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Workplace Stress for Health Care Assistants in a UK National Health Service Dementia Hospital after 10 Years of Financial Austerity: A Qualitative Study

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Abstract:

Health care support workers have patient-facing roles within care teams but little autonomy; work is allocated. This study reports work stress experiences of Health Care Assistants (HCAs; UK support workers) in a dementia unit in 2018 towards the end of national austerity, a period of significant staff reduction in the UK National Health Service. HCAs (15; 40% of total) were individually interviewed, and in a focus group (6). Analysis revealed high job demands but low job resources. HCAs were altruistic regarding stressful dementia care but tension from the work environment was high. Difficulties directly or indirectly related to staff shortage: workload, inadequate staffing, and reliance on inexperienced temporary staff who required supervision, poor team skill mix, and poor shift patterns. Serious relationship issues for HCAs were exposed so post-hoc interviews with nurses (n=10) from the same unit were undertaken for further insight. HCAs considered nurses unsupportive, poor leaders and disrespectful of their experience. Nurses considered HCAs obstructive, compounded by failure to recognise nurses' professional responsibilities. Coping by HCAs was mainly through short, time-out breaks but these were constrained by lack of staff cover. Tensions had been left to fester. Better awareness of managers is required that staffing impacts extend beyond workload.

Keywords: *Workplace Stress; Job stress; Job strain; Health Care Assistants; Healthcare Support Worker; HCA; Dementia*

Introduction

Support workers (mainly health care assistants, HCAs, in the UK) make a key contribution to delivery of dementia care, which is highly demanding. Carers are exposed to significant and distinctive psychosocial and physical engagements with patients [1,2] and risk work-related stress and ill-health [3] that potentially compromises patient care [4]. As a staff group they are under-represented in practitioner research [5]. Much of our understanding of their work environment comes from studies by [6] but workplaces have changed considerably since then as a consequence of national financial austerity that in the UK included reduced funding of the National Health Service (NHS). This paper therefore reports a detailed evaluation of HCAs' work environment in a NHS dementia care unit that was conducted towards the end of the austerity period in the UK.

Background

Dementia is characterised by loss of memory, depression, impaired communication, confusion, poor judgement, aggression, disorientation and difficulty in swallowing, walking and speaking [3,7]. Most patients exhibit limited social functioning and so require a high degree of assistance with their activities of daily living [8,9] made more complicated by impaired communication by people with dementia [10]. Carers may also experience abuse and aggression from patients who have serious behavioural symptoms so making staff anxious and sometimes fearful [2].

Dementia care in UK hospitals adopts a team approach. Doctors are not regularly based on the units, only occasionally visiting patients for review and/or admission, and so teams mainly involve nurses and unqualified support workers, mainly health care assistants (HCAs) in the UK, who depend upon nurses to ensure a fair distribution of work and to provide leadership, support and risk management. Effective care delivery therefore depends upon good managerial support and staff relationships, a sound team identity, and interdependent working [6].

Identified a predominantly positive work environment for HCAs in [2] three dementia care settings but also identified insufficient staffing as a source of concern. That study was conducted early in the period of global financial austerity. In the UK, funding cuts to the National Health Service (NHS) from 2008-2019 compromised staff recruitment which, alongside high staff attrition, led to a significant

shortage of health care employees. At the end of the austerity period NHS Trusts (July–Sept 2019) identified 43,590 nursing vacancies [11]. Staff shortage is linked to work intensification and the UK health and social care sector now has the second highest rate of work-related stress, depression and anxiety in the country [12] while approximately 40% of all staff sickness absence in the NHS is stress-related [13].

Recent initiatives to increase recruitment produced increases in NHS staffing (+0.7%; 2014-2019) that are modest compared to the underlying chronic shortage [14]. Within those statistics support workers increased by around 11% but recruitment figures were skewed by recent introduction of Nursing Assistant Practitioners, a new stratum of UK carer located between qualified nurses and unqualified HCAs [15]. The increase in HCAs was only 2% but the figure varied according to clinical specialism; in mental health care support workers actually decreased by -0.1%. HCAs play a key patient-facing role in delivering dementia care and it might therefore be anticipated that the demands of patient care, coupled with inadequate staffing and subsequent work intensification, has increased the exposure of HCAs to significant work environment stressors. Indeed, [16], reporting at or around the time of the present study, identified that inadequate staffing levels and poor leadership characteristics were demotivating for both HCAs and nurses, and a lack of development opportunities, were a negative influence on their intention to remain in their jobs.

Aim

This is clearly a challenging time for health care staff. This study, conducted in 2018, applied the Job Demands-Resources framework [17] to evaluate the local work environment for HCAs within a dementia care setting. It aimed to answer two research questions: (1) 'What perceptions do HCAs have of workplace stress in a UK in-patient dementia unit after approximately 10 years of financial austerity and (2) 'How do those HCAs delivering dementia care cope with their work?'

The study

Setting

The study was located in an in-patient dementia care unit in a regional hospital in SE England. At the time of the study in 2018 there were 46 beds in the unit, and all were occupied. The unit employed 19 staff nurses and 24 HCAs, plus numbers of temporary agency staff. Whilst transient, some temporary staff worked regularly, even preferentially, on the unit wards and for the purpose of this study those who were HCAs were also considered as part of the study population of experienced dementia carers. The total accessible substantive and temporary staffs at the time of study therefore was approximately 50-60 persons, of whom 30-35 were HCAs familiar with the selected wards.

Design

This cross-sectional, qualitative study applied semi-structured interviews with individuals and a focus group to enable a detailed analysis of the work environment for HCAs.

Recruitment

An invitation letter, participant information sheet (PIS), and consent form were emailed via the unit manager as gatekeeper to all HCAs on the Unit staff email list and regular agency HCAs. Fifteen were recruited to the study so representing in excess of 40% of those who worked regularly in the unit. After the interview phase was complete, HCAs in the unit were again emailed to ask if they would be interested in joining a focus group. Eight responded but just 6 eventually took part, three of whom had taken part in the individual interviews.

Data collection

1. Interviews with HCAs

An interview schedule was developed based on generic workplace factors which articulated well with those in the Job Demands-Resources model at the core of this analysis 07). Additional questions specifically related to overall perception of stress, and to patient care.

Interviews were conducted at a mutually convenient time in a quiet room within the hospital but away from the wards. Consent and use of audio-recording was reaffirmed. Interviews lasted approximately 45 minutes.

2. Focus group with HCAs

A focus group was convened partly to seek confirmation of issues raised by the interviews but also to provide opportunity for further or more expansive insights to emerge. The group met after work hours in a room at the authors' university. Consent and permission to record the discussions was reaffirmed, 'group rules' were established to ensure equity in responding, and attendees were reminded of the need for confidentiality. The meeting lasted for 50 minutes facilitated by CU with AM present as notetaker.

Ethical Considerations

Main ethical concerns were confidentiality and anonymity. Only author CU was aware of the identities of responders, which were stored in a locked cabinet. HCAs who responded to the invitation to attend a focus group were sent a new consent form and PIS. All participants consented to the interviews being audio-recorded. Participant details were held confidentially, and all audio transcriptions and worksheets were anonymised using coded identifiers.

Participants were asked to confirm their consent before commencing their respective meetings and were also assured of anonymity in any dissemination medium. Ethics and R&D approvals were obtained prior to commencement of the study from the NHS Health Research Authority (IRAS 201685) and University faculty (FHSCE-DREP-17-003)

Data analysis

Transcriptions of individual and group interviews were analysed thematically following the framework of [18], commencing with familiarization of data by carefully listening to the audio recordings alongside notes made during data collection. Relevant quotes, information or descriptions were then extracted from the transcript and initially coded by author CU and corroborated by the other authors. Codes were secondarily collated into sub-themes and themes for interpretation [Table 1].

Rigour

Individual and group interviews took place in quiet and undisturbed locations and were audio-recorded. All analyses applied established protocol (Braun & Clarke, 2006) and followed criteria for credibility and dependability [19], for example by checking of transcriptions and of primary and secondary coding by at least two authors.

Post-hoc interviews with nurses

During the data analysis it became evident that numbers of negative comments from HCAs were directed at nurses in charge. This was important as it signalled inter-professional/interpersonal relationship issues between the two staff groups that went beyond what might be considered the general work environment for HCAs. A decision was taken to follow published suggestions that perspectives of both HCAs and nurses working as care teams should be taken into account [20].

With extended ethical consent and Trust approval, ten nurses were therefore recruited via an email from the unit manager to nurses on the staff list. The interview questions were restricted to just those themes/sub-themes that had appeared relevant to the interpretation of data from the HCA interviews (see Findings). Importantly, the nurses were not provided with a priori information as to the outcomes of the interviews with HCAs. Interviews took place 6-8 weeks after data had been collected from HCAs and lasted 20-30mins. As for HCAs, interviews were audio-recorded, with permission, anonymity and confidentiality were assured.

Findings

This section presents the interview and focus group data from HCAs regarding patient care and their work environment. This is followed by data from the interviews with nurses.

Individual and focus group interviews with HCAs

The following presents findings collated under three categories: Job demands, Job resources and Coping strategies. Main themes (9) mostly aligned with work environment dimensions that had guided the interview schedule, but in addition also to demands arising from patient care, and HCAs views on coping. The veracity of the emergent sub-themes was confirmed by the focus group. Selected illustrative extracts from transcripts are included in the narrative below and others are included in [Table 1].

Extract	Sub-theme	Theme
"Yea....vulnerability is a thing you have to look into and..because they are advanced in age they are frail so you have to put in extra effort and extra care, so that is why I said it is demanding" (HCA 5).	Frailty	Demands of patient care
"..with dementia clients or patients ..they have varying..characters they can exhibit depending on what might trigger each action at any particular time. You know, with dementia patients with cognitive impairments (they) are stressful and they are unpredictable" (HCA 6).	Unpredictable behaviour	
"Some of these patients, they are very strong.... I have been hurt several times" (HCA 7)		
..... I think it's not very nice to have a ward of say 20 to 30 patients for instance and you have like two HCAs to get them up.. it's not fair on staff. (FG participant)	Insufficient staff	Demands of the work environment
"I've worked ... in several mental health facets and ..the recommendation is that dementia clients require more staffing support than others.. I'm of the opinion that NHS hospitals do not provide that "(HCA 13).		
I think it's more on the people..doing the staff mix, for instance knowing if you are setting up your ward you should know if you are bringing on an agency or someone who is not regular on the ward. It's good to have people who are regular on the ward as well to just complement you.." (HCA 14).	Reliance on temporary staff/ Skill mix	
Sometimes you have to restrain patients who are aggressive so you might have staff ..who has not enough training or has not been given an experience. If.... someone just let go, that patient will just hit you ... it has happened on this ward with me. It's all about training and skill (HCA 5).		
"If you have inexperienced workers, that also increases stress because you end up teaching them other than having them assisting with the works", (FG participant)		
"..the shift patterns are horrible. We rarely have enough rest before going back to work. It's absolutely stressful (HCA 9).	Shift patterns	
"it would be easier for us to do long days than half days daily. It's killing. It's so difficult. The [another part of the region] don't do short days like us" (FG participant).		

..we know this thing, we should be telling you what to do. (HCA 7) 'The problem ..we face in most areas is when the roles are not defined. You know there is this job allocation that should be done.... When these roles are not defined this is when you see people playing around looking for what to do...(HCA 11) .. (nurses) say 'okay...you have a goal for that day, this is what we must achieve'.... but you have people who just (allow) free will....the roles are not defined ....we need more defined roles during shifts so that all hands can be on deck. FG participant	Decision latitude Role clarity/ definition	Control
..when people aren't working as a team and you are left to do everything by yourself whilst other people are sitting in offices...when you got to get people up washed and dressed, you always end up getting the same ones (nurses) sitting in the office and the other people doing all the work.... that is very off putting. (HCA 8)	Inter-personal relations	Relationships
..the mental disposition by some nurses is that they are only there to do medication... after doing medication they believe they are done for the day. They will go and probably sit down and be doing paper work and they will leave the rest of the work to the support worker" (HCA 6). When you are struggling, you won't want to ask for assistance (from a nurse) because the outcome or the way the person will turn you down will make you feel inferior or incapable so you won't want to ask. (HCA 6). "some qualified nurses, not all...they don't help out. They feel the work is only for HCAs" . (FG participant).	Inter-personal skills/respect	
I tell you what is the most stressful thing? ..It is the Bradford Scale for sickness. I've seen people coming to work and they have to be sent back (i.e. home).. they are unwell, they shouldn't have come in, but they were worried about their Bradford Score..It's like a threat, it's awful (HCA 4). "most nurses don't help us at all. HCAs even assist them in doing their own jobs. We are a team and we need to help each other. Dementia is chaotic, all hands should be on deck" (HCA15)	Managerial Team colleagues	Support
You just get on with it ha ha and (on night shift) pray that day break comes quickly", .(FG participant) ..you just get on with it, you gotta get on with it. You can't run away, can you? You don't have any choice, the work has to be done. (FG participant) "if we say something, nothing would be done, and if you keep on saying, your name would be crossed off if you are bank..... We've said things and nothing was done"(HCA 12) "Definitely, I never take anything home. As soon as I walk out that door, I don't need to think about patients or what's going on, no", .(FG participant) "I don't take it home. It's not that you don't care, obviously you have done what you could as soon as I leave I just so yeah someone else is taking them" .(FG participant) ..for me if I know I have the same shift the following day and I'm having the same group of people that I know during the previous shift. I orient.. them to what they should do, I'm comfortable and I'll ..go home and relax (FG participant). ..when I'm seeing another team of group of people who might be experiencing same thing as I did that night then, I can also talk to those taking over from us to have a review... if there is something they can do, maybe an extra staff or bring someone or swap with another regular. In that way when I'm coming back, I know the work is going to be easier than it was in the previous shift... I did that a few times (FG participant).	Pragmatic reality Compartmentalise work and home life	Acceptance Work-home balance

Table 1: Categories, themes, sub-themes arising from individual (n=15) and focus group (FG) interviews with HCAs, together with extracted examples. Others also in the narrative.

1. Job Demands

Evaluation of job demands related to two themes, that is, those presented by meeting the needs of patients and those arising from the work environment.

Theme1 Demands of patient care

Analysis identified two sub-themes: patient frailty and unpredictable mood changes. Frailty was equated with high patient vulnerability and this meant that HCAs had to apply effort across a wide spectrum of daily needs:

"..our patients obviously are elderly people and they obviously need our support in nearly everything, you know; toileting, ..bathing, washing, feeding and a whole lot, and you still have to do laundry for them obviously on eh daily on daily basis, you see, it's really difficult. You can't compare it with other wards". (HCA 15).

The demands of caring were highly stressful, complicated by patients' unpredictable moods including abuse or sudden aggression, and difficulties in communication:

"..the worst part of it is that sometimes they don't know you are helping them and they will start fighting you" (HCA10).

"..the challenging behaviour from the patients can also make work very very stressful. You're trying to express, you're trying to understand the patient, and eh the patient is in a different world". (FG participant)

When participants were asked to comment on their level of job stress responses varied from 'moderate' (at times) to 'very high':

"Yes, I would say working in a dementia unit is a stressful job to do, it's very stressful, yea. On a scale of 1-10 . I will rate it 9.5" (HCA1).

"...to be honest, sometimes it's like 5 but sometimes its 10..... [patients] change like every minute" (HCA 7)

These findings reflect the emotional labour that is associated with dementia care [21]. Despite this, the consensus from HCAs was that challenges from patients were to be expected and they were largely altruistic, summed up in this example:

"..they've lived their lives and at old age they really need to be taken good care of. But, I enjoy doing it. Personally, that's what I like to do" (HCA 3).

The implication therefore was that demands of dementia care are integral and accepted sources of stress for HCAs. In contrast, they perceived serious challenges within the work environment, illustrated by the following:

"..the nature of the [work] environment affects how I feel after some shifts; stressed, angry, tired you know.." (HCA 3)

Theme2 Demands from the work environment

Comments identified four sub-themes. HCAs experienced high workload (Table 1) largely attributed to staff shortage. Insufficient staffing at times introduced concerns that care might be compromised:

"Sometimes, I'm very concerned because some of the ehm residence or patients we have ehm, have challenging behaviours so eh...m, when you are going to work and you know you have such huge number of people to deal with and different presentations, yea, you get worried". (HCA 8)

Staff shortage also was perceived as being detrimental to staff allocation to the teams. HCAs did not know who they might be working with until arriving at the unit:

"When you see the rota it can make you either happy or sad. If you are on with a good team you are happy about it. Sometimes when I look at the rota I just smile because I know it's gonna be a good night". (FG participant)

".. I'm not worried working with patients with dementia but sometimes what worries me is the people I'm working with" (HCA 2).

This study had invited agency staff familiar with the ward and an important issue here was increased reliance on inexperienced new, temporary (or new, substantive) staff who reduced the efficiency of the team, for example:

"I worked on a shift where the nurse and my other HCA were agency and it was as if I was alone on that shift". (FG participant).

Shortage of substantive staff also contributed to poor shift work patterns, associated with impacts on HCAs' well-being (Table 1). Short shifts especially were considered to compromise the quality of time away from the workplace, for example:

"I do not have enough out of work hours after a shift. Knowing I'll be going back to work in few hours and with the same patients, and probably staff who are not very helpful, I think we just need more time off the ward for ourselves, families.." (HCA 14).

2. Job Resources

Job resources were collated within 5 themes generally aligned with recognised workplace dimensions [22]: 'Control', 'Relationships', 'Support', 'Role clarity' and 'Change'.

Theme 3 Control

HCAs look towards nurses to allocate work activities for their shift. They lack autonomy and so have little or no input into decision-making and this can cause frustration for them when working with a patient:

"..some of the decisions we make..it might take a long process If a client is supposed to be on a higher level of observation due to their behaviour, and to keep other clients safe...I can't put the client on a level of observation like three to four without a doctor or other professional group's input" (HCA 6)

Poor team leadership from nurses was also a strong sub-theme for interviewees as it left them feeling disorganised and confused. Communicating their work activities was therefore very important, for example:

"The easiest shifts I have are the ones where communication at the beginning of the shift has been clear and concise. ..Whoever is in charge of a shift needs to let everybody know in a nice way what they want done, and that makes for a good shift, definitely...[so] you know exactly where you are and what you are doing and who's doing what." (HCA 11).

But comments also extended to some nurses' lack of organising skills:

". it depends on the nurse handing over. If ..the service users' presentations need more hands then ..he's supposed to tell the Bleep Holder or the ward manager so that they provide extra staff...[if available]...but if the nurse did not make adequate provision then you have no choice. The nurse I worked with that handed over to us didn't manage that situation very well" (HCA 6).

Theme 4 Relationships

The benefit of a positive team spirit was recognised (Table 1)

"Good team spirit helps a shift go well. Even if you are short staffed but the staff on ground is willing to work, it makes it go well" (HCA 4).

but concerns as to team functioning were noted:

"As a team, at least you have only one set of people to deal with who are the dementia patients but if you are not working as a team, you got two sets of people to deal with". (FG participant)

HCAs commented very strongly that inter-personal relations were often poor, largely blaming nurses for poor leadership (above) and lack of assistance even when needed. For example (Table 1)

"When they [nurses] are not very busy, what stops them from toileting a patient?" (HCA 12)

Relatedly, nurses were considered frequently to be absent from the ward. One HCA identified that this might be inevitable because they have excessive administrative duties:

"nurses are definitely under pressure...to ensure that every paperwork is completed. Apparently ..this is pressure coming from top management, CQC and government" (HCA 12).

But most were cynical and suggested that completing paperwork provided a convenient distraction for nurses to minimise their time on the ward. For example (Table 1)

"There are some staff [nurses] who came to do paperwork...yea.. they find things to do....they look for things." (FG participant).

One HCA claimed that this could potentially have detrimental patient outcomes:

"Could you imagine nurses leaving patients in need..just to update their paperwork? But this happens all the time. Not nice at all." (HCA 2).

Further, this situation was aggravated by some nurses considered to have poor inter-personal skills (Table 1).

"Some (nurses) don't have good interpersonal skills. They delegate roles to you as if you are a nobody, as if you are a robot". FG participant

Theme 5 Support

Within the teams, HCAs generally considered themselves supportive of each other though one suggested that this was not universal:

"To be honest, some health care assistants shy away from work. They are lazy and do unimportant stuffs, leaving the important ones. It could be so sad to work with such people. Even the nurses..don't like working with them" (HCA13).

However, it was perceived lack of support from nurses that attracted most comments. This was evident under the theme 'Relationships', above, but a lack of support, whether directly or indirectly, permeated HCAs views of the work environment, for example poor leadership and lack of direction, noted above. Additionally, lack of concern and/or support from managers for an individual's personal well-being was strongly criticised by some, for example:

"I had no support, nothing (after a patient injured the HCA's hand). No. I was left literally...seeking support somewhere else from other than my own team" (HCA 4)

This HCA's issue was not the injury itself but rather the perceived lack of acknowledgement of the serious effect it had on him after the event. This apparent lack of concern was exemplified further by what HCAs considered poor management of staff sickness absence. This is monitored using the 'Bradford Score' of absence, a tool which HCAs strongly perceived to be misused by pressurising staff to coming to work despite them feeling unwell or over-stressed (Table 1).

Theme 6 Role clarity

Role clarity, a problem HCAs had indirectly related to disorganisation and poor leadership, above, was considered to be diminished by poorly defined activities:

"The problem with the stress we face in most areas is when the roles are not defined..... When these roles are not defined, this is when you see people playing around looking for what to do..Some dedicated ones are stressed and it helps more when people know what to do, when to do it and how to do it" (HCA 11).

Frequent reliance on inexperienced agency staff also risked imbalance in the skill mix profile of the team, meaning that HCAs had to take on training or supervisory roles:

"Staff who don't know the ward or our patients are a bit of pain really. You've got to show them literally everything and that is difficult when you've got stuffs to do, really" (HCA 14).

Theme 7 Change

Few comments from HCAs referred to organisational change, and those that did suggested they were reconciled to a view to not being consulted about developments and change in practices. For example, whereas one focus group comment had suggested a possible, positive action to move the situation forward.

"..a regular feedback or forum where one can put in suggestions, one can put in comments, one can put in your complaint, one can put in your observation... not only ...a suggestion box.., but a functional one" (FG Participant).

others in the group were sceptical of the likelihood of success (Table 1).

3. Coping

In addition to verifying interview outcomes, identified in the extracts above and in Table 1, the focus group were asked to comment on how they managed their stress. HCAs appeared reticent to discuss coping strategies but comments made pointed to two themes: 'Acceptance' and 'Work-Home balance'.

Theme 8 Acceptance

HCAs appeared reconciled to their work situation as being a pragmatic reality of working on the unit. The main strategy for coping was one of acceptance of challenges within a difficult job but taking short, unscheduled recuperative breaks whenever possible, for example:

"you just get on with it, you gotta get on with it. You can't run away, can you? You don't have any choice, the work has to be done. You just get on with it", .(FG participant)

"I take 5 minute breaks at work and that helps. I think .. more breaks should be encouraged in this job really, it's so stressful" (HCA 10).

Theme 9 Work-home balance

Some participants felt that they were able to compartmentalise work and home life so making a clear distinction between work and home (Table 1). However, they were not forthcoming as to just how, or if, they were able to mentally 'switch-off' after their shift. Respite was acknowledged as only temporary:

"preparing my mind for anything and on my off days, I take my mind off work, in order for me to relax. Coming back to work, I prepare myself ahead of the shift in case the staffing strength is low. I prepare myself psychologically to go through my shift" (FG participant).

but two participants did suggest a more constructive approach by trying to anticipate problems and take steps to ensure that unresolved care issues had not been left behind after a shift (Table 1).

Category	Theme	Sub-theme	Extract
Job Demands	Demands of patient care	Frailty	It's mentally draining [and] very physically challenging because of the patients [who have] high physical needs and on the ward (Nurse 2)
		Unpredictable behaviour	"it's really difficult to manage [the patients] because they are unpredictable" (Nurse 3) "the worst part of it is that sometimes, they don't know you are helping them and they will start fighting you" (Nurse 10)
	Workload	Insufficient staff	"But ehm overall, I think it's more of nurse staffing on the ward that's causing a whole lot of problems" (Participant 9); "..Nursing workloads need to be cut down or better still, eh bring in more staff" (Nurse 9). "it's just so difficult to manage 17 to 18 patients on the ward and you still have families to deal with. Sometimes, we spend a whole hour or more attending to family needs for the people...without helping people on the floor to do other things" (Nurse 10)
	Dependence on agency staff	Skill mix	"...some of these agency staff, they are not trained" (Nurse 4) "...if the [agency] staff are not knowledgeable enough to know how to support clients... then it affects the whole team, it becomes like a ripple." (Nurse 8)
	Shift patterns		"imagine after a late shift and going back at nine o'clock at night, sorting yourself out and getting up again at five in the morning for an early shift" (Nurse 2)

Job Resources	Relationships	Inter-personal relations	"Some HCAs do not like it when you are firm ...but you are more responsible as the nurse in charge of shift and ...you're going to get people who are going to talk behind you. (Nurse 2) "They [HCAs] could do anything and get away with it but I've got PIN (registration) to protect. Some of them do understand and appreciate that..they can understand why you do certain things. But some of them, most of them, I can tell you, they think they are not being respected" (Nurse 8). "Few [HCAs] understand the fact that you are responsible" (Nurse 2) "HCAs who have been there for a long time, sometimes they will tell you hey, this person needs Lorazepam and they would be telling you what to do. But you are here to protect your registration, you are there to do your job so you don't need to be told what to do by a HCA" (Nurse 7) "With the HCA, it's ..somebody who's been there for 15 years and you've just done University for 3 years, now you are commanding them" (Nurse 6)
	Team leadership		"The only people we have problems with are the HCAs because some of them don't want you to tell them things to do" (Nurse 1) "As RMNs, one of our duties is delegation. Now, when you delegate work to HCAs, some of them don't do it whilst some will do it reluctantly. It's just so difficult." (Nurse 9). "if you don't have good personal relationship with HCAs they can frustrate you. You as a nurse, you can delegate duties but HCAs won't do them." (Nurse 10) "Allocating roles or telling [HCAs] when jobs are not done as the nurse in charge only means that I'm doing my job but most of them don't take it well. Sometimes, these HCAs are even difficult to work with. Some feel demeaned whilst some have a lot of ego and always want to show you they know; no team support" (Nurse 10)

Table 2: Post-hoc interview comments from nurses (n=10) related to selected themes and sub-themes from Table 1. See text for explanation.

Nurses agreed that patient care was very stressful, for example:

Yes, it's stressful. I'll put between 9 and 10" (Nurse 7)

They corroborated comments made by HCAs as to the need for more staff, for example:

"But overall, I think it's [lack of] nurses on the ward that's causing a whole lot of problems" (Nurse 10)

As with HCAs, difficulties included the impact that subsequent reliance on temporary (agency) staff had on the skill mix of the team (see Table 2). Likewise the negative impact on shift work patterns.

Nurse 3 acknowledged that her colleagues could be unsupportive, noting as HCAs had that

"Obviously some nurses are so lazy, claim to be doing paper work that never finishes and not helping other staff on the floor... its really that bad."

but continued by highlighting the complexity of administration that nurses have to manage:

"It's like more work and everything has to be documented.... You are targeting the time frame 'oh, I phoned family at 10 o'clock...doctor at 2 o'clock...bleeped the doctor 10 o'clock...again because there was no response. The doctor came at 10:20 am, family informed again, everything has to be documented ...if there's any adverse result, it comes down to what have you done. And if it is not documented, it was not done" (Nurse 3)

That responsibility was not acknowledged by the HCAs and indeed had been dismissed by most.

Regarding inter-personal relations, nurse 6 noted a high level of satisfaction when the team worked well:

"Sometimes you have these HCAs…they come down, the shift goes smoothly, they clean the board, get the book, bring the patients out, do their laundry…some.don't even wait for you to direct them, they go straight (and) before you know it they've finished" (Nurse 6)

But then added a post-script that was echoed by other interviewees:

"..but some just want to make the situation difficult for you".

(Table 2) also identifies comments supporting HCAs' views that team working was problematic. However, perceptions were very different as to the cause. Thus, nurses strongly identified that HCAs could be negative and difficult, being resistant to work allocation particularly when the nurse was deemed less experienced than those they were delegating the work:

"With the HCA, it's somebody who's been there for 15 years and you've just done University for 3 years, now you are commanding them" (Nurse 6)

This negativity was often interpreted by nurses as indicative that HCAs lacked appreciation of their responsibility and accountability for patient care and, relatedly, a need to protect their professional registration **(Table 2)**. This was summed-up in the following comments:

"HCAs who have been there for a long time, sometimes they will tell you 'hey, this person needs Lorazepam' and they would be telling you what to do. But you are here to protect your registration, you are there to do your job so you don't need to be told what to do by a HCA" (Nurse 7)

"They [HCAs] could do anything and get away with it but I've got my PIN (registration) to protect. Some of them do understand and appreciate that..they can understand why you do certain things. But some of them, most of them, I can tell you, they think they are not being respected" (Nurse 8).

Discussion

National austerity measures introduced in the UK 2008-2019 had serious negative impacts on staffing and resources [14]. The aim of the present study, conducted in 2018, was to evaluate the workplace environment for HCAs working in an in-patient dementia care unit after almost 10 years of public sector finance cuts, including to the NHS.

Support workers (mainly health care assistants, HCAs, in the UK) make a key contribution to delivery of dementia care, which presents significant challenges [1,2] that risk job stress and related ill-health [3]. In this study HCAs (and nurses) reported moderate, often high, stress but were altruistic in that respect consistent with findings of others [6,16]. It was additional sources of demands from the work environment that HCAs considered most problematic. An impact of staff shortage was evident throughout much of the present data: high workload, a negative influence on shift patterns, and a reliance on agency staffs that often were inexperienced and need their supervision. [16] Also identified in their study that HCA staffing (and nurses) was inadequate.

Deficits in job resources may themselves present as job demands [23] so exacerbating the pressure from high workload. Poor relationships between HCAs and nurses were of particularly high concern, a situation which HCAs largely attributed to nurse colleagues. In particular, they identified poor inter-personal practice from nurses, criticism of work allocation by nurses to HCAs, and poor support on the ward from nurses. Excessive paperwork for nurses, dismissed by HCAs as a convenient distraction, exacerbated HCAs' perceptions of poor team leadership. However, nurses in the post-hoc interviews made strong comments regarding the high administrative loads that they have, so suggesting that misunderstandings may have added to this image of poor within-team collaboration. Further evidence of this came from nurses who identified negative attitudes of HCAs that made work allocation to them very difficult, citing comments from HCAs that nurses were disrespectful of their care experience. [6] Suggested that HCAs might promote self-worth as a response to a perceived marginalisation in health care. However, nurses in this study also identified a lack of appreciation by HCAs that it is they who are accountable and have to meet responsibilities in order to protect their professional registration.

For HCAs, therefore, high demands of dementia care were exacerbated by perceived ineffective leadership, poor support, and poor collaborative working, compounded by a lack of decision-latitude, and poorly-defined roles. The picture therefore is one of high demands and poor job resources. Much of this was related directly or indirectly to staff shortage but it was made worse by misunderstandings within the teams of staff group roles, capacities and responsibilities, and perhaps by poor interpersonal communication skills.

The Job Demands-Resources framework [17] suggests that there is always risk of job strain in work places where there is an imbalance of high job demands and low job resources. The significant imbalance apparent in this study suggests that HCAs were may have been predisposed to having difficulties in completing their work, to emotional disengagement from it, and decreased

productivity [24,25] factors that are linked to burnout [26]. Some of the tension might be reduced if HCAs' skills and experience had better recognition by having more input into decision-making. As support workers HCAs have to respond to decisions made by nurses (and doctors) and their lack of autonomy in that respect was an issue for them especially for those who had a lot of dementia care experience. In [2] suggested that training of HCAs, especially those with considerable experience, would enable them to contribute to care rounds and to engage with clinical issues for individual patients. Such training might go some way to improving the team ethos but present findings suggest that little has changed for HCAs in the intervening 10 years or so, at least at the study site.

Strengths and Limitations

Sample size was modest and so findings may have been influenced by some participants self-selecting on the basis of negative experiences. This couldn't be ascertained but the local focus meant that the sample of HCAs still captured around 40% or more of those registered or familiar with the unit, a reasonable snap-shot of this single site. Additionally, introduction of a focus group that included HCAs who had not been interviewed confirmed many of the findings.

Another strength is that *post-hoc* introduction of interviews with nurses added more insights into interpersonal relationships within the teams, revealing what appeared to be mutual misunderstandings between HCAs and nurses of their respective roles and skills, experience, and responsibilities.

Nevertheless, findings cannot be generalised to other organisations. Stress priorities are affected by the local context and current socioeconomic climate [27,28] and so practices, resources and stress-management are likely to differ from the study site. However, a difficulty within the host site in recruiting/retaining HCAs was not atypical of similar dementia care units which have also experienced serious reductions in funding over the last 10 years or so. Present findings therefore may have a degree of resonance with settings elsewhere coupled with the fact that generalizability in qualitative study encourages transferability of methods and knowledge and should not be misconstrued with that of the quantitative study.

Relevance to practice

Present outcomes suggest occurrence of structural workplace and psychosocial issues developed over a considerable period of time, arising during the austerity period in the UK. Findings suggest that interventions are urgently required to moderate impacts of staff reductions by improving staff support. The respective roles of both HCAs and nurses are integral to team delivery of quality patient care but the ethos at the core of effective team working was markedly deficient in this study. In-group behaviours can present an obstacle to inter-personal working [6] so fostering intimidation, impoliteness and complaints [29,30]. More thoughtful approaches to skill mix in the teams would help to reduce the supervisory burden on HCAs, while improvement in communication between nurses and HCAs, and vice versa [31-36], would go a long way to removing misunderstandings between the two groups. Alongside that, giving HCAs more say by providing training to enable them to contribute to discussions concerning the care of individual patients would recognise (for some) their considerable experience in dementia care.

Conclusions

The last 10 years have seen effects of austerity measures on job dissatisfaction and staff turnover in the NHS. Dementia care is itself very challenging, but in this study staff shortage subsequently saw increased workloads, unpopular shift patterns, and reliance on temporary staff, that have added to the demands on HCAs. Perceived deficits in team leadership, inter-personal relationships, and role definitions, plus lack of input into decision-making commensurate with their status as support workers, also contributed to what appeared to be a very complex and difficult work environment. Job resources for HCAs were insufficient and stressful as a consequence, indicative of a significant need for intervention to reduce the exposure of HCAs to elevated risk of stress-related ill-health.

The situation likely accrued over a period of time and current findings likely have some resonance with experiences of other dementia hospitals across the NHS over the last 10+ years. Staff shortages are unlikely to be resolved in the near future but a message from this study is that managers in particular should monitor and deal with psychosocial tensions, and in-group behavioural issues, before rather than after they become established. Enabling training for HCAs to have more decision-latitude in their role, supporting better inter-professional communication and understanding of responsibilities, and enabling access to personal stress management, potentially could help this staff group.

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