Hospital Policies and Nurses'Attitudes in Israel towards Paid carers' Tasks during Patient Hospitalization*

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RÉSUMÉ

Beaucoup de patients âgés hospitalisés sont fonctionellement dépendant et, pendant leur hospitalisation, ils emploient soignants rémunérés pour effectuer diverses tâches. Cette étude a examiné les attitudes des infirmières au sujet des tâches que les soignants doivent ou ne doivent pas être autorisés à jouer dans la prestation de soins durant l'hospitalisation, et les facteurs sous-jacents ces attitudes des infirmières vers les soignants rémunérés. L'étude a impliqué des interviews de cinq informateurs clés, tels que les infirmières en chef et les directeurs médicaux dans deux hôpitaux et des enquêtes sur 265 infirmières en médicine interne et gériatrie générale. Bien que pas de politiques ou directives formelles existent en ce qui concerne les tâches effectuées par les soignants rémunérés, la plupart des infirmières croyaient que les soignants rémunérés devraient être autorisés à effectuer certaines tâches, sauf pour celles qui entraînent soins infirmiers professionnels. Les caractéristiques des infirmières et des hôpitaux ont contribué à expliquer les attitudes des infirmières envers la participation des soignants remunérés avec les bénéficiaires âgés de soins. Les résultats de cette étude indiquent un besoin de politiques explicites et des orientations pratiques pour soignants rémunérés de patients âgés au cours de l'hospitalisation.

ABSTRACT

Many hospitalized older patients are functionally dependent and, during their hospitalization, employ paid caregivers to perform various tasks. This study examined nurses' attitudes regarding the tasks these care workers should or should not be allowed to perform in providing care during hospitalization, and the factors underlying nurses' attitudes towards these paid carers. The study involved interviews of five key informants such as head nurses and medical directors in two general hospitals and surveys of 265 nurses in internal medicine and geriatric wards. Although no formal policies or guidelines existed with respect to the tasks that paid carers perform, most nurses believed that paid carers caregivers should be allowed to perform certain tasks except for those involving professional nursing. Hospital and nurses' characteristics were significant in explaining nurses' attitudes towards paid carers' involvement with older care recipients. The study results indicate a need for explicit policies and practice guidelines for paid carers of older patients during hospitalization.

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Introduction

As older adults age, they increasingly use more health care services, including in-patient care. The majority (56%) of patients in internal medicine wards in Israel hospitals are aged 65 and older, although they comprise only 10 per cent of the general population. Their total bed-days are 40 per cent of the total bed-days in hospitals (Ministry of Health, 2010a), and they represent 64.7 per cent of the patients in internal medicine wards (Ministry of Health, 2010b). In the United States, 40 per cent of bed-days are occupied by older people, although they are only 12 per cent of the population (Masttison & Marcantonio, 2012).These proportions are expected to increase with the aging of the population.

Many older adults who are hospitalized are functionally disabled, bedridden, or cognitively impaired, and they need intensive and extensive assistance with basic daily activities (Silverstein & Flaherty, 2012; Zisberg et al., 2011). Yet work overload and a growing shortage in the nursing labor force significantly limit the ability of nursing staff to effectively meet the complex nursing needs of these patients (Hui, Wenqin, & Yan, 2012). For example, the standard for nursing staff in Israeli hospitals did not increase between 1995 and 2010 (Ministry of Health, 2012), and projections foresee a severe shortage in nursing staff in the future (Stessman, 2011). Therefore, family members share caregiving tasks, stay with their family members, and/or employ paid carers to look after their older family members during hospitalization. However, permission to employ paid carers in hospitals varies across countries. For example, in most Northern European welfare states, the practice of paid carers working alongside hospital staff is either non-existent or is a marginal phenomenon. In contrast, the phenomenon is very common in Mediterranean countries (Sapountzi-Krepia et al., 2006).

Research findings (Hemsley, Balandin, & Worrall, 2011b) have shown that there is ambiguity regarding paid carers' roles and responsibilities, and that there are no policies or practice guidelines to guide paid carers' roles and role boundaries. It is important, therefore, to examine the policies determined by top management and the attitudes of frontline nurses regarding the tasks that paid carers should or should not be allowed to perform during hospitalization. This is an issue that has rarely been examined, particularly with regard to functionally disabled older patients with complex care needs.

Theoretical Framework

The socio-ecological model (Bronfenbrenner, 1979, 1999) is an appropriate theoretical framework to guide our understanding with respect to how a combination of hospital organizational characteristics, hospital policies, and nursing staff qualifications and characteristics are connected with nurses' attitudes towards the involvement of paid carers during the hospitalization of their functionally dependent older care recipients. According to this theoretical model, a system is composed of several subsystems that interact, transact, and affect each other. These include the *microsystem* (the patient), which is the focus of intervention, the *mesosystem* (nursing staff, paid carers) that has the direct and closest contact with the microsystem, and the *exosystem* (the hospital as an organization, policies), which directly affects the behaviors of the mesosystem and, indirectly, the microsystem.

The core concept of the socio-ecological model is that behavior has multiple levels of influence, often including the intrapersonal (biological, psychological), the interpersonal (families, paid carers, work groups), and the organizational (organizational culture, management styles, organizational structure, physical environment). We hypothesized that nurses' attitudes towards migrant live-in paid caregivers who care for functionally dependent older patients would be connected to the hospitals' characteristics and policies as well as to the nurses' own characteristics.

Private Paid Carers in Hospitals

Because of the heavy workload imposed on them, the nursing staff can barely give adequate attention to and meet the complex needs of their patients (Sapountzi-Krepia et al., 2006, 2008), particularly those who are bedridden or cognitively impaired (Cho & Kim, 2006). Also, families have limited time to stay with and care for their older family members in hospitals. To combat this situation, many families hire paid carers to replace them, particularly when the patient is an older person who is functionally dependent or cognitively impaired. In Greece, for example, researchers have found that the majority of in-patients had paid carers and about a quarter of the families reported that the staff recommended hiring a paid carer (Sapountzi-Krepia et al., 2006). In Korea (Cho & Kim, 2006), the majority of paid carers in hospitals provided care to older patients who were functionally disabled and hospitalized for longer durations. Furthermore, some paid carers even stayed in the hospital around the clock (Eldar & Eldar, 1984).

Paid carers perform a variety of roles in hospitals. For example, McCluskey (2000) found that hired personal carers performed five different roles: attendant, protector, friend, coach, and negotiator. Hemsley et al. (2011b) found that paid carers of adults with developmental disabilities had an important role in supporting their care recipients: they provided information, delivered basic care, and facilitated communication with hospital

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staff. Furthermore, Hemsley et al. found that due to lack of time, the nurses avoided communication with the patients, preferring that family or paid carers communicate on behalf of the patient (Hemsley, Balandin, & Worrall, 2011a).

However, studies that examine paid personal care to functionally disabled older persons in hospitals are rare. In Israel, included in the general practice guidelines determined by the Israel Ministry of Health (2009) is the responsibility imposed on the nursing staff for providing all nursing care tasks. The employment of paid carers is forbidden unless several strict conditions are met (e.g., they must undergo some specific training to qualify to provide personal care in the hospital).

Migrant Care Workers in Elder Care

In Israel, migrant live-in home care workers comprise about one third of all care workers who provide home care services to functionally disabled older adults. The phenomenon of migrant live-in care workers in the field of elder care has started to develop in many Western and aging countries due to a shortage of local care workers. To some extent, these workers become fictive kin of their care recipients because they co-reside with them and develop close relationships that resemble family relationships (Cox & Narula, 2003; Iecovich, 2010). According to the long-term care insurance law in Israel (Iecovich, 2012), disabled older persons are eligible to receive in-kind benefits and hire migrant live-in home care workers who are available around the clock. When the care recipient is hospitalized, he or she can continue receiving this benefit during hospitalization for up to 14 days. Studies conducted in Israel (Ayalon, 2009; Iecovich, 2010) have found that migrant live-in care workers performed personal care (e.g., washing, dressing, feeding, toileting), home chores, surveillance, errands, and provided social and emotional support. It is expected, therefore, that when their care recipients are hospitalized they will continue providing these kinds of support during their care recipients' hospitalization.

In the study addressed in this article, we sought to examine the extent to which there were explicit policies determined by the top management of two general hospitals, and to examine the extent to which nurses' attitudes regarding tasks that paid carers should or should not perform while looking after older patients during hospitalization were in line with these policies. In other words, it was assumed that if organizational policies prohibit involvement of paid carers in care provision, the attitudes of nurses towards the involvement of paid caregivers in providing care during older patients' hospitalization would be negative. It likewise was assumed that if organizational policies allow involvement of paid carers, then nurses would express positive attitudes towards the involvement of paid carers caring for their care recipients during hospitalization. In addition, based on the socio-ecological model, the study aimed to examine the factors that explain nurses' attitudes towards involvement of paid caregivers in care provision to their care recipients during hospitalization.

Methods

Design

The study was conducted in two big general not-for-profit hospitals: one government hospital and one non-government hospital in central Israel. The government hospital was larger than the non-government hospital in terms of total number of beds (1,430 compared to 770 respectively) and in terms of nursing personnel (about 2,000 and 1,050 respectively). In the non-government hospital, about 200 nurses were undergraduate registered nurses, 40 were graduate registered nurses, and the remainder included practical or registered nurses with no academic degree. In the government hospital, about half of the nurses were undergraduate registered nurses, about 300 nurses were graduate registered nurses, and about 700 nurses were practical or registered nurses with no academic degree.

Sample

The study combined qualitative interviews with a quantitative cross-sectional survey questionnaire. In the qualitative component of the study, interviews were undertaken with five key informants who occupied top managerial positions: two were chief nurse executives; one was a vice chief nurse executive; one was the medical director of the hospital; and one was the medical director of a wing of four geriatric wards.

The quantitative study included all the nurses from 11 internal medicine and six geriatric wards. In the government hospital were six internal medicine wards and four geriatric wards with 350 beds in total. Altogether, these 10 wards had about 290 nurses, working part-time or full-time. In the non-government hospital were five internal medicine wards and two geriatric wards with 290 beds and about 300 nurses in total. The number of nursing staff positions per ward ranged from 14 to 30, depending on the size and type of ward. All nurses were invited to participate in the study but only 265 nurses consented to participate, for a response rate of 46 per cent. In the government hospital, 122 nurses participated in the study, 62 of whom worked in internal medicine wards and 60 in geriatric wards. In the non-government hospital, 143 nurses participated in the study, 96 of whom worked in internal medicine wards

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and 47 in geriatric wards. The number of nurses in each ward who participated in the study ranged from 11 to 30, depending on the size and type of ward.

Inclusion criteria called for nurses (both practical and registered) who had been working in the ward for at least 3 months and who were proficient in either Hebrew or Russian (because many of the nurses immigrated to Israel from former Soviet Union countries [FSU] after the collapse of the Soviet regime in 1989 and their mother tongue was Russian).

Data Collection

Qualitative data collection involved semi-structured face-to-face interviews using several open-ended questions presented to each respondent. The interviews were conducted by the primary researcher who also transcribed the information obtained from the interviewees. The interview questions focused on issues such as the extent to which the respondents were familiar with the Ministry of Health practice guidelines; the extent to which the hospital had explicit policies and guidelines regarding tasks that paid carers should or should not be allowed to perform and means for their enforcement; their attitudes towards paid workers in general; and the perceived advantages and disadvantages of their presence in the wards. In addition, they were asked if the issue of paid caregivers was ever discussed in senior hospital staff meetings.

Data collection of the quantitative part of the study was performed using structured questionnaires. Respondents were given questionnaires in Hebrew or in Russian and were asked to complete them after they were given information on the goals of the study. In order to increase the response rate, respondents' anonymity was guaranteed (respondents were not asked to provide identifying personal details such as name or telephone number). Questionnaires were collected by research assistants who were employed in each hospital.

The study was approved by the institutional review boards (IRBs) (called: Helsinki Committees) in each hospital. Because of the anonymity of the questionnaires, respondents were asked to give oral informed consent to participate in the study. Thus, only those nurses who consented to participate in the study were included in the sample.

Measures

Outcome Variables

Attitudes of nurses towards paid carers' involvement in providing care in hospitals were based on measures that examined roles performed by family caregivers during hospitalization. Three items were drawn from the Bellou-Milona et al. survey (2002) (e.g., measuring temperature, giving a massage), and 30 items were drawn from the In-Hospital Informal Care Questionnaire (IHICQ) (Sapountzi-Krepia et al., 2008) (e.g., washing, dressing, providing information to the staff, monitoring inhalation/oxygen). Thus, a measure that included 33 different types of tasks was constructed. For each task, the nurses were asked if paid workers should or should not be allowed to perform it. Scores were dichotomous with 0 = no and 1 = yes. The 33 tasks were classified into 5 groups: personal care (13 items), nursing care (7 items), social support and surveillance (6 items), making the bed (2 items), and collaboration with the nursing staff (5 items). Scores for perceived roles of paid carers were summed and ranged from 0 to 33 with higher scores indicating more positive attitudes towards paid carers' involvement.

As recommended by several authors (e.g., Werner & Campbell, 1970), back-translation was used to evaluate adaptability and validity of the measures. The English version was translated to Hebrew by two bilingual translators and then from Hebrew into English and again into Hebrew, until there was agreement between the two translators that the Hebrew version fit the original version. The same procedure was used for translation of the measure to Russian. Thereafter, to examine the clarity of the questions a pre-test was conducted on 10 nurses who were asked to complete the questionnaire and give their comments. Internal consistency of the measure in this study was good ($\acute{\alpha} = 0.78$).

Independent Variables

Organizational characteristics included two primary types: (a) type of hospital – coded as government versus non-government; and (b) type of ward – coded as internal medicine versus geriatric. Four groups of organizational units were created: government internal medicine wards, government geriatric wards, non-government internal medicine wards, and non-government geriatric wards. For awareness of rules regarding paid carers' roles, respondents were asked a general question: "Do you know about rules defining what paid carers are allowed to perform in the ward?" with dichotomous responses: 1 = no and 2 = yes. Regarding the need for rules, respondents were asked a general question: "Do you think that there should be explicit rules regarding what paid caregivers should or should not perform during their care recipient's hospitalization?" with responses coded as 1 = no, 2 = don't know, and 3 = yes.

Professional qualifications included three variables. The first was professional education in nursing. In Israel there are several levels of nursing education: registered nursing includes education through high school

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and three years of nursing studies at schools of nursing; undergraduate registered nurses involves four years of study in schools of nursing in universities and colleges; and graduate registered nurses involve masters-level study in schools of nursing located in universities and colleges. In the past, there were also schools for practical nurses, but these have now been closed. There are still practical nurses working in hospitals, although they are a minority. Professional education was classified in four categories: 1 = practical and registered nurses, 2 = undergraduate registered nursing students, 3 = undergraduate registered nurses, and 4 = graduate registered nurses. In addition, the study considered professional experience (in years) and length of time working in the current ward.

Co-variates included socio-demographic characteristics of the nursing staff: age, gender, marital status (coded 1 = married and 0 = unmarried), length of residence in Israel, and place of birth (recoded 2 = born in FSU countries and 1 = otherwise).

Data Analyses

Thematic analysis was used to analyze the top management's responses to the open questions. Based on grounded theory (Glaser & Strauss, 1967), the information obtained was categorized in themes, reflecting the respondents' attitudes towards the presence of paid carers in hospital wards. For the quantitative data, descriptive analyses (percentages, means, and standard deviations) were initially performed to present the characteristics of the respondents and of the dependent and independent variables. Bivariate χ^2 analyses were carried out to examine the connection between nurses' attitudes on tasks that paid carers should or should not be allowed to perform by type of hospital and type of ward. Regression analyses were performed to examine the factors that best explain nurses' attitudes towards involvement of paid carers. Data storage and analysis were performed using IBM SPSS PC+ package version 17.

Results

Interviews

Several key issues emerged from the semi-structured interviews with the top management respondents. First, with regard to the guidelines on tasks that paid carers in hospitals should or should not be allowed to perform, all of the respondents reported that in their hospitals there were no formal policies or written practice guidelines regarding the tasks that paid carers should or should not be allowed to perform. As one of the respondents said:

"This is a gray area whereby everybody does what he or she likes."

Only one respondent recalled that there were guidelines published by the Ministry of Health a few years ago, but she did not remember what was written there. The respondents' views were that, in general, it is the responsibility of the nursing staff to meet all the nursing needs of the patients. Yet there are informal implicit guidelines stipulating that paid carers should not perform professional tasks such as administration of medicines, but should provide only help with daily activities such as feeding or surveillance. One of the respondents argued thusly:

> "Formal guidelines means formalization of the status of paid carers, and this we try to avoid because paid carers are actually surrogates of family caregivers and there are no guidelines for what family members should or should not be allowed to perform. Therefore, it is preferred that it will remain a gray area, otherwise we will have to enforce these guidelines and we're unable to do so."

Another respondent mentioned that it can raise medico-legal problems if the roles of paid carers are formally legitimized. For example, should the nursing staff share the care tasks with the paid carers? If the answer is yes, then the nursing staff is responsible for the quality of care provided by paid carers and can be legally responsible in case of mistreatment.

Second, in terms of the advantages of having paid carers, one of the respondents said:

> "It is convenient to all sides to view the paid carer as a family surrogate – he or she speaks with the patient and looks after him or her. But it is also convenient for the nursing staff because it relieves their workload. Alternatively, if there were more nurses there would be no need for paid carers."

Another respondent said:

> "It is preferable for cognitively impaired older patients to have a paid carer who looks after them than to be sedated."

One of the nurses observed:

> "The shortage in nursing staff does not allow for devoting much time on personal care, social support, or surveillance. According to the National Health Insurance law, personal surveillance is provided to patients only when there is a medical reason and not for other reasons."

In other words, hospitals had no specific organizational formal policies and/or practical guidelines regarding the tasks that paid carers should or should not be allowed to perform, although these carers play an important role in looking after older patients and relieving the workload of the nursing staff.

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Participants' Characteristics

Table 1 presents the socio-demographic characteristics of the nurses by hospital and in total. The findings show that the average age of the respondents was about 37. The vast majority were women, married, and born in European or American countries or in Israel. Most were registered nurses with academic education (undergraduate or graduate degree), while only 30 per cent were practical nurses. They had been working as nurses for an average of 13.5 years and working in the current ward approximately nine years. Significant differences were found between hospitals in the characteristics of the nursing staff. In the government hospital, the nurses were more likely to be male, younger, to have a higher professional education, and to be born in European or American countries. However, they were less likely to be married, had less professional experience, and had been working fewer years in the current ward compared to those in the non-government hospital.

Nurses' Attitudes by Type of Hospital and Ward

Table 2 presents the percentage of nurses who answered that the paid carers should be allowed to perform each of the 33 tasks by hospital and type of ward. In general, the findings indicate that most felt that paid carers should be allowed to perform all tasks connected with personal care – making the patient's bed, providing companionship and social support, and collaborating with the nursing staff – except for helping the patient to drink and escorting the patient to other units in the hospital for medical exams. Significant differences existed between type of hospital and ward with regard to these tasks. Yet only a minority of nurses had positive attitudes towards allowing paid carers to perform tasks that require professional nursing skills such as monitoring intravenous infusion, taking care of wounds, medication administration, or doing inhalations.

The findings show that, for two thirds of the tasks, there were no significant differences in nurses' attitudes by type of hospital and type of ward. However, significant differences were found between hospitals and types of ward for 11 tasks that were mostly related to professional tasks such as measuring temperature, looking after intravenous infusions, and providing inhalations. More nurses in the geriatric wards of the non-government hospital expressed positive attitudes towards allowing paid carers to perform specific personal care tasks such as helping with drinking or providing massage, compared to nurses in the geriatric wards in the government hospital. More nurses in the geriatric wards of the government hospital expressed positive attitudes towards allowing paid carers to perform nursing care tasks such as doing inhalations, measuring temperature, and looking after infusions compared to the attitudes of nurses in the geriatric wards

Table 1: Socio-demographic characteristics of the respondents

Variable	Total ($n = 265$)				Government hospital ($n = 122$)				Non-government hospital ($n = 143$)				$\chi^{2/a}$	*p*
	n	%	*M*	*SD*	*n*	%	*M*	*SD*	*n*	%	*M*	*SD*		
Age (years)	251		37.57	9.44	118		36.20	9.23	133		38.79	9.49	2.19	.029
Gender													13.14	.000
Male	38	14.5			28	23.0			10	7.1				
Education (years)													22.06	.000
Practical nursing	79	30.2			25	20.4			54	38.6				
Student	4	1.5			4	3.3			0	0.0				
Undergraduate	147	56.1			69	56.6			78	55.7				
MA+	32	12.2			24	19.7			8	5.7				
Marital status													7.49	.112
Married	192	73.8			81	66.9			111	79.9				
Place of birth													17.90	.000
Europe/America		37.0				50.0				25.9				
Asia/Africa		2.6				0.8				4.2				
Israel		60.4				49.2				69.9				
Years in Israel[b]			18.03	8.58		60	17.18	7.74		40	19.31	9.67	1.22	.224
Professional experience			13.42	9.76			12.27	9.93			14.43	9.53	1.78	.076
Years in the ward			8.83	7.09			6.93	6.61			10.48	7.10	4.13	.000

[a] Either χ square or t test is used to examine associations between two variables or differences between two groups, depending on the type of the variable.
[b] Includes only those who were not born in Israel
***SD* = standard deviation**

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Table 2: Tasks perceived by nursing staff that migrant paid caregivers should be allowed to perform, by hospital and type of ward ($n = 265$)

Task[a]	Total		Non-Government Internal Medicine		Non-Government Geriatric		Government Internal Medicine		Government Geriatric		χ^2	*p*
	n	%	*n*	%	*n*	%	*n*	%	*n*	%		
Personal Care												
1. Mouth hygiene	233	87.9	84	87.5	41	87.2	53	85.5	55	91.7	1.18	.759
2. Change pajamas	256	96.6	93	96.9	46	97.9	58	93.5	59	98.3	2.56	.464
3. Feeding	254	95.8	90	93.8	47	100.0	60	96.8	57	95.0	3.34	.342
4. Provide a bedpan	250	94.3	90	93.8	44	93.6	59	95.2	57	95.0	.24	.972
5. Shampoo hair in the bathroom	255	96.2	91	94.8	46	97.9	61	98.4	57	95.0	1.94	.585
6. Shampoo hair in the bed	221	83.4	79	82.3	43	91.5	54	87.1	45	75.0	5.98	.113
7. Wash in the bathroom	254	95.8	92	95.8	46	97.9	61	98.4	55	91.7	4.13	.248
8. Wash in the bed	216	81.5	74	77.1	43	91.5	54	87.1	45	81.5	7.23	.062
9. Transfer from bed to chair	225	85.2	77	80.2	41	87.2	55	90.2	52	86.7	3.35	.341
10. Help with walking	248	93.6	88	91.7	46	97.9	60	96.8	54	90.0	4.36	.225
11. Change positions in bed	211	79.6	76	79.2	41	87.2	48	77.4	46	76.7	2.20	.532
12. Help to drink	120	45.6	47	49.0	28	60.9	14	23.0	31	51.7	18.26	.000
13. Give massage	230	86.8	83	86.5	45	95.7	56	90.3	46	76.7	9.34	.025
Making the bed												
14. Make the bed	223	84.2	80	83.3	38	80.9	55	88.7	50	83.3	4.98	.699
15. Change sheets	211	79.6	74	77.1	40	85.1	45	72.6	52	86.7	4.98	.173
Nursing care												
16. Make inhalation	35	13.2	10	10.4	3	6.4	7	11.3	15	25.0	10.04	.018
17. Take care of wounds	50	18.9	17	17.7	7	14.9	12	19.4	14	23.3	1.36	.715
18. Measure fever	71	26.8	17	17.7	9	19.1	19	30.6	26	43.3	14.28	.003
19. Perform physiotherapy	143	54.0	42	43.8	27	57.4	41	66.1	33	55.0	7.98	.046
20. Administer oral medicines	120	45.3	38	39.6	18	38.3	35	56.5	29	48.3	5.53	.137
21. Administer other medicines	50	18.9	21	21.9	6	12.8	9	14.5	9	23.3	3.26	.353
22. Look after infusion	51	19.2	15	15.6	5	10.6	11	17.7	20	33.3	10.80	.013
Social support and surveillance												
23. Surveillance	256	96.6	92	95.8	46	97.9	59	95.2	59	98.3	1.34	.719
24. Make sure the nursing staff respond to the patient's calls	191	72.1	61	63.5	32	68.1	48	77.4	50	83.3	8.50	.037
25. Walk with the patient out of the ward	225	84.9	83	86.5	36	76.6	54	87.1	52	86.7	3.09	.387
26. Do errands	185	69.8	56	58.3	31	66.0	53	85.5	45	75.0	14.33	.002
27. Converse with the patient	259	97.7	94	97.9	46	97.9	62	100.0	57	95.0	3.48	.323
28. Provide emotional support	256	96.6	95	99.0	46	97.9	57	91.9	58	96.7	5.97	.113
Collaboration with the nursing staff												
29. Escort to other departments in the hospital	104	39.2	27	28.1	22	46.8	11	17.7	44	73.3	47.37	.000
30. Cooperate with the nursing staff in providing care	247	93.2	87	90.6	45	95.7	57	91.9	58	96.7	2.78	.427
31. Take part in nursing treatment	196	74.0	59	61.5	35	74.5	52	83.9	50	83.3	13.70**	.003
32. Discharge from hospital	227	85.7	82	85.4	33	70.2	58	93.5	54	90.0	13.20	.004
33. Provide vital information to staff	231	87.2	79	82.3	42	89.4	59	95.2	51	85.0	6.04	.110

[a] **Only those who replied "yes"**

in the non-government hospital. Compared to their peers in the non-government hospital geriatric wards, nurses in the government hospital also had positive attitudes towards allowing paid carers to run errands for the patients and escort them to other medical units in the hospital, take part in nursing treatments, and arrange the discharge of the patients from the hospital.

With regard to the internal medicine wards, the findings indicated that, in the non-government hospital, fewer nurses had positive attitudes towards allowing paid carers to measure temperature, make sure nurses responded to the patient's calls, run errands for patients, and take part in nursing treatments. Compared to their peers in the government hospital, however, more nurses in these wards had positive attitudes towards allowing the paid carers to help with drinking and escorting the patient to other medical units in the hospital.

Regarding rules, when nurses were asked whether they were aware of rules about the tasks that paid carers should be allowed to do, 28.3 per cent did not answer this question, 54 per cent were not aware of such rules, and only 17.7 per cent reported they were aware of some rules in this regard. This suggests that the majority of nurses were not aware of rules regarding tasks that paid carers should or should not perform. In addition, the vast majority (89.4%) thought that paid carers' roles should be defined in rules, which differs from the attitudes expressed by the respondents in the qualitative part of the study.

Factors Explaining Perceived Involvement of Paid Carers

Table 3 presents the results of regression analyses conducted to assess the factors that explain nurses' attitudes towards involvement of paid carers in hospitals. The findings show that a combination of variables was significant in explaining nurses' attitudes: type of hospital, experience of the nurses (length of time working as a nurse), and birth and length of stay in Israel. In other words, nurses who worked in the non-government hospital, with longer experience, who were not born in FSU countries and who had lived in Israel for a shorter period of time, were more positive regarding the overall involvement of paid carers in care provision during hospitalization of their care recipients compared to their counterparts who worked in the government hospital, had less experience, were born in FSU countries, and had lived for a longer time in Israel. The variables in the equation explained 41 per cent of the variance in the outcome variable.

Table 3: Regression analysis of factors explaining attitudes of nurses towards paid care involvement in care provision

Variable	*B*	*SE*	β	*p*
Hospital characteristics				
Type of hospital	–2.22	.95	–.29	.023
Type of ward	–.85	.98	–.11	.392
Professional qualification				
Education	.80	.65	.14	.228
Professional experience	.16	.06	.45	.001
Length of work in ward	–.15	.09	–.27	.101
Rules				
Awareness of rules regarding paid caregivers	–1.40	.98	–.17	.159
Need for rules	1.84	.95	.23	.058
Co-variates				
Length of residence in Israel	–.13	.06	–.32	.024
Place of birth[a]	–4.82	1.39	–.45	.001
R^2	0.41			
Adj.R^2	0.30			
F	*3.84*			0.001

[a] 1 = born in other countries except former Soviet Union countries
2 = formerly Soviet Union country
***F* = significance of the model fit**
R^2 = the proportion of variation explained by the regression
***SE* = standard error**

Discussion

Policies and Guidelines

The qualitative interviews revealed that four of the five key-informant interviewees were not aware of the guidelines determined by Israel's Ministry of Health regarding the paid carers in hospitals. In addition, there were no formal organizational policies and practice guidelines regarding this issue, and respondents expressed ambivalence about the need for such policies and guidelines. They actually preferred to ignore it and to view paid carers as surrogates of family members as a means to avoid formalizing their roles and responsibilities, which then might have forced them to monitor and enforce these guidelines. This attitude of hospital top management is contrary to the attitude of the majority of nurses who perceived a need for formal guidelines in this regard. In other words, while top management had some reasons not to formalize the roles of paid carers, frontline nurses working with the patients expected more explicit policies and guidelines.

Nurses' Attitudes towards Paid Carers' Involvement in Care Provision

Our findings showed that, in general, for most tasks, no significant differences in nurses' attitudes were evident by type of hospital and type of ward. This suggests that nurses' attitudes were that paid carers should be allowed to perform most tasks related to personal and environmental care, as well as to provide social

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support and surveillance, regardless of type of hospital or type of ward. There was one exception – tasks that related to nursing care. Most nurses felt that paid carers should not be allowed to perform tasks that intruded into their specific professional domain and required professional nursing skills, judgment, and responsibilities. This suggests that nurses' attitudes towards paid carers are, in general, positive and reflect their attitudes that these carers play a vital role during the hospitalization of their older care recipients. From this perspective, the findings of this study are consistent with those found in previous studies (Hemsley et al., 2011b; McCluskey, 2000).

However, the paid carers in this study comprised a unique group: they were migrant, live-in, home care workers who provided care to a unique group of care recipients – functionally dependent older people – prior to the recipient's hospitalization. It is expected, therefore, that this type of caregiver, compared to regular paid carers, would be more familiar with their care recipients' needs and more experienced with meeting these needs. Therefore, it might be that the nurses relied on them more than they would have if the carers were not so familiar with the needs of their care recipients. From this perspective, the findings shed some light on an issue that has been barely examined but merits further research: that is, nurses' attitudes towards live-in paid carers compared to those who are live-out, and paid carers who are hired only during hospitalization. Furthermore, additional research is needed to examine the ambiguity of paid carers' roles among frontline nurses who work directly with patients. Qualitative studies could provide new insights and shed light on this issue.

Finally, certain care-recipient activities may cause the paid carer to feel uncomfortable or overloaded, especially if the tasks require a level of professional qualification that the paid carer does not have. Thus, it is also important to explore paid carers' attitudes toward performing these types of tasks. Furthermore, more research is needed to examine ambiguity among hands-on nurses with regard to paid carers' roles. Qualitative studies can provide new insights and through light on these issues. In addition, it is important to learn about the paid carers' attitudes towards performing tasks that require professional qualifications, which they have not and may cause them feel uncomfortable or overload.

For a third of the tasks, we found significant differences between hospitals and types of wards, and most of these tasks were in the domain of professional nursing care. In the government hospital, more nurses agreed that paid carers should be allowed to perform nursing care tasks compared to those in the non-government hospital. This might be because in the government hospital there were fewer nurses per bed than in the non-government hospital. In addition, more nurses in the geriatric wards than nurses in internal medicine wards agreed that paid carers should be allowed to perform nursing care tasks. It might be that because length of stay in geriatric wards is generally longer than in internal medicine wards, the nurses have more time to become acquainted with the needs of their older patients and their paid carers. Therefore, it might be that these nurses, compared to their peers in the internal medicine wards, perceived that the latter can be relied on and be allowed to perform a greater variety of nursing care tasks.

In line with the theoretical model, the regression analysis showed that a combination of the mesosystem (nurses' qualifications and characteristics) and the exosystem (type of hospital) factors were significant predictors of perceived overall involvement that paid carers should be allowed. Although in both hospitals there were no formal policies or practice guidelines regarding roles of personal paid carers, it might be that this imposed a heavy workload on the nursing staff who therefore welcomed the help of personal paid carers. This explanation is consistent with a current study (Hui et al., 2012) conducted in China, which found that paid caregivers were involved in most of the bedside nursing care due to the heavy workload of nurses and inadequacy of staffing. However, this issue was not examined in our study and merits further examination. Further examination is also needed to examine the extent to which nurses' attitudes in this regard are connected with additional organizational qualities, such as leadership styles in top management, organizational culture, and values (Nolan, Davies, Brown, Keady, & Nolan, 2004), as well as nurses' attitudes towards older people, in particular those with dementia (Tolson, Smith, & Knight, 1999).

Our study findings also showed that more-experienced nurses were more positive in allowing involvement of paid carers in caring for their hospitalized care recipients. It might be that they were more confident and so were willing to share the responsibility with paid carers; alternatively, it might be that they experienced more burnout compared to younger nurses and therefore welcomed this kind of assistance. These issues, however, were not examined in this study and merit further investigation. One interesting finding is that nurses who came from FSU countries expressed less favorable attitudes towards the involvement of paid carers. This suggests that cultural background might play a significant role in this regard. It may also be that the countries they came from were characterized by a centrality of regime on one hand and communality on

the other hand, which thus influenced their attitudes about sharing responsibilities with others. However, this point also merits more scrutiny.

Study Limitations

Several limitations of the study should be identified. First, the sample was not randomly selected although a high proportion of the nurses were surveyed. We could not examine differences between those who participated in the study and those who did not because of the anonymity of the respondents. Therefore, assumptions of sample representativeness are unwarranted. Second, the study was conducted in two general hospitals and in two types of wards and included only nurses' attitudes specifically towards migrant care workers who were co-residing with their older care recipients prior to their hospitalization. Therefore, generalization of the findings is limited to this group. Further studies that include a wider variety of hospitals and types of wards as well as all kinds of paid carers to various age groups of patients can throw more light on nurses' attitudes towards tasks that paid carers should or should not be allowed to perform. Finally, more variables should be included in further studies to examine additional personal and organizational factors that might be connected with nurses' attitudes towards the involvement of paid carers.

Conclusions and Implications

This study aimed to examine nurses' attitudes as well as top-level management's views on the involvement of paid carers in providing care to older patients who are physically disabled or cognitively impaired. This is a unique group of patients that is rapidly growing and is expected to occupy an increased share of bed-days. Hiring paid carers to look after functionally disabled older patients is a rapidly increasing practice. The projections about the rapid aging of the older population suggest a substantial increase in the number of older adults with complex care needs who will be hospitalized and need extensive personal care. However, there is much ambiguity around the tasks that personal paid carers should be permitted to perform or prohibited from performing. This lack of explicit policies and practice guidelines can also result in misunderstanding and conflicts between staff members, family members, and paid carers, and may even hinder the provision of good-quality care.

The guidelines that were published by the Israel Ministry of Health a few years ago were very general and did not detail the specific tasks that paid carers should or should not be allowed to perform. Therefore, the nursing management in each hospital must interpret these general guidelines to apply to more-specific and practical guidelines. This necessitates that enforcement mechanisms will be developed in each hospital to monitor the quality of care provided by paid carers and the tasks they perform. It also necessitates that hands-on nurses will be familiar with these guidelines and follow them.

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