

What Should Be the Roles and Training Needs of Health Care Assistants/Nursing Auxiliaries in Nigeria? A Critical Realist Review

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Abstract: Healthcare is viewed as a service provided by health workers in order to satiate the pressing health needs of a population. It is however, difficult and in extreme cases, impossible to achieve this without an adequate supply of the health workforce as health cannot exist without a workforce.

This dissertation focuses on a branch of Nigeria's health workforce called the nursing auxiliaries otherwise known as health care assistants (HCAs), nursing assistants and nursing aides. Nigeria was chosen because it is the writer's country and based on observed evidences, literature and anecdotes, auxiliaries in Nigeria lack training despite the fact that they work in mainly private hospitals where they are substituted for nurses, performing simple to complex roles.

A critical realist review is therefore applied in this paper to explore what the roles and training needs of nursing auxiliaries in Nigeria should be, identify their relevance in the health sector and make recommendations for future service improvement and advancement in nursing practice in the Nigerian as well as the universal health system.

These aims will be achieved through extensive search of relevant literature, policies and theories while comparing practices in different countries and drawing on exemplary strategies adopted by countries in the training of HCAs. Personal, educational and professional experiences have also contributed to the dissertation process.

The paper concludes with the dissertation achievements which include recommendations for a training programme for nursing auxiliaries in Nigeria, some preliminary plans on the project implementation and suggestions on maintenance of healthcare practices through regular monitoring and supervision.

An adequate supply of appropriately educated and motivated health care workers is therefore, needed in a population to promote and maintain a high quality of health.

Keywords: health care workers, Health Care Assistants, nursing auxiliaries, health system.

Abbreviations	-	Meaning
AIDS	-	Acquired Immune Deficiency Syndrome
ANA	-	American Nurses Association
ANM	-	Advancing Nursing and Midwifery
ANP	-	Advanced Nursing Practice
BBC	-	British Broadcasting Corporation

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CR	-	Critical Review
CRR	-	Critical Realist Review
CSC	-	Communication Skills Checklist
EBM	-	Evidence-Based Medicine
EBP	-	Evidence-Based Practice
EFH	-	Evidence for Health and social care
EI	-	Emotional Intelligence
GDP	-	Gross Domestic Product
HCA	-	Health Care Assistant
HIV	-	Human Immuno-deficiency Virus
HRH	-	Human Resources for Health
HSC	-	Health Service Commission
ICN	-	International Council of Nurses
JBI	-	Joanna Briggs Institute
LTC	-	Long Term Conditions
MOH	-	Ministry of Health
NHS	-	National Health Service
NMC	-	Nursing and Midwifery Council
NMCN	-	Nursing and Midwifery Council of Nigeria
NNPC	-	Nigerian National Petroleum Corporation
NP	-	Nurse Practitioner
NVQ	-	National Vocational Qualification
PDSA	-	Plan, Do, Study, Act
PICo	-	Population, phenomenon of Interest, Context
PICO	-	Participants, Intervention, Comparison, Outcome
RCN	-	Royal College of Nursing
RCTs	-	Randomized Control Trials
SDG	-	Sustainable Development Goal
SIT	-	Social Identity Theory
SPC	-	Statistical Process Control
SR	-	Systematic Review
SSA	-	Sub-Saharan Africa
SWOT	-	Strengths, Weaknesses, Opportunities and Threats
TLH	-	Teaching and Learning in Health and social care
TOWS	-	Threats, Opportunities, Weaknesses and Strengths
TPN	-	Theory and Practice of advanced Nursing
UK	-	United Kingdom
USA	-	United States of America
WHO	-	World Health organization

Terminologies

Care certificate: a document of a set of standards that health and social care workers adhere to in their daily practice to ensure competence

Competency-based training: an approach to teaching and learning whose focus is on concrete rather than abstract skills acquisition

Critical review: a research method that seeks to critically analyse literature and social interventions through exploring various policies, theories and literature in different fields

Critical realist review: a critical review that studies the underlying causes of phenomena and focuses more on the normative i.e. 'what should be' whilst also considering 'what is'

Epistemology: a branch of philosophy that studies what constitutes knowledge, beliefs and truth

Feminism: a theory that advocates a higher level of equality for women

Intransitive: the physical and social world people live in

Nursing auxiliaries: health workers that assist nurses in carrying out delegated tasks under supervision. Also called health care assistants and nursing assistants/aides

Ontology: a branch of philosophy that studies the nature of existence and being

PDSA tool: a tool used to guide project implementation

Realism: a theory that studies causal factors that cannot be seen, but are believed to influence behaviours. It focuses on the real i.e. 'what is' rather than 'what should be'

Stakeholder analysis: an analysis of individuals or groups who might influence, be involved in, or affected by a project

SWOT analysis: analysis of strengths, weaknesses, opportunities and threats that might affect project implementation

Task-shifting: re-distribution of tasks where specific roles in healthcare are moved from qualified personnel to less qualified workers in order to improve on the human resources for health

The actual: concerned with what will happen when real powers are activated

The normative: concerned with activities that affect social justice; suggests 'what should be'.

The real: concerns the characteristics of objects or interventions and their causal factors

TOWS matrix: a tool used to convert threats to opportunities and weaknesses to strengths when planning project implementation

Transitive: theories, values and beliefs held by people in order to understand the physical and social world

1. INTRODUCTION

The health of a community is often associated with its wealth, and vice versa (Ekins, 1986; Bloom and Canning, 2000; Deaton, 2002); however, what constitutes 'wealthy health' is seldom stressed, especially in developing countries such as Nigeria. An early work by Culyer (1971) presents healthcare as a product or service provided by health workers in order to satiate a population's health needs. When there is an inadequate supply of qualified and trained personnel providing this service, it is arguable that the service will be substandard, leading to poor health and dissatisfaction of service-users.

As the World Health Organization (2013) maintains that health cannot be achieved without a workforce, this paper focuses on a branch of the Nigerian health workforce called the nursing auxiliaries, also known as health care assistants (HCAs), nursing aides/assistants. Nigeria was chosen because it is the writer's country. According to Fawole, Hunyinbo and Adekanle (2009), nursing auxiliaries in Nigeria function mainly in private hospitals where they perform the roles of nurses without undergoing any kind of formal training. This has also been experienced by the writer, as inappropriate practices (discussed later) that endanger the lives of patients were observed which can be attributed to their lack of

training. Conversely, service-users feel safe in the hands of trained personnel as this assists them in gaining independence over their health and wellbeing (Carayon ,2016).

A critical realist review is used in this dissertation to explore the roles and training needs of this group in the Nigerian context by making comparisons in different countries across the globe and identifying ways that a training programme could be introduced for them through adopting and modifying practices that will soothe the Nigerian context, whilst analysing potential barriers to the project. Relevant theories and literature are also applied for proper understanding of concepts. The fact that health care needs are speedily increasing and the healthcare system requires more hands to provide care, should make the training of health workers a priority. The health of a nation becomes wealthy when the government and the people invest in it and ensure its quality-in this case, training and sustaining a sufficient and competent workforce.

This section gives an introduction to the entire dissertation which asks the question *'What should be the roles and training needs of health care assistants in Nigeria?'* The dissertation comprises of five chapters: the first chapter deals with the background to the topic, history of nursing in Nigeria and the United Kingdom (UK), aims and objectives, rationale for the topic, global comparisons of HCA trainings and roles and the relevance of the dissertation to advanced nursing practice. Chapter two will discuss the themes of the dissertation with the aid of relevant literature and theories in view of discussing emergent themes later in chapter four. Chapter three gives a clear view of the methods and methodology (critical realist review) with justifications, as well as an explanation of the research question and search strategies. Emergent themes and theories will be discussed in chapter four with a wider view of the dissertation topic, involving empowerment, politics and power. The problem will further be identified and analysed while references will be made to observations and general information acquired by the writer. It will also discuss the writer's preliminary future implementation plans for the training programme of HCAs in Nigeria.

Finally, chapter five will draw inferences from the entire dissertation and give a comprehensive conclusion. Recommendations will be made for future service improvement in Nigeria and the global health system. The section will also reflect on the writer's achievements throughout the advanced nursing programme as it connects with the dissertation work. Strengths and limitations of the project will also be identified.

1.1. Aims

This paper aims to:

- Explore what the roles and training needs of HCAs in Nigeria should be
- Identify their importance in health care
- Provide recommendations for future implementation of training, licensing/registration of this group

1.2. Objectives

The aims of this paper will be achieved through:

- Extensive search of relevant literature, policies and theories
- Comparing global trends on the topic and drawing examples from global healthcare practices
- Incorporating experiences from the Advancing Nursing and Midwifery (ANM) in a global context module for service improvement.

1.3. Relevance to Advanced Nursing Practice (ANP)

This dissertation is expected to make contributions to the advancement of nursing practice in Nigeria and internationally. The nursing profession has been viewed as a second or even third class when compared with other professions and this stems from the social image painted by the public (Kelly, Fealy and Watson, 2012) who seem to have misunderstood the true essence of nursing existence i.e. quality patient care. Internationally, nurses have begun to work towards consolidating their identity and advancing practices in terms of education, autonomy, evidence-based practices in order to improve patient care (Hoeve, Jansen and Roodbol, 2014).

This paper therefore, openly discusses the struggles faced by the nursing profession from its inception to present, encouraging nurses to empower themselves and support the HCAs to be trained as they are part of the nursing family. With their training, they will have a sense of belonging, accountability and competence in carrying out their roles of healthcare.

Themes: Nursing, training, education, HCAs/auxiliaries, competence, accountability, registration, regulation, service-users.

1.4. Background-Nigeria

An introduction to the writer's background is essential to understand the passion behind exploring the roles and training needs of HCAs in Nigeria.

Located on the continent of Africa, Nigeria is one of the western sub-Saharan African countries, with a growing population of over 182 million, making it one of the largest in the continent (Central Intelligence Agency, 2015). Nigeria is made up of 36 states in the north, south, east and west; Lagos (in the west), with a population of 21 million, being the mostly populated (World Population Review, 2015). The health care system is divided into primary, secondary and tertiary levels, under the control of the local, state and federal governments respectively (Ukwaja, Alobu, Nweke and Onyenwe, 2013). According to Abiodun and OluAbiodun (2014), all patient services are being provided by the public and private health sectors; however, the private sectors are run mainly by physicians. Despite the expensive nature of these private hospitals, Dekker and Dijk (2010) maintain that they are of less quality when compared to the government sector. The writer believes that this could be attributed to the presence of untrained auxiliary nurses who are employed in place of registered nurses in the private hospitals due to shortage of nurses and quest for cheap labour.

Based on the writer's experience as a staff nurse in one of the private hospitals in Lagos- consisting of 16 auxiliary nurses and 2 nurses, auxiliary nurses are allowed to perform all nurses/midwives roles e.g. taking deliveries and performing male circumcisions without undergoing any formal training. The rationale for the dissertation will therefore be discussed in order to understand the need for training HCAs in Nigeria.

1.5. Rationale for Dissertation

Healthcare is a major global concern; however, it cannot exist without a workforce (WHO, 2013). There have therefore been iterated emphases on training and improving the skills of the workforce to enhance quality of life (eg. Rowe, De Savigny and Lanata, 2005; Chinn and Kramer, 2014). This section will explore global trends on health in order to provide a basis for the topic interest.

1.5.1. Global Evidence on Health Workforce

With a demographic increase in the aging population, an epidemiological shift from infectious diseases to Long-term conditions (LTCs) and drug-resistant infections, Crisp and Chen (2014) stress that there is a high demand for health care world-wide. To buttress this point, Sustainable Development Goal (SDG) 3-section 3.c of the 17SDGs that Buse and Hawkes (2015) emphasize their importance, draws attention to the relevance of recruiting and maintaining a solid health workforce that will assist with the growing health needs of the population. Presently, the World Health Organization (2016b) records a health workforce reduction of about 4.3 million; this reduction, mainly affecting the SSA region that has a ratio of below 30,000 health professionals per 10 million population as opposed to the developed regions with above 60,000 professionals per population of 10 million (WHO, 2011 as cited in Hunter and Fineberg, 2015). WHO (2016d) further estimates an 18million reduction in the health work force of developing countries by 2030 despite the growing need for health sector jobs. It is however ironic that the regions with the greatest need for health care lack sufficient human resources to meet those needs.

1.5.2. Contributors to Health Workforce Shortage

Among factors such as bureaucracies surrounding recruitment of health professionals and loss of health workers to deadly diseases e.g. HIV/AIDS in the SSA region, migration majorly contributes to the shortage of health workforce (Dovlo, 2007). Dovlo (2007) further expatiates that most health professionals in developing countries move to developed or urban regions in search of greener pastures due to 'push and pull' factors. According to Kline (2003), push factors are

influencing factors that encourage one to leave home e.g. poor wages, while being attracted to pull factors e.g. job satisfaction found in recipient regions.

In order to deal with this problem affecting 57 countries, a global health workforce alliance of multi-sectoral stakeholders was formed in 2006 (WHO, 2016a). The alliance adopted the global code of practice in 2010 which encouraged voluntary responses by member states to this issue, by developing strategies essential to curb emigration of health workers to recipient countries (WHO, 2010).

A recent study by Dambisiya, Malema, Dulo and Matinhure (2013) shows that only a few countries in different parts of Africa have begun to adopt these strategies though not much has been achieved in the past few years. With the great burden of diseases such as HIV/AIDS in South Africa, the government reviewed its human resources for health (HRH) strategies and adopted the concept of task-shifting by training lower-level health workers to help with the issue of health personnel shortage (Gilbert, 2013). This initiative, according to Gilbert (2013) resulted from the need to train more doctors and nurses/midwives whose training will take a long time; hence the need for a quicker alternative to meet the pressing needs of the population. Similar practices have been recorded in Kenya, Malawi, Uganda, Tanzania and Mozambique as Fulton, Scheffler, Sparkes et al. (2011) believe that it is cost effective and less time-consuming to make use of the lower cadre workers; however, they stress that lack of proper training of this group can lead to irreparable damages on the health and economy of a country.

One of Nigeria's neighbouring countries that revised its HRH strategies is Ghana. Delucas (2014) records that Ghana faced a national health workforce shortage as trained professionals were being recruited by countries in the developed world. Just as other developing countries, Ghana 'exported' health professionals, especially nurses, without importing any. This led to high mortality rates and increased burden of disease in Ghana. However, following the proposed WHO code of practice, Ghana tightened its workforce policy and began to train nursing assistants who are unique to Ghana alone; giving them a competency-based training which has helped to improve their general healthcare system (Appiah-Denkyira, Herbst,

Saucat et al., 2013), for instance, there has been a significant decline in infant mortality from 64/1000 to 41/1000 over the past 10 years (Dogbevi, 2015)

A challenge of this approach of recruiting lower-cadre health workers is stressed by Darko (2015) in a *British Broadcasting Corporation Africa* report, that the Ghanaian government has gradually neglected the qualified nurses/midwives and has embraced cheap labour, leaving the professionals jobless. The writer believes that this challenge is firstly, due to inability of the government to regulate training of both nurses/midwives and nursing assistants. Secondly, there are no set standards on the nurse: nursing assistant ratio and nursing assistants being under the supervision of nurses, which has led to unequal distribution of both cadres. Supervision is important since they (assistants) have less training than the nurses.

1.5.3. Workforce Shortage in Nigeria

The issue of workforce shortage has lingered over the years in Nigeria. It is recorded that over 50% of the Nigerian population lives in rural regions where there exists insufficient number of competent health workers (Awofeso, 2010). It is not surprising that whenever the issue of insufficient workforce is raised (especially in African regions) the entire blame is on the popular 'brain drain' phenomenon (e.g. Mountford, 1997; Docquier and Rapoport, 2012); yet, the reason behind the massive exodus of health professionals from poorer to richer regions is rarely paid attention to. When a working population decides to leave its original country and move to another country for the same type of work, it means the receiving country has better opportunities to offer (Dywili, Bonner, O'Brien et al. 2013). Nonetheless, when it is impossible for them to migrate, due to policies or restrictions, they tend to move to other satisfying jobs and businesses (Okwaraji and Aguwa, 2014).

Nigeria has been a major oil producing country in the world and presently produces about 2.5 million barrels per day, needless to mention that the gas production in 2010 (1,681.66 billion scf) supersedes that of present oil production (NNPC, 2016) and is likely to have increased since then. With this data, it is expected that Nigeria should be one of the world's richest countries; however, the reverse is the case. With the shattered economy and political instabilities (Inekwe, 2013) it is nearly impossible to maintain a strong health workforce. Though Anyangwe and Mtonga (2007) propose

training of more health workers to combat workforce shortage, this might be difficult to sustain in a country where politicians, who can afford to go abroad for their health care (Nairaland Forum, 2012), do not count it as priority to work towards improving their own country's health care system. On the other hand, some Nigerians seek foreign healthcare due to an abandoned Nigerian healthcare system (News Africa, 2016)

In 2014, Nigeria's total expenditure on health as percentage of gross domestic product (GDP) was 3.7 with a total health expenditure per capita of \$217 and a population of over 182 million (WHO, 2016c). When compared to the UK that has a population of nearly 65 million, a total expenditure on health as percentage of GDP of 9.1 and health expenditure per capita of \$3,377 (WHO, 2016e), it is no wonder that the UK is ahead of Nigeria and most countries in terms of health care delivery (Schoen, Osborn, Huynh et al., 2006). Nigeria is a representation of some other African countries that are in the same situation where hospitals lack adequate facilities and encouragements for staff (Anyangwe and Mtonga, 2007). The writer therefore believes, that until the Nigerian health care sector is paid proper attention to, workforce shortage will continue. There is therefore a need for reviving the health sector and promoting the training of auxiliaries as they play a major part in the health system.

This paper will give a brief and summarized account of nursing progression in the UK and Nigeria to provide an understanding of the need for HCAs and why their training is essential in the health sector. Because the writer has observed the health system in the UK, it was chosen to compare practices in the writer's country.

1.6. Nursing History in the UK

The act of nursing is as old as time itself. The Royal College of Nursing (2014) identifies nursing as a service that promotes and maintains health, providing care for people with poor health and assisting them to recovery, thereby promoting well-being and aiding independence. D'Antonio (1999), records that these activities were carried out in the UK early in the 19th century, when family members cared for their sick ones, assisting with basic needs of personal hygiene, toileting and bathing which was sometimes officially performed by paid and independent "handy women" (Dingwall, Rafferty and Webster, 2002, p.7). There was therefore, a distinction between domestic and formal care.

In the mid-19th century, Florence Nightingale, known as the mother of nursing portrayed what true nursing meant during the Crimean war (1854-1856) by providing quality care for wounded soldiers; after which she led the great nursing reformation by organizing training programmes and establishing the first nursing school at St. Thomas hospital in 1860 (Bingham and McEwen, 2015). Catalano (2015), states that this reformation helped to change the public's perception of nurses as doctors' handmaids/servants, thereby professionalizing the image of nursing as being an evidence-based practice.

During the Crimean war, HCAs, then called nurses' aides/auxiliaries assisted trained nurses with care under supervision and were recognized as part of the nursing team (Kershaw, 1989); Witz (1992) however, explains that there was an attempt to create boundaries between the fit (trained nurses) and unfit to practice (auxiliaries) but the idea failed and in 1955, the roles of HCAs were officially recognized (Thornley, 2000). Thornley (1996) accounts that the government began to make use of the HCAs as cheap labour especially during the time of shortage of nurses and this practice continued over the years. The physicians also preferred working with these subordinates who took orders without questioning (Cook and Webb, 2002). Despite these challenges, nursing in the UK has been able to move from diploma training to degree level as a minimum standard and advanced practices have been in progress (Collins and Hewer, 2014).

1.7. Nursing History in Nigeria

The emergence of nursing in Nigeria is similar to that of the UK, as it initially involved family members caring for their sick ones (Adisa, 2015). The reformation by Florence Nightingale had a positive impact on the Nigerian health system when British missionaries who came to Nigeria, combined the Christian gospel with nursing and medical care to sick people (NMCN, 2016); therefore, health care in Nigeria underwent reformation from the mid1900s, based on human health needs (Asuzu, 2005). During this period, nurses and midwives were being trained formally and in 1952, the first school of nursing was established by the university college hospital (UCH), Ibadan; Mrs. Bell, a former student of Florence Nightingale, being the first principal (Dolamo and Olubiyi, 2013). The nursing profession is presently progressing from diploma level to university based degree as Olanipekun (2007 cited by Dolamo and Olubiyi, 2013)

argues that these steps will help improve the individual's cognitive, affective and psychomotor abilities that will in turn serve the needs of the general public.

1.8. Summary

This chapter has given an introduction and structure to the dissertation. It discussed global trends in healthcare and how a strong workforce is needed for the health of the global population. The possible causes of workforce shortage in Nigeria were analysed and suggestions based on strategies adopted from other countries were made. The chapter also compared the history of nursing in the UK and Nigeria in order to form a basis for the analysis of the dissertation.

2. PRELIMINARY LITERATURE REVIEW

This chapter will discuss the aforementioned themes and related theories as a starting point, with view of discussing emergent themes further in the review. The themes include nursing, training, education, HCAs/auxiliaries, competence, accountability, registration, regulation and service-users. These themes were selected because they are the major areas of interest for this dissertation.

The topic directly involves the nursing profession as HCAs are part of the nursing fold. Education and training are seen by the writer as essential for nurses and HCAs to provide evidence-based practice. This will however, improve competence and help nurses and HCAs perform activities within their roles and take responsibility for their actions. Registration and regulation are also discussed because the writer acknowledges their importance in improving commitment and accountability of health workers. Service-users are not left out of the picture as they are the direct recipients of health care; therefore, their opinion on what type of health care and who provides this health care is important.

2.1. Nursing

Nursing as a profession, has struggled with its identity and the public's reluctance to view it as a profession (Willets and Clarke, 2014), as evidenced in a number of literature (e.g. Duffield, 1986; Freidson, 2001; Prowse and Prowse, 2008). Liaschenko and Peter (2004) however contend that nursing is not worthy to be called a profession, and believe that though nursing is advancing, it is still psychologically under the rule of the medical profession. A seminal work by Greenwood (1957) disproves this and describes what makes up a profession: "systematic theory" (guiding theories and frameworks), "authority" (influence and autonomy), "community sanction" (discipline), "ethical codes" (guiding principles) and "culture" (beliefs, values and responses that bond a group) (p.45). It could however, be argued that modern nursing meets all these attributes and can therefore be called a profession. Willets and Clarke (2014) nonetheless, believe that the struggles of this profession started when nurse training moved from apprentice-based to higher education learning, as physicians and others who felt threatened by the progress of this 'female job' rebelled against the movement.

Hoeve et al.'s work (2014) suggests that these challenges are due to social constructs, traditional values and perceptions of the public towards the nursing image. This has negatively affected individual nurses' insights to the great relevance, value and contributions of the nursing profession. This is explained by the social identity theory (SIT)

2.1.1. Social Identity Theory (SIT)

According to Tajfel and Turner (1986) the social identity theory explains that an individual or a group's self-concept stems from the already existing perceptions and images created by the public of the group or individual i.e. an individual or organization will have a feeling of self-worth if they think that the public thinks well of them. Relating it to the nursing profession, the media, over time, has put forward nurses as sex objects and servants to physicians (Takase, Kershaw and Burt, 2002); leading to nurses feeling less worthy and powerless when faced with other professions. Hoeve et al. (2014) however contend that this image is a complete opposite of what nursing is.

While the impact of these actions could be destroying to individuals and groups, Huddy (2001) strongly believes, from a political point of view, that individual choices can make or mar identities. He further explains that when groups overlook their ascribed identities, for instance, the socially constructed negative image of nurses, they work towards acquiring better identities. A research by Fagerberg and Kihlgren (2001) proves that these acquired identities are influenced by work, environment and education, as people who have positive relationships at work and build themselves up with

continued education, are more likely to have a good self-concept. Interestingly, some nurses have taken up the challenge to improve and advance themselves in terms of education; nevertheless, education in nursing is still in a state of tension. Nagy, Lumby, McKinley and Macfarlane (2001) record in their work that most nurses do not believe in the correlation between research and care which they think comes naturally. A study by Cowin and Johnson (2011) in a global Australian university, also shows the concerns expressed by student nurses (experienced and inexperienced) over the implications of nursing education stating that nursing is shifting from a caring job to an administrative profession as nurses keep advancing in their career. In contrast, Potter, Perry, Stockert and Hall (2016) make it clear that education and research are needed to provide holistic evidence-based care through adopting relevant practices and modern technology. The writer therefore, argues that since all nurses cannot be managers and administrators at the same time, there are still nurses who can provide the personal care needed at a particular period.

2.2. Education/training

Carper (1978) developed a practice model for nurses which serves as a means to liberate nursing from the subjugation of the medical model that Reed and Watson (1994) suggest supports nursing values sometimes while other times, it could be limiting to the holistic care that the nursing profession strives to achieve. Carper's model proposes four patterns needed to structure nursing education: empirics, ethics, personal knowing and aesthetics. Kenney (2002) however, lays emphasis on the importance of treating these patterns as a whole as none of them can stand alone when it comes to delivering quality care.

Empirics: this is the science of nursing which deals with research into evidence and scientific knowledge. It posits that objective truth is what people perceive and accept based on evidence (Chinn and Kramer, 2014). It is therefore essential that nurses get involved with researching into practices that will benefit patients/service users. Stein, Corte, Colling and Whall (1998) further explain that this pattern also involves knowledge from clinical experiences.

Ethics: involves morals and attitudes governing the profession. It also involves identifying, clarifying and justifying values and beliefs held by groups and individuals; evidenced in the practice standards, nursing code of ethics and philosophies (Fawcett, Watson, Neuman et al., 2001).

Personal Knowing: in as much as it deals with knowing oneself, it extends to the authenticity and expressions involved in being aware oneself in relation to being aware of other people's styles (Chinn and Kramer, 2014) in a nurse-patient relationship; achieved through reflection, listening and thinking (Fawcett et al., 2001).

Aesthetics: this act and art of nursing involves the expression of what the nurse perceives to be significant in the behaviour of the patient by foreseeing possibilities and being creative (Fawcett et al., 2001) e.g. playing a soothing music to calm an aggressive patient, creating works of art that represent significant aspects of the patient's life or skilfully dealing with patient's anxieties by being polite, yet assertive. The writer believes this comes with experience and is based on proper history taking on the patient.

Though this model has been critiqued by some as incomplete i.e. not having a scientific base, and being dogmatic (e.g. White, 1995; Garrett and Cutting, 2015), the writer argues that the model still accepts scientific evidences as explained in the empirics; however, clarifying that nursing practice is not fully based on the objective but also on the real (Wolfer, 1993) which is mostly experienced than experimented. Fawcett et al. (2001) therefore believes that the model will encourage nurses to develop a sense of autonomy and improve advanced practices.

2.2.1. Advanced Nursing Practice (ANP)

Developed countries such as the UK, United States of America (USA) and Australia have acknowledged the need for advanced nursing roles considering the task shifting subject brought about by the increased need for health care (Lowe, Plummer, O'Brien and Boyd, 2012). According to the International Council of Nurses (2008, p.29), an advanced practice nurse is "a registered nurse who has acquired the expert knowledge base, complex decisionmaking skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A Masters degree is recommended for entry level". Though there has not been a clear line drawn between the ANP role and the Nurse Practitioner (NP) role (Lowe et al., 2012), they both are expanded roles that have been taken up by nurses to gain autonomy and break the walls of traditional restrictions in the profession.

In Nigeria, the advanced nursing role has not been officially recognized; however, specialist roles such as nurse anaesthetics (Ajibade and Olaitan, 2013) exist, and sometimes, experienced and educated nurses/midwives perform physician duties (Lasebikan and Oyetunde, 2012) when the need arises. These roles could be arguably termed advanced roles. With regards to this, lower-cadre health workers such as HCAs have been introduced into the health care system to assist staffing levels by performing some roles that previously belonged to the nurses.

2.3. Health Care Assistants (HCAs)

HCAs/auxiliaries have always been used to assist staffing levels in health care (Kershaw, 1989); likewise, assistants exist in other fields such as teaching (Balshaw and Farrell, 2013), medicine (Chou, Li and Hu, 2014) and dentistry (Park, Lee, Na and Jwa, 2014). There is existing evidence that these assistants undergo intense training before practice (e.g. Bach, Kessler and Heron, 2006; Mittman, Cawley and Fenn, 2002; Chou et al., 2014). The free flow of training for these assistants is not the same in the nursing profession and this could be partly attributed to the fact that male-dominated jobs gain more attention. Men, initially involved in nursing, gradually withdrew into other jobs (Cyr, 1992) because females were perceived to be weaker vessels and could only perform weaker jobs of caring for the sick i.e. no training was needed since they had natural caring attributes (Fraser, 2011). Feminists however, dispute this belief and contend that there should be equality amongst all professions, whether male or female-dominated (Hedin and Donovan, 1989).

2.3.1. Feminism

Feminism is a theory or set of social and political beliefs that strives towards achieving a higher level of equality for women (Mitchell, Oakley and Cott, 1986). While Kane and Thomas (2000) earnestly believe that feminism has an integral part to play in nursing, Larsen and George (1992) oppose to this notion and propose that nursing is bound to a concept based on women's obligation not their rights. Feminists have therefore, identified such propositions as invisible and intrinsic factors that have contributed to the stereotypical images created of nurses (e.g. Chinn and Wheeler, 1984; Bunting and Campbell, 1990; Sayer, 2000b; McPherson, 2003).

The writer however, stresses the importance of adopting Carper's ways of knowing into the training of these HCAs as Cavendish (2013) sees them as part of the nursing fold because they are constantly in contact with patients while assisting nurses. The training will give them a sense of competence and confidence in carrying out their roles.

2.3.2. Training Auxiliaries in Nigeria

There is no existing data on the numeral representation of nursing auxiliaries in Nigeria; however, they constitute a large fraction of the workforce. Training this group will therefore be beneficial to the Nigerian community and economy as health will be promoted and healthy individuals can live productive lives. The average life expectancy of Nigerians in 2014, at birth- 52.75, was significantly low when compared to other African countries such as Tanzania- 64.94, Ghana- 61.31 and Kenya-61.58 and other non-African countries e.g. China-75.78, Philippines- 68.27, India- 68.01 and the UK- 81.40 (Expansion/Countryeconomy.com, 2016). It is arguable that inadequate healthcare is a major contributory factor to this; hence, training and sustaining a strong, competent health workforce will contribute to improving the health of Nigerians.

2.4. Competence

Epstein and Hundert (2002), delineate that competence involves regularly and conscientiously applying skills in knowledge, cognition, technology, communication, reflection and values to attain a positive patient outcome. As the burden of disease and health systems vary immensely worldwide, Crisp and Chen (2014) propose a competency-based training for health workers and emphasize the need for competencies that go beyond rigid health system cultures and re-examine skills that are needed for a dynamic health system. In other words, there is need to introduce new strategies or build on existing policies that will help meet the pressing health needs of a particular region.

It is important to note that with the high demand for health care and shortage of health workers, roles of health professionals are changing rapidly as nurses carry out physician roles and lower cadre workers such as HCAs, assist nurses. A study by Pereira, Cumbi, Malalane et al. (2007) in Mozambique shows that nurses were given extra training to perform major roles of doctors e.g. caesarean sections which they did satisfactorily but were paid much less than the

physicians. The writer however, believes that task-shifting should be a fair deal where nurses and other health workers are paid appropriately for the type of tasks they carry out and not used as cheap labour.

In the UK, Thornley (2000) records that HCAs proved their competencies in the past by acquiring the national vocational qualification (NVQ) in the national health service (NHS) based on the structure of each organization. Recently, the government introduced the *Care Certificate*, launched in April 2015 for all health support workers (NHS, 2015). Furthermore, this 15-component document (see appendix 1) aims to ensure quality skills, behaviours, values and competencies for the health workers after undergoing intense training.

When HCAs are trained appropriately, they are competent in their roles and therefore develop a sense of responsibility and accountability.

2.5. Accountability

Accountability has been identified as the ability of an individual or group to perform activities or tasks that are within their roles and taking responsibility for their actions in the interest of the customer/service user (Emanuel and Emanuel, 1996; Scrivener, Hand and Hooper, 2011). It is however, important to distinguish accountability from responsibility for proper understanding of the concepts. According to Brees and Martinko (2015), responsibility involves assessing what or who caused an incidence, while accountability assesses if someone should be punished for the occurrence of a behaviour that led to an outcome. They believe that accountability can be traced initially through assessing responsibility. Though accountability can be viewed in forms such as economics/finance i.e. giving account of funds, and governance i.e. holding public office bearers answerable for their activities (Cornwall, Lucas and Pasteur, 2000), it would be appropriate to focus on the accountability model that involves the care of service-users in this context.

From the writer's experience, Nigerian nurses are held accountable for the actions of auxiliaries. Though the auxiliaries are held responsible and punished, the nursing image is marred since the general public cannot differentiate between a nurse and an auxiliary. This has caused conflict between both groups, as nurses do not want to accept them and are against their existence. The writer however, argues that there is an intense need for the auxiliaries to assist nurses, considering the latest available data (2008) on the ratio of Nigerian nurses/midwives: 1.6/1000 population as compared to the UK 2013 data- 8.8/1 000 population (WHO,2015) and therefore agrees to Cavendish's (2013) advice for nursing directors to be responsible for their (HCAs) training, employment and upkeep as she argues that this has a positive psychological impact on their self-esteem as they know they belong to a powerful group. Nurses are also accountable for allocation of HCA duties. In order to authenticate this group of health workers, Hopkins (2008) suggests their registration and regulation as it will enhance patient safety and role clarification.

2.6. Registration and Regulation

These two terms are sometimes used interchangeably, but they slightly differ. According to Pearson (2005), registration involves enrolling professionals e.g. nurses/midwives with regulatory bodies who are responsible for setting essential standards as regards admission into the register, and organizing opportunities for continuing development programmes which ensure a continuous membership. On the other hand, Vaughan, Melling, O'Reilly et al. (2014) expatiate that regulation entails setting rules that members, including unregistered staff, must legally follow and be punished when such rules are broken.

The debate on whether or not to register and regulate the HCAs is on-going (e.g. Spilsbury and Meyer, 2004; Castledine, 2013; Duffield, Twigg and Purgh, 2014); however, Vaughan et al. (2014) out-rightly contends that it is not a necessity to regulate the HCAs, as public protection is not based on regulation but it is only essential to make sure that the right care is given to the right individuals at the right time by the right provider as implied by the

Department of Health (2013). The writer however, believes that registration and regulation will play a part in strengthening their (HCAs) commitment to providing quality care because of the feeling of acceptance, value and accountability. These are all paramount to delivering care to service-users.

2.7. Service-users

Service-users in health care are identified as people who could be patients/clients or people contacting health providers on behalf of someone else (Warren, Abel, Lyratzopoulos et al.,

2015). It is very easy to neglect service-users' opinions when making decisions about health care which directly affects them. However, it is interesting to note that service-users include even the health workers, and whatever decision is made about health care delivery, such as training of HCAs, affects everyone. A qualitative research by Keeney, Hasson, McKenna and Gillen (2005) on the perceptions of women about trained HCAs in a maternity ward in northern Ireland showed their satisfaction and confidence in trained HCAs, though some of them believe that HCAs should still be under nursing supervision. A more recent study in the UK shows satisfaction of patients and family members with palliative care rendered by HCAs which involved emotional support and collaboration with family members (Ingleton, Chatwin, Seymour and Payne, 2011)

Though there is no written evidence of patient opinion in the Nigerian context, it has been observed that patients know that the auxiliaries lack training and therefore, prefer to be seen by a qualified nurse if possible. It is, nonetheless, very unlikely for one to escape the auxiliaries especially during the periods of strike (Chima, 2013) when government hospitals shut down and the general public is left at the mercy of private hospitals where these auxiliaries reside. Advocacy for their training is therefore needed as no one knows who will fall victim in the future.

2.8. Summary

This chapter provided a preliminary literature review, discussing the main themes for the dissertation. Various emergent theories were also discussed, throwing more light on arguments raised. The essence of nursing and its identity was emphasized as well as the need for education/training of nurses and HCAs which will lead to competence, accountability and improved outcome for the service-user.

3. METHOD AND METHODOLOGY

This chapter will discuss the critical review method and will further discuss critical realism as an evidence-based practice (EBP), comparing it with other EBPs. It will therefore justify applying the critical realist review (CRR) approach in exploring what the roles and training needs of HCAs in Nigeria should be. The review questions and search strategy will also be discussed in this section.

3.1. Justification of the Method-Critical Review

As stated earlier in Carper's fundamental patterns of knowing, empirics is the science of nursing that deals with evidence-based practice. EBP is defined as the "conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett, Rosenberg, Gray et al., 1996, p.71); also involving integration of clinical expertise and service-user preferences in the decision-making process (FineoutOverholt, Melnyk and Schultz, 2005) (see appendix 2). Randomized control trials (RCTs) and their systematic reviews (SR) are often viewed as the 'gold standard' for EBP (Ingersoll, 2000; Meher and Alfirevic, 2014). Clegg (2007) however, argues that in as much as 'seen' evidence is needed, it is also essential to consider diverse ontological evidences i.e. values and beliefs especially in health and social care. Whilst SRs have clear criteria for inclusion and exclusion of literature (e.g. He, Li and Macgregor, 2013; Prince, Bryce, Albanese et al., 2013; Rashidian, Shakibazadeh, Karimi-Shahanjarini et al., 2013), critical reviews explore theories and other fields such as sociology, politics, economics and psychology in order to understand underlying or 'unseen' factors that affect policies and practices in social interventions e.g. nursing (Edgley, Stickley, Timmons and Meal, 2014).

RCTs are used to identify the effectiveness of treatments by experimenting on cases and controls, and are said to exclude any confounding variables during this process (Attia, 2005; Meher and Alfirevic, 2014); however, Shadish, Navarro, matt and Phillips (2000) draw attention to the question of why these clinical trials seem to be more effective in research than in the day-to-day clinical practice. Roth and Fonagy (2013) give a clear answer to this, stating that there are underlying factors that positively or negatively affect outcome; for instance, the mental state of groups, economic/financial status, beliefs and values. They therefore conclude that there is not one 'perfect' way to determine the outcome of an intervention but a combination of evidences is needed in health care, considering societal influences.

Nursing is a social construct in that, the nurse-patient relationship occurs within the context of values and beliefs of both parties; also, the society's wellbeing and the profession is affected by public policies and the health systems (ANA, 2010). The writer therefore believes that a critical review will give a deeper explanation about the challenges faced by the nursing profession and how the idea of training auxiliaries in Nigeria will be implemented considering perceived hindrances and culture differences in countries of comparison.

3.2. Methodology-Critical Realist Review (CRR)

Critical realist review is a research methodological approach involving philosophical and social developments and perspectives, stemming from the original work of Bhaskar in 1978 (Danermark, Ekstrom and Jakobsen, 2001). Philosophically speaking, Danermark et al. (2001) clarify that, though critical realism (CR) involves epistemology, it further deals with ontology, out of which it focuses on mechanisms that influence events, rather than the events themselves. In other words, CR deals with underlying causal effects that influence the manifestation of events which could be measured empirically (observed). They therefore stress that research should not be based solely on the observable but also, the causal.

According to Edgley et al. (2014), CR gains its roots from realism, which focuses mainly on the *Real* i.e. 'what is'. However, CR goes beyond the real to investigate the *normative* i.e. 'what should be', through exploring theories and policies, focusing on activities that affect social justice. Nevertheless, both CR and realism share ontological beliefs that there are theories and values we use (transitive) in order to understand our physical and social world (intransitive), and no matter how the transitive might change, the intransitive remains the same. Therefore, since the world can be studied, our theories and values can also be studied because they are the causal mechanisms of our behaviours (Sayer, 2000a), for example, addressing students as participants may influence their behaviour and increase participation in class.

In as much as Pawson, Greenhalgh, Harvey and Walshe (2005) expose the limitations of empiricism, stressing the importance of realism in complex social interventions, Pawson (2006) does not support the normative stand taken by CR and sees it (normative) as a political grip on evidence-based policy; expressing concern over the social intervention achieving what it promises to achieve instead of foreseeing the benefits of the intervention (Edgley et al., 2014). It could be argued that this paper does not only underline the training of HCAs, but the benefits of this intervention are clearly stated e.g. competence and improved patient care. Realists however, explore necessities and probabilities i.e. the real is explored to find causal powers and what will happen when these causal powers are activated (actual). This paper will therefore discuss the implications of this approach for the dissertation.

3.3. Implications for the Dissertation

Training of HCAs has been critically emphasized (e.g. Department of Health, 2013; Cavendish, 2013); its effects have also been measured in the past using tools such as questionnaires and communication skills checklist (CSC) and through interviews (e.g. Spore, Smyre and Cohn, 1991; Grumbach and Bodenheimer, 2004). A systematic review by Polus, Lewin and Glenton (2015) on training HCAs, only measured the impact of task-shifting among the health workforce, paying less attention to role clarification. Another SR by Lassi, Commetto, Huicho et al. (2013) appears to be in support of making use of lower-level workers to complement the shortage of health professionals, but at the same time, it indirectly encourages the substitution of qualified nurses with auxiliaries by proving that there is no difference between care rendered by the qualified and unqualified.

The writer however, believes that in order to introduce a training programme for auxiliaries in Nigeria, a CRR will prove more effective for in-depth diagnosis of the problem and working out strategies or policies for implementation, after which empirics and SRs will help to check effectiveness of the training. These policies should however, be implemented in such a way that no group in the health care team will feel threatened.

With this CRR, changed perceptions about nursing will be promoted and nursing will be viewed from an angle of professionalism, encompassing care and evidence-based practice.

This will, in turn, give nurses the power to advocate for proper training of auxiliaries (especially in Nigeria) who will have the confidence and competence to provide optimum care to service-users. It will also help the public to read diverse meanings into the 'seen' and 'unseen' causes of phenomena, rather than looking at only the objective truth. Since it seeks

to explore what 'should be', CRR will help with answering the dissertation question: 'What should be the roles and training needs of HCAs in Nigeria?' through comparisons of practices with other countries. However, like other methodologies, CRR has its limitations

3.4. Limitations of CRR

According to Edgley et al. (2014), a major limitation of this approach is that writers tend to express their assumptions based on personal knowledge, beliefs and values which may not be relevant to another writer with a counter-view i.e. ontological and epistemological views vary. This is in tandem with McEvoy and Richards' (2003) concern that a potential hindrance to the effectiveness of CRR is a lack of empirical evidences that prove the assumptions of causal factors. It is therefore important to buttress all arguments in a CRR with other forms of evidences to prove that it is more than speculations (Pawson, 2006).

This paper will proceed to discuss the review steps and the search strategies adopted to answer the research question in this dissertation.

3.5. The Review Process

Whilst concerns have been raised about EBP being a prescriptive approach (Melnik and

Fineout-Overholt, 2005), French (1999) equally argues that the similarity existing between EBP and Evidence-based medicine (EBM) in terms of observable research, may affect more open social interventions such as nursing, as the nursing profession seems to rely more on this approach. This could be because EBM is general to the medical field (Straus and McAlister, 2000) and its definition as combining the best observable research from systematic studies with individual clinical expertise in making decisions about patient care

(Sackett, 1997), seems to neglect patient values/preferences; though Straus and McAlister (2000) argue that this is a mere misconception.

Barker (2013) nevertheless, suggests that in order to carry out any research, some form of evidence is needed and this can be proven by applying suggested EBP steps to guide the whole process. Inspiration has therefore, been drawn from Aas and Alexanderson's (2012) five-step EBP process (see appendix 3): Assess, Ask, Acquire, Appraise and Apply; this has however, been modified in order to give meaning to the context of this dissertation as reference will be made to relevant sections of Pawson, Greenhalgh, Harvey and Walshe's (2004) realist synthesis (see appendix 4). An overview of how these steps are used is briefly given:

Assess the problem: involves diagnosing the problem. The process of problem identification has commenced in previous chapters and will further be discussed in chapter 4 using the WHO (2005) toolkit on problem identification. Emergent themes will also be discussed. **Ask the question:** developing a research question that arises from the identified problem. This is done in chapter 3.

Acquire evidence: searching for evidence in terms of literature and observations on the training of HCAs. The search strategies are described in chapter 3. Following Pawson et al.'s (2004) steps on clarifying the review purpose and articulating programme theories, global comparisons have been made in chapter 1 in view of discussing in depth in chapter 4. Relevant theories have also been applied in chapter 2; however, chapter 4 will discuss more theories, policy interventions and observations made by the writer.

Appraise evidence: this involves critiquing the relevance of literature, theories/models, as well as observations and information acquired in the CRR process (chapter 4).

Apply evidence: involves studying the Nigerian context e.g. social and political, and choosing relevant policy implementation strategies from countries of comparison that will fit into the

Nigerian context. Pawson et al. (2004) sees this as synthesizing findings (discussed in chapter

4). The application process is expected to take place fully upon the writer's return to Nigeria where a team of supporters will be formed and stakeholders consulted.

The last stage of Pawson et al.'s (2004) work, lacking definition in Aas and Alexanderson's (2012) EBP steps, is *recommendations/conclusions* (chapter 5). This also includes involving stake holders in the review process (chapter 4).

3.6. Identifying the Research Question

This paper will adopt the Joanna Briggs Institute (JBI) (2013) modified PICo (Population, phenomenon of Interest, Context) framework. This approach is different from the quantitative PICO (Participants, Intervention, Comparison, Outcome) framework (Barker, 2013) as it (PICo) deals with what the researcher is interested in examining (phenomenon), and the social context to be reviewed; while PICO focuses on the outcome of an intervention (JBI, 2013). Based on this explanation, it is therefore relevant in answering the dissertation question: ‘*What should be the roles and training needs of HCAs in Nigeria?*’ It will also assist in a structured search of relevant literature. The question is divided in the table below:

Table 1: PICo- Framing the question

Population (P)	Health care assistants
Phenomenon of Interest (I)	Roles and training needs
Context (Co)	Nigeria

The question attempts to investigate why auxiliary nurses are not trained in Nigeria, and then explores and compares strategies used by other countries in training their HCAs/auxiliaries. It will further explore the possibilities of adopting or modifying these strategies to fit into the Nigerian context. This will be achieved through extensive literature search in fields such as sociology, psychology and politics. One of the initial steps taken to help with the structure of this dissertation is the development of a CRR proposal.

3.7. CRR Proposal

The writer developed a CRR proposal which helped with structuring the entire dissertation and in answering the dissertation question. This concurs with Offredy and Vickers' (2013) position that researchers develop a proposal in order to satisfactorily produce a research work. No changes were made to the research question; however, corrections have been made based on the feedback on the proposal work which advised making use of relevant theories in the dissertation (see appendix 11 for the proposal).

3.8. Investigation Strategies

The writer made use of a wide range of online databases such as Embase, Google Scholar,

Ovid, CINAHL, Medline, Web of Science, Cochrane Library and JBI, in search of literature evidence, all in English language. Search terms included auxiliary nurses, nursing aides, nursing assistants, health care assistants, unregistered/unlicensed health workers, support health workers, Nigeria health care system, combined terms such as HCAs\$Auxiliary nurses were also used. In addition to medicine and health science discipline, the search explored psychology, sociology, philosophy, education and political science disciplines.

Initially, the search began by identifying the meaning of auxiliary nurses in different contexts globally. Results showed that the terms auxiliary nurse, HCA, nursing aides etc. only differed in titles but had the same meaning. The themes for the study were also explored alongside emerging theories. Cochrane library database and JBI respectively provided a few systematic reviews on the effect of training HCAs and information on the modified PICo research design. Verbal information, personal observation and other information sources e.g. Blogs, internet forums and newspapers were explored.

Generally, there was poor literature availability on nurse auxiliaries and their training in Nigeria.

3.9. Summary

Chapter three has attempted to give a clear view of the method-critical review and methodology-critical realist review of the dissertation. These were justified and the research question was analysed using the modified PICo framework. The concept and importance of the use of EBP in the dissertation was made clear and the section also discussed the search strategy which involved searching a wide range of databases as well as other information sources.

4. FINDINGS AND DISCUSSION

This chapter will provide a general overview on the dissertation topic and discuss emergent themes and theories in order to give a deeper meaning to the research purpose. Observations made by the writer, including verbal information will also be analysed. Firstly, HCAs will be discussed generally and in the Nigerian context. The problem will then be identified and analysed using the WHO (2005) problem identification toolkit. The section will also provide an implementation plan sketch for the introduction of a HCA training programme in Nigeria.

4.1. Health Care Assistants-who are they?

The lack of sufficient health workers globally, coupled with growing health demands, has led to the increased need for a strong health workforce. In addition, McKenna, Hasson and Keeney (2004) draw attention to the economic reason of cost-effectiveness in making use of less trained support workers such as HCAs.

A questionable definition by Spilsbury and Meyer (2004) describes HCAs as “non-registered nurses” (p.412) that support the registered nurses in carrying out roles. The writer disputes the use of the phrase ‘non-registered nurses’ in this context as nursing has moved from being a perceived ‘natural female characteristic’ to being a profession which Christman (1998) maintains, requires licensure and registration with a nursing organization. In other words, it is either one is a nurse or not. In consideration, terms such as ‘non-licensed doctor’ might seem inappropriate for the medical profession; therefore, descriptive phrases such as “substitute health workers” (Dovlo, 2004, p.1), support staff, nursing auxiliaries or nursing assistants (McKenna et al. 2004) may seem more appropriate in describing this group. They are also known with these titles in different countries for instance- nurse assistants (e.g. Ghana, USA); auxiliaries (e.g. Nigeria); HCAs (e.g. UK).

4.2. HCAs/Auxiliaries in Nigeria

Nursing auxiliaries function in the Nigerian health sector, mainly in private hospitals (Fawole et al., 2009) where they perform simple-to-complex roles that originally belonged to nurses.

A few studies on the Nigerian healthcare system (e.g. Emelumadu, Onyeonoro, Ukegbu et al., 2014; Deller, Tripathi, Stender et al., 2015) have mentioned in generic terms, the training needs of health workers but have failed to lay proper emphasis on nursing auxiliaries. The writer perceives that this might not be a priority to Nigerian healthcare researchers, including the government authorities who Ezeonwu (2013) believes, have neglected the nursing profession and focused more on other male-dominated professions. From the writer’s experience, most private hospitals in Nigeria are owned by doctors and a few experienced nurses/midwives who, in search of cheap labour, employ auxiliaries and show them how to perform tasks in the hospital. Therefore, these professionals may rebel against the introduction of a training programme for auxiliaries if they perceive that they might run at a loss.

4.2.1. Potential Barriers to Training Nursing Auxiliaries in Nigeria The extent to which nurse auxiliaries have been substituted for nurses in Nigerian private hospitals has led to the public being unable to identify who is who, resulting in nurses’ rebel against the use of auxiliaries (e.g. Naijanurse, 2012; Emmanuel, 2015). On the contrary, Munjanja, Kibuka, and Dovlo (2005) see such opposition as a lack of unity among the nursing fold. The nurses’ concerns are understood as they believe auxiliaries bring them bad reputations and rob them of their jobs; however, these concerns have been neglected. One of the reasons could be that the doctors responsible for the misuse of auxiliaries are the same people in political positions, making policies, as they are viewed as the most influential in health care. It is therefore, nearly impossible to get rid of these auxiliaries, not forgetting the fact that they contribute to the Nigerian health workforce. The writer therefore, argues that the energy expended on trying to eradicate this group, should be diverted into supporting their training and pushing for even distribution of nurses and auxiliaries. This could be possible if nurses brace up and get involved in politics.

4.3. Nursing and Politics

Undoubtedly, nurses make up a very large percentage of the health work force; ironically, this numerical representation does not translate into substantial organizational influence, authority and politics (Porter-O’Grady, 2011). In other words, nurses’ suggestions and opinions are not regarded as significant, and decisions about their own practices are being imposed on them. Daly, Speedy and Jackson (2015) identify nursing as the mostly stereotyped profession that can be

traced back to history. This stigma lingers on and affects various decisions made about the profession. Arguably, this is what is being played out in the Nigerian political and health systems.

A seminal study by Chesterman (1953) proves the existence of Nigerian trained assistants in professions such as dentistry, laboratory science and radiography. These assistants undergo some years of training before practicing. Even though the Nigerian medical profession does not have named medical assistants, general practitioners or medical officers carry out complex roles, of which it could be argued that they undergo formal education and have a generic knowledge of such procedures (Dovlo, 2004). This entirely being the opposite in nursing, where auxiliaries who have no theoretical or practical idea of what nursing is, learn on the job. A major reason could be that nurses do not have advocates in political positions to speak for the profession; so, nurses keep grumbling and never speak up.

Nurses' involvement in politics has been a subject of debate in various contexts over the years (e.g. Rogge, 1987; Ehlers and Phil, 2000; Allen and Lyne, 2006). Ehlers and Phil

(2000), stress that a good knowledge of political techniques is paramount for the survival of a profession. Though this concern over nursing losing its identity was expressed in the political milieu of South Africa, the same applies to Nigeria and arguably the entire globe as nurses seldom get involved in decision-making processes that affect them and their service-users.

This however, seems very difficult considering underlying barriers of marginalization.

4.3.1. Perceived Barriers to Political Involvement of Nurses

Though nursing is a female-dominated profession, there are still a few males involved. While Evans (2004) advises against neglecting their contributions to the profession, it is worth taking note that these males are usually found in leadership positions which they do not find difficult to attain, unlike their female counterparts (Eagly, Makhijani and Klonsky, 1992; Evans, 2004). Also, Eagly and Karau (2002) observe that attitudes are less positive to the females than the males, this being attributed to the perceived 'natural' male leadership characteristics which include logic, competition, aggression, decisiveness and being able to think in a 'leadership way' (Eagly and Johannesen-Schmidt, 2001).

On the other hand, nurses themselves do not feel the need to be involved in politics as they unconsciously queue into the traditional belief that women are not political (Kalisch and Kalisch, 1982). An early work by Milbrath (1965) suggests lack of education as the main factor that discourages political involvement. In as much as this would have been the case in the past, modern educated nurses still do not get involved. A later research by Winter and Lockhart (1997) delved into understanding why the few nurses who were involved in politics did, and the challenges perceived from getting involved. This phenomenological study reported that nurses were involved in politics because they wanted to make a change in the profession; however, some nurses expressed that the inability of more nurses to get involved has rendered them powerless as they cannot fight alone.

Hindrances to involvement included combining multiple roles as mother, wife, student and carer; the ambiguous nature of the nursing role in hospitals which infringed into their time; lack of societal support as people believe that the nurse's place is only at the bed side; lack of unity within the nursing fold also discouraged some as they did not gain support from their peers and lacked a role model. There is no doubt that these factors are still in play presently. He therefore, posits that nurse educators and researchers have a greater role to play in encouraging upcoming students through including political courses in the nursing curriculum and serving as role models, arguing that this will lead to empowerment.

4.4. Empowerment

According to Nyatanga and Dann (2002, p.235) the concept of empowerment gains its meaning from a Latin action word *potere* meaning "to be able"; therefore the noun

'empowerment' with the prefix 'em' means "cause to be", presenting empowerment as a process (Kuokkanen and Leino-Kilpi, 2000) and not just an act. Rao (2012) views this concept as a vital ingredient that enables productivity while paying attention to ideas of working collaboratively, decision-making processes, assisting others and taking responsibility.

Though many articles stress patient empowerment by nurses (e.g. Mok, 2001; Nyatanga and Dann, 2002; Laschinger, Gilbert, Smith and Leslie, 2010), this paper focuses on the need for nurses to empower themselves before empowering

others. Because nursing has an important role to play in the present and future healthcare, MacPhee, Skelton-Green, Bouthillette and Suryaprakash (2012) believe that nursing leadership and development require supporting empowerment theoretical frameworks in order to make a difference in the society.

4.4.1. Structural Empowerment Theory

This organizational theory originating from the work of Kanter (1993), accentuates factors in the organization that impact on the productivity and satisfaction of its employees such as supportive/strong nursing team and leadership, adequate staffing, good communication processes, educational/training support and acknowledgement of staff effort in the progress of the organization (MacPhee et al., 2012). When employees are not satisfied and feel unnecessarily manipulated and neglected, they tend to leave the job as in the case of nurses leaving the profession for other jobs, leading to nursing staff shortage (Rao, 2012). Therefore, these factors, when put in place, will empower nurses.

4.4.2. Social Psychological Empowerment Theory

The intrinsic nature of this theory helps in the motivational support of employees. It has to do with the personal values, beliefs and convictions that people have towards their roles in an organization (Kuokkanen and Leino-Kilpi, 2000). When individuals attach importance to their work (meaning), show confidence in carrying out their roles (competence), have control over their work (self-determination) and have a positive influence in their organization (impact), they exhibit the four cognitive dimensions to socio-psychological empowerment identified by Spreitzer (1995): meaning, competence, self-determination and impact.

The writer argues that for these four factors to be complete in an individual, organizational empowerment is key. Conversely, a person with positive attitudes, supported by others of like-mind will influence an organizational structure to work in favour of uplifting the profession. Therefore, nurses/midwives should not wait for policies to be made by those in higher positions, but should work towards making their capabilities known in the sociopolitical environment to influence change.

It is however, noteworthy that the concept of power is essential to fully understand empowerment.

4.5. Power

Power is intangible and sometimes difficult to explain. In general terms, power is viewed as a hierarchical phenomenon of authority where some people are believed to have more power than others (Dahl, 2007). Power is also viewed in terms of legitimation-people giving up part of their power for others to take up (Beetham 2013), while others view it from the perspectives of knowledge, eloquence and communication (e.g. Brown, 1991; Thorne, Hislop, Armstrong and Oglov, 2008; Gustafson, 2012).

The issue of 'who is in charge' in the health sector cannot be over-looked. Doctors have always been placed at the top of the pyramid as the most powerful (Keddy, Jones, Gillis et al.,

1986) and the doctor-nurse-patient relationship is viewed as a "father/mother/child" relationship where the husband is in control and the wife takes care of the children (James, 1992, p.493).

While Stein, Watts and Howell (2010) see the traditional doctor-nurse relationship as a game where nurses fearfully expressed their opinions about the decisions of doctors without directly challenging them, Svensson (1996) believes that this game resulted from the outmoded medical dominance model, which is being replaced by a model of negotiation. He argues that nurses now have more influence on decisions about patient care than they used to because, they have adopted a more open sociological approach of holistic care. While negotiation might sound as a call for the 'strong' doctors to carry the 'weak' nurses along, Svensson (1996) was arguably referring to what Fagin (1992) identifies as collaboration. This is in line with what a senior colleague pointed out in her opinion, that there is no hierarchy in the healthcare team-everyone is on the same line; the only differences are the unique roles of each group which when combined, promote patient health and satisfaction.

Though the subject of hierarchy is also found in nursing (Kuokkanen and Leino-Kilpi, 2000), this paper focuses more on Kanter's (1979) work which describes power in terms of being goal-oriented and efficacious i.e., even though "leaders may lack power" (Kuokkanen and Leino-Kilpi, 2000, p.236), individuals can generate power through personal acts,

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support and motivations. The power embedded in empowerment is therefore essential for the success of an individual, organization or group. The concept of power belonging to the physicians is still in existence and its negative influence on nursing can only be neutralized if nurses work together. On the other hand, its positive influence, if any, also requires unity as nurses are propellers of the profession.

This paper will proceed to describe the writer’s experience and observations of power influence within the nursing organization in the UK in terms of training HCAs and compare it with the Nigerian system.

4.5.1. Effects of ‘Nursing Power’ on Training HCAs in the UK

The writer made several observational visits to the HCA clinical skills academy of a local health higher education institute in the UK. These observational visits were in partial fulfilment of the ANM module, which required comparison of health care between selected countries. From the writer’s experience in the UK, it was observed that nurses have

developed, over the years, the characteristic of unity in order to move the profession forward. This is evident in the training of HCAs which is majorly the responsibility of nurses unlike the traditional training of nurses by physicians. (Keddy et al., 1986).

The HCA clinical skills academy is responsible for the training and upkeep of HCAs in the NHS and therefore, organizes 3-week training programmes for them, where they are taught theoretically and are then deployed to the clinical settings for more experience. This programme which started about three years ago is also done in preparation for fulfilling the requirements of the *care certificate* (NHS, 2015). Though the introduction of the care certificate resulted from the 2013 Francis report on an incident of malpractice at a MidStaffordshire NHS foundation trust, nurses worked collaboratively to save the name of the profession and its assistants, knowing that the main aim of competence is to provide patients with the maximum care needed to improve health and wellbeing. The writer strongly believes that without support, encouragement, self-determination, empowerment and perseverance, this would not have been achieved. The writer also had the privilege of informally interviewing trained HCAs who verbalized satisfaction and acquired levels of competence and confidence through training.

Despite the fact that the Nigerian and UK environments are not very similar, and the UK health system as well as other countries’ health systems cannot be said to be ‘super perfect’, lessons can still be learnt and modified to soothe the Nigerian context. There are also exemplary practices in other African countries (as earlier mentioned) that Nigeria can easily adopt since they are in the same region. It is however, important to identify and analyse the problems at hand.

4.6. Problem Identification

This paper will further identify and analyse problems in order of perceived priority, from most urgent and important to least, concerning their potential effects in achieving maximum care. This will be achieved with the help of the WHO (2005) toolkit on problem identification for a deeper understanding of the concept. This is mainly based on the writer’s experience and selected verbalized complaints taken from personal anecdotes in the Nigerian context; though the writer acknowledges that personal bias can result from personal anecdotes.

Table 2: Problem identification

Issue	Complaints
Role clarity	Role clash between nurses and auxiliaries
Uniforms	In most private hospitals, auxiliaries wear the white uniform as nurses do; service-users do not know who is who (Naija Nurses Forum, 2012)
Communication skills	Most lack good communication techniques
Character	There is lack of compassion, care, patience
Evidence-Based Practices	Though some are able to perform tasks, they cannot provide explanations for their actions; some make avoidable mistakes (Ikeji, 2015)
Appearance/dressing	Many pay less attention to the way they dress

It would therefore, not be out of place to summarize the problem as lack of training of nurse auxiliaries leading to malpractice and dissatisfaction of service-users. This paper will further discuss these factors briefly as they are very crucial in health care.

4.6.1. Roles and Uniforms

Thornley (2000) argues that though auxiliaries in the UK have their roles (e.g. assisted bathing, making beds, feeding), they are sometimes delegated roles that coincide with that of nurses (Spilsbury and Meyer, 2004). The Nigerian healthcare system experiences such and even more as they (auxiliaries) carry out all the roles that belong to nurses. Service-users also get confused with the similarities in the uniforms worn by these two groups in most private hospitals. There is a lack of literature surrounding this; however, the writer explored social media such as *Nairaland Forum* and *Naija Nurses Forum* where concerns about auxiliaries in Nigeria are raised. There are arguments and concerns about how to differentiate a qualified nurse from an auxiliary and whether they are needed in the health sector or not (Brighton, 2005; Emmanuel, 2015).

4.6.2. Communication Skills

Emphases have been laid on communication skills as essential in rendering care to patients (e.g. Grover, 2005; Arnold 2015). Dimbleby and Burton (1992), stress that communication is more than words spoken as it also involves body language, expressions, and gestures. There is no doubt that communication study needs to be incorporated in the training of health workers including HCAs because, it is a means by which information is passed to serviceusers about their health-verbally or non-verbally. Dimbleby and Burton (1992) further identify communication study as: *Knowing* what happens when people communicate with others and within themselves, *understanding* how this act of knowing can be used to infer the communication process in day-to-day life and having the *skills* of applying the knowledge and understanding to enable communication effectiveness.

A study by Aspegren and LØnberg-Madsen (2009), tried identifying the communication skills that could be learnt and those that occur spontaneously. They found out that, major skills such as building a relationship, gathering of information, explaining and planning, required training and experience. Bolton (2009) however argues, that in as much as it is believed that people have natural communication skills, all skills are learnt either informally (from parents/siblings) or formally (in institutions of learning). Aspegren and LØnbergMadsen (2009) further stress that, perceptual skills which involve creating a rapport with patients is very important in health care. A positive outcome is always expected but sometimes, there might not be a significant change as in the case of Burgio, Allen-Burge, Roth et al.'s (2001) study where trained HCAs in communication skills communicated effectively with residents in a care home but the behaviours of the residents remained the same.

It could be argued that many factors can hinder the positive effects of good communication e.g. state of health such as dementia, age, climate, environment etc. it is therefore important for health workers to put into consideration these factors when making conclusions about people's responses. Grover (2005) insists that various values need to be considered before an effective communication takes place:

Empathy involves understanding the feelings of others i.e. putting yourself in one's shoes but at the same time, not being overtaken by those feelings by applying behavioural, emotional and intellectual skills (Williams and Stickley, 2010). Kunyk and Olson (2001) expatiate that understanding the patient's needs, will help in providing solutions.

When one shows competence in solving patient's needs, it leads to trust.

Trust is needed both on individual and organizational levels. Rutherford (2014) believes that service-users tend to choose certain care providers over others based on their feelings of security in the care of those providers. Trust also involves confidentiality between patients and care givers as well as among care providers. On an organizational level, Laschinger and Finegan (2001) believe that workers who are empowered by their organization turn out to be more effective and productive than those that do not.

In his emotional intelligence (EI) paradigm, Morrison (2006) identifies the domains of intrapersonal and inter-personal communication. He maintains that the former deals with being aware of, and able to manage one's emotions, while the later involves being aware of others' feelings and exhibiting good relationship skills e.g. empathy (see appendix 5). There have been past experiences, where service-users exchanged harsh words with auxiliaries and even nurses due to poor communication techniques. The issue of poor communication however, affects everyone, as patients usually bank on the

saying that service-users are right always (Muir and Jackson, 2013). There is therefore, the need for people to study themselves and learn to control their emotions when interacting with others.

4.6.3. Attitude/character

This is usually associated with mood. Briant and Freshwater (1998) argue that nurses, like others, have emotions and sometimes show expressions based on previous experiences. They however, advice that nurses learn to control their feelings and emotions when dealing with people. This factor is very important as there have been complaints of Nigerian nurses being rude and uncompassionate to their patients (This Day, 2015). If this is the case with trained and qualified nurses, then worse is expected from the untrained auxiliaries. Though there is a lack of written information on the character of auxiliaries towards service-users in Nigeria, the writer has, in the past, experienced patients' complaints over this issue.

4.6.4. Evidence-Based Practices

Irrespective of their years of experience in the clinical settings, auxiliary nurses in Nigeria lack the knowledge base that guides their actions. This argument also lacks literature support; however, a blog post by Ikeji (2015) reveals the complaints of a concerned senior nurse over this issue, where she calls the attention of the Nursing and Midwifery Council of Nigeria (NMCN) to the unacceptable practices of this group, as they perform actions without a backup rationale. The writer believes that this represents the views of other nurses in the country.

4.6.5. Appearance/Dressing

The writer found no literature on the issue of dressing as regards auxiliaries in Nigeria. This is totally based on past experiences. Service-users often complained about the auxiliaries' careless ways of dressing e.g. wearing of slippers, dirty, rumpled and torn uniforms, unkempt hair etc. on duty. Service-users would therefore, prefer to be attended to by a neatly dressed staff. It is arguable that dressing plays an important role in the judgement of patients about the care-provider. This is also proved in a study by Thomas, Ehret, Ellis et al. (2010) which contends that people can often have the right or wrong perceptions about healthcare providers based on appearances.

With the above-discussed, it is important to note that leadership and performance monitoring is essential to maintain standards after training (Dieleman, Gerretsen, Van der Wilt et al., 2009). Introduction of a training programme for HCAs and regular monitoring of practices in health practices is therefore crucial in improving patient care. This is however, a very large and intensive project which will require different minds and experiences in order to implement plans. The writer therefore, presents ideas on the project with the aim of modifying and improving on these plans when a project team is formed in Nigeria.

4.7. Preliminary Project Plans

Inspiration was drawn from the writer's ANM project which involved exploring and evaluating the roles and training needs of HCAs in Nigeria. Healthcare systems were compared among three countries-Nigeria, Ghana and the UK for the purpose of the project. The writer therefore sees this dissertation as an extension of the ANM project and has found the NHS (2016) Plan, Do, Study, Act (PDSA) tool (see appendix 6) useful in the project development. This tool was selected because of its simple, yet effective nature in the NHS as it is known to assist with simple to complex projects, whilst avoiding unnecessary errors (NHS, 2016). The writer therefore believes that it will help with a pilot study in one or two hospitals in Lagos-Nigeria, before the project goes national if successful. The PDSA tool asks three questions:

- What are we trying to accomplish? (aims of the study/planning)
- How will we know that a change is an improvement? (measurement/study)
- What changes can we make that will result in improvement? (ideas for change/act)

(NHS, 2016).

4.7.1. What are we trying to accomplish?

As stated in chapter one, the aim of the study is to discover what the roles and training needs of Nigerian auxiliary nurses should be, through exploring and comparing practices in different countries with the aid of relevant literature and useful information in order to recommend a training programme for them. This is the beginning of the planning stage, involving short-term/long-term objectives and outcomes. The short-term objectives include observational visits to the HCA clinical skills academy in a local NHS educational institution, participation in the four modules that make up the MSc advanced nursing programme, extensive literature search, verbal information, as well as the dissertation work. These have improved knowledge and exposure in light of the essence of training HCAs.

The long-term objectives are expected to take place in Nigeria where a team of supporting colleagues will be formed and contacts made with stakeholders (see appendix 7 for stakeholder analysis). Stakeholders are individuals, organizations or groups who might have an interest, influence or be involved in a project (Weiss, 2014). Since it is a new project, developing a business plan might be helpful and this will be presented to the NMCN for approval. In the long run, this will help with the introduction of the programme at least within the next five years of the writer's return to Nigeria.

As every project has their challenges, Lewin's (1951) force field analysis is used to identify the forces that might work in favour or against the project (see appendix 8). Included in the planning stage, are the strengths, weaknesses, opportunities and threats (SWOT) analyses. According to Yuan (2013), strengths and weaknesses are internal influences in individuals or group members, seen as capabilities e.g. good communication skills; or areas that require improvement e.g. poor advocacy skills. Since the project will require full team work, these factors will be analysed among members. Conversely, Yuan (2013) identifies opportunities and threats as external influences that could support or prevent the success of the project. Appendix 9 shows some of the writer's analyses of these factors. Dyson (2004) however argues that these threats and weaknesses could be converted to strengths and opportunities through a tool called TOWS matrix (threats, opportunities, weaknesses, strengths). Examples of changing threats to opportunities are represented in appendix 10; the weaknesses-strengths conversion will be analysed by the team members in Nigeria.

4.7.2. How do we know if a change is an improvement?

This involves monitoring and evaluation of the training programme i.e. assessment of project success and judgement of expected outcomes (Huda, Khan, Ahsan et al., 2014). It requires collaboration among team members as observations will be made in health facilities in order to record progress. Monthly progress recording is suggested by the NHS (2016) with the use of graphs and statistical tools to prevent bulky data which might be difficult to read. The writer suggests informal and formal interviews on service-users, colleagues and HCAs, to identify any progress, concerns or lapses. Team members might find it beneficial to make use of Kirkpatrick's (1996) four-level evaluation model from the initial stage of implementation to the measurement of outcomes as this will help identify areas for improvement. This is represented in the box below in order not to exceed the word limits for the dissertation.

Box 1: Kirkpatrick's Evaluation Model

Reaction: assesses the satisfaction level of the participants/trainees in a training programme. It involves evaluating the feelings of the participants towards the programme. Kirkpatrick (1996) emphasizes the need to understand this process as learning cannot occur without those involved being comfortable with the programme. He therefore suggests the use of quantifiable forms/questionnaires where trainees are expected to make comments on how they perceive the programme. These comments are intended for future amendments and improvement of the programme. Records should also be kept by co-ordinators, and observations noted.

Learning: following the feedback of trainee's feelings, it is expected that learning takes place if the feedback was positive. Kirkpatrick (1996) however argues that positive reactions do not always guarantee learning. This argument is based on the argument that though some teachers/presenters may have colourful presentation slides, visual aids and attempt to display total expertise, a close examination may reveal that learning did not take place because the participants were not fully involved in the process (Collins, 2004). Collins (2004) suggests participatory activities such as group discussions, questioning and role-play in order to enhance learning as individuals tend to learn in different ways.

Again, Kirkpatrick (1996) advises the use of quantifiable tools, to make objective analyses of the learning outcomes through trainee opinions. A pre-test and post-test is also advisable to identify an increase in knowledge of the subject area.

Behaviour: is the practical aspect of the four levels where trainees are expected to demonstrate what they have been taught. Kirkpatrick (1996) contends that it is not enough for participants to perform well in the class; 'doing' is the zenith of all learning. He further clarifies that in order to make a change in behaviour, individuals should: possess the zeal to improve, acknowledge their own weaknesses, be helped by a more experienced and skilled person, work in a tolerant environment and try out innovative ideas. It is expected that the HCA training programme will have a practical session where participants will work in the clinical settings under the supervision of nurses. The writer therefore, suggests that observations be made and noted in these settings by the managers and nurses in charge. Information can also be acquired from service-users verbally in the initial stage. This is in order to make corrections and assist in their (HCAs) learning.

After the training programme, observations and assessment of behaviour will continue and biweekly/monthly reports given to track progress. Patient interview is also expected. This stage could however, be seen as inter-mediate or long-term evaluation process as it involves long periods of assessment.

Results: this last stage is a long-term process where evaluation is made based on the advantages of the training programme on improved quality, patient satisfaction, reduced cost and better production. From a business point of view, Praslova (2010) suggests involving experts in the evaluation and considering the interests of stakeholders at this stage. Patient satisfaction will be measured through interviews and health improvement will be analysed by comparing data before the programme implementation with the present data. NHS (2016) suggests the use of statistical process control (SPC) tools such as graphs in gathering data.

Whilst Holton (1996) sternly argues that this model lacks complexity and research in the causal factors leading to outcomes e.g. motivation to learn and change behaviour, there is no doubt that this simplicity will aid proper understanding of the steps and will help with its effective application. It is however, important for trainers to understand the reason behind the interest of trainees enrolling into a programme in order to devise effective training methods. This could be done at the first contact between trainees and trainers possibly with the use of questionnaires.

4.7.3. Change Ideas- what changes can be made that will result in improvement?

Change ideas are expected to arise after implementation (see below) and evaluation. It is the obligation of team members to meet and reflect on the outcome of the project i.e. reflect on what went right or wrong and make corrections. When an approach does not yield good results, it is advised to make changes by developing sequential PDSA cycles and seeking the opinion of stakeholders, colleagues and experts on alternative approaches (NHS, 2016). The writer has made a sketch of implementation plans for the project. This is expected to be reviewed and improved when the project team is formed.

4.8. Implementation Plans

Evidence, facilitation and context are three influencing factors identified by Kitson, Harvey and McCormack (1998) that are essential when implementing a project. They emphasize that absence of one of these factors might lead to failure of project implementation. As mentioned earlier, evidence encompasses the use of clinical expertise, studies and patient values in making decisions about health care (Fineout-Overholt et al. 2005). Heron (1989) describes facilitation as the skilful support given by team members or individuals to others in order to assist them with behaviour modification. While Schmidt, Beigl and Gellersen (1999) define context in view of surroundings and situations where communication and information processing occur, this description fits well into Senge and Sterman's (1992) definition which identifies a context as the setting where a desired change implementation is to take place.

Evidence: in as much as there is a dearth of written evidence surrounding the training of HCAs in Nigeria (Fawole et al., 2009) unlike the UK where there is a lot of literature in this regard (e.g. McKenna, Hasson and Keeny, 2004; Keeny, Hasson, McKenna and Gillen, 2005; Bosley and Dale, 2008) it is evident, from all that has been discussed that training is essential if they are needed in the system, as anyone could be a victim of malpractice (see DWN, 2015)

Context: in the Nigerian context, based on the writer's experience, people are more interested in stopping the existence of the auxiliaries than to advocate for their training. However, in developed countries such as the UK, the environment is

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receptive to this concept. Awareness in Ghana is also increasing as the need for their training has been identified (Appiah-Denkyira, Herbst, Saucat et al., 2013).

Facilitation: as observed by the writer, there is a high level of support given to HCAs from nurses and the UK government, as the nurses are in charge of their training and the government has endorsed this with the introduction of the *care certificate* (NHS, 2015). Though many Nigerian nurses still do not support their existence, a few still believe that they need to be regulated (Brighthp, 2005). The following table shows the implementation plan sketch.

Table 3: Implementation Plan Sketch

Factor	Description	Activities involved
Human resource	Colleagues and individuals that will make up the team	<ul style="list-style-type: none"> • Consult experienced and interested people for advice • Develop a project team • Explore theories and literature on team formation and team work
Time resource	Time needed to achieve goals	<input type="checkbox"/> Set deadlines for each step of the project and work towards achieving goals within set time
Financial resources	Funds and capital needed for the project	<ul style="list-style-type: none"> • Research by team members on potential support organizations • Seek support from organizations when project is approved
Business proposal development	A business plan for the project	<ul style="list-style-type: none"> • Brainstorming amongst members of the team and experts on how to develop a convincing business proposal. • Develop the proposal considering the current situation of Nigeria at that point in order to come up with ideas that will motivate stakeholders
Business plan appraisal	Identifying the strengths and weaknesses of the proposal through Critiques	<ul style="list-style-type: none"> • Seek professional and expert opinion • Give a pseudo presentation to colleagues and professional friends • Make amendments from their feedback
Ethical Endorsement	Approval from authorities	<input type="checkbox"/> Seek approval of the project from the NMCN and Ministry of Health (MOH)
Project implementation (small scale)	Project testing and evaluation	<ul style="list-style-type: none"> • Conduct a pilot study in one or two government approved hospital in Lagos using a PDSA tool. • Training can last from 3-6 weeks depending on project team/stakeholders' decision. • If outcomes are successful (evaluated within an estimated period of two years), full implementation may take place.

4.9. Summary

The chapter presented an overview of the dissertation topic, discussing emergent underpinning theories, available and relevant literature as well as verbalized and observed evidences. The WHO (2005) toolkit on problem identification proved useful in identifying and analysing the healthcare issue on auxiliary nurses in Nigeria. The section further presented a plan sketch for implementation of the training programme in Nigeria.

5. CONCLUSION AND RECOMMENDATIONS

This chapter will give a general conclusion of the entire dissertation and make recommendations expected to contribute to the service improvement of the Nigerian health system as well as the global health system. The writer will also reflect on achievements of the entire advanced nursing programme that have led to the dissertation work. Strengths and limitations of the dissertation will also be pointed out.

The dissertation commenced with an introduction to the need for a strong, reliable, trained and competent health workforce in Nigeria. Focus was on nursing auxiliaries who lack formal training but carry out the roles of professionals in mainly Nigerian private hospitals. These muddling up of roles and lack of training has led to improper practices that endanger serviceusers' lives; hence the question- '*What should be the roles and training needs of HCAs in*

Nigeria?'

This question was seen as one that would need an answer that is not based only on observed data, but one that will need in-depth analysis of the problem at hand, exploring the possible causes of the absence of a training programme for these auxiliaries in Nigeria through giving a concise history of nursing in the UK and Nigeria and comparing healthcare trends and training practices of HCAs in other parts of the world. The critical realist review was therefore selected for the dissertation as it involves studying underlying factors that influence observable phenomena especially in social interventions such as nursing.

Whilst limitations of the CRR were noted, it was justified that this review is essential in studying the Nigerian healthcare system, identifying potential barriers to the introduction of a training programme for the auxiliaries and adopting strategies from other countries that can be modified to soothe the Nigerian context. The use of empirical studies and systematic reviews in research was not condemned; however, it was clarified that these will be beneficial when the training programme is eventually implemented as they will measure its effectiveness on patient care and satisfaction.

A wide range of databases were used to search for evidences for the dissertation work. Search was however, not limited to published articles and books, but went as wide as exploring internet forums and blogs in relation to the review topic as there was a lack of literature concerning Nigerian auxiliary nurses.

The paper further discussed relevant literature in diverse fields such as sociology, economics, education, psychology and politics as well as related theories in order to promote a deeper understanding of the subject matter. Since the dissertation stresses the need for a training programme, the writer provided a sketch for introduction of the programme and its implementation in view of developing and modifying it with the help of a project team and stakeholders in the near future. Nevertheless, it is essential to identify the strengths and limitations of this dissertation for future service improvement.

5.1. Strengths of the Dissertation

With the aid of a CRR, this dissertation attempted to provide a vivid understanding of social interventions such as nursing, emphasizing that patient care is an open sociological process that requires a holistic approach by combining clinical research, expertise/experience and patient preferences in the plan of care (Fineout-Overholt et al., 2005). It means that every possible evidence, whether experimented or experienced is essential in patient care. There is no 'best way' to gather evidence but a combination of these evidences will go a long way in promoting health and wellbeing. It is therefore expected that this dissertation will be presented to stakeholders for review in order to device strategies that will work towards the training programme based on the recommendations.

5.2. Limitations of the Dissertation

In addition to limitations of CRR in chapter 3, there was a lack of literature on Nigerian auxiliary nurses as some of the information was mainly from the writer's experience and anecdotes. There is however, a pressing need for training HCAs in Nigeria as this directly involves the health of the nation. With this in mind, this paper will provide some recommendations for future service development.

5.3. Recommendations for Practice

It is important to note that these recommendations are not prescriptions but suggestions that may contribute to the development of health systems. They are also subject to adjustments in future:

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- More research in this subject area: This is a call for nurse researchers to carry out more study on the roles and training needs of Nigerian auxiliary nurses to build up more evidence for the introduction of a training programme.
- Training of HCAs in Nigeria: The introduction of a training programme will promote competence, accountability and quality patient care.
- Defining the roles of HCAs: Though their roles sometimes overlap with that of nurses, there is need to identify major role differences.
- Supervision by nurses: since HCAs have minimum training when compared with nurses, supervision by nurses is recommended.
- Regulating the number of trained HCAs per year, in order to promote an even distribution of nurses and HCAs especially in Nigerian private hospitals. This will prevent unemployment for nurses.
- Deciding on a common title: the different titles e.g. nurse assistants, auxiliaries, aides, HCAs tend to cause confusion among the general public. A common title is therefore recommended for easy identification.
- Registration and regulation: these will encourage accountability, commitment and a sense of belonging for the HCAs. A registration document e.g. certificate or licence will help to endorse this.
- Rewards and incentives: these will improve performance and minimize unacceptable behaviours; for instance, an outstanding performance will attract advancement into the nursing programme.
- Frequent monitoring and evaluation of practices in healthcare by the NMC, MOH and health service commission (HSC).

5.4. Reflection on Achievements

The advanced nursing programme has widened my knowledge about the nursing profession. It comprised of four rigorous yet interesting modules that have helped me achieve this dissertation work.

Firstly, the theory and practice of advanced nursing (B74TPN) module exposed me to theories, frameworks and concepts in nursing and these have guided my dissertation work as well as my personal/professional activities by triggering my thought process in the analysis and synthesis of concepts. Secondly, the evidence for health and social care (B74EFH) module threw more light on available research methodologies of which, the CRR approach seemed more suitable for my topic after seeking professional/expert advice and guidance. Next, the teaching and learning in health and social care (B74TLH) module, helped with identifying various teaching methods and teaching/learning theories. This is expected to serve as a guide for the training programme of HCAs upon my return to Nigeria. Lastly, the advancing nursing and midwifery in a global context (B74ANM) module challenged me to explore global health trends, making comparisons among countries and learning exemplary practices that will benefit the Nigerian healthcare system. This involved observational visits (as discussed earlier) which have created an indelible positive impact in my personal and professional life.

All these activities have contributed to my present achievement which is expected to advance nursing locally and internationally by creating awareness of what nursing is and the importance of training HCAs to improve patient care.

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APPENDICES – A

Appendix 1: The Care Certificate

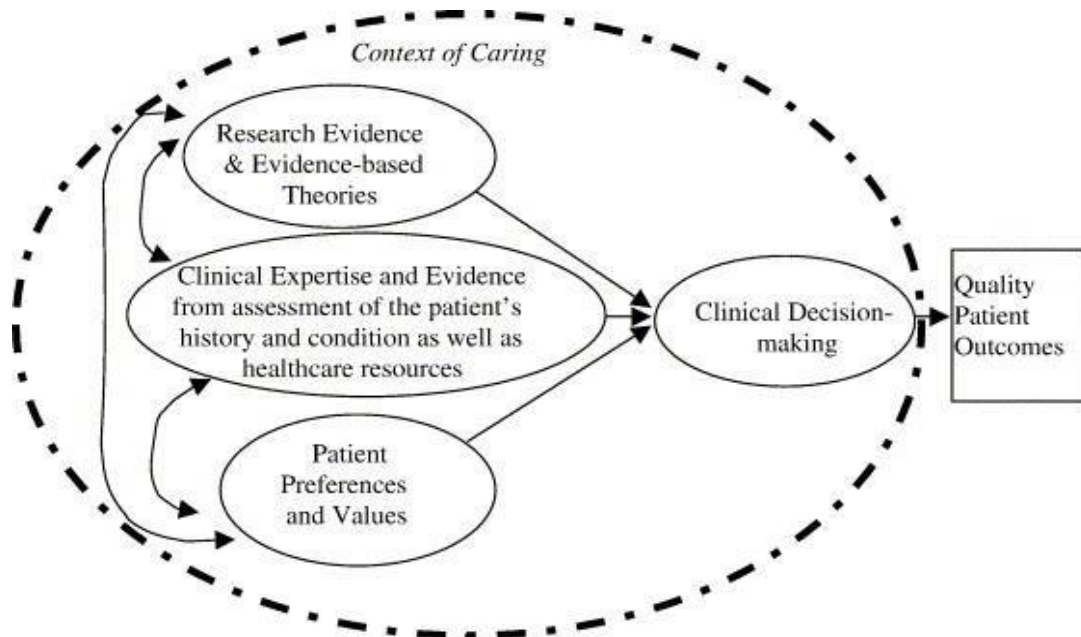
What is the Care Certificate? The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Designed with the non-regulated workforce¹ in mind, the Care Certificate gives everyone the confidence that these workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Regulated staff (e.g. Doctors, Nurses, Social Workers, Occupational Therapists) gain similar skills and knowledge within their professional training so they do not need to also achieve the Care Certificate. The Care Certificate: applies across health and social care; links to competences (National Occupational Standards) and units in qualifications; covers what is required to be caring; will equip workers with the fundamental skill they need to provide quality care; and gives them a basis from which they can further develop your knowledge and skills as their career progresses. What are the standards? The 15 standards in the Care Certificate are:

1. Understand your role
2. Your personal development
3. Duty of care
4. Equality and diversity
5. Work in a person centred way
6. Communication
7. Privacy and dignity
8. Fluids and nutrition
9. Awareness of mental health, dementia and learning disability
10. Safeguarding adults
11. Safeguarding Children

- 12. Basic Life Support
- 13. Health and Safety
- 14. Handling information
- 15. Infection prevention and control

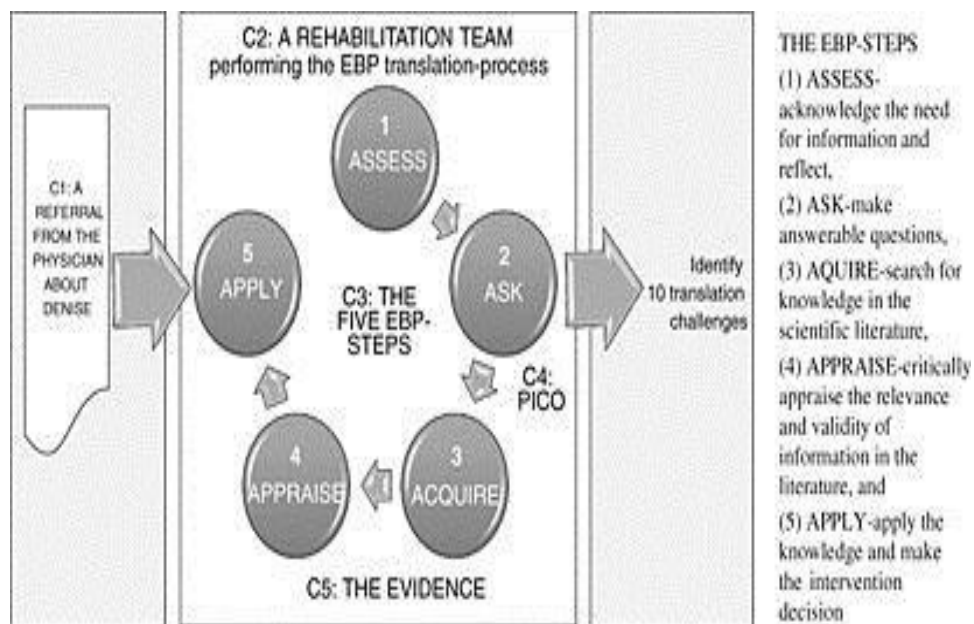
Adopted from HEE (2015)

Appendix 2: Evidence-based practice



Adopted from Fineout-Overholt et al. (2005)

Appendix 3: Evidence-Based Practice steps



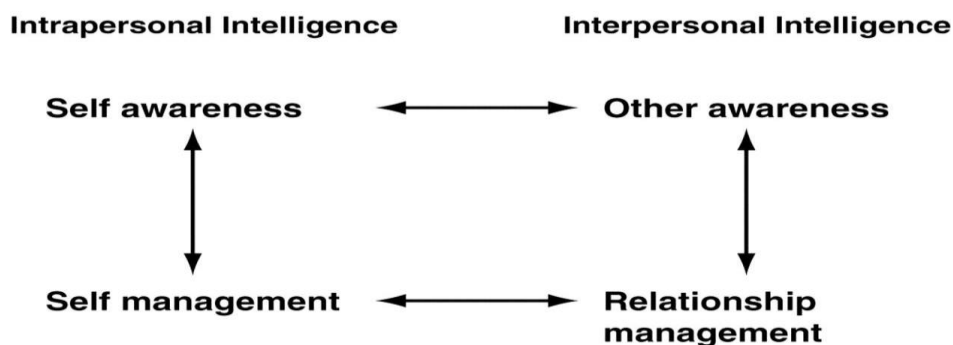
Adopted from Aas and Anderson (2012)

Appendix 4: Pawson et al’s (2004) initial sketch of the realist review synthesis

Define the scope of the review	Identify the question	<input type="checkbox"/> What is the nature and content of the intervention? What are the circumstances or context for its use? <input type="checkbox"/> What are the policy intentions or objectives? <input type="checkbox"/> What are the nature and form of its outcome or impacts? <input type="checkbox"/> Undertake exploratory searches to inform discussion with review commissioners/decision makers
	Clarify the purpose(s) of the review	<input type="checkbox"/> Theory integrity - does the intervention work as predicted? <input type="checkbox"/> Theory adjudication - which theories about the intervention seem to fit best? <input type="checkbox"/> Comparison - how does the intervention work in different settings, for different groups? <input type="checkbox"/> Reality testing - how does the policy intent of the intervention translate into practice?
	Find and articulate the programme theories	<input type="checkbox"/> Search for relevant theories in the literature <input type="checkbox"/> Draw up ‘long list’ of programme theories <input type="checkbox"/> Group, categorise or synthesize theories <input type="checkbox"/> Design a theoretical based evaluative framework to be ‘populated’ with evidence
Search for and appraise the evidence	Search for the evidence	<input type="checkbox"/> Decide and define purpose sampling strategy <input type="checkbox"/> Define search sources, terms and methods to be used (including cited reference searching) <input type="checkbox"/> Set the thresholds for stopping searching at saturation
	Appraise the evidence	<input type="checkbox"/> Test relevance – does the research address the theory under test? <input type="checkbox"/> Test rigour – does the research support the conclusions drawn from it by the researchers or the reviewers?
Extract and synthesise findings	Extract the results	<input type="checkbox"/> Develop data extraction forms or templates <input type="checkbox"/> Extract data to populate the evaluative framework with evidence
	Synthesise findings	<input type="checkbox"/> Compare and contrast findings from different studies <input type="checkbox"/> Use findings from studies to address purpose(s) of review <input type="checkbox"/> Seek both confirmatory and contradictory findings <input type="checkbox"/> Refine programme theories in the light of evidence
Draw conclusions and make recommendations		<input type="checkbox"/> Involve commissioners/decision makers in review of findings <input type="checkbox"/> Draft and test out recommendations and conclusions based on findings with key stakeholders <input type="checkbox"/> Disseminate review with findings, conclusions and recommendations

Adopted from Pawson et al (2004)

Appendix 5: Morrison’s (2007) Emotional Intelligence Paradigm



Adopted from Morrison (2007)

Appendix 6: The Plan, Do, Study, Act (PDSA) cycle



Adopted from NHS (2016)

Appendix 7: Stakeholder Analysis The table below will show the stakeholder analysis, a method identified by WHO (2016) that assesses the level of influence or importance of stakeholders. It will also present a draft of the strategies expected to be applied in order to gain their support. It is in order of the mostly affected (top to bottom)

Stakeholders	How affected, involved or interested	Strategies to win their support
Service-users/patients	They are directly affected and can influence project through social media	<ul style="list-style-type: none"> • Develop a friendly relationship with them • Identify their preferences/choices on the training of nursing auxiliaries through informal/formal interviews • Involve those with advocacy abilities in the whole process
Nursing auxiliaries	Directly involved and affected	<ul style="list-style-type: none"> • Approach them in a friendly manner • Acknowledge their contributions to the health system • Seek their opinions on the training subject • Provide reliable answers to their questions
Nurses/peers	Completely affected; some might not get involved	<ul style="list-style-type: none"> • Initially seek supporters • Consult experienced and interested colleagues • Involve the resisting group and find out reasons for their resistance • Offer to speak at workshops and seminars • Give convincing presentations at seminars/workshops on the need for training auxiliaries

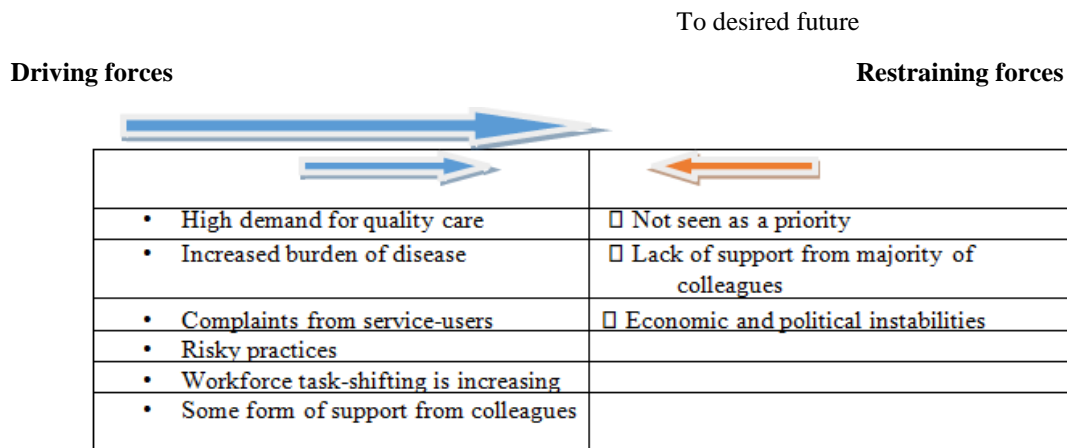
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Doctors	Fully affected but some might not get involved	<ul style="list-style-type: none"> • Consult medical colleagues and friends for advice • Include influential supporters in the project team • Offer to make presentations at their conferences if invited
Immediate manager	Might show some interest in implementing change	<ul style="list-style-type: none"> • Be friendly, yet professional with him/her • Be credible at work • Present ideas and seek advice
Senior manager	May be interested and partially involved	<input type="checkbox"/> Have a good professional relationship <input type="checkbox"/> Work credibility <input type="checkbox"/> Seek advice and suggestions
Policy makers/Government executives	May be interested in economic benefits of the programme	<input type="checkbox"/> Look for links through colleagues and friends who have connections with the government <input type="checkbox"/> Present ideas in a convincing manner
Ministry of health	Expected to be fully interested, involved and influential	<input type="checkbox"/> Make connections through friends and colleagues in the ministry or those who have contacts with the ministry
Ministry of education	Not very affected but expected to be involved	<input type="checkbox"/> Make links through friends and colleagues
Media	Highly interested and involved	<input type="checkbox"/> Make contacts through friends and colleagues

Ideas from WHO (2005) toolkit for nurses and midwives- stakeholder analysis guide

Appendix 8: Applying Lewin’s Force Field Analysis



Adopted from Lewin (1951)

Appendix 9: Analysis of Opportunities and Threats

Opportunities	Threats
<input type="checkbox"/> Support from the general public	<input type="checkbox"/> Oppositions from the medical profession
<input type="checkbox"/> The media will be willing disseminate information to	<input type="checkbox"/> Oppositions from nurses
<input type="checkbox"/> Support from some colleagues	<input type="checkbox"/> Minimal interest of the government
<input type="checkbox"/> Seminars and workshops	<input type="checkbox"/> Unstable economic and political status
	<input type="checkbox"/> Negative image of nursing created by the media

Ideas from Yuan (2013)

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Appendix 10: Changing Threats to Opportunities The table below will show how threats can be converted to opportunities through various strategies

Threats	Opportunities	Approaches
<input type="checkbox"/> Oppositions from doctors	<input type="checkbox"/> Seminars, workshops, networking	<ul style="list-style-type: none"> • Talk to medical friends • Offer to speak at seminars, meetings • Make contacts with office holders in the profession
<input type="checkbox"/> Oppositions from nurses	<input type="checkbox"/> Workplace, seminars, meetings	<ul style="list-style-type: none"> • Discuss with colleagues at work • Discuss with direct manager • Offer to speak at seminars
<input type="checkbox"/> Negative image of nurses by media	<input type="checkbox"/> The media is willing to give information about nurses	<ul style="list-style-type: none"> • Gain access through friends/colleagues and provide useful information about the training • Create forums for discussion on social media
<input type="checkbox"/> Economic instability	<input type="checkbox"/> Many private hospitals	<ul style="list-style-type: none"> • Gain approval and suggest pilot study in one or two hospitals in Lagos • Seek funding from support organizations • Evaluate outcomes and present results to stakeholders

Adopted from Dyson (2004)