The role of the health-care assistant in general practice

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Abstract

The role of the health-care assistant (HCA) has developed rapidly in general practice and has occurred on an ad hoc basis across the UK, with the precise role shaped by the requirements and culture of individual practices. Currently, there is no regulation of HCAs and little published material about the remit of the role. This study aimed to describe general practice colleagues’ perceptions of the HCA role; identify key areas of inter-professional agreement and disagreement about the role; and describe the likely impact of these on the direction and development of HCAs. The study used a multiple-method qualitative study, using focus groups and semi-structured interviews and was set in general practices across one primary care trust. It featured uni-professional focus groups of practice nurses, HCAs and practice managers and interviews with GPs and practice managers. Transcribed material was analysed using constant comparison to derive robust themes. Participants focused on issues surrounding communication and teamwork and the fact that the individual nature of practices will affect the development of the HCA role. Questions regarding the development and structure of the HCA role were also broadly debated. The study concluded that the development of the HCA role in general practice is variable and the success of the role within a practice depends on good preparation for its future direction as well as the broad inclusion of team members in discussion and decision-making about the role.

Key words: Communication n General practice n Health-care assistants n Role development n Teamwork

The health-care assistant (HCA) in general practice is a relatively new role that has developed over the past eight years. While the number of practice nurses in England and Wales continues to rise dramatically, it appears that a national shortage of nurses and a continual development of roles and clinical services provided within primary care, has encouraged many practices to take a fresh approach to the development and make-up of their nursing teams (Crossman, 2005; Vaughan, 2006).

HCAs have no formal qualification and instead have usually undergone some form of training in order to provide direct clinical care for patients in the primary care setting. There is currently no regulation of HCAs although discussions are underway, led by the RCN (RCN, 2007). RCN guidance also stipulates that they must be supervised by a qualified health-care professional, usually a qualified nurse.

In the acute sector, HCAs have been working within clinical teams for over 20 years and their role is well-established. This is also the case in community teams, where almost all community nursing teams are supported by an HCA. Nationally, there is a drive to increase nursing responsibilities and this includes increasing the number of HCAs (Department of Health, 2006). The RCN published an issue paper supporting skill-mixing, including the employment of HCAs, in general practice and included a number of conditions of practice, such as delegation of appropriate activities only and ensuring that roles are within individual HCAs capabilities (RCN, 1997). The introduction of HCAs in general practice, however, is relatively recent. Anecdotally, five years ago there would only have been a handful employed in general practices across the UK. National figures are not available as to the number now employed, but locally approximately 70% of general practices employ an HCA.

The role appears to be developing in a similar way to that of the practice nurse, in an ad hoc manner and mainly in response to local need (Hirst et al, 1998). As a result, there are wide variations in roles, the training received and, speculatively, variations in the competency of individuals to undertake the designated roles. There are scarce accredited courses available and some practices have taken a structured approach to in-house training to tackle this shortage (Brant, 2004). As HCAs are unqualified practitioners there are other considerations that have needed to be addressed in terms of supervision, accountability and working within strict protocols (Fulbrook, 2007). There is a need for ongoing supervision and monitoring of the role to ensure appropriate development of individuals and maintenance of quality standards (RCN, 2005). HCAs tend to carry out a range of roles in primary care from venesection and recording blood pressure, to cervical screening and travel immunisations.

Despite the rise in the number of HCAs nationally and the growing importance of their role, there is a dearth of published literature that has sought to understand the views and perceptions of members of primary health-care teams regarding the HCA role. It is crucial that we understand how the HCA role is being interpreted, implemented and developed to ensure the needs of patients, HCAs and their primary care colleagues are met.

Method

The aim of the study was to identify the views and perceptions of members of primary health-care teams about the role of the HCA within general practice.

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Sample
Practice nurses and HCAs were purposively selected from 38 practices across south-west Hampshire and invited by letter to take part in uni-professional focus groups. The intention was that the sample would ensure maximum variety representation of each discipline from practices both currently with and without a HCA in employment. Practice managers from each of the 38 practices were invited to take part in a focus group. While the authors were interested in GPs' shared values about the HCA role, based on prior difficulties recruiting GPs to focus group research, the authors elected to conduct individual GP interviews and five GPs were invited, of whom three agreed to take part.

Focus group procedure
Groups were facilitated and interviews conducted by CB and each lasted for an average of one hour. An independent observer was present in the focus groups, which were purposely uni-professional to encourage open and honest dialogue. Each group involved following a topic guide, which covered topics germane to the research question and these included the nature of the roles undertaken, training, support, management and role limitations.

Interviews
All interviews were conducted at one general practice and each lasted an average of 45 minutes. Interviews covered all topics on the interview schedule, but were sufficiently flexible to permit interviewees to raise issues not anticipated by the schedule. Each interview began with a question about the specific roles undertaken by HCA's and proceeded to cover a number of general topics.

Transcription
The groups and interviews were transcribed verbatim in preparation for thematic analysis. A selection of transcripts were second transcribed to check for accuracy.

Analysis
Analysis was conducted by CB drawing on the method of constant comparison (Silverman, 2001). For both data sets, analysis was undertaken manually and electronically. Initial familiarization involved developing individual summaries of each interview on A5 cards. This was followed by further repeated reading and re-reading of the transcribed interviews, ensuring both within (vertical) and cross-case (horizontal) comparison. Repeated readings involved annotating transcripts with manifest and latent codes. Focus group analysis concentrated on shared perceptions across the groups and levels of agreement and disagreement concerning the topics discussed, while analysis of interviews sought to identify individual perspectives of interviewees and their relation to other interviewees' views. Coding was later conducted by GL to test the reliability of data coding and the logic or validity of the coding framework.

Findings
Five focus groups and five individual interviews were conducted over a four-month period. Numbers taking part in the focus groups ranged from three to seven with the breakdown as follows:

- Group 1 – six practice nurses
- Group 2 – seven practice nurses
- Group 3 – three practice managers
- Group 4 – four HCAs
- Group 5 – four HCAs.

Individual interviews were held with three GPs and two practice managers. Ten of the participants in the practice nurse focus group currently worked with an HCA, and three worked in practices without HCAs. Participants in the other focus groups and interviews all came from practices, which currently employed a HCA.

Five key themes were identified as important and the first three of these were: communication, team working and the individuality of the HCA and the general practice. These three themes were present throughout the data corpus and appeared to influence the direction in which the HCA role developed. The final two core themes identified were role definition and general role structure. These themes and constituent sub-themes are discussed in turn. Exemplary quotations are used to illustrate each.

Communication
Barriers and enablers to role development
Participants from all disciplines described issues surrounding the HCA role that had created conflict. While individual personalities and differences had reportedly played a part in creating conflict, a lack of clear communication between all staff about the decision to employ a HCA in the first place was conveyed to be a crucial contributor to conflict:

‘Well … it was discussed that we were going to have one [HCA] but I wasn’t involved in the interview and the purpose was to free up our time. It hasn’t exactly worked out as planned’ (Practice nurse)

and:

‘I would like to think that if you are changing people’s roles and changing what we expect, that they should feel like the whole practice is involved because if it feels like it’s just coming from the practice manager or the senior nurse or whatever, then there’s a lot more room for … you know, niggles’ (GP)

Some views expressed appeared to be based on HCAs’ ideas about their colleagues’ beliefs:

‘I think it’s resistance from the nurses to actually refer the patients through’ (Practice manager)

and:

‘I don’t do that [coronary heart disease management], no. I would be interested in doing it, but I wouldn’t feel the nurse at the surgery would like me doing it’ (HCA)

As well as viewing communication as a barrier, conversely good communication was recognized as beneficial in terms of preventing conflict.

Team Working
Poor team working – a barrier to role development
Related to communication, participants raised the importance of ‘good teamwork’ and how it could contribute positively to
the HCA role and the prevention of conflict. Practice nurses gave the impression of automatically including the HCA as a team member and routinely reported that HCAs were an essential part of the team:

‘Our HCAs have started to develop their own specialties, e.g. leg ulcers, and this works well. It is a sharing of expertise – the HCA goes to the practice nurse and vice versa’ (Practice nurse)

In contrast, HCAs experienced difficulties with team membership and in feeling valued, as the following examples show:

‘I mean sometimes you sit there and you talk to someone doing a blood pressure and they (practice nurses) just walk in and leave. That’s naughty, we wouldn’t do it to them’ (HCA)

and:

‘I find sometimes I come into value when suddenly there’s a space and they don’t want to get another nurse and suddenly I’m allowed to do certain things and I’m trained very quickly to do it’ (HCA)

Similarly, GPs appeared to feel disconnected from the HCA role:

‘I’m only just getting my head around, you know, that some HCAs can do the smoking cessation stuff … but who does weight, the obesity counselling? It’s not always clear to me where the boundaries are’ (GP)

and:

‘I’m happy and content with the review process (of the HCA role) being done by the nursing team …. but I do feel that means a slightly bigger gulf between ourselves and the nursing assistants’ (GP)

This quote from a practice manager demonstrates the fundamental issues and associated challenges:

‘A lot of it is down to sort of communication isn’t it really and trying to work together as teams and, and that’s quite a hard one isn’t it, I think?’ (Practice manager)

HCAs also reported feeling that their roles had naturally evolved as they gained competence and experience:

‘If someone comes in for blood pressure, we now look and see about their medication and look for things before they even come in, whereas before I used to just do a blood pressure and put it on the screen’ (HCA)

and:

‘I’ve got a better knowledge of why they’re in. I’ve learned so much in the last six months’ (HCA)

HCAs perceived barriers to role development

Some HCAs appeared to feel uninvolved in and disconnected from the development of their own role. There was repeated use of
the word ‘allowed’ in their verbal contributions, which suggested a lack of input in decision-making about their own role:

‘We’re not allowed to start work until there’s somebody there’ (HCA)

and:

‘Mmm, we’re allowed to do the wound care and sutures but we’re not allowed to do Dopplers’ (HCA)

Some HCAs pointed to the threat they may pose to nurses’ professional identity and how their threat may thwart their attempts to develop their roles further:

‘There are problems, sort of restrictions within the role, sometimes through other nurses just see it as taking over their role’ (HCA)

and:

‘I think nurses are worried because we are cheaper –I think that’s probably why they feel threatened’ (HCA)

Some of the HCAs reported that they could or should be ‘doing more’ and were specific about the kinds of roles they would like to undertake. They suggested that roles and particular tasks could be ‘taught’ successfully:

‘No, but they’re jobs I could physically do, you don’t have to be a nurse. If you look at the actual activity of taking a smear, it’s a very practical thing. Yes, I understand that, you know, I don’t want to give them the pill or the contraceptive side even though if someone taught me I’d happily do it, but I could do the physical side (of the smear)’ (HCA)

Safety concerns – which tasks can be safely taught?

In common with HCAs, GPs also reported that some roles could be safely taught, including flu immunisations and cervical screening:

‘I mean, it’s all down to training and assessment of competence... what you’re talking about here is not a highly intellectual task’ (GP)

There were some concerns about injections in general:

‘Injections are a bit different because, I think, you have to be very clear that someone doing them knows the possible side-effects and possible antidotes and what to do if someone has anaphylaxis’ (GP)

Practice nurses did not want HCAs to be taking cervical smears, ear syringing or doing general injections. Their reasons for this were not clear and appeared, in part, to be influenced by ‘gut reaction’:

‘I don’t think they ought to do injections, I don’t think they ought to do smears’ (Practice nurse)

and:

‘I’d say no to ear syringing and smears at the moment’ (Practice nurse)

Both practice nurses and HCAs agreed that wound care is a role that can be safely and competently carried out by HCAs, as long as they are capable and working within safe guidelines. However, an exchange of views on ear syringing in one of the focus groups demonstrated the complexities involved:

‘With the syringing, there’s a lot more to think about. I mean, how to recognize perforation, infection, do they know the consequences of syringing the wrong way? There could be more complications with ear syringing than venesection’ (Practice nurse)

and:

‘You could argue that someone could be trained to recognize it, couldn’t you? I mean, I had absolutely no idea about ear irrigation until I came to primary care and it’s the training I have received that enables me to do it safely’ (Practice nurse)

There was a perception that although practical tasks can be effectively taught, there are other aspects of a patient consultation, such as the intuition built from previous patient experiences, that cannot and HCAs possible lack of skill in this regard could interfere with patient care:

‘They’ve been well trained in clinical things and they have communication skills and it’s just that grey area which I’m not quite sure if they’ve got the background for’ (GP)

and:

‘It may be that in the past the patient’s had abnormal smears and she may want to talk about that’ (Practice manager)

Task-orientated roles and decision-making

Practice managers appeared to be clear about the HCA role being task-orientated and they all indicated a belief in the importance of tight protocols:

‘I think it’s task-orientated. I wouldn’t want her to be going off making decisions that she hasn’t talked about or discussed with someone else. She works within clear guidelines’ (Practice manager).

They seemed to use their business acumen when developing the role. For example, one felt that teaching HCAs to do flu injections was not necessary because she could not see how it would result in more efficient working. In addition, practice managers spoke in terms that suggested they attempted to evaluate the HCA role from a patient perspective:

‘They [patients] want to know they’ve got a professional person looking after them – I certainly wouldn’t want somebody who’d just been taught that role. Looking at another profession, would you want an unqualified person tinkering with your car just because they’ve been taught to look after a single part of it?’ (Practice manager)

Chronic disease management was not discussed in detail in either of the practice nurse groups. One practice manager reportedly felt that chronic disease management was not
an appropriate role for HCAs, believing that the decision-making could not be removed from it:

‘Chronic disease, the decision making? I don’t think, without the correct training, an HCA can make (these) decisions. They need to be made by qualified people’ (Practice manager)

One of the GPs expressed concerns about carving up the work of chronic disease management and the implication of loss of continuity of patient care:

‘Part of undertaking spirometry is the interaction and her understanding of the background and everything else. Do we have to go back to the process of “I’m just doing these bits but actually the rest of it I can’t do”’ (GP)

Yet, such allocation of tasks to different members of the health-care team, including HCAs, was clearly a part of modern practice for many:

‘I do geriatric checks, I do the BP’s, I do basic CHD checks, which I call the yearly MOT. They come individually for the test and any queries just to check they’re taking medication. Any queries I refer back to the nurse or their doctor’ (HCA)

Skill-mixing
The majority of participants discussed the importance of ensuring that roles were undertaken by the ‘appropriate person’. GPs reported that:

‘We can’t have, there’s no way that we can be having G or H grade nurses taking blood. You know, it’s just, you cannot defend that on any, on any sensible ground at all, thank goodness we’ve moved away from that’ (GP)

and:

‘You’re not going to employ an HCA and then let them do more complex tasks when actually, what you need is for them to do the less complex tasks, the more basic stuff’ (GP)

One practice nurse view was that:

‘Qualiﬁed nurses should not be taking bloods and blood pressures – they would lose out under Agenda for Change. That is not a G-grade role’ (Practice nurse)

The language used by a spread of GPs, practice nurses and practice managers to describe the HCA role included ‘routine’, ‘menial’, ‘basic’, ‘straightforward’ and ‘lower-end’. HCAs themselves used phrases such as ‘taking work off the practice nurses’ rather than a descriptive account of the jobs they did.

Skills escalator
In relation to the clinical practice team, GPs and practice nurses talked about the ‘skills escalator’ and the blurring of professional roles. GPs, practice managers and HCAs commented on the new role potentially creating threats to the professional identity of practice nurses, although there were no comments from the nurses themselves about this. Some GPs suggested that they themselves are becoming de-skilled in some areas and losing their ‘generalist skills’ as a result of them being undertaken by others. Consequently, there was some concern as to where their future areas of expertise might exist.

‘If the escalator continues what will be left for us to do? We will just “drop off” at the top’ (GP)

Negative feelings about the lack of financial recompense associated with additional responsibilities were voiced by HCAs:

‘None of us would do our job if we were doing it for the money. Why did our role come into being? – it’s much less than the cost of a nurse. That’s the cynical side of it’ (HCA)

Awareness of limitations
Practice nurses had no doubts about the ability of the HCAs to work within their capabilities and to know when to ask for help.

‘Certainly with our HCAs, if they’re unsure of anything, anything at all, they’ll just come in and say’ (Practice nurse)

In line with this, the HCAs discussed the importance of asking for help when they were unsure of a particular task:

‘I will only do things that I’m happy doing, I won’t go outside of that. They wanted me to do checks for asthma and diabetes. Well I don’t know anything about that, inhalers and all that. It’s not my department and I won’t do it’ (HCA)

and:

‘If I have any problems (with wound care), I’ll go to a sister or a doctor. You know, you can tell it’s infected, you can see that and the doctor comes and he prescribes antibiotics’ (HCA)

The subject was not discussed in any detail with GPs and practice managers.

General structure of the HCA role
The final theme centred around the general structure of the HCA role and related to practical, organisational and educational issues, such as room space, education and training, future regulation of HCAs, medico-legal issues and human resource issues, such as management and supervision. The lack of regular available education and training for HCAs was a concern for practice managers and some practice nurses, while conversely, HCAs did not appear to view this as a problem:

‘I just go on the courses as I see them and they have all been very good. I don’t have a problem going on courses’ (HCA)

The value of experiential learning was highlighted by several practice nurses as was the need to be able to demonstrate competence:

‘We have to make sure that they [HCAs] are competent in anything new and that simply go-
ing on a course is not enough for them to start doing a new task’ (Practice nurse)

The medico-legal issues surrounding the HCA role were thought to be vague and appeared to have caused practice managers some confusion:

‘The terms of reference in the new contract ….say that HCAs are not allowed to help with minor operations’ (Practice manager)

With reference to management, all practice nurses reported that HCAs should be managed by a practice nurse. Conversely, one practice manager believed that management was their domain, while another made a distinction between types of management:

‘I think that the clinical management [of the HCA] should be from the senior practice nurse and I should do all the other, personnel etc management’ (Practice manager)

The issue of supervision appeared to be most important to practice nurses and various views were held on the actual form it might take. One practice took an organized approach:

‘Our HCA always knows who is supervising her on whichever day. A practice nurse should always be supervising when the HCA is doing clinical work’ (Practice nurse)

Discussion
Summary of main findings
Findings suggest that good communication and teamwork are fundamental to successfully founding and developing the HCA role in general practice. Research suggests that the introduction of the HCA role must take into consideration the potential tensions around efficiency and equity and the effect of these on the worker (Thornley, 2008). The findings of this research seem to suggest that negative feelings about the initial creation of the role may adversely impinge upon future HCA role development.

GPs, practice nurses and practice managers held quite strong views on role boundaries and how ‘risky’ particular tasks may be, although many struggled to articulate how or why they had arrived at their decisions. Similarly, strong feelings were voiced about the need for appropriate skill-mixing, but participants were not clear about how best to classify ‘appropriate roles’. The ‘skills escalator’ is one of the four pillars of Human Resources and some confusion: (Thornley, 2008). The medico-legal issues surrounding the HCA role were thought to be vague and appeared to have caused practice managers some confusion:

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Strengths and limitations of this study
Participants were self-selected and seemed to welcome the opportunity to discuss the issues around the HCA role. This small study included only a small number of practice staff and did not include patients. Future studies could build on these findings to explore them further with larger numbers and wider representation. Having said that, new themes were not identified towards the end of data collection and the depth of experience expressed has highlighted important factors that may facilitate or enable the successful integration of the HCA role in general practice.

Comparison with existing literature
Although there is scarce material on the HCA role in general practice for direct comparison, some of the issues raised reflect some of those found in other literature. Perhaps most obviously, for some time the academic literature has highlighted the essential nature of open communication, team working, and the importance of accountability, commitment, enthusiasm and motivation to the success of a team (Pearson et al, 2006).

In terms of the HCAs’ hypothesis of their having a negative impact on nurse practitioner’s professional identity, there is some evidence to suggest that nurses in general may perceive the HCA role as threatening to their professional identity (Pearce, 2007).

Conclusion
This article shows clearly how communication and teamwork are essential in successfully developing a new role and how a failure to fully address these may negatively affect the role development.

It has highlighted how varied the roles and responsibilities of a new HCA role can be and how uncertain staff are about the possible direction of the role in the future.

There are opportunities for future research raised by this work, including analysis of staff perceptions about clinical risk and clinical decision-making in primary care and the effect of the continuing ‘skills escalator’ on the roles of GPs and practice nurses in primary care.