The Care Certificate and its impact on health care assistants identifying and managing the deteriorating patient - A service evaluation

Abstract

Aim: To understand the impact that the Care Certificate training programme has on the HCAs in assisting them to identify and manage the acutely ill patient.

Method: A mixed methods Service evaluation.

Findings: The study has shown that the Care Certificate is beneficial to all HCAs however, to assist with increasing confidence levels as well as further improving their knowledge and skills further studies are required.

Discussion: This is a small-scale study therefore our recommendations are for further study to understand the issues identified and understand the impact the Care certificate has on improving patient care in acute hospital settings.

Keywords: Care Certificate, Healthcare assistant education, Patient care, Patient safety, Deteriorating patients.

Introduction

In 2015, the Care Certificate (CC) was introduced. This included a structured educational programme for all new healthcare assistants (HCAs) to undertake (Cavendish, 2013, CQC, 2017). The CC was designed to safeguard patients by ensuring that HCAs provide appropriate, safe and high standards of care in all clinical settings. In turn, it also safeguards the HCAs by providing a clear set of standards which they are required to meet to assist in gaining the knowledge and skills to effectively undertake the HCA role (Skills for care, 2016).

Spilsbury and Meyer, (2005) suggested that HCAs are the eyes and ears of the wards, working alongside the registered nurse (RN) to deliver essential nursing cares (Gov.uk, 2017). The role of the HCA has changed significantly over recent years, incorporating tasks which historically would have been that of the RN, such as taking observations and documenting patient cares (Pearcy, 2000, Thornley, 2000, Hogen 2006, Skills for care, 2016). Contemporary healthcare requires the HCAs to play a vital role in the recognition and management of a deteriorating patient (James et al, 2010).

In 2013, Robert Francis QC, conducted a public inquiry into the care of patients in Mid Staffordshire and highlighted that the HCAs spend more time with the patients than that of their qualified colleagues (Cavendish, 2013) performing intimate and vital cares to patients when they are at their most vulnerable. Following this, an independent review was launched to identify what could be

done to ensure patients cared for by non-registered staff received the care and compassion they required (Cavendish, 2013).

There are approximately 1.1 million non-registered staff who deliver hands-on care to patients in hospitals, care homes and independent houses in England (NHS Digital, 2016). Around 1/3 of these are HCAs within a hospital setting. It was identified that this group of staff had no formal education or training prior to undertaking their role (Care Quality Commission (CQC), 2015) and recommendations were made that all HCAs should complete a certificate in fundamental care prior to working independently (Cavendish, 2013). The CC was developed, comprising of 15 standards (Table 1). This study would like to identify the impact the CC has had on the HCAs who have completed it, by focusing in the confidence, skills and knowledge gained and attitude following its completion.

Understanding your role	Communication	Safeguarding Children
Personal development	Privacy and Dignity	Basic Life Support
Duty of Care	Fluid and Nutrition	Health and Safety
Equality and Diversity	Learning disabilities, Mental health and Dementia	Handling Information
Working in a person-centred way	Safeguarding Adults	Infection prevention and control

Table 1 The Care Certificate Standards

The Certificate is delivered in two parts, firstly the HCA is given a work book to complete which contains some of the theory and has sections for the HCA to complete independently with supervision and support, secondly the HCA must gain knowledge and show competency by either attending taught sessions or supervised practices.

Background

HCAs have been part of the nursing team since the 1850's (Stokes, 2004) known as 'nursing aids' they were acknowledged at that time, as an assistant to the trained nurse (Kershaw, 1989). There were few changes for the HCA until 1943 (Table 2), when the responsibilities of the General Nursing Council were extended by the Nurses Act 1943 to include a register for assistant nurses, these nursing assistants then later became known as state enrolled nurses (The Health Foundation, 2018). However, for the nursing assistants who did not follow the enrolled training programme to become registered there was still no formal education or training until 1992, when the National Vocational Qualification (NVQ) became established (Thornley, 2000).

1850	Recognition as part of the nursing team known as 'Nursing Aids'

1919	The Health Service act introduced
1943	The National Health Service launched including a register for nursing assistants.
1955	Nursing Assistants became known as Auxiliary Nurses and became formally recognised
1982	UKCC reviewed and reformed nurse education
1988	UKCC announced support staff to be employed to assist nurses Establishment of the National Council for Vocational Qualification in healthcare was developed.
1992	RCN published The role of the support worker within the professional nursing team. NVQs became established.
2013	The Certificate in Fundamental care developed
2015	The Care Certificate introduced.

Table 2 historic changes to HCA role and education.

The CC was formulated by Health Education England (HEE), Skills for Health and Skills for Care and has been imposed by the CQC, allowing for the first time a standardised approach to the level of knowledge and skills which the HCAs should achieve prior to attending to patients independently. It is recommended that all HCAs should complete the CC within a 12 weeks period of commencing their role however, there remains no regulatory body or monitoring for the HCAs accountability to date.

Literature Review

The CC is a relatively new educational programme (CQC, 2015, Skills for Care, 2016), there is little literature to reinforce that the formal education given to HCAs is of any benefit. A study is currently being undertaken to evaluate the effectiveness of the CC to improve experience of induction, training and career progression for the HCA to improve patient care. There were also 2 journal entries identified which are relevant to this service evaluation;

The first by a journalist Alison Moore, March 2015, which was looking into the implementation of the CC, following a pilot of the programme, and how the standards within it will assist the HCAs in delivering better all-round care. This paper highlighted that the CC is largely for staff who are just starting out within the healthcare setting. There is also discussion regarding how the Certificate is delivered and how long the programme is delivered over. Furthermore, Moore (2015) highlights that as there is no governance for the completion of the CC, and as such suggests that unless this programme is made mandatory or a legal requirement, then there may remain inconsistencies in the standard of care which the HCAs deliver. There is also concern that smaller agencies, such as care homes, may not implement the CC due to the cost implications which it would incur.

The second piece identified was conducted in September 2015, by Diane Wolfe, an HCA in an acute hospital trust. She wrote an paper on her journey through the CC. It shows the personal perceptions of the HCA and the value of the CC and her perception of her practice changing as a result in areas such as assisting her in providing a holistic approach to patient care and person-centred values. Whilst this provides interesting information regarding potential links to improvement to patient care, there remains little evidence as to whether the CC programme gives the HCAs the confidence, they require should they be faced with an unwell patient.

Aims

This service evaluation provided the opportunity to identify what impact the CC has on the HCAs confidence in identifying an unwell patient when working independently, and if after completion of the CC does the HCA have the knowledge and skills to assist in the management of these patients.

Design, Method and Validity.

The evaluation was conducted at a teaching hospital in the Yorkshire and Humber region. Prior to commencement ethical approval was gained by the trust's clinical audit department and the academic institute supporting the study. A survey questionnaire was used; by completing the questionnaire participant consent was assumed therefore, taking the design of a service evaluation (Neale, 2009, Qureshi, 2015). The data collection took the form of a mixed method questionnaire (Tang et al, 2015) which was designed to explore the thoughts, feelings and experiences of the HCAs who had completed the CC (Hicks, 2004, Parahoo, 2006).

Eighteen open, closed and free text questions were developed to allow for a broad range of data. To assist in the validity and reliability the survey was given to five colleagues to pilot (Parahoo, 2006). Minor adaptions were made prior to dissemination.

Sampling

DATE	January 2016 – March 2017	April 2017 – March 2018
Total enrolled on programme	337	148
Total left trust or withdrawn	38	13
Total completed	220	56
Total Ongoing	79	44

Table 3 HCAs between January 2016 – April 2018.

A total of 276 new and existing HCAs competed the programme since the trust introduced the CC in 2016. HCAs working in out-patients, diagnostic departments, critical care, emergency department

and theatres, were excluded as these HCAs are unlikely to be working independently. This resulted in 168 eligible HCAs. From the 168, HCAs working in the emergency care group were then selected. This was done to select a variety of ward areas where the HCAs are at the forefront of patient care and are relied upon to provide independent care to patients as part of the care team. This resulted in only 30 HCAs. The questionnaire was then disseminated by hand with a return addressed envelope and included a participant information sheet. The HCAs were unidentifiable and marked as HCA1 etc on return of the questionnaire to maintain confidentiality. A total of 11 questionnaires were returned. It is acknowledged that this is a low response however, as identified by Holloway (2002) it is possible to generate enough data to identify the themes required with more than 10 responses therefore, despite small numbers the quality of the responses provided opportunity to address the initial aims of the study adequately.

Data Analysis

Following review of demographic information, opening coding and thematic development was the data analysis method of choice. Direct quotes have been used to assist in reinforcing the validity of this study (Walker, 2014). The analysis process was conducted manually using a Microsoft Excel spreadsheet to organise and highlight key words and phrases.

Findings

The findings of the service evaluation have been divided into the 3 categories. These being, does the CC provide the HCA with the confidence, skills and knowledge to identify a deteriorating patient and has the CC changed the attitude of the HCAs about the need for formal education.

The study identified that all HCAs who taking part have themselves identified and unwell patient in their care, this reinforcing that HCAs are a key part of the nursing team.

Confidence

The HCAs were asked if following the CC, do you feel that you have the confidence to manage an unwell patient which you have identified? All but 1 HCA answered yes; when asked to expand on this these are some of the comments; ‘I feel it enables new HCA to learn about the role and gain lots of knowledge prior to starting their role’ (HCA 10) and ‘It gives you the competency to enable you to do your job with confidence’ (HCA 5).

However, none of the HCA’s stated that they attempted to support these unwell patients themselves but would hand over to the qualified staff promptly. One of the communication tools

which the HCAs are taught is SBAR (Situation, Background, Assessment, Recommendation) tool, HCA 10 specified: 'I used SBAR to hand over and what the EWS was and then stood back'.

When HCA 3 identified an unwell patient, they wrote 'I did not have the competence to deal with the matter, or assist, I stepped back unless asked.' This HCA indicated that they did not feel that by completing the CC they had gained any more confidence.

Knowledge and skills

Of the 15 standards which the HCAs had completed, the survey asked which they felt to be the most beneficial and which was most difficult to complete.

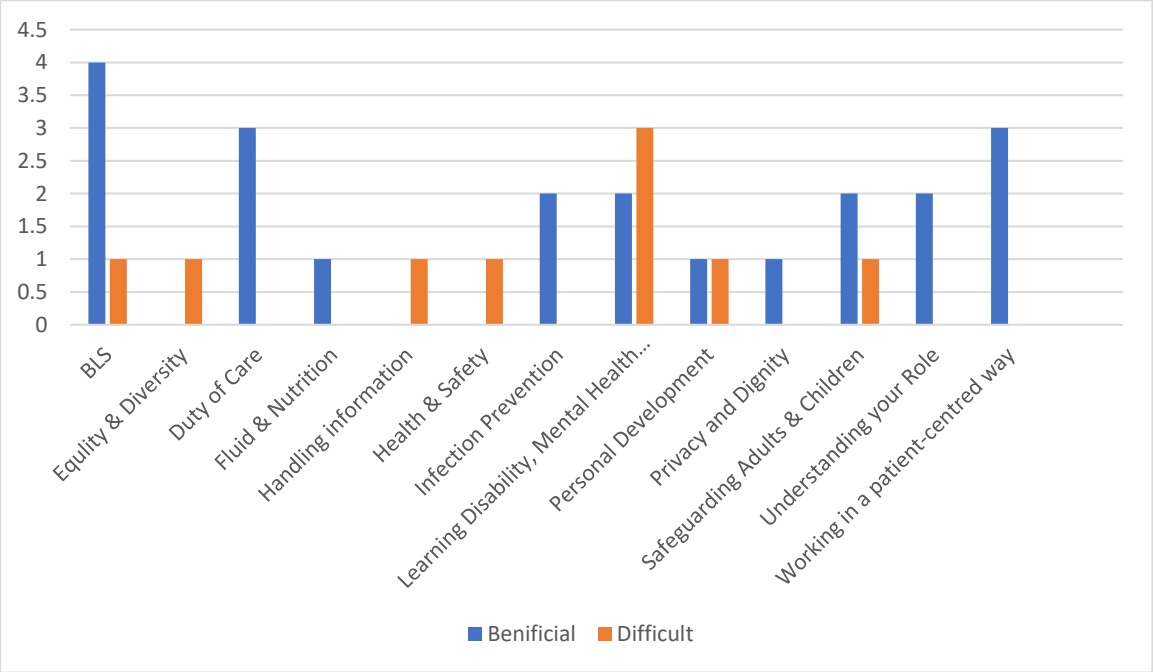


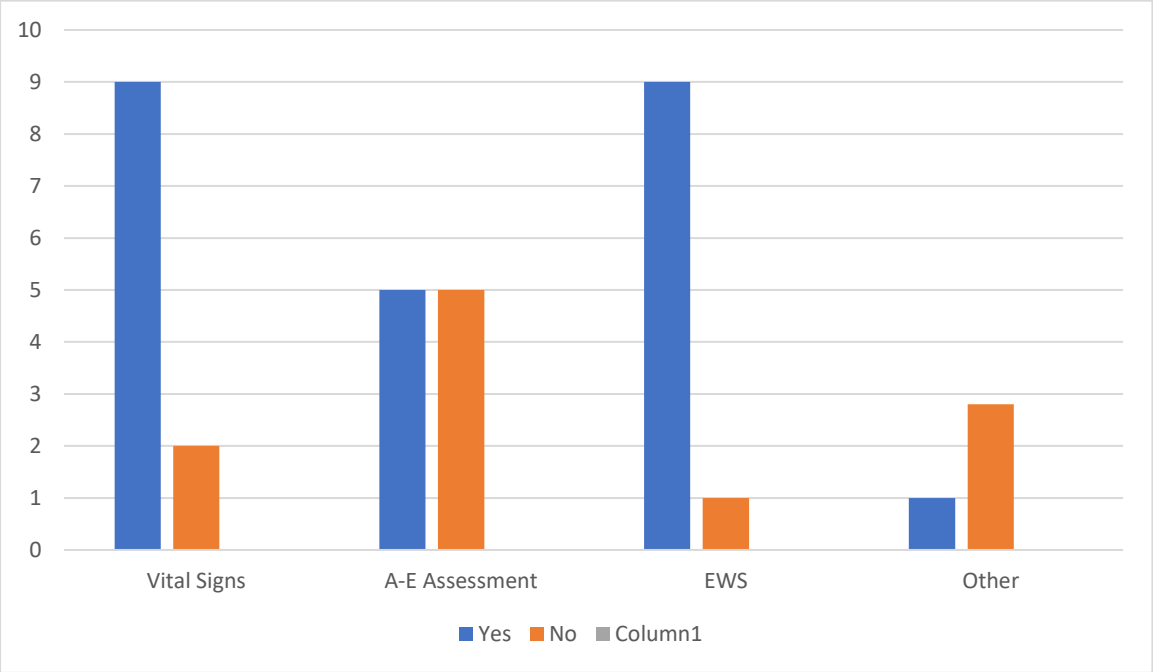
Chart 1 – Benefit and difficulty of 15 standards

Several HCAs identified more than one section to be beneficial with the Basic Life Support (BLS) standard highlighted to be of most benefit. The BLS training was centred around the HCA role, allowing them to focus on their responsibilities during the critical event and enabled them to practice the initial management of a deteriorating patient via the A-E assessment. When questioned why this was most beneficial the HCAs responded: 'It details my role and requirements' (HCA 11), 'As long as you understand your role, you can gain help and support from others' (HCA 6), 'Although I have done BLS before I found that this was more specific and especially useful when working on the wards' (HCA 5).

The study indicated that 8 of the participants found only 1 standard difficult to achieve (Chart 1), with Learning disabilities, mental health and dementia (which is all one standard) being the most

challenging, indicating that 'the topic can be a little dense' (HCA 5) and 'it is difficult due to the complexity of it' (HCA 3).

As part of the CC the HCAs are taught how to perform an A-E assessment, take Vital signs and how to use the Early Warning Score (EWS) to calculate the urgency of care required, all these skills now being essential to their role (Chart 2). The chart below indicates the response to this question with one participant commented on their development stating 'when doing observations, I couldn't hear them when I first started, now I feel confident' (HCA 7) and 'Initially insecure, but with increasing experience my confidence grew' (HCA 3).



Bar Chart 2 – Identification method used

However, when asked their thoughts and feelings when carrying out the above skills responses included: 'It's important to share my concerns with the senior management' (HCA 9), 'I feel confident in my abilities and knowledge when escalation this and handing over to the nursing staff' (HCA 10), 'I went Straight to nurse to tell her my concerns' (HCA 6). Further investigation would be required to investigate if this is more a confidence issue or a skill issue.

Attitude

As it is clear these are changing times for the HCA with the introduction of the CC it was appropriate to ask the thoughts and feelings of the HCAs with regards to the need to complete the CC programme. The HCAs felt it should be recommended that ALL staff complete the Certificate with comments including 'All HCAs across the trust should complete the CC because it makes you a

better HCA in all areas' (HCA 1) 'I feel that the CC will benefit all staff including service assistants, allowing staff to have a better understanding of why things are done' (HCA 2) 'I feel the greatest benefit was for those who are new to the healthcare setting' (HCA 4), 'It gives you skills and knowledge, so you are ready to go into practice' (HCA 6) 'It benefited me as it gave me greater understanding' (HCA 8).

However, in contrast to these positive comments one HCA stated, 'I already have an NVQ 3 in care and feel it un-necessary' (HCA 7)

The overall attitude appears to be that the CC is having a positive impact on the HCAs with increased knowledge and skills as well as a positive attitude to learning developing.

Discussion

The initial findings indicated that most of the participants have found the course to be of benefit to them in some way, regardless of their experience or prior education. HCAs play a vital role in recognising and caring for deteriorating patients (James et al, 2010) and now spend more time with the patient than the RNs (Cavendish, 2013), however uncertainty remains if the CC makes a clear difference to HCAs knowledge, skills and confidence to both identify and begin management in these situations independently and effectively without the direct request from a qualified colleague.

Within this study most HCAs stated they had identified the unwell patient however, of the eleven HCAs taking part, only five indicated that they had utilised the A-E assessment (chart 2) when they identified an un-well patient in their care. Despite the HCAs being able to identify the unwell patient interestingly no-one indicated that they initiated the initial management by either administering oxygen therapy or changing the patient's position. The question remains is this a confidence issue or a knowledge and skill issue.

Conclusion

From this small service evaluation, it has been highlighted that the HCAs are gaining a lot of skills and knowledge to assist them in delivering better patient care, and whilst indicated they gain confidence, further investigation is required to identify to what extent this confidence is. The general attitude towards formal education from the HCAs appears to be positive, however, further study using focus groups may prove useful in expanding on this issue.

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