Upon gaining registration, I applied for, and was subsequently offered, a number of positions with both the NHS and with NuH providers. My instinct was to accept one of the NuH positions, as I felt that I would enjoy, and was more suited to, working in this environment. However, some of my NHS colleagues warned me against this move, saying that NuH work was a 'dead end job', which would primarily involve personal care, rather than the practice of advanced clinical skills, and would therefore be an uninteresting, low status occupation. Some suggested that if I began my nursing career in NuHs, I would find it difficult to secure employment with the NHS in the future because NuH nurses are generally not very good nurses. Others said that the NHS had a better reputation, and provided better care, than private companies. I began to feel concerned about these claims, and as a result, I decided to look for a position in NuHs that provided NHS-contracted care as well as long-term nursing care, thinking that this would add variety to the role, enhance my skill development opportunities, and benefit from the NHS' reputation.

I eventually accepted a position in a NuH that had two units – one providing long-term nursing care (LTNC) for older people with multi-morbidities including dementia, and the other providing NHS-contracted rehabilitation care, primarily for older people recovering from surgery, stroke, and exacerbations of chronic obstructive pulmonary disease. My role required that I alternate between the units every few months. The NHS-contracted unit involved the practice of a number of nursing skills such as assessment, implementation and evaluation of care interventions, practice of clinical interventions, formal rehabilitation

activities, multi-disciplinary team (MDT) working, and transfer of care and discharge planning. As such, the role was not dissimilar to hospital nursing, and I felt that my existing nursing skills, acquired and developed at university and during hospital practice placements, fitted the role well. The role also necessitated a good deal of interaction with the local hospital nurses, medics and allied healthcare professionals, who appeared to regard staff on the NHS-contracted unit as colleagues.

Although I enjoyed working on the NHS-contracted unit, I preferred the time I spent on the NuH unit. Here, I practiced some of the same nursing skills described above, but the long-term nature of the care environment meant that I could get to know residents very well, develop relationships with them and their families, and endeavour to provide a safe, comfortable and fulfilling environment in which they could spend the remainder of their lives. Because of my preference, I eventually decided to work solely in NuH nursing care environments. However, the role was not easy. One difficulty was dealing with some of my healthcare colleagues' expressed assumption that NuH nurses are low status, inferior nurses. This assumption arose from their perception that NuH nursing is a low-skilled job that focuses on personal care activities. Although other healthcare professionals regarded nurses working on NHS-contracted units in NuHs as colleagues, their attitudes towards nurses solely working in NuH nursing care settings could be disparaging. For example, during my first year of registration, I was informed that I had won an award for academic and practice achievement. Although my manager and work colleagues were delighted, a local general practitioner (GP) who was at that time visiting our NuH, enquired why, if I had won an award, I was only working in a NuH, as he thought NuH nursing was a low status occupation that demanded little skill, and NuHs are renowned for employing nurses who cannot get jobs in the NHS. It therefore appeared to me that some of my healthcare colleagues associated skill level with occupational status.

For me, the most difficult aspect of NuH was feeling out of my depth in seeking to support residents with dementia and other cognitive impairments to participate in, and be included in, NuH life, without other residents becoming frustrated or distressed by their behaviours. I did not feel that my nurse education had prepared me for this challenge, and while I completed an in house training course on dementia care, and studied and read around the topic in my own time, I felt that this did not translate well into NuH practice. I therefore had to rely upon learning via sharing experiences with colleagues, and developing experiential knowledge. With regard to other learning, I attended many in house and bought in training courses, the content of which was generally very good, regarding topics that were pertinent to NuH and LTNC such as end-of-life care, capacity and deprivation of liberty

safeguarding with regard to older people, person-centred care planning for the older person, nutrition for older people, the dining experience, and purposeful activity for older people. I also completed an extended course on medicine management and polypharmacy in NuHs provided by a private training company. In addition, I initiated some reflective practice study groups with RN and HCA colleagues. I began to contribute towards the development of teaching materials and facilitating learning sessions for CHs within the company.

Eventually, I left the NuH sector as I wished to pursue a career in teaching and researching the care of older people. My current role in pre-registration nurse education has highlighted to me how much working in, and studying, NuH nursing has changed the slant of my skills. The skills utilised in NuH nursing are qualitatively different to those utilised in other settings, in that they focus on managing multi-morbidities and maintaining quality of life for older people on a long-term basis in their place of residence. Furthermore, it seemed to me that, despite this difference, many of the skills required for NuH nursing are complex and specialised.

Thus, a contradiction was apparent regarding NuH nursing. On one hand, in their care of older people with complex needs, NuH nurses are required to develop specialist skills, but on the other hand, they are not perceived as highly skilled professionals, which diminishes their status within the healthcare environment.

1.4 Focus of the study

The above contradiction led to a curiosity to understand more about NuH nurses working in LTNC for older people. I had ambiguous feelings about the world in which I had worked, as I felt that I was a skilled practitioner, but simultaneously felt disheartened by my low occupational status. Other healthcare professionals appeared to assume that the NuH nurse role primarily involves personal care activities, that NuH nurses are mediocre nurses, and that the NHS provides better care than private healthcare companies. My experiences and feelings prompted me to undertake a study that explored the views and experiences of NuH nurses regarding their role and status.

To-date, a number of research studies have focused on negative attitudes to LTNC of older people. Others have investigated the activities undertaken by NuH nurses during the performance of the role. However, few studies have investigated the views and experiences of NuH nurses themselves regarding the contradictions that arise from role and status issues. Fewer studies have considered the role and status of English NuH nurses who work in settings that are primarily provided by private companies in a

healthcare environment dominated by the NHS. No studies have developed and utilised a methodology and methods (chapters 3 and 4) that elicit the views and experiences of NuH nurses in such a way as to develop understanding of how their own perceptions of role and status are generated.

1.5 Background

This section provides the historical and contextual backdrop to the study. Firstly, the historical background and current context of NuHs are explained, followed by demographical overviews of the NuH population and NuH nurse workforce.

1.5.1 Historical background and current context

It is well documented that in England, long-term residential care for older people has its origins in the workhouse system of poor relief (Townsend, 1962; Thomson, 1983; Stanley & Reed, 1999; Borsay, 2005; Skinner, 2005). These institutions were initially founded following the Poor Relief Act of 1601, and by the nineteenth century the workhouse system was well established. Workhouses accommodated any individual who was without the family support or resources to remain independent. Internees were therefore destitute, aged, disabled, sick (physically or mentally), homeless, wageless, orphaned or abandoned. According to Borsay's (2005) history of British social policy, the aims of the workhouse system were twofold. It was a means of providing charity to the aged and sick, and a method of reducing the 'inappropriate dependency' of those whose destitution was regarded as being a consequence of dissolute living (p.20). Williams (1981) proposes that accommodating both 'deserving' and 'undeserving' poor (p.53) within the same system prompted legislation and guidance to classify internees, and direct that living conditions should depend upon this classification. The author quotes the Royal Commission preceding the Poor Law Amendment Act 1834, as an example:

Each class might thus receive an appropriate treatment; the old might enjoy their indulgences...the children be educated...and the undeserving be subjected to such courses of labour and discipline as will repel the indolent and vicious (Williams, 1981, p.57).

Indeed, Borsay's (2005) examination of historical records suggests some workhouse regimes recognised that often internees accessed support because illness, disability and age prohibited independence, or because seasonal work led to temporary unemployment. These regimes responded generously, and with compassion to these groups of internees. However, Gazeley (2003) argues, in his analysis of early twentieth century reform policy, that many communities associated internship with dissolute living, leading to harsh workhouse living conditions for all internees, regardless of their circumstances.

Social reform studies performed in the early twentieth century (for example, Booth, 1902; Rowntree, 1901) identified that poverty, destitution and illness were not consequences of moral failings, but rather of poor public health and healthcare, death of wage earners, unemployment, low wages, poor housing and large families. The results of such studies contributed to a change in governmental and public attitudes towards the poor and destitute, who were now viewed as vulnerable, rather than dissipated (Borsay, 2005). This shift in outlook resulted in the social welfare reforms of the Liberal government (1906 - 1914) including the establishment of specialised institutions that catered for the needs of different indigent groups (for example, hospitals, orphanages and asylums). Also, the introduction of the Old Age Pension Act 1908 provided financial assistance, and thus a level of autonomy, for older people assessed as being of good character and who had worked to their full potential (Gazeley, 2003). These initiatives had a significant impact on workhouses in that the numbers of internees in these settings began to rapidly diminish, and those that did seek workhouse support were older people who were not eligible for pensions. Peace, Kellerher and Wilcox (1997) argue in their analysis of social policy, that the predicament of older people living in workhouses was increasingly acknowledged by government bodies, as understanding of vulnerability and poverty developed during the first decades of the twentieth century. This new understanding led to the realisation that the needs of older people were different to those of the poor, as they required support that addressed frailty, disability and psychosocial issues. However, Gazeley (2003) suggests that because eligibility for the Old Age Pension depended on good character and a life of full employment, those who were ineligible and resorted to workhouse living may still have been regarded by their communities as somewhat dissolute.

In 1947, the government established the Nuffield Survey Committee in order to investigate living conditions in workhouses (or public assistance institutions). The committee found conditions to be so appalling that it subsequently called for the abolition of workhouses and recommended that smaller, purpose-built residential homes should be provided for the care of dependent older people instead. In 1948, the NHS was founded and for the first time the population was able to access free-at-the-point-of-care health services financed by government funds. While the care of older people with long-term nursing needs was assigned to the NHS and implemented on geriatric wards and in NHS NuHs, local authorities funded the building of purpose-built RHs for older people who did not require medical care (Johnson, Rolph & Smith, 2010). However, there were two difficulties associated with the LTC of older people – the risk of institutionalisation, and inappropriate categorisation of need:

Institutionalisation: Despite the move away from the workhouse system, some residential institutes for dependent older people and children in need, and asylums for people with mental health illnesses, remained problematic. From the 1950s onwards, a number of influential academics and researchers turned their attention to institutional living (Bowlby, 1951; Barton, 1959; Goffman, 1961; Polsky, 1962; Townsend 1962; Abel-Smith, 1964), exposing the depersonalisation of residents living in these establishments, and depicting life in institutions as driven by organisational efficiency, rather than resident choice. They instigated a movement towards deinstitutionalisation, and to the generation of policies that promoted community and home-based health and social care options. In addition, the movement provided evidence to support the development of more personalised care for those that did require residential placements (Watson, 2010).

Although the anti-institutional movement was a constructive force in that it contributed to the initiation of home-based and community care options, and improvements in institutional care itself, not all outcomes were positive. According to Stanley and Reed (1999), descriptions of life in institutions by writers such as Bowlby, Goffman and Polsky have tarnished perceptions of all residential institutions, regardless of population, setting, or approach to care. Tobin and Lieberman (1976) proposes that the poor reputation of institutional care led to the perception that RH care practices reinforced, if not caused, residents' dependency and low quality of life, when in fact, these problems were often already present prior to entry to the home.

Categorisation of need: The categorisation of older people into 'those in need' and 'those in need of healthcare' was (and continues to be) problematic. Townsend (1962) comments:

This distinction proved to be an uneasy one. Throughout the post-war years, welfare authorities have complained that they have been unable to get some aged sick persons into hospital, and hospital authorities, in their turn, have complained that some persons occupying chronic sick beds should be in residential homes (p.33).

Concern regarding the categorisation of service-users was expressed by a number of health professionals and researchers during the 1970s and early 1980s (for example, Godlove & Mann, 1979; MacDonald et al., 1982), who observed that placement decisions were based on economic factors rather than care needs assessments. These authors suggested that people with complex needs were being placed inappropriately in RH care rather than healthcare facilities in order to conserve NHS funds. Their solution was to increase the numbers of local authority-funded NuHs that, 'combine medical and nursing

care with the emphasis on privacy, comfort, individuality and dignity' (Godlove & Mann, 1979, p.419).

However, it was the private sector, rather than local authorities that ultimately undertook this proposal. Due to the weakening economy of the 1970s, financial constraints compelled local authorities to curb the building of RHs, and transfer responsibility to central government for overseeing the funding of social care. Simultaneously, there was a significant reduction in NHS long-stay beds. New government benefit legislation meant that older people with low incomes were able to claim benefits that could be used to contribute towards the cost of their care (Johnson, Rolph & Smith, 2010). The availability of this government funding, together with the reduction in local authority RH building projects and NHS geriatric care, attracted business from private companies, and development of the sector boomed. Since 1970, the number of nursing care placements has increased by 573%, and the number of care-only placements has increased by 58% (Higgs & Victor, 1993; Office of National Statistics, 2014). It is estimated that, currently, there are 6,300 CHs providing services for older people in England. Of these, approximately 2,200 are NuHs (NMDS-SC, 2014a). 89% of NuHs are owned and administered by the private sector, while the voluntary sector and local authorities manage the remaining 11% (Laing & Buisson, 2014). Around a third of CHs are owned by large national companies (owning 30 or more homes each), while two thirds are owned by companies with small or solo portfolios (Carehome.co.uk, 2012).

In recent years, the sustainability of the NHS has been questioned as pressures on NHS services have intensified, and the costs of social care have increased. Simultaneously, there has been a drive towards person-centred care for older people (for example, Department of Health (DH), 2010a). As a result governments have introduced a range of social care/NHS integrated services for older people with the aims of preventing hospital re-admissions, expediting discharges from acute services, and reducing precipitous permanent admissions to RHs and NuHs (National Audit Office, 2013; Care Act 2014; DH, 2014). The recent Care Act 2014 underlines the drive towards person-centredness and efficiency by legislating for integrated services between health and social care providers. Martin, Hewitt, Faulkner and Parker (2007) argue that this move has had a profound effect on the nature of NuH services. According to their survey of 106 Primary Care Trusts, 15% of these services are commissioned temporary NuH care places, in which NuHs provide intermediate rehabilitation and post-operative care for older patients. Liffé and Bourne's (2013) summary of recent NHS policy suggests that this trend will continue:

The NHS is likely to have a significant part of its community health services (and some hospital services) provided or managed by the private sector...governments [are] encouraging NHS Trusts to become franchise-like organisations (p.92).

Nevertheless, NuHs continue to primarily provide LTNC for older people, and it is the long-term NuH environment on which this study will focus.

1.5.2 The nursing home population

There are approximately 291,000 older people residing in 6,300 CHs in England, representing 3.2% of the older population (Office of National Statistics, 2014). Of these residents, 103,000 live in NuHs (NMDS-SC, 2014a). Moore and Hanratty's (2013) review of available data regarding CH residents reports that there is no national data about NuH residents' health status. However, a few cohort studies provide some information. Bowman, Whistler and Ellerby's (2004) census of 16,043 residents in 244 CHs included 183 NuHs in the sample. The study states that 90% of admissions are driven by medical morbidity and sensory impairments, and associated disability, rather than frailty, housing issues, or social isolation. The study also found that 78% of residents have at least one mental impairment. Gordon, Franklin, Bradshaw, Logan and Elliott's (2014) survey of the health status of 227 residents in 11 CHs included five NuHs in the sample. This study reports that the mean number of morbidities for NuH residents is 5.5, and 75% of residents have some level of cognitive impairment. Gordon et al. (2014) conclude that 'multi-morbidity is a defining feature' of this population (p.101).

48% of the NuH population self-fund their personal care costs (Institute of Public Care (IPC), 2010). An individual's funding arrangement is dependent upon the results of health/personal/social needs assessments and a financial assessment. The impact these assessments have on the requirement to self-fund has led to much debate. Healthcare in England is provided free-at-the-point-of-care by the NHS, and older people who require long-term residential 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 (DH, 2012a). 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 RN, receive a joint package of care, where 'health needs' are funded by the NHS via direct payments to NuHs, but individuals undergo means testing (assessment of financial resources) to establish private and social services' contributions to the cost of personal care needs. 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) review of the

eligibility criteria for NHS continuing care funding in relation to benchmark court cases, suggests that this is because health, social and personal assessments of need lie at the confluence of these sectors, so that need is difficult to conclusively define. As a consequence, payment of care often depends upon how need is conceptualised and evaluated by the subjective appraisal of assessors, rather than solely as the result of objective measurement.

1.5.3 The nursing home nurse workforce

Although effective health and social service commissioning and planning requires accurate information about the entire nursing workforce, establishing an overview of the older persons' NuH nurse workforce is difficult. The Royal College of Nursing (RCN) (2009; 2014) states that the dimensions of non-NHS registered nurse labour markets cannot accurately be obtained due to the scarcity and disparity of source information, and because Nursing and Midwifery Council (NMC) registration data does not include employment data. However, since the mid-2000s, the National Minimum Dataset for Social Care (NMDS-SC)¹ has collated and integrated some data about registered nurses within its social care sector surveys.

NMDS-SC reports on workforce structure estimate that 18,000 RNs work in NuHs for older people in England on a directly employed basis (NMDS-SC, 2014b). The NMDS-SC (2014c) also states that many RNs are employed by more than one service provider on temporary, bank or agency bases. As a result, there is a high risk of inaccuracy within the statistical analysis, and vacancy rates are difficult to determine. The following table utilises current NMDS-SC reports to summarise and contextualise the demographic configuration of NuH nurses.

¹ It should be noted that a substantial minority of social care providers are not enrolled with the NMDS-SC. Their data is therefore not represented. Nevertheless, the NMDS-SC claims that sufficient data is available to enable statistically valid inferences.

Table 1.1: Demographic configuration of the NuH workforce

	NuH Nurse Workforce	Comparative Figures
	NuH nurse workforce (NMDS-SC, 2014d)	Total nurse workforce (NMC, 2009)
Gender: female	86%	89%
male	12%	11%
unknown	2%	
Median age	NuH nurse workforce (NMDS-SC, 2014e) 47 years	Total nurse workforce (RCN, 2010a) 42 years
Non-UK born	NuH nurse workforce (NMDS-SC, 2014f) 43%	NHS nurse workforce (HSCIC, 2014) 14%
Turnover rate	NuH nurse workforce (NMDS-SC, 2014g) 33%	NHS nurse workforce (Mackinnon Partnership, 2009) 7%

1.5.4 Summary and aims

The primary purpose of the majority of NuHs for older people is the LTNC of residents. This study therefore focuses specifically on NuH nurses providing this type of care. These settings are populated by residents assessed as having complex nursing needs, but as well as health assessments, these residents have undergone means-testing of their assets to determine whether, and what, they are required to contribute towards the cost of their care. The turnover rate of RNs employed in this environment is high (table 1.1) suggesting that working as a NuH nurse may be an unappealing prospect, and NuH nursing may be viewed by RNs as a transitory role.

Although an in depth explanation of how the study's aims were developed is presented in 2.6, it is useful to state them at this stage in order to clarify the focus of the study:

- To explore the experiences and views of NuH nurses working with older people regarding their status and role.
- To generate an understanding of how and why these experiences and views occur.
- To explore whether emerging insights regarding NuH nursing can inform workforce development processes.

1.6 Structure of the thesis

I have already indicated that my experiences as a NuH nurse provided a context, rationale and incentive to undertake this study (1.3). In addition, the background information presented in 1.5 locates NuHs in historical and current contexts. However, contextual knowledge is also gained by a review of relevant literature that forms the theoretical background of the study, and to which I will add through answering my research question. Thus a literature review is presented in chapter 2.

Chapter 3 gives a detailed account of the chosen research methodology and methods. The study adopts the approach of hermeneutic phenomenology that includes aspects of reception theory. The research design, which utilises episodic and multiple interview techniques is presented, and methodological challenges, and issues concerning validity are explored.

The research process is described in chapter 4. Here, an explanation of how data were collected, analysed and interpreted is provided.

In chapters 5 and 6, the interpretation of the data is presented. Findings arising from the initial interpretation are portrayed in chapter 5. The chapter begins with short descriptions of the participating NuHs and brief introductions to the participants. However, most of the chapter consists of a presentation of the unifying categories resulting from the comparison of participants' responses. Chapter 6 focuses on an in-depth interpretation, in which the study's themes are presented within the context of the wider health and social care world. This interpretation addresses the study's aims to explore the experiences and views of NuH nurses regarding role and status, and to generate understanding of how and why these experiences and views occur.

The final chapter 7, addresses the study's aim to explore whether emerging insights can inform workforce development processes. This chapter discusses the study's implications and original contribution to knowledge. The chapter concludes with a discussion of the study's limitations and areas for further research.

2 Literature Review

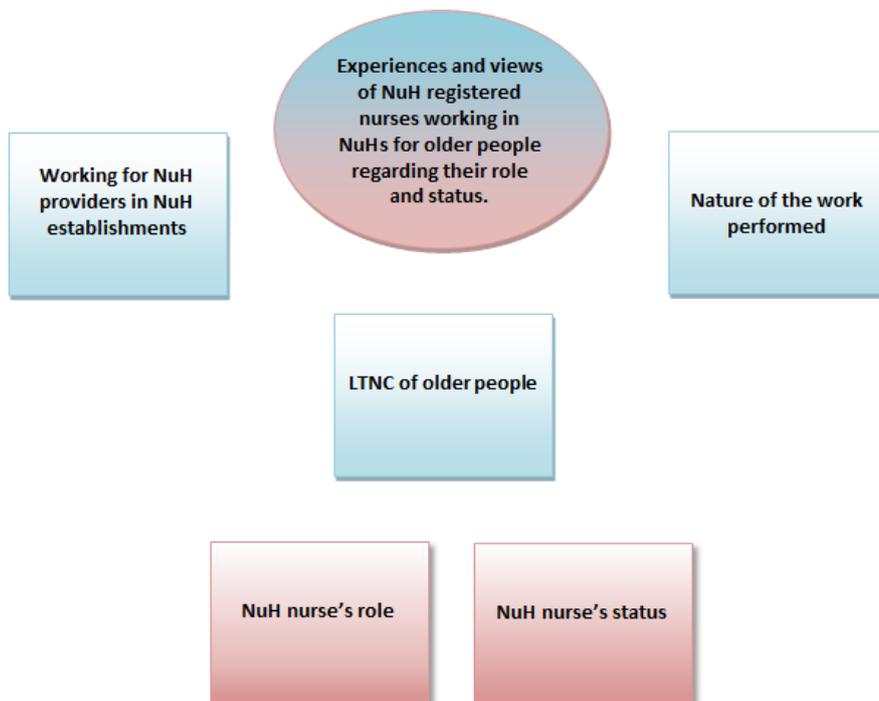
In this chapter the literature about the role and status of NuH nurses is reviewed. Explaining the theoretical context via a literature review serves two purposes. Firstly the review locates the thesis within a contextual time frame, and provides a ‘snapshot’ of NuH nursing at the present moment. In addition, the literature review offers an account of what is already known about NuH nursing, how this knowledge has developed, and whether, and what gaps in knowledge exist.

The analysis of the literature identified four key areas: definitions of occupational role and status, attitudes to the LTNC of older people, perceptions of NuHs, and the NuH nurse’s role. Prior to the literature review, an overview of the search strategy is presented.

2.1 Literature search strategy

In order to arrive at a comprehensive understanding of the theoretical context that relates specifically to the research topic, it is necessary to ensure that the primary facets of the topic are included within the literature search. This study focused upon the role and status of NuH nurses working with older people. NuH nursing involves three aspects of work: working for NuH providers in NuH establishments, LTNC of older people, and performing nursing care on a day-to-day basis. In addition, role and status are topics in their own right. All of these aspects had to be included in the literature search (figure 2.1).

Figure 2.1: Key aspects of the topic



The literature search strategy was therefore designed to ensure the primary aspects were explored. In this study, a six step process was undertaken. Firstly, health-related bibliographic databases were searched using keywords and keyword combinations. When selecting keywords, it was essential to include alternative terms for each concept in order to reduce the risk of omitting relevant literature. For example, some countries and regions refer to 'NuHs' as 'care homes', and, as NuHs are residential settings, the terms 'residential homes' and 'residential care' were included. In addition, because NuHs provide long-term, chronic care services, and services for people with multi-morbidities, the terms 'long-term care', 'chronic care', 'co-morbidities' and 'multi-morbidities' were incorporated into the search. Searches were carried out on the following databases for the period 2000 (i.e. from the introduction of the Care Standards Act 2000 – legislation regarding the regulation of care settings) to the present:

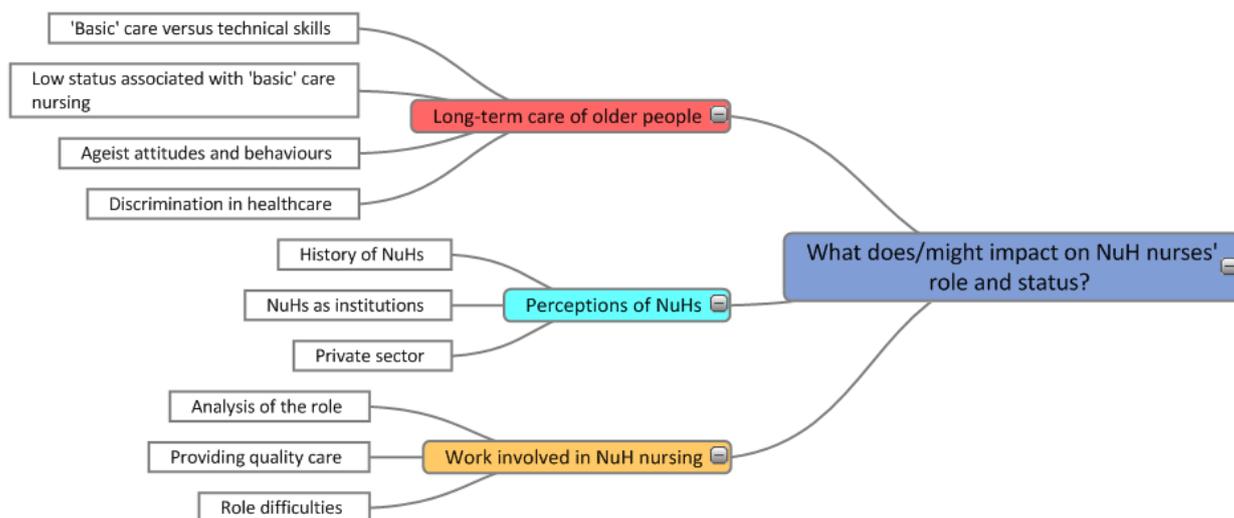
- ASSIA
- CINAHL
- Cochrane Library
- Proquest
- Science Direct
- Swetswise
- Web of Science

Electronic 'alerts' and 'feeds' were set up using the keywords 'NuHs, care homes, residential homes, residential care, long-term care, chronic care, co-morbidities, multi-morbidities', 'occupational role, occupational status, role stigma', and 'care of older people, elderly care'. These provided notification of relevant new studies. During this first stage of the search strategy, 463 studies were identified. The second stage of the process was the sifting stage. As the results of the initial search included a number of 'false hits', these were sifted out. Only items that were specifically related to 'NuH nurses for older people's role', and 'NuH nurses for older people's status' were selected at this stage of the process. These items were retrieved and reviewed. Thirdly, further references were harvested from the original selection, and relevant items were retrieved and read. Fourthly, searches were performed to identify relevant reports, for example, government reports, statistical reports and voluntary sector reports. It is important to note that the vast majority of retrieved studies were located in Western, post-industrial countries, in particular, Australia, USA, and Western Europe. As such, the literature review may not reflect the situations of non-Western countries. However, as the current study is located and contextualised within the Western world, these studies are highly relevant.

The fifth step involved synthesising the selected literature into themes. This was achieved by a mapping process, which involved charting the research geography of the topic under review. Hart (1998) proposes that mapping is a useful activity because it assists researchers to attain declarative knowledge (familiarity with key concepts, theories, and methods related to the topic), but it also promotes the development of procedural knowledge (knowledge about how concepts and theories are developed, and how they relate to one another). As procedural knowledge is about the relationships between the different aspects that make up research topics, it enables researchers to structure declarative knowledge in specific ways so that their specific questions can be addressed. In this way, researchers are able to create new insights and interpretations from the existing knowledge base. In effect, mapping in order to develop procedural knowledge opens up a 'dialogue' between the researcher and the existing data which furthers researchers' understandings of topics in relation to their own studies. In addition, mapping allows researchers to develop relevant frames of reference and locate their studies within these frames of reference ². In this study, I commenced by 'asking' the literature collected, 'What does, or might, impact on NuH nurses' role and status?' I then utilised *Mindgenius* mapping software to organise and file the literature according to answering themes, and to how each answering theme linked and related to other themes (figure 2.2). By undertaking this process, I was able to create a frame of reference relevant to my specific topic/question, thus locating the study within the wider literature concerning the field of NuH nursing.

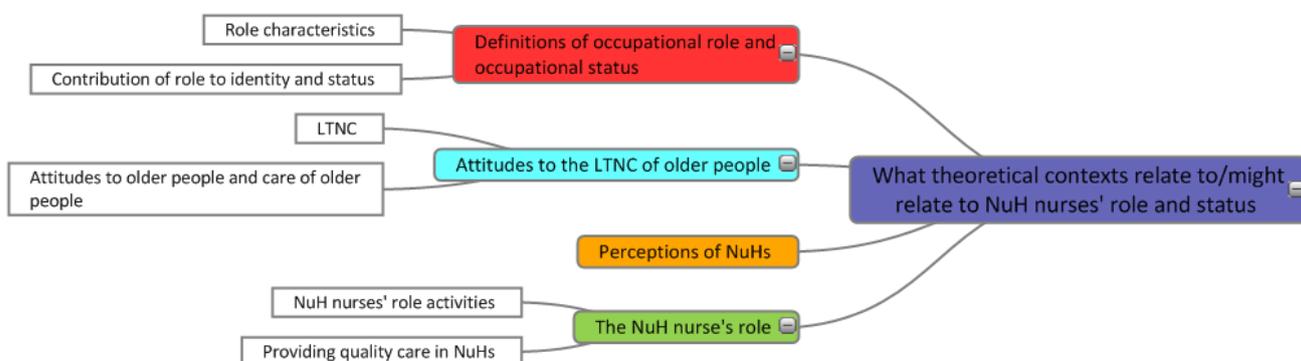
² The idea of holding a 'dialogue' with texts in order to develop understanding is proposed by Gadamer (1976; 1979; 1980). This is discussed in detail in chapter 3, as Gadamer's hermeneutic phenomenology forms the basis of the research methodology utilised in this study.

Figure 2.2: Snapshot of mindmap home page illustrating key themes extracted from literature retrieved in stages 1 to 5.



The synthesis of the literature led to a further search for items related to the key themes. Various sources, such as library catalogues, electronic databases and government archives were searched. At this stage, a theme regarding the definition of occupational role and status was added. Literature underpinning this theme supported my understanding of factors that define and influence perceptions of occupational role and status, which led to a further sifting of the literature regarding NuH nursing, and a re-appraisal of what literature was relevant to the question, 'What does, or might, impact on NuH nurses' role and status?' This final step in the search process modified the map themes (figure 2.3). The revised map illustrates the main four themes and sub-themes that emerged from the synthesis of all the selected literature. A discussion of these themes is presented in the following sections of the chapter.

Figure 2.3: Literature review themes



2.2 Definitions of occupational role and occupational status

A number of studies attempt to define the concepts of occupational role and status. These can be divided into two interrelated groups. The first group considers the characteristics inherent within occupational role, and the expectations regarding the performance of these characteristics against which actual performance is compared and assessed. The second group considers the contribution of occupational role to identity and status.

2.2.1 Role characteristics

Hackman and colleagues' seminal research, performed in the 1970s, investigated the effect of role characteristics on employees' attitudes and behaviours at work (for example, Hackman & Lawler, 1971; Hackman & Oldham, 1975). Quantitative correlational studies using self-administered questionnaires were carried out across heterogeneous jobs in a number of organisations. Findings led to the development, and validation, of the role characteristic model (Hackman & Oldham, 1980), which has since been utilised in a number of other quantitative studies performed in a variety of different work settings throughout the USA, Europe and Asia (Thakor & Joshi, 2005; Devaro, Li, & Brookshire, 2007; Nurita, Abd, & Saeed, 2010). The model supposes that job satisfaction results from individuals' abilities to perform the work characteristics which they perceive to be intrinsic to their role. The performance of expected characteristics associated with any role (for example, skill variety, role complexity or significant tasks) increases job satisfaction because there is a link between expectations regarding role and feelings of personal meaningfulness. When the actuality of the role does not equate with expectations, then job satisfaction is diminished and feelings of anxiety and disarray occur. It should be noted that these studies are primarily dependent upon self-administered questionnaires for data.³ This allowed researchers to reach large numbers of participants across a range of sites, thus enhancing generalisability of findings. However, little opportunity was afforded to participants to elaborate on, or clarify, responses, or for researchers to probe further, or consider participants' personal contexts in which responses were formulated.

Judge, Bono and Locke's quantitative study (2000) focused specifically on the concept of skill complexity. These authors define complexity as the level of variation, magnitude and challenge involved in a role. The study, which investigated the influence of personality on job satisfaction, hypothesised that role complexity is a mediating factor. The study involved two phases. Phase one utilised a postal survey to obtain data regarding respondents' job details and personality traits. A 22% response rate from 2,000 questionnaires distributed in

³ Hackman and Lawler (1971) interviewed and observed staff to arrive at job descriptions, but used questionnaires to determine the relationship between job characteristics and attitudes to work.

one American city was achieved. Phase two analysed data from a 30 year longitudinal study of personality traits commenced in the 1920s at Berkeley University. The study concluded that complexity of tasks involved in an occupational role strongly correlates with job satisfaction. The researchers suggested that this is because complex roles are more likely to require and encourage skill improvement, interest and innovation, aspects which promote feelings of fulfilment and positive self-concept. A potential weakness of this study is ambiguity with regards to the definition of the variables involved. The authors' measurement of role complexity is based upon independent assessments of job descriptions and job observations, rather than on workers' own perceptions. This opens up the possibility that an observer's perception of variation, magnitude and challenge may not correspond with that of a worker. In other words, to an observer, a role may appear to be complex, but to the worker, it may appear routine and straightforward, and vice versa.

2.2.2 Contribution of role to identity and status

While the above studies address how the characteristics inherent within a role impact on how role is perceived by workers themselves, they do not explain how occupational role becomes part of a worker's identity. Literature that explores role identification proposes that occupational role is a significant aspect of self-definition. For example, Pratt (1998) theorises that the perceptual construction of the self incorporates occupational role, so that role becomes part of how the individual conceives and defines the self. However, other theorists, building upon research which explores the influence of employing organisations on role identity, emphasise that occupational role is a means of social, as well as personal, definition and identification (for example Tajfel & Turner, 1986; Mael & Ashforth, 1995; Hogg & Terry, 2000; Van Knippenberg & Sleebó, 2006). In Van Knippenberg and Sleebó's (2006) quantitative study, 133 employees of a Dutch university completed an organisational identification scale questionnaire. The study found that occupational role is not unique to the individual, but brings with it social identity, in that it generates membership of a group (an occupational group and/or an organisation). Thus, occupational role implies that the self is similar to other group members, and group characteristics can be assigned to the self. This process of self-identification with a group reflects what Van Knippenberg and Sleebó (2006) describe as 'psychological oneness' (p. 572) – a state of being that leads to a sense of belonging, and a strong sense of self-definition. Mael and Ashforth's (1995) large quantitative study used a questionnaire to explore the correlation between biography, organisational identity and attrition. 2,535 American army recruits from active duty, reservist corps and the National Guard participated in the study. Findings suggested that when identification with the group is strong, group values and interests become incorporated into those of the self so that the collective-definition strengthens self-definition with regard to role. In these circumstances,

individuals are likely to remain within the group. When identification with the group is weak or uncertain, individuals struggle to define themselves in relation to the group, and as a result, the risk of attrition increases. However, these studies do not investigate fully whether group occupational identity is more about identifying with the employing organisation or with the occupational role, or what the implications of this might be. For example, in Mael and Ashforth's (1995) study, because of lack of clarity with regard to variables, it is not entirely clear whether participants' feelings of group identity stem from being part of the US army, or from being soldiers, or a combination of both.

Some people, however, despite strong group affiliation, nevertheless choose to leave their occupational group because they aspire to join a different group. In other words, the above studies do not consider that society includes numerous occupational groups, some of which are perceived as higher status than others, and may therefore entice individuals away from their original occupations. Another area of inquiry investigates occupational status. These studies acknowledge that occupations have relative positions within wider social contexts. The latter half of the twentieth century witnessed much debate regarding the definition and constituents of occupational status (for example, Hughes, 1951; 1958; Weber, 1968; Goode, 1978; Ashforth & Kreiner, 1999; Zhou, 2005; Kreiner, Ashforth, & Sluss, 2006; Ashforth, Kreiner, Clark, & Fugate, 2007). According to Weber's (1968) sociological treatise *Economy and Society*, social status is defined as a ranking of groups according to their perceived significance within a cultural context. Goode (1978) and Zhou (2005) hypothesise that the concept of occupational status is embedded within a state of cultural consensus, whereby the consensual acceptance of occupational rank by all groups within the social framework under review, results in a validated status system.

Goode (1978), in his analysis of prestige processes in societies, explains that occupational status is not simply about social contracts and exchanges that rank individuals or groups within specific occupations or organisations (for example status acquired via position or promotion within a single occupation or organisation), but it considers and compares all occupations. Third parties outside the social transaction must accept the ranking system if it is to be recognised and validated. Goode (1978) describes occupational status as 'not dyadic, but triadic. It is the outcome of interaction between one person, another, and significant third parties' (p.18). Zhou's (2005) quantitative analysis of a number of American occupational ranking reports attempted to identify and explain variations in occupational prestige classifications. According to Zhou (2005), occupational status is given credence by the acceptance and consensus of individuals who may exist outside the occupations under consideration, but are located within the shared social setting. Zhou (2005) describes this process as 'differentiation and incorporation' (p. 94), whereby

occupations are separated from one another according to the characteristics of each. These characteristics are interpreted and judged by the wider social group which incorporates these judgements into a value system. The result is an occupational hierarchy.

Researchers that study occupational status are not in agreement about which occupational attributes affect status. Zhou's (2005) study proposes that two types of occupational prestige exist – authority-based and knowledge-based. The level of authority-based occupational status depends upon an individual's authority-relationship with others within society. Zhou (2005) acknowledges that authority does not always lend itself to status, however, because authority figures are often required to manage social conflicts and tensions, which can destabilise their standing (for example, politicians and police).

For Zhou (2005), knowledge-based status depends upon the possession of knowledge, skills and qualifications (for example, academics, doctors, lawyers). However, according to Bourdieu and colleagues' social analyses of education and culture (for example, Bourdieu & Passera, 1977; Bourdieu, 1986), skills and qualifications only elevate status if they are formally recognised by the dominant socioculture as 'cultural capital'. The dominant socioculture is defined by Gramsci (2000) as a hegemony in which the predominant class within society attains consent to its predominance by the entire society. The predominant class achieves this by influencing and manipulating the value systems of society, so that its view becomes the world view. Laclau and Mouffe (2001) and Bourdieu (1977; 1990) propose that dominance does not just relate to class systems. Laclau and Mouffe (2001) suggest that hegemony is achieved when any particular social group is assumed to represent the total population. Bourdieu's (1977; 1990) concept of 'doxa' indicates a process whereby perceptions and evaluations that are socially or culturally structured become accepted and internalised as the norm or 'natural' (1977, p.164). Bourdieu (1986) describes cultural capital as knowledge and skills acquired by pedagogy within a dominant sociocultural context. Cultural capital is 'institutionalised' via formal qualifications, which become, 'a certificate of cultural competence which confers on its holder a conventional, constant, legally guaranteed value with respect to culture' (Bourdieu, 1986, p.50). These qualifications, because they arise from, and then become entrenched within, the fabric of the socioculture, are imbued with intrinsic value that has little to do with the quality of the educational content which they represent (Bourdieu & Passeron, 1977). Access to, and attainment of, these qualifications contributes towards increasing an individual's cultural capital, which elevates their social status and secures a 'place' within the dominant socioculture. Qualifications that do not originate from the

beliefs and tenets of the dominant group, however, hold no intrinsic worth, so despite any content worth, they are not valued by the dominant socioculture, and are therefore not endorsed.

The above studies suggest that authority and recognised knowledge-bases lead to high occupational status. However, it could be argued that the standing of occupations such as, lawyers, journalists, bankers and executives – occupations which have authority and/or knowledge-bases - can be undermined because often the public has an aversion to these groups. Hughes' (1951; 1958) seminal essays that discuss the sociology of work acknowledge the effects of aversion and attempt to explain why aversion occurs. He proposes that occupational status is affected by the nature of work activities. He suggests that one factor which reduces status is 'dirty work': activities or occupations that society perceives as repulsive, demeaning or corrupting. Hughes (1958) argues that work is 'dirty' if it is 'physically, socially or morally tainted' (p.122), although he leaves it to later researchers, most notably Ashforth and colleagues, to expand upon his definition. Ashforth and colleagues' extensive research and theorising has led to the development of criteria for the three types of taint (for example, Ashforth & Kreiner, 1999; 2002; Ashforth et al., 2007). These criteria are perhaps the most widely used framework for exploring the nature of stigmatised work and the construction of work identities:

Physical taint occurs where an occupation is either directly associated with garbage, death, effluent, and so on, or it is thought to be 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 generally regarded as somewhat sinful or of dubious virtue, or where the worker is thought to employ methods that are deceptive, intrusive, confrontational, or that otherwise defy norms of civility (Ashforth & Kreiner, 1999, p.415).

Aspects of the definition, and its generalisability could be contested. For example, performing work in dangerous conditions, or working with stigmatised groups, could be perceived 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). In addition, these studies do not appear to acknowledge that differences in social contexts may influence perceptions of what constitutes 'dirt'. For example, different countries or regions may have different views, or social contexts may change over time. A further criticism of these theories is that they do not acknowledge that social identity constructs associated with gender, ethnicity or migration may influence perceptions of occupational status.

Others studies do consider such social identity constructs. For example, Jervis (2001) investigated whether personal care and personal domestic work is associated with workers' status. The author conducted ethnographic observations of care and domestic workers, and their interactions with service users, then interviewed 16 workers and 14 service users. The study suggests that care and domestic work conforms to traditional ideas about femininity and masculinity and that, care, service, and domestic work have been customarily associated with the 'feminine' disposition perceived by society to be embodied in women. Jervis (2001) suggests that, because women have traditionally held a lower gender status, then care, service and domestic roles have likewise been perceived as low occupational status roles. Huppatz' (2010) study utilised in depth interviews with 39 female nurses and social workers. This investigation of gendered and classed practices in paid caring work proposes that esteem and respect for these roles is limited because they are 'feminised' roles. However, Gregg and Wadsworth's (2003) analysis of the impact of economic conditions on work trends, and attitudes to work, argues that economic changes that have occurred in the Western world over the last 30 years have revised this traditional norm. These authors suggest that de-industrialisation in the 1980s and 1990s in parts of Europe resulted in men moving into care and service roles that were previously considered 'feminised' and thus avoided as incongruent with masculinity. 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 a positive impact on occupational status.

Gender/work issues are further complicated by social identities associated with ethnicity and nationality. Anderson's (2000) studies and theories of domestic labour points out that migrant men, and men from ethnic minorities, are often employed in institutional domestic work and care work. Anderson (2000) argues that as such, gender/work status is therefore challenged by citizenship and ethnicity. Espiritu (2005) (see also Boyd & Grieco, 2003; Tacoli, 1999) carried out in depth interviews with 100 Philippino workers, including female nurses living in the USA. The study suggests that the migration of women workers results in their transition to becoming the 'breadwinners' for their families. In some cases, it may transpire that men are unwilling to take on household duties, meaning women are subjected to the 'double burden' of being responsible for both productive (paid) and reproductive (unpaid work). For others, this transition to 'breadwinner' can cause a reversal of traditional gendered family roles, and lead to men shouldering the traditional 'feminised' household or reproductive roles, as women are transformed into the 'masculine' role of providing economic support. The author suggests that, in the latter cases, nurses' enhancement of status within the family and community

can have the effect of them perceiving their paid care work as gender neutral or even masculine.

As stated above, ethnicity and migrancy have an association with occupational status. Skeggs' (2004) work, which explores the influence of work role on self-perceptions of class and culture, notes that migrant workers and ethnic minorities often take up jobs that indigenous workers find undesirable (for example, domestic, care or service work). Skeggs (2004) suggests that the association of migrant workers with undesirable jobs is a cyclical association i.e. low status undesirable jobs are delegated to migrant workers, then because these roles are associated with high rates of migrant employment, the low status of the roles is reinforced. Lee-Treweek's (2010) study, which utilised semi-structured interviews to explore the experiences of 25 Polish economic migrants, proposes that, paradoxically, despite the unattractiveness of these jobs, the status of migrant workers is affected when societies' views are influenced by economic anxieties i.e when uncertain or anxious about the state of the economy, societies may view the employment of migrants as immoral, because of the perception that migrants are taking away jobs from indigenous workers.

Some research investigates how having low occupational status influences attitudes, behaviours and self-esteem. Ashforth and Kreiner's (1999) literature review of the impact of 'dirty work' on occupational status and occupational identity found that employees engaged in 'dirty work' exercise ideological techniques to moderate the impact of social perceptions of 'dirt', and thus preserve self-esteem. According to these authors, 'refocusing', 'neutralising' and 'aggrandising' strategies negate negative work attributes or create positive attributes. 'Refocusing' involves ignoring properties of work that are likely to be stigmatised, or transferring attention away from the stigmatising aspects of work towards acceptable aspects. If an entire occupation is considered 'dirty', then refocusing may involve shifting focus away from the occupation itself towards advantageous extrinsic elements such as salary and working conditions. 'Neutralising' is a technique whereby the objectionable facets of an occupation are negated by denial strategies. In general, this technique is used to cope with morally tainted aspects of occupations which are perceived to be exploitative or injurious. 'dirty workers' commonly neutralise the 'dirty' aspects of their job by denying involvement in, or denying responsibility for, these aspects. 'Aggrandising' involves assigning importance to role, in order to retain self-esteem. Hippel et al.'s (2005) Australian/American study tested the hypothesis that people cope with the stereotype threat of low status through denial. The study involved four phases utilising quantitative questionnaires. Phase one tested the hypothesis in relation to occupational status. During phase one, responses of 114 Australian temporary workers threatened by a stereotype of

incompetence and low occupational status were ascertained. A significant number of participants managed the stereotype by denying that the aspects of work perceived as low status were relevant to themselves. As a result, they were able to maintain self-esteem and confidence.

Other research acknowledges that having low occupational status influences attitudes and behaviours, but proposes that workers respond with poor self-esteem and reduced confidence, rather than with moderation strategies. For example, Elsbach's (2000) study utilised interviews to explore the experiences and views of Californian legislative staff. After the publication of an opinion poll that highlighted the public's extensive dissatisfaction with, and devaluing of, local politics and legislature, staff disidentified with their role by leaving, or they accepted their low status position, which led to poor self and collective esteem, and reduced confidence in their skills.

At first sight these two sets of literature are contradictory in that the first set found that low occupational status leads to the utilisation of strategies to maintain esteem and confidence, while the second set found that having low occupational status leads to low confidence, underperformance and reduced self-esteem. Kreiner et al.'s (2006) study of identity dynamics in 'dirty work' attempts to explain this apparent contradiction. This study integrated theories of hegemony with social identity theory – an integration which led to the development of a series of propositions about how low occupational status groups react to their status position. One proposition is that people may be ambivalent about their own status in that they both internalise the pervasive societal view, yet because they are associated with that role, they also defend the role. This leads to the contradictory behaviours of having reduced self-esteem *and* using defensive tactics such as denial and aggrandising. To-date few studies have tested this hypothesis.

2.2.3 Summary

It appears that a number of factors influence perceptions of occupational role. Strong generalisable evidence suggests that for workers, being able to match their work to their expectations of what work entails increases job satisfaction. Some studies suggest work should be complex enough to maintain interest, although defining what actually constitutes complexity is problematic. Workers identify themselves by their role, and role contributes to feelings of affiliation and belonging, but it is unclear whether this belonging arises from organisational or occupational association. Furthermore, role is a means of locating workers within the wider social context. This latter point is important as it highlights that role is not just about how the self is perceived by the self, but also about how the self is perceived by others – i.e. occupational role is linked to occupational status, and so is to

some extent, a social construct. The literature suggests that a number of occupational attributes influence role perception and status - for example the level of authority associated with the role, the knowledge-base of the worker, or whether role involves 'dirty' activities. However, some of these proposed influences are flawed in that a number of exceptions to the rule can be identified. For instance, status acquired by authority or knowledge may be counter-acted by 'dirty work' (a journalist's knowledge-based status may be disregarded because of the moral 'dirt' associated with tabloid reporting), or physical 'dirt' associated with dangerous and noxious working environments may increase status if it lends altruism or heroism to the role (fire service personnel). A further flaw in these theories is that they do not acknowledge that social identity constructs associated with gender, ethnicity or migration may influence perceptions of occupational status. But literature that investigates these issues is itself contradictory. Some studies conclude that traditional ideas of 'femininity' with regard to certain occupational roles lead to lower status, while other studies suggest that gender status can be undermined by ethnicity/migrancy status, or complicated by the economic state of nations and societies. It is not therefore possible to arrive at a full explanation of status, or what influences perceptions of this phenomenon. Explanations seem to differ depending upon individual occupations, or differences in social contexts. Also, it is unclear how low status due to stereotyping affects behaviour. There is a suggestion that stereotype threat leads to contradictory and ambivalent behaviour, but this is based upon theoretical proposition rather than research evidence.

The literature reviewed thus far attempts to define and explain occupational role and status but it does not relate specifically to NuH nursing. However, it raised a number of issues that now need to be investigated further by examining literature concerning NuHs and NuH nursing. The next step of the review was to initiate a dialogue with the literature that specifically relates to the role and status of the NuH nurse in order to delineate the meanings, antecedents and consequences of role and status for NuH nursing. As already stated in 2.1, NuH nursing of older people is comprised of three aspects: LTNC of older people, working for NuH providers in NuH establishments, and the nature of the work performed. In the following sections of this chapter, literature regarding these aspects is explored and evaluated in turn, in order to clarify whether they influence the role and status of the NuH nurse, as defined and discussed in 2.2. Firstly, literature regarding attitudes to the LTNC of older people is reviewed.

2.3 Attitudes to the long-term nursing care of older people

The LTNC of older people is a fundamental aspect of, but not exclusive to, NuH nursing, as it may occur on long-term care wards in hospitals, or within the domestic setting, as well as in NuHs. LTNC is defined as the provision of care on a continuing basis to older people with multi-morbidities. It involves the provision of personal and social care, and also a level of healthcare that requires the expertise of RNs to address the complex multi-morbidity conditions of patients (DH, 2012b).

Many studies investigate attitudes to the LTNC of older people. These can be broadly divided into two areas of research: LTNC, and attitudes to older people and caring for older people.

2.3.1 Long-term nursing care

A number of studies consider student nurses' attitudes towards LTNC. For example, Stevens and Crouch's (1998) performed a mixed methods longitudinal study of 610 student nurses from 14 Australian universities. Students completed a questionnaire regarding career preferences, and a sample of participants were then interviewed. The study found that student nurses rate LTNC lowest in their scale of career preferences, primarily because these roles have low occupational status – a status that results from the perception that medical knowledge and clinical and technical skills are not required to any great extent in these settings. In Wade and Skinner's (2001) UK study, 17 student nurses, and the managers and staff from seven NuHs were interviewed regarding student placements in NuH settings. Several students, and all staff reported that the LTNC environment promotes person-centred care. However, many more students felt that LTNC nursing is 'basic', and that NuH 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). Abbey et al.'s study (2006) utilised focus groups to explore the views of student nurses and clinical teachers regarding NuH practice placements. Participants included 14 students and 12 clinical teachers. All participants viewed LTNC as 'basic nursing' (p.16). However, while clinical teachers felt that basic care is integral to the maintenance of patients' skin integrity, nutritional status, and psychological health, students perceived this type of care to be 'inferior' to acute care. This was because they viewed the utilisation of medical, scientific and technical knowledge associated with acute care as 'the core of modern nursing' (p.16-17). Neville, Dickie and Goetz' (2014) literature review regarding nurses' career preferences includes studies from Europe, Australia, the Middle East and Far East. The study shows that gerontology nursing in LTNC is an unpopular career choice because nurses place higher value on the technological interventions linked to acute care, than on other forms of nursing care.

No studies were identified that specifically investigate the views of other healthcare professionals and nurses working in other settings regarding LTNC. However, Reed and Stanley's (2003) UK study, which describes the development and evaluation of a patients' daily living plan designed to facilitate communication between hospitals and NuHs, did explore hospital nurses' ideas about the NuH sector. This action research study involved focus groups and interviews with 37 hospital nurses and 19 NuH staff. The study reported that hospital nurses hold negative views about NuH staff, portraying NuH staff as less trained and less professional than NHS nurses. As the focus of the study was the effectiveness of the daily living plan, issues around occupational status were not discussed. Also, it is unclear whether the negative views of hospital nurses arose because NuH nurses work in LTNC settings or because they work in NuH establishments.

The link between the view of LTNC as 'basic care' and low occupational status can be witnessed when literature concerning the views and behaviours of LTNC nurses themselves is reviewed. For example, Wells, Foreman, Gething and Petralia's (2004) quantitative study utilised a self-administered questionnaire to determine healthcare professionals' attitudes towards working with older adults. The study involved 727 participants, 205 of whom were gerontology nurses working in a variety of settings. The study found that nurses working in LTNC settings such as NuHs perceived themselves to have few skills, which impacted on their confidence and self-esteem, and contributed to work-related stress. Moyle, Skinner, Rowe and Gork's (2003) Australian study of job satisfaction in LTNC environments utilised focus groups with 27 staff, including nine RNs from two LTNC facilities. The majority of RNs in the sample explained that previous to working in LTNC, they had extended periods of absence from nursing, and had thus sought employment in LTNC settings because they perceived these settings to require fewer skills and less knowledge than acute settings. They 'felt that their knowledge levels made them unsafe to go back to acute care' (p.171). In Venturato, Kellett and Windsor's Australian study (2007), 14 NuH nurses were interviewed to explore the tensions between their values of aged care, and politically and socially mediated values of aged care resulting from policy reforms. Some participants were interviewed a second time in order to clarify their accounts. The study reported that NuH nurses themselves believe that professional nursing is synonymous with continuous knowledge development and the practice of medical and technological skills, so do not feel able to return to acute environments because these skills and knowledge had been lost. Raikkonen, Perala and Kahanpaa's (2007) quantitative study utilised a self-administered questionnaire survey of 1,262 staff in 40 LTNC institutions in Finland to investigate staffing adequacy, staff

education and care quality. The study found that staff who have worked in LTNC settings for long periods feel de-skilled and had lower opinions of their own professional status. These studies may illustrate Elsbach's (2000) notion (discussed in 2.2.2) that perceived status of occupation impacts on notions of self-worth and confidence in one's ability.

Many of the studies cited above are qualitative and therefore their individual transferability might be questioned. However, reading these studies together, and in conjunction with relevant quantitative and mixed methods studies, provides cumulative evidence to suggest that within health and social care, LTNC is imbued with lower status than acute care nursing. This is because of the perception that medical and technical skills associated with acute care are highly valued within the socioculture of nursing. This is not a recent idea. A number of studies of nursing history propose that Western healthcare has for centuries been dominated by a medical model, in which life and health were located in the arena of doctors' scientific inquiry and technological practices (for example, Carpenter, 1993 – discussion of professional hierarchies in healthcare; Aggleton & Chalmers, 2000 – review of nursing models; Borsay, 2009 – review of the history of nursing; Harrison, 2010 – discussion of cultural authority in natural history and biology). According to these authors, these practices and knowledge-bases were, and are, highly valued within Western societies, and as a result, the occupational status of the medical profession was heightened. As Bourdieu (1986; discussed in 2.2.2) suggests, occupations enjoy elevated professional status if they involve the possession and utilisation of knowledge-bases that are deemed eminent by the dominant socio-culture.

In the 1970s, nurses in all settings began to undertake research, and develop nursing plans and processes with a view to investigating, rationalising and formalising nursing care. According to Harrison (2010), the prominence of evidence-based and inquiry-based practice advanced the professionalisation of nursing by assigning a degree of authority and intellectual status to the role. However, Harrison (2010) concludes that the primacy of scientific and medical topics meant that nurses were unable to achieve equal status to doctors. Bleakley's (2013) essay about the development of interprofessional care proposes that since the 1990s, a dislocation of medical dominance has occurred, partly because nurses' and other healthcare professionals' knowledge is increasingly accepted as valuable to the holistic, interprofessional care of patients. However, Bleakley's (2010) evidence does not substantiate his theory, in that he states one reason for the dislocation was:

In the 1990s, nurses were able to carry out roles previously exclusive to doctors, such as prescribing, referring patients and ordering tests. Nurses also developed clinical judgement expertise

that augments medical diagnostics (p.26).

Far from demonstrating dislocation, Bleakley reinforces the dominance of the medical profession. Here, nurses' status is increased, not because their knowledge dislocates medical and technical knowledge, but because it emulates it. If the status of nurses is increased by an involvement in medical and technical interventions, then the student nurses' and NuH nurses' views cited above are understandable. These studies propose that in effect, participants view nursing as a split occupation, each faction being defined by the principle tasks performed. Where skills overlap with those of medics, 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 HCAs, are devalued because they are viewed as activities that emanate from 'basic care', rather than scientific inquiry.

Twigg (2000a; 2000b) also proposes that performing 'basic care' reduces occupational status, but her explanation takes a different tack. Twigg's (2000a; 2000b) study, which explores the notion that carework is a form of bodywork, used interviews and focus groups to ascertain the views and experiences of 30 older and/or disabled people, 34 careworkers, and 11 care managers with regard to personal care activities. The study's findings, echoing Ashforth and Kreiner's (1999) theory, suggest that personal care is viewed by society as distasteful, not because of the perception that it requires a low knowledge-base, but because it is physically 'dirty'. This taints the repute and status of occupations that deliver personal care. Twigg (2000a; 2000b) surmises that as a consequence, these activities are delegated away from healthcare professionals to untrained staff, although the evidence presented in the findings sections of these texts in the form of participants' quotes, do not strongly support this supposition. Twigg's work also considers the relationship between personal care and social factors – something that Ashforth and colleagues' work fails to do, as discussed in 2.2.2. For example, Twigg, Wolkowitz, Cohen and Nettleton's (2011) literature review, which investigates paid bodywork, suggests that assumptions about gender and race may influence perceptions of personal care and the occupational status of those hired to undertake it. The review argues that bodywork is a female, or 'racialised' (p.178) activity, although the authors appear unclear about whether the social status of these workers affects the status of personal care occupations, or whether personal care activities diminishes the status of these workers. Although Twigg and colleagues' (Twigg, 2000a; 2000b, Twigg et al., 2011) conclusions are not entirely clear or well evidenced by the data, they nevertheless

suggest some link between occupational status, physically 'dirty work', and the social positioning of the workers involved – an association discussed earlier in 2.2.

The above studies suggest that beliefs about the value of knowledge-bases, and/or physically 'dirty work', influence occupational status. But status is not the only issue that affects the appeal of work. Whether work is enjoyed or is fulfilling has an impact. There is cumulative evidence to suggest that LTNC nursing is unappealing because it is uninteresting. For example, Happell's (1999; 2002) and Happell and Brooker's (2001) mixed methods longitudinal study of 793 student nurses from nine Australian universities utilised questionnaires to ascertain participants' career preferences. Working with older people in LTNC was the least preferred option. The primary reason given was that LTNC is perceived as 'boring and repetitious with insufficient challenge', and lacking in intellectual stimulus (Happell & Brooker, 2001, p.502). Intensive care and theatre nursing were the most popular choices because these areas of practice were considered exciting, challenging, and interesting. Henderson, Xiao, Siegloff, Kelton and Paterson's (2008) study investigated 262 student nurses' intentions for practice, and attitudes towards older patients, at one university. A mixed methods questionnaire was used to determine career preferences, and a scale containing attitude statements about older people determined the propensity towards ageism. Working with older people in LTNC was again the least preferred choice, the main reason being lack of challenge and excitement, and the repetitive nature of the work. Fussell, McInerney and Patterson's (2009) study investigated recruitment and retention of nursing staff in LTNC facilities for older people in Australia. Semi-structured interviews were used to ascertain the views of 11 graduate nurses working on rotation in six facilities. The majority of participants reported they had not chosen these rotation areas, and stated they did not wish to seek permanent employment there at the end of their term of rotation. This was because they felt work in LTNC was repetitive and unstimulating, although some also stated that the lack of medical technology, which they felt led to low status, was also off-putting. These studies offer further insight into the unpopularity of LTNC nursing, in that they suggest the problem may be to do with the perceived complexity of the activities inherent within the role. As discussed in 2.2.1, Judge et al. (2000) proposes that the complexity of tasks (i.e. variation and challenges) involved in a role correlates with job satisfaction. Thus, where nurses and student nurses perceive LTNC 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, or be anxious about the development and maintenance of knowledge and skills.

2.3.2 Attitudes to older people and care of older people

The studies cited in 2.3.1 suggest LTNC of older people is unappealing because of the nature of the work involved. However, some studies propose that negative attitudes towards older patients may also be a factor. For example, Cherry, Ashcraft and Owen's (2007) study used semi-structured interviews to investigate perceptions of job satisfaction of 38 charge nurses and nurse aides in five American NuHs. Although many participants said they were committed to, and enjoyed, working with residents, a few reported an aversion to working with older people, referring to residents as combative, uncooperative and abusive. Happell and Brooker's (2001) study, cited in 2.3.1, found that although LTNC is primarily unpopular because it is viewed as uninteresting, age of patients is an issue to some extent. A few participants stated that they are uncomfortable with, and dislike, older people, who they view as being depressed and slow, and whose physical and mental state is 'off-putting' (p.16). Karlin, Schneider and Pepper's (2002) study utilised a questionnaire to investigate what gerontology nurses think attracts and deters nurses from working in LTNC of older people. Participants consisted of 36 gerontology nurse practitioners from one American state. The study found that the most significant appealing factor was enjoying working with older people. Although a minor deterrent, dislike of working with older people was not reported to be a major factor in swaying career decisions.

Other studies investigate why some healthcare professionals have negative attitudes towards older people. Schwaiger's (2006) review of the theories of ageing argues that the authority and professional stature of medical science endorses 'wellness' and 'cure' as the norm and goal of healthcare, so that decline due to old age is feared. Phelan's (2011) discussion paper regarding nurses' social construction of older people suggests that nurses have bought into the biomedical model of care in recent years and have redefined ageing from a natural, accepted process to the preservation and perpetuation of healthy physical and cognitive functioning. These two authors also propose that the frailty associated with older age has connotations of economic and physical dependency, which lead to the perception that older people are a burden on society. They also argue that nurses perceive older people to have limited years to live, which leads them to question the worth of investing in services and resources for this patient group. The authors propose that these perceptions may result in a devaluing of older people. Phelan (2011) argues that discrimination of older people in healthcare ensues, in that health professionals do not support the implementation of care interventions because they do not perceive older people to be deserving recipients. Higgins, Slater and Peek's (2007) research appears to confirm this theory. This study explored the attitudes of acute care nurses towards the care of older people. Participants were nine nurses from one hospital

in Australia. Data were collected via single interviews in which scenarios exemplifying attitudes to older people were used as prompts for discussion. The study found that participants view nursing older people as futile, and a waste of time and resources, because they believe old age is incurable and quality of life cannot be significantly improved by nursing efforts. The study concluded that acute care nurses' ageist attitudes towards older patients with long-term illnesses and co-morbidities leads to care differentials and systematic denial of healthcare opportunities for those patients. It could be argued, however, that rather than providing evidence of age discrimination in healthcare, Higgins et al.'s (2007) study demonstrates a clash of philosophies and incompatible outcome aims between acute care and LTNC. The prime philosophical position of acute care is to treat and return patients to optimum health status, but LTNC acknowledges that cure is not always possible, so focuses on addressing disabilities and multi-morbidities, and striving to improve quality of life. Older people with long-term conditions in acute settings may not therefore 'fit' the acute care model, regardless of their age. Thus, in Higgins et al.'s (2007) study, the participants may respond to older people negatively, not because they are older, but because management of their long-term conditions is not regarded as being part of the acute care remit. As such, acute care nurses disengage with this patient group.

Some studies suggest that ageism in healthcare leads to a devaluing of the occupational status of nurses who provide care for older people. Henderson et al.'s (2008) study, cited in 2.3.1, found that LTNC of older people is unappealing mainly because it is perceived as uninteresting, but it also reported that a minority of participants felt that the status of nurses working in this area is low because their patients are old. A very illuminating quote from one of Henderson et al.'s (2008) research participants encapsulates this feeling: 'I work with elderly people now and feel I can aim higher' (p.38). Kelly, Tolson, Schofield and Booth's (2004) UK study aimed to develop a description of gerontological nursing and its underpinning principles. The participant group consisted of 30 nurses from a variety of practice settings that provided services for older people. During group activities, participants were required to consider the rationale for, and generate a description of, gerontological nursing. Participants proposed that gerontological nursing is perceived as low status because it deals primarily with patients that require chronic or long-term care services within an arena which is rooted in medical and technical models of care. Although these studies argue that working with older people reduces the occupational status of staff involved, it is difficult to determine from the data presented whether this is in fact the case. It could be contended that low status is less a result of the association with older people,

but rather because the curative model of care is more highly valued within the healthcare socioculture (as discussed in 2.3.1).

2.3.3 Summary

Research investigating perceptions of, and attitudes to, LTNC uses a variety of quantitative and qualitative methods, and explores the topic from a number of perspectives. The consensus of these studies is that LTNC is not perceived as an occupation that requires the medical and technical knowledge and skills valued by the dominant socioculture, so its status is low compared to acute care nursing, in which the recognised knowledge-base is adopted and practiced. In addition, when LTNC activities are not perceived as complex and varied, and the LTNC environment is not considered stimulating or intellectually challenging, LTNC is regarded as an unfulfilling occupation and is therefore unappealing. As the findings of these studies are consistent and cumulative, they are persuasive. There is also some suggestion that status is influenced by the perception that personal care activities associated with LTNC are physically ‘dirty’ activities, and that the status of these activities may influence, or be influenced by, social identity constructs such as gender, ethnicity or migrancy (Twigg, 2000a; 2000b; Twigg et al., 2011). However, the conclusions of these studies are not well-evidenced by the data, so are less convincing.

Some studies suggest that a few nurses dislike working with older people and that this may lessen the appeal of gerontological nursing, although they conclude that this is a minor deterrent. However, the research evidence does not necessarily indicate that discrimination against older people in healthcare leads to a devaluing of gerontological nursing; this may be more to do with the devaluing of LTNC in a socioculture that values medical and curative models of care over LTNC models, rather than because patients are older per se.

This section of the literature review has explored attitudes to LTNC of older people. While these issues relate to NuH nursing of older people, they do not always specifically relate to NuH environments as older patients with long-term care needs may be nursed in other healthcare and community environments. The next section reviews the literature regarding attitudes towards the NuH sector as a unique health and social care setting, in order to explore whether perceptions of NuHs have a bearing on the role and status of NuH nurses.

2.4 Perceptions of nursing homes

2.4.1 Perceptions

A consideration of the history of NuHs (1.5.1) suggests that health and social policy has been, and is, sensitive to the needs of older people, yet nevertheless marginalises them. Successive government policies have in effect made judgements regarding who, and who should not, be eligible for the various types of available assistance. In the early twentieth century, those assessed as being of good character had the opportunity to remain at home and maintain a level of autonomy via receipt of a pension. Those dependent older people who were not reputed to be of good character were left to the workhouse. In more recent times, the need to ration scarce resources has led to the implementation of eligibility criteria for access to, and funding of, services. Policy changes have resulted in a shift towards private sector involvement in care provision for older people, in an arena claimed, since the inception of the NHS and social care legislation, to be primarily a concern for public sector involvement. A few studies have explored the possibility that NuHs' history has affected perceptions of contemporary NuHs.

Brittis (1996) interviewed residents in five NuHs in London and five in New York to determine the most significant qualities of, and obstacles to, the provision of quality care. The study suggests that privatisation of NuH care in England has damaged the public perception of NuHs:

The image of nursing homes has suffered. In England, nursing homes have become associated with privatization and the perception that that the government is no longer committed to the oldest members of society (p.37).

However, the study found no evidence to suggest this perception affects nurse/resident relationships. Rather, it found that nurse/resident relationships are primarily influenced by nurses' willingness and abilities to provide quality care. The study did not consider the effects of privatisation on NuH nurses' role and status. In another study, Skinner (2005) interviewed older members of an urban community in Oxford and their families, to ascertain memories and views of the care of older people before and after the inception of the welfare state. The study focused on memories of a specific workhouse, the site of which was later used to build a NuH. This is a major limitation of the study, as the shared site could lead to a strong association between the two types of institute. The study found that older participants' memories of workhouses as punitive places where staff were cruel and quality of life was limited by institutionalisation, influenced their views of NuHs, so that admission to NuHs was feared. Furthermore, because participants linked NuHs with workhouses, they felt that the shame related to workhouse admission vilifies admission to

NuHs as well. The study did not, however, explore in any depth if, and how, the role and status of NuH nurses is affected by these views.

In recent years, throughout the Western world, the image of NuHs has been damaged by media reports of poor practice, institutional abuse and scandal (Mendelson, 1975; Menio & Holder, 2001; Ursell, 2005; Chandra, Smith, & Paul, 2006; Venturato et al., 2007). However, only Venturato et al.'s (2007) Australian study, cited in 2.3.1, considers the impact on NuH nursing and the views of NuH nurses. Findings indicated that NuH nurses believe negative media reports fuel public prejudice against NuHs to such an extent that understanding of contemporary residential and nursing home care is highly inaccurate. However, the study does not discuss whether these reports specifically affect NuH nurses, as it focuses on NuH nurses' sense of values, rather than on their views regarding their status.

Concerns about the impact of long-term care funding on older people are constantly debated in the media (for example, Trigg, 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). Wright's (2003) mixed methods study, conducted on behalf of the Nuffield foundation, utilised a postal questionnaire to survey all local authorities' procedures for needs assessments and means-tests. The survey achieved a 77% response rate. Five local authorities were then selected for further study: 15 care managers, six legal advisors, 27 self-funding residents, and 29 relatives of other self-funding residents were interviewed. The study revealed that many self-funding residents feel discriminated against because they pay more than contracted local authority prices for placements, and because they are encouraged to directly, and sometimes inappropriately, enter RHs and NuHs without full needs assessments having been performed. Henwood's (2010) study, in which key providers (number not specified), and 30 self-funding service-users from a variety of settings were interviewed, was conducted on behalf of the Association of Directors of Adult Social Services, the Social Care Institute for Excellence and the Joseph Rowntree Foundation. Many service-user participants reported that care providers appear more concerned with individuals' ability to pay, than with their health needs. These two studies suggest that self-funding residents' experiences may negatively affect their perceptions of NuHs in that they view NuH providers with mistrust. The studies cited above imply that controversies surrounding health and social care funding damages public perceptions of NuHs. However, there is no evidence to suggest that NuH nurses are similarly viewed.

2.4.2 Summary

Few studies explore whether the historical context of NuHs has a bearing on public perceptions of NuHs. Those that do provide weak evidence due to their focus on other issues (Brittis, 1996; Venturato, 2007), or due to methods with potentially limited validity (Skinner, 2005). Stronger evidence (Wright, 2003 and Henwood, 2010) derived from studies located in a range of settings, involving both quantitative and qualitative data, suggest that the image of NuHs is influenced by funding controversies. It could be argued that this evidence may imply that NuHs are viewed by residents as morally dubious in that funding controversies appear to stimulate mistrust of these establishments. However, the conclusions drawn by these authors do not directly relate to the role and status of NuH nurses. Also none of the studies cited in this section sought to investigate the views of NuHs nurses themselves regarding if, or how, the historical context of NuHs affects their role and status. Thus, it is apparent that there is a gap in the knowledge base concerning this issue.

2.5 The nursing home nurse's role

The intention of this literature review is to explore aspects of NuH nursing that may impact upon NuH nurses' role and status. However, the conclusions drawn in the above two sections of the chapter have primarily focused upon status issues i.e. whether attitudes to LTNC for older people affect the status of NuH nurses, and whether there is a possibility that an association exists between the image of NuHs as organisations and institutions, and the status of NuH nurses. Thus far, the literature reviewed has not to any great extent considered the actual role activities of the NuH nurse, and whether these influence occupational status. This section therefore addresses these questions.

2.5.1 Nursing home nurses' role activities

A number of studies describe and analyse the activities inherent within the NuH nurse role. Hunter and Levitt-Jones' (2010) study provides a description of nursing practice in six NuHs in Australia. 48 nurses and 16 NuH managers completed questionnaires, and 32 participants were subsequently interviewed. In addition, documented role descriptors were analysed. All participants felt that due to the frailty, dependency, increasing acuity and high incidence of multi-morbidities within the resident population, NuH nurses require complex and extensive clinical skill sets. Participants stated that these skills include ongoing assessment and evaluation of residents' health needs, building relationships with residents and families, individualised care-planning, pharmacology and dementia care. However, the study found that nursing activities form only one aspect of the role. Other facets include running the facility, leading and role-modelling, organising resources, arranging building and equipment maintenance, ensuring compliance with regulations, and developing quality

improvement strategies. Buelow and Cruijssen's (2002) American study utilised single interviews to analyse a 'typical day' for nurses working in LTNC of older people. Interviews were conducted with 50 nurses, 25 from NuHs and the remainder from assisted living facilities and home care agencies. The study found that NuH nurses deliver healthcare interventions and are responsible for recognising and managing health crises. Participants also reported that their role involves the supervision of nurse aides. Venturato et al.'s (2007) Australian study (cited in 2.3.1), explored the impact of political reform on NuH nurses' practice. The study found that NuH nurses are becoming more involved in management issues such as supporting their facility to acquire accreditation for quality care.

Some studies analyse the role of the NuH nurse by comparing it with other roles within the NuH setting. For example, Bedin, Droz-Mendelzweig and Chappuis' (2013) study utilised mixed staff focus groups. Participants in the study consisted of 72 staff, including 16 nurses from nine NuHs in Switzerland. Groups were asked to identify and discuss a situation at work which they deemed to have been disruptive. The aim of the discussions was to reveal the nature of nurses' professional activity within the NuH setting, and their role within the NuH staff team. The study found that NuH nurses are primarily organisers, responsible for co-ordinating and evaluating care, and supervising and training staff. In common with HCAs, they build relationships with residents and assist with personal care, but nurses use these activities in conjunction with their knowledge of residents' multi-morbidities and care needs to exercise clinical judgement. In addition, they deal with ethical dilemmas concerning potential conflict between residents' personal safety and personal preferences. A study by Perry, Carpenter, Challis and Hope (2003) was located in four NuHs in England. Semi-structured interviews were used to explore the views of 12 HCAs and nine nurses regarding their role responsibilities. The study found that there is much overlap between the roles, particularly regarding personal care activities. However, both groups felt that nurses' professional knowledge means their involvement in personal care is a nursing, rather than a carer skill, as they use these opportunities to assess and monitor residents' health and well-being. Both groups also felt that their roles differ in that nurses exercise medical and clinical skills during their work, delegate work to non-professional staff, and are ultimately accountable for the care provided. Kane et al.'s (2006) study was located in four cities in three American states. A number of professional and care staff, including 54 nurses, 21 doctors and 91 nurse aides completed a quantitative questionnaire concerning their perceived ability to influence NuH residents' quality of life. The study found that the roles of the nurse and nurse aide overlap to a great extent in that both share perceived abilities with regard to performing activities that

promote choice and provide comfort, safety, respect and privacy. However, nurses share perceived abilities with doctors with regard to pain management.

These studies give rise to a number of issues. For example, whilst NuH nurses implement personal care activities and relationship-building they use these experiences to support their clinical judgement and nursing care. Nevertheless, involvement in personal care activities is associated with HCA work, which is viewed disparagingly by healthcare professionals in other settings (discussed in 2.3.1). This may contribute to an explanation of why NuH nurses are viewed as low status. These studies also suggest that the frailty, dependency, increased acuity, and multi-morbidities of residents require NuH nurses to have a wide knowledge-base and practice an array of complex and challenging skills. If this is the case, then NuH nurses' knowledge-based status should be high. In addition, the review of the literature suggests that the NuH nurse's role includes a great number of managerial and supervisory tasks, which implies that the role should be imbued with authority-based status. This then, presents a contradiction with regard to role and status. Perceptions that NuH nursing is an uninteresting role that does not require much clinical knowledge or skill has led to low occupational status. However, studies which investigate role activities show that NuH nursing is a highly complex skilled role, both clinically and managerially. It may be that this contradiction arises from a lack of clarity regarding what is meant by skill complexity. To-date, no studies have investigated this contradiction by exploring the views and experiences of NuH nurses themselves regarding this issue. An understanding of how NuH nurses define and perceive skill complexity may provide an insight into how this contradiction may be resolved.

2.5.2 Providing quality nursing care in nursing homes

Throughout the Western world, governments have acknowledged that quality care is integral to LTC provision, and have therefore introduced policy and legislation in an attempt to drive up care standards and ensure care is appropriate to individuals' needs (UK examples include DH, 2003; Care Quality Commission (CQC), 2010). Many studies focus on what nurses should do to provide quality care for residents. For example, Murphy (2007) conducted a mixed methods study in Ireland in which 337 nurses working in LTNC settings completed a questionnaire regarding their perceptions of what factors affect quality care. Carlson and McHenry's (2006) Swedish study explored nurses views concerning what caring for older people should entail. Seven focus groups involving a total of 30 participants were carried out. In Edvardsson, Varrailhon and Edvardsson's (2014) Swedish study, qualitative content analysis was used to analyse 436 NuH staff's written descriptions of how quality care is facilitated. In all three studies, participants felt that NuH nurses should 'get to know' residents, and provide person-centred holistic care. Murphy's

(2007) and Edvardsson et al.'s (2014) studies propose that, in addition, NuH nurses should contribute to the promotion of independence and autonomy, and meaningful and pleasurable living, and support the development of a homelike environment. Nolan and colleagues' extensive research into the care of older people has led to the development of the 'senses framework', which suggests that the nurse's role in gerontological care should be providing patients/residents with senses of security, continuity, belonging, purpose, achievement and significance (Davies, Nolan, Brown, & Wilson, 1999; Nolan, Davies, Brown, Keady, & Nolan, 2001; 2004; Nolan et al. 2008). This is achieved by enabling patients/residents to feel safe and free from pain and discomfort, recognising and valuing personal biography, providing consistent care delivered within an established relationship, and providing opportunities for patients to form meaningful relationships and engage in purposeful activity, and feel valued as a person of worth (Nolan et al., 2008, p.80). McCormack and colleagues have undertaken a number of studies with the aim of developing and evaluating models for person-centred practice (McCormack, 2003; 2004; McCormack et al., 2010). These authors propose that nurses should 'orientate' themselves to the patient/resident via particularising patients/residents, building relationships, and understanding patient/resident beliefs and values. These studies suggest that patient/resident biographies should be used and valued as guides for this orientation process. According to McCormack and McCance (2006), the success of these processes depends upon whether nurses possess certain attributes or 'prerequisites'. These prerequisites include professional competence, interpersonal skills, commitment, clarity of beliefs and values, and self-knowledge.

A number of studies discuss the difficulties faced by NuH nurses during care provision for residents. Many of these difficulties are stressors for NuH staff and contribute to nurses having reduced levels of job satisfaction. An issue that is repeatedly cited as a major problem is not having time to care. Participants in Venturato et al.'s (2007) study (referred to in 2.3.1), felt that time constraints arise because NuH nurses' management and supervisory activities distract them from care concerns. However, the most commonly mentioned factor that leads to time constraints is short-staffing. As already discussed, NuH nursing is not an attractive career option because it involves the delivery of LTNC, which is perceived as a low status activity. Some studies propose that these factors contribute to high levels of staff vacancies and staff turnover in NuHs and gerontological care (Stevens & Crouch, 1998; Kelly et al., 2005; Venturato et al., 2007; Henderson et al., 2008; Eley et al., 2007; Fussell et al., 2009). Eley et al.'s (2007) study used a postal questionnaire to survey 1,000 Australian NuH nurses regarding their working conditions. The study, which achieved a 40% response rate, found that nurses are dissatisfied with staffing levels, and

that a lack of permanently employed staff results in a heavy reliance on casual and inexperienced staff. Raikkonen et al.'s (2007) study (referred to in 2.3.1) reports that staff shortages due to high levels of staff vacancy, turnover, absence and sickness rates, lead to poorer care outcomes and low staff morale because the nurses who remain on duty have insufficient time to provide effective, individualised support for each resident. Murphy's (2007) study (cited above), found that lack of time restricts the provision of quality care because time constraints lead to a focus on physical aspects of care, limited choice for residents, and care driven by routine. Shin's (2013) study investigated the correlation between staffing levels and skill mix, and quality of life for NuH residents. Quality of life indicators were determined from questionnaires completed by NuH residents and staff in one American state. Results were compared to 'staff hours per resident day' for nurses and care assistants. The study concluded that without adequate staffing levels and skill mix, residents' functional competence, comfort, opportunities for meaningful activity and relationship-building, and autonomy are compromised. Tolsen, Maclaren, Kiely and Lowndes' (2005) study investigated the influence of policies on nursing practice in NuHs. The study used a Delphi approach to obtain the consensus of 30 senior nurse leaders in Scotland with regard to the ten most current policies in this practice area. A survey of 2,000 gerontology nurses was carried out, of which 598 were NuH nurses, to ascertain the impact of the chosen policies on practice. 41% of participants in NuHs reported that lack of time and staff shortages limit opportunities to keep up-to-date with current policies and practice. The study concluded that this leads to a mismatch between nurses' priorities, and the priorities of older people represented by current policies and guidelines, which reduces nurses' job satisfaction.

Another significant influence on NuH nurses' ability to deliver quality care is the availability and accessibility of education, training and information. Although Eley et al.'s (2007) Australian study, (referred to above), found that 90% of nurses working in private NuHs have access to training, the majority of participants reported that they are often unable to attend because they do not have time, they are unable to obtain relief staff, or fees are unaffordable. Hannan, Norman and Redfern's (2001) literature review of work factors that impact on care quality also suggests that training is available in NuHs. However, this study found that training is often not relevant to the needs of nurses or their residents. Ross, Carswell and Dalziel (2001) agree. In this Canadian study of corporate philosophies and approaches to NuH staff education needs, ten NuH administrators were interviewed using single, semi-structured interviews. The study found that due to fiscal and human resource constraints, managers are more likely to provide basic mandatory training, and courses that fulfil legislative and organisational requirements, rather than education programmes

that address staff-reported needs. The study suggests that this diminishes levels of job satisfaction.

These studies provide strong cumulative evidence which suggests that the NuH nurse's role should focus on the provision of quality care for residents, and that this primarily involves ensuring that residents' quality of life is maintained. However, the low occupational status afforded to the role causes staff shortages. This in turn impacts negatively on NuH nurses' work performance, which reduces job satisfaction. Here then, it appears that the effects of role and status are cyclical in that negative perceptions of the role decrease occupational status, and this low status (leading to staff shortages) adversely affects NuH nurses' ability to carry out their role.

These studies also propose that NuH nurses find relevant training and education programmes difficult to access. Thus, despite having the same nursing qualification and registration status as all other nurses, an inability to access continuing education may reduce NuH nurses' knowledge-based status. However, none of the studies reviewed explore this possibility.

2.5.3 Summary

An examination of the literature that explores the various aspects of the role of the NuH nurse demonstrates that these nurses view their role as being primarily about the provision of person-centred care that focuses on promoting independence, autonomy, a homelike environment and meaningful living for residents. Many of these studies state that these nursing occupations require high levels of professional competence and interpersonal skills. Studies that analyse NuH nurses' activities reveal that although providing person-centred care is integral to the role, NuH nurses perform a number of clinical, management and supervisory tasks too. The studies reviewed in 2.3.1, however, suggest that LTNC of older people is perceived as unskilled and uninteresting by many nurses, and that these attitudes contribute to high levels of staff vacancies and staff turnover. The literature review therefore highlights a contradiction with regard to the complexity (defined as the level of variation, magnitude and challenge involved) of the NuH nurse role. While some studies suggest that the role is unpopular because it involves delivering basic, repetitive and unchallenging care tasks, other studies propose that the role consists of a variety of activities that are both challenging and important as they have a significant impact on the quality of life of residents. Further study is therefore required to investigate the impact of perceptions of role complexity on role and status.

The contradictions regarding this issue also give rise to other questions about the impact on occupational status. If the role requires high levels of interpersonal, clinical and management skills proficiencies, NuH nurses should enjoy high levels of knowledge-based and authority-based status. However, this is clearly not the case. As no studies to-date have addressed these issues, further study is required.

2.6 Summary analysis of the literature review and generation of research questions and aims

As stated in 2.1, NuH nursing involves three aspects: LTNC of older people, working for NuH providers in NuH establishments, and performance of nursing care on a day-to-day basis. Although much has been written about these different aspects, I have identified gaps in knowledge with regard to the role and status of NuH nurses.

There is strong evidence to suggest that the reduced status of LTNC of older people is due to the perception that the skill set associated with the role is 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 LTNC are 'dirty' activities may also influence status. Furthermore, there is a perception that LTNC of older people does not require the practice of varied or complex skills, which may lead to the view that the role is unfulfilling. While these studies report that the status of NuH nurses is affected by issues relating to the LTNC of older people, they do not explain whether the NuH work setting itself is also an influence. Literature that considers historical contexts of NuHs in England suggest that their workhouse origins, anti-institutionalism and social care funding controversies have damaged the image of the NuH sector, but these studies do not explore whether this damaged image affects the status of the nurses who work in this sector. Further research is therefore required to investigate this possibility.

A review of the literature regarding occupational role suggests that there is a link between a worker's role expectations, and feelings of meaningfulness, fulfilment, positive self-concept and job satisfaction. Literature which investigates care provision in NuHs reports that NuH nurses expect to provide quality care for residents, and when circumstances prevent this from happening, their job satisfaction is indeed reduced. However, studies that describe the day-to-day activities of the role do not address, or are unclear about, whether these activities match the initial expectations of NuH nurses, or whether expectations regarding day-to-day role activities influence their feelings and views about the role. The literature also highlights a contradiction with regard to the complexity of the NuH nurse role. Further studies are therefore required to investigate the impact of role expectations and role complexity on perceptions of role and status.

According to the literature, occupational role is a significant aspect of self-definition and self-conception. In addition, it brings social identity, in that an occupational role generates membership of a group (an occupational group and/or an organisation). Some research finds that the level of belonging experienced and perceived by employees influences retention and attrition, although it remains unclear whether occupational identity is more about identifying with the employing organisation or occupational group. To-date there have been few studies that have investigated how occupational role and status contribute to, and are affected by, NuH nurses' concept and definition of self as belonging to a group. Research is therefore required to explore this issue.

Some studies suggest that low occupational status results in reduced self-esteem and loss of confidence in one's abilities. Other studies propose that low status leads to behaviours and strategies that attempt to preserve self-esteem. A few studies propose that NuH nurses may regard themselves to be less skilled than their acute care counterparts, but further research is required to investigate reactions to low status in greater depth.

The following study, in its consideration of role and status of NuH nurses, addresses the omissions and criticisms of earlier research by:

- Focusing specifically on NuH nursing for older people, rather than on LTNC of older people aspects only. In this way, issues regarding working for NuH providers in NuH establishments may also be addressed.
- Exploring NuH nurses views and experiences regarding their status.
- Exploring NuH nurses' views and experiences regarding role in terms of expectations and complexity.
- Exploring NuH nurses' views and experiences regarding their relationships and partnerships with other nurses and healthcare professionals, residents and the general public.

In this manner, this study will generate new and original insights and contribute to the literature regarding the nature of NuH nursing.

The review of the literature has highlighted gaps in knowledge, and topics for further inquiry, regarding the role and status of NuH nurses. In order to capture all of these aspects, and also remain open to the introduction and development of other topics, the following research questions were developed:

- What does it mean to be a NuH nurse?
- How do NuH nurses view their role and status?

- What are the lived experiences of NuH nurses?
- What influences and experiences shape their views of their role and status?
- What aspects of their work shapes NuH nurses' views of their role and status?

In addition to these questions, a further question was added to allow for reflection upon how the insights generated might advance the development of NuH nursing workforce issues:

- In what ways could insights into being a NuH nurse inform workforce development processes?

From these questions, the study's aims were constructed as follows:

- To explore the experiences and views of NuH nurses working with older people regarding their status and role.
- To generate an understanding of how and why these experiences and views occur.
- To explore whether emerging insights regarding NuH nursing can inform workforce development processes.

The next chapter will discuss the research methodology that was chosen to address these aims. The chapter will explain the methodological approach employed, and the research design adopted.

3 Research Framework

3.1 Introduction

Understanding and knowledge of the views and experiences of NuH nurses regarding their role and status is evolving. Nevertheless, the literature review presented in the previous chapter indicated that a number of gaps remain. The purpose of this research study is to advance understanding and knowledge of the topic, by addressing some of these gaps. However, it is essential to consider not just what the study is aiming to do, but how its aims can be achieved. Thus, in commencing this study, some of my initial deliberations were as much to do with the research process as the research aims. I reflected, 'How do I go about the investigation?' and, 'How, and by what means, should the study proceed?' These considerations led to a further question, 'What research framework would be most appropriate for this investigation?'

The goal of the investigation is to understand the meaning NuH nurses attribute to their role and status. As I began the research process, reviewed relevant literature and spoke to colleagues in the research and NuH arenas, I realised that although I had many experiences and views in common with other NuH nurses, mine were nevertheless unique to me. I also realised that during discussions with other people, my understanding of their experiences and views arose from my interpretation of their accounts, and that those accounts were in turn interpretations of their actual experiences. In other words, actual experience is interpreted by the experiencers, via the process of relaying those experiences, in accounts of the experiences. These accounts are interpreted by researchers, and then research studies are interpreted by readers of those studies. As such, my interpretations (or any interpretations) can never be absolute truths, but are rather accounts of how experiences are perceived. I therefore had to develop a research framework that allowed participants to express their experiences and views, but also permit me to arrive at an interpretation that was probable, reasonable and valid.

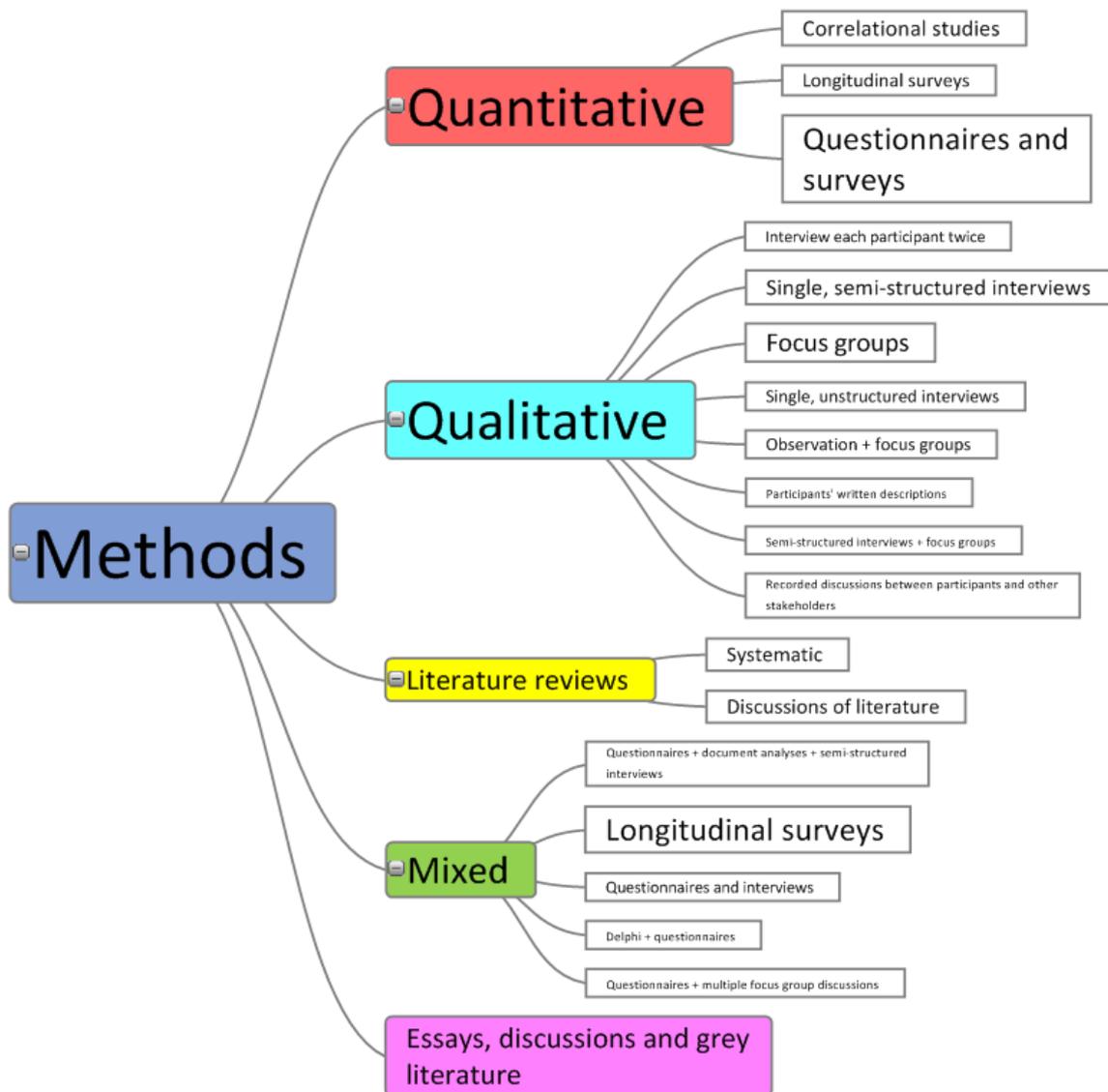
It was via reading and considering the philosophies of Heidegger (1962; 1968), Schutz (1962; 1967), Ingarden (1973), Gadamer (1976; 1979), Iser (1978a), Ricoeur (1981; 1991) and Husserl (1982) that the relevance of my reflections to the development of a research framework became apparent. This chapter provides a description of the research framework chosen. It begins with a brief discussion of the strengths and limitations of previous studies' methodological and methods approaches. Then, in the following sections, the chosen methodology and research design are presented. Throughout these sections, I refer to philosophies and literature that influenced my decisions regarding

paradigm, methodology and research design. Methodological challenges are also acknowledged, and approaches and techniques for addressing these challenges are explained. Presenting this information allows readers to understand my stance regarding the approach to the investigation. In addition, the chapter provides a background and context for the research process discussed in chapter 4.

3.2 Previous studies' methodological and methods approaches

The literature review provided an insight into the range of methodologies and data collection methods which have been employed to investigate occupational role and status, and NuH nursing issues. Figure 3.1 is a tag cloud map that illustrates the most common methods used in research concerning the topics under review (a tag cloud is a weighted list that utilises font size to represent the significance of concepts. This visual representation allows prominent items to be perceived easily and clearly). This provided information about what methods were frequently used, and what appeared to be considered the most appropriate and valid methods of data collection by other researchers. Furthermore, it allowed deliberation of the limitations of these methods, and consideration of what alternative methods could be used to advance research in this area, and contribute to the development of new insights.

Figure 3.1: Tag cloud of methods used in studies reviewed



Positivist and postpositivist approaches using quantitative methods have proved valuable, for example, when determining correlations between job characteristics and job satisfaction, self and group identity, or attitudes to LTNC or older people and nurses' career intentions. Quantitative methods have also been used to describe the role of the NuH nurse by identifying its inherent activities. The large, representative and/or random samples used in these studies facilitates generalisability. However, some of these quantitative studies are flawed. For example, Judge et al. (2000) and Mael and Ashforth (1995) fail to adequately define variables leading to findings that are ambiguous or lack clarity. Also, understanding the complexities of perception, experience and feelings can only be partially achieved by quantitative research. For example, Hackman and Lawler's (1971) and Raikkonen et al.'s (2007) use of quantitative self-administering questionnaires

does not permit participants to elaborate upon, and clarify, responses. As this study in the main seeks to explore views and experiences, quantitative methods were deemed to be unsuitable.

Other studies that aim to understand the complexities of perception, experience and feelings utilise qualitative approaches. A common criticism of qualitative studies is that findings are not generalisable because samples are small and localised, and may not be representative. However, Parahoo (2014) argues that the aims of these studies are less about generalisability, than about understanding, and/or developing theories and concepts that reveal the various manifestations of the phenomenon under review. Polit-O'Hara and Beck (2006) propose that qualitative methods yield richer, in depth knowledge of how individuals think, experience and behave within the contexts in which they live. These authors, in their discussions of studies that explore nursing practice, suggest that qualitative methodologies are the most appropriate means by which to understand how experience, perception and beliefs influence practice and outcomes. They propose that identifying the interplay between personal, contextual and environmental issues can lead to a better understanding of nursing practice, and help to direct operational, educational and support mechanisms. As the present study seeks to explore views and lived experiences within work, and health and social care contexts, and whether emerging insights can inform workforce development processes, a qualitative research approach was deemed to be most appropriate.

However, many of the qualitative methods utilised in studies of NuH nursing involve limited interaction between individual participants and researchers (for example, single interviews, focus groups, observations). Alvesson and Deetz (2000) propose that limited interaction may not always be conducive to investigating complex topics in great depth (such as role complexity and role expectations), or promoting frank discussion about sensitive subject areas (for example, status or relationships). These authors argue that data collection methods that encourage prolonged engagement and opportunities to build relationships between participants and researchers over time, may initiate richer dialogue and more comprehensive discussion, and facilitate the researcher's understanding of contextual influences. Thus, in order to mitigate some of the criticisms of earlier studies' methods, for this study I decided to employ a methodology and research design which permits participants to discuss views and experiences on a number of occasions over an extended time period. The following sections present the chosen methodology (3.3) and research design (3.4).

3.3 Methodology

3.3.1 Choosing a paradigm and methodology

As the study's aims were to explore and understand views and experiences of individuals living those experiences, an epistemological paradigm was required that acknowledges truth and reality are subjective, and each individual operates by making sense of the social environment in which they live (Milburn, Fraser, Secker, & Pavis, 1995). A review of methodological literature suggested that the study's aims could be addressed by either of the two principal paradigms that focus on the sense-making activities of humans – interpretivism and constructivism.

As well as sharing an ontological position which emphasises that human sense-making is social and pragmatically provisional, these two paradigms share a focus on interpreting perceptions and subjective experiences of individuals in an effort to understand their meaning. Schwandt (1998) explains that both paradigms involve processes of construction and interpretation:

The constructivist and interpretivist believe that to understand this world of meaning one must interpret it. The inquirer must elucidate the process of meaning construction, and clarify how and what meanings are embodied in the language of social actors. To prepare an interpretation is itself to construct a reading of the meanings (p.222).

However, each paradigm is unique in its approach to the processes of construction and interpretation. Interpretivists, in their pursuit of understanding the meaning of social phenomena, deny the opposition of objectivity and subjectivity (Rabinow & Sullivan, 1987; Hammersley, 1989; Denzin, 1992). Interpretivist researchers initially give precedence to subjective views and experience, and acknowledge that there are as many perceptions of the world as there are individuals perceiving and experiencing the world. But then interpretivists extricate themselves from those multiple perceptions, and objectify and transcend them in order to arrive at an interpretation of the world that leads to understanding (Schutz, 1962). As a result, the researcher's interpretation and understanding are independent of the experiences and views of the study's participants.

Constructivists, like interpretivists, are concerned with experiences as they are lived. However, commonly constructivists believe that individuals create or construct knowledge, truth and reality in order to make sense of their experiences. These constructions are constantly modified and adapted when individuals undergo new experiences (Schwandt, 1998). Thus, unlike interpretivists who believe there are multiple perceptions of the same world, constructivists advocate that there are multiple world constructions i.e. 'multiple

realities' (Goodman, 1978). If, as constructivists believe, there are 'multiple realities' rather than multiple perceptions of the same world, then interpretation via disengagement and objectification cannot occur, but rather the researcher must remain entangled with participants and their experiences. Accordingly, interpreting is a transactional process whereby researcher and participants construct theory together. This means that the end construction is dependent upon participants' experiences and views (Denzin & Lincoln, 2000).

When considering an appropriate paradigm, it is important to identify what the study is, and is not, aiming to do. This enables the researcher to eliminate some approaches, and justify the use of the approach ultimately chosen (Moustakas, 1994; Gerrish & Lacey, 2010). This research study is not primarily aiming to construct theories and conceptualisations about the nature of NuH nursing, or investigate the process of knowledge construction. Principally, in an exploration of the social meaning and personal significance of lived experiences, it aims to understand the phenomenon of being a NuH nurse. This involves transcending and objectifying participants' views and accounts of their experiences to arrive at an understanding of the phenomenon. For these reasons, I decided that an interpretivist paradigm, rather than a constructivist paradigm was most appropriate.

A number of interpretivist methodologies support the deliberation of participants' experiences. For example, ethnographic studies explore how individuals' behaviours are influenced by the culture in which they live. They focus on the values and norms of the group, and how group members interact (Barton, 2008). Case studies offer in-depth illuminations of single-unit phenomena over a prolonged period (Gerring, 2004). They explain and describe phenomena by placing great emphasis on the contextual aspects in which the phenomena under review are located. Phenomenology is a means of exploring an individual's perspective and subjective experience with a view to emphasising and understanding human experience (Husserl, 1982). When considering possible methodologies, I again returned to the questions and aims of the study in order to reflect upon what the study was, and was not, aiming to do. It was not attempting to investigate the culture of nursing within NuHs, hence ethnographic approaches were considered unsuitable. Likewise, case study methodology was not appropriate as, while I acknowledged that context influences experience, I did not specifically aim to focus on the relationship of context and phenomenon. Rather, I was more interested in understanding what it is like to have experienced a particular phenomenon. Therefore, the aims of this

study appeared consistent with those of phenomenology because of its focus on exploring NuH nurses' individual views, experiences, feelings and expectations.⁴

The following section discusses phenomenology, and provides a rationale for the approach chosen for this study i.e. hermeneutic phenomenology which utilises aspects of reception theory.

3.3.2 Phenomenology, hermeneutics and reception theory

Essentially, phenomenology aims to trace what it is to 'live' an experience, and how living that experience is perceived. There are various approaches to achieving this aim, notably descriptive approaches and hermeneutic approaches. In order to identify the approach that was most appropriate for my study, I considered both possibilities. This section is an account of the methodology decision-making process, in which I outline how and why I rejected Husserl's descriptive approach and arrived at the decision to employ a Gadamerian hermeneutic approach that utilises aspects of reception theory.

For Husserl (1982) and his proponents, phenomenological knowledge is not about generalised definitions and explanations, but about examining phenomena in various forms until the common aspect, or 'essence' is exposed. These writers propose that every phenomenon has fundamental properties, or 'essences', and that these essences are defined as the characteristics of a phenomenon that are recognised by all perceptions or experiences of that phenomenon. The establishment of essence depends for Husserl (1982), on 'phenomenological reduction' – the 'bracketing' of everything beyond immediate experience (for example, the contextual worlds of researchers, authors and readers) so that only a description of the absolute characteristics remain. Description of experience, for exponents of this methodology, is the most reliable way to truly capture the essence of participants' experiences. For these researchers, explanations and interpretations that emerge from researchers' pre-understandings filter or cloud the truth within the data. For instance, Abbey et al.'s (2006) descriptive study (cited in 2.3.1) which explores student nurses' practice placement experiences, aimed to 'explore and describe the phenomenon

⁴ Reading this chapter so far, it may appear that arriving at a research framework was a logical, uncomplicated process, but this was not in fact the case. While developing and constructing questions and aims to address omissions and criticisms of earlier research was comparatively straightforward, determining a paradigm and methodology that would appropriately respond to the questions and aims was a complex process that required much study and contemplation. This was because I was initially uncomfortable with the concept of interpretivism, as its propensity for objectifying experiences and perceptions of participants led me to feel that it was in some way ethically unsound. A reflection on the decision to use an interpretivist paradigm is presented in appendix 9.

under study' and 'uncover and make sense' of the essences revealed (p.15). As Giorgi (1985) summarises, 'by adopting a strictly descriptive approach, we can let the phenomena speak for themselves' (p.151). In order to achieve description, objectivity is required, but also neutrality and disinterestedness. As such, description is a passive act.

However, for many phenomenological researchers, 'passivity to data', and 'research' are incompatible concepts. Researchers choose their field of expertise for a number of reasons, but often choices are intertwined with personal and/or professional interests, values, beliefs and experiences. Topics are chosen because the historical and cultural contexts of our own lives and times throws particular phenomena into prominence. For example, Venturato's et al.'s hermeneutic study (cited in 2.3.1) of nurses' experience of practice and political reform in long-term aged care acknowledges that research topics often arise from their contexts, and that understanding is situated within, and influenced by, contexts. In my own case, my experiences of working as a NuH nurse within the current English health and social care system (discussed in chapter 1) were hugely influential in my choice of research topic. If then, the very reasons why we embark on specific research projects are not passive, then it becomes extremely difficult to achieve a fully passive research process. If we are interested in the research topic, how can we be disinterested in its unfolding? At this point, I rejected Husserlian phenomenology as a methodological approach for this particular study, and turned to hermeneutics.

The above question echoes hermeneutic phenomenologists' (for example Heidegger, 1962; Gadamer, 1976; 1979) argument that being is actually synonymous with being-part-of-the-world: rather than disinterested observers, our capacity to know is formed by, actively invests in, and takes meaning from, interaction with our environments.⁵ If to be is to be-part-of-the-world, then understanding does not arise from 'phenomena speaking for themselves' as Giorgi (1985, p.151) suggests, but from what we unreflectively bring with us when we approach phenomena (i.e. our pre-understandings). Thus, understanding is driven and restricted by the contexts from which we view phenomena. Contexts are therefore interpretative tools.

⁵ Modern hermeneutics is generally associated with the works of Martin Heidegger (1889 - 1976) and Hans-Georg Gadamer (1900 - 2002). Both have made significant contributions to the development of the philosophy. It is not within the scope of this thesis to explore their extensive works, therefore the discussion is restricted to those aspects of Gadamer's (1976; 1979) work that have influenced the shape of this study.

But research is not simply about understanding what it is to be in the world. It is also about critically considering that understanding, so that limitations, contradictions and conflicts in views can be understood. In other words, a critical reflection of being is necessary. Gadamerian hermeneutics in particular acknowledges this point. Gadamer (1976; 1979) proposes that understanding does not only arise from an awareness of where we stand in relation to the world, but by opening up to, and learning from, the world via the process of dialogue with the phenomena of the world. When Gadamer (1980; Gadamer & Hahn, 1997) discusses dialogue, he is not specifically referring to conversation in its conventional sense i.e. the dialogue that occurs when two people verbally interact. He proposes that a willingness to open the self and learn allows dialogue with any phenomena, including art, literature, religion, architecture and even natural events. The following comment explicates the process using art and literature as examples:

But how it is with artwork, and especially with the linguistic work of art? How can one speak here of a dialogical structure of understanding? The author is not present as an answering partner, nor is there an issue to be discussed as to whether it is this way or that. Rather, the text, the artwork, stands in itself. Here the dialectical exchange of question and answer, insofar as it takes place at all, would seem to move only in one direction, that is, from the one who seeks to understand the artwork...[However] the dialectic of question and answer does not here come to a stop...Apprehending a poetic work, whether it comes to us through the real ear or only through a reader listening with an inner ear, presents itself basically as a circular movement in which answers strike back as questions and provoke new answers (Gadamer & Hahn, 1997, pp.43-4)

Gadamer (1979) explains that we all have a perception of the world (which he describes as a 'horizon'). Understanding occurs when our own horizon of pre-understandings 'fuses' with the contextual horizon within which the phenomenon under scrutiny is placed. During fusion, we view the other's horizon and simultaneously draw the other into our own horizon. Thus, fusion allows us to attain both an appreciation of the other, and a greater understanding of the self. Due to my knowledge and experience of NuH nursing and my resultant pre-understandings, I felt that Gadamer's approach to hermeneutics was particularly appropriate, as my insider experiences of the impact of historical and socio-political factors on practice might facilitate understanding of the complexities and paradoxes of work situations and experiences.

Of course, the fusion of horizons is not altogether a straight forward process. Criticising Gadamer, Derrida (2005) explains that understanding cannot exist without the possibility of misunderstanding and conflict. While Derrida (2005) accepts that we cannot escape pre-understandings and contexts, and acknowledges that these can support understanding, he

proposes that there is always a chance that, in spite of our best efforts, we are unable to understand aspects of the other's horizon, or that understanding will be distorted, or limited, by our pre-understandings (this challenge is discussed in 3.3.3).

In the extract quoted above, Gadamer uses the term 'dialogue' to describe interaction with any phenomenon, not just human conversation. Also, he uses the term 'text' to denote any phenomenon, not just what is written.⁶ 'Text' becomes a metaphor for our partner in dialogue, 'voice' becomes a metaphor for what the text says, and 'dialogue' becomes a metaphor for the question/answer process that occurs when we attempt to understand text. According to Gadamer (1980), all phenomena that we aim to understand are texts because no phenomenon, whether it is a discourse, work of art or written piece, is an expression of reality, but in different ways can be regarded as a claim of truth which requires interpretation. Regardless of whether texts are listened to, read or viewed, dialogue emanates from what we want to know and understand, not what is said. To take this metaphor concept further, in Gadamerian hermeneutics, 'reading' therefore becomes a metaphor for interpretation, and the 'reader' a metaphor for anyone engaged in interpretation.

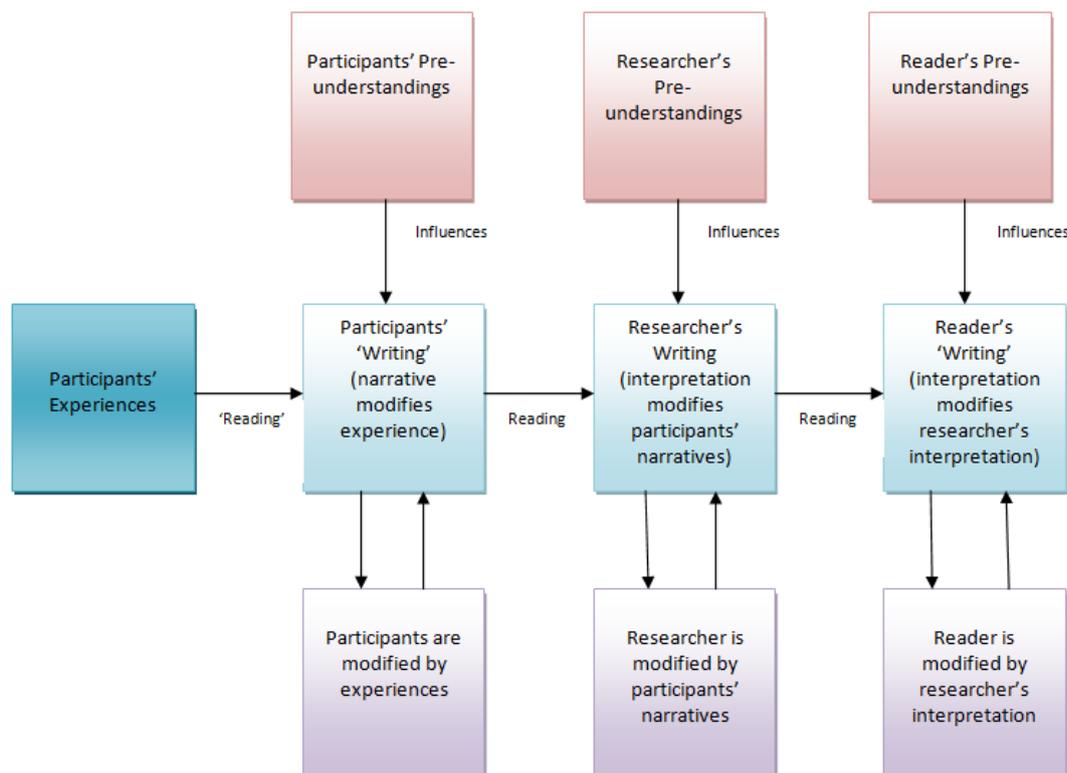
Gadamer (1979) states that the nature and product of fusion depends upon the questions we construct from within our current context and to which the text is used as an answer. Even when texts remain fixed (for example, written pieces, or works of art) readers' standpoints are different, so that the text is addressed differently at each reading. This results in numerous 'fusions', each producing a different response. In effect, hermeneutic phenomenology involves a shift away from the text towards the reader. Readers in research include participants ('readers' of their own experiences), the researcher (reader of participants' narratives), and the research audience (readers of the completed thesis, and the papers that will be elaborated from it). A branch of hermeneutics known as 'reception theory' develops this text-to-reader shift further (for example, Ingarden, 1973; Iser, 1978a; 1978b; Barthes, 1981). For reception theorists, reading is an active pursuit

⁶ Unlike Ricoeur (1991), who is very specific that writing constitutes text, Gadamer (1980) is able to extend the concept of text far beyond that of writing. Ricoeur's (1981; 1991) definition stems from the idea that distance (or 'distanciation') between author and reader is created during the writing process. Although Ricoeur (1981) acknowledges that a level of primitive distanciation occurs during discourse, texts distance author and reader to a much greater extent because no contextual reference and opportunities for confirmation exist. Written texts have no real world – they are 'in the air, outside or without a world...outside time' (p.148). Ricoeur concludes that, in effect, texts 'intercept' contextual references, creating a distance between author and reader that does not occur between interlocutors. Gadamer (1980) on the other hand, sees all phenomena which we wish to understand as texts.

whereby readers generate understanding by drawing on their pre-understandings and tacit knowledge of the world, and relating these to the text. These pre-understandings and knowledge are affirmed or undermined as the process of reading proceeds. The text itself becomes a series of cues or 'schemata' which readers integrate with their own historical or contextual pre-understandings to arrive at an understanding (Ingarden, 1973; Iser, 1978a). Iser (1978a) purports that by reading from our own standpoint, we are both modifying the text, and being modified by it. Reading, for Iser (1978a), is an action that allows us to not only critically review the text, but also to re-appraise ourselves and the wider assumptions of our culture.

Barthes (1974; 1981) refers to this receptive reading as 'writerly' reading because the readers' involvement in the generation of understanding implies that they are 'no longer a consumer, but a producer of the text' (Barthes, 1974, p.4).

Figure 3.2: 'Writerly' Reading



For Iser (1978b) and Barthes (1981), readers' own versions of a text speak to, and of, them personally, so that reading becomes a process of self-knowing and self-enlightenment, and a vehicle for change. In addition, seeing the 'self' within texts stimulates empathy, and a greater understanding of the experiences of others, as well as enabling us to reappraise our own views and experiences of the world. This study aims to

understand the lived experiences of NuH nurses, and also contribute to change through exploring how emerging insights might modify and enlighten workforce development processes. I therefore felt that utilising aspects of reception theory would be advantageous. According to Iser (1978b), certain texts particularly lend themselves to 'writerly' reading. Such texts maximise the interaction between specific episodes of experience expressed as narratives and stories (i.e. 'what happened?'), and readers' assumptions and theories that arise from their own knowledge and theory of the world in which the narrated episodes occurred (i.e. 'why did the episode of experience happen?' 'What does the episode of experience mean?' 'Does knowing/reading about the episode of experience confirm or alter my knowledge/perception of the world?'). Iser (1978b) refers to this interplay between narration of specific episodes, and assumption and theory about their relevant contexts, as 'semantic potential'. For Iser (1978b), the maximisation of semantic potential which occurs in writerly texts may compel readers to question cultural philosophies, and disturb habitual views, so that new ways of understanding might be achieved.

If research is to reproduce a writerly outcome, then it must also exploit semantic potential by utilising both the participants' and the researcher's semantic and episodic knowledge at the data collection, data analysis, and interpretation stages. Episodic knowledge is associated with the experiences that arise from situations and circumstances. Semantic knowledge is defined as the generalised assumptions and theories which emerge from these experiences. In this study, this involved utilising a data collection technique that inspired dialogue (conversational dialogue) between participants and researcher. This dialogue and discussion prompted participants to narrate their unique experiences, relate these experiences to wider contexts, and comment on the relationship between experience and context. These discussions were recorded and transcribed. During my 'reading' (via dialogue with the transcribed data), I, as the researcher, considered the participants' accounts of their experiences and views in the light of my own semantic and episodic knowledge of the relevant contexts. This reading modified and challenged my knowledge and views, permitting the 'writing' of an interpretation that was personally meaningful. This interpretation is presented to the readers of the thesis in the findings chapters. It is hoped that this presentation will in turn stimulate readers of the thesis to utilise their semantic and episodic knowledge to 'write' interpretations meaningful to themselves. The following section – 3.3.2.1, and the data collection and data analysis sections (chapter 4) explain this process in greater detail.

3.3.2.1 The influence of the methodological approach on the structure of the thesis

The structure of the thesis, in particular the presentation of findings, needed to reflect the chosen methodological approach. This section explains how methodology penetrated decisions about the thesis structure.

As discussed in 3.3.2, reception theory hermeneutics requires production of a writerly outcome via the generation of data rich in semantic potential. This process is essentially double hermeneutics, defined by Giddens (1984) as 'mutual interpretative interplay between social science and those whose activities compose its subject matter (p.xxxii). Giddens (1984) proposes that 'lay actors' i.e. the people or populations (including participants), are themselves social theorists because all have some degree of knowledge of the theories and nomenclature of social science, in that universal assumptions about the world generally arise from social science theory: 'the 'findings' of the social sciences very often enter constitutively into the world they describe' (Giddens, 1984, p.20). As such, individuals as 'lay actors' use their knowledge of social science to help them to make sense of their own experiences. Exploiting semantic potential is a double hermeneutic exercise in that it prompts participants ('lay actors') to inter-relate episodic events (their own experiences) and universal assumptions (social theory) i.e. they are interpreting their original experiences (as illustrated in figure 3.2, first column). This study begins from a premise of social theory as it requires participants to consider 'role' and 'status' – sociological concepts that have 'constitutively' entered the world. Participants use these social theories – their assumptions and understanding of 'role' and 'status' – to interpret their episodic knowledge. They use the sociological nomenclature 'role' and 'status', as well as other sociological terms, for example, 'stigma', 'community', 'communal', 'professional', 'culture shock', 'customer', to describe and interpret their personal experiences and explain their views. The role of the researcher in this process is primarily to assimilate, integrate, and categorise participants' responses, to reach understanding that is relevant to the study's topic of investigation (in this case, exploring participants' views and experiences of role and status). In this study, the categorisation of double hermeneutic data is presented in chapter 5, while an in depth explanation of the data analysis process is presented in 4.5.2 (see 4.5.2.7 for a discussion of the generation of unifying categories).

Chapter 6 presents the researcher's thematic interpretation that emerges from the data. As already discussed in 3.3.1, this study is an interpretivist study that aims to explore social meaning by considering multiple perceptions of the world, then extricating, objectifying, and transcending these perceptions to arrive at an interpretation that is independent of the participants. The interpretation is generated by fusing the researcher's pre-understandings

(informed in part by knowledge of contexts and social theory) with the data (unifying categories), in order to situate the data in wider social contexts, and disturb and question these accepted or habitual ideas about the world (figure 3.2, column 2). Key to this kind of research is the objectification of participants' responses, and independence of the researcher from the participants. It has already been debated in 3.3.1 and appendix 9 that issues of objectification and independence may constitute an ethical dilemma, but another potential criticism of objectification and independence is that in effect, these lead to single hermeneutics, in that participants are not given the opportunity to co-opt the researcher's knowledge and ideas during theory development, or assist in construction of theory. In other words, during thematic construction, the interpretation uses social theory and debates about the world that arise from the researcher, not the participants. Thus, the validity of the interpretation may be questioned.

Some sociologists and psychologists (for example, Grint, 2008; Henriques, 2011; 2013) are not too concerned about this for a number of reasons. For example, Grint (2008) proposes that sociology of work theories do not aim to reach definitive definitions of work, but use social, cultural and political ideas to interpret work activities and discourses, in order to suggest implications and new insights that contribute to the knowledge debate. Thus, for instance, if a worker is asked to explain why he/she undertakes activities in a certain way, they may answer, 'because it's more efficient'. It is unlikely that they will mention (or be expected to know about) Weber's theory of rational action, or Marx's theory of capitalist alienation, or any other social or political theory. Similarly, in this study, questions about status and the nature of work did not lead participants or refer to the sociological concepts of, for example, 'acculturation', 'dirty work' or 'cultural capital' – concepts with which they were unlikely to be familiar (see 4.5.2.8 for a detailed discussion of theme construction). However, the researcher may, after analysing the context and content of the response, relate such theories to the response in order to situate and interpret the response within the wider social world.

Of course, there is an argument for introducing social theories that were previously unfamiliar to participants into research interviews in order that participants may then validate the researcher's interpretation, and comment about whether theories match their own experiences i.e. introducing a double hermeneutic into the research process as a method of respondent validation. Henriques (2013), however, proposes that validity can be undermined even further if this activity is undertaken:

When the observed is a concept-using being, the very conceptions of their actions enter into the actions themselves...in other words the justifications generated by human scientists to explain some

human behavioural phenomenon are digested by human actors with genuine causal consequences. This reality has lots of complicated ramifications for how and what we think about facts, values and philosophy (web page).

Henriques (2013) suggests that introducing social theory into explorations of human action with actors themselves, can lead actors to distort, modify or refute their original thoughts and statements about action. Bar-On (1996), DeLaine (2000) and Costley, Elliott and Gibbs (2010) agree. These authors propose that presenting participants with interpretations during the data collection process is potentially problematic. This is because participants may not have had time, opportunity or inclination to study or absorb methodological and theoretical issues embedded in, or emerging from, the study. Bar-On (1996) suggests that this may lead to participants misunderstanding interpretations and theories, or perceive interpretations and theories to be critical, unfavourable or pejorative. The author suggests that such perceptions may result in participants altering or retracting responses, or looking for alternative justifications for actions, that are in opposition to their original responses.

Thus, chapter 6 presents the researcher's interpretation, in which my pre-understandings are used as an interpretative tool, and from which the study's themes emerge (see 4.5.2.8 for a discussion of this analysis stage).

Of course, defending the subjectivity of hermeneutics, and the independence of the researcher as an interpreter, does not negate the researcher's responsibility for generating a valid interpretation. The researcher is required to explain how interpretation and validity challenges that are associated with the chosen methodology are addressed and mitigated against. These challenges are discussed in the next section (3.3.3).

3.3.3 Methodological challenges

Using hermeneutic phenomenology as a methodology in research is not unproblematic. A major concern stems from the fact that participants are the primary interpreters or 'reader/writers' of their own experiences. They are able to choose which experiences to disclose, which experiences to omit, and how experiences should be described (Qu & Dumay, 2011). Also, Alvesson (2003) and Qu and Dumay (2011) suggest that participants may offer narratives that present themselves 'mobilised' in situations, rather than give more mundane, but factual accounts. In other words, there is a distance between actual experience and narrated experience from which arises a risk that participants do not say what they mean, or mean what they say.

Because participants and researchers are 'reader/writers' within the data collection process, the actual events experienced by participants' have been filtered twice already by both the participants' narratives and the researcher's interpretation. The research could therefore be construed as being biased, leading to what Eagleton (1983) calls 'hermeneutical anarchy' (p.86) in which interpretations are not constrained, but thrust off track. Derrida (1982) suggests that this is to some extent inevitable in that we can never approach original experience or events because language itself (whether spoken or written) is fundamentally a signifier - a representation of meaning - and meaning and signification are not entirely congruent. Derrida (1978; 1982) proposes that language may therefore display surplus or deficit over the precise meaning or intentions of the speaker/writer. He does, however, fully acknowledge that the instability of language as a conveyor of meaning does not necessarily render speech/writing as unrepresentative of meaning. This is because meaning and understanding arise and are held sufficiently in place by wider social contexts and practices from which language itself emerges:

Every sign, linguistic or nonlinguistic, spoken or written as a small or large unity, can be cited, put between quotation marks; thereby it can break with every given context, and engender infinitely new contexts in an absolutely nonsaturable fashion. This does not suppose that the mark is valid outside its context, but on the contrary that there are only contexts without any center of absolute anchoring (1982, p.320).

For Derrida (1982; 2001), the possibility of hermeneutical anarchy is best mitigated against by thought and reflexivity, whereby understanding is achieved by a process of negotiation in which alternative understandings are weighed up and evaluated. This does not ever reach a single 'right' interpretation, but it does by degrees constrain interpretations from heading too far off track and becoming invalid. Derrida terms this process 'responsible decision-making' with regard to interpretation.⁷ This however, begs the question, how can such a process be demonstrated in research? In this study, I attempted to support 'responsible decisions' by reflecting upon, and utilising the concept of 'shared intelligibility' (3.3.3.1), by a process of reflexivity (3.3.3.2), and by undertaking ongoing validity checking processes (3.3.3.3).

3.3.3.1 Shared intelligibility

Yacobi (1985), Zerweck (2001) and Nunning (2005) explain that readers are able to guard against hermeneutical anarchy, and achieve hermeneutical significance, by utilising shared knowledge. Fish (1980) first suggested this idea when he proposed that the distinctive characteristics of readers that emerge from the cultural environments in which

⁷ For discussions of the Gadamer/Derrida debate, see for example, DiCesare, 2004 and Bernstein, 2008.

texts are placed, influences reading. Because readers are familiar with these cultural environments, they utilise 'shared intelligibility' (p.320) which they have in common with other individuals within their environments, to facilitate and validate their interpretations. Fish is not denying the multifarious nature of reader interpretation due to the multifarious nature of readers' experiences and pre-understandings, but he is suggesting that readers' approaches to interpretation are influenced, or constrained, by the conventions of the 'systems of intelligibility' (p.320) of their readership. These conventions limit reader responses and protect against wide and unreasonable deviations. Yacobi (1985), Zerweck (2001) and Nunning (2005) develop this argument and suggest that 'shared intelligibility' can serve as a safeguard against unreliability. These authors demonstrate that readers are able to recognise and appraise potentially 'unreliable' elements in both narratives and interpretation of narratives, by applying contextual and semantic frameworks to texts. These frameworks can be divided into groups. One group includes 'real world' frames of reference (Zerweck, 2001, p. 155) whereby the reader compares the narrative against shared historical and cultural knowledge, social norms, and moral values. Another group consists of 'textual' frames of reference (Zerweck, 2001, p.155), for example, shared conventions, methods, forms of coherence and discourse contexts.

In this study, the use of 'shared intelligibility' to safeguard against unreliability involved firstly capitalising on shared 'real world' contexts that arise from my pre-understandings and experiences as an insider within the NuH nursing community of practice. Also, my knowledge and insider experiences of the influences of historical and socio-political factors on practice supported my understanding of the participants' work situations and experiences. Furthermore, the data collection technique employed generated contextual and semantic data which reinforced narrative and interpretative reliability (discussed in 3.4). 'Textual' frames of reference were also utilised in the study. These were comprised of conventions of research and thesis production such as explicit accounts of methodology and data analysis processes (discussed in this chapter, and 4.5).

As the participants and the researcher share intelligibility regarding NuH nursing contexts, and the researcher and reader of the thesis share intelligibility of research processes, then the range of potential interpretations is narrowed. Moreover, by presenting contextual information to readers of the thesis, readers will be able to apply contextual and semantic frameworks to the text and evaluate the reliability of participants' narratives, and the researcher's interpretation, so that credibility of interpretation can be gauged.

3.3.3.2 Reflexivity

Although participants and researchers may share intelligibility regarding social norms and contexts, thus narrowing the range of potential interpretations, there remains a risk that researchers (particularly insider researchers) may allow their own experiences that occurred within these social norms and contexts, to influence or bias their interpretations. This risk can be mitigated by reflexive processes.

Consistent with the literary reception theory approach that informs the study's methodology, reflexivity was achieved during the research process by applying Iser's (1978a) 'oppositional arrangement of perspectives' and 'backgrounding' approaches, and reflecting upon decisions about interpretation.

Oppositional arrangement of perspectives: According to Iser (1978a), in order to promote reflexivity, individuals are required to become aware of the range of perspectives that are at work within an established frame of social norms. Having acknowledged that a range of perspectives exist, individuals can arrange each perspective in opposition to the others with the aim of exposing the deficiencies of each. Iser (1978a) calls this process the 'reciprocal negation of perspectives' (p101), and argues that, by undertaking this process, individuals can begin to understand, and reflect upon, how social norms and experiences may have manipulated their own perceptions, and thus modify their perceptions. Simultaneously, the traditional norm is modified by individuals because an awareness of different perspectives allows individuals a transcendental viewpoint from which all negated positions can be evaluated.

The oppositional arrangements of perspectives process as a method of enhancing my reflexivity in this study can be demonstrated by considering the issue of training and education. The unifying category 'professional isolation and exclusion' is presented in 5.3.5. This section reports that many participants argue that the NHS should provide and fund NuH nurse training, and feel excluded by the NHS because this does not occur. These views and experiences resonate with my own. As discussed in 1.3, I worked in a NuH that provided NHS-contracted care, as well as LTNC. At that time, I was frustrated with the NHS because advanced clinical skills training that was available to local NHS-employed nurses was not accessible to me. I felt that I was missing out on important skills development that would support the care of residents. I did not consider at that time that many of the skills I wished to acquire were not relevant to the care I was required to deliver. During the research process, there was a risk that I would align participants' perceptions with my own original views and fail to objectify their responses or critically interpret the data. The oppositional arrangement of perspectives method, however, enabled me to place my own original perspective in opposition to other perspectives (for

example, participants' perspectives, the NHS funding policy perspective, and the skills needs perspective). The consequence of using this reflexive technique was that I was able to acknowledge my original view as deficient, which modified my perspective in that I became open to the possibility that the acquisition of advanced clinical skills is desirable for many more reasons than those that arose from my own views (these reasons are discussed in 5.3.5). A detailed explanation and example of how the oppositional arrangement of perspectives was utilised during the data analysis process is presented in 4.5.2.2.

Backgrounding: As already discussed in 3.3.3, Derrida proposes that interpretation is achieved by a process of negotiation in which alternative interpretations are evaluated, before a 'responsible decision' is made regarding which interpretation to selected. The selection is influenced by shared intelligibility, which, although helps to constrain hermeneutical anarchy, nevertheless is flawed in that bias due to the influence of individuals' experience may occur. Oppositional arrangement of perspectives assists individuals to mitigate against experience bias, but a weakness nevertheless remains. While the process of oppositional arrangement of perspectives supports reflexivity, decisions regarding interpretation are invariably influenced, if not governed, by what we expect the text/data to be about. There is therefore a risk that data that does not relate to these expectations fades into the background. In order to reduce this risk, literary reception theorists (for example, Ingarden, 1973; Iser, 1978a) suggest that a process of 'backgrounding' such as that developed by Rubin (1958) should be employed.

Rubin's (1958) theory of figure/ground distinction can be used to elucidate this idea (Rubin, 1958; Pind, 2012). Rubin's (1958) figure/ground experiments demonstrate that if observers are instructed to perceive an image in a particular way, their perception of the image in a later recognition test will default to that of the original instruction. For example, when viewing an image of a 'Rubin's vase', if observers are prompted to see a vase as the foregrounded figure, they will see a vase when tested at a later date. In both the instruction and recognition tests, the two faces - the backgrounded field - will not be immediately obvious. Rubin (1958) suggests that if observers are then stimulated into a reverse perception of the image, new and surprising phenomena will be exposed (i.e. the faces become apparent). This study utilised Rubin's (1958) figure/ground process in order that backgrounded data could be transformed into foregrounded data. This transformation allowed me to investigate whether any other topics of potential significance that I had not expected to find were encompassed within the text.

Backgrounding as a reflexive tool can be demonstrated by referring to the unifying category 'business aspects of the NuH nurse role'. My own experience of NuH nursing, and the initial holistic reading data analysis stage, did not lead me to expect business/profit aspects to be important issues with regard to role and status, so there was a risk that during the early stages of the research process, I would miss or discount the significance of this topic. However, utilising the backgrounding activity during data analysis, revealed that this topic was a significant influence on participants' perceptions of role and status. A detailed explanation and example of how backgrounding was utilised during the data analysis process is presented in 4.5.2.3.

Decisions about interpretation: Reflexivity is not just about how the context of the researcher's knowledge and experience influences interpretation. It is also sensitivity to how the research aims and questions shape participants' responses and ultimately, the interpretation. In this study, the interpretative process led to the identification of four initial findings or 'unifying categories' and three themes (the analysis process is discussed in 4.5, unifying categories are presented in chapter 5, and themes are presented in chapter 6). These unifying categories and themes are notable in that they appear to primarily reflect upon the negative feelings of the participants regarding the role of the NuH nurse. Throughout the interviews, participants' discourses situated them as striving to provide high quality care for residents, and as fervent advocates for residents. However, participants rarely referred to NuH nursing as a role that generated much enjoyment or job satisfaction for those undertaking it. It is unlikely that such a negative stance reflects the entirety of participants' feelings, experiences and views of the role, so an important question to consider during data analysis was why do the findings expose the challenges of performing the NuH nurse role, but do not refer to the rewards? The occurrence of negativity in participants' discourses may be explained if we refer to the study's aims and questions (2.6). As the study aimed to explore views and experiences regarding role and status, topics for discussion initiated by the researcher referred to both these concepts (3.4.4). Enquiring about role and status together appeared to have influenced the manner in which participants perceived both concepts. As already discussed in 3.3.2, reception theory hermeneutics proposes that pre-understandings and contexts are interpretative tools. Iser suggests that words, phrases or expressions can become pre-understandings and contexts for other words, phrases or expressions, when placed in a position of association with them. In other words, when words, phrases, or expressions are arranged or positioned together, the meaning of each individual word or phrase is influenced by its association or relationship with the others within the text. This combination of uniqueness of, and relationship between, words and phrases influences how they are understood:

Every segment of the text [is] a two-way glass, in the sense that each segment appears against the others and is therefore not only itself but also a reflection and illuminator of those others...individual segments, then, take on their significance only through interaction with other segments (p.98).

Hence, by linking the two concepts of role and status in interview questions, each became located within the context of the other i.e. 'status' was viewed from the context of 'role', which led participants to interpret 'status' as 'occupational status'. Likewise, 'role' was viewed from the context of 'status'. As already discussed in 2.2.2, status refers to the relative position of an individual within the wider social context. Thus, because participants were prompted to view their role through a 'two-way glass' of role and status, they were more likely to discuss their role in terms of its position within the wider healthcare service, which involved comparing their own role to that of other nurses, and hypothesising about others' perceptions of the NuH nurse role. Furthermore, because the participants perceived their status to be low, their discussions focused, not on the positive aspects of their role, but on explaining which aspects of the role might lead to low status, and on the challenges that low status brings to the role (the use of relationships between phrases as an data analysis tool is discussed in 4.5.2.4).

Thus, by focusing on the issues of role and status together, the study's approach did not lead to an all-encompassing account of participants' views and experiences regarding their role, but rather prompted them to focus on the negative aspects. Nevertheless, this approach addressed the study's aims, and facilitated the identification of a number of role challenges that have not been recognised, acknowledged or considered in previous literature.

An example of the influence of relating role and status on participants' responses can be demonstrated by referring to participants' discussions about nursing residents. During these discussions, participants compared their role activities to the activities they perceive nurses in acute settings to practice. In these discussions they expressed the view that nursing residents in NuHs is different to nursing patients in other environments. Analysis of their responses and accounts about this issue led to the generation of the unifying category 'nursing 'residents' rather than nursing 'patients''. Participants said that in the NuH environment, nurses and residents can develop close relationships that support continuity of care, and promote residents' social well-being. While they acknowledged that this is positive for residents, because discussion topics were framed to prompt discourse about role and status, they spoke at length of the consequences to NuH nurses' role and status of developing these close relationships. For example, they felt that the provision of care continuity can render their role routine and repetitive, and reduce opportunities for

professional learning and development, and for variety in clinical skills practice. Many viewed acute settings to be more conducive to learning and the practice of a wide range of clinical skills. They suggested there is an assumption that NuH nurses practice less clinical skills than other nurses, which they said leads to the perception that NuH nurses' skill set is weak. They proposed that this perception detrimentally affects NuH nurses' status. Analysis of these responses contributed towards the generation of the unifying category 'NuH nursing as a stigmatised role'.

Consistent with addressing the study's aims, I, as the researcher, was also looking through a 'two-way glass' that reflects both role and status, when questioning, analysing and interpreting the data with the aim of generating themes i.e. I was not looking for messages about role *or* status as independent, distinct concepts, but about role *and* status, as associated concepts. Consistent with the reception theory hermeneutic approach, participants' responses are considered against a system of intelligibility that arises from my 'real world' contexts which I share with NuH nurses working within a NuH community of practice, and my knowledge of previous research, and historical and socio-political factors about NuH nursing. This system of intelligibility suggests that contradictory perceptions of NuH nursing exist because, on the one hand, the role is perceived as low status, in part because it is viewed as requiring the practice of few clinical/technical skills. On the other hand, management of residents' multi-morbidities requires NuH nurses to be highly skilled. Using a backgrounding technique to consider the data against this system of intelligibility context reveals that the participants 'buy into' the perception that their work is routine, repetitive and offers little in the way of development opportunities, but there is an absence of discussion or acknowledgement that the skills used to manage multi-morbidities are important and complex. This absence of discussion about multi-morbidity management, when brought from the background into the foreground, led to my interpretation that the participants do not value managing multi-morbidities as a skilled activity. The participants view residents' social well-being as the primary focus of their care, but do not appear to recognise that it is their successful management of multi-morbidities that allows residents to focus on social pursuits. Seeing their role as primarily about attending to residents' social well-being, rather than their medical health leads to comments such as that expressed by Alice in her second interview - 'I'm not sure if I'm a nurse' - which contributed to the interpretation that participants question their occupational identity (discussed in detail in 6.2).

3.3.3.3 Validity

There has been much debate regarding the nature of information generated from qualitative research, and how the quality of this information can be assessed. Numerous

terms have been suggested to articulate validity in qualitative research (for example truth value and credibility – Lincoln & Guba, 1985; trustworthiness – Eisner, 1991; authenticity – Guba & Lincoln, 1989; goodness – Emden & Sandelowski, 1999). However, Whitemore, Chase and Mandle (2001) suggest that such language and terms of reference do not alone articulate validity criteria satisfactorily. These authors propose that terms of reference are less important than the actual techniques employed to demonstrate validity of any given study. They suggest that techniques should be chosen that match specific research processes of individual studies, rather than checklisting techniques against a list of validity terminologies. Whitemore et al. (2001) propose a synthesis of terms, and instead make a distinction between primary validity criteria, i.e. criteria that are necessary to all qualitative enquiries (encompassing for example, credibility, reliability, trustworthiness, authenticity and integrity), and secondary criteria, i.e. criteria that are applicable to particular investigations (such as explicitness, vividness and thoroughness).

For phenomenological studies, these authors suggest that primary validity criteria techniques include ensuring the interpretation is grounded in the data, demonstrating confidence in the interpretation, ensuring the interpretation is true to the phenomenon, and exploring ambiguities so that alternative explanations can be accounted for. Secondary criteria in phenomenological studies include explicit audit trails which allow the reader to follow the researcher's interpretative efforts. Also, vivid and rich descriptions help to highlight salient facets of themes, and support readers to experience and understand the phenomenon under review.

In line with this argument, validity criteria issues in this study were less concerned with terms of reference than with specific techniques that demonstrated and evaluated validity. I utilised a number of validity techniques, and employed a validity assessment model in order to check and critique the validity of the research process. The assessment model chosen was designed by Mays and Pope (2000) and it was selected because it complements the methodology of this study, in that it acknowledges that hermeneutic phenomenology involves subjective interpretation, rather than developing formal theory (unlike for example, Hammersley's 1990 model, which focuses on testing the degree to which substantive and formal theory is produced). Mays and Pope's (2000) adaptable and accommodating approach accepts that validity cannot always be proven, but that it can be improved if the researcher enters into a dialogue with readers by describing and identifying the limitations of the validation processes so that readers can exercise their own judgement regarding the quality of the study. The purposeful engagement of readers in the

evaluation process also accords with the use of reception theory within the chosen methodology.

Utilising Mays and Pope's (2000) model involved comparing the study against five validity criteria, reflecting upon the extent to which the study meets the criteria, and acknowledging the study's strengths and limitations regarding these criteria. One of these criteria is reflexivity (already discussed in 3.3.3.2). The remaining four criteria are discussed below.

Triangulation: Triangulation is a comparison of results from two or more different data collection methods from which patterns of convergence lead to the corroboration and development of interpretation. This study, however, utilised only one method of data collection – interviews. Nevertheless, a level of triangulation was achieved via the multiple episodic interview technique employed. Because this technique prompts semantic *and* episodic responses, in effect, two approaches to data collection are utilised, which increases validity to some extent (this is discussed in greater detail in 3.4.1 and 3.4.4).

Member checking of data: During member checking of data, the researcher's summary of the data collected in previous interviews is checked by the participants in order to establish correspondence between the two accounts. However, although member checking of data can be a check of the validity of researchers' summaries and initial analyses of data, participant reviews are also potentially problematic. As Bar-On (1996), explains, participants may feel original statements seem unguarded and attempt to modify or retract them, or participants may not agree with, or accept, data summaries or initial analyses that they perceive as critical or unfavourable. In this study therefore, participants were not invited to review transcripts, data summaries and interpretations. I instead addressed the dilemma by firstly using the multiple interview technique employed to verbally verify participants' intentions when statements in previous interviews appeared contradictory (this is discussed in 3.4.2). Secondly, I undertook final, semi-structured interviews during which I verbalised to each participant a summary of their responses from earlier interviews. Here participants could consider, comment and reflect upon previous discussions (see 3.4.4). Participants' reactions to the researcher's queries and summaries of discussions were incorporated into the findings.

Clear exposition of methods of data collection and analysis: Clear exposition of methods requires sampling, data collection and data analysis processes to be well-defined and described in detail so that the reader may evaluate whether the data satisfactorily supports the researcher's interpretation. In this study, the current and subsequent chapter

(chapter 4) regarding the research framework and research process describe these methods in detail.

Fair dealing and attention to negative cases: Fair dealing and attention to negative cases allows for discussion of different perspectives and contradictions in the data. Analysis of negative cases helps to refine interpretation. For instance, in this study, the outlying views of some participants regarding their business role, supported the revision of explanations of experience. For example, unlike most other participants who found the integration of business activities into the NuH nurse role uncomfortable, Anne, a NuH manager who had worked in a commercial environment prior to becoming a nurse, had no difficulty. Her views and experiences led to a revision of the interpretation that business activities are uncomfortable for nurses, to an interpretation that suggests education and habituation may alleviate some of this discomfort.

3.4 Research Design

During the review of the methodology literature, decisions were made regarding the development of the research design. The design chosen had to be consistent with the aims of the study and the methodological approach taken. It had to provide a context in which participants were able to express their views, ideas and assumptions regarding the topics under review, but also allow participants to narrate specific experiences related to these topics. By addressing these requirements, the design would support the methodological approach (discussed in 3.3.2) that aimed to utilise the technique of maximising semantic potential (the interplay between universal assumptions and theories that arise from relevant contexts which are expressed as narratives and stories) in order to enhance understanding of the data. However, accessing semantic potential in research can be challenging. As verbal accounts of participants are integral to gaining personal perspectives, rich and meaningful data can be difficult to obtain from participants who struggle to articulate their views fluently and fully (Wood & Kerr, 2011). To promote articulation of rich data, the data collection method for this study utilised two techniques - Flick's episodic interview technique (Flick, 2000; 2009), and a multiple interview technique. The advantages of these techniques are discussed below.

3.4.1 Episodic interview technique

The basis of the episodic interview is the supposition that participants' experiences are related via narratives that involve utilising both episodic and semantic knowledge. During episodic interviews, the researcher both asks the participant to narrate specific episodes, and prompts generalised discussions based on assumptive knowledge and views. This combination of episodic and semantic knowledge generates data that springs from a wider

range of experience than life events only, so that participants are located in general, as well as concrete experiential contexts. Flick (2009) summarises thus:

The episodic interview facilitates the presentation of experiences in a general, comparative form and at the same time it ensures that those situations and episodes are told in their specificity. Therefore, it includes a combination of narratives oriented to situational or episodic contexts and argumentation that peel off such contexts in favour of conceptual and rule-oriented knowledge (p. 186).

The similarities between Flick's interview method and the reception theorists' use of semantic potential are clear. In both techniques, semantic knowledge emerges from narrative episodes, but simultaneously, semantics free narratives from the burden of 'wholeness'. Instead, semantic knowledge initiates, and 'links up' with, new narrative episodes. The obvious benefit of this technique is that it helps the data to retain its focus on the topic in hand, without being diverted or engulfed by less relevant minutiae. The technique has an added benefit in the research arena because participants are not obliged to manage large single narratives – a task that can prove difficult and daunting for many. Thus, episodic interviewing complements hermeneutics in that it facilitates the 'fusion of horizons' and the transcendence of views and experience that are necessary to the reception of meaning that informs the reader's understanding. This is demonstrated in an extract from Faye's second interview. During the interview, I asked Faye about her views regarding the quality of health and social care for older people, and what experiences had led her to hold these views (episodic experiences are presented in non-italics, and semantic assumptions are presented in italics):

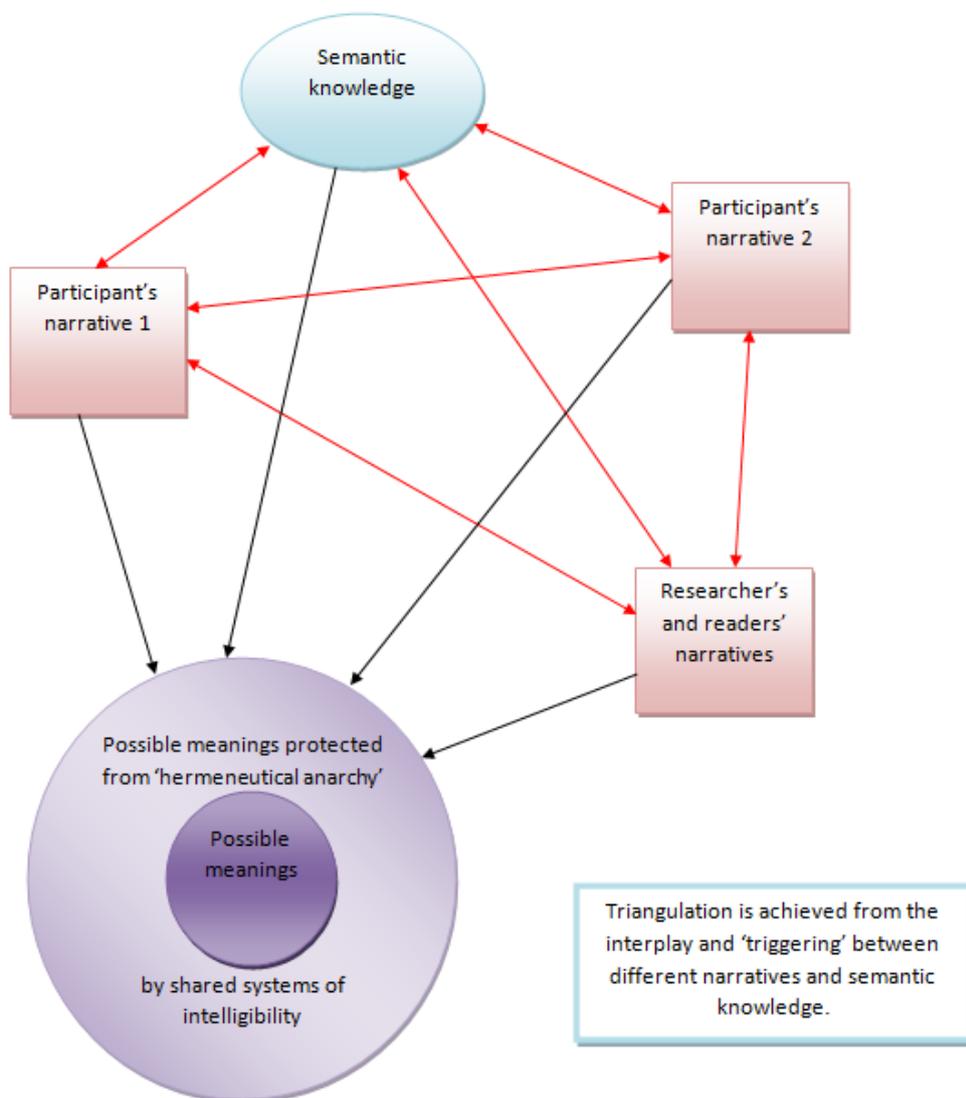
Faye (2): There's many people in the team that come in with a self-righteous approach, a judgemental approach on the nursing aspect, but we don't get the tools to do it properly. *You know I think it's very much them saying, 'Well what's the point of investigating because whatever the outcome's going to be, what are we going to do? We're not going to act upon it, so don't investigate'.* So sometimes you're nursing them blind in this area, you know. There's a mass on their lung. What is it? 'Well we'll not bother putting in the expense because you know.' So you can find yourself nursing them blind. What is the diagnosis? What is the prognosis? What do we do to prepare the client and the family? You've just got to go with it. *But definitely not, I don't think there's much money invested in the elderly. And I think it's really wrong. And it's very close to my heart in that they're a part of society still, and they've worked hard.*

Here, the narrative elements elucidate possible meanings more effectively than methods aimed at exploring semantic knowledge only. However simultaneously, the semantic elements (which are a product of shared 'systems of intelligibility') lessen what Flick (2009)

calls the 'one-sidedness' and 'artificiality' of the narrative (p.190). In effect, triangulation is accomplished because two approaches to data collection are utilised (figure 3.3). Whether the narrative is a mirror of the actual occurrence described is not critical, because the purpose of the episodic interview i.e. to initiate and illustrate the semantic ideas from narratives, is successful. These ideas then trigger more narratives. The participant is reminded of other episodes which exemplify the concepts further.

This 'trigger' effect between narrative and semantic utterances influences the reader's response in the same way. The semantic knowledge that emerged from Faye's narratives reminds us of our own narratives (episodes that we have experienced) and these in turn lead us to develop our own understanding of the text that supports understanding of semantic assumptions even further.

Figure 3.3: Interpretation and triangulation of data



During the final interviews (the interview sequence is discussed in 3.4.4), I verbally summarised the main aspects of previous interviews with individual participants and invited the participant to comment. Sometimes, the participant responded with a semantic statement:

Researcher: You mentioned that residents and families, when they first come in, are often very suspicious, and that's something you've got to work on, to build up that trusting relationship.

Alice (5): And you don't want - as with all things - one negative incident can out shadow all the nice things that are done.

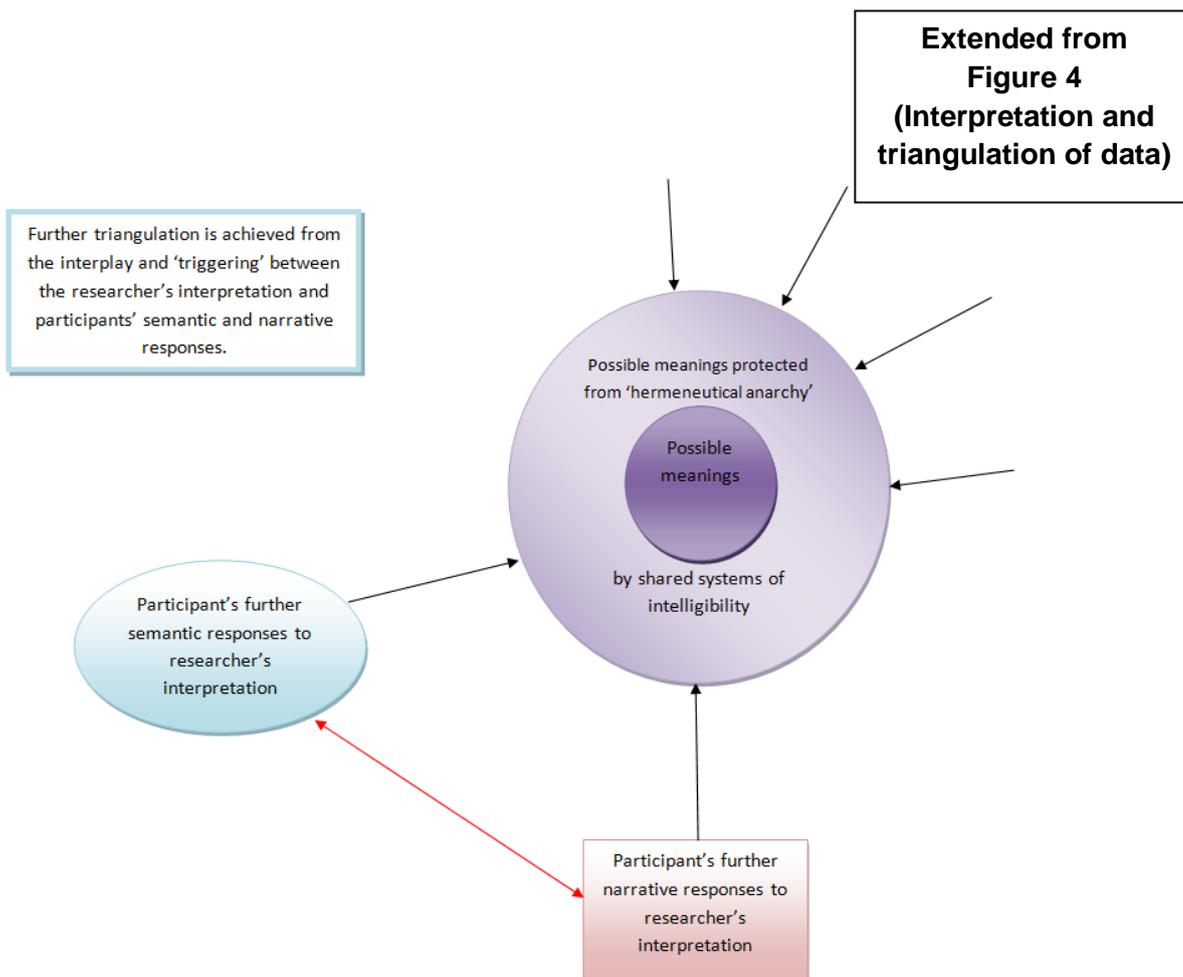
Participants also used further narrative episodes as responses:

Researcher: Researcher – We talked about the fact that this is a business as well as it being a unit for healthcare. And you said that when you're showing people around, because you are selling them a home in some sense, it's uncomfortable. You're always careful to be very honest about things.

Elaine (5): Definitely. Erm, 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.

The 'shared intelligibility' (see 3.3.3) between the researcher and participant regarding the interview and research field contexts functioned as a 'credibility check' of the researcher's interpretation. Also, further triangulation of data occurred when the researcher's interpretation triggered, and was validated by, new participant semantic and narrative responses (figure 3.4 – an extension of figure 3.3).

Figure 3.4: Final interview: triangulation and validation of data



3.4.2 Multiple interview technique

Data validation, and fluent and comprehensive articulation of participants' discourses, can be further facilitated by the use of multiple interviews. Although interviewing each participant a number of times can be time consuming and difficult to negotiate, the benefits to research are significant. These benefits are explained below.

3.4.2.1 Clarification

If inconsistencies are identified within the data of single interviews, understanding becomes difficult for the researcher. Cohen, Zhan and Steeves (2000) state that multiple interviewing corrects inconsistencies because the researcher has opportunities to revisit problematical issues with participants, and gain clarification. Faye's interview sequence can be used as an illustration. In Faye's first interview, training prospects in her NuH were deliberated. Early in the interview, she stated that training opportunities in her NuH were 'magnificent'. However later, she appeared to contradict this statement by saying that training was not 'equally available'. By returning to this issue in the second interview, Faye was able to explain that in her experience, although her NuH provided a range of staff

development opportunities, few were provided by, or recognised by the NHS so were valueless in terms of transferability between public and private sectors.

3.4.2.2 Participant reflection

Cohen et al. (2000) suggests that multiple interviewing allows participants to reflect on previous interviews leading to richer, more extensive data in subsequent interviews. Indeed, many of the participants reported that multiple interviewing allowed them to contemplate past interviews in preparation for the next ones. The technique also prompted discussions about the research topic between participants and their families, friends and colleagues, which meant that to a certain degree, the sample was increased to include a kind of 'shadow sample' of the opinions of participants' acquaintances. These points can be illustrated by Diane's and Anne's comments on the interview process:

Diane (4): Through you coming here has made me think very carefully and things. Yeah, analyse things.

Anne (4): My deputy has just said to me, although she hasn't taken part in this study, she said to me, 'I wouldn't be interested in working here if it wasn't for the NHS floor'. I said, 'It's funny you should say that because that's exactly what we're looking at, at the moment [in the study]'.

Although unintentional, the reflective process initiated by multiple interviews meant that interviews became instruments of data generation, and even instigators of participants' behaviour change, rather than data collection tools only. This was particularly apparent in Diane's case. The 'thought-provoking' interviews (see quote above) led her to analyse, and polarise her ideas, regarding her employment situation, so that in the fourth interview, she informed me that our encounters had helped her to realise that there were other career opportunities she wished to explore before retiring. Diane's actions subsequent to the interviews demonstrate the views of localist researchers such as Silverman (1983), Holstein and Gubrium (1995), Hammersley (2007) and Dumay (2010). The localist view is that interviews themselves are phenomena and their position within the social context of interviewees' lives has a generative role in narrative processes, the application of semantic knowledge, and ultimately the interviewees' understanding of their own situation. As such, the researcher must acknowledge and consider the impact of the interview process on the data collected during the analysis stage.

3.4.2.3 Interview topic generation

Dumay (2010) and Qu and Dumay (2011) explain that multiple interviewing permits the researcher's preliminary analysis of early interviews to generate topics for exploration in subsequent interviews. This is illustrated by the following extract from an interview with

Beth (this extract is taken from a wider discussion about the behaviour of acute care nurses and other health professionals towards NuH nurses):

Researcher: What about community nurses and district nurses (I know you're a bank community nurse too)?

Beth (1): Erm, I think the thing that I've witnessed is that some of the district nurses, you know when we have to call them because a resident is in a residential bed, and that's a bit awkward at times. They come in and are like, 'Why can't you do this kind of thing? You know they're in a nursing home, and, 'There's nurses employed here'. But it's all to do with politics, because *they aren't paying the same rate as people are for nursing care.*

The short comment (italics) concerning the impact of funding on the NuH nurse's occupational standing does not immediately stand out as significant within the context of this discussion, but using a 'backgrounding' technique (a technique whereby data that may not initially stand out as significant is re-reviewed - see 4.5.2.3) as part of the data analysis process revealed funding as a potential topic for further exploration in subsequent interviews. Thus, in the next interview with Beth, we discussed the impact of funding on the NuH nurse's role in greater detail:

Beth (2): 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...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.

During this second interview, Beth's responses showed that funding of care is a major issue for her (as it subsequently proved to be for most of the other participants) as it creates role anxiety, and affects her relationships with those in her care. This demonstrates that the multiple interview supports the research aims by facilitating the exploration of a wide range of participants' experiences and views regarding their role.

3.4.2.4 Participant-researcher trust

The trust established during multiple interviews also encourages participants to speak freely about the personal episodes that are invaluable as illuminations of their social contexts and experiences. For example, during Alice's first interview, she presented as someone with little motivation or ambition regarding her career as a nurse. She felt that NuH nursing is 'not a career, it's a job', and she stated a number of times that she works in a NuH because it is 'convenient' to do so. However, in later interviews, because Alice and I had had the opportunity to develop our relationship, she appeared more at ease with me, and willing to discuss more personal information. As such, she was able to explain that in fact she does have career aspirations, but the ill health of her young son prohibited the pursuit of these aspirations at that time.

3.4.2.5 Questioning technique appraisal

Multiple interviewing enables the researcher to appraise the questioning technique initially utilised, and adapt and improve it in order to support the collection of richer data in later interviews. For example, Ellen in particular struggled with narrative discourse in the first interview, often responding with 'yes' or 'no' answers. This demonstrated that my questioning technique was inadequate to stimulate full discussions. After contemplating the difficulties encountered during this initial interview, I decided to use reiterative statements rather than questions, to prompt discussion in the next interview. Reiterative statements are used by the researcher to reiterate, confirm or clarify participants' accounts. Hannabuss (1996) states that this technique avoids condensed answers, and stimulates pace and persistence of discourse, because participants are encouraged to reflect on, reaffirm and paraphrase their views. According to Hannabus (1996), when this technique is utilised, participants feel that they are conversing, rather than being interrogated. This approach did prove more successful as demonstrated in the following extract from the second interview:

Researcher: You mentioned there about relatives coming in to look around, and they notice the building.

Ellen (2): Well they're not sure at first. They may have been told by the hospital they have to find somewhere for their relative, so they've got a few, two or three homes to visit, so they look at homes easy for the family to visit. But then once they get in, it's like the atmosphere, and they remark on the carpet and curtains.

Researcher: So they're swayed by the environment rather than the care.

Ellen (2): Yes. The ones I've met. I mean obviously we do tell them about, we've got diversional therapy, the hairdressers and the shop, and the opticians. We tell them about the care that their relatives will get. But it's the initial impression. Same as when you're buying a house, isn't it? First time you set foot in it, you either like it or you don't.

3.4.3 Ethical dilemmas resulting from the interview approach

According to Briggs (2002) and Kvale (2006), the interview process inevitably entails an asymmetrical relationship due to differentials in power between interviewer and interviewee. Kvale's (2006) summary of principle power dynamics demonstrates that the process of asking and answering promotes submissiveness rather than partnership. In order to address the researcher/participant power imbalance when collecting data, researchers typically allow participants to choose dates, times and venues for interviews, and, at the commencement of each interview, confirm consent. Kvale (2006) suggests that the power imbalance can be more effectively reduced if participants are encouraged to ask questions and pose challenges during the interview process regarding the topics under scrutiny. However, this may prove difficult for participants to undertake unless they

are at ease with both the interviewer and the interview situation. Establishing interviewee ease depends upon building rapport between researcher and participant. Alvesson and Deetz (2000) believe this is most likely to occur in situations of prolonged engagement, such as during multiple interview processes. In this study, confidence, commitment and trust between participants and myself increased as relationships progressed.

Conversely, prolonged engagement between researcher and participant can generate ethical difficulties during the conclusion of interview sequences and the researcher's withdrawal from the field. This problem is most evident in cases where researchers become involved with vulnerable people who perceive research studies as opportunities to increase social encounters and boost self-esteem (Taylor, 1991; DeLaine, 2000). Such problems do not generally occur when interviewing participants in their professional roles, and indeed, in this case, many participants appeared to view the interviews as part of their working day (appointments were pre-arranged and written into the NuH diaries as clinical tasks or meetings). Nevertheless, Gibbs (2009) believes that if disengagement occurs without thought or care, any participant may feel dejected, 'Confusion, disappointment and de-motivation can occur and can lead to the participant feeling like a mere object, with corresponding loss of dignity' (p. 62).

For Gibbs (2009), agreeing to participate in a research study is an act of generosity. The participant is presenting the researcher not only with a 'gift' of data, but with the 'gift' of contributing to the stimulation of the researcher's thinking. Gifts, for Gibbs (2009) 'have functional necessity which binds us through the reciprocity of gratitude' (p. 57). It is therefore imperative to demonstrate gratitude towards participants as part of a successful disengagement process. At the conclusion of interview sequences in this study, I presented each participant with a small material gift (chocolate or wine), but the most significant expression of gratitude involved presenting each participating NuH with a summary of the study's findings. This was particularly appropriate as many participants were curious about whether their responses corresponded to those of other participants, and also they showed an interest in how their discourses contributed to the study's findings.

3.4.4 Interview sequence

Initial data was collected via recruitment information sheets (appendices 5 and 6). Subsequent data was collected via taped interviews, which I then transcribed and analysed (the data collection process is explained in 4.4. The analysis process is discussed in detail in 4.5).

The primary purpose of the original recruitment information sheets (appendices 4 and 5) was to drive sample selection. The first interviews built upon the recruitment information sheet data, in order to collect further background information with a view to developing contexts for the described experiences. Subsequent interview topics were informed by the topics underpinning the study's aims, and analyses of preceding interviews. Because much of the informing data was unknown, and because qualitative data collection is a dynamic process, it was not appropriate at the pre-interview planning stage to produce explicit topic schedules. However, a broad outline of interview topics was proposed, that reflected the research questions and supported achievement of the study's aims:

- What are your experiences, expectations, motivators, feelings and reservations about your role and status as a NuH nurse? Why do you feel this way?
- How do these feelings come about?
- What are your future aspirations? Does your current role and status affect your future aspirations? If so, how and why?
- What are your experiences and feelings regarding relationships with other stakeholders, the general public, and the media? Are your role and status affected by these relationships? If so, how and why?
- Do you think your experiences, motivators, feelings and reservations about your role and status as a NuH nurse influences the quality of care provided? If so, how and why?

While the proposed topics were all addressed during interviews, precedence and order of chronology were not strictly adhered to. This was because during interviews, participants sometimes initiated lines of discussion. When relevant to the aims of the study, these lines of discussion were further explored by the researcher and participants, and the original discussion topic plan was returned to later in the interview, or during subsequent interviews. The dynamic data collection process posed a problem in that it was impossible at the planning stage to determine whether or not ethical issues not previously considered might emerge during interviews. In order to address this, it was proposed at the planning stage that any potential ethical issues would be discussed with the supervision team, and any necessary amendments regarding data collection would be submitted to the Ethics Committee before continuing the study.

The purpose of the final interviews was to allow participants to verify the researcher's interpretation of the accounts of their experiences, views and feelings. This exercise supported validity of interpretation as it allowed the participant to take on the role of 'reader'. As already discussed in 3.4.1, 'shared intelligibility' between the researcher and participants served as a 'credibility check' of the interpretation, and provided further opportunities for triangulation of data.

3.4.5 Insider researcher implications

When researchers are connected with participants' experiences in terms of social and cultural background, there is a risk that participants may adapt their narratives to align with certain insider attributes of the researcher. Bar-On (1996) and Simmons (2007) refer to this as 'interviewer dependence', and suggest that the phenomenon impacts negatively on the validity of research. These insider issues include dependence on insider researchers' established knowledge. For example, Simmons (2007) describes how participants shorten explanations because they rely on researchers' insider knowledge to 'fill in the gaps', thus leaving interpretation open to assumption. During this study, I reiterated my academic role ('distancing') at the beginning of each interview, and requested that participants answered questions as comprehensively and clearly as possible. This approach was successful in the main, and on the few occasions where participants referred to insider knowledge, I requested clarification.

3.5 Conclusion

Gadamer's (1979) concept of 'fusion of horizons', and the reception theorists' notion of 'writerly' reading, propose that understanding can occur when we enter a dialogue with a text. This dialogue contributes to the development of insight, understanding and knowledge of the phenomenon under review. It also modifies our consciousness regarding that phenomenon. What is more, the question-and-answer ebb and flow of dialogue allows us to expose our understandings, and test our biases and assumptions. This leads us to clarify our own views and perceptions which supports and enhances self-knowledge and self-understanding. Although my original purpose when writing this chapter was to demonstrate my rationale for choice of methodology, and explicate the methodological framework, the process of contemplating and writing about methodology came to mean much more than this. Contemplation and writing prompted me to open up a dialogue with the interpretative paradigm and with the chosen methodology, as phenomena in their own right (see for example, my reflection on the use of an interpretivist paradigm, appendix 9). The questions I posed, and the answers I sought, challenged, modified and clarified my views, not just regarding my research topic, but also regarding going about the research process.

In the following chapter, an explanation of the research process is presented. In effect, chapter 4 will describe the development of the research process, which arose from my dialogue with methodological matters.

4 Research Process

4.1 Introduction

In the previous chapter, it was proposed that even when the schemata of texts remain fixed, understandings vary. This is because readers' standpoints in relation to the phenomena explored within the text depend upon their unique cultural and social systems and beliefs (for example, Iser, 1978a). The chapter explained that 'hermeneutical anarchy' (dissolution of the text due to too contentious readings) is avoided by the 'shared intelligibility' which readers have in common with other individuals within the broad cultural environments in which they are located. This shared intelligibility helps readers to evaluate the validity of findings by comparing narratives and interpretations against their own prior knowledge. Of course, if readers (in this case, the researcher as a reader of the raw data, and the readers of the thesis) are to draw on shared intelligibility as a means of validating their interpretations, information regarding the contexts and pre-understandings of the participants and researcher must be presented in order to establish frames of reference. In this study, this information is primarily provided by:

- Cultural and historical contexts provided in the introduction and literature review (presented in chapters 1 and 2)
- Reflections regarding my own experiences as a NuH nurse (presented in chapter 1).
- The presentation of brief biographical particulars of the participants (these will be presented in chapter 5).
- The stimulation of semantic as well as narrative participant responses consequent to the use of a multiple episodic interview technique (this will be discussed in this chapter).

However, in order to provide a complete frame of reference, an explanation of the research process is also requisite, so that readers of the thesis may evaluate whether the approach employed is sufficiently valid. Thus, this chapter discusses the research process of the study. It begins by discussing how the sample was obtained, the ethical issues considered and how data was collected, before going on to explain the analysis stages involved that ultimately led to the construction of themes.

4.2 Sample

4.2.1 Inclusion criteria

The purposeful sampling strategy employed in the study follows Sandelowski's (1995) phenomenon 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. Sandelowski (1995) comments that phenomenon variation is essential 'in order to have representative coverage of variables likely to be important in understanding how diverse factors configure as a whole' (p. 182).

Utilising this approach required the inclusion criteria to be relatively unrestrictive. The inclusion criteria for NuHs:

- Registered as a NuH in England.
- Provision of nursing care to some, or all, residents.
- Employ RNs.
- Provide services for older people.

Inclusion criteria for participants:

- RNs (to primarily include staff nurses. However, a small number of RN deputy managers and RN home managers were included to ensure a range of experience).

4.2.2 Research field

Sections 1.5.2 and 1.5.3 provided demographic information regarding the NuH population and NuH nurse workforce in England. However, if phenomenon variation is to be achieved successfully, it is essential that knowledge of the demographics of the chosen research location is acquired. In this case, this involved collating information regarding the NuH nursing population, their employers and their working environments in the North East (NE) of England.

The study was located in NE England in order to facilitate frequent, economical access to participants. At the date of sample selection (August 2012), in total there were 305 NuHs providing nursing care in the NE region, the majority of which were situated in densely populated urban areas (Carehome.co.uk, 2012). In order to facilitate diversity of participants, two geographical locations were chosen. The selected locations accommodated NuHs providing services for a wide range of older residents. Location A served urban and suburban areas, while location B served a rural area. In location A, 16.3% of the population was above the state pension age, and 2.2% of the population was over 85 years old. In location B, 25.8% of the population was above the state pension age, and 3% of the population was over 85 years old (Office of National Statistics, 2012). The total number of NuHs in the two chosen areas that met the inclusion criteria was 160. 132 were situated in location A, and 28 in location B (Carehome.co.uk, 2012).

According to the NMDS-SC (2014b), approximately 1,100 NuH nurses work in the NE region. NMDS-SC (2014d;e;f;g) reports demonstrate that most of the demographic particulars of NE NuH nurses are typical of the country as a whole. For example, 84% are female (national 86%), their median age is 47 years (national 47 years), and the staff turnover rate is 34% (national 33%). However, only 35% of NE NuH nurses are non-UK born (national 43%). Statistics specifically regarding NuH nurses' country of origin are not available, but the NMDS-SC (2014a) does provide this information for professional adult social care (ASC) workers – a group which includes NuH nurses. The report states that the top two countries of origin for non-UK born professional ASC workers are India and the Philippines. In the NE, 25% of this group originate from the Philippines (national 15%), while 27% come from India (national 21%).

4.2.3 Original sampling plan

Attempting to calculate optimum sample sizes in qualitative research is problematic, but some authors endeavour to estimate optimum numbers. Approximations vary between 6 and 20 participants (Guest, Bunce & Johnson, 2006; Onwuegbuzie & Leech, 2007; Kerr, 2010). Literature which specifically considers phenomenological research proposes that intensity of contact with participants, rather than participant numbers, determines sufficiency of data (Cohen et al., 2000; Creswell, 2007; Todres & Holloway, 2010). These authors argue that small sample sizes can achieve insightful explorations without forfeiting analytical depth. For this study, a small sample of participants drawn from a range of NuHs was planned. In addition each participant would be interviewed on a number of occasions. This approach aimed to maximise the sources of rich, in depth data but also comply with the requirements for diversity specified by the chosen phenomenon variation sampling strategy.

4.2.4 Insider researcher implications

Taking on the researcher role within one's community of practice changes the nature of the relationships previously established in that community. Griffiths (1998) proposes that if this change is not made explicit to participants, researchers risk exploiting the community's 'normal ground rules of reciprocity and trust' (p.40). Simmons (2007) encountered this problem when conducting her insider study:

The recipients consented almost without further question. They never queried my intentions, and I had the sense they wanted to participate because they believed unconditionally that the study would be of benefit to nurses and nursing because of my 'insider' status. (pp.12-13).

To address this risk, it was imperative that I 'distanced' myself from potential interviewees. Distancing was achieved by using gatekeepers during participant recruitment (see 4.2.5).

In addition, Miller and Bell (2002) propose that highlighting the researcher's university connections, both on information documents and during interviews, enables the researcher to reinforce an impersonal posture.

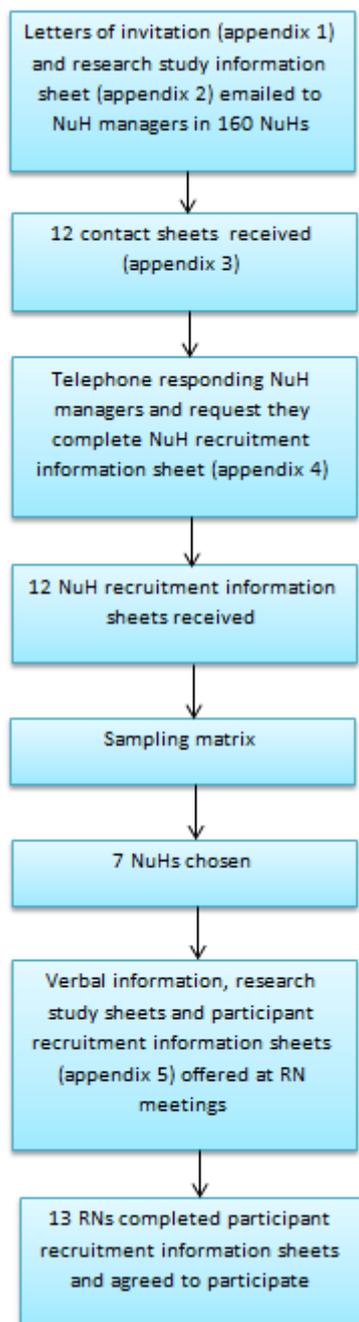
During the period of data collection, I continued to work as a bank NuH nurse, and was therefore familiar with some local NuHs. It was therefore possible that some potential participants felt obliged to contribute to the study (Costley et al., 2010; Research Ethics Sub-Committee, HCES, Northumbria University, 2011). In order to mitigate against coercion, the following steps were taken:

- Gatekeepers were used to support participation recruitment (see 4.2.5).
- Information and consent documents (appendices 2 and 6), and early interactions with potential participants highlighted the voluntary nature of participation.

4.2.5 Actual sampling process

Initially NuH managers were contacted via an email, which incorporated a letter of invitation to participate (appendix 1) and a research study information sheet (appendix 2). Fetterman (1998) emphasises the value of gatekeepers as a means of extending and developing professional understanding and trust between researchers and participants, and as a method of protecting potential participants from the risk of researcher coercion. The obvious candidates for gatekeepers in this study were NuH managers. However, utilising NuH managers presented an ethical problem in itself, as this group are the line managers of the targeted population. There was a risk that these gatekeepers would control, rather than facilitate, access to potential participants. DeLaine (2000) explains that gatekeepers in controlling positions have the power to coerce or exclude participants and influence data to promote and protect their own, or their employing organisations', objectives. To reduce the risk of gatekeeper influence, it was essential that the information and invitation documents indicated the inclusive nature of the study, as well as reiterating that participation was voluntary (appendices 1 and 2). Once introductions to potential participants were made, contact between participants and myself occurred without further gatekeeper intervention.

Figure 4.1: Sampling Process



Twelve interested NuH managers responded by returning a contact sheet (appendix 3). The response rate to the invitation to participate in the study was low. This could be attributed to a number of causes, for example, managers may have made judgements regarding the significant commitment that was required for participation, non-respondents may not prioritise participation in research projects, or respondents may have a particular reason for participating.

All respondents were private, for-profit establishments. As such, respondents were not entirely representative of all NuHs in England. However, as the vast majority (89%) of NuHs in England are owned and operated by private companies – a trend that is likely to continue and escalate (Lliffe and Bourne, 2013), this was not considered to be a major limitation of the study, but rather a reflection of the usual.

Responding managers were contacted via telephone and requested to complete an email recruitment information sheet outlining details of resident numbers, types of care provided, proprietor particulars, and numbers of RNs employed (appendix 4). NuHs were anonymised by the prefix NuH followed by a numeral identifier. Responses were analysed using a sampling matrix (table 4.1) to ensure maximum diversity of sample in terms of company and NuH size, and types of care provided (Reed, Proctor & Murray, 1996).

Seven NuHs were selected (recorded in bold. Note that NuH10 was not selected as it transpired that most nursing care services provided related to the care of young residents). Responding managers from NuHs that were not selected were contacted to inform them of the decision, to thank them for their response, and to offer to provide them with a summary of the findings once the study had concluded.

Table 4.1: NuH sampling matrix (NuHs selected for the study are highlighted in bold in the table)

Care Provided	Location		Proprietor Size (all are private, 'for-profit' companies)			Number of Resident Places	Number of Registered Nurses
	A	B	National	Local	Sole		
N, P(NHS)	NuH1		NuH1			30	8
N, R, Res, Older persons rehab (NHS)		NuH2	NuH2			50	10
E, N, R,	NuH3	NuH9		NuH3	NuH9	NuH3=77, NuH9=28	NuH3=6, NuH9=8
E, N,		NuH4			NuH4	22	6
E, N, Res	NuH5 NuH8		NuH5 , NuH8			NuH5=55, NuH8=60	NuH5=13, NuH8=13
N, R, Neuro rehab (private & NHS)	NuH6 NuH11		NuH11		NuH6	NuH11=72, NuH6=66	NuH11=20, NuH6=16
N, R, Res	NuH7	NuH12	NuH7 , NuH12			NuH7=52, NuH12=52	NuH7=8, NuH12=12
E, LD, MH, N, SM,	NuH10		NuH10			67	16

Key:

E = elderly mentally infirm
LD = learning disability
MH = mental health (younger people)
N = nursing
NHS = NHS funded unit
P = palliative
Private = privately funded
R = respite
Res = residential
SM = substance misuse

Once the sample NuHs were chosen, arrangements were made with managers to attend RN staff meetings at each NuH in order to provide potential participants with verbal information about the study, research study information sheets (appendix 2) and participant recruitment information sheets (appendix 5). After discussing the requirements of the study with potential participants, 13 nurses agreed to participate. The primary reason why other attendees at the staff meetings did not wish to participate was that the study required a significant commitment in terms of time and arrangement of meetings. Participants were requested to complete a participant recruitment information sheet detailing age, gender, ethnicity, job title, contracted hours, shift pattern, length of qualification as a RN, and years employed in NuH nursing (appendix 5). Participants were

anonymised by their NuH identifier followed by a participant numeral identifier. Participants were then assigned a pseudonym. Respondents' recruitment information sheets are summarised in Table 4.2.

Table 4.2: Summary of participants
(N.B. All participants were female)

Identifier Code/ Pseudonym	Role	Age	Country of Birth	Country of Qualification	Years Qualified	Years as CHN	Hours/ Shifts
NuH1-P1 Andrea	RN	40-49	Philippines	Philippines	10-20	6-10	FT Both
NuH1-P2 Anne	Manager	50-59	UK	UK	1-5	1-5	FT Days
NuH1-P3 Alice	RN	40-49	UK	UK	10-20	10-20	PT Days
NuH2-P1 Barbara	Manager	50-59	UK	UK	10-20	1-5	FT Days
NuH2-P2 Bella	RN	40-49	Philippines	Philippines	10-20	6-10	FT Days
NuH2-P3 Beth	RN	20-29	UK	UK	1-5	1-5	FT Days
NuH3-P1 Cath	Palliative Lead	40-49	UK	UK	1-5	1-5	FT Days
NuH4-P1 Diane	RN	50-59	UK	UK	16+	1-5	FT Nights
NuH5-P1 Emma	RN	30-39	UK	UK	1-5	1-5	PT Nights
NuH5-P2 Ellen	RN	40-49	UK	UK	20+	1-5	FT Both
NuH5-P3 Elaine	RN	20-29	UK	UK	1-5	1-5	FT Days
NuH6-P1 Faye	Nurse Manager	40-49	UK	UK	20+	20+	FT Days
NuH7-P1 Georgia	Deputy Manager	40-49	UK	UK	20+	10-20	FT Days

In comparison to national and regional demographics (see 1.5.3 and 4.2.2), this sample was representative in terms of median age (47 years). However, representation was not achieved in terms of British/non-UK born ratio as only 15% of participants were immigrants (national – 43%; regional 35%). Also, only UK and Philippine born nurses were represented in the sample. The sample was not representative in terms of gender,

as although some male nurses attended staff meetings, none wished to participate in the study. The implications of these sample limitations are referred to in 6.4.1.

4.3 Ethical issues

4.3.1 Ethical approval

Internal university ethical approval was obtained, as research involving NuH staff who are recruited because of their professional role does not require National Research Ethics Services (NRES) review (DH, 2011). The role of ethics committees is to alert researchers to potential ethical concerns. However, because of the dynamic nature of research, researchers remain responsible for properly addressing any emerging ethical challenges during the research process (see for example, Renold, Holland, Ross & Hillman, 2008). Indeed, this study was not without 'ethics-in-practice' challenges, particularly during the data collection process. These challenges were discussed in 3.4.3.

4.3.2 Informed consent

The provision of comprehensive, accurate information, and the attainment of ongoing consent were particularly important because:

- The dynamic nature of research and the potentially sensitive and provocative topics of discussion may have led participants to reconsider their willingness to contribute (Cohen et al., 2000).
- If participants felt that the research project was enabling their 'voice' to be heard, expectations and hopes regarding dissemination and the impact of results in terms of enlightening the public may not resonate with actuality (Miller & Bell, 2002).

All potential participants were therefore provided with the research study information sheet (appendix 2). The sheet included information that facilitated informed decision-making concerning participation. It particularly highlighted that participants were free to withdraw from the study at any time. The information sheet also provided details regarding the dissemination of findings.

Once individuals agreed to participate, they were asked to complete a consent form (appendix 6). Consent was revisited at the commencement of each meeting, when participants were asked if they were happy to continue the process. However, these verbal re-affirmations of consent were not always straightforward undertakings. This was because contexts which allow researchers and participants to develop close relationships over a period of time (such as the prolonged engagement afforded by the multiple interview technique utilised in this study) mean that participants do not always present themselves in the role of participant, but at times, lapse into 'acquaintanceship' roles.

Renold et al. (2008) refer to this situation as 'the ebb and flow of participant-non-participant' (p.441). This was especially evident in this study prior to, and after recordings, when 'small-talk' occurred. It could be argued that I could legitimately use these snippets of small-talk as data (because some of the small-talk topics were relevant to the research, because they were offered within the interview setting, and because consent was always re-affirmed at the beginning of each meeting). However, as this information was offered prior to, or after, the commencement of recorded interviews when the status of the interviewees as research participants was ambiguous, consent for its use in the study was debateable. Thus, when presented with relevant small-talk topics, I clarified whether they constituted sanctioned research data by asking participants if they were happy to revisit these topics when the digital recorder was in operation. Reiterating the function of the digital recorder as a research tool (Renold et al., 2008), supports 'participant' rather than 'acquaintanceship' engagement. For instance, outside of the interview process, both Bella and Diane informed me that they had applied for jobs in the NHS. Aware that I may have been told of these events because of my role as an acquaintance rather than as a researcher, I asked if they were willing to discuss these developments during recording. Both agreed, allowing me the freedom to integrate the events into the study's findings.

4.3.3 Confidentiality

Participants were assured that their identity would remain anonymous throughout the study. Participants were allocated unique identifier codes, which supported anonymity of all data, including verbatim quotes used in the study. The identifier code key was stored separately from raw data, and only I had access to the code key and participants' personal information. All data storage and use complied with the Data Protection Act 1998. Data was recorded using a digital voice recorder, and both recordings and transcribed data were uploaded to my personal university secure network location drive. The information was password protected (the password is known only to myself). Hard copy data was stored in a locked cabinet accessible to me only.

Participants were advised that any information disclosed during data collection which raised professional concerns, would be managed according to my professional responsibilities i.e. the NMC professional standards (2015). These standards state that registrants have a duty to disclose information relating to unacceptable practices that result in residents, visitors or staff being at risk of harm. However, no situations that could be considered as unacceptable practice arose during data collection.

Confidentiality regarding communities of practice may be compromised if it is known that the research project is insider-led. Costley et al. (2010) and the Research Ethics Sub-Committee, HCES, Northumbria University (2011) describe some of the ramifications:

- If the researcher's community of practice is known, participants' identities are susceptible to exposure.
- The researcher may have knowledge about organisations and individuals which lies outside the permissible research remit. However, possessing this knowledge will unavoidably influence data analysis.

For this study, promoting anonymity and confidentiality within my community of practice involved:

- Ensuring that the sample included a number of settings, and describing the chosen NuHs in loose terms to inhibit identification.
- Ensuring that letters of invitation and participant information documents adequately explained the purpose of the study and its use of data collected (Research Ethics Sub-Committee, HCES, Northumbria University, 2011).
- Constantly reflecting on data collection and analysis processes in order to evaluate the impact of insider knowledge on the study.

Once the sample had been obtained and issues regarding confidentiality addressed, data collection could commence.

4.4 Data collection

Data collection involved collating information about the participating NuHs, and conducting interviews with NuH nurses. As already stated in 3.4.4, initial data was collected via recruitment information sheets. Although the primary purpose of these was to drive sample selection, the information obtained was also used to provide contextual backgrounds about the participating NuHs and NuH nurses. In addition, online NuH brochures were accessed and this material also supported understanding of the contexts of the chosen NuHs. The analysis of this data contributed to the development of participant biographies (presented in 5.2). The main focus of data collection, however, was the responses expressed by participants during the interview process. In total 60 interviews were completed over a period of five and a half months (August 2012 to mid-January 2013).

The number of interviews with each participant was negotiated with individual participants and their managers, and depended upon:

- Participants' own views regarding saturation (Richards, 2005).
- Participants' availability, consent and agreement to proceed.
- The outcome of negotiations with managers regarding capacity in participants' workloads to permit interviews during the working day, and the willingness of participants to be interviewed in their own time.

- Availability of a suitable environment in which to hold interviews.

The duration of each interview was no more than one hour so that the risk of participants feeling fatigued or unduly beleaguered by the process was reduced. 11 participants were each interviewed five times. One participant (Georgia) was interviewed three times, but then decided to move abroad for an extended holiday so was unavailable for further interviews. One participant (Emma) was interviewed twice but was unavailable for further interviews due to family health issues.

4.5 Data analysis

4.5.1 Transcription process

As previously stated in chapter 3, shared intelligibility between individuals, which emerges from common cultural contexts, assists in the development of understanding when we engage in dialogue with texts. It is important to recognise that discourse (as a text in the Gadamerian sense) is itself one such cultural context, because understanding depends as much upon the performance of speaking as it does upon the words spoken. Cavell (2002) explains:

Since saying something is never merely saying something, but is saying something with a certain tune and at a proper cue...the sounded utterance is only a salience of what is going on when we talk...But a native speaker will normally know the rest; learning it was part of learning the language (pp.32-33).

In other words, discourse is more than a verbal exchange. Comprehension depends upon shared conventions regarding intonation and cadence of speech; and non-verbal cues such as facial expression, gesture and posture. Indeed, Shadden, Hagstrom and Koski (2008) suggest that such displays are more honest conveyances of views and experiences than the actual words spoken.

If context is significant to comprehension during discourse, analysis of interview data is problematic from the outset. This is because contextual information is distorted or curtailed by the transcription process. Consequently, there is a risk that the systems of shared intelligibility between participants and the research audience will be undermined. Because of this risk, Oliver, Serovich and Mason (2005) advise researchers to reflect upon the impact of transcription decisions on the data and its reception by readers (readers include the researcher analysing transcribed data, the research audience reading data cited in the study, and the participants themselves in the event that they have been invited to review their transcribed responses). In this study, transcription decisions were unlikely to influence my reception of data because I transcribed the interviews myself. However, the reception of data by the research audience and participants could be affected (see below).

In order to reduce this risk, I adopted a transcription method which utilised the elements of naturalised and de-naturalised transcription that preserve the contextual information relevant to qualitative studies.

Naturalised transcription remains close to verbalised diction (pronunciation and enunciation). It also includes detailed descriptions of response tokens (for example, 'erm', 'eh', 'yeah'), non-verbal gestures, and temporal organisation (timing and pauses). De-naturalised transcription still involves a verbatim record of the discourse, but diction and response tokens are adjusted to reflect Standard English (SE) (i.e. the language mode accepted as the national norm), and non-verbal signals are omitted (MacLean, Meyer, & Estable, 2004). A naturalised approach maintains the intricacies and socio-cultural features of speech and is therefore a useful transcription method in linguistic studies, and some discourse analysis and ethnographical studies (Edwards, 2001). However, purely naturalised transcription can disguise the substance of what is being said (Oliver et al., 2005). This is primarily because the idiosyncrasies of speech that we might ignore when we listen, may become conspicuous and distracting, or appear ineloquent, when we read. In other words, the ear is more forgiving than the eye. On the other hand, an entirely de-naturalised transcription may undermine systems of shared intelligibility so significantly, that the data is left open to unreasonable interpretations.

During the transcription of the first few interviews of this study, it became apparent that the influence of dialect and accent on diction was magnified by the process. I therefore decided to de-naturalise pronunciation and enunciation. However, I retained dialect vocabulary that indicated ethnic and regional characteristics (for example 'mam'). Response tokens and non-verbal communication were retained in the transcriptions because Oliver et al. (2005) argue that these devices protect data from confused interpretations. While response tokens can denote thoughtfulness, reflection or discomfort, non-verbal communication (for example, pauses, gestures, facial expressions, laughing) is often used by speakers as a substitute for verbalised contexts and explanations. Omitting non-verbal communication may therefore be tantamount to omitting whole phrases.

In order to demonstrate the impact of transcription on interpretation of data, the following extract from Emma's first interview is presented three times. The first version is naturalised, the second is de-naturalised, and the final version formed the basis for the data analysis.

Version 1: Naturalised:

Emma (1): But when A told them A was leavin', er, the [hospital], they'd said, the manager had said, 'A'm not givin' yer a reference to go to the nursin' home mind' [Emma shakes her head and looks down].

Version 2: De-naturalised:

Emma (1): But when I told them I was leaving the [hospital], they had said. The manager had said, 'I'm not giving you a reference to go to the nursing home'.

Version 3: Chosen version (basis for data analysis)

Emma (1): But when I told them I was leaving, er, the [hospital], they had said, the manager had said, 'I'm not giving you a reference to go to the nursing home mind' [Emma shakes her head and looks down].

In the naturalised transcription, Emma's accent appears exaggerated, so there is a risk that the reader may be distracted from the substance of her response, by her mode of response. The reader may also be tempted to make incorrect assumptions about Emma's social and educational circumstances. The de-naturalised transcription allows the reader to focus on the substance of Emma's verbalisation. However, by omitting dialect vocabulary and non-verbal signs, the transcription 'white-washes' (Oliver et al., 2005) over the shared socio-cultural contexts that assist interpretation. In the chosen version (on which the data analysis is based), Emma's diction has been adjusted so that her accent does not distract the reader from the gist of her answer. However, the word 'mind' was not removed from the sentence 'I'm not giving you a reference to go to the nursing home mind' as its use in this context appeared to imply a warning. By retaining the word, the theatre manager's disapproval of Emma's career choice is emphasised. Response tokens and non-verbal communication were also retained because reliance on verbalisations alone widens the range of possible meanings regarding Emma's feelings about the theatre manager's comments to include distress, disgust, shame, anger, nonchalance, amusement, etc. However, the response tokens and descriptions of Emma's gestures, enable the reader to disregard some of these possibilities as unreasonable interpretations.

4.5.2 Stages in the data analysis approach

4.5.2.1 Overview

As discussed in 3.3.2, the chosen methodology was hermeneutic phenomenological that utilises aspects of reception theory. These aspects relate to the maximisation of semantic potential in order to enhance deep understanding of participants' experiences and views, by stimulating readers (i.e. the researcher, and readers of the thesis) to 'tap into' their own

semantic and episodic knowledge and 'write' interpretations that are significant to themselves and that allow a reappraisal of the wider assumptions of our culture. As already discussed, the episodic interview technique employed (3.4.1) stimulated semantic potential. A data analysis method now had to be found that realised this potential. The method employed combines Van Manen's (1997a; 1997b; 2002) hermeneutic phenomenological research approach and techniques adapted from the approaches of Iser's reception theory (1978a).

Van Manen's (1997a; 1997b; 2002) hermeneutic phenomenological research approach to analysis focuses on uncovering semantic potential by not only asking 'What does the data say?' but, 'How does the data say what it says?' Van Manen's analysis methods aim to reveal both semantic assumptions and universalities, and narrative illustrations and language, in order to strengthen interpretation, and enhance understanding. Van Manen (1997b) proposes that analysis methods which achieve both these outcomes 'evoke' and 'intensify' understanding:

A focus on the thematic aspect of the text is primarily concerned with what the text says, its semantic, linguistic meaning and significance. In contrast when we focus on the mantic [illustratory] aspect of the text, we try to capture how the text speaks, how the text divines and inspires our understanding. Both forms of meaning are methodologically of critical importance to hermeneutic phenomenological inquiry...[and] has the true effect of making us suddenly see something in a manner that enriches our understanding of everyday life experience (pp.345-6).

Techniques adapted from approaches proposed by Iser (1978a) in *The act of reading: A theory of aesthetic response* were integrated into the data analysis method employed. Iser's (1978a) methods that were adapted for this study include: 'oppositional arrangement of perspectives', whereby the episodic and semantic responses of each perspective are set in opposition in order to test or modify traditional norms; 'backgrounding', to ensure that all participants' views and experiences are accounted for and considered, and 'relationships between phrases' in which understanding of phrases is confirmed or modified by their relationship with other phrases within the text (a detailed account of how these techniques contribute to the analysis process is given in the following sub-sections of this chapter).

The following sub-sections demonstrate the stages in the data analysis method adopted in the study.

4.5.2.2 Stage 1: Holistic reading

Each interview transcript initially underwent a 'holistic reading' in order to determine the fundamental significance of the text as a whole. Van Manen (1997a) believes that this aids construction of a consistent and coherent frame of reference within which each element of the text can be interpreted. He also proposes that a holistic reading is the first step in ascertaining what is 'essential' to a phenomenon, because reading holistically prohibits the intricacies of the text from muddying its elemental message. In order to capture an initial understanding, Van Manen (1997a) suggests the formulation of a 'sententious phrase' – a concise phrase that identifies the core notion of the text under review. As an example, the following extracts from Beth's first interview are presented:

Beth (1): I don't know. I think there's just a big stigma around working in nursing homes, you know. I think she [mother who is a nurse working in a local hospital] wanted me to get the experience of working in a hospital on a busy ward, because with me being newly qualified, I think she thought I would get more, I would you know, develop skills and things that I wouldn't here specifically.

Researcher: Do you think that's been the case?

Beth (1): Erm, I don't know because I think when you're working upstairs in the [NHS rehab unit], you still get to sort of develop your skills with things like you know, the ward rounds and the MDT, you do quite a lot of involvement which is similar to the hospital. But then again you don't get to practice things like IVs, and cannulation and things, which is what I've missed out on.

Researcher: So do you consider those things as missing out?

Beth (1): I think so, yeah, because a lot of the people I qualified with, when I meet up with them, they're telling me what things they've learned, and I have learned things, but completely different things. Mine's all based around managerial, and the running of a business and a home, and things like erm, just like working with the MDT quite closely, where theirs are all practical things like setting up IVs and drips, and er, just a lot more acute things.

Researcher: Do you think some people think that's more important?

Beth (1): I think they, I think it's something, not showing off, but a bit like, 'Oh this is what I can do, you know this is what I've learned', and I think some people do think yeah, that is more important.

The text illustrates the ebb and flow of semantic and episodic data that centres around the topic regarding the influence of clinical skill development on the NuH nurse role. In this extract, Beth feels that acute care nurses (represented by her mother and the nurses she qualified with) view the NuH nurse role as less skilled, and indeed, she herself states that she has missed out on opportunities to develop practical clinical skills. She acknowledges that she has other skills, but she feels that practical clinical skills associated with acute care may be perceived by nurses as more desirable skills to acquire and practice. As such she appears to view herself as somewhat disconnected from her old student clique. From

this extract, a 'sententious phrase' was formulated thus: *'the level of clinical skills acquired and maintained by a nurse influences role perception and status'*.

It is one thing to summarise a piece of text with a view to identifying its essential meaning, but identifying with that meaning in order to create understanding is difficult unless we are familiar with its norms and contexts. Iser (1978a) explains:

Unfamiliar experience contains elements which at any one moment must be partially inaccessible to us. For this reason [we are] guided by those parts of the experience that still seem familiar. They will influence the gestalt we form (p.126).

However, as discussed in 3.3.3.2, familiarity, norms, contexts or pre-understandings may manipulate our perceptions leading to a risk of bias in interpretation. Iser's (1978a) 'oppositional arrangement of perspectives' can be used to mitigate against this risk. As explained in 3.3.3.2, during this process, the variety of perspectives at work within an established frame of social norms are set in opposition to one another so that the deficiencies of each perspective become evident. If we accept Iser's proposal, then we may assume that researchers who are familiar with the stereotype which implies that NuH nurses are less professional and less skilled than other nurses (see 2.3.1 of the literature review), can begin to understand how these norms may have manipulated their own perceptions. Consider again the extract above. First of all, it is necessary to untangle the text so that the different perspectives are clearly delineated:

- Episodic perspective – Beth has some skills but she has missed out on opportunities to develop and practice clinical skills, which social norms dictate are superior skills. This confirms the stereotype of the NuH nurse as less skilled than acute care nurses.
- Beth's perception of acute care nurses' perspective (represented by Beth's mother and friends) – Practical clinical skills are more important nursing skills. NuH settings are not conducive to skill development. This also confirms the stereotype of the NuH nurse.
- Beth's perspective – Beth feels that she is missing out on skill development. She also feels disconnected from her old colleagues because she does not share their skill set. Again, the stereotype of the NuH nurse is confirmed.

Viewed as single perspectives, all confirm the stereotype which states that NuH nurses are less skilled than other nurses. However, when perspectives are set in opposition, and attention is switched from one to another, the standpoint of each perspective highlights the shortcomings of the others. Perspectives undermine each other thus:

- Episodic – NuH nurses do have skills, but these are different skills to those of acute care nurses.
- Beth's perception of acute care nurses' perspective – Acute care nurses hold hierarchical, prejudiced attitudes about NuH nurses. Alternatively, Beth may have misinterpreted or overgeneralised the acute care nurses' perspective because she is influenced by her own stereotypical views of acute care nurses, or because she is intensely conscious of the stereotype of NuH nurses.
- Beth – NuH nurses do have skills but in order to be valued as nurses, they require clinical skills proficiency.

The consequence of this 'reciprocal negation of perspectives' is that the traditional norm is modified by researchers because they have a transcendental viewpoint from which all negated positions can be seen. Thus, for example, the researcher may no longer regard the NuH nurses as less skilled, but understand them as figures stigmatised by this stereotype (indeed, Beth mentions the word 'stigma' in her response).

It can be seen then, that norms, contexts and pre-understandings allow the researcher (as reader of the data) to understand, as well as identify, the essential quality referred to in the original sententious phrase.

4.5.2.3 Stage 2: Highlighting and backgrounding

Subsequent to a holistic reading, Van Manen (1997a) recommends that revealing statements and phrases within the transcript are highlighted. This process serves to corroborate, modify or refute some of the original conjectures generated from the 'holistic' reading. However, a serious flaw is embedded within this highlighting method. Iser (1978a) reminds us that the act of interpreting what we read involves a process of selection. As discussed earlier in 3.3.3.2, selection depends upon the contexts and pre-understandings which the reader brings to the text. While, the process of reading holistically might have modified these norms via the oppositional arrangement of perspectives, the norm topic areas remain the focus. During highlighting, the researcher (as reader of the data) decides which phrases are significant, and which are discountable. Decisions are at risk of being influenced by expectations regarding understanding that were generated during holistic reading. There is therefore a possibility that any data that does not relate to the initial understanding disappears into the background. As discussed in 3.3.3.2, in order to mitigate against this risk, reception theorists propose that a process of 'backgrounding' should be employed. This process is demonstrated using the extracts from Beth's interview quoted above.

In the above extracts, the holistic reading generated a fundamental understanding concerning the practice of clinical skills, so during highlighting, the researcher might concentrate primarily on searching for corroborative or contradictory statements about the practice of clinical skills. The researcher is aware that other data exists, but may be at risk of overlooking its significance.

As explained in 3.3.3.2, this study utilised a backgrounding process in order that backgrounded data could be transformed into foregrounded data. This transformation allowed me to investigate whether any other topics of potential significance were encompassed within the text. For example, the extract previously analysed via holistic reading was re-read and revealing phrases were numbered, and highlighted or backgrounded, according to Van Manen's (1997a) and Rubin's (1958) approaches (yellow signifies highlighting; blue signifies backgrounding):

Beth (1): I don't know. **1** I think there's just a big stigma around working in nursing homes, you know. I think she wanted me to get the experience of working in a hospital on a busy ward, because with me 'being' newly qualified, I think she thought I would get more...I would you know, develop skills and things that I wouldn't here specifically.

Researcher: Do you think that's been the case?

Beth (1): Erm, I don't know because I think when you're working upstairs in the **1** [NHS rehab unit], you still get to sort of develop your skills with things like you know, the ward rounds and the MDT, you do quite a lot of involvement which is similar to the hospital. **2** But then again you don't get to practice things like IVs, and cannulation and things, which is what I've missed out on.

Researcher: So do you consider those things as missing out?

Beth (1): I think so, yeah, because **3** a lot of the people I qualified with, when I meet up with them, they're telling me what things they've learned, and I have learned things, but completely different things..**2** mine's all based around managerial, and the running of a business and a home, and things like erm, just like working with the MDT quite closely, where theirs are **4** all practical things like setting up IVs and drips, and er, just a lot more acute things.

Researcher: Do you think some people think that's more important?

Beth (1): I think they **5**...I think it's something, not showing off, but a bit like, 'Oh this is what I can do, you know this is what I've learned', and I think some people do think yeah, that is more important.

The original holistic reading suggested the sententious phrase: '*the level of clinical skills acquired and maintained by a nurse influences role perception and status*'. The process of reciprocal negation might help us to understand that having less need to acquire and practice clinical skills supports the stereotype of the NuH nurse as being less skilled. The

highlighted phrases (yellow) confirm this understanding, but also bring other related issues to the fore:

Phrase 1-4 Beth associates a lack of clinical skills practice with stigma. She feels other nurses (represented by her mother and friends) think that the acquisition and development of clinical skills is more likely to occur in the hospital environment than in the NuH setting. Beth's fixation about clinical skills implies that she genuinely covets these skills and she believes that her role is devalued without them. Beth specifically refers to skills that are prohibited in NuHs such as cannulation and intravenous drug administration. Beth omits to acknowledge that these practices are not just prohibited in NuHs, but in all community settings.

Phrase 5 Acute care nurses appear to feel that clinical and technological skills linked to acute care nursing are viewed as more important than the skills associated with long-term nursing. Is there an implication of stigmatising behaviour on behalf of acute care nurses against NuH nurses here?

As can be seen, many of the highlighted phrases re-affirmed the sententious phrase produced by the holistic reading. After highlighting however, the debate about clinical skills development and practice is developed further. Does stigma emerge from the clinical skills debate only, or could it partly stem from being a non-NHS nurse? This latter proposal is suggested by Beth's failure to acknowledge that cannulation and intravenous drug administration are not practiced in any community setting, yet she aspires to be an NHS community nurse (Beth's aspirations are presented in 5.2.2.3). By focusing on the prohibition of these activities in NuHs only, is she inferring that stigma results from working in a NuH, as well as from a lack of clinical skills practice? Is the relationship then between NuH nurses and other nurses problematic? Because a multiple interview technique is employed in the study, it was possible to explore these questions with both Beth and the other participants in later interviews.

The remaining non-highlighted text was then re-read. By omitting the highlighted sections, the original understanding and all the associated contexts and pre-understandings were removed. In effect, I was able to view the text 'in reverse' (the foregrounded figure became the background field, and the backgrounded field became the foregrounded figure). This technique permitted minor topics and phrases (blue) that were present in the text in the form of asides rather than direct responses, to take centre stage. At this point, these topics were 'in their infancy'. They were little more than murmurs:

Phrase 1 Beth mentions the similarities between the NHS funded unit in the NuH, and hospital wards. This reaffirms she connects the concept of the NHS with clinical skills and role status.

Phrase 2 NuH nursing requires business and management skills, rather than clinical skills.

Once again, utilising the multiple interview technique was advantageous because these 'murmurs' could be explored in more detail during later interviews, enabling the opportunity for backgrounded topics to evolve into significant topics.

4.5.2.4 Stage 3: Line-by-line analysis

The third stage of analysis involved a line-by-line examination of the text. Although the text was split into phrases, the aim was not to separate and code its terms. Rather, the aims of this process were firstly to enable participants' chosen expressions and language to gain prominence, and secondly to emphasise the relationships and links between the separate phrases. These two undertakings were performed with a view to exposing the presence of sub-texts.

Expressions and language: According to Eagleton (1983), Van Manen (1997a; 1997b) and Strowick (2005), the 'unconscious' use of language can promote understanding and enable researchers to investigate possible meanings that might arise from ambivalences in expression. These authors explain 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 signals or clues to underlying issues. Eagleton (1983) elucidates:

Works contain one or more sub-texts, and there is a sense in which they may be spoken of as the 'unconscious' of the work itself. The work's insights...are deeply rooted to its blindness: what it does not say, and how it does not say it, may be as important as what it articulates; what seems absent, marginal or ambivalent about it may provide a central clue to its meanings...by attending to what may seem like evasions, ambivalences and points of intensity in the narrative – words which do not get spoken, words which are spoken with unusual frequency, doublings and slidings of language – it can...expose something of the sub-text (pp.178-182).

By separating the text's phrases, it was easier to isolate words and expressions that may indicate the presence of sub-texts. As with highlighting and backgrounding, unearthing sub-texts contributed towards affirming, refuting or developing understanding.

Relationships between words, phrases and expressions: As already discussed in 3.3.3.2, Iser (1978a) believes it is important to both perceive words, phrases or expressions, not only in isolation, but also within context, so that the standpoint of each individual segment

of text can be confirmed or altered by its association with the others within the text. This concept is analogous with that of the oppositional arrangement of perspectives (discussed above), but in this instance, we separate aspects of the text in order to determine their connectedness rather than their deficiencies. For Iser (1978a), it is the combination of uniqueness, and connectedness, of semantic and episodic phrases within a text that ultimately leads to understanding.

We can clarify this idea by considering a rainbow. If light is 'split' via reflection in airborne water, a colour spectrum is formed. We can distinguish each individual part of the spectrum as a separate colour, but when these colours are located side-by-side, we come to understand them as something beyond a colour range – they become a rainbow. Likewise, each phrase within a text is a determinate element that contributes to, but is transcended by, a greater meaning. According to Iser (1978a), when phrases are viewed as separate but adjacent to each other, they retrospectively respond to previous sentences - modifying them, and simultaneously stimulate expectations regarding the following sentences. This backwards/forwards process corroborated or undermined the understanding attained from the earlier holistic reading and highlighting/backgrounding process.

By deliberating sub-texts, and utilising a phrase relationships technique, the text was annotated. Phrase repetitions, choice of vocabulary, unfinished sentences, etcetera revealed sub-texts which illuminated and added to previous analyses:

Researcher: So why do you think she thought that?

Beth (1):

12. I don't know.

13. I think there's just a big stigma around working in nursing homes, you know.

14. I think she wanted me to get the experience of working in a hospital on a busy ward, because with me being newly qualified, I think she thought I would get more...I would you know, develop skills and things that I wouldn't here specifically. Summary

Researcher: Do you think that's been the case?

Beth (1):

15. Erm, I don't know because I think when you're working upstairs in the [NHS rehab unit], you still get to sort of develop your skills with things like you know, the ward rounds and the MDT, you do quite a lot of involvement which is similar to the hospital.

16. But then again you don't get to practice things like IVs, and cannulation and things, which is what I've missed out on. Summary

Researcher: So do you consider those things as missing out?

Beth (1):

17. I think so, yeah, because a lot of the people I qualified with, when I meet up with them, they're telling me what things they've learned, and I have learned things, but completely different things...

18. mine's all based around managerial, and the running of a business and a home, and things like erm...

19. just like working with the MDT quite closely,

20. where theirs are all practical things like setting up IVs and drips, and er, just a lot more acute things. Summary

Researcher: Do you think some people think that's more important?

Beth (1):

21. I think they...I think it's something, not showing off, but a bit like, 'Oh this is what I can do, you know this is what I've learned' and I think some people do think yeah, that is more important.

Comment [A14]: Feeling of stigma looms large.

Comment [A15]: Hospital is about experience, skills.

Comment [A16]: Feeling that CHs aren't busy?

Comment [A17]: Hospital is a learning environment.

Comment [A18]: Stigma, slower-pace of work, skills and development occur in hospital, not CH.

Comment [A19]: 'sort of' 'quite a lot', 'similar' these comments are vague, uncertain. NHS rehab unit is better than nothing, but not as good a learning/skills environment as hospital.

Comment [A20]: Focus on what can't do, instead of what can do.

Comment [A21]: Excluded?

Comment [A22]: NHS rehab unit is a substitute ward, not ideal because can't perform certain practical tasks. Strong focus on boundaries of practice. These boundaries lead to feelings of exclusion.

Comment [A23]: Old friends, now excluded from peers.

Comment [A24]: Different – outsider, excluded.

Comment [A25]: Business, managerial skills not viewed as nurse skills, so aren't seen as important. Not traditional nurse task, so importance is undermined.

Comment [A26]: Chooses MDT as significant to her role – desires team, belonging, participation.

Comment [A27]: Again, focuses on what is unobtainable.

Comment [A28]: Differentiates between acute and chronic...acute is more professional?

Comment [A29]: Language of exclusion and difference. Hankers for inclusion via group affiliation and skill development.

Comment [A30]: NHS nurses reiterate own abilities and learning, 'I can but you can't'. Constantly comparing which reinforces exclusion. Almost oppressive, disparaging behaviour.

The above line-by-line analysis modified the previous readings thus:

- The existence of stigma is identified. The link between acute care and the NHS is underlined.
- The association between acute care nursing, and skill development and practice, is verified. It is proposed that hospitals, not NuHs, are authentic learning environments.
- A potential topic regarding 'exclusion' is introduced. Beth focuses on the boundaries of NuH clinical practice, and the differences between long-term care

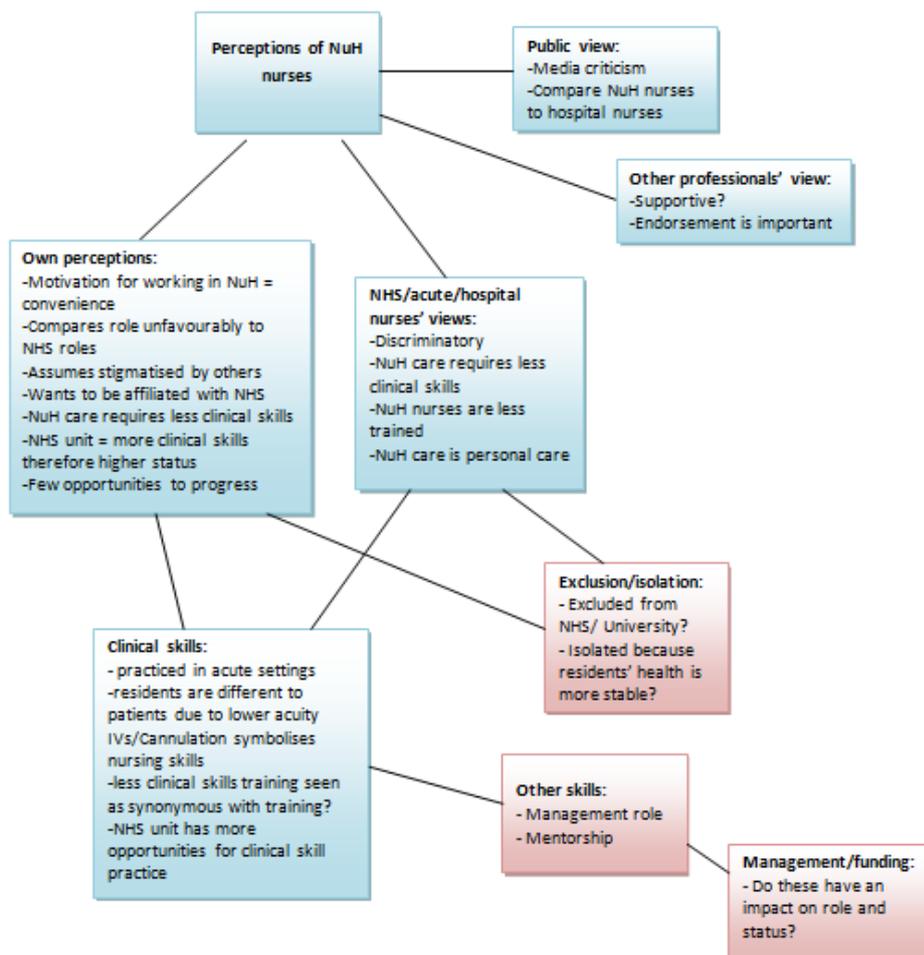
and acute care nurses. She feels disconnected from her hospital peers and attempts to correct this situation by seeking to affiliate herself with the MDT.

- Beth herself 'buys into' the negative view of NuH nurses. She acknowledges NuH nurses have certain skills, but she believes that these qualities are inferior to those demonstrated by acute care nurses.

4.5.2.5 Stage 4: Topic mapping – individual interviews

Each interview was subject to the three analysis stages outlined above. Upon completion of each interview analysis, issues raised were presented in a diagrammatic form in order to trace their sources, consequences and potential outcomes (an example of the process is provided in appendix 8). Major topics (blue) and minor 'murmurs' (red) were identified, and these were then used to inform subsequent interviews with both the cited participant, and the other participants (figure 4.2 is a topic map of the extracts cited above from Beth's first interview):

Figure 4.2: Topic mapping: Individual interview 1



As discussed in chapter 3, episodic interviewing exploits the semantic knowledge of participants as well as their narrative accounts. This means that although topic development is researcher-led, the initial topic mapping process already incorporates a 'resonance' between participants' utterances and the researcher's reception of these utterances. For example, I have coded one of the topics from Beth's first interview as 'perceptions of NuH nurses - stigma'. This code evolves from Beth's narratives about the attitudes of other nurses and health professionals to NuH nursing (Beth describes *what* has happened). However, asking *why* these attitudes occur prompts a semantic reflection in which Beth refers directly to stigma, thus simultaneously instigating, matching with, and confirming the selected code. In addition, the multiple-interview technique strengthens the resonance between participants' meaning and researcher's understanding by initiating an ongoing dialectic debate, in which topics can be re-visited and verified in subsequent interviews (see chapter 3).

4.5.2.6 Stage 5: Topic mapping – individual participants

As discussed above, topic mapping of individual interviews, both initiates topic development and informs subsequent interviews. Once all interviews had been mapped in this way, individual participant's transcripts and topic maps were re-reviewed and assimilated into participant topic maps (figures 4.3 and 4.4 illustrate this process using Beth's maps as examples):

Figure 4.3: Topic mapping: Assimilation of individual interviews

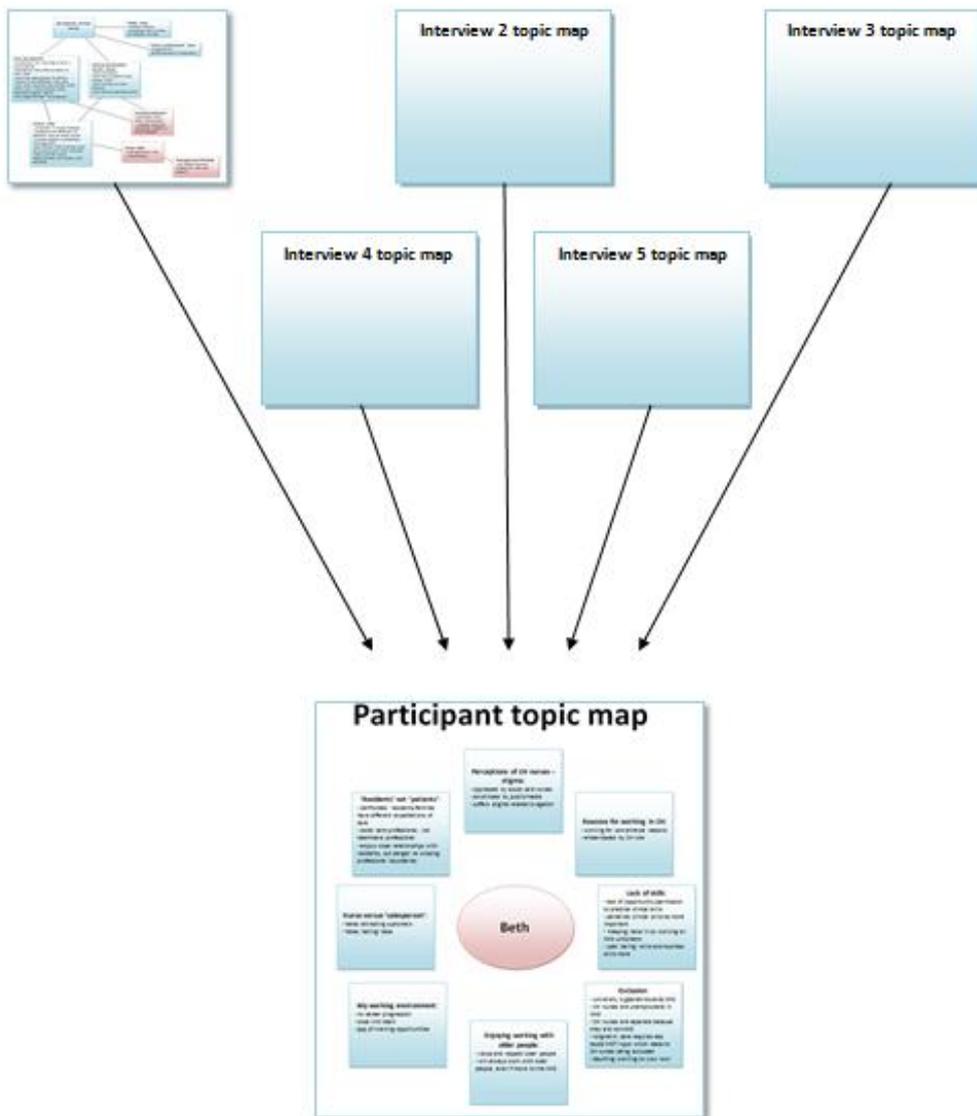
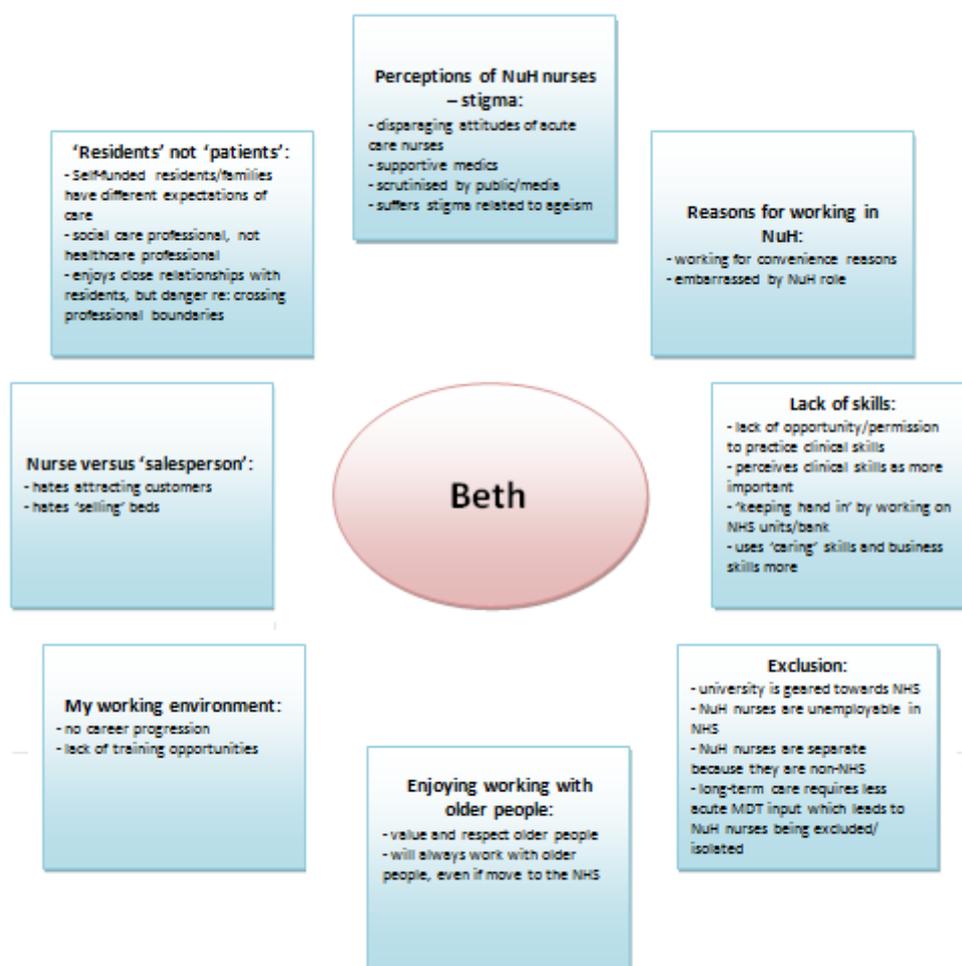


Figure 4.4: Participant topic map



4.5.2.7 Stage 6: Unifying categories

Further examination of all transcripts and participant topic maps, relating to all 13 participants, clearly illustrated the uniqueness of the experiences and views discussed, but also revealed the presence of common areas of interest. The next stage of the data analysis process therefore involved comparing all participant topic maps, then creating topic categories - each category encompassing all the different views and experiences, of all the participants, relating to the topic under consideration. This was not an altogether straightforward undertaking because codes assigned to individual participants did not always correspond to those of other participants. For example, the topic 'nurse versus salesperson' represented Beth's experiences, but did not characterise the experiences of Anne. However, the topic 'customer care' represented Anne's experiences of 'provision of quality care', and 'sustaining competitive advantage'. Although unique to Anne, these experiences nevertheless resonated with Beth's experiences of 'nurse versus

salesperson'. After re-reviewing all 13 participant topic maps, it was possible to categorise these associated topics under the unifying category 'business aspects of the NuH nurse role'.

As the analysis process advanced, all categories were integrated and assimilated into unifying categories. Once all data had been encompassed within unifying categories, this stage of the analysis process was brought to a conclusion. In this study, 4 unifying categories were ascertained:

- Nursing 'residents', rather than nursing 'patients'
- Business aspects of the NuH nurse role.
- NuH nursing as a stigmatised role.
- Professional isolation and exclusion.

These are presented and discussed in chapter 5 of the thesis.

4.5.2.8 Stage 7: Theme construction

While the unifying categories demonstrated connections and consistencies between participants' responses, they were not interpreted within the context of what is already known about the experiences and views of NuH nurses. The next stage of analysis therefore considered the links between the findings and the wider social world. This next stage focused on a Gadamerian hermeneutic process that fused the horizon of the participants' responses (represented in the unifying categories), and the researcher's horizon, which consisted of:

- my pre-understandings of the topic arising from my personal experiences of NuH nursing.
- my knowledge of the literature (presented in the literature review).
- the outcomes of earlier data analysis stages, which had extended my awareness of alternative meanings and prompted me to widen my studies of literature beyond those examined in the initial literature review.

During this stage, I (as both reader and researcher) became the 'writer' of the text, by the acts of reading and reflecting on the participants' responses presented within the unifying categories. As discussed in chapter 3, readers 'concretise' the text via the act of reading, i.e they 'write' for themselves works founded on the integration of their own understandings and the 'schemata' offered by the data. This process of 'writerly' reading is a creative activity in which thematic aspects are refined from unifying categories. These are then deliberated upon by the reader (researcher) to be made relevant by referencing them to the reader's (researcher's) own contexts. Van Manen (1997a) explains this vital process thus:

A genuine artistic expression is not just representational or imitational of some event in the world. Rather, it transcends the experiential world in an act of reflective existence...the artist recreates experiences by transcending them (p.97).

Thus, themes are different to categories in that categories reflect participants' actual experiences and views, whereas themes reflect concepts which exist within the experiences and views, but which transcend the experiences and views of the individual and relate to, and are recognised within, wider social contexts. For example, in the participants' responses about:

- their discomfort regarding business and sales activities (discussed in unifying category 'business aspects of the NuH nurse role'),
- their responses concerning social and personal care for residents (discussed in the unifying category 'nursing residents rather than nursing patients'), and
- their responses about feeling stigmatised (discussed in the unifying category 'NuH nursing as a stigmatised role')

they discussed their experiences, perceptions and feelings. They did not refer to concepts of social identity constructs, 'knowledge-based status', or 'dirty work'. These concepts exist in the culture of academic sociology, and were introduced by the researcher after reflecting on participants' responses and exploring literature with the aim of identifying concepts that were congruent with the participants' views and experiences.

During the theme construction process, three themes emerged:

- Uncertainty about role identity
- Unpreparedness for the demands of the role
- Low occupational status

For Iser (1978a; 1978b), the act of 'writerly' reading results in a modification of readers themselves, because the process not only prompts readers to bring their own experiences to the text, but enables them to learn more about their experiences from the text. This occurred in this study during the process of theme development. During this process, some aspects of the data resonated with my own knowledge gained from my experiences as a NuH nurse, and my studies of the topic (presented in the literature review). In these cases, the fusion of the data's horizon with my own horizon supported understanding of the data within a broader context or frame of reference. Other aspects of the data, however, opened up enquiries into areas that I was unfamiliar with in terms of experience or study. Such occurrences prompted me to explore new lines of enquiry by reflecting upon these occurrences and investigating topics in the literature that were not relevant during the project's initial literature search. This process modified my knowledge and understanding of the topic, and allowed the identification of gaps in the literature specific to

the topic of the NuH nurse's role and status. For example, it became apparent that no studies explore the 'moral taint' that business and sales bring to the NuH nurse's role and status, the impact on role identity that emanates from integrating business and sales within the nursing role, or the unpreparedness of NuH nurses for their business role.

As stated in chapter 3, 'writerly' reading is not only the remit of the researcher interpreting the data. It is as much a concern for readers of the thesis, as for the researcher. Thus, the aim of offering researcher interpretations via 'writerly' outcomes is not to provide a definitive understanding of the text under review. 'Writerly' reading is more a process of debate – a Gadamerian dialogue - whereby the researcher offers his/her own interpretation which emanates from his/her own contexts (and which was checked against participants' interpretations via discussions facilitated by the multiple interview technique), in order to invite readers to join the discussion. During the process, the researcher is saying to readers, 'This is what I understand from within my context, and in the light of what the participants say. What do you understand from within your context, and in the light of my interpretation?' In this manner, participants' responses are embedded in, and simultaneously illuminate increasingly wider social contexts.

4.6 Structure of the findings chapters

In qualitative research, the possibility of multiple interpretations of the data can lead to distorted interpretations or misinterpretations. Researchers must therefore take steps to avoid this 'hermeneutical anarchy', and arrive at 'responsible decisions' regarding understanding. It is imperative that these steps are made transparent to readers, so that readers can make an informed judgement regarding whether the researcher's interpretation is valid. This chapter has provided a detailed description of the research process, outlining all stages involved from obtaining ethical approval, to data collection and analysis methods. This will support readers of the thesis to evaluate the interpretation in order to determine if my understanding of the data is legitimate.

In the following two chapters, the interpretation of the data is presented. Findings emanating from the simple interpretation are portrayed in chapter 5. The chapter begins with short descriptions of the participating NuHs and brief introductions to the participants. However, most of the chapter consists of a presentation of the unifying categories resulting from the comparison of all participant topic maps. Chapter 6 focuses on an in-depth interpretation of the study's themes presented within the context of the wider social world. This interpretation depicts aspects of NuH nursing that shape what it is to be a NuH nurse in terms of role and status. Via the methodology and methods employed, it was possible to

gain new and original insights from a different standpoint, and advance knowledge regarding the experiences and views of RNs working in NuHs.

5 Findings: Overview of Participants and Unifying Categories

5.1 Introduction

This chapter is divided into two sections. The first section (5.2) provides brief overviews of the participating NuHs, and introduces the NuH participants, explaining how they came to work in the NuH sector, and describing their aspirations and intentions regarding their future careers⁸. The purpose of this section is to assist readers to understand the circumstances, both personal and professional, that influenced participants' career choices. It also offers an insight into the personal and professional contexts of individual participants, and to how these contexts might impact upon their interview responses. In addition, the provision of biographical information promotes articulation of the 'real world' contexts of participants' narratives, which supports 'shared intelligibility' and reliability (see earlier discussion in 3.3.3). Furthermore, locating participants' narratives in biographical contexts allows readers to make judgements regarding the transferability of the study's findings. Although it is not the purpose of this section to provide a synthesis of the data, key recurrent topics emerging from the overview are presented (table 5.1) in order to assist readers to assimilate overview information in preparation for the subsequent section of the chapter.

The second section of the chapter (5.3) presents the unifying categories that were ascertained during stage 6 of the data analysis process. As discussed in 4.5.2.7, unifying categories were developed by identifying features of the data that were consistently referred to by participants. These categories thus illustrated the common issues that pervaded the working lives of most, or all, participants.

5.2 Introduction to the participants⁹

5.2.1 Nursing home 1

NuH1 is one of approximately 30 NuHs owned and operated by the same private for-profit company (the company's other NuHs were located in the Midlands and North of England). The owner had recently acquired NuH1, and during the data collection period, was in the process of introducing policies of strict budgetary control and maximisation of occupancy.

⁸ Specific personal information that may compromise anonymity and confidentiality has not been included in these biographical sketches.

⁹ Statistical and demographic information regarding the participating NuHs and NuH has already been summarised in 4.2.5, and tables 4.1 and 4.2.

NuH1 is situated within a densely populated urban area that was once renowned for heavy industry, and is now undergoing substantial redevelopment. The NuH is a relatively new purpose-built home, located in the centre of a residential estate that primarily houses independent-living older people. NuH1 has 22 LTNC places, and eight NHS-funded places for palliative care patients. At the time of data collection, the NuH was fully occupied, although had no residents' 'waiting list'. The NuH operates a key worker system whereby each resident is allocated a key RN and HCA. This system aims to enable staff to develop understanding of residents' needs and preferences. In an attempt to develop a sense of community spirit, staff provide group activities for residents, and facilitate monthly resident meetings. Eight RNs are permanently employed at the NuH. Turnover of all staff including RNs is high. Manager turnover is also high – the current manager is the third to be appointed within the 18 months prior to commencement of data collection. Staff training is bought in from private education companies, although participants said that training tended to focus on mandatory topics.

5.2.1.1 Andrea: RN

Andrea trained as a nurse in the Philippines. She stated that she decided to work in England because working in the 'West' would allow her to contribute financially to the support of family members still residing in the Philippines. She moved to England in the 2000s after being recruited by a large private care provider organisation. She would have preferred to have been recruited by the NHS as she thinks the NHS has a better reputation as a care provider than NuHs, but said that NHS opportunities were limited at the time of her application. She is a senior staff nurse in the NuH, and alternates her shifts between the NHS-funded palliative unit, and the nursing unit. She stated that although she now enjoys her work, she did not initially choose to work with older people - she did so because her employer assigned her to this post.

Andrea stated that in the future, she would like to become a nurse specialist in palliative care, wound care or Parkinson's disease. She said, however, that a move into a specialist role would also require a move into the NHS because in her experience, working for private companies excludes specialist role development as they are unwilling to fund the necessary training.

5.2.1.2 Anne: Manager

After being employed in the service industry for many years, Anne decided to change career and train to be a nurse. She completed her nurse education programme in the 2000s, and upon qualification, worked for the NHS. However, she found that travel to and from work was a lengthy and inconvenient process, as she lived many miles from her

place of work. She therefore left her job, and commenced working at a local NuH that was situated close to her home. This was not the career move that Anne had envisaged. She would have preferred to continue working in the NHS, developing clinical knowledge with a view to becoming a nurse practitioner. After a period of time, Anne moved into NuH management roles, and is currently the manager of the NuH in which she works.

Anne said that the NuH nurse role is primarily a customer care role that involves selling quality services in order to ensure the NuH remains a profitable going concern.

A few years ago, Anne applied for a position with the NHS but was unsuccessful. She stated that NuH nurses are excluded from employment in the NHS because their status is adversely affected by the assumption on behalf of other healthcare professionals that NuH nurses are 'failed nurses' who lack nursing skills. She has now resigned herself to remaining in the private NuH sector.

5.2.1.3 Alice: RN

Alice qualified as a nurse in 1990s. During the first few years after qualification, Alice travelled extensively, but had bases in England and abroad. She returned to these bases for short time periods during which she worked in NuHs, as she found it easier to obtain temporary employment in these settings. Upon starting a family, she settled permanently in NE England, and began to work part-time in her current NuH. Once her children reached school age, she began to consider applying for positions within the NHS in adult acute care services. However, at that time, family health issues prompted her to remain in her current role because she found that it was difficult to find work in the NHS which gave her the flexibility to work around her personal life. Alice alternates her shifts between the NHS-funded unit and the nursing unit.

Although Alice stated that she 'won't rule out hospital work in the future', at present she is happy with her position because it allows her to concentrate her efforts on her family. She said that obtaining employment in the NHS might be difficult for her anyway because of the stigma attached to NuH nursing. Alice said that stigma arises because the public and other healthcare professionals hold a stereotypical perception that NuH nurses' practice and skills are poor. She proposed that negative media reports reinforce this perception.

5.2.2 Nursing home 2

NuH2 is one of approximately 40 NuHs owned and operated by the same private for-profit company (the company's other NuHs were located throughout England). The owner had recently acquired NuH2, and during the data collection period, was in the process of introducing policies of strict budgetary control and maximisation of occupancy. NuH2 is situated in a small town in a sparsely populated rural area in which farming and light

industry are the primary industrial activities. The NuH is a purpose-built home and located on the main street within the retail and commercial area of the town. NuH2 is divided into three units. Unit one accommodates 25 residents requiring nursing care, unit two houses 11 residential care residents, and unit three has 14 NHS-funded rehabilitation places. At the time of data collection, the nursing and residential units were fully occupied, and there was a residents' 'waiting list'. The NHS unit was half occupied, and the new owner was considering ending the NHS contract, and converting the NHS beds to residential places. The NuH operates a key worker system whereby each resident is allocated a key RN and HCA. This system aims to enable staff to develop understanding of residents' needs and preferences, and therefore provide individualised care. In an attempt to build a community, staff provide group activities for residents, and facilitate monthly resident meetings. Ten RNs are permanently employed at the NuH. Turnover of all staff including RNs is high, although the current manager, who was appointed to the post five years ago, has stated she intends to remain long-term. Some staff training is bought in from private education companies, and some is provided in house. The new company has a range of in house education modules, which all staff are required to complete.

5.2.2.1 Barbara: Manager

Barbara explained that many years ago, she had had personal experience of life in care, and that this experience had led her to conclude that the quality of care provision in care homes varied greatly. Barbara initially trained as a social worker and primarily worked with individuals living in care environments, because she wished to contribute to the improvement of standards in these settings. During her years as a social worker, she also owned and ran a small business. In the 1990s, Barbara decided to change career and train to become a RN. Upon qualification, she worked for the NHS on long-stay wards for older people, and then with a community mental health team. She found, however, that she preferred to work with older people, so decided to move into NuH management because she said in this role, she could consolidate all of her interests and skills, and would be best placed to influence and improve the quality of long-term care for older people.

Barbara very much enjoys working in the NuH sector, and she said she cannot imagine working in any other environment. Her primary goal is to ensure that the older people residing in her NuH receive the best possible care. She actively lobbies and negotiates with regional managers and directors in order to acquire funding for resources and more staff training, and she regularly works 'on the floor' in order to role model and promote good practice.

5.2.2.2 Bella: RN

Bella trained as a nurse in the Philippines, and prior to relocating to England, she worked in hospitals throughout the Philippines in a variety of settings including paediatrics, midwifery and care of older people. Bella stated that she prefers to work with older people. She would have liked to have been recruited onto an NHS 'care of the elderly' ward, as she had heard that the NHS has a good reputation as an employer. However, NHS opportunities were limited at the time of her application, so the idea of working in a NuH for older people appealed to her. She moved to England in the 2000s after being recruited by a large private care provider organisation. She is a staff nurse in the NuH, and alternates her shifts between the NHS-funded rehabilitation unit, and the nursing unit. She also works occasional bank shifts at the local NHS hospital, mainly on an 'elderly care ward'.

Prior to the conclusion of the interview sequence, Bella accepted a full time position on the NHS elderly care ward where she worked as a bank nurse. The final interview took place during her period of notice from the NuH. Bella stated that although she had enjoyed working in the NuH, she felt isolated from other healthcare professionals because residents do not require much interprofessional input. She also said that the hospital environment was more conducive to learning and professional development, because turnover of patients is higher, affording opportunities to deal with many and varied conditions.

5.2.2.3 Beth: RN

Beth qualified as a nurse in the 2000s. She said that around the time of qualification, for personal reasons she felt obliged to obtain a job quickly, but was unable to immediately secure a position with the NHS, so began to work in a local NuH. She continues to work in the same NuH, and alternates her shifts between the NHS-funded rehabilitation unit, and the nursing unit. Recently, she has also commenced working as a bank nurse with the local NHS community nurse team.

Although Beth did not proactively pursue a career in services for older people, she stated that due to her experience in the NuH, she would like to continue to work with older people for the duration of her nursing career. She stated that she hopes her experience as a bank community nurse will improve her chances of obtaining a full time position as a community nurse. Once she has achieved this goal, she would like to undertake further professional studies in order to become a qualified district nurse. She said she would prefer to work full time for the NHS, because doing so would afford more opportunities for interprofessional working and career development.

5.2.3 Nursing home 3

NuH3 is one of 12 NuHs owned and operated by a local private company. It is situated in a suburban residential village on the outskirts of a city. The NuH is a purpose-built home and located at the edge of the village within its own gardens and park. NuH3 is divided into three units. Unit one accommodates 20 nursing care residents and is managed by RNs and a team of HCAs on each shift. Unit two is a large residential care facility that accommodates 30 residents, and unit three accommodates 27 residents requiring dementia care. Units two and three are managed by HCAs only. At the time of data collection, the NuH was 90% occupied. Six RNs are permanently employed at the NuH. Staff turnover is low. Most staff, including the manager, have worked at the NuH for a number of years. The company's philosophy of care is based upon providing high quality accommodation and services, facilitated by well-trained staff. The company invests heavily in maintaining and improving the building, equipment, consumables and staff education. Staff education is a priority, and staff are able to access online training, and attend regular training sessions provided by in house and private education companies. The company is keen to provide training for specialist roles, for example infection control nursing, palliative care nursing and dementia care nursing. The NuH provides a wide variety of group activities for residents and facilitates weekly resident meetings. In addition, the NuH has a resident's bar, a shop, a library and a cinema.

5.2.3.1 Cath: RN

Cath had worked in office and administration roles until embarking on her nurse education programme in the 2000s. She explained that as a student nurse, she had enjoyed working with older people, so upon qualification, accepted a full time position as a staff nurse on an NHS 'elderly care ward'. She also commenced working as a bank nurse in a NuH, and after a few months, decided that she preferred NuH nursing so altered her working hours in order to work full time in the NuH, and bank shifts for the NHS. In the 2010s, her manager offered her the role of palliative care lead nurse, and paid for specialist training for this role.

Cath stated that she intends to continue to work as a palliative care nurse within older people's services. She said she has no preference regarding employer or sector.

5.2.4 Nursing home 4

NuH4 is owned and operated by a sole trader and is situated in a rural farming area. The NuH has been converted from farm buildings and is located approximately half a mile from the closest neighbouring farm, and about ten miles from the nearest town. NuH4 accommodates 22 residents with nursing care needs and/or dementia care needs. It is managed by one RN and a team of HCAs on each shift. Six RNs are employed there. Staff

turnover is low. Most staff, including the manager, have worked at the NuH for a number of years. During data collection, the NuH was operating at 75% occupancy. Participants said that the property's remote location, which is particularly difficult to access during periods of bad weather, deters prospective clients. Due to the high vacancy rate at the time of data collection, the NuH was operating on a reduced budget. Training is bought in from a private education company, although the participant said that training tends to focus on mandatory topics.

5.2.4.1 Diane: RN

Diane qualified as a nurse in the 1980s. For family reasons, she relocated to different areas in the UK on a number of occasions. Diane sought employment in the local area within the NHS whenever the family moved. As a result, Diane has had a varied career, and has developed a broad knowledge and skill base in nursing. The family settled permanently in NE England in the 2000s, and Diane accepted a position in a local NHS hospital. Shortly after this, a member of Diane's family became ill, and in order to care for him, she gave up her job with the NHS and commenced working in a NuH. She said this was because the NuH setting was less pressurised, and because the NuH proprietors offered her the option to work permanent night shifts on a set shift pattern.

During interview four, Diane said that her personal circumstances had changed and she now felt able to consider working during the day again. She also said that she was beginning to miss working with patients from other age groups, and working with other healthcare professionals. However, she stated that she did not wish to return to a hospital setting because of the physical demands, stress and irregular shift patterns that working on a busy ward would necessitate. During the interview, she disclosed that had she had applied for a practice nurse position at a local GP surgery. She said that the post would be ideal as it would enable her to work with a variety of patients, and her working hours would be regular.

5.2.5 Nursing home 5

NuH5 is one of approximately 30 NuHs owned and operated by the same private for-profit company (the company's other NuHs were located in the Midlands and North of England). The owner had recently acquired NuH5, and during the data collection period, was in the process of introducing policies of strict budgetary control and maximisation of occupancy. NuH5 is situated within a densely populated urban area that was once renowned for shipbuilding, and is now undergoing substantial redevelopment. The NuH is a relatively new purpose-built home, located in the centre of a residential estate that primarily houses independent-living older people. NuH5 provides nursing care, residential care and dementia care for 55 residents. At the time of data collection, the NuH was fully occupied,

except for three nursing care places. There was no residents' 'waiting list'. The NuH operates a key worker system whereby each resident is allocated a key RN and HCA. This system aims to enable staff to develop understanding of residents' needs and preferences. In an attempt to develop a sense of community spirit, staff provide group activities for residents, and facilitate monthly resident meetings. 13 RNs are employed at the NuH, many on a part-time basis. During each shift, one nurse and a team of HCAs manage the care of residents receiving nursing care, while the residential care and dementia care wings are managed by HCAs only. Turnover of all staff including RNs is high. Manager turnover is also high – the current manager is the third to be appointed within the 24 months prior to commencement of data collection. Staff training is bought in from private education companies, although participants said that training tends to focus on mandatory topics.

5.2.5.1 Emma: RN

Emma had worked as a HCA in a NuH for many years before training to be a RN. She qualified as a nurse in the 2000s and accepted a full time position with the NHS. After the birth of her children, however, she wished to return to work on a part time basis, but her employer was not able to offer this option. Emma therefore resigned from her post and commenced working in a NuH where she was able to work part time set nightshifts.

Emma stated that she intends to remain working in the NuH sector until her children go to school. She would then like to specialise in tissue viability nursing because she has an interest in pressure damage prevention and wound care. With this aim in mind, she is currently saving funds in order to pay for a tissue viability course offered by the local university's continuing workforce development programme. She said that achieving this qualification would widen opportunities to work as a specialist nurse in the NHS.

5.2.5.2 Ellen: RN

Ellen qualified as a nurse in the 1990s and has worked in various NHS settings. During the 2010s, Emma was obliged to leave her NHS post for personal reasons. She commenced working for a nursing employment agency, and after working a few agency shifts in this NuH, she was offered a permanent contract, which she accepted. Ellen said that her status as a nurse had lowered since she had commenced working in NuHs. She attributed this to the public's view that the NuH nurse role is primarily concerned with the provision of personal care than clinical care, and thus requires less skill.

Ellen stated that she will remain working in the NuH sector because she values the opportunities to provide personalised care that the setting affords.

5.2.5.3 Elaine: RN

Elaine worked in the service industry for a few years before commencing her nurse education programme. As a nursing student, she had been allocated to this NuH for one of her practice placements. She enjoyed the experience so much that for the remainder of her studentship, she worked as a bank HCA in the home. Upon her qualification as a nurse in the 2000s, Elaine was offered two RN positions – one in a local hospital, and the other in this NuH. She said that she chose to work in the NuH setting because of her preference for working with older people, and because long-term care is more conducive to the development of close relationships with residents. Elaine is the infection control link nurse for the NuH, and is also responsible for maintaining the duty rota.

Elaine stated that she will remain working as a NuH nurse in this NuH for the foreseeable future. She reiterated that she enjoys working with older people, and said that because she has developed close relationships with residents, families and staff in this NuH, she cannot imagine working anywhere else.

5.2.6 Nursing home 6

NuH6 is owned and operated by a sole trader and is situated in a suburban residential village on the outskirts of a city. The NuH is a purpose-built home and located in the centre of the village in its own gardens. NuH6 provides care for 66 residents, and is divided into three units. Unit one accommodates nursing care residents, unit two is a residential care facility, and unit three provides neurological rehabilitation care for patients of all ages. Units one and three are managed by RNs and teams of HCAs, and unit two is managed by HCAs only. In general, staff remain allocated to the same unit permanently. During data collection, all units were fully occupied, and had residents' 'waiting lists'. 16 RNs in total are employed by the NuH. Staff turnover is low, and most staff, including the manager, have been employed at the NuH for many years. The NuH owner is committed to providing high quality accommodation, and resources and activities for residents. The company invests heavily in maintaining and improving the building, equipment, consumables and staff education. Staff education is prioritised, and they staff are able to access regular training sessions provided by private education companies. In an attempt to integrate into the community, the NuH has sport/swimming facilities which residents, families, and members of the local community are encouraged to use.

5.2.6.1 Faye: Nurse manager

Faye qualified as a nurse in the 1980s. She worked for the NHS for the first few years post-qualification. However, after the birth of her children, she found it difficult to organise her family life around her changing shifts. She therefore decided to seek employment in the NuH sector because shift patterns in this health sector were more flexible. Faye

worked in NuHs for a number of years. She then returned to the NHS and accepted a position on a hospital ward, but resigned shortly afterwards. She said this was because the quality of care for older people on the ward was not of a high standard, and because the ward staff were unwilling to listen to her recommendations regarding practice improvement as they did not respect her as a professional because of her NuH background. Faye commenced working in her current NuH shortly after leaving the hospital ward. She is now nurse manager, and has overall responsibility for the nursing unit. Faye stated that NuH nurses are stigmatised by other healthcare professionals because they are perceived as less skilled. She said that because of their low status, NuH nurses are segregated by healthcare professionals working for the NHS. As a result, they are excluded from NHS training opportunities.

Faye asserted that she enjoys her role immensely. She stated that she is confident in her ability to provide quality care and uphold the good reputation of her NuH.

5.2.7 Nursing home 7

NuH7 is one of approximately 40 NuHs owned and operated by the same private for-profit company (the company's other NuHs were located throughout England). The owner had recently acquired NuH7, and during the data collection period, was in the process of introducing policies of strict budgetary control and maximisation of occupancy. NuH7 is situated within a densely populated area within a coastal tourist district. The NuH is a relatively new purpose-built home, located in the centre of a residential estate. NuH7 provides nursing care, and residential care for 52 residents. Approximately one month prior to the commencement of data collection, the NuH had re-opened after being closed for six months following a major flood. During the NuH's closure, residents and staff had been re-allocated to other NuHs in the group. Upon re-opening, the NuH was not operating at full occupancy, so was undergoing strict budgetary control and a drive to boost occupancy. The NuH operates a key worker system. Staff provide group activities for residents, and facilitate monthly resident meetings in order to promote a sense of community. Eight RNs are employed at the NuH on a permanent basis, although bank and agency staff are employed when necessary. During each shift, one nurse and a team of HCAs manage the care of residents with nursing needs, while HCAs only look after residents who do not require nursing care. Turnover of all staff including RNs is high, and while the NuH was closed due to the flood, more than 25% of staff, including the manager, found permanent jobs elsewhere, so did not return when the NuH re-opened. A temporary manager is now in place. Some staff training is bought in from private education companies, and some is provided in house. The new company has a range of in house education modules, which all staff are required to complete.

5.2.7.1 Georgia: Deputy manager

Georgia qualified as a nurse in the 1980s. Upon qualification, she worked for the NHS for a few years then worked in various countries abroad. She came back to England in the 1990s and worked in Southern England in NuHs on temporary contracts for six months before returning to the NHS. However, due to family health concerns, she returned to NE England and, in order to secure a post that allowed her to work shifts suited to her family obligations, she accepted a position in a NuH. She worked in that NuH for a number of years, but during the last few of these years, she also worked as an agency nurse, and was regularly placed in a local NHS hospital. The agency work allowed her to practice a wider variety of clinical skills than those demanded or permissible in the NuH setting. After a while, Georgia therefore began to think that the hospital might be a more varied environment in which to work, affording more opportunities for learning and development, so when the opportunity to acquire a permanent position became available in the hospital, she decided to take it and leave the NuH. She worked on this ward for a couple of years, but found that she missed working with older people in long-term care, so she returned to the NuH sector and commenced working at her current NuH, where she was quickly promoted to deputy manager.

Georgia stated that after working in both the NHS hospital setting and the NuH setting, she realised that she was happier working in NuHs, so felt that she would be unlikely to return to more acute environments in the future.

5.2.8 Summary

This section has presented a brief overview of the circumstances that influenced participants' career choices, and offered insights into the personal and professional contexts of individual participants, and to how these contexts might impact upon their interview responses. This information also facilitates the construction of a contextual framework, which can assist the evaluation of the reliability of participants' responses. For example, because we are aware that Anne applied unsuccessfully for positions within the NHS, we are able to take this circumstance into account when interpreting the meaning of her criticisms of the NHS, or her fervent defence of NuH nursing (discussed in the following section).

Although it is not the purpose of this section to provide a synthesis of the data, key recurrent topics arising from the overview are shown in tabular form (tables 5.1 and 5.2). This will support readers' assimilation of the overview information in preparation for section 5.3. Tables 5.1 and 5.2 introduce how key facets of NuH contexts might impact upon the NuH role, and suggests how participants' experiences, views and aspirations are influenced by, and influence, each other. Aspects of the overview are further developed

and integrated into unifying categories (5.3). Tables 5.1 and 5.2 detail chapter locations of these developments.

These biographies have addressed briefly what the participants have said about themselves and their backgrounds. In the next section, hermeneutic techniques are applied to participants' comments in order to gain an understanding of their views and experiences with regard to role and status.

Table 5.1: Overview of the key facets of participating nursing homes

NuH Philosophy	Participating nursing homes	Potential impact on NuH nurses	Developed in unifying categories
Philosophy of care	Philosophy of quality care (all NuHs) Key worker system (NuHs 1,2,5,7)	Provide activities, meetings to promote community spirit. Continuity of care in that residents are allocated the same staff; Opportunities to develop relationships with residents to promote individualised care.	5.3.2 Nursing 'residents' rather than 'patients'
Investment/budget philosophy	Philosophy of investment (NuHs 3,6) Budgetary control; maximisation of occupancy (NuHs 1,2,4,5,7)	Availability of resources to provide quality care for residents and opportunities to access staff education/training. Need to be aware of financial concerns; Required to support maximisation of occupancy.	5.3.3 Business aspects; 5.3.4 Stigma
Training/education philosophy	In house training; training bought from private education companies (all NuHs) Training focuses on mandatory topics (NuHs 1,4,5) Extensive training provided (NuHs 2,3,6,7)	Education/training separate/different to that provided for NHS nurses. Less skilled NuH nurse workforce. Well trained NuH nurse workforce?; Relevance of training.	5.3.2 Nursing 'residents' rather than 'patients'; 5.3.3 Business aspects; 5.3.4 Stigma; 5.3.5 Professional isolation and exclusion

Table 5.2: Overview of the views of participating nursing home nurses

Participants' experiences	Participants' views	Developed in unifying categories
Work in NuHs for convenience/family/health reasons (Andrea; Anne; Alice; Beth; Bella; Diane; Emma; Ellen; Faye; Georgia)	NuH nursing is not perceived as a career, but rather as a 'stopgap'/convenience/or last resort.	5.3.4 Stigma
Choose to work specifically in NuHs (Barbara; Cath; Elaine)	Enjoys working in LTNC.	5.3.2 Nursing 'residents' rather than 'patients'
Preference for working for the NHS/more acute care environments at some point in their career (Andrea; Anne; Alice; Beth; Bella; Diane; Emma; Ellen; Faye; Georgia)	Feeling that NHS/acute care environments are more conducive to professional development opportunities and the practice of nursing skills.	5.3.2 Nursing 'residents' rather than 'patients'; 5.3.4 Stigma; 5.3.5 Professional isolation and exclusion
NuH nursing is stigmatised (Alice; Anne; Beth; Faye)	Difficult to move into the NHS; Excluded from the NHS; Leads to a preference for NHS/acute care; Leads to criticism of the NHS/acute care; Leads to defence of NuH care.	5.3.3 Business aspects; 5.3.4 Stigma; 5.3.5 Professional isolation and exclusion
Previous business experience (Anne; Barbara; Elaine)	Supports ability to lobby for resources; Supports understanding of business aspects of NuHs; Able to consolidate business/nursing skills.	5.3.3 Business aspects
Previous social work experience (Barbara)	Able to consolidate social work/nursing skills.	5.3.2 Nursing 'residents' rather than 'patients'
NuHs provide person-centred care for older people (Barbara; Bella; Beth; Cath; Ellen; Elaine; Faye; Georgia)	Enjoy and aspire to working with older people; Continuity of care in that residents are allocated the same staff; Opportunities to develop relationships with residents to promote individualised care; Need to lobby for resources to ensure quality care.	5.3.2 Nursing 'residents' rather than 'patients'; 5.3.3 Business aspects; 5.3.5 Professional isolation and exclusion
Enjoys working with older people (Anne; Barbara; Bella; Beth; Cath; Ellen; Elaine; Faye; Georgia)	Intend to continue to work with older people, regardless of whether employed in NuHs, NHS or other settings.	5.3.3 Business aspects; 5.3.4 Stigma

5.3 Unifying categories

5.3.1 Introduction

It is already clear from the brief biographies outlined in the previous section that the experiences and views of individual participants are different – a circumstance which was evidenced in all, not just the biographical data collected. Nevertheless, while participants' experiences were unique to themselves, their common situation of working as NuH nurses gave rise to shared topics of interest. They all spoke of their experiences of caring for

residents, and proposed that this was different to caring for patients in more acute care settings. Participants stated that the NuH role is stigmatised. They offered a variety of reasons for this, and suggested stigmatisation leads to a number of professional challenges. In addition, many expressed concern about the business/funding issues involved in their role. Some participants also proposed that caring for residents in LTNC settings leads to professional isolation and exclusion. They said this is because this type of care does not require much interprofessional working, and because NuH nurses are stigmatised by their colleagues working in other settings. As explained in 4.5.2.7, the synthesis and assimilation of these shared topics, undertaken in stage 6 of the analysis process, resulted in the development of unifying categories. Four unifying categories were ascertained, and these are presented in remainder of the chapter:

- Nursing ‘residents’ rather than nursing ‘patients’
- Business role
- Stigma
- Isolation and exclusion

Within each section summary (5.3.2.3, 5.3.3.4, 5.3.4.4, 5.3.5.2), concerns arising from unifying categories which are indicative of themes are identified (the themes arising from the unifying categories are: uncertainty about role identity, unpreparedness for the demands of the role, and low occupational status). Although themes are discussed primarily in chapter 6, they are introduced in this chapter in order to demonstrate their descendancy and relationship with unifying categories.

5.3.2 ‘Your priorities are different’: Nursing ‘residents’ rather than nursing ‘patients’

Throughout the interviews, participants referred to their role as being different to the roles of other nurses. They said this is because it incorporates a much more significant social care element. They suggested that NuH nurses are required to focus on service-users’ social needs because service-users are ‘residents’ not ‘patients’. This section will present the participants’ views that differences exist between caring for ‘residents’ and caring for ‘patients’. It will then consider their suggestion that addressing the specific care needs of the resident population pose challenges for NuH nurses.

5.3.2.1 Differences between caring for ‘residents’ and caring for ‘patients’ and the impact on nursing home nurses’ identity

Beth works in a NuH that accommodates both a nursing care unit, and an NHS contracted unit which provides intermediate care. During the analysis of expression and language which occurred in stage 3 of the data analysis process, it became apparent that in Beth’s

early interviews, when she discussed the nature of the NuH nurse's role, she referred to nursing care service-users as 'residents', and intermediate care service-users as 'patients'. In her third interview, she was asked why she referred to these two groups using different terms, and whether nursing residents was different to nursing patients:

Beth (3): They're a resident because they live here, and they're a patient because they're being treated for whatever illness they've got...Primarily it is a social environment for them because it is their home. You know, they, they can decide if they want er, you know whatever they want to do. It shouldn't be structured around like a, you know, how a hospital is. It should be sort of structured about how they want to live their life, so in that way, yeah, it's more of a social thing.

Later in the interview, Beth stated that the nurse/patient relationship is different to the nurse/resident relationship:

Beth (3): In the hospital [referring to the intermediate care unit], you know, they're in and out, kind of thing. Whereas you're looking after someone, probably for the rest of their lives, and you know, end-of-life...Because I think, you know, when you work in a hospital, you know there's a much quicker turnover, and when I'm doing my bank nursing [as a community nurse], I go and see someone for 15 minutes and then, they're you know, left at home. Whereas here, there're long shifts and you're quite often in long days, you know, day after day, erm, so you do have a different relationship with people. You know people better.

Beth's responses inferred that she perceives caring for 'residents' and caring for 'patients' as different activities, so that consequently for her, the NuH nurse role as carer of 'residents' is distinct from other types of nursing roles that involve – caring for 'patients'. She acknowledged that non-NuH nurses work in diverse environments, at different points in the patient's journey (i.e. in her references to hospital nursing and community nursing), but nevertheless regarded all as associated with 'patients'. She suggested that nursing 'patients' in hospital is primarily about treating physiological illnesses within an institutionalised healthcare environment that caters for a rapid patient turnover. She proposed that nursing 'patients' in the community involves treating 'patients' in their own home (or community health location) by holding pre-arranged visits or meetings, that last for short periods of time, after which 'patients' and nurses disengage until their next arranged meeting. However, caring for 'residents' in a NuH is different in that the care location is both a permanent clinical setting and the resident's home. She also proposed that because NuHs are 'residents' homes, care involves supporting social well-being and promoting the same level of choice and control that people would have if they were still residing in their own homes. She stated that NuHs should not be structured like hospitals, which she feels are institutionalised environments that may erode 'patients' choice and

control. Furthermore, Beth stated that caring for 'residents' leads to a different kind of nurse/service-user relationship because the long-term nature of the association enables the parties involved to get to know each other well.

The differences between caring for 'residents' and 'patients' that Beth suggested, were corroborated and expanded upon by the other participants. For example, Andrea explained that she felt permanence, familiarity and continuity are essential aspects of providing a home for 'residents', so NuH nurses need to account for these requirements in their nursing care:

Andrea (3): It's already their home, and we make it a homely environment for them. So for those who have awareness, they regard it as their home already. The staff are like the family members already because they know them. They knew them already, they know their voices, they know their faces. They get used to the regular staff.

Diane emphasised her view about the importance of maintaining 'residents' choice and control over their everyday activities within the NuH setting. She asserted that hospitals are regimented, institutional environments which curtail 'patients' choices and preferences regarding daily living activities and health decisions. She suggested that the loss of choice and control due to hospital admission, although undesirable, is nevertheless transitory. However, she suggested that the permanency of NuH residency means that choice and control are imperative to the preservation and promotion of 'residents' quality of life:

Diane (3): We always give the residents more choice I think, have more er, I feel as if they're able to make their own decisions. While in hospital, it's more clinical, and it's very set, you know. You come in and you have an operation to get better, or there's a purpose usually while you're in hospital.

In the above comment, and the following comments, Alice and Diane indicated that due to the long-term chronic, rather than the acute, nature of 'residents' conditions, 'residents' care priorities often focus on social pursuits or the 'little things' (Alice, 3) that make up everyday life, rather than physiological and medical concerns that are the focus of hospital admission:

Alice (3): I mean medical needs, if they had stronger medical needs, they wouldn't be here. They're stabilised more or less...we're more of their advocates. I think we're more involved in what they want, their wishes.

Diane (3): They [residents] still consider me a nurse, but it's totally different...in hospital usually they're so poorly that in some ways their guard's down. You know, because if you're feeling rough and you're on the commode, and you're in pain and everything, you don't want everybody to see you but, you go past caring, don't

you? If you're so poorly and you're in discomfort. Well, here, they're usually quite comfortable, they're not in a lot of pain. They have aches and pains and we give them pain relief, but most of them aren't in agony or discomfort...I think your priorities are slightly different aren't they.

These responses also illustrate a contradiction about the care of residents. Alice commented that residents live in NuHs because they do not have urgent medical needs that require treatment, but of course people enter NuHs because their complex health needs render living at home difficult. An analysis of these responses suggests that the management of multi-morbidities achieved in NuH care frees residents from focusing on their physiological conditions so that they are able to turn their attention to other concerns such as social pursuits.

All participants stated that they felt nursing care should be holistic, in that it should account for the physiological, social, psychological and spiritual concerns of patients. However, they suggested that in response to residents' particular care priorities, NuH nurses modify their caring activities by dedicating a much greater proportion of their role to supporting social well-being. They regard these care activities as the facilitation of meaningful activity, and the formation of close, genial relationships with residents and their families.

Bella (3): I think, erm, for the residents, for our permanent residents here, I think it's more of like making their life, like there's still quality. I know they haven't been well, they're away from their family. That's what they need, it's like companionship, and like, keep themselves like busy. They still manage to see the beauty of life, you know. It's not just because you live in a NuH 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.

Diane explained that focusing care on social well-being affects the relationship between the nurse and service-user. Her response suggested she views the nurse/resident relationship is based as much upon social as on therapeutic interaction:

Diane (1): [It's] sociable. Yeah, I think its social contact. I went on holiday to Scotland and I was telling them all about the seals and everything, and they enjoy that. So in some ways they're very aware of erm, what I get up to. Not all my details, but like I've got a dog in the car. Erm, I bring my dog in sometimes so they can pat the dog in the mornings, and er they're aware that I might go to the beach and I'll talk about the beach and things like that. So in some ways, it's more of a social thing...You know, we discuss what's on the TV, and we might all watch the proms together.

As discussed above, participants purported that working as a NuH nurse necessitates a significant shift in their caring activities towards the concerns of creating a home for residents, supporting choice and control, facilitating social activity, and developing close

relationships. This proposed shift leads some participants to question their professional identities as nurses. For example, Alice asserted that nursing usually involves the inclusion of clinical undertakings within the work remit, so because the emphasis of NuH nursing is on social issues, she is 'not sure if I'm a nurse' (Alice, 2):

Alice (2): [Clinical tasks] erm. It's, well its part of what you think you are as a nurse, you know. What I was expecting to do as a nurse...It does seem important that you have more clinical tasks when you're still doing bedside nursing. Here, it's more social care.

Here Alice's comment appears to contradict the premise that nursing is about attending to the holistic needs of patients. Such statements could be indicative that while the participants do see their role as being about the provision of holistic care, they nevertheless view clinical tasks as being significant, if not central, to that care (as Alice states, she expected to practice these skills as part of her nursing role). Thus, when this aspect is removed or diminished – as the participants' responses suggest occurs in NuH nursing – then uncertainty regarding role identity may result.

Rather than succumbing to this uncertainty, Cath inferred that she has devised a strategy for dealing with her predicament. This strategy involves the creation of a new job title for herself which both acknowledges her nursing roots and reflects the amplified social aspect of her role:

Cath (3): You're doing your health side, but you have got to do a lot more on the social bit...it's more medical in the hospital. You're more social on this side. Erm, on the hospital side, you're a nurse, that's it. I tell them [residents] I'm a care nurse. And they go, 'What's a care nurse?' and I say, 'I'm a nurse, but I work in a CH'. So I say, 'I have two jobs. I'm a nurse, but I'm also a social carer as well'.

Although the participants reported that they adapt their care behaviours to accommodate a shift in their activities towards social care provision, their discourses indicated a conflict between their expectations and aspirations regarding what they perceive the role of the nurse to be, and the actuality of delivering nursing care that meets residents' requirements. The challenges that result from this conflict are discussed below.

5.3.2.2 Challenges of providing care for 'residents' rather than 'patients'

Providing continuity of care: All participants acknowledged that continuity, familiarity, and the maintenance of the routines of daily life are essential elements of 'feeling at home' for residents, and they take steps to ensure these conditions are achieved. However, they proposed that attainment of these aspects of care can lead to monotonous practice and professional inertia for the participants themselves.

The suggestion that NuH nursing practice is monotonous is inherent in the discordant meanings that participants attributed to the term 'continuity'. For example, Andrea and Alice inferred that continuity signifies comfort, reassurance, and psychological safety for residents. However, they stated that, for NuH nurses, continuity could signify the tedium of repetitive care activities. Andrea described how the constant heavy physical work involved in caring for residents on the nursing unit in her NuH becomes tiring, while Alice explained that the permanency of the NuH residency means there is little respite from taxing situations that arise from the challenging behaviour of some of the residents:

Andrea (3): And if there's a change in staff, or a new face is there, they would ask, 'Where is, where is she?' and it becomes like, they become more reluctant with the care of this new person. So that's why sometimes the management will say, 'You are regular on this floor. They know you already, so for continuity of care, you need to be here.' But sometimes staffing is difficult. Some staff would say, 'I'm always here. Why am I not rotated?'

Alice (5): There's a lady who picks at her dressings. The hospital I worked at in America, they would have put mittens on her, which you can't do that here. But you have to, they might not follow what you would like to do, but you have to keep working with them. It's a continuous thing. It's not like you see the beginning to the end because they get discharged in hospital. It's just a continuous thing that we're doing with them, working with them. So that can be quite challenging you know, so it is challenging, and that is a part of your job, just to keep working with them and maybe they'll improve on certain habits, or maybe they won't, but you're there anyway.

Participants reported that providing familiarity and continuity for residents can also contribute to NuH nurses' professional inertia. Participants affirmed that they do carry out a number of clinical tasks in their day-to-day practices of supporting residents to maintain health, and facilitating reablement:

Ellen (3): We do dressings here. We put catheters in, we do subcut fluids overnight, erm we take blood samples regularly. There are skills to be maintained here.

However, most participants indicated that they do not perceive these skills as high level competencies or proficiencies, or opportunities for learning and development. They suggested that this is because the act of providing continuity and consistency of care within a long-term care facility, renders the practice of clinical and assessment skills repetitive, routine and unchallenging:

Andrea (1): 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. There's nothing new...There's no everyday challenge [emphasis on 'routine'].

Bella's view that clinical practice is routine in the NuH context was a significant contributory factor in her decision to seek employment in the acute sector. During her final interview, Bella indicated that she had accepted a position on an acute elderly care ward 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.

It appears from these comments that the routine nature of participants' skills practice hinders them from recognising the importance of these skills to the management of residents' complex multi-morbidities. It can also be inferred from these comments that this type of care optimises stability in residents' conditions within the context of multi-morbidity.

Promoting choice and control: As seen above, participants indicated their awareness that choice and control are fundamental to residents' psychosocial well-being and their adjustment to the NuH setting as their home. However, all participants reported that because NuHs are communal settings, facilitating choice and control for individuals can be difficult to achieve:

Georgia (3): It's not easy sometimes, I think. Without taking away somebody else's choices and liberties.

Participants suggested that once residents have relocated to NuHs, issues of choice and control continue to centre on individual rather than community concerns, so that even opportunities to contribute to group decisions regarding the administration of homes are seldom taken up. For example, participants reported low attendance at residents' meetings. Elaine proposed that this is because residents prefer to express their choices individually by informing staff:

Elaine (3): Do you know, there's not a massive turn out. We have them and we put posters up all over, erm, and there's not a big, it seems the same families all the time. In the last meeting there was only three people attended that.

Researcher: So the residents don't really...?

Elaine (3): Yeah, they tell us, and then we say it.

Elaine's comment suggested that residents do not perceive themselves as belonging to a community, but rather as a number of individuals, all with different objectives, choices and aspirations, who find themselves under the same roof. A number of participants reported that this at times, leads to discord between residents. They explained that managing such dilemmas can be challenging:

Faye (2): And if I was to speak to somebody individually, one-to-one, I can totally see their point of view. Then I go to the other, flip

side, and I can see their point of view. And I don't think there's any happy medium.

All participants stated that obstacles to facilitating choice and control primarily stem from the integration of residents with disparate physical and mental illnesses. As Elaine explained, NuHs that provide general nursing care accommodate both residents with cognitive impairments, and without cognitive impairments:

Elaine (2): We get a lot of people that were on mental health units, then their nursing needs take over. They were on EMI residential and their nursing needs take over, so that becomes the most important thing. But they've still got dementia and challenging behaviour, but they're on the [general] nursing side. We get a lot of people like that, if the nursing needs are much more.

However, most participants proposed that supporting choice and control for all within one setting is particularly difficult, because the facilitation of preference and self-determination for residents with cognitive impairments can lead to the reduction of choice for residents without cognitive impairments:

Georgia (3): You know, you can't isolate one person just because they shout. But then another person shouldn't feel that they should be confined to their room because they don't like the other person shouting. I think it's just trying to find that happy medium. I think most places have more than one lounge to a unit or floor or whatever. Erm, you know even if you do have a quiet room, it's hard to be fair for everybody.

Alice and Georgia stated that the best they can do is to supervise residents with cognitive impairments, maximise environmental space, and find, as Georgia described it, 'a happy medium'. In other words, they attempt to facilitate compromise between residents. However, Faye stated that she does not believe 'a happy medium', or compromise is possible:

Faye (2): You'll always have that person sitting that's cognitively spot on and it's so distressing to them because its communal living, isn't it? And it's getting that balance isn't it? I know for a fact that there's people that say, 'I really object to that lady being brought into this unit, because it upsets my mam. And why should she put up with that?'...I think it's a hard one to answer, and I don't think there's a set answer.

Here, Faye suggested that communal living is not the same as community living, where individuals come together with the intention of forming, or being part of, a community. In Faye's view, communal living in the NuH setting, brings together individuals, each with their own agendas regarding choice and needs, and who are not necessarily able, willing or prepared to negotiate and compromise with others.

Most participants agreed that residents' choice and control are limited because of staffing issues. They stated that the situation will not improve unless staffing levels increase, and NuH nurses receive support and advanced training regarding dementia, challenging behaviour, and caring within a long-term communal setting. Until these matters are addressed, the participants stated that nurses will struggle to facilitate residents' preferences:

Alice (2): I don't think we have enough staff when there is mental health challenges. A lot of them need supervision and we don't have the staff for it...But as far as aggressive residents and that, I mean I've done a couple of courses called Dr Strong. It's over in America, and it's what you do with an aggressive resident. You just try not to escalate stuff, so, but I have seen other staff not do the right thing and it escalates, but there definitely needs to be more understanding about confused aggressive patients...we definitely need more support [training] in that respect.

Nurse/resident relationships: As discussed above, participants said that much of the NuH nurse's role is committed to the support of residents' social well-being. Participants proposed that part of this process involves establishing nurse/resident relationships that have social meaning for residents. Many participants expressed concern that close social relationships between nurses/residents can erode the professional boundaries that distinguish professional therapeutic relationships from personal relationships. Many admitted that professional boundaries can be difficult to maintain in a long-term care environment, in which nurses and residents/families have the opportunity to get to know each other very well:

Barbara (3): It is easy to forget that you're not a friend, you're not er, somebody who's, it's a paid contact. You've got to keep professional boundaries, and over time it does get lost sometimes.

Beth (4): And I think it's a dangerous thing, because you know, you do sort of build up a friendship with people because you're working with them like, for a long time, but it's just knowing where the boundaries are.

Despite acknowledging that professional boundaries should be maintained, some participants spoke of residents in the closest of social terms, referring to them as 'friends', and 'family':

Alice (2): They're a lot more familiar with you because you spend so much more time with them, than in the hospital. So it's about making friends basically, with them, and getting to know them really well.

Anne and Elaine both referred to this closeness as 'seeing past the uniform' (Anne, 3; Elaine, 3), which suggests that some participants and residents perceive each other on a

personal, rather than professional level. The consequences of eroding the professional boundaries within the nurse/resident relationship can cause problems. Faye explained that becoming friends with residents and families can be emotionally draining:

Faye (4): And I feel as if I've touched a lot of people's lives, and I've made a difference to a lot of people's lives. Hand in hand with that is the negativity of it all. It has a massive draw on you emotionally, personally.

For Faye, the emotional costs of close relationships are particularly highlighted when residents die:

Faye (2): I nursed somebody who just recently died, and I nursed him for 10 years. He came shortly after I started. And you know, you grieve for them because I saw his son get married, and I saw his son have his first son, and then his second son.

Faye (3): I know I definitely grieve, to the degree that even if I'm not around on shift and I know somebody's going to pass away, I ring up and see how things are going. We do get massively involved and I think we grieve for the relatives too in that we don't see them [after the resident's death].

Faye also explained that she feels hurt when she believes she has developed close relationships with residents and families who subsequently make complaints about care. In such circumstances, Faye finds it hard not to view the complaints as personal attacks:

Faye (3): I think it's erm, the negative of it all is that you can develop quite a good relationship with families, and then if there's any safeguarding issues or any alerts made, it's more of a personal attack on the nurse, because you've developed that relationship with the family.

Alice proposed that close relationships between nurses and residents allows residents to feel able to voice their irritations and vexations in a way that they might once have done with their families when they lived at home. She suggested this may be beneficial for the residents in terms of airing grievances or 'getting things off the chest', but found it challenging and tiring for herself. She described one such episode that occurred when one of the residents returned to the NuH after a hospital appointment:

Alice (2): You know it's a different challenge because of the nature of the relationship is different, you know. More in depth.

Researcher: What kind of challenges does that bring?

Alice (2): Well, I think familiarity sometimes. They can transfer their frustrations out on you. You know there's more, you've got, but also it's got benefits. You can become very close to your patients.

Researcher: Transfer frustrations? How do you mean?

Alice (2): Well, there's one guy here, you know, he was just complaining a lot about the nurses to me just this morning [after returning from a hospital appointment]. But you know that's just him

venting and er, and I don't think he would do it in the hospital situation. It's because he's been here for so long and he's probably frustrated about his diagnosis. So he transfers his frustration out a little bit. So I let him vent and I listen. But there's, I think that's all he needed to do, vent, and for me to agree with him.

Many participants reported that another difficulty that arises from establishing close relationships with residents concerns the consequent close and prolonged engagement between NuH nurses and families. All nurses, regardless of their work setting, are expected to understand, and account for, the fact that the context and circumstances of many patients' lives involves family life, and as such, families should be considered during patient care delivery. Indeed, as the above participants' comments illustrate, NuH nursing leads to the development of close relations with families as well as residents. Participants stated that they view NuH nursing as an opportunity for family-centred care. However, many participants suggested that, because they develop such close relationships with family members as well as with residents, they are at risk of becoming embroiled in family quarrels. They felt that if relatives view participants as friends, relatives might be led to believe that 'friendships' will override nurses' professional responsibilities, and thus assume that favouritism occurs:

Faye (3): You get a sister coming around, 'Well our Gloria, we don't speak mind you', and then she'll be coming and she gives you all of that you know. I always say from day one, my priority is obviously the resident you know. Explain that they've got to be fully aware that we've got to be equal to each family member.

The participants' response to this predicament is to distance themselves from the situations in order to demonstrate their objectivity and impartiality. The most common strategy for dealing with these difficulties is to involve social workers. Anne, Barbara, Cath, Elaine and Faye all reported that they have felt the need to withdraw from involvement in family affairs at one time or another, and refer cases on to social work colleagues, who they regard as having more specialised knowledge and experience of family dynamics. Cath explained:

Cath (3): If a family come in and they're in with problems, I try to steer them off to the right direction, who to get in touch with. And if it's too emotionally involved, then I say to them, 'You need to talk to [social worker]'. And I pass, it's passing the buck basically onto her. Because she can give them what they need. I can't.

Some participants stated that NuH nurses are unprepared for the intensity of their involvement with families and family conflicts. Barbara expressed a belief that this unpreparedness arises because nurse education lacks a social work element that would be useful to the role:

Barbara (2): I think you need to give them [NuH nurses] far more training. I mean I think I'm only erm, successful at it because I'm dual trained [as a nurse and a social worker] because I'm used to dealing with people's expectations and the complexity, and recognising the dynamics within relationships.

5.3.2.3 Summary

Participants consider the NuH nurse role to be different to other nurse roles because they view nursing 'residents' as a different activity to nursing 'patients'. This is because they feel they modify their care activities to account for the high level of residents' social needs. Participants suggested that this modification involves a reduction in the amount of acute clinical skills activities required, while the clinical procedures that are performed tend to be routine and repetitive tasks. As such, some participants said that NuH nursing does not provide opportunities for clinical skills learning or development. Analysis of these responses led to two conclusions. Firstly, that once residents have moved into NuHs, their multi-morbidities are more likely to be managed and controlled because they have access to 24 hour nursing care. This means they are able to change their care priorities and focus on their social needs. As a result, participants change the focus of care delivery so it primarily addresses the residents' social needs. Secondly, for participants, management of multi-morbidities becomes so routine that they do not recognise the care activities as involving the practice of important clinical interventions.

The consequences of this modification in care activities is two-fold, and these two concerns are indicative of two themes (discussed in depth in 6.2 and 6.3) that arise from nursing 'residents' rather than 'patients':

Uncertainty about role identity: Participants were uncertain about their role identity, because their expectations regarding the role of the nurse (for example, as a role that involves acute clinical skills practices), and the actuality of NuH nursing practice, are in conflict. Some participants (for example, Cath) manage this uncertainty by creating a hybrid role that acknowledges both nursing and social facets of the role. Also, a lack of acute clinical skills practice and development leads to feelings of professional inertia and routine. For Bella, this led to attrition from the NuH sector.

Unpreparedness for the demands of the role: Many participants suggested that focusing on social issues within residents' home environments can be very challenging. They said that this is because NuH nurses are not provided with enough staff, or do not have the requisite skills and training to negotiate the tensions that sometimes arise when attempting to support individual residents' choice and control within a communal setting. In addition, participants indicated that their immersion in residents'/families' lives that emanates from close and extended contact with residents/families, means that they often

risk becoming involved in residents' personal issues or family quarrels – a situation which many were unprepared for because they do not possess social work skills. Some participants suggested that training in these areas may mitigate against these problems.

The initial analysis of participants' responses indicates that the NuH nurse role poses a problem in that participants expected, and are trained for, some aspects of care (such as acute clinical skills practice) which in actuality, are not much required by residents when their health status is stable. For some participants, this leads to their perception that the role is undemanding, routine and monotonous. Conversely, participants find the role challenging when they are required to perform activities that they did not expect, or which they do not feel equipped (for example, dealing with the diverse and sometimes conflicting needs of individuals in a communal setting, and negotiating family dynamics).

5.3.3 'I just don't like the salesperson that you become': Business aspects of the nursing home nurse role

Like the vast majority of NuH nurses working in England, the participants were employed by private for-profit companies. In the early interviews, some participants referred to another aspect of the role that they neither expected, nor felt equipped to perform – business activities that arise due to working in the private sector. The use of 'backgrounding' during stage 2 of the data analysis process facilitated identification of this topic, and the multiple interview technique utilised meant that it could be explored further. Participants' responses indicated that NuH nurses working for private companies contribute significantly to NuH business management. However, many reported that business activities are unwelcome elements of their role – the undertaking of which they find uncomfortable and challenging. They suggested that these challenges arose from maintaining occupancy levels, attracting 'customers', and negotiating the changing expectations of self-funding residents. These activities are discussed below.

5.3.3.1 Occupancy: Residents as 'turnover/profit units'

In an economic climate in which the sustainability of publicly funded health and social services is in question, all health and social care professionals are required to be 'cost aware', in order to foster cost-effective practice. However, these participants stressed that NuH nurses also need to be 'turnover/profit aware', because their employing organisations were privately owned and are in the business of making money, as well as saving money. All participants stated that they have come to understand that turnover and profit depend upon maintaining occupancy. However, for some, this realisation only occurred after they had commenced working in a NuH. This is because these participants' previous knowledge of health services was based upon the premise that health service provision is about delivering care, not sustaining businesses. Consequently, the

suggestion that residents need to be perceived as 'turnover/profit units', as well as 'care recipients', was a revelation to them. In her second interview, Elaine exclaimed, 'I never thought of it as a sales side of things. Definitely not!' Cath went further, stating that nurse educators' failure to address sales, funding and profit issues leaves NuH nurses unprepared for the business aspects of their role:

Cath (2): That's total culture shock when you come in, 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, Yeah, yeah there should definitely be a little bit about it, It's just awareness. Just so that you can say, 'Look, if you're going to step into the private sector, you've got this, that and the other to go alongside what else you've got to deal with.'

However, Cath's comment implied that a need for business education is not simply about gaining business knowledge, but it is also about helping nurses to understand, reflect upon, and reconcile their feelings and views regarding the juxtaposition of care and business. Here, Cath seemed to refer to the fact that nurse education in England is embedded within a healthcare system which promotes a philosophy of, and provides, publicly-funded healthcare. She inferred that learning within such a culture effectively excludes discussion about funding and profit concerns, thus creating nurses who believe that care and business are antagonistic and incompatible concepts. Indeed, while all participants suggested that viewing residents in terms of turnover/profit units becomes a necessity, some said they struggle with this notion, and expressed their frustration and anger about the moral dilemma that the care/business conflict forces them to face.

Beth (2) 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 [frowning, raised voice].

Emma (2): No. I don't, I don't class this as a business. Yeah, it is a business, but at the end of the day, I'm a nurse.

Other participants indicated that they can accept the idea of 'resident as turnover/profit unit' because they are able to look beyond the concept of turnover as leading solely to a monetary profit. For example, Ellen and Georgia reported that high occupancy leads to higher levels of turnover and profits, which they said, supports security of a home and retention of services for residents, and job security for staff:

Ellen (2): We need to keep the home going because it is a business. For the residents' sake, we don't want the home to close, and for them to be moved on.

Georgia (2): 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.

On the face of it, it appears that this basic business knowledge allows these participants to allay their discomfort regarding the association between residents and income. Analysis of these comments suggests alternative interpretations. For example, they may not personally feel uncomfortable about the juxtaposition of care and business, but they may believe that some colleagues/other professionals/residents/families are dissatisfied with the situation, so they consider it appropriate to refer to philanthropic goals when discussing their views. Alternatively, these participants may be uncomfortable with the juxtaposition of care and business, so search for altruistic justifications in order to make the situation more palatable to themselves. Whatever the reasoning behind these comments, it is evident that these participants feel that a concern about the association between care and business does exist.

Anne, Barbara and Elaine indicated that they have little problem with reconciling care and business concerns, and had more business confidence than the other participants. These participants described how they had worked in more commercial-orientated occupations prior to entering the nursing profession. Before commencing their nurse education programmes, Anne and Elaine had been employed in hotel management, and Barbara was a social worker, who also ran her own small business. In addition, Anne and Barbara, as the only two NuH managers in the sample, are accustomed to dealing with company funding, budgets and finances.

Barbara's comments suggested that she can dispel concerns regarding profit by using her business knowledge, firstly, to prove to herself that NuH fees are such value for money that NuH residents actually live rather economically, and secondly, to separate the concepts of business and care completely:

Barbara (2): The money that's paid, if you break it down is very, a very small amount. I mean, you know in some places, if you're just paying £460 a week for somebody in a residential bed, if you break that down, its, you know, you would never be able to get bed and breakfast in any three star hotel in the country. So for what they pay, they actually get a very good service. You know they get their own room personalised, and they get their meals and they get entertainment and all their laundry. If you could source that outside for that amount that most people are paying, you'd be very lucky. So it shouldn't influence the care, I think the care should be that you still value those individuals, and you recognise that they need that support that's been identified in their care plan. You know, you can't put a monetary value on it.

Here, Barbara explained her belief that residents' fees do not pay for 'care', but for tangible, measurable services and facilities that make up living expenses – services, she feels, are provided extremely cheaply, thus financially benefitting, not harming, residents. In addition, she purported that nursing care remains a freely given, virtuous, altruistic act

that has nothing to do with where the patient is physically located. While Barbara suggests that 'service' depends upon fee income and monetary investment, 'nursing care' depends upon the values and integrity of nursing staff. Here Barbara uses her knowledge of business to explain and justify the relationship between care and business in the NuH setting. Her explanation about the cost of this form of service integrated housing for older people is indicative of her personal attempt to resolve discomfort about the care/business conflict.

On the other hand, possessing business skills permits Elaine and Anne to regard the 'resident as turnover/profit unit' concept as a service-improvement tool. Elaine explained that now she has recovered from the shock that, in the NuH setting, residents are 'customers', she is able to view high occupancy as a means of generating profits, which can be re-invested for the benefit of residents. Elaine sees part of her nursing role as negotiating with company managers about how best to spend this money:

Elaine (3): I think where they spend their money is important...I've wrote on the manager's report [about spending priorities]. We've had higher people in, and I've mentioned it.

Anne explained that she views the relationship between high occupancy, profit, and service-improvement is a cyclical business process. Like Elaine, she sees profit as a means of generating re-investment income for the residents' benefit, but she also recognises that investing in better services and facilities attracts and retains custom. In effect, Anne amalgamates the concepts of resident and turnover/profit unit into a unified entity – 'customer care':

Anne (2): Customer care is a very important part of what we do, and I come from, before I was a nurse, I was in the service industry, customer care, and I don't see that as a conflict, because what we're looking at, at the end of the day is the patient as customer. So yes, we're selling care services, erm, and like I say, it's just like anything else. If you were in a hotel or something and you asked for something to be delivered to your room or whatever, then that's the same thing, so it's still customer care. Admittedly in my role, I came from the service industry, yes I have to sell those services, and I don't have any problem with it because we do a good service, and therefore I'm telling the person that I'm doing a good service. So for me, I don't see a conflict at all, I actually see that it's one and the same. It's complementary. Because we're serving the patient, so I don't see that there's a difference. [It's] maintaining the home's occupancy level, because that impacts on the whole of the profitability and survivability of the home.

Anne is utilising what she terms as 'customer care' as a means of sustaining competitive advantage. During her discussions regarding her previous career in the service/hotel industry, she described customer care as the provision of good service for customers, with

the aim of achieving high customer satisfaction in order to generate and maintain sales and custom. When discussing resident care, she uses the same terms of reference, viewing residents as customers, who are cared for well, in order to enhance the NuH's reputation, which will improve and maintain occupancy levels and therefore generate profits. Thus, while some of the other participants view care and business as conflicting entities, which when come together create a moral dilemma, Anne sees no conflict. During close examination of the language she used, it became apparent that she combines business and care terms, or substitutes and switches between business words and care words arbitrarily, which reinforces the idea that she sees business and care as 'one and the same'. For Anne, reasoning behind care provision – whether altruistic or profit-generation - is immaterial. She has no misgivings about applying a business model to resident care, because the add-on benefits for residents (i.e. good quality care), although possibly not attained for altruistic reasons, nevertheless exist.

Like Cath, Anne suggested that nurse education has a part to play in preparing NuH nurses to come to terms with, and undertake, the business activities that the role requires:

Anne (3): But, I mean we need to realise that we are delivering a service. It's a health service, and there is room within training to be saying, 'Well actually we are looking after people', and you need to be able to reassure people, and be able to sell your services and abilities in order to alleviate those anxieties that they may have. I think it's something that could be done, and certainly a lot of conflicts can be avoided if that approach is taken. So certainly I think there's probably room [for training].

Here, she explained her view that including business training in nurse education will help nurses to recognise that selling and customer service skills are integral, rather than antagonistic, to the provision of quality care.

5.3.3.2 Attracting customers: 'Selling beds'

Participants said that they are often required to show potential residents and their families around NuHs. This activity is not just confined to the NuH setting, as nurses in all care settings frequently show patients around facilities prior to admission. This activity provides opportunities for nurses to inform patients about the care processes they will encounter, which promotes patient involvement in their own care, and supports the development of good nurse/patient relationships. However, participants in this study expressed the view that, when performed in the NuH setting, this activity is about attracting, and selling to, customers. Indeed, many of the participants use sales language when discussing this activity (for example, 'salesperson', 'selling beds', 'estate agent'). As we have already seen, reconciling the concepts of business and care can be challenging, but for some participants, the active involvement in attracting customers is even more problematical.

Some are so repulsed by 'selling beds' that they ignore, avoid, refuse to engage in, or redirect, the activity:

Beth (2): 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 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...If anybody has questions about erm, like payment and things like that, then I would straight away say, 'Oh go and see the manager'. I just don't like the salesperson that you become [shaking head, raised voice, indignant tone, frowning].

These comments suggested that the introduction of 'price' results in participants transforming an activity that is usually viewed as good nursing practice, into a commercial transaction – something that some indicated they are not prepared to be involved with.

Other participants, however, do become involved in sales. Paradoxically, these participants practice selling in order to inform, advocate for, and protect, residents. They inferred that they worry that if this activity is left to non-nursing staff to perform, potential residents may make choices and 'buy' beds based on unrealistic assurances motivated by income rather than care. For these reasons, and despite their own discomfort regarding sales, these participants agree to undertake the selling of beds themselves. By assuming the role of salesperson, they believe that potential residents will receive an honest, realistic, full and balanced account of the service on offer:

Elaine (5): 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. We take one person out, and people have to take turns, because we can't manage, but you can always take him out', 'Oh no, I've got to work'. 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.

The strong ethical nursing culture, initiated and supported by nursing's professional code of conduct, nurse education, and healthcare policies and guidelines, encourages and expects nurses to act with integrity and honesty in their relations with service-users. This culture pervades the participants' sales behaviours to the extent that all participants without exception, stated that they deem honesty to be the fundamental element of their dealings with potential residents (participants used words such as 'honesty', 'truthful', 'trustworthy', 'right', 'fair'). Therefore, the participants who are most comfortable with selling are those who believe in the quality of their service:

Anne (2): I believe in what it is we're doing here, right. And I believe that we deliver a good service. And I answer the questions that are asked of me, er, fully, and hopefully I think demonstrate a good knowledge of what it is we're doing here.

Alice and Ellen have worked in NuHs where they felt quality care was lacking. Selling beds under these circumstances was troubling for both:

Alice (2): 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.

In both cases, the participants attempted to improve care delivery in these NHs, but the prospect of selling, what was in their opinion, poor quality services proved too uncomfortable, and consequently, both participants left to work in NuHs that they respected more highly.

5.3.3.3 Self-funding residents' changing expectations

Because long-term care often includes personal care elements which are not funded by the NHS, residents undergo means-testing of their assets and income to determine whether they are required to contribute to the cost of their care, and if so, what sum they must pay. As a result of this system, different residents have different funding arrangements, so that while some do not contribute to care costs at all, others wholly fund their own care. In addition, many NuHs accommodate a mix of self-funding and social service funded residents. Participants indicated that a number of consequences regarding residents' expectations of care, result from the funding system. For example, participants suggested that there is a disparity between the expectations of self-funding residents and those of healthcare professionals regarding what constitutes quality care. Participants stated that quality assessments should be based on the standard of care delivered. However, participants indicated that while potential residents and families take this into consideration, they look for more tangible, material niceties such as superior décor, pleasant views, and modern facilities:

Beth (2): 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.

Bella (3): 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 [looks around the room and gestures with hands to demonstrate]. We have the care. It's how people are being looked after.

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

Andrea (2): 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'.

Elaine (2): They expect better quality of care, so they want you in the room 24/7 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'.

Here Andrea and Elaine 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 be more demanding and develop a supercilious attitude towards staff:

Beth (2): Because they're kind of like a customer. (I mean, you can imagine in a shop or whatever) and they always have 'the-customer-is-always-right' motif.

Cath (2): 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.

Difficulties in relationships appear to stem from two causes. Firstly, some participants attributed relationship difficulties to residents' disclosure regarding funding. As discussed earlier, residents undergo means-testing of their assets and income to determine whether, and what, they are required to contribute to the cost of their care. Although funding details are confidential, Anne explained that some residents choose to divulge details of their funding arrangements 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 suggested 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:

Anne (2): But I mean, who pays for the care, and who doesn't pay for the care is confidential. And so people on the floor in theory don't know. 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.

Faye (2): 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.

Secondly, some participants attributed residents' altered attitudes to funding transitions, i.e. the shift from 'free' NHS healthcare to long-term care that requires some residents to

contribute towards their care and residential costs. Participants suggested that this funding transition prompts some residents and families to alter their expectations and attitudes towards care home staff. This phenomenon is particularly noticeable in NuHs which accommodate both permanent nursing beds and NHS contracted beds:

Alice (2): 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.

Beth (2): I think because a lot of people don't understand, like if certain relatives have been in hospital and had free healthcare for that long, then come to the [NHS unit] and you say, 'Oh, your mam needs permanent nursing care', you know it changes everything, and you can see straight away that the families are, their expectations and everything change...Now they want to get what they're paying for you know, so sometimes the dynamics can change, between you and the relative.

Participants' responses indicated that they recognise and anticipate that self-funding leads residents to have altered expectations and attitudes:

Faye (2): 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.

But, difficulties do arise when participants perceive residents' expectations and attitudes detrimentally affect their 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 participants suggested that such residents are potentially foregoing rehabilitation opportunities:

Barbara (3): I think the residents do think they erm, because I mean quite often a lot of people think because they're paying, you will do, you know you'll dress them and you'll feed them, and you'll do things, when they're actually more, they're capable of doing that.

Georgia (2): 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.'

5.3.3.4 Summary

Participants' responses cited in section 5.3.2 indicated that in their view, a high proportion of the NuH role focuses on residents' social well-being. This creates dissonance about the

nature of the role for participants because they are required to undertake some activities that they did not expect, or feel prepared for. This situation creates a level of uncertainty and unpreparedness about role identity for some NuH nurses. The vast majority of NuH nurses are employed in the private sector, and the views presented in the current section of the chapter suggest that role difficulties and uncertainties are exacerbated by the inclusion of business activities within the NuH nurse remit, and that the two themes identified in 5.3.2.3 are also embodied within the business aspects of the NuH role. Findings indicate that although selling and maintaining occupancy are required skills for NuH nurses, they may not have expected, or feel prepared, to undertake these practices. Regardless of whether participants struggle with care/business integration (for example, Cath), or can seamlessly integrate business into the care role (for example, Anne), both groups agreed that the introduction of business training to nurse education practices may mitigate some of the role challenges faced by NuH nurses.

Consideration of the role's business aspects reveals a further issue. Participants indicated that they perceive the business aspects of their role influence views of NuH nurses. Their responses suggested they themselves are disconcerted by the association of their role with controversial funding issues and profit. Participants also proposed that funding issues can change the nature of nurse/resident relationships.

Discomfort with the business aspects of the role: Some participants stated that care and business are conflicting concepts, whose juxtaposition leads to moral dilemmas. Others described how they incorporated business activities into their role, but were disquieted by the assimilation, leading them to explain and justify their business involvement. This suggests they are aware that a controversy exists. The findings also suggest that, because residents may be required to contribute to the cost of their care, NuH nurses view showing potential residents around NuHs as an act of selling. Participants' responses to selling differ. Some refuse to become involved. Others do get involved, not just to provide information about services, but because by performing the activity, they are protecting residents from unrealistic assurances that may arise from the profit-generating motivations of the commercial side of care provision.

Changes to the nurse/resident relationship: As discussed in 5.3.2.2, participants said that therapeutic relations between nurses and residents/families can be difficult to maintain because these relationships are so close. However, they reported that their relationships with self-funding residents can be complicated further. Participants said that residents who contribute to the cost of their care may become more critical of care services, may expect their care to be prioritised, or may regard staff superciliously. Some participants also suggested that residents may also be less motivated to exploit rehabilitation opportunities

arising from activities of daily living exercises, and may be less likely to get involved in their own care because they are paying someone else to perform these activities. The participants suggested that these behaviours can have a damaging effect on NuH nurses' abilities to develop therapeutic relationships with residents, utilise rehabilitation processes to maintain residents' independence, and support resident participation in care.

5.3.4 'There's just a big stigma around working in nursing homes': Nursing home nursing as a stigmatised role

As well as discussing aspects of their role as NuH nurses, participants referred to their views and experiences regarding their occupational status, and how they thought they were perceived by both the public and other healthcare professionals. Participants reported their view that generally, other people view NuH nurses in an unfavourable light. Throughout the interviews, they spoke about being subjected to negative perceptions, attitudes and behaviours expressed by the public and other health professionals – behaviours which they suggested stigmatises the NuH nurse role (they discussed their experiences using language that refers to stigma, for example, 'stigmatised', 'second rate', 'looked down on', 'lower option'). Participants proposed that disparaging views regarding the NuH nurse role emanate from a number of possible causes, and they stated that they find being the subject of stigmatising behaviours intensely challenging. Analysis of participants' responses revealed that they perceived six causes of stigma to exist. These are presented below. After this presentation, sections ensue which discuss the consequences of stigma, and how participants' responses indicate how they manage stigma.

5.3.4.1 Possible causes of stigma

The causes of stigma most commonly cited by the participants were: lack of understanding on behalf of the public and other healthcare professionals regarding the NuH nurse's role, the juxtaposition of care and business, and the view that NuH nurses are uninspiring and enervative. A few participants suggested that damaging media reports, ageism in healthcare, and the social status of migrant nurses were also influencing factors. A discussion of these causes follows.

Lack of understanding regarding nursing homes and the nursing home nurse's role: Participants suggested that the public and other healthcare professionals lack understanding of what the NuH nurse role entails. They said, this leads to assumptions about NuH nursing activities. Ellen suggested that because most NuH nurses are greatly involved in assisting residents with their personal care – activities which are associated with the HCA role, then the distinction between the nurse's role and the HCA's role lies on 'woolly ground' (Ellen, 1). The participants indicated that consequently, the public and

other healthcare professionals view NuH nursing as the provision of personal care rather than clinical care, or even assume that NuH nurses are in fact, not RNs, but a type of HCA:

Beth (2): 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?'

Emma (1): One of the ladies, one of her [mother's] friends said to me, 'What do you do then?' 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'.

Many participants proposed that these assumptions lead the public and other healthcare professionals to doubt NuH nurses' clinical ability, and consequently regard NuH nursing disparagingly:

Alice (1): I think we're definitely looked down upon. I think they think we don't have any skills, erm, and it's very misunderstood...And I think, I think the hospital nurses just think that we're not as skilled as they are.

Beth (1): I think there's just a big stigma around working in nursing homes, you know. I think she [mother] wanted me to get the experience of working in a hospital on a busy ward, because with me being newly qualified, I think she thought I would get more, I would you know, develop skills and things that I wouldn't here specifically.

Faye commented that the assumptions of the public and other healthcare professionals are sometimes inadvertently strengthened by NuH nurses themselves. This is because certain clinical procedures which are routinely performed in hospitals are not permissible in community settings. NuH nurses therefore have to admit to their limitations in terms of their ability to provide acute care. Faye stated that this admission gives the impression that NuH nurses are less proficient than acute care nurses:

Faye (4): I think they think that we're not as skilled. Because obviously we've got to turn around and always highlight what we can't do, you know. Where you'd probably never see a hospital nurse doing that. As I say, if they want surgery, they go onto a surgical ward and hopefully skilled nurses. But we've got to be able to say, 'You do realise that if you need IV, you've got to go into hospital.' So you're kind of like just saying, 'They're better'. You can be perceived as saying that. I do think that they think that hospital nurses are more competent.

The juxtaposition of care and business: All participants suggested that the public in England view healthcare as a gratis entitlement in which commercial gain should play no part. Consequently, they said that because NuHs are generally private businesses rather than public-funded services, the public assume NuH providers' objective is purely profit attainment and not the provision of quality care. Anne explained her view that as a result, the public view NuHs as preying on the vulnerable:

Anne (1): 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.

With regard to business and funding issues, however, some participants indicated that the pressure of overcoming the censorious attitudes of others is not the only challenge that NuH nurses face. As already discussed in 5.3.3, a significant difficulty for participants is reconciling their own negative views regarding long-term care funding, with their nursing role. Some suggested becoming a nurse in England involved supporting a health service financed by public funds, and free-at-the-point-of-care. However, in the long-term care setting, residents are often required to contribute to their care costs. Many participants referred to this funding scheme as 'unfair', and reported feeling 'uncomfortable' about being part of what they perceive as an inequitable system. In this instance, the stigma arising from other's perceptions and attitudes is not the main issue. For these participants, doubt and uncertainty about being involved in a system which they view as morally questionable, taints their view of their own practice and role:

Alice (2): 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.

Image of the nursing home nurse: Most participants reported their view that other people, in particular other healthcare professionals, have a preconceived image of the NuH nurse role that portrays NuH nurses as uninspiring, undistinguished, enervated and inept:

Barbara (1): This is a much kind of lower option and some people view the fact that if you work in a nursing home, you don't have the skills to be employed elsewhere, or you're at the end of your career and you kind of want to step down from, you know, the acute, busy side of things. And I think that's very sad and it's not true, er, so I think it puts a lot of people off.

As can be seen from the above comment, this participant denied this image. However, an examination of the reasons behind the participants' career choices reveals that only Barbara, Cath and Elaine had pro-actively sought positions in NuHs because they wish to work specifically in this sector. Most participants work in NuHs for personal reasons that

have little to do with progress towards, or achievement of, career goals (see 5.2). These participants stated that they work in NuHs because they are unable to obtain positions, or suitable positions within the NHS, that accommodate their personal circumstances. What is more, many participants do (or have at some stage in their careers) aspire to work in other settings once they are able to secure a position there, or when their personal circumstances allow. It could be argued therefore, that the career moves and behaviours of the majority of participants supports the perception that NuH nursing is not as dynamic a career as other types of nursing. While participants did not view the reasoning behind their career choices as problematic in itself, they proposed that it becomes so within the NuH context. They expressed the opinion that this is because NuH nursing is already imbued with a negative image. Anne and Georgia explained that their behaviours regarding their career choices reinforces the image of the NuH nurse as uninspiring, while the image magnifies their behaviours so they are perceived as enervated:

Anne (1): [Working in a NuH] it was a bit of an accident really. It wasn't by choice. I think that's probably the case for a lot of people in a lot of jobs...But in nursing homes, I think they perceive it as a second rate job, so by going there, you're somehow, you're a failed nurse, and you're just working there just to, just for something to do.

Georgia (1): Due to the ill health of my parents, [I] came back to this region and needed a job. So that's really what got me into the nursing home sector. It wasn't something I wanted to do, something my heart was set on...I think there was a stigma attached, so everybody just thought it was a little bit of a cop out, an easy option.

Barbara suggested that the image of the NuH nurse as uninspiring and enervated is so pervasive that although she pro-actively chose to work in a NuH, other healthcare professionals question her abilities because they are unable to equate successful, dynamic nursing with the NuH environment:

Barbara (1): But I think many people look at you and think, 'Well she's a manager because she couldn't go any further in the other areas that she may have worked in'. Not that they would know about it, but you know that's very much the thought.

Media reporting: Although media reporting was not discussed at length by any of the participants, some said they felt it contributed to the stigmatisation of NuH nursing. These participants acknowledged that poor practice has, and does, occur in a minority of NuHs. For example, in her second interview, Anne stated that in some NuHs, 'there are issues, there are evidences of negligence'. While participants did not deny that incidences of

abuse do happen, they suggested that the media's portrayal of NuHs focuses so strongly on reporting poor practice, that the reputations of all NuHs suffer:

Barbara (1): Well, I think the public's view of nursing homes generally is negative. I mean because there's a lot of bad press about situations. So I think we're all being kind of tarred, lumped in the same group.

Of course, in the light of recent scandals regarding substandard and inadequate care in the NHS (House of Commons, 2013; Keogh, 2013), other healthcare settings are not immune from pejorative media attention. Many participants recognised this:

Georgia (1): There's been a lot of black marks over the years. You know various documentaries and press. But then again, the NHS hasn't fared much better.

However, Elaine suggested that damning media reports are more destructive to the reputation of NuHs than to other healthcare environments. She proposed that this is because other settings benefit from positive reports as well as being subject to negative attention, leading to a more balanced representation of their services. Elaine explained that NuHs do not benefit from affirming testimonials by the media, so that the incidence of damaging reports is not moderated, thus resulting in a biased view:

Elaine (5): I think that in the media you see a lot. Well you see a lot of bad things about hospitals, but you see a lot of good things like, 'Oh they've saved my child'. But you never see a good thing about a nursing home. It's always bad. It's always bad.

Ageism in healthcare: A few participants expressed the view that the current healthcare system is ageist, and the devaluation of the older population in healthcare leads to a lack of investment and resources in service provision. They proposed that, as a result, older people do not benefit from the same healthcare opportunities as other patient groups. Faye said that in her view, such ageist practices have an impact on NuH nurses' ability to carry out their nursing activities adequately and effectively.

Faye (2): There's many people in the team that come in with a self-righteous approach, a judgemental approach on the nursing aspect, but we don't get the tools to do it properly. You know I think it's very much them saying, 'Well what's the point of investigating because whatever the outcome's going to be, what are we going to do? We're not going to act upon it, so don't investigate'. So sometimes you're nursing them blind in this area, you know. There's a mass on their lung. What is it? 'Well, we'll not bother putting in the expense, because you know'. So you can find yourself nursing them blind. What is the diagnosis? What is the prognosis? What do we do to prepare the client and the family? You've just got to go with it [angry tone throughout].

Faye's response indicated a view that healthcare professionals' discrimination against older patients has two outcomes. Firstly, older people receive substandard services, and secondly, NuH nurses are subjected to the criticism and 'judgemental' attitudes of other professionals for delivering these substandard services – criticism that Faye deemed unfair, as she proposed that NuH nurses' inability to provide adequate care arises from the healthcare system's failure to provide the necessary resources in the first place.

Barbara suggested that healthcare professionals' lack of insight into older people's health issues, discounts older people from benefitting from acute interventions, which in turn inhibits NuH nurses from further developing their clinical skills. Barbara purported that ageism in healthcare fuels the assumption that NuH nurses are less dynamic and less skilled than acute care nurses.

Barbara (2): I don't think they [older people] get the service they should have in a clinical, medical or surgical environment...I don't think hospital staff erm have enough empathy for older people. I think they see them as an intrusion on their clinical field, you know medical or surgical wards. And they do sometimes take a bit more time to recover, and I think they [staff] find that frustrating...I think there's still very much an ageist attitude, er, which is institutional.

Researcher: Institutional ageism?

Barbara (2): I think so. I think, I think my impression from being a nurse and social worker in the hospital environment, that makes people perceive people working in NuHs as not being as skilled as the nurses in the hospitals.

Social status of migrant nurses: Two participants were non-UK born of Asian ethnicity – Andrea and Bella. All other participants were UK-born of white ethnicity. During discussions regarding their views of occupational status, Andrea and Bella, like their UK-born colleagues, focused primarily on the nature of NuH nurses' work activities, and their perception of the public's and other healthcare professionals' views of private NuH care. Andrea, however, also described experiences of being subjected to racism by some residents:

Andrea (3): Erm, I have encountered patients who are racist. Several times. A woman, a man as well. And when I go inside the room, the patient would say, 'Go back where you came from. We don't need you'. Well, erm, I'm hurt. I'm hurt. Especially as I didn't come here for government to pay benefits. There's a company that recruited nurses in the Philippines - I'm paying taxes. I don't get any benefits, so, because that's their thinking - we're here for help from the government. It's quite hurtful before. But I think if you get to know the patient, they see you work and pay, and say, 'You're nice'.

Researcher: Do you think your race affects your employment chances.

Andrea (3): No no. Not from the hiring system. Only times I have encountered with residents.

Offering this information during discussions implies that ethnicity and migrancy are implicated in her experiences of status. However, her narratives of racism do not appear to be directly related to her work role, but rather describe experiences that emanate from assumptions that she has migrated to exploit the UK benefits system. In these circumstances, her response indicates that her work role can mitigate against her migrancy status because it demonstrates she is contributing to health and social care services and the economic health of the country.

Bella briefly discussed migrancy too, but her narrative was not in response to questions about status or role, but occurred early in her first interview when she was providing biographical details. During this discussion, she described her experiences of being welcomed by people living in her locality:

Everyone is just nice. The people just greet you. They don't know you but they lead you - like I was lost one time and an elderly couple even walked to go to that place, so I said, 'Oh, its really nice to be here. A home away from home', because my place in the Philippines is just like this as well.

The findings presented in this section suggest that while participants feel stigmatised for a variety of reasons, they are particularly concerned about three of these reasons i.e. the perception that their role primarily involves the practice of basic care which leads others to doubt both their clinical abilities and their identity as nurses, the censorious attitudes of both themselves and others regarding long-term care funding which leads to a tainting of their caring role, and the image of the NuH nurse as uninspiring and enervated. Andrea also referred to her experiences of racism during discussions about status, which implies she associates ethnicity and migrancy with meanings of status, although her responses suggested her work role mitigates against her migrancy status. Participants referred to other contributing factors (media reporting of abuse cases, and the perception that nurses working with older people are less skilled) to a lesser extent, which suggests that they are less concerned about these factors. It could be argued that this is because the primary causes seem to be directed against the participants' personal abilities, values and professional and social identities. Conversely, the other factors are generally directed at organisations (media reporting), or are incidental to stigma directed at other groups (ageism in healthcare services). In other words, the primary causes have personal meanings for the participants, which prompts them to focus on these issues.

5.3.4.2 Consequences of stigma

Many participants reported that the stigma originating from the work-associated causes described above leads to stigmatising behaviours on the part of other healthcare professionals and the public. A number of participants used the term 'suspicion' to describe how these behaviours are manifested, and to describe other's mistrust of, and doubt about, NuH nurses' ability and willingness to care for residents adequately. For example, Anne purported that other professionals mistrust the clinical decisions and abilities of NuH nurses, and hence perform verifying actions and instigate unnecessary safeguarding alerts:

Anne (1): Some of them are suspicious. That automatically, you can't possibly be doing things right. And they'll check, erm what you're doing and how you're doing it. They seem to be looking for faults... you know, safeguarding alerts are put in that are silly.

Barbara suggested that suspicion also occurs on an organisational level, leading to over-regulation of the NuH sector:

Barbara (5): I think suspicion is a concern for the nurses. They're criticised and assessed by so many people. And I know they are in hospital, but you've got so many outside agencies, councils and stuff, with a view. Then we're scrutinised far closer, too closely.

Using the 'oppositional arrangement of perspectives' technique during stage 1 of the data analysis process, in which participants' perspectives were viewed in opposition to the standpoint of NuH regulatory authorities, the potential shortcomings of the participants' views are revealed. For example, over-regulation and checking may arise, as the participants suggest, from the suspicious responses of others. However, there is a possibility that scrupulous regulation and checking might be because NuHs are high risk environments, in terms of the autonomous care practices of people who work there. Alternatively, there may be no difference between the level of scrutiny between NuH environments and other healthcare environments, but because the participants are aware that their role is stigmatised (for the reasons outlined above), their responses may be defensive reactions to their assumption that others' behaviours will be stigmatising behaviours. For example, due to recent high profile abuse cases, in which health and social care services are perceived as having failed to protect or support vulnerable people, health and social care professionals are actively encouraged to use safeguarding alerts in an effort to reduce risks of abuse and poor practice. The prevalence of safeguarding incidences may therefore be more to do with the influence of recent policy directives, than any particular suspicion of NuH nurses.

A small number of participants proposed that suspicion of NuH nurses and mistrust of their abilities has a detrimental impact on their career choices. For example, Beth and Anne narrated episodes when they had applied unsuccessfully for positions in the NHS. They stated that their failure to secure these positions resulted from suspicious and exclusory behaviours of other healthcare professionals towards the stigmatised NuH nurse role:

Anne (4): I had a go at trying to go back into district nursing a couple of years ago, and I was unsuccessful. I'm not saying that's because of that stigma, maybe I just didn't present myself that well, but yeah, I think it is actually difficult to get back in, because again, it's about the perception about what it is you're actually doing in a nursing home. I had a go at two jobs and I didn't get either and I was more than qualified. It was right up my street. It wasn't a case of me trying to do something I wasn't familiar with. It was care of the elderly unit in the community. And I should have just been able to walk into that, but, or I would have thought so.

It is possible that Beth's and Anne's failure to gain employment in the NHS resulted from reasons other than their NuH nursing background. Again then, it could be debated that participants' belief that their role is stigmatised may lead them to perceive others' behaviour as more judgemental than may actually be the case.

It is unclear whether participants' statements concerning others' suspicious behaviours describe the actuality of the situation. However, it is very clear that they perceive these behaviours to occur. This perception leads participants to feel wronged, which in turn influences how they themselves react and behave.

5.3.4.3 Dealing with stigma

All participants stated that they find dealing with the stigma associated with their role challenging. Their responses revealed that they utilise a variety of strategies in order to deal with this stigma. The most popular strategy is to avert discussion about their role. Participants explained that they find fielding questions about their occupations uncomfortable and embarrassing because of the stigma they say is specifically attached to NuH nurses. Their responses to these questions omit or underplay the NuH aspect of the role. 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): Because I know from experience that I'm going to get that slightly disappointed reaction. And so therefore you might actually try to hide the fact that you're actually in a NuH. So you know, yeah you do, you sort of like, say you're a nurse and then maybe change the subject.

Diane's and Emma's responses inform enquirers that although they work in NuHs now, they have worked for the NHS in the past. Emma inferred that she does this so that people do not get the impression that she is in some way an inferior nurse:

Emma (1): When people say to me, like [husband's] friends, or whoever, will say to me, 'What do you do? Where do you work', I start my sentences by saying, 'Well I used to work at the [hospital]'.

Alice and Beth both work in NuHs 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.

Another popular strategy is separating the self from, or denying, the business activities inherent with the NuH nurse role. As already discussed in 5.3.3, some participants expressed the view that their role is tainted and stigmatised by business issues. In particular, they have reservations about the funding of long-term care, and are uncomfortable with this facet of NuH nursing. When discussing business activities during the interviews, some participants' responses indicated that they deal with the taint of business by denying the business aspects of their role. For example, Faye's strategy is to claim that powerlessness excuses her from any blame regarding unsavoury commercial aspects of NuH nursing:

Faye (4): There's a difference. 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.

Beth's and Emma's strategy, however, is to focus solely on their nursing role and disaffiliate themselves from the business:

Beth (2): 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 [frowning, raised voice].

Emma (2): No. I don't, I don't class this as a business. Yeah, it is a business, but at the end of the day, I'm a nurse.

Other strategies are used to deal with the perceived suspicious attitudes and behaviours of others to NuH nurses. Some participants' responses indicated that they react against such

stigmatising behaviours by denigrating and criticising their perceived accusers (primarily NHS and acute care nurses), while simultaneously commending their own abilities and working environments. Many participants were critical of hospitals. Some suggested that residents prefer and trust NuH nurses' care skills over those of acute care nurses:

Anne (3): We have a great deal of difficulty often of persuading people to go to hospital, and that is to do with feeling anonymous. Feeling old and not looked after.

Others proposed that the NHS is so overstretched that the provision of safe, effective care is at risk. These participants suggested that, contrary to common belief, NuH environments are in fact more conducive to safe care:

Diane (1): I felt really the NHS...people were being told bad diagnoses, erm, and there was always a pressure on time really. Erm, in the nursing, caring environment, I just felt that as a nurse, that I could be more hands on nursing, better for my patients or clients.

A few participants expressed the opinion that working in the NHS leads to unhappiness, stress and disillusion. They inferred nurses employed in the NuH setting are more content and satisfied with their work-life balance:

Ellen (1): The NHS has changed so much in the last few years that lots of people are thinking they want to come out, that I speak to...they're as miserable as sin, because the wards are so busy, and there's such pressure on the beds.

It could be argued that by employing denigrating and criticising strategies, participants are attempting to increase the value and meaning of their own work in comparison to the work of others. They are trying to enhance the status of their role, because by doing so, they may be able to alleviate their feelings of being stigmatised.

5.3.4.4 Summary

The findings presented in this section suggest that NuH nurses feel that their role is stigmatised. The aspects of stigma that the participants in this study appeared to be most concerned about were those that questioned their identities and abilities as nurses, and their personal values and motivations with regard to care. This suggests that two themes pervade the unifying category of stigma – low occupational status, (discussed in detail in 6.4) and uncertainty about role identity (discussed in detail in 6.2):

Low occupational status: Participants proposed that doubts about their identities and abilities arise because the public and other healthcare professionals lack understanding of the NuH nurse role, and perhaps assume that NuH nurses are a type of HCA rather than

registered professionals, and therefore believe that their clinical abilities are wanting. In the literature review, it was suggested that status emanates from the possession of formalised knowledge and skills that the dominant socio-culture recognises and values (Bourdieu, 1986; Zhou, 2005). Because long-term nursing is not perceived as an occupation that requires such knowledge and skills, status is low compared to acute care nursing in which the recognised knowledge-base is adopted and practiced. Also, status may be lowered because of the perception that NuH nursing activities are similar to those performed by HCAs i.e. activities which involve personal care, which Twigg (2000) (cited in 2.3.1) proposes are viewed by society as physically 'dirty work'. In addition, participants were concerned that their business activities, and the uninspiring image of NuH nurses, portrays their values and motivations as being based upon profit-generation, and/or upon an inability to obtain positions within the NHS, rather than on a desire to care.

Feeling stigmatised by the perceived behaviours of others influences the participants' own behaviours, in that they attempt to mitigate the effects of stigma. They do this by employing strategies such as denial and aggrandising – strategies described by Ashforth and Kreiner (1999) and Hippel et al. (2005) (cited in 2.2.2). Participants demonstrate these strategies when they deny the aspects of their role associated with NuHs, or they add value and meaning to their role by comparing it favourably to the roles of other nurses. Although these are contradictory strategies, they nevertheless both lead to the same result i.e. the care/nurse aspects of the role are reinforced. By utilising the first strategy, participants are separating the NuH connotations of business, low skill and abuse away from nursing, and by doing so, emphasise their identity and role as 'nurses'. In the second strategy, they highlight the association between nursing and the NuH setting, which in this instance is presented as the optimum environment in which to perform compassionate and high quality nursing care. In effect, then, both strategies are methods by which participants stage-manage the image of NuHs and the relationship between the concepts of 'nurse' and 'NuH' in order to emphasise the nursing/caring aspects of the NuH nurse role.

In the literature review, theories about occupational status were criticised because they undertheorise the potential impact of social and cultural contexts (for example, Ashforth & Kreiner, 1999; Zhou, 2005). For instance, they do not acknowledge that social identity constructs associated with gender, ethnicity or migration may influence perceptions of occupational status. A limitation of the current study is that no male participants were involved, so the study cannot offer comment about whether, from a man's perspective, occupational status of NuH nurses is associated with gender status. However, none of the participants referred to gender when discussing role and status. This does not say that

gender is not an issue, as gender and role/status associations may be implicit, and concealed in social values and assumptions that are taken for granted. With regards to the influence of ethnicity and migrancy issues on status, again it is difficult to comment about whether these issues influence occupational status of participants in this study, as migrant nurses are under-represented. Nevertheless, Andrea mentioned racism during her discussions, suggesting that race and migrancy are implicated in her experiences of status. During the generation of themes, it was necessary to consider the potential influence of these social identity constructs on occupational status. This discussion is presented in 6.4.1.

Uncertainty about role identity: As already discussed in 5.3.2 and 5.3.3, participants' responses indicated that they feel uncertain about a number of the social care and business aspects encompassed within their role. For example, they view some elements of care as routine and monotonous, and requiring little acute clinical skills practice. In addition, some participants are unsure about the juxtaposition of care and business. It is possible that the feelings of stigma arising from their perception that others have doubts about the skill involved in, or the morality of, certain aspects of the role, contributes to participants' dissatisfaction with, and dislike of, these aspects.

The participants appeared very concerned by their perception that their role is stigmatised. It could be argued that this perception leads them to be highly sensitive to the attitudes and behaviours of others - perceiving the behaviours of others as emanating from role stigma. As a result of this, they believe others are in the main, suspicious of NuH nursing practice. Whether the participants' views can be substantiated or not, is not the issue here - the point is, they feel stigmatised.

5.3.5 'We're cut off': Professional isolation and exclusion

Sections 5.3.2 and 5.3.3 demonstrate how the NuH nurse's role might be perceived as different to those of other nurses in that it involves business activities and a high proportion of social care provision. Section 5.3.4 proposes that participants perceive themselves to be stigmatised by the public and other healthcare professionals. Throughout the interviews, participants' responses indicated that perceived stigma, and aspects of their social care and business undertakings, lead them to feel isolated and excluded from the rest of the healthcare workforce. These issues will be explored in this section of the chapter. The causes of isolation and exclusion will be discussed first, followed by a consideration of the challenges that feeling isolated and excluded bring to the NuH nurse role.

5.3.5.1 Causes of isolation and exclusion

The participants, without exception, stated that, as NuH nurses, they are 'separate' from the rest of the healthcare workforce. During interviews, all participants discussed their professional situations using language that referred to isolation and exclusion (for example, 'isolated', 'separate', 'remote', 'excluded', 'cut-off'). Although NuHs are generally located away from other health service premises, geographical remoteness was not cited as the cause of participants' isolation. Participants' discourses indicated that feelings of isolation stems from professional concerns resulting from their perceived lack of opportunities to develop mutually supportive collaborative relationships or participate in team-working and training with other healthcare workers. Possible causes suggested by the participants are: nursing individuals with long-term conditions, and professional exclusion due to working outside of the NHS organisation.

Nursing individuals with long-term conditions: Participants stated that nursing individuals with long-term conditions leads to professional isolation. They suggested that this is because the care of NuH residents does not usually necessitate intense levels of inter-professional input or team nursing, as their health is evaluated as being relatively stable. Physiological aspects of long-term care centre upon preventative interventions and management of chronic illnesses, and participants proposed that, in the main, these needs can be accommodated by the care of a RN supported by a team of HCAs. The participants proposed that because other health professional involvement is only necessary if residents become acutely ill, NuH nurses are at risk of becoming isolated. This phenomenon is particularly highlighted by the experiences of the participants who work in NuHs that accommodate NHS contracted wards, and are required to rotate their shifts between NHS services and NuH nursing duties. The unique position of these participants permits them to alternate between the NuH nurse role, and intermediate care roles. The contrasts between these experiences emphasise the differences in the levels of inter-professional and team working involved in long-term care, and other types of care:

Beth (2): You kind of don't have the same day-to-day role on the nursing unit [compared to the NHS unit], because often the people you're looking after are quite stable and not needing any acute treatment. You don't therefore need like, speech and language. You don't need like a consultant to come down to review them, erm. You don't need physios and things. I mean we're cut off in those terms, because you literally come in and you're a little bit isolated. You don't have other people to liaise with and you don't have other people to discuss the patient's care with, because at this stage they're normally stable and they're not needing any sort of medical treatment as such...generally they don't need it and therefore it's just you and the resident, you know. Every day.

Here, Beth proposed that in the intermediate care setting, inter-professional and team input are required to carry out ongoing patient assessments in order to ascertain the level and type of care patients may require post-discharge. However, she suggested residents who enter the NuH setting, have been assessed as having reached their optimum potential in terms of rehabilitation and reablement. In addition, she implied that in order to manage their multi-morbidities, they have access to 24 hour nursing care. Hence, inter-professional and team interventions are deemed as being no longer required.

Working outside the NHS: In England, the NHS pay NuH providers fees to cover the costs of the nursing elements of care. Many participants proposed that as such, when performing nursing activities, they are doing so on behalf of the NHS, so should be viewed by the NHS as partners. However, they stated that although they would like to work in partnership with the NHS, they feel actively excluded from doing so:

Anne (2): But one of the key issues for me is we should be working far more in partnership with the NHS, and know what is happening within the NHS. Because actually, like I say, we're a service that is complementary to the NHS, but I do feel not associated with them. That's somewhat compounded by the fact that their attitude towards us is, 'That's them over there', type thing [dismissive hand gesture].

Anne's response above, reiterated the findings presented in 5.3.4, in which participants reported their view that NuH nurses are the subject of stigmatising behaviours on the part of NHS healthcare professionals. In this comment, Anne implied that stigma, and segregating and exclusory activities are at play, and reinforce each other. As already discussed in 5.3.4.2 the reported stigmatising behaviours of other healthcare professionals are participants' perceptions, and may not necessarily reflect actual behaviours. Nevertheless, the participants' conviction that they are subjected to stigma leads them to feel excluded. Cath offered an explanation for the exclusory activities of the NHS:

Cath (2): We've been excluded by the NHS because we're in the private sector...but if you look at it the other way, they'll see that we're keeping people there, trying to stop them from going to hospital, which in the long-term, is saving them money.

In the above comment, Cath seemed to infer that exclusion arises because NuHs are primarily private companies. She insinuated that the NHS 'exclude' NuHs because the organisation does not wish to be associated with the 'private' sector. While the legitimacy of Cath's argument is debatable, it nevertheless alludes to an issue that many participants discussed i.e. their view that private care is perceived as wrong by a society in which 'free at the point of delivery' healthcare is promoted as the norm. Participants

proposed that private care providers are excluded from the NHS which represents that norm, and which wants to disassociate itself from private care. This echoes participants' views regarding the business aspects of their role. As discussed in 5.3.4.1, participants suggested that the association between care and private business is 'immoral'. Their discussions regarding their exclusion from the NHS appeared to be connected to this claim. As already suggested in 5.3.4.1 because private care is associated with unfair care, NuH nurses feel stigmatised. When discussing exclusion, they appeared to be suggesting that, if NuH care was publicly-funded, then, NuH nurses would not feel excluded, but belong to, and feel part of, the wider healthcare system.

Many participants suggested that although they work outside the NHS, they perform nursing activities on behalf of the NHS because the NHS fund the nursing care elements of NuH care. As such, they felt that the NHS should pay for and provide clinical skills training for NuH RNs. The 'oppositional arrangement of perspectives' technique, which in this instance sets the standpoints of the participants and NHS policies in opposition, reveals the paradox in the participants' arguments. Participants argued that because the NHS fund NuH nursing aspects of care, then NuH RNs should receive NHS training. Yet by funding NuH nursing care, the NHS has already contributed to NuH costs which include training costs. As organisations in their own right, NuH providers are responsible for disbursing their funding income, including the procurement of training. The NHS has no obligation to contribute further. The participants' argument is therefore not legitimate, but it nevertheless highlights the implications of their exclusion from NHS training.

For example, participants stated that, as nurses, they are very aware of the registration requirement for Continuing Workforce Development - CWD (NMC, 2011). In addition, all acknowledged that training is necessary to the enhancement of service provision, to the improvement of employment marketability, and to the maximisation of career development opportunities. Many proposed that the most appropriate source of training courses for nurses involved in nursing activities is the NHS, but they stated that accessing NHS courses is difficult because they work outside the NHS. Some participants expressed a desire to advance their learning and skills by undertaking university degrees (for example, Faye and Beth) or advanced practice courses (for example, Andrea and Emma), but reported that this is not possible because their employers will not provide funding, and they themselves are unable or unwilling to self-fund. Thus, because participants found NHS and university courses unattainable, they turned to other options, such as bought in, or in house programmes. However, participants' reported that in their experiences, the quality and content of these courses can be dubious:

Anne (3): Because training is an obstacle anyway. Because we don't have access to the NHS training programmes. So when it comes to prep and things like that, then, very difficult for us to find courses for us to go on. Not only courses but courses of a decent quality. So, I recently put a couple of girls on a venepuncture course. It was £50 a head. They came back - it was only half a day - they came back and said it was absolutely rubbish.

Alice (5): I went on a catheter care course, and it wasn't very informative. And also the other course was a PEG [percutaneous endoscopic gastrostomy] feeding course. It was very limited. I'm sure if the courses were being held in the NHS they would have been more in depth.

In the above responses participants compared NHS and NHS commissioned courses to non-NHS courses. They viewed NHS training as good quality, but questioned the value of non-NHS courses. However, bearing in mind that Alice has never worked for the NHS, and it is a number of years since Anne worked there, their evaluations are not based upon direct recent experience. Their assumptions might have arisen in the context of a culture which situates NHS care environments as more conducive to learning and professional development than NuHs (as discussed earlier in 5.3.2.2), and thus imagine NHS course content will be creditable. Alternatively, they may prefer NHS courses, not because of their content, but simply because they are provided by the NHS. This last point was alluded to by a number of participants, who reported that they are able to access good quality, private courses. Faye, for example, described a recent bought in training programme as 'magnificent' in terms of content and relevance to practice. However, these participants proposed that bought in quality courses that support competence development do not necessarily support career development or practice opportunities. Despite the worth of some education sessions, some participants said that in their view private or in house provided courses are not accepted by the NHS as valid qualifications or updates:

Faye (1): After today I'm training all week, but it's not recognised by the NHS. It's just for my own personal development, and what's relevant to the unit.

Some participants said that private or in house training is not regarded as evidence of skill development and maintenance. They suggested that this is problematical for two reasons. Firstly, NuH nurses find that their lack of NHS recognised CWD renders entry into the NHS job market difficult, if not impossible:

Faye (1): So why can't we do the same type of training that's recognised by the NHS to give these girls opportunities in the future? No we don't want to lose them but it would be selfish to think that this is where they'll want to be for the next x number of

years of their lives, you know. And I just think we need to get together where training is accessible across the sectors, NHS and private.

Secondly, some participants suggested that without NHS recognised training updates, NuH nurses are prohibited from practicing some clinical procedures:

Anne (2): We're not offered or given the opportunity and almost excluded from the training. And I think if we're all doing the same training, then naturally that would help with being integrated. Because we're working, we're doing the same thing. We should be you know, all have the same goals and the same standards and things like that. I mean staff, we cannot access NHS training, although we are technically working in partnership, very close partnership with them, we can't access it and we should be able to. Classic example is anaphylaxis training, which we've got to have every year in order to deliver certain vaccinations. We can't get anaphylaxis training. It's not available to us. We then have to turn round and say, 'Well actually, we can't give the flu jabs. We can't give the flu jab because we're not up-to-date with our anaphylaxis training'...But I mean that's across the board with other things as well.

Faye (1): There's a lady with a Hickman line in, and we didn't have that knowledge to nurse her. We were willing to learn...but the powers to be from the NHS said, 'No, we're not prepared to train you'. And you just think, 'Well why?' And it's going to be a long standing acquired brain injury. She's going nowhere. We wanted the Hickman line in to get antibiotics into her, and stop her bouncing back and forwards if she gets a chest infection, and things like that. So from a financial point of view it was going to save them money, but they just weren't prepared to give us that training. And I think, 'Why? Why can't we be a partnership?' Because we're not daft. We've done our nurse training. We have qualified and we've studied like every other nurse [very strong emphasis on 'why']

In the above comments, Anne and Faye expressed concern that the veto of NuH nurse clinical interventions, which results from their inability to access NHS recognised training, has a detrimental impact, not only on their own professional development, but on residents' healthcare experiences, integrated continuous care, and resource management. However, these participants do not acknowledge that, as long as courses provide adequate training to ensure recipients develop and maintain clinical competence, then courses can be provided by any educational body i.e. they do not necessarily have to be provided or delivered by the NHS. In their insistence that the NHS should provide training, participants omit to explore or concede that other options exist.

Nevertheless, despite not reflecting their exact position with regard to training, the participants' comments reveal a number of important issues. For instance, participants are RNs who are employed to provide nursing care for residents assessed as having primarily

nursing needs i.e. they attend to all residents' needs, including their healthcare needs. Residents who are not assessed as requiring nursing care are looked after by HCAs only, and any health or nursing needs that may arise are attended to by visiting community nurses, who in the vast majority of cases, are employed by the NHS. Visiting NHS nurses also provide clinical interventions for nursing-residents, if NuH nurses are not trained in these interventions (as Anne and Faye's comments explain). This situation may influence NuH nurses' views regarding training. The participants appeared to regard the practice of certain clinical activities (for example, vaccination administration and Hickman line maintenance) as healthcare, not social care, interventions – interventions that they appeared to feel are generally associated with NHS care provision. If nurses are to deliver these interventions to NHS patients, the NHS must take steps to ensure nurses are competent to undertake them, by for example, stipulating and checking that training courses and updates are adequate to support competency. However, participants proposed that, as RNs, they are capable of delivering such care cost effectively, and in a manner that would provide consistent care for residents. But, if they were to deliver this care, they feel they would be doing so on behalf of the NHS (see the two comments above), and so suggest that the NHS should provide, and pay for, rather than simply assess, the necessary training. Thus, the participants' views, although imprecise with regard to the availability of training options, nonetheless highlight the confusion and the subsequent difficulties concerning the responsibility and costs of nurse education that arise when healthcare and social care overlap within the NuH setting.

Participants' comments also inferred that they wish to undertake the same training courses as their NHS counterparts because, by doing so, their 'sameness' to other nurses may be recognised (see the two comments above), and they will have opportunities to be involved in clinical care which will support their sense of identity as nurses. Being the same as other nurses appeared important to the participants, as they viewed 'being the same' as a way in which they could be included, and feel part of, the wider healthcare system.

In addition, the participants were speaking from within a context in which: they perceive themselves to be stigmatised by NHS professionals (see 5.3.4.2), view themselves as providing different care (see 5.3.2), and believe themselves to be excluded and isolated (see the points made earlier in this section). Thus, it could be argued that when discussing their exclusion from NHS training, they naturally view this as evidence of stigmatisation, rather than seeing it as simply arising from the fact that the NHS has no obligation to train external personnel. This perception, that an association exists between exclusion from NHS training and stigma, is illustrated by the following extract, in which Anne suggested

that the reasoning behind the NHS exclusory decisions is partly based upon the NHS' perception of NuH nurses as wanting in ability to learn and manage clinical skills:

Anne (2): I think part of this perception is of being second rate nurses, so it's very, very difficult to get clinical skills training, and I think this feeds into the fact that we're seen as second rate nurses because our skills may not be up-to-date. Because it's so difficult to get that up-to-date training, and up-to-date information about when things are changing...but it's actually very difficult to access, because it's all within the NHS, and we don't have access into the portals, you know, things like this, and where things are. So there's that image again, that we're not at the cutting edge of what it is that's changing.

5.3.5.2 Summary

All three of the study's themes (uncertainty about role identity, unpreparedness for the role, and low occupational status) are embodied with the unifying category of professional isolation and exclusion. The findings reveal that NuH nurses can feel isolated from the rest of the healthcare workforce. Participants suggested that this is because the nature of long-term care provision does not necessitate the input of other healthcare professionals to any great extent. In addition, participants proposed that NuH nurses are stigmatised by the NHS due to the low status nature of NuH work, which leads them to feel excluded. Participants suggested that, as a consequence of isolation and exclusion, NuH nurses are not able to access NHS training which, they suggested, is detrimental to NuH nurses' future job prospects, professional development, and their preparedness to perform some clinical procedures.

These findings highlight a number of important issues. For example, the NHS fund the nursing elements of NuH care, and is under no obligation to contribute to the direct cost of services provided in NuHs, or provide and deliver training for NuH nurses. Yet the participants view this as a failure on behalf of the NHS to support NuH nurses. At first sight, the participants' reaction may appear unreasonable, but if we consider the context from which their response arises, we may reach an understanding regarding their reaction. As already discussed in 5.3.4.2, participants feel that they are stigmatised by other healthcare professionals. It could be argued therefore, that the context of feeling stigmatised prompts participants to read the behaviours of other professionals and organisations towards NuH nurses as acts of persecution. This is indicative that rather than viewing the NHS' stance as reasonable and rational, participants' perceive it as a means of disassociating from, or excluding, NuH nurses.

The findings also suggest that NuH nurses' opinions concerning which organisations should be responsible for the provision of resources and training, run in opposition to the current system. These differences between participants' views and the actuality of the

situation demonstrate that confusion and difficulties exist regarding funding and provision of services in environments that address both social care and healthcare needs, and in cases where social and health needs intersect.

In addition, the findings highlight NuH nurses' struggle to position themselves within the wider health and social care system, and find a role identity. Section 5.3.2 proposed that NuH nurses perceive their role to be different to those of other nurses because a high proportion of their work involves addressing residents' social needs, and many participants explained that, as a result, they often work with, and refer to, social care professionals. Nevertheless, they insisted that they feel isolated. This indicates that because engagement with social care professionals does not prevent feelings of isolation, isolation is therefore due specifically to a lack of engagement with healthcare professionals. This suggests that NuH nurses may regard healthcare as their natural arena of practice, and healthcare professionals as their closest associates and partners - with whom they wish to identify. Indeed, the participants' desire to train in, and be involved with, healthcare interventions and clinical tasks (and their frustration at being isolated and excluded from doing so), seems to reinforce their wish to identify with healthcare professionals.

5.3.6 Conclusion

5.3.6.1 Moving towards theme construction

The analytic process, which led to the development of the four unifying categories, revealed the connections and consistencies between the views and experiences of the individual participants regarding role and status. Common areas of interest arose as the participants all shared the experience of working as a NuH nurse. The interpretation presented in this chapter portrays NuH nurses as being faced with a number of challenges which emanate from the nature of their work and issues concerning their occupational status: business aspects of the role; nursing 'residents' not 'patients'; 'feeling stigmatised'; 'feeling isolated and excluded. However, it became apparent that three notable threads permeated all of the unifying categories:

- Participants feel unclear about their role identity because the role involves a number of activities that they did not expect to have to undertake, while the activities that they did expect to perform are not required to any great extent.
- Participants feel ill-equipped to undertake certain aspects inherent within the NuH nurse role.
- Participants feel stigmatised and perceive their role to have low occupational status because of the type and nature of the work involved in NuH nursing.

Chapter 6 explains how these threads were developed into the study's themes, and presents each theme in detail in order to relate how participants' experiences and views can have relevance to, and illuminate, broader contexts. These themes are:

- Uncertainty about role identity.
- Unpreparedness for the demands of the role.
- Low occupational status.

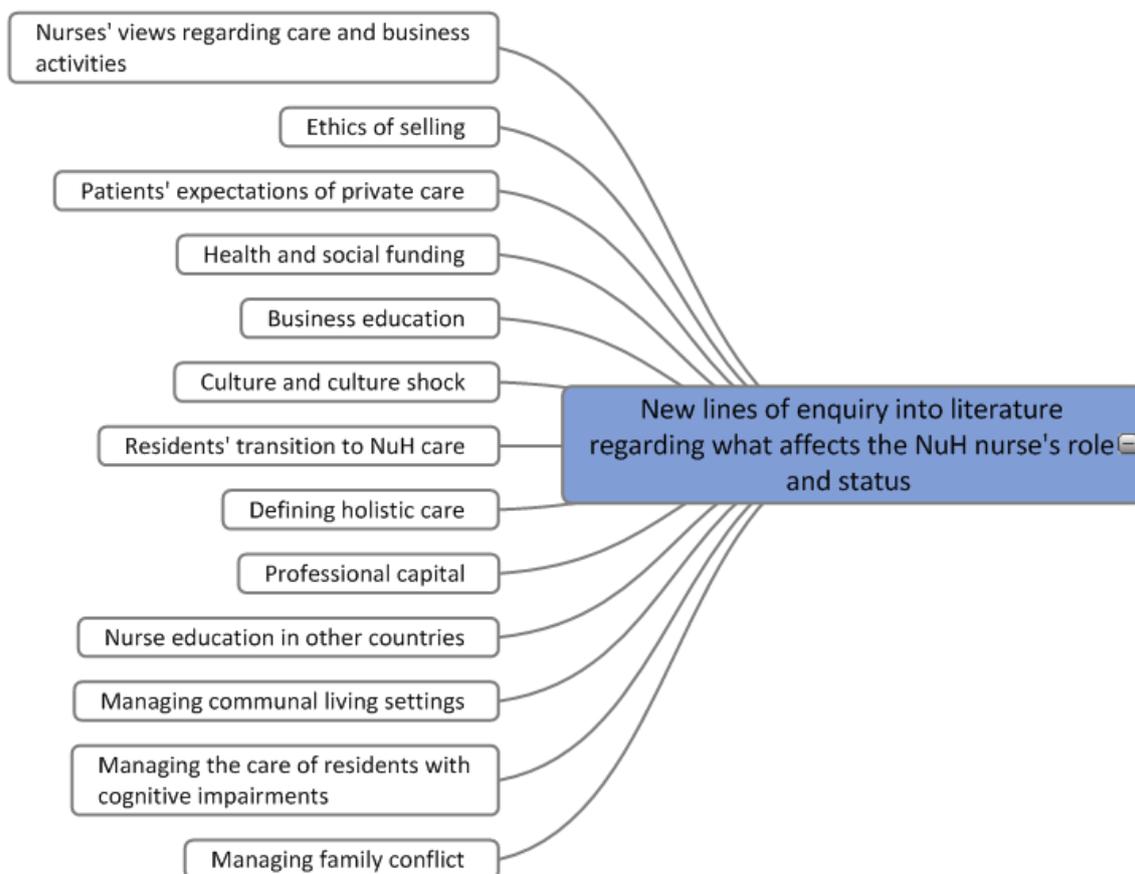
6 Findings

6.1 Introduction

The unifying categories discussed in the previous chapter began to address the study's aims (outlined in 2.6), in that they offered insight into participants' experiences and views regarding their role and status, and of the factors that influenced those perceptions. As explained in chapter 5, participants suggested that their role and status is influenced by the social needs of 'residents' (needs, which according to the participants, are different to the needs of 'patients'), the business activities inherent within their role, and the feelings of stigma, isolation and exclusion that they reported they experience. However, these experiences and views presented as unifying categories, were not interpreted within the contexts of the wider social world, so do not fully address the study's aims. Further analysis was therefore required to firstly, move the study's findings on from insight into these individuals' experiences and views, to an in depth exploration and understanding within the broader context or frame of reference of the wider social world; and secondly, to consider whether, to what extent, and in what way, understanding the experiences and views of NuH nurses regarding their role and status might inform workforce development processes. The movement from insight to understanding was achieved via the process of theme construction (see below).

As explained in 4.5.2.8, theme construction focused on a Gadamerian hermeneutic process that fused the horizon of the participants' responses (represented in the unifying categories), and my horizon as the researcher. My horizon consisted of my pre-understandings of the topic arising from my personal experiences of NuH nursing, and my knowledge of occupational role and status issues and NuH nursing issues, which was acquired during the literature review process. Furthermore, the findings arising from the initial analysis led to an awareness of new and alternative possible meanings, which opened up enquiries into areas which had not been previously explored because they were not made salient by the initial literature search. These new areas are illustrated in figure 6.1 below.

Figure 6.1: Subject relevance map of the literature regarding what affects the NuH nurse's role and status



This new awareness, and the new lines of enquiry which this awareness had instigated, were now encompassed within my horizon, so that my horizon became modified further. Thus the fusion of horizons supported my unique understanding of the data within the frame of reference developed from the literature review. This was further informed by previous analysis I had undertaken whilst engaged within the research process, as well as from my personal experiences and knowledge of NuH nursing.

In this way, the interpretation presented in this chapter is a unique understanding, or my 'writerly reading', of what it is to be a NuH nurse in terms of role and status. It is not a set of connections and consistencies between individual participants' experiences and views, but rather an arrangement of themes signifying concepts embodied within these experiences and views, yet which transcend these experiences and views and are recognised as belonging to a wider frame of reference i.e. the wider social world. In table 6.1 below, the assimilation of the participants' responses is summarised as 'conclusions from unifying categories'. The table also shows themes which exist within the unifying categories:

Table 6.1: Unifying categories and theme construction

Conclusions from Unifying Categories	Themes
Nursing 'residents' , rather than nursing 'patients'	
Less requirement for clinical skills practice	Uncertainty about role identity
Routine and repetition leads to less opportunities for learning and professional development	Unpreparedness for the demands of the role
Doubt about role identity because role expectations are not fulfilled	Uncertainty about role identity
Doubt about role identity because of the high proportion of social care involved	Uncertainty about role identity
Lack of training to support residents' choice and control in a communal environment	Unpreparedness for the demands of the role
Lack of social work training to deal with family issues/relationships	Unpreparedness for the demands of the role
Business aspects of the NuH nurse role	
Moral dilemma arising from the juxtaposition of care and business	Unpreparedness for the demands of the role Low occupational status
Lack of training in business/selling	Unpreparedness for the demands of the role
Self-funding residents' expectations of care affect nurse/resident/family relationship	Uncertainty about role identity Unpreparedness for the demands of the role Low occupational status
Doubt about role identity because of the business activities involved	Uncertainty about role identity
NuH nursing as a stigmatised role	
Most concerned about being stigmatised when stigma arises from questions about NuH nurses' abilities, values, motivations, identities	Uncertainty about role identity Low occupational status
Stigma influences NuH nurses' feelings about the social care and business aspects of their role	Uncertainty about role identity
Stigma prompts NuH nurses to attempt to find value/identity in the role	Uncertainty about role identity Low occupational status
Professional isolation and exclusion	
Feel that isolation and exclusion are intensified by what is perceived as the suspicious behaviours of other healthcare professionals	Low occupational status
Confusion and uncertainty arises where health and social care intersect	Uncertainty about role identity
Lack of training/updates to maintain clinical skills	Unpreparedness for the demands of the role
Social care role isolates NuH nurses from healthcare	Uncertainty about role identity

In their responses, participants did not specifically refer to the themes 'low occupational status', 'uncertainty about role identity' or 'unpreparedness for the demands of the role'. These themes were developed from the researcher's interpretation. Nevertheless, the participants' experiences and views that were captured in the unifying categories can be understood in the wider contexts of the themes, as ways in which dimensions of the thematic concepts are experienced.

The following section discusses and critically analyses the study's themes, and by doing so, portrays aspects of NuH nursing that shape what it is to be a NuH nurse in terms of role and status. Firstly, the theme of 'being uncertain about role identity' is considered.

6.2 Uncertainty about role identity

Some participants suggested that because NuH nurses' activities include supporting residents with their personal care, then the public and other healthcare professionals do not perceive NuH nurses as 'proper' professional nurses. These perceptions concur with the findings of other studies that explore the views of student nurses and RNs regarding placements in NuHs (Wade & Skinner, 2001; Abbey et al., 2006; Fussell et al., 2009). For example, the student participants in Wade and Skinner's (2001) study reported that whilst they are on practice placement in NuHs, they feel more like 'glorified health care assistants' than nurses (p.14). The participants in this study resisted the view that their role is more aligned with that of a HCA than a nurse, but most nevertheless did express uncertainty about their professional identities. However, their uncertainty emanated from three other causes:

- The inclusion of business matters in their remit.
- Addressing the needs of 'residents' rather than 'patients'.
- Attitudes regarding the practice of acute clinical skills.

6.2.1 Business activities

Participants were all employed by private companies. All introduced the topics of business and care funding, and the business aspect of the NuH nurse role, into their discussions, suggesting that these are significant concerns for them. Most participants suggested that they felt uncomfortable and uncertain about integrating business activities into their role, because, they consider the juxtaposition of care and business to be a moral dilemma. To-date, there has been little research exploring the impact of business and funding considerations on NuH nurses' experiences and views of their role and status. Venturato et al.'s (2007) Australian study does investigate the effects of political and funding reform on NuH nurses' practice. Although the research finds that management activities (such as supporting facilities to acquire quality care accreditation) distracts NuH nurses from care

concerns, it does not report on participants' views about how these activities influence their role and status.

The few studies that do explore nurses' views and feelings regarding the morality of business activities are located in other areas of nursing. A review of these studies reveals that nurses' views are influenced by whether the care provided in their work setting is publicly or privately funded; their knowledge, education and expectations regarding business and funding issues, and the culture in which they work. For example, Blackman and Cook's (2010) study, located within a publicly funded care setting, surveys English NHS community nurses' attitudes regarding the Government's Transforming Community Services initiative (DH, 2009). The study finds that nurses are adamant that their roles should centre on care, and they are thus resistant to the DH's (2009) proposal that nurses should be entrepreneurial practitioners, 'exploring business opportunities' (p.7). The study suggests that this resistance arises because business terms and processes are not embedded within English nurse education and culture, so nurses struggle to recognise entrepreneurial activity as part of their role. Indeed, they feel that business activities corrupt care, because they view care as a moral, altruistic activity. 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. These nurses choose to work in private care with patients who elect to pay for their own care. This culture centres around business, and the nurses who work in this setting perceive care to be a marketable business commodity on which the survivability of service providers depends. These nurses get involved in business and marketing practices 'consciously, knowingly and actively' (p.345), recognising that business acumen can be used for effective resource utilisation, which can enhance care at a population level.

However, the responses of participants in the current study inferred that the position of NuH nurses is unique within the English healthcare system, in that it sits at the intersection of health and social care funding provision. As such, previous studies' findings located in either publicly funded or privately funded care settings are not altogether transferrable to English NuHs. Like public sector nurses, the participants' previous knowledge of 'service' was based upon care, not business. The participants' education and experiences within a care culture in which free-care-at-the-point-of-delivery is regarded as a moral right, has shaped their views, so they now feel uncomfortable with the business aspects of their role. But unlike public sector nurses, once in the NuH environment, participants became immersed in a different culture – a culture in which residents are framed as 'turnover/profit units', as well as 'care recipients', and in which business and sales activities become encompassed within the responsibilities of the

nurse. However, although the participants now work in the private sector, their working environment is different to many other types of private care in England in that NuHs provide services for individuals who have undergone means-testing of assets and income in order to determine whether, and to what extent, they must contribute to the costs of their own care. As such, many residents who pay for care have not chosen to do so. This funding system is viewed as unfair by many participants, who consequently stated that they feel uncomfortable being part of what they perceive as an inequitable system. In addition, unlike private sector nurses, for some participants, business and sales activities were unexpected aspects of their role. These participants feel that nursing education does not make nurses aware of, or prepare them for, the complexities of care funding systems.

Cath described this initiation into the private care sector as a 'culture shock' (Cath, 2). Although she was the only participant to use this particular phrase, the phrase could be used to describe the feelings of many other participants concerning the juxtaposition of care and business. During the interviews, a number of participants discussed their views and experiences regarding working in an environment that involves business practices which they regard as alien to the culture of English nursing and English nursing education, in which they had previously been immersed. Culture is defined by Oberg (1998) as cultivated behaviour, ideas, values and customs acquired via social learning and socialisation. 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). Triandis (1990) proposes that this adjustment is particularly difficult when individuals lack knowledge and understanding of the new culture's value system, so rely on their own cultural values as a benchmark. This can lead to individuals making judgements about the new culture, and feeling uncertain regarding their position within it. In this study, participants suggested the 'culture shock' that arises from the juxtaposition of business and funding (unfamiliar culture) and healthcare (traditional, familiar nursing culture) can be problematic.

Berry and colleagues' work on immigration and long-term movement between cultures describes sustained contact between different cultures as 'acculturation' (Berry, 2001; Berry, Poortinga, Brengelman, Chasiostis, & Sam, 2011). These authors argue that as a consequence of acculturation, individuals respond with 'acculturation strategies'. Strategy selections are dependent upon the importance and value that individuals place upon two issues: their original culture, and their willingness to embrace the new culture. If individuals value the new culture, but not their original culture, they assimilate the new culture. If they value their own culture, but not the new, they separate themselves from the new culture. If they value both cultures, then they integrate the two. Berry and colleagues

suggest that a fourth strategy exists where individuals do not value either culture, and 'marginalise' themselves from both.

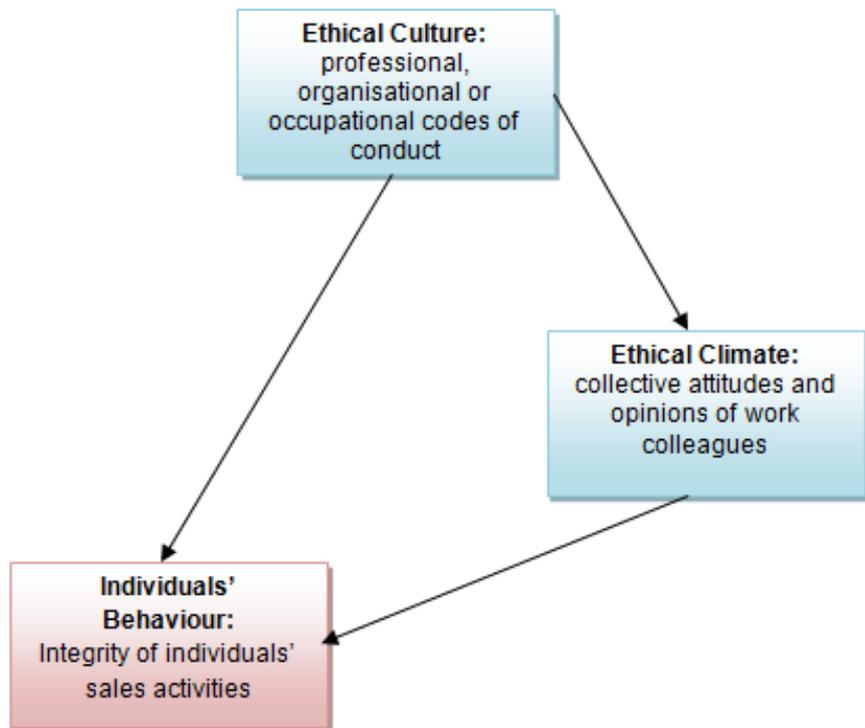
None of the participants in this study are 'assimilators', as no one has entirely foregone their nursing identity in favour of a solely business identity. This is of course unsurprising, because, as all are employed as nurses, nursing practices and values remain implicit within the role, regardless of their working environment. The 'separator' outcome was displayed by some participants. Frustrated and critical regarding the commercial aspect of their role, Beth, Emma and Cath stated that they avoid becoming involved in business and sales. However, such rejection of business/sales in an environment in which these aspects are inextricable, actually results in participants omitting to perform the important nursing activity of supporting service-users in times of transition. According to Meleis' transition theory, whilst undergoing transitions within healthcare systems, individuals' sense of self, and psychological health are 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, so it is appropriate that they support residents to make decisions regarding the transition to residential nursing care (Schumacher & Meleis 1994; Meleis, Sawyer, Im, Messias, & Schumacher 2000; Meleis & Trangenstein, 2010). 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, Cook, Sullivan, & Burrige 2003; Davies 2005; Toles, Young and Ouslander 2012). Beth, Emma and Cath's comments implied that their discomfort regarding business and sales influences their understandings regarding the purpose of showing potential residents around homes. Rather than viewing the activity as integral to their role as advocates, they perceive it as 'selling beds' and so refuse to be involved. In effect, as well as separating themselves from business culture, they reject important aspects of the nursing role. It could therefore be argued that they are displaying some signs of marginalisation, rather than rejection.

Andrea, Alice, Bella, Diane, Ellen, Faye and Georgia 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, their adaptation of business/sales practices is more an acquiescence than a positive undertaking. These participants stated that they are uncomfortable with showing people around their NuHs because they view the activity as 'selling', but they agree to engage in sales in order to advocate for, and protect, residents. Unlike their 'separator' colleagues, these participants indicated that sales and advocacy in this setting are linked, therefore a rejection of sales activities

simultaneously 'diminishes' the nursing role. This response reveals a new dimension to the concept of the acculturation strategy of integration. These participants are integrating, but not in the way that Berry and colleagues define integration (i.e. integration occurs when both cultures are valued). Rather, they integrate not because they value both cultures, but because not integrating is detrimental to both cultures. Thus, the current study develops the theory of integration in that it proposes a sub-category exists, which might be termed 'reluctant integration'.

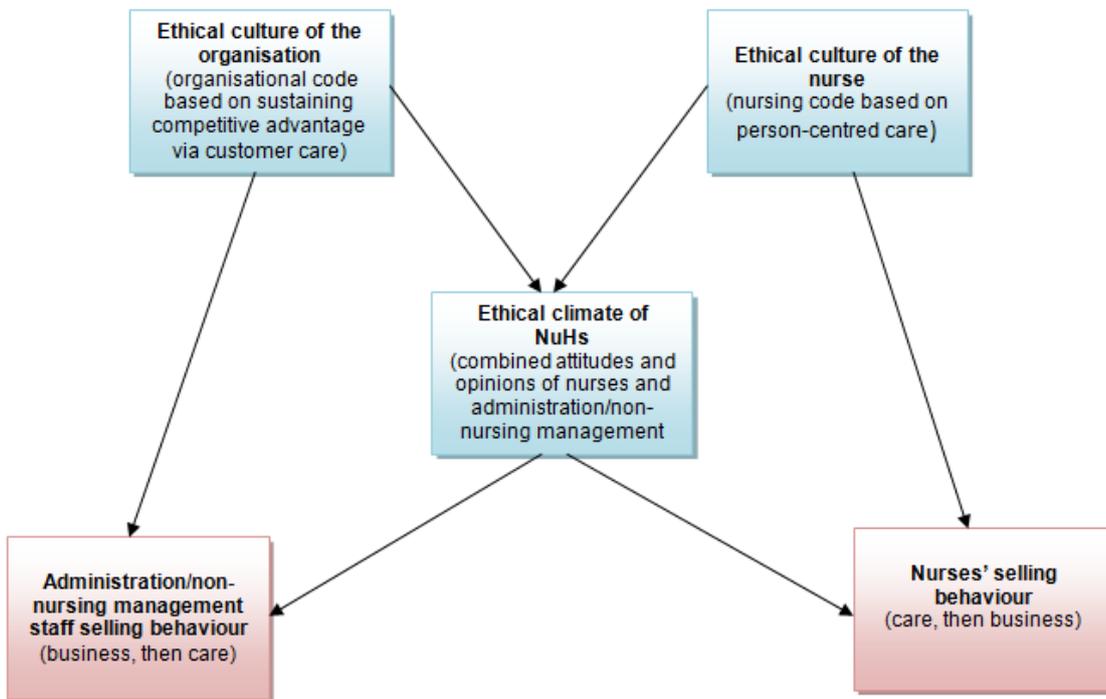
We can explore this concept of 'reluctant integration', and the link between selling and advocacy, by referring to literature that explores ethics in the sales industry. Studies by Aquino (1998), Trevino, Butterfield and McCabe (2001) and Grover and Enz (2005) conclude that the integrity of individuals' sales activities are strongly influenced by the 'ethical culture' of the environment in which they operate. Ethical culture is defined by these authors as professional, organisational or occupational conduct and values acquired via socialisation. Where no ethical culture exists, because for example, individuals are not affiliated with a profession/organisation/occupation that incorporates a strong values system, philosophy, or code, then 'ethical climate' becomes the primary influence. Ethical climate is defined as the collective attitudes and opinions of work colleagues. Where both culture and climate are present, ethical culture affects both individuals and the ethical climates in which they work, so that the impact on the veracity of individuals' conduct is reinforced (Trevino et al., 2001; see figure 6.2).

Figure 6.2: Ethics of selling (adapted from Trevino et al., 2001)



However, as already discussed, the climate of NuHs is influenced by two cultures – the ethics and philosophies of care; and the customs, values and conduct of business and commerce. As the literature to-date does not consider to any great extent environments where more than one culture exists, the above model (figure 6.2) is not appropriate for NuHs. Although two cultures affect the NuH climate, they still independently influence their own affiliates. Consequently, two types of sales staff emerge: nurses who are primarily concerned with caring for residents, but are aware of business requisites; and administration/non-nursing management staff who concentrate principally on occupancy levels and business issues, but are conscious of care needs (figure 6.3).

Figure 6.3: Ethics of ‘selling beds’



In terms of sales, the ethical climate of NuHs is somewhat indeterminate, in that the individuals involved are uncertain about some aspects of the selling process and/or the product for sale. While Andrea, Alice, Bella, Diane, Ellen, and Georgia (as nurses) stated that they are uncomfortable with the concept of selling, they suggested that administration/non-nursing management staff are unfamiliar with the practicalities and principles of care. For these reasons, and despite their own discomfort regarding sales, these participants agree to undertake the selling of beds themselves. By assuming the role of salesperson, they believe that potential residents will receive an honest, realistic, full and balanced account of the service on offer. However, difficulties arise when participants do not value the quality of care provided. The participants deem honesty and advocacy to be the fundamental elements of their dealings with potential residents, so when Alice and Ellen viewed the care delivered in the NuHs in which they previously worked as inadequate, they felt it was unethical to ‘sell’ the services. Consequently, these participants became ‘separators’, not because they rejected business/sales culture (like Beth, Emma and Cath), but because they rejected the ‘selling’ of inferior products. In both cases, the participants attempted to improve care delivery in these NuHs, which demonstrates their implementation of the advocacy aspect of the nursing role. But, the

prospect of selling poor quality services proved too uncomfortable, and consequently, both participants left to work in other NuHs. Alice and Ellen's behaviour shows that integration depends as much upon valuing positive aspects of their original culture as well as new culture.

Elaine and Anne are the only true integrators. Anne in particular displays integrating behaviour by amalgamating the concepts 'resident' and 'turnover/profit unit' into a unified entity – customer care – a model which she utilises to ensure high quality services for residents, which in turn sustains competitive advantage. Anne's merging of the two cultures demonstrates integration, because by blending aspects of both cultures, she 'creates' a NuH nurse role identity. However, the success of Anne's integrated NuH nurse identity depends upon her positive perception of aspects of both business and nursing cultures. In other words, Anne is comfortable with integrating sales and care into one role because she values the quality of service her NuH provides. It could be argued that Anne's successful integration of business and nursing into a single NuH nurse role occurred because her original culture was business (she worked in hotel management prior to training to be a nurse), and because although her new culture is nursing, she is a NuH manager. Having had experiences of business/sales, she views these activities as integral to supporting the position of long-term care facilities operating in an uncertain political and financial market. Thus, she is habituated into accepting business issues are part of her nursing role. She therefore does not view business as morally suspicious in the same way as other participants.

Berry and colleagues' (Berry, 2001; Berry et al., 2011) theory is challenged further by the behaviour of Barbara. Barbara is neither a separator nor an integrator, as she neither rejects the new culture in favour of the old, nor merges the two cultures to create a single unique culture. Barbara values both cultures that exist within the NuH environment, but she is unable to reconcile them, so she attempts to detach them completely. Her description of NuHs oscillated between the provision of a business service and the provision of nursing care. She proposed that 'you can't put a monetary value' (Barbara, 2) on the service, yet stated a monetary value. Barbara's somewhat confused response may indicate that some NuH nurses are deeply uncertain about the funding of long-term care, and the role of the nurse working within this system.

6.2.2 Addressing the needs of 'residents' rather than 'patients'

Participants suggested that nursing 'residents' is different to nursing 'patients'. This is because participants perceive 'patients' as individuals whose acute illnesses dominate their lives at that time. Participants proposed that 'residents' are individuals whose physiological diseases are well-managed, so 'residents' do not give the physical aspect of

illness primacy, but continue to seek to fulfil their self-actualisation and social needs. Diane's (3) comment that 'their priorities are different' summarised this point and inferred that the acuity/stability and management of disease impacts upon the care requirements of individuals. This suggestion is borne out by research which investigates hospital patients' determinants of quality of life, and studies exploring NuH residents' views of what enhances quality of life. While 'patients' with acute conditions are concerned with social and psychological issues, they primarily focus on biophysical quality of life indicators such as pain relief, treatment options, symptom recognition, disease prevention and self-care strategies (Caress, Luker, Woodcock, & Beaver, 2002; Leino-Kilpi et al., 2005; Rankinen et al., 2007; Rantanen et al., 2008). However, studies by Bergland and Kirkevold (2005), Cook and Clarke (2010), Cooney (2012) Bradshaw, Playford and Riazzi (2012), Cook, Thompson and Reed (2014), Ryan and McKenna (2012), and Cook and Thompson (2015) conclude that NuH 'residents' and their families associate quality of life and well-being with social activities such as maintaining choice and self-identity, developing social relationships, maintaining biographical continuity, and accessing opportunities for meaningful activity.

In response to residents' care priorities, participants suggested that NuH nurses modify their caring activities by dedicating a significant proportion of their role to the maintenance and promotion of residents' social lives. However, this shift in activities leads some participants to question their professional identities as nurses to the point where Alice pondered whether she is a nurse at all. At first sight, Alice's deliberation appears to be somewhat surprising because NuH nursing is no different from any other type of adult nursing in that interventions are initiated by illness and disease events, but address all holistic care requirements that ensue. As already evidenced in the literature review, attending to residents' social well-being is obligatory if the nurse is to provide holistic care that considers all dimensions of human need (for example, Murphy, 2007; Nolan et al., 2008; McCormack et al., 2010; Edvardsson et al., 2014).

So, if the concept of holistic care is common to all types of adult nursing, why do some of the participants question their professional identities? An exploration of what is considered by the nursing profession to constitute nursing care may contribute to an explanation of why participants see themselves differently. These definitions either emphasise the clinical nature of nursing care, or therapeutic relationships between nurses and patients.

6.2.2.1 The clinical nature of nursing care

The RCN acknowledges that 'there is a considerable variation in perception' (p.5) regarding what nursing is, so has defined it in broad terms:

The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death (RCN, 2003).

Definition statements from other countries are equally all-encompassing:

Nursing practice incorporates the application of knowledge, skills and attitudes towards alleviating, supporting or enhancing actual or potential responses of individuals or groups to health issues. It focuses on the promotion and maintenance of health, the prevention of injury or disease and the care of the sick or disabled so that people with identified nursing needs may maintain or attain optimal wellbeing or achieve a peaceful death (Queensland Nursing Council, 1998).

Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response. Also advocacy in the care of individuals, families, communities, and populations (American Nurses Association, 2014).

Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well, and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles (International Council of Nurses, 2002).

Although all definitions are broad, and indicate that the role involves the provision of holistic care that attends to all dimensions of life, definitions are nevertheless expressed in language that implies a medical meaning (for example, 'injury', 'disease', 'sick', 'disabled', 'dying'), and which emphasises that nursing knowledge is clinical knowledge. Advocacy, which many participants in the study consider to be one of their major activities, in the above definitions is little more than an 'also'. The emphasis on medical aspects apparent in the definitions is echoed in studies cited in the literature review, that investigate the views of nurses and student nurses about what constitutes 'nursing'. For example, the student participants in Abbey et al.'s (2006) study viewed technical and clinical proficiencies as 'the core of modern nursing', while long-term care nursing, with its emphasis on social well-being and social care was seen as 'inferior' (p.16-17). In addition, the participants in Fussell et al.'s (2009) research found that the acuity and high patient turnover associated with acute care nursing provides 'constant learning and stimulation' because of the requirement for advanced clinical skills (p.220).

The responses of many participants in this study were similar to these findings. Although they acknowledged that they do perform clinical tasks, they stated that at times they find

the routine nature of these tasks (which arises because residents' physiological conditions tend to be relatively stable or well-managed), coupled with the high proportion of social care, monotonous. This study does, however, provide a new dimension to the current literature, as it suggests that NuH nurses themselves, although they are immersed in the NuH environment, nevertheless expect and aspire to provide care that is primarily clinically based. When this does not occur, they find themselves in a predicament regarding role identity. The comments of Cath indicated that she has devised a strategy to deal with her predicament. This strategy involves the creation of a new job title for herself, which both acknowledges her nursing roots and reflects the amplified social care aspect of her role. Here, Cath is attempting to fashion a hybrid professional identity that encompasses both healthcare and social care. However, she describes her position as 'having two jobs' (Cath, 3) which, rather than emphasising the holistic nature of the nurse's role, paradoxically reinforces the division between health and social concerns. Also, in spite of trying to forge a new identity, in an earlier interview, Cath admitted that she lacks skills and knowledge to deal with social concerns, and actually refers these issues on to her social work colleagues (social work education is discussed at greater length in 6.3.2).

6.2.2.2 Defining nursing as a therapeutic relationship between nurse and patient

Recently, McEvoy and Duffy (2008), Bullington (2009) and Bullington and Fagerberg (2013) have used concept analysis to arrive at meanings of nursing that reflect the holistic, person-centred focus of the role. McEvoy and Duffy (2008) refer to the individual in terms of 'wholeness' and 'harmony', while Bullington and Fagerberg (2013) describe the person as a single entity, rather than a series of separate needs (i.e physical, social, psychological, spiritual). It is 'the lived body...always embedded in and present to a concrete situation' (p.493). These definitions move towards 'totality', and acknowledge that the nurse's role is to respond to the unique needs of the patient, rather than needs that are separated and defined by scientific nomenclature. For these authors, the key to nursing the individual is via the implementation of a nurse/patient therapeutic relationship:

Holistic nursing care embraces the mind, body and spirit of the patient, in a culture that supports a therapeutic nurse/patient relationship, resulting in wholeness, harmony and healing. Holistic nursing care is patient led and patient focused in order to provide individualised care, thereby, caring for the patient as a whole person (McEvoy & Duffy, p.418).

McCormack and colleagues' studies on person-centred nursing (McCormack, 2003; 2004; McCormack et al., 2010), Nolan and colleagues research on relationship-centred care (Davies et al., 1999; Nolan et al., 2001; 2004; 2008) and Haugan and colleagues' studies of the effect of nurse/resident interaction on depression (Haugan, 2002; 2014; Haugan,

Rannestad, Hanssen, & Espnes, 2012; Haugan, Innstrand, & Moksnes, 2013) propose that a defining aspect of the nurse's role is the therapeutic nurse/patient relationship. This research finds that when relationships between nurses, patients/residents and families are prioritised and highly valued, the outcome is increased patient/resident satisfaction, positive health outcomes, and feelings of well-being. These studies confirm earlier seminal works by Peplau (1952) and Ramos (1992) that assert nurse/patient relationships involving close cognitive and emotional bonds persuade all parties to perceive coping with illness as a holistic undertaking that is a shared responsibility. Close relationships facilitate patients' ability to manage illness and enjoy a better quality of life despite illness. They also result in deeper levels of professional satisfaction for the nurses involved. Although these studies refer to close relationships, they nevertheless reiterate the necessity of maintaining a professional aspect. McCormack (2004) views the nurse's role within the relationship as 'nurturing' (p.33) and as providing 'skilled companionship', while Ramos (1992) describes the relationship as a 'modified social relationship' (p.500) because although close, it is purposefully therapeutic. In other words, close nurse/patient relationships must retain a professional boundary if they are to be successful.

However, the findings of this study contribute a new element to the discussion regarding therapeutic relationships. Many participants admitted that professional boundaries can be difficult to maintain in a long-term care environment, in which nurses and residents/families have the opportunity to get to know each other very well. Time and again, participants referred to residents as 'family' or 'friends', rather than 'residents' which effectively erodes the professional boundary that distinguishes 'nurses' from 'personal acquaintances'. Although participants did not suggest that this erosion is a violation of professional boundaries, they reported that being so close to residents can be emotionally draining for themselves, and disconcerting for both themselves and residents/families because it can at times become difficult to discern whether they are professional care workers or friends. This becomes particularly problematic when close relationships with families lead to relatives attempting to involve participants in family quarrels. In such cases, participants assert their professional persona in order to demonstrate objectivity and impartiality, but many are unable to resolve the situation because they do not have the necessary social work skills and knowledge to manage family conflict. This reinforces the idea that current nursing skills do not adequately 'fit' the NuH nurse role (this is discussed later in 6.3.2).

Despite the overtures of holism that the above definitions of nursing offer, an emphasis on clinical matters and/or therapeutic relationships is nevertheless apparent in the discourse of participants. Participants stated that although they do provide holistic care, they

predominantly focus on residents' social well-being rather than on healthcare, and engage in more personal relationships with residents. As such, participants feel uncertain about their identity as nurses.

This uncertainty can be explored further by considering the isolation and exclusion that participants reported they are subjected to. Participants proposed they are isolated because they work with residents who are evaluated as having reached the optimum level of ability and so, inter-professional working or team nursing has been withdrawn. In addition, they stated that, because they are employed by private companies in a healthcare system that is dominated by the NHS, they feel excluded from mainstream healthcare services. However, the findings also suggest that, in actuality, the participants do work collaboratively with other professional groups – in particular, social care professionals. Such contradictory evidence might be explained by referring to literature regarding occupational role. By returning to the literature review, we can remind ourselves that occupational role is not unique to the individual but brings with it social identity, in that it generates membership of a group (an occupational group and/or an organisation) (Tajfel & Turner, 1986; Hogg & Terry, 2000; Van Knippenberg & Sleebo, 2006). Occupational role implies that the self is similar to other group members, and group characteristics can be assigned to the self. This process of self-identification with a group reflects what Van Knippenberg and Sleebo (2006) describe as 'psychological oneness' (p. 572). For participants in this study, could it be that they feel isolated and excluded because, despite their engagement with social care professionals, they no longer view themselves as members of the nursing occupational group, so do not experience 'psychological oneness'? This proposal can be explored further by examining the NuH nurse role in the context of 'professional capital'. Beddoe (2010) defines professional capital as the combined worth of: a professional qualification and/or professional registration which provide the professional worker with a clear and credible knowledge-claim, a well-defined territory of practice, and congruent values within the profession. According to Beddoe (2010), the presence or absence of these characteristics impacts upon the development or maintenance of professional identity. Beddoe (2011; 2013) proposes that having a sense of professional identity depends upon the individual sharing values with other members of the profession, practicing within one's own professional field, and utilising one's own evidence-based professional skills and knowledge within that field. In this study, participants expressed their accordance with health and social care values (for example, holism, person-centred practice, advocacy) but suggested that their expectations regarding clinical practice and utilisation of their nursing expertise do not meet the reality of their actual practice. Alice, for example, expected nursing to be about acting as a health clinician, using her health-based knowledge and qualifications within a

healthcare environment, and collaborating with other healthcare professionals. However, she finds herself primarily addressing the social concerns of residents, within a very undefined territory of practice in that it lies at the intersection of health and social care. Furthermore, she perceives herself to be utilising her acute clinical skills (which she feels define nursing) to a limited degree. In other words, the participants are working outside of (or at least, at the edge of) the healthcare arena – an arena which they feel should be their natural practice environment. As such, despite working with social care professionals, they feel uncertain, isolated and excluded.

Likewise, some participants' expectations regarding their relationships with residents are not fulfilled by the reality of practice. The long-term nature of the NuH nurse/resident relationship modifies the relationship so that it becomes personally rather than professionally based. Some participants expected to support residents via therapeutic relationships, but suggested that the familiarity that grows between nurses and residents in the NuH setting erodes professional boundaries so that nurses become 'friends' rather than health professionals. Beddoe's (2011) exploration of the professional identity of health social workers suggests that these practitioners feel like 'guests' in their work settings because their social care knowledge is not valued in a setting where medical needs and medical knowledge dominate. As a result, the professional identity of health social workers is weakened. The responses of participants in this study suggest that a similar outcome occurs. They inferred that their professional healthcare knowledge is not valued by residents whose care priorities are social rather than clinical. This contributes to a waning of the participants' sense of professional identity. As a result, participants either no longer feel like nurses (for example, Alice), or they try to establish a new hybrid role (like Cath).

6.2.3 Aspiring to the practice of acute clinical skills

Participants' uncertainty regarding the role of the NuH nurse is reiterated by their contradictory attitudes to the clinical aspect of their role. They proposed that nursing 'residents' rather than 'patients' reduces the need for acute clinical skills practice and development, while the clinical skills that are required to manage multi-morbidities tend to be routine and repetitive. They did not appear to consider these skills as high level competencies or proficiencies. However, literature that explores the management of multi-morbidities in NuHs indicates that the presence of RNs in NuHs has a significant influence on residents' health and well-being. For example, Condelius, Edberg, Hallberg and Jakobsson's (2010) study of the utilisation of medical healthcare of older people finds that despite the high incidence of multi-morbidities and dependency in NuH residents, this group access external healthcare services less frequently than people dwelling in their

own homes. The study suggests that this may be because NuH staff are able to monitor residents' medical conditions and support the stabilisation of these conditions, thus preventing the need for acute interventions and hospitalisation. Kwong, Pang, Aboo and Law's (2009) study of pressure ulcer management in RHs and NuHs finds that the presence of RNs in NuHs reduces the risk of residents' health deterioration and the need for acute interventions. It seems then, that participants' negative and disparaging attitudes regarding their own skills practice suggests that they do not recognise the management of multi-morbidities as highly skilled nursing practice.

Contrariwise, the participants in this study also stated that acute clinical skills development and maintenance are necessary so that NuH nurses can provide continuity of care, and promote efficient health service resource management. They said that training and developing acute clinical skills is essential, but they reported that such training is difficult to access. These views are similar to the findings of research which explores NuH nurse education (cited in the literature review). For example Hannan et al. (2001), Ross et al. (2001) and Eley et al. (2007) find that NuH nurses believe clinical skills competence is crucial to the delivery of quality care, but struggle to access relevant education programmes. What is interesting in the present study, however, is that the participants appeared particularly concerned that they are denied NHS training opportunities, and suggested that the NHS should, to some extent, take responsibility for NuH nurse clinical training and updates.

This contradiction regarding the necessity for clinical skills practice and development, highlights NuH nurses' uncertainty about their role in a number of ways. For example, the participants seem unsure about the function of NuH nursing. On one hand, they acknowledge that their function is to support residents to maintain their quality of life. Participants suggested that this group of service-users' care priorities are different in that they are more concerned with social pursuits than with medical matters. As such, participants said that much of their role involves addressing residents' social needs. On the other hand, they asserted that they should be involved in acute care and public health interventions (for example, vaccination delivery and Hickman line maintenance) – healthcare interventions that they felt are usually provided by NHS nurses specialising in these areas, and trained by the NHS. The participants' keenness to be trained in, and practice, acute and public health clinical skills might be because they believe this will support continuity of care and resource efficiencies, but it could also result from a desire for 'sameness', i.e. generate role identity via group membership (Van Knippenberg & Slebo, 2006). In other words, by practicing acute care skills, they feel that they are

performing the activities that they expected to perform as nurses, which will strengthen their nurse identities. Also, by training with the NHS, and carrying out tasks usually performed by NHS nurses, they may feel less isolated and excluded from the rest of the healthcare workforce. Furthermore, participants may desire acute clinical skills competence so they can become involved in practices other than those they regard as repetitive, routine and monotonous i.e. by increasing the complexity of the role, they may increase their job satisfaction (Judge, 2000).

The contradiction also highlights uncertainties about health and social care funding. Participants asserted that the NHS should provide training and updates – something which the NHS is under no obligation to do because the organisation already funds the nursing care of residents by paying NuHs fees that cover the cost of nursing elements of NuH care. It is therefore the responsibility of NuH providers to support staff training. However, participants' responses inferred they feel that because clinical skills tasks are healthcare, not social care interventions, if they were to deliver clinical interventions, they would be doing so on behalf of the NHS. These ambiguities and inconsistencies in participants' attitudes and feelings with regard to their clinical role demonstrates uncertainty about what should be within the remit of a role that sits at the cusp of health and social care, and highlights the confusion that numerous authors over the years have drawn attention to - what constitutes health and social care, and who is responsible for paying for, and providing, the resources to carry out this care (Townsend, 1962; Godlove & Mann, 1979; Clements, 2010).

6.2.4 Summary

This study provides an original contribution to knowledge in that it reveals business activities, and nursing 'residents' rather than 'patients', which are inherent aspects of the NuH nurse role, lead to uncertainty regarding role identity. Despite current, high profile deliberations concerning health and social care funding, and the blurred boundary between health and social care, the participants suggested that the nursing profession remains embedded in a culture of free care provision. They therefore expressed uncertainty about role identity because they find themselves immersed in a new, unfamiliar business culture. In addition, notwithstanding strong declarations on the part of the profession that nursing care is holistic, participants treated nursing as defined by its association with acute clinical skills. Thus, because the nursing management of multi-morbidities allows residents to focus on social pursuits, and because participants perceive the clinical skills that they do perform as routine, participants do not regard themselves as highly skilled healthcare clinicians. As such, they are uncertain about their role identity. Some participants' devised strategies to deal with role uncertainty. These include creating

a new blended culture that integrates care and business, attempting to develop a hybrid role incorporating health and social care, or striving to retain their nurse identity by aspiring to develop and practice more acute clinical skills. Such attempts suggest that having a professional role identity with which participants are comfortable and which contextualises them within the wider healthcare environment, is important to them. Taking the lead from NuH nurses' own efforts, it is apparent that there is work to be done for these nurses to forge a NuH nurse role that incorporates business, and values the activities they undertake to address the specific social needs of residents. In order to do this, activities of NuH nurses that were not expected need to be identified and investigated (as discussed in this section), and the specific habituation and education requirements relevant to the sector need to be identified and addressed (next section).

6.3 Unpreparedness for the demands of the role

As discussed in the previous section, the study's findings suggest that NuH nurses perceive that their role requires less clinical skills with regard to acute physiological conditions than other areas of adult nursing. Nevertheless, NuH nurses are keen to train in, and practice, acute clinical skills. The findings also reveal that the NuH nurse role incorporates business activities, while a high proportion of the role is focused on residents' social well-being. This section suggests that these factors impact on the preparedness of NuH nurses for the demands of the role:

- Nurse education in England does not adequately address business and funding aspects of care.
- Nurse education does not adequately address the health and social needs of residents with long-term conditions living in NuHs.
- NuH nurses have difficulty accessing clinical skills updates and clinical skills training.

6.3.1 Business activities

As already discussed, the English social care funding system is viewed as 'unfair' by many participants, and consequently, their association with it leads to moral discomfort. In addition, for some participants, the collocation of business and nursing within the remit of the NuH nurse role can lead to uncertainty about role identity. Cath and Anne suggested that much of the responsibility for this state of affairs lies with nursing education providers who, they felt, do not prepare nurses for the business aspects of the role, or the moral dilemmas that result from the juxtaposition of business and sales activities, with care activities.

The views and experiences of participants who obtained business skills while working in previous occupations (Barbara, Elaine and Anne), or who practice business skills in their role as NuH managers (Barbara and Anne) substantiated the suggestion that business education would help to habituate or prepare nurses for this aspect of the role. However, the differing perspectives of these three participants regarding the resident as a unit of turnover/profit also suggest that the business topics covered within education programmes influences nurses' views. For example, Barbara attended a business and finance course when she owned and managed a small business before commencing her nurse education programme. This knowledge supports Barbara's ability as a NuH manager to fully understand, and successfully control, the financial management of her NuH establishment, because she is familiar with budget and procurement processes. However, despite her knowledge, she struggles to reconcile the concepts of the resident as a 'customer', and the resident as a 'care recipient'. On the other hand, as well as gaining financial knowledge, Elaine acquired 'customer care' skills whilst working in the hotel industry prior to becoming a nurse. For Elaine, this experience has led her to understand that the utilisation of business and selling skills allows her to advocate for better services for residents by negotiating with management for resources. She is also able to protect residents from assurances of non-nursing staff that she said may be motivated by profit rather than care needs, by undertaking ethical selling (i.e. during her sales activities, she ensures residents receive an honest, realistic and full account of the services on offer). Anne, who also gained financial and customer care experience during her previous career in hotel management, is able to create a 'new' integrated role in which the 'customer care' concept is used to both improve the sustainability of the NuH as a business, and to enhance the quality of the NuH as a care provider.

Little previous research investigates the possibility that business education is useful to nurses working in NuHs. However, a few studies explore nurses' views concerning the influences and barriers of becoming nurse entrepreneurs working in the private sector. For example, 96% of the Australian-based nurse entrepreneur participants in Wilson, Averis and Walsh's (2003) delphi study felt that the acquisition of management and business skills is requisite to the success of their role. Elango, Hunter and Winchell's (2007) focus group study of USA-based nurse practitioners reports that a lack of business and financial knowledge is a considerable barrier to most participants considering entering private practice. Perhaps more significantly, customer care knowledge can mitigate the ethical concerns emanating from conflicting cultures of business and care that have an impact on nurses' willingness to involve themselves in private practice. The participants in Elango et al.'s (2007) and Blackman and Cook's (2010) studies stated that business practices are 'against their personal ethical norms and values' (Elango et al., 2007, p.201) so they resist

involvement. However, 100% of the entrepreneur participants in Wilson et al.'s (2003) study conceded that knowledge, experience, and training in customer service, support their perception that doing the best for the patient goes hand-in-hand with business success. These studies echo the findings of the current study which suggest that education and knowledge of business and customer service issues habituates and prepares nurses to accept that business aspects are integral to the role of the private sector nurse, and enables nurses to reconcile the seemingly conflicting concepts of business and care.

The current study highlights that NuH nurses face an added difficulty emanating from business and funding issues. Participants professed that a major challenge is contending with the expectations of self-funding residents and their families regarding service provision. This is not an entirely unique challenge. A number of research studies explore private health service quality, and patient and staff expectations of private services. However, to-date, studies focus on hospital care (Angelopoulo, Kangis, & Babis, 1998; Jabnoun & Chaker, 2003; Pager & McCluskey, 2004; Taner & Antony, 2006; Arasli, Ekiz,& Katircioglu, 2008; Mohsin & Ernest, 2010; Zarei, Arab, Froushani, Rashidian, & Ghasa Tabatabaei, 2012). All suggest that, because private patients assume clinical needs are automatically addressed for all service-users, paying should afford services over and above what are perceived as the norm. Therefore, private patients are extremely conscious of the cost of care, and scrutinise services to ensure their 'beyond the norm' expectations are met. As a result, the introduction of private funding alters expectations about what constitutes care services. While staff and public patients' definitions centre on staff communication skills, compassion, competence and qualifications, private patients are concerned with tangible facilities such as attractiveness of the care environment, quality of food, and the amenities on offer, and also with the availability and attentiveness of staff (Angelopoulo et al., 1998; Zarei et al., 2012).

Findings from this study support these conclusions as they demonstrate a similar disparity between participants' definitions of quality service, and what they reported are residents' definitions of quality service. Participants said they offer a service based on care, but said that while potential residents and families take this into consideration, they look for more tangible, material niceties such as superior décor, pleasant views, and modern facilities. This study also corroborates previous research findings that suggest private patients are preoccupied with staff availability and attentiveness. However, this study adds a new element to the current literature, as it suggests the distinctive manner in which NuHs are funded creates extra difficulties for NuH nurses. As explained in the introduction (1.5.2), healthcare in NuHs is provided by the NHS and is 'free-at-the-point-of-care'. Individuals

who require NuH care undergo an assessment of their care needs in order to determine whether their needs are primarily health-related. If residents are assessed as having a 'primary health need', their care is funded by the NHS. People who do not meet the 'primary health need' criteria but require the support of a RN receive a joint package of care. The 'health needs' of this package 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 (DH, 2012a). This means that care provided in NuHs is multiple-source funded (a mix of privately, publicly and jointly funded care). 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 NuH residents to become supercilious in their behaviour to staff. Participants also stated that they perceive a tension between the duty of the nurse to provide an equitable care service that promotes residents' independence, and the expectation of residents to be provided with a tariff-related hospitality service. In addition, the resultant difference in the relationship between nurse and resident was reported to adversely affect residents' motivation to maintain independence.

Due to the controversial nature of the current care funding system, it is unlikely that the difficulties faced by NuH nurses regarding residents' funding frustrations will abate in the foreseeable future (Clements, 2010). In response, some participants attempt to utilise reflective practice techniques to understand self-funding residents/families' experiences (for example, Faye, Georgia and Emma), but in general, while participants acknowledged that self-funding residents' changing expectations of care posed a challenge for nurses, they appeared unsure about how to manage this challenge. Cath commented that it may be beneficial to include the topic of care funding in nurse education programmes. Such an initiative may assist NuH nurses to prepare for the demands of their role regarding self-funding issues, as well as business and sales issues.

Currently in England, there is no requirement for pre-registration or post-registration education nursing programmes to incorporate business training (NMC, 2010; 2011). Although the *Standards for pre-registration nursing education* (NMC, 2010) include 'organisational aspects of care' within the essential skills clusters, this skills cluster focuses on patient management issues such as MDT working, health promotion, safeguarding, care management, safe care, and legal frameworks. The document does not refer to organisational management in terms of business and funding. The CWD standard for RNs does not specify any required domains of learning within its directive (NMC, 2011). This allows nurses the freedom to choose relevant professional

development topics, but while some business courses are available for higher grade nursing personnel, they are not generally provided for frontline nurses (for example, the Institute of Healthcare Management's (2014) *Managing health and social care* programme is aimed at first line managers, NuH managers, and clinicians moving into operational management). The findings of this study, however, suggest that frontline NuH nurses would benefit from business training.

Conversely, in the USA, the American Association of Colleges of Nursing (AACN) has recommended that the curricula of nurse education programmes should include business and finance topics (AACN, 2008). This is perhaps unsurprising because 78% of all American health and social care facilities are operated by private companies, and primarily funded by health insurance or self-funding (American Hospital Association, 2014). 'Essential V' of the AACN's baccalaureate programme aims to prepare nurses to understand the economic value of nursing services, and how healthcare is financed. The rationale for this initiative is that an appreciation of business and funding models will enable nurses to recognise the link between care and business. Such recognition will strengthen their abilities to provide high quality care, understand the challenges that funding systems may pose for patients, and act as patient advocates:

Essential V: Healthcare Policy, Finance, and Regulatory Environments

Rationale

Healthcare policies, including financial and regulatory policies, directly and indirectly influence nursing practice as well as the nature and functioning of the healthcare system. These policies shape responses to organisational, local, national, and global issues of equity, access, affordability, and social justice in health care. Finance policies also are central to any discussion about quality and safety in the practice environment...[finance] policy shapes the nature, quality, and safety of the practice environment and all professional nurses have the responsibility to advocate for patients, families, communities, the nursing profession, and changes in the healthcare system as needed. Advocacy for vulnerable populations with the goal of promoting social justice is recognized as moral and ethical responsibilities of the nurse (AACN, 2008, p.20).

This section of the curricula incorporates twelve educational objectives which include:

- Demonstrating basic knowledge of finance and funding policy.
- Describing how healthcare is organised and financed, including the implications of business principles, such as patient and system cost factors.
- Comparing the benefits and limitations of the major forms of reimbursement on the delivery of healthcare services.

- Discussing the implications of healthcare policy on issues of access, equity, affordability, and social justice in healthcare delivery.
- Using an ethical framework to evaluate the impact of social policies on healthcare, especially for vulnerable populations.
- Advocating for consumers and the nursing profession.

(AACN, 2008, pp.20-1)

Although American universities are implementing curricula changes to reflect the AACN's recommendations (for example, Education Committee of the Association of Community Health Nurse Education, 2010; Mailloux, 2011), no studies have been published that evaluate the impact of 'Essential V' on nurses' business skills, their views regarding business issues, or the quality of care provision. However, the responses of participants in this study suggest that education regarding these issues would be advantageous. Habituation via previously acquired business and customer care skills enables Elaine and Anne to reconcile the business and care aspects of their role. Participants with no prior business experience either reject the business facets of the role, or engage in it reluctantly. Those who do engage are able to do so because they appear to recognise some link between ethical selling and advocacy. None of the participants have undertaken training programmes that explore the effects of funding systems on patient experience, which may have contributed to their struggle to cope with the altered expectations of self-funding residents. The educational objectives proposed by the AACN (summarised above) address many of the participants' concerns. For example, the objectives consider the relationship between finance and sales and a well-resourced quality service, and how nurses' involvement in these issues does constitute a form of advocacy. In addition, the objectives reflect upon the impact of care funding systems on health and social justice, and on the delivery of equitable care. If these topics were therefore introduced into pre-registration nurse education or NuH nursing CWD programmes, NuH nurses may feel more prepared for the business activities inherent within their role.

6.3.2 Addressing the needs of 'residents' rather than 'patients'

Participants proposed that much of the NuH nurse's role involves addressing residents' social needs and issues. However, they reported that they lack some of the skills and knowledge required to manage these issues, which at times leaves them feeling unprepared for the demands of their role. They suggested that promoting choice and control in community settings, and dealing with internal family conflict are particularly challenging.

6.3.2.1 Promoting choice and control in community settings

As discussed earlier, studies investigating NuH residents' views regarding quality of life factors propose that being able to maintain choice and control enhances quality of life (Bergland & Kirkevold, 2005; Bradshaw et al., 2012; Cooney, 2012). All participants agreed that the preservation of choice and control is an essential aspect of residents' psychosocial well-being and ability to acclimatise to the NuH environment. However, all also stated that facilitating individuals' choice and control within communal settings can be problematic. Many participants suggested that residents do not perceive themselves as members of a community, but as individuals with specific and personal preferences who reside in the same building as other individuals with their own specific and personal preferences. Some participants reported that such circumstances can lead to conflict between residents whose priorities and choices differ, so that promoting choice and control can at times be difficult.

According to studies exploring the meaning of community, (for example, Hinshelwood, 2001; Taylor, 2003; Vaisey, 2007), 'community' depends upon structural experience (formal organisational characteristics such as environment and power relations) and substantive experience (members having shared values, shared moral cultures and a shared sense of moral order). These authors propose that it is substantive experience that drives feelings of solidarity. Hinshelwood (2001) suggests that, as such, 'experience of community' is hard to attain in care institutions and communal care settings. He argues that a person enters such a setting, not because of a belief in the ethos and unity of the group, but because 'he is motivated by a desire to do well for himself' (p48). The social system of the communal care setting is primarily a place where the individual can recover or maintain his/her own health, well-being, and quality of life. As the participants' comments illustrate, these circumstances can lead to tensions because the diverse desires, choices, values and cultures of the individuals living within the care setting may conflict. Difficulties arise because, in the main, residents enter NuHs for reasons based upon individuals' care needs, and not upon a desire for group affiliation. For example, the decision to live in a NuH may be founded upon severe physical or cognitive disability, or on a diminution in an individual's care network. As such, many residents join NuH communities reluctantly, and choice of home is sometimes made on behalf of residents rather than by residents themselves (Reed et al., 2003; Bradshaw et al., 2012, Ryan, McKenna, & Slevin, 2012). Alternatively, residents may have proactively chosen to relocate. Reed et al.'s (2003) study of residents' experiences of relocation to NuHs reports that while preference relocations (moves in which residents have exercised choice) are sometimes based on group orientation (for example, religious or cultural membership),

choices are more often based upon 'what-the-NuH-can-offer-me' or 'what-the-NuH-can-offer-my relative' factors such as NuH reputation, tangible facilities on offer, and location. Ryan et al.'s (2012) study of rural family care-givers' decisions concerning NuH entry reports that choices are frequently determined by familiarity with the locale and local people. Nevertheless, the study emphasises that older people prefer to remain in their own homes, which suggests that moving into a NuH is not due to a desire to proactively join a NuH community.

Although only three of the NuHs in the sample provided elderly mentally infirm (EMI) care, all participants have experience of working with residents with cognitive impairments and mental health needs. This is because all the general nursing care units in the sample accommodate both residents with cognitive impairments and without cognitive impairments. The participants indicated that facilitating choice and control within communal environments is particularly difficult in settings which accommodate both these groups. Some participants suggested that this is because the two groups struggle to adapt to living in close proximity. Residents with cognitive impairments are often unable to recognise and comprehend the diverse needs and preferences of other individuals or the community in general, while residents without cognitive disabilities can feel distressed or threatened by the behaviours of those residents with impairments.

The comments of the participants are corroborated by the findings of research that explores the experiences of cognitively intact residents living within the same facility as residents with cognitive impairments (Gorman, 1996; Oh, 2006, Cheng, Hu, Ou-Yang, Kaas, & Wang, 2013). These studies report that some of the behaviours displayed by residents with cognitive impairments (for example, agitation, aggression, shouting, wandering, sleep disorders and unpredictable conduct) can be severely disturbing to cognitively intact residents, leading to feelings of fear, powerlessness, anger and dislike. The resident participants in Cheng et al.'s (2013) study suggested that when staff are alerted to incidents of conflict or disruption, they are more likely to attend to the needs of the residents with cognitive impairments, rather than to those without, which can further exacerbate conflict. Ragneskog, Gerdner, & Hellstrom's (2001) survey of nurses' experiences of integration of patients/residents with and without cognitive impairments in the same care facility concludes that staff believe that cognitively intact patients/residents have negative feelings about the behaviours of patients/residents with cognitive impairments. The participants in the present study had similar views, but in addition, they stated that they at times feel overwhelmed by the challenges of negotiating compromise and harmony. While they said that staffing levels are inadequate to meet the demands of residents with cognitive impairments, participants suggested that the primary obstacle is

the lack of staff training, not only with regard to cognitive impairments, but also in caring within a long-term communal facility.

The participants' concerns regarding their lack of training in caring for people with cognitive impairments confirm findings of earlier studies that suggest staff in NuHs have poor knowledge of these conditions (Mozley et al., 2000; Hughes, Bagley, Reilly, Burns, & Challis, 2008; Alzheimer's Society, 2013). This may be explained by referring to literature exploring the availability and quality of training programmes. Tsolaki et al.'s (2010) recent consensus statement on dementia education in Europe reports that training in the field is inconsistent and non-standard, and when it is available, quality of courses vary considerably. Jones, Moyle and Stockwell-Smith's (2013) studies of staff perception of knowledge and training in cognitive impairment conditions, state that while staff are committed to the value of education, they are often critical of its nature, and struggle to relate it to practice. However, the current study's findings differ from those of previous studies in that some participants suggested inadequate training in facilitating choice and control within a communal care setting for a diverse range of individuals, presents a greater challenge than that of caring for individuals with cognitive impairments. To-date, there is a dearth of research which specifically examines this issue in NuHs. Studies of inter-group contact in other communal settings (for example, Berryman-Fink, 2006 – boarding education; Pettigrew and Tropp, 2006 literature review; Olson, Jason, Davidson, & Ferrari, 2009 - mental health treatment facility) conclude that 'mere social contact' is not a strong precursor to tolerance between 'ambivalent groups', as it can create added tension and suspicion. These authors suggest that harmony within communities is best achieved when staff are committed to, and educated in, social contact and interactive involvement strategies. Although this research was not performed in a NuH environment, the results may provide some useful insights regarding training in communal care issues.

6.3.2.2 Dealing with internal family conflict

As discussed in 6.2.2.2, many participants stated that their close relationships with residents and families that develops as a result of the long-term nature of NuH care, at times results in an erosion of professional boundaries which can be disconcerting for NuH nurses and lead them to question their professional identity. They said this can be particularly difficult when close relationships with relatives place participants at risk of becoming embroiled in internal family quarrels. Participants stated that in order to cope with this challenge, they assert their professional persona, but their lack of social work knowledge results in a distancing of themselves from such situations, or passing these cases onto social workers. This reinforces the notion that current nursing education does not prepare NuH nurses for the demands of the role. Barbara, Cath and Elaine expressed

the view that NuH nurses would be better prepared to deal with these difficulties if their education incorporated topics regarding family dynamics and family conflict. Barbara stated that she is able to successfully cope with family quarrels because she is both a qualified social worker and a RN. She uses her own case to illustrate that NuH nurses would benefit from training in social work.

Although a number of studies investigate the experiences of NuH staff regarding their relationships with residents' families (for example, Sandberg, Nolan, & Lundh, 2002; Weman & Fagerberg, 2006; Wilson, Davies, & Nolan, 2009; Abrahamson, Sutor, & Pillemer, 2009; Abrahamson, Anderson, Anderson, Sutor, & Pillermer, 2010; Salin, Kaunonen, & Astedt-Kurki, 2013), there is a dearth of research exploring the challenges that internal family conflict pose for NuH nurses. Of the few studies undertaken, Abrahamson and colleagues find that staff/family conflict in NuHs has an impact on staff stress and burnout (Abrahamson et al., 2009; 2010), while Weman and Fagerberg (2006) suggest that NuH nurses may find family conflict difficult to negotiate. Most studies that consider family conflict in healthcare focus on medical, palliative or home settings, but not NuHs (Strawbridge & Wallhagen, 1991; Kissane, Bloch, Burns, McKenzie, & Posterino, 1994; Breen, Abernethy, Abbott, & Tulsky, 2001; Back & Arnold, 2005; Randall & Downie, 2006; Lichtenthal & Kissane, 2008). These studies have proposed that family arguments are prevalent in healthcare settings. However, most of the studies conclude that clinicians are not confident or well-trained to deal with these issues. Randall and Downie (2006) suggest that part of the problem lies in the fact that health professionals must necessarily prioritise the care needs of patients over those of relatives if they are to fulfil their ethical and professional obligations. However, a lack of clinician training regarding family care means that the necessity of prioritising patient care could lead to family members' needs being ignored or devalued. Indeed, this is demonstrated by Faye when she explained that she 'cuts' herself off from family disputes and refers these on to her social worker colleagues because her priority is caring for the resident. Barbara on the other hand, said that because she is dual trained in nursing and social work, she is able to 'focus on the individual' resident, but still facilitate compromise across the family. These responses confirm the findings of Lichtenthal and Kissane's (2008) literature review which discusses the management of family conflict in palliative care. The review concludes that educating clinicians to apply family assessment and family intervention techniques (for example, assessing family cohesiveness/dysfunction, conflict resolution, conducting family meetings, psycho-educational interventions, and facilitating multiple-family support groups) alongside person-centred care techniques may help to resolve family strain, promote optimal patient care, and reduce clinicians' own stress.

Some training deficiencies could possibly be addressed by educating NuH nurses to become specialists in gerontological nursing care, as this would involve training in the care of patients with cognitive impairments, and in the care of older people with long-term chronic conditions. Gerontology specialisms are achieved via post-registration and/or pre-registration nurse education and training. In terms of post-registration education, a range of gerontology courses are available (Robinson & Griffiths, 2007). However, participants in this study reported that these are difficult to access for NuH nurses (this will be discussed further in 6.3.3). With regard to pre-registration nursing education, currently in Western countries, most programmes are 'generalist' (i.e. generic courses that cover all fields of nursing). According to Robinson and Griffiths' (2007) report on the profiles of international nurse education, only Germany offers direct specialist entry gerontology nursing. Nevertheless, in other countries, increasingly, universities and other education providers are beginning to initiate education and training in gerontology, and in particular cognitive impairments, in order to support staff's ability to provide quality, person-centred care (for example, Baillie, Cox, & Merritt, 2012a; 2012b; Baillie & Thomas, 2013). But, even if gerontology courses were to become more widely accessible to NuH nurses, the findings of the present study suggest that any such education programmes would need to include training in facilitating care in communal settings and family care, if NuH nurses were to benefit.

6.3.3 Aspiring to the practice of acute clinical skills

Participants stated that the routine nature of long-term care does not usually require NuH nurses to become proficient in a diverse range of acute clinical skills. Thus, by their own admission, the acquisition of such skills makes little difference to their preparedness for the NuH nurse role. Nevertheless, all participants expressed a desire to develop and maintain clinical skills competence, and reported that they seek clinical skills training and education opportunities. This suggests that participants have other reasons for wishing to access acute clinical skills training that are unrelated to their ability to undertake the requirements of their role. It was suggested in 6.2.3 that participants desire acute clinical skills training because they view clinical skills practice as a method of strengthening their identity as nurses, and as a way of increasing the complexity of their role, and therefore their job satisfaction. However, the study's findings infer that another possible reason may exist - the attainment of 'cultural capital' that the completion of educational courses confers upon attendees.

Participants referred to three sources of clinical skills training provision – universities, private training companies, and the NHS. Most participants suggested that their preferred

source of training was the NHS, but reported that they struggle to access NHS courses. Many stated that they cannot access university programmes because they are unable to secure financial support from their employers, and cannot afford to self-fund. With regard to courses offered by private training companies, while participants found that the quality varied significantly, some courses were highly praised. According to Hannan et al. (2001), Raikkonen et al. (2007) and Eley et al. (2007), quality training, and the attainment of qualifications within practice, increase nurses' job satisfaction. In this study, however, access to quality courses does not in itself guarantee job satisfaction. In spite of the content worth of some private training courses, participants found that they are not always recognised by the NHS or by regulatory bodies as valid qualifications or updates. In other words, they do not contribute towards 'cultural capital' within the context of English healthcare and therefore hold little value. Cultural capital, discussed in the literature review, relates to the value of skills and qualifications. According to Bourdieu (1986), the value of qualifications depends upon whether they are endorsed by the dominant socioculture. Qualifications devised and recognised by the dominant socioculture hold most value – an intrinsic value - so attainment of these elevates the status of the attaine. Qualifications not derived from the tenets of the dominant socioculture are less valuable. In other words, the value of qualifications is less to do with their educational content, than with their association with the dominant socioculture. In this case, participants' responses suggested that courses offered by organisations that are external to NHS/universities (dominant healthcare and education sociocultures) may have no intrinsic value, so cannot be used as evidence of clinical skills proficiency within the NHS. This is of no consequence within the NuH sector, or for participants wishing to remain as NuH nurses. However, those participants aspiring to a move to the NHS suggested it is a potential barrier. Indeed, when discussing the attainment of training and qualifications, some participants discussed these as a means of entry into the NHS job market, as well as a means of developing competencies.

This begs the question, what does training in acute clinical skills prepare NuH nurses for? It is debatable whether the answer is solely to improve their ability to perform their role, as by the participants' own admission, acute clinical skills are not much required. Perhaps then, it is more to do with maintaining and developing flexibility and adaptability as nurses so that they are able to move between sectors and nurse specialisms. This seems to be a reasonable interpretation bearing in mind many participants view NuH nursing as a transient role – something they settle for until circumstances allow them to move on.

Some participants stated that exclusion from access to recognised training isolated them from the rest of the healthcare workforce. For Georgia, this led her to seek employment in

an alternative setting. These experiences are echoed by studies that explore the relationship between training and employee retention (Hegney & McCarthy, 2000; Martin & Young, 2006; Weymouth et al., 2007; Yuginovich & Hinspeter, 2007; Lenthall et al., 2009; O'Donnell, Jabareen, & Watt, 2010). A study by O'Donnell et al. (2010) proposes that a lack of opportunity to attend training courses, and acquire qualifications that are recognised and accepted by dominant healthcare sociocultures, results in nurses feeling alone as well as unprepared. Consequently, the retention of staff is adversely affected. O'Donnell et al.'s (2010) study concludes that this is because recognised training sessions, as well as providing definitive and up-to-date instruction and qualifications, offer valuable opportunities to connect and collaborate with peers from the dominant socioculture. Bourdieu (1986) explains the significance of associating with the dominant socioculture. He proposes that connecting with, and becoming a member of the dominant social group enables individuals to procure additional cultural capital, by the simple fact they become 'one of us'. However, when social connections of individuals are incongruent with the dominant group, then their cultural capital is diminished. Participants in this study stated they are denied opportunities to attend recognised training courses. If this is the case, this constitutes a double setback in terms of cultural capital attainment, because they are unable to attain the qualifications necessary to perform certain clinical skills and to gain entry into the NHS job market. In addition, their exclusion from the dominant socioculture as a consequence of exclusion from recognised training programmes perpetuates their lack of cultural capital.

6.3.4 Summary

Many participants suggested they are unprepared for the business and social elements inherent within the NuH nurse role. Participants who were most prepared to cope with these aspects were those who were already habituated and trained in business and social issues. However, these participants had acquired experience and knowledge of business and social care outside of the nursing profession (Anne, Elaine and Barbara), or because they are trained and work as NuH managers (Anne and Barbara). This suggests that traditional nursing education is not adequate to meet the demands of NuH nursing. While findings are similar to those of other studies in that they suggest NuH nurses require training in the care of people with cognitive impairments, they are original in that they indicate NuH nurses require training in business topics, facilitating care within communal living settings, and family care, if they are to effectively carry out these aspects of their role. The study is also original in that it explores participants' motivations behind their desire to acquire advanced clinical skills. Although by their own admission, the acquisition of a diverse range of acute clinical skills is not really necessary, they are nevertheless desirable because they strengthen NuH nurses' nursing identity, increase job satisfaction,

and increase cultural capital which improves nurses' flexibility and adaptability as nurses, and enhances their occupational status.

6.4 Low occupational status

The findings presented in the previous chapter revealed that participants feel the occupational status of NuH nurses' role is low, in part, because the role is a stigmatised role. Participants proposed that this stigma stems from a variety of causes. For example, they suggested that the public and other healthcare professionals lack understanding of the NuH nurse role – perceiving it to primarily entail the provision of personal care, and as such, confuse the role with that of HCAs. Participants also inferred that the public views NuHs as morally dubious because NuH providers operate commercial businesses within a culture of free care. Indeed, many participants themselves suggested that the juxtaposition of care and business creates a moral dilemma. Participants said that their abilities and skills are unrecognised and undervalued simply due to the fact that they are NuH nurses, and as such are viewed as 'second rate' (Anne, 1). A small number of participants proposed that negative media reporting leads to suppositions that NuHs are imbued by poor practice and incidents of abuse against residents, and a few participants said that other healthcare professionals have ageist attitudes about the older population, which fuels the assumption that nurses working with older people are less dynamic and less skilled than other nurses. In addition, Andrea referred to her experiences of racism during discussions about status, although her responses suggested her work role mitigates against her migrancy status.

Reaching an understanding of participants' experiences of, and views about, their status involved consideration of potential social and work-related influences. The literature review referred to research and theories that propose occupational status is attributed to authority-based prestige (Zhou, 2005) and low knowledge-based prestige (Bourdieu, 1977; 1986; 1990; Bourdieu & Passera, 1977; Zhou, 2005). It also referred to Hughes' (1951; 1958) and Ashforth and colleagues' (Ashforth & Kreiner, 1999; 2002; Ashforth et al., 2007) research that suggest 'dirty work' – work activities that society perceive as repulsive, demeaning or corrupting – lowers occupational status. In the literature review, these theories were criticised because they undertheorise the potential impact of social and cultural contexts. For example, they do not acknowledge that social identity constructs associated with gender, ethnicity or migration may influence perceptions of occupational status, issues that other authors suggest are significant influences (for example, Jervis, 2001; Skeggs, 2004; Huppatz, 2010; Lee-Treweek, 2010). Thus, when considering explanatory frameworks for NuH nurses' low occupational status, social and cultural contexts, gender and ethnicity/migration issues, as well as authority-based and

knowledge-based prestige, and perceptions of work activities were explored. These explorations are presented below. Section 6.4.1 discusses the association between status and gender, ethnicity and nationality, then 6.4.2 considers work activities, knowledge and skills status constructs.

6.4.1 Social constructs of identity: gender, ethnicity and migrancy

As discussed in the literature review, Jervis (2001) and Huppertz (2010) propose that care, service, and domestic work have been customarily regarded as 'feminised' activities, which may limit the roles' statuspotential. 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. Gender/work issues are further complicated by social identities associated with ethnicity and nationality. For example, Anderson (2000) argues that gender/work status is challenged by citizenship and ethnicity, because men from ethnic minorities and migrant men are often employed in institutional care and domestic work. In addition, Espiritu (2005) suggests that the migration of female care workers results in their enhancement of status within the family and community, which can have the effect of them perceiving their paid care work as gender neutral or even masculine.

A limitation of the current study is that no male participants were involved, so the study cannot offer comment about whether, from a man's perspective, occupational status of NuH nurses is associated with gender status. However, none of the participants referred to gender when discussing role and status. This does not say that gender is not an issue, as the 'backgrounding' analysis technique revealed. Participants did suggest that the image of NuH nurses as uninspiring and enervated in terms of career motivation and development, contributes to the role being viewed as a 'lower option' (Barbara: 1), and indeed, for half of the participants, the primary reason for choosing to work in NuHs are 'uninspiring feminised' reasons i.e because NuHs allow flexible working for staff with family care obligations – either childcare, or care of infirm relatives. Also, participants suggested that the public and other healthcare professionals lack understanding of the NuH nurse role – perceiving it to primarily entail the provision of personal care, and as such, confuse the role with that of HCAs. If Jervis' (2001) and Huppertz (2010) theories are applied, it could be argued that, although participants did not explicitly refer to gender issues, gender and role/status associations are implicit, and concealed in social values and assumptions that are taken for granted. However, if Gregg and Wadsworth's (2003) stance is applied (i.e that in recent years, care work has become gender neutral), or Espiritu's (2005) theory is applied (i.e. the work of migrant women nurses may be perceived as gender neutral or masculinised), then it could be concluded that participants

lack of explicit reference to gender demonstrates that they view their image and their work activities to lead to their low status, independent of the fact that they are women.

Participants' suggested other causes of their low status. They felt that the public views NuHs as morally dubious because NuH providers operate commercial businesses within a culture of free care. Indeed, many participants themselves suggested that the juxtaposition of care and business creates a moral dilemma. In addition, a small number of participants proposed that negative media reporting leads to suppositions that NuHs are imbued by poor practice and incidents of abuse against residents, and a few participants said they think other healthcare professionals have ageist attitudes about the older population, which, they said fuels the assumption that nurses working with older people are less dynamic and less skilled than other nurses. None of these suggested causes of low status imply a link with gender identities, but rather relate to the taint of moral and social 'dirty work' activities (discussed in detail in 6.4.2 below).

A further argument for questioning the influence of gender issues on participants' views of their status is that they constantly measured their status by comparing themselves with NHS and hospital nurses – who are also primarily women i.e. because all respondents are female, working in a traditionally 'feminised' role, and comparing their role to other 'feminised' roles, then this study does not have the scope or need to engage with the issue of gender. It could be contended that participants' desire for advanced clinical skills development and practice is about moving away from the 'feminised' personal care role, but as already discussed in 6.2 and 6.3, this desire may be more about supporting feelings of belonging to the nursing community, acquiring cultural capital, and adding variety and interest to their role, as well as reducing the stigma of personal care work. Also, when comparing themselves to NHS nurses, they discussed their views and experiences of status that arise from differences between NHS and NuH funding and business models, which has little to do with gender concerns.

On balance then, while gender issues may influence the status of NuH nurses, it is not possible to suggest that gender is a major explanatory framework with respect to participants' views of status. Alternative explanations are considered below.

As stated briefly above, ethnicity and migrancy have an association with occupational status. As discussed in the literature review, Skeggs (2004) notes that migrant workers and ethnic minorities are often employed in domestic, care or service jobs - jobs that indigenous workers find undesirable. Skeggs (2004) suggests that the association of migrant workers with undesirable jobs is a cyclical association that reinforces these roles as low status. Lee-Treweek (2010) proposes that, despite the unattractiveness of these

jobs, the status of migrant workers is also affected by society's view that their employment is immoral because of the perception that migrants are taking away jobs from indigenous workers. If these theories are transposed to NuHs, then it could be argued that the high proportion of migrant NuH nurses is attributable to the unattractiveness and low status of the role, and simultaneously, because the role is associated with migrant workers, it is regarded as a low status role.

It is difficult to comment about whether such ethnicity and migrancy issues influence occupational status of participants in this study, as migrant nurses are under-represented (only two participants – 15% of the sample, compared to 43% in the NuH nurse workforce). However, all NuHs in the sample employ both UK born and non-UK born nurses. None of the UK born nurses explicitly linked ethnicity and migrancy to occupational status during the interviews, and indeed, did not mention at all the fact that a high proportion of their colleagues are migrants. Again, this does not say that ethnicity/migrancy is not an issue. It may be that these concerns are implicit, unspoken suppositions, or UK-born participants may have felt that it was inappropriate or unacceptable to refer to migrancy/status issues during interviews. But, it should be pointed out that because discussions were about status, participants were actively requested to discuss what they felt influenced their status. Because they omitted to refer to migrancy, but spoke at length about other issues (for example, work activities, knowledge bases, or where their work was situated within health and social care services) indicates that their concerns about their occupational status may not be strongly linked to ethnicity and migrancy associations.

Two participants were non-UK born and of Asian ethnicity– Bella and Andrea. When discussing her move to England, Bella described the local population as helpful and welcoming. Her concerns about her occupational status, like her UK born colleagues, were more about the nature of NuH nurses' work, knowledge-base, and about the influence of the public' view of private NuH care. Andrea too was concerned with these issues, but she also discussed her experiences of being subjected to racist behaviours on the part of some residents. However, she stated she had not encountered racism from other healthcare professionals. Although Andrea was the only participant to mention ethnicity/migrancy issues, the lack of other reported experiences may be attributable to sample limitations, rather to a scarcity of incidences. The fact that she mentioned racism during her discussions, suggests that race and migrancy are implicated in her experiences of status. However, she does not perceive that racism and her social identity status as a migrant is related to her work role. Rather, she expressed her view that residents view migrants as exploiting the UK benefits system, which leads to racist attitudes and

behaviours. Indeed, she indicated that once residents are made aware of her work ethic, they refer to her as 'nice'.

Some participants proposed that their role is low status which hinders them from obtaining employment with the NHS. However, the findings do not suggest that ethnicity/migrancy is perceived as a barrier to NHS working. During her last interview, Bella reported accepting a position on an NHS ward after having worked there as a bank nurse. Andrea stated that she would like to move to the NHS in future. When asked if she thought issues of ethnicity and migrancy affected potential employment opportunities, she replied in the negative: 'No. No. Not from the hiring system'. Rather, like some of her UK born colleagues, she proposed that other healthcare professionals act with suspicion and exclusory behaviours towards NuH nurses, and view NuH nurses as 'unskilled', leading to difficulties for NuH nurses attempting to move between sectors.

It is acknowledged that limitations in the sample in terms of gender, and ethnicity/migrancy make it difficult to draw conclusions regarding the impact of these social identity factors on the occupational status of NuH nurses. Nevertheless, a consideration of the data available suggests that for these participants, such social divisions do not significantly influence their views and experiences of work-related status. Andrea did discuss her experiences of racism, but in her opinion, these experiences arose from what she felt is society's stereotypical view of migrants as exploiting the UK benefits system. She did not link these experiences to occupational status, and indeed, she was emphatic that her ethnicity and migrancy status does not influence employment opportunities.

Participants' responses to questions about role and status explicitly focused on the nature of work activities, knowledge and skill, in particular, the activities and skills required to nurse residents rather than patients, and business activities i.e activities specifically associated with NuHs and personal care activities. They spoke of feeling stigmatised, but their feelings of stigma primarily arose from their perception that society views their NuH work and personal care activities, and their knowledge and skills as low status, or suspicious. As participants' discussions, focused strongly on occupational role activities, knowledge and skills, and occupational status management, social theories that consider the contribution of occupational role to identity and status are used as a relevant framework by which to interpret the findings. These social theories include 'dirty work' (for example, Hughes, 1958; Ashforth & Kreiner, 1999), and knowledge-based status (for example, Bourdieu, 1986; Ashforth & Kreiner, 1999). In this study, these theories are grouped under the descriptor 'work activities, knowledge and skills' status constructs. It should be noted at this point that the term 'dirty work' is not a perjorative term. It is a

commonly used sociological term to describe work activities that influence societies of occupational status.

It was argued in the literature review that theories in the 'work activities, knowledge and skills' framework may undertheorise the impact of social and cultural processes on occupational status, and indeed these theories give little priority to the social and identity characteristics of workers. However, the above discussion about gender and ethnicity/migrancy suggests that for participants in this study, status is less about these social divisions, and more about the 'dirty' nature of their NuH and personal care work, and questions about their knowledge-bases. Nevertheless, even if we interpret the findings through these 'activity, knowledge and skills' status frameworks, one type of social division cannot be discounted – participants' status as professional registrants. Simpson, Sltskaya, Lewis, and Hopfl (2012) argue that having social status arising from having a profession allows individuals to manage their 'dirty' activities. The authors use the example of healthcare professionals carrying out personal care to illustrate their point:

Dirty work undertaken by those of a higher standing (e.g. bodily care performed by doctors or nurses) can be 'integrated into the whole' – rendered less salient by being absorbed into the prestige-bearing role of the person who does it. For these well-positioned individuals, contact with dirt can be mitigated by other, more positive and socially privileged aspects of identity (p.10).

However, the findings of this study suggest that the breadth of the perceived 'dirty' activities undertaken by NuH nurses, mean they may feel uncertain about their professional identity, so may not be able to mitigate the 'dirt' and perceptions of low knowledge-bases. Rather, the 'dirty' activities, and perceptions of low knowledge-bases negate social status associated with professions. This idea, and a discussion of 'activity, knowledge and skills and knowledge' status constructs, are presented in the next section.

6.4.2 'Work activities, knowledge and skills' status constructs

As already discussed above, the findings presented in chapter 5 revealed that participants feel the occupational status of NuH nurses' role is low, in part, because the role is a stigmatised role. Participants proposed that this stigma stems from a variety of causes that in their opinion are associated with perceptions of work activities, knowledge and skills that arise from their role as NuH employees, their role in delivering personal care, and their association with older people:

As nursing home employees: Participants inferred that the public views NuHs as morally dubious because NuH providers operate commercial businesses within a culture of free care. Indeed, many participants themselves suggested that the juxtaposition of care and business creates a moral dilemma. In addition, participants said that their

abilities and skills are unrecognised and undervalued simply due to the fact that they are NuH nurses, and as such are viewed as 'second rate' (Anne, 1). Although these sources of stigma related to NuH employment caused participants the most concern, another cause was cited. A small number of participants proposed that negative media reporting leads to suppositions that NuHs are imbued by poor practice and incidents of abuse against residents.

As deliverers of personal care support: Participants suggested that the public and other healthcare professionals lack understanding of the NuH nurse role – perceiving it to primarily entail the provision of personal care, and as such, confuse the role with that of HCAs.

As nurses for older people: A few participants said that other healthcare professionals have ageist attitudes about the older population, which fuels the assumption that nurses working with older people are less dynamic and less skilled than other nurses.

6.4.2.1 Impact of the association with nursing homes on nursing home nurses' status

All participants referred to an aspect of their role that has not been previously reported in research literature as a contributor to low occupational status – the issue of care funding. Participants said that because the majority of NuHs are private businesses, rather than public-funded services, some members of the public and other healthcare professionals assume that the primary objective of NuHs is profit attainment, rather than care. Participants suggested that NuHs are viewed as immoral organisations that prey upon the vulnerable. This finding is supported by research that explores service-users' views of care funding. Studies by Henwood (2010) and Colombo, Llana-Nozal, Mercier and Tjadens (2011) find that, because residents and families often struggle to understand and negotiate the financial implications of living in NuHs, 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 the current study inferred that because NuHs and NuH staff become necessarily involved in the funding and business aspects of social care, some residents/families' low opinion of the care funding system colours attitudes to NuHs and NuH staff as well. In other words, participants' responses inferred that some residents perceive the funding/business aspects of the NuH nurse's role as morally 'dirty', as defined by Ashforth and Kreiner (1999) as occupations that are generally regarded as somewhat sinful or of dubious virtue.

It could be contended that funding issues also result in social 'dirt', and diminution of authority-based status. As discussed in 6.2.2.2, participants stated that therapeutic

relationships are at risk because of the closeness between nurses/residents/families. However, relations between nurses and self-funding residents are further complicated by funding issues. Participants indicated that self-funding residents become supercilious in their behaviours towards NuH nurses because they are paying for their care. For example, Cath (2) commented that self-funding residents at times treat her like a 'servant'. According to Ashforth and Kreiner (1999), social 'dirt' can arise from subservience, which 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, it is possible that social 'dirt', and the absence of authority-based status, contributes to participants' struggle to negotiate and maintain therapeutic relationships with residents, in that residents may not recognise and value NuH nurses as healthcare professionals attempting to provide nursing and rehabilitation care, but instead view them as service industry staff.

Participants' responses inferred that further social 'dirt' arises from the perception of the public and other healthcare professionals that NuH nurses are enervative and uninspiring, and undertake the role not because they pro-actively seek to work in NuHs, but because they are unemployable in other settings, or because NuH nursing is convenient, which may lead to a perception that it is 'feminised' or 'racialised' work (refer to the earlier discussion in 6.4.1 regarding the influence of the gender and ethnicity social constructs). Bern-Klug, Buenaver, Skirchak and Tunget's (2003) study of medics working in gerontological care suggest that a number of worker 'types' exist, including workers who enter an occupation because they have inherited a position, or because they have settled for any position due to a lack of ambition, opportunity, qualification or skill. These individuals 'accept, but do not relish' their professional role (Bern-Klug et al., p.147). Bern Klug et al. (2003) refer to this type of worker as 'inheritors'. The authors argue that if an occupation's workers are primarily 'inheritors', then occupational status is lowered, and the occupation becomes an unattractive employment prospect, because potential employees do not wish to be labelled as 'inheritors'. The experiences and views of some of the participants in the current study illustrated this process. Participants suggested that the negative image of NuH nurses stigmatises the role, and 'puts a lot of people off' (Barbara, 1) from working in NuHs. In other words, the social 'dirt' related to the role reduces its appeal because potential workers do not wish to be associated with a stigmatised role.

Another possible influencing factor on participants' occupational status is institutional stigma. Although institutional stigma was not discussed at any length by the participants, some nevertheless indicated that it existed, and was exacerbated by negative media

reporting. They proposed that this leads to a public perception that NuHs are environments in which immoral and morally dubious practices, such as abuse, institutionalisation and inadequate care occur. Some participants referred to this issue when questioned about their occupational status, hence they were linking their perception of their status with negative perceptions of NuHs. This proposal advances knowledge regarding perceptions of NuHs, as while previous literature suggests anti-institutionalism, fuelled by media commentaries, results in a public prejudice against NuHs, (for example, Skinner, 2005; Chandra et al., 2006; Venturato et al., 2007) it has not evidenced a link between anti-institutionalism and low occupational status arising from the perceived morally 'dirty work' of NuH nurses.

6.4.2.2 Impact of the association with personal care activities on nursing home nurses' status

The findings indicate that in the participants' opinion, the public and other healthcare professionals perceive the NuH nurse role as predominantly involving personal care activities that are more associated with the HCA role. This is similar to the findings of studies cited in the literature review. For example, studies that compare the roles of NuH nurses and HCAs conclude there is much overlap between the two roles, particularly with regard to the provision of personal care activities (Perry et al., 2003; Kane et al., 2006). Other studies referred to in the literature review propose that student nurses and acute care nurses perceive long-term care nursing as inferior to acute care nursing (Wade & Skinner, 2001; Reed & Stanley, 2006; Abbey et al., 2006), because it does not necessitate the practice of medical and technical skills. However, Bedin et al. (2013), cited in the literature review, argue that personal care is far from unskilled work, as it is an important method of assessing skin integrity, mobility, nutritional status and elimination – care activities that are firmly located within the remit of RNs and which require a strong knowledge-base. More recently, NHS campaigns attempt to reframe personal care as 'essential' or 'fundamental' care for these reasons (for example, DH, 2010b; National Institute for Health and Care Excellence (NICE), 2012). This suggests then, perceived low status associated with physically 'dirty work' could be attributed to causes other than the level of knowledge-base.

The participants' responses, suggest attempts to frame personal care as skilled work may not be succeeding, as they referred to personal care as basic, unskilled work that does not require a strong knowledge or skill base. According to Zhou (2005), the perception of a weak knowledge-base significantly reduces occupational status, which may explain why an association with personal care and HCA work diminishes NuH nurses' status. It could be argued that this is a further reason why participants are keen to acquire clinical skills training and become involved with clinical skills practice i.e. by doing so, they may feel

they would be boosting their knowledge-based practice, and therefore their occupational status.

Participants' discourses suggest that low status could result from a perception that personal care is 'physically dirty', defined by Ashforth and Kreiner (1999), as being associated with dirt or effluent. According to Duschinsky (2013), physical 'dirt' such as bodily waste can re-construct identity. Usually bodily waste is disposed of personally, by hidden acts performed by the individual him/herself. However, during personal care support, this private act becomes a shared, aired concern. The need for personal care support is in danger of altering a resident's identity from one of personhood to something that is dirty, distasteful and embarrassing, and needs to be cleaned up. Likewise, within this frame, personal care support can appear as a contamination of the person who carries out this activity, such that it appears to encompass all that they do. Indeed, Beth (2) stated that the public and other healthcare professionals view personal care as 'wiping people's bottoms' thus associating the provision of personal care as involving contact with the body, and in this case human effluent. Thus, similarly to Twigg's (2000) work, this study suggests that personal care is viewed by society as distasteful, tainting the reputation and lowering the status of occupations that deliver this care, rendering these occupations unattractive.

6.4.2.3 Impact of the association with the care of older people on nursing home nurses' status

A few participants' responses inferred that NuH nursing is socially 'dirty' because of its association with the care of older people – a group they proposed were discriminated against by society, and subjected to stigma. Faye and Barbara proposed that ageist attitudes of healthcare professionals devalues occupations involved in gerontology care. These views are similar to the conclusions of Kelly et al. (2004) and Henderson et al. (2008) cited in the literature review. However, in the present study, the effects of ageism on occupational status was not widely discussed, and in fact, the majority of participants made no reference to the link at all. This could suggest that participants are less concerned with the stigma that arises from their association with older people, than with stigma caused by other issues. As suggested earlier, this may be because participants focus on causes that call into question their personal values, motivations, abilities, and identities as nurses, rather than on causes that are incidental to stigma or directed at other groups. It is also possible that the enjoyment and satisfaction they derive from working with older people overrides concerns regarding any impact that working with this group might have upon their occupational status. Indeed, while participants' reasons for considering alternative employment settings could be said to be related to occupational status issues (for example, to boost knowledge-bases, practice more clinical skills, or

escape business practices), none of their reasons were due to dissatisfaction with working in gerontology care settings. Although many participants did not enter the NuH sector because they had a particular interest in the care of older people, most professed a desire to continue to work within older people's care provision. This is evidenced by their career aspirations. Some participants said that they wish to remain working in the NuH sector (Anne, Barbara, Elaine, Ellen, Georgia), while others stated that they would like to train and work in areas in which the main patient groups are older people (Andrea, Bella, Beth, Cath, Emma).

As discussed in 6.4.1, Simpson et al. (2012) and Twigg (2000) propose that, despite undertaking 'dirty' activities within the role, workers with professional status are able to manage these by absorbing them into 'positive and socially privileged aspects of identity' (Simpson et al., 2012), or delegate them to non-professional staff. This study, however, suggests participants are not able to achieve this. This is because, as suggested in 6.2, professional identity is uncertain and undermined by the amount of 'dirty' activities associated with the role i.e. business activities that participants perceive, and feel others perceive, morally and socially taint their role, and because the role is so heavily associated with the 'physical dirt' of personal care. In addition, as discussed in 6.3, participants responses suggested they do not view their role as having, or being able to access, cultural capital, which contributes to the social status associated with having a profession. Thus, the current study advances knowledge about the nature of social status arising from professionalism, by suggesting that when the breadth of 'dirty' activities perceived to be inherent within the role is wide, and combined with perceptions of low knowledge-base and feelings of role uncertainty, these 'activities, knowledge and skills' issues cannot be absorbed into socially privileged aspects of identity, but rather diminish this social identity status.

Despite expressing the view that their occupational status is perceived as low, participants attempted to acquire occupational esteem. The strategies utilised to acquire esteem are discussed in the next section.

6.4.3 Attempting to acquire occupational esteem

Studies cited in the literature review (Ashforth & Kreiner, 1999; Hippel et al., 2005) suggest that workers who are perceived as having low occupational status, do not always suffer from low occupational esteem because they may be able to implement strategies to validate their work. The responses of the participants in the current study agreed with these suggestions. Participants' comments indicated they are deeply aware of the stigma attached to NuH nursing, but are able to retain a degree of occupational esteem by employing 'refocusing', 'aggrandising' and 'neutralising' strategies.

Refocusing was demonstrated on a number of occasions. For example, Anne stated that when questioned about her career, she discloses that she is a nurse, but hides the fact that she works in a NuH. Diane and Emma explained that although they now work in NuHs, they emphatically inform enquirers that they used to work for the NHS in order to impress upon enquirers that they are capable and skilled professionals who work in NuHs by choice rather than necessity. Alice and Beth both work in NuHs that accommodate NHS contracted units. They said they respond to questions about their occupations by stressing the NHS commission, in order to suggest they are strongly affiliated with the NHS. By doing so, they are attempting to align themselves with acceptable, non-stigmatised nursing occupations. Ashforth and Kreiner (1999) also propose that if an entire occupation is considered to be tainted by low status activities, knowledge and skills, then refocusing may involve shifting focus away from the occupation itself towards advantageous extrinsic elements such as salary and working conditions. Again, some participants demonstrated this strategy. Elaine and Ellen, for example, proposed that NuH nurses are more content in their role, and have a better work-life balance than NHS nurses who they view as 'miserable' (Ellen, 1) and 'stressed' (Elaine, 1).

Ashforth and Kreiner (1999) and Hippel et al. (2005) suggest that low status workers' occupational esteem is constantly under threat by the stigmatising beliefs and attitudes of others. These workers therefore have to reconcile their own need for self-esteem with others' pejorative views. One method of achieving this is to challenge the legitimacy of critical others' qualities by aggrandising their own role, thus enabling low status workers to reject their condemners' perceptions. Participants in this study exhibited this behaviour. For example, Anne proposed that acute care nurses are less caring than NuH nurses, while Diane suggested that NuH nurses practice more safely than NHS nurses.

'Neutralising' is a technique whereby the morally tainted facets of an occupation are negated by denial strategies (Ashforth and Kreiner, 1999). In this study, participants' responses indicated that they use neutralising techniques to negate the moral taint emanating from funding and business controversies. For example, Beth and Emma focused solely on their nursing activities, and disaffiliated themselves from the business aspect of their role, while Faye denied responsibility for 'unfair' funding issues by asserting that the government has enforced these policies onto older people, and by being involved, she is simply carrying out her job.

In the main, the strategies employed by the participants to dismiss the stigmatising attitudes of the public and other health professionals assist them to retain a degree of occupational esteem and continue to work in the role of NuH nurse. However, the study's findings suggest that circumstances do arise that render occupational stigma difficult to

endure i.e. when the taint of 'dirty work', or accusations of low knowledge-base and poor skill-base are internalised by the participants. For example, with regard to the business aspects of the role, the participants acknowledged that the censorious attitudes of the public regarding the 'unfair' manner in which long-term care is funded, contributes to their low occupational status. However, in this case, the taint is more than a social construct imposed upon the participants because they *agree* that the funding system is morally wrong. Rather, it is more a consequence of interpellation, defined for example, by Althusser (1971), as the process by which a social situation precedes or produces an individual's sense of their own identity. This is because, for many participants, becoming a nurse in England is about providing a health service financed by public funds, and free-at-the-point-of-care. However, because NuH care includes personal care elements and accommodation costs which are not funded by the NHS, residents undergo means-testing of their assets and income to determine whether they are required to contribute to the cost of their care, and if so, what sum they must pay. Most participants referred to this method of funding as 'unfair', and reported feeling 'uncomfortable' about being part of what they perceive as an inequitable system. Thus, for these participants, the moral taint that emanates from funding issues is internally, as well as externally imposed. Kreiner et al. (2006), referred to in the literature review, hypothesise that in cases where workers internalise taint, defence strategies have a limited capacity to curb the effects of stigma, and consequently, workers are ambivalent about their activities. They wish to defend their role from the criticism of others, but they are unable to do so fully because the stigma which they object to pervades their own perceptions. This internalised taint leads workers to display contradictory views and uncertainty regarding their role. Such behaviours were exhibited by participants in this study when they were discussing the business aspects of their role – thus adding weight to Kreiner et al.'s (2006) theory. For example, during Emma's vacillation about whether NuHs are businesses or not, Beth's inconsistent views that insist she is purely a nurse, yet acknowledge she is also a salesperson, and Barbara's contradictory comment in which she stated that the service provided cannot be valued in monetary terms, then proceeds to do just that.

Neutralising internalised moral taint is not an easy process. Ashforth and Kreiner (2002) suggest that one possible method is 'habituation'. These authors propose that thrusting workers immediately into a morally controversial environment causes uncertainty, anxiety or even revolt (as is the case with Emma and Beth, discussed above). However, habituation involves a process of regulated exposure over a period of time to the 'dirty' aspects of work, allowing workers to become desensitised to the 'dirt' until they accept it as a 'normal' element of their role. Although participants in this study have not deliberately been subjected to formal habituation techniques, the experiences of some nevertheless

reflect how the process works. Anne, Elaine and Barbara were exposed to business cultures during their careers prior to becoming RNs. They are able to moderate negative views regarding the NuH nurse's business activities that stem from the care funding system operated in England. This is because they are already accustomed to business cultures so are able to adapt their views in order to reconcile the business and nursing aspects of their role. This reinforces the points made in 6.3.1 i.e. that habituation via education and cultural change is important, if NuH nurses are to find a role identity with which they are comfortable, and which contextualises them within the wider healthcare milieu, and if they are to feel prepared for their role. However, this section also highlights that habituation may enable NuH nurses to re-evaluate their role regarding whether or not it is imbued with moral taint, which may assist them to re-assess and improve their occupational self-esteem.

6.4.4 Summary

Limitations in the study sample make it difficult to draw conclusions regarding the impact of social identity factors such as gender, ethnicity and migrancy on occupational status of NuH nurses. However, consideration of the available data suggests participants are more concerned that their association with NuHs, and with personal care, lowers their occupational status.

This study does identify a number of new findings that contribute to the existing literature, in particular about the influence of NuH nurses' association with NuHs on their status. For example, the study reveals that moral 'dirt' associated with funding issues and anti-institutional feeling affects the status of NuH nurses as well as perceptions of NuHs as organisations and establishments. Furthermore, the study identifies that self-funding of care has a negative impact on NuH nurses' ability to develop therapeutic relationships with residents, and perform certain aspects of the role (such as informal rehabilitation activities). The study also reveals the behaviours of NuH nurses concerning their role and relationships with other healthcare professionals as responses to feeling stigmatised as 'dirty workers', and as ways of retaining a level of occupational esteem. The study identifies that education is not just important as a means of increasing competency and knowledge-based status, but as a means by which NuH nurses can reflect on, and re-assess, their role with regard to whether or not it is tainted by 'dirty work'.

6.5 Conclusion

Stage 7 of the data analysis process led to the development of the three themes presented in this chapter – themes that provide new and original insights into the role and status of NuH nurses working with older people. The methodological approach utilised in

the study was integral to developing new understandings of the phenomenon under review, in that the approach prompted a process of dialogue between myself as the researcher, and the data at various stages of analysis. Each analysis stage was modified by previous dialogues, so that the horizon of the phenomenon has been expanded (in that the study has achieved new understandings of what it is to be a NuH nurse).

Insights and understandings developed during discussion of the three themes presented in this chapter has highlighted a number of implications with regard to the role and status of NuH nurses, and workforce development processes. These understandings:

- Contribute to current knowledge about the occupational role and status of NuH nurses.
- Reveal that health and social funding policy affects NuH nurses' occupational status, and consequently, their ability to perform their role.
- Highlight that despite overtures that nursing care is holistic, clinical tasks are perceived by nurses as significant, if not central, to care, and suggest that aspects of the NuH nurse role concerned with managing residents' multi-morbidities are not recognised as complex, important skills.
- Demonstrate that to perform their role successfully, NuH nurses require training and education in a number of areas not currently addressed adequately by education/training providers.

These new insights suggest that, in order to address these issues, workforce development initiatives are required that:

- Develop nurses' current perception of what constitutes holistic nursing care to ensure it is based upon the unique needs of individual service-users.
- Acknowledge that the organisation and funding of health and social care affects NuH nurses' role and status, and address this issue when structuring service provision and developing education/training programmes.
- Develop CWD and pre-registration nursing education programmes that: equip the NuH nurse workforce with the relevant skills to deliver care; reduce marginalisation of NuH nurses; change the perception that the role is a low status role requiring little skill.

The contribution of the study's findings to current understandings of the role and status of NuH nurses, and the implications of these findings to workforce development processes are discussed in detail in chapter 7.

7 Discussion and Conclusion

By utilising a hermeneutic phenomenological methodology, the study has generated new insights into how and why role and status issues affect the working lives of NuH nurses. This chapter considers the implications of the participants' experiences and views. It commences with a brief account of how undertaking this study has modified and developed my horizon and knowledge regarding both the topic under review, and the research process. The next section reflects on the predicament that arises from role and status concerns. After this, the contribution of the study to knowledge about NuH nursing, and implications for workforce development processes is presented. The chapter concludes with a discussion of the study's limitations and areas for further research.

7.1 Reflection on the interpretative process

In 3.3.3.2, an explanation of the reflexive approach adopted during the study was presented. The section discussed how participants' responses, and my interpretation, were influenced by the aims and questions of the study. It was suggested that associating the two concepts 'role and status' led participants and the researcher to look through a 'two-way glass' of role and status, so that the concepts took on a definition and significance by their interaction with other. Because participants perceived their status to be low, they focused on the challenges that they felt low status brings to the role. This resulted in data that portrayed the role in a rather negative light. Likewise, I, as the researcher, was looking for messages that say something about role and status, as associated concepts. This led to an interpretation of the role that was arrived at by looking through, and relevant to, a 'lens' of status.

Further reflection on completion of the full draft thesis led me to understand how important semantics and relationships between words, phrases and expressions are to participants' interpretation of interview questions, and my interpretation of how their responses relate to the research aims i.e. understanding of the term 'role' was influenced, if not altered, when the term 'status' is associated with it. This directed me to consider some of the topics that participants discussed during interviews, and how a different associated word/phrase (other than 'status') may have shifted the focus of responses, and my subsequent interpretation. For example, during the interviews, participants discussed their relationships with residents, but focused on the challenges posed by these relationships. However, if the aims and questions of the study had been 'to explore NuH nurses' views and experiences of their role and relationships with residents, the outcome of their responses, and my analysis and interpretation may have been very different. It is impossible (and academic) to predict the findings of this alternative study, but perhaps participants may have focused on positive aspects of relationships, and on the rewards of

working closely with older people, as well as, or instead of, discussing relationship challenges and tensions? In other words, using the term 'status' in the study's aims and questions shifted the standpoint of both participants and researcher, so rather than offering a balanced account of participants' views and experiences regarding their role, negative aspects were brought to the fore.

Another issue that may have influenced participants' responses is that the study's aims and questions focus on the views and experiences that relate to themselves, rather than to residents or care. On its own, the term 'role' implies a connection with the external world - relationship with others or performing activities in relation to other people. For NuH nurses, 'role' is about attending to residents' needs, thus to a large extent, the concept of 'role' foregrounds residents' needs and professional care activities, and backgrounds the personal needs of NuH nurses. But by asking participants to consider 'role and status' together, I was manoeuvring them into the foreground, and backgrounding residents – I was inviting them to consider themselves, to disengage somewhat from putting residents first. I was in effect, aiming to get beyond the nurse as carer or attention-giver, to the nurse as an individual requiring attention. I was not asking participants to discuss their role as a means of providing care for residents (i.e. how does your nursing care activities affect the resident), but rather I was asking them to consider how providing care for residents affects them. In other words, asking about role and status prompted inward-looking responses about 'you' and not outward-looking responses about 'caring for residents', so although the participants did discuss care of residents, the questions enabled them to discuss from the perspective of the self.

Ultimately, the aim of healthcare research is to improve the care of patients. It may be said therefore, that there is little value in a research study that focuses so specifically on nurses themselves, and in particular, the negative aspects of their experiences – would it not be better to focus on residents' experiences, or nurses' views of care? While studies about patient perspectives and care are undoubtedly important methods of identifying quality care needs, there is still a place for studies that consider the concerns of staff, and what challenges and difficulties they face while carrying out their role within the healthcare socio-culture. The unique approach adopted by this study has facilitated the identification of a number of role challenges that have not been recognised, acknowledged or considered in previous literature, but are nevertheless imperative if support for NuH nurses is to comprehensively address their needs, with the aim of enabling them to provide a quality service for the residents in their care.

As the thesis is brought to a conclusion, the participants' views and accounts of their experiences, presented through the interpretation offered in this thesis, add to the

literature and to the development of understanding of the role and status of NuH nurses. These understandings can then influence NuH workforce development processes, as discussed in the next sections of this chapter.

7.2 Nursing home nurses' predicament

NuH nurses are positioned at a location where health and social care funding issues intersect, and healthcare and social care work overlaps. The findings of this study suggest that working at this location requires nurses to modify their care activities, but that this modification is not an easy process.

Participants' responses indicated that they have a set of expectations regarding what the role of the nurse entails - expectations which arise from a number of assumptions. Firstly, they have expectations that as nurses they will practice technical and clinical skills, as they view these skills as integral to the nurse's role, and as a defining attribute of nursing. Also, because they are employed as healthcare professionals in England where healthcare is dominated by the values and culture of the NHS, they expect the care they deliver to align with those values and culture. For example, because the NHS provide care that is free-at-the-point-of-care, participants expect the care that they deliver to be free-at-the-point-of-delivery. Furthermore, they expect to work in close supportive partnerships with colleagues in the NHS, because they feel that NuH nursing is a complementary service to healthcare provided by the NHS. However, within the NuH setting, these expectations are not met. Participants' responses suggested that because the actuality of the NuH role does not equate with their expectations about what the nurse role should involve, they become uncertain about their role identity, and feel unprepared for the demands that unexpected role activities impose upon them. They also feel stigmatised by other healthcare professionals, residents, and at times themselves, primarily because of the 'work activities, knowledge and skills' status constructs associated with the role.

Participants suggested that they modify their caring activities in response to the social needs of residents. If it is the case that residents' personal priorities focus on social pursuits rather than their clinical conditions, then this may suggest that residents' multi-morbidities are being managed, and that NuH nurses are practicing complex clinical skills to support this management. Participants spoke at length about their discomfort regarding their involvement in showing potential residents/families around their facilities - an activity which many said was tantamount to 'selling beds' - although it is an act of care and advocacy in that it supports residents/families to choose a NuH that is appropriate to their needs. Despite these indications that participants do practice complex, caring skills in their efforts to manage residents' multi-morbidities, and advocate for residents/families, these skills do not appear to be recognised by other healthcare professionals, or indeed the

participants themselves as important skills. Rather, these activities are perceived as routine, repetitive, or morally 'dirty' work.

The findings suggest that participants are striving to construct an occupational identity and status with which they are comfortable, and which contextualises them within the wider healthcare community. They appeared to feel that this is necessary, because for a number of reasons, they are uncertain about their role identity. For example, their role involves activities which they do not associate with nursing, such as business activities and addressing residents' social well-being. Also, they do not recognise the skills that they use in the management of multi-morbidities as clinical skills, and feel that in fact, their role does not necessitate much clinical skills practice. Furthermore, they feel excluded and separate from their healthcare colleagues in the NHS. Participants constantly referred to, and compared themselves to, the NHS. It was not always clear whether the term 'NHS' meant the organisation as a whole, or its employees, but this may not be consequential, as the participants used the term more to denote that they were 'other than', isolated from, and disregarded by, the dominant nursing socioculture. Participants' responses showed that they employ a number of strategies in an effort to construct professional identity and status. For example, Cath views her role as a hybrid role, incorporating both health and social care. Anne has blended care and business cultures in an attempt to develop a new culture unique to NuH nursing. Others criticise the practice of the NHS and acute care nurses, while commending their own caring qualities in order to boost their own value and esteem. Many participants pursue the acquisition and practice of acute clinical skills in an effort to preserve their nursing identity.

It is apparent from the findings that participants do want to provide quality care that addresses residents' social needs, but they also want this role to incorporate clinical skills that they perceive to be challenging and complex. They want to train and practice in partnership with the NHS, and they would prefer to practice in an arena where there is a clear boundary between the provision of care and the funding of care. Achieving these wishes would enable participants to fulfil their role expectations, which may lead to increased job satisfaction, and a sense of belonging to the wider professional healthcare community. In addition, by realising these wishes, participants would acquire knowledge-based status in that they would possess training and skills that the dominant socioculture recognise. They would increase their authority-based status in that their relationships with residents would be nurse/resident based, rather than service-user/service industry worker based, which would mean that the therapeutic relationship would not be undermined. Also, the risk of being labelled as, and feeling like, low status workers may be reduced. The majority of the participants, however, suggested that these wishes are unlikely to be

achieved in the NuH setting. Many indicated that the only way to realise these aspirations is via a move into other healthcare settings.

7.3 Contribution to knowledge

The understandings of the role and status of NuH nurses that emerged during the study contribute to knowledge, perspectives and debates in a number of research areas and academic disciplines, for example, occupational role and status, health and social funding policy, nursing care, and nurse education. The implications for this original contribution are explored in this section. In addition, a table (table 7.1) which summarises this contribution is presented in this section.

7.3.1 Occupational role and status

This is the first study to suggest that NuH nurses are uncertain about their role identity because their actual role involves business activities and high levels of social care provision – activities which do not meet their expectations regarding the role of the nurse. The study reveals that NuH nurses also feel uncertain because they perceive themselves as being separate, and excluded, from the wider healthcare community, which they feel is represented, in England, by the NHS. Findings indicate that role uncertainty may contribute to NuH nurses' decreased job satisfaction. These findings add weight to the theories proposed by Hackman and Oldham (1980), Van Knippenberg and Sleebo (2006) and Mael and Ashforth (1995). Hackman and Oldham's (1980) role characteristic model suggests that job satisfaction is affected by workers' abilities to perform the work characteristics they perceive to be intrinsic to their role. Van Knippenberg and Sleebo (2006) and Mael and Ashforth (1995) propose that the collective-definition that arises from group membership leads to a sense of belonging, and strengthens self-definition. When identification with the group is weak, feelings of uncertainty and isolation occur.

NuH nurses have low occupational status for a number of reasons. Limitations in the study sample make it difficult to draw conclusions regarding the impact of social identity factors such as gender, ethnicity and migrancy on occupational status of NuH nurses. However, consideration of the available data suggests participants are more concerned that their 'work activities, knowledge and skills' status constructs lowers their occupational status. The findings of studies presented in the literature review (for example, Neville et al, 2014; Moyle et al, 2003; Fussell et al, 2009) suggest that LTNC is perceived as inferior to acute nursing because it is less medical, and perceived as routine, repetitive and unstimulating. The present study is similar in that it suggests both NuH nurses and other healthcare professionals value technical and clinically-based skills, varied and complex nursing activities, and opportunities for training and learning. This study, however, adds to

this debate, as it proposes that because NuH nurses practice fewer acute clinical skills, and are unable to access training that is recognised by the NHS, their occupational status is lowered, which may hinder movement between healthcare sectors and employers. This supports the theories of knowledge-based status (Zhou, 2005) and cultural capital (Bourdieu & Passera, 1977) which hypothesise that status depends in part on the value placed upon workers' skills and knowledge by the dominant socio-culture.

This study reveals that relationships between NuH nurses and residents is affected by residents' personal payment of care costs. This is similar to the findings of Angelopoulo et al. (1998) and Zarei et al. (2012) which suggest that private patients are preoccupied with staff availability and attentiveness. The current study, however, is original in that it suggests 'funding transitions' which occur as service-users move through health and social care systems, can lead self-funding NuH residents to become supercilious in their behaviours towards NuH nurses. Paying for care may alter residents' views of NuH nurses in that they may perceive these nurses as service-industry workers rather than healthcare professionals. This supports Zhou's (2005) theory of authority-based status, and Ashforth and Kreiner's (1995) theory of socially 'dirty' work. These theories propose that when a worker has a subservient relationship to others, occupational status diminishes.

Furthermore, the study suggests that NuH nurses' status is low because it is imbued with physically and morally 'dirty' work, as well as social 'dirt'. NuH nurses are not so concerned with the 'dirt' arising from anti-institutionalism, and their association with older people as a discriminated against group. They are more concerned with 'dirt' that calls into question their personal values, motivations, identities and abilities. Thus they are disconcerted by the perception that they are the same as HCAs performing personal care. They are also perturbed by their perception that they are labelled as enervated and uninspiring nurses, and by being viewed as service-industry workers rather than nurses. The study adds a new aspect to the literature in that it suggests NuH nurses are concerned by their involvement in 'immoral' business and sales activities.

This new insight regarding NuH nurses' occupational role and status proposed here is analogous to Ryan, Nolan, Reid and Enderby's (2008) application of the 'senses framework' as a means of encouraging service provider organisations to address the needs of their staff. Ryan et al. (2008) suggest that if staff are to attain job satisfaction and provide quality care for their patients, a number of 'senses' criteria must be fulfilled. Three of these 'senses' are similar to the NuH nurses' role and status needs that are revealed in the present study. Firstly, both studies highlight the importance of having a sense of belonging whereby workers 'feel part of a team with a valued and recognised contribution...belong to a peer group, a community' (Ryan et al., 2008, p.80-1). Secondly,

both studies find that having a sense of achievement, whereby staff can 'use skills and ability to the full' (Ryan et al., 2008, p.80-1) is imperative. Thirdly, both studies emphasise the importance of having a sense of significance, whereby staff feel that their 'practice is valued and important, that [their] work and efforts matter' (Ryan et al., 2008, p.80-81). However, while Ryan et al. (2008) petition for change within service provider organisations, this study suggests that change is required throughout the entirety of nurse practice.

The study proposes that some NuH nurses' may respond to uncertainty about role identity and low occupational status by using strategies to try to construct identity, and/or increase their status. These strategies include creating a hybrid role that combines health and social care, integrating business and care cultures, and pursuing the attainment and practice of acute clinical skills in an attempt to retain the 'expected' nurse role. Other strategies include aggrandising their own practice, criticising the practice of acute care nurses, and refocusing and neutralising techniques which are utilised to deny or ignore stigmatised and low status aspects of the role. Theories and studies that explore occupational role and status suggest that these latter strategies are commonly used by low status workers to boost their occupational esteem (for example, Ashforth & Kreiner, 1999; Hippel et al., 2005). However, this study is original in that it demonstrates the relevance of these theories to NuH nursing. Where 'dirty' work is a consequence of interpellation, the above strategies may not work. Within this study's sample, this appears to occur when participants are acculturated into believing that the care funding system is inequitable. This supports Kreiner et al's (2006) theory which proposes that internalised 'dirt' limits workers' capacities to retain role esteem. If NuH nurses are unable to acquire an acceptable level of occupational esteem, they may leave the NuH sector altogether.

7.3.2 Health and social funding policy

This study does not provide evidence to suggest that the workhouse history of NuHs affects NuH nurses' role and status, although it does suggest that there may be a link between anti-institutionalism fuelled by media reporting, and NuH nurses' low occupational status. However, the study does indicate that for NuH nurses working in for-profit organisations, role and status is strongly affected by two aspects of health and social funding policy. Firstly, the manner in which NuH care is funded. Secondly, the fact that the majority of NuHs in England are owned and operated by private companies.

Currently in England, healthcare is funded by the NHS, while social services are responsible for determining how other care needs are funded. If individuals require social and personal care, they are means assessed to ascertain if, and how much, they are required to contribute towards the cost of these services. Because NuHs are located at

the intersection of health and social care, where both services are provided by the same staff, and health and social care activities overlap, what constitutes healthcare and non-healthcare activities is difficult to clarify and as a consequence, funding issues are plagued by controversy. Wright (2003) and Henwood (2010) suggest that this controversy damages public perceptions of NuHs. The present study advances knowledge about the impact of this controversy by showing that NuH nurses' role and status are also affected. As stated in 7.3.1, NuH nurses internalise the moral 'dirt' that arises from their beliefs that the care funding system is inequitable, and that business and care should not be integrated. This results in a moral dilemma for NuH nurses. The findings of this study, however, indicate that education and habituation in business topics may mitigate against this dilemma.

Also, the study suggest that NuH nurses that work in the private sector feel separate, and excluded, from the NHS. Because the NHS is the dominant healthcare socioculture in England, exclusion is in effect a type of marginalisation. Additionally, as discussed in 7.3.1, self-funding affects the nurse/resident relationship in that residents expectations of care change. Residents may become more concerned with tangible facilities and staff availability and attentiveness, while NuH nurses must continue to ensure equity in care provision regardless of individual residents' funding arrangements. This difference in stance with regard to care priorities can be difficult for NuH nurses to negotiate. This study adds a new dimension to literature about the impact of funding on care, as it suggests residents' expectations of a tariff-related hospitality service can adversely affect NuH nurses' abilities to promote reablement activities and the maintenance of residents' independence.

7.3.3 Nursing care

The study suggests that NuH nurses define nursing as the provision of healthcare and the practice of clinical skills. They view healthcare and the healthcare community as their natural arena of practice. NuH nurses do want to provide quality of care for residents, but feel that residents' care priorities are different in that they focus on social pursuits, rather than their medical needs. NuH nurses therefore modify their care activities to the extent that they are uncertain about their role identities and may no longer define themselves as nurses. This suggests that although nursing aims to provide holistic care, nurses' expectations and perceptions of the role are strongly influenced by the medical model of care that is centred around disease and illness processes. This is akin to the theories and studies that explore attitudes to LTNC and acute care, and the development of healthcare, social care and interprofessional roles. For example, Bleakley (2010) suggests that nursing is increasingly becoming a medicalised profession, and Abbey et al. (2006)

concludes that nurses view medical, scientific and technical knowledge as 'the core of modern nursing' (p.16).

According to Kwong et al. (2009) and Condelius et al. (2010), managing multi-morbidities is a highly skilled nursing activity. This study suggests that if NuH nurses successfully support the management of residents' multi-morbidities, residents are able to focus on their social well-being rather than on their medical needs. This is similar to studies that explore service-user care priorities. For example, Rankinen et al. (2007) and Rantanen et al. (2008) conclude that patients with acute and unmanaged medical conditions primarily focus on biophysical quality of life indicators such as pain relief and treatment options. Cook and Clarke (2010), Bradshaw et al. (2012) and Cook et al. (2014) argue that older residents in RHs and NuHs associate quality of life with social activities and maintaining self-identity. The present study, however, proposes that the skills involved in managing multi-morbidities and addressing social needs pose a problem for NuH nurses. This is because NuHs and other healthcare professionals do not recognise the skills involved in managing multi-morbidities as complex, important skills. Rather, they view these as routine, repetitive work. Furthermore, some of the skills involved in addressing residents' social needs (such as promoting choice and preference in communal settings, developing effective therapeutic relationships with residents, and dealing with family dynamics) can be challenging because NuH nurses do not feel prepared or trained for these care activities.

7.3.4 Nurse training and education

Hannan et al. (2001), Ross et al. (2001), and Jones et al. (2013) propose that nurse training and education is not always relevant to the needs of NuH nurses, which has a deleterious impact on the quality of care provision and workers' morale and job satisfaction. However, these studies focus on training with regard to cognitive impairments. This study identifies that NuH nurses are unprepared for some other activities inherent within the role, such as business activities, promoting residents' choice and control in communal settings, and dealing with family conflict. The findings suggest that both CWD training and pre-registration nurse education do not address these learning needs.

This study adds a new dimension to the debate regarding NuH nurse training and education by suggesting that NuH nurses' desire for NHS-provided training may be less about skills development as about the acquisition of cultural capital, and a sense of group membership – attainments which may strengthen their identity as nurses.

The following table (table 7.1) summarises the study's contribution to existing knowledge.

Table 7.1: The study's contribution to existing knowledge

Research area	Existing knowledge	Findings of this study	Original contribution to knowledge
Occupational role and status	Job satisfaction is affected by workers' ability to perform expected job characteristics (Hackman & Oldham, 1980).	NuH nurses expect to perform clinical skills. NuH nurses do not expect to participate in business activities, or some of the social care aspects of the role.	Suggests the role characteristic model may be applicable to the NuH nurse role.
	The collective definition of role that arises from group membership leads to a sense of belonging, and strengthens self-definition (Mael & Ashforth, 1995; Van Knippenberg & Sleeb, 2006).	NuH nurses perceive themselves to be different to other nurses. NuH nurses perceive themselves to be excluded from the NHS.	Suggests theories about role identity may be applicable to NuH nurses.
	Personal care is physically dirty work (Twigg, 2000a; 2000b).	NuH nurses perform personal care. NuH nurses perform business activities. NuH nurses' relationships with residents is affected by funding issues.	Suggests the role is imbued with physical, social and moral dirt.
	Private patients are pre-occupied with tangible facilities, and staff availability and attentiveness (Angelopoulos et al., 1998; Zarei et al., 2012).	Funding transitions within the English health and social funding system exacerbate this, which undermines the relationship between NuH nurses and residents.	Suggests that self-funding social care imbues the NuH role with social dirt and low authority-based status.
	Strategies to manage low occupational status (Ashforth & Kreiner, 1999; Hippel et al., 2005).	NuH nurses use strategies to manage low occupational status.	Suggests the relevance of theories about strategies to manage low occupational status to NuH nursing.
Health and social funding policy	Health and social funding policy negatively affects service-users'	Policy consequences contribute to NuH nurses' moral dirt.	Suggests that policy consequences negatively affect NuH nurses' occupational status and

	perceptions of NuHs (Wright, 2003; Henwood, 2010).	Policy consequences negatively affect relationships between NuH nurses and residents. Policy consequences marginalise NuH nurses from the NHS.	ability to perform their role.
Nursing care	LTNC is viewed as low-skilled because it requires fewer advanced medical/clinical skills ((Wade & Skinner, 2001; Abbey et al., 2006; Neville et al., 2014). However, contrariwise, managing multi-morbidities is a highly complex, skilled activity (Kwong et al., 2009; Condelius et al., 2010).	When multi-morbidities are managed successfully, residents are able to focus on social well-being rather than medical concerns.	Suggests NuH nurses are skilled at managing multi-morbidities, but do not recognise these skills as complex or important.
Nurse education	The acquisition and practice of advanced clinical skills are perceived as a high status activities (Wade & Skinner, 2001; Abbey et al., 2006; Neville et al., 2014), and/or more interesting and complex activities (Happell, 2002; Henderson et al., 2008; Fussell et al., 2009).	NuH nurses aspire to the acquisition and practice of advanced clinical skills because this supports their identity as nurses, supports a sense of belonging to the wider healthcare community, and leads to the acquisition of cultural capital, as well as reducing stigma and adding to the variety and challenge of the role.	Suggests the attraction of acquiring and practicing clinical skills is more complex than a desire for role status and variety.
	NuH nurse training/ education is not always relevant to NuH needs (Hannan et al., 2001; Ross et al., 2001; Jones et al., 2013).	NuH nurses require training/education in business skills, managing care in communal settings, and family dynamics.	New education/training needs for NuH nurses are identified.

7.4 Implications for workforce development

The understandings of NuH nurses' role and status generated by this study provide insights that may inform workforce development processes with regard to nursing care,

health and social funding policy, integrated working, and nurse education. The implications for workforce development are explored in this section.

7.4.1 Focus of nursing care

The study indicates that there is a mismatch between NuH nurses' expectations of what the role involves, and the actuality of the role. This is because residents, whose medical multi-morbidities are managed, and who are not acutely ill, focus on other aspects of well-being such as maintaining choice and self-identity, developing social relationships, maintaining biographical continuity, and accessing opportunities for meaningful activity. In response, NuH nurses feel that they are required to modify their care activities to address social, rather than medical needs – a response that leads them to feel uncertain about their role identity. This suggests that adult nurses continue to identify their role as primarily medically and clinically based. Social well-being is not perceived as a fundamental nursing concern, and indeed, in some cases, as not within the remit of nurses. This implies that nurses' perception of what constitutes nursing care is required to change. This poses a challenge to develop practice that moves away from the idea of holistic care as addressing the needs of service-users as separate needs (for example, social, physiological, psychological, spiritual needs) to the concept that individuals are 'total', 'whole' beings, as proposed by McEvoy and Duffy (2008). If this change was to be brought about, then perhaps nurses could perceive care as responding to the inter-related, unique needs of individual service-users, rather than to separate needs based upon contrived categorisation. If nursing becomes 'totality' focused, then NuH nurses may not feel that they are modifying activities to achieve a shift from medical to social care – thus undermining their role identity. Instead, they would be adapting their nursing activities to suit the unique needs of individual residents, and therefore would preserve their role identity.

7.4.2 Health and social funding

The confusion and controversy surrounding health and social care funding not only affects residents/families, but NuH nurses in that reconciling care and business aspects of the role poses a moral dilemma. Funding issues also hinder NuH nurses' abilities to develop therapeutic relationships with residents, and perform some nursing activities. From 2017, the government aims to implement the proposals of the Dilnot Report (Commission on Funding Care and Support, 2011) in an attempt to provide a fairer funding system. The policy change will increase the upper capital and savings limit, cap personal contributions to the costs of care, and introduce 'hotel costs' for accommodation and subsistence. Nonetheless, the policy has been heavily criticised by some finance and policy analysts (for example, Lloyd, 2013) who regard the proposed limits and caps as artificial and

misleading, and who argue that the care system's relationship with the NHS remains confusing in that what defines health and care needs remains unresolved. Local authorities are also critical of social care policies, forecasting that an increasing proportion of their budgets will be spent on social care, leaving less for other services (for example, Travers, 2011). It appears that there is no imminent solution that is acceptable to all stakeholders. Therefore, it is unlikely that NuH nurses' predicament regarding care funding can be resolved by policy changes.

However, this study suggests that NuH nurses who are trained and/or habituated in business and selling processes are able to reconcile moral dilemmas associated with funding issues, and indeed, are able to use these skills to act as advocates for residents, maintain the sustainability of their NuHs, and improve the quality of care provided. Perhaps then, the solution to the problems brought about by health and social care policy is to support NuH nurses to comprehend and reflect upon the implications of funding policy. This might take the form of training or education that incorporates information about funding and business, so that NuH nurses might be better able to understand the economic value of nursing and care services, how health and social care is financed, and appreciate the challenges that funding systems may pose for patients and NuH nurses.

7.4.3 Integrating health and social care

In recent years, governments and political parties have promoted, and legislated for, integrated working between health and social services and commissioned organisations, with the aim of developing a personalised service that focuses on service-users' individual needs (for example, DH, 2010c; NHS Future Forum, 2012; Care Act 2014; Labour Party, 2014; NHS, 2014). The NHS' (2014) *Five year forward view* which supports the improvement and integration of services, acknowledges the need for integrated teams. One of the first steps towards delivering this plan was to introduce 'vanguard' sites that aim to transform local care provision via initiatives such as models of 'enhanced health in care homes' (NHS England, 2015a). For example, NHS Gateshead clinical commissioning group have used the 'enhanced health in care homes' model to create an 'integrated community bed service' (which includes care home beds) to provide holistic care and seamless support across health and social care boundaries (NHS Newcastle Gateshead Alliance (NHSNGA), 2015; NHS England, 2015b). Since the introduction of the initiative, avoidable hospital admission numbers have reduced and care quality has improved. However, NHSNGA (2015) state that sustainable success depends in part upon changing traditional cultures so that teams can be built around community bed bases, rather than agencies and employers. Also, NHSNGA (2015) acknowledge that the challenges posed by the funding system need to be accounted for. This echoes the findings of Rand

Europe's (2012) evaluation of 16 integrated care pilot initiatives, which indicates that integration is difficult to achieve when conflicting organisational priorities, objectives, and cultures are apparent, and when relationships and engagement between organisations or professions are weak. Rand Europe (2012) propose that the creation of health and social care teams based around service-users' total care needs may develop effective working across organisational boundaries.

This current study's findings suggest that NuH nurses feel excluded from the NHS, an organisation which they view as the dominant healthcare socioculture. Feelings of not belonging to the healthcare socioculture, but not viewing themselves as belonging to the social care socioculture contributes to doubts about role identity, to low status, to a lack of cultural capital, and to attrition. The initiatives cited above, in which integrated health and social care teams that bring organisations and professionals from both sectors together, may be appropriate arenas of practice for NuH nurses working at the intersection of these two sectors, because they may feel involved and valued, and included within the team vision.

7.4.4 Nurse education

In order to mitigate against uncertainty, support NuH nurses to prepare for the role, and improve the occupational status of the role, NuH nursing should be promoted as a specialist role that requires specialist knowledge and skills acquired by specialist training and education programmes. Achieving this, would primarily involve a change to the current system of nurse education. This could involve either changes to CWD education, or changes to pre-registration education such as the introduction of a specialist gerontology nurse education programme at the pre-registration stage, or developing the current pre-registration nurse education curriculum to include NuH nursing. These alternative changes are considered and evaluated below.

7.4.4.1 CWD education

A number of studies propose that CWD training must be relevant to the needs of NuH nurses, if nurses are to engage with it and acquire any benefit (for example, Hannan et al., 2001; Ross et al. 2001). The present study suggests that if CWD training is to be relevant to NuH nursing, it should include business and funding topics, caring for individuals with cognitive impairments, managing care in communal living facilities, and family care. In addition, service provider organisations must invest in quality training courses that support proficiency development and expertise, so that attendees feel that their knowledge-base is enhanced, which will both prepare them for the demands of the role, and increase their occupational esteem.

However, the content and quality of training courses are not the only issues affecting the role and status of NuH nurses. This study reveals that education programmes and qualifications that are recognised by the dominant socioculture (in this case, the NHS) are methods by which cultural capital can be obtained. As discussed in 6.3.3, the acquisition of cultural capital increases knowledge-based status, augments nurses' flexibility and adaptability so that they are able to move between sectors and specialisms, strengthens role identity, and promotes a sense of belonging. Participants' keenness to access NHS training and acquire clinical skills training appeared to be as much about attaining cultural capital for these reasons, as about developing clinical competency. If this is the case, then CWD training, unless it is recognised by the dominant socioculture, does not confer cultural capital upon course attendees, and therefore does not address these concerns. Thus, changes to CWD training may not be enough to resolve the challenges faced by NuH nurses regarding role and status.

7.4.4.2 Pre-registration education

Prior to entering the NuH sector, some NuH nurses had not expected to perform many of the activities inherent within the role. This suggests that pre-registration nurse education does not support understanding of, or skill development for, the role of the NuH nurse. As such, changes to pre-registration education may be required. Possible initiatives are outlined below.

Pre-registration specialist gerontology nurse education programme: As discussed in 6.3.2, Germany offers direct specialist entry gerontology nursing at the pre-registration education stage. The findings of this study suggest that if such a programme were to be of benefit to NuH nurses, then training should include business and funding topics, facilitating care in communal settings, and family care, as well as topics concerning ageing and nursing older people with long-term conditions. A programme of this nature would assist NuH nurses to prepare for the demands of their role, and support their sense of role identity by promoting and locating the role as a specialism within health and social care. In addition, the course and consequent qualifications would provide registrants with cultural capital, and hence knowledge-based status.

However, creation of a direct entry specialism may not address low occupational status issues. The findings of the study show that NuH nurses feel stigmatised by the public and other healthcare professionals, and that this stigma is caused in part by a lack of understanding of the role, and negative views regarding the social care funding system operated in England. Therefore, creating a specialist role would not necessarily change this situation because status is a social construct imposed upon role. Only a change in views of the dominant socioculture could change status. A possible solution to this

problem would be to develop a pre-registration adult nursing education programme that included modules about NuH nursing.

Developing the current pre-registration adult nurse education programme: The inclusion of modules that address the role of the NuH nurse within the pre-registration education of all adult nurses, may assist all adult nurses to understand and value the work of NuH nurses. Modules may consider gerontology topics, business and funding topics (similar to those offered by American universities), the NuH nurse's role in the provision of long-term care and social well-being, managing care in communal living environments, and care of the family. The inclusion of such information within pre-registration adult nursing courses may assist nurses to acknowledge that nursing is not necessarily defined by the acquisition and practice of advanced clinical skills. This approach may also prompt nurses to consider and re-evaluate the contribution of non-NHS care and education providers to health and social care. This may lead to a greater acceptance of the NuH nurse role as a valid and significant contribution to health and social services, and imbue it with higher occupational status.

7.5 Study limitations and areas for further research

This section identifies the study's limitations and suggests areas for future research. A critique of the methodological approach, methods and research process was presented in chapters 3 and 4, hence this section focuses on the limitations imposed by the study's aims and sample.

A common criticism of qualitative research is that it cannot be regarded as transferable because it usually produces highly contextualised data (Scotland, 2012). Murphy, Dingwall, Greatbatch, Parker and Watson (1998) propose that if a study provides sufficient contextual and relational detail regarding the phenomenon under consideration, then readers can make informed judgements regarding whether the findings of the study are transferrable to other settings. In this study, the background of NuH nursing in England, and the contexts of gerontological nursing and long-term care nursing were described in detail in the literature review (chapter 2). Biographical details of the researcher were presented (chapter 1), and participants' brief biographies were also presented (chapter 5). In addition, data collection and data analysis techniques used episodic and semantic data to contextualise participants' responses.

The participant sample did not include any men, and migrant nurses were under-represented. Despite this, the study was able to offer some comments about the influence of gender and ethnicity/migrancy social identity constructs on role and status. It must be acknowledged, however, that sample constraints limited these discussions. Further

studies are therefore required to explore male NuH nurses' views and experiences of role and status, and to extend knowledge of migrant NuH nurses' views and experiences of role and status.

All respondents were private, for-profit establishments. As such, respondents were not entirely representative of all NuHs in England. However, as the vast majority (89%) of NuHs in England are owned and operated by private companies – a trend that is likely to continue and escalate (Liffé and Bourne, 2013), this was not considered to be a major limitation of the study.

This study focuses solely on the perspectives of NuH nurses. During the study, participants referred to their perceptions of the views and behaviours of other stakeholders regarding the role and status of NuH 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, NuH service providers, and education providers.

It could be argued that the study's transferability on an international scale is problematic because of the distinctiveness of England's NHS and social care funding systems. While it is acknowledged that the findings regarding NuH nurses feeling excluded from the NHS as a dominant socioculture may not be internationally transferable, 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 which could be construed as unfair, and which therefore could have implications for NuH nurses. For example, though Australia, Ireland and France have universal benefit systems, benefits received are adjusted to reflect residents' income, while 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). Nevertheless, it must be acknowledged that funding policies of individual countries and regions may influence NuH nurses' experiences and views in different ways. The impact of business and funding activities upon the role and status of NuH nurses should be considered by other studies in other contexts.

There is potential to develop themes and unifying categories beyond the scope of the study. For instance, the unifying category 5.3.3 discusses the business aspects of the NuH role. While undertaking step seven of the data analysis process (theme construction), gaps in the current knowledge were identified, and therefore an article and

conference presentations were developed to explore these ideas further. For example, the article *“I feel like a salesperson”: The effect of multiple-source care funding on the experiences and views of nursing home nurses in England* (Thompson, Cook, & Duschinsky, 2014) examines the influence that multiple-source care funding issues have on NuH nurses’ practice and appeal of the role. By continuing to explore each unifying category and theme, further understanding of the NuH nurse’s role and status will develop.

There is also potential for developing and implementing pilot interventions, and evaluating their impact on NuH nurses’ views and experiences of role and status. For example, initiatives to promote ‘totality’ focused nursing care, initiatives to develop integrated health and social care teams that include NuH nurses, and training and education initiatives that address the specific needs of NuH nurses.

7.6 Conclusion

This study provides an original insight into the role and status of NuH nurses. The innovative methodology and methods utilised, enabled participants to discuss and reflect in depth, their experiences and views, leading to new understandings of the role. By considering the issues of role and status together, the study captures the unique circumstances faced by NuH nurses, and the strategies they employ in their attempts to overcome associated difficulties.

Appendices

Appendix 1

[UNN letterhead]

Date:

Dear:

An invitation to take part in a research study

I am a PhD student from Northumbria University currently involved in a research study that explores the experiences and views of nursing home registered nurses regarding their role and status. I am writing to ask you, as a nursing home manager, if you or any of your registered nursing staff would consider taking part in the study. The study will be used to increase the general understanding of nursing home nursing. It may assist education providers to enhance nursing students' understanding of nursing home nursing and long-term care, and may also provide useful information for service providers engaged in workforce recruitment and retention. I have attached a Research Study Information Sheet, which explains the study more fully.

The study is open to all registered nurses in your nursing home. However, you and your staff are not obliged to participate. If you or any of your staff decide to take part, you can withdraw at any time, without giving any reason, and without your employment or legal rights being affected.

If you or any of your registered nursing staff are interested in participating in the study, then please return the contact sheet attached, to this email address. I will then telephone you to discuss the study further.

Thank you for taking the time to consider this request.

Yours sincerely

Juliana Thompson

Room M008, Manor House
Northumbria University
Coach Lane Campus West
Newcastle upon Tyne, NE 7 7XA
Tel: 0191 215 6497
Email: juliana2.thompson@northumbria.ac.uk

Appendix 2

[UNN Letterhead]

Date:

Title of the study - Being a nursing home nurse: An exploration of the experiences and views of nursing home registered nurses regarding their role and status.

Research study information sheet

You are invited to take part in a research study. Before you decide if you would like to participate, it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with colleagues, family and friends. Ask me if there is anything that is not clear. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

As the UK population ages, there is a greater need for registered nurses to work in nursing homes. Nursing home nursing is distinct and can be rewarding. Despite this, nursing homes struggle to attract registered nurses, while nurses who do work in nursing homes are often considered to have low status. Existing research studies say that this is because:

- Many nurses prefer to work in acute care, rather than long-term care or older persons' services.
- The public and the media have a negative view of nursing homes.
- Terms and conditions of employment can disadvantage nursing home nurses.

Some research shows that educating nurses and student nurses about nursing homes and caring for older people improves views about these care settings. In spite of this, nursing homes still struggle to attract and retain nurses. This suggests that other factors may also influence nurses' attitudes and decisions about nursing home nursing.

This study seeks to investigate the above factors and what other factors influence nurses' views and decisions about nursing home nursing. It will do this by exploring the experiences and views of nursing home nurses themselves about their role and status.

Why have I been chosen?

You have been asked to take part in the study because you are a registered nurse working in a nursing home.

Do I have to take part?

It is up to you to decide to join the study. If you do decide to take part, you will be given this information sheet to keep, and you will be asked to sign a consent form. Your consent will be re-affirmed verbally during the course of the study. If you decide to participate, you are free to withdraw at any time without giving a reason, and without your employment or legal rights being affected.

What will happen if I take part?

- I will ask your nursing home manager to complete a short recruitment information sheet about your place of work.

- I will then meet with you to tell you more about the study and answer any questions you may have.
- If you decide to take part, I will ask you to complete a recruitment information sheet about yourself and your job.
- I will then conduct a series of up to five interviews with you. The questions in the first interview will be based on your recruitment information sheet answers.
- In the next interviews, we will discuss your experiences and feelings about your role and status as a nursing home nurse.
- During the final interview, you will have the opportunity to consider and comment upon previous interviews, so that your views can be checked and verified.

The length of each interview will be determined by you, but interviews will normally last no longer than one hour. I would like to tape the interviews using a digital voice recorder to ensure that our discussions are accurately recorded.

Will my information be kept confidential?

All information collected during the study will remain strictly confidential. Only the researcher will have access to your personal information. Your identity will remain anonymous throughout the study. For the purposes of this study, you will be assigned an identification number so that your name and personal details cannot be recognised. Identifying information will not appear in any printed documents. All data storage and use will comply with the Data Protection Act 1998. Data will be kept for one year following completion of the study. After this time, all data will be regarded as confidential waste and subsequently destroyed.

You are advised that any information disclosed during data collection which raises professional concerns, must be managed according to the researcher's professional responsibilities ie the Nursing and Midwifery Council's Professional Standards (Nursing and Midwifery Council. 2008. *The code: standards of conduct, performance and ethics for nurses and midwives*, London, Nursing and Midwifery Council). These standards state that registrants have a duty to disclose information relating to unacceptable practices that result in residents, visitors or staff being at risk of harm. Any situation that is considered as unacceptable practice will be discussed with the supervisory team to inform decisions about appropriate actions.

Are there any disadvantages of taking part?

Being interviewed can be tiring. You may also feel you do not want to answer some of the questions asked. You can withdraw from the interviews at any time, or decline to answer any of the questions asked.

What are the benefits of taking part?

You may not benefit directly from the study. However, the study will be used to increase understanding of nursing home nursing, and the role and status of nursing home nurses. The study may assist education providers to enhance nursing students' understanding of nursing home nursing and long-term care. It may also provide useful information for service providers engaged in workforce recruitment and retention.

What will happen to the findings of the study?

The information collected during the study will be used in the researcher's PhD thesis, and will be reported and published in academic and professional literature.

You will be sent a summary of the findings.

Who has reviewed the study?

The research proposal has been approved by the School of Health, Community and Education, University of Northumbria Research Ethics Committee.

What if something goes wrong?

If you have any concerns about any aspect of the study, or about the way you have been approached during the study, then please contact Professor Glenda Cook or Professor David Stanley (contact details below).

Further information and contact details.

Further information about the study is available from:

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Professor David Stanley
Northumbria University
Coach Lane Campus (West)
Newcastle upon Tyne, NE7 7XA
Tel: 0191 215 6261
Email: david.stanley@northumbria.ac.uk.

Contact Sheet

Nursing Home Name:

Manager's Name:

We are interested in taking part in the research study and would like to discuss the study with you further.

Please state the number of registered nurses interested in taking part in the study

Please indicate if the nursing home manager is included in this number

Yes

No

Contact Name:

Job Title:

Date:

Nursing Home Address:

Nursing Home Telephone:

Nursing Home Email:

Please return this contact sheet to:
Juliana Thompson
Email: juliana2.thompson@northumbria.ac.uk
Tel: 0191 215 6497

Nursing home managers' recruitment information sheet

Thank you for taking the time to complete this recruitment information sheet.

Question 1

Please confirm the name of your nursing home's proprietor.

Question 2

Please state all the types of care you provide (eg. nursing, EMI, residential, respite, etc.).

Question 3

Please state how many resident places your nursing home provides.

Question 4

Please state how many registered nurses are employed in your nursing home.

Question 5

If you have any further comments which you feel may be of relevance to the study, please include them here.

Thank you.

Please return your completed recruitment information sheet to:

Juliana Thompson

Email: juliana2.thompson@northumbria.ac.uk

Tel: 0191 215 6497

Nursing Home ID No:

Participants' recruitment information sheet

Thank you for taking the time to complete this recruitment information sheet. The recruitment information sheet has 2 parts. Part 1 asks about you, and Part 2 asks about your work.

Part 1: Questions about you

1. Please indicate your gender.

Female Male

2. Please indicate your age (years).

20-29 30-39 40-49 50-59
60+

3. In which country were you born?

4. If you were born in a country other than the UK, in which country did you train as a nurse?

5. If you have children, what is the age of your youngest child (years)?

0-5 6-10 11-15 16+

Part 2: Questions about your work

1. Please indicate your job title.

Manager Deputy manager Staff nurse
Other

2. Please indicate your contracted hours.

Full time Part time Bank

3. Please indicate your usual shift pattern.

Days Nights Days & nights

4. How many years ago did you qualify as a registered nurse (years)?

Less than 1 1-5 6-10 10-20

20+

5. Have there been any gaps in your nursing career? If so, please give details.

6. How long have you worked as a nursing home nurse (years)?

Less than 1 1-5 6-10 10-20

20+

7. How far do you live from your place of employment (miles)?

Less than 1 1-5 6-10 10+

8. How do you travel to work?

Walk Drive Public transport Lift

9. If you have any further comments which you feel may be of relevance to the study, please include them here.

Thank you.
You can return your recruitment information sheet by post (using the SAE provided) or email to:
Juliana Thompson
Email: juliana2.thompson@northumbria.ac.uk
Tel: 0191 215 6497

Participant ID No:



*Professor Kathleen McCourt FRCN
Dean*

This matter is being dealt with by:
*Research and Enterprise Office
School of Health, Community & Education Studies
Room H007
Coach Lane Campus East
Newcastle upon Tyne
NE7 7XA
Tel: 0191 215 6701
Fax: 0191 215 6083
E-mail: julie.blackwell@northumbria.ac.uk*

Juliana Thompson
Northumbria University
School of HCES
Newcastle upon Tyne
NE7 7XA

24 July 2012

Dear Juliana

School of HCES Research Ethics Panel

Title: Being a care home nurse: a phenomenological exploration of the experiences and views of care home registered nurses regarding their role and status

Following independent peer review of the above proposal, I am pleased to inform you University approval has been granted on the basis of this proposal and subject to compliance with the University policies on ethics and consent and any other policies applicable to your individual research. You should also have recent CRB and occupational health clearance if your research involves working with children and/or vulnerable adults.

The University's Policies and Procedures are available from the following web link:
<http://www.northumbria.ac.uk/researchandconsultancy/sa/ethgov/policies/?view=Standard>

All researchers must also notify this office of the following:

- Commencement of the study;
- Actual completion date of the study;
- Any significant changes to the study design;
- Any incidents which have an adverse effect on participants, researchers or study outcomes;
- Any suspension or abandonment of the study;
- All funding, awards and grants pertaining to this study, whether commercial or non-commercial;
- All publications and/or conference presentations of the findings of the study.

We wish you well in your research endeavours.

Yours sincerely

A handwritten signature in blue ink, appearing to read "Jim Clark".

Jim Clark
School Research Ethics Review Panel

Appendix 8: Example of transcript annotation (extract from Beth's first interview)

NuH2P3-1

Researcher – What made you decide to pursue a career in a NuH?

1. Erm...to be honest, when I qualified...I got an email through about jobs becoming available through...it was [different company] at the time.
2. Erm, and when I qualified, jobs weren't, you know, they weren't giving them away.
3. It was quite difficult, and because I'd just moved house I was really eager just to get a job as quickly as I could, so to be honest, that was my main focus...I needed a job.
4. That's not saying that, you know, that was my only...but that was the main reason, because I wanted a job quickly, and this became available and I went for the interview, and I got it.
5. And that was my main reason. *Summary*

Struggled to get a job, motivated by personal needs, not career-minded.

Researcher – Was that the main reason you specifically picked this home as well?

6. Yeah, because of the locality and erm, at the time the reputation was good.
7. When I came for a look round, I liked it, so yeah. *Summary*
8. but when I think back, even my mam, who you know is a nurse...I could tell she was a little bit like, 'Oh, is that what you really want to do?'
9. And I kind of said to her at the time, 'Well you know I need a job now'.
10. It wasn't an excuse as such, but it was trying to give her a reason, because it was a bit like, 'Are you sure you want to work in a NuH? Do you not think it would be better to work for the NHS?'
11. Erm but for me, I didn't have a problem with it. *Summary*

Indication that NHS nurses see NuH nurses as lower status?

Researcher – So why do you think she thought that? Why do people think that?

12. I don't know.
13. I think there's just a big stigma around working in NuHs, you know.
14. I think she wanted me to get the experience of working in a hospital on a busy ward, because with me being newly qualified, I think she thought I would get more...I would you know, develop skills and things that I wouldn't here specifically. *Summary*

Researcher – Do you think that's been the case?

15. Erm, I don't know because I think when you're working upstairs in the NHS rehab unit, you still get to sort of develop your skills with things like you know, the ward rounds and the MDT, you do quite a lot of involvement which is similar to the hospital.
16. But then again you don't get to practice things like IVs and cannulation and things, which is what I've missed out on. *Summary*

Comment [A1]: Confessional, ashamed? Embarrassed? This is repeated in S3

Comment [A2]: 'Job' is repeated 4 times – 'low' word, got, career, vocation, just job. Secondary to personal needs.

Comment [A3]: Not a proactive word – settle for what's available, not a proactive action. Repeated in S4.

Comment [A4]: Stresses difficulties, mitigating circumstances to justify actions, excuses? Repeatedly justifies actions in S3 & 4.

Comment [A5]: Unfinished sentence, trying to search for more altruistic or dynamic reasons? But can't think of any?

Comment [A6]: 'Main reason/focus' repeated 3 times – feels need to have a reason, justification for the job choice.

Comment [A7]: Over-explaining, justifying, confessing, needing to be understood and approved of. These statements are defensive, as if participant assumes she's being judged because she views a job as secondary to other parts of her life. This corroborates 'inferior' role, and suggests there is a stigma apparent.

Comment [A8]: Convenience

Comment [A9]: Afterthought?

Comment [A10]: Convenience is main reason for choosing this job. Reputation and liking it are secondary to convenience. Again 'inferior'.

Comment [A11]: Mother is nurse – knows problems that her child will face so is discouraging/protective.

Comment [A12]: NHS is better – status differentials.

Comment [A13]: Mother is concerned because she regards NuH nurses as lower status. Participant takes the job because she needs to find work, not because she really wants it. Confirms 'inferior'. Demonstrates NHS nurses view NuH nurses as low status.

Comment [A14]: Feeling of stigma looms large.

Comment [A15]: Hospital is about experience, skills

Comment [A16]: Feeling that NuHs aren't busy?

Comment [A17]: Hospital is a learning environment.

Comment [A18]: Stigma, slower pace of work, skills and development occur in hospital, not NuH.

Comment [A19]: 'sort of' 'quite a lot', 'similar' these comments are vague.

Comment [A20]: Focus on what can't do, instead of what can do.

Comment [A21]: Excluded

Comment [A22]: NHS rehab unit is a substitute ward, not ideal because can't

Researcher – So do you consider those things as missing out?

17. I think so, yeah, because 7 a lot of the people I qualified with, when I meet up with them, they're telling me what things they've learned, and I have learned things, but completely different things...
18. 6 mine's all based around managerial, and the running of a business and a home, and things like erm...
19. just like working with the MDT quite closely,
20. where theirs are 8 all practical things like setting up V/s and drips, and er, just a lot more acute things. Summary

Researcher – Do you think some people think that's more important?

21. I think they... 9 I think it's something, not showing off, but a bit like, 'Oh this is what I can do, you know this is what I've learned', and I think some people do think yeah, that is more important.

The level of clinical skills acquired and maintained by a nurse influences role perception and status.

Researcher – The NHS unit here is important then?

22. 10 Yeah. 100%. Definitely.
23. I think if they didn't have the [NHS rehab unit], I wouldn't be working here.

Trying to associate self with the NHS – not just a NuH nurse.

Researcher – Why is that?

22. Because I feel like I'm sort of 7 still keeping my finger in, do you know what I mean?
23. I'm still sort of 11. I've got connections with the hospital, so I still feel I'm part of working with the NHS, because I see the doctors and consultants and, you know you have erm... you liaise quite a lot with them so you don't feel totally cut off you're not your own separate thing, you're still getting some links.

Researcher – So are you saying when you're working in a NuH, you feel cut off?

24. Yeah, 12 I do feel but off sometimes.
25. I mean I'm working downstairs now, so I don't really have a lot to do with the [NHS rehab unit], and I think you do feel a bit separated from the hospital and from the NHS because, 8 things like training, you don't get a lot of that through erm, and just generally we do get patients that come from the [NHS rehab unit] down to us and we do have that link, but 13 you know you don't see any doctors from the hospitals or anything like that, or physios and things.
26. So you are quite separate in that way.

NuHs are cut off from the NHS, excluded?

Researcher – You mentioned training – not getting much through. Are you saying that makes you feel different?

27. Er, erm, I suppose a little bit, yeah, you do.

Comment [A23]: Old friends, now excluded from peers.

Comment [A24]: Different – outsider, excluded.

Comment [A25]: Business, managerial skills not viewed as nurse skills, so aren't seen as important. Not traditional nurse task, so importance is undermined.

Comment [A26]: Chooses MDT as significant to her role – desires team, belonging, participation.

Comment [A27]: Again, focuses on what is unobtainable.

Comment [A28]: Differentiates between acute and chronic... acute is more professional?

Comment [A29]: Language of exclusion and difference. Harkens for inclusion via group affiliation and skill development.

Comment [A30]: NHS nurses reiterate own abilities and learning, 'I can but you can't'. Constantly comparing which reinforces exclusion.

Comment [A31]: Absolutely certain. Need connection with NHS to make job bearable.

Comment [A32]: Touching base, in the loop.

Comment [A33]: Language – connections, part of, liaise, see, links vs cut off, separate. NHS is a team, NHS rehab unit is a window into that team, without it, isolated.

Comment [A34]: Cut off, separated, again excluded.

Comment [JT35]: Training/education not associated with NuHs?

<p>28. Just because when 14 the girls that I've qualified with, I've seen them progress from Band 5 to Band 6 to sister, and we don't have that opportunity here.</p> <p>29. We go from staff nurse to deputy, but you know it's not the same, erm so in that way, in that respect, 15 I do feel like I'm not progressing, as much as them and therefore you know. <i>Summary</i></p>	<p>Comment [A36]: No longer part of that group.</p> <p>Comment [A37]: Different here</p> <p>Comment [A38]: Different here again.</p> <p>Comment [A39]: Career structure does not allow progress development</p> <p>Comment [A40]: Exclusion and differences extend to past groups and future advancement.</p>
<p>Researcher – So if you had the chance, would you think about changing jobs?</p>	
<p>30. Yeah, yeah.</p>	
<p>Researcher – Is that your goal?</p>	
<p>31. Erm, 9 I mean I'm quite comfortable at the moment, but I mean 16 if I was to progress, I wouldn't want to progress here.</p> <p>32. I'd want to progress into the NHS then work up to a Band 6.</p>	<p>Comment [A41]: Repeated 3 times – views progression as important, but linked to traditional NHS progression. Doesn't value progression development in NuH system.</p>
<p><i>NuHs are not conducive to career progression.</i></p>	
<p>Researcher – How you think other professionals perceive NuH nurses? You've mentioned the MDT.</p>	
<p>33. To be honest, 10 I'm really surprised because 17 I think some of the MDT are supportive, especially the doctors.</p> <p>34. You know they're really grateful that they do have hard-working nurses working here.</p> <p>35. Especially people like Dr xxx [consultant gerontologist], you know he's really keen to get more nurses into – newly qualified into nursing homes because he wants to change the whole perspective that people have, you know.</p> <p>36. And I think he's really supportive.</p> <p>37. I don't think he's got negative sort of thoughts about NuHs or anything. <i>Summary</i></p>	<p>Comment [A42]: Suggests that had a prior assumption that NuH nurses are stigmatised by everyone, so surprised when this is refuted.</p> <p>Comment [A43]: Really repeated 4 times, emphasises surprise and delight</p> <p>Comment [A44]: Admits can be busy and hard here too.</p> <p>Comment [A45]: Name-dropping. Views will change only if NuH nursing is recognised and valued from within the NHS itself, can't be forced by NuH nurses.</p>
<p><i>Assumption of stigma is unfounded with regards to MDT?</i></p>	<p>Comment [A46]: NuH nurses themselves bought into idea that are lower status. This only changes with endorsement of NHS itself.</p>
<p>Researcher – What about community nurses and district nurses (I know you're a bank community nurse too)?</p>	
<p>40. Erm, I think the thing that I've witnessed is that some of the DNs, you know when we have to call them because a 11 resident is in a residential bed, and that's a bit awkward at times.</p> <p>41. They come in and are like, 'Why can't you do this?' kind of thing, you know they're in a NuH, and, 'There's nurses employed here'. But it's all to do with politics, because they aren't paying the same rate as people are for nursing care.</p>	<p>Comment [A47]: Connotations of funding/money implied here, due to DN's response.</p> <p>Comment [A48]: Feel awkward that NuH role involves 'politics', business.</p>
<p><i>Difficulties are political that arise from funding issues?</i></p>	
<p>Researcher – Do people gravitate towards the NHS? Do they just naturally want to work for the NHS rather than NuHs?</p>	
<p>43. 18 When I was training there was never any opportunity to come and work in NuH, so I think you didn't even consider it to be honest.</p> <p>44. You were always driven to go and work in a hospital or in the community.</p>	<p>Comment [A49]: Forced, pushed into NHS, no choice offered?</p>

45. 12 You know, during lectures, and things like that, nobody talked about this is what it would be like to work in a NuH, and these are the skills that you would get.
46. 19 Erm, you would just...you wouldn't consider it really because there were no placements here, so people didn't get the opportunity to explore what working in a NuH was about really. Summary

Comment [A50]: Never opportunity, nobody talked about it, no placements – as if don't exist or kept secret?

Comment [A51]: Admits again that she does have some skills.

Comment [A52]: NHS only option, alternatives are dismissed.

University is orientated to educating nurses for the NHS.

Researcher – How do you think the residents and relatives view NuH nurses?

47. Erm, I think sometimes when you're working on the [NHS rehab unit], they do sometimes compare you to the nurses that have been looking after them prior to coming here...
48. they may say the nurses at the hospital, they do it like this, but 20 I know for a fact that it's the reverse in hospital because if we send residents up to hospital for treatment,
49. I know from people that work there that they said the opposite thing as well.
- Researcher – So it's not that residents say, well in the hospital, nurses do it like this, so you're doing it wrong?

Comment [A53]: Comparison with NHS nurses

Comment [A54]: Reverse, opposite – highlights differences?

50. Well they have done in the past.
51. There have been a couple of incidents where I've heard that a couple of times, but it's not often, and like I said it's the same for the nurses in the hospital.
52. I've heard them say, well the nurses in the home do it this way.
53. 21 So it's kind of both ways.

Comment [A55]: Again, differences but equal status?

Researcher – How do you feel the general public and media view NuHs and NuH nurses?

54. 22 I think NuHs are often scrutinised for practice, you know, the whole [company name] thing.
55. It was horrendous when that went on, and it does give NHS a really bad name.
56. They don't seem to erm, you know, you don't seem to find articles that praise NHS for what they've done.
57. If you ever see anything in a newspaper or on the television, it's always criticising bad care, erm.
58. But that's because that's what people like to read, that's what people like...you know it's a sad world, you know, it's much more interesting for someone to read something like that, 23 but I think it's the same for the NHS as well, they get slated in the media, but I think it is because that's what people like to know about, so they can then go and tell people, 'Oh, you'll never guess what I've read', you know.

Comment [A56]: Suspicious, horrendous, bad name, criticising – investigated, not trustworthy

Comment [A57]: Acknowledges NHS are criticized too, but earlier statement suggests NuHs only get negative press.

Bad press affects NuHs, but acknowledges the same about the NHS.

Researcher – Do you have a preference about working on the rehab unit or nursing unit? Why is that?

60. Erm, I think sometimes you feel that when you're nursing a 14 patient on 24 the NHS unit, it's a little bit more acute because they've still got conditions that need treating, whereas when you're looking after a 15 resident, they're usually a lot more stable, so therefore there's not a lot...you know unless they're poorly for whatever reason, and most of the time the residents are stable and you don't really need to give 16 the same amount of care as someone in the [NHS rehab unit], 25 where they're quite often are poorly or

Comment [A58]: Patients are acute, conditions, treatment, undergoing assessments – busy. Residents are stable, less care needed? Does this suggest care is viewed as clinical care?

undergoing various assessments and things, where you need a lot more input from the nurse then.

Patients are different to residents.

Researcher – So you prefer the NHS unit? Because they need more care?

Oh yeah, definitely, yeah.

61. 26 I can't stand it when you tell people that you work in a NuH and their first thing is something about you know like, personal care, 'Is that all you do?'

62. And I hear that a lot, more than anything else.

63. Is that what you spend your day doing, [wiping people's bottoms]?

Comment [A59]: Very certain about this point.

Comment [A60]: Defensive and upset

Comment [A61]: Chosen a base, undignified task to demonstrate people's views of NuH nurses. Quite bitter.

Personal care activities lead to lower status?

Researcher – Does that make a difference? How you're viewed?

66. Erm, it sometimes does, yeah.

67. when I think back to what people have said, because sometimes..17 it depends who you're talking to, and I know in the past when I've applied for a job erm, 28 I know this because I actually knew the ward manager at the time...they didn't realise that the application form was from me, but he even told me that as soon as he saw on the application form that I worked for a private NuH, and not for the NHS, he didn't look at the application form.

68. 18 And that's really stuck with me, you know.

Comment [A62]: Remembers, negative experiences are very much in mind.

Comment [A63]: Known, 18ppg, even told me – fact, proof, not just conjecture – colours participant's views of NHS staff and self.

Comment [A64]: Shock, anger, disbelief is evident in this section.

Excluded from NHS activities and careers due to NuH background.

Researcher – So within the NHS, there's a feeling about NuHs.

69. Yeah, I got that feeling anyway, but that was actual proof and he told me that's often what happens. 29 that they have an application form, and you know on the online form it says, do you currently work for the NHS.

70. If you don't tick that box, then they look to see where you've worked, it just goes against you straight away.

Comment [A65]: Proof of stigma

Comment [A66]: Don't tick box, goes against you – exclusion, difference.

Researcher – Why do you think that is?

71. I think its, you know, because people don't think that...30 people think that by working in a NH, you're not going to have much [experience] and skills as somebody working in a hospital.

Comment [A67]: Experience and skills seems to be acute hospital remit only.

Comment [A68]: Comparing to hospital again

Researcher – Do you think people like that ward manager have an image in their head of what a NuH nurse is, and what do you think that image is?

72. Just probably somebody that 31 couldn't get a job anywhere else, you know.

73. Because they'll probably think that, like I said, 'You don't have the same knowledge and experience as somebody working in the NHS'.

Comment [A69]: Assumption. Assume stigma, assume and imagine other's images of NuH nurses.

Comment [A70]: Comparison with NHS. Both uses terms NHS/acute hospital interchangeably.

Researcher – So if you settle to work in an NuH, people think you're not knowledgeable?

74. Yeah. 32 And you're not motivated.

75. I'm not saying that about everybody, and I don't personally feel that, but you know, it's the [impression] you sometimes get from people.

Comment [A71]: Belief, perception, assumption about other's views.

Excluded from the NHS due to perception of abilities/knowledge/motivation?

Researcher – What do you think would improve the image of NuH nurses? What needs to happen?

76. Erm, I think its more about starting right at the beginning by...I know we've tried it here but...33 trying to get students to come in, erm and have placements here, just so we get noticed a bit more.
77. I think that would be a good starting point, but it doesn't ever seem to take off, even 19 despite doing your mentorship and everything, they're just not interested.
78. I think that would've been a good starting point, just to get people aware that 20 this is a good place for people to learn and especially for those in their management stage coming to work somewhere like this.

[Summary]

Comment [A72]: Back to the start, before stereotype gets a chance to develop

Comment [A73]: Because usually ignored, excluded.

Comment [A74]: Has trained, but doesn't see this skill as important compared to clinical skills – need to ask if any others are mentors?

Comment [A75]: Be recognised, not ignored.

Comment [A76]: Contradicts other statements about not progressing, training, developing.

Comment [A77]: Reiterates stigma, exclusion, clinical skills issues – but some contradiction apparent.

Holistic reading – topic framework:

- Initially struggled to get a job, and pressing personal circumstances and convenience dictated that this job was taken. No initial career plan. Seems to regret decision to take this job now. Ties in with 'inheritor/pursuer' idea i.e. confirms stereotype of 'inheritor'.
- Indication that NHS nurses stigmatise and stereotype NuH nurses and view them as lower status. This does not seem to be true of some other professionals.
- Constantly compares self and own practice to NHS nurses, feels excluded from the NHS. Feels university is geared to producing NHS nurses only. Aspires towards an NHS job in the future. This feeling of being 'cut-off' is a new topic.
- Much of the problem lies with the lack of practical clinical skills utilised, and acute care being regarded as more 'professional'. Confirms idea that acute/clinical is more professional than caring.
- Politics/funding have an impact on how NuHs are perceived. This is a new topic.
- Patients are different to residents due to acuity of illness. This is a new topic.

Highlighting/Backgrounding (potential topics)

Stereotype/Stigma

Inheritor

- H1 Settled for the job
- H2 Chosen for convenient locality
- B1,2,3,4 Justifying self for choosing this job, defensive, over-explaining
- B9 Despite stigma, says 'comfortable'

NHS nurses stereotypical views/discrimination

- H3,4 NHS nurses view NuH nurses as lower status (mum is concerned)
- H28,29 NHS nurses' direct discrimination affects job prospects

NH nurses assume they are stigmatised

- H5 Stigma actually mentioned
- H26 Believe people view them as providers of personal care only.
- H28,29,30,31 Assume others have prejudiced beliefs about them
- B17 Assumption of stigma prompts job-hunting
- B18 Stigma is very painful, remembered, 'stuck' in mind
Compares self to NHS nurses constantly.

NuH nurses buy into stigmatised view of themselves

- B5 Affiliate self with NHS to reduce stigma? (by working on the NHS unit)
- H9 Comparing self unfavourably with NHS counterparts
- H10 Feels that the NHS unit reduces stigma?
- H14,15,16 Compares career progression unfavourably with that in NHS

Other professionals' views

- H17 MDT can be supportive
- B17 Surprised when the MDT are supportive
Endorsement of other professionals is only way to change stereotypes? Cultural capital?

Public views

- H22 All health service providers are criticised, not just NuHs, but NuHs never receive positive press.

Professional nursing/clinical skills

Professional/clinical skills correlate with acute settings

- H5 Skills are gained in acute settings
- H24 Acute areas require more clinical skills input
- H30 Lack of clinical skill development debars nurses from NHS
- B14,15,16 Residents are different to patients because they are less acute

Clinical skills are more important than other skills

- H6 IVs and cannulation symbolise clinical competence
- H9 Acute/clinical skills are more important skills than any others

NuH nurses 'miss out' on clinical skill development

- H8 IVs and cannulation are not practiced, so 'missing out'
- B8 Less training in clinical skills in NuHs
Focus on what cannot do, not what can do (boundaries of practice).

NHS rehab unit is important for professional development

- B5 NHS unit has opportunities to develop some clinical skills
- H24 NHS unit requires clinical skills

Lower status because of association with personal care

H26 Upset that others view clinical skills as higher status, and do not recognise NH nurses as skilled

Acknowledge do have some important skills

B6 Management and running the home

B19 Mentorship skills

B20 In spite of previous comments, still feels NuH is good learning environment – contradiction?

Cultural capital?

Excluded/cut off

NHS rehab unit is a link to NHS

B7, H12 NHS connects NuH to the hospital, (suggesting that without connection, are cut off)

H11 NHS unit is similar to 'real' nursing (some participants are bank nurses in NHS – need to investigate further – is it to maintain NHS links?)

MDT in rehab unit gives sense of belonging, participation, teamwork.

NHS unit better than nothing, but still not as 'good' as hospital.

Acute care leads to participation/teamwork, stability leads to isolation.

University is geared to NHS only

H18 University does not recognise NuHs

H33 If university recognised NuHs, may help recognition by other providers, help inclusion

Politics/funding (possible topic?).

Different role

B5 Admits has skills, but in business and management – appears to view these as less significant than clinical skills? (investigate further)

Funding

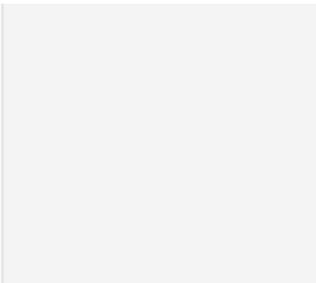
B17 Does funding source and rates affect care? DNS' behaviour is affected indirectly by funding issues (investigate further)

Comments

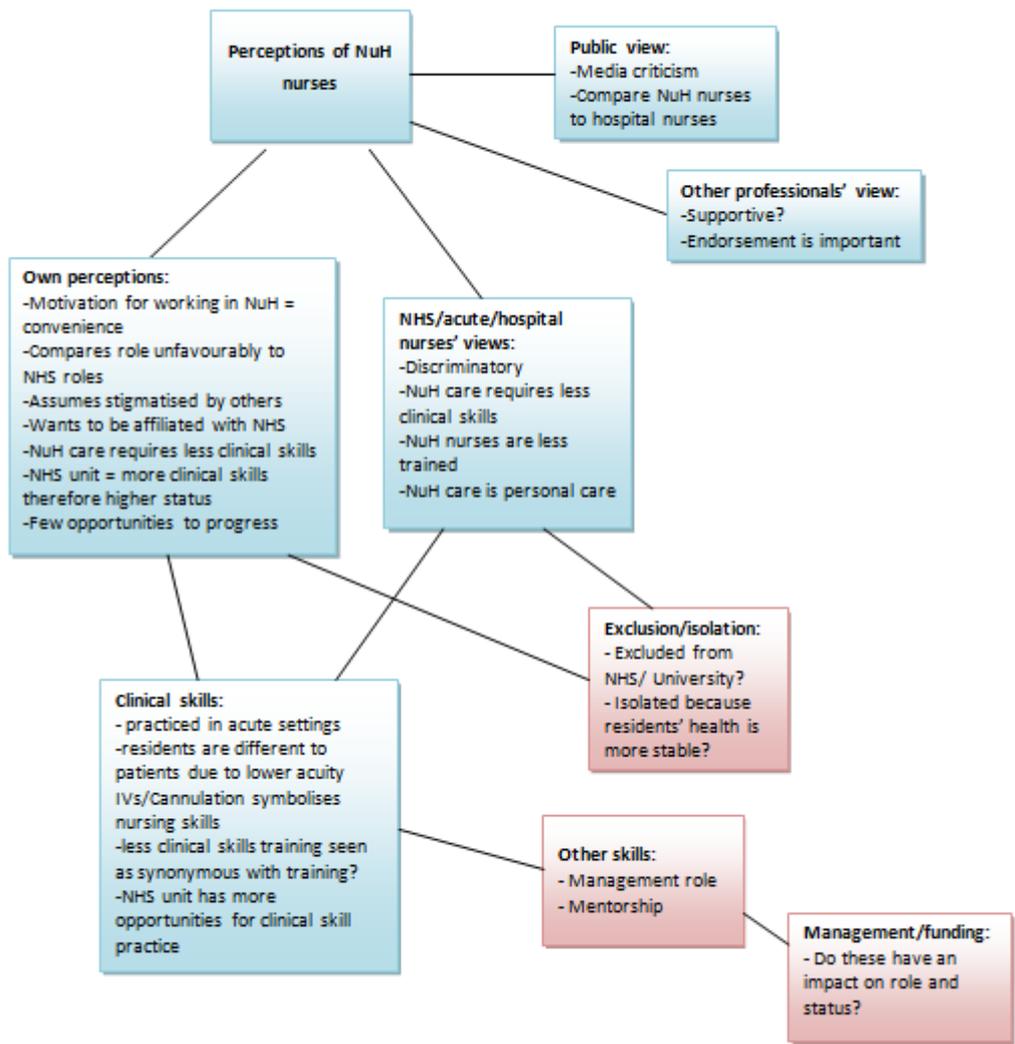
No mention of patient group i.e. older people? (investigate further)

Possible topics for next interview:

- Working with older people
- Elaborate on 'cut off'
- Explaining your job to others
- Is it beneficial to work on bank in NHS (training/skills)?
- Business/funding



Topic map



Appendix 9: Reflection on the use of an interpretivist paradigm

While developing and constructing questions and aims to address omissions and criticisms of earlier research was comparatively straightforward, determining a paradigm and methodology that would appropriately respond to the questions and aims was a complex process that required much study and contemplation. This was because I was initially uncomfortable with the concept of interpretivism, as its propensity for objectifying experiences and perceptions of participants led me to feel that it was in some way ethically unsound. I felt that the paradigm's aim was to 'use' participants, without giving them opportunities to really participate in the construction of interpretations to any great extent. I also felt that this may impair the validity of the study because interpretation is exclusively researcher-led. However, there was still no doubt in my mind that the aims of the study fitted with an interpretivist paradigm.

A study of Ricoeur's works (1981; 1991) reinforced my concerns regarding interpretivism. Ricoeur (1981) proposes that while the aim of language and words is to relate meaning, what we wish to convey during discourse (meaning), and what we actually say (language and words) are different entities. Meaning during discourse has an objective dimension (what language and words mean) and a subjective dimension (what the speaker means). Ricoeur (1981) describes this separation between what is said and what we are saying as 'primitive distanciation' (p.132). That is, distance occurs because the discourse act is a real time event in which language and words are exchanged. However, the process of understanding meaning, a process that occurs outside of time, surpasses the discourse event in order that we can understand what is said in the saying. For Ricoeur (1981), distanciation during discourse is generally unproblematic because 'reference' (i.e. the speaker's original world) is not at risk:

In oral discourse, the problem is ultimately resolved by the ostensive function of discourse; in other words, reference is determined by the ability to point to a reality common to the interlocutors. If we cannot point to the thing about which we speak, at least we can situate it in relation to the unique spatio-temporal network which is shared by the interlocutors. It is the 'here' and 'now' determined by the situation of discourse, which provided the ultimate reference of all discourse (p. 141).

Bearing Ricoeur's (1981) account in mind, I remained reticent about interpretivism, and inclined to favour the constructivist paradigm. In constructivist approaches, although the interpretation is ultimately written, the consensus methods, whereby researcher and participants construct an interpretation via a transactional discourse process, protect 'references', which enhances validity and demonstrates that participants are valued and respected.

The interpretivist transition from discourse to text is less participatory, because although dialogue occurs during interviews, a greater emphasis is placed on objectifying the contribution of the participants. During the interpretation process, participant interlocutors are absent, and no 'reference' is apparent which frees researchers to interpret texts as they wish. This creates 'alienating distancing' (Ricoeur, 1981, p. 131) whereby there is separation between the discourse event, the meaning inherent within the discourse event, and the meaning inscribed within the text. Ricoeur (1981) is not unduly concerned about this:

Distancing is not...superfluous and parasitical; rather it is constitutive of the phenomenon of the text as writing. At the same time it is the condition of interpretation...We are thus prepared to discover a relation between objectification and interpretation (pp.139-40).

Despite Ricoeur's (1981; 1991) assurances that objectification and distancing are not 'parasitical' processes, it was not until I further studied and contemplated the works of Ingarden (1973), Iser (1978a) and Schutz (1962) that I concluded that there is no real dilemma, and that in fact, certain thoughtful modes of objectification support valid interpretation. According to these authors, objectification separates interlocutors/participants as people from their experiences, views and discourses. The act of objectifying 'concretises' experiences and views referred to within texts so that they are no longer representations of authors/interlocutors/participants, but phenomena in their own right. In effect then, by using an interpretivist paradigm, I would be objectifying experiences of participants, not the participants themselves. This directed me to a further contemplation of Ricoeur's (1981) concept of distancing. Could this also apply to memories of experiences? Like discourse, our memories of experiences have 'references' common to us as the experiences occurred within our lives at definite times. Yet during the process of remembering, we at times objectify experiences by assigning meaning outside of time – meaning that surpasses the experience events. Neville (1981) explains:

Sometimes we attend to and objectify past thoughts, such as memory...we can attune ourselves to be aware of the impingement of the past on our immediate experience, and to objectify this awareness in our conscious, judgmental experience (p. 181. For further discussion of the objectification of memory, see Leith, 1993; Vallega-Neu, 2005).

If this is the case, then we are constantly objectifying and creating distancing at different points on the continuum between primitive and alienating distancing. Whether the phenomenon under review is remembered, discussed or textualised, we are always at some distance from the original event because objectification is inherent in both assigning

meaning to phenomena and ultimately understanding phenomena. In my study, I (as the researcher) was not the only objectifier, as participants themselves objectify experiences during remembering, then narrating their experiences, and the reader of the thesis objectifies the researcher's interpretation during the act of reading.

The process of reflecting upon paradigm and methodology choices supported my decision-making, and sanctioned my belief in the research framework chosen, so that I was then able to fully engage with the philosophies underpinning the methodological approach, and acknowledge and address the challenges and pitfalls associated with this approach, as presented in chapter 3.

Appendix 10: Conference papers, journal articles and book chapters arising from, or related to, this thesis

Thompson, J. (2013). *Care home nursing in the UK: Practicing in the juxtaposition of care and business*. 4th Nursing and Midwifery Conference, Galway. 15-16 April 2013

Thompson, J. (2013). *Reconciling business with care: A challenge for care homes nurses in the UK*. National Care Homes Research and Development Forum, Newcastle-upon-Tyne. 29 May 2013.

Thompson, J. (2014). *Being a care home nurse in the UK: Practicing in the juxtaposition of care and business*. New understandings of old age and the life course: 43rd British Society of Gerontology Conference, Southampton. 1-3 September 2014.

Cook, G., Thompson, J., & Reed, J. (2014). Re-conceptualising the status of residents in a care home: older people wanting to 'live with care'. *Ageing and Society*. doi: 10.1017/S0144686X14000397

Thompson, J., Cook, G., & Duschinsky, R. (2014). 'I feel like a salesperson': The effect of multiple-source care funding on the experiences and views of nursing home nurses in England. *Nursing Inquiry*. doi: 10.1111/nin.12066

Thompson, J. (2015). *A literary reception theory approach to data collection and analysis*. 5th Nursing and Midwifery Conference, Galway. 30-31 March 2015.

Thompson, J. (2015). *Uncertainty about role identity: Care home nurses practicing at the intersection of health and social care*. Progression or regression: British Sociological Association Conference, Glasgow. 15-17 April 2015.

Thompson, J. (2015). *Unpreparedness for the role: Nursing home nurses practicing at the intersection of health and social care*. Ageing in changing times: Challenges and future prospects: 44th British Society of Gerontology Conference, Newcastle-upon-Tyne. 1-3 July 2015.

Cook, G., & Thompson, J. (2015). Purposeful activity. In M. W. Kazer & K. Murphy (Eds.), *Nursing case studies on improving health-related quality of life in older adults* (pp. 119-130). New York: Springer.

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

The difficulties faced in the recruitment and retention of nursing staff in nursing homes for older people are 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 were 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: healthcare costs, long-term care, nursing, nursing homes, nursing role, phenomenology, residential care.

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).

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, ongoing 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

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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 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 need 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 service 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 (cf. Trigg 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. Although 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, upfront 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 et al.' (2011) report 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 Angelopoulou, Kangis and Babis (1998), Arasli, Ekiz and Katircioglu (2008) and Zarei et al. (2012) explores 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 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) phenomenological 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 were 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 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 arise 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 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. Strouwick (2005) explains that expressions used in texts and speech may have hidden subtexts. 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 mean-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 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 the role and emphasised the morally acceptable nursing aspect of the 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' and '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 it's 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... 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 (Ebaine).

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!'

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Participants suggested that there is a disparity between the expectations of self-funding residents and those of health-care 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... 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 twentyfourseven 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...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' health-care 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 cer-

tain 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 ... 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).

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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. First, 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 'salespersons', 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 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' (1999, 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 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.

Second, 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 healthcare 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 make 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 involve

ment 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.

Third, 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 Angelopoulou et al. (1998), Arasli et al. (2008) and Zarei et al. (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 care 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 affects 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 findings suggest 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 findings also imply 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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