

Healthcare assistants and their role in tissue viability

The role of the healthcare assistant in tissue viability has been changing over the past few years. This review discusses the five main themes found within the literature regarding the extended role of HCAs: patient and wound assessment; competencies and education; accountability; task-orientated care; and skill-mix/role perception/role threat. It then considers how these findings have informed an HCA training initiative at the author's NHS trust. It concludes that there appears to be a lack of national consensus on the role a healthcare assistant should have in tissue viability and this needs further investigation.

Amy Oldfield

KEY WORDS

Healthcare assistants
Support workers
Tissue viability
Wound care
Extended roles

The role of the healthcare assistant (HCA) in the NHS has been changing nationally and locally for numerous reasons (Stokes and Warden, 2004; Spilsbury and Meyer, 2005). Changes to doctors' working hours have meant that tasks previously completed by doctors are now being taken on by nurses (Hancock and Campbell, 2006). As a consequence, some roles that were traditionally undertaken by nurses are now being delegated to other members of staff. With these changes in mind, this article reviews the literature relating to the developing and expanding role of HCAs with the aim of investigating evidence of the effectiveness of HCAs when taking on these roles, specifically in tissue viability. This review has informed

a project which is currently under way within the author's NHS trust aimed at educating and then assessing the competence and skill of experienced HCAs when undertaking tasks in wound care (University Hospitals Coventry and Warwickshire NHS Trust, 2006). This initiative was developed due to concerns within the trust that HCAs were performing wound care tasks without the necessary skills and competence to do so. It is hoped that it will allow boundaries to be created for this group of experienced staff to allow them to develop their skills safely.

Search strategy

An extensive search of the literature using the electronic search engines Cinahl, Medline, Google, Scholar and The Cochrane Database was undertaken. A hand search was also undertaken of *Wounds UK*, *Wound Care* and *Wound Essentials* as these were not available on these electronic databases. The search was limited to English language texts to ensure adequate understanding of the published work. There was no date limit set so that all available literature on this topic could be identified. The following search terms were used: healthcare assistant, support worker, nursing auxiliary, nursing assistant, role perceptions, wound care, tissue viability, pressure area care, role expansion, extended roles, wounds, wound healing, professional roles, skill mix and clinical competence.

Results

A considerable body of literature was found on expanded roles: delegation of tasks; changing roles; regulation of HCAs; competence of the HCA and role perception by other staff members (Workman, 1996; Fletcher and Rush, 2001; Spilsbury and Meyer, 2004; Hancock and Campbell, 2006; Cressey, 2007). When this search was narrowed further, seven of these articles were found to directly relate to the field of tissue viability (Maddux, 1990; Anderson, 2004; Hampton, 2004; Edwards, 2005; Hampton, 2005; Lloyd-Jones and Young, 2005; Anderson, 2006). One of these (Maddux, 1990) was unobtainable despite extensive searching involving the British Library and a clinical librarian. Of the remaining articles, five were opinion-based rather than research studies and one described a small-scale research study that had no subsequent follow-up (Lloyd-Jones and Young, 2005). All of these articles were critically analysed and the focus of this article is on the themes identified among the articles. The main themes identified were:

- ▶▶ Patient and wound assessments
- ▶▶ Competencies and education
- ▶▶ Accountability
- ▶▶ Task-orientated care
- ▶▶ Skill-mix/role perception/role threat.

Patient and wound assessments

The expansion of the HCA's role in relation to holism and wound assessment is discussed at length in the

Amy Joanne Oldfield is Clinical Nurse Specialist in Tissue Viability, University Hospitals Coventry and Warwickshire NHS Trust, Coventry

literature. Hampton (2005) focuses on the development of the role of HCAs in skin and risk assessment for pressure ulcers. The background to this paper and the reason given for the expansion of the HCA's role, is a response to several court cases after the deaths of patients as a consequence of the development of pressure ulcers (Hampton, 2005). Hampton acknowledges that HCAs are an integral part of the multidisciplinary team and believes that some of the patients' deaths could have been prevented had HCAs been trained in skin assessment and risk assessment. To this end, Gledhill and Hampton (2004) devised a two-stage pressure ulcer assessment tool for HCAs to use. They suggest that HCAs should report the findings of their assessment to a nurse who will assist them in taking the appropriate actions. Gledhill and Hampton also discuss lower-risk pressure-reducing equipment that can be obtained and used by HCAs while waiting for a more comprehensive assessment by a nurse. While this may only be a temporary allocation of equipment, it involves the planning, implementing and evaluation of care, which other authors have suggested should remain the responsibility of the nurse.

Bergman (1981) suggests that if the assessment, implementation and evaluation of care have been carried out by a nurse then tasks can be delegated to the HCA. This view is supported by Storey (2005) who comments that accountability for assessment, planning and standards of care rests with nurses, and this includes tasks subsequently delegated to an HCA. Similarly, Edwards (2005) strongly emphasises to participants on her development programme for HCAs that it is not part of their role to assess the wound. However, the HCAs are taught the processes involved in normal wound healing so that they can recognise abnormal signs and request assistance when necessary.

Lloyd-Jones and Young (2005) audited pressure area care within their trusts and then went on to study the HCA's role both in the community

and acute care settings in relation to all aspects of tissue viability. Their results showed that a variety of wounds were being cared for by HCAs either through removal of dressings, wound cleansing, dressing selection and dressing replacement. The study highlighted the fact that HCAs were making decisions about wound care options without reference to nurses.

At the 2004 Leg Ulcer Forum conference (Anderson, 2004), some delegates suggested that HCAs could apply compression therapy. This debate was raised again by Anderson in 2006 by presenting a discussion of the benefits and disadvantages of HCAs applying compression bandages as part of leg ulcer assessment. Discussions at the 2004 conference among tissue viability and wound care practitioners indicated that presumptions have been made by some clinical and non-clinical staff that HCAs can be taught the application of compression therapy and, when deemed competent, can apply it in an unsupervised environment. However, it is the author's opinion that compression therapy forms a significant part of leg ulcer management and should only be commenced after a holistic patient and wound assessment. If used inappropriately, compression therapy can potentially cause extensive damage to a patient's limb (Callum et al, 1987). Therefore it would appear to be inappropriate for HCAs to undertake compression therapy in the absence of holistic assessment.

Anderson (2006) points out that if leg ulcer management is separated into individual components it becomes task-orientated. If a task-orientated approach to leg ulcer management is adopted by allowing HCAs to apply compression therapy, it is very probable that significant elements of the assessment will be lost, including consideration of the patient's psychological state and/or level of pain. Anderson (2004) makes an interesting comment when discussing why components of leg ulcer care, such as compression therapy, are being delegated to HCAs and suggests that this delegation could arise from it being an unpopular element of patient care.

This requires research and could be investigated by identifying which other nursing tasks are being passed to HCAs.

Competencies and education

All but one of the articles mentioned the importance of education for HCAs in order to develop and maintain their skills, though the type of education discussed varies widely. While Hampton (2005) does not specifically mention education, it has to be assumed that some education would be provided to assist in the implementation of the pressure ulcer assessment tool she devised. However, as the project was in response to a number of court cases, it would seem sensible to plan an evaluation and further education as part of the implementation. Brant (2004) discussed the use of informal and formal evaluation of a training plan for HCAs in a GP practice and highlighted how useful this had been in informing training needs.

Edwards (2005) detailed a list of tasks that HCAs should be competent to undertake once they have completed a development programme. These include taking a wound swab, suture removal, and replacement of dressings. However, it is disappointing to note that not all of these tasks were detailed in the formal competency assessment that Edwards (2005) details. Cressey (2007) described a similar framework for development of HCAs in a primary care setting that includes, among other things, a competency framework covering a variety of topics such as tissue viability and infection control. This framework used by Cressey at her trust in Croydon outlines competencies in a range of clinical skills which develop the HCA role safely. It allows time for the teaching of the theory as well as the practical skills needed to perform their role. This annual programme is adapted each year in line with the results of evaluation and national agendas such as the Healthcare Commission's annual review (Healthcare Commission, 2007). It has been reported that some of the HCAs that have completed this competency framework have gone on to become nurses which suggests value in a structured competency

framework for healthcare as a whole. This view is supported by Edwards (2005) who found that staff who had undertaken structured training, albeit not a competency-based framework, found increased satisfaction with their role and the development of new skills. The structured training programme consisted of sessions aimed at increasing their knowledge to assist practice nurses, not taking on overall assessment and management of the wound. The content of the training day included anatomy and physiology of the skin, stages of wound healing and dressings and bandaging. However, the impact of this course in clinical practice is unknown as there was no reported audit regarding utilisation of skills in practice. With cost-effectiveness always being relevant in the NHS, an audit of knowledge and skills gained and the impact on clinical practice would be beneficial as would an assessment of the views of patients on any changes in the care they received. Stokes and Warden (2004) also commented on the lack of research that investigates patients' views when receiving care from HCAs.

An audit by Lloyd-Jones and Young (2005) identified that only 20% (n=9) of HCAs in the acute setting and 49% (n=20) in the community who were performing wound care tasks had attained an NVQ level 3 in which wound care education is a key part of the course. This audit of 319 HCAs showed that 275 (86%) of those who participated in wound care felt positive about their extended role and demonstrated that they welcomed the opportunity to develop their skills. A similar enthusiasm among HCAs was also identified by Artley and Menhennet (2002) and Hancock et al (2005). However, Lloyd-Jones and Young (2005) also found that 60% of 319 participating HCAs had not received any training in wound care and only 16% provided any feedback to an accountable practitioner regarding the care they carried out. It has been suggested that the accountable practitioner may not always know what the HCA is doing (Percy, 2000) which raises issues surrounding professional accountability especially when associated with poor standards of care.

Accountability

The issue of accountability in relation to tasks allocated to HCAs is discussed at length in the literature (Leigh, 2003; Anderson, 2004; Lloyd-Jones and Young, 2005; Hand, 2007). It appears that many HCA development and competency programmes have been initiated as a result of concerns about HCAs' skills and awareness of their own accountability. Discussion of the range of tasks already being carried out by HCAs that took place at the start of one development programme revealed that they were often working beyond their competency (Edwards, 2005). Lloyd-Jones and Young (2005) reported on a competency framework that included formal education sessions on accountability and asepsis for all HCAs undertaking wound care that was devised in an attempt to resolve this problem. The additional issue of maintaining skills was addressed by providing yearly updates for all HCAs who completed the programme.

One of the main reasons for implementing a competency-based programme in the author's own acute trust was to ensure the HCAs are skilled and competent to carry out tasks that they are asked to undertake (UHCW, 2006). The programme is open to experienced HCAs who are working in an area where undertaking wound care tasks without supervision is essential such as in the outpatients department. Managers are asked to nominate staff who they feel have the experience to expand their roles in wound care. Similar to Edwards (2005) the author found that staff had already expanded their roles over the years to include tasks that they did not have the theoretical basis for: Some staff had been asked to work beyond their boundaries and had not realised the potential accountability implications for this. The competency course within the author's trust, similar to Lloyd-Jones and Young (2005), has a formal session on responsibility and accountability, which ensures that the HCAs realise their responsibilities and the boundaries in which they are to perform safely. It also includes theoretical and practical advice on asepsis and ensures they can

perform an aseptic technique safely and understand the rationale behind this task before being able to practice their skills in their clinical area.

It has also been recognised that HCAs need to be taught how to identify tasks which are beyond their competence. The NMC code of conduct (NMC, 2008) discusses how the nurse remains accountable when a task is delegated to an HCA and that supervision or support should be provided. Therefore, it is important to ensure that an HCA is competent in the delegated task and, if not, that the nurse in charge recognises this and does not delegate to them. From a risk point of view, it is also important that HCAs understand their own competency and responsibility and will refuse to take on a task if they do not feel able to complete it competently. Within the session on accountability and responsibility on the author's competency course the HCAs are faced with a role play discussing a scenario where they are asked to perform a skill in which they feel they are not competent. This session allows them to discuss this scenario away from the pressures of the clinical environment and equips them with ways of dealing with this situation and how to say no.

Lloyd-Jones and Young (2005) found that in their acute sector 13% (n=8) of HCAs worked unsupervised which increased to 59% (n=24) in the community. When this unsupervised care involves the selection and application of a dressing they argue that this should be the role of an accountable practitioner (Lloyd-Jones and Young, 2005). The author would similarly argue that HCAs should not be asked to prescribe and apply dressings without the supervision of an accountable practitioner. The concerns are that such practice may lead to HCAs carrying out wound and patient assessments beyond their competence which will compromise patient safety, not considering the obvious disregard of professional accountability by the registered nurse. This could lead to HCAs feeling pressured in some clinical areas to undertake tasks which are

beyond their competence and that they have never received training for particularly where staffing shortages are an issue. If HCAs undertake more and more it gives opportunity for them to be exploited in areas where the accountable practitioner role can be replaced with an HCA role which may result in superficial cost savings for the clinical area.

Task-orientated care

Nurses take responsibility for the holistic assessment, planning and evaluation of care of patients in their care. The literature discusses the risks of delegating tasks to HCAs because this may reintroduce a task-orientated approach to care and a subsequent loss of holistic perspective. Anderson (2004) and Hampton (2004) both discuss leg ulcer management by HCAs. Anderson believes compression therapy involves holistic assessment, complex skills and evaluation of care and that this cannot be delegated to an HCA. In contrast, Hampton's opinion is that while assessment, planning and evaluation of care remain the responsibility of nurses, the skill of compression can be taught and practised by an HCA. However, she does emphasise that this is only safe in a controlled environment, such as a leg ulcer clinic, under direct supervision.

Guidance from the RCN (2006) can be interpreted either way and adds to the confusion. It states 'compression systems should be applied by a trained practitioner' (RCN, 2006). It could be presumed from these guidelines that trained means qualified and accountable, but Hampton (2004) suggests that an HCA could be assessed as competent in this skill and be that 'trained practitioner'. Hampton's work, as previously discussed, was in a closely supervised environment and replication of her results to other settings should be considered carefully in terms of appropriateness and the impact on patient safety.

Skill mix/role perception/role threat

All of the literature reviewed identified that there are areas of care that can be safely delegated to HCAs (Anderson, 2004; Lloyd-Jones and

Young, 2005; Edwards, 2005; Hampton, 2005; Anderson, 2006) but it was also suggested that this may lead to nurses feeling threatened by the changes to their own role. Edwards (2005) sees this as a potential problem when planning to extend the HCA's role in wound care and identifies a need to ensure an adequate skill mix among teams, allowing each task to be delegated to the most appropriately skilled member of the healthcare team. However, she did not discuss or evaluate further, leaving the reader uncertain about whether it actually became an issue in clinical practice. Hand (2007) describes how practice nurses previously felt uncomfortable with the delegation of tasks such as phlebotomy in the 1990s when these tasks transferred to the phlebotomy service. This was a new concept, and it was reported that practice nurses were hesitant to delegate tasks to them but came to accept the delegation of the task. Hand (2007) suggests that this could also apply to extensions to the HCA role.

Competency-based training

The training course at University Hospitals Coventry and Warwickshire NHS Trust is a competency-based course that has attempted to address the issues raised in the previous review.

Patient and wound assessments

The course does not teach wound assessment as this is the responsibility of an accountable practitioner such as a qualified nurse, podiatrist or doctor; instead the HCAs are taught how wounds heal and how to recognise an unhealthy wound. They are also taught about the holistic patient assessment that the accountable practitioner will undertake and how they can assist in aspects such as advising on patient nutrition, smoking cessation, skin care and pressure area prevention.

Competencies and education

As already mentioned the author's trust uses a competency-based course with a theoretical component over two days to educate the HCA about pressure area care and wound care and also assess practical skills such as

bandaging, asepsis and taking a wound swab in a skills lab environment. They are provided with a competency book containing a self assessment section and also a skills grid to be completed under supervision with their supervisor before being deemed competent. \

Accountability

The accountability and responsibility aspect of any development course for HCAs is essential to it being a success. Any HCA undertaking any extended roles needs to recognise their responsibility and the accountability that is faced by the person delegating the task to them.

Task-orientated care

While the course discussed does not aim to facilitate task-orientated care, the reality is that if the HCA has been delegated a task it means that the wound and patient assessment have already been performed by an accountable practitioner and the task of approving the dressing has been delegated to them. This inevitably leads to a task-orientated environment for HCAs. However a positive can be found in this as this course has enabled the HCAs to recognise their boundaries in wound care and decline to carry out tasks where appropriate and it has also led to some HCAs developing new skills such as suture and clip removal and taking of wound swabs which they had not previously performed and can now carry out competently.

Skill mix/role perception/role threat

In regards to skill mix, part of the reason the author's trust developed the competency course was due to a change in skill mix particularly within the outpatients departments. This is an area where a substantial amount of wound care is carried out on patients who are reviewed by medical staff and have ongoing plans of care from community colleagues. The number of qualified nurses within this clinical area has reduced considerably over the years and the reliance on HCAs carrying out wound care tasks unsupervised has grown. The competency course has allowed them

to carry these tasks out safely following a period of supervision.

Conclusion

The literature demonstrates that the HCA's role is changing and that this is being viewed in different ways. Some view the changes as a way to develop the nursing role and help to relieve workload pressures while others see it as a threat to the status of the nurse.

This review of the literature on the role of HCAs in tissue viability has revealed that there is limited research evidence. Discussions appear to be based around opinion rather than consensus statements or formal research projects. There also appears to be a lack of follow-up from the research regarding its impact on clinical practice and patient outcomes. In the context of a changing HCA role it is important that there is research-based understanding of the effect of these changes and how they can have an impact on those concerned. Also, as some of the discussion has concerned HCA competencies, it is vital that the impact of education and assessment of competency is evaluated; a view that is echoed by a number of authors (Pearcy 2000; Fletcher and Rush 2001; Bowman et al 2003). Nursing in the UK should continue to evolve and challenge boundaries and role definitions, but it should do so carefully and safely to ensure evidence-based care is provided by skilled healthcare staff. **WUK**

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Key Points

- ▶▶ The role of the healthcare assistant is changing. Roles are being expanded to include wound care tasks such as dressing changes, patient education, compression bandaging, taking wound swabs, and clip and suture removal.
- ▶▶ Healthcare assistants are undertaking tasks which they have not always been trained to do or assessed as being competent to perform.
- ▶▶ Training and competency--based courses develop skills and competence of HCAs which can improve their job satisfaction.
- ▶▶ This expansion of role may lead some qualified staff to feel threatened by the HCA role.
- ▶▶ More research is needed within the expansion of the HCA role in tissue viability to determine the impact on patient outcomes and the staff involved.