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Unlicensed personnel administering medications to older people living at home; a challenge for social and care services

Abstract

Background: Administration of medication to care recipients is delegated to home care assistants working in the municipal social care, alongside responsibility for providing personal assistance for older people. Home care assistants have practical administration skills, but lack formal medical knowledge.

Aim: The aim of this study was to explore how home care assistants perceive administration of medication to older people living at home, as delegated to them in the context of social care.

Methods: Four focus groups consisting of 19 home care assistants were conducted. Data were analysed using qualitative content analysis.

Results: According to home care assistants, health and social care depends on delegation arrangements to function effectively, but in the first place it relieves a burden for district nurses. Even when the delegation had expired, administration of medication continued, placing the statutes of regulation in a subordinate position. There was low awareness among home care assistants of the content of the statutes of delegation. Accepting delegation to administer medications has become an implicit prerequisite for social care work in the municipality.

Conclusions: Accepting the delegation to administer medication was inevitable and routine. In practice the regulating statute is made subordinate and

consequently patient safety can be threatened. The organisation of health and social care relies on the delegation arrangement to meet the needs of a growing number of older home care recipients.

Relevance to Clinical Practice: This is a crucial task which management within both the health care profession and municipal social care needs to address to bridge the gap between statutes and practice, to create arenas for mutual collaboration in the care recipients' best interest and to ensure patient safety.

Key Words: delegation, knowledge, home care assistants, district nurse, administration of medication

SUMMARY STATEMENT

What does this research add to existing knowledge in gerontology?

- Shows how the responsible authorities' organisation of health and social care influences home dwelling care recipients' medical safety.
- Sheds light on the need to improve integrated health and social care of older people living at home from the perspective of patient safety.
- Identifies necessary skills and prerequisites for social care workers within municipalities to meet the future needs of care recipients in their homes.

What are the implications of this new knowledge for nursing care with older people?

- The organisation of health and social care depends on the delegation arrangement to meet the needs of care recipients.
- Solutions must be identified to better facilitate the work of home care assistants and district nurses; accepting involuntary delegation should not be a prerequisite to performing their job.
- Reorganisation is necessary to avoid inappropriate delegation of administration.

How could the findings be used to influence policy or practice or research or education?

- The findings suggest that a closer collaboration between home care assistants and district nurses is imperative to maintain patient safety in home care.
- Awareness of the increasing expectations placed upon home care assistants to handle situations that are theoretically outside the bounds of social care.
- The responsible authorities need to provide relevant and continuous in-job training to meet the future needs of integrated health and social care.
- The research findings contribute knowledge to the development of more integrated and professional health and social care.

Introduction

The growing number of older adults in the populations is a worldwide phenomenon and is associated with an increase in chronic diseases. Thus it is likely that future health care will increasingly be performed in people's homes (Meyer 2004; Wright 2004) and medication use is a major element in healthcare for old people (Beers 2005). The current trend towards shorter hospital stays with qualified treatment after discharge appears to be the result of health and medical policies in the western world (Anderson 2001). The ability to supply more patient-centered health care will need to be balanced against worker shortages and financial constraints (Wright 2004), leading to delegation of tasks from licensed personnel to unlicensed. Delegation between registered and unregistered personnel is a practice in a number of countries, e.g. U.K and U.S.A (Dickens 2008), The American Nurses Association (ANA) (2006, p.4) has defined delegation as "the transfer of responsibility for the performance of an activity from one individual to another while retaining accountability for the outcome". The Nursing and Midwifery Council (NMC) (2012) states that any aspect of care can be delegated, but only if the Home Care Assistant (HCA) is skilled to undertake the task. The National Board of Health and Welfare (NBHW, 1997, 2001) have issued statutes to the effect that delegation of medical tasks to unlicensed personnel must not compromise patient safety, and similar statutes exist in other countries, e.g. U.K and Australia (Durham and Tees Valley Regional Medication Policy Group, 2010; Australian Pharmaceutical Advisory council, 2006).

In Sweden, a district nurse (DN) working for the county council has the prerogative to delegate the administration of medication, across disciplinary boundaries, to a HCA working for the municipality social care (NBHW 1997, 2001). A delegation for administration is individually given and limited to one year. If it is not renewed, the assignment to administer

medication returns to the delegating DN, and the HCA is not allowed to perform the task. In these periodic reviews it is essential to follow up the skills of the HCA, because the outcome quality of delegation influences patient safety (Potter *et.al*, 2010). Half of the states in the USA allow delegation of medication administration to care workers, and the education to fulfil the task varies widely (Reinhard *et. al*, 2006).

HCAs working in social care perform personal assistance, including medical assistance of older people in their homes. They are usually neither registered nor licensed by a regulatory body (NBHW, 2007). The Care Quality Commission (2011) in England, reported that standards relating to medications and staffing constitute an area where home-care agencies struggle. It can be difficult for a nurse to evaluate a HCA's knowledge and expertise. This may look uncontroversial at first glance, but the tasks that are delegated are part of nursing and nursing responsibilities (Nazarko,1999).

The person, to whom the medication administration is delegated, may lack formal knowledge of medical topics, but nevertheless have sufficient practical skills to carry out the task. This must be assessed by the delegating DN. The DN is accountable for the appropriateness of the delegation, and for providing support and adequate supervision (NBHW, 1997, 2001; Nazarko 1999) The Swedish statutes (NBHW, 1997, 2001) are in line with NMC (2012) and ANA (2006) definitions. Accepting a delegation means that the HCA is responsible and held accountable for ensuring that the administration is correctly and safely performed. According to Swedish statutes, accepting a delegation is voluntary and therefore the HCA is obligated to inform the DN if s/he is uncertain of how to perform the task, and if s/he does not wish to accept the delegation. Budden (2012) underlines the importance of HCAs being able to refuse

to accept the delegation of a task when it is beyond their expertise. The delegator must also be aware of the laws and offer proper supervision.

In Sweden, municipal social home care has its roots in the 1950s when the organisation of “home helpers” for older people was established. Middle-aged women who had experience of housekeeping typically performed the tasks, and no formal education was required. Today HCAs in municipal social care perform more complex tasks. They generally work alone and independently in older people’s homes, providing direct personal care, service, and housekeeping and are also expected to perform medical tasks such as the administration of medication (Astvik, 2003). Hence medical tasks generally appear in an HCA’s job assignment, and knowledge and training in this area is needed (NBHW, 2006). The most common mistake among HCAs concerning medication was administering without following instructions properly (Kapborg & Svensson, 1999). Hansson and Engström (2005) found that 14% of HCAs’ working time concerned medical assignments, and 95% of the HCAs had been delegated responsibility for medication (Axelsson & Elmsthål, 2004). Delegated medical tasks can foster the professional development of HCAs, and such recurring education may reduce a high staff turnover among HCAs (NBHW, 2006). This also emphasizes the importance of properly educated personnel and time to provide care and a consistent service.

Previous studies show that the heavy workload of DNs pressures them to delegate the administration of medication to HCAs regardless of their skills, and not always in an appropriate manner (Bystedt, Eriksson, & Wilde-Larsson, 2011; Craftman, von Strauss, Rudberg, & Westerbotn, 2013). The delegation process requires sound judgment, communication skills and a willingness to collaborate on the part of the HCA and the DN (Potter, 2010). Medication administration has become a mutual question between health care

and social service care, as well as becoming a remit of “unqualified” HCAs (Bradford, 2012). In Sweden, the municipality and the county council are now facing the challenges of collaborating to meet the rising demands of extended caring and nursing outside the hospital, and an essential element in this is ensuring a safe medication process. Earlier studies in community settings focusing on DNs’ experiences indicate that due to an increased professional burden DNs struggle to meet legal requirements as to whether to delegate medical administration to HCAs, while, at the same time, ensuring patient safety (Craftman *et al.*, 2013). In this study, the term HCA is used to denote unregistered staff; various terms are used in the literature and in different countries, e.g. unlicensed assistive personnel, health care assistants and unlicensed caregivers. This study aims to explore how HCAs perceive administration of medication for older people living at home, when it is delegated to them in the context of social service and care. **The objective of this study was to outline areas for improvement in administration of medication.** Assistance with medication as directed by the older people is not explored in this study.

Method

This study adopted a descriptive qualitative approach using Focus Group Interviews (FGIs) to explore HCAs perception of the topic. According to Patton (2002) this approach is helpful for understanding the complexities of human behaviour in the field. To capture the HCAs’ perception FGIs were chosen since they are a useful way of conducting group interactions. When participants share a common frame of reference they can relate their experience of a certain subject (Kitzinger, 1995; Krueger, 2008).

Setting and participants

This study was performed within an urban central municipality in Sweden. Participants in the first FGI were recruited from a social care unit. An information letter was sent to the manager, who advised the unit about the study and the voluntary nature of participation in the focus group. The HCAs who joined the FGI suggested a suitable time and place for the interview, and notified the first author. All participants gave oral consent to participate in the study. The first contacted manager suggested the next social care unit, whose manager, in turn, suggested the next unit, in line with chain sampling described by Polit and Beck (2012). In total 19 ($n=19$) HCAs from four different units volunteered to participate in FGIs. The length of their professional experience varied between 1 and 27 years; 4 lacked formal health care related education.

Insert Table 1 about here

Data collection

Four FGIs were conducted, one FGI with each unit. Each FGI took place in a separate room at the respective unit at the participants' workplace. The participants were invited to sit around a table to enable eye contact, interaction and awareness of non-verbal as well as verbal communication. Each interview session lasted about one hour and was audio recorded and transcribed verbatim. The FGIs had open ended questions aiming to encourage free discussion. The same opening question was asked in all interviews, *'Could you please tell me what it means to you as an HCA to accept a delegation to administer medication'*. This question was followed-up with probing questions to ensure that the FGIs stayed within the aim, and to explore the participants' interpretation of the topic. The probing questions were dependent on the content of the discussions, and could therefore differ in the four FGIs. The first author moderated sessions while the fifth author assisted and kept notes.

Data analysis

Qualitative Content Analysis, described by Elo and Kyngäs (2008), was performed on the interview text. This analysis included several steps. First, in the preparation phase, the text was read thoroughly by the first and fifth authors individually to obtain a sense of the data and the whole. As described by Elo and Kyngäs (2008), during reading, notes were made in the margins of transcripts. Furthermore, relevant codes from each interview were marked and transferred to a matrix. Thereafter, depending on similar descriptions or statements in the codes, they were interpreted, abstracted and grouped into subcategories. Each subcategory was analysed with regard to similarities and differences. Following Elo and Kyngäs (2008) the subcategories were interpreted and similar statements were abstracted into generic categories named with content-characteristic words. According to Elo & Kyngäs (2008), the abstraction should continue as far as reasonable and permitted by the data. In this study, the generic categories- *Adopting an inevitable and prominent task*, *Lacking knowledge leaving common sense as a vague competence* and *Being on the frontline* were on the highest level of abstraction of this study. An example of the analysis process is shown in table 2.

Insert Table 2 about here

Ethical considerations

This study was approved by the Regional Ethical Review Board in Stockholm, Sweden (EPN 2008/103-331/2). The participants were informed of the study, and the voluntary nature to participate, the right to withdraw at any time, and advised that data would be treated confidentially in line with Swedish Research Council (2011). Before each interview, the use of an audio recorder was explained. The participants were reminded of the confidentiality of

the content of the interview in respect of other participants. Each transcribed focus group interview was coded with a number to ensure confidentiality.

Findings

The generic categories are described below and illustrated by quotes from the transcripts.

Adopting an inevitable and prominent task

Participants described accepting to carry out the administration of medication as an inevitable task in an HCA's job. Experienced HCAs encouraged temporary staff not to accept the responsibility nor sign a delegation agreement until they felt secure about the assignment. On the other hand, participants described refusing to administer medication was not seen as a realistic alternative in terms of performing the daily work of an HCA. This is an inevitable task. The administration of medication was regarded by some participants as just another task they had to perform, while others felt they were given confidence and trust. When an HCA served care recipients' breakfast, it was natural to administer their medication at the same time. The participants often knew the care recipients better than the DNs did and could assess the care recipients' health status. The participants stated that the main reason for DNs delegating the task was to save time and reduce their own workload. The DNs were perceived as taking the acceptance of delegation for granted, and the procedure was seen as mainly a money saving strategy of the county council. One participant said:

"...so, delegate to us with respect for what we do, and do not use us as an easy way out."

(HCA, group 3)

The participants did not feel familiar with the statute of delegation as a whole, but recalled that the DN had informed them of its content. They voiced the need for annual renewal of the delegation process as a prerequisite to administering medication. However, most participants' delegation had not been renewed, but they nevertheless continued to administer medication. The responsibility for this situation was attributed to their manager and the DN.

“...but it's also the responsibility of the manager of our home care unit. I can't get in trouble for giving medication without valid delegation because the boss knows that, the district nurse knows, the last one who's guilty is me. That's what I think.” (HCA, group 4)

The participants were aware of the complexity and meaning of the issues of medication and diagnosis. Improved collaboration with the DNs is required, when HCAs' knowledge of the care recipient can be helpful to both the care recipient and the DN when assessing health status.

“Improved collaboration [with DNs] would be a credit to the care recipient. If we could collaborate, then they [DNs] would get a lot of help and information from us too.” (HCA, group 3)

HCAs expressed the view that well-functioning collaboration and communication with DNs made them feel secure and supported, and they could solve difficulties and have an information exchange that would benefit both parties. However, participants indicated that such collaboration was unusual, due to the increasing number of district health care centres, as a result of which several different DNs are stationed within the same geographic area. The main opinion was that DNs were responsible for assuring that the care recipients' pill dispenser contained the correct medication.

1: The question is: who has the responsibility?

3: You have the responsibility, if you sign the delegation form.

1: But if there's no name connected with it [monitored dosage system]. . .

3: But then you shouldn't give any medication. And you have to decide that yourself, it's your own decision. If you're not sure, then . . .

3: Yes, I understand that the responsibility is mine, but so then it's not . . . then it's the one who gave the responsibility to me who is responsible if it goes wrong.

1: Yes, but you still have a responsibility to see to it that you give the right medication.

(Participants 1 and 3 in Group 4)

To administer medications is incorporated in the job, but the responsibility is unclear. If the delegation is no longer valid, the task is, nevertheless, performed.

Lacking knowledge leaving common sense as a vague competence

The view of fundamental knowledge and skills for medication assignments was expressed as “common sense”, meaning that one is supposed to *know*, or *feel*, the right thing to do under circumstances one might encounter. Participants stated that this was not something that could be learned from reading books; it required work experience. Performing social home care is a complex assignment. An HCA is supposed to be able to perform in any situation that can occur when assisting older people with varying health problems.

HCAs normally work alone and make their own decisions. Sometimes their decisions were not in accordance with prerequisites for the delegation; e.g. when allocating pills by following

the instructions on the packaging without contacting a DN. One participant also attributed this to common sense.

“Sometimes maybe you do things you’re not allowed to (laughs). I think that’s human. It’s like when I go and buy paracetamol and give it. I care for a totally senile person, and she has a terrible back pain, but what shall I do, she doesn’t have any other medications. Then I give her paracetamol.” (HCA, group 1)

Other participants voiced that it was unnecessary to have formal knowledge; *being a good judge of character* was expressed as more important, since a facial expression or a glance from the care recipient might be enough to get an impression of the care recipient’s needs, health status and mood. This information was important when meeting the care recipient and when performing social and health care as a whole.

“I think all that talk about education is overrated. I heard my boss say about a colleague: “she’s really good because she has formal education as an assistant nurse”, but when I’ve seen that person work, well, I don’t think it’s so great. I can’t say that my education [same education] made me a better home care assistant...” (HCA, group 3)

The participants, who had worked in municipal social home care for many years, expressed their concerns regarding an increased disease burden among older care recipients, leading to major changes featuring a medical prerequisite in the social care assignment. The participants expressed that some kind of formal education was necessary for employment as an HCA. Some participants expressed a need for, and an interest in, gaining deeper knowledge; e.g. of

how to administer medication, such as whether you may crush or blend a pill in food or liquid and better knowledge of the most common medications older people take.

“...or if you find a pill on the floor..... Well, is it a tablet of artificial sweetener or is it a pill? How should I know? ” (HCA, group 1)

Most of the HCAs did not generally know the purpose of the medication they were administering and, consequently, neither the possible side effects. Medication administered more often was more familiar.

Formal requirements could also be stimulating and help to increase the status of HCAs. Their work was perceived as undervalued, and that their opinions were not taken into account.

The necessity was stated of having practical skills and being sure of how to administer medication when dealing with a serious task involving people's health and lives. However, they expressed the opinion that it is impossible for a DN to properly assess whether a HCA is suitable and has the practical skills and knowledge needed to be delegated the administration of medication. The current organisational structures did not allow time for meetings and evaluation. In a sense, the two professional groups did not work in the same arena.

“Well, delegation is also about that you should know, what kind of medication the care recipient uses. You have to be aware of what you give and if there have been some changes since last time... Someone came in here a week ago and said that Sally [a care recipient], seemed ill and I answered, yes, well, has she had her insulin? ‘Insulin?’ the person asked. Well, end of discussion, you know. So, it can be really serious.” (HCA, group 4)

When an HCA provided care to the same care recipient on a regular basis, they became responsive to the old person's health and thus were able to notice changes in the care recipient's health status. When the visits were more irregular it became harder to obtain a comprehensive impression relating to medical treatment and the prevailing health status.

Being on the frontline

Another problem participants defined was when there are inaccuracies or lack of medication in the care recipient's pill dispenser. Sometimes the DN mixed up the care recipients' pill dispensers when handing them out and the HCA was left to sort out the situation.

The HCAs may find themselves alone when they report matters. Sorting out these issues is outside the boundaries of a delegation and a time-consuming task. There was also a perception of being met with incredulity, especially when calling district nurses on duty in the evening and at the weekend. Nevertheless, the participants' loyalty toward the care recipients in the situation led them to take on such tasks, resulting in involuntarily taking over the DN's responsibility. When a home care recipient needed acute medical help, the HCA was often the first person that communicated with other professionals. This was exemplified by citing ambulance personnel who expected a full medical explanation from the HCAs.

".....hmm, does he take insulin or heart pills? I don't know, and when you're going to send them to the hospital and they ask: what's the basic problem? No idea! Measles, maybe?"

(HCA, group 4)

HCAAs expressed irritation and frustration due to situations they judged as requiring immediate medical attention when DNs were not accessible. They were left alone in stressful situations where they had no influence or support.

“Once we called [the DNs] every five minutes and said you have to come now. And they didn’t care; when they finally came the lady had already passed away. She had a lot of anxiety in the end, so they should have come with something [medication] to alleviate the anxiety.” (HCA, group 4)

The HCAAs reported that they had to be careful and monitor the whole process of administering medication, including the status of the care recipient. It was their responsibility to make sure that the dosage had been administered safely and correctly. Sometimes safety routines were lacking. One HCA exemplified how she handled a situation.

“Once for me, a lady took her evening medication in the morning because the HCA [who visited her the evening before] had put them in an eggcup, and not checked that she [the care recipient] had taken them. The lady saw them [the pills] in the morning and swallowed them...I let her sleep, we understood what had happened. I came back to check once in a while to see that she was doing all right.” (HCA, group1)

Participants expressed a problem with not being updated on the medication since appearances changed often and brands were interchanged. This also made it harder to verify the pills only by scrutinizing them. Some care recipients refused to take their medication when it looked different. When uncertain, the DN was contacted, or guidance was sought in FASS (a medical dictionary containing all medications available for prescription in Sweden). One HCA voiced this as:

“....and then it turns out that it is the same kind of pill. I get confused, and it is confusing for the older person when you explain that it’s the same pill, they just changed the way it looks. Sometimes they [care recipients] refuse to take their medication because of this.”
(HCA, group 2)

The participants also stated that the DN did not always report to them changes in medication in the care recipients’ pill dispenser. The medication administration record sheet was often missing, as well as the name and the personal identity number on the pill dispenser, making safety controls impossible.

Discussion

In this study a generic category was formulated; *adopting an inevitable and prominent task*.

These results indicate that the regulatory organisation of health and social care in the municipality treats the process of delegating medication administration as an inevitable routine procedure. Accepting delegation is an integral part of the HCAs’ job that generally is not questioned. The administration of medication was perceived as a regular element in the overall task of caring, even if personnel were unfamiliar with the administered medication. However, the content of the statute of delegation (NBHW 1997) was little-known and not of interest to the participants. In our study, participants found it impossible for a DN to appraise their knowledge; instead, DNs needed to demonstrate trust in them. This raises the question of whether the current delegation practice sufficiently safeguards patient safety and is in line with the findings of Bystedt *et al.* (2011). Delegation for administering medications was sometimes performed even when the skills and knowledge of the HCAs could not be appraised. To abstain from delegation which is a core right stipulated by the statute of

delegation (NBHW 1997, 2001) may not be realistic in practice. Abstaining from delegation makes it difficult to continue working as an HCA in social care and means the DNs cannot perform their job timely (Craftman *et al.*, 2013). This leaves DNs and HCAs in a hostage situation since both are dependent on each other to fulfil working requirements. Personal perception of skills (Stacey, 2005) is essential for HCAs in establishing vocational pride. Instead, this present study showed that the HCAs expressed the feeling of being used for the benefit of the DNs, since the delegation was perceived as a way to lighten the DNs' workload, rather than meeting the needs of the care recipients. The HCAs also revealed that when the delegation had expired, medications were administered regardless of this fact. This exemplifies how integrated the task has become in the organisations. There is a risk, that self-interest can be seen as more important than the interest in patients, thus jeopardizing the quality of care (Rhéaume, 2003).

The results from *Lacking knowledge leaving common sense as a vague competence* showed a need for theoretical knowledge to accompany work experience and "common sense", even if the latter was seen as a basis of the participants' ability to administer medications. They viewed themselves as skilled in a wide range of work responsibilities and felt that not just anyone could do their job. The HCAs stated that care recipients' needs were their first priority. At the same time Weiler (1998) finds that the quality of care and of social services depends to a great extent on the education and knowledge of staff and their attitude towards care recipients. Also NBHW (2011) emphasizes fundamental knowledge and skills needed in social care of older people. In addition, how to perform personal help and daily life issues, knowledge in medication and medicine use among older people is proposed. When needed, personnel should be offered in-job training, which has also been advocated by Axelsson and Elmståhl (2004). Spellbring and Ryan (2003) suggest that a standardized education for HCAs,

e.g. in medication, should be provided to ensure a minimum knowledge level for patient safety requirements. Lack of staff, time and funding can be an impediment to the delivery of education and, if mandatory, resource provision requires clarity (Griffiths 2010).

Result showed that HCAs are *on the frontline* when required to perform medical tasks beyond their responsibility and which actually are those of a registered nurse. This was also found in the study by Budden (2012) where HCAs were required to take on responsibilities beyond their role. The participants in this study expressed a perception of close contact with the care recipients and having a sense of duty towards them, which leads to performing time-consuming tasks out of their job description, for example when medications are missing. In this way the DNs' responsibilities are assumed by an HCA, which in the end could risk the safety of the care recipients. Budd (2012) found indications of a fear of being disciplined for administering medications at the wrong time. Participants also reported that a licensed nurse never assessed a patient before or after medication administration. Meeting with other health care staff could cause frustration due to unclear expectations. Implicit expectations of the HCAs were raised when communicating with other professions; e.g. ambulance staff expected the HCA to have medical information and knowledge about the care recipient's health status. Yet they were not taken seriously when imparting changes in the health status of a care recipient to the appropriate health care personnel. The varying expectations of other people involved create a grey area for the HCAs. Sharing of valuable information about mutual issues regarding care recipients was not appreciated, which resulted in important observations going unreported. This could be linked to Denton, Zeytinoglu, and Davies (2002) reporting that lack of supervision or poor supervisors and limited control of tasks were common sources of stress for HCAs. Additionally, Spilsbury and Meyer (2004) claim it is a case of misuse when the HCA's contributions of inherent knowledge and gained experience are not taken

into account when discussing patient care. In the present study, independent decision-making without first establishing contact with a DN was common, e.g. administering non-prescribed medication like paracetamol to a care recipient. This is in line with the results of Axelsson and Ehlmsåhl (2004). Our results showed that the participants felt safe when they experienced effective communication with the DN. On the other hand, when support and medical advice fell short, the HCAs were left alone in uncertain situations. Examples include cases such as when the personal information of a care recipient could not be found on the pill dispenser or mandatory administration controls were impossible for the HCAs to perform, putting the patient's safety at risk. Communication is a prerequisite for a well-functioning delegation process between registered nurses and HCAs, as reported by Potter *et al*, (2010). When the care recipients were in poor health, HCAs' personal meetings with DNs were especially useful (Kraus, 2007). This gave them the opportunity to receive supervision and to discuss medical issues.

Methodological discussion

FGIs as a data collection method are considered suitable when the researcher wants to gather a group's experiences of a certain subject. It is believed that group dynamics can help the participants clarify and explore their view of a topic, which otherwise may be less accessible within an individual interview (Krueger 2008). A possible disadvantage of using FGIs is that the discussion can be steered by a dominant participant or by the moderator (Kitzinger 1995). However, our impressions were that the interview climate was open; agreement and disagreement, as well as positive and negative views, were expressed and enriched the interviews. To increase trustworthiness, all authors were involved in the analysis proceedings. Eventual disagreement e.g. with regard to labelling, was discussed by the authors until consensus was reached. Study limitations included the chain sampling method that was used

when recruiting participants. According to Faugier and Sargeant (1997) allowing acquainted people to recruit each other poses a risk. They may imitate one another's views of the topic and this needs to be considered before inferring results. Individual HCAs in our study had no contact with HCAs from other units, thus reducing the risk of sampling bias.

Conclusion

According to the participants, accepting the delegation to administer medication was an inevitable and routine process, apparently regarded as a mandatory task in the social home care services. This places the regulating statute in a subordinate position, and consequently patient safety can be threatened. Occasionally HCAs carry out this work without a valid delegation and assume the responsibility of the DNs. The organisation of health and social care relies on the delegation arrangement to meet the help needs of a growing number of older home care recipients. The work situation for HCAs on the municipal social care frontline can be questioned since they seem to be forced to operate outside their level of knowledge and skills. This places them in a challenging position between the care recipients, on the one hand, and the DNs' and the HCAs' formal care responsibilities, on the other. HCAs work alone, in close contact with the care recipients, and are required to solve all issues or problems that can arise in caring for older persons with varying health conditions. This is a crucial task which management in both the health care profession and municipal social care needs to address to bridge the gap between statutes and practice and to create arenas for mutual collaboration in the care recipients' interests and to ensure patient safety.

Contributions to the manuscript

Study design ÅC, EvS, MW data collection and analysis ÅC, MW, LMH and manuscript preparation ÅC, LMH, EvS, PH, MW.

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Table 1. Information about focus groups

Focus group	1	2	3	4
Number of HCAs	5	4	5	5
Gender (women/men)	5/0	4/0	5/0	4/1
Working years	1-15	1-30	1-25	7-27

Table 2. Examples of the condensation and analysis process

Meaning unit	Code	Subcategory	Generic-category
<p><i>1: Yes, of course you can [not accept delegation] but of course everything [job situation] will be more complicated.</i></p> <p><i>4: Then the district nurse must come and do it.</i></p> <p><i>5: No, but I do not think it is possible.</i></p> <p><i>2: Or you must go only to care recipients that do not have medications but it will be troublesome anyway.</i></p>	<p>You can work without delegation but it will be more complicated. Then district nurse must do it You can only visit those who do not need assistance with medication. But it will cause problems.</p>	<p>Being part of the job to accept the delegation</p>	<p>Adopting an inevitable and prominent task</p>
<p><i>This sounds a bit odd but many who receive home care services are people like maybe relatives cannot take care of actually... And then it is handed over to us. Or that they [care recipients] are very sick and we do not have the qualification required for their condition. Of course this wears us out.</i></p>	<p>Meeting and performing qualified tasks without proper skills, which is negatively demanding.</p>	<p>Being unqualified for demanding tasks.</p>	<p>Lacking knowledge leaving common sense as a vague competence</p>
<p><i>Who owns the problem? The same thing happens on the weekends when medication is missing or is not correct. Then you call, and it's always the same. No, talk to the next person, who tells you to talk to the next</i></p>	<p>Troublesome to get adequate help when medication is missing or is not correct.</p>	<p>Alone in solving problems</p>	<p>Being on the frontline</p>

<i>one, etc.</i>			
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