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Developing the role of the generic healthcare support worker: phase 1 of an action research study

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Abstract

This paper reports on the first phase of an action research practice development project to explore, develop and evaluate the role of the generic healthcare support worker in a high dependency rehabilitation service. The project is being jointly conducted by staff from the University of Southampton, the University of Portsmouth and the Isle of Wight Healthcare NHS Trust and phase 1 is supported by a grant from the NHS Executive (South and West).

The aim of phase 1 of the project is to explore the attitudes of staff towards the implementation of the role of the generic healthcare support worker, particularly regarding the practical, professional and ethico-legal problems of the role.

Professional and support staff from different parts of the service were interviewed in groups and the interviews were tape recorded, transcribed and subjected to a simple thematic analysis. Four themes emerged from the data relating to the challenge to professional boundaries, being a generic worker, outcomes for service and patients and implementing the role.

As an action research project, the aim was not to produce findings that are generalizable beyond the practice areas in which they were generated, but it is nevertheless hoped that the reader might be able to apply some of the conclusions to his or her own setting.

1. Introduction

This paper reports on the first phase of a large-scale practice development project conducted jointly by teachers and researchers from the University of Southampton and the University of Portsmouth, and practitioners and managers from the Isle of Wight Healthcare NHS Trust. The aim of the project is to explore, develop and evaluate the role of the generic health care support worker and this first phase is supported by a grant from the NHS Executive (South and West).

The clinical focus for the project is the Frank James Hospital (FJH), a high dependency unit situated on the Isle of Wight which provides both rehabilitation and continuing care for patients with complex physical and psychological needs. The original intention of the study was to introduce and evaluate a training programme for generic health care support workers (GHCSW), with one university providing the training course and the other carrying out the evaluation. However, this approach was felt to be unsatisfactory both to the course team and the research team, each of whom favoured a more collaborative action-oriented approach in which the qualified and unqualified prac-

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titioners themselves could help to develop the GHCSW programme. Clearly, this approach to practice development, in which practitioners, managers, educationalists and researchers work together in order to initiate and monitor clinical change, lends itself readily to an action research methodology.

Action research has been described as "a way of generating knowledge about a social system while, at the same time, attempting to change it" (Lewin, 1946) and (Kemmis, 1982):

under which practice can be regarded strategically and 'experimentally' and under which practitioners can organize as a critical community committed to the improvement of their work and their understanding of it.

Phase 1 of the project includes:

- Setting up an education programme for health care support workers from a variety of disciplines in order to share and learn new skills and develop competencies at NVQ levels 2 and 3, to discuss ideas and to come to a better understanding of each other's roles.
- An exploration of trained and untrained staff's attitudes towards the concept of the generic health care support worker.
- An exploration of the anticipated problems and difficulties raised by the implementation of such a role.
- The identification of the issues to be addressed in phase 2 of the project.

2. Background to the project

As an action research study, this project is concerned with a single specific clinical setting. For this reason, a detailed account of the unique and individual context of the project has been provided, with only a brief review of the wider literature. A rationale for this approach will be given later when the validity and reliability of the study are discussed.

2.1. Historical perspective

This study was initiated at a time of significant change within the Trust. The development of new services at FJH and the imminent merger of the two Trusts on the Isle of Wight provide a backdrop of major organizational change against which the development of the generic support worker role must be viewed.

These local developments must also be set in the context of national trends in health care. It could be argued that the period from the implementation of the NHS and Community Care Act (DoH, 1990) to the present time has seen the most fundamental change in the way that health care is delivered. Changes have taken place in the commissioning and provision of care, the development of GP fund-holding and the consumer-oriented nature of 'new' health care. These developments have set the scene for changes in the ways that professional health care workers, and those who support them, will work.

A range of factors influenced the initiation of this project to explore and develop the role of the generic support worker:

- An ageing population that was on the increase.
- The complexity of the needs of older people on the Isle of Wight.
- Increasing dependency levels of the client group.
- The prioritization of services to meet needs more effectively and holistically.
- Patients receiving 'social care' in hospital beds.
- Pressure to effect cost savings and to provide value for money, particularly in relation to the return of extra-contractual referrals.
- The desire to establish new partnerships between the statutory, private and voluntary sectors.
- The need to develop an integrated interdisciplinary approach to rehabilitation.
- The introduction of criteria for continuing care.
- The need to introduce and develop new services, e.g. for people with traumatic brain injury.

In order to address these factors, task groups were set up at the end of 1995 and following their recommendations the services were reconfigured to focus on high dependency care.

As a result of this reconfiguration, Frank James Hospital became the focus for the new in-patient service, with two wards of twelve beds. One of these wards was intended for people with complex needs and a high level of dependency, and the other was for people with posttraumatic brain injury who were also considered to be a high dependency group, with the respite care that was formerly given at FJH being relocated in nursing homes. The plan had the approval of the Health Commission, providing as it did a mixed economy of care by shaping new partnerships with the private sector, informal carers, and between professionals.

As a new service, practitioners of all disciplines approached their work at the Frank James Hospital from a variety of philosophies and caring orientations, from technical, task-centred practice to primary, holistic, patient-centred care. Clearly, a common model of care was required and the decision was taken that the needs of patients in this new service would be best served by reviewing the skill mix of professional staff

and by the creation of a multi-skilled group of generic support workers. The move towards generic support working has a number of far-reaching implications: it challenges professional conventions and boundaries and has implications for the training and development of professional and support staff and their working practices. Unfortunately, the internal politics of the situation dictated that medical staff were excluded from the study, thus limiting the extent to which the traditional status quo of power relationships could be challenged.

The decision to develop the role of the GHCSW was, of course, based on a major assumption by the team that the generic support worker role would make a positive contribution to patient care and there were a number of beliefs underpinning this assumption. Firstly, we believed that the GHCSW role would result in increased continuity of care, since a single worker would be able to assist all the relevant health care professionals in their particular specialisms, rather than requiring separate support workers for occupational therapy, physiotherapy and nursing. Secondly, we felt that this would in turn promote holistic care, since the generic support workers would be more likely to see the patient as a whole person rather than as a pair of hands to occupy, a pair of legs to be mobilised or a body to be washed. Thirdly, we believed that the generic support workers might produce a more cost-effective service, thus, releasing money for other patient needs. Fourthly, we hoped that a more holistic role which involved working with the whole patient might improve job satisfaction for the support workers, and thus attract more able staff. Finally, as a spin-off from the benefits to patients and to the GHCSWs, we felt that the new role might promote interdisciplinary co-operation between healthcare professionals, since they would be required to work more closely together in planning the work of their generic support workers. However, we also acknowledge a number of reservations about the role, which will be discussed further in the literature review.

Clearly, then, the project is founded on beliefs and assumptions as much as on empirical research, but this is to be expected in such an underresearched area as generic support working. Furthermore, the ethos of action research supports (and often encourages) the notion that the researcher brings with her a subjective agenda, such that she "has an interest in transforming the situation from what it is *to something [s]he likes better*" (Schon, 1983, our italics).

2.2. The role of the generic health care support worker

Workers from each health care discipline currently train in isolation from one another and as part of this process become 'professionally socialised' into ways of working which delineates them from other health care professionals. Thus, occupational therapists work in a particular way, with a particular focus, and in a particular location, as do physiotherapists and speech and language therapists. Nurses have traditionally worked in hospital and community settings, where they have acted as a contact point through which other therapists practice and channel their prescriptions for care.

Furthermore, and in addition to having its own training, each professional group is located within its own hierarchy, leading to the situation where each health care professional is part of a 'professional pyramid' that could, and often does, operate in isolation from the others and this has tended to compound the professional isolation and tribalism of each of the groups. Of course, where professional groups communicate well and closely share therapeutic aims, separatism is not encountered. Nevertheless, the existence of separate ideologies, hierarchies, professional bodies, training, experiences, therapeutic focus, departments and uniforms will necessarily tend to create separate workforces within a total workforce.

It might, of course, be in the interest of the patient to have subdivisions within the workforce; indeed, these subdivisions are at the heart of specialist practice, with the notion that each professional group has its own body of knowledge and skills to offer to the patient. This argument is particularly strong when applied to professional health care workers who have been trained and educated within a speciality, but it carries much less weight when applied to support workers who have not. In particular, the division of support workers into professional groups can lead to tensions between 'therapy' and 'care' and an imbalance in therapeutic resources provided to the patient. There would seem to be little justification, then, for employing a number of different types of support staff, each following the working patterns of their professional group. Rather, multiple prescriptions for both therapy and care could effectively be enacted by a single unified group of workers.

The separatist way of working described above has been challenged by initiatives within the health care service on the Isle of Wight, whose aim has been to develop an integrated service which pushes against the conventions of professional boundaries. The first stage of these initiatives has been an exploration of the role of the generic support worker, who would offer support and help to all health care professionals and through whom those professionals could implement their care prescriptions. For the purpose of this study, the term 'generic support worker' is taken to mean a nursing, physiotherapy or occupational therapy assistant who could be trained at National Vocational Qualification (NVQ) level 3 in order to provide coher-

ent support for patient rehabilitation across all three disciplines.

2.3. Brief review of the literature

Previous research into the role of staff in rehabilitation teams has focused mainly on relationships within the team or on team processes, and although there have been a number of studies exploring stroke rehabilitation, especially comparing outcomes as a result of differing settings or provision of care, there does not appear to be any literature specifically relating to generic support staff in rehabilitation settings. However, there are two related areas of literature which could profitably be explored, namely the role of the nursing support worker and the notion of the 'patient focused' hospital.

There are a number of studies which explore the role of the nursing assistant (now confusingly called the Health Care Assistant or HCA). Whilst a number of these acknowledge that nurses' time is often used inappropriately on tasks which could be performed by support workers (DHSS, 1986; Jones, 1986; Robinson and Stilwell, 1990; Audit Commission, 1991; Crouch, 1992; Blee, 1993), there is also concern about HCAs' training (Dewar, 1992; RCN, 1992; Ahmed and Kitson, 1993) and the boundaries of their role (Ahmed and Kitson, 1993). MacLeod (1994), for example, argued that the therapeutic value of nursing lies to a large extent in "the little things" that the nurse does and the knowledge about individual patients that comes with doing those little things. Unfortunately, it is precisely these little things which are often being handed over to HCAs, leading MacLeod to question the contribution that HCAs are able to make to patient care. Boyes (1995), makes a similar point, and whilst supporting the deployment of HCAs, she is concerned that they often "perform tasks that otherwise would be the domain of qualified nurses" and that "this does not always occur as a conscious decision". However, despite the concern that HCAs reduce overall standards of care, there is a lack of evidence to support that assertion (Audit Commission, 1991; Buchan and Ball, 1991).

Turning to the 'patient focused' hospital, an exploration of the literature suggests that a number of ideas related to the generic support worker are currently under consideration. The patient focused hospital requires the members of the workforce to be trained to perform a range of tasks traditionally undertaken by workers from a variety of different professions (Brider, 1992; Morgan, 1993; Buchan, 1995; Heymann and Culling, 1996; Needham, 1996), with the focus of care being on the needs of the patient rather than of the employees. To this end, Brider (1992) argued that cross-training with multiskilling is a way of improving patient care, with fewer staff involved in the care of any individual patient (Morgan, 1993), decreased job demarcation (Buchan, 1995), and a reduction in 'non-productive' time (Buchan, 1995). Furthermore, Heymann and Culling (1996) saw patient focused care as a means of enhancing the nurses' skills to provide holistic care, since they are able to meet a greater proportion of their patients' needs.

However, in his review of the literature on the management of stroke patients, Gibbon (1993) asserted that there is little work which clarifies the nurses' roles with regard to this patient group, other than as the provider of 'maintenance care'. If the nurse's role in rehabilitation is unclear, this would suggest that the training for generic support working may be problematic, at least for the nursing profession.

Role ambiguity (Workman, 1996) might further compound the problems associated with generic working. Workman's study found that qualified nurses perceived health care assistants as a threat to their own roles; if generic working is to succeed, then roles and responsibilities must be clearly defined. Furthermore, protocols for care management and quality standards also need to be established (Royal College of Nursing, 1994; Buchan, 1995) and the role that professional jealousy might play in compounding this problem cannot be ignored (Heymann and Culling, 1996). Furthermore, evaluation of care delivery might also be difficult to measure (Benson and Ducanis, 1995), especially since assessment of the effectiveness of patient focused care is extremely limited (Buchan, 1995). Finally, demands to produce a cost effective service are unprecedented (Dale et al., 1994; Needham, 1996), as are demands by consumers for service quality (Patterson, 1992).

This brief review of the literature suggests that whilst the idea of working generically might generally be feasible, it would appear that a number of issues need further exploration. This study seeks to explore some of these concerns.

3. Methodology

3.1. Project philosophy

As previously discussed, the most appropriate approach to this project is through an action research methodology. Action research was developed by the American social psychologist Kurt Lewin in the 1940s and has been defined as (Lewin, 1946):

> a spiral of steps each of which is composed of a circle of planning, action and fact-finding about the result of the action.

From this definition, it can be seen that one of the distinguishing features of action research is its ability to integrate action and research into a single act which includes a series of cycles of planning, implementation and evaluation. Since each subsequent planning stage depends on the implementation of the previous evaluation stage, it can also be seen that it is impossible to plan very far ahead and to know in advance exactly how practice will develop as a result of the research. That is not to say, however, that the researcher enters the practice situation blindly and without any preconceived ideas about how practice might be developed, but rather, as we saw earlier, that the practitioner has an interest in transforming the situation from what it is to something she likes better. This clearly involves a value judgement on the part of the researchers, but it does not mean that they enter into the research project with an anticipation of the outcome, merely that they can distinguish positive from negative change and that they actively pursue the former rather than the latter.

The second distinguishing feature of action research is its emphasis on collaboration. It is (Reason, 1988):

> a way of doing research in which all those involved contribute both to the creative thinking that goes into the enterprise — deciding on what is to be looked at, the methods of the inquiry and making sense of what is found out — and also contribute to the action which is the subject of the research.

Because of the history of this particular project and its last minute conversion into an action research methodology, it was difficult to fully involve the practitioners in planning and conducting the first phase. However, as the study progresses, there will be a gradual handing over of responsibility for its direction and implementation. Thus, although the project began as what Carr and Kemmis (1986)termed ''technical action research'', the eventual aim is to transform it into ''emancipatory action research''.

Clearly, this shift in ownership, power and responsibility is bound to create difficulties which would have been avoided if an emancipatory model had been employed from the outset, and the method for promoting the transition has been to establish the FJH as a practice development unit (PDU). This will serve as a practice-oriented framework for the continuation and development of the project, such that ''the practitioner group takes joint responsibility for the development of practice, understandings and situations'' (Carr and Kemmis, 1986). The PDU will therefore constitute the 'critical community' advocated earlier by Kemmis (1982), with the eventual aim that the outside research team should play only a minimal advisory role.

It should also be noted that the PDU is an interdisciplinary expansion of the Nursing Development Unit (NDU) movement (Pearson, 1988), which Ersser (1988) described as suitable for patients who ''do not require frequent contact with medical staff (and) would be likely to benefit most in a nursing unit where nursing becomes the fundamental therapy, supported by the multidisciplinary team''. The PDU movement extends this philosophy so that nursing is no longer the 'fundamental therapy', *supported by* the multidisciplinary team, but rather that the *inter*disciplinary team (which includes nurses) works together in a patient-centred way. The goal of emancipatory action research in this case is therefore to engage the entire interdisciplinary care team in the project.

A third feature of action research projects is that they are local and practice-based, usually focusing on a specific case and the problems of bringing about change in that case. The aim of action research is not to produce generalizable knowledge and theory (although the knowledge and theory it produces *might* be generalizable), but to improve practice.

3.2. Research design

In keeping with the earlier definition by Lewin of action research as a cycle of planning, action and fact-finding or evaluation, phase 1 of this study has been designed as follows:

3.2.1. Planning

The objective of phase 1 of the project was to raise awareness of the concept of the generic worker, particularly amongst support staff and to facilitate discussion. To achieve this objective, the planning stage involved designing an education programme for support staff from a variety of disciplines and clinical areas, the aims of which were to introduce the basic concepts of generic working, to disseminate ideas and information, to provide basic skills training and to give the opportunity for staff to meet with each other and discuss ideas and achieve level 2 and 3 competencies in rehabilitation. This course was designed according to NVQ guidelines as a traditional classroom-based programme.

3.2.2. Action

At this stage, the education programme was introduced with a total of ten support workers, consisting of 1 occupational therapy helper, 3 physiotherapy helpers and 6 nursing assistants. These staff were drawn from across the Trust and not just from the Frank James Hospital, in order to generate a wider range of views and attitudes. The history of the project, which was discussed earlier, dictated that the programme was introduced without prior empirical research in the form of exploration with staff or patients of their attitudes, opinions and anticipated

problems. However, this sequence of planning, action and empirical evaluation leading to revised plans, revised action and so on, is in keeping with traditional action research methodology.

3.2.3. Evaluation

The impact of the programme was evaluated by conducting two semistructured group interviews with the participants ($n=10$) and two other group interviews with a purposive sample of trained staff from a variety of disciplines and clinical areas ($n=14$). The focus of these interviews was on:

- Attitudes and opinions about the possible effects of generic working on the quality of care.
- Practical, professional and ethico-legal problems and difficulties of generic working and how they could be resolved.
- Attitudes and opinions about role differentiation, role cohesion and job satisfaction.

The interview schedule was also designed to allow other relevant issues to emerge from the group discussions, and all the interviews were taped with the permission of the respondents.

It must be emphasised, in keeping with the philosophy of action research, that the aim of the education programme was not to initiate the role of the generic health care support worker, but to explore the issues and problems which would be likely to be encountered in establishing it, as well as the attitudes and opinions of the trained and untrained staff involved in its possible implementation. It is, as an action research project, "a hypothetical probe into the unknown beyond one's present understanding, to be reviewed in retrospect as a means of extending that understanding" (Elliott, 1991). Clearly, if the findings from phase 1 of the project had been overly negative, they would significantly effect the structure and design, or indeed the existence, of phase 2.

In addition to the interviews, other baseline data were collected at this stage. These included a quantitative measure of attitudes to, and satisfaction with, the current service using a visual analogue scale, and an 'ethnographic' snapshot taken over a period of several days. These data collection strategies will be repeated later in the study in an attempt to gauge the impact that the action research project has made on service provision and the attitudes and satisfaction of staff and will, therefore, not be reported in this paper.

3.3. Reliability and validity

Issues of reliability and validity in qualitative research are well documented (see, for example, Sandelowski, 1986; Koch, 1994; Schutz, 1994) and will not be rehearsed here and the usual validity checks of returning to the participants at various stages of the data collection and interpretation process were carried out. However, it is necessary to consider the particular challenges to reliability and validity introduced by action research. Usher and Bryant (1989)took an extreme position by arguing that the purpose of action research is the generation of 'insider knowledge' which, they pointed out, makes it difficult to validate its truth claim to outsiders. In fact, they went further to question whether action research can, or indeed should, attempt to justify itself to outsiders at all, that is, whether validity and reliability are relevant concepts for action researchers.

Elliott (1991) took a less radical position. He saw the primary aim of action research as improved practice, and thus the internal validity of the knowledge and theory it produces depends entirely on its "usefulness in helping people to act more intelligently and skilfully". Thus "in action research 'theories' are not validated independently and then applied to practice. They are validated through practice". If the application of a theory leads to better practice, then the research which produced that theory, and the theory itself, can be said to be valid.

Greenwood (1994) made a similar point that action theories are simply "chunks of practical reasoning" and that

> The propositions operational in practical reasoning are valid or true if they lead to the successful bringing about of the state of affairs that is desired.

It is impossible, then, to consider the internal validity of the findings of action research in isolation from the changes to practice that those findings bring about, and the validity of action research can only be assessed once the changes have been implemented. Furthermore, the validity of a single cycle in the action research spiral can only be judged within the context of the entire project.

The issue of internal validity is closely related to that of external validity, the 'generalizability' of the study. If, as has been argued, internal validity is closely linked to the successful implementation of change, then the aims of each action research project are unique to the situation in which it is conducted and the specific changes that it is intended to bring about, and the whole issue of generalizability becomes largely irrelevant. All that the researchers can do is to provide a clear description of the situation in which the study took place; it is the responsibility of the reader to determine whether it is applicable to his or her own practice setting. This, of course, is the qualitative researcher's notion of 'fittingness' (Koch, 1994), 'transferability' (Guba and Lincoln, 1989), or 'naturalistic

generalization' (Stake, 1980), in which (Sandelowski, 1986):

> a study meets the criterion of fittingness when its findings can 'fit' into contexts outside the study situation and when its audience views its findings as meaningful and applicable in terms of their own experiences.

This in turn leads to the issue of reliability, the question of whether the research can be consistently replicated, and once again the unique nature of the setting in which action research projects are conducted challenges this entire notion. As Hamilton (1980) pointed out:

> It is possible to state that two studies produced identical results. It is never possible to say that they were conducted under identical conditions: if they were conducted at the same time, they must have occupied different places; if they were conducted at the same place they must have occurred at different times.

Action research projects are individually designed to respond to the unique needs of a specific practice situation, and should be judged on the changes which they bring about. They are not intended to be repeated or to be generalized from, and the responsibility for doing so lies in the hands of the reader of the action research report. Conversely, the responsibility of the researchers with regard to validity and reliability is to describe clearly both the setting of the project, its theoretical findings and the changes which it initiated.

4. Data analysis

Following transcription of the interview tapes, a simple content analysis was performed on the data as follows:

> Stage one: each of the five researchers worked separately to extract units of meaning from the first interview.
> Stage two: a group discussion was held to place the units of meaning into themes, and after much debate, five themes were identified.
> Stage three: the units of meaning were extracted from the remaining interviews and allocated to themes. No new themes emerged at this stage and two of the existing themes were merged into one. Saturation of data was achieved before the analysis of the final interview had been completed.
> Stage four: each theme was written separately, including verbatim quotations from the participants, in order to provide a cohesive description of the perceptions of the generic worker role.
> Stage five: the written description was reviewed separately by each researcher to establish validity of the findings and conclusions. themes were also externally validated at this stage.
> Stage six: the issues to be addressed in the next phase of the project were identified by the researchers. The four themes will now be described in detail.

4.1. The challenge to professional boundaries

All four groups of respondents suggested that the role of the generic worker would result in a blurring of the boundaries between the separate professional areas of practice and identified positive and negative consequences of this.

Respondents derived security and a sense of identity from what they saw as discipline-related skills, were proud of their role in patient care, and were able to gain confidence from "knowing your own job" and "belonging to a particular professional background". A move away from these 'professionally' defined roles was seen as threatening to this identity. Support workers also voiced concerns regarding interaction with an increased number of professional staff and were uncertain as to whom they would consult regarding care decisions. This was summarised by one respondent in the following way:

> if you're working for a range of people, all with different goals, it has to be very clear what the goals for the patient/client are; it really has to be clearly defined and everybody working towards the same end, otherwise I can imagine there will be even more confusion than there is at present.

As a result of these worries, the support workers appeared insecure at the thought of not 'belonging' to a certain group of staff and were concerned as to where their support would come from. They equated the extension of their role with relegation and losing the status that they associated as attached to the individual professional groups; it was as if, for example, being a physiotherapy assistant somehow gave them the identity of being a member of that professional group.

The professional groups were concerned about the blurring of boundaries in relation to the issues of responsibility and accountability for care. In particular, they felt threatened by the creation of a 'subprofession' which would to some extent take over their own roles. Taken to the extreme, they could see the generic worker as coordinating patient care, with the professionals acting in a consultancy role as required, a fear which was also expressed in the literature (Coombs and Sutton, 1994; MacLeod, 1994;

Nicholson, 1996). These fears were more in evidence amongst the nursing staff than other professionals, possibly due to the nature of the relationship between nursing and the other professions and to the 24 h provision of nursing care as opposed to the 'office' hours worked by their colleagues. All groups voiced the idea that nurses were more like, or "closer to being" a generic worker already.

On a more positive note however, all four groups suggested that professional boundaries impeded care and that a blurring of the boundaries between the traditional roles would increase understanding and enable staff to take a more holistic view of the patients' needs. The generic workers were excited at the opportunity to extend their knowledge and skills in order to be able to provide a better quality of care, with one suggesting that it is "time to get away from individual professional thinking". The professional staff, however, felt that this loss of specialism might be appropriate at the support worker level, but not at the professional level. None of them could see a place for a 'generic' professional; as one cynically remarked "you can't know everything!"

4.2. Being a generic worker

All groups saw a danger that the extension of the support role could result in the GHCSW becoming a "jack of all trades, master of none". Support workers feared that this would result in a dilution of their competence and confidence; they were concerned for the adequacy and scope of their training and about "not knowing enough". They also felt that they would not be trained to assume the added responsibility involved in becoming a patient's key worker and that the strain of doing this would create stress. In particular, one of the physiotherapy aides highlighted the effects on relationships of caring for fewer patients with higher intensity, claiming:

> if I am following a patient's treatment from the cradle to the grave, how many clients can I afford to do that with? Three at the most. Whereas at the moment I see half a dozen, maybe more, very often more, you sort of... you are picking them out through the day; but if I'm assigned to three clients, and that's my three, I can't imagine coping emotionally with any more than three, if I'm going to be at that person's beck and call for my six hours a day.
>
> You need to be able to walk away and think "I want to get out of that" because it's just getting deeper and deeper. But if you know that you are with that person all day, or for a good part of the morning there is no getting out of it, there is no handing over. That is a lot to take on board.

This view was supported by a nursing assistant, with an example from her own practice of "getting too close to the patient" and becoming emotionally drained. This fear of emotional involvement is in direct contrast to the therapeutic importance of a close relationship between nurse and patient recognised in the 'therapeutic nursing' initiative (McMahon and Pearson, 1991), the 'new nursing' movement (Savage, 1995) and other relationship-based models (for example, Patterson and Zderad, 1976; Meutzel, 1988).

Although the support workers anticipated dissonance within the role, they could see that it might have positive consequences for them. They felt that the increase in their knowledge base gave them greater confidence in making decisions, and enabled them "to recognise when a client needs a professional", thus giving them greater control over their own workload and a sense of autonomy. However, the relationship that the generic worker would have with the professionals was also a source of anxiety. The support workers questioned whether the professionals would be able to let go of some of their traditional roles and allow the generic worker to take responsibility. They were also sceptical of the perceptions that other staff might have of the new role. One respondent said:

> they probably feel more uncomfortable to ask us to do things as well; I mean... they won't ask us to do anything. I mean we've got the training behind us and we'll probably still plod along just like we used to,

suggesting that the other staff, both qualified and support workers, would not allow them to enact the new role. This was in part attributed to the perceived problem of only having one or two of the newly trained workers in each area, rather than retraining all the staff in one area at a time and implementing the role wholesale.

The professional groups saw more benefits to having a multiskilled generic worker with a good overview of the basic skills of all the professions and the ability to manage more aspects of care. They identified this role expansion as incorporating more responsibility than the assistant role, particularly in terms of coordinating care, and suggested that a separate pay scale and career structure should evolve to reflect the levels of skill and training, thus reinforcing the fear expressed by Nicholson (1996) that the role "is simply repeating history and creating a replacement 'enrolled nurse'". In addition, they saw the new role as quite different to the old 'assistant' roles, requiring a different sort of person, and anticipated difficulty for staff in adapting

to the changes. They clearly felt it was unfair to expect existing staff to retrain for no tangible reward and could anticipate the likely creation of stresses similar to those identified by the support workers themselves.

Both groups saw the problems of the new role as being a consequence of the way in which they perceived it was being implemented.

4.3. Outcomes for service and patients

Improved continuity of care was the main issue identified as resulting from the generic role. All groups felt that workers providing 24 h care with a broader base of skills and knowledge would result in increased confidence and patient satisfaction. For instance, one support worker said:

> I think if a patient has one person they can get up a rapport with that person, they tend to do more and feel safer. I mean, I've got patients that only like me showering them, and there's another one that only likes someone else giving them their bath. I think it would work that way if you could do more for that patient in general.

However, problems were also anticipated with one person working more intensively with a smaller number of patients, particularly in relation to possible personality clashes, familiarity and boredom. On the whole though, improved job satisfaction for the generic worker was seen as coming from the ability to see the "overall picture of the patient" and taking on more responsibility for managing a group of patients. One of the professional staff described the advantages of the broader role thus:

> they've got a general idea, there is always going to be a certain baseline of things that people can deal with straight away without continually having to run to someone else higher or a different professional to deal with it.

This was also seen as having the effect of resolving conflict between the professional workers, with the generic worker mediating and ensuring continuity without professional boundaries inhibiting care provision.

The effects of the introduction of the generic worker on the quality of care provision was seen as another key issue for the service and related to the anticipated increase in continuity of care. The generic worker was seen as the key to ensuring that patients received the treatment required, with the consequences described thus:

> they (the patient) go through a period when they are going to progress at a faster rate if they get the correct treatment, and if you can improve that intense treatment then they are going to achieve more.

The devolving of the coordination of care from professional staff to generic support workers was anticipated as being more cost-effective for the health service; in particular this was perceived as attractive to fund-holding GP practices and for units with a high ratio of professional to support staff. Whilst there were fears that more staff would be needed and that professional staff would be relegated to a consultancy role, it was acknowledged that quality of care could be improved with a concurrent reduction in staffing costs, thus having all-round benefits.

> If you have Mrs Jones on a ward for two weeks sitting doing nothing because she is not getting the right input then that's a costly exercise... but if you have got sufficient rehab then they will go to their home instead of ending up in residential care, that's a cost saving too.

However, the fears expressed in the literature of the possible detrimental effect of removing qualified staff from direct patient care (MacLeod, 1994; Boyes, 1995) were not acknowledged. But whilst positive outcomes of the introduction of the generic role could be anticipated by all the groups, these were seen as dependent upon the ways in which the role was implemented, and how key issues arising from this were going to be resolved. These are explored in the final theme.

4.4. Implementing the role

All four groups recognised the creation of the new role as a major development in the delivery of health care, which needed a 'culture change' with commitment from management and re-education of the total workforce. Many of the staff had already been through significant changes during their careers in the health service and had witnessed poorly managed change with insufficient resourcing. They had little reason to think that the introduction of the new role would be any different. For instance, all groups identified the piecemeal introduction of one or two generic workers to an area and suggested

> it needs to be just one area taken and used as a trial and properly controlled,

and

> you can't change a culture if there is only one person doing it a different way... they need the support of each other and they all need to be working together in the same area.

Thus, the importance of establishing teams of multidisciplinary and multigraded staff was highlighted as essential for the success of implementing the role, and anticipated as bringing the perceived benefits of increased continuity and quality of care. Although the generic workers were proud to see themselves as pioneers, they had reservations about being guinea pigs when many issues regarding implementation of the role did not appear to have been addressed.

Educational issues were identified as a major concern. Firstly, the efficacy of the training programme was questioned. Whilst the generic workers derived confidence from their expanded knowledge and skill base, the professional workers were concerned about the breadth of this in terms of competence. The content of the training was a major issue for all groups, as they were very aware of the problems associated with expanding a role without appropriate preparation. These concerns have been echoed in other studies (Hardie, 1987; Robinson and Stilwell, 1990; Rhodes, 1994). Input into the training from all professions was seen to be crucial, with assessment of competence being the responsibility of each separate specialism rather than of a 'generic' assessor.

The other issue related to this was the education of all other staff into the practicalities of the new role. This was a recurrent theme in all groups, as professional staff attempted to understand the implications of the new role, whilst support workers anticipated problems in being unable to enact the role if professional staff did not fully comprehend it or felt threatened by it. Again, similar concerns have been expressed in the literature (Hardie, 1987; Reeve, 1994).

The second group of concerns related to managerial issues. All staff identified concerns about who would be accountable for the generic worker, especially when the work they were doing was delegated from different professional groups. For instance, one support worker said

> we can imagine having an OT, a physio, a senior nurse and many other bosses as it were, whereas at the moment we are accountable to our senior therapist.

This lack of a secure base led to feelings of insecurity in the generic support workers, and a concern that they were not able to work in the way they had been trained because managerial issues had yet to be resolved.

Problems were anticipated by the professional staff where a generic worker was implementing a therapeutic regime from one discipline, and there was no senior member of staff from that discipline available for supervision. The key concern here was "who takes responsibility for that if something goes wrong", with the professionals appearing clear as to the limits of their own responsibilities and being unwilling to assume responsibility for issues which they saw as beyond their expertise. They were all worried that the lack of depth to generic worker training would give a false sense of security and lead staff to "have a go" without anticipating the possible consequences of their actions. The support workers had similar concerns in terms of wanting the security of having someone available to consult and someone to whom they related in a line management capacity. None of the groups were convinced that these issues had been addressed, and identified the bottom line as being the liability for actions taken by a worker who is not registered as a professional and therefore is not professionally accountable.

The solution to both the educational and managerial issues was seen as establishing improved communication networks through the use of such strategies as well-defined teams, multidisciplinary case planning, staff education, improved liaison and tackling the physical boundaries which inhibit people working together.

4.5. Summary

The findings from these interviews suggest that overall the role of the generic worker is seen positively. All groups of staff were optimistic that the role could work and could identify benefits of introducing a worker who could operate across the traditional professional boundaries. This optimism was tempered by the need to address operational issues before the project progresses any further.

5. Discussion

It is hoped that sufficient background information about this study has been provided to allow the reader to assess the fittingness or transferability of the findings to his or her own clinical setting. Furthermore, although the limited generalizability of the findings from this study has been emphasised, the respondents raised most of the issues described in the brief literature review, along with a large number of others. It should be remembered, however, that the aim of data analysis in action research is not to produce generalizable knowledge and theory, but to evaluate the effects of the action component of the project and to provide material for the planning stage of the next phase. With these objectives in mind, the following issues were identified from the data.

Theme 1: the challenge to professional boundaries:

- Defining the boundaries of the role and establish-

ing limits to role function.
- Creating a sense of belonging.
- Managing professional dissent.

Theme 2: being a generic worker:
- Identifying competence.
- Setting limits to responsibilities.
- Developing coping strategies to manage role strain.
- Informing others of the role.

Theme 3: outcomes for service and patients:
- Facilitating continuity of care.
- Cost-effectiveness.
- Improving quality and standards.
- Threats to job satisfaction.

Theme 4: implementing the role:
- Managing the culture change.
- Sorting out issues of accountability, responsibility and line management.
- Implementing the role further (blanket coverage of an area versus one or two areas at a time.
- Establishing mechanisms for multidisciplinary working.
- Improving communication networks.
- The assessment of competence — issues relating to assessors, supervisors, etc.

As the first phase in a larger action research project, this study was not designed to produce answers, but rather to raise more questions for the next phase. It does seem clear from the findings, however, that the notion of a generic support worker has broad support from both the trained and untrained staff that were interviewed, albeit with certain provisos and modifications. The team therefore feels encouraged to progress to phase 2 of the study, also funded by the NHS Executive (South and West), which will centre on the establishment of a Practice Development Unit as a framework to further develop and refine the role in a narrowly focussed, well controlled clinical environment in which the members of the clinical team can take increasing responsibility for the project.

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