How nursing support staff contribute to care

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- The impact of clinical support workers on care
- Issues that need to be tackled to ensure the best skill mix

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Ensuring the best skill mix is about more than registered nurse to patient ratios. Emerging research suggests clinical support workers have a positive impact on care.

In a recent Nursing Times article, Robb et al (2011) stated: “Large studies in several countries have shown unequivocally a correlation between low nurse-to-patient ratios and mortality, morbidity and adverse event rates.”

While acknowledging the commitment of nursing clinical support workers, the article also suggested there is an inverse relationship between the proportion of healthcare assistants employed and hospital standardised mortality rates.

This article has two aims. First it seeks to briefly review evidence on the link between nurse levels and outcomes, and the implications for deploying clinical support workers. Second, it sets out some findings from emerging research on the impact on health outcomes and productivity of HCAs and assistant practitioners. Box 1 explains the terms used to describe these workers, their qualifications and roles; this article refers to them generically as clinical support workers.

While we argue that emerging evidence suggests that clinical support workers can improve outcomes, we do not suggest that role redesign is a straightforward case of swapping X number of nurses for Y number of support workers. Far from it – inappropriate skill mix may lower productivity, increase costs and increase nurses’ workload (Willis et al, 2011). Nursing workforce redesign requires considerable and context-dependent diagnostics, risk management and clinical leadership (Hyde et al, 2005).

Staffing levels and outcomes

Robb et al (2011) quoted a number of studies that suggest higher levels of nurses result in better patient outcomes such as lower inpatient mortality rates.

The most recent of these (Needleman et al, 2011) begins by drawing attention to limitations in previous research, including the inability to account for differences in patient requirements and the possible existence of unmeasureable or unobserved variables. Indeed, a key rationale for this research was to address such limitations. Others have also pointed out that the quality of research in this area is poor (Robinson, 2009; Sibbald et al, 2004).

Finally, the majority of studies, including Needleman et al (2011), are based on healthcare providers in the US (Robinson, 2009). The NHS Confederation (2011) has noted that not enough is known about the impact of changes in skill mix and roles in healthcare staff, including the support worker.

While Needleman et al (2011) provided compelling evidence of the link between patient outcomes and nurse levels, albeit in one hospital, their study compared fully nurse-staffed areas with understaffed ones, rather than different skill mixes. Indeed the authors acknowledged that a limitation

5 key points

1 Although research has suggested a link between nurse levels and patient outcomes, such studies have a number of limitations

2 Caution should be exercised about the implications of this research for skill mix reviews

3 Skill mix review depends on context, and requires considerable diagnostics, risk management and clinical leadership

4 Research suggests that assistant practitioners can have a positive impact on services

5 Enduring issues over support workers include lack of role clarity and underuse of posts

Clinical support workers often spend more time at the bedside than other staff
of their study was that they did not take account of the impact of other staff. What this and other studies have found is that when shifts are understaffed, nurses’ workloads are, not surprisingly, higher. As a result, patient surveillance is impaired.

This is not an argument against deploying support workers. It could be argued that deploying higher-level clinical support workers to complement nurses’ work could alleviate workload pressures.

The lack of high-quality research on the implications of skill-mix changes means some caution needs to be taken in generalising findings on the links between nurse levels, skill mix and patient outcomes.

Support workers’ contribution
The Department of Health (2010) acknowledged the importance of developing all staff: “To survive, thrive and become more productive, employers in every industry invest in the talent of all their workforce.”

An underused clinical support workforce, particularly at the higher level, presents an opportunity to release productivity gains, address service and workforce pressures and improve quality of care.

Research on the impact of clinical support roles is emerging (NHS Confederation, 2011). The National Nursing Research Unit (2010) concluded that HCAs “spent more time with patients than registered nurses and that this provided more opportunities to talk and develop informal and empathetic relationships with them”.

Kessler et al’s (2010) case studies found the role was most commonly deployed as a “bedside technician”. HCAs, in the three hospitals studied, were the main bedside presence. It appeared, as the NNRU (2010) also found, that patients had a closer relationship with support workers than nurses, although patients preferred to engage with nurses on specific issues. HCAs tend, Kessler et al (2010) also found, to be more representative of local communities, particularly the local ethnic mix.

Schneider et al’s (2010) study of HCAs in dementia wards found they played a significant part in managing the ward environment, including maintaining a consistent emotional climate. Robinson (2009) reported that investment in both nurses and HCAs reduced the incidence of pressure ulcers and therefore treatment costs. Griffin et al (2012) found that ward-based HCAs had, following training, a positive impact on nurses’ workloads, teamwork and patient outcomes.

In general practice, there is some evidence that delegating tasks from practice nurses to HCAs can improve access and quality of care, including for patients with long-term conditions (Griffin et al, 2011).

The Royal College of Nursing’s (2010) review of assistant practitioner roles found evidence of positive effects on services, staff and performance. Spilsbury et al’s (2011) study of assistant practitioners found the role was seen to contribute to care delivery, including providing leadership to other support workers.

Issues
While emerging evidence is showing that appropriately trained support workers can improve services, further research is needed, particularly outside hospital settings.

A number of enduring issues need to be addressed. These include: a lack of role clarity (titles, boundaries, grading and job descriptions); underuse of roles due to nurses’ reluctance to delegate tasks; poor understanding of roles; and limited development opportunities (Spilsbury, 2011; Kessler et al, 2010). Developing support workers should be driven by health and service needs as well as being organisationally led.

Conclusion
The NHS continues to address skill mix in terms of staff ratios rather than – as the term suggests – a collection of skills needed to support patients in a safe and efficient way.

The number of people employed by a trust and their grades tend to be historically determined (Hyde et al, 2005). This may or may not provide the optimum skill mix. A careful consideration of the right blend of staff at appropriate levels is needed. This will well require role redesign and the creation of higher-level clinical support roles.

The emerging evidence is worthy of consideration and suggests that, where studies have been conducted with due diligence, the right mix of staff at the right levels should result in improvements for patients, support workers and nurses. NT

References
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BOX 1 NURSING CLINICAL SUPPORT WORKER ROLES

Three levels of clinical support worker are deployed in nursing teams:
- The first is employed at band 2 and supports patients’/clients’ basic needs. Typically, such posts require knowledge equivalent to at least five GCSEs.
- The second – a senior support worker role, employed at band 3 – undertakes delegated care, is educated to A-level standard and has knowledge of facts, principles and general concepts.
- Finally the higher support worker – also called assistant or associate practitioner – is usually employed at band 4 and has deeper understanding, including theoretical knowledge. They can perform holistic care, often autonomously, including planning activities. Many higher support workers complete foundation degrees.

Support workers may be described as assistants, healthcare assistants, clinical support workers, assistant practitioners or associate practitioners. Skills for Health is undertaking a review on behalf of the Department of Health to develop a code of practice and training standards for support workers.