

Exploring the experiences of unaccompanied care services in China from the perspective of multiple stakeholders: a qualitative study

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Abstract

Background

China's demographic shifts and evolving family structures have increased healthcare demand. The National Health Commission has promoted the Healthcare Assistant (HCA) system to reduce reliance on family caregivers. However, most existing studies examine this service from single-stakeholder perspectives.

Objective

To explore real-world experiences of unaccompanied care from the perspectives of patients, family members, nursing administrators, and HCA company managers, and to provide evidence for service optimization.

Methods

A phenomenological qualitative study was conducted from January to April 2026 in a tertiary Class-A hospital in Xi'an. Purposive sampling recruited 25 participants. Data were collected through semi-structured interviews and analyzed using thematic analysis. This study specifically explored participants' perspectives on multiple dimensions of unaccompanied care, including trust relationships, HAs competency, attitude change, service experience, emotional support, and model evaluation.

Results

A total of 25 participants were recruited via purposive sampling, including 9 patients, 4 family members, 8 nursing administrators, and 4 nursing assistant company managers. Three core themes were extracted: (1) Perceived value and barriers to acceptance: participants acknowledged the benefits of unaccompanied care for reducing family care burdens and meeting patients' daily care needs, but identified traditional cultural norms and out-of-pocket payment costs as major obstacles; (2) The gap between ideal and actual competency of healthcare assistants: while all stakeholders shared consistent expectations for competent HAs, nursing administrators reported that practicing HAs generally have widespread deficiencies in communication skills, clinical observation ability, and the capacity to provide proactive care; (3) Collaboration patterns and challenges in the service system: currently, hospitals and third-party service agencies operate under a divided responsibility framework, which leads to insufficient quality oversight and high turnover rates for HAs.

Conclusion

From a multi-stakeholder perspective, unaccompanied care alleviates family burden and meets daily needs, yet faces cultural and economic constraints. A significant gap exists between idealised and actual HCA competency, which affects both care quality and patient-provider trust. Future efforts should prioritise improving HCA competency and workforce stability for sustainable service development.

What is already known

- Driven by global population ageing, shrinking family care capacity, and growing burdens from chronic diseases, healthcare assistants (HAs) have become an indispensable part of the healthcare workforce worldwide.
- While the role of HAs has been formally established in many countries with structured training and standardized regulatory frameworks, it remains in the early development stage in China, and was only officially classified as a formal occupation in 2015.
- Existing domestic studies on unaccompanied care have mostly adopted single-stakeholder perspectives, and have separately focused on topics such as operational management, training system construction, and patient experiences.

What this paper adds

- This study offers empirical evidence drawn from four stakeholder groups—patients, family members, nursing administrators, and company managers—revealing divergent expectations and shared concerns that cannot be captured by single-stakeholder research designs.
- The study identifies a critical gap between stakeholder expectations and actual HA competency: while all stakeholders expect home care attendants (HAs) to be compassionate, skilled in communication, and competent in clinical observation, the actual workforce in practice generally only completes tasks mechanically, with inflexible communication and limited clinical observation capabilities.
- It demonstrates that HA competency plays a pivotal role not only in determining care quality, but also in the dynamic process of building trust between patients and care providers.

Highlights

- Four stakeholder perspectives on unaccompanied care in China were explored.
- A critical gap exists between expected and actual HA competency.
- HA competency is pivotal for building patient-provider trust.
- Policy implementation has outpaced workforce development.

1. Introduction

Global population aging has become an irreversible trend over the past decades, placing enormous pressure on the delivery of health and long-term care services worldwide(1). The rising prevalence of chronic diseases, multi-morbidity, and functional impairment among older adults has greatly increased the complexity of clinical care, while the ongoing shortage of formal nursing staff has further strained healthcare systems across the globe(2). In this context, healthcare assistants (HAs), as a core component of the nursing workforce, play an indispensable role in undertaking routine and daily care work, enabling registered nurses to focus on complex

clinical tasks and improving the overall efficiency of care delivery(3). In many healthcare settings, especially hospitals and long-term care facilities, HAs have gradually become the primary providers of basic activities of daily living for patients(4).

This workforce shift is a global phenomenon, yet it presents distinct characteristics in China. Here, a combination of demographic and social changes has accelerated the transition from traditional family-based care to professional care services. For instance, accelerating population ageing, paired with dramatic transformations in family structures—such as shrinking nuclear family sizes and the prevalence of the "4-2-1" household model—has fundamentally eroded family members' ability to provide continuous bedside care(5). Furthermore, modern work-related pressure, geographic separation from family members, and the lack of professional care skills among relatives have increasingly made informal accompanying care unsustainable(6). In response, the National Health Commission of China has actively promoted the rollout of unaccompanied care as a new inpatient service model. This model replaces informal family caregivers with registered nurses and systematically trained healthcare assistants (HAs) to deliver comprehensive daily care and support services, with the goals of reducing family burdens, standardizing care delivery, and improving patient safety and care continuity.

However, the institutional infrastructure to support the HA workforce remains nascent. The HA role was only formally incorporated into China's National Classification of Occupations in 2015 (Code: 4-14-01-02) (NOC Revision Committee, 2015), and was subsequently revised in 2022 (NOC Revision Committee, 2022). Yet, unlike in many Western countries where HAs receive standardized pre-employment vocational training, HAs in China often enter the workforce without uniform educational requirements or clear role definitions. This institutional gap has led to substantial ambiguity in daily practice, which is reflected in inconsistent service quality, unclear divisions of responsibility between nurses and HAs, and divergent expectations(7–9) across stakeholders. As a result, although the unaccompanied care policy has been rolled out on a growing scale, its implementation has progressed faster than the development of a stable, well-defined HA workforce. This makes it urgent to investigate how stakeholders involved actually experience and perceive this service model.

These workforce challenges are not unique to China. Internationally, academic literature has extensively documented persistent issues facing the HA workforce, including insufficient professional competence, inadequate awareness of humanistic care, high turnover intention, and unstable staffing(10–12). These systemic workforce challenges pose serious risks to the quality and safety of care models that rely heavily on this worker group. While these challenges are well documented across the world, they are particularly acute in China, where unique demographic and cultural factors exacerbate the situation. Recognizing this urgency, Chinese researchers have begun to investigate various aspects of unaccompanied care.

Existing domestic research has provided valuable insights into operational management, training systems, and patient experiences from single-stakeholder perspectives. However, there remains a critical lack of studies that systematically integrate the views of multiple stakeholders. This omission is significant, because divergent perceptions across stakeholder groups may lead to unaligned expectations, hidden implementation barriers, and suboptimal service outcomes that cannot be captured through single-stakeholder research designs. Notably, unaccompanied care involves diverse stakeholder groups with distinct roles and interests: patients are the direct end-users, family members act as key decision-makers, nursing administrators serve as on-site supervisors, and company managers function as staffing authorities. Differences in standpoints often lead to

divergent perceptions, which means that relying solely on patients' perspectives cannot fully reveal the practical challenges, hidden risks, and developmental bottlenecks in real clinical practice.

Against this background of existing research gaps, this study adopted a descriptive phenomenological qualitative approach and recruited patients, their family members, hospital nursing administrators, and healthcare assistant company managers as participants, to explore their authentic experiences and evaluations of unaccompanied care services. This research aims to provide empirical evidence and optimization strategies for improving service quality, advancing the professionalization of the healthcare assistant workforce, and supporting the sustainable operation of unaccompanied care in clinical settings.

2. Methods

2.1 Study Design

This study adopted a descriptive phenomenological qualitative research design. Semi-structured in-depth interviews were used for data collection to comprehensively explore the real experiences of unaccompanied care among different stakeholders.

2.2 Participants

Purposive sampling was applied to recruit participants from unaccompanied care wards of Shaanxi Provincial People's Province. To ensure data richness and diversity, patients with different ages, genders, educational backgrounds and economic conditions were selected; administrators from various departments and management levels were also included. Data collection was terminated when data saturation was achieved (no new themes emerged from subsequent interviews). The inclusion and exclusion criteria for each group of participants were formulated as follows.

2.2.1 Patients

Inclusion criteria: (1) Aged 18 years or above; (2) Clear consciousness and normal communication ability; (3) Voluntarily received unaccompanied care with a hospital stay of no less than 5 days; (4) Voluntary participation and signed informed consent. Exclusion criteria: Patients with severe chronic diseases, infectious diseases, consciousness disorders or severe mental illnesses. Basic information of patients is shown in Table 1.

Table 1
Demographic characteristics of patients (N = 9)

ID	Age	Education Level	Department	Marital Status	Payment Method for Hospitalization Expenses	Children Status	Diagnosis
P1	67	Technical Secondary School	Neurology	Married	Urban Employee Medical Insurance	Non-only Child	Subclavian Artery Steal Syndrome, Lacunar Infarction
P2	61	Junior High School	Gynecology	Married	Urban and Rural Resident Medical Insurance	Only Child	Endometrial Cancer
P3	70	Senior High School	Orthopedics	Married	Urban Employee Medical Insurance	Non-only Child	Lumbar Disc Herniation with Radiculopathy
P4	72	Senior High School	Orthopedics	Married	Enterprise Employee Medical Insurance	Non-only Child	Left Proximal Humeral Fracture
P5	54	Junior High School	Orthopedics	Married	Rural Cooperative Medical Care	Non-only Child	Meniscus Injury, Post Knee Surgery
P6	80	College and Above	Neurology	Married	Xi'an Enterprise Medical Insurance	Non-only Child	Benign Prostatic Hyperplasia, Coronary Heart Disease, Cerebrovascular Stenosis
P7	65	Senior High School	Neurology	Married	Xi'an Enterprise Medical Insurance	Only Child	Cerebral Infarction
P8	61	Master's Degree	Neurology	Married	Urban Employee Medical Insurance	Only Child	Hypertension
P9	59	Senior High School	Cardiac Surgery	Married	Urban Employee Medical Insurance	Only Child	Aortic Dissection

2.2.2 Family members

Inclusion criteria: (1) Aged 18 years or above; (2) Clear consciousness and normal communication ability; (3) Primary caregivers of patients receiving unaccompanied care; (4) Voluntary participation and signed informed consent. Exclusion criteria: (1) just family members visiting; (2) with consciousness disorders or severe mental illnesses. Basic information of family members is shown in Table 2.

Table 2
Demographic characteristics of family members (N = 4)

ID	Age	Education Level	Only Child or Not	Marital Status	Relationship with Patient	Primary Caregiver or Not	Living with Patient or Not	Payment Method for Medical Expenses
F1	58	Technical Secondary School	No	Married	Daughter	Yes	Yes	Urban Employee Medical Insurance
F2	42	Bachelor's Degree	Yes	Married	Daughter	Yes	No	Urban Employee Medical Insurance
F3	44	Master's Degree	No	Married	Daughter	Yes	No	Urban and Rural Resident Medical Insurance
F4	60	Junior College	No	Married	Daughter	Yes	No	Urban Employee Medical Insurance

2.2.3 Nursing administrators

Inclusion criteria: (1) Aged 18 years or above; (2) Engaged in the management of unaccompanied care wards continuously for more than 6 months; (3) With more than 1 year of nursing management experience; (4) Voluntary participation and signed informed consent.

Exclusion criteria: Those who had job transfers in unaccompanied care wards more than once in the past year. Basic information of nursing administrators is shown in Table 3.

Table 3
Demographic characteristics of nursing managers (N = 8)

ID	Age	Working Years	Education Level	Professional Title	Department	Position	Duration of Involvement in Accompaniment-Free Care Management
NM1	51	30	Bachelor's Degree	Associate Chief Nurse	Neurology Department	Head Nurse	1 year and 3 months
NM2	36	14	Bachelor's Degree	Supervisor Nurse	Neurology Department	Deputy Head Nurse	1 year and 3 months
NM3	49	29	Bachelor's Degree	Supervisor Nurse	Gynecology Department	Head Nurse	1 year
NM4	38	15	Bachelor's Degree	Supervisor Nurse	Gastroenterology Department	Head Nurse	1 year
NM5	55	30	Master's Degree	Chief Nurse	Nursing Department	Chief Head Nurse	1 year and 3 months
NM6	53	35	Bachelor's Degree	Chief Nurse	Nursing Department	Chief Head Nurse	1 year and 3 months
NM7	55	35	Bachelor's Degree	Chief Nurse	Nursing Department	Chief Head Nurse	1 year and 3 months
NM8	39	13	Bachelor's Degree	Supervisor Nurse	Traditional Chinese Medicine Department	Head Nurse	6 months

2.2.4 Healthcare assistant company managers

Inclusion criteria: (1) Aged 18 years or above; (2) Engaged in the management of unaccompanied care services continuously for more than 6 months; (3) Voluntary participation and signed informed consent. Exclusion criteria: Those who had job transfers related to unaccompanied care management more than once in the past year. Basic information of company managers is shown in Table 4.

Table 4
Demographic characteristics of nursing assistant company managers (N = 4)

ID	Age	Education Level	Position	Duration of Unaccompanied Care Management Work (Years)
CM1	51	Technical Secondary School	Nursing Assistant Team Leader	1
CM2	36	Bachelor's Degree	Project Manager	5
CM3	54	Senior High School	Nursing Assistant Team Leader	2
CM4	49	Junior College	Project Manager	4

2.3 Interview Guide

Preliminary interview outlines were developed based on research objectives, literature review and group discussions, in accordance with the characteristics of different participants. Pre-interviews were conducted among 2 patients, 1 family member, 2 nursing administrators and 1 company manager to test the intelligibility and practicability of the outlines. Formal interview outlines were revised and finalized according to pre-interview feedback.

Interview guide for patients (5 questions):

- 1.What were your main considerations when choosing the unaccompanied care service? (Motivation)
2. During your hospital stay, what specific assistance did the healthcare assistant provide? How would you evaluate these services? (Service Experience)
- 3.How did you feel when no family members were around, especially at night? What did The healthcare assistant do to alleviate these feelings? (Emotional Support)
- 4.Has your level of trust in the healthcare assistant changed from admission to now? What specific factors made you trust (or not trust) him/her? (Trust relationship)
5. In your mind, what qualities should a "perfect" healthcare assistant possess? Ideal Image

Interview guide for family members (5 questions):

1. Why did your family choose unaccompanied care? Were there any concerns when making this decision? (Decision-Making Process)
- 2.Has your attitude towards this service model changed from admission to now (or discharge)? (Attitudinal Change)
- 3.How much trust do you have in the healthcare assistant? Has your attitude towards unaccompanied care changed from the initial decision to the present or discharge? What specific behaviours make you feel "reassured" about leaving your family member in their care? (Trust Assessment)

4. In your view, how should nurses and healthcare assistants collaborate to provide the best possible care for patients? (Collaboration Expectations)

5. In your mind, what qualities should a "perfect" healthcare assistant possess? (Ideal Image)

Interview guide for nursing administrators and company managers (5 questions):

1. In your opinion, what are the greatest strengths of unaccompanied care? What are the greatest challenges? (Model Evaluation)

2. In actual practice, what "real-world" problems do you observe among healthcare assistants? (Reality Gap)

3. In your view, what core competencies (personal traits, communication, professional skills) must a qualified healthcare assistant possess? (Competency)

4. What does your ideal model of nurse-HA collaboration look like? (Ideal Collaboration Model)

5. What quality monitoring and evaluation mechanisms are currently in place at both the hospital and agency levels? (Quality Management)

2.4 Data Collection

Face-to-face semi-structured interviews were conducted by researchers with systematic training in qualitative research. Prior to each interview, the research purpose, procedures and relevant regulations were fully explained to participants, and written informed consent was obtained. Interviews were carried out in quiet, undisturbed meeting rooms, and scheduled to avoid participants' meal and rest time. During interviews, researchers flexibly adjusted the order of questions, maintained a relaxed atmosphere, and adopted inquiry and clarification skills to encourage participants to fully express their ideas. All interviews were audio-recorded, and non-verbal cues such as facial expressions, gestures and tones were observed and documented. Each interview lasted 20 to 40 minutes. Participants' demographic information including age, gender, education level, marital status and working years was also collected.

2.5 Data Analysis

Within 24 hours after each interview, two researchers independently listened to the audio recordings verbatim and transcribed them into text. Data were analyzed using Braun and Clarke's thematic analysis approach(13). In cases of disagreement between the two researchers, discussions were held within the research group until consensus was reached. The combined codes were then aggregated to form final themes. Throughout the data analysis process, any information that could identify individual participants was kept confidential and not disclosed to anyone outside the research group.

2.6 Ethical Considerations

This study was approved by the ethics committee of Shaanxi provincial people's hospital (reference identifier: 2026-R029). The principles of voluntariness and confidentiality were strictly followed. Participants were informed that they could withdraw from the interview unconditionally at any time without any impact on their medical treatment. All data were anonymized. Audio files and text materials were only used for this research and would be destroyed after the study was completed.

3. Results

A total of 9 patients, 4 family members, 8 nursing administrators and 4 company managers were interviewed, with no repeated interviews conducted. Three core themes and nine sub-themes were extracted from the interview data: perceived value and barriers to acceptance, expectations and reality of HAs, and the collaboration model and challenges of the unaccompanied care service.

3.1 Perceived value and barriers to acceptance

3.1.1 Benefits of unaccompanied care

3.1.1.1 Demand for professional care due to insufficient family care resources

With the deepening of population aging and the continuous expansion of groups including people with chronic diseases, people with disabilities, and empty-nest older adults, most families are facing caregiving dilemmas. Unaccompanied care services have significantly reduced the caregiving burden on families. Most patients reported that they chose unaccompanied care because their family members were unable to provide continuous bedside care during their hospitalization. The commonly cited reasons include adult children's work obligations, advanced age of patients' spouses, and long geographic distance between patients and their family members. Patients, family members, nursing administrators and company managers consistently agreed that unaccompanied care resolves caregiving dilemmas brought by shifting family structures, and delivers professional, accessible care for empty-nest elderly and dual-income households.

A patient explained: *'Unaccompanied care is really necessary. My children are filial, but they have their own work and kids to take care of' (P1)*. Another patient who lived apart from her children stated: *'My children live far away and cannot look after me, so I chose this service' (P6)*.

Some patients reported selecting the service based on prior positive experiences with professional caregivers. One patient who had previously used healthcare assistant services for her father noted: *'I have hired healthcare assistants for my father in another hospital before, and the service was good. Now my children are not around and my wife is in poor health, so I decided to use it again, and it works well' (P8)*.

Family members similarly expressed that unaccompanied care alleviated their caregiving burden. One family member who balanced work and childcare responsibilities stated: *'With professional caregivers, I can go to work while taking care of my parents and two kids, which brings me great convenience' (F2)*. Another family member, herself elderly, remarked: *'We are too old to take good care of my mother, so we feel reassured to have professional staff help' (F4)*.

Nursing administrators confirmed that the model responded to social needs and reduced family burdens. One administrator noted: *'Unaccompanied care can provide professional services for patients, while family members usually lack care expertise. It also solves the care dilemma of empty-nest elderly and single-child families'* (NM6). Another administrator highlighted the safety benefits: *'Many elderly patients have high fall risks. Having dedicated caregivers can improve their safety'* (NM8).

Company managers also identified three groups for whom the service was most suitable: *'working young people, elderly family members incapable of care, and commuting workers'*(CM1). One manager shared a typical case: *'An elderly couple was sent to hospital by emergency services, while their children lived in other cities. They immediately turned to our service'* (CM1).

3.1.1.2 Meeting patients' daily and medical care needs

HAs provided timely and comprehensive assistance with a wide range of daily activities, including meal delivery, water fetching, walking accompaniment, and examination escort. Additionally, some patients further emphasized the round-the-clock availability of healthcare assistants, noting that their presence provided a sense of security that was particularly valuable during nighttime hours, when nursing staff were also occupied with multiple responsibilities. Patients particularly valued the examination escort service, reporting that it greatly enhanced their efficiency in accessing medical care. The family member also expressed that such physical assistance not only facilitated the completion of essential diagnostic procedures but also prevented potential injury to family members who would otherwise have attempted to perform the same tasks without proper training.

A patient described: *'The caregiver will buy meals as I request'* (P2). Another patient who required frequent imaging examinations remarked: *'He pushes me for CT scans and is familiar with the examination procedures. He is always on call at night and helps me get out of bed to use the toilet'* (P4).

Beyond routine daily tasks, healthcare assistants also assisted with physically demanding procedures that family members, particularly those who were elderly or had health limitations, would have struggled to perform. A family member recounted: *'My father weighs over 60 kilograms. The examination bed was not allowed to enter the MRI room, so the healthcare assistant carried my father in and out personally'*(F2).

3.1.2 Barriers to the popularization of unaccompanied care

3.1.2.1 Restrictions from traditional concepts and economic burdens

Participants across all stakeholder groups identified traditional cultural norms and financial constraints as major barriers to the widespread adoption of unaccompanied care. Many elderly patients express reluctance to receive care from unfamiliar individuals, and this hesitation is rooted in the traditional belief that filial piety requires direct family involvement in caregiving, even when families face practical caregiving challenges. Notably, the reluctance to accept professional care was not uniformly distributed across all patient groups. Participants suggested that younger patients and those with prior positive experiences with formal care services tended to exhibit less resistance, while older adults from rural backgrounds or with limited exposure

to institutional care demonstrated the highest levels of hesitation. This variation pointed to the role of prior experience and generational differences in shaping attitudes towards professional caregiving.

A family member described her father's resistance: *'My father thinks we are abandoning him by hiring others to take care of him, so I try to accompany him as much as I can'*(F2). One nursing administrator noted: *'Patients feel unfamiliar with strange caregivers, and the service fees are not covered by medical insurance, which becomes a major obstacle'* (NM6). These accounts suggested that the lack of familiarity and established trust relationships posed significant psychological barriers to acceptance, particularly among older patients who held more traditional views on family roles and responsibilities.

The economic dimension of the barrier was equally pronounced. The fully self-funded nature of unaccompanied care imposed substantial financial pressure on patients and families, particularly those from low- and middle-income backgrounds. Company managers confirmed that financial concerns frequently led to service refusal. One manager stated: "Some patients refuse our service because of distrust or financial difficulties. Medical insurance coverage would greatly promote the development of unaccompanied care" (CM3).

3.1.2.2 Unmet emotional needs of patients

Hospitalisation represents a significant role transition for patients, accompanied by separation from their familiar work and home environments, which may trigger psychological distress, including anxiety and fear. These emotional responses necessitate attentive emotional support from caregivers. Yet, beyond practical barriers to service uptake, participants from both the patient and nursing administrator groups identified inadequate emotional support as a major limitation of current unaccompanied care. Most HAs were described as passively completing assigned tasks with little active communication or emotional engagement. Patients and nursing administrators consistently reported that this heavily task-focused working style left patients' emotional needs largely unmet—a finding that underscores effective communication as a core component of positive care experiences.

A patient reflected: *'I only call the caregiver when I need help, and we barely talk at ordinary times. Family company is warmer, while caregivers just finish their tasks mechanically'*(P5).

Nursing administrators corroborated these observations. One administrator stated: *'Most HAs work just for tasks rather than companionship, which makes patients feel a sense of gap'* (NM7).

Patients themselves emphasized that emotional comfort was essential. One patient articulated: *'Chatting and emotional comfort are very important for patients. Good communication can improve our mood'* (P8). Patients reported feelings of loneliness and awkwardness during non-care periods, with the absence of conversation creating an uncomfortable silence.

3.2 The gap between ideal and real image of healthcare assistants

3.2.1 Ideal image of a healthcare assistant: a three-dimensional competency framework

Competence is operationally defined as the demonstrated integration of clinical knowledge, technical skills, and interpersonal abilities required for an HA to safely and effectively execute delegated care tasks within their defined scope of practice. HAs are the primary providers of direct daily care for patients, and their competence directly shapes the quality of care patients receive. Patients, family members, nursing administrators, and company managers reached a unified consensus on the competencies expected of qualified HAs. An ideal HA was described as possessing good personal traits—including kindness, empathy, patience, carefulness, and a strong sense of responsibility—alongside proficient communication skills and professional care abilities (Fig. 1). This shared vision across all stakeholder groups suggests that expectations for HAs extend beyond mere task completion to encompass a holistic caregiving role. Patients valued both the affective dimension of care—feeling respected and emotionally supported—and the technical dimension—ensuring that daily needs were met competently.

A patient stated: *'They must be caring, patient and responsible, and treat patients like family'* (P2). Another patient emphasised the importance of professionalism: *'Professional caregivers make me feel comfortable'* (P8). A third patient highlighted practical knowledge: *'Good caregivers know well about patients' diet, rest and daily care requirements'* (P1).

Family members expressed similar expectations: *"Patience, diligence and responsibility are essential for caregivers"* (F2). For family members, the emphasis placed on diligence and responsibility reflects their particular focus on reliability and trustworthiness, since they are delegating care duties that they would otherwise have carried out themselves.

Nursing administrators focused on the combination of personal and clinical competencies. One administrator commented: *'Kindness and empathy are the most fundamental qualities, followed by active service awareness'* (NM4). Another elaborated: *'Qualified staff need to be responsible, patient and careful, and master observation, practical skills and communication abilities'* (NM6). Administrators' perspectives revealed a more structured understanding of competence of HAs.

Company managers also prioritised interpersonal attributes during recruitment. One manager stated: *'We prioritise communication skills, interpersonal competence, working attitude and affinity during recruitment'* (CM2).

3.2.2 The actual image of healthcare assistants

In stark contrast to this shared vision of the ideal healthcare assistant, nursing administrators consistently describe the reality of the current workforce as falling far short of expectations. They report that most HAs work mechanically, demonstrating low initiative, inadequate communication skills, and insufficient professional observation capabilities. These documented deficiencies are not isolated incidents, but rather reflect systemic patterns that administrators encounter in their daily work. The passive, task-only orientation described by participants directly contradicts the proactive, attentive, and emotionally engaged caregiver profile that patients, families, and administrators themselves have defined as the ideal.

One administrator stated: *'Most of them are passive and only complete assigned work without active service awareness'* (NM4).

Another observed: *'Their communication is stiff and perfunctory'* (NM7).

A third administrator noted a critical gap in clinical competence: *'They are incapable of observing changes in patients' conditions'* (NM1).

3.2.3 Gradual establishment of patient-caregiver trust

Trust, defined as the firm belief in the reliability, ability, or strength of another person, is foundational to therapeutic relationships. In the context of unaccompanied care, trust between patients, family members, and HAs emerged as a dynamic and incremental process rather than an instantaneous outcome. Participants across all stakeholder groups consistently described trust as developing progressively through sustained contact, consistent professional performance, and effective communication.

A family member recounted this evolution explicitly: *'I only trusted them half at first, but after two days of contact and seeing their good performance, I fully trust them now'* (F2). Another family member expressed complete confidence based on observed behaviours: *'The caregiver has a good attitude and strong sense of responsibility, so I trust him completely'* (FM1).

Nursing administrators corroborated this pattern, offering a broader perspective on its prevalence. One administrator estimated: *'Currently, 70% to 80% of patients gradually build trust, but complete trust is still not universal'* (NM7).

3.3 Collaboration modes and challenges of the unaccompanied care model

3.3.1 Lack of effective management constraints between hospitals and service agencies

A fundamental challenge identified by nursing administrators is the separation of employment and supervision responsibilities between hospitals and external service agencies. HAs are employed and remunerated by third-party companies rather than by the hospitals themselves. Consequently, this separation of powers and responsibilities between hospitals and agencies constitutes a major barrier to effective service quality oversight. Hospitals bear clinical responsibility and reputational risk without the authority to enforce performance standards, while agencies control recruitment and compensation but face limited consequences for the clinical impacts of substandard care.

One administrator explained: *'They sign labor contracts with agencies, and the agencies have no effective restrictions on their resignation'*(NM1). Another administrator elaborated on the practical consequences: *'We can only make suggestions to the company but have no jurisdiction over their staff'*(NM6).

This accountability gap becomes particularly evident when problems arise. One administrator noted: *'When problems occur, healthcare assistants often shift responsibilities to hospital nurses'*(NM7). This practice of shifting responsibility reflects the underlying ambiguity of role boundaries between nurses and healthcare assistants, leaving registered nurses accountable for tasks they do not directly control.

3.3.2 High turnover of healthcare assistants

Nursing administrators consistently identify high staff turnover as the most prominent workforce challenge. They uniformly report that high turnover undermines workforce stability and prevents the development of a competent, experienced team. Frequent staff turnover also hinders the accumulation of professional experience and the continuous improvement of service quality.

One administrator stated: *'The turnover rate is extremely high, resulting in staff shortages and unstable teams'* (NM1). Another noted: *'We hope to fix the staffing to ensure stable service'* (NM2). A third attributed the problem to recruitment practices: *'The recruitment threshold is low, and staff often resign shortly after employment'*(NM4).

As one nursing administrator observed, high mobility made it *'impossible to precipitate professional skills and standardised training effects'*(NM1).

3.3.3 Ideal operational model

Despite the challenges described above, managers collectively articulated a vision for an ideal operational model. Managers consistently described an ideal model built on three mutually reinforcing elements—team stability, clear role boundaries, and flexible staffing ratios—which collectively formed the foundation for improving service quality. These elements reflected managers' shared vision for a more sustainable workforce model.

Regarding team building, managers emphasized the importance of assigning relatively fixed healthcare assistant teams to each department. One administrator stated: *'Each department should have fixed staff so they can feel a sense of belonging. Only when staff are fixed can they integrate and absorb the department's culture'* (NM4). Another added: *'Fixed staff, like medical or nursing teams, can accumulate extensive specialist experience over time'* (NM2).

Regarding role division, the ideal model envisioned clear boundaries between nurses and healthcare assistants. One administrator noted: *'With clear role division, mutual understanding and support can promote effective collaboration'* (NM3). Nurses would focus on clinical observation and health education, while healthcare assistants would attend to daily care and provide timely feedback when abnormalities were detected.

Regarding staffing ratios, managers advocated for flexible allocation based on patients' conditions and self-care abilities. One explained: *'The ratio should be determined mainly by the patient's condition, nursing grade, and self-care ability. For older patients with fair self-care ability, one-to-three is appropriate; for relatively younger patients with essentially normal self-care ability, one-to-six is acceptable'* (NM6). Another added: *'One nursing assistant per room, with three patients in a room. Working across different rooms would not be ideal'* (NM8).

4. Discussion

This study provides novel insights into the unaccompanied care service model from the perspectives of four stakeholder groups within the Chinese healthcare context. Our findings reveal a fundamental tension between the recognized value of professional care services and the cultural and economic barriers to their public acceptance. Furthermore, we identify a critical gap between the idealised role of healthcare assistants and the

actual realities of workforce competency and systemic instability. By interpreting these findings against the background of existing literature, we advance understanding of how healthcare systems undergoing workforce transformation can better integrate and support healthcare assistants to achieve both high service quality and long-term workforce sustainability.

4.1 Cultural and economic factors affecting service acceptance

This study found that regarding the acceptance of unaccompanied care: the service is practically needed by most families, yet its popularization is hampered by dual barriers from traditional culture and economic pressure. Rooted in Chinese traditional filial piety culture, providing bedside care for sick family members is widely regarded as an inescapable family obligation. This cultural norm creates an inherent psychological resistance to receiving care from unfamiliar professional staff, which is consistent with previous domestic research(14). By contrast, in Western countries, patients and families tend to place greater trust in the professional competence of hospital systems and are more willing to delegate care responsibilities to trained professionals, while family members primarily assume roles in medical decision-making and emotional support(15). The core difference lies in families' greater acceptance of nursing assistants' professional competence in these contexts. Hence, Different national contexts have led to divergent development trajectories. Another concurrent challenge is that, unlike most formal medical services covered by medical insurance, unaccompanied care currently operates on a full self-payment basis. Our study found that for middle and low-income families, the additional care fees impose a substantial financial burden, which has become a critical restrictive factor for service promotion- a finding consistent with other domestic study(16). At present, only a few pilot regions in China have attempted to integrate unaccompanied care into long-term care insurance or commercial insurance, while a nationwide unified payment system is still absent(17). Drawing on international experiences, countries such as Germany and Japan have successfully incorporated unaccompanied care services into public long-term care insurance schemes, offering potential models for China's payment reform(18). Obviously, this financing mechanism requires further optimisation. To address this dilemma, it is urgent to establish a diversified payment model that integrates medical insurance, commercial insurance, and individual out-of-pocket contributions, thereby reducing the financial burden on families and enhancing the accessibility and sustainability of unaccompanied care services.

4.2 The ideal-reality gap and trust construction of healthcare assistants

HAs are the core executors of unaccompanied care services. In this study, all stakeholders reached a unified consensus on the competency requirements for qualified HAs, encompassing three dimensions: individual portrait (e.g., kindness, patience, empathy, responsibility), communication skills (e.g., proactive communication, psychological comfort), and professional capabilities (e.g., fundamental care, clinical observation, care procedures). This tripartite framework aligns with existing domestic literature on HA core competencies (19). Furthermore, this framework resonates strongly with the broader international evidence. A comprehensive scoping review by Song et al. (2026)(20), which synthesised 49 studies, confirmed that HCA competence five resulting categories: (1) fundamental care; (2) observations; (3) specialised care; (4) clinical knowledge and skills.

Personal traits such as kindness, empathy, patience, and responsibility emerged as foundational to quality care in this study, a finding consistent with Oeseburg et al. (2015), who noted that personal attributes significantly influence patient care outcomes(21). Kindness and responsibility ensure that HAs perform their duties with both precision and compassion, while empathy and patience are essential for building trust and establishing smooth relationships with patients and families(22). HAs who demonstrate a favourable attitude are more capable of providing high-quality nursing services (23). Beyond these interpersonal attributes, professional competencies are equally indispensable and have undergone notable expansion. Beyond these interpersonal attributes, professional competencies are equally indispensable and have undergone notable expansion. Traditionally, HAs were primarily responsible for basic daily care. However, their role has evolved considerably: they now devote substantial time to observing and tracking patient outcomes, assisting with mobilisation, implementing care plans under registered nurse supervision, and initiating pressure-relieving devices. Some studies have found that HAs are often the first to recognise and alert professionals to patient changes, and their observations are relied upon to develop and implement care plans (24). The scope of practice has broadened to include wound care, pressure care, medication assistance, bowel and ostomy care, and vital signs/blood sugar monitoring (25). Cheng et al. (2020)(26) similarly emphasised that NAs' knowledge, skills, and beliefs directly affect care quality for older adults with disabilities. In summary, evidence from both Chinese and international studies converges on two essential dimensions of HA core competence: technical capabilities for care delivery and interpersonal attributes for patient engagement. Moreover, the evolving nature of the HA role underscores the urgent need for continuous training and competency development to keep pace with expanding responsibilities and ensure patient safety and quality of care.

However, despite this shared understanding of the ideal competency profile, the real-world workforce in our study fell far short of this expectation. Nursing administrators consistently reported that HAs worked mechanically, communicated rigidly, and lacked basic observation skills. This competency gap is not unique to China; Song et al. (2026)(20) found that substantial heterogeneity also exists globally in advanced observational and communication competencies. To understanding these deficits more deeply, the Iceburg Model provides a valuable analytical lens(27). Within this framework, competence comprises both "surface" characteristics—knowledge and skills that are relatively trainable—and "hidden" characteristics—self-concept, traits, and motives—that profoundly influence performance. Applying this lens, the observable deficits in our study—poor observation, rigid communication, and mechanical task execution—reflect deficiencies at both levels: insufficient clinical knowledge and skills at the surface, and low professional identity and intrinsic motivation beneath. So this section ultimately underscores the issue of nursing assistant competency, which can be addressed from multiple angles. Although our study did not delve into the underlying reasons for these deficiencies, existing domestic research has consistently identified these as shared challenges across the workforce. For example, Tan et al. (2023)(28) found that Chinese nursing assistants often internalised their work as low-value, which eroded their professional identity and motivation for self-improvement. Therefore addressing this competency gap is imperative to improve patient safety, care quality, and workforce satisfaction(29). Notably, while international evidence indicates that the HA role is expanding to include advanced clinical monitoring and complex task delegation, HAs in China remain predominantly confined to basic daily care, with advanced competencies rarely performed. This disparity highlights a critical direction for the future development of China's HA workforce.

Additionally, this study found that trust between patients and HAs is established gradually through sustained, high-quality daily interactions rather than instantaneously. This trust evolves from initial uncertainty to gradual acceptance, driven by daily professional performance, effective communication, sustained contact, and proactive care. Currently, research on this type of trust relationship among HAs, patients, and patients' family members is lacking, but this trust-building process has also been observed in other populations and settings. For instance, Hu et al. (2024) (22) found that empathy helps nursing assistants build trusting relationships with residents in long-term care facilities, creating a positive reciprocal cycle of care. In their (2016)(30) concept analysis of trust in home healthcare, Leslie and Lonneman further identified communication, connection, and reciprocity as core attributes of the RN-patient trust relationship. They also noted that perceived incompetence is a key barrier to trust—a finding that mirrors the 'mechanical and perfunctory' care reported by our participants. Similarly, Van Kuppenveld et al.(31) found that effective coaching of nursing assistants by registered nurses required proactive relationship-building—being visible, reachable, and communicative—rather than simply expecting trust to form automatically. Overall, these findings suggested that workforce development requires a fundamental shift: from passively 'waiting for trust' to actively 'earning trust'. This entails not only professional and practical training but also fostering professional identity and relational competencies (including empathy and communication).

4.3 Management dilemmas and optimization paths for service operation

Most unaccompanied care services in China adopt an outsourced operation mode, which has led to a typical management dilemma: hospitals bear responsibility for service supervision but lack effective administrative and economic restraint measures, while external institutions control personnel recruitment and salary distribution but lack sufficient incentives to improve service quality. This separation of power and responsibility has become a common pain point for outsourced nursing auxiliary services(32). Against the current development background of domestic medical nursing assistants, all links of the industry remain underdeveloped: for example, the sector operates without standardized regulations, clear role boundaries, or systematic education and training. This situation has aroused widespread serious concerns, especially regarding patient safety and quality of life. Although both hospitals and external service agencies have established multi-dimensional quality supervision systems, the overall supervision effect remains limited due to the lack of effective binding mechanisms. By comparison, European and American countries have a long history of employing nursing assistants as part of their healthcare workforce. It is recommended that China continuously improve the management of this workforce by drawing on the mature operating systems of these countries, so as to alleviate the burden brought by nurse shortages and population aging.

Meanwhile, this study found that the extremely high turnover rate of HAs further exacerbates operational difficulties. Frequent staff turnover undermines the effectiveness of systematic training and hinders the accumulation of specialized care experience. A large body of overseas research has explored the drivers of high HA turnover: for example, studies on home care and nursing home nursing assistants in other countries have confirmed that low income, heavy workload, and unclear role positioning are the main contributors to high turnover(12, 33). In a 2024 systematic review synthesizing 28 studies across 11 countries, Norful et al. found that younger age, limited clinical experience, lower income, and financial strain were consistently associated with higher burnout risk among healthcare assistants, and these factors are closely linked to stronger turnover

intention and actual staff departure(34). This conclusion may also be applicable to the domestic healthcare context. A qualitative study conducted among Chinese nursing assistants also identified that low salary, poor working environment, low professional identity, insufficient external incentives, and high work intensity are the primary factors driving turnover intention(28). In our study, nursing managers proposed an ideal operating model that provides practical guidance for addressing current challenges: assigning relatively fixed healthcare assistant teams to each department, clarifying the division of labor between registered nurses and auxiliary care staff, and adopting flexible staffing ratios based on patients' conditions and levels of self-care ability. Overall, the role of HAs has not been established for a long time in China, and various aspects, including relevant regulations and policies, clear role boundaries, and systematic education and training, remain underdeveloped. Future research should continue to explore these issues and address practical challenges to improve patient safety and enhance the overall quality of unaccompanied care services.

4.4 Comprehensive implications for clinical practice and policy

This study offers several implications for clinical practice and policy. First, healthcare organisations should develop a stratified and standardised training system for HAs, covering fundamental care skills, clinical observation, communication, and other related competencies, to bridge the gap between the ideal and actual competency profiles. Second, hospitals and third-party agencies should establish shared responsibility mechanisms, including unified recruitment standards, joint quality supervision, and a clear division of labour between registered nurses and HAs, to address the current management dilemma. Third, policymakers should consider integrating unaccompanied care services into medical insurance or long-term care insurance schemes to reduce patients' financial burden and improve service accessibility, particularly for low-income and empty-nest elderly populations. Fourth, nursing home organisations and hospital managers can improve workforce stability by establishing fixed departmental teams, offering competitive salaries, and providing clear career development pathways, thereby reducing turnover intention among HAs. Finally, nursing education programmes should enrich curricula with content on coaching and leadership competencies, enabling registered nurses to effectively guide and support HAs in daily practice.

5. Limitations

This study has several limitations. First, it was conducted in a single tertiary hospital in Xi'an, and the findings may not be fully transferable to other regions or healthcare settings with different economic and cultural contexts. Second, although we achieved data saturation through purposive sampling, all nursing administrators and company managers were recruited from the same hospital and its partnered agencies, limiting the diversity of organisational perspectives. Third, the qualitative design did not allow for quantitative validation of relationships between variables. Fourth, interviews were conducted at a single time point; longitudinal studies would be valuable to understand how experiences and perceptions evolve over time. Despite these limitations, the multi-stakeholder design and rigorous thematic analysis strengthen the credibility of our findings.

6. Conclusions

This qualitative study explored unaccompanied care services from the perspectives of patients, family members, nursing administrators, and company managers. Three themes were identified: perceived value and barriers to acceptance, the gap between ideal and real images of healthcare assistants, and collaboration modes and challenges of the service system. Our findings indicate that while unaccompanied care alleviates family burden and meets daily care needs, its promotion is constrained by cultural norms, economic pressure, insufficient HA competency, and management difficulties.

Declarations

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Ethical Approval

This study was reviewed and approved by the ethics committee of the studied hospital.

Availability of data and materials

The datasets generated during this study are not publicly available due to ethical restrictions and participant confidentiality. Anonymised data may be available from the corresponding author upon reasonable request, subject to institutional ethics approval.

Consent for Publication

Not applicable. The manuscript does not contain any individual person's data in any form (including individual details, images or videos).

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Figures



Figure 1

Ideal images of healthcare assistants