

Unregulated Health Workers: A Canadian and Global Perspective

A Discussion Paper

Canadian Nurses Association

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This paper has been prepared by CNA to stimulate dialogue on a particular topic or topics. The views and opinions
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Foreword

In December of 2005, this discussion paper was prepared for the Canadian Nurses Association (CNA).

It was to be used as background for CNA's dialogue with nurses and other health-care partners about the increase in the number of unregulated workers in the health-care sector, and it was sent out for consultation in the spring of 2006.

The final recommendation of the paper was to work with key stakeholders to explore, develop and implement strategies to address identified issues. In November 2006, the CNA Board of Directors approved a 2007 workplan that was based on the recommendations in this paper.

In the spring and summer of 2007, CNA continued to work with government and non-government colleagues and partner associations to explore the issues outlined in this paper and promote new models of collaborative care that value unregulated workers and provide quality care.

As part of that dialogue, CNA has decided to publish *Unregulated Health Workers: A Canadian and Global Perspective* in the hope it will contribute to the exchange of ideas.

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1. Executive Summary

This paper provides an overview of unregulated health workers (UHWs). It includes a description of titles, functions or duties, educational background, and issues and trends related to UHWs in Canada, the U.S., the U.K., Australia and other countries where data were available. The paper also highlights initiatives of the International Council of Nurses (ICN) and other national nursing associations (NNAs) and provincial/territorial nursing organizations in Canada. The paper will be used to inform the decision-making process of the Canadian Nurses Association (CNA) as it considers its next steps related to UHWs.

UHW is an umbrella term used to describe care providers or assistant personnel who provide some form of health service and who are not licensed or regulated by a professional, governmental or regulatory body. UHWs who assist nursing professionals are known by dozens of titles worldwide. However, there appears to be general consistency in the broad descriptors used to identify UHWs. The terms *unregulated* or *unlicensed* are used in most countries, even though the job descriptions may vary.

In Canada, most patient care before the 1980s was provided by registered nurses (RNs) and licensed practical nurses¹ (LPNs); some supportive assistance was provided by orderlies, porters and other UHWs. However, with the onset of the nursing shortage and the need “to increase the efficiency and decrease the costs of nursing care delivery,” the role of UHWs shifted in the 1980s and 1990s from being exclusively supportive and focused on the patient care unit to assistive and focused on patient care (McGillis Hall, 1998, p. 291). Since the early 1990s, similar changes have occurred in other practice settings worldwide. The roles and functions of UHWs have expanded accordingly. Today, UHWs work in diverse settings, including traditional and non-traditional health-care settings, with a wide range of clients with varied acuity levels.

Internationally, there is significant diversity in the training and standardization of use of UHWs. Training and education programs range from on-the-job learning to semi-formalized on-the-job training to the completion of formal courses with practical experience. Certification and/or examination may form part of formal training expectations.

Globally there appears to be an increasing trend toward using UHWs, particularly in community-based or home care settings. The key factors contributing to the increased use are cost containment, the nursing shortage, an aging population and the evolving role of nurses. On the other hand, restrictive funding models, inconsistent interpretation of legislation related to delegation of nursing duties, lack of standardized education, potential disconnect with workplace competencies and liability issues have proven to be barriers to effective use. Concerns about patient safety have also been identified. Many studies link nurse staffing levels with patient outcomes. However, some authors argue that while the evidence supports linkages, it is not yet conclusive (Needleman & Buerhaus, 2003). Therefore, it is essential to establish baseline data between staffing levels and patient outcomes to facilitate objective

1 Practical nurses across Canada, except in Ontario, are referred to as licensed practical nurses (LPNs). In Ontario, practical nurses are referred to as registered practical nurses. In this document, all practical nurses will be referred to as LPNs.

assessment of the data collected before changes are enacted (Potter, Barr, McSweeney & Sledge, 2003).

A variety of models that support and sustain RN roles and ensure safe patient/client care – such as legislation to enact nurse-to-patient ratios and regulation of UHWs – are identified in this paper, along with a description of UHW initiatives by ICN, NNAs and Canadian provincial/territorial nursing organizations.

Implications for CNA in relation to its mandate are outlined, along with four key issues:

1. inconsistent UHW titles;
2. lack of statistics on UHWs or an accurate count of UHWs working in most sectors;
3. inconsistent education/training; and
4. lack of employer standardization, including regulation.

Although UHW regulation may resolve these issues and facilitate the protection of the public, it is unclear – based on stakeholder feedback – whether regulation is the best option to pursue in Canada at this time. Further, it is suggested that CNA await the outcome of the Health Professions Regulatory Advisory Council review, expected in spring 2006, before making decisions about UHW regulation.

It is recommended that CNA adopt a multi-strategy, broad policy approach to address issues associated with UHWs that are affecting the nursing profession.

2. Purpose

The purpose of this paper is to identify and explore policy issues and options for, and make recommendations to, CNA.

The paper outlines the variety of titles and roles of UHWs in Canada and in other countries. Educational background and statistics are highlighted and key issues related to UHW roles are identified, including perspectives from key Canadian informants. Initiatives undertaken by ICN, selected NNAs and provincial/territorial nursing regulatory colleges and associations are described. Finally, policy options and a recommendation for CNA is provided, and strategies are listed related to UHWs.

It should be noted that the term *UHWs* is used in this paper because it captures all of the possible titles and roles of workers who assist nurses and other health professionals or clients in the delivery of health services and who are not self-regulating. Although UHWs who work with other professionals are discussed in this paper, the primary focus is on those workers who assist those in the nursing profession by providing some aspects of personal or nursing care in conjunction with professional nurses or who provide nursing services but work independently without RN involvement. UHWs, as identified in the literature, can be unpaid caregivers, such as family members, neighbours and other volunteers, but the primary focus of this paper is the employed UHW workforce. Finally, for the purposes of this paper, the following terms will be used to describe each regulated nursing group:

- registered nurse (RN);
- licensed practical nurse (LPN); and
- registered psychiatric nurse (RPN).

3. Method

The topic and related issues were explored using a variety of sources. CNA provided the author with more than 300 articles, including provincial, territorial, national and international research papers, reports and jurisdictional documents. The author also undertook an extensive review of the websites of governments, Canadian and international nursing associations and colleges, and health organizations (e.g., World Health Organization [WHO], Pan American Health Organization) to compile documents, statistics and other information on the subject. Key informants from Canada and other countries were contacted, in collaboration with CNA, to obtain information about the current status of UHWs and related issues in their respective jurisdictions or health-care sectors.

4. Unregulated Health Workers: A Description

UHWs is an umbrella term used to describe care providers or assistant personnel who provide some form of health service and who are not licensed or regulated by a professional or government regulatory body. Pharmacy technicians, personal support workers and pathology assistants are examples of *UHWs*.

UHWs, unlike registered or licensed professionals, do not have any of the following attributes:

- a legislated scope of practice;
- a protected title;
- a mandatory educational requirement;
- a set of professional standards for practice; or
- a professional conduct review process.

(College of Registered Nurses of British Columbia [CRNBC], 2002; National Council of State Boards of Nursing [NCSBN], 2005a; and Department of Health [U.K.], 2004)

These attributes of a regulated profession are intended to help ensure that the public receives safe, competent and ethical patient care.

As members of a regulated profession, nurses need to understand their accountability and responsibility when working with *UHWs*, particularly when delegating nursing tasks or procedures. In some countries, there is a move to regulate *UHWs* to address these very issues and to standardize education and titles. An overview of regulatory approaches to address nursing practice concerns and clarify *UHW* accountability and other strategies, such as standardizing curriculum and clarifying employer responsibility, is presented later in this paper.

The key characteristics of *UHWs* are that they assist many professions, are known by numerous titles, work in a variety of settings and perform various functions. *UHWs* may be formally trained to function in an assisting role through instructional or vocational training, or they may have no formal training and learn on the job. In South Africa, for example, some *UHWs* are only semi-literate, while others are retired RNs interested in working in the community (D. Russell, personal communication, December 14, 2004). In Canada, the *UHW* workforce includes internationally educated nurses and physicians awaiting regulation in their respective professions (N. Lefebvre, personal communication, December 14, 2005; S. Sholzberg-Gray, personal communication, December 2, 2005; R. Parker, personal communication, November 25, 2005).

4.1 UHWs Assisting the Nursing Profession

Table 1 (Appendix A) lists some of the titles used to describe the roles of UHWs in Canada, the U.S., Australia and the U.K. A sampling of titles from other countries is also listed. There appears to be general consistency in the way the roles are described; however, the titles and jobs are diverse.

The table shows that there is some overlap in the use of titles. For example, the term *nurses' aide* is used in Canada and the U.S., *health care assistant* in the U.K. and Hong Kong, *nursing assistant/attendant* in Canada, the U.S., the U.K. and Australia, and *patient/personal assistant/attendant* in Canada, the U.S. and Australia.

Another similarity is that the title may describe the workplace or the role the worker performs (e.g., home support worker, community worker, psychiatric assistant, mental health assistant, medication aide, feeding assistant). The roles are established by employers or educators, and in some instances they are referenced in regulation to ensure labour standards are met. For example, wages and working conditions are listed in regulations in Manitoba and Ontario.

Overall, there is significant inconsistency in the terminology used to identify UHWs. In Canada alone, there are at least 15 titles used to describe UHWs; these titles are not used in all provinces and territories, and the list is by no means exhaustive. Interestingly, Victorian Order of Nurses Canada (VON) recently moved from the term *personal support worker* to the broader term *unregulated care provider* (UCP) to identify all the roles and titles of workers that are captured within this role. Further, nursing associations and colleges in British Columbia, Saskatchewan, Manitoba, Ontario and Nova Scotia have also adopted *UCP*.

The use of common terminology would help the public understand who is providing their care and what they can expect from the providers. Similarly, professionals working with UHWs would be able to understand what to expect from the worker and to clarify their own professional accountabilities and responsibilities (Home Care Sector Study Corporation, 2004; Department of Health, [U.K.], 2004). Without consistent titling, it is difficult to determine who is actually performing nursing work and to establish standards covering their work (Australian Government, Department of Education, Science, and Technology [DEST], 2002).

4.2 UHWs Assisting Other Health Professions and Assistants in Other Professions

Although UHWs most commonly perform nursing assistive roles, the role of assistant or technician is also frequently associated with other professional groups in both health-care and non-health-care fields. In health care in Canada, the U.S., Australia, and the U.K., for example, UHWs work with health professionals in pharmacy, medicine, midwifery, dentistry, nutrition, occupational therapy, physiotherapy, audiology and speech-language pathology (Brown, 2003; Department of Health [U.K.], 2004). Although some UHWs do not have traditional assistant roles, they support the role or work of other regulated health professionals. For example, paramedics and laboratory technicians perform services that

overlap with those provided by regulated professionals, such as venipuncture for purposes of collecting blood samples or, in the case of paramedics, intravenous administration of fluid and medications through a peripheral line. It should be noted that some of these roles are regulated in certain jurisdictions in Canada. Human Resources and Social Development Canada (HRSDC) provides a list of titles of workers who support other health professionals (Appendix B). Titles include orthopaedic technician, autopsy or morgue assistant, chiropractic assistant, occupational and physical therapy assistant and rehabilitation assistant.

New roles and functions are emerging for workers who traditionally have assisted the nursing profession. For example, the Canadian Pharmacists Association (CPhA), in collaboration with the Canadian Association for Community Care (2004), proposed that home support workers (HSWs) monitor clients taking prescriptions at home. The overall objective of the three-phased project was “to reduce medication-related illness in the independent-living elderly” and included the “development of a training program and tools to assist home support workers and seniors with medication management” (p. 2). Among the final recommendations from the project were the following:

- The role of HSWs in medication-related activities needs to be clearly defined.
- The roles and responsibilities common to all HSWs should include monitoring changes in clients’ well-being or health status and reporting changes to a supervisor or other health-care provider, as appropriate.
- Training for HSWs should be standardized with regard to the monitoring of clients’ medication use.
- National training standards for HSWs should be developed (CPhA, 2005, p. 3).

There are unregulated assistant roles in non-health-care professions such as engineering and law, such as engineering technologists and paralegals respectively. In recent years, these professions have moved toward the regulation of these groups (Professional Engineers of Ontario, 2005). In a move to protect the public, approximately 2,000 paralegals will soon be regulated in Ontario.

“[C]urrently anyone can offer paralegal services in Ontario without any training or qualifications, and do so without insurance or any code of conduct. Consumers have no protection and no recourse if something goes wrong when using paralegal services, unlike when they use the services of a lawyer” (Law Society of Upper Canada, 2005).

4.3 Settings and Tasks or Procedures Performed by UHWs

Before the 1980s, most patient care was provided by RNs and LPNs, with some supportive assistance provided by UHWs such as orderlies and porters. However, with the onset of the nursing shortage and requirements “to increase the efficiency and decrease the costs of nursing care delivery,” the role of UHWs shifted in the 1980s and 1990s from being exclusively supportive and focused on the patient care unit to assistive and focused on patient care (McGillis Hall, 1998, p. 291). Since the early 1990s, similar changes have occurred in other practice settings worldwide, and the roles and functions of UHWs have expanded accordingly.

In concert with the nursing shortage and economic pressure, other factors have affected the location of UHW services and the roles they perform. These include isolation, retention of health professionals and unique community needs (e.g., cultural and community norms that cannot be readily understood or met by regulated health professionals) (Buchan & Calman, 2005; Minore & Boone, 2002).

Today, UHWs work in widely diverse traditional and non-traditional settings and have a wide range of clients with varied acuity levels. This trend is seen in the U.K., U.S., Australia and Canada.

4.3.1 Traditional Health-Care Settings

Traditional health-care settings in which UHWs work include:

- hospitals (tertiary, regional and community), across a range of units including medical/surgical, critical care and emergency departments;
- long-term care (LTC) and assisted-living facilities;
- mental health centres;
- physician offices, nursing outposts and community health clinics; and
- home care and other community care settings.

(British Association of Critical Care Nurses, 2003; Minore & Boone, 2002; Patterson, Del Mar & Najman, 2000.)

In these settings, UHWs may provide direct patient care, such as carrying out or assisting with basic personal hygiene, or perform more technical skills, such as administering medication, venipuncture, dressing changes, observing patients and providing advice. Table 2 in Appendix C lists nursing procedures or tasks performed by UHWs in settings in Canada, U.K., Australia and the U.S.; there is significant overlap among the countries. It is important to note that the context of practice, competency of the UHW and authority to perform procedures (i.e., procedures or tasks delegated by an RN or another regulated health professional) will change the role.

UHWs may also perform supportive functions that do not involve direct patient care. For example, resident assistants working in U.S. assisted-living facilities perform nursing functions, such as giving enemas, taking vital signs and performing passive motion exercises and other personal care duties, as well as non-nursing duties, such as housekeeping, laundry and meal service (Mitty, 2003). Pilon (1998) described nursing assistant-type roles (service associates and care partners) that were introduced in large tertiary care centres in the U.S. Service associates performed a range of supportive duties such as patient transport and dietary aide, whereas care partners were considered “nurse extenders,” performing “semi-skilled tasks” such as dressing changes and providing personal care under the direction of the nurse (p. 44). Other supportive duties include carrying messages, reports, requisitions and specimens from one department to another, making beds and maintaining patients’ rooms.

4.3.2 Non-traditional Health-Care Settings

In non-traditional settings such as schools, daycares and correctional facilities, the provision of health-care services is not the primary function of the UHW. Nursing tasks or procedures typically performed by UHWs in these settings include:

- administering medications (performed by correctional officers, school secretaries and early childhood educators/daycare workers);
- assisting with personal hygiene and activities of daily living, including technical skills such as catheterization (performed by special education assistants); and
- participating in public health screening programs such as checking students for pediculosis, fifth disease or other communicable diseases (performed by school secretaries, receptionists, teachers and daycare workers).

(CRNBC, 2002; McCarthy, Kelly & Reed, 2000; NCSBN, 2005a)

In both traditional and non-traditional settings, UHWs generally perform procedures or tasks under the direction and/or supervision (direct or indirect) of a client, family member, regulated health professional or employer (Government of Ontario, 2005; McCarthy, Kelly & Reed, 2000; NCSBN, 2005a; Rhodes, 1999). There also appears to be general consistency across the U.K., U.S., Australia and Canada about the responsibility and accountability of RNs delegating to unregulated workers. For example, these countries require RNs to delegate according to legislation governing nursing practice and relevant practice guidelines (American Nurses Association [ANA], 2005a; Australian Nurses Federation [ANF], 2004; CNA, 2003; ICN, 2000). Initiatives to facilitate appropriate delegation by national and Canadian jurisdictional nursing associations are discussed in section 6 of this paper.

4.4 Training and Education – UHWs Assisting the Nursing Profession

Training and education programs for UHWs assisting the nursing profession range from no formal training to on-the-job learning, semi-formalized on-the-job training, and completion of formal courses with practical experience. Certification and/or examination may also form part of formal training expectations. There is significant diversity among countries respecting UHW training and standardization of training. Additionally, within some countries, a career laddering option is available to UHWs to support career advancement into the nursing profession. Four countries are highlighted to illustrate the diversity in training and education of UHWs: the U.K., Australia, U.S. and Canada.

4.4.1 United Kingdom

In the U.K. there is currently no consistent training requirement for UHWs entering the workforce. The Department of Health has recently suggested that through regulation, health care assistants (HCAs) and other UHWs be required to “meet specified training and practice standards” as a means of strengthening quality of care (2004, p. 7). Currently, HCAs or nursing care assistants are able to complete formal training to meet the National Vocational Qualifications (NVQs) as set by the Department for Education and Skills in the NVQ grouping of “providing health, social care, and protective services.”

In 1999, the U.K. Department of Health identified a need to provide unregulated health staff with opportunities for career advancement and as a result “established a staffing profile that lent itself to the gradual progression of staff, providing them with a career pathway to undertake registered nurse education, when it became available” (Joy & Wade, p. 19).

Workplace educational or training qualifications required of UHWs appear to be employer driven. For example, according to Nazarko (2003), citing a survey completed in 1997, only 30 per cent of HCAs employed by the National Health Service had NVQ qualifications, but they were performing nursing duties such as medication administration and venipuncture. Young (2004) identifies UHWs employed as emergency department assistants (EDAs) who, with eight weeks of on-the-job training, support the performance of non-nursing positions such as receptionist and porter, as well as performing clinical or nursing duties including “cardiopulmonary resuscitation, taking observations, assisting in the theatre, attending to personal hygiene needs, and applying dressings” (p. 10).

Perceptions of nurses toward the HCAs may be altered by the level of educational preparation the latter have attained. For example, the results of one study showed that RNs working in the acute care sector in the U.K. viewed the UHW role more positively than did RNs in the same sector in the U.S. (UHW training in the U.S. is discussed in section 4.4.3). The authors of the study suggest that the difference in perception between U.K. and U.S. nurses may be associated in part with the fact that HCAs in acute care in the U.K. have attained NVQs; they thereby meet certain performance standards of which the nurse is knowledgeable because RNs are required to participate in HCA preparation as part of their professional responsibilities (McLaughlin et al., 2000, p. 55).

4.4.2 Australia

According to Gleeson (1998), most UHWs or personal carers (PCs) in Australia are “untrained and learn on the job” (p. 1320). Aberdeen (2004) confirms this perspective, quoting the Community Services Health Industry Skills Council (CSHISC), which had indicated that “70% of PCs have no post-school education” (p. 15). Concerns were raised by government and stakeholders regarding gaps between current UHW knowledge and the need for appropriate education to ensure safe, competent care and comfort of clients. As a result, core competencies were developed by the CSHISC that provide “the only nationally recognized standard or appraisal criteria for the role of the PC” (p. 15).

Nationally recognized accredited courses to teach these core competencies were subsequently developed at the certificate level III, the level the government has recommended all PCs attain by 2008 (Aberdeen, 2004, p. 16). Certificate III is a recognized qualification within the Australian Qualifications Framework (AQF), which encompasses all qualifications from school through to university and is endorsed by the Australian government (DEST Report, p. 8). Responsibilities of the UHW Aged Carer include:

- providing care support responsive to the specific nature of dementia;
- providing services to meet aged people’s personal needs;
- assisting in the provision of an appropriate environment;
- ensuring duty of care is provided; and

- coordinating service provision programs
(National Training and Information Service, n.d.).

Other certificate level III programs have been developed for UHWs, including Disability Worker and Community Care (DEST, 2002). By attaining the AQF certificate level III, PCs are provided with further career advancement opportunities, including the potential to achieve a certificate level IV in nursing through the completion of additional formal education.

Aberdeen (2004) points out that although nationally accredited competencies are intended to support care, training of the PC is usually a “work-based traineeship,” and as such, “with the variable quality of aged care organizations,” issues may arise for students, such as educators and employers having differing perspectives on appropriate roles and responsibilities, and practising beyond scope because of misinterpretation of the meaning of the competencies (p. 15).

Other UHWs in Australia, such as medical receptionists, are providing services under the direction of a physician that have been traditionally part of nursing practice. Patterson et al. (2000) found that medical receptionist’s duties may include clinical duties such as assessment, telephone advice and technical skills (e.g., EKGs, venipuncture and dressing changes). In some cases, the medical receptionist may have completed a non-accredited 40-hour training course to perform this role. Instruction includes one-hour courses on prioritizing patient needs and “surgical skills” (e.g., dressing changes and urinalysis), a three-hour course on resuscitation, and two half-hour courses on electrocardiography and infection control (pp. 231, 233).

4.4.3 United States

Education and training of UHWs in the U.S. are highly varied. Nursing aides, psychiatric aides and home health aides in many cases are not required to have a high school diploma or previous work experience. These workers provide a multitude of services, including providing personal care, taking vital signs and monitoring for physical, emotional and psychological changes in patients and clients. These workers generally work under the supervision of a team that includes nurses. In some settings, such as LTC and home care, they work more independently (U.S. Department of Labor, 2005a).

Some employers require some form of training or experience – acute care hospitals require high school graduation and six months to one year of experience as a personal care aide or home care aide (discussed below) – but others do not and train on the job (Employment Development Department, State of California, 2005). Workers who are hired without experience “must complete a minimum of 75 hours of mandatory training and pass a competency evaluation program within four months of their employment. Aides who complete the program are certified and placed on the State registry of nursing aides” (U.S. Department of Labor, 2005a). Without formal training, opportunities for advancement to other health professional jobs are limited. Some employers and unions provide career laddering opportunities by “simplifying the educational paths to advancement.”

Training for nursing aides is offered in secondary schools, adult education programs, community colleges, private vocational schools and some nursing care facilities. Courses covered through formal nursing aide training “include body mechanics, nutrition, anatomy and physiology, infection control, communication skills, and resident rights. Personal care skills, such as how to help patients bathe, eat, and groom, also are taught” (U.S. Department of Labor, 2005a). Formal training for psychiatric aides is mandatory in some states. Agencies that receive Medicare funding are required by federal law to hire only home health aides who have passed a competency test in 12 areas:

1. communication skills;
2. documentation of patient status and care provided;
3. reading and recording vital signs;
4. basic infection control procedures;
5. basic body functions;
6. maintenance of a healthy environment;
7. emergency procedures;
8. physical, emotional and developmental characteristics of patients;
9. personal hygiene and grooming;
10. safe transfer techniques;
11. normal range of motion and positioning; and
12. basic nutrition.

(U.S. Department of Labor, 2005a).

Training for personal or home care aides also varies from state to state, and usually occurs on the job or through formal training. These roles usually involve homemaking, personal care, meal planning, and accompanying clients to appointments. The role can also involve teaching clients and providing psychological support (U.S. Department of Labor, 2005b).

The National Association for Home Care offers voluntary national certification for home health aides and personal or home care aides. “The certification is a voluntary demonstration that the individual has met industry standards” (U.S. Department of Labor, 2005a and 2005b).

4.4.4 Canada

There is no national standard for education of UHWs in Canada. In 1998, four western community colleges based in Manitoba, Saskatchewan, Alberta and British Columbia entered a partnership agreement to standardize curriculum, testing and recognition of credits (Association of Canadian Community Colleges [ACCC] conference, Feb. 13-14, 2004). Similar standardization has occurred in eastern Canada as a result of colleges having a presence in more than one jurisdiction (e.g., the Holland College resident care worker [RCW] program offered in New Brunswick and Prince Edward Island). Examples of community and

private UHW educational programs offered in a sample of Canadian jurisdictions are listed in Table 3 in Appendix D.

As Table 3 shows, there is a range of educational attainments required for entry to UHW programs, from Grade 10 to Grade 12 or equivalent, although there is movement in Saskatchewan to change the entry requirement from completion of Grade 10 to Grade 12 starting in 2007 (Saskatchewan Institute of Applied Science and Technology [SIAST], 2005). The cost and length of programs also vary. For example, the length of programs listed in Table 3 range from three to eight months depending on the course. Core courses also vary depending on the nature of the program and program length; however, most courses provide training related to performing personal care, body mechanics and communication. Some programs include courses on dementia and other cognitive disorders and on working in an interdisciplinary team.

In Nova Scotia, Ontario, Manitoba and Alberta, there has been movement toward standardized curricula based on core competencies within the respective jurisdiction for certain types of UHWs (in Nova Scotia for CCA, Ontario for personal support workers [PSWs], and Manitoba and Alberta for Health Care Aides, respectively) (A. Mann, personal communication, November 12, 2005; R. Parker, personal communication, November 25, 2005; K. Neufeld, personal communication, November 23, 2005; Government of Ontario, 2005). Entry requirements vary from completion of Grade 10 to high school diploma, and in some jurisdictions a prior learning assessment review (PLAR) process is used whereby entry into the vocational or instructional program is based on a review of the applicant's previous education and experience. In Manitoba, the standardization requirement applies to both public and private sector schools (A. Osted, personal communication, November 16, 2005). The PSW program in Ontario was developed as a joint project by the Government of Ontario and the Ontario Community Support Association (OCSA), a membership-based, not-for-profit organization made up of 360 home and community care agencies in Ontario (OCSA, 2004).

In Nova Scotia, the government has taken the concept of standardization one step further by having all new graduates of the CCA program write a provincial exam. (At this time, personal care workers and home support workers who are currently in the field are not required to upgrade to a CCA certificate.) This means that to become a CCA, the candidate must take the requisite courses offered by community colleges and private career colleges and then write the provincial examination. A Continuing Care Advisory Committee monitors the educational component of the CCA, who at this time is not licensed. CCAs currently are educated to provide care primarily in home care and LTC settings. A pilot project is underway at a regional hospital in Nova Scotia, where CCAs are working in an acute care setting (A. Mann, personal communication, November 12, 2005).

In 1998, the National Association of Career Colleges (NACC), "an association of private career institutions from across Canada," introduced a standardized curriculum for member colleges offering PSW and personal attendant programs. Member schools based in British Columbia, Saskatchewan, Manitoba, Ontario and the Northwest Territories have chosen to use the NACC curriculum and examination. Students at member schools receive an NACC certificate on successful graduation (NACC, n.d.). Given the diversity among educational programs and in provincial/territorial requirements for UHW positions, it is not surprising that the OCSA made the following statements on its website:

There is no evidence that a national exam or any other “end of program” exam demonstrates knowledge or skill. Classroom and practical skill marks are the best indicators of an individual’s ability to work as a PSW....the national exam offered by some private career colleges is an advertising and marketing strategy....in ON a PSW certificate is all that is needed to work as a PSW (OCSA, 2004).

It appears that standardization of curricula is becoming more common in Canada, although it varies from jurisdiction to jurisdiction and between public and private career colleges. It is likely that without some form of regulation or legislation of either the worker or the practice environment, the nature and length of programs are likely to remain varied. In some sectors, employers are reporting that a formal education program is becoming a more common requirement. For example, in the home care sector, home support workers increasingly have completed some form of educational program to support the competencies required in their role (Home Care Sector Study Corporation, 2002).

In northern Aboriginal communities, the educational preparation of Aboriginal paraprofessionals can range from no education to formal programs. For example, community workers may have completed a 10-month program at the Nunavut Arctic College, or a four-semester integrated program from Confederation College in northwestern Ontario that provides a generic, broad-based curricula to prepare various community workers (e.g., with health and social services focus) (Minore & Boone, 2002). However, determination of the educational requirement resides with the employer, as evidenced by a recent government job posting for a home and community care representative in Nunavut. The advertisement does not list any education requirement, yet the employee will provide personal care and perform other activities that enable clients to remain in their homes (Government of Nunavut, 2005).

In other settings, despite efforts to employ trained UHWs, a changing health-care environment is affecting the ability of workers to maintain the necessary competencies to meet the ever changing needs of the population they serve. The Canadian Healthcare Association (2004) reported increasing levels of acuity and complexity of care needs in the LTC setting, including increased medical and technical interventions being required. These changes are putting greater demands on staff, leading to staff burnout and problems with quality of care (pp. 78-79). It was acknowledged in the report that a specialized body of knowledge was needed to work in LTC (p. 78). Some educational programs are responding to the changes in practice environments: in July 2005, a 45-hour program on dementia was added to the Saskatchewan home care aide program (SIAST, 2005).

5. Issues and Trends Related to UHWs

As we have seen, the nursing shortage and economic pressures resulted in the changing role of, and increased demand for, UHWs. In this section these and other drivers affecting UHW utilization are discussed in more detail, numbers of UHWs (where available) are identified, and issues related to the continual growth of UHW numbers are explored, particularly in relation to their impact on RNs and on patient safety and outcomes. As well, models that have been used to support and sustain RN roles and ensure safe patient/client care – such as legislation to enact nurse-patient ratios and regulation of UHWs – are reviewed.

5.1 Drivers for the Utilization of UHWs

Health-care systems around the world are changing in response to a number of factors, including advances in technology; the emergence of new medical interventions and higher numbers of elderly people in many western nations; increases in the demand for and access to health services; fiscal and economic pressures to reduce health-care spending; shifts from hospital-based care to home- and community-based care; and shortages of informal caregivers, nurses and other health-care professionals. All of these factors affect staff mix and contribute to the continued use of UHWs (Brown, 2003; Bryant, 2005; Buchan & Calman 2005; DEST, 2002; Home Care Sector Study Corporation, 2004; Saskatchewan Health and Saskatchewan Learning, 2002).

Buchan and Dal Poz identified “marked variations between countries and regions” in determining a health-care skill mix (2002, p. 575). To explain these global differences, they present several factors that affect decision-making regarding skill mix:

- skill shortages – may result in skill substitution
- cost containment – reduce labour costs by changing skill mix
- quality improvement – improve use and deployment of staff skills to achieve best mix
- technology innovation – re-train staff in new skills or introduce different mix or new types of workers
- new health-sector initiatives – determine cost-effective mix of staff, enhance skills of current staff, introduce new type of worker
- health sector reform – adjust staff roles; introduce new roles and new types of workers
- change in legislative/regulatory environment – adjust staff roles; introduce new skills and new types of workers. The authors also identify this last factor as a possible intervention (p. 576).

In Canada and other developed countries, these factors combine to varying degrees to determine the staff mix and the use of UHWs. With fewer health-care professionals available, roles are being redefined, scopes of practice are evolving and expanding, legislation is changing to support new roles, the emphasis on interdisciplinary care and team-based approaches is increasing, and new health worker roles are emerging (Romanow, 2002; Buchan & Dal Poz, 2002).

5.1.1 Cost Containment

In the U.S. in the late 1980s and early 1990s, there was a significant drive to reduce overall health-care costs, which were often linked to nursing models that were perceived as too costly (Lookinland, Tiedeman & Crosson, 2005). This resulted in the restructuring or re-engineering of the health-care delivery system, particularly in acute care settings. Given the “belief that the percentage of RN staff drives hospital costs” (Potter et al., 2003, p. 4), RN numbers were often reduced and replaced by UHWs (McGillis Hall, 1998). Similar re-engineering initiatives have since been instituted in Canada and the U.K. in an effort to reduce costs in LTC and home care settings, despite evidence that links higher RN staffing and/or increased nursing hours with better patient outcomes (Sovie & Jawad, 2001; Hodge, Ramano, Harvey & Samuels, 2004). A more in-depth discussion of patient safety and UHWs is provided in section 5.3.

In various health-care settings in Canada, including LTC and home care, increasing numbers of patients who require more acute and complex care means that more providers with specialized skills are needed; however, there is less funding to meet those needs (CHA, 2003; Home Care Sector Study Corporation, 2004). For example, dementia is one of the primary reasons for admission to a LTC facility, yet few UHWs have specialized training in this area (CHA, 2004). With fewer professional nurses and informal caregivers available, UHWs have become a mainstay in certain practice settings; indeed, they constitute approximately 70 to 80 per cent of the entire home care workforce (Home Care Sector Study Corporation, 2002).

In South Africa, UHWs are known as community health workers (CHWs) or community home care workers (CHCWs), and they address needs in the community rather than in hospitals. The increased use of CHWs and CHCWs is related to the out-migration of nurses as a result of recruitment by wealthier countries and the HIV/AIDS epidemic, but cost containment is also a significant contributor. The majority of health-care services are provided in the home because of the high costs associated with hospitalization in these countries (D. Russell, personal communication, December 14, 2005).

5.1.2 Nursing Shortage and the Evolving Role of Nurses

The shortage of nurses (defined as an inadequate number of nurses to meet projected demand) has been identified as a key factor in the increased utilization of UHWs. A skills shortage, as Buchan and Dal Poz (2002) have noted, is often addressed by substituting in other workers. Given this, an understanding of UHWs is predicated on a clear understanding of the impact of the nursing shortage.

Buchan and Calman (2005a) found that true shortages exist in countries in Africa, Asia, and Central and South America. Countries in Central Africa with the greatest need for nursing staff have “less than 10 nurses per 100,000” population, whereas western European countries have “more than 1,000 nurses per 100,000” population (p. 3). Interestingly, the term *nursing shortage* is used in wealthy or “high-income countries,” where the ratio of nurses to population far exceeds the ratio of nurses to population in far poorer or “low-income countries,” which indicates that the supply and demand balance in various regions and sectors of countries must be taken into account.

The true nature of nursing shortages has been debated, with causes in western nations including nurses leaving the profession because of the “working conditions, non-competitive salaries, and absence of full-time jobs” and in developing countries “because local nurses migrate to more affluent countries,” Baumann et al. (2004) confirm that the number of older workers in the current nursing workforce is increasing. Further, in Canada increased educational requirements and the costs of attaining those requirements may result in fewer entrants into nursing education programs (McMullin, Cooke & Downie, 2004).

Advances in technology and education as well as an evolving scope of practice with expanded legislative authority are shifting nursing from a generalist to a more technical or specialist role, or to that of an advanced nursing practitioner (e.g., nurse practitioner, nurse anesthetist, registered nurse first assistant, transplant nurse, nurse case manager). This movement appears to be facilitating the use of UHWs in more traditional nursing roles to address unmet patient care requirements. Bryant (2005), in a review of the literature on skill mix, cites a 2003 study by Carr-Hill et al. that identified two main changes in nursing deployment: specialization and unlicensed assistants. These trends are confirmed by the U.K. Department of Health: “professional staff are increasingly working as part of a wider health-care team...unregulated...are extending their skills so that they can undertake work previously done by registered professionals in order to meet patients’ needs” (2004, p. 5).

Interestingly, at the 2004 annual meeting of the Royal College of Nurses (RCN) in the U.K., it was proposed that “the caring component of nursing...be devolved to health care assistants to enable registered nurses to concentrate on treatment and technical nursing.” Although the resolution was defeated, it had been proposed “in the context of estimates of the amount of work that could be shifted from physicians to nurses (20%) and from nurses to health care assistants (12%)” (The Editors of *Nursing2004*, 2004). Bryant (2005) cites a 2000 study by Adams et al. that identified negative outcomes on nursing after expanded or extended roles were introduced. For example, nurses reported spending more time acquiring the new skill, incurring overtime and increased workload, while their usual duties were delegated to the UHW and led to a “deskilling of the workforce” (p. 31).

5.1.3 Barriers to UHW utilization

Sub-sections 5.1.1 and 5.1.2 describe trends that enabled the placement of UHWs in the health system. In this sub-section, examples of barriers to UHW use are described. Barriers range from funding models that result in reduced collaboration among health-care agencies or service providers to lack of standardized education, concerns about patient safety and liability associated with UHWs, lack of support by the nursing profession, and cultural and language-related barriers associated with UHWs. Many of these barriers are interrelated and dependent on context.

For example, a significant barrier to UHW utilization arises in the managed-competition care environment in jurisdictions such as Ontario, where a variety of agencies may be contracted to provide home care or community-based care to clients (N. Lefebvre, personal communication, December 12, 2005). This method of funding can result in a variety of competing companies or organizations providing support services to clients in their home at the same time – one company provides the registered nursing services, a second company provides the personal care services and a third provides rehabilitation services. As a result, UHWs may not function to their full capacity because of the need for supervision from a

regulated health-care provider who might be from a different organization. The regulated health-care providers may not be comfortable with being accountable for the supervision of the UHWs, or they may not have the appropriate mechanisms and processes in place to ensure the necessary follow-up. For example, if an additional visit is made to ensure competency of the UHW, this may not be funded by the purchaser. As a result, issues and concerns related to regulated health-care provider accountability are raised (N. Lefebvre, personal communication, December 12, 2005).

Different interpretations of nursing acts and related legislation and the variety of legislation can lead to differences in UHW utilization. According to Joan MacDonald of VON (personal communication, November 30, 2005), UHW policies of nursing regulatory bodies are inconsistent across provinces, and nurses across Canada receive varied perspectives on the nursing procedures and tasks that may be delegated to UHWs. In some jurisdictions, broader interpretation of nursing legislation permits innovative approaches to care that provide flexibility to meet client care needs, while in other jurisdictions there is less flexibility.

Liability is often cited in the literature as an issue, particularly for regulated nursing staff working with or supervising UHWs in the provision of health-care services (Rhodes, 1999). RNs in particular are often concerned about the risk of liability for negligence when delegating nursing functions. Although this concern is relevant, it can result in the underutilization of UHWs and decreased client access to health services in certain contexts. Clarity with respect to legislative and regulatory authority, agency policy and procedures, and education to support appropriate delegation and understanding of the roles of both regulated staff and UHWs reduces barriers to UHW utilization and helps ensure UHWs provide services within their own competence.

A contributing factor to liability concerns and to barriers to the appropriate use of UHWs is the lack of standardization of titles, education and roles of UHWs. Further discussion of patient safety in relation to education and workplace competencies and delegation is outlined in section 5.3 of this paper.

5.2 Statistics, Growth and Nurse Replacement

It is difficult to identify how many UHWs are assisting nurses or performing nursing duties around the world. Inconsistency in titles and lack of clarity regarding how UHWs are categorized or grouped for the purposes of data collection contribute to the uncertainty.

Difficulties in collecting accurate statistics on RN numbers have been noted in two recent reports by Buchan and Calman (2005) and Baumann et al. (2004). Buchan and Calman note that a key issue “is the lack of a universal definition of nurse...different international agencies...have developed different definitions, some related to educational level, some years of training....definitions of nursing may include nursing assistants [UHWs]” (p. 1). Similarly, Baumann et al. noted that quantifying RN staff internationally is difficult because of the various ways in which RNs are defined.

Table 4 (Appendix E) provides a snapshot of the number of regulated nurses or RNs, where available, and UHWs from a sample of countries. Given the difficulty in compiling accurate and complete data, and because of the various sources used to access and gather data, the data are presented in some instances as percentages of the health workforce and in others as

numbers. For Canada, only the number of RNs is listed owing to the lack of data on UHWs. The “other” category is used for Brazil and Suriname for roles that could not be clarified as being regulated or unregulated. Finally, where available, WHO data from two points in time are used to show trends in regulated nurse numbers and include actual numbers and the number of nurses per 100,000 population.

As Table 4 shows, UHWs in Brazil, Paraguay and Suriname are identified as nurse auxiliaries. The Brazilian data also include nurse technicians and community health workers. It is unclear whether these three categories include both regulated workers – such as RNs and LPNs – and unregulated workers or solely UHWs. Nurse auxiliaries in Brazil, for example, have three years of formal education, which relates more closely to an RN diploma program or a practical nursing program (Pan American Health Organization [PAHO], 2005). However, in a review of international literature conducted by Buchan and Dal Poz (2002), nurse auxiliaries were identified as UHWs.

Data for European (except the U.K.), Asian and African countries are not presented in the table because of WHO’s use of the term *nurse*. It is difficult to tell in WHO data which category of health worker is being counted as a nurse, whether regulated or unregulated. The authors of the ICN report (2005a) state that the WHO nursing data may not be limited to registered nursing personnel and may include midwives or UHWs or both (p. 2).

It is reasonable to speculate that in African countries, in which the professional nursing workforce has been affected by HIV/AIDS, there are greater numbers of UHWs – including unpaid caregivers – providing care today than a decade ago because there is nobody else to provide care (Buchan & Calman, 2005; D. Russell, personal communication, December 14, 2005).

In Australia, according to Patterson et al. (2000, p. 229), “the greatest identified change has been in the proportion of nurses, which declined from 71% of the health workforce in 1986 to 65% in 1996...primarily because total nurse numbers increased by only 0.5% from 1991 to 1996, while the increase in the total number of persons employed in other health occupations was 15.7%....the diminishing proportion of nurses is a trend to appropriate the work of nurses to unqualified, less expensive workers.” A 2002 DEST report on nursing notes that from 1987 to 2001, there was a 424 per cent increase in the number of unregulated workers, a 20 per cent decrease in enrolled nurses (LPNs), and a 20 per cent increase in RNs; these changes were also calculated as a 10 per cent annual increase in unregulated workers, a 1.2 per cent annual decrease in LPNs, and a 1.4 per cent annual increase in RNs. These trends suggest that with an increasing number of UHWs, more nursing duties are being undertaken by this group, resulting in a decrease in RNs and in particular enrolled nurses.

The actual number of UHWs working in the U.S. is unclear. Although the number of nurses has increased, this growth did not match population growth nor explain why there is a reported nursing shortage in the U.S. (ICN, 2005a). In 1995, there were 783.7 nurses per 100,000 population; by 2004 the ratio had decreased to 772.5 nurses per 100,000 population (WHO nursing data, U.S.) and, as in the U.K. and Canada, nursing roles were becoming more specialized. With increased specialization, fewer nurses available to carry out traditional nursing and continued economic pressure to reduce health-care budgets, the literature supports an increase in the number of UHWs and in UHWs performing nursing work instead of RNs.

The substitution of RNs with UHWs was certainly commonplace in the U.S. in the 1980s and 1990s as a cost-saving measure (McGillis Hall, 1998), and it appears that substitution continues to be a trend across many settings in the name of the nursing shortage, even when nurses are available to perform the work (Trossman, 2002, p. 10). In addition to an increased use of UHWs, there has also been legislation in the U.S. that supports UHWs performing more traditional nursing work. For example, legislation has been considered or enacted to provide teachers and school secretaries with the authority to administer insulin and glucagon in schools, and for medication technicians to administer a range of medications in LTC homes even in the absence of adequate training. The latter group would be trained by the employer with “no pre-set curriculum,” yet would be responsible for administering medications topically, orally and subcutaneously. In one report, a sample of school nurses in the U.S. stated that they delegated 75.6 per cent of their medication administration duties, primarily to school secretaries (McCarthy, Kelly & Reed, 2000).

According to the U.S. Department of Labor (2005a, 2005b), there were more than 2.6 million UHWs working in assistive roles in 2002 – more than the number of regulated staff. Further, the department reported that overall employment for nursing aides, home health aides and psychiatric aides is “growing faster than the average of all occupations through the year 2012,” which equates to a growth rate of 21 to 35 per cent. Additionally, “employment of home health aides is expected to grow the fastest, as a result of both growing demand for home health-care services from an aging population and efforts to contain health-care costs by moving patients out of hospitals and nursing care facilities as quickly as possible. Consumer preference for care in the home and improvements in medical technologies for in-home treatment also will contribute to faster-than-average employment growth for home health aides” (U.S. Department of Labor, 2005a). This rapid growth, along with evidence in the literature, supports the concept that RNs are being replaced by UHWs in many practice settings.

In Canada, the actual numbers are unclear. The Canadian Institute for Health Information does not currently collect data on UHWs. Statistics Canada collects data on these workers through the Labour Market Survey, but these data were not readily available to the author. A survey on the nursing workforce conducted by the Human Health Resource Unit at the University of British Columbia (2000) asked Canadian employers about practices and policies related to nursing workforce deployment of both professional staff (RNs, LPNs and RPNs) and nurses’ aides. A cross-section of employers from tertiary or teaching hospitals, regional and community hospitals, LTC facilities, mental health agencies, public health and home care were surveyed. The survey identified 4,964 UHWs employed full time, compared with 13,776 RNs employed full time.

In Nova Scotia, data collected on UHWs (PCWs and CCAs) showed that 4,000 of these workers were employed in LTC facilities in 2001 (Nova Scotia Health Human Resources Study, 2001). In 2002, 1,621 UHWs (HSWs and CCAs) were employed with non-profit home support agencies (Nova Scotia Health Human Resources Study, 2002). No comparison data were available to determine trends. Manitoba saw an increase in all full-time nursing positions from 2003 to 2004, with RNs having the largest increase, from 41 to 44 per cent, and UHWs a one per cent increase, from 39 to 40 per cent (Government of Manitoba, 2005).

Because of the limited data available on the number of UHWs in Canada, key informants were asked to gather perspectives on the issue in their jurisdiction or sector and to identify

where UHWs were working and whether the numbers were growing. Three respondents shared their perspectives. The following commentary was offered by a workforce planning consultant with Alberta Health and Wellness:

The number of UHWs is growing, as is the population to which these workers provide care. This workforce is more of a transitional workforce than a permanent one (e.g., individuals move in and out of this workforce more quickly than other individuals move in and out of their profession). One reason for this may be the type of applicants to the programs – women re-entering the workforce who may after a short time move on to other types of jobs or advance along the continuum into other health-care provider professional opportunities (R. Parker, personal communication, November 25, 2005).

Manitoba informants provided perspectives from two sectors: mental health and acute care. It was reported that there is an increase in the use of UHWs or psychiatric nursing assistants for suicide observation, and in some cases UHWs have been assigned their own patient in both in-patient and community mental health facilities (A. Osted, personal communication, November 16, 2005). In acute care, there is a move in one large tertiary hospital in Winnipeg to reduce the number of UHW staff and replace them with RN staff (K. Neufeld, personal communication, November 23, 2005).

5.3 UHWs and Patient Safety

5.3.1 UHW Education and Workplace Competencies

As we saw in section 4, there is a broad range in UHW training. The training, however, is primarily geared toward UHWs working in the long-term and home care sectors. Education ranges from no training to on-the-job training to more formal education with theory and practice. Additionally, for formal programs, there is variation in entry requirements, length of programs and competencies taught. Given this variability, there may be a disconnect in some settings between training and the requisite competencies to do the job. This is particularly true in settings that are not governed by regulation (e.g., public hospital legislation, LTC legislation) or that lack appropriate employer policies (e.g., hiring requirements, performance standards).

Kido suggests that the lack of standardized training of UHWs working in hospitals in the U.S. has “contributed to the surrounding controversy about their use” (2001, p. 29). As noted earlier in this paper, UHWs employed in acute care were more readily accepted by RNs in the U.K. than in the U.S. because the education of UHWs in the U.K. is standardized and at a higher level, and RNs know what to expect from these workers as a result (McLaughlin et al., 2000). Although UHWs in Canada are working in acute care settings, their roles appear to be more focused on providing personal care and supportive services than on performing technical skills (T. Rowe and N. John, personal communication, December 2, 2005; K. Neufeld, personal communication, November 23, 2005).

Further, the tasks or procedures performed by UHWs were identified as being appropriate for the context of UHW practice, according to a cross-section of key informants surveyed or interviewed for the purposes of this paper. They indicated that the UHWs received adequate training to support the functions they performed, they understood their roles and boundaries,

and the nurses supervising the UHWs care generally understood their accountabilities (B. McGill, personal communication, December 6, 2005; C. Kohm, personal communication, December 12, 2005; N. Lefebvre, personal communication, December 12, 2005).

In Australia, Patterson et al. identified clinical duties performed by medical receptionists such as dressing changes, venipuncture, patient assessment and telephone advice, yet only some of the study participants had completed a non-certified 40-hour course designed to prepare receptionists to perform these duties (2000, pp. 231, 233). It can be argued that a 40-hour course will not adequately prepare a receptionist to implement appropriate infection control techniques when changing a dressing or assessing a patient or client health concern, and then provide accurate telephone advice. Several nursing associations explicitly state that it is inappropriate to delegate assessment because it requires knowledge, critical thinking skills and judgment beyond the competency of UHWs (ANA, 2005a; NCSBN 2005a; Saskatchewan Registered Nurses' Association [SRNA], 2004).

The public are often unaware of who is providing their care and are not always able to easily distinguish between an RN and a UHW (Lange & Polifrani, 2000). This can be a significant safety concern, especially if UHWs are providing care within the domain of RN practice without the necessary training or education to support that care. The public would likely be surprised to learn that the care they are receiving is provided by a medical receptionist with limited or no training. The lack of standardization in UHW education also creates confusion and patient safety concerns for RNs. For example, the RN may not be aware of the educational background or training of the UHW and, as a result, delegate nursing duties that, under nursing legislation, should not be delegated or that the UHW is not competent to perform (ANA, 1992b).

Another issue related to competency in the workplace is supervision of care. In LTC and home care settings, supervision by an RN or other regulated professional can be limited or restricted by distance (College of Nurses of Ontario [CNO], 2005; S. Sholzberg-Gray, personal communication, December 2, 2005). For example, home health aides in the U.S. who provide a range of personal care services to long-term clients, including caring for ventilator-dependent clients, "generally work alone, with periodic visits by their supervisor" (U.S. Department of Labor, 2005a).

Limited supervision occurs in both publicly funded and privately funded care settings, but it is more of a concern in the private sector. In some instances, there may be no supervision at all, as in the example of a self-employed UHW who provides user-pay services directly to clients in their homes (U.S. Department of Labor, 2005b). The clients may be unaware that the UHW is performing the task incorrectly or that the UHW may not have the knowledge to identify certain health problems. If there is supervision, the supervisor may not be aware there is an issue unless the UHW reports it (S. O'Hare, personal communication, December 2, 2005; S. Sholzberg-Gray, personal communication, December 2, 2005).

In 1998 in the U.S., the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry released a report recommending that "minimum standards for education, training, and supervision of unlicensed paraprofessionals be established." The commission called for more research into "the type of training such individuals require, the kinds of tasks they are assigned, and the relationship of those factors to quality" with emphasis placed on the home and community sectors, "where unevenness of

quality, training and supervision appear to be matters of some urgency” (Health Care Quality Commission, 1998).

5.3.2 Delegating to UHWs in the Workplace

The need for education to support delegation is paramount. RNs must clearly understand the principles of delegation, including what, when and how to delegate, to ensure that only appropriate activities or tasks are delegated (CNO, 2004; CRNBC, 2005). The need for RN education was identified as a key issue by informants. Two informants stated that nurses may not always understand their accountability in the context of delegation (K. Neufeld, personal communication, November 23, 2005; C. Kohm, personal communication, December 12, 2005). Another informant indicated that there had been instances “in facilities where there are more unlicensed assistive personnel (UAP) than there are regulated persons, the UAP often end up defining their own role and sometimes even that of the regulated person. With the low staffing ratios in places like personal care homes/nursing homes, the regulated person is very dependent on the UAP to ensure basic needs and safety are met” (A. Osted, personal communication, November 16, 2005).

According to the Canadian Nurses Protective Society (CNPS) (2000), “delegation occurs when either the employer or the nurse transfers authority to a health care worker in a selected situation to do work traditionally performed by a nurse.” The practice of nursing, that is, the overall assessment, identification of client status, planning care, interventions and evaluation of care, should not be delegated (CNPS, 2000; CRNBC, 2005). Delegation to a UHW occurs when a task or procedure function being delegated is primarily performed by RNs and is outside the training and role description of the UHW (CRNBC, 2005). In some jurisdictions, such as Ontario and Alberta, the functions performed by RNs are defined in legislation and called “controlled” or “reserved” acts. The RN may delegate a procedure or task that falls under a controlled or reserved act that the RN has the authority to delegate and the UHW is competent to perform (CNO, 2004; College and Association of Registered Nurses of Alberta [CARNA] et al., 2003).

The RN is accountable for the decision to delegate based on an assessment of the client’s needs, for supervising the UHW and for evaluating outcomes of the care. The UHW is responsible for the safe performance of the task and for knowing what they as an UHW are able to perform and what would require additional training to safely perform (CRNM, 2003). Employers are responsible for establishing policies that support safe and appropriate delegation and for providing the necessary training (CNPS, 2000).

Initiatives related to UHWs, appropriate staff mix, RN accountability and responsibility, and delegation developed by ICN, national nursing associations and Canadian jurisdictional nursing associations and regulatory colleges, including legislation, practice standards and position statements, are discussed in sections 6 and 7.

5.3.3 UHWs and Patient Outcome Studies

McGillis Hall and Doran (2001) conducted a nursing staff mix outcomes study in Ontario involving 19 teaching hospitals and found that “more than 60% of the hospital units in this study utilized a staff mix of both regulated and unregulated staff.” Results of the study showed that higher proportions of regulated nursing staff resulted in decreased patient care

hours, increased patient satisfaction, better pain outcomes and decreased ER visits post-discharge. Additionally, a lower proportion of regulated nursing staff was linked to increased medication errors and wound infections (McGillis Hall & Doran, 2001; McGillis Hall, Doran & Pink, 2004).

White and McGillis Hall also provided an overview of the evidence linking nurse staffing with adverse occurrences and factors that affect or influence patient safety outcomes, such as perceptions about error and system issues (Doran, 2003, p. 213). System issues, such as gaps or disruptions in care created by the increasing complexity in patient care needs, have been linked to adverse outcomes. The introduction of UHWs, for example, has exacerbated potential gaps in service because the number of patients that RNs are responsible for has increased at the same time they have taken on additional supervisory responsibilities.

There have been many other studies, conducted primarily in the U.S., that link nurse staffing levels with patient outcomes. For example, a recent discussion paper published by the Canadian Federation of Nurses Unions (CFNU) on nurse-to-patient ratios cited findings from numerous studies that linked “inadequate nurse staffing and a wide range of adverse outcomes including pressure ulcers, urinary tract infections, pneumonia, postoperative wound infections, medication error, failure to rescue, and readmission” (2005, p. 9). Needleman and Buerhaus (2003) found strong evidence for the link between mortality and nurse staffing in a study review, while other authors have emphasized that it is important to establish the baseline association between staffing levels and patient outcomes before changes to staffing are enacted to ensure objective assessment of the data collected (Potter et al., 2003).

Buchan and Dal Poz (2002) analyzed international literature on the effect of skill mix in relation to health-care professionals and UHWs. They found that most of the research focused on the nursing workforce and examined cost-effectiveness and impact on quality of care. Some research concluded that introducing UHWs may lead to cost savings and positive patient satisfaction, whereas other studies linked UHWs to decreased quality of care, increased sick leave and higher workload for RNs. These studies were viewed as methodologically weak in that they were based on short-term implementation and demonstrated bias, for example, study authors supporting or opposing the use of UHWs.

With an aging nursing workforce, decreased enrolment in nursing schools and changing roles for nurses, there is a danger that there will not be enough nurses to take care of basic patient or client care needs, resulting in gaps in service. Some have suggested that UHWs could provide basic nursing services as a strategy for addressing the nursing shortage, but training must be enhanced to support the necessary skill development (McGillis Hall, 1998; Buerhaus, Staiger & Auerbach, 2000). This is particularly important in acute care settings, where the acuity and complexity of patient or client needs have increased and thereby require more nursing care than ever before (Lang, Hodge, Olson, Romano & Kravitz, 2004, p. 326).

The same increase in acuity and complexity has occurred in other sectors, particularly home care. Given that the latter is the fastest-growing sector, the number of UHWs will continue to grow. In Canada, as we saw earlier, 70 to 80 per cent of the entire home care workforce are reported to be UHWs. As acuity increases, workers are providing fewer traditional services, such as housekeeping, and more personal care, including “skilled nursing tasks delegated by professional nurses” (Home Care Sector Study Corporation, 2002). It is therefore critical that UHWs have the necessary training.

In addition, a Canadian study by Markle-Reid et al. (2003) provided evidence for the effectiveness and efficiency of adding a nurse to the usual home care service personnel to provide health promotion and preventive care. Specifically, the study showed “that having nurses provide seniors with health promotion, compared to providing professional services on a reactive and on-demand basis, results in better overall mental health functioning, a reduction in depressive symptoms, and an enhanced level of perceived social support at no additional expense from a societal perspective” (p. iii). Given today’s fiscal climate, the drive to use UHWs to reduce health-care costs and the growth of the home care sector, this study is timely and important because it supports the key role nurses play in improving the quality of life of seniors living at home without additional cost to the system.

5.4 Staff Mix Models or Approaches Used to Facilitate Patient Safety

Two types of staff mix models or approaches used to promote patient safety in relation to UHWs were identified in the literature:

- nurse staffing plans and nurse-to-patient ratios; and
- regulation of UHWs.

5.4.1 Nurse Staffing Plans and Nurse-Patient Ratios

Major cutbacks in hospital nursing budgets, which resulted in “fewer nurses working longer hours, while caring for sicker patients,” were the catalyst for legislated nurse staffing plans and nurse-patient ratios in the U.S. The legislation is intended to hold hospitals accountable for ensuring adequate nurse staffing (ANA, 2004). The ANA describe three legislated or regulatory approaches:

1. Nurse staffing plans, which require hospitals, in collaboration with nurses, to determine appropriate nurse staffing based on patient or client needs;
2. Nurse-patient ratios, which require employers to establish specific nurse-patient ratios; and
3. A combination of nurse-staffing plans and nurse-patient ratios.

To date, eight states have introduced legislation or regulations to implement nurse staffing plans in hospitals. This flexible approach to nurse staffing is based on the principles developed by the ANA (2005a) and takes into account the unique features of the hospitals, including staffing skills and mix, patient needs and acuity, and technology. In addition to state legislation, federal legislation has been introduced that requires nurse staffing plans as a condition of participation in Medicare (ANA, 2004).

Legislated nurse-patient ratios were first introduced in California in 1999. The legislation “requires the California State Department of Health services to establish minimum nurse-patient ratios in acute care general, special and psychiatric hospitals” (Lang et al., p. 326). Since then, four other states have introduced legislation. A key feature of the legislation is the penalties associated with violation, which include “loss of hospital license, fines, termination of Medicaid reimbursements, private right of action and civil penalties.” In 2004, eight states introduced a combined legislative approach; that is, legislation includes both nurse-patient ratios and staffing plans (ANA, 2004).

In the late 1990s in the state of Victoria, Australia, nursing shortages resulted in hospital administrators using various approaches to address the issue, including increasing nursing workload, implementing mandatory overtime and introducing UHWs to perform nursing duties. The Australian Nurses Federation (ANF) identified these strategies as endangering patient safety and exacerbating the shortage, since nurses were either leaving nursing practice or choosing to work in other practice settings. In 2001, legislated minimum nurse-patient ratios were established for all public hospitals (CFNU, 2005, pp. 15, 16).

To date, Canada does not have legislated nurse staffing plans or nurse-patient ratios in any province or territory, although nurses' unions in Alberta and Ontario have raised the issue during the collective bargaining process and the CFNU is currently exploring the subject (CFNU, 2005, p. 12). CNA (2003) developed principles to facilitate decision-making with respect to staffing and safe nursing care that are applicable to any practice setting but are not mandatory. The principles outline responsibilities of RNs, nurse leaders, employers and others to facilitate safe decision-making. As a side note, LTC regulations in Ontario were amended in 2004 to ensure that at least one RN is on staff 24 hours a day in LTC facilities (Government of Ontario, 2004).

Researchers have mixed views on nurse staffing plans and specific nurse-patient ratios. Some study results associate nursing hours and staff mix with important patient outcomes, but methodological issues (such as not adjusting for skill and/or patient mix) make it difficult to define specific ratios based on this research (Sovie & Jawad, 2001; Buerhaus, Staiger & Auerbach, 2000; Lang et al., 2004). Lang et al. (2004) further suggest that "if as expected the number of RNs declines in the future, then some reduction in nurse staffing levels is inevitable...the real issue is ensuring that the results of...staffing reductions on quality of care are minimized...rather than focus on regulation...efforts could be more productively directed at monitoring hospitals that cut nurse staffing excessively and making information publicly available" (p. 281).

Other authors such as Curtin (2003) state that "the literature reports data that help determine what is, indeed, appropriate staffing...ratios are important – a consensus seems to be emerging supporting a range of from 4 to 6 patients per nurse in most acute care hospital inpatient settings."

5.4.2 Regulation of UHWs

In 2004, the Department of Health in the U.K. initiated consultations with numerous stakeholders to regulate UHWs in England and Wales. The three main reasons given were:

- "to protect the public requiring these staff to meet standards of practice and conduct and training and by dealing with those who do not meet the standards;
- to provide a regulated workforce of practitioners who can safely fill jobs vacated by professional practitioners as they take on extended medical roles, and who can build on this to go on to professional practice if they wish; and
- to plug gaps in the overall regulatory framework so that all staff in health and social care whose work could impact on patients or clients are subject to similar regulation."

The proposed regulation is intended to close “current loopholes,” where regulated staff have been struck from the register but return to work in unregulated roles performing the same functions (Department of Health, U.K., 2004, p. 6). According to Nazarko, there are many examples of UHWs performing nursing duties who are not regulated or may have been regulated in another country, such as enrolled nurses from Australia who do not qualify for registration in the U.K. because an equivalent registry no longer exists (2003, p. 9). The Nursing and Midwifery Council (NMC) have responded to the consultation in support of regulation of these workers and have suggested that the NMC regulate workers providing nursing assistive service (2004). Although the movement to regulate UHWs in the U.K. appears to be proceeding swiftly – that is, a report about the regulation of health-care support staff is to be given by year-end to the secretary of state – the actual length of time before a decision is made is uncertain (P. Mullany, personal communication, November 2, 2005; S. Skytes, personal communication, December 13, 2005). Additionally, to date no decisions have been made about who should regulate these staff or what the nature of the regulation would be (S. Skytes, personal communication, December 13, 2005).

In the U.S., various methods exist to regulate the practice of nurses’ aides (NAs). NAs who work in Medicare or Medicaid-funded LTC facilities are required to complete the state-approved training program, pass an examination and acquire state certification (U.S. Department of Labor, 2005a). They are then registered on state registries; 13 of these registries are currently managed by state boards of nursing (NCSBN, 2005a). As noted in the NCSBN paper, there is no regulation for NAs working in acute care.

Reference to NAs may also be included in state nursing statutes and/or regulations under sections dedicated to NA practice (23 states), training and educational requirements (25 states), NA certification or licensure (13 states) and regulation of medication assistants (20 states) (NCSBN, 2005a; Kido, 2001). Most states also provide definitions of delegation (44 states), a delegation section in the statute (30 states) and discipline rules respecting delegation and supervision (32 states).

In Canada, no jurisdiction currently regulates UHWs. Several jurisdictions have standardized curriculum for some UHWs who work primarily in the long-term and home care sectors. Nova Scotia has built on this model and developed standardized education, a competency examination, a certification process and a registry for CCAs. However, at this point the CCAs are not “licensed” (A. Mann, personal communication, November 12, 2005). Ontario, on the other hand, is fully engaged in a formal review process to determine whether certain UHWs should be regulated. The Health Professions Regulatory Advisory Council (HPRAC), which provides policy advice to the minister of health and long-term care on issues related to the regulation of health professionals, is currently conducting a review in response to a recent Ministerial Referral (HPRAC, 2005a). Part of this review, which is to be completed by April 2006, will explore the regulation of UHWs such as pharmacy technicians and PSWs.

The PSW project in Ontario will, among other objectives, “review the range of work carried out by personal support workers and make initial recommendations on whether all or some part of this range would indicate that personal support workers should be considered for regulation under the RHPA [*Regulated Health Professions Act*]” (HPRAC, 2005b).

Although Manitoba standardized its curriculum for health care aides in 2002, there does not appear to be movement to regulate UHWs. Alberta is not interested in regulation or in a provincial or national exam at this time. The current curriculum includes an examination that is felt to be satisfactory in testing necessary competencies. Additionally, there is concern in Alberta that a national or provincial exam would place significant pressures and unnecessary strain on these workers (R. Parker, personal communication, November 25, 2005).

Joan MacDonald gave a personal perspective when she stated that “a standard of expectation for service and care delivery at the point of care is critical; but regulation is not necessarily the answer. I do support standardization of competencies at the point of care, and processes that encourage that uptake to meet increasingly complex home care needs. However, in a worst case scenario, not having enough potential employees because they lack a ‘credential’ could be a barrier to staffing, especially as UCPs can be a transient work force” (J. MacDonald, personal communication, November 30, 2005). Administrators from the Northern Health Authority in British Columbia indicated support for standardization of competencies and educational programs, with the caveat that programs remain flexible and creative in order to meet the unique needs of jurisdictions and workplaces. For example, in northern areas of the country, the ability to recruit and maintain UHWs could be negatively affected by standards that cannot readily be met. These administrators viewed regulation of UHWs as a barrier because it limits flexibility in utilization and in ensuring a stable workforce. However, they also indicated that for the public, regulation is a vehicle to address conduct issues, and they concluded that it may warrant more discussion (T. Rowe and N. John, personal communication, December 2, 2005). The Canadian Practical Nurses Association (CPNA) has engaged in informal dialogue on the subject and has indicated that the regulation of UHWs may be the best way to protect the public (S. O’Hare, personal communication, December 2, 2005).

Jurisdictions in Canada will be closely monitoring the outcome of the Ontario review in light of the federal/provincial/territorial agreement on internal trade, which requires all jurisdictions, except Quebec, to enable labour mobility across the country’s workforce.²

At present, only the U.K. regulates or is considering regulating UHWs, although a number of NNAs expressed interest at a recent forum in Taipei, Taiwan, in supporting regulation of these workers (ICN, CNR Forum III, 2005; P. Hughes, personal communication, July 25, 2005). Australia has a campaign currently underway to explore UHW regulation. This initiative will be discussed in more detail in the next section.

² Labour Mobility - Chapter 7 of the Agreement on Internal Trade (1994) is intended to grant qualified workers in one province or territory the same access to employment opportunities in another Canadian province or territory (HRSDC website, retrieved December 1, 2005, from <http://www.hrsdc.gc.ca/asp/gateway.asp?hr=en/hip/hrp/corporate/labourmobility/labourmobility.shtml&hs=hzp>).

6. Synopsis of International and National Nursing Association UHW Initiatives

RNs who work with unregulated workers face challenges related to delegation, accountability and liability. This section provides an overview of UHW initiatives involving the International Council of Nurses (ICN) and NNAs and includes legislative or regulatory vehicles supporting the regulation of UHWs, position statements and guidelines. Some of the initiatives are intended to assist or guide RNs in understanding their responsibilities and accountability when working with UHWs and include legislation, practice standards and position statements. These initiatives also inform RNs, UHWs, the public, employers and the government about issues related to UHWs from the nursing association perspective.

6.1 International Council of Nurses

ICN, like many of its member NNAs, has developed position or policy statements in recognition of the impact of the changing health-care environment and the “proliferation of new categories of health workers” on the workload and accountability of RNs (ICN, 2000). The ICN position statement *Assistive or Support Nursing Personnel* (2000) states that “the role, preparation, standards, and practice of assistive nursing personnel must be defined, monitored, and directed by Registered Nurses.” It further identifies – given that the work of UHWs is inextricably linked to the work of professional nurses – roles for UHWs, nurses, employers, educators and NNAs in ensuring safe, effective, quality care, including appropriate delegation.

A revised version of the ICN document (2004) contains the following statement: “persons receiving health care and those employing nurses have a right to know whether they are dealing with a legally qualified nurse. Reserving the title Nurse for those who meet the legal standard allows the public to distinguish legally qualified nurses from other nursing care providers.”

ICN is aware that many countries are increasingly interested in regulating UHWs. As a result, while preparing for its 7th International Regulation Conference, held in Taiwan in 2005, the ICN called for papers on the theme of regulation of assistive personnel and other unlicensed workers in nursing, but, surprisingly, received no abstracts on the subject (P. Hughes, personal communication, July 25, 2005).

The ICN Council of National Representatives (CNR) held a forum on patient safety and its relation to staffing on May 21, 2005, as part of its quadrennial meeting. Participant countries included Australia, Canada, Denmark, Ghana, Greece, Japan, Mexico and the U.K. Themes emerging from the forum included the need for continuing education to maintain competency, introduction of nurse-to-patient ratios that support quality of care, and identification that “cost-containment policies were leading to widespread substitution of registered nurses by auxiliary staff” (ICN, CNR Forum III, 2005).

6.2 National Nursing Associations and Regulatory Boards

6.2.1 United Kingdom

As we saw in section 5, there is movement in the U.S. to regulate UHWs, or unregulated health-care staff, as they are referred to in the U.K. RCN, the professional association of nurses, and NMC, the regulatory body for nurses and midwives in the U.K., have been involved in the consultation process related to the government's proposal to regulate UHWs.

NMC has endorsed the government's proposal to regulate UHWs (2004). Other key points made by NMC are:

- emphasis needs to be placed on the role the employer plays in regulation, particularly in relation to managers discharging their responsibilities;
- regulation facilitates clarity regarding delegation of care; and
- NMC should be the sole regulator of UHWs who work under the supervision of NMC members.

Interestingly, although NMC endorses staff development or continuing education to enhance the competencies of UHWs, it does not support setting “a new standard of proficiency ...associated with a specified academic performance” (p. 2).

RCN is also engaged in activities related to nurse's roles and patient safety. In a recent focus group consultation, concerns were raised about skill mix and patient safety. RCN plans to address themes arising from this study during the coming year (ICN, CNR Forum Report, 2005, p. 58). Additionally, RCN commissioned a study of the relation between the registered nursing workforce and patient outcomes. The study results suggest that a higher proportion of RNs is linked to decreased patient mortality, a reduction in infection rates and decubitus ulcers and a lower incidence of falls and medication errors. RCN is planning more research on the economic issues raised in the study report (ICN, CNR Forum III Report, 2005, p. 58).

6.2.2 Australia

The Royal College of Nursing Australia (RCNA) and ANF developed a joint position statement to “assist the nursing profession, employers, governments, and consumers to clarify [the] relationship between registered and enrolled nurses and assistants in nursing and other unlicensed workers (however titled) in the provision of safe, competent, and ethical health care” (2004, p. 1). The statement provides direction and guidance for the process of delegation, respecting the roles, responsibilities and accountabilities of those delegating (RNs) and delegates (enrolled nurses and UHWs).

As in most countries, the process of delegation in Australia is governed by relevant nursing legislation. The position statement outlines eight principles to guide the delegation process:

Principle 1 – Assessment – RNs undertake the initial and ongoing assessments of nursing care needs;

Principle 2 – Delegation – Following assessment by RNs, aspects of nursing care may be delegated;

Principle 3 – Supervision – RNs supervise (direct or indirect) aspects of nursing care that are delegated;

Principle 4 – Education – Assistants in nursing and other unlicensed workers should have relevant education and training consistent with Level III of Australian Qualifications Framework;

Principle 5 – Competence – Aspects of nursing care that can be undertaken must be consistent with their level of education, training and competence and the level of acuity and stability of the person requiring care;

Principle 6 – Accountability – Assistants in nursing and other unlicensed workers remain accountable for their own actions and are responsible to RNs and employers for delegated activities;

Principle 7 – Right to Know – People receiving nursing care and their families have the right to know the name, designation, qualifications and role of the worker who is involved in their care, and who is supervising them; and

Principle 8 – Employer’s Responsibility – Provide clear policies and protocols within which enrolled nurses and other unlicensed workers function, having regard to the provision of safe care, legal requirements within the particular jurisdiction care is being provided and educational preparation of the assistant/UHW.

In November 2004, ANF endorsed two additional position statements: *Assistants in Nursing and Other Unlicensed Workers (However Titled) Providing Aspects of Care* (2004a) and *Delegation by Registered Nurses* (2004b). Both statements are based on the principles endorsed by ANF and RCNA in the joint statement (2004). The ANF statements identify the responsibilities of RNs, assistive personnel and unlicensed workers, and employers respecting the provision of nursing care and delegation. Perhaps the most salient points from these statements relate to the education of UHWs and the role and responsibilities of employers to ensure competent care. For example, the first statement suggests that the education of assistant personnel and other unregulated workers “be competency based, recognize prior learning and experience...be conducted in the vocational education sector at a level appropriate to facilitate articulation and credit transfer to other nursing programs...and prepare a worker to achieve a relevant ...qualification at AQF Level 3” (ANF, 2004a).

The second statement includes a number of employer responsibilities respecting delegation such as ensuring that:

- employees have the necessary competencies to carry out their role.
- RNs are aware of, or have access to, information about the competency level of personnel to whom they may delegate nursing duties.
- RNs are not expected to delegate care that is prohibited by relevant legislation.
- workplace policies and practices are consistent with relevant legislation regarding standards for nursing practice.

Additionally, employers must be aware of staffing levels, skill mix and the nursing care needs of clients when employing and allocating staff and providing resources to support continuing education for all staff responsible for patient care (ANF, 2004b).

As noted earlier, the ANF is in the initial phases of exploring regulation of UHWs. According to Victoria Gilmore (personal communication, October 24, 2005), an ANF federal professional officer, ANF branches in each state and territory currently have campaigns underway, although many of these campaigns are in the early stages:

It is early days yet and there is significant opposition from governments, employers and other members of the nursing profession to licensing of assistants in nursing and other health care workers (however titled). It will be a long haul campaign, I think, but the release of the position statement was an important first step as we have only recently reached consensus within our own organization.

6.2.3 United States

For many years, the American Nurses Association (ANA) has lobbied government for appropriate or safe RN staffing levels in the U.S. as a means of ensuring patient safety and facilitating appropriate use of UHWs. The regulatory frameworks used, including legislation, were discussed in subsection 5.4 of this paper. In 1992, for example, ANA issued two position statements: *Registered Nurse Utilization of Unlicensed Assistive Personnel* (1992a) and *Registered Nurse Education Relating to the Utilization of Unlicensed Assistive Personnel* (1992b).

In the first statement (1992a), ANA purported that UHWs were “inappropriately performing functions which are in the legal scope of nursing practice...it is the nurse who must have clear definition of what constitutes the scope of practice.” Underlying principles for the utilization of unlicensed assistive personnel (UAP) were identified:

- It is the nursing profession that determines the scope of nursing practice.
- It is the nursing profession that defines and supervises the education, training and utilization for any unlicensed assistant roles involved in providing direct patient care.
- It is the RN who is responsible and accountable for the provision of nursing practice.
- It is the RN who supervises and determines the appropriate utilization of any unlicensed assistant involved in providing direct patient care.
- It is the purpose of unlicensed assistive personnel to enable the professional nurse to provide nursing care for the patient.

The second statement (1992b) was developed to help nurses understand their professional accountability regarding what can be delegated and how when working with UAP. This is important because nurses’ understanding of scope of practice differs according to their educational preparation and experience, and thus issues of accountability and delegation to UHWs may be unclear. ANA advocates for nursing education programs to include “content on supervision, delegation, assignment and legal aspects regarding nursing’s utilization of assistive personnel.” Additionally, employers should provide staff development and continuing education opportunities to address gaps in knowledge in this area.

More recently, ANA developed a set of principles for delegation that provides information on the association's current stance on the use of nursing assistive personnel. ANA and NCSBN have reviewed each other's complementary work in the area (R. Munley Gallagher, personal communication, November 3, 2005).

The principles document outlines both nurse (including nurse leader and nurse educator) and organization/employer accountabilities and responsibilities related to delegation. A delegation model clearly shows that the nurse is responsible for the assessment of the patient and determination of what may be delegated and to whom (ANA, 2005a).

Further, at ANA's 109th Congress on Legislative and Regulatory Priorities (2005b), two initiatives proposed and discussed were enacting adequate nursing facility staffing levels in nursing homes and mandating "valid and reliable nurse staffing systems in acute care and require standard, public reporting of nurse staffing levels and mix and patient outcomes" (p. 9).

NCSBN, whose members are the state nursing regulatory boards, adopted the position paper *Working with Others: Delegation and Other Health Care Interfaces* at its 2005 Delegate Assembly. It also adopted *Model Acts and Rules for Delegation and Nursing Assistant Regulatory Model* (NCSBN, 2005b). The paper addresses the concept of delegation and provides guidance for RNs when they work with others, including UHWs. The rules outline "a regulatory model for the oversight of nursing assistive personnel in agencies or facilities with structured nursing organizations" (i.e., settings that have a designated chief nursing officer) (NCSBN, 2005a).

7. Canadian Nurses Association and Provincial/Territorial Jurisdictions

7.1 Canadian Nurses Association

CNA has been actively engaged in facilitating appropriate staff mix decisions with respect to patient safety and nursing care across all sectors. Since 2003, CNA has produced several documents to inform RNs, nurse leaders, educators, researchers, employers, nursing associations and regulatory bodies, and government on the topic: two position statements, 11 research summaries, two policy/discussion papers, and a *Nursing Now* publication on issues and trends titled *Nursing Staff Mix: A Key Link to Patient Safety* (2005a). The latter summarizes research linking a staff mix of fewer RNs and more UHWs with a higher incidence of negative patient outcomes and adverse events. Strategies are outlined for assisting nurses in the use of evidence to ensure an appropriate staff mix at the organizational and political level.

The position statement *Staffing Decisions for the Delivery of Safe Nursing Care* (2003), identified previously in this paper, includes 10 principles to guide decision-making to facilitate appropriate staffing and support safe nursing care. A key principle pertains to UHWs: “The safety of clients must never be compromised by substituting less qualified workers when the competencies of a RN are required.” The principle states that the complexity and acuity of the client and changing practice environment are key drivers in determining whether RN services are required. Further, it confirms that it is the RN who decides “how and when unregulated care providers can safely assist in the provision of tasks associated with nursing care.”

Although it is not mandatory for RNs to adhere to these principles or other related CNA policies or guidelines, these documents inform policy development and serve as a guide, particularly for provincial and territorial nurses associations, and potentially for nursing unions and employers, in the development of their own policies and guidelines. This type of integration facilitates the implementation and dissemination of CNA policies.

CNA has endorsed a multi-stakeholder collaborative approach and engaged partners to facilitate the incorporation of “the nursing perspective on improving systems and patient safety.” For example, “CNA has partnered with the Canadian Council on Health Services Accreditation (CCHSA)...to advance the use of quality work-life indicators in the accreditation process” (CNA, 2005b). In addition, CNA, CPNA, the Canadian Council for Practical Nurse Regulators and the Registered Psychiatric Nurses of Canada (2005) developed an evaluation framework to determine the impact of nursing staff mix decisions. The framework was developed based on an extensive literature review and national consultation “to enable employers to determine how effectively they are using nursing resources.”

Although CNA had a position on UHWs in the mid 1990s (1995), currently it does not. CNA’s position on the roles of various health-care providers is addressed in *National Planning for Human Resources in the Health Sector* (N. Freeman, personal communication, December 2, 2005). CPNA will be revising its position statement on UHWs. Privatization is

a key issue that affects LPN practice and UHWs (S. O’Hare, personal communication, December 2, 2005).

7.2 Provincial/Territorial Jurisdictions

Across the country, the majority of nursing associations and regulatory colleges have developed position or policy statements, practice standards and journal articles on the use of UHWs or the facilitation of professional nursing practice when working with and delegating to UHWs to support safe and competent patient and client care. These publications sometimes include information about RNs working with LPNs because RNs may also assign or delegate functions to LPNs. Typically, these documents:

- define the term *unregulated* in the context of the jurisdiction (British Columbia, Saskatchewan, Ontario, and Nova Scotia use the term *UCP* to describe this worker, and Manitoba uses *unregulated worker*);
- distinguish between assignment (tasks that do not require delegation) and delegation;
- distinguish which skills, procedures or tasks can and cannot be delegated;
- outline RN responsibility and accountability when working with UHWs, particularly when delegating; and
- outline UHW responsibility.

(CRNBC, 2002, 2005; CRNM, 2003; College of Registered Nurses of Nova Scotia [CRNNS], 2004; SRNA, 2004.)

Table 5 identifies jurisdictions that have position statements, standards or guidelines approved by their respective governing boards or councils regarding RNs and UHWs. This information was taken from association or college websites. Notably, only the CRNNS has a position statement on the regulation of UHWs, titled *Regulation of Personal Care Workers* (1995, 2002). CRNNS does not endorse regulation or self-regulation of these workers: “the capacity to self-regulate in the public interest requires educational preparation, skills, and abilities that are beyond those of personal care workers.” The college does support “provincial standards for entry requirements and training programs” under the government authority, and specifies that employers are responsible for “setting performance standards.”

Table 5: Jurisdictions with Council- or Board-Approved Documents Regarding RNs and UHWs		
Jurisdiction	YES	NO
Nunavut and the Northwest Territories		X
Yukon		X
British Columbia	X	
Alberta	X	
Saskatchewan	X	
Manitoba	X	
Ontario (CNO)	X	
Quebec		
New Brunswick	X	
Nova Scotia	X	
Prince Edward Island		X
Newfoundland and Labrador	X	

The Registered Nurses' Association of Ontario (RNAO) has not developed documents that focus on RN accountability and UHWs and is therefore not identified in the table. However, RNAO has produced a joint position statement with the Ontario Nurses Association (1996), titled *Replacement of Registered Nurses by Less Prepared Providers*, as well as several other papers, submissions and commentaries regarding nursing skill mix and linkages to quality patient and client care.

In Alberta and Saskatchewan, CARNA and SRNA partnered with their provincial counterparts for LPNs and RPNs to develop guidelines for supporting collaborative decision-making regarding UHWs (2003 and 2000, respectively). In Alberta, the resulting document stated: "The three nursing groups recognize the importance of consistent interpretation and application of the Act and regulations where all nurses practice...to promote safe, competent and ethical nursing care, and to improve clarity of communication between and among health care workers and the public they serve...members of all three groups may have responsibility to supervise health care aides in performing restricted activities and nursing care" (CARNA, College of Licensed Practical Nurses of Alberta, and College of Registered Psychiatric Nurses of Alberta, 2003, p. 2).

CNO has recently initiated a series of teleconferences with RNs working in the LTC sector (CNO, 2005). The purpose of the teleconferences is "to further explore the realities of long-term care practice settings, and to provide opportunities for nurse leaders to engage in collective problem-solving." In May 2005, CNO hosted a LTC teleconference titled *Working*

with Unregulated Care Providers. Questions for the teleconference were submitted in advance by participants, and topics included:

- regulation of UHWs
- accountability of UHWs
- role clarity and delegating
- issues related to assigning procedures to UHWs
- supporting novice nurses

Trends and issues emerging from these sessions will likely be used to inform policy at CNO. Additionally, participants and reviewers of the website can increase their own understanding of the issues and inform their own workplace policies.

8. Implications for CNA

The stated vision of CNA is “Registered nurses: leaders and partners working to advance health for all,” and its mission statement, found on its website, is that CNA is the national professional voice of registered nurses, supporting them in their practice and advocating for healthy public policy and a quality, publicly funded, not-for-profit health system. In the context of this vision and mission, CNA commissioned this paper to identify relevant issues and options for its consideration. Four key issues and two policy options are outlined below.

8.1 Issues

On the basis of this review and analysis of the information, four UHW issues have been identified that CNA may wish to address in light of its mandate:

1. **Inconsistent UHW titles:** There is a profusion of titles used to describe UHW roles that leads to:
 - public confusion about who is providing their care and what they can expect from these providers
 - uncertainty among registered nursing professionals about the role of UHWs and their own accountability and responsibility, including when nursing tasks or procedures are delegated to UHWs
2. **Lack of statistics or accurate counts of UHWs working in most sectors:** It is unclear how many UHWs are working in Canada and whether RNs are being replaced by UHWs. However, on the basis of the findings of this review, it appears that internationally and in Canada, there is increasing use of UHWs in a variety of practice settings performing functions traditionally carried out by RNs. Three key factors contributing to the increased use of UHWs are:
 - economic pressures – there is a significant shift from hospital to community-based care, and many governments and employers perceive UHWs as less expensive than RNs and able to perform duties traditionally performed by RNs in all health-care sectors, even though significant literature refutes this perspective
 - nursing shortage – the nursing workforce is aging and declining in numbers, and there are fewer nurses entering the profession. Advances in technology and specialization of the profession are also contributing to the shortage of nurses who provide traditional or basic nursing services
 - aging population – the number of patients and clients with increasing acuity and complexity requiring nursing services is increasing, particularly in long-term and home care, while fewer informal caregivers are available to provide care
3. **Inconsistent education/training:**
 - standardization of curricula for certain UHW roles has taken place in some jurisdictions, but significant differences remain within and among jurisdictions. Further, standardized curricula may apply only to publicly funded colleges in

some jurisdictions; in others, it applies to public and privately funded career colleges. A PLAR process may be used in some jurisdictions to assess entry eligibility.

- for provinces with standardized curricula, the programs are geared for specific categories of UHWs such as CCAs in Nova Scotia or health care aides in Alberta, and training is typically focused on knowledge required in sectors with the greatest need
 - standardized curricula can erect barriers, particularly in northern, remote or under-serviced areas, where standardization could result in training that does not meet the needs of the population and decreased access to trained UHWs may affect recruitment and retention;
 - there are few opportunities for career advancement without formalized training
 - if curricula are standardized, it is unclear how the education will be funded
4. **Lack of employer standardization:** Educational requirements set by employers to work in facilities or agencies vary across the country and from sector to sector. Publicly funded facilities are bound by legislation, regulation and government policies, which set minimum care standards or expectations for care, whereas privately funded agencies are not. Ultimately, facilities and agencies determine the minimum educational criteria when hiring UHWs. In Nova Scotia, UHWs must also be certified and entered in a provincial registry. Currently, no jurisdiction in Canada regulates UHWs.

Based on stakeholder feedback, regulation of UHWs may resolve many issues and help protect the public, but it is unclear whether regulation is the best option to pursue in Canada at this time. As identified in the literature and by key informant responses, regulation would:

- promote consistent titling;
- set entry requirements (e.g., successful completion of an educational program and examination);
- set practice standards (e.g., clarify expectations for practice, including accountability and responsibility when working with other regulated staff); and
- provide the public and employers with a vehicle to address conduct issues (particularly for self-employed individuals and in work settings where there is limited supervision, such as long-term and home care, or no supervision or government oversight, such as privately funded residence homes).

However, the concept of regulating UHWs was met with mixed responses from key informants. Some felt strongly that regulation could erect barriers and decrease availability of UHWs in the workplace, while others supported the concept but indicated it warranted further discussion. Others indicated that these issues should be resolved at the provincial or territorial level before national approaches were explored. Most of the key informants agreed with examining the issue of curricula standardization, and some identified the exploration of the Nova Scotia model as a good first step.

Given these perspectives, it is appropriate that CNA considers what its role should be in the resolution of these issues, including UHW regulation. This is timely, given the recent movement in the U.K. to regulate UHWs and the NMC's expressed intention that as the U.K.'s regulatory body for nurses, it is the appropriate agency to regulate UHWs. Similarly, ICN initiatives and the recent campaign initiated by the ANF to regulate UHWs suggest it is appropriate for CNA to identify its role in relation to these issues. Examples of questions for CNA to consider include:

- What is CNA's role? Is CNA an active participant in working to resolve these issues?
- Should CNA work in partnership or independently?
- What role, if any, should stakeholders play?
- Should CNA endorse regulation, and if so, what is/are the appropriate body/bodies to regulate UHWs?

To facilitate CNA's decision-making in relation to these questions, broad policy options or approaches are presented with related strategies for the CNA's deliberation. Further research and information is needed to assist CNA in decision-making with respect to the specific issue of UHW regulation, including awaiting the outcome of the HPRAC review in Ontario in the spring of 2006.

8.2 Policy Options and Recommendation

In its deliberation, CNA will decide what its role, if any, should be with respect to the issues identified in the preceding section. In reviewing the following two policy options and recommendation offered for CNA's consideration, it is important that CNA keep in mind the following points about UHWs as described by key informants and identified in the literature:

- UHWs have been part of the health-care system in Canada for many years and in all sectors
- UHWs are needed to provide necessary personal and supportive care
- UHWs' contribution to patient and client care is sometimes undervalued (e.g., their observations are often ignored by regulated professionals, or they are not part of discussions or involved in care planning)
- some UHWs have other educational preparation, sometimes at the university level, that complements the role they play
- without UHWs, the gaps in health-care services, including access to service and increased wait times, will expand as the population ages and as the shift to community-based care continues

Two policy options are presented:

Policy option 1: Maintain current approach (i.e., broad position statements and policy initiatives that address skill mix and patient safety; CNA does not engage in specific activities associated with UHWs).

Pros:

- Stakeholders may consider this approach more consistent with CNA's mandate
- Significant resources that may not be readily available would be required to address issues regarding UHWs

Cons:

- RNs and other stakeholders may not perceive CNA's current approach as adequate or specific enough to address issues related to UHWs
- Public confusion and risk remain without a coordinated approach
- The approach is inconsistent with work being done by ICN and other NNAs
- Without CNA's leadership, many of these issues that significantly affect the advancement of nursing practice in the public interest may go unanswered
- If issues regarding UHWs are addressed by government or other stakeholders, the RN issues related to UHWs may go unanswered or may not be adequately addressed

Policy option 2: Build on current approach by working with key stakeholders to further explore, develop and implement multi-pronged strategies to address identified issues.

Pros:

- Likely perceived by the majority of RNs and other stakeholders as consistent with CNA's mandate
- A nationally coordinated approach facilitates work that needs to be done on UHWs in provinces and territories, especially in jurisdictions with limited resources, and ensures the RN voice is heard
- Next step in the evolution of CNA's work on skill mix and patient safety
- Approach is consistent with work being done by ICN and other NNAs
- CNA's leadership and reputation nationally and internationally with government, nursing organizations, etc., may significantly contribute to the successful and timely resolution of these issues

Cons:

- May be deemed by some stakeholders as being outside CNA's mandate
- As CNA takes a position on these issues, that position may be controversial if it contradicts that of other key stakeholders, including some provincial and territorial governments
- Resource-intensive undertaking for CNA

Recommendation: Policy option 2

9. Summary

This policy paper provides an overview of UHWs in Canada, the U.S., U.K., Australia and other countries based on available data, to inform the decision-making of CNA as it considers next steps on this important topic.

The paper outlines the variety of titles and functions of UHWs from both a Canadian and global perspective. Educational background and statistics were highlighted and key issues related to UHWs were identified, including perspectives and initiatives from key informants on the topic of UHWs in Canada and internationally. Initiatives by ICN and selected NNAs and provincial and territorial nursing regulatory colleges and associations were described. Finally, the mandate of CNA was described in relation to UHWs, as were identified issues. Two policy options were outlined, and a recommendation was made for CNA's consideration as it moves forward in its deliberations.

References

- Aberdeen, S. (2004). PCs in aged care – problems and possibilities. *Australian Nursing Journal*, 12(1), 15, 17.
- American Nurses Association. (1992a). *Registered nurse utilization of unlicensed assistive personnel* [Position statement]. Maryland: Author.
- American Nurses Association. (1992b). *Registered nurse education relating to the utilization of unlicensed assistive personnel* [Position statement]. Maryland: Author.
- American Nurses Association. (2004). *ANA state legislative trends report*. Maryland: Author.
- American Nurses Association. (2005a). *Principles for delegation*. Available at http://www.healthsystem.virginia.edu/internet/e-learning/principles_delegation.pdf
- American Nurses Association. (2005b). *Nursing's legislative and regulatory initiatives for the ANA's 109th congress on legislative and regulatory priorities*. Maryland: Author.
- Australian Government, Department of Education, Science, and Training. (2002). *Our duty of care* [Position statement]. Retrieved November 14, 2005, from http://www.dest.gov.au/archive/highered/nursing/pubs/duty_of_care/default.html
- Australian Nurses Federation. (2004a). *Assistants in nursing and other unlicensed workers (however titled) providing aspects of care*. Retrieved November 15, 2005, from http://www.anf.org.au/anf_pdf/PS_AINS_Nursing_Care.pdf
- Australian Nurses Federation. (2004b). *Delegation by registered nurses*. Retrieved November 15, 2005, from http://www.anf.org.au/anf_pdf/G_Delegation_RNs.pdf
- Baumann, A., Blythe, J., Kolotylo, C., & Underwood, J. (2004). *The international nursing labour market*. Available at http://www.cna-aiic.ca/cna/documents/pdf/publications/international_nursing_labour_market_e.pdf
- British Association of Critical Care Nurses. (2003). Position statement on the role of health care assistants who are involved in direct patient care activities within critical care areas. *Nursing in Critical Care* 8(1), 3-12.
- Brown, T. G. (2003). Integrated health human resource options: The impact on occupational therapy professional practice. *Scandinavian Journal of Occupational Therapy*, 10(3), 127-137.
- Bryant, R. (2005). *The global nursing review initiative: Regulation, roles and competency development*. International Council of Nurses: Geneva.
- Buchan, J., & Calman, L. (2004). *The global nursing review initiative: Summary: The global shortage of registered nurses: An overview of issues and actions*. International Council of Nurses: Geneva.
- Buchan, J., & Dal Poz, M. R. (2002). Skill mix in the health care workforce: Reviewing the evidence. *Bulletin of the World Health Organization*, 80(7), 575-580.

- Buerhaus, P. I., Staiger, D. O., & Auerbach, D. I. (2000). Policy responses to an aging registered nurse workforce. *Nursing Economic\$, 18*(6), 278-284, 303.
- Canadian Federation of Nurses Unions. (2005). *Enhancement of patient safety through nurse-patient ratios: A discussion paper*. Ottawa: Author.
- Canadian Healthcare Association. (2004). *Stitching the patchwork quilt together: Facility-based long-term care within continuing care – realities & recommendations*. Ottawa: Author.
- Canadian Nurses Association. (2003). *Staffing decisions for the delivery of safe nursing care* (2003) [Position statement]. Retrieved October 22, 2005, from http://cna-aiic.ca/CNA/documents/pdf/publications/PS67_Staffing_Decisions_Delivery_Safe_Nursing_Care_June_2003_e.pdf
- Canadian Nurses Association. (2005a). *Nursing Now: Nursing staff mix: A literature review*. Ottawa: Author.
- Canadian Nurses Association. (2005b). *The nursing perspective on patient safety* [Position statement]. Ottawa: Author
- Canadian Nurses Association, Canadian Practical Nurses Association, Canadian Council for Practical Nurse Regulators, & Registered Psychiatric Nurses of Canada (2005c). *Evaluation framework to determine the impact of nursing staff mix decisions*. Ottawa: Authors.
- Canadian Nurses Protective Society. (2000). *Infolaw: Delegation to other health care workers*. Ottawa: Author.
- Canadian Pharmacists Association. (2004). *Screening and managing medication problems in isolated, independent-living seniors*, project overview. Retrieved November 2, 2005, from http://www.pharmacists.ca/content/about_cpha/Whats_Happening/CPhA_in_Action/pdf/ProjectOverview.pdf
- Canadian Pharmacists Association. (2005). *Screening and managing medication problems in isolated, independent-living seniors*, final recommendations. Available from http://www.pharmacists.ca/content/about_cpha/whats_happening/cpha_in_action/homecare.cfm
- College and Association of Registered Nurses of Alberta, College of Licensed Practical Nurses of Alberta, & College of Registered Psychiatric Nurses of Alberta. (2003). *Decision-making standards for supervision of health care aides: Restricted activities and activities of daily living*. Alberta: Authors.
- College of Nurses of Ontario. (2004). *Working with unregulated care providers*. Toronto: Author.
- College of Nurses of Ontario. (2005). *LTC Teleconference: Working with unregulated care providers*. Retrieved November 30, 2005, from http://www.cno.org/new/events/ltc_teleconference/2005-05-17_ltc_highlights.htm
- College of Registered Nurses of British Columbia. (2002). *Assigning and delegating to unregulated care providers*. Retrieved November 14, 2005, from <http://www.crnbc.ca/downloads/98.pdf>

- College of Registered Nurses of British Columbia. (2005). *Delegating tasks to unregulated care providers*, practice standard. Retrieved November 14, 2005, from <http://www.crnbc.ca/downloads/429.pdf>
- College of Registered Nurses of Manitoba. (2003). *Registered nurse responsibilities regarding unregulated workers*. Retrieved October 29, 2005, from http://www.crnmb.ca/downloads/registeredresponsibilities_web.pdf
- College of Registered Nurses of Nova Scotia. (1995, 2002). *Regulation of personal care workers* [Position statement]. Halifax: Author.
- College of Registered Nurses of Nova Scotia. (2004). *Delegation guidelines for registered nurses*. Halifax: Author.
- Curtin, L. (2003). An integrated analysis of nurse staffing and related variables: effects on patient outcomes. *Online Journal of Issues in Nursing*. Retrieved December 1, 2005, from <http://www.nursingworld.org/mainmenucategories/anamarketplace/anaperiodicals/OJIN/keynotesofnote/staffingandvariablesanalysis.asp>
- Department for Education and Skills. (2005). *National vocational qualifications*. Retrieved November 20, 2005, from <http://www.entodirect.co.uk/nvqs/overview.php>
- Department of Health. (2004). *Regulation of health care staff in England and Wales: A consultation document*. U.K.: Author.
- Employment Development Department, State of California. (2005). *Labour market information: Nursing careers*. Retrieved November 28, 2005, from <http://www.calmis.ca.gov/file/occguide-archive/nursing.htm>
- Gleeson, M. (1998). Nurses nursing and the unlicensed worker providing nursing care. *Australian Nursing Journal*, 5(7), 20-1.
- Government of Manitoba. (2005). *Manitoba nursing strategy: Five-year progress report*. Manitoba: Author.
- Government of Nunavut. (2005). *Employment opportunity: Home and community care representative*.
- Government of Ontario. (2004). *Regulation 832 under the Ontario Nursing Homes Act*. Retrieved December 19, 2005, from http://www.e-laws.gov.on.ca/Download?dDocName=elaws_regs_900832_e
- Government of Ontario. (2005). *Personal support worker program standard*. Retrieved November 28, 2005, from <http://www.edu.gov.on.ca/eng/general/college/progstan/health/supportworker.pdf>
- Health Human Resources Unit. (2000). Kazanjian, A., Rahim-Jamal, S., MacDonald, A., Wood, L., Cole, C. *Nursing workforce study – volume IV: Nursing workforce deployment: A survey of employers*. Vancouver: Centre for Health Services and Policy Research University of British Columbia:
- Health Professions Regulatory Advisory Council. (2005). *Minister referral letter*. Retrieved November 20, 2005, from http://www.hprac.org/downloads/Ministers_Referral_Letter.pdf

- Home Care Sector Study Corporation. (2002). *Canadian home care human resources study phase 1 report: Setting the stage: What shapes the home care market*. Author.
- Home Care Sector Study Corporation. (2004). *Canadian home care human resources study: Synthesis report*. Author, from www.cdnhomecare.ca/media.php?mid=1030
- International Council of Nurses. (2000). *Assistive or support nursing personnel* [Position statement]. Retrieved November 2, 2005, from <http://www.icn.ch/psassistive.htm>
- International Council of Nurses. (2004). *Protection of the title "nurse"* [Position statement]. Retrieved November 2, 2005, from <http://www.icn.ch/pstitle99rev.htm>
- International Council of Nurses. (2005). Council of National Representatives. *Forum on patient safety and its relation to staffing*. Geneva: Author.
- Joy, P., & Wade, S. (2003). Opening the door to health care assistants and support workers. *Nursing Older People*, 15(6), 18-20.
- Kido, V. J. (2001). The UAP dilemma. *Nursing Management*, 32(11), 27-29.
- Law Society of Upper Canada. (2005). *Law society welcomes introduction of legislation to protect consumers of paralegal services*. Retrieved December 19, 2005, from <http://www.lsuc.on.ca/media/oct2705paralegallegislation.pdf>
- Lang, T. A., Hodge, M., Olson, V., Romano, P. S., & Kravitz, R. L. (2004). Nurse-patient ratios: A systematic review on the effects of nurse staffing on patient, nurse employee, and hospital outcomes. *Journal of Nursing Administration*, 34(78), 326-337.
- Lange, J. C. W., & Polifroni, E. C. (2000). Nurses and assistive personnel: Do patients know the difference? *Journal of Nursing Administration*, 30(11), 512-514.
- Lookinland, S., Tiedeman, M. E., & Crosson, A. E. (2005). Non-traditional models of care delivery: Have they solved the problems? *Journal of Nursing Administration*, 35(2), 74-80.
- Markle-Reid, M., Weir, R., Browne, G., Henderson, S., Roberts, J., & Gafni, A. (2003). *Frail elderly homecare clients: The costs and effects of adding nursing health promotion and preventive care to personal support services*. Retrieved December 15, 2005, from http://www.chsrf.ca/final_research/ogc/markle_e.php
- McCarthy, A. M., Kelly, M. W., & Reed, D. (2000). Medication administration practices of school nurses. *Journal of School Health*, 70(9), 371-376.
- McGillis Hall, L. (1998). Policy implications when changing staff mix. *Nursing Economic\$,* 16(6), 291-312.
- McGillis Hall, L. & Doran, D. I. (2001). *A study of the impact of nursing staff mix models and organizational change strategies on patient, system and nurse outcomes*. Faculty of Nursing; University of Toronto
http://www.chsrf.ca/final_research/ogc/pdf/mcgillis_report.pdf
- McGillis Hall, L., Doran, D. I., & Pink, G. H. (2004). Nurse staffing models, nursing hours, and patient safety outcomes. *Journal of Nursing Administration*, 34(1), 41-45.
- McLaughlin, F. E., Barter, M., Thomas, S. A., Rix, G., Coulter, M., & Chadderton, H. (2000). Perception of registered nurses working with assistive personnel in the United Kingdom and the United States. *International Journal of Nursing Practice*, 6(1), 46-57.

McMullin, J. A., Cooke, M., & Downie, R. (2004). *Labour force ageing and skill shortages in Canada and Ontario*, report summary. Canadian Policy Research Networks.

Minore, B., & Boone, M. (2002). Realizing potential: Improving interdisciplinary professional/paraprofessional health care teams in Canada's northern Aboriginal communities through education. *Journal for Interprofessional Care*, 16(2), 139-147.

Mitty, E. L. (2003). Policy perspectives: Assisted living and the role of nursing. *American Journal of Nursing*, 103(8), 32-43.

National Association of Career Colleges. (n.d.). *About NACC*. Available at www.canlearn.ca/en/about/overview/ogov.shtml

National Council of State Boards of Nursing. (2005a). *Working with others: Delegation, other healthcare interfaces and the regulation of nursing assistive personnel*. Available from <http://www.ncsbn.org>

National Council of State Boards of Nursing. (2005b). Delegate assembly overview. *NCSBN Council Connector*, 5(3). Retrieved November 29, 2005, from http://www.ncsbn.org/pdfs/CC_September2005.pdf

National Training and Information Service. (n.d.). Certificate III in Community Services (Aged Care Work). Retrieved November 8, 2005, from <http://www.ntis.gov.au/default.aspx?/trainingpackage/CHC99/qualification/CHC30199/rules>

Nazarko, L. (2003). Questioning qualification. *Nursing Management*, 9(10), 9.

Needleman, J., & Buerhaus, P. (2003). Nurse staffing and patient safety: Current knowledge and implications for action. *Journal of the International Society for Quality in Health Care*, 15(4), 275-277.

Nova Scotia Health Human Resources Study. (2002). *Home Support Workers/Continuing Care Assistants*. Retrieved November 11, 2005, from <http://www.gov.ns.ca/health/hhr/Home%20Support%20Workers.pdf>

The Editors of *Nursing2004*. (2004). Are you "too posh to wash"? *Nursing* 34(11), 57.

Ontario Community Support Association. (2004). *Personal support worker*. Retrieved November 15, 2005, from http://www.ocsa.on.ca/whoware/body_psw.html

Pan American Health Organization. (2001). *Country health profile: Brazil*. Retrieved November 22, 2005, from <http://www.paho.org/english/sha/prflbra.htm#servicios>

Patterson, E. A., Del Mar, C. & Najman, J. M. (2000). Medical receptionists in general practice: Who needs a nurse? *International Journal of Nursing Practice*, 6, 229-236.

Pilon, B. A. (1998). Outcomes and surprises of work redesign. *Nursing Management*, 29(8), 44-45.

Potter, P., Barr, N., McSweeney, M., & Sledge, J. (2003). Identifying nurse staffing and patient outcome relationships: a guide for change in care delivery. *Nursing Economic\$,* 21(4), 158-166.

President's Advisory Committee on Consumer Protection and Quality in the Health Care Industry. (1998). *Quality first: better health care for all Americans*, from <http://www.hcqualitycommission.gov/final>

- Professional Engineers of Ontario. (2005). *Independent practice for limited licence holders* [Position statement]. Available from <http://www.peo.on.ca/>
- Registered Nurses Association of Ontario. (1996). RNAO and ONA Joint statement: *Replacement of registered nurses by less prepared providers*.
- Registered Psychiatric Nurses Association of Saskatchewan, Saskatchewan Association of Licensed Practical Nurses, & Saskatchewan Registered Nurses' Association (2000). *Nursing in collaborative environments*. Saskatchewan: Author.
- Rhodes, A. M. (1997). Liability for unlicensed assistive personnel, part 1. *The American Journal of Maternal/Child Nursing*, 22(5), 269.
- Romanow, R. J. (2002). *Building on values: The future of health care in Canada*. Retrieved October 25, 2005, from http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/HCC_Final_Report.pdf
- Royal College of Nurses of Australia & Australian Nurses Federation. (2004). *Assistants in nursing and other unlicensed workers (however titled)*. Retrieved November 17, 2005, from http://www.rcna.org.au/UserFiles/anf_rcna_position.pdf
- Saskatchewan Health and Saskatchewan Learning. (2002). *Labour market study of home care/special care aides in Saskatchewan*, report summary. Saskatchewan: Author.
- Saskatchewan Institute of Applied Science and Technology. (2005). *Home care/special care aide changes*. Retrieved November 21, 2005, from www.siastr.sk.ca/pdf/hcscachanges05.pdf
- Saskatchewan Registered Nurses' Association. (2004). *Practice of nursing: RN assignment and delegation*. Retrieved October 27, 2005, from http://www.srna.org/nurse_resources/2004_RN_assignment_delegation.pdf
- Sovie, M. D., & Jawad, A. F. (2001). Hospital restructuring and its impact on outcomes: Nursing staff regulations are premature. *Journal of Nursing Administration*, 31(12), 588-600.
- Trossman, S. (2002). No shortage of excuses: Nurses worry that health care industry will use staffing crisis to replace RNs. *American Nurse*, 34(6),1, 10-11.
- U.S. Department of Labor. (2005a). *Bureau of Labor Statistics: Nursing, psychiatric, and home health aides*, occupational outlook handbook. Retrieved December 2, 2005, from <http://www.bls.gov/oco/ocos165.htm>
- U.S. Department of Labor. (2005b). *Bureau of Labor Statistics: Personal and Home Health Care Aides*, occupational outlook handbook. Retrieved December 2, 2005, from <http://www.bls.gov/oco/ocos173.htm>
- Warne, T., & McAndrew, S. (2004). The mental health assistant practitioner: An oxymoron? *Journal of Psychiatric and Mental Health Nursing*, 11(2), 179-184.
- White, P., & McGillis Hall, L. (2003). Patient safety outcomes. In Doran, D. (Ed.), *Nursing-sensitive outcomes: State of the science*. (pp. 211-242). Mississauga: Jones & Bartlett.
- Young, A. (2004). The developing role of EDAs. *Emergency Nurse*, March 11(10), 10-11.

Appendix A: Titles of UHWs Who Assist Nurses

Table 1: Titles of UHWs Who Assist Nurses	
Country	Titles
Canada	<p>Broadly referred to as unregulated or unlicensed care providers or assistive personnel and auxiliary health-care workers.</p> <ul style="list-style-type: none"> • client care attendants • community workers (e.g., community health representative; mental health workers; national native alcohol and addiction program [NNADP] workers) • continuing care assistants • family aides • health-care aide • hospital attendant • home support worker/home aides • long-term care (LTC) aide • nurse aide • nursing attendant • orderly • patient care aide • patient service associate • personal aide • personal care attendant • personal support workers • psychiatric aide • recreational therapist • resident care workers • visiting homemaker
United States	<p>Broadly referred to as nursing assistant personnel (NAP) or unlicensed assistive personnel (UAP).</p> <ul style="list-style-type: none"> • attendants • care partners • feeding assistants • home care aides • home health aides • medication aides • medication technicians • nurses' aides • nursing assistants orderlies • patient care attendants • personal aides

Table 1: Titles of UHWs Who Assist Nurses	
Country	Titles
	<ul style="list-style-type: none"> • psychiatric aides • resident assistants • service associates
Australia	<p>Broadly referred to as assistants in nursing and unlicensed workers.</p> <ul style="list-style-type: none"> • aged person carer • assistant in nursing • community worker • direct care worker • disabled person carer • personal carer • personal care assistants or attendants
United Kingdom	<p>Broadly referred to as unregulated health care staff.</p> <ul style="list-style-type: none"> • health-care assistant • therapy assistant • nursing care assistant • assistant and support worker • maternity care assistant • mental health assistant • emergency department assistants (EDAs)
Hong Kong, China	health care assistant
Argentina, Brazil, Paraguay and Suriname	nurse auxiliary
South Africa	community health workers community home care workers

Appendix B: National Occupation Classification (NOC) 2006, Human Resources and Social Development Canada

The following information has been retrieved from <http://www23.hrdc-drhc.gc.ca/2001/e/groups/3413.shtml>.

Nurse Aides, Orderlies and Patient Service Associates

Nurse aides, orderlies and patient service associates assist nurses, hospital staff and physicians in the basic care of patients. They are employed in hospitals, nursing homes, and other health-care facilities.

Example Titles

- health care aide
- hospital attendant
- long term care aide
- nurse aide
- nursing attendant
- orderly
- patient care aide
- patient service associate
- psychiatric aide

Main duties

Nurse aides, orderlies and patient service associates perform some or all of the following duties:

- Answer call signals; supply and empty bed pans; bathe, dress and groom patients; serve meal trays, feed or assist in feeding of patients and assist patients with menu selection; lift, turn or massage patients; shave patients prior to operations; supervise patients' exercise routines, set-up and provide leisure activities for patients and accompany patients on outside recreational activities; and perform other duties required for patient care.
- Take patients' blood pressure, temperature and pulse; report or record fluid intake and output; observe or monitor patients' status and document patient care on charts; collect

specimens such as urine, feces or sputum; administer suppositories, colonic irrigations and enemas; and perform other procedures as directed by nursing and hospital staff.

- Transport patients in wheelchairs or stretchers for treatment or surgery.
- Carry messages, reports, requisitions and specimens from one department to another.
- Make beds and maintain patients' rooms.
- Maintain inventory of supplies.
- May perform maintenance tasks such as assisting with the set-up and maintenance of traction equipment; cleaning or sterilizing equipment; maintaining and repairing equipment; and assembling, setting up and operating job-related equipment.

Employment requirements

Some secondary school education and on-the-job training or a nursing aide or health care aide college or private institutional program, or a college nursing orderly program and supervised practical training are required. Some health-care facilities may also require the completion of specialized courses such as CPR (cardiopulmonary resuscitation), first aid, and food handling and sterile processing.

The following information has been copied from
<http://www23.hrhc-drhc.gc.ca/2001/e/groups/6471.shtml>.

Visiting Homemakers, Housekeepers and Related Occupations

Example Titles

- companion
- foster parent
- home support worker
- housekeeper
- personal aide
- personal care attendant
- visiting homemaker

Main duties

Visiting homemakers perform some or all of the following duties:

- Care for individuals and families during periods of incapacitation, convalescence or family disruption;
- Administer bedside and personal care to clients such as aid in ambulation, bathing, personal hygiene, dressing and undressing;
- Plan and prepare meals and special diets, and feed or assist in feeding clients;
- Demonstrate infant care to new parents;
- May perform routine health-related duties such as change non-sterile dressings, administer medications and collect specimens under the general direction of home care agency supervisor or nurse; and
- May perform routine housekeeping duties such as laundry, washing dishes and making beds.

Employment requirements

Some secondary school education is usually required. Child-care or home management experience may be required. Visiting homemakers may require college level (or other) courses in home support. First aid certification may be required.

The following information has been retrieved from
<http://www23.hrdc-drhc.gc.ca/2001/e/groups/3414.shtml>.

Other Assisting Occupations in the Support of Health Services

This would include workers who provide services and assistance to health-care professionals and other health-care staff. They are employed in hospitals, clinics, offices of health-care professionals, nursing homes, optical retail stores and laboratories, pharmacies and medical pathology laboratories.

Example Titles

- autopsy assistant
- blood donor clinic assistant
- cast room technician
- central supply aide
- chiropractic assistant

- clinical laboratory helper
- lens grinder, ophthalmic
- morgue attendant
- occupational therapy assistant
- ophthalmic laboratory technician – retail
- optical laboratory assistant
- optometrist assistant
- orthopaedic technologist
- pharmacy assistant
- physiotherapy assistant
- rehabilitation assistant
- therapy assistant

Main duties

The following is a summary of main duties for some occupations in this unit group:

- Orthopaedic technologists assist orthopaedic surgeons in the treatment of orthopaedic diseases and injuries by applying and adjusting casts, splints, bandages and other orthopaedic devices; assisting in the application, maintenance and adjustment of traction equipment; cleaning and dressing wounds; and removing casts, sutures, staples and pins. They also instruct patients and their families and other health-care professionals with respect to orthopaedic matters.
- Therapy assistants prepare and maintain equipment and supplies, assist patients as directed by health-care professionals such as physiotherapists, occupational therapists and chiropractors, and may perform routine office functions.
- Optical/ophthalmic laboratory technicians and assistants operate laboratory equipment to grind, cut, polish and edge lenses for eyeglasses according to prescriptions received and fit lenses into frames; make minor repairs for customers such as replacing frame screws or straightening frames; and maintain and repair optical laboratory equipment or machinery.
- Pharmacy assistants support pharmacists by compounding, packaging and labelling pharmaceutical products, and by maintaining prescription records and inventories of medications and pharmaceutical products.
- Central supply aides collect and sort soiled supplies and instruments from hospital departments; operate machines such as instrument washers, sonic sinks, cart washers and steam autoclaves to clean, reprocess and sterilize these supplies for re-use; and assemble packs of sterile supplies and instruments for delivery to hospital departments.

- Blood donor clinic assistants set up and dismantle equipment; prepare and maintain cleanliness of collection areas; maintain supplies; record information on donors; monitor donors throughout procedure and assist with post-donation care and donor reaction care as assigned under supervision of a registered nurse; and label and process donated blood.
- Morgue attendants assist pathologists at autopsies by laying out surgical instruments; preparing solutions for preservation of specimens; transferring bodies from morgue to examining table; removing organs and tissue specimens, as instructed by attending pathologist, and placing them in preservative solutions; and cleaning and sewing up bodies for release to funeral home.

Employment requirements

Orthopaedic technologists usually require the completion of secondary school and several months of on-the-job training or the completion of a college orthopaedic technologist program. Registration with the Canadian Society of Orthopaedic Technologists is available and is usually required by employers.

Health-care courses or short-term college programs related to the work of medical assistants, such as occupational therapy assistant or physiotherapy assistant programs, or a program in central supply service techniques, are available and may be required by employers.

Pharmacy assistants require the completion of secondary school and several months of on-the-job training or the completion of a five- to nine-month college program in pharmaceutical services.

For other assisting occupations in this unit, completion of secondary school and several months of on-the-job training are usually required.

Appendix C: Examples of Nursing Tasks and Procedures Performed by UHWs

Table 2: Examples of Nursing Tasks and Procedures Performed by UHWs	
Country	Nursing Tasks and Procedures
Canada	<ul style="list-style-type: none"> • Providing personal hygiene and support services, including assisting with activities of daily living (ADL), answering call bells, supplying and emptying bed pans, feeding patients • Assisting with body mechanics such as lifting, turning or massaging patients • Supervising patients' exercise routines • Performing technical skills such as taking vital signs, collecting specimens, venipuncture, blood glucose monitoring, administering medications (e.g., oral and suppositories) and giving enemas • Counseling including grief counseling and other mental health support activities • Engaging in health promotion activities
United States	<ul style="list-style-type: none"> • Providing personal hygiene and support activities such as feeding patients and assisting with ADL • Performing range of passive motion exercises • Conducting maternal pre- and post-partum home visits • Assisting in collecting data and patient assessment • Performing technical skills such as assisting with diagnostic procedures, dressing changes, catheterizations, gastrostomy feeding, tracheal care and suctioning and medication administration, including narcotics
United Kingdom	<ul style="list-style-type: none"> • Providing personal hygiene and support activities such as feeding and assisting with ADL • Performing technical skills such as venipuncture, CPR, taking vital signs, administering medications, dressing changes and assisting with minor surgical procedures • Observing and monitoring patients
Australia	<ul style="list-style-type: none"> • Providing personal hygiene and support activities such as feeding and assisting with ADL • Performing technical skills such as administering ECGs, taking vital signs, providing spirometry, dressing changes and removing sutures, and assisting with minor surgery; administering oxygen and venipuncture and blood glucose monitoring • Monitoring patients and triage and providing telephone advice

Appendix D: Examples of UHW Education Programs and Standards in Canada

Table 3: Examples of UHW Education Programs and Standards in Canada

Province or Territory	Course and Prerequisite (if identified)	Program Length	Competencies and Areas of Study	Standards, Regulations and Other Information
Nova Scotia	<p>Continuing Care Assistant</p> <p>Nova Scotia Community College (NSCC)</p> <p>Entry prerequisite: high school graduation diploma or equivalent and a clear criminal record check.</p> <p>Clinical placement prerequisite: First aid and CPR BCLS Level C</p> <p>Continuing care graduates provide direct supportive care to elderly, disabled and convalescent clients in a variety of private and clinical settings: in the clients' residence, in LTC facilities and through home support agencies.</p>	<p>35 weeks</p> <p>Credential issued: certificate</p>	<p>Courses</p> <p>CONC 1001 Personal and Prof. Develop 60hrs</p> <p>CONC 1002 Body Mechanics and Activity 45hrs</p> <p>CONC 1003 Personal Care 60hrs</p> <p>CONC 1004 Household Management 30hrs</p> <p>CONC 1005 Nutrition and Meal Prep 45hrs</p> <p>CONC 1006 Body Structures, Functions 120hrs</p> <p>CONC 1007 Comm Awareness and Resources 30hrs</p> <p>CONC 1009 Palliative Care 18hrs</p> <p>CONC 1060 Clinical (Long Term Care) I 30hrs</p> <p>CONC 1070 Clinical (Home Support) I 50hrs</p> <p>CONC 1200 Alzheimer Disease/Dementias 27hrs</p> <p>CONC 2060 Clinical (Long Term Care) II 80hrs</p> <p>CONC 2070 Clinical (Home Support) II 50hrs</p> <p>CONC 2500 Long Term Care Mentorship 120hrs</p> <p>GDEV 1001 Human Life Cycle 30hrs</p> <p>SAFE 1000 Intro to WHMIS 4hrs</p>	<p>The Nova Scotia Department of Health requires all workers entering the field to have a continuing care assistant certificate that meets the department's standards for entry-level workers as of November 30, 2005. NSCC's continuing care graduates can be confident that their program measures up, and that their knowledge and training gives them the freedom to explore all career options in this field.</p> <p>Both community and private career colleges are required to meet the standards set by the departments of health.</p> <p>There is a bridging program from the PCW (personal care worker) role and HSW (home support worker) role. A pilot program is taking place at the Aberdeen hospital in New Glasgow where they have been introduced into the hospital.</p>

Table 3: Examples of UHW Education Programs and Standards in Canada

Province or Territory	Course and Prerequisite (if identified)	Program Length	Competencies and Areas of Study	Standards, Regulations and Other Information
			<p>SAFE 1001 Intro to NS OH and S Act 4hrs</p> <p>Portfolio Development</p> <p>Standard First Aid</p> <p>Computer Course requirement: Students are required to complete (both COMP 1217 and COMP 1218) or (COMP 1200) or (COMP 1220). Communication Course Requirements: Students are required to complete (both COMM 1227 and COMM 1228) or (either COMM 1200 or COMM 2215)</p> <p>Food Handler's Course requirement: Students must complete FDVB 1007</p>	
Nova Scotia -- http://www.nsc.ca/Learning_Programs/Programs/PlanDescr.aspx?prg=HHCR&pln=CONTCARE				
Prince Edward Island	Resident Care Worker Holland College program “designed to train individuals for employment in LTC facilities. Students also gain an appreciation of their role in mental health, community and with in-home support services as a Resident Care Worker or Home Support Worker.”	6.5 months Credential issued: Certificate, Resident Care Worker LTC facilities Home support services Mental health facilities Self-employment	<p>Areas of Competency:</p> <p>Identify and develop personal competencies</p> <p>Communicate effectively with clients</p> <p>Assist in meeting physical and psychosocial needs</p> <p>Assist with comfort and special client care needs</p> <p>Care of clients with mental health conditions</p> <p>Care of clients with home care needs</p> <p>Develop a basic knowledge of chronic conditions impacting the older adult</p> <p>Record/report client information on medical records</p> <p>Utilize and maintain client care equipment</p>	

Table 3: Examples of UHW Education Programs and Standards in Canada

Province or Territory	Course and Prerequisite (if identified)	Program Length	Competencies and Areas of Study	Standards, Regulations and Other Information
	Admission requirement: Grade 12 or equivalent		Participate as a member of an interdisciplinary health-care team Non-Violent Crisis Intervention (Certificate) Palliative care (Certificate) Transfer/Lift/Reposition safety (Certificate) WHMIS (Certificate)	
Ontario	Personal Support Worker Programs	The PSW course is a minimum of 500 hours (three months) in length. The training includes practical work experience. The PSW training program includes a minimum of: * Theory (classroom): 225 hours * Evaluation: 10 hours * Practicum (work placement): 265 hours	Synopsis of the Vocational Learning Outcomes Personal Support Worker Programs The graduate has reliably demonstrated the ability to: 1. Act within the personal support worker role, under supervision, and by following care/service plans and established policies and procedures. 2. Participate as a member of care/service teams in both community and institutional settings. 3. Use, under supervision, basic knowledge, care/service plans, and established policies and procedures. 4. Provide client-centered and client-directed care under supervision and by following care/service plans and established policies and procedures, in both community and institutional settings. 5. Make, collect, and report to the supervisor relevant observations in an ongoing and timely manner and record this information promptly.	

Table 3: Examples of UHW Education Programs and Standards in Canada

Province or Territory	Course and Prerequisite (if identified)	Program Length	Competencies and Areas of Study	Standards, Regulations and Other Information
		<p>There is no officially recognized “certification” or “registration” and no regulating body for graduates.</p>	<p>6. Support the client's personal care requirements by following care/service plans and established policies and procedures.</p> <p>7. Support the client's home management services by following care/service plans and established policies and procedures.</p> <p>8. Communicate effectively and appropriately using oral, written, and nonverbal methods.</p> <p>9. Assist in the promotion and maintenance of a safe and comfortable environment for clients, their families, self, and others.</p> <p>10. Perform the personal support worker role in an ethical manner and within the law.</p>	
<p>http://www.ocsa.on.ca/whoweare/body_psw.html</p> <p>http://www.edu.gov.on.ca/eng/general/college/progstan/health/supwork.html#P303_25186</p>				
Manitoba	<p>Health Care Aide program: Robertson College prepares graduates for positions as Health Care Aides, Home Care Attendants, Home Support Workers or Personal Support Workers.</p> <p>Graduates are prepared to work in personal care homes, LTC facilities, hospitals and home care</p>	<p>Five months to a maximum of eight months for international students</p> <p>Cost: \$4,500</p>	<p>Individuality of the Person</p> <p>Role of the Worker</p> <p>Interpersonal Skills</p> <p>Assisting a Person with Mobility</p> <p>Abuse</p> <p>Providing Optimal Support/Care Planning</p> <p>Cognitive Impairment and Mental Health Issues</p> <p>Assisting a Person to Manage Ongoing Conditions</p> <p>Assisting a Person with Medications</p>	<p>No government policies or regulations setting educational standards</p> <p>Home Support Workers and Residential Care Workers Regulations:</p> <p>http://web2.gov.mb.ca/laws/regs/pdf/e110-061.99.pdf. Sets employment standards for workers such as fair wages and treatment by employers.</p> <p>Nationally Certified Health Care Aides* (?created by private CC to entice students)</p> <p>http://www.robertsoncollege.com/healthC</p>

Table 3: Examples of UHW Education Programs and Standards in Canada

Province or Territory	Course and Prerequisite (if identified)	Program Length	Competencies and Areas of Study	Standards, Regulations and Other Information
	agencies.		Safety Household Management and Meal Preparation Assisting a Person with Personal Hygiene Assisting the Family Assisting a Person Who is Dying Clinical Placement (Both supervised and precepted placements)	areAide.html
Saskatchewan	Continuing Care Assistant – title change July 2005 (formerly known as Home Care/Special Care Aide Program Changes) SIAST Admission requirements: Grade 10; however, effective 2007, the admission requirements will be Grade 12. Personal and physical suitability Security clearance and interview may be required for your	30 weeks Certification issued: certificate Tuition: \$2,449 Books and supplies (approximate): \$655	Communication in the Workplace COMM 291 Interpersonal Communications DEMC 183 Dementia PRAC 101 Mid Practicum PRAC 197 Mid Practicum SFTY 194 P.A.R.T. Assault Response SPCR 180 Safe Environment SPCR 182 Personal Care SPCR 192 Personal Competence Semester 2 COMM 197 Communications Skills DEMC 280 Dementia Strategies	SBC offers Personal Care Aide *Approved by Saskatoon District Health * SEIU or CUPE wages * Work in home care or LTC Note: An interview to determine suitability for the program will be scheduled prior to acceptance. Prerequisite: Grade 10 plus entrance exam or Grade 12 or GED12 Start dates: January and August Length: six months

Table 3: Examples of UHW Education Programs and Standards in Canada

Province or Territory	Course and Prerequisite (if identified)	Program Length	Competencies and Areas of Study	Standards, Regulations and Other Information
	<p>practicums and clinical experiences</p> <p>Note: Standard First Aid and CPR Level C are required prior to participating in the final practicums for special care and home care.</p> <p>The program provides knowledge and skill development in helping people help themselves in their homes and in special care facilities.</p>		<p>HUMD 187 Human Growth and Development</p> <p>NUTR 198 Nutrition</p> <p>PRAC 199 Final Practicum</p> <p>PRAC 206 Final Practicum</p> <p>SANT 181 Food Safe Level 1</p> <p>SPCR 184 Post Acute Care</p> <p>SPCR 284 Special Needs 1</p> <p>SPCR 285 Special Needs 2</p>	<p>SIAST (public – approved by Saskatchewan Health)</p> <p>SIIT (public)</p>
<p>http://www.siastr.sk.ca/kelsey/educationtraining/oncampusprograms/5888/5498/5850/index.shtml#programdetails</p> <p>http://www.saskbusinesscollege.com/programs/healthcare/personal_care.php</p>				
Alberta	Health Care Aide	16-20 weeks	<p>The role of these providers includes:</p> <ul style="list-style-type: none"> • knowing about normal health, illness and disease and how to care for someone who is ill or disabled or requiring support for activities of daily living, etc. • providing emotional support to clients and families • knowing how and what to do to make the client comfortable • knowing how to give encouragement and help the client be as independent as possible 	<p>Alberta has created a provincial prototype curriculum for these workers and is moving toward full implementation of program by educators (granting a certificate either as a result of completion of full program or the PLAR process) or by employers who can use the modules as an in-service tool and potentially give a certificate of completion of modules x, y and z. A component of the curriculum is</p>

Table 3: Examples of UHW Education Programs and Standards in Canada

Province or Territory	Course and Prerequisite (if identified)	Program Length	Competencies and Areas of Study	Standards, Regulations and Other Information
			<ul style="list-style-type: none"> • helping the client achieve a better quality of life • understanding their role and responsibilities as a member of the health-care team and the roles of other health-care providers and how everyone works together • following organizational policies and procedures and work within the job description. 	<p>a performance checklist that is a tool employers can use to consistently evaluate employees performance and learning needs. The full program is about 16-20 weeks in length depending on educational institution and factors such as days in the week or hours in the day.</p> <p>The curriculum was built on a competency framework.</p>

Appendix E: Number of Regulated Nurses and UHWs by Country

Table 4: Number of Regulated Nurses and UHWs by Country			
Country	Regulated (nurses)	UHWs (nursing type assistants)	Other
Argentina Source: PAHO	26,000 (1,000 graduate and 25,000 tertiary level nurses) (1994)	59,000 (49,000 nursing auxiliaries and 10,000 lay nurses)	N/A
Australia Source: WHO and DEST	WHO: 2000: 157,057 nurses or 820 per 100,000 population 2004: 149,936 or 774.9 per 100,000 population	DEST: 424% increase in assistants	N/A
Brazil Source: PAHO	109,088 nurses	486,588 (nurse auxiliaries) 195,228 (technicians)	193,046 (community health workers)
Canada Source: CIHI (RNs only) and WHO (includes all regulated nurse categories)	CIHI: 232,566 RNs in (2000) and 246,575 RNs in (2004) – 6.0% increase WHO: 1996: 312,855 nurses or 054.9/100,000 population 2004: 310,733 nurses or 1009.8 /100,000 population	N/A	N/A
Paraguay Source: PAHO	1,567 (nurses and midwives) in 2000	4,452 auxiliary nurses	N/A
Suriname Source: PAHO	81 (degree nurses – 4 years)	550 auxiliary nurses (3 year program)	63 dental nurses
United States Source: WHO and U.S. Department of Labor	1995: 2,115,800 nurses or 783.7 per 100,000 population 2004: 2,201,800 nurses or 772.5 per 100,000 population	In 2002, 2 million jobs were held by nursing aides (1.4 million), home health aides (580,000), and psychiatric aides (59,000). An additional 608,000 jobs were held	N/A

Table 4: Number of Regulated Nurses and UHWs by Country

Country	Regulated (nurses)	UHWs (nursing type assistants)	Other
		by personal and home care aides.	
United Kingdom (Great Britain and Northern Ireland) Source: WHO, NHS and <i>The Guardian</i>	WHO: 1993: 284,578 nurses or 496 per 100,000 population 2004: 284,578 nurses or 496 per 100,000 population	<i>The Guardian</i> 221,000 HCAs (2005)	

N/A=not applicable.