The role of the Health Care Assistant in the Emergency Department

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A qualitative exploration of the Health Care assistant role across five hospital Emergency Departments within Waikato District Health Board

Abstract

Background: Globally, Health Care Assistants (HCA) make up a significant proportion of the health care workforce. However, they remain unlicensed and lack a standardised role title which has been found to cause confusion among healthcare professionals concerning the role of HCAs in practice. Literature cites a multitude of nursing care issues which stem from this role confusion which ultimately impact on patient safety and quality of care. Though studies show the HCA role is increasingly being utilised in acute care settings, there is little research published about their role in providing front line care within Emergency Departments (ED).

Objective: This study aims to explore the views and understanding of HCAs and Registered Nurses (RN) who work within ED, concerning the roles and activities performed by HCAs.

Participants: Five groups of participants consisting of RNs and HCAs were recruited from five respective hospital EDs within Waikato District Health Board (DHB).

Methods: A mixed methods study involving an initial qualitative phase with a focus group undertaken at each of the five EDs in Waikato DHB. Focus group sessions were audio-recorded and transcribed verbatim to allow for later thematic analysis using a general inductive method of enquiry. The second phase involved collation, linking and analysis of two routinely collected DHB datasets – staffing and patient volumes per shift, per day over fiscal year ending 30 June 2016, to compare HCA utilisation across the five EDs.

Findings: Five relevant themes emerged: Tasks and activities; Role perceptions; Challenges of the HCA role; Training and education; and Future of the HCA role. Analysis of quantitative data revealed that Tokoroa and Taumaranui EDs (which did not employ HCAs) had lower RN-to-patient ratios than Waikato and Thames EDs. Ratios for HCA-to-RNs and HCA-to-patients were low, linked to HCAs feeling overloaded with jobs and under-appreciated for their extensive job responsibilities.

Conclusion: There is need for re-examination of the role and tasks undertaken by ED HCAs. Both RN and HCA staff would like to see specific education and training relevant to the spectrum of care provided in the ED.

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Contribution

I, the researcher undertook all aspects of this study under the direct guidance of my supervisors. This entailed selecting the appropriate research design, the data collection and analysis, and the publishing of the findings in this thesis.

Dedication

This work is dedicated to my Health Care Assistant (HCA) colleagues at Waikato hospital Emergency Department. It is a privilege to work alongside you and I admire you for the hard work you do and the excellent and compassionate care you give to our patients every day. I would also like to acknowledge all HCAs within Waikato District Health Board for your invaluable contribution to care.

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Chapter 1: Introduction

Common discourse throughout healthcare literature cites ageing populations, ageing workforce, increasing patient acuity and economic constraints as the main challenges for health care in the developed world. Health care services are called to innovate health care planning and delivery to meet the increasingly complex needs of current and future populations. Registered Nurses (RN) make up the largest proportion of health care professionals (NCNZ, 2013) and account for a significant portion of health budgets. Changing the skill mix of the nursing workforce to include health care assistants has been part of the strategy to reduce costs and maximise resources (Hasson, McKenna & Keeney, 2013; Kleinman & Saccomano, 2006).

Health Care Assistants (HCA) are an integral part of health care teams across all settings. Their role is essentially to assist and support the registered nurse by performing direct patient care, housekeeping and non-clinical duties which allows the RN to focus more on activities like assessment, technical procedures, co-ordination of care and discharge planning. Though the HCA workforce is expanding and being increasingly utilised in acute care settings, they remain an unlicensed workforce and therefore practice under the direction and supervision of their registered nurse colleagues; this means RNs are legally and professionally accountable for patient care undertaken by HCAs (NCNZ, 2011).

HCAs account for a large proportion of the health care workforce and recruitment of HCAs is predicted to keep rising to meet future demand (NZNO, 2011). The increasing number of HCAs in acute care has generated concerns about dilution of nursing skill mix and the impact on patient safety and quality of care (British Association of Critical Care Nurses, 2003; Cassie, 2014).

International studies report blurring of role boundaries as HCAs are taking on more tasks and activities that were once performed by nurses, while RNs are taking on expanded roles and performing procedures that were traditionally performed by doctors (Pearcey, 2007). Despite managing increasingly complex workloads in acute care RNs are also responsible for supervising and monitoring care provided by

HCAs (Hasson et al, 2013). Hence, RNs need to understand the meaning of direction and delegation of care and the role and task responsibilities of their HCA colleagues to delegate nursing care appropriately.

International research regarding delegation to HCAs in acute care shows there is confusion about the role and capabilities of HCAs partly due to lack of standardised role titles and training (McKenna, Hasson & Keeney, 2004). Lack of role clarity was a causative factor in under and over-delegation of tasks leading missed nursing care (Kalisch, 2006). For health care teams to communicate and collaborate effectively, team members must understand the roles, responsibilities and capabilities of inter-professional colleagues (Lancaster, Kowlakowsky-Hayner, Kovacich & Greer-Williams, 2015). This is vitally important in the dynamic clinical environment of the Emergency Department (ED). Arguably there is more vulnerability for staff, including HCAs in the ED compared to other acute settings (Zimmerman, 2000) due to unstable patients waiting to be medically assessed/diagnosed, high patient turnover, overcrowding and fluctuating staff-to-patient ratios, high acuity, and life-threatening conditions requiring resuscitative care. HCAs play an important role in providing frontline care within emergency departments though there is little published about the role of the HCA in emergency care. On this basis, exploration of the health care assistant role in the emergency department is warranted.

In many health care settings, HCAs are integral to the functioning of the nursing team, though some researchers conclude that the work of HCAs is under-recognised (Thornley, 2000; Hancock, Campbell, Ramprogus & Kilgour, 2005). Respective of this viewpoint, the proposed research intends to highlight the value of the HCA within the emergency nursing team. Furthermore, there is considerable research about the experience of physicians and nurses working in the ED but minimal research exploring the experience of HCAs. This research dissertation seeks to answer the question 'What is the role of the health care assistant in the emergency department?' from the perspective of HCAs and RNs who work in the ED. This is important because ultimately the participants' knowledge and attitudes will guide their individual practice and determine their ability to work in a successful partnership. It is anticipated that study findings will highlight the value of the HCA

role in ED and provide scope to determine how HCAs may be best utilised to support RNs in the provision of timely, safe, quality care for acutely unwell patients presenting to the ED. Secondly, the study aims to identify the tasks which are currently (or prospectively) undertaken by HCAs across the five hosptial emergency services within the Waikato District Health Board: Waikato; Thames; Taumaranui; Tokoroa and Te Kuiti. More specifically, the research seeks to address the following questions:

1. What are the perceptions of Health Care Assistants regarding their own role within the Emergency Department nursing team?

2. What are the perceptions of Emergency Department Registered Nurses about the role of the Health Care Assistants within the Emergency nursing team?

3. What are the tasks which could be/are performed by Health Care Assistants in each of the five Emergency Departments within Waikato District Health Board?

4. How does Health Care Assistant practice relate or differ amongst the five Emergency Departments in the Waikato region?

Chapter 2: Literature review

The more extensive a man's knowledge of what has been done, the greater will be his power of knowing what to do

Benjamin Disraeli (1804-1881)

2.1 Introduction

Public health services are constantly challenged to maximise health resources within budget constraints, while striving to meet the diverse needs of patients and communities, maintaining optimum standards of care and fulfilling government health mandates. The nursing workforce accounts for a large amount of health expenditure, therefore supplementing the nursing workforce with lower paid health care assistants is one way to contain costs. However, current research proves that apart from providing cheaper labour, Health Care Assistants (HCA) provide valuable contributions to patient care and are an indispensable resource within the health care workforce.

This chapter will provide context around the role of the HCA in the current health climate, as a basis for further exploration of the HCA role within the emergency setting. The review of literature will be presented in three parts: Part I will highlight current challenges for health care systems and present an overview of the Emergency Department (ED) and the increasing challenges for hospital EDs. Part II will begin with an introduction of the HCA role, followed by a look at the conflicting views within contemporary nursing literature about the HCA role in acute care. Part II will conclude with research findings about practice issues regarding HCAs working in acute care settings. Lastly, Part III will present research exploring the HCA experience of working in acute care and perceptions of acute care RNs who work alongside HCAs.

2.1.1 Definitions of terms

There are many terms used in the literature to describe HCAs such as unlicensed assistive personnel, patient care assistant, nursing assistant and nurse aide. The term

'Health Care Assistant' or HCA is the title chosen by professional organisations such as Nursing Council of New Zealand (NCNZ) and New Zealand Nurses Organisation (NZNO) to refer to all unlicensed workers within the New Zealand healthcare system. A survey undertaken by NZNO found that 'Health Care Assistant' is also the term most preferred by HCAs themselves (2011). NCNZ defines the HCA role as follows, "...to assist the registered nurse by completing personal care and other activities that do not require specialist nursing knowledge, judgement or skill" (NCNZ, 2010, p8). HCA will be the term used throughout the literature review and dissertation.

'Delegation' is defined by the NCNZ as "the transfer of responsibility for the performance of an activity from one person to another with the former retaining accountability for the outcome" (p5, 2007). Additionally, 'direction' is defined as an active process of guiding, monitoring and evaluating nursing care performed by others, which can occur directly or indirectly provided the delegator is readily accessible (NCNZ, 2007).

2.1.2 Literature search

A comprehensive literature search was carried out through Cinahl, Ovid, ProQuest & Ebsco Host databases. The following search terms and key words were used; Registered Nurs* OR Nurs* (truncated); Health Care Assistant OR Unlicensed Assistive Personnel OR Nurse Assistant, 'role' 'emergency', 'acute care', 'perception', 'experience'. There were 73 articles of relevance, while most sources cited are peer-reviewed research studies using qualitative descriptive methods and are published after the year 2000. Literature reviews, commentaries, policy documents and reports from professional organisations and national government are incorporated where relevant to support discussion. Online searches were done using Google and Google Scholar.

Part I: A changing healthcare system

2.2 21st Century challenges within healthcare

The World Health Organization (WHO) recognises ageing as the greatest challenge of the 21st century (2015). Globally, people are living for longer and birth rates are declining, causing a shift in population demographics with a greater proportion of people reaching the age of 60 and beyond (WHO, 2015). In New Zealand, the number of people over 65 is predicted to reach 1.37 million by 2041 with the 65+ age group expected to reach 22 percent of NZ's total population by 2032, compared with 14 percent in 2014 (Statistics New Zealand, 2016). This growth is attributed to the 'baby boomer' generation with the largest predicted growth of the over 65 age group to happen between 2011-2037 (Statistics NZ, 2016). Longevity is also being improved by increasing technological and medical advancements. However, more advanced treatment modalities are associated with increased cost which requires balancing against capped financial resources (Clendon, 2011). The Ministry of Health (MoH) has recently released figures showing that District Health Board (DHB) spending on health services for those over 65 (15% of the population) consumes 42 percent of total DHB expenditure and has increased exponentially beyond other DHB expenses over the past 10 years (2016).

The health workforce is also an ageing demographic, both in New Zealand and internationally. National statistics show the largest group of doctors are aged 50-54 years with 40.1 percent aged over 50 years. The nursing profession is following the same trend with the average age of a nurse being 46.3 years with 42.5 percent aged over 50 years (MoH, 2015). Therefore, a large percentage of the medical and nursing workforce are expected to retire over the next 20 years, leading to a projected shortage of experienced health professionals (MoH, 2015). It is forecast that over 50 percent of the nursing workforce will retire by 2035 which leads to the issue of replacing these nurses to meet the demand of future populations (NCNZ, 2013). Going by the current model in NZ the predicted future need for nurses is greater than the number of nurses in training (NETS/NENZ, 2007; Nana, Stokes, Molano & Dixon, 2013). Other factors linked to staff shortage include poor retention,

advances in medical and information technology and expansion of nursing roles to include traditional medical tasks (McKenna, Hasson & Keeney, 2004).

Current planning and health service initiatives are aimed at directing more resource into primary health and community care, health promotion, self-management and 'ageing-in-place' – focussing on functional health and keeping the older population well within their homes (WHO, 2015; Clendon, 2011). However, with the increasing incidence of chronic illness and co-morbidity, acute care providers are facing increasing challenges to meet demand. National data regarding attendances to ED over the 2014 to 2015 shows an increasing number of people presented with immediately or potentially life threatening conditions, with one in three events resulting in admission to hospital (MoH, 2016). If people are presenting to the ED more acutely unwell, they will likely have more complex care needs, requiring significant resource to provide the necessary care and treatment. Meanwhile, hospital executives are challenged with reducing admission rates and patient length of stay to conserve funds, though this impacts directly on the demand for staff, even when acuity is high (Kent-Hillis, 2001).

2.3 The Emergency Department

The ED is the frontline of acute care. The MoH states the purpose of the ED is "to provide care and treatment for patients with real or perceived, serious injuries or illness…providing resuscitation or stabilisation of critically unwell or injured patients that often require hospital admission" (2016, p1). Presentations to ED across New Zealand topped one million over the fiscal year ending 2015 (MoH, 2016). Waikato District Health Board (DHB) is among the five most populated DHB regions in the country, servicing a total population of 394,340, spanning from northern Coromandel to the Mount Ruapehu district in the south and from the west coast town of Raglan across to Waihi on the east coast (Waikato DHB, 2016). Waikato DHB recorded the highest number of ED presentations per population head in 2015 at over 105,000. ED attendances have increased approximately five percent per year since 2011 (MoH, 2016), a trend which is also reflected internationally (Aboagye-Sarfo, Mai, Sanfilippo, Preen, Stewart & Fatovich, 2015; Cowling, Soljak, Bell & Majeed, 2014). Along with increasing attendances to the ED there are additional

factors causing pressure on ED staff such as limited inpatient beds - meaning patients admitted under specialties become boarders in ED, causing overcrowding and increased patient-to-staff ratios (Ray, Jagim, Agnew, Ingalls & Sheehy, 2003). There is rising incidence of chronic conditions and co-morbidities causing patients to present with more complex care needs, which manifests as higher patient acuity within the department, requiring more dedicated nursing time. On top of these challenges, NZ EDs are required to perform to the MoH target of 'Shorter Stays in Emergency Departments' which aims for 95 percent of ED patients to be seen, treated and either discharged or admitted under an appropriate specialty within six hours of arrival (MoH, 2016). This objective is based on research that shows increased length of stay in the ED coupled with overcrowding leads to increased patient morbidity and mortality (MoH, 2016; George & Evridiki, 2015). However, when inpatient beds are limited, patients admitted under specialties can be kept waiting in ED for much longer than six hours. Thus, ED staff including HCAs, maintain care of these often patients (many with critical care needs) while managing a steady influx of new ED patients.

One strategy to meet increased demand has been to expand Emergency Nurse roles to include Clinical Nurse Specialists (CNS) and Nurse Practitioners (NP). NCNZ defines the nurse practitioner role as "expert nurses who work in a specific area of practice incorporating advanced knowledge and skills… they provide a wide range of assessment and treatment interventions including differential diagnosis, ordering, conducting and interpreting diagnostic and laboratory tests…" (NCNZ, 2017, p. 54). Though Waikato DHB does not employ ED NPs, there are a group of ED CNS' who work to an expanded scope, independently seeing and treating patients alongside and under supervision of ED doctors. NCNZ acknowledges the need for expanded scopes of RN practice to address growing care demands across the health sector. An expanded scope of practice is attained through a formal pathway of education and qualification, allowing the RN to work with "increased autonomy, accountability and responsibility" (NCNZ, 2011, p10). Characteristics which differentiate expanded practice and relate to the ED CNS role are; undertaking activities that are generally not undertaken by RNs; performing interventions that traditionally have been done by other professionals such as doctors; and activities

that require a higher level of autonomy in clinical decision-making and intervention (NCNZ, 2011). Translated in to practice, examples of such expanded tasks include administration of local anaesthetic and suturing, diagnosis and treatment of single system illness or injury involving the ordering and interpreting of x-rays and specimen samples and deciding on the appropriate treatment or management (College of Emergency Nurses New Zealand, 2013). It can also be argued that ED RNs work to the upper limits of their scope of practice; generally having a broad knowledge and skill base and working with a high level of autonomy, as is required when triaging, assessing and managing care of acutely ill patients who are waiting to be seen by an ED doctor. Many studies have examined the extension of the ED nursing role, yet the role of HCAs who work alongside ED RNs remains largely unexplored. With nurses taking on expanded roles and HCA workforce remaining unregistered with lack of standardised education and training this has raised the issue of a knowledge gap increasing between the two positions (Fowler, 2003) and may present risk to effective functioning of the RN-HCA partnership and have a flow-on negative impact for patient care.

HCAs who work in EDs within Waikato DHB receive in-house training to perform extra tasks which most hospital ward HCAs are not (except Cardiac Care) such as point-of-care testing (PoCT) for urinalysis and urine pregnancy testing and Electrocardiograms (ECG). These tasks can occupy a significant portion of their work time, though delegation of these tasks allow RNs more time to dedicate to assessment, planning, intervention and evaluation of care. At this point in time, there is no discussion about further expansion the ED HCA role or task profile within Waikato DHB.

Part II: Health Care Assistants in acute care

2.4 Introducing the Health Care Assistant role

HCAs come under the umbrella of 'unregulated health care workers' which means they are not licensed or governed by a regulatory body (NZNO, 2011). HCAs "...assist registered nurses by completing personal care and other activities that do not require specialist nursing knowledge, judgement or skill" (NCNZ, 2010, p. 10). The intended purpose for the HCA role is to assist and support registered nurses in providing patient care and technical tasks, allowing RNs to focus on other nursing activities such as assessment and evaluation of interventions, liaising with other health care professionals, care and discharge planning and co-ordination of care (Bosley & Dale, 2008). HCAs are employed across the spectrum of healthcare settings, undertaking a range of tasks including direct and indirect patient care, housekeeping and administrative duties, which were traditionally performed by the registered nurse (McInnes & Parsons, 2009).

The role of HCAs spans back to WWI and WWII when nursing students and 'nurse assistants' would provide most of the personal care duties (Stankes-Ross, 1996). A subsequent nursing shortage throughout the 1950s produced a 'functional nursing' model which saw the nursing care workload divided into tasks with an RN overseeing cares, largely undertaken by nurse assistants and trainee nurses. Due to increasing acuity of patients and the complexity of care required, nursing theory and models of care throughout the 1960s and 1970s were centred on total care of the patient which led to the notion of the 'primary nurse', who gave complete patient care to an allocated number of patients based on a 24-hour care plan created for each patient (Stankes-Ross, 1996). The 1980s saw the restructuring of health systems and shortage of nurses, hence, the widespread re-introduction of the nursing assistant role - now known as Health Care Assistant (Kovner, Jones & Gergen, 2000). With an increasing number of HCAs entering the nursing skill mix, nursing care in hospitals is delivered somewhere between the primary nurse and team nursing approach. Primary nurses are allocated responsibility for a group of patients but work within a team structure, usually alongside HCAs, to provide comprehensive patient care.

Though increasing the number of HCAs in acute and critical care settings is driven by the demand for efficiency (Huston, 1996), it has generated concern for the impact on nurses and patient safety (BACCN, 2003). RNs are providing more complex care for an increasing number of patients as well as being legally and professionally responsible for care undertaken by HCAs. Currently there are no nationally agreed employment standards or standardised education requirements for HCAs in New Zealand (NZNO, 2011). National accreditation *is* being offered throughout most NZ DHBs through the New Zealand Qualifications Authority (NZQA), such as the Level 3 National Certificate in Health, Disability and Aged Support (Core Competencies) developed by Waikato DHB. Though, education and training varies between hospitals and DHBs, with HCA roles and job descriptions determined by the employer and specific practice setting (NCNZ, 2011). Thus, RNs remain legally and professionally responsible for direction, delegation and supervision of patient care undertaken by HCAs. Some argue that it places extra burden on RNs who are taking on extended roles to include management and supervisory duties and performing tasks which have traditionally been the role of doctors. (BACCN, 2003; Pearcey, 2007).

The Health Practitioners Competence Assurance Act (2003) is a legal statute with the purpose of protecting the health and safety of the NZ public and ensuring registered health professionals – including Registered Nurses, are competent to practice. HCAs are not covered under the HPCA Act (2003), meaning there are no legal obligations on an HCAs competency to practice, which causes concern among nurse leaders about lack of accountability for care provided by HCAs, particularly care of critically ill patients (Meikle, 2002). However, they *can* be held legally accountable to the public for the care they provide under the Code of Health and Disability Services Consumers Rights (1996) and Health and Disability Services Standards (2008) (NZNO, 2011).

Hospital administrators are continually faced with the challenge of containing costs while providing an efficiently functioning health service to meeting ever increasing demand. Registered Nurses make up the largest group of health professionals employed in hospitals (Clendon, 2011) which represents a high percentage of

expenditure, so arguably from a business perspective the strategy of employing lower paid HCAs to supplement the nursing workforce makes sense. National statistics show that employment of HCAs into hospitals in increasing and will continue to increase to meet predicted demand. There were 3,156 HCAs and 25,078 RNs employed across 20 DHBs in the year ending 2013 (Cassie, 2014). The NZ hospital HCA workforce grew by 30 percent from 2008-2013, while the RN workforce grew 17.6 percent over the same period (Cassie, 2014). This has produced a change in nursing skill mix, reflected by the increase in the average HCA to RN full time equivalent (FTE) ratio which grew from 1:9.7 in 2007 to 1:8 by 2013 (Cassie, 2014). Professional organisations and academics continue to raise the issue of 'dilution of skill mix' and there is wide-spread insistence within nursing literature that HCAs are appropriately educated and trained to the required level for delivery of safe, quality patient care in acute settings (BACCN, 2003; McKenna, Hasson & Keeney, 2004; Boyes, 1995; Fowler, 3003; McGloin & Knowles; NZNO, 2011).

In their position statement 'Unregulated Health Care Workers, 2011" NZNO explicitly states they do not support the regulation of HCAs but call for more precise delineation of their role and responsibilities as separate from those of nurses. NZNO does not support the education or training of HCAs past level 4 on the NZQA framework for the risk it may 'conflict with regulated health professionals' such as Enrolled Nurses.

2.5 The Health Care Assistant debate

Common rhetoric throughout nursing literature declares that HCAs are part of a short-term solution to the increasing problems faced by health systems worldwide, such as workforce shortages and financial constraints. Nurse academics have cited reasons for introducing more HCAs in to the nursing skill-mix, including the need to maximise the use of Registered Nurse time, the evolution of the 'patient-centred' care model and the drive for increasing operational efficiency (Norrish & Rundall, 2001). National nursing representatives argue that HCAs were introduced to alleviate a nursing shortage in New Zealand which can be partly attributed to poor workforce planning in past decades (NETS/NENZ, 2007; Meikle, 2002). Much nursing literature throughout the 1990s centred around the re-structuring of health

systems and controversy about the introduction of the unlicensed HCA role and its impact on nurse staffing in acute care (Huston, 1996; Kovner, Jones & Gergen 2000). Some felt the move would cause degeneration of basic nursing skills and that the essence of 'nursing' would be reduced to a series of tasks, putting patient safety at risk (Meikle, 2002). Studies found the implementation of HCAs into nursing care teams was met with trepidation, resistance and frustration which some argue was due to lack of consultation with nurses regarding the planning and implementation of changes (Norrish & Rundall, 2001; Orne, Garland, O'Hara, Perfetto & Stielau 1998).

Qualitative researchers examined the psychological and clinical impact of these changes by exploring RN experiences of working with HCAs. Earlier studies of acute care nurses found that HCAs were perceived as a threat to the nursing profession and represented the erosion of core values and foundations of nursing. RNs felt HCAs were infringing on their practice and felt burdened at taking on extra delegation and supervisory duties on top of already heavy workloads (Orne et al, 1998; Huston, 1996). Nurses had difficulty adapting to the new model of care and researchers concluded that RNs were ill-prepared by management and clinical leaders for understanding the concept and practice of delegation to HCAs.

A pilot study by Chang, Lam & Lam (1998) compared nursing activities before and after the introduction of HCAs in four acute wards of a Hong Kong teaching hospital. The study concluded that incorporation of HCAs into the nursing team released RNs from non-clinical duties to spend more time on higher level nursing tasks. The authors cautioned that though introducing HCAs may alleviate challenges associated with nursing shortages, the advantages of employing more HCAs should be considered against increasing RNs workload with delegation and supervisory duties (Chang et al, 1998).

More recent studies provide recognition and acceptance of the HCA role and highlight the positive aspects of RN-HCA partnerships, acknowledging the value of the HCA role within the nursing team (Standing & Anthony, 2008; Gravlin & Bittner, 2010; Saccomano & Pinto Zipp, 2011; Lancaster et al, 2015). Researchers also shifted focus to exploring the HCA role from the perspective of HCAs

themselves. An outcome of these studies are calls from some nurse researchers to re-evaluate competencies for HCAs and for recognition of their knowledge and skill, alongside the critical need to implement compulsory standardised professional development and specialised training programmes, in the interest of public safety and quality of care (Thornley, 2000; Nwosu, 2006). Professional organisations also support the introduction of standardised education and training (NZNO, 2011; NCNZ, 2011)

There is concern among the New Zealand nursing profession that increasing the use of unlicensed HCAs comes at the expense of the Enrolled Nurse (EN), as ENs struggle to find work in NZ public hospitals (Cassie, 2014). There is also the assertion that a team nursing model consisting of RNs and ENs is not being utilised enough to assess outcomes of this model for patient care (Cassie, 2014). Enrolled Nurse training takes 18 months, culminating in a level 5 diploma under NZQA standards and awarding of EN registration from the Nursing Council of New Zealand. New Zealand Nurses Organisation (2011) holds the position that the employment of ENs should take precedence over HCAs in providing direct patient care in the interest of public safety, recognising ENs level of training and regulation under the HPCA Act (2003).

There is still concern today among nurse leaders about how introducing a larger number of HCAs in to the nursing skill mix is affecting quality of care and patient safety (Cassie, 2014; Clendon, 2011, McKenna, Hasson & Keeney, 2004). Meikle (2002) warned that increasing the HCA-to-RN ratio may result in reduced quality of care, leading to increased length of stay and increased hospital re-admission rates. Accordingly, there is evidence to suggest that increasing the number of RNs, thus increasing the RN-to-patient time improves patient care outcomes (Zimmerman, 2000; Ray, Jagim, Agnew, McKay & Sheehy, 2003). In response to skill mix and patient safety concerns researchers and professional nursing bodies stress the importance of safe staffing and allocation of nursing resource based on patient acuity, length of stay (LOS) and associated skill requirement to adequately meet patient needs, as opposed to traditional staffing models based on staff-patient ratios,

medical diagnosis or budget allowances (Meikle, 2002; Emergency Nurses Association, 2003; Ray et al, 2003; CENNZ, 2006).

There are international studies evaluating the outcomes of training programmes for HCAs. Fowler (2003) conducted a study on advanced training for developing a higher-level support role for HCAs in acute care. The study found most of the HCA respondents were keen to further their skills and competencies, showing enthusiasm for increased responsibility and challenges at work. Fowler (2003) emphasised the importance of developing the HCA role in accordance with advancing nurse practice. McGloin & Knowles (2005) evaluated a training programme for the Critical Care Assistant (CCA) role within an acute NHS Trust Critical Care Unit. Six CCAs were recruited and undertook an extensive 18-month programme with dedicated clinical and academic support, resulting in the achievement of National Vocational Qualification (NVQ) Level 3 and further advanced support worker competencies specific to the critical care setting. CCAs were trained in such tasks as measuring and monitoring vital signs and recognising changes in patient condition. Advanced competencies included managing care of mechanical ventilators and assistance with removal of endotracheal tubes. The programme was considered successful overall, though it was discontinued thereafter due to lack of funding. All six trainees completed the programme and gained skills and knowledge which allowed to them to continue into higher education. The authors perceived the rushed introduction of the programme and lack of consultation with the critical care nurses caused problems initially with resistance to delegation and confusion from RNs about the tasks and capabilities of CCAs, though concerns diminished as nurses became familiar with the CCAs role and competencies. However, the study did not evaluate the value of the role within the CCU from the perspective of management or RNs, nor its effects on patient quality of care. Though the authors claim the model was successful, the question remains whether it could be transferrable or sustainable due to the extensive amount of resource required to implement.

While there is much criticism of the increasing number of HCAs being utilised in acute care there is research claiming that HCAs are essential to the functioning of the nursing team, assisting with nurses increasing workload and allowing RNs to focus

on specialised nursing activities (Thornley, 2000). Albeit, this partnership can only function successfully dependent on the delegation partnership between RNs and HCAs.

2.6 Delegation of care from Registered Nurses to Health Care Assistants

The Nursing Council of New Zealand's 'Guideline: delegation of care by a registered nurse to a health care assistant' (2011) supports nurses in decision-making for direction and delegation to HCAs, with emphasis on maintaining accountability and responsibility for assigned care. NCNZ promotes 'The Five Rights of Delegation': Right Activity; Right Circumstances; Right Person; Right Communication; and Right Direction. Additionally, the document contains an algorithm of the decision-making process for delegation to an HCA. It is the RNs legal and professional responsibility to be familiar with such directives and to understand the correct practice of delegation and the implications of inappropriate delegation. Despite that HCAs have been working in acute care settings for many years, international research has uncovered issues around delegation which are problematic for RNs and HCAs, affecting quality of nursing care and patient safety.

Literature about delegation in acute care settings cites a multitude of factors affecting the successful delegation of care from RNs to HCAs including role ambiguity, varied understanding of the concept and practice implications of delegation, skill mix and communication with the RN-HCA team. Multiple authors have highlighted 'role ambiguity' – RNs being uncertain about the scope and practical capabilities of HCAs, partly due to lack of standardised role title or training requirements (McKenna et al, 2004). International studies revealed hospital based RNs had varying understanding about their own legal and professional responsibilities regarding delegation and supervision, despite published national regulatory and organisational guidelines (Pearcey, 2007; Kaernsted & Bragadottir, 2012). Bittner & Gravlin (2009) found that role ambiguity manifested in mutual lack of understanding and expectations between RNs and HCAs about their respective roles.

2.7 Blurring of role boundaries

Conventional role boundaries have shifted to align with new models of healthcare provision. The research shows that HCAs are increasingly taking on tasks and responsibilities that were traditionally the domain of RNs, while, RNs are moving away from the bedside to take on extended roles including supervisor and co-ordinator duties (Pearcey, 2007; McKenna et al, 2004). This shift in practice has raised concern among RNs about de-valuation of the nursing role and departure from traditional nursing values and care philosophies in the pursuit of extended roles and responsibilities (Pearcey, 2007; Keeney, Hasson, McKenna & Gillen, 2004; Spilsbury & Meyer, 2005; Duffield, Gardner & Catling-Paull, 2008). Drawing on results from the authors' 2004 study, Spilsbury & Meyer (2005) reported that RNs explicitly stated that basic patient care was central to the nursing role, despite being largely performed by HCAs.

Numerous studies have found that HCAs perceived little difference between their own roles and that of the Registered Nurse, regarding the giving of medication to be the main difference between the RN and HCA role (Pearcey, 2007, Standing & Anthony, 2008). Conversely, studies regarding nurse perception of the HCA role found RNs expected HCAs to exhibit assessment, prioritisation, critical thinking and decision-making skills. These erroneous views and expectations were proven to cause resentment and difficulties within the delegation partnership (Bittner & Gravlin, 2009).

A triangulation of studies across the United Kingdom regarding the role of HCAs highlights the fact that role boundaries between HCAs and RNs are fluid with HCAs widely undertaking what may be considered 'nursing' work and technical or advanced tasks for example, administering medication, venepuncture, suturing, operating diagnostic machines, and attending ward rounds with doctors (Thornley, 2000).

2.8 'Over-burdened' and 'under-recognised'

Thornley's (2000) triangulation of studies about the roles of HCAs across different settings in the NHS revealed that over 50 percent of HCAs reported receiving little

or no practice supervision by a registered nurse. HCAs claimed they performed the bulk of direct patient care and they also admitted to performing an extensive list of advanced tasks which they were not permitted to do. There was no classification of practice settings, therefore findings cannot be generalised to the acute care setting. Even so, these statistics depict large amount of direct and technical care performed by HCAs and the overlapping of HCA and nursing roles, which carries implications for patient safety, delegation and supervision across all practice settings. Thornley (2000) acknowledges the undervaluation of HCAs work, calling for a revision of competencies and recognition of their experiential learning and skills. Efforts are being undertaken globally to address these concerns as evidenced by the introduction of national vocational qualifications as earlier mentioned.

Similarly, Spilsbury and Meyer (2004) observed HCAs in a London teaching hospital working largely independently without adequate supervision and spent the bulk of their time focussed on direct care activities. They also performed extra tasks such as clinical observations and electrocardiogram (ECG) tracings which deviated from the hospital's policy. Objective and subjective findings revealed RNs spent less time with patients, instead spending more time on technical tasks, documentation, care/discharge planning and liaising with other health professionals. Lack of RN supervision was mainly attributed to under-staffing and high workload (Spilsbury & Meyer, 2004). The authors alluded to 'exploitation of the HCA role' whereby HCA's were asked to go beyond their scope to suit the RN in times of increased workload and staff shortages. This scenario suggests HCAs work is influenced by workplace culture and role boundaries are socially negotiated rather than being directed by workplace policy, as found in related studies (Bosley & Dale, 2008).

Whilst literature widely recognises nursing shortages and increasingly complex workload for nurses (Kleinman & Saccomano, 2006), multiple studies have discussed the impact of staffing ratios on the workload of HCAs. Commonly the assignment of one HCA to multiple nurses leads to communication problems, difficulty for HCAs with priority setting (Standing & Anthony, 2008; Kalisch, 2011) and 'assignment overload' or being overwhelmed with tasks (Bittner & Gravlin, 2009). This results in patient safety issues like missed nursing care and thus, depicts an

ineffective functioning of the RN-HCA partnership, ultimately affecting patient safety and quality of care (Kalisch, 2011).

2.9 Research underpinning the study

There are numerous international studies regarding the experience of HCAs in acute and critical care settings which explore the perception of the role from HCAs' perspective, as well as that of their RN colleagues. Kent-Hillis (2001) studied HCAs experience of providing personal care to patients in a Canadian hospital. The study uncovered themes of poor communication, inadequate delegation and minimal teamwork between RNs and HCAs. However, HCAs took a more positive view of their relationship with patients describing their patient care role as satisfying. Analysis of HCA work practices revealed HCAs provided most the of physical care, so much so that patients, their families and even doctors mistook the HCA as their main caregiver. Due to HCAs spending more time at the bedside RNs were dependent on them for basic patient information about such things as mobility status and skin integrity. However, Kent-Hillis (2001) notes that when HCAs provide physical care, there is missed opportunity for a complete assessment of the patient. The author proposes that routine activities and hands-on patient care are necessary for the nurse to develop a deeper connection and assessment of patients' needs. The hospital administration claimed to support the model of primary nursing though the author perceived a different model of care like 'functional nursing' whereby task completion and routines took priority over individual patient needs. The author asserted that patient care was provided by HCAs as a list of tasks, causing 'fragmentation' of care which is linked with reduced quality of care (Kent-Hillis, 2001).

A study by Lancaster et al (2015) of physicians, nurses and HCAs in a metropolitan hospital were asked to describe their own roles and the roles of respective colleagues. Some HCAs perceived the RN role to be the same as that of the HCA with the added responsibility of administering medications. HCAs held a common view that their role was primarily assisting the RN and attending to patients' basic care needs and comfort. Nurses viewed HCAs as a 'support system' to RNs but also play an important role in alerting RNs about patient concerns. Conversely, some RNs stated

their working relationship with HCAs was difficult, with one nurse suggesting that HCAs felt over-burdened and under-appreciated by RNs. From an HCA perspective, some felt dis-respected and exploited within the hierarchical RN-HCA relationship (Lancaster et al, 2015). The authors discussed 'fragmentation of care' between physicians, nurses and HCAs caused by lack of interdisciplinary collaboration which is linked to sub-optimal care outcomes for patients. The authors theorised a model of care likened to a "conductorless orchestra" whereby physician, nurse and HCA contributions to care would each be acknowledged in the best interest of the patient.

Nwosu's (2006) doctoral thesis explored the relationship between HCA job satisfaction and quality of care from the perspective of both HCAs and patients. The study found that low pay, lack of opportunities for further education or promotion and work conditions including heavy workload, and peer relationships were key factors affecting job satisfaction of HCAs, which is perceived to impact quality of patient care provided. Nwosu (2006) found that patients' perception of care was lower than what HCAs rated for the level of care they provided, noting patient satisfaction as an important indicator of quality of care. The author advised health service managers and supervisors to recognise the importance of HCAs in the delivery of care and their effect on patient satisfaction. Furthermore, imploring them to invest in the HCA resource by increasing education and training opportunities and providing ongoing appraisal of work conditions and salary, in a bid to increase HCA satisfaction and performance thereby enhancing patients' experience and perception of care.

A key theme throughout studies exploring the HCA role is the idea that the HCA and RN roles are interdependent, and working in partnership allows them to fully accomplish their respective roles in patient care. Spilsbury & Meyer (2005) employed a mixed-method single case study in a medical-surgical unit to explore HCAs perceived work content and their relationships with RN colleagues. The authors critiqued the method of other descriptive studies which used participant self-report methods, citing the need to strengthen data collection with objective methods. Hence, the authors employed participant observation to create a comprehensive

picture of HCA work in the acute setting. The study found that HCAs spent more time at the bedside than RNs which gave them the capacity to gather much information about patients, however the passing on of information was dependent on the quality of the RN-HCA relationship. HCAs were seen by RNs as the 'ears and eyes' of the unit which conveys a certain level of trust and reliance on HCAs to communicate valuable patient information, however if communication between RNs and HCAs is poor, patients are at risk of inadequate care. The study also revealed that a significant portion of work goes unseen or unrecognised, for example 'covering gaps' in times of staff shortage or helping new graduate nurses and students in their roles. Yet in other ways their years of caring experience and organisational knowledge was under-utilised. This finding aligns with Thorley's (2000) earlier mentioned assertion, calling for a review of competencies for HCAs and recognition of their experiential knowledge and skills.

Based on the premise that HCAs are being increasingly employed in Emergency Departments and performing tasks which are known to be the domain of Registered Nurses, Boyes (1995) used a self-report survey to determine what tasks were performed by HCAs in EDs across the United Kingdom (UK). Analysis of the data proved lack of difference in the amount of direct care provided by RNs and HCAs except for a handful of tasks including administration of IV medicines, anaesthetics and airway management. There was also lack of consensus among RN respondents about what tasks HCAs performed in ED which verified that HCAs were all working at different levels. This was also due to lack of nationally standardised education with only some groups of respondents having access to National Vocational Qualifications (NVQ) specific for the HCA role, though most training occurred in house. Most notably there was an absence of nationally recognised Emergency specific training for HCAs. Boyes (1995) conceded that when HCAs performed tasks beyond their delegated responsibilities it was not always deliberate but rather with the intent of helping alleviate the RN workload and patient wait times. Boyes (1995) points out that policies directing HCA work stated only after area-specific training and supervision could HCAs perform direct care for 'relatively stable patients' though the author doubts whether ED patients meet that criteria.

Having the right person perform the right task was the impetus for management and staff of a 23-bed acute medical unit to create a new HCA model of care (Kummeth, de Ruiter & Capelle, 2001). Prior to the new model, HCAs were assigned a patient load as well as being 'an extra pair of hands' for RNs when needed which resulted in lack of structure and lack of role clarity. Meanwhile RNs were spending too much time on technical tasks and missing ward rounds which affected care and discharge planning. Unit leaders, RNs and HCAs gave equal input into developing a task inventory for all patient care on the ward, followed by a task list for each respective role. Kummeth et al, (2001) concluded that working under clearer delineation of RN and HCA roles equalled clarity of role expectations and increased efficiency and job satisfaction and subsequently improvements in patient care and earlier discharge planning. Kummeth et al (2001) informed of the need to monitor the RN-HCA ratio and recommended it be based on workload and 'right person, right job' as opposed to cost savings, in the interest of providing optimum care for patients. Ideas from this study may be transferrable in discussion about the RN-HCA partnership model in the emergency setting, however the more predictable environment of a specialised medical ward does not reflect the unique demands of emergency care which include a diverse patient population, high patient turnover and fluctuating staff-to-patient ratios.

Stankes Ross (1996) explored registered nurses experience of working in partnership with Health Care Assistants in a 'patient focussed' model of care delivery, three years after transitioning from the previous model of 'primary care' which saw one nurse provide total patient care for four to six patients. RNs preferred working alongside HCAs as it allowed them to focus on higher level nursing interventions, closer monitoring and RNs perceived being able to provide a higher quality of care. Stankes-Ross (1996) theorised that the 'caring' unique to the RN-patient relationship is not present in the caring provided within the HCA-patient relationship. Though HCAs may perform a patient related task in a caring *manner*, they do not conceive of or practise caring in the same way as an RN, who's practice is grounded in philosophies of caring which is the framework for therapeutic interactions with patients (Stankes-Ross, 1996).

2.10 Summary

With the mounting challenges faced by healthcare systems worldwide the roles of health care workers have evolved accordingly. Most nursing teams in acute care including emergency departments include unlicensed HCAs and the most current research generally acknowledges that HCAs play a valuable role within nursing teams in acute care.

2.11 Research aims

The purpose of this two-phased study is to examine the role of the HCA in the ED from the perspective of RNs and HCAs who work in the ED. Understanding their perceptions and experience is valuable because ultimately their knowledge and attitudes will guide their practice and determine their ability to work in partnership, for the benefit of their patients. Furthermore, the study aims to identify a task profile for ED HCAs and explore RN and HCA visions for the future of the ED HCA role. Data analysis will involve comparison and contrast of the differences in HCA practice across the five hospital emergency services within the Waikato District Health Board: Waikato; Thames; Taumaranui; Tokoroa and Te Kuiti. The following questions will be addressed:

1. What are the perceptions of Health Care Assistants regarding their own role within the Emergency Department nursing team?

2. What are the perceptions of Emergency Department Registered Nurses about the role of the Health Care Assistants within the Emergency nursing team?

3. What are the tasks which could be/are performed by Health Care Assistants in each of the five Emergency Departments within Waikato District Health Board?

4. How does Health Care Assistant practice relate or differ amongst the five Emergency Departments in the Waikato region?

Chapter 3: Methodology

> *Research is to see what everybody else has seen and think what nobody else has thought*
>
> Albert Szent-Gyorgyi (1893-1986)

3.1 Introduction

The research methodology is the theoretical framework which guides the researcher in determining the best method to address the study question (Braun & Clarke, 2013). The following chapter will explain and discuss underlying philosophies used to guide the research methods.

3.1.1 Research paradigm

A research paradigm is a theoretical perspective based on a set of assumptions about our reality and the nature of the world, on which the research question is based. These theoretical underpinnings also determine how the research data will be interpreted (Bowling, 2014). When creating a framework to conduct research the methodology will be determined by ontological and epistemological theories. Ontology is the study of the nature of reality, while epistemology refers to the theory of knowledge and how we come to know the 'truth' about the world (Green & Thorogood, 2009; Braun & Clarke, 2013). Qualitative and quantitative methodologies have contrasting views about ontology and epistemology. Qualitative methodology aligns with the ontological view of 'relativism', which argues that reality is subjective and there are multiple realities or ways of viewing the world, which transform across time and context (Braun & Clarke, 2013). At the opposite end of the continuum is 'realism', that states there is one true reality knowable through observable scientific methods, which underpins quantitative methodology (Braun & Clarke, 2013).

Epistemology is concerned with the legitimacy of knowledge (Green & Thorogood, 2009). Qualitative research tends to follow a naturalistic approach, whereby people are studied within their social context which allows the researcher to gain a deeper

and more authentic understanding of participants' subjective realities (DePoy & Gitlin, 2016). In contrast, quantitative research takes a 'positivist' perspective, believing that social phenomena can be studied using scientific methods to create reliable and 'un-biased' knowledge (Bowling, 2009). Therefore, different research perspectives will create and place value on different types of knowledge (Depoy & Gitlin, 2016).

The type of research question being asked will determine the appropriate methodology and methods to undertake the study (Bowling, 2009). To frame this study within a methodology, the theory and design of the research is primarily qualitative. Accordingly, the main methods of data collection and analysis were qualitative, though a quantitative component is included with the use of basic demographic and statistical data to provide context and support the interpretation and discussion of qualitative findings.

3.2 Qualitative research

Qualitative research aims to study people in their natural setting in the attempt to understand individual perspectives and meanings within their social contexts (Bowling, 2009; Braun & Clarke, 2013). The qualitative method is exploratory by nature, asking 'what', 'how' or 'why' about the studied phenomenon, which lends wider scope for increasing knowledge and understanding (Braun & Clarke, 2013). Qualitative samples tend to be smaller due to the depth of information and subsequent analysis required. Smaller samples allow the researcher to uncover the complexity of participants' ideas and experiences and reasons for their actions (DePoy & Gitlin, 2016, Green & Thorogood, 2009). The main data collection approaches in nursing research are interviews and focus groups. Both allow the researcher to gain a deeper understanding of the studied phenomena by gaining clarification of meanings and further development of concepts. Qualitative methods also allow for flexibility with data collection as ideas and discussion can evolve and be accommodated within the study (Carr, 1994).

3.2.1 Focus group

Focus groups are deemed an appropriate method when needing to explore a broad range of ideas from a specific population. Focus groups are traditionally a face-to-face method of data collection whereby a moderator (usually the researcher) guides a semi-structured discussion about the study topic among a small group (n=2-8) of participants. The objective of focus groups as a method of inquiry is to prompt natural interaction and discussion among group members with the hope of gaining authentic data and a deeper understanding of the realities of participants, as well as attitudes and group dynamics (Braun & Clarke, 2013; Bowling, 2014).

There are some known disadvantages of the focus group method for example, the researcher's presence may have a biasing effect on participant responses (Walsh & Wigens, 2003) which would affect the validity and reliability of data. Findings may also be dependent on the group dynamic with dominant members affecting the thoughts and responses of others, hence, the necessity for discussion to be skilfully moderated (Bowling, 2014).

3.3 Quantitative research

Quantitative methods are based on the 'scientific method' also known as the 'positivist' approach, which is based on the theory that the nature of reality can be objectively known and the 'truth' can be obtained by studying phenomena using a systematic process under a controlled environment to gain a measurable set of data (Polit & Beck, 2004). By controlling variables surrounding the phenomenon the quantitative researcher is aiming to eliminate bias and enhance accuracy and validity of the data. Thus, quantitative research sets out to provide empirical evidence, usually expressed in numbers, which can be deduced to fact. Quantitative approaches in nursing research include surveys and systematic observations.

The purpose of collecting numerical data for this study was to depict the patient throughput versus staff mix over a year in each of the five Emergency Departments, serving as a contextual basis for examining the role and work of Health Care Assistants within the ED. Since quantitative data sets are usually condensed in to

numbers, quantitative data analysis uses statistical methods. The quantitative data used in this study will organised and presented as a series of numerical tables and graphs to be compared across the five ED services.

3.4 Mixed methods

The mixed method approach involves the use of both qualitative and quantitative approaches for data collection and analysis, allowing the study of separate aspects relating to the same topic. Using mixed methods is a pragmatic approach to research, recognising the value of both subjective and objective views of the studied phenomenon (Polgar & Thomas, 2013). Thus, mixed methods were chosen for the proposed study to gain a more comprehensive set of data and gain a deeper understanding of the role and value of the Health Care Assistant within the emergency nursing team. Using qualitative and quantitative methods will ideally make the study more robust, allowing corroboration between the two sets of data while presenting a broader picture (Polgar & Thomas, 2013). Triangulation is the process of analysis by drawing on multiple data sets to reach a considered conclusion to the research query (Polit & Beck, 2004). Triangulation by means of combining quantitative and qualitative approaches is undertaken to increase the relevance and validity of findings (Parahoo, 2014).

3.5 The researcher

The researcher is currently a registered staff nurse employed at the Waikato Hospital Emergency Department (ED). The researcher works alongside HCAs and therefore has practical experience of the phenomenon being explored in this study. As an ED nurse the researcher hopes the shared experience of working in the ED setting will help to build rapport with participants and encourage them to openly express their thoughts and experiences in relation to the study topic. The researcher graduated with a Bachelor of Nursing from Waikato Institute of Technology and obtained Comprehensive Nurse Registration from the Nursing Council of New Zealand in the year ending 2013. Subsequently the researcher entered the Waikato District Health Board 'Nurse Entry to Practice' programme in Hamilton hospital ED and is now currently in her third year of practice. This research dissertation is being undertaken

as part of the University of Auckland Bachelor of Nursing (Honours) post-graduate qualification, funded by Waikato DHB through Health Workforce New Zealand.

3.6 Summary

This chapter has provided an overview of the theoretical underpinnings of qualitative and quantitative research methodologies. The qualitative approach was identified as the principle methodology for this research study, however it is mixed method in design due to the inclusion of quantitative data which adds background context to the research. This study aligns with the paradigms of relativism and naturalistic perspectives, attempting to gain valid and meaningful answers to the research question. The focus group was introduced as the primary method of data collection.

Chapter 4: Methods

Innovation is the key to the future, but basic research is the key to future innovation

Jerome Isaac Friedman (1930 to present day)

4.1 Introduction

The study methods are a specific set of planned procedures for collecting and analysing data to address the research question (Braun & Clarke, 2013). This chapter will detail the research design and explain the process of statistical and qualitative analysis which leads to the discussion and study outcomes detailed in later chapters.

4.2 Research design

The study is primarily a qualitative research design however it is a two-phased project which includes a quantitative component. Phase I involved the collection of statistical data from all five Emergency Department (ED) regarding patient attendance values and staffing matrix for the fiscal year ending 30 June 2016. This information will provide a picture of each department regarding scale and patient throughput, providing context for the analysis and discussion of Phase II data. Phase II will use focus groups to collect qualitative data about Registered Nurse (RN) and Health Care Assistant (HCA) perceptions and experiences of the ED HCA role. The reason for this combined approach is to gain and present a more comprehensive picture and discussion about the research topic. Figure 1 illustrates this two-phased approach.

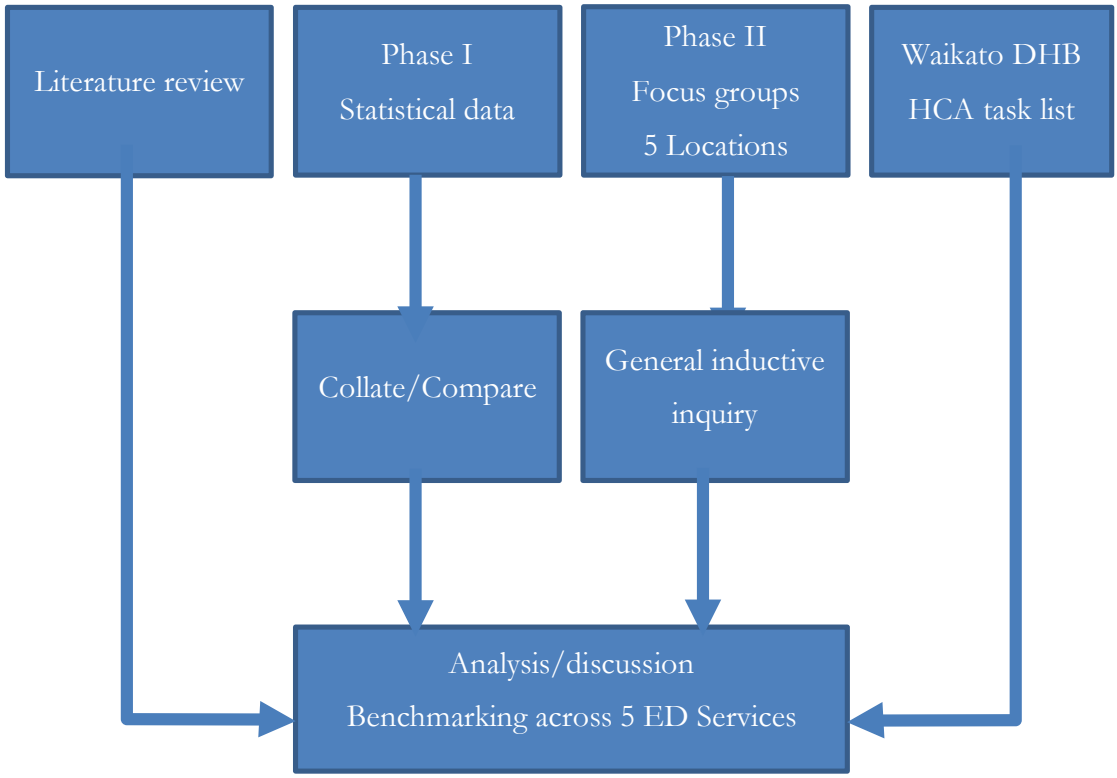


Figure 1: Research design

4.2.1 Phase 1

Quantitative data in the form of a spreadsheet of numerical values representing patient presentation numbers for each ED were obtained from the Waikato District Health Board (DHB) capacity planner. Information regarding staffing matrix (number of RNs and HCAs rostered on each shift) over the corresponding time-period was collected in person from the Charge Nurse Manager (CNM) of each ED. The purpose of collecting this information was to set the scene and allow benchmarking across the five ED services with regards to mean patient throughput and how the team of RNs and HCAs were structured to share and manage patient workload over the year long period. The overall objective of Phase I was to provide a foundation for the analysis and discussion undertaken in Phase II.

4.2.2 Phase 2

The aim of Phase II was to address the study topic using qualitative methods. A total of five (n=5) focus groups were undertaken, one at each respective Emergency Department. Most groups consisted of a mixture of Registered Nurses and Health Care Assistants. These representative samples allow for generalisation of findings for the wider population of ED RNs and HCAs within Waikato DHB without studying the entire population (Polgar & Thomas, 2013).

4.3 Population

The population under investigation are RNs and HCAs employed across five respective ED services within Waikato DHB; Waikato; Thames; Tokoroa; Te Kuiti and Taumaranui. While RNs employed across all five emergency settings only Waikato and Thames EDs employed dedicated ED HCAs at the time of data collection. The RN population was varied in skill level and included; New graduate and junior RNs; Intermediate RNs; Senior RNs; Nurse Educators; an ED Clinical Nurse Specialist; and Nurse in Charge.

4.3.1 Sampling framework

Phase I involved collecting anonymised (routinely collected) data over the year ending 30 June 2016 (morning, afternoon and night shifts inclusive) about each of the five EDs regarding; number of patient presentations, number of RNs and HCAs working on each shift. The purpose for this information is to set the scene by calculating staff-to-patient ratios, providing context for the later analysis and bench-marking of qualitative data across the five ED services.

Phase II involved a total of 20 participants; 13 RNs and seven HCAs from across the five ED services within Waikato DHB. Individual focus group numbers are as follows:

Table 1: Sampling framework

Staff	Waikato	Thames	Tokoroa	Te Kuiti	Taumaranui
Registered Nurse	4	2	3	2	2
Health care assistant	4	2	0	0	1
Total Participants	8	4	3	2	3

4.3.2 Setting

Phase I involved obtaining anonymised numerical data from the CNM of each ED service prior to focus group sessions. Phase II was carried out over five days. The researcher travelled to each of the five locations; Waikato; Thames; Tokoroa; Te Kuiti and Taumaranui. Focus groups were conducted at each respective site in allocated meeting rooms. Both Phase I and II were undertaken between July to September 2016.

4.3.3 Inclusion criteria

The invitation to participate in focus groups was extended to all RNs and HCAs employed within an ED service across all five hospitals within the Waikato DHB.

4.3.4 Recruitment strategy

Participant information sheets (PIS) were emailed to the nurse educators (NE) and CNMs of each ED. The nurse NEs and/or CNMs then discussed and disseminated the PIS' amongst staff at shift handovers and sent the PIS' via email to all RNs and HCAs employed within their departments. Voluntary participants then notified their interest to the NE who notified them of time and date for the focus group session in their respective setting.

4.4 Data collection

The data collection period was undertaken between July and September 2016. Phase I was collected prior to focus group sessions. Both the statistical and qualitative data

was collated, coded and analysed as a basis for benchmarking across the five ED settings.

For Phase I, the researcher gained permission from the CNM of each ED service to obtain routinely recorded numerical values about the number of patient presentations for each shift (morning, afternoon and night) as well as the staffing matrix (number of RNs and HCAs employed on each shift) over the fiscal year ending 30 June 2016. Phase II involved a series of five focus groups, one undertaken at each of the five ED services within Waikato DHB. Upon gaining informed consent from all participants, focus groups were audio recorded for ease of data collection. The focus group sessions ran from 20-45 minutes, varying between each site and were moderated by the researcher. A set of semi-structured questions relating to the research topic were used to stimulate and guide open conversation within the groups. All five audio recordings were transcribed verbatim into written format for later coding and analysis.

4.5 Data analysis

During Phase I, numerical data from each ED service was collated using an Excel spreadsheet. Data was then organised into tables depicting average ratios of HCA to patient and HCA to RN per day of week. Benchmarking then occurred across the five ED settings regarding average size of department, population serviced, patient throughput and the staffing matrix employed to manage patient workloads.

Phase II used general inductive inquiry to analyse the large amount of raw data gained from focus groups. The general inductive approach to qualitative analysis allows a simplified method for making sense of large amounts of raw data (Thomas, 2003). Inductive reasoning allows the researcher to study a smaller population in depth and create a broader generalisation about the studied phenomenon (DePoy & Gitlin, 2016). Therefore, general inductive inquiry was undertaken to analyse data obtained from the five focus groups as follows:

The researcher transcribed each of the five focus group recordings verbatim into written format. Data immersion then followed which involved reading through

transcripts multiple times to become familiar with the content. Recurring ideas were highlighted and extracted and similar responses were organised into distinct categories, also known as coding. Themes will be described and discussed in relation to the study question and aims. Findings from each focus group were compared amongst each other allowing benchmarking between the five emergency services.

4.6 Ethical considerations

Ethical approval was gained from the University of Auckland Ethics Committee and was approved for three years on 12 July 2016 (Approval number 017327). Ethical approval was also gained from the Waikato DHB. When researching human participants, it is granted that no harm or risk should come from taking part in the research and the rights of participants are upheld (Long & Johnson, 2007). There are three critical ethical considerations which must be addressed by the researcher; informed consent, confidentiality and vulnerability (Long & Johnson, 2007).

Informed consent was assured by the dissemination of PIS and consent forms prior to the study and participants were also taken through the consent process prior to the commencement of focus groups. It was conveyed to focus group participants in the PIS, CF, prior to commencing and after focus group sessions that confidentiality of information could not be assured by the researcher, but that all participants had an obligation to uphold the privacy and confidentiality of their colleagues. The researcher endeavoured not to collect or publish any personal or identifying information during either phase of study, thus allowing anonymity of participants.

Vulnerability was a factor for participants – especially HCAs, due to the nature of investigating their work practices. CNMs of each department gave formal assurance during the consent process that participants' (Waikato DHB employees) decision to partake or not would not affect their relationship or employment with Waikato DHB. It was also detailed in the PIS that if information were to be divulged and deemed by the research team as a threat to patient safety, the researcher would be obliged to escalate the matter through appropriate channels and the participant would themselves be encouraged to discuss the matter with their line manager and file an incident report as per departmental health and safety policy. There is a power

relationship between the researcher (an RN) and HCAs involved in the study as HCAs legally work under the direction of RNs, however the researcher is a junior nurse and holds no authority to reprimand any participant.

4.7 Summary

A two-phased study was undertaken. The primary methodology is qualitative with an added statistical component, while the primary method of data collection was focus groups. This method allowed the researcher to explore the thoughts, attitudes and experiences of RNs and HCAs about the HCA role in the ED. The general inductive method was used to organise and analyse data which was then subject to benchmarking between the five ED services. The rights of participants were upheld as detailed above.

Chapter 5: Findings

The best research you can do is to talk to people

Terry Pratchett 1948-2015

5.1 Introduction

The purpose of this study is to explore the role of the Health Care Assistant (HCA) within the Emergency Department (ED). This chapter details the findings from both statistical and qualitative data collection in response to the research questions outlined in Chapters I and II.

This study employs a mixed method approach to data collection. It is essentially a qualitative study (Phase II) with an added statistical component (Phase I) which provides a contextual representation of nurse staffing across the five EDs within Waikato District Health Board (DHB), to support the qualitative exploration of the HCA role in the ED. Phase I will present numerical data in a series of tables and graphs which represent patient presentations and staffing ratios across the five EDs over the fiscal year ending 30th June 2016. Phase II data were analysed using a general inductive method, resulting in five key themes which will be discussed and explored.

Part 1: Quantitative findings

5.1 Introduction

The quantitative component (Phase I) of this study sought to review RN and HCA staffing numbers in relation to patient throughput over 12 months across the five EDs, as a basis for qualitative exploration of the ED HCA role within Waikato DHB. Numerical data were collected from each service regarding the number of RNs and HCAs on each shift per day from 1 July 2015 to 30 June 2016. Patient presentation values were obtained for each ED service, per shift, per day over the specified time-period.

The purpose of collecting this quantitative data were to depict mean values for patient throughput in relation to number of allocated staff over 12 months for the five EDs within Waikato DHB. This section will address the following questions: (i) What are the mean patient attendance values by month over one year; (ii) What was the mean ratio of RN to HCA staff per shift; (iii) What was the mean RN to patient ratio per shift, per month; and (iv) What was the mean HCA to patient ratio per shift, per month?

5.2 Describing the Emergency Department sample

Emergency Departments in New Zealand carry a rating from level two to level six, depending on the range of services delivered (NZNO, 2006). Of the five ED services, Waikato ED is the largest site, serving the Waikato region but also encompassing the other 4 districts within the Central North Island; Tairawhiti; Taranaki; Lakes; and Bay of Plenty, collectively known as the Midland region. Waikato ED is a level six service providing all specialist services and is the major trauma centre for the Central North Island. Waikato ED also has an integrated paediatric ED for patients aged up to age 17. Thames ED is the second largest within Waikato DHB, servicing Thames, Coromandel, Hauraki and Paeroa regions. It is a level two service, led by an Emergency Physician on each shift. The other rural EDs, Tokoroa, Taumaranui and Te Kuiti are also level two services which respectively cover South Waikato, North King Country, and Taumaranui

borough/wider King Country down to Ruapehu. All patients referred to specialty doctors by rural (secondary) services will be admitted through Waikato ED. Due to the much smaller scale of rural hospitals, particularly in Taumaranui and Te Kuiti, nurse staffing and is more flexible between ED and inpatient wards, depending on workload. An RN from ED may be called to assist in the ward and vice versa. HCAs are also called from the ward at times to assist RNs in ED if necessary though at the time of data collection there were no HCAs assigned specifically to ED in Tokoroa, Taumaranui or Te Kuiti. The EN role was excluded from staffing ratios as only 1 EN was employed in Waikato ED and no ENs allocated to ED in rural hospitals.

5.2.1 Patient volumes

Table 2 displays the number of patient presentations for each ED service per month and the total number of presentations over the year ending 30th June 2016.

Table 2: Patient presentations by month across the five Waikato DHB EDs (2015 and 2016)

Months	Waikato	Thames	Tokoroa	Taumaranui	Te Kuiti
July	5991	1244	885	563	215
August	6299	1241	994	514	203
September	5846	1284	952	501	176
October	5730	1437	919	503	193
November	5497	1347	882	477	207
December	5632	1471	947	537	214
January	5333	1705	998	522	192
February	5778	1487	969	499	198
March	5825	1508	987	501	190
April	5546	1388	992	478	157
May	5980	1393	966	456	165
June	5687	1304	976	529	171
Total no. patients	69344	16809	11467	6080	2281

5.2.2 Staffing

Table 3 shows the mean number of RNs and HCAs rostered on each shift over the year ending 30 June 2016.

Table 3: Mean funded staffing complement across Waikato DHB EDs

Shift	Waikato		Thames		Tokoroa		Te Kuiti		Taumaranui	
	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA
AM	17	2	4.7	1	2	0	1	0	1	0
PM	20	3	4.7	1	2	0	1	0	1	0
N.	11	2	2	0	1	0	1	0	1	0

Note: The decimal value for Thames RN staff on AM and PM shifts is due to a change in RN staffing over the weekend. From Monday to Friday Thames rosters 5 RNs while on the weekend staffing changes to 4 RNs.

5.3 Staffing ratios

Staffing ratios were calculated using an Excel spreadsheet. Raw data for patient attendance values were collated with RN and HCA staffing numbers for each shift, per day over the year ending 30 June 2016. Ratios were calculated by dividing the number of respective RN and HCA staff over the number of patient presentations for all shifts over 24 hours – morning, afternoon and nights, per day. Mean staff-to-patient ratios for morning, afternoon and night shifts per month were then calculated and graphs were created using the resulting values for each respective ED.

5.3.1 Waikato Emergency Department

Figure 2 (over page) represents mean RN-to-patient and HCA-to-patient ratios over morning, afternoon and night shifts by month over the year ending 30 June 2016.

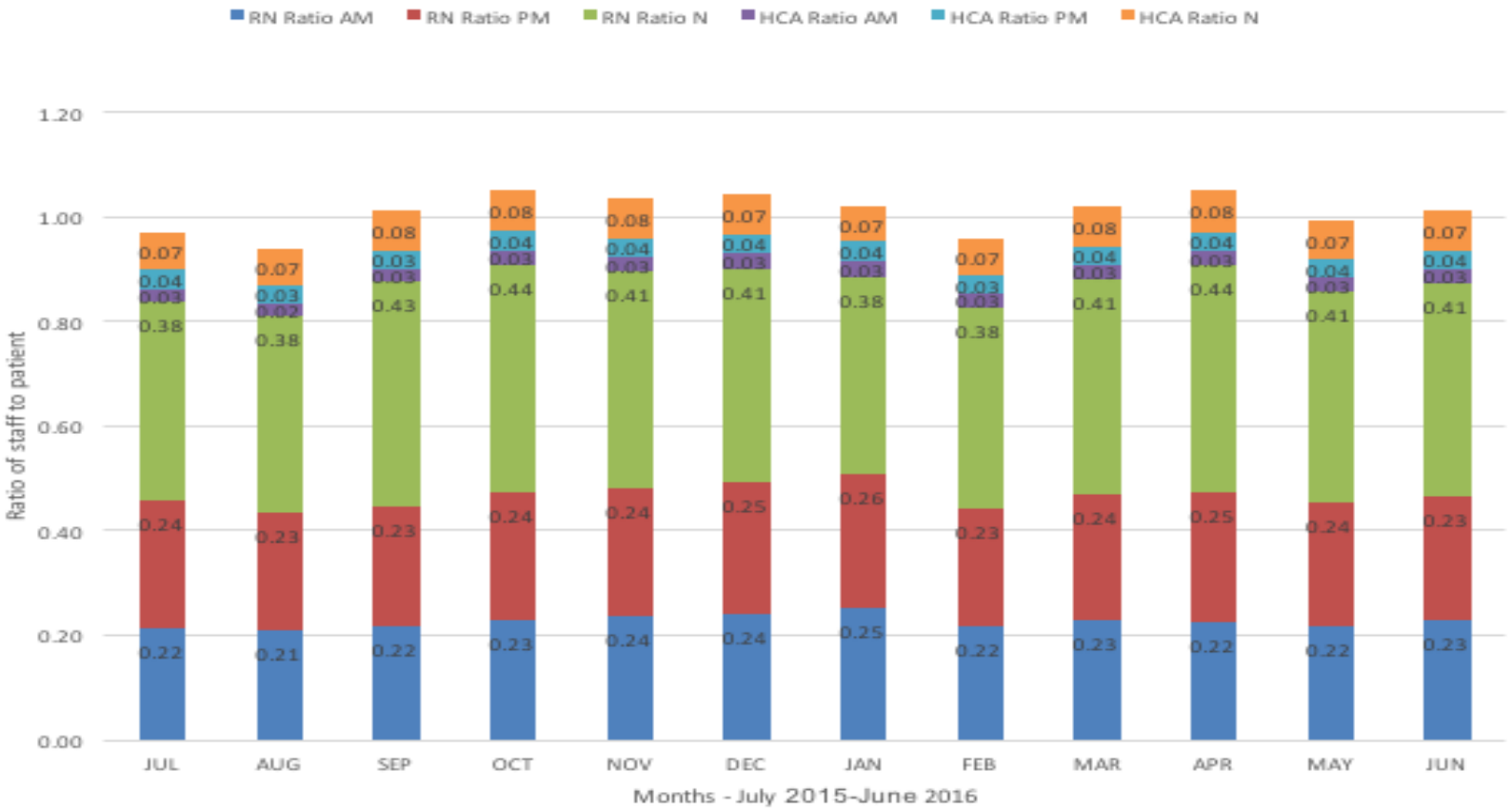
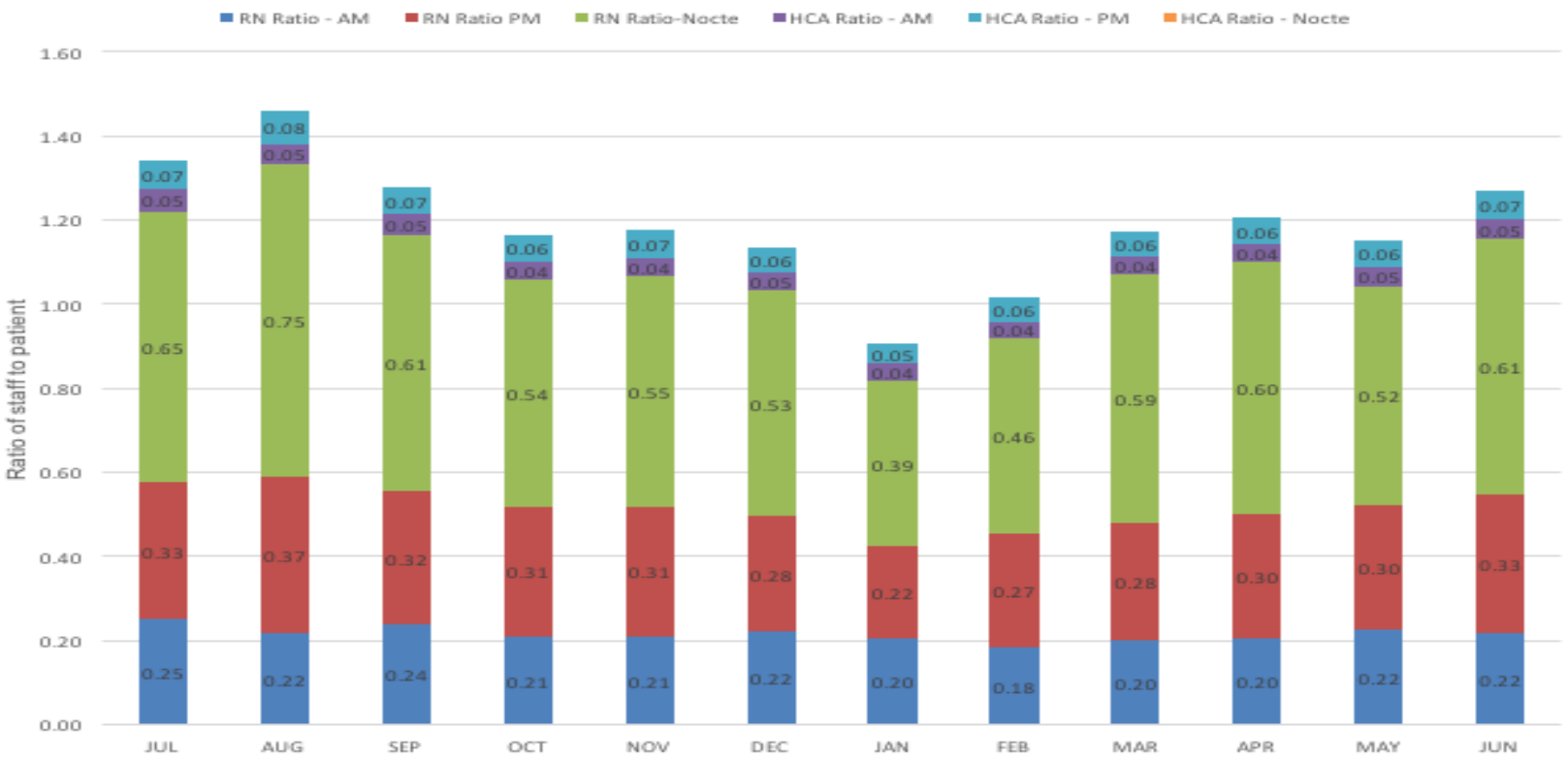


Figure 2: Waikato mean staff to patient ratios per shift, per month

Waikato ED was the only service of the five EDs within Waikato DHB to employ HCAs on all shifts over 24 hours; morning, afternoon and night. The RN and HCA ratios correspond over the three respective shifts, generally showing a lower ratio of staff to patients on the morning shift, then an increase in staff to patient ratio for the afternoon shift. The values for night shifts show both RN-to-patient and HCA-to-patient ratios almost doubling from day shift ratios. Notably, the RN-to-patient ratio ranges from around five to 10 times higher than the HCA-to-patient ratio across all three shifts.

5.3.2 Thames Emergency Department

Figure 3 (over page) displays mean RN-to-patient and HCA-to-patient ratios for each shift by month over the year ending 30 June 2016.



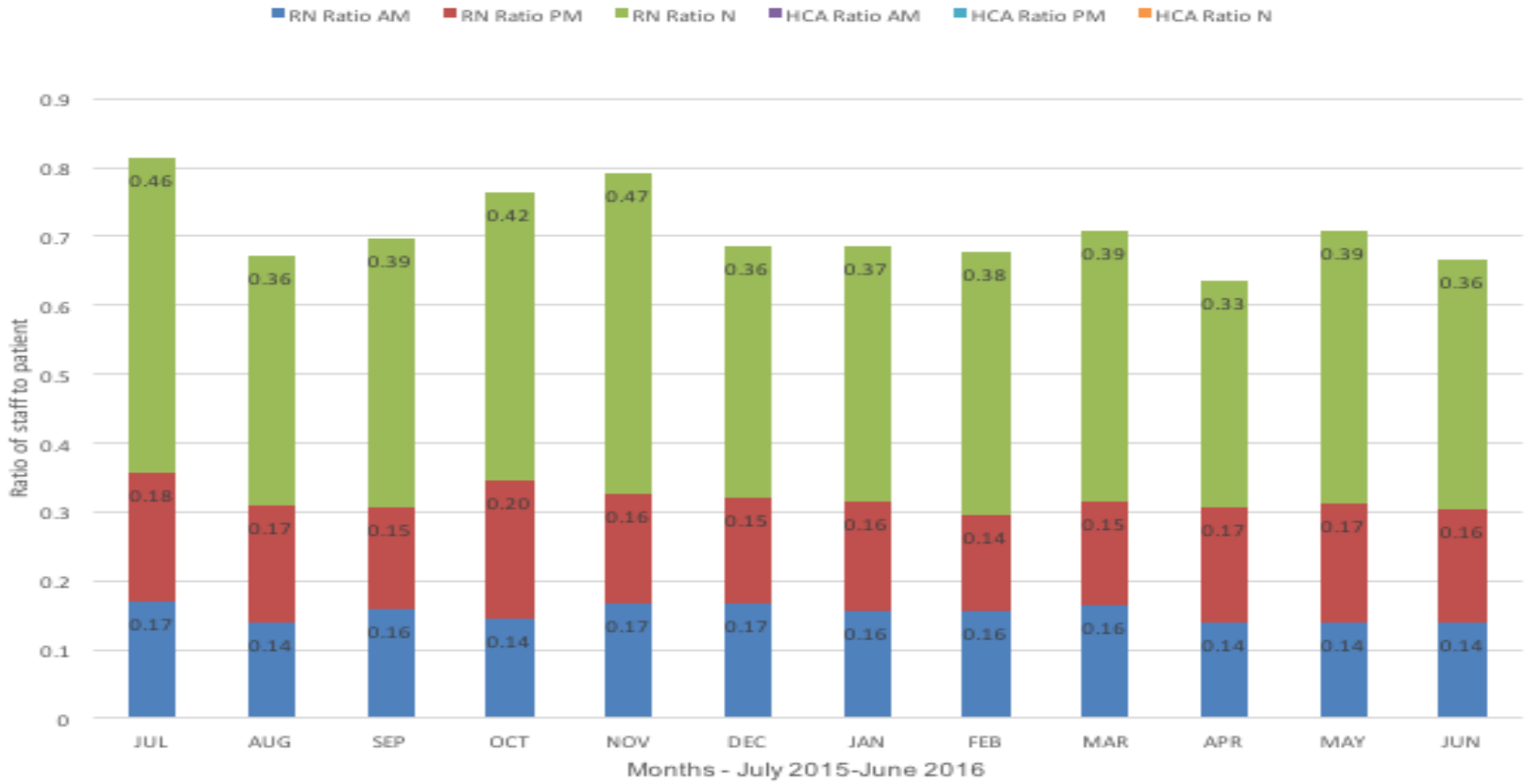
Note: There were no HCAs rostered on night shift

Figure 3: Thames average staff to patient ratios, per shift, per month

Thames ED employs HCAs on the morning and afternoon shifts. This graph shows staff-to-patient ratios are higher for both RNs and HCAs on the afternoon shift over 12 months, meaning there are consecutively lower RN-to-patient and HCA-to-patient ratios for the morning shifts. Though there are no HCAs rostered on overnight, the RN-to-patient ratio for night shift is effectively doubled from afternoon shifts.

5.3.4 Tokoroa Emergency Department

Figure 4 (over page) displays the mean RN to patient ratios for each shift per month over the year ending 30 June 2016.



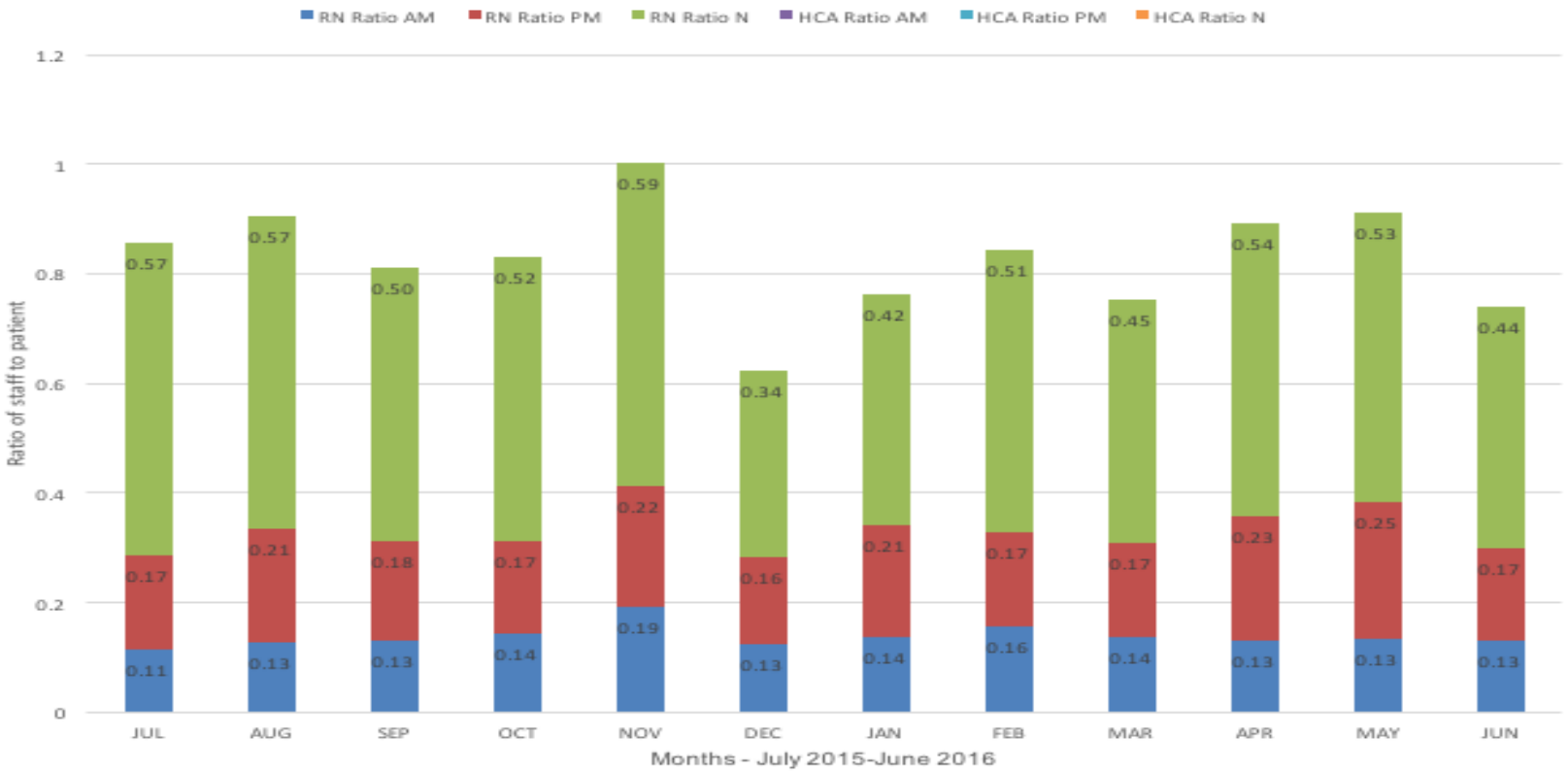
Note: There were no HCAs employed at Tokoroa ED

Figure 4: Tokoroa ED mean RN to patient ratios per shift, per month

RN-to-patient ratios were exponentially higher on night shifts compared to morning and afternoon shifts over all months of the year in Tokoroa ED. The difference in RN-to-patient ratios between morning and afternoon shifts varied and alternated between months. For six months of the year there were higher mean RN-to-patient ratios on the afternoon shift, while another six months show higher RN-to-patient ratios for the morning shift.

5.3.4 Taumaranui Emergency Department

Figure 5 (over page) represents the mean RN-to-patient ratio per shift, per month over the year ending 30 June 2016.



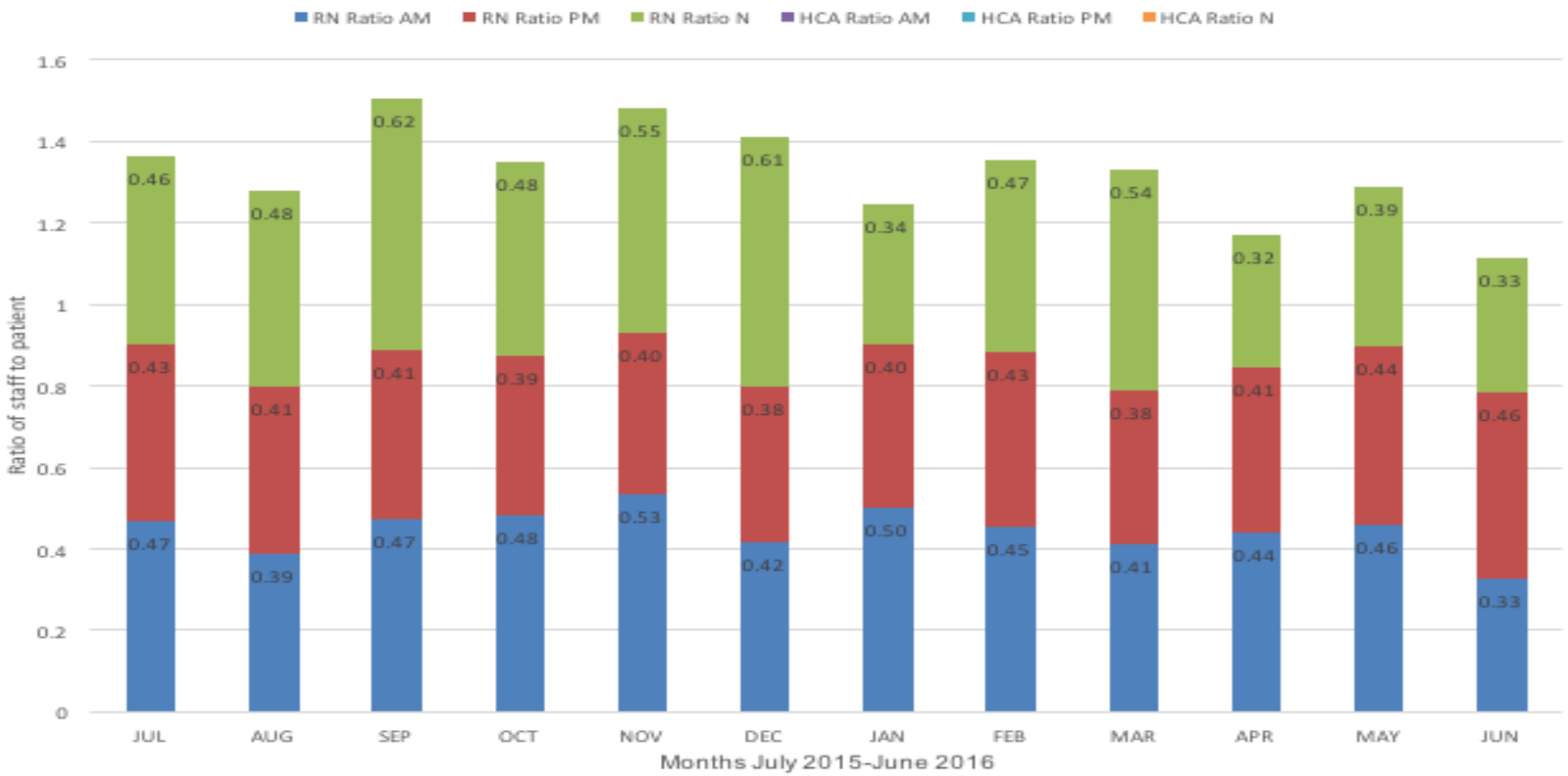
Note: HCAs are not rostered to ED but may assist in ED dependent on hospital workload

Figure 5: Taumaranui mean RN to patient ratios per shift, per month

Taumaranui ED had the lowest mean RN-to-patient ratio of all five EDs for morning shifts over the year, with its highest ratio of 0.19 for November 2015. In contrast, the RN-to-patient ratio on night shifts were greatly increased from morning and afternoons with the highest ratio of 0.59 also in the month of November 2015.

5.3.5 Te Kuiti Emergency Department

Figure 6 (over page) illustrates the mean RN-to-patient ratios within Te Kuiti ED per shift, per month for the year ending 30 June, 2016.



Note: No HCAs were employed at Te Kuiti ED

Figure 6: Te Kuiti average RN to patient ratios per shift, per month

Of the five ED services, Te Kuiti ED values show the least variation in mean RN-to-patient ratios between morning, afternoon and night shifts over 12 months. Afternoon shifts had the lowest RN-to-patient ratios overall, followed by morning shifts, with night shift RN-to-patient ratios being the highest. The largest variation within shifts occurred on nights with the mean ratio for September 2015 reaching 0.62, while in April 2016 the ratio dipped to 0.32 - which is the lowest value calculated from all shifts (and months) for Te Kuiti ED.

Table 4: Mean staffing ratios by shift for year ending 30 June 2016

ED staff ratios	Shift	Waikato	Thames	Tokoroa	Taumaranui	Te Kuiti
Mean RN-to-patient ratios for year	AM	0.23	0.21	0.15	0.14	0.45
	PM	0.24	0.3	0.16	0.19	0.41
	N	0.41	0.57	0.39	0.5	0.47
Mean HCA-to-patient ratios for year	AM	0.03	0.05	0	0	0
	PM	0.04	0.06	0	0	0
	N	0.07	0	0	0	0
Mean HCA-to-RN ratios for year	AM	0.1	0.21	0	0	0
	PM	0.15	0.21	0	0	0
	N	0.18	0	0	0	0

Table 4 displays the mean staffing ratios for each shift from 1 July 2015 to 30 June 2016. As there were no HCAs rostered for Tokoroa, Taumaranui or Te Kuiti EDs comparison is discussed mainly with RN-to-patient ratios. There is a firm trend across the five EDs that RN-to-patient ratios are higher on night shift. Furthermore, night shift values have the smallest amount variation in mean RN-to-patient ratios between the five EDs compared to morning and afternoon shifts. All services except Te Kuiti ED had a higher mean RN-to-patient ratio on the afternoon shift compared to mornings. Tokoroa and Taumaranui had the lowest RN-to-patient ratios for both morning and afternoon shifts. Between Waikato and Thames EDs who both employ HCAs, the mean HCA-to-patient and RN-to-HCA ratios were higher for Thames.

While the above numerical findings represent mean patient presentation and staffing ratios over 12 months they do not reflect workload or acuity within the respective EDs over that time. This is significant when looking at an ED because the number of patients in the department is constantly fluctuating. For example, in Waikato ED there may be 15 patients in the adult waiting room, all beds occupied within the main department, as well as four resus rooms operating - each requiring a 1:1 Registered Nurse-to-patient ratio. Therefore, if the ED is staffed with two RNs allocated for the resus area, the extra two nurses required to staff resus are sourced from elsewhere in the department, thereby affecting the RN-to-patient ratio in other areas. With heavier workloads and increased patient-to-staff ratios, HCAs are delegated more tasks. However, as reflected in the tables presented, rural EDs do not have the HCA support to draw on when RN-to-patient ratios are low as represented values for Tokoroa and Taumaranui ED on morning and afternoon shifts.

The above data also does not account for non-clinical resource within the department such as clerical staff or hospital attendants. This is important to note as rural EDs do not employ clerical staff 'after hours' or over-night. This means that rural RNs are required to perform administrative duties and other roles after hours as well as their primary role of RN. Furthermore, there was one RN rostered on the night shift for Tokoroa, Taumaranui and Te Kuiti EDs.

Part 2: General inductive analysis of focus group data

This section will present the qualitative findings gained from focus group sessions across the five Waikato District Health Board Hospital Emergency Departments. The study topic and aims are as follows: (1) What are the tasks performed by health care assistants in the emergency department (2) What are the perceptions of emergency department HCAs regarding their own role within the emergency nursing team; (3) What are the perceptions of emergency department RNs about the role of the HCA within the nursin team and (4) Identify variables and consistencies in HCA practice among the five emergency services.

5.2 Thematic analysis

The focus group method was employed to address the research aims as a group discussion may allow or provoke participants to naturally reveal their thoughts and experiences, thus permitting the researcher to gain deeper insight and clarify meanings about the phenomenon under study. A focus group allows for dialogue to take new direction or add information, which can add value to the research but also tends to produce large amounts of raw data. Before data analysis can occur, the data must be organised and pieced together in the form of common ideas or 'codes' and wider themes to present a logical, relevant interpretation which responds to the research topic. After coding and categorisation of the data the following five themes were derived: (i) Tasks and activities; (ii) Perceptions of the HCA role; (iii) Challenges for the HCA role; (iv) Education and training; and (v) The future of the HCA role. Figure 7 depicts the general inductive analysis.

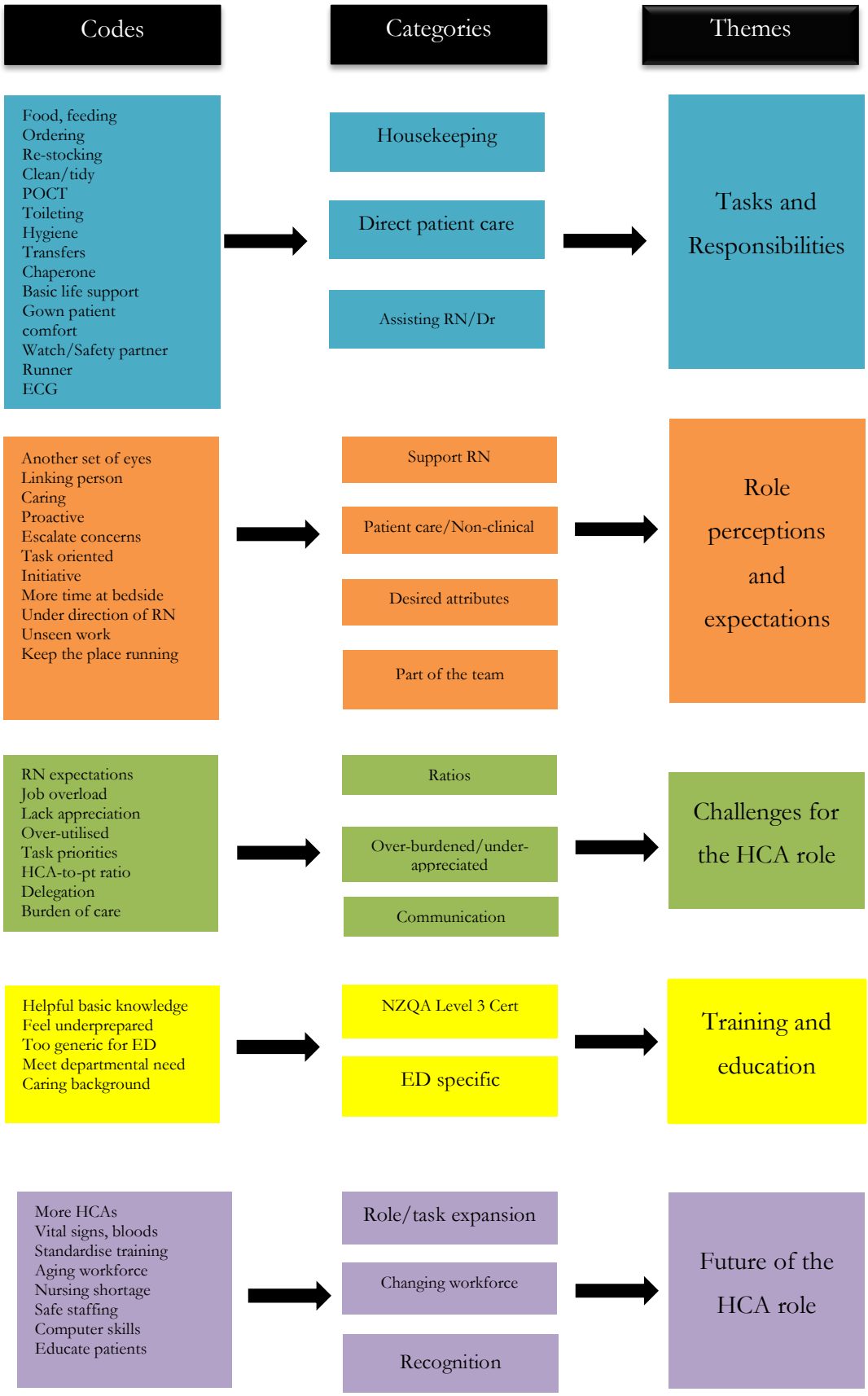


Figure 7: Thematic analysis

5.2.1 Tasks and responsibilities

The researcher began each of the five focus groups by asking participants to list and describe tasks/activities currently undertaken by HCAs in ED. Staff who worked in rural hospitals which did not employ HCAs were asked to identify which tasks or activities are currently being undertaken by a registered or enrolled nurse that could be safely undertaken by an HCA under the direction and delegation of an RN. Among the tasks and activities listed three sub-themes of activities emerged: Housekeeping, Direct patient care and Assisting the nurse/doctor.

Table 5: Health Care Assistant task profile

Housekeeping	
• Making breakfasts • Ordering food • Restocking all areas and trolleys (IV, dressing, catheter) • Transporting/retrieving items • Make/clean/source beds • Quality Control testing on glucometers	• Sterilisation of equipment • Sluice rooms • Ordering stock/equipment • Make up take home packs (eg catheter) • Maintaining kitchen bays • Cleaning/tidying staffroom • Laundry
Direct patient care	
• Feeding • Toileting – bedpan, urinal • Stable patient transfers (CT, x-ray, ultrasound, within ED) • Manual handling/mobilisation • Patient watch (safety partner) • CPR – basic life support • Clean up deceased • Shower/wash/hygeine	• Undress, help patient into gown • Connect to acuity monitoring • Pressure area cares • Make tea/coffee • ECG • Collect urine specimen • Holding babies • Comfort cares • Answer call bell
Indirect care and assisting RN/Dr	
• Transporting/retrieving items (medications, blood products, capillary gas samples) • catheterisation • plastering • suturing • lumbar puncture • chaperone for internal exams	• Another set of eyes • Escalate to RN • Urinalysis/pregnancy POCT • iPM entries (enter patient data into patient management system) • Answering phone, taking messages • Scribe (resuscitation scenarios)

Housekeeping tasks were those activities which HCAs may perform with a higher level of autonomy and indirect supervision such as restocking equipment trolleys and clinical areas, ordering stock and tidying and maintaining various areas within the department for example sluice rooms and kitchen bays. HCAs from multiple

services felt part of their role and the tasks they performed were important in maintaining the clinical environment for the successful running of the department.

> *...also our role is to keep the department running smoothly… they've got to have everything there because they're the ones who are hands on and …need the stuff right there and then*
>
> HCA, rural

It became evident that in rural services who function without HCAs, nurses perceived spending a considerate amount of time on non-clinical tasks which could be delegated, to allow RNs more time with patients.

> *You're unpacking cartons and cartons and it's just time consuming and it takes you away from patient care*
>
> Senior RN, rural

> *I would say about 65 percent of my nursing assessment time is dealing with things that could be done by another role… not that it's below me, I'll do it, but how does this benefit our patient when I'm not able to use my skill or my time…?*
>
> Intermediate RN, rural

> *The HCA role is probably a pivotal role to do some of those non-nursing tasks like ordering and putting away stores and making sure everything is topped up*
>
> CNM, rural

Direct patient care tasks are delegated by registered nurses, which means care is directed by the Registered Nurse, carried out by the Health Care Assistant then evaluated by the delegating RN. Direct care consisted of personal cares such as toileting (including use of bed pans, urinal bottle, commode chair), showering, bed-bathing, providing cups of tea and food, feeding, manual handling and assisting to mobilise and being a 'safety partner'/'watch' (direct supervision of a patient at risk of harm). After specific training, Emergency Department HCAs can perform 12 lead electrocardiogram (ECG) readings and collection of patient urine samples and subsequent urinalysis/urine pregnancy testing, also known as point-of- care testing (POCT). All HCA participants reported that over half their time on the floor was spent doing 'patient care' and perceived that they often spent more time on direct

patient care than RNs. The RNs also thought HCAs had/would have more time to spend at the bedside and therefore play a valuable role in meeting patients physical and emotional support needs, thereby improving the patients journey.

> *We spend quite a bit more one on one time with the patients than what nurses are able to…so we can sit down and have a good talk to them and the holistic approach of everything that's going on in their life and everything that's happened in the past and it's really interesting…*
>
> HCA, rural

> *It decreases patient anxiety knowing there's someone available to help them with their ADLs… if they understand that there is someone available [who's] priority is the care of the ADLs they're more likely to ask for help, rather than they see a nurse running around [and think] 'I won't bother them' and so increases patient outcomes as such*
>
> NE, rural

> *The HCAs see a lot that we don't see and they have the time to spend with the patient… as we [RNs] get more technologically advanced we're losing that and then that's coming down to the health care assistant who has the opportunity… they can actually go in and spend a bit more quality time with the patient and meeting their psychological needs…caring*
>
> Senior RN, Waikato

However multiple nurses stated they would like Health Care Assistants to be *more* focussed on patient care, though they acknowledged the difficulty for HCAs caused by staff expectations for their (HCA) task priorities.

> *I wish they could increase that [patient care], like when they're not busy sometimes if they could just, you know go around and… an old lady who's sitting down like this, like sit her up and just give her some mouth cares. That would be good, but they don't always get time*
>
> RN, rural

> *They haven't just got the patient care role [they have to] restock everything and a lot of them put that at the top of their priority list because that's what they've been told to do*
>
> Intermediate RN, Waikato

> *I think we all work differently. Some people just do patient care, don't bother about the stocking, which puts a lot of pressure on us*
>
> HCA, Waikato

> *They can't win because if they don't do it then they get colleagues running after them going 'you haven't restocked in here all day and now we've run out' which is more work than actually walking to the cupboard and restocking yourself*
>
> CNS, Waikato

Some senior nurses advocated for working with more of a team approach and sharing of workload, they reflected on the shift in task responsibilities between Health Care Assistants and nurses due to increasing demand on all Emergency Department staff.

> *But why is it that restocking is a health care assistant job… if you're responsible for your area you need to make sure all your ducks are in a row, yeah? So, if you're in that area that's your role and if you work as a team then it's not 'your job, my job*
>
> Senior RN, Waikato

> *For some reason it's [re-stocking] shifted to the HCAs. I suppose as our workload has got bigger, their workload has got bigger, which has meant they can't do what they've got to…what they should be doing*
>
> Intermediate RN, Waikato

Being assigned to perform a patient 'watch' was viewed by some as a waste of the Health Care Assistant resource. A recent policy update now refers to a patient watch as a 'safety partner'. Being a safety partner requires direct one-on-one supervision of a patient who poses a risk to self or others, for example a patient presenting with self-harm or suicide attempt/ideation, intoxication, or a medical complaint such as delirium. While clinically necessary and being in the best interest of patient safety, assigning an HCA to a patient watch consequently increases the workload for HCA staff remaining on the floor. HCAs were also concerned at not being able to accomplish their list of required tasks and the flow on effect it has for the HCAs taking over for the next shift.

If you get a watch well that's it, you're stuffed

HCA, Waikato

Yeah, that's the end of patient care…see ya patient care

HCA, Waikato

That person [HCA on the floor] is just getting hammered, yeah absolutely… It's really frustrating

HCA, Waikato

They don't feel like they're actually contributing because they have to watch a patient and they're concerned because all their other jobs… and then staff see them sitting down and there's that disconnect 'oh they're just sitting down doing nothing'… Well actually, you've delegated them that job so you can't have it both ways… Some people say 'Oh they should be doing this [re-stocking] while they're doing that' but you've got to give the patient your full attention, we're here for the patient not for the packing

Senior RN, Waikato

The more watches we're having to do the more the HCAs job is being negated

Senior RN, Waikato

Health Care Assistants said that at times they feel under-qualified to deal with some situations they have faced while on a patient watch.

On the whole you haven't got any nursing experience… You're put with this person you've got to try and keep on the bed or…stop them harming themselves

HCA, Waikato

It is crazy…the amount of care, like we're not taught to look after them as much as what we should be

HCA, Waikato

Though Health Care Assistants within Waikato District Health Board have a generic designated task list (see appendix) with added capabilities dependent on clinical area, the role of the HCA in the Emergency Department requires them to work flexibly and dynamically in accordance with the workload in the department. They may perform urgent tasks such as being a runner for transport of blood samples and

retrieval of blood products; chaperoning for doctors to perform physical exams; assisting with procedures such as catheterisation, suturing, plastering and lumbar puncture; and being 'another set of eyes' to advocate for patients, to recognise and escalate concerns to the primary RN. Therefore, HCAs are called upon and utilised to assist in most if not all facets of care throughout ED.

> *There's heaps of stuff you're doing around the department that's just not re-stocking, but it's not necessarily patient care*
>
> HCA, Waikato

> *There's just the two staff [nurses], there's lots of things that might take two people [but] don't actually need to take two RNs…the list would be huge*
>
> NE, rural

Rural hospitals who did not employ Health Care Assistants in their EDs listed a range of indirect care tasks which could be delegated to an HCA, thereby freeing up RN to maximise their nursing knowledge and skill and spend more time with acutely unwell patients. RNs in rural EDs have the added pressure of taking on extra roles after hours such as administration which adds to their workload, thus leaving less time for nursing care.

> *But after hours is when it all turns to crap and we don't have the capacity for all that admin that the HCA could do*
>
> Intermediate RN, rural

> *If they had iPM training - registering the patient, getting patient labels, taking bloods to the lab, answering the telephone, lots of non-clinical jobs…all those sorts of things we really struggle with*
>
> NE, rural

> *And really a lot of the work is HCA work and if we could just release that time so we have that time to do troubleshooting with our patients and do more assessments that would be great*
>
> Intermediate RN, rural

> *You know I would rather be doing nursing stuff than walking blood samples down to the lab…occupying my time making phone calls to the lab people, to the x-ray guys, I would rather be with my patient than anything else*
>
> Intermediate RN, rural

> *I think doing point of care testing would be good…especially when we've got a busy emergency department and you've only got one nurse working in there as such, if the HCA can run around doing point of care testing… it would be fantastic*
>
> Senior RN, rural

> *It's time saving, improving patient outcomes. That extra set of hands is just so useful…like especially in ED it means if the nurse can have someone be a runner, I suppose be a communicator as such it means you don't have to leave your patient… It's a safety thing*
>
> Senior RN, rural

Health Care Assistants view part of their responsibility as keeping the Emergency Department running smoothly by keeping on top of their housekeeping, maintaining a clean, tidy and well stocked clinical environment. They also support and assist nurses and doctors in performing a range of procedures and need to act in time critical situations like running blood products and communicating/escalating patient concerns. However, all HCA participants recounted that most of their time on an average shift was spent providing direct patient care. Overall, Registered Nurses from all five services recognised the value of the work of HCAs for being able to assist with patients' care needs but also appreciate (and require) the ability to delegate non-clinical tasks which allows them (RNs) to provide more patient-focussed care, utilise their specialised skill and knowledge and prioritise care of patients with acute and urgent health needs.

5.2.2 Perceptions and expectations of the Health Care Assistant role within the Emergency nursing team

Both HCAs and RNs stated that the primary role and work of HCAs is care of the patient. When asked about the role of the HCA *in relation to the RN* in the Emergency Department there was a unanimous reply among respondents from all services that their role is to support and assist RNs and to take direction and carry

out delegated tasks as requested by RNs. HCAs also voiced awareness of their own position within the Emergency Department and their role limitations within the nursing team.

> *We're supposed to be a support for the RNs but we work under the direction of the RNs*
>
> HCA, rural

> *It's a nursing assistant role, so they're under the delegation of a registered nurse and they do care duties*
>
> RN, Waikato

> *We ask them before we do anything so they are aware…it's important we report back to them so they know what's happening*
>
> HCA, rural

> *We've got such a good team here, everybody knows their scope of practice, what we're allowed to do, what we can't do, what we can assist with and what we can't*
>
> HCA, rural

While HCAs voiced confidence in the knowledge of their own role and limitations of practice, it was brought up that some nurses lacked understanding of the HCA role and task responsibilities which is a factor in unnecessary or inappropriate delegation of tasks.

> *They don't have an understanding of what we do behind the scenes when they can't see us*
>
> HCA, Waikato

> *We're there to help them, not be their slaves*
>
> HCA, Waikato

> *Your new ones [new graduate RNs] don't have a clue. They just know you ring an aide. That's why I had to say to Nurse X when they were teaching them the urinalysis… Nurse X said 'this is one of the aides that do it'… I said 'no, you [nurses] do it, if you can't then we do it', but it's like you've taught them already to rely on the aide… no good*
>
> HCA, Waikato

Both Health Care Assistants and Registered Nurses brought up the issue of appropriate delegation; rural RNs emphasised the importance of RN accountability for delegation of nursing care, knowing the HCA role and job description and not taking advantage of the HCAs' capabilities.

> *It's really important that RNs and Health Care Assistants are really clear on their roles and their expectations of each other so that the HCA might not be given something that's not within their scope*
>
> Senior RN, rural

> *It's knowing what's appropriate to be giving them not just shoving it off just [because] they can do more*
>
> New Graduate RN, rural

> *It will be a partnership…so they will be working under the supervision of the RN and they would be responsible to the RNs… but making sure we all know what each other's roles are and what their [HCA] responsibilities are…[because] it could easily be abused*
>
> Intermediate RN, rural

Nurses also acknowledged the HCAs contribution to the workload; they talked about the value of the RN-HCA partnership and acknowledged HCAs' important place within the nursing and emergency care team.

> *You try working without an HCA…It's just so important to have them and you feel it when they're not here*
>
> Senior RN, Thames

> *…nurses are running around… running ragged anyway, but having that person to follow up that will complement the nursing [care] that would be really good… I just think they would be complementary and they would add more value to the service that's already being provided*
>
> Intermediate RN, rural

> *They are the people that will spend all that time with the patients, that will spend a lot more other than what we're [RNs] doing… and they're nice people to talk to when you don't want to talk to a nurse*
>
> Intermediate RN, rural

> *We're looking at things like intentional rounding and actually, having an HCA physically walk around going 'are you OK?', 'can I get you anything?' You imagine patient satisfaction from that because the people that are sat there thinking 'I could really do with a drink but I don't want to bother anyone', or 'actually my pain's coming back…*
>
> Senior RN, Waikato

> *Rounding would be a fantastic way to use the HCAs, especially in the waiting room… it's fantastic use [of the HCA resource] and it gets them engaged with their patients*
>
> Senior RN, Waikato

> *I think they've got a role to play in terms of actual hands on care… I think if we had more [HCAs] they could actually do more hands-on care and they would be more part of the individual patient journeys as opposed to just completely task orientated*
>
> Senior RN, Waikato

The above statements reflect views shared by several nurses who perceived the HCA role as having more time to focus on meeting patients' physical *and emotional* needs. The notion of 'caring' sits traditionally in the domain of nursing philosophy, though with the role of the nurse evolving to meet more complex care demands it seems spending time at the bedside with patients and 'caring' is equally, if not more so the domain of health care assistants and acknowledged as such by both RNs and HCAs during this research.

While nurses acknowledged the importance of the Health Care Assistant role in direct patient care and patient comfort, they also described a more in depth perception and range of expectations for the role. RNs valued attributes such as using initiative, being proactive, being 'a second pair of eyes' and being able to recognise issues and report to the RN.

> *I see the good ones as another set of eyes…they come to you and say, you know 'this is what we've seen is going on'… you know it's a real help*
>
> CNS, Waikato

> *…and acting as a linking person…the nurse… you flit in and out but the health care assistants see a lot that we don't see as nurses*
>
> Senior RN, Waikato

> *And they do have a part to play because you know we can't get around and do everything that we need to do and even just using them as a second pair of eyes who can deal with a lot of stuff before it even develops and escalate the stuff that needs to be escalated but you've gotta get the right people in that role*
>
> CNS, Waikato

The above statements assume a certain level of trust within the RN-HCA partnership and an inherent expectation that HCAs will use initiative and recognise clinical risk or issues and report to the RN. Health Care Assistants from both Waikato and rural services discussed patient care scenarios which did demonstrate these attributes, but also highlighted the fact that HCAs can be a source of valuable information, which may not always be communicated. This same issue has been identified in numerous studies with researchers concluding that poor inter-professional communication increases clinical risk and leads to sub-optimal care.

> *I've got to admit if they are super flat out I will put on the [blood pressure] cuff but let them [RN] press the button…and we put telemetry leads on too. The thing is I'm not actually pressing the button but I've got it set up for them, which does save you guys [time]*
>
> HCA, rural

> *Sometimes you go to the nurse and say, 'that dressing on their leg looks like it's three-days old, should it be changed?' They'll say 'I wasn't aware of it'… Cause you've got them in a gown, or else you've turned or rolled them or taken them to the toilet, you notice all those sorts of things*
>
> HCA, Waikato

> *And we're the ones who spot the bruises or the cuts and they [RNs] go 'Oh I didn't know that'… If you get an HCA that doesn't even look at that or will just not report it, well how are you going to know? You're not going to know*
>
> HCA, Waikato

> *We all know what we've got to get done and we just try to get it done, but everyone's on a different wavelength of what 'done' means to them…everyone's at a different level*
>
> HCA, Waikato

These last few statements acknowledge the fact that Health Care Assistants may function at different levels and furthermore, there is no nationally standardised education for HCAs in general, nor a certified Emergency-specific HCA training programme. The implication is that Registered Nurses need an awareness of the capabilities of their individual HCA colleagues to delegate care appropriately. RNs must uphold their legal and professional accountability for patient care by being explicit in their direction, delegation and evaluation of care and taking care not to assign HCAs more responsibility than is appropriate, safe or manageable.

Clearly the Health Care Assistant plays an important role within the Emergency Department nursing team. They are seen to complement the care of Registered Nurses by spending more time with patients, ensuring their basic needs for safety, physical and emotional comfort are met. Some HCAs said they often feel their role and work is under-appreciated by colleagues and both HCAs and RNs spoke about the importance of role awareness and appropriate delegation. While HCAs in ED are governed by a generic task list and ED service specific job description, their RN colleagues valued other attributes for the role such as taking initiative, being proactive and being able to recognise risks and concerns and report them to the RN. The information presented thus far depicts the ED HCA role as both a dynamic and demanding role, which seems indispensable for the optimum day to day running of a busy ED. There is perhaps a need for re-evaluation and acknowledgement for HCAs' unique place within the team.

5.2.3 Challenges for the Health Care Assistant within the emergency nursing team

Though HCAs remain an unlicensed workforce and are professionally answerable and accountable to RNs, they may still carry a similar burden in terms of striving to meet patient care and departmental needs of a busy ED. The constant flux within the ED can bring swift changes in staff to patient ratio and patient acuity. The

patient population within the department are each at different stages within their ED journey. For example, while some may have been assessed and diagnosed and are receiving time critical treatment, another group will have just arrived, needing rapid assessment and intervention to stabilise their condition; others may have been assessed and treated by emergency staff and sit waiting for specialty input or admission, thus remain under the responsibility and care of the Emergency team until they leave the ED. At times, a significant number of the patients in ED can be considered 'unstable' and acutely unwell with complex care needs, so when the patient to staff ratio is high and acuity within the department is high it can cause staff to feel overwhelmed, making it more difficult to prioritise workload. All staff are exposed to these pressures, HCAs included, as when the nursing workload is high more tasks are delegated to HCAs increasing their workloads also.

A few of the focus groups spoke to the theme of Health Care Assistants feeling at times overburdened with tasks and being delegated to by multiple clinicians including staff RNs, shift co-ordinators as well as doctors, which can cause difficulty with task prioritisation. RNs in rural areas without HCAs also raised this as a prospective issue.

> *I think it's also the nurses being aware that when you're in the main area you have six to seven nurses who are [delegating]…you might get one [job] in five minutes and four in the next 10 minutes and you're trying to prioritise and then you'll have a NIC (Nurse-In-Charge) who will say 'I need you to take this patient to… It's like 'whoa hold up, I've already got four jobs'*
>
> HCA, Waikato

> *If you expect a nurse to take a certain number of patients, why would you expect the Health Care Assistant to take more? They're only human*
>
> Senior RN, Waikato

> *Whether they're working under the direction of the RN as opposed to being directed by doctors to go and do stuff or not, I mean it may be a bit of conflict as to who is my boss and who do I talk to*
>
> Senior RN, rural

> *That's who we're supposed to answer to [RNs] but if the doctor rings you well you've got to go*
>
> HCA, Waikato

> *You would expect them to prioritise a little bit but clinically the nursing staff should know what's going to take priority and they should be directing the HCA to do that*
>
> NIC, rural

There were also some views raised by HCAs from different services about feeling under-appreciated at times, perceiving a lack of acknowledgement within the team and from those above in management.

> *You can start to resent your job cause no one is appreciating you and you're overloaded with jobs and then I think that's where the barrier comes in between nurses and HCAs sometimes*
>
> HCA, Waikato

> *used to [*receive recognition*]…sorry to bring it up…you don't feel that you're valued that way*
>
> HCA, rural

> *I think sometimes we have a little too much on our plates, as in you go to the wards, they're basic… but we've got more and above and we don't get paid extra for that more and above*
>
> HCA, Waikato

> *Sometimes this place stresses us out because we carry a lot of weight on our shoulders…with the patients*
>
> HCA, Waikato

Though HCAs from a rural ED described a similar experience of taking direction from multiple clinicians and feeling overwhelmed with jobs, they cited efficient communication within the HCA-RN partnership as a critical factor for task prioritisation and workload management.

> *Sometimes because you've got four RNs and there's only one of us…you're getting all these directions fired at you. I just say to them 'ok now which is the most important? Because we don't know the patients…we haven't triaged them. This is why it's vital that our role is that we work in very much with the RNs and communicate. Communication is your biggest thing. It's so we work out which is most important as far as they're [RNs] concerned*
>
> HCA, rural

Communication was a central theme raised across all five Emergency Departments. Staff in rural EDs perceived that working within a smaller team was conducive to good communication and effective teamwork.

> *We communicate in a big way here [because] we are small… yeah it's one of the advantages of being a small area*
>
> HCA, rural

> *Some teams work better than others and it is all about communication…I guess in a smaller team you are much more aware of people's strengths and limitations*
>
> NE, rural

> *…and [Health Care Assistants] being included as part of the team, so it's just about making sure the communication is there and that everyone's aware about what's happening*
>
> NE, rural

On the contrary working within a large team in a significantly larger setting means the web of communication is exponentially larger. All doctors, nurses and HCAs within Waikato ED wear an electronic communication device (known as Vocera) which means all staff can make contact regardless of where they are physically located within the department. There are advantages and disadvantages to this form of communication though one of the specific challenges HCAs identified was being called from nurses in multiple areas of the department and needing to prioritise and accommodate an increasing list of tasks as they are delegated. HCAs also perceived that Vocera permitted disrespectful interaction between colleagues.

> *…and the thing is, if you say 'look no I can't at the moment I'm busy doing such-and-such, you'll get 'uugghh' and you get cut off…you know? Like you've done something wrong*

HCA, Waikato

> *…or [you get asked] 'Well how long are you going to be?!'…"about quarter of an hour"…'oh well that's no good!*

HCA, Waikato

Notably, the use of Vocera carries critical implications for the delegation process and patient safety, though the researcher has chosen not to elaborate on these here, as the subject of 'direction and delegation' is a complex phenomenon deserving more robust analysis and discussion. Another factor of significance for Waikato HCAs is being part of such a large team means they may work under the leadership of a different charge nurse each shift who may have different expectations for how HCAs should prioritise their workload.

> *What I find hard is not all the [Associate Charge Nurse Managers] are on the same page, and nurses probably get that too… You've got to know which one wants what when they're on*

HCA, Waikato

RNs from Waikato ED thought one of the challenges for the Waikato HCAs was not being included in the nursing team. One factor perceived to be causing this is the allocation of HCAs to cover certain areas of the department as opposed to being assigned a specific patient load. Accordingly, the patient-to-HCA ratio and RN-to-HCA ratios are high which encourages 'task-giving' by RNs, resulting in 'tasking' by HCAs, as opposed to being involved in the care of the patient and providing continuity of care throughout the patient journey. RNs perceived that the current staffing model in Waikato ED causes fragmentation of care and cited under-utilisation of the HCA resource regarding patient centred care and involvement in the nursing team.

> *I think with the way they're allocated though to an area, that encourages task giving… You know it's 'can you come and do an ECG in 10?', 'can you come and do this in short-stay?'… and from a continuity point of view that's really difficult for us and for them*

CNS, Waikato

> *They cover huge areas… If you could reduce the size of that, even if they were still responsible for two or three pods, that's 12 patients they would get around… they could actually take part in handover, they could do more hands-on care and they would actually be more part of the individual patient journeys as opposed to just completely task oriented*
>
> CNS, Waikato

> *I personally don't think we utilise them as much as we should… I think there is still this divide and I think we should embrace them in to the team…we tend to make them task… I think if we bring the team together [and] look at it as 'the patient needs this and how can we best together manage that?' rather than 'that's your role, this is my role'... If we utilised them as a unit within the team and incorporate them more I think we'd get more bang for our buck*
>
> Senior RN, Waikato

In contrast, working within a smaller team as with the rural EDs, HCAs conveyed an obvious sense of inclusion within the nursing team, stating they felt appreciated within the nursing team and spoke of their close collegial relationships.

> *We're really appreciated here…I get told thank you at the end of each shift…it makes you feel appreciated that's for sure*
>
> HCA, rural

> *The nurses here are absolutely brilliant, our RNs, and they are always very appreciative and always thank us…and they do appreciate what we do…so therefore it makes it worthwhile…us coming to work*
>
> HCA, rural

> *I think you'll find that most community hospitals, they're tight knit teams…In a big hospital you don't necessarily have that relationship other than you go to work and 'oh we're on the same shift today'*
>
> NE, rural

HCAs from both Waikato and Thames brought up the challenge of being delegated tasks by multiple clinicians, which can cause difficulty for the HCA with prioritisation of tasks. HCAs in Waikato ED have the highest RN-to-HCA ratio and reported times of being overwhelmed with tasks, perceiving that RNs do not always appreciate the HCAs workload, host of responsibilities and expected demands. Waikato RNs also acknowledged staff mix and the issue of HCAs work being spread

over a large clinical area and patient population, encouraging tasking rather than a team nursing model of care. In contrast, HCAs who worked in a smaller rural team with a smaller RN-to-HCA ratio reported positive and efficient communication as an enabling factor for successful delegation and task prioritisation. HCAs in rural EDs shared the experience of working in partnership with RNs and perhaps a greater sense of appreciation for their efforts within the nursing team.

5.2.4 Education for Emergency Department Health Care Assistants

In recognition of the need for standardised education for HCA, Waikato DHB has created a generic training and education programme for the HCA role across all settings within Waikato DHB. It is the National Certificate in Health, Disability and Aged Care, Core competencies Level 3 on the New Zealand Qualifications Authority (NZQA) framework. The main topics covered in the programme include; Patient Rights; Cultural Safety; Chronic Conditions; Personal Cares; Manual Handling; Infection Control; Falls; and care of the patient with Dementia. All HCA participants in this study had or were in the process of achieving certification. There were mixed views from both HCAs and RNs about whether the programme was beneficial in guiding HCAs care of patients in the Emergency Department. While some acknowledged it as a good foundation in basic patient care, others saw the need for further ED specific training and education.

> *I have [found the Certificate helpful] with the cultural side of things and it's just like a basic layout in skills and stuff*
>
> HCA, rural

> *It was really good, a lot of it was reinforcing stuff which doesn't hurt at all, it's good to go over stuff because you can become a bit complacent after a while*
>
> HCA, rural

> *It's more [focussed on] patient care in the ward, there's not a lot of emergency department stuff in it*
>
> HCA, rural

> *[ED is] faster paced than what aged care would be and things can change more rapidly and being able to know when there's something happening in the waiting room perhaps that they would need to alert us to*
>
> Senior RN, rural

Nurses expanded on the idea of HCAs needing ED specific education and training, furthermore, expressing their views about the NZQA Level 3 Certification. Waikato RNs perceived HCAs lacked a sense of achievement with having to perform 'tick-box' exercises and critiqued the current education and training offered as non-specific for the skill and competencies needed within the emergency department, but tailored more to ward or community settings.

> *That seems to be a tick box exercise…for me it doesn't sort of sit with what they have to do in their clinical area…I think it's fine from an academic point of view but you need to make it specific to the area so that you get the skills and the competencies from the health care assistant that you need, because it's very generic… It's demeaning for them and it's not fulfilling what we need for the department*
>
> Senior RN, Waikato

> *There's no real sense of achievement for them…tick this box, somebody sign it off*
>
> Senior RN, Waikato

Some HCAs thought along with ED specific education a longer orientation to the emergency setting would be beneficial. The following comments made by HCAs from Waikato ED portray sense that some HCAs felt underprepared for the nature of their role in ED.

> *A day training, maybe two, and then you're in this job and sometimes I'm like 'this is so crazy' that you can walk in to this job with zero training…really you're just put on the floor and then…you've got to play catch up for a good time*
>
> HCA, Waikato

> *Some of our new ones, cause they're not here that often they miss things…and it's not their fault, it's just because they haven't had time to be shown about it*
>
> HCA, Waikato

> *I find that if we get new people on the job, you might get one day [of orientation]*
>
> HCA, Waikato

HCAs thought people entering the role should ideally have relevant life experience or a background in 'caring' to perform well in the role.

> *In my day you used to always have to come from a nursing background or teaching, or something like that*
>
> HCA, Waikato

> *I think you have to have had children, or come from some sort of caring background because when you come here it's stressful, you know? You don't know what you're dealing with*
>
> HCA, Waikato

In summary, most HCAs had achieved (or were working toward) the NZQA Level 3 National Certificate in Health, Disability and Aged Care offered by Waikato DHB. Some HCAs found doing the certificate beneficial, seeing it as providing a good foundation of knowledge, applicable to their role and informing their care of patients. Though others, primarily those from the Waikato ED focus group including RNs, perceived a lack of adequate training for the reality of HCA role requirements within ED. Participants from all five services expressed an interest in more ED specific education, for example care of mentally unwell patients – which account for a significant portion of the ED patient population. Some RNs urged the importance of tailoring education and training to the specific needs of the department, to cope with increasing care demands.

5.2.5 The future of the Health Care Assistant role

Participants from the ED who employed HCA advocated for more HCA staff to cope with increasing care demands, while services without dedicated HCA staff were keen to see the role implemented into their respective service, anticipating the positive effect it would have for patient care and better utilisation of Registered Nurse time. Each group brought up the 'shifting of traditional role boundaries' and expansion of existing scopes of nursing practice. The topic of expanding HCA practice was discussed with interest among all five focus groups and both HCAs and

RNs advocated for additional clinical interventions to be added to the HCA task profile. Discussion also centred around current and future challenges of the health care system and the implications for HCA practice. There was a unanimous view amongst all focus groups that further education and training should be standardised and additional specialised training should be created for ED HCAs.

> *I think doing [observations] would be good*
>
> HCA, Waikato

> *I think they [HCAs] will probably get a bit more advanced and that just seems to be happening through every single role in the department…so I think they're going to get allocated more and more jobs*
>
> Intermediate RN, Waikato

> *We need them to be able to do vital signs…and in saying that, being responsible for doing the [observations] and then coming and showing the RN, not going 'oh they're ok'*
>
> Senior RN, rural

> *It's that escalation process…it doesn't take a qualified nurse to wrap a blood pressure cuff around a person's arm and press a button on a machine… it takes a qualified nurse to interpret what you've got and if you give them the parameters which are normal, anything outside that they report to the RN, then you're covered under your delegation… but it's getting that accepted*
>
> CNS, Waikato

RNs cited issues such as aging workforce and projected health workforce shortages as legitimate reasons to consider expanding the HCA role and task capabilities.

> *It has been written about that we're going to have such an aging workforce and not the number to replace them so people are going to have to widen their scope, therefore why can't HCAs? [if we] provide them with the information and the skills*
>
> NE, rural

> *I think we're going to be in a big pile of poop…because in 2020 there is going to be an international shortage…but it's not just happening with the nursing profession, it's also happening with the medical profession so we [nurses] are gonna be stepping up…so the health care assistants are all of a sudden going to step in to that role and you're gonna have one nurse who's going to have the responsibility for looking after a*

> *heck of a lot of HCAs…that's a huge responsibility for an RN, but those HCAs have also got to have the skills and competency and that's where we're not training enough nurses [or] the skills for the HCAs…because that's the way it's going*
>
> Senior RN, Waikato

> *It's gonna be more like the system they have in residential homes, where you have one RN…who's responsible and all the rest under you are health care assistants*
>
> CNS, Waikato

> *You can already see the demand is getting bigger and bigger and bigger…*
>
> Intermediate RN, Waikato

Though RNs discussed rationale for expanding HCA roles to include skills such as taking vital signs, they recognised the challenges and complexity such a step would involve within the realities of practice and the implications for patient safety.

> *I suppose where it falls down[the idea of expanding HCA role] is having that team trust though… If there is trust in the team that the HCA understood what the parameters were, that if the patient isn't in these parameters these are the symptoms they may be showing and you need to get help straight away…If you knew that it was going to happen every time… I suppose in circumstances where you know that you don't have tight knit teams and you've got high staff turnover can you trust that that's going to happen… and what's happening with patient safety?*
>
> NE, rural

Nurses who had practised in the United Kingdom discussed the differences in HCA practice between Waikato hospital and metropolitan hospitals in England.

> *There's definitely additional skills that we could devolve as RNs to the HCAs…which is what happened in the UK…we stopped being a blood-letting service…enabled the HCAs to do that, which was great and they got incredibly good at it very fast*
>
> CNS, Waikato

> *The big difference I've noticed coming here from the UK is that those boundaries have shifted …traditionally between the doctor and nurse…nurses now take on much more of a doctors role…you may be a bit behind in New Zealand or maybe we were just very forward in the UK but we had our HCAs doing bloods, doing observations, doing all sorts of stuff which would then free up the nurses to basically do more of the*

> *junior doctors role…but it's still that escalation process through the team and through the different skill sets*
>
> CNS, Waikato

Whilst acknowledging the reality of expanded HCA practice happening internationally and seeing the potential for the same within Waikato DHB, nurses from multiple services argued strongly for the necessary planning and resources to safely implement changes in practise.

> *I definitely think there's scope for it [expanding the HCA task profile] but you have to make sure you've got that culture that supports it…you can't have a high challenge there without the support and our biggest thing is patient safety that gets put at risk… If you've got teams that are able to do it then it's gotta be able to apply to others and you've got to sustain that sort of culture…that is an open culture cause that's where the risk is*
>
> NE, rural

> *…they will get allocated more responsibility and they'll need additional skills, but then that's got to fit alongside the fact that we will need additional HCAs…*
>
> Senior RN, Waikato

> *If nurses are going to take on more, then we devolve some of our roles to [HCAs]It's got to be staffed safely and fairly because if a nurse will look after a pod of four patients and that's a safe limit then you can't devolve some of those skills to an HCA and say 'here's your twelve' [patients]… at the end of the day you're asking people without all of the background skills and knowledge to take on a lot of our responsibility and you know without that back up you can't then expect them to do something that we ourselves consider to be unsafe*
>
> CNS, Waikato

> *I think they'll become a regulated profession much like nurses are and they'll have a governing body*
>
> Senior RN, Waikato

Rural services yet to employ HCAs discussed skills and roles they would like to see as part of future practice for HCAs.

> *…computer skills, cause we're going in to the virtual world so you know, for them to at least know how to use the tele-health and be part of virtual health…they have to be*

involved in that journey, we can't leave them behind… we want to have an educational hub computer…rather than the nurse we'd say to the HCA 'can you go into this website, set that up for the patient'

CNM, rural

I would like to see in the future that they are doing some of the iPM [administration] stuff…also just being another set of eyes… keep an eye out on the waiting room

Intermediate RN, rural

[In future I would like to see they them have more] education opportunities…feel valued and feel like they're learning within their role

Senior RN, rural

I'd like them to have more education opportunities…it could be a stepping stone for them and create a career pathway like maybe towards being an enrolled [nurse] or a doctor, who knows…

Intermediate RN, rural

…things like teaching them [patients] how to use spacers (medication inhalation device), wash spacers, all that sort of thing

CNM, rural

They are really important people, [important] part of the whole health sector and they do need to be recognised

Intermediate RN, rural

Similar themes uncovered across the five focus groups centred around the potential and perceived need to expand the HCA role to meet current care demands within ED. RNs recognised certain factors such as safe staffing and the need for adequate support with implementation if the ED HCA role was to be expanded in future. Overall, RNs think HCAs have a vital role to play and recognise a need to maximise the potential of their role within nursing teams and in healthcare settings moving into the future.

5.3 Summary

In summary, this section has detailed qualitative and quantitative findings of this mixed method study exploring the role of the HCA in ED. Numerical findings of

Phase I were presented as tables and graphs: Tables listed patient throughput for each department per month over the year ending 30 June 2015, as well as staff mix allocated for each shift in each service over the corresponding year. Graphs were used to depict mean staff-to-patient ratios by month for each of the five EDs over the same time-period and apparent trends were highlighted.

Qualitative findings gained from Phase II were detailed according to the five relevant themes regarding RN and HCA perceptions of the role of the HCA in ED; Tasks and responsibilities; Role perceptions and expectations; Challenges for the HCA role; Education for the HCA role; and the Future of the HCA role. As Identified in Phase I, two of the ED services employed HCAs allocated specifically within ED, which meant RN perspectives were more widely represented within focus group data.

Chapter 6: Discussion

There is nothing so terrible as activity without insight

Johann Wolfgang von Goethe 1749-1832

6.1 Introduction

As challenges for the health system increase due to ageing populations, ageing workforce, rising incidence of chronic conditions and co-morbidities as well as advancements in medical and information technology, models of care provision are changing. Traditional role boundaries are shifting, giving way to new roles with expanded practice and task responsibilities. In a bid to cap health spending the nursing workforce is being supplemented with the less costly Health Care Assistant (HCA) workforce. HCAs can be found working across all areas of the health sector, including critical care and emergency departments. There has been ongoing debate within health and nursing literature since the widespread introduction of HCAs in the 1980s about their status as unregulated workers and the lack of standardised education for HCAs, raising concern among professional nursing bodies and nurse researchers about the impact of this change in skill mix on patient safety and quality of care, particularly in acute settings.

A review of literature found many international studies exploring the views and experience of Registered Nurses (RN) in acute care who work alongside HCAs, though there was little significant national research found regarding HCAs in acute care or emergency care. There is a generic role description and task profile for HCAs working across Waikato District Health Board (DHB) denoting added capabilities for those in specific areas such as the Emergency Department or Cardiac Care (See appendix 3). There is also generic national certification available for HCAs within Waikato DHB, but no formal qualification which is Emergency Department (ED) specific for HCAs. Arguably the role of the ED HCA differs greatly from that of the hospital wards and community settings as was earlier discussed. This study focuses on the role of the HCA within the Emergency setting. With patients presenting to the ED more unwell with more complex care needs while RNs look to

further expand nursing practice to meet these needs, there is the threat of a widening knowledge gap between RNs and HCAs, who in theory work in a partnership model. So what implications does this have for the HCA role heading in to the future? Hence, the necessity to focus on the role of the HCA in ED and realities of their work in the emergency setting, from the perspective of HCAs themselves and their Registered Nurse colleagues. This section seeks to answer the following questions:

1. What are the perceptions of Health Care Assistants regarding their own role within the Emergency Department nursing team?

2. What are the perceptions of Emergency Department Registered Nurses about the role of the Health Care Assistants within the nursing team?

3. What are the tasks which could be/are performed by Health Care Assistants in each of the five Emergency Departments within Waikato District Health Board?

4. How does Health Care Assistant practice relate or differ amongst the five Emergency Departments in the Waikato region?

The discussion of findings is presented in three parts; Part I will focus on answering the above research questions drawing on results from both quantitative and qualitative findings. Part II will discuss the implications of findings from part I and how this research adds to the current theoretical knowledge base about the role of HCAs in the emergency setting. Lastly, Part III will identify limitations of the study and discuss future education and policy implications regarding the role of Health Care Assistants within Emergency Departments.

6.1.1 Triangulation of quantitative and qualitative findings

Triangulation is the process of drawing on multiple data collection methods to explore the same phenomenon, integrating them to produce a more reliable and valid outcome than could be obtained from using a single approach (Bowling, 2014). This study incorporates data from both quantitative and qualitative sources in the hope that data from Phase I regarding staffing levels across the five EDs, will serve to corroborate findings from Phase II about the role and tasks performed across the

various ED services. Ideally, triangulating the data will generate more robust and meaningful discussion.

Part 1: What are the role and tasks performed by Health Care Assistants in the Emergency Department?

6.2 Introduction

At the time of data collection two of the five Emergency Departments (Waikato and Thames) employed dedicated Health Care Assistants. Taumaranui hospital rostered one HCA to the inpatient ward for morning and afternoon shifts, though the HCA was utilised between ED and the ward according to workload. Tokoroa did not employ an ED HCA and Te Kuiti hospital – including the ED, did not employ an HCA. Hence, three of the five services within Waikato DHB are represented within this section regarding perception of HCAs about their role.

6.3 How do Health Care Assistants perceive their role within the emergency nursing team?

Overall, HCAs perceived their role within the ED to be a support person to the RNs in carrying out delegated tasks such as patient care, other clinical and non-clinical duties and maintaining the clinical environment or 'house-keeping' for the efficient running of the department. Supporting and assisting the RN was considered the primary focus of their work. All HCAs acknowledged that they worked under the direction and delegation of their RN colleagues and voiced clear examples of their job responsibilities in relation to the RN, and voiced awareness of their role and task limitations as directed by their employers.

By keeping abreast of house-keeping duties such as re-stocking and tidying clinical areas and maintaining a clean and orderly work environment, HCAs perceived they were 'keeping the place running smoothly' and adding to the efficiency of nurses' and doctors' work. House-keeping and non-clinical tasks were considered by some as 'behind the scenes' work. Whilst occupying a significant a part of their job responsibilities some HCAs implied this area of their work was often over-looked or taken for granted by colleagues. Spilsbury and Meyer (2005) touched on a similar theme in their objective study of HCAs work, revealing the occurrence of 'unseen

work' such as covering staff in times of shortage and taking time to help new graduate nurses or students in their roles. This links to the theme of HCAs, especially in Waikato ED, feeling over-burdened with tasks which appears directly related to the high RN-to- HCA and HCA-to-patient ratio in Waikato ED. Waikato HCAs shared examples of feeling disrespected, taken for granted and under-recognised by some RN colleagues, a phenomenon which appears in other studies of the HCA experience (Lancaster et al, 2015; Kalisch, 2011; Bittner & Gravlin, 2009). In contrast, those from rural services felt their smaller teams fostered trust, closer collegial relationships and effective communication, which are qualities found by other studies to promote effective delegation of nursing care (Standing & Anthony, 2008; Kalisch, 2011). Rural HCAs also conveyed a greater sense of inclusion and appreciation for their role within the nursing team thus implying a greater sense of job satisfaction.

All HCA participants said they generally spent more time on direct patient care activities than what RNs did, or were able to. This finding is prevalent throughout international studies exploring the role of HCAs in acute settings (Kent-Hillis, 2001; Nwosu, 2006; Lancaster et al, 2015). One rural HCA talked about the idea of being able to provide more holistic care through spending more time at the bedside, building rapport with patients and providing both physical and emotional support. Waikato HCAs raised the point that because they undertake a significant portion of direct patient care activities such as mobilising, toileting and assisting patients in to gowns, they may observe things such as skin integrity, wounds or mobility status, which the primary RN may be unaware of. Though HCAs described advocating for patients by reporting potential issues to an RN, they raised the point that issues may not be recognised or may go unreported. Related studies have cited, multiple factors affecting the reporting of information, such as the ability of HCAs to recognise issues as well as trust and open communication within the RN-HCA partnerships (Potter et al, 2010; Spilsbury & Meyer, 2005). Various studies have found that HCAs were excluded from sharing input about patient care, which is a risk to patient safety (Lancaster et al, 2015; Kalisch, 2011; Bittner & Gravlin, 2009).

HCAs from Waikato ED reported frequent instances of being delegated to perform a patient watch which occupied a significant portion of their time on a shift. Current figures show there are an increasing number of attendances related to intentional self-harm (Waikato DHB, 2016) which may be one contributing factor to why HCAs perceived an increase in the number of patient watches happening in the department. The reality for Waikato HCAs in practice is that there may be several watches required simultaneously, leaving either one, or no HCAs remaining on the floor (depending on staff mix on shift), which was identified as an issue for multiple reasons; firstly, HCAs were concerned it took them away from a mounting list of 'other jobs' putting increased workload pressure on the HCA/s remaining on the floor or coming on for the next shift. Secondly, some shared views that they felt under-prepared for the task of caring for patients in psychological crisis, behaving aggressively or in altered cognitive states such as delirium.

HCAs from Waikato discussed the nature of working in ED compared to that of the hospital wards, perceiving that they did 'more and above' what HCAs do in the ward. Though most of the HCAs in this study had achieved (or were in the process of) their Level 3 Certification in 'Health, Disability and Aged Support' delivered by Waikato DHB, they expressed an interest in undertaking further emergency specific education. Additionally, HCAs stated that a person should have some life experience and a background in 'caring' to perform well in the role, to deal with some of the unpredictable and extreme situations that unfold within the department.

6.4 What are the perceptions of Registered Nurses about the role of the Health Care Assistant within the Emergency nursing team?

Consistent with views of their HCA colleagues, RNs from all focus groups viewed the role of the HCA as a supportive and assistant role to the nurse. Services who did not employ HCAs advocated for the implementation of the role in their respective services, while RNs from Waikato ED - which has the highest mean RN-to-HCA staffing ratio, argued the necessity for more HCA resource. There was a shared rationale that introducing or increasing the HCA resource would help with increasing

workload demands and serve to maximise RN time and skill. Despite some HCAs' experience of feeling over-used and under-recognised, RNs from all five EDs acknowledged the value of the HCA role within the ED nursing team. One rural RN described how many of the tasks which occupy RN time are 'HCA work', explaining that although it was not beneath her to be doing non-clinical tasks and house-keeping duties, she felt her time would be better spent using her specialised skills and knowledge to benefit her patients, which is an argument supported in the literature (Duffield et al, 2008). Thus, the ideal was a 'working partnership' with HCAs serving to complement the care given by RNs.

When asked about the role of the HCA within the emergency nursing team RNs from all services recited their legal and professional responsibilities for direction, delegation and evaluation of care undertaken by HCA colleagues. While RNs who worked alongside HCAs acknowledged HCAs' heavy workload, they also talked about wanting HCAs to be *more* involved in patient care. Waikato RNs reasoned this was not currently feasible due to the RN-to-HCA and HCA-to-patient ratios (tables 5.3.1 & 5.3.6), which manifests as HCAs 'tasking', as opposed to providing some continuity of care for a smaller number of patients. This links with the concept of 'fragmentation of care' cited in international studies (Kent-Hillis, 2001; Lancaster, 2015). The term 'fragmentation of care' in the context of an acute setting sees patient care being separated into a series of tasks, completed by different members of the multi-disciplinary team thus failing to provide patient-centred care, leading to sub-optimal outcomes such as increased length of stay (Lancaster et al, 2015; Kummeth et al, 2001; Kent-Hillis, 2001).

It was acknowledged by RNs that lack of nationally standardised education is an issue, due to the potential of an increasing knowledge gap between RNs and HCAs as nursing practice continues to advance, which is a concern highlighted in literature (Clendon, 2011). RNs' from multiple services saw the need for HCAs to have Emergency Department specific education, acknowledging that ED is a more dynamic and fast paced environment where the patient's condition can rapidly change and staff need to maintain a state of preparedness. There were several expectations and desired role characteristics that RNs held for their HCA colleagues.

They felt that HCAs should be proactive and take initiative, for example approaching RNs to offer their assistance with patient care and 'being a second pair of eyes' – able recognise issues that require escalating to an RN, such as a patient deteriorating in the waiting room. Similarly, research concerning RNs in a medical-surgical setting found they had expectations for HCAs to think critically, recognise and report issues and demonstrate assessment and prioritisation of tasks, thus needing to engage in more advanced decision making which was above the HCA scope of practice (Bittner & Gravlin, 2009). Generally, RNs from all services perceived that HCAs had more time to spend at the patients' bedside, thereby having more time to provide both physical and emotional support, as they acknowledged the blurring of traditional role boundaries and their own increasing responsibilities taking them away from the bedside; a concept also supported by international research (Pearcey, 2007).

Overall, rural RNs thought HCAs would be an invaluable addition to the team in helping manage their workload, in the sense that RNs could delegate a proportion of non-clinical tasks which would enable them to better prioritise and meet patients' care needs. Waikato RNs discussed the idea of the HCA role being utilised for 'intentional-rounding', a clinical care initiative whereby patients are regularly checked on and their needs assessed regarding pain management, cultural, physical or psychosocial needs, escalation of issues or a change in the patient's condition (Waikato DHB, 2016). It was suggested by RNs from multiple services that having an HCA to monitor the waiting room would increase patient safety and patient satisfaction.

6.5 What are the tasks performed by Health Care Assistants in the Emergency Department?

The three focus groups which included HCAs collectively recounted an extensive list of tasks undertaken by HCAs in the Emergency Department. Also, added to the list were tasks which Tokoroa and Te Kuiti RNs stated could be delegated. House-keeping tasks such as re-stocking and tidying clinical areas, ordering supplies and equipment and maintaining areas such as sluice rooms and kitchen bays were seen by HCAs as important for the smooth day-to-day running of the department. These

tasks were reported to occupy a significant amount of time for HCAs and more notably, for RNs working in services which did not employ HCAs. There are numerous studies which support the premise that delegation of non-clinical tasks to HCAs releases RNs to focus on nursing care (Chang et al, 1998; Bosley & Dale, 2008). Consequently, other studies have revealed that HCAs in acute settings are providing more direct patient care while RNs are seen to be moving away from the bedside (Pearcey, 2007; McKenna et al, 2004). When asked how their time was spent on a typical shift, all HCA respondents replied that patient care accounted for the bulk of their work on the floor. 'Patient care' refers to tasks such as toileting; mobilising/transferring; comfort care; ECGs; assisting to change into a patient gown; and doing a patient watch. Waikato HCAs perceived that ECGs were one of the most commonly delegated patient care tasks, but also thought that non-urgent ECGs were sometimes unnecessarily delegated. This links with another issue raised - that there are a range of tasks that are considered the domain of HCAs but which are also the shared responsibility of RNs. These include the tasks fore-mentioned and others such as urinalysis; re-stocking clinical areas; and cleaning of used equipment.

An international study about re-development of the HCA role in an acute medical ward was concerned with 'Having the right person perform the right job'. Prior to the initiative, HCAs on the ward lacked clear role expectations and were responsible for personal cares of acutely unwell patients, but also subject to many spontaneous delegation requests, causing frustration for HCAs and fragmentation of care. Together RNs and HCAs created a task inventory and assigned each task to the role deemed most appropriate to perform it, with extra HCA staff employed to accomplish the change in practice. The reported outcomes were increased clarity of roles and role expectations, increased job satisfaction for both HCAs and RNs and improved patient outcomes (Kummeth et al, 2001). Though the medical ward setting is in many ways different to the ED environment, there is potential for this model to be adapted for HCAs in ED.

RNs from Waikato and rural services did acknowledge their responsibility for sharing workload of both patient care and non-clinical tasks and they also recognised the expectation on HCAs to meet workload demand of house-keeping, patient care and

other non-clinical or assistive tasks. When RNs talked about the future of the HCA role they predicted that HCAs will be increasingly given more tasks due the expansion of nursing roles to taking on more of doctors' functions.

The point was raised by the Waikato group that although the role and task responsibilities of HCAs are governed same job description within a specific setting, they may be working at different levels within their role. A 1995 study exploring tasks undertaken by HCAs in EDs across the United Kingdom found that HCAs were all working at different levels and there was a general lack of consensus by ED RNs about the range of tasks HCAs performed (Boyes, 1995). Furthermore, in some instances there was found to be minimal difference between the amount of direct patient care undertaken by RNs and HCAs (Boyes, 1995).

The Waikato focus group perceived that HCAs spent a significant amount of time performing patient watches. Both RNs and HCAs saw it as poor use of the HCA resource and taking them away from accomplishing their other tasks, especially when workload and acuity were high in the department. The group discussed how there was a negative perception among staff that doing a watch was associated with laziness and inefficiency. However, one RN argued its importance as a delegated task, in the interest of patient safety, which is of the highest priority for all staff in the ED (CENNZ, 2006).

A rural nurse used the term 'HCA work' to describe a list of non-clinical tasks such as those which are undertaken by RNs at rural EDs, but which could be delegated to releases RNs to focus on nursing tasks. In rural services without HCAs, the introduction of the role was regarded as a necessity and highly anticipated by all RN participants. Apart from being able to delegate a range of non-clinical and patient care tasks ranging from ordering and un-packing stock to ECGs and urinalysis, there were other roles suggested which are unique to the rural settings. RNs thought HCAs could cover the roles of administrative and attendant staff after hours. Rosters for night shifts in Tokoroa, Taumaranui and Te Kuiti allocated one RN to ED, which means doing any administration or non-clinical tasks (for example, registering patients or running blood samples to the laboratory) take RNs away from

patient care. RNs from all rural services identified this as a risk to patient safety, even more so if the patient is critically ill, requiring one-on-one nursing care.

Due to the method of self-reporting of tasks, the research does not accurately reflect all tasks which may be undertaken as specified in the Waikato DHB HCA task list, therefore, it is unclear how the reality of HCA practice across Waikato complies with the directives of the task list. Overall, focus group participants expressed varied recognition of the document but were generally more accustomed to their service specific guidelines. Documentation in patient notes was one task which is clearly stated on the DHB task list, but not mentioned in any of the focus groups. Considering the Waikato focus group thought HCAs spent a significant amount of time on patient watches, it would be appropriate for them to contribute to patient clinical notes about their observations or care interventions for the patient (counter-signed by the primary RN).

6.6 How does Health Care Assistant practice relate or differ amongst the five Emergency Departments within Waikato District Health Board?

Of the five EDs within Waikato DHB, Waikato and Thames were the only hospitals to employ HCAs exclusively in ED. Taumaranui hospital employed HCAs who were allocated to the ward but utilised in ED if required, therefore the one HCA participant from Taumaranui was represented within the qualitative data but discounted from the quantitative sample. The most obvious and significant difference between the EDs is the size and staffing of the respective departments. Waikato ED is the largest and best resourced department which offers all specialty services and had 69,344 patient presentations (from a total 105,981 across all services) in the year ending 30 June 2016. In contrast, Te Kuiti is the smallest ED with 2,281 presentations recorded for the same year. Though Waikato has the largest team of RN and HCA staff, they also have the lowest mean HCA-to-RN and HCA-to-patient ratios. Due to these factors, it became evident why Waikato HCAs reported being overloaded with jobs, had difficulty with task prioritisation and had experienced disrespectful communication between colleagues, which are findings

supported by other studies (Standing & Anthony, 2008; Bittner & Gravlin, 2009; Kalisch, 2011). Waikato HCAs also expressed a lack of recognition for the work they do, some of which was considered 'behind the scenes'. In contrast, rural HCAs reported a greater sense of team work, positive communication practices and generally felt recognised and appreciated for their work and role within the nursing team.

While ECGs were a task commonly delegated by RNs at Waikato, Thames and Taumaranui, Point-of-Care testing for urinalysis was undertaken only at Waikato and Thames EDs, while quality control testing for glucometers was only done by Waikato HCAs. These tasks all require training and certification within the workplace. Yet despite these differences in task capabilities, all HCA participants had achieved (or were completing) a nationally recognised qualification created for HCAs by Waikato DHB, which demonstrates efforts to standardise education and training for HCAs; one of the primary concerns declared throughout nursing literature (Boyes, 1995; Thornley, 2000; Fowler, 2003; McGloin & Knowles, 2005, NZNO, 2011) In addition, all HCAs had received training on Basic Life Support including Cardio-pulmonary Resuscitation (CPR), while Waikato HCAs listed having performed CPR as part of their delegated duties for direct patient care.

Both Tokoroa and Taumaranui EDs had overall lower mean RN-to-patient ratios over all shifts compared to Waikato and Thames EDs. Te Kuiti ED had the overall highest mean RN-to-patient ratios for morning and afternoon shifts, when considering the reduction in resources after hours and rural RNs' assertion that more than half of their nursing time is spent on non-clinical duties, the addition of an HCA to all three rural services could serve to alleviate workload pressure from RNs and increase RN-to-patient time.

When considering quantitative and qualitative findings together it seems many practice issues for Waikato HCAs are related to large patient volumes and disproportionate HCA-to-RN and HCA-to-patient ratios. In comparison, rural EDs have higher RN-to-patient ratios, however the small size of their departments mean their infrastructure and limited resources cause difficulty for RNs in meeting patient care demands.

Part 2: The future of the Health Care Assistant Role within Emergency Departments in Waikato District Health Board

HCAs are part of teams who provide frontline care in ED to patients with critical health needs, yet they remain an unlicensed workforce. The number of people presenting to EDs within Waikato DHB continues to increase at an average of five percent per year (MoH, 2016). Larger patient volumes can increase staff-to-patient ratios, while the increasing acuity of patients requires more dedicated nurse-to-patient time. With the added factors of limited inpatient beds causing overcrowding in ED and the requirement to achieve the Ministry of Health six-hour target (for patient admission or discharge), nurses in ED are working under increasing pressure to meet patient care demands, while striving to ensure patient safety and quality of care. Health Care Assistants work alongside, but under the direction and supervision of Registered Nurses, so when nurses experience increased workload pressure it filters down to HCAs, which was made evident in this study. It is timely to consider the role and task responsibilities delegated to HCAs and the future of their role in the ED.

6.7 Emergency specific education for Health Care Assistants

In a study profiling nursing resources in Australian ED the authors point out the correlation between advanced (post-graduate level) education of nurses and enhanced patient outcomes (Morphet, Kent, Plummer & Considine, 2016). Based on this premise, it could be theorised that patient outcomes could also be optimised by relevant education for ED Health Care Assistants. Education for HCAs was a dominant theme across the five focus groups. Though most HCA participants had achieved national certification in 'Health, Disability and aged support' (level three), it was suggested that the academic requirements to achieve certification were not easily achievable for everyone. There were mixed views about the certificate's relevance to practice in the ED with both HCA and RN participants from Waikato and rural services reflecting about how the ED setting differs from ward or community settings. The ED was described as more dynamic, fast paced with high patient

turnover and potential for more rapid changes in patient condition. HCAs expressed interest in receiving more ED specific education including care of patients with mental health issues, as they reported spending a significant amount of time with this patient population, performing watches. Waikato HCAs also said they would have liked a more substantial orientation to the role, implying a lack of preparedness for both the expectations and reality of the HCA role in ED. Research supports the view of one Senior RN who pointed out that education and training for HCAs should be tailored to meet the specific needs of the department, in the interest of optimum patient care and best utilisation of resources (Boyes, 1995; Kummeth et al, 2001).

6.8 Considering expansion of the Health Care Assistant task profile

The expansion of the HCA task profile was a theme that emerged across all five ED services. Both RNs and HCAs expressed interest in the upskilling of HCAs', generally based on the rationale of 'saving time' for RNs and allowing them to focus on other nursing responsibilities. There was comparison made between a Senior RNs practice experience in the United Kingdom compared to Waikato DHB, acknowledging that HCAs in the UK were certified to perform direct patient care tasks including vital signs and venepuncture. Research from the UK about the work of HCAs shows that in times of nursing shortage they are called to work above their designated responsibilities - administering medicines, suturing and operating diagnostic equipment were among a list of duties performed outside HCAs' remit (Thornley, 2000). However, it should be noted that there is no second-tier nursing workforce in the UK equivalent to Enrolled Nurses in New Zealand (NZNO, 2011), who can legally carry out nursing assessments and evaluation of care as well as venepuncture and administration of medicines, under the supervision of RNs (NCNZ, 2012).

The Nursing Council of New Zealand states the role of the HCA is to "...assist registered nurses by completing personal care and other activities that do not require specialist nursing knowledge, judgement or skill" (Nursing Council of New Zealand,

2010, p. 10). Therefore, any activity included in an HCAs task responsibilities should be considered against the requirements of NCNZ's definition for the role, in the interests of patient safety and quality of care. The three focus groups which included HCAs all advocated for expanding the HCA task profile to include taking clinical observations, which includes the measuring of blood pressure, heart rate, oxygen saturation, temperature and respiratory rate. Both RNs and HCAs saw it as a development which would assist the RN with patient workload, thereby releasing the RN to focus on other tasks. The rationale was put forward that though HCAs could not be responsible for the interpreting of information, if they were taught of the parameters of normal versus abnormal values – including related physiological signs and symptoms, *and* could consistently report findings to the RN, then delegation of clinical observations may be feasible. RNs thought this scenario would comply with legal and professional obligations for direction, delegation and supervision of care provided by HCAs, as directed by NCNZ competencies for RN practice (2007). RNs thought such a change in practice would necessitate an open and supportive workplace culture and high level of trust within the team. There was comparison made to the specialized training and education that RNs and ENs undertake, and inquiry as to the depth of information HCAs would need to learn to safely undertake clinical tasks.

In their position statement on 'The use of Health Care Assistants in Primary Care Accident and Emergency settings', NZNO (2011) supports the recording of vital signs by HCAs, excluding triage/initial assessments. Hypothetically, if ED HCAs had specific training coupled with a supportive team environment with clear role expectations and a high level of trust between colleagues (as described by rural services), delegation of clinical observations for patients deemed stable by the delegating RN might be feasible. Though there has been debate about the extent to which ED patients can be considered stable (Boyes, 1995). One scenario where this might be applicable is obtaining a final set of observations on patients being prepared for discharge home from ED, though this is also an opportune time to provide discharge education which is a responsibility of the RN. Therefore, careful consideration is needed with regards to aligning patient care interventions with the appropriate knowledge and skill level of staff.

It was emphasised that upskilling and extension of HCAs responsibilities should be transferrable to other services, though one NE thought that large teams with higher staff turnover (such as Waikato ED) would be harder challenged in fostering team trust which raises concerns for appropriate delegation and supervision of tasks, in the interest of patient safety and quality care. Waikato RNs talked about the disproportionate RN-to-HCA and patient-to-HCA ratios in Waikato ED, adding that safe staffing is crucial to any extension of the HCA role - a finding reiterated in studies about the HCA role in acute and emergency settings (Kummeth et al, 2001; Boyes, 1995). The point was raised that RNs are paid significantly more than HCAs for their level of knowledge, skill and responsibility, which brings in to question the appropriateness of devolving further nursing tasks to HCAs. Perhaps this suggests more recognition and utilisation of the registered and appropriately skilled EN workforce, as endorsed by nurse leaders and professional nursing organisations (Clendon, 2011; Cassie, 2014; NZNO, 2011; NCNZ, 2012)

6.9 Re-evaluation of the Health Care Assistant role in the Emergency Department

There could be advantages in re-evaluation of the Waikato DHB HCA task list as it relates to the reality of work undertaken in Waikato EDs'. Re-allocation of tasks by adapting the 'right skill, right job' model as evaluated by Kummeth et al (2001) could lead to optimum utilisation of HCA and RN resource, without necessarily needing to devolve extra tasks to HCAs. Though RNs from Waikato and Thames were keen to see HCAs being more involved in patient care, the quantitative data regarding staffing ratios attests to HCAs experience of already heavy workloads, which clearly limits scope for delegating HCAs further responsibility. In the workplace under study by Kummeth et al (2001), RNs and HCAs were the key contributors to the creation of respective task lists. After implementation of the revised role responsibilities staff reported clarity of role expectations and more efficient utilisation of RN and HCA resource which was perceived to improve patient outcomes and proven to decrease patient length of stay (Kummeth et al, 2001). The issue was raised in the Waikato focus group that the task of a patient watch was a

waste of the HCA resource when considering HCA-to RN and HCA-to-patient ratios and the perceived increase in frequency of patient watches being performed. Waikato HCAs also objected to performing ECGs on Triage two patients presenting with chest pain prior to being assessed by the primary RN. Though HCAs indicated this was acting outside of their designated responsibilities, it was done with the intention of alleviating workload of RNs, as is reported in other studies (Thornley, 2000; Spilsbury & Meyer, 2004). This scenario has implications for patient safety and the legal and professional accountability of RN practice in delegating and supervising care undertaken by HCAs. Hence, the necessity for a large department such as Waikato ED to have to a consistent set of expectations and role responsibilities for HCAs and for all staff to have role clarity of both their own and their colleagues' roles and responsibilities.

6.10 Registered Nurse to Health Care Assistant ratios in the Emergency Department

The College of Emergency Nurses New Zealand (CENNZ) state in their position statement on 'Nursing Staff requirements in Emergency Departments' that rural hospital EDs should have a minimum of two RNs per shift in the ED (2006). The quantitative data presented in chapter five depicts staffing levels which differ from this ideal. Both Taumaranui and Te Kuiti EDs had one RN allocated to ED for morning, afternoon and night shifts, while Tokoroa had two RNs allocated to morning and afternoon shifts, reducing to one RN on nights. Though RN-to-patient night shift ratios are collectively higher across all EDs, it was previously noted that rural EDs do not have designated HCA resource and furthermore, rural RNs substitute other roles after hours, further limiting their RN-to-patient time. CENNZ maintains that EDs "must have appropriate infrastructure and staffing requirements" (2006, p.1) for RNs to provide safe quality care to patients to achieve the best outcomes. Te Kuiti ED had the overall highest RN-to-patient ratios, with the least variation between morning, afternoon and night shifts. Tokoroa and Taumaranui had significantly lower RN-to-patient ratios than Waikato and Thames EDs, which, along with rural RNs' perceptions of spending more than half of their time on non-clinical duties, supports their rationale for implementation of the HCA role.

Waikato ED was the only service to allocate HCAs on all shifts and had the lowest HCA-to-RN and HCA-to-staff ratios. Waikato RNs explained how HCAs were allocated to 'areas' of the department as opposed to RNs being assigned to a specific group of patients. Due to the disproportionate number of RNs and patients versus HCAs and high patient turnover, RNs cannot expect to rely on HCAs in the way they described, including being able to notice changes in patient condition. This is not practicable if HCAs are not assigned patients and therefore, lack information about patient presentation or clinical history; nor are they trained in assessment of clinical signs and symptoms of patient deterioration. Therefore, maintaining safe staffing levels is paramount as literature cites RN-to-patient ratios are directly linked to patient length-of-stay and patient outcomes (Zimmerman, 2000; CENNZ, 2006) Triangulation of quantitative and qualitative data indicates the need to review HCA ratios, particularly in Waikato ED. In the acute care setting, high workloads and issues with collegial relationships has been linked to decreased job satisfaction for HCAs which is associated with decreased quality of patient care (Nwosu, 2006). This is important to consider as patient perception is recognised as a key indicator of quality of care (Nwosu, 2006)

Part 3: Limitations, conclusions and implications

6.9 Limitations of study

The subjective method of gaining a task inventory for Health Care Assistants by self-report during focus groups was a limitation to comprehensive data collection regarding the HCA task profile across the five Emergency Departments. It is likely that some tasks were not recounted and therefore the list of tasks presented within the study is not an accurate or exhaustive list. This is a limitation to the accurate representation of the reality of HCAs' work on the floor and therefore to the integrity and reliability of data. However, having a total of five focus groups conducted with the same questions may allow content validation. Recruitment of focus group participants was more difficult in rural EDs due to smaller numbers of staff, and the length of time required to participate in focus groups. Due to the small qualitative sample size, there is less scope for generalisation of findings across the total ED Registered Nurse and HCA population within Waikato EDs'.

The focus group method has known limitations; findings may be influenced by dominant members of the group, who may affect the opinions or participation of other members and discussion can deviate from the topic of focus, hence the need for skilled moderation (Bowling, 2014); the researcher's presence may have a biasing effect as participants may be inclined to give answers to satisfy the researcher (Walsh & Wigens, 2003).

The researcher is a Registered Nurse at Waikato ED which lends the study to researcher bias. Maintaining objectivity during focus group moderation and data analysis is a limitation due to the researcher having direct experience of the studied phenomenon, as the researcher carries their own views and understanding of topics discussed within focus groups. There is risk for the researcher to over-identify with findings which may affect objectivity with qualitative data analysis and discussion, thus affecting the validity of findings.

6.10 Conclusions

By undertaking triangulation of quantitative and qualitative study findings, several concepts were developed. Both RNs and HCAs perceived 'patient care' to be the primary focus of the HCA, as HCAs are seen to have more available time to spend at the patients' bedside providing for physical and psychological needs and 'caring'. Contradictory to this, considering quantitative data at face value suggests that HCAs would have less time for patient care as the mean HCA-to-RNs and HCA-to-patient are substantially less than RN-to-patient ratios. Accordingly, HCA perceived working under pressure for example Waikato HCAs reported times of being overloaded with jobs, causing difficulty with priority setting and trying to meet the various expectations of numerous colleagues.

Though Waikato and Thames RNs acknowledged HCAs' heavy workloads and low HCA-to-RN and HCA-to-patient ratios leading to 'tasking' and less involvement in individual patient care, they still held expectations for HCAs to use initiative and be proactive in assisting RNs with both patient care and non-clinical duties, be trusted to recognise clinical issues such as a change or deterioration in patient condition, and provide caring and psychological support. Assisting and supporting RNs was considered the main purpose of the HCA role, though despite all the duties this may entail, HCAs also carry responsibility in the up-keep of the clinical environment which includes cleaning/tidying, ordering and re-stocking equipment and supplies. In a large department such as Waikato ED these tasks can occupy a significant amount of HCAs' time, though was acknowledged by some HCAs as being 'unseen work'.

Though most HCAs had completed Level three NZQA training in 'Health, Disability & Aged support' and generally found it beneficial as a general foundation of knowledge and skill, multiple services noted that it was not specific to the ED setting. Waikato HCAs reported feeling under-prepared and lacking skills to deal with some situations they faced in the ED which points to the need for specific education for HCAs in the ED setting.

This research shows that the role of HCAs in ED is more complex and physically and emotionally demanding than generic role descriptions and practical task lists can account for. This warrants a need for recognition of the HCA role within the ED nursing team and re-evaluation of their role and task responsibilities for optimum utilisation of the HCA resource and recognition of their contribution to safe, quality care of patients in the ED.

Health service demands are increasing in volume and complexity due to aging population demographics, rising incidence of chronic conditions and technological and pharmacological advancements. Fiscal constraints will continue to challenge the efficiency and efficacy of care delivery models. Though there is a drive to direct more resource into primary care initiatives, presentations to the Emergency Department continue to increase by five percent per year within Waikato District Health Board. Within the current health climate HCAs are being increasingly involved in the care of acutely unwell patients within critical care and ED settings, though they remain unregistered and lack nationally standardised training. This study sought to explore the perception and experiences of ED HCAs with the purpose of highlighting the value of the HCA role within the ED nursing team.

6.11 Study implications

For health professionals including RNs their role places them in a social position which involves performing a certain range of tasks within a network of relationships and exhibiting an array of behavioural characteristics (Bosley & Dale, 2008). Firstly, what this research adds provides evidence that the HCA role is substantially more than being purely task related and appears more like the above description of a health professional. Throughout research literature, position statements and national policy documents defining the role of the HCA there is often a generalised, simplified description of their role and functions. Examining the views of HCAs themselves and their RN colleagues has shown the role requirements in practice include that of nurse assistant, support person, eyes and ears, counsellor, safety partner and linking person. The embodiment of these roles see them performing an extensive range of tasks from house-keeping duties to direct patient care and non-clinical duties, which are considered collectively to be the domain of 'HCA work'. Like other studies this

research highlights HCAs' significant contribution to patient care and unique place within nursing teams (Lancaster et al, 2015; Spilsbury & Meyer, 2005) and more specifically, within the Emergency Department.

Both the RN and HCA population in this study were in support of ED specific education and training for HCAs, a theme cited in earlier literature by Boyes (1995), who stressed that HCAs working with high acuity and unstable patients should receive emergency specific training.

6.12 Poilcy implications

New Zealand Nurses Organisation recognises the increasing utilisation of HCAs in efforts to contain costs and provide a more sustainable workforce heading into the future (2011), while nurse commentators argue that HCA work has rapidly expanded in New Zealand without adequate safety mechanisms due to lack of planning (Clendon, 2011; Meikle, 2002). There are several national policy documents outlining the role, position and utilisation of HCAs within the nursing skill mix (NZNO, 2011; NCNZ, 2011). These serve to guide DHBs in the formulation of generic and service specific guidelines which delineate and differentiate HCAs role and task responsibilities. However, HCA training and education requirements are inconsistent across practice settings and DHBs, hence there is an obvious need to nationally standardise training and education for HCAs. Furthermore, this study has highlighted the need for specific training relevant to the spectrum of care provided by HCAs in ED. HCAs have expressed a lack of preparedness for some of the expectations and situations they encounter, such as caring for patients presenting with mental health issues. Not only would ED specific education be in the best interest for patient safety, it would support HCAs by equipping them with the appropriate level of knowledge and skill to perform their unique role demands within the ED setting.

6.13 Future research

A more effective method of gaining an accurate profile of tasks undertaken by HCAs would be participant observation of HCAs work. This could provide objective data on the range and frequency of tasks performed, but also length of time spent on each task. This may prove interesting in terms of patient watches, which Waikato staff perceived as under-utilisation of the HCA resource. Obtaining such data could inform re-evaluation of the HCA role in determining how HCAs time on the floor can be best utilised in the interest of patient safety and quality of care, but also to ensure appropriate workloads and job satisfaction for HCAs. There is also potential for this study to be adapted to a national study, comparing the role of HCAs in EDs across New Zealand, as a foundation towards standardisation of training and education. If Waikato DHB were to consider expanding the task profile of the HCA role in Waikato EDs there is potential for the initiative to be trialled in rural EDs where RN and HCAs of the current study perceived high levels of team trust and role clarity and lower staff turnover numbers. This environment could potentially provide a higher level of support and supervision for such a change in practice to occur.

As previously noted, a key marker of quality of care is patients' perception of care. There is potential for a study obtaining the ED patient's understanding of the HCA role and their experience of being cared for by HCAs. This could highlight positive aspects of the HCA role which are yet to be acknowledged as well as possible issues to be addressed.

Lastly, it has been highlighted that ENs are registered and trained in skills which participants in this study have considered as being expanded tasks for HCAs. In the interest of patient safety and aligning the right skills to the right job, it makes sense to utilise the EN within nursing teams, alongside RNs and HCAs. This would provide a comprehensive three-tiered approach, to meet current and increasing demands of providing timely, safe, quality care to patients presenting to ED. There is potential to assess RN and HCA staff perceptions prior to and after introduction of the EN into the nursing care team.

Appendices

Appendix 1 University of Auckland Ethics approval

Appendix 2 Waikato DHB Ethics support

Appendix 3 Waikato DHB HCA task list

Appendix 1: University of Auckland Ethics Approval

Office of the Vice-Chancellor
Finance, Ethics and Compliance

The University of Auckland
Private Bag 92019
Auckland, New Zealand

Level 10, 49 Symonds Street
Telephone: 64 9 373 7599
Extension: 87830 / 83761
Facsimile: 64 9 373 7432

UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE (UAHPEC)

12-Jul-2016

MEMORANDUM TO:

Prof Matthew Parsons
Nursing

Re: Application for Ethics Approval (Our Ref. 017327): Approved

The Committee considered your application for ethics approval for your project entitled **The role of the health care assistant in the emergency department**.

We are pleased to inform you that ethics approval is granted for a period of three years.

The expiry date for this approval is 12-Jul-2019.

If the project changes significantly, you are required to submit a new application to UAHPEC for further consideration.

If you have obtained funding other than from UniServices, send a copy of this approval letter to the Research Office, at ro-awards@auckland.ac.nz. For UniServices contracts, send a copy of the approval letter to the Contract Manager, UniServices.

In order that an up-to-date record can be maintained, you are requested to notify UAHPEC once your project is completed.

The Chair and the members of UAHPEC would be happy to discuss general matters relating to ethics approvals. If you wish to do so, please contact the UAHPEC Ethics Administrators at ro-ethics@auckland.ac.nz in the first instance.

Please quote reference number: **017327** on all communication with the UAHPEC regarding this application.

(This is a computer generated letter. No signature required.)

UAHPEC Administrators

Appendix 2: Waikato DHB Ethics support

Quality and Patient Safety
Waiora Waikato Hospital Campus
Private Bag 3200
Hamilton 3240, New Zealand
www.waikatodhb.health.nz

4 July 2016

Rikki Lee Reynolds
Registered Nurse
Waikato Hospital

Dear Rikki-Lee,

Research Project

Thank you for providing information on your proposed research project "The role of the Health Care Assistant in the emergency department". I understand you have received support from the relevant people at Waikato District Health Board.

Waikato District Health Board supports your study, contingent upon you gaining Ethics Approval for the research. Once you have received ethics approval, we request that you forward that to our Research office, and we will complete our internal sign-off process.

I look forward to seeing the outcomes of your research.

Yours sincerely,

Mo Neville
Director, Quality & Patient Safety

Appendix 3 Waikato DHB HCA task list

Health Care Assistant (HCA) tasks and activities that may be performed across Waikato DHB facilities

Activities that a HCA can perform with indirect supervision

- Make and wash down beds – this may also be done by non-clinical support (cleaners) or other non-HCA roles
- Keep cubicle / bed space tidy
- Restocking and tidying in ward areas
- Check suction and oxygen equipment
- Paging personnel
- Answering the phone and taking messages from staff
- Help pack / unpack a patient's belongings on discharge / admission.
- Locating, moving and cleaning equipment
- Administrative tasks:
  - maintenance requests
  - photocopying, filing
  - stock ordering – Oracle
  - CSU ordering
  - IPM entries
  - Update patient boards

HCA activities when either working with a registered nurse or delegated by a registered nurse *once the patient has been assessed by the registered nurse*

- Shower / bed bath a stable patient who requires minimal assistance. Wash hair
- Personal care such as hair grooming, teeth cleaning (permanent & dentures) and facial shaves
- Apply anti DVT stockings (TEDs) after having procedure demonstrated to them by the registered nurse
- Mobilise a patient who can get out of bed with minimal assistance and needs guidance only e.g. walking frame, stick
- Take a patient to the toilet who requires minimal assistance to mobilise
- Bed-pan a patient who requires minimal assistance to move in bed
- Accompany stable patients who do not require a clinical handover e.g. to transit lounge
- Washing a patient who requires two people due to high acuity or decreased mobility
- Transferring, lifting or mobilising a patient using sliding sheets, hoist and other moving equipment using LITEN UP techniques
- Basic life support and emergency management
- Document in a patient's notes. Registered nurse to countersign any documentation in the clinical notes
- Assist a patient without compromised swallow to eat and drink
- Apply a pressure-relieving mattress to the bed
- Measure and record adult and paediatric height
- Adult and paediatric weighs
- Assist with baby bath
- Accompany a low-acuity stable patient to x-ray
- Patient watches
- Valuables checking with a registered nurse

Specific HCA activities delegated by a R/N - after area specific training has been completed

- Empty an indwelling catheter bag / colostomy bag measure, record and dispose of urine in a safe manner
- 12 lead ECG taking
- Using the Lamson tube
- Patient urinalysis testing
- Obtain an MSU specimen
- Urine HCGs
- Make up packs such as catheter packs
- **Emergency Department and CCTV HCAs only**: Glucose and urine meter quality control after competency documents signed off by the Key Operator in the clinical area as per the Point of Care Testing procedure. This does not include calibration.

Community HCA tasks delegated by the registered health professional – after area specific training has been completed

- Correct use of continence products which includes emptying an indwelling catheter bag / colostomy bag, measuring recording and disposing of urine and faeces in safe manner
- Demonstrates working knowledge of common physiotherapy equipment used with patients
- Demonstrates prescribed functional exercises
- Assists with education programmes
- FIM language training

HCA activities not to be performed across the DHB or delegated to the HCA

- Taking patient observations, eg blood pressure, pulse, respirations and temperature.
- Administer medications in any form, tablet or liquid. This includes eye drops, ear drops, nebulisers and oxygen (these are prescribed drugs)
- Point of Care Testing – this includes blood glucose monitoring
- Touch or manage a pump used to administer fluid, medication or feeds. This includes silencing alarms or disconnecting them from a patient
- Have patients allocated to them
- Assess, plan or evaluate care
- Wound or pressure area dressing
- Discuss patient's condition with visitors and medical staff
- A HCA may not delegate a patient related task to another HCA or any other employee

Sue Hayward
Director of Nursing and Midwifery
Waikato District Health Board

Last updated on 22/4/15

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