British Association of Critical Care Nurses

Position statement on the role of health care assistants who are involved in direct patient care activities within critical care areas

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The British Association of Critical Care Nurses aims to promote the art and science of critical care nursing by providing representation for its members, by responding to political and professional change; and by producing and publishing position statements. The position statement that follows this article is intended to demonstrate the organisations commitment to contribute to policy debates and to inform and influence the national agenda on issues that are important to the critical care nursing community.

Summary

Intensive care has developed as a speciality since the 1950's, during this time there have been major technological advances in health care provision leading to a rapid expansion of all areas of critical care

The on going problem in recruiting qualified nurses in general has affected and continues to be a problem for all aspects of critical care areas

During the last decade nursing practice has evolved as qualified nurses have expanded their own scope of practice to develop a more responsive approach to the complex care needs of the critically ill patient

The aim of this paper is to present the BACCN position statement on the role of health care assistants involved in direct patient care activities, and addresses some of the key work used to inform the development of the position statement

Key words: critical care, health care assistants, research, evidence

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Position Statement on the role of health care assistants who are involved in direct patient care activities within critical care areas

BACCN Position:

- Health care assistant roles within critical care settings must only be introduced for the benefit of patient care
- To ensure a systematic approach to the development of the health care assistant roles units should ensure there is a designated co-ordinator who is responsible for their overall role development and training
- It must remain the responsibility of the registered nurse to assess, plan, and evaluate direct patient care activities
- Health care assistants must only undertake direct patient care activities for which they have received training and have been assessed as competent by an appropriately qualified practitioner.
- Health care assistants must only take on direct patient care activities under the supervision of a registered practitioner.
- All critical care units where health care assistants are employed to undertake direct patient care activities must ensure that these activities are linked explicitly to a competency framework. With this competency framework being linked to an identified educational programme, such as a National Vocational Qualification level 3 or equivalent, appropriate to their area of practice.
- Work should be undertaken to develop national core competencies for health care assistants involved in direct patient care activities in critical care areas
- A national database of education and training should be developed in order to provide a basis for regulation of health care assistants

Background and Introduction

Intensive care has developed as a speciality since the 1950's, during this time there have been major technological advances in health care provision, leading to rapid expansion of all areas of critical care (Audit Commission 1999, Hind et al 1999). The ongoing problem in recruiting qualified nurses in general, has affected, and continues to be a problem for all

aspects of critical care areas. In reviewing guidelines on qualified staffing for critical care it is suggested that there must be a 1:1 nurse-patient ratio to provide safe, research based and individualised patient care when nursing those who are unconscious, critically ill and requiring mechanical ventilation. (Department of Health 1996, ICS 1997, BACCN 2001) However, the continued problems affecting most parts of the United Kingdom in recruiting and retaining qualified and experienced critical care nurses, (Naish 1995, Scott 1998) has led to an increased use of non-registered staff, working in these areas (Hind et al 2000, Thornley 2000, Mcleod 2001, Roberts and Cleary 2000). It has been suggested in recent reports and policy documents that critical care needs to question it's strict adherence to the 1:1 nurse patient ratio, adopt a more flexible approach to staffing units, including the delegation of some skilled and non-clinical tasks to support staff. (Audit Commission 1999, Department of Health 2000, Ball 2001)

During the last decade nursing practice has evolved as qualified nurses have expanded their own scope of practice, undertaking roles and tasks once performed by medical staff. This blurring of professional boundaries continues to be endorsed and encouraged through subsequent policy documentation. (Department of Health 2000, 2001). Therefore the workload of qualified nurses has increased, with little expansion in the workforce, consequently qualified nurses have found that they have had to delegate to others, care they traditionally provided. The increasing use of such support staff has led some qualified nurses to believe that the dilution of skill mix, could threaten the quality of care delivered to the critically ill patient. This perspective is supported with the notion that the increased use of unqualified nursing staff is a cost cutting exercise by health service managers, (Thornley 2000), as the high nurse patient ratios in critical care areas is the most costly resource in these specialist areas (Audit Commission 1999, Metcalfe and McPherson 1994, Beattie and Calpin-Davies 1999)

Increasingly, BACCN members have been voicing their concern over the use of non-registered staff in critical care areas, and the subsequent roles and tasks they may be undertaking. This was evident by the number of individuals contacting the BACCN through the website, and subsequently identifying this area as one of the biggest challenges currently effecting critical care nurses. The BACCN as one of the main national organisations for critical care nurses in the United Kingdom, with over 3,700 members, perceive that it is their responsibility to provide support to the membership through the formulation of position statements. A group of critical care nurses were brought together to form the working party. This group was formed by nominations from regional BACCN groups, through representation from the National Board of the BACCN, and by seeking expert opinion from individuals who had been identified as being particularly interested in this subject area.

Methodology

To gather the relevant evidence and develop this position statement a number of databases were searched these included:

- Medline
- CINAHL
- The Cochrane database
- The Department of Health database
- The ENB database
- The Natioanl Research Register

The literature was then reviewed through the following categories:

- Roles, tasks, identity and supervision and responsibilities
- Accountability, definition, registration

- Competence/competencies
- DOH. Policy and other professional documents
- Legal aspects
- Ethical aspects

To provide a contemporary account of the use of health care assistants and the role and tasks they undertake within critical care areas, a questionnaire was constructed and sent to all senior nurses of critical care units in the UK. In total 670 questionnaires were sent out, and 376 were returned (a 58% response rate). Respondents were asked about the number of unqualified staff they employed, their titles, training and if this training was co-ordinated in any way. They were also asked to rate the importance of direct and indirect tasks related to patient care, in relation to whether non-registered staff currently undertook certain tasks, and if these tasks should be considered for unqualified staff given appropriate training, or if they would not be considered at all. The number of questionnaires returned and the complexity of the data collected meant that the investigators decided that the full results of this questionnaire should be detailed through a separate paper, and therefore just the demographic distribution of returned questionnaires, as well as the units sampled is utilised within this paper, (please see appendix A).

The Modernisation Agenda

The need to modernise and reconstruct fundamental issues in relation to the planning, management and delivery of health care services is a recurrent theme in many policy documents (Audit Commission 1999, Department of Health 1998, 1999, 2000, 2001). A fundamental concept central to this process is the need to develop a more flexible and strategic approach to workforce planning. This requirement has been made explicit within a number of documents, which have been published by the Department of Health

(Department of Health 1998, 1999a. 1999b, 2000, 2001). These documents have consistently supported the notion of the creation of support workers, which could function across traditional boundaries to support the work of health care professionals.

Specifically, in relation to critical care service management and delivery, Comprehensive Critical Care (2000) continued the theme of supporting the need for developing new ways of working. This document also recommended that there should be an appropriately balanced team of staff, including support workers to ensure the effective delivery of critical care services, and these support workers should be available on a similar basis to professional staff according to workload and patient need.

In 2001 the Department of Health published further recommendations concerning the role and development of critical care services (Department of Health 2001). This document was specifically designed to explore the nursing contribution to the effective delivery of critical care services. A recurrent theme within this document was the need to explore creative approaches to workforce planning, which included the development of health care assistant roles educated to NVQ level 3, to support the critical care team. They also recommended that a central component of this process was the development of specific competencies to ensure effective care delivery under the supervision of registered practitioners.

The Professional Agenda

There is a perception by some registered nurses within critical care, that health care assistants are being introduced as a method of overcoming the nursing shortages (Chang 1995, Roberts and Cleary 2000), rather than addressing the fundamental issue of needing to increase the overall numbers of registered nurses practising in this country, and the numbers of students into nurse training. McKenna (1995) acknowledges that a high skill

mix of registered nursing staff is costly to the NHS, but argues that it is highly probable that substitution of registered nurse posts with health care assistants, could lead to low moral amongst registered nurses, which in turn could result in higher costs and lower quality of care. As it is perceived that a vicious cycle could develop where staff cuts and substitution could result in more work for the remaining staff which would cause them to feel dissatisfied. This would in turn lead to more absenteeism, and would cause an increase in cost to replace them, as well as a reduction quality of care (McKenna 1995). Savage (1997) argues that core nursing activities should not be allocated to health care assistants, as these require high levels of clinical knowledge and expertise. Neenan (1997) expressed concerns about nurses concentration on medico - technical skills within critical care and that delegation of core nursing care to health care assistants may result in them becoming distanced from this care and losing their essential nursing skills.

The reluctance of nursing staff to delegate core nursing care tasks to health care assistants, is evident through a number of research studies that have addressed this area (Hurst and Ball 1990, Ormandy et al 2001). Goldman (1999) identified that although registered nurses supported the use of health care assistants to undertake tasks such as cleaning and preparing bed areas, lifting turning and mobilising patients, and assisting in basic nursing care. This study identified that registered nurses perceived that activities conducted by health care assistants should only be done under the direct supervision of a registered nurse. Chang et al (1998) found that although health care assistants did contribute to the work of the registered nurse, that the benefits had to be weighed against the potential for increasing the work of the registered nurse in delegation and supervision of these staff. This perspective is supported by the work of MacKinnon et al (1998), this wide-scale Australian review of critical care nursing practice revealed that the use of health care

assistants could actually increase the work of the registered nurse due to the increased need to provide supervision.

As identified there are a number of debates within the literature about the exact nature and boundaries of the role of the health care assistant. However, the literature review also revealed a number of studies, which supported the integration of health care assistants into the critical care workforce (Powers et al 1990, Elliot 1995, Hind et al 2000). In an American study undertaken by Powers et al (1990), they reported that registered nurses were actually able to spend more time with their critically ill patients when there were health care assistants present. McKenna (1995) reports on numerous studies from across the world where it has been demonstrated that non - nursing duties take up a significant amount of time for the registered nurse in any working day. Elliot (1995) reports that nurses freely allocate basic nursing care to health care assistants once they are in post, despite having previous concerns about the role being introduced. Both Hind et al (2000) and Wainwright (2002) found that the majority of respondents in their study agreed with the introduction of health care assistants. Hind et al (2000) did note however that before any such introduction could take place, staff needed to be educated about the exact nature and boundaries of each others roles. Also evident in Hind et al's (2000) study was the expressed concerns by some respondents that the introduction of health care assistant roles may lead to registered nurses losing too much of their skills and competence with specific nursing tasks (Hind et al 2000).

Roles and Supervision

Recognition of the developing roles of nurses in critical care (Audit Commission 1999) has meant reorganisation of roles and a more innovative approach to workforce planning (Hind et al 2000). In the past health care support workers have taken on housekeeping roles

(unpacking stores, cleaning bed areas), however more recently they have taken on more direct patient care activities. Training for these new roles is offered at NVQ level 2 and 3. Hogan et al (2000) argues that appropriate delegation of patient care not considered essential for qualified nurses to undertake, is more cost effective.

The role of the support worker in critical care is not clearly defined, all hospitals have their own definition of what duties these group of staff can undertake, and what level of training they provide for them to be able to undertake these duties. However the literature surrounding the use of health care workers in critical care is growing with some units developing the NVQ level 3 training to allow a greater input to patient care delivery (Pratt 1999). The NHS plan (Department of Health 2000) identifies the potential for expanding the role of the health care assistant, with investment into training using individual learning accounts and NVQ training. Whilst such training schemes allow for more flexibility in the use of support workers, who can now work alongside qualified nurses to provide quality nursing care, other hospitals are still using these staff to maintain the housekeeping roles. The expanding role of these unregulated group of staff is widely debated, and often controversial, with a reluctance by qualified nurses to accept their part in the delivery of health care (Murray 2001).

The identity of the health care support worker is also not clearly defined with different titles and pay structures throughout the country. None of the literature reviewed provided explanations for different titles or the salary scales involved, especially following extensive training. Most specified that health care assistants taking on extra training and responsibility may be able to enter nurse training, however it would appear that this was not a cost effective exercise as training incurred some expense, then staff left. It would be

beneficial to provide a generic title for this group of individuals so that they are universally identifiable.

With regards to supervision of these staff, there was a strong collective view that any roles taken on by support workers should be under the direct supervision of qualified nurses.(Mcload 2001, Hind et al 2000). With Mcload (2001) identifying that supervision should only be provided by experienced critical care nurses.

The Notion of Competence

In relation to the developing role of health care assistants, the notion of competence is central to this process. Competence and competency are often used interchangeably, however competency is defined as ' the quality of being competent' ' whilst competence is defined 'having the necessary skills and knowledge to do something successfully' (Soars 2002).

Critical care is a dynamic environment and levels of competency both within and across the grades of all clinical staff can vary greatly. The assessment of competence is open to much criticism and when exploring the current literature it is evident that most models and tools designed to assess competence have proved difficult to validate (Cutler, 2000). Much of the work undertaken to address this issue in relation to competence, pertains to assessment of nurses' registering with the UKCC, yet it is argued that fundamental principles in relation to this process are transferable to the non-registered health care practitioner (Queensland Nursing Council 2001, Pratt 1999)

Although the issues of assessing competence is a contentious issue, there are also complex issues in relation to maintaining competence, which also need to be navigated when

analysing this area in relation to the non registered health care practitioner. For example, Jeffrey (2000) identifies that competencies necessitate regular review and should be regarded as a framework that is receptive to innovation and change. Black and Wolf (1990) emphasise the need for competence to include the ability to perform effectively in different circumstances and subsequently assessment must include the ability to identify potential risk to the patient and acknowledgement of the practitioners' limitations, ultimately ensuring continued patient safety.

The unique individuality of practitioners will also contribute to the level of competence attained and in some instances may cause failure of a practitioner to reach a satisfactory level. Dimond (1992) suggests that registered nurses who are assessing practitioners must not be afraid to deem someone not competent, and should also be aware of their own duty of care. In light of the above, assessors must themselves be competent practitioners and fully aware of their accountability and responsibility in assessment. Moreover, assessment of competence is seen as subjective, hence documentation used in the assessment needs to be explicit.

Based upon the notion that competence is assumed as an adequate criteria of proficiency to register as a qualified nurse (NMC 2002), the working group makes recommendation that the attainment of competence in the non-registered practitioner will ensure the delivery of the prescribed standard of care to the critically ill adult. Of equal importance in this process, is the need for organisations, and individuals to ensure that the employee's organisation must also accept vicarious liability, providing health care assistants work within the predetermined boundaries and has the ability to acknowledge their own limitations.

Accountability and Registration

Integral to the introduction of any new or enhanced role within a workforce is to ensure that the definition of that workforce, their accountability, and the lines of responsibility are clearly defined within their role. Within the United Kingdom (UK) currently, there is varying terminology utilised to describe these roles, which adds to the confusion. (support workers, health care assistants, senior health care support workers.) Therefore, a clear structured approach to titles, posts, and career progression supported by a defined training and development pathway would add clarity to titles and enable an understanding of roles to be defined at both a national and local level.

When addressing the issues of accountability there are two clear components that need defining in relation to this concept, what does accountability mean for the professional i.e. the registered nurse, and the workforce for whom they are accountable and what part does the delegation aspect of the roles contribute towards this. If the identified "nursing activity" is to be appropriately delegated then the practitioner needs to understand what being accountable actually means, and what the difference is between being accountable and being responsible in relation to patient care and management. Dimond (1995) identifies that responsibility relates to being liable to be called for account, and answerable, whereas Batey et al (1982), defines accountability in relation to the fulfilment of a formal obligation to disclose to others the purpose, principles, procedures, relationships, results, income and expenditure for which one has authority.

The lines of responsibility is usually identified clearly within any job description, in relation to who or what the health care worker is responsible for and to whom. It is this identification of responsibility and the definition and application of accountability that becomes difficult when registered practitioners undertake the process of delegation of roles

and tasks. (Ormandy et al 2001). To navigate through these complex issues it is therefore necessary to define the distinction between legal and professional accountability. Clarke (2000) suggests that legal accountability relates to the obligation of every citizen, including nurses to obey the laws of the country, and to be able to defend his or her actions through the court. Whereas, professional accountability relates to the additional obligation of the professions, not to abuse the trust, and to be able to justify their professional actions even when it is not against the law. (Clark 2000)

In relation to accountability there are a number of pre-conditions which are perceived to be essential to this process. To be able to justify your actions, this can only be achieved if the alternatives, the reasons and the consequences for taking that action are understood. Therefore to understand why you are accountable and to achieve accountability it is important that the three elements of knowledge, ability and authority are identified. An example of these concepts and how they may relate to the work of the health care assistant is identified in appendix B

If all these three components are present, then the health care assistant is accountable for the task that they undertake, the registered nurse accountability rests upon the notion that that task has been appropriately delegated. The health care assistant is also responsible for that task, because they are adequately prepared and are working within Trust guidelines and protocols, and have the authority delegated by the registered nurse. (Storey 2002)

When delegating any role it is important that the reason for delegation serves the interest of the patient. This can be achieved by:

- Delegation is appropriate

- The level of experience, competence, role of the person to whom the task is delegated is appropriate.
- Delegation to junior colleagues of tasks and responsibilities is not beyond their level of skill and experience.
- There is appropriate assessment, planning and implementation and evaluation of the delegated role.
- Communication related to the delegated role is in a manner understandable to the person to whom the role is being delegated.
- The level of supervision and feedback is appropriate to the task being delegated.

Therefore the person who delegates is accountable for the decision to delegate and must ensure that the person is competent in relation to the task to be undertaken. National Vocational Qualification (NVQ) training is utilised as a competency framework. The introduction of NVQ's is seen to provide professionals with a framework, which facilitates an assessment of competence of staff, and then to use our judgment to determine the most appropriate person to deliver care. (Dimond 1995) The acquisition of an NVQ is not a permit to practice, but merely identifies the holder as competent to undertake a range of duties in a care environment. Decisions as to who should do what remain with the manager (nurse). It is therefore essential that the professional is involved in monitoring and evaluating the quality of care, and that the assessment and training of the care team is an integral component the professional role. (Storey 1991)

The Nursing and Midwifery Council (NMC) Code of Professional Conduct (2002) is explicit on the issue of delegation and accountability;

> 4.6 "*You may be expected to delegate care delivery to others who are not registered nurses or midwives. Such delegation must not compromise existing care but must be directed to meeting the needs and serving the interests of patients and clients. You remain accountable for the appropriateness of the delegation, for ensuring that the person who does the work is able to do it and that adequate supervision or support is provided*."

Therefore, it is important that professionals understand the issues of accountability, and delegation and where the responsibility for undertaking a role commences and where it ends. The development of support roles across all professional groupings is increasing, and nurses should be involved in these developments so that the support role can be designed to ensure that professional skills are used appropriately for the benefit of the patient. The NMC code of professional conduct (NMC 2002) also recognises that registered nurses are not alone in delivering "nursing" care, they state that as a registered nurse;

- You are expected to work cooperatively within teams and to respect the skills, expertise and contribution of your colleagues. (4.2)
- You must communicate effectively and share your knowledge, skill and expertise with other members of the team as required for the benefit of patients and clients. (4.3)

At present health care assistants are not subject to professional registration and are therefore not professionally accountable. Although carers in nursing homes and registered care homes are being regulated under the Care and Standards Act (Department of Health 2001). This does not apply to those working within the acute sector, and as such this is an area that both the Department of Health and the profession needs to address. Therefore, as nurses it is important that a clear understanding exists surrounding the complex issues of accountability and the accountability of other disciplines. Central to this process is the role that nursing as a profession plays in the preparation, supervision and performance of health care assistants.

Ethical and Legal Considerations

To ensure a robust framework for the development of health care assistant roles within critical care areas, it is important that this is underpinned by explicit integration with ethical and legal principles. The ethical principles which have been utilised to develop this framework, are those of respect and trust, beneficence and utilitarianism. The current confusion surrounding the roles, tasks and titles used to describe health care assistants provides unique challenges in itself, as without coherence within these processes, it is difficult to define the exact nature and boundaries of these roles, which can lead to confusion surrounding appropriate delegation. According to Blegen et al (1992), health care assistants need to be adequately trained for the roles they undertake and nurses need the appropriate knowledge and skills to delegate effectively. Without these skills, Erlen et al (1996) suggest that there will be role confusion, which in turn will lead to mistrust, and a lack of respect within the team. Respect means having regard for another and seeing them as unique with the ability to make a contribution, which is valued (Davis and Aroskar, 1983). The code of professional conduct (NMC 2002), clearly identifies the professional responsibility of the nurse is to work co-operatively within teams, and a key component of this work is respecting the skills, expertise and contribution of colleagues.

Trust and respect go hand in hand with creating a good working relationship and promoting quality patient care. Beauchamp and Childress (1994) suggest that concepts of trust crystallises around having confidence in one another, and an individuals ability to perform in a particular manner. Individuals being able to demonstrate their capabilities and others being aware of those capabilities is seen to earn trust and respect. The onus then is on both qualified and unqualified staff to get to know each other's abilities and work collaboratively to maintain the quality of patient care.

From the patients' point of view, trust relates to the particular knowledge a professional has. The patient depends on the "professional" and "trusts" them to carry out the functions of that profession. Staff need to be open with patients and clearly identify their status so that patients autonomy, freedom and privacy are not compromised through unwitting deception. Promoting the welfare of patients is a central goal of health care and is intrinsically linked with the ethical principle of beneficence, or any form of action to benefit others (Beauchamp & Childress, 1994). Nurses must carefully examine the benefits and potential harm when allocating patient care to other health care workers. The NMC (2002) are explicit in relation to this aspect of the nurses' role, when they identify that they are 'personally accountable for ensuring that they promote and protect the interests and dignity of patients' (NMC 2002).

The principle of utility, asserts that nurses ought always to produce the greatest possible balance of value over disvalue (Beauchamp and Childress 1994). Nurses have a responsibility to utilise scarce resources, in today's health care system, "nurses" are that scarce resource. It is the nurse's responsibility to attempt to distribute the best available resources to the people with the most need, by knowing the ability of the staff; health care assistants and qualified nurses can be allocated to care for patients in a safe and appropriate manner.

In the analysis of the literature surrounding the legal ramifications of developing the role of the health care assistant, there were no reported incidents pertaining to role of health care assistants within the United Kingdom (UK) critical care environment. However, there were several articles from the United States and Australia. Although, it is difficult to identify the significance of these articles in view of the different social, health and legal systems

operating in these countries. There are key principles and themes which arise from this literature, which can be translated to the UK health care system.

Currently health care assistants are currently unregulated and therefore when undertaking nursing tasks, they should be supervised by an appropriately qualified practitioner. Within this process the delegation of tasks to the health care assistant needs to be made explicit through an appropriate education and competency based training programme. This is perceived to be pivotal to the protection of the general public, so that if an untoward incident did occur, both the registered nurse and the employing health care institution can clearly demonstrate that a rigorous system was in place to support the health care assistants delivery of care. Nazarko (1999) suggests that if registered practitioners fail to delegate care appropriately this would result in the registered practitioner jeopardising their registration status. In reviewing the uniformity of training hours, federal and community standards in relation to unliscensed assistant personnel Zimmerman (2000) discovered that there were no standards for training, and 55% of respondents indicated that their employing institutions provided three weeks or less of job training. With half of the registered practitioners who responded stated that they believed that there was inadequate training and preparation for these roles. Without nationally agreed standards for training this can place both registered practitioners and health care institutions at risk if care delivery is suboptimal

Conclusion

The aim of this paper has been to explore the complex issues surrounding the development of the role health care assistant within critical care areas. It is clear from a policy perspective that there is support for these developments, as a central concept in the creation of a more flexible and responsive approach to workforce planning and development

(Department of Health 2000a, 2000b, 2001). However, the professional perspective appears to be more sceptical in relation to the potential for this role and its development within critical care areas (Savage 1997, Neenan 1997, McKenna 1995, Chang 1995). Although many of these authors identify that health care assistants could offer a valuable contribution to the health care team. There are very real concerns about the creation of these roles to undertake direct patient care activities.

Nevertheless, in undertaking a critical analysis of the literature which surrounds this important aspect of patient care and management, what emerges is the perspective that these role developments should only be innovated when appropriate education and training is provided, with the developments of core competencies to ensure the continued delivery of high quality patient centred care (McLoad 2001, Hind et al 2000, Pratt 1999). In undertaking this work the BACCN aims to provide a robust framework which can be translated into different critical care environments in order to provide practitioners, educators and managers with key infrastructural requirements if these roles are to be developed. The main recommendations developed by the working party are imbedded within the position statement, further issues which require clarification in order to support these role developments include:

- Further work needs to be undertaking to clarify the professional and legal responsibility and accountability for care delivery, when health care assistant roles are developed to undertake direct patient care activities

- There should be nationally agreed titles to describe the role of the health care assistant in order for meaningful comparisons of roles to be undertaken

- Each employing institution should accept vicarious liability for the health care assistant, provided they are working within defined boundaries and has the ability to acknowledge their own limitations

- Further research is required to fully understand the complexities of these role developments, and the potential impact they may have on patient care and management

- The general public should be fully informed about the level of care that they should expect to receive within critical care environments, and the different roles and responsibilities of personnel in delivering that care.

- Health care assistants themselves should be involved in these systems to ensure that are developed in such a way that will support their overall career and work role satisfaction

Glossary of Terms

Accountability: Taking responsibility for an action whilst ensuring you have the authority, knowledge, skills and understanding to inform and act upon that action

Authority: Having the delegated power/permission to act or enforce, based upon the recognised knowledge or level of expertise

Critical Care Environment: An environment specifically staffed and equipped for the continuous monitoring, observation and care of individuals with a critical illness

Direct Care: Direct care relates to care which directly involves the patient

Indirect Care: Indirect care relates to care which may be related to the care and management of the patient, but does not involve directly touching the patient.

Competence: Competence is defined as an individual is deemed competent when they demonstrate that they possess the knowledge and skill to carry out a given task

Competent: Being competent is identified as having the requisite ability to carry out a given task

Competency: Competency is the quality of being competent

Responsibility: Refers to the state of having control or authority over an area or task

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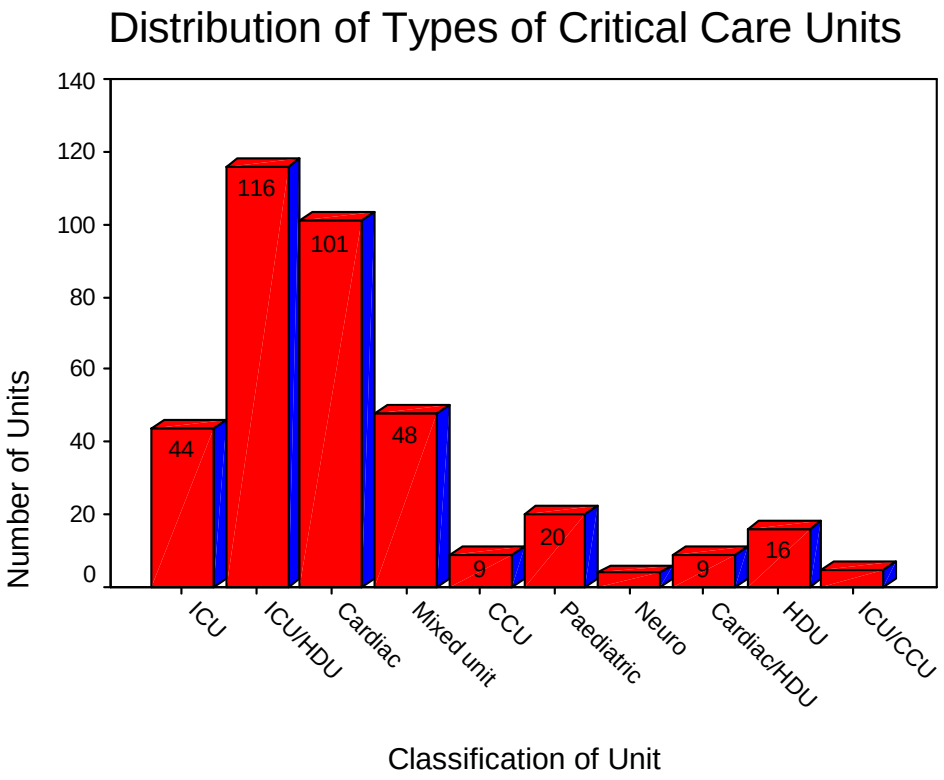

645 Questionnaires were sent out to units as follows:

Cardiothoracic Units	62
Coronary Care/cardiology	234
Intensive Care Units	237
Neurological Units	30
Paediatric Units	39
Mixed CC/ITU/HDU	43

Response rate therefore of 58%

Appendix B

Pre-conditions for Accountability

Ability	Having the knowledge, skills and values to decide when to act on the issues in question
Responsibility	Having achieved the ability, you can now carry out the action
Authority	Having the responsibility to carry out the action

Example

For a health care assistant to be accountability for the hygiene of a patient they would have to demonstrate the following:

Ability	Knowledge of the patients hygiene needs, skills to carry it out, the values associated with the ability such as comfort, dignity nd the feelings of the patient
Responsibility	Identified in relation to delivering the hygiene needs of the patient through the job description of the health care assistant
Authority	To undertake this role through the delegation from the registered nurse