THE EXPANDING ROLES FOR CARE AIDES: IMPLICATIONS FOR CARE AIDES, PROFESSIONAL NURSES, PATIENTS, AND FAMILIES

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Abstract

To meet increasing demands for healthcare, changes are being been made in the way healthcare is delivered. Healthcare aides who provide care to people who live in residential care facilities, assisted living facilities, and in the community are now being employed in acute care settings. Healthcare aides are unlicensed personnel and are trained to provide fundamental care. Their work loads, however, are expanding and the skill mix is changing to meet the needs of higher acuity patients. This review is focused on what is known about task shifting between healthcare aides and nurses, and the implications that task shifting has on healthcare aides, nurses, patients/residents and their families. The method chosen was a scoping review. Two electronic databases were selected for this review because they are known to house nursing health literature. Each database was searched using a variety of key titles for healthcare aides combined with key phrases "Skill creep, task shifting, role extension, role overlap, delegation, task sharing, accountability, and responsibility". Forty-one articles met the selection criteria. The results indicate that there are a number of benefits for patients/residents and families and it is imperative to recognize healthcare aides as essential members of the healthcare team. Registered nurses and licensed practical nurses often do not fully understand the healthcare aide role or completely comprehend their own responsibilities and accountabilities when assigning or delegating tasks to healthcare aides. Therefore, registered nurses and licenced practical nurses need additional support to learn to communicate clearly with healthcare aides and supplemental training to ensure that they can safely assign or delegate tasks to healthcare aides.

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The Expanding Roles for Healthcare Aides:

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Healthcare aides are unlicensed healthcare personnel who are trained to provide fundamental care to people who live in residential care facilities, assisted living facilities, and in the community. According to the most current job classification, fundamental care includes making beds, maintaining supplies, performing light housekeeping duties, assisting with leisure activities, and assisting with activities of daily living such as hygiene, dressing, and toileting (Statistics Canada, National Occupational Classification, 2011). Healthcare aides always work under the supervision of regulated health professionals. Their roles and responsibilities, however, are slowly expanding across Canada and globally (Canadian Nurses Association [CAN], 2008). Some healthcare aides now take on responsibilities and perform tasks that were previously only in the domain of professional nurses (Bosley & Dale, 2008). Expanding roles and responsibilities of healthcare aides is called "task shifting" or "skill creep". The purpose of this review is to explore what is known from existing literature about this phenomenon, and examine the implications of "task shifting" and "skill creep" for patients, families, care aides, and professional nurses.

Definitions

Task Shifting

Task shifting occurs when "specific tasks are moved, where appropriate, to health workers with shorter training, fewer qualifications and may also involve the delegation of some clearly delineated tasks to newly created cadres of health workers who receive specific, competency-based training" (World Health Organization [WHO], 2008, p.7).

Skill Creep

Skill creep occurs when healthcare aides are "trained on the job in more complex tasks" (Duffield, Gardner, & Paull, 2008, p. 3270).

Delegation

Delegation to unregulated care providers involves a task that is "performed primarily by nurses and is outside the role description and training of the unregulated care provider" (College of Registered Nurses of British Columbia[CRNBC], January 2013, p. 6).

Healthcare Aides

Healthcare aides are unlicensed healthcare workers who are directly or indirectly supervised by a variety of regulated health professionals and can work in a variety of roles (Munn, Tufanaru, & Aromataris, 2013, p. 4). Nomenclature for healthcare aides is expansive and includes nursing assistant, nursing assistive personnel, healthcare assistant, care aides, support workers, unlicensed assistive personnel, residential assistant, and nurse extenders. In British Columbia, healthcare aides are tracked through a care aide registry, however they are not licensed professionals. For the purpose of this review, healthcare aides will be the term used to represent these roles.

Nurse

Nurses are professionally trained care providers who are registered and licensed by a nursing regulatory body. Nurses included: Registered Nurses (RNs), Nurse Practitioners (NPs), Registered Psychiatric Nurses (RPNs), Licensed Practical Nurses (LPNs) (CNA, 2012).

Residential Care

Residential care facilities "provide 24-hour supervision and continuous professional care" (British Columbia Ministry of Health, 2008a, p.4). Residential care services include administration of medications, provision of meals and snacks, provision of social and recreational activities, and assistance with activities of daily living such as eating, mobility, dressing, bathing, grooming or personal hygiene (British Columbia Ministry of Health, 2008a).

Background

The Health Professions Act of British Columbia is authoritative legislation that provides a common regulatory structure for British Columbia's health professions. The Act authorizes colleges, such as the College of Registered Nurses (CRNBC), to regulate the practice of designated health professionals in British Columbia (CRNBC, 2014). The Health Professions Act does not regulate healthcare aides. As a result, healthcare aides always work under the supervision of a regulated healthcare professional such as a registered nurse (RN), a registered psychiatric nurse (RPN), or a licensed practical nurse (LPN). Although they are supervised, their roles have slowly expanded to include: monitoring of vital signs, observing patient status, recording fluid and dietary intake and output, administering suppositories and enemas, in some cases conducting colonic irrigations, and collecting specimens for laboratory work such as urine, feces, and sputum (Statistics Canada, 2011). In British Columbia, some healthcare aides who have additional training can perform procedures such as urinary catheterization and sterile dressings (British Columbia Ministry of Health, 2008b). In other provinces, some specially trained healthcare aides can administer medications, monitor patients' blood glucose levels, and perform venipuncture (CNA, 2008). In the United States, some healthcare aides administer narcotics, including injectables, order blood work, transcribe orders, administer medications

through nasogastric tubes, oversee gastrostomy feeding, and perform tracheal care and suctioning (Budden, 2012; Mitty et al, 2010; Standling, Anthony, & Hertz, 2001).

Training

Training for healthcare aides varies depending on the country and even within the country. In Canada, there are no national standards regarding training. The course length ranges from 500 hours in Ontario to 8 months in Nova Scotia, Manitoba, and British Columbia (CNA, 2008). In British Columbia, private and public colleges have endorsed a provincial curriculum based on enhanced competencies and practice standards (Ministry of Advanced Education, 2008). This curriculum prepares healthcare aides to work in residential care homes and home support-type settings but "does not prepare healthcare aides to work in acute care or other speciality settings" (British Columbia Ministry of Health, 2010, p. 11). Healthcare aides, however, can supplement their basic training with additional courses in acute care contexts, diabetic foot care, and mental health (Ministry of Advanced Education, 2008).

The lack of acute care training in the basic healthcare aide curriculum is a concern, as the utilization of healthcare aides in acute care is increasing in British Columbia's health authorities and across Canada (British Columbia Ministry of Health, 2010; CNA, 2008). For example, on Vancouver Island the health authority (Island Health Authority) made extensive changes to include more healthcare aides in their care delivery model redesign. According to Island Health Authority's five-year strategic plan, the new care delivery model would improve resource use, provide the right skill mix for patient needs, enhance interprofessional collaboration, and increase productivity while addressing staff shortages (Island Health Authority, 2009). Island Health Authority proposed that healthcare aides would assist with meals and help patients to wash or access the toilet, while the RNs would perform patient assessments, plan care, deliver

patient education, discuss care goals, and complete discharge planning with patients and their families (Island Health, January 2014). The strategic plan, however, did not include the specific responsibilities or roles of the nurses and healthcare aides.

The British Columbia Nurses Union (BCNU) argued strongly against this new care delivery model, suggesting that the new model actually results in the replacement of 26 RN and LPN positions with 31 HCA positions. BCNU also argued that the model increased "the number of patients each professional nurse oversees", "with each nurse responsible for 12 patients" (BCNU, 2013, September 13). The new Care Delivery Model Redesign was first implemented at Nanaimo General Hospital in September 2013. In October 2013 the British Columbia Nurses Union (BCNU) filed a single employer policy dispute regarding the new delivery model redesign backed by 200 filed professional responsibility forms (PRFs) indicating nurses were under moral distress because they were not able to meet their standards and deliver safe nursing care (BCNU, 2015, May 26). An agreement was reached on May 26, 2015 for the restoration of nursing jobs lost with the implementation of the care delivery model redesign (BCNU, 2015, May 26).

Healthcare authorities are searching for ways to meet healthcare demands in a cost-effective economic manner. One cost cutting technique is to change the skill mix in healthcare settings. The training and roles of healthcare aides are important to understand, because healthcare aides will continue to be intricately linked with professional nurses in the provision of healthcare to Canadians (CNA, 2008).

Primary and Secondary Questions

The primary question is: What is known from existing literature about expanding roles and duties (known as task shifting or skill creep) of healthcare aides in acute and residential care settings? The secondary questions are:

- What are the implications for healthcare aides when their roles and duties expand?
- What are the implications of "skill creep" or "task shifting" for professional nurses, patients/residents and families?

Chapter Two

Method

The method chosen to conduct this literature review was a scoping review (Arksey & O'Malley, 2005). A scoping review is an exploratory project designed to synthesize a wide range of research and non-research material and involves searching through a variety of resources such as: databases known to house literature about the topic, influential key journals, influential key authors, and references lists within articles (Arksey & O'Malley, 2005; Davis, Drey, & Gould, 2009). The most widely used definition of a scoping review is from the Canadian Institutes of Health Research (CIHR, 2010): "exploratory projects that systematically map the literature available on a topic, identifying key concepts, theories, sources of evidence and gaps in the research" (p. 34).

Arksey and O'Malley (2005) developed a five-stage framework:

1. Stage One involves identifying the research question
2. Stage Two involves identifying relevant studies
3. Stage Three involves identifying the study selection
4. Stage Four involves charting the data
5. Stage Five involves summarizing the results and identifying areas of interest and possible gaps within the literature.

Scholars who undertake a scoping review typically do not evaluate the quality of the research but disseminate the information in a descriptive format (Arksey & O'Malley, 2005).

Search Strategy

The focus of this review is on the implications of "task shifting" and "skill creep" on healthcare aides, nurses, and those who are receiving care. Two electronic databases: Cumulative Index of Nursing and Allied Health Literature (CINAHL) (2000 to 2015), and Medline (2000 – 2015) were chosen for this review because they are known to house nursing health literature. Each database was searched using two sets of key terms or phrases:

1. Care aide, nursing assistants, nurse assistant, nurse aide, nurse aides, nurse extender, unlicensed assistive personnel, healthcare attendant, residential care aide, personnel care attendant, health personnel unlicensed, Unlicensed Healthcare Personnel.
2. Skill creep, task shifting, role extension, role overlap, delegation, task sharing, accountability, and responsibility.

The use of the Boolean phrase "or" within each set, and the Boolean phrase "and" between the two sets ensured inclusion of all relevant articles. The search was limited to peer-reviewed English language articles with abstracts and full text online, focused on the expanding roles and duties of healthcare aides, limited to hospital and residential care settings. The search excluded home care settings due to the diversified nature of home care delivery system. Key terms or phrases were entered individually, and then in combination, to encompass a broad search of all relevant articles (Table 1).

Table 1

Key Words and Subject Headings Used in the Literature Search

Database	Search Terms	Limiters	Results
CINAHL [Cumulative Index to Nursing and Allied Health Literature]	Care aide, OR [MeSH] Nursing Assistants OR Nurse Assistant, OR [MeSH] Nursing Assistants OR Nurse Aides, OR [Mesh] Nursing Assistants OR Nurse extender, OR [MeSH] Personnel, Unlicensed OR unlicensed assistive personnel, OR healthcare attendant, OR residential care aide, OR personnel care attendant OR [MeSH] Health Personnel Unlicensed, OR [MeSH] Health Personnel, Unlicensed OR Unlicensed Healthcare Personnel, AND skill creep, OR task shifting, OR Role Extension, OR Role Overlap, OR Delegation, OR Task Sharing, OR [MeSH] Accountability OR Responsibility	Inclusion Criteria: English Language, peer reviewed, focused on the expanding roles and duties of healthcare aides, limited to hospital and residential care settings, abstracts and full text online, year 2000-2015, Exclusion Criteria: Home care settings	322
Medline	Care aide, OR Nursing Assistants OR Nurse Assistant, OR Nursing Assistants OR Nurse Aides, OR Nursing Assistants OR Nurse extender, OR Personnel, Unlicensed OR unlicensed assistive personnel, OR healthcare attendant, OR residential care aide, OR personnel care attendant OR Health Personnel Unlicensed, OR Health Personnel, Unlicensed OR Unlicensed Healthcare Personnel, AND skill creep, OR task shifting, OR Role Extension, OR Role Overlap, OR Delegation, OR Task Sharing, OR Accountability OR Responsibility	Inclusion Criteria: English Language, peer reviewed, focused on the expanding roles and duties of healthcare aides, limited to hospital and residential care settings, abstracts and full text online, year 2000-2015, Exclusion Criteria: Home care settings	64

The search yielded 322 articles in CINAHL, and 64 articles in Medline. Three hundred and eighty-six articles were reviewed by title to establish 116 potential articles. The abstracts of the 116 articles were reviewed, and duplicates were removed. The result was 64 articles for full-text review. Of the 64 articles, 24 articles were selected based upon their relevance to the scoping review questions. After reviewing the reference lists, 11 additional articles were identified. Finally, six additional articles published before 2000 were included due to their seminal nature (Table 2).

Table 2

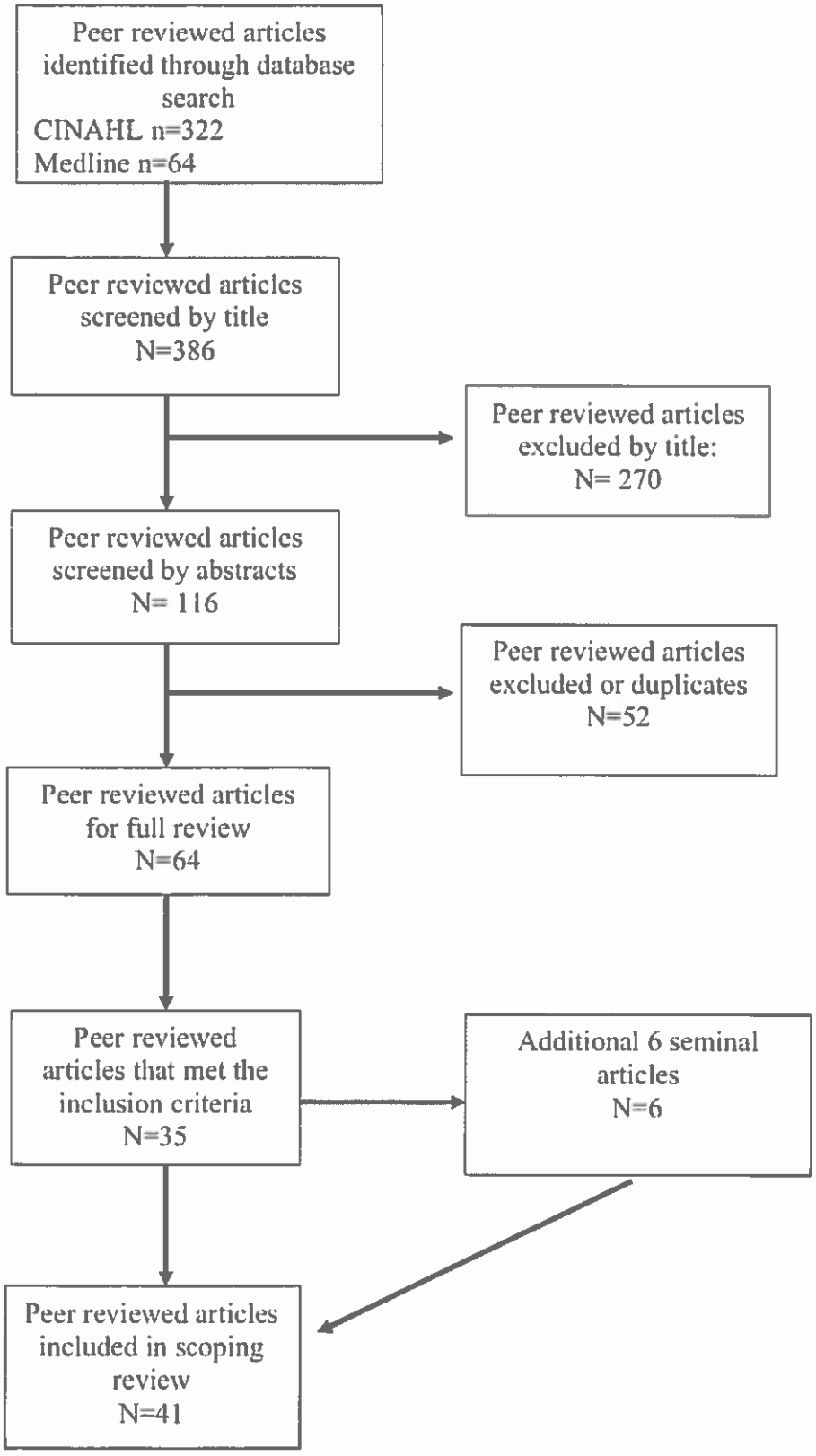
Forty-One Selected Articles

Searches	Articles
CINAHL and MedLine	12 articles from the United States, 9 from the United Kingdom, 1 from Australia, 1 from West Africa, and 1 from Sweden: 6 qualitative studies, 6 quantitative studies, 2 mixed methods, 4 literature reviews, 1 audit, 5 descriptive or opinion articles.
Primary Search of References of Key Articles	7 articles from the United Kingdom: 2 qualitative, 2 quantitative, 2 mixed methods, 1 literature review.
Secondary Search of References from Primary Search	4 articles from the United Kingdom and 6 from the United States: 2 qualitative, 1 mixed methods, 1 quantitative, 2 opinion articles, 5 literature reviews.

A summary of the selection process is provided in Figure 1. The synthesis of the data for this review included: author, year of publication, country, purpose of the article, and category of article and can be found in Appendix A.

Figure 1

Flow-chart of Articles Included and Excluded



Preview of the Next Chapters

In Chapter Three implications for healthcare aides are presented and discussed. Generalized lack of knowledge regarding healthcare aide roles combined with lack of respect for their work leave many care aides feeling discouraged and subservient. In Chapter Four the implications for nurses who work with healthcare aides are presented and discussed. Professional nurses often feel frustrated and confused about the care aide role many have difficulties assigning or delegating tasks to care aides. Implications for patients and families are presented in Chapter Five. When care aides are employed in acute care settings, patients and families may benefit from improved efficiencies but may also suffer from compromised care. Finally, in Chapter Six, the implications of care aides' expanding roles are summarized and suggestions for future research are offered.

Chapter Three

Implications for Healthcare Aides

The lack of national standards for training has resulted in: generalized confusion about the knowledge and abilities of healthcare aides, misperceptions of what they are currently doing, and assumptions about what they should be doing (Butler-Williams et al., 2010; Kessler, Heron, & Dopson, 2015; McKenna, Hasson, & Keeney, 2004). Generalized confusion, misperceptions and assumptions have led to distress and frustration among healthcare aides. They have indicated that they often feel disrespected or discouraged and subservient, making it difficult for them to refuse delegated tasks and/or resist exploitation (Butler-Williams, James, Cox, & Hunt, 2010; Spilsbury &Meyer, 2005; Vail, Bosely, Petrova, & Dale, 2010).

Feeling Disrespected: Lack of Knowledge Regarding Healthcare Aide Roles

Although healthcare aides have a historical presence in healthcare, professional nurses who work alongside care aides sometimes lack knowledge about their abilities, leaving the healthcare aides feeling disrespected. This feeling stems from a) the ways in which information is communicated between some healthcare aides and some nurses, or b) lack of communication between healthcare aides and nurses (Spilsbury & Meyer, 2005). For example, the majority of care aides say that they do not have a recognized role in patient handovers (the passing of patient information from one healthcare professional to another) (Spilsbury & Meyer, 2004). When healthcare aides feel "out of the loop regarding patient information and updates" they question their impact on patient outcomes (Ray & Overman, 2014, p.66). In many facilities, it is normal for healthcare aides to work with patients, without ever having received patient information from professional nurses (Potter, Deschields, & Kuhrik, 2010), to the detriment of patient care and patient outcomes. Cultivating good communication between professional nurses and healthcare

aides would help healthcare aides to feel valued and respected as team members, and improve patient care outcomes (Butler-Williams, et. al., 2010). Effective communication between regulated professional nurses and care aides regarding patient status is becoming increasingly important as care aides take on more duties at the bedsides of patients, become more accessible to patients and families, and more responsive to patients' and families individualized needs (Bach, Kessler, & Heron, 2012; Spilsbury, & Meyer, 2004, 2005).

Multiple researchers agree that there are a number of ways to reduce feelings of disrespect among healthcare aides. For example, some researchers have found that healthcare aides who perform both direct care tasks such as toileting or bathing, and indirect care tasks such as housekeeping, or bed making become more responsible for clinical observations such as monitoring systemic changes or ECG tracings (Butler-William et al., 2010; Kessler, Heron, & Dopson, 2009; Spilsbury, & Meyer, 2005). According to Thornley (2009), healthcare aides who complete clinical observations perceive their roles as similar to that of professional nurses, and this perception leads to an improved sense of professional identity, prominence in the delivery of patient care, and a feeling of being valued as a healthcare team member (Bach et al., 2012; Kessler et al., 2015; Vail et al., 2010).

Another reason for an engrained sense of disrespect is drudgery or what Bach et al. (2012) describe as the "dirty work" routinely assigned to healthcare aides (p. 218). Due to perceived unfair distribution of the workload and/or perceived assignment of care tasks best avoided by some professional nurses, some healthcare aides feel disrespected and invisible within the hospital hierarchy (Bach et al., 2012). Researchers note that some healthcare aides also do not feel a sense of gratitude for their direct and indirect patient care workloads, their

emotional investment in the role, or the stressors associated with healthcare work (Butler – William et al., 2010; Bystedt, Eriksson, & Wilde-Larsson, 2011; Conway, & Kearin, 2007).

Most authors agree that the true extent of care aide work remains largely hidden and undervalued (Spilsbury, & Meyer,2004, 2005; Bach, et al., 2012; Butler-Williams et al., 2010). As healthcare aides will continue to be a part of the healthcare delivery system, and as the roles between healthcare aides and professional nurses blur, more equal distribution of unpleasant tasks, as well as recognition and respect for their expanding roles is needed (Butler-Williams et al., 2010; Vail et al., 2010).

Feeling Discouraged: Lack of Respect for Experiential Knowledge

In a seminal article, Orne, Garland, O'Hara, Perfetto, and Stielau (1998) acknowledged that many healthcare aides are provided with few, if any, opportunities to expand their knowledge or skills. Spilsbury and Meyer (2005) concur and note that some professional nurses appear to actively discourage the acquisition of additional healthcare aide competencies. Care aides can feel discouraged if they must rely on professional nurses to determine what they can do, but they feel most discouraged if professional nurses are reluctant to help them become competent by providing only limited professional support (Vail et al., 2010).

In addition, many healthcare aides have reported that healthcare agencies fail to recognize someone without an academic background as competent enough to provide direct patient care. As a result, healthcare aides have reported that they often feel "inferior", "stupid" and "de-skilled" (Butler-Williams et al., 2010, p. 791, Spilsbury & Meyer 2005, p. 416).

Due to varied levels of education, training, preparedness, and experiential knowledge, most healthcare aides hold completely individualized sets of knowledge and skills. According to Spilsbury and Meyer (2005), researchers have failed to adequately "capture the skills,

experience, qualifications and competencies" of healthcare aides (p. 68). Therefore, healthcare aides are considered by most health professionals to possess only generic skills and not the academic knowledge necessary to provide safe patient care ((Bach et al., 2012; Hogan, & Playle, 2000; Thornley, 2000). There is little reason to exclude them from direct care, however, because most demonstrate a maturity and high level of caring practice derived from experiential learning (Hand, 2011; Thornley, 2000). In fact, care aides who have learned most of their skills at the bedside often have sufficient expertise to allow them to mentor or support newly graduated professional nurses (Kessler et al., 2015).

Feeling Subservient

Healthcare aides spend the majority of their time involved in direct patient care, and the aspect of their work that they value the most is their interactions with patients (Bach et al., 2012; Spilsbury, & Meyer, 2004; Vail et al., 2010). According to Vail et al. (2010) the second aspect of work that care aides value is task diversity— "whether you're taking somebody's blood or you're checking a urine sample, it's going to be different every time" (p. 35). Interactions and task diversity inform healthcare aides' sense of "dignity" and "self-worth" therefore care aides often feel devalued when they are routinely assigned to the most mundane, repetitive or unpleasant tasks (Bach et al., 2012).

Some authors note that the potential of diversity within the care aide role and their commitment to patient relationships have increased care aides' desires for a greater role in patient care (Daykin, & Clarke, 2000; Conway, & Kearin 2007). In an older but seminal article, the authors described how healthcare aides can experience less boredom and show increased self-confidence and efficiency when they are provided with extra training and diversity in their work (Crawley, Marshall, & Till, 1993). Today work diversity is dependent on delegated tasks,

and these delegated tasks give healthcare aides an opportunity to develop and provide greater job satisfaction (Bystedt et al., 2011; Daykin, & Clarke, 2000).

In some countries such as the United States, care aides are routinely delegated to tasks previously limited to professional nurses. These tasks include: performing sterile procedures, initiating intravenous lines, performing complex wound care, patient assessment, setting up diagnostic machines, initiating infusion feeds, administering injections, liaising with physicians, supervising staff, venipuncture, performing electrocardiograms, peak flow measurements, and ear syringing (Bayliss, 2013; McKenna, Hasson, & Keeney, 2004; Vail et al., 2010). Healthcare aides are more likely to "under-report" the magnitude of their roles as some of the tasks they perform are done "unofficially" or "informally" (Thornley, 2000, p. 454).

Although professional nurses are able to delegate complex tasks, some professional nurses overload the care aides or otherwise exploit their availability for such tasks (Bystedt et al., 2011). In addition, many of these delegated tasks are unsupervised, or completed with minimal or no supports (McKenna et al., 2004; Spilsbury, & Meyer, 2004, 2005; Standing, & Anthony, 2006). Some professional nurses falsely assume that healthcare aides have the necessary expertise to perform the complex tasks delegated to them (Spilsbury &Meyer, 2004) while others simply fail to provide instruction and support (Butler-William et al., 2010; Potter et al., 2010). Care aides assigned to complex tasks without training and support often feel as if they are "left to get on with it" (Butler-Williams et al., 2010, p.792). These care aides feel pressured to comply with any requests made by professional nurses without questioning them (Conway, & Kearin, 2007), which can lead to healthcare aides performing tasks that are beyond their capabilities (Bittner, & Gravlin, 2009; Conway, & Kearin, 2007; Spilsbury, & Meyer, 2004, 2005).

As healthcare aides take on more direct care activities through delegation in acute care, their workloads also increase, and their patient assignments can reach six to ten patients per shift (Gravlin, & Phoenix-Bittner 2010; Musanti, O'Keefe, & Silverstein, 2012; Potter et al., 2010). Despite the high workloads and the demands of the job, most healthcare aides attempt to perform their tasks to the best of their capabilities (Plawecki, & Amrhein, 2010). Healthcare aides value patient care as an important component of their role, to the extent that they repeatedly go beyond their level of comfort or training when providing direct patient care (McKenna et al., 2004).

Some care aides feel largely invisible within the healthcare hierarchy and have expressed distress and frustration with the lack of respect they are afforded for their role in patient care, particularly when they are excluded from patient care communications or are assigned to only the most mundane, repetitive, unpleasant chores or an unfairly distributed workload. Lack of recognition for their experiential knowledge leaves some healthcare aides feeling inferior or unintelligent. Further, the expectation on the part of some healthcare professionals that healthcare aides are to accept any delegated task, even if it exceeds their capabilities, leaves some feeling subservient to professional nurses. Healthcare aides should be assigned to varied and interesting tasks, but they should not be required to complete tasks beyond what they are trained to do and must feel safe enough to be able to a) request support or b) decline complex delegated tasks if they feel they are not adequately trained (Bayliss, 2013; Conway, & Kearin, 2007). Like other individuals working in healthcare, healthcare aides will require ongoing training and clinical support, especially from nurses, to extend their clinical skills as their roles expand and as they begin to work in other clinical areas (Shelley & Cohen, 2009; Sutton, Valentien, & Rayment, 2004; Jennings, Yebadokpo, Affo, Agbogbe, & Tankoano, 2011; Wainwright, 2002).

Chapter Four

Implications for Professional Nurses

Healthcare aides and professional nurses (registered nurses and licensed practical nurses) have been working together to attend to patient needs, and most professional nurses believe they would not be able to do their jobs without the assistance of healthcare aides (Kessler et al., 2015). Some nurses, however, are concerned about the possibility that healthcare aides will exceed their scope of responsibility; completing all direct patient care such as toileting or bathing, and indirect care tasks such as housekeeping, or bed making, and assuming responsibility for clinical observations such as monitoring systemic changes or ECG tracings (Butler-William et al., 2010; Kessler, Heron, & Dopson, 2009; Spilsbury, & Meyer, 2005). Researchers have suggested that senior nurses believe that this new distribution of care has devalued the nursing role (Spilsbury & Meyer 2004; 2005). Contrary evidence indicates that when healthcare aides are working on acute care nursing units and providing direct care, professional nurses become more dependent on healthcare aides (Bach et al., 2012; Spilsbury, & Meyer, 2004).

A holistic approach to patient care is fundamental to nursing and providing hands-on care is an important component of holistic care, but this approach may be jeopardized by healthcare aides who deliver most of the hands-on care (Bach et al., 2012). Concerns about nurse dependency and role reduction have led some professional nurses to experience feelings of resignation and misgivings regarding the role of the healthcare aide. Finally, some professional nurses are confused and frustrated because they do not completely understand the role of the healthcare aide, and do not feel competent to delegate tasks to healthcare aides (Spilsbury, & Meyer, 2004; Spilsbury, & Meyer, 2005).

Feelings of Resignation and Misgivings

The increase in professional nurses' workloads have necessitated the delegation of certain tasks to others on the healthcare team (Bystedt, Eriksson, & Wilde-Larsson, 2011). However, the very act of delegation can impact nursing work by creating an environment where some nurses feel unable to control standards of care or comfortably regulate care tasks, with a wide-ranging sense of ambiguity regarding who is responsible for care (Bystedt, Eriksson, & Wilde-Larsson, 2011). Bystedt et al. note that feelings of resignation are most apparent when nurses discuss the future of their profession and their expectations of increasing delegation to healthcare aides. In a seminal article some professional nurses felt unrewarded if they delegate bedside care to a healthcare aide (Orne et al., 1998).

Multiple researchers agree that misgivings and fearfulness arise from nurses' concerns about the adequacy of the healthcare aides' knowledge and skills, and their abilities to make patient care decisions (Bystedt et al., 2011; Hogan, & Playle, 2000). For some nurses, assignment or delegation creates anxiety, uncertainty, and apprehension about maintaining safe patient care (Bystedt et al., 2011). If nurses perceive that certain care aides have poor work ethic, they will not assign or delegate to them preferring instead to complete the activities themselves (Potter, Deschields, and Khurik, 2010). Other nurses report that some care aides do not communicate with them when care is incomplete, or when there are abnormal or unusual findings (Bittner, & Gravlin, 2009; Gravlin, & Bittner, 2010). Further, nurses find extra congestion on the patient units with the presence of care aids. One nurse, in an interview with Orne et al. (1998), stated, "We have more bodies on the floor.... a lot more auxiliary help, and yet it seems like there's more confusion" (p. 105)

Unsuccessful or absent task delegation can create unmanageable workloads for nurses, increasing the risk that patient care could be omitted (Potter et al., 2010). In the United States some nurses reported omissions of care occurred in every shift, often as multiple events (Bittner & Gravlin, 2009). When care is omitted repeatedly, professional nurses experience rising levels of frustration with their employers and deepening levels of dissatisfaction with their profession (Bittner, & Gravlin, 2010; Bystedt et al., 2011).

Another important concern for professional nurses is healthcare aides' refusal of delegated tasks (Conway, & Kearin, 2007; Kleinman, & Saccomano, 2006; Potter et al., 2010). Kleinman and Saccomano (2006) note that nurses may avoid delegating tasks to healthcare aides to avoid feelings of humiliation should they refuse the delegated tasks. According to some nurses, healthcare aides may perceive delegated or assigned tasks as nurses "bossing them or lording their position over them" (Standing, & Anthony, 2006, p. 11). Further healthcare aides, who perceive that the professional nurse could complete a delegated task with greater ease, may refuse to complete the delegated task (Potter et al., 2010). When healthcare aides refuse to complete a task delegated to them, professional nurses need to feel supported by their nurse managers. Without managerial support, professional nurses will continue to experience increased interpersonal conflict and frustration on the job (Potter et al., 2010).

Feelings of Frustration and Confusion

The increasing distance between professional nurses and direct patient care creates frustration for some professionals (Gravlin, & Bittner, 2010; Kessler et al., 2015; Ray, & Overman, 2014). Frustration is rooted in professional nurses' perceived inability to provide care in a way that is true to nursing theory acquired during their nursing education that contributes to perceived gaps in their nursing roles (Bach, et al, 2012; Kessler et al., 2015; Spilsbury, & Meyer,

2005). In a mixed methods study by Daykin and Clarke (2000), one dissatisfied nurse who wished to reduce rigidly structured care tasks and enhance the focus on evidence informed practices questioned, "How can you do that when you're bringing in a whole new school of people who have been taught that the job is task-oriented" (p. 353). A number of authors suggest that there is a gradual erosion of critical cultural and organizational practices driven by fiscal constraints (Kido, 2001; Ray, & Overman, 2014; Spilsbury, & Meyer, 2005). For example, Daykin and Clarke (2000) suggest that hospital administrators may be reluctant to accept holistic care, that considers the whole of a patient and their lives, because it is costlier. They found that when administrators viewed patient care as a set of discrete task-related events, they were comfortable hiring healthcare aides. Hospital administrators' decisions to hire on the basis of fiscal goals rather than quality care, were seen as a way of deskilling and routinizing professional nurses' work.

When healthcare aides complete patient care tasks at the bedside, some nurses report feeling devalued (Bach, Kesslor, & Heron, 2012; Daykin & Clarke, 2000; Zimmerman, 1995). Nursing is the integration of knowledge, assessment, prioritization, and trained critical thinking and much more than a grocery list of tasks (Orne et al., 1998; Zimmerman, 1995). In summary, nurses' frustration with care aides is the product of a) "a task-centered and narrow approach to care delivery" (Kessler, et al, 2015, p. 740) and b) care aides who are reluctant or refuse to accept assigned or delegated tasks (Bach et al., 2012; Potter, et al, 2010, p. 162).

Multiple researchers argue that nurses are confused about the role of healthcare aides because there are so many titles, with no consensus on the meaning of those titles. The definitions vary widely, across units, institutions and countries ((Standing, & Anthony, 2008; Spilsbury & Meyer, 2005; Vail et al., 2011). A surplus of titles for healthcare aides creates role

ambiguity, and confusion for nurses because they are not sure which tasks they can safely delegate to healthcare aides (Bayliss, 2013; Ray, & Overman, 2014; Vail et al., 2010). Role ambiguity has resulted in the lack of clear expectations of healthcare aides (McKenna et al., 2004; Thornley, 2000). Further, some authors argue that professional nurses not only lack a full understanding of healthcare aides' roles, but also lack the ability to clearly define their own role (Cavanagh, 1997; Perry et al., 2003; Thornley, 2000). Lack of clarity surrounding the roles of both professional nurses and healthcare aides results in role conflict (Crossan, & Ferguson, 2005; Nyberg, 1999; Potter, et al, 2010), contributing to anxiety, and the desire to protect the professional nursing role (Conway, & Kearin, 2007).

The inability of the nursing profession to clearly define the nursing role was raised by Cavanagh (1997) nearly two decades ago when she stated, "Nursing must decide what it is and what it is not. Failure to do so will ensure that other professional or management groups will dictate this" (p.337). The need for clearer understanding of professional roles and duties as well as healthcare aide roles and duties will reduce risk in healthcare settings, give rise to more cohesive and effective teams, and decrease the confusion surrounding task delegation (Anthony et al., 2000; Ray, & Overman, 2014; Plawecki, & Amrhein, 2010).

Delegation Dilemmas

A nurse's level of comfort and ability to assign or delegate tasks can impact workload, making workload easier or more difficult. If a nurse is confused about which tasks he or she can safely delegate due to lack of standardized healthcare aide titles and role ambiguity, then there is a risk to patient safety. Understanding task assignment and task delegation is important for professional nurses in delivering healthcare (Bayliss, 2013; Bystedt et al., 2011; Kessler et al., 2015). A task that is assigned to a care aide is a task that is already within a care

aide's description of job duties as set out by the employer. On the other hand, a task that is delegated is a task that is not within a care aide's description of job duties as set out by the employer complete (College of Registered Nurses of British Columbia [CRNBC], January 2013). Standing and Anthony (2008) state, "delegation is the basis of the nurse – [healthcare aide] microsystem" (p. 13), and a critical piece in providing quality care safely to patients (Nyberg, 1999). In order to safely delegate a task, a professional nurse must be knowledgeable, confident, and competent to delegate (Standing, & Anthony, 2008) and ensure that the tasks delegated are within the ability, knowledge, and skills of the care aide (Bayliss, 2013; Crawley et al., 1999). Standing and Anthony (2008) suggest that baccalaureate nursing programs should contain more practical lessons in human relations and communication in the context of working with coworkers such as healthcare aides, rather than just a patient and family's context. This experiential learning would enable nurses to be better prepared for task delegation to other members of the healthcare team (Standing & Anthony, 2008).

A care aide who is delegated a task should be provided with clear directions and expectations, and should be questioned to ensure that he or she understands the task (Ray, & Overman, 2014; Potter et al., 2010; Standing, & Anthony, 2001). A delegated task also involves a level of trust (Bittner, & Gravlin, 2009; Standing, & Anthony, 2006). Trust is a component of a successful interpersonal relationship between a professional nurse and a healthcare aid and can impact the outcome of delegation and affect the quality of care for the patient (Ray & Overman, 2014). Nurses expressing comfort with delegation also express that they depend upon the quality of their relationship with the healthcare aide in question (Standing & Anthony, 2006). Building a trusting relationship requires skilled communication, which is a key element of delegation (Orne et al., 1998; Potter, et al, 2010). Nurses' opinions of the quality of the interpersonal

relationship rather than healthcare aide's competence often dictates which tasks they will delegate, as many nurses do not have a clear understanding of what may or may not be appropriate to delegate (Hand, 2011).

Although task delegation is thought to create greater stability by providing patients with an increased sense of security, continuity of care, and faster treatment (Bystedt et al., 2011), nurses need to remember that their role is to determine what care is needed and who is best suited to deliver the care required (Hand, 2011). The expectation is that the nurse will determine the healthcare aide's competence before delegating any task (Kleinman & Saccomano, 2006). Determining competence and ensuring appropriate delegation may fall to the wayside, however, if nurses feel obligated to delegate (Bystedt et al., 2011; Orne et al., 1998).

Some researchers suggest that professional nurses rely more on their experience than on their knowledge when delegating tasks (Standing & Anthony, 2001). Older, more experienced nurses will delegate tasks more often than newer and younger nurses who are still developing their own levels of expertise and competency (Anthony et al., 2000; Crawley et al., 1993. Standing and Anthony (2006) also found that novice nurses felt uncertain when delegating tasks, and often learned to delegate through "trial and error" (p. 9). One of the barriers to successful delegation was insufficient knowledge regarding the capabilities of healthcare aides due to a lack of knowledge of the training and skills of healthcare aides (Mussanti et al., 2012; Potter et al., 2010). Kleinman, & Saccomano (2006) found that delegation is more difficult when nurses have not been directly involved in the training of healthcare aides. Moreover, there is discrepancy between what tasks need delegation and the reasons why such tasks are delegated (Bystedt et al., 2011; Perry et al., 2003; Standing, & Anthony, 2001, 2006). Researchers have found that some professional nurses believe that when tasks are routinely carried out by the healthcare aide, they

are not delegating (Standing & Anthony, 2006). These professional nurses believe, instead, that only tasks that are not routine for healthcare aides could be considered delegable (Standing & Anthony, 2006). Authors agree that nurses' fluctuating levels of confidence regarding delegation, differing opinions regarding the definition of delegation, and inadequate preparation for delegation are not acceptable in healthcare systems facing increased patient care demands (Bittner, & Gravlin, 2009; Huston, 1996; Kleinman, & Saccomano, 2006). As the amount of delegation increases due to increased use of healthcare aides providing care at the bedside, professional nurses' abilities to successfully delegate will rest on both their educational and clinical experience (Gravlin, & Bittener, 2010).

Accountability. Within the changing nature of healthcare, there are increasing expectations for professional nurses to supervise healthcare aides in acute and residential care settings and monitor the tasks delegated to them (Anthony et al., 2000). Given the confusion surrounding roles, responsibilities, and definitions of delegation (Conway, & Kearin, 2007), many professional nurses are unclear about their roles in the delegation process and uncertain about their accountability for delegated tasks (Standing, & Meyer, 2006). Nurses are accountable and responsible for the care that patients receive within their scope of practice, including any tasks assigned or delegated to healthcare aides. Therefore knowledge of accountability and responsibility should impact nursing decisions about which tasks are assigned or delegated (Perry et al., 2003). Even though 80.3% of professional nurses believe that they should not be held responsible for the work done by healthcare aides (Conway and Kearin, 2007), it is clear that professional nurses are indeed responsible for their decisions to assign and delegate care tasks, for ongoing assessments of patient/resident status while the task is being performed, and

for supervision of care aides until the assigned or delegated task is complete (College of Registered Nurses of British Columbia[CRNBC], January 2013).

Supervision. Daykin and Clarke (2000) argue that professional nurses are moving away from direct patient care, in favor of focusing more on "technical, administrative, and supervisory tasks" (p. 353). Healthcare aides are unregulated workers who are now involved in nursing tasks and nursing work. Supervision of unregulated workers by professional nurses has become one of their most important responsibilities but is often inadequate or inconsistent (Jennings et al., 2011; Kleinman, & Saccomano, 2006; Potter et al., 2010). Professional nurses require both theoretical education and practical training in real clinical settings on how to supervise the work done by healthcare aides (Standing, & Anthony, 2008). Supervision is a critical aspect of assignment and delegation, and when supervision is lacking or absent, reduced standards of care may result (Anthony et al., 2000; Crossan, & Ferguson, 2005).

Chapter Five

Implications for Patients and Families

Multiple authors have debated about the significance of experience versus the significance of formal training and whether formal training is really what patients and families most need and desire when they require nursing care (Standing, & Anthony, 2008; Spilsbury & Meyer, 2005; Vail et al., 2011). The growing utilization of healthcare aides on acute care nursing units has been presented by many as a means to improve efficiencies in healthcare, and to improve the quality of patient care (Perry, Carpenter, Challis, & Hope, 2003; Sutton, Valentien, & Rayment, 2004). Healthcare aides add to the overall workforce, and most have the best interests of patients and nurses at the forefront. Healthcare aides can enhance the flexibility and efficiency of registered nurses (RNs) by creating more time for them to focus their energies on medication administration, discharge planning, and more complex aspects of care (Shelley, & Coyne, 2009: Thornley, 2000). Little is known, however, about the long-term impact of healthcare aides on the quality of care provided in acute care units or the potential for healthcare aides to compromise patient care (Spilsbury & Meyer, 2004).

Improved Efficiencies

Those who embrace the efficiency rationale suggest that RNs will have more time to meet complex patient needs such as wound care, pharmacological interventions for pain or other distressing symptoms, patient assessments and patient teaching, and follow up on patient changes when care aides are employed in acute care areas (Conway, & Kearin, 2007; McKenna et al., 2004; Standing, & Meyer, 2006). Other authors suggest that patients in acute care will benefit because healthcare aides will be able to respond to their basic needs faster than the less numerous RNs (Bystedt et al., 2011; Jennings et al., 2011).

Improved Quality of Care

Multiple researchers have asserted that healthcare aides can contribute substantially to the goal of providing quality patient care. For example, some authors suggest that care aides can be more compassionate and empathetic with acute care patients than nurses because they have more time to communicate with patients (Bach et al., 2012; James, Butler-Williams, Hunt, & Cox 2010). Patients have indicated they want someone who is willing and able to listen to them (Spilsbury, & Meyer, 2004), a form of communication that Jennings et al. (2011) argue is also associated with better patient outcomes. Other authors suggest that when tasks are shared between RNs and care aides, the RN's work stress and accompanying risk of errors will be reduced, therefore patients and families will benefit (provided that RNs delegate tasks to healthcare aides appropriately) (Bystedt, Eriksson, & Wilde-Larsson, 2011; Nyberg, 1999; Standing, & Meyer, 2006).

There is, however, a lack of consistent evidence linking the employment of healthcare aides to improved efficiencies and quality of care. Some researchers have found no change in patient satisfaction, small improvements, or even mixed results (Butler-Williams et al., 2010; Kleinman, & Saccomano, 2006; Lookinland, Tiedeman, & Crosson, 2005; Ray, & Overman, 2014). Although appropriate delegation is important to the quality and safety of care, most authors agree that patient supervision by RNs remains key to quality of patient care and patient safety (Butler-Williams et al., 2010; Hogan, & Playle, 2000; Jennings et al., 2011; Kleinman, & Saccomano, 2006; McKenna et al., 2004).

Compromised Patient Care

In general, a substantial number of authors argue that recent reductions in numbers of RNs employed in acute and residential care settings, combined with increased patient loads,

increased patient acuity, and inappropriate use of healthcare aides leads to compromised patient care and increased morbidity and mortality (Crawley et al., 2003; Kleinman, & Saccomano, 2006; Perry et al., 2003; Spilsbury & Meyer, 2004; Zimmerman, 2000). In a seminal article about the replacement of nurses with care aides, and subsequent reduction of nurses employed, Huston (1996) noted that "consumers, by and large, are completely unaware of the changes taking place" (p. 68). The confusion surrounding the various titles for healthcare aides has contributed to the lack of public awareness. Patients may not be able to discern the differences between healthcare aides and registered nurses (Vail et al., 2010). In addition, healthcare aides have varied roles and duties because of the lack of standardized training and regulation (McKenna et al., 2004).

When healthcare aides provide more and more of the bedside care, effective communication between RNs and healthcare aides becomes increasingly important ((Bach et al., 2012; Spilsbury, & Meyers, 2005; Vail et al., 2010). Unfortunately, the communication between healthcare aides and RNs has been described as 'ad hoc' (Spilsbury, 2004). Multiple authors note that healthcare aides either do not receive information or receive insufficient information from nurses which leads to unsafe and fragmented care (Gravlin, & Bittner, 2010; McKenna et al., 2004). Fragmented care eventually leads to 'missed care' (Bittner, Gravlin; 2009; Gravlin, & Bittner, 2010). Missed care includes the monitoring of vital signs, ensuring proper skin care, mouth care, and hygiene, as well as missed feeding, turning, positioning, and ambulating patients (Bittner, & Gravlin, 2009; Gravlin, & Bittner, 2010).

Standing & Anthony (2006) reported that healthcare aides missed reporting abnormal vital signs, missed appointed times for tasks, and had improper communication with patients. Potter et al. (2010) reported that some Healthcare aides refused to complete delegated tasks,

resulting in increased workload for RNs. Ray and Overman (2014) cautioned that, when "communication and delegation are ineffective, it can lead to inaccurate information, and in turn adverse outcomes" (p. 64).

In summary healthcare aides are perceived to have the ability to respond to patient care needs faster and have more time to communicate with patients. Patients perceive healthcare to be more empathetic to the concerns of the patients (Bach, et. al., 2012; James, Butler-Williams, Hunt, & Cox 2010; Spilsbury & Meyer, 2004). However, incorrect or inappropriate tasks delegated by RNs to healthcare aides increase the risk of errors and missed care, and will lead to compromised patient outcomes (Potter et al., 2010; Ray, & Overman, 2014; Standing, & Anthony, 2006). Healthcare aides should only be assigned or delegated tasks for which they are best suited, based on their training, and they should receive adequate direct supervision. Although adequate direct supervision takes time, it reduces the potential risk to patient safety (Butler-Williams et al., 2010; Spilsbury & Meyer, 2005; McKenna et al., 2004).

Chapter 6

Summary of Findings

This scoping review has revealed multiple reasons for healthcare aides to feel discouraged while on the job. Some healthcare aides report feeling overwhelmed with workplace demands (Gavlin, & Phoenix-Bittner, 2010; Musanti et al., 2012; Potter et al., 2010). Others report feeling subservient and argue that other healthcare professionals often do not respect their opinions or judgments. For example, registered nurses or licensed practical nurses may not include them in patient care conferences or other team communications (Potter, Deschields, & Kuhrik 2010; Ray, & Overman, 2014; Spilsbury, & Meyer, 2004,2005).

Some healthcare aides describe feeling disheartened by inadequate workplace orientation programs, lack of opportunities for knowledge and skills expansion while at work, and inability to attend other training opportunities such as conferences. In some healthcare agencies, healthcare aides complain that their varied and sometimes extensive academic backgrounds are often not recognized (Butler-Williams et al., 2010; Spilsbury, & Meyer, 2005).

Some healthcare aides find it objectionable when they are assigned to the most repetitive and disagreeable tasks, even though professional nurses who are working alongside them could assist with the same disagreeable tasks (Bach et al., 2010; Bystedt et al., 2011; Conway, & Kearin, 2007; Daykin, & Clarke, 2000). When healthcare aides feel subservient, it is difficult for them to refuse delegated tasks and/or resist exploitation (Buttler et al., 2010; Spilsbury, & Meyer, 2005; Vail, et. al., 2010). Finally, some care aides report that they are often left to complete tasks on their own, without adequate professional oversight or assistance (Bach, et. al., 2012; Daykin & Clarke, 2000; Kessler et al., 2015; McKenna et al., 2004; Potter et al., 2010; Spilsbury & Meyer, 2004, 2005; Standing, & Anthony, 2006).

Professional nurses, on the other hand, describe feelings of misgivings about working with healthcare aides, due to role ambiguities and confusion about healthcare aides' responsibilities (Bystedt et al., 2011; Conway, & Kearin, 2007; Crossan, & Ferguson, 2005; Potter et al., 2010). Some nurses are concerned about healthcare aide competencies and abilities to follow through with delegated tasks (Bittner, & Gravlin, 2009; Gravlin, & Bittner, 2010; Hogan, & Playle, 2000; Potter, et. al., 2010). In addition, some nurses report feeling frustrated when healthcare aides provide care in a manner that differs from their own nursing knowledge (Bach et al., 2010; Kessler et al., 2015; Spilsbury, & Meyer, 2005). When nurses are concerned about care aide competencies, they have difficulty supervising care aide work and may have struggle to make decisions about assigning tasks or delegating tasks (Conway, & Kearin, 2007; Crawley et. al., 1999; Mussanti, et. al., 2012; Perry, et. al., 2003; Standing, & Anthony, 2008).

There is a dearth of research about the impact of care aides' expanding roles on patients/residents and their families. Some patients and families have reported that healthcare aides are able to spend more time with them than professional nurses, and that care aides have reduced response time to patient care requests in comparison to professional nurses (Bystedt, et. al., 2010; Conway, & Kearin, 2007; McKenna et al., 2004; Spilsbury, & Meyer, 2006). In addition, the presence of healthcare aides on acute care nursing units can result in more time for nurses to focus on patient care needs that require higher skill levels such as care planning or discharge planning (Bystedt, et. al., 2010; Conway, & Kearin, 2007; McKenna et al., 2004; Spilsbury, & Meyer, 2006). Increasing reliance on healthcare aides, however, can bring about corresponding reductions in the numbers of registered nurses. Multiple researchers have noted that reduced numbers of registered nurses can lead to compromised patient care (British Association of Critical Care Nurses, 2003; McKenna, et. al., 2004; Vail, et. al., 2010).

In conclusion, the ambiguities surrounding healthcare aides' titles, roles, and training negatively impact their ability to be recognized as important members of the healthcare team. Additional work is needed to clarify their titles, and regulate their training and scope of practice. Future research should focus on: the effects of healthcare aides' expanding roles on patient outcomes, the impact of care aides' expanding roles on patients/residents and their families, the ratios of healthcare aides to professional nurses that is necessary for adequate supervision and task assignment or delegation, and ways to improve communication between nurses and healthcare aides. Registered nurses and licensed practical nurse require supplemental training and support in order to safely assign or delegate tasks to care aides. Assigning and delegating are essential skills that should be included in baccalaureate programs. Finally, registered nurses or licensed practical nurses must be aware of their responsibilities and accountabilities for assigned or delegated tasks. In order to help healthcare aides become fully recognized as key members of the healthcare team, nurses must feel confident to assign, delegate, and supervise healthcare aides in ways that are supportive, collegial, respectful, and encouraging.

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Appendix

Data Synthesis

Author name	Year	Study Location	Title	Methodology
Anthony, M.K., Standing, T., & Hertz, J.E.	2000	United States	Factors influencing outcomes after delegation to unlicensed assistive personnel	Quantitative
Bach, S., Kessler, I., & Heron, P.	2009	United Kingdom	Nursing a grievance? the role of the healthcare assistants in the modernized national health service	Quantitative
Bayliss, D	2013	United Kingdom	The changing role of the healthcare assistant	Case Study Article
Bittner, N., & Gravlin, G.	2009	United States	Critical thinking, delegation, and missed care in nursing practice	Qualitative
British Association of Critical Care Nurses	2003	United Kingdom	Position statement on the role of heath care assistants who are involved in direct patient care activities within critical care areas	Position statement base on Literature Review
Butler-Williams, C., James, J., Cox, H., & Hunt, J	2010	United Kingdom	The hidden contribution of the healthcare assistant: a survey-based exploration of support to their role in caring for the acutely ill patient in the general ward setting.	Quantitative Survey
Bystedt, M., Eriksson, M., & Wilde-Larsson, B.	2011	Sweden	Delegation within municipal healthcare	Qualitative
Cavanagh, S.J., & Bamford, M.	1997	United States	Substitution in nursing practice: clinical, management and research implications	Literature Review
Conway, J., & Kearin, M.	2007	Australia	The contribution of the patient support assistant to direct patient care: an exploration of nursing and psa role perceptions	Quantitative
Crawley, W.D., Marshall, R.S., & Till, A.H.	1993	United States	Use of unlicensed assistive staff	Literature Review
Crossan, F., & Ferguson, D.	2005	United Kingdom	Exploring nursing skill mix: a review	Literature Review

Daykin, N., & Clarke, B.	2000	United Kingdom	They'll still get the bodily care. Discourses of care and relationships between nurses and healthcare assistants in the NHS	Mixed Methods
Gravlin, G., & Bittner, N.	2010	United States	Nurses' and nursing assistants' reports of missed care and delegation	Quantitative
Hand, T	2011	United Kingdom	Applying hca resources to general practice	Commentary/Opinion Article
Hogan, J., & Playle, J. F.	2000	United Kingdom	The utilization of the healthcare assistant role in intensive care	Quantitative
Huston, C.	1996	United States	Unlicensed assistive personnel: a solution to dwindling healthcare resources or the precursor to the apocalypse of registered nursing?	Literature Review
James, J,. Butler-Williams, C., Hunt, J., & Cox, H.	2010	United Kingdom	Vital signs for vital people: an exploratory study into the role of the healthcare assistant in recognizing, recording, and responding to the acutely ill patient in the general ward setting	Quantitative
Jennings, L., Yebadokpo, A. S., Affo, J., Agbogbe, M., & Tankoano, A.	2011	Africa	Task shifting in maternal and newborn care: a non-inferiority study examining delegation of antenatal counseling to lay nurse aides supported by job aids in Benin	Quantitative
Kessler, I., Heron, P., & Dopson, S.	2015	United Kingdom	Professionalization and expertise in care work: the hoarding and discarding of tasks in nursing	Quantitative
Kido, V.J.	2001	United States	The uap dilemma	Commentary/Opinion Article
Kleinman, C.S., & Saccomano, S.J.	2006	United States	Registered nurses and unlicensed assistive personnel: an uneasy alliance	Literature Review
Lookinland, S., Tiedeman, M.F., & Crosson, A. E. T.	2004	United States	Nontraditional models of care delivery	Literature Review
McKenna, H.P., Hasson, F., & Keeney, S.	2004	United Kingdom	Patient safety and quality of care: the role of the healthcare assistant	Literature Review

Musanti, R., O'Keefe, T., & Silverstein, W.	2012	United States	Partners in caring: an innovative nursing model of care delivery	Mixed Methods
Nyberg, D.B.	1999	United States	Successful delegation skills enhance patient care	Commentary/Opinion Article
Orne, R.M., Garland, D., O'Hara, M., Perfetto, L., & Stielau, J.	1998	United States	Caught in the cross fire of change: nurses experience with unlicensed assistive personnel	Qualitative
Perry, M., Carpenter, I., Challis, D., & Hope, K.	2003	United Kingdom	Understanding the roles of registered general nurses and care assistants in UK nursing homes	Qualitative
Plawecki, L.H., & Amrhein, D.W.	2010	United States	A question of delegation: unlicensed assistive personnel and the professional nurse	Descriptive Article
Potter, P., Deschields, T., & Kuhrik, M.	2010	United States	Delegation practices between registered nurses and nursing assistive personnel.	Qualitative
Ray, J.D., & Overman, A.S.	2014	United States	Hard facts about soft skills	Commentary/Opinion Article
Shelley, H., & Coyne, R.	2009	United Kingdom	Employing healthcare assistants in paediatric oncology units	Quantitative
Spilsbury, K., & Meyer, J.	2004	United Kingdom	Use, misuse, and non-use of healthcare assistants: understanding the work of healthcare assistants in a hospital setting	Mixed Methods
Spilsbury, K., & Meyer, J.	2005	United Kingdom	Making claims on nursing work: exploring the work of healthcare assistants and the implications for registered nurses' roles	Mixed Methods
Standing, T., & Anthony, M.K.	2006	United States	Delegation: what it means to acute care nurses	Qualitative
Standing, T., Anthony, M.K., & Hertz, J. E.	2001	United States	Nurses' narratives of outcomes after delegation to unlicensed assistive personnel	Qualitative

Sutton, J., Valentine, J., & Rayment, K.	2004	United Kingdom	Staff views on the extended role of healthcare assistants in the critical care unit	Audit
Thornley, C.	2000	United Kingdom	A question of competence? Re-evaluating the roles of the nursing auxiliary and healthcare assistants in the NHS	Mixed Methods
Vail, L., Bosley, S., Petrova, M., & Dale, J.	2010	United Kingdom	Healthcare assistants in general practice: a qualitative study of their experience	Qualitative
Wainwright, T. A.	2002	United Kingdom	The perceived function of healthcare assistants in intensive care: nurses' views	Qualitative
Zimmerman, P.G.	1995	United States	Increased use of unlicensed assistive personnel: pros and cons	Literature Review
Zimmerman, P.G.	2000	United States	The use of unlicensed assistive personnel: an update and skeptical look at a role that may present more problems than solutions	Literature Review