

What role should HCAs have in tissue viability?

The introduction of a single level of registration education for nurses in 1986 resulted in a drop in the student nurse workforce. This necessitated the development of the role of the healthcare assistant (HCA). More latterly, as registered nursing roles have expanded, the gaps left in the care continuum have been taken on by HCAs, who have been prepared for their extended practice through national vocational qualification (NVQ) programmes.

The HCA role in wound care comes under NVQ training units X13 and X19 (Care Sector Consortium). The elements of competence for these units include preparing clients for clinical activities, obtaining and testing specimens, and undertaking clinical procedures, treatments and dressings. Thus, there is established recognition that HCAs do and will play some part in meeting the needs of clients with wounds. However, the level of input is open to debate.

The HCA is meant to work under the direct supervision of the registered nurse (RN) and, in relation to tissue viability, is responsible for following care plans and reporting any changes in a wound's condition. There are clear cost advantages to HCAs carrying out the bulk of wound care activities. However, the downside includes the HCA's lack of professional accountability, which may be a problem in the community where HCAs work at arms' length from their RN supervisors. The regulation of HCAs is being considered. In the meantime, defining the scope of practice of the HCA is key to the future of good wound care. AK

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Do you think there is a role for the HCA in tissue viability, and if so, what is it and why?

MLJ: Ideally the HCA should work alongside the RN and be there to offer assistance, but this is often not the case and the HCA has to work alone. This is expected practice within a community setting as staffing issues and geography mean it is impractical to have a RN working alongside a HCA in all situations.

However, this can also be the case within acute settings. It is therefore important that the role of HCAs in tissue viability is made absolutely clear. My view is that they can, with appropriate training, undertake the following activities without direct supervision: pressure ulcer prevention, including the application of barrier creams/emollients; the removal and application of secondary dressings; the removal of compression bandaging; the application of temporary dressings in cases where the original dressing has become displaced (until RN intervention); the care of intact skin in the after care of healed venous leg ulcers, which involves application of emollients; and assisting patients with the application of prescribed compression hosiery.

PB: I believe the HCA plays a valuable role in the nursing team. Often that role involves delivering intimate care to patients, e.g. washing, toileting, and repositioning. As such they are in a prime situation to identify the possible risk of pressure damage and to take action to prevent it from occurring. It is a contentious issue, but I believe that

under strict guidelines and working closely with a RN, there may be a role for the HCA in pressure damage risk assessment of patients in both primary and secondary care. This would involve training, supervision and regular competency checks.

Under the present circumstances, HCAs working in primary care complain that when they report to a RN that they believe a patient is at risk, there may be a delay of up to a week before the RN assesses the patient and takes appropriate action. While in secondary care the role of the RN has expanded to fulfil some tasks that were previously the remit of junior doctors, this is inexorably moving their emphasis of care away from fundamental nursing care, which is leaving a gap that must be filled. Surely the HCA, with their remit for basic nursing care, is in a prime position to fill this gap.

Do you believe anyone can be trained to apply compression bandages?

MLJ: Yes. I believe that anyone can be trained to apply compression bandaging but it takes skill to recognise when a bandage has been inappropriately applied and this is something that comes with in-depth knowledge and experience. It should also be stated that the management of a leg ulcer is far more complicated than simply applying bandages. In-depth knowledge and skill is required to assess and prescribe appropriate treatment. Assessment is necessary before every bandage application. One cannot just assume that because a compression

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bandage has been removed, it is safe to reapply it. In my opinion, this assessment is the role of the RN who has the appropriate skills and knowledge base. Inappropriate application of compression bandaging can lead to limb amputation and I feel that HCAs should not be applying compression bandages unless they are under the direct supervision of a RN.

PB: Anyone can be educated to apply compression bandages, but whether anyone can be trained to recognise complications of venous disease, i.e. dermatitis, eczema, acute venous insufficiency, skin damage, etc, is another matter. For that reason I dispute that compression bandaging should be carried out by HCAs without thorough training in the aetiology of venous disease, skin care, wound management, recognition of problems associated with venous disease and application of a wide range of bandaging. The application of compression bandages is a more appropriate role for a RN skilled in the procedure.

What training is required for the HCA and whose responsibility is it?

MLJ: The training requirement is dependent on the job description and local practice guidelines. With regard to tissue viability, I feel that it is the responsibility of tissue viability nurses (TVNs) to determine which tasks can be delegated to HCAs. They should therefore take responsibility for ensuring that appropriate educational opportunities are made available and that, as far as possible, all HCAs are given the same standard of education.

It may not be practical for the TVN to do all the training themselves and ward managers, team leaders and/or link nurses could be trained as trainers. The ward manager or team leader has a responsibility to ensure that HCAs are able to access that training. However, it is the responsibility of the RN delegating the task to ensure that the HCA has the competencies to undertake it, as the RN is ultimately accountable.

PB: Currently, HCAs receive a broad and task-oriented training to achieve their NVQ, provided by training specialists who are very often nurses. However, there is little training regarding pressure ulcer prevention unless an organisation recognises this to be part of the HCA role. I believe that training for HCAs in pressure ulcer prevention is the responsibility of the TVN.

I organise a two-day workshop for HCAs. I find them a challenging and stimulating group, who are genuinely interested in fundamental patient care. Following the workshop, the HCAs complete a workbook to demonstrate they have absorbed the knowledge. They also have a competency assessment to show their ability to perform pressure ulcer risk assessment, nutrition assessment, and simple (non-cavity) wound assessment and management.

Despite specific training, HCAs will still require supervision and regular competency checks; it is important that they work within guidelines in designated areas of practice decided upon by their

organisation and TVN. What is, and what is not, appropriate for the HCA role needs to be debated and agreed by TVNs in order that a consensus can be reached regarding the scope of the HCA remit.

How do you think competencies of HCAs can be assured?

MLJ: Within our trust, we have set up a competency-based framework for HCAs for pressure ulcer prevention care. It is a package that provides taught as well as self-directed learning and a set of competencies that need to be signed off 10 times before the HCA is deemed competent. They are then expected to attend a study day once a year. Is it sustainable? I hope so.

Nevertheless, I feel it is my responsibility to make the education available and the responsibility of the HCA's line manager to ensure that they both attend study sessions and undertake the education package, as well as ensuring that competencies are maintained through regular supervision and assessment.

PB: It is important not to relax after a HCA, or indeed a RN, has demonstrated competence once. The demonstration of competency needs to be repeated, to ensure any healthcare practitioner continues to uphold standards of care; the HCA is no exception. By so doing, we ensure patient safety and maintain professional standards. This serves to reassure the patient and relatives that the nursing team is competent to care. It may be appropriate that

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Do you think the role of the RN is being eroded by the HCA?

MLJ: No. What I do feel is that RNs no longer see the delivery of what used to be defined as 'basic nursing care' as important or a priority, and are therefore eroding their own role by delegating these traditional nursing activities to the HCA. In principle I would have no problem with HCAs undertaking some of these tasks; however, HCAs are often expected to undertake these roles without any training or guidance.

Also, at present, care plans are either not done or are incomplete, repositioning charts are not in use, and continence and nutritional assessments are not carried out. How can we expect HCAs to provide care if we as RNs have not identified problems and instigated the required care?

Registered nurses are the role models for HCAs and if they can't see the importance of tissue viability care, how can care be delegate appropriately to the HCA? No one would be expected to drive to an unknown destination without a map, yet every day HCAs are delegated tasks without any plan to follow and without appropriate training. How would we feel if the recipient of that delegated care was a close relative of ours?

Furthermore, it is contrary to the NMC Code of Professional Conduct. 4.6 which states;

'You may be expected to delegate care delivery to others who are not registered nurses or midwives. Such delegation must not compromise existing care but must be directed to meeting the needs...of patients and clients. You remain accountable for the appropriateness of the delegation, for ensuring that the person who does the work is able to do it and that adequate supervision... is provided'.

Training alongside competencies for pressure ulcer and basic wound care should in my opinion be mandatory for all nurses and HCAs who give direct patient care.

PB: No, I believe the role of the RN is changing as a result of natural expansion as new technology and approaches to care are developed. In addition, nurses are being encouraged to perform tasks once carried out by junior doctors. Both of these factors, together with integration of overseas nurses, has led to changes in nursing practice. The HCA plays a vital role in the nursing team and should work closely with the RN. Sadly, I do not find that all RNs have an interest in pressure ulcer prevention and therefore some are all too willing to delegate that role to the HCA.

This is a matter of grave concern to TVNs. While we all need to value the work of the HCA, this should not be a signal to the RN that such fundamental nursing care is unimportant. It is this

nursing care which is peculiar to our profession and something in which we should take great pride.

Are HCAs simply a cheap labour option that will ultimately reduce the standards of care delivered?

MLJ: No. There is no doubt that HCAs are an important part of the team and in my opinion it is RNs who will reduce standards of care by not ensuring that the tasks delegated are appropriate and that the person undertaking a particular task has the necessary skill and knowledge. It is most important that as RNs the role delegated is not devalued. It should be noted that although HCAs may have NVQs in healthcare, in the event of litigation, it is the RN delegating the task that will be held accountable. NVQs are proof of competencies to undertake certain tasks and not a permit to practice.

It is therefore the RN's responsibility to undertake the assessment, plan and document the care and delegate appropriately to a person they know is able to undertake the task to a given standard. This will ensure that the care given is supervised, and that standards will be maintained.

PB: That will ultimately depend upon the commitment both in nursing and each organisation to ensuring that HCAs are trained responsibly, their competency ensured and that clear boundaries exist between roles. HCAs are here to stay; we all need to be committed to equipping them for their role in order to ensure both patient safety and that the position of the HCA is not abused. **WUK**