Developing National Standards:
‘Determining the role of the health care assistant within acute medicine’

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Session overview

• Background drivers
• Tensions
• Four perspectives on role definition
• A framework in evolution?
• VITAL development for HCAs
• Future practice
Background drivers

Broad Policy:
• 2000 – European Working Time Directive
• 2005 – Modernizing Medical Careers
• 2006 – Modernizing Nursing Careers

Specific/related evidence /policy:
2010 – Nursing Midwifery Council (towards 2013)
2011 – NIHR – SDO (Kessler et al)
2011 – DH: Enabling excellence
2012- The Francis Report
2013 - The Cavendish Review
2014 …. The CQC – Certificate in Fundamental Care
Background drivers


Five areas within this for consideration:
1. Code of conduct
2. Common induction standards
3. Core and Common competencies
4. Technical and social care – training framework
5. Technical and health care – training framework
Healthcare assistants 'should get standard training'
By Michelle Roberts
Health editor, BBC News online

- Healthcare assistants provide vital support
- Continue reading the main story
- There is no minimum standard of training for healthcare assistants before they can work unsupervised, an independent report has found.
- Workers should get at least two weeks' training to prepare them for providing basic care in hospitals, care homes and at home in England, its author said.
- Journalist Camilla Cavendish also said some staff were only given a training DVD to watch before starting work.
- The review was set up in the wake of the Stafford Hospital scandal.
- Ms Cavendish found that HCAs - who provide basic care such as feeding and washing patients - were given no "compulsory or consistent" training, and said some were doing tasks usually performed by doctors or nurses, such as taking blood.
Patients are at risk as hospitals axe 5,000 nurses, warns union Royal College of Nursing claims switch to healthcare assistants is putting lives in danger

• Carter said: "We are concerned that there is a dilution, to the detriment of patient care, of the ratio of qualified nurses to health care assistants. That has been compounded by so many employers not giving their health care assistants any training.

• "So you have the double whammy of not having enough registered nurses and replacing them with people who do not have rudimentary training."
‘Compulsory and Consistent’

EMERGENT
Tensions

- Blurring the boundaries between RGN & HCA
- Merge all the information?
- Transferability of competencies across settings
- Multiplicity of employers
- Delegation and Accountability
- Contextually specific issues – particularly in social care
- One size will not fit all!!

The Cavendish Review, July 2013
Role Definitions

In looking specifically at Hospital settings there is some clarity in the literature:

1. Relief
2. Substitute
3. Apprentice
4. Co-Producer

The Nature and Consequences of the Support Workers in a Hospital Setting, NIHR, SDO, 2011 (Kessler et al)
Relief

‘The standard HCA is more likely to deliver direct and in-direct care than the Registered nurse and is generally valued for taking routine tasks away from Nurses’
‘In taking on routine technical tasks HCAs are extending their role into traditional nurse activities. A substitute for registered nurses’.

• The question is where do we draw the line?
• Some HCAs extend the role significantly beyond this point - raises the issue of cheap labour.
Apprentice

‘Many HCAs show an enthusiasm for in-role development but this can be frustrated by weaknesses in the operation of the Trust or NVQ frameworks. HCAs have enduring nurse aspirational tendencies, but Trusts show little inclination to manage or address these expectations’.
Health care assistants have distinctive contributions to make to care. They find it easier to deal with certain difficult patients and more readily relate to patients than registered nurses. If the role of the HCA were made clearer to patients this relationship to care contribution would be even stronger.'
How would you describe the role?

• How would you describe the HCA role within acute medicine - without describing the tasks that a healthcare assistant or health care support worker carries out?
A framework in Evolution:

Basic tasks

- Bathing
- Feeding
- Bed making
- Collecting TTO
- Escorting patients
- Stocking up
- Taking bloods
- Cannulation
- Simple dressings

- Taking observations
- ECG recording
- Blood glucose monitoring

Framework in evolution: Advanced tasks

- Complex dressings
- Female catheterization
- Monitoring using diagnostic machines
- Change of tracheotomy tubes
- Giving injections
- Updating care plans
- Relating medical information to relatives

Kings College Nation Nursing Research Unit: moving forward with healthcare support workforce regulation (2010)
A framework in evolution: Desirable attitudes

- Listening
- Observant
- Diligent
- Mature (stable emotionally)
- Caring
- Compassionate
- Courage
- Commitment
- Communication
Part 2 – VITAL ‘virtual interactive teaching and learning for HCAs’

1. Demographics
2. The learning experience
3. Impact on practice
4. Fit with 6Cs for Nursing
5. The Acid test
Survey Method

- Surveyed all HCAs who had completed VITAL
- Voluntary enrollment via email link
- Survey Monkey platform with 23 questions
- 50 HCAs enrolled with 41 completed surveys
- Used pre-piloted questions from a question bank created by research team
Part 1 – HCA Demographics
Age range of HCA

- Age:
  - 18 to 24: 29.0%
  - 25 to 29: 16.1%
  - 30 to 34: 6.5%
  - 35 to 39: 0.0%
  - 40 to 44: 9.7%
  - 45 to 49: 9.7%
  - 50 to 54: 16.1%
  - 55 to 59: 9.7%
  - Over 60: 3.2%
Gender of HCAs

- Male: 80.6%
- Female: 19.4%
HCA Workbase

• Huge spread of areas (16)
• OPD, Theatres, Respiratory, Ophthalmology, Dermatology, General Surgery, General medicine, Renal and ENT
Highest educational attainment

- GCSE: 0.0%
- A-Levels: 13.3%
- NVQ: 0.0%
- Diploma: 13.3%
- Undergraduate Degree: 73.3%
- Postgraduate Degree: 0.0%
Part 2 – Experience reported
Utilized variety of learning approaches

22.6% Strongly Agree
67.7% Agree
9.7% Unsure
0.0% Disagree
0.0% Strongly Disagree
Out of 10, how would you rate your experience of the course, in terms of: (1 being the lowest and 10 being the highest)

- Usefulness of the materials: 7.80
- The course assessment (Scenarios): 8.20
- Accessibility of the materials: 8.40
- The relevance of the materials: 7.00
Part 3 – Impact on practice
Has VITAL has a positive impact on your practice?

- Yes: 74.2%
- No: 25.8%
Vignettes – positive impact

‘Informative, enabled me to have greater confidence’ (p02)

‘The course has made me more aware, I think what, why and when to do a task now’ (p04)

‘The information has re-instated my thirst for learning’ (p23)

‘it has helped me to work better with doctors and nurses in the team’ (p46)
If not positive impact – why?

• ‘The VITAL course was not relevant to my area of work in clinic’ (p04)
• ‘I think we need a VITAL for theatre HCAs’ (p05)

• NB: 7 responses in this category only, same themes
Part 4 – fit with 6Cs
VITAL provided me with knowledge to effectively care for my patients.
Care (safety)

My learning through VITAL has enabled me to identify potential risks to patients in my clinical area.
You have become more compassionate as a result of completing VITAL
Completing VITAL has helped me to communicate better aspects of care with patients and the team.
Confidence (competence)

Undertaking the course has made you more confident in your practice.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

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0.0% 10.0% 20.0% 30.0% 40.0% 50.0%
Commitment

I am more committed to meeting patients’ needs in my clinical area.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

0.0% 10.0% 20.0% 30.0% 40.0% 50.0% 60.0%
Courage

• ‘By preventing complacency through ongoing learning’ (p08)
• ‘Made me aware and to assess situations differently’ (p15)
The acid test!

I would recommend VITAL to other HCA's.

- **Yes**: 96.8%
- **No**: 3.2%
A way forward?

• We need to provide clarity on what **skills**, **competencies & attitudes** we want our HCSW or HCAs to have to work in acute medical areas

• We need to set out minimum training standards

• We need to work with our educational providers to achieve, these with continuity & quality assured.

• National guidance will come along soon enough – but we have to set our stall in acute medicine.
Thank you for listening

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