

*The education, training and
qualifications of nursing and care
assistants across Europe*

Eurodiaconia is a **dynamic**, Europe wide **community** of organisations founded in the **Christian faith** and working in the tradition of Diaconia, who are committed to a Europe of **solidarity, equality** and **justice**. As the **leading network of Diaconia in Europe**, we connect organisations, institutions and churches providing **social and health services and education** on a Christian value base in over 30 European countries.

We bring members together to **share practices, impact social policy** and **reflect on Diaconia in Europe today**.

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This publication has received financial support from the European Union Programme for Employment and Social Innovation “EaSI” (2014-2020). For further information, please read <http://ec.europa.eu/social/easi>. Eurodiaconia is a network of social and health care organisations founded in the Christian faith and promoting social justice.

Foreword

Eurodiaconia is a federation of organisations, institutions and churches providing social and health services on a Christian value base. Eurodiaconia creates a platform for diaconal actors in Europe with the aim of facilitating trans-national networking. It also creates a link between the regional, national and European levels, developing ideas and feeding into policies to combat social exclusion; in creating more just societies and in securing dignity for every human being.

One of Eurodiaconia's focus areas is healthy ageing and long-term care. Many Eurodiaconia members provide residential, community and home care to older people, and some experience staff shortages for this work. Staff shortages in some countries is one of the drivers for an increasing number of care and nursing staff crossing borders within the EU to work. Numerous members of Eurodiaconia are hiring care staff that were not trained or educated in the country in which they are operating. This can be challenging, in that the education or training of such staff varies from country to country and it is not clear before they arrive what skills or knowledge the staff will bring with them.

Eurodiaconia, therefore, wishes to improve understanding among its members of the main topics addressed and skills obtained in education and training qualifications of healthcare, nursing and care assistants in different countries so that they can be better prepared for reception and further training of staff not trained or educated in the country in which they are employed.

This research has been commissioned, monitored and steered by Eurodiaconia and Dr Peter Bartmann (Diakonie Deutschland). It has benefited from funding by Ecclesia Versicherungsdienst GmbH.

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Introduction

In Europe, the number of old and very old people is increasing. This positive development of increased life expectancy, however, brings with it a situation in which more people in their daily life depend on care support. The number of elderly depending on care support steadily rises, while there is already an acute lack of qualified care workers. Such staff shortages in some European countries are a reason why an increasing number of care workers migrate to work in other EU countries. The aim of this report is to provide an overview of the training, education and professional fields of a professional group of care workers – the *health care assistants* – referred to as HCAs hereafter – across several European countries.

This is intended to form the basis for better comparability of the HCA profession in the selected different countries. For this purpose a literature review was conducted on the research results of training of HCAs between 2011 and 2015. Ongoing projects that explore qualifications, education and training of HCAs were also taken into account.

As mentioned in almost every initiative, few data on the education and qualification of HCAs in Europe are available. Many of the existing studies refer to the education of Registered Nurses (RN). Nevertheless, since 2011 at least three major projects have focused mainly on HCAs in Europe, namely the project *Development and Coordination of a Network of Nurse Educators and Regulators (SANCO/1/2009)*¹, the *Francis Report*², and the *Cavendish*

*Review*³. All led to implementation of common standards and codes of conduct in relation to HCAs and assistant practitioners (APs). Below will be found a description of the projects' declared aims, the methodological approach as well as the background and the modifications to HCA regulations that emerged in Europe, especially the UK.

An important issue – with which both literature and project and research work are concerned – is to achieve comparability in training and working skills of HCAs across the

Volume 1:

www.webarchive.nationalarchives.gov.uk/20150407084003/www.midstaffspublicinquiry.com/sites/default/files/report/Volume%201.pdf (last visited February 15th 2016);

Volume 2:

www.webarchive.nationalarchives.gov.uk/20150407084003/www.midstaffspublicinquiry.com/sites/default/files/report/Volume%202.pdf (last visited February 15th 2016);

Volume 3:

www.webarchive.nationalarchives.gov.uk/20150407084003/www.midstaffspublicinquiry.com/sites/default/files/report/Volume%203.pdf (last visited February 15th 2016);

Francis Report Summary (2013). CoG 07/13. www.healthwatchhillingdon.org.uk/wp-content/uploads/downloads/2013/10/Francis_Report_Summary_of_recommendations.pdf (last visited: February 15th 2016)

- 3 Cavendish C (2013): *The Cavendish Review. An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings*. www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf (last visited: February 13th 2016)

1 Braeseke et al. (undated: 5)

2 The Mid Staffordshire NHS Foundation Trust PublicInquiry. Chaired by Francis, Robert. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. February 2013.

European Union. Different projects have examined the practicability of this goal. Comparing content, curricula and duration of training and qualification is one major aspect. Improved comparability through a common European evaluation framework – the European Qualifications Framework (EQF) – is expected.

However, little or no consideration has been given so far to the following particular problem: when HCAs – especially from Eastern European

countries and new EU Member States – migrate, the care situation in Western countries may ease as a result. On the other hand, a care drain in the afore-mentioned countries may occur. Thus the problem is merely shifted, not solved.

In the long term it would therefore be appropriate if care and work as HCAs attained better social prestige so that more people would be willing to do this job. This presupposes improved working conditions and especially higher wages.

Health Care Assistants: Terminology and job description

The Health Care Assistant (HCA) terminology is most common in the UK and is often adopted whenever the role of nursing assistants is referred to. HCAs often work in hospital settings, with a focus on geriatric and gerontological psychiatry wards. Generally – and in accordance with the qualification of most HCAs – it is assumed they work under the supervision of Registered Nurses (RN). Therefore in some curricula it is mentioned that HCAs work “in structural support to nurses who delegate tasks to them”.⁴ However, owing to a tight schedule in care and hospital day-to-day work they might carry out tasks for which they have not been trained.⁵

The typical content of training and tasks for all or most countries includes care assistance, nutrition, hygiene, first aid, safety, and documentation.⁶ Regular tasks of HCAs include “making beds, helping patients to eat and bathe, monitoring and recording patients’ glucose tests, temperature, pulse, respiration and weight, carrying out simple

dressings and escorting patients to theatre.”⁷

With regard to levels of education – provided by the European Qualifications Framework (EQF) and adopted by the European Parliament in 2008 with the aim of translating between different systems – one must notice that they seem to be available for a few countries only. In principle the qualifications of HCAs lie between EQF-levels 2 and 4, depending on the specific requirements in their countries.⁸

The term *Assistant Practitioner* (AP) is used to describe higher-level support workers. APs take on more responsibility at work than HCAs. They work at level 4 of the National Health Service career framework whereas Registered Nurses (RN) work at level 5.

4 EU-Project: *Creating a pilot network of nurse educators and regulators (SANCO/1/2009)*. List of Country Profiles (undated: 22).

5 Cavendish (2013: 18)

6 EU-Project: *Creating a pilot network of nurse educators and regulators (SANCO/1/2009)*.

List of Country Profiles.

www.hca-network.eu/downloads/ALL%20Country%20Profiles%20131004.pdf

(last visited: February 15th 2016)

7 Cavendish (2013: 18)

8 cf. Bundesministerium für Bildung und Forschung (2014: 51)

Country Analysis

The main source used is the [SANCO/1/2009](#) report⁹, which is quite comprehensive in providing information on the regulation, tasks and education of HCAs in 15 different European countries.¹⁰ Unless otherwise stated the [SANCO/1/2009](#) report is the source used. In addition, Waldhausen et al. report on the role of HCAs in various European countries.¹¹

1. Austria

1.1. Professional Title

In Austria the term *Pflegehelfer/-in (care assistant)* is commonly used for HCAs in the healthcare sector. A *Heimhelfer/-in (home helper)* is in charge of nursing at home with basic knowledge of care, nutrition, drugs and gerontology.¹² *Care assistants* are better qualified than *home helpers*.¹³

1.2. Education and Training

Law regulates the work and education of both care assistants and home helpers. Both occupa-

tions require a mandatory licence and a compulsory education. Responsible for regulation are the federal government, the federal ministry of health, and the federal state government. The legislative foundation of care assistants is the federal occupational law. Home helpers are regulated by an agreement between the federation and the federal states.

Training for care assistants takes one year. The training consists of theoretical and practical components in the same proportions totalling 1.600 hours¹⁴

According to the project [SANCO/1/2009 care assistants](#) need to acquire knowledge in these keyfields:

1. [...] nature and ethics of the profession of health-care and nursing
2. healthcare and nursing including care of elders
3. palliative care and home health care
4. hygiene and infection training
5. nutrition
6. invalid and diet food
7. basics of pharmacology
8. first aid
9. catastrophe and radiation protection
10. basics of mobilization and rehabilitation
11. jobs and institutions in the healthcare and social service system
12. including management
13. introduction to psychology, sociology, social hygiene, communication, and conflict management
14. job-specific legal foundation
15. animation and motivation of leisure time activities.¹⁵

As they have no officially recognized curriculum, requirements for *home helpers* follow the

9 EU-Project: [Creating a pilot network of nurse educators and regulators \(SANCO/1/2009\)](#). List of Country Profiles.

10 cf. Braeseke et al. (undated: 9)

11 Waldhausen A, Sittermann-Brandsen B, Matar-ea-Türk L (2014): *(Alten)Pflegeausbildungen in Europa. Ein Vergleich von Pflegeausbildungen und der Arbeit in der Altenpflege in ausgewählten Ländern der EU. Abschlussbericht*. Beobachtungss-telle für gesellschaftspolitische Entwicklungen in Europa. www.beobachtungsstelle-gesellschafts-politik.de/uploads/tx_aebgppublications/PflegeEU_Aug2014_01.pdf (last visited: February 15th 2016).

12 cf. EU-Project: [Creating a pilot network of nurse educators and regulators \(SANCO/1/2009\)](#). List of Country Profiles (undated: 4, 6)

13 cf. Waldhausen et al. (2014: 24)

14 cf. *ibid.*; cf. Waldhausen et al. (2014: 24)

15 EU-Project: [Creating a pilot network of nurse educators and regulators \(SANCO/1/2009\)](#). List of Country Profiles (undated: 6)

Umbrella Organisation of Social Institutions, Vienna.

1. Every training, however, has to cover the following minimal standards:
2. organising work, planning, and documentation work ethics
3. first aid
4. basics of applied hygiene
5. basics of assistance, care, and supervision of elderly, disabled or chronically ill persons
6. basic knowledge of drugs and medicine
7. basic knowledge of nutrition and diet
8. basics of ergonomics and mobilisation housekeeping, protection of the environment, safety, and safeguarding in a household basics in gerontology
9. basics of the management of communication and conflict
10. basics of social security and other legal aspects.

1.3. Possibilities of higher education

Home helpers can undertake training as *care assistants*; their qualification as *home helpers*, however, is not recognized and does not count towards further training.

1.4. Tasks and duties

Care assistants are employed in the following areas:

1. Hospitals and rehabilitation facilities of (acute) care with a focus on curation, rehabilitation, and palliative care.
2. [...] Residential (care) homes for the elderly and facilities for the care of persons with disabilities in the context of (long-term) care. [...]
3. Home-based care with a focus on the support of durable and tertiary prevention.¹⁶

¹⁶ ibid. 8; cf. Waldhausen et al. (2014: 26)

The tasks of *care assistants* include:

1. undertaking of basic care methods
2. undertaking of basic mobilization methods, personal hygiene and nutrition
3. surveillance of the sick
4. preventative care measures
5. documentation of care measures [...]
6. care, cleaning, and disinfection of devices.¹⁷

Home helpers are employed in the following areas:

1. domestic support and “care at home” (with [a] focus on housekeeping)
2. in growing numbers [in] nursing homes for the elderly (with focus on housekeeping and application of basic medical care”¹⁸ under supervision)

Traditionally home helpers were meant to work at the client's home. However, for the present they are increasingly employed in public facilities such as nursing homes or facilities for the care of people with disabilities.

The tasks of *home helpers* include: “household assistance (especially cleaning and tidying) [...]; heating of the home; support with shopping, mail, dealing with authorities [...]; support with cooking and eating; stimulation of activity; support in social relations; hygiene measures; general observation of the person's condition [...]; support from other care professionals; documentation; support with basic care including support relating to [...] taking and application of medication”.¹⁹

¹⁷ EU-Project: *Creating a pilot network of nurse educators and regulators (SANCO/1/2009)*. List of Country Profiles (undated: 9-10)

¹⁸ ibid. 8

¹⁹ ibid. 11, source: Weiss, S. et al. (2011): *Gesundheitsberufe in Österreich*. Bundesministerium für Gesundheit, Wien.

Waldhausen et al. (2014) note that there is no clear distinction of responsibilities according to qualification of the corresponding professional group at work.²⁰ In Austria, an appreciation and increased employment of care helpers in the nursing sector is being discussed.²¹

1.5. Regulation and Registration

Care assistants and *home helpers* are regulated by law; a compulsory licence requirement, as well as compulsory training, exist.

1.6. EU-mobility

The *SANCO/1/2009* report states “[t]hat there are no experiences in regard of target group employees leaving Austria to work in other EU member states and no account on how many workers from other EU countries are working within the target group in Austria.”²²

Conditions under which foreigners enter the Austrian labour market and work as care assistants include the following: “written request; proof of first place of residence in Austria respectively an application for employment in Austria; diploma or vocational school certificate; proof of attended vocational school subjects and [exams]; curriculum vitae; [...] passport; all kind of evidence of employment in Austria, respectively letter of intent from the employer; if applicable proof of marriage”.²³

20 cf. Health Education England (2013-2015): *Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values*. Project research. www.gov.uk/government/uploads/system/uploads/attachment_data/file/203332/29257_2900971_Delivering_Accessible.pdf (last visited: February 13th 2016)

21 cf. Waldhausen et al. (2014: 26)

22 EU-Project: *Creating a pilot network of nurse educators and regulators (SANCO/1/2009)*. List of Country Profiles (undated: 13)

23 *ibid.* 13-14

2. Belgium

2.1. Professional Title

The professional title *health care assistant* corresponds to the Belgian *aide soignant(e)*.

2.2. Education and Training

In order to become an *Aide Soignant(e)* the educational aim is to gain skills for working under the supervision of registered nurses. The vocational education and training of an *Aide Soignant(e)* takes one year. The diploma leads to the officially recognized title of HCA. Thereafter the HCA is registered. The following skills and knowledge are required:

1. professional activity in nursing hygiene and security and safety
2. care and support and assistance
3. technical intervention
4. prevention and maintaining of autonomy and resources
5. nutrition and clothes
6. domestic and logistic activities
7. administration and work organisation.²⁴

Belgium has a formal curriculum for HCAs. The curriculum includes the “fields of hygiene, safety, care assistance, technical tasks, logistics, [the] organisation of daily life, administration, work planning, nutrition, clothing and washing, emergency, family, patient[,] and social environment.”²⁵ The curriculum gives equal importance to practical and theoretical components. The practical part “takes place in hospitals [...], nursing homes, care homes, rehabilitation [centres], ambulatory care, [and] residences for the elderly of medical [centres] for elderly people.”²⁶

24 *ibid.* 18-19

25 *ibid.* 20

26 *ibid.*

2.3. Possibilities of higher education

Belgium offers several ways to become a HCA: Most trainees undertake diploma courses, which mean a full-time-education for one year. In general, this course begins after 12 years of compulsory education. It includes both theoretical and practical components. “Following the first year of [their] nursing diploma education” and “[a]fter the first year of their Bachelor of Nursing [...] students can work as HCAs.”²⁷

2.4. Tasks and duties

Tasks and duties of HCAs include the following:

1. The accomplishment of basic care methods
2. The accomplishment of basic mobilization methods
3. Personal hygiene and nutrition
4. Surveillance of the patient
5. Preventative care measures
6. Infection control [...].²⁸

In detail this means that HCAs are responsible for various tasks and duties:

1. taking into account factors such as religion, culture, age, gender, habits, living conditions[,] and the environment of the patient
2. supporting the daily personal care, dressing and undressing, giving food and beverages
3. mobilizing the patient
4. technical activities under supervision of the nurses such as measuring [...] blood pressure or pulse and temperature
5. changing bandages, giving medication or conducting simple laboratory tests

6. cleaning [...] used materials
7. giving first aid
8. cooking, making the bed, washing and cleaning at the location where the patient is cared for
9. administrative or organizational tasks
10. helping at the reception of care facilities.²⁹

2.5. Regulation and Registration

Since 2006 the Ministry of Health has been responsible for the regulation of *Aide Soignant(e)s*. Within the Ministry of Health the Federal Council of Nursing is responsible for the definition of the job profile as well as for the level of education and its content. Registration is carried out by the Commission for Nursing and Health Care Assistants.

Since 2001 law has regulated the duration of education as well as the tasks. This is also relevant for the delegation of tasks between HCAs and registered nurses.

In 2006, following Ministry of Health legislation, the occupational group of HCA was established. Before then employees with fewer qualifications than registered nurses were not required to have a licence to practice or have had any education in that field.

HCAs are compulsorily registered by law (Royal Law 2006). HCAs are registered after their graduation.

In 2012, 82.000 HCAs had been registered in Belgium. Most work in the elderly care sector.

27 ibid. 19

28 ibid. 21

29 ibid. 21-22

2.6. EU mobility

In Belgium most of the employed HCAs are from abroad, mainly from Eastern Europe – “Romania, Bulgaria, Latvia [,] and some French-speaking African countries”³⁰. No reliable numbers are available on how many foreign workers enter Belgium to work as HCAs or how many Belgians leave the country to work elsewhere.

Requirements for foreign workers to work as an HCA in Belgium include passing of an equivalence test to have their education recognized within the range of Belgian requirements.

3. Bulgaria

3.1. Professional Title

The professional title of HCA in Bulgaria is *health assistant*, but the term referred to in practice is *sanitaries*.

3.2. Education and Training

Education consists of theoretical and practical components. Theoretical training takes place in training rooms; practical training takes place individually in clinical settings such as hospitals, hospices, nursing homes, and homes of medical and social care.

3.3. Possibilities of higher education

Nurses sometimes work as HCAs during their education. For *health assistants* no bridging courses to aid acquisition of higher education exist.

No information on normal training duration is available.

3.4. Tasks and duties

In Bulgaria a detailed description of demands for the education of *health assistants* is available. According to Ordinance No 72 of 26 September 2012 on the acquisition of the vocational qualification ‘health assistant’, the required theoretical and practical knowledge includes:

1. Know and apply the standards and criteria for patient care
2. Know the physiology and pathophysiology of healthy and sick people (systems): joints, cardiovascular, respiratory, digestive, excretory and reproductive, nervous system and sensory organs

30 ibid.

3. Perform independently or under supervision specific activities in surgical, orthopaedic, internal, infectious, and oncological emergencies
4. Know and apply [...] rules of the general and special care for seriously ill [patients]
5. Know and apply rules to implement general and specific health care for a sick child
6. Know and apply safety rules on accommodation, care and movement of patients
7. Know the different dressings, soft and hard medical instruments, disinfectants and more
8. Know the rules for the management of inventory
9. Know and apply standards in asepsis, antisepsis, disinfection, sterilization, and general hygiene
10. Aid in situations of risk to health and life of patients and inform medical professionals
11. Communicate with patients, explaining procedures for providing basic health care
12. Organize [...] preparation[s] of various devices, systems and tools required to perform the procedures
13. [be] able to detect deviations from normal operation of medical equipment
14. Show the ability to master various emergencies and psychological resilience in times of stress
15. Support of patients [in their] social integration
16. Know and apply standards and principles of medical psychology, ethics in medicine and deontology
17. [be] able to collect and process information given to [her/]him to fill out forms, preparing reports, draw up reports and records [...]
18. Observe the rules and norms of medical ethics [...].³¹

3.5. Regulation and Registration

Since 2012 acquisition of the 'Health Assistant' vocational qualification has been issued by the Ministry of Education and Science. In 2011, a degree was developed to regulate fully the education and tasks of *health assistants*. Education and training of *health assistants* is carried out by the National Agency for Professional Education and Training.

In 2011, when the *SANCO/1/2009* project started, there was no compulsory examination for *health assistants*. The Ministry of Health, however, was already working on compulsory and structured regulations.

3.6. EU mobility

Health assistants in Bulgaria face difficulties because of low payment and social status. It is for this reason that nobody takes HCA courses willingly. Therefore no training is required to perform the tasks of HCAs which are often carried out by people of minority groups, for example ex-prisoners. Because of the low wages, a large number of *health assistants* leave the country to apply for jobs in other EU or non-EU countries.

31 *ibid.* 26-27, 30

4. The Czech Republic³²

4.1. Official title

In the Czech Republic the official title *Ošetřovatel* (hospital attendant) is common for HCAs. *Hospital attendants* work in both the health and social services sectors.

4.2. Education and Training

Compulsory educational preparation takes four years and concludes with a licence to practise, provided a secondary school certificate has been obtained. Education and training of HCAs includes the following skills:

1. collect information about patients' needs
2. work with documentation
3. monitor all objective and subjective displays of physiological functions
4. measure temperature, pulse, breath, blood pressure [...]
5. care for good, appropriate nutrition and hydration
6. attention to the bed with and without the patient
7. control cleanliness of all environments
8. carry on rehabilitation in cooperation with physiotherapist including prevention of decubitus and immobilisation syndrome
9. take care of [health aid], instruments, apparatus
10. disinfection and sterilisation of [devices] and instruments
11. preparation of medical drugs, their application for skin, breathing, subcutaneous and [intramuscular] [...]
12. take care of oxygen therapy
13. care for acute and chronic wounds, bowel movements
14. preparation of patients [for] medical scans and assistance
15. care for patients with venous catheter

32 I would like to thank Romana Bělová, from Slezska Diakonie, for providing information on this part.

16. [take care of] all activities with receipts, translation and discharge of patients.³³

A compulsory curriculum regulates training patterns and is implemented by nursing schools.³⁴ Training duration takes four years.

1st year: 96 hours of nursing care theory, 32 hours of first aid, Czech, history, Latin, biology, mathematics, physics, English or German, somatology etc.

2nd year: 192 hours of nursing care theory, surgery, pathology, epidemiology, hygiene, clinical medicine-propaedeutics etc.

3rd year: 32 hours of internal medicine, 160 hours of nursing theory and 140 hours of practice in hospital or [...] internal medicine department, surgery [department], gynaecology and paediatrics etc., in total it makes 396 hours of practice in that year.

4th year: nurse care for 140 hours, practical training for 70 hours, in that year it is 378 hours of [practical training]. [Common workplaces are] internal medicine, surgery, gynaecology, paediatrics [and] terrain, policlinics, [and] home care. [...]³⁵

Hospital attendants have secondary school (or vocational school) education (at least three years) and attend professional training for hospital attendants (accredited by the Ministry of Health).

Training takes place in secondary school or vocational school (at least three years). Also professional training (retraining) is possible, which takes 700 hours (accreditation by the

33 EU-Project: *Creating a pilot network of nurse educators and regulators (SANCO/1/2009)*. List of Country Profiles (undated: 34-35)

34 cf. Braeseke et al. (undated: 25)

35 EU-Project: *Creating a pilot network of nurse educators and regulators (SANCO/1/2009)*. List of Country Profiles (undated: 35)

Ministry of Health).

What should be included in the curriculum is a training in soft and communication skills as well as skills in caring for dying patients. It is also important to include the topics of the quality of provided services and an individualized, person-centred approach.

4.3. Possibilities of higher education

It is possible for HCAs to enter into nursing studies. Many of them enter into bachelor studies. There are certified courses for higher qualifications authorized by the Ministry of Health and by the National Institute of Nursing. Furthermore, HCAs become general nurses after three years of work experience in hospitals or after three years of secondary school plus a three-year bachelor in nursing studies.

4.4. Regulation and Registration

HCAs are regulated by law. Compulsory qualification is provided by nursing and care schools. The [SANCO/1/2009](#) report cites laws that apply to regulation of HCAs, e.g.

1. Law No. 39/2005 regulates the minimal requirements for a study program.
2. Law No. 96/2004 regulates the education of all medical workers.
3. Law No. 394/2004 regulates examinations and certificates of post-graduate education.
4. Law No. 423/2004 regulates the credit system in the Czech education system. For health care assistants the credit system [is applied] after [three] years [of] practice [...]. It is organized by the Czech Ministry of Health and National Institute for Nursing.
5. Law No. 424/2004 regulates the competence of general nurses. [...]
6. Law 463/2004 regulates branches of special education within post-graduate education.³⁶

36 ibid.

The HCA profession is regulated by Regulation No. 55/2011 Sb §37 on the activities of health care and other specialised workers. It is subject to professional training (or retraining).

4.5. EU mobility

Many HCAs in the Czech Republic with adequate language skills leave for the UK, Germany, Italy, Austria, and Switzerland or non-EU countries such as the UAE, the USA or Kuwait. There is also labour migration into the Czech Republic, mainly from Slovakia. Some immigrants are from Ukraine and a small group is “from Moldova, Russia [,] and Bulgaria”.³⁷

Some HCAs go abroad. Their main reason is of a financial nature. But their mobility is limited by a lack of foreign language proficiency.

There are not so many HCAs from abroad because financial conditions are not as attractive as in other European countries and there are also language barriers. Foreigners have to follow Czech regulations, and need Czech professional training.

4.6. Working conditions

Working conditions are considered quite acceptable. Wages are slightly above the minimum wage (about 20%) but are below the average wage in the Czech Republic. The social status of this profession is not very high compared with others. Consequently public opinion gives lower recognition to the standing of HCAs and therefore the profession to be suitable for those with a lower level of education. Because of low prestige anybody affected by long-term unemployment is considered a candidate for retraining in this profession.

37 ibid. 38

5. Denmark

5.1. Official title

The official title for HCAs in Denmark is *social health care assistant*.

5.2. Education and Training

Education of *social health care assistants* is regulated by the Danish Act No 343 dated 16.5.2001. The equivalent level on the European Qualifications Framework (EQF) is 3.³⁸ The following skills are acquired through vocational education and training:

1. Practical and personal help
2. Personal care nursing tasks
3. Health promotion and prevention activities
4. Coordination, supervision, and instruction
5. Activity and rehabilitation.³⁹

The duration of the education and training programme is eight months.⁴⁰ Education is full-time and the practical parts consist of work-based learning. An official curriculum exists for the vocational education of *social health care assistants*.

The *SANCO/1/2009* report states that there is a relatively high dropout rate of about 20 per cent.

5.3. Possibilities of higher education

It is possible to take additional courses during education as a *social health care assistant*. This would save one year in the nursing programme. For social workers their education as *social health care assistants* partly counts as credit.

5.4. Regulation and Registration

Social health care assistants need a work licence to be eligible to work. They can prepare for that licence with a nationally recognized compulsory education. Likewise, a compulsory registration exists for *social health care assistants*. Denmark also has an official curriculum for the vocational education of *social health care assistants*. In Denmark an official body exists that regulates the use of the occupational title, namely the Danish Authorization for HCA. A “Law in basic social and health education” (Law No. 343 of 16/05/2011) exists that defines the areas in which *social health care assistants* are trained to work.

5.5. EU mobility

At present the employment situation for *social health care assistants* is undergoing a change. Jobs in the hospital sector are being cut due to the restructuring of the healthcare sector, but at the same time more jobs are being created in municipalities.

No information is available concerning Danish *social healthcare workers* who have left their country. Many *social healthcare workers* are from Sweden, mainly to upgrade their education in the psychiatric field. There is no further information on EU mobility in relation to Denmark. Labour migration to Denmark requires an education equivalent to that possessed by Danish *social health care assistants* and a good knowledge of the Danish language.

38 cf. Waldhausen et al. (2014: 18)

39 EU-Project: *Creating a pilot network of nurse educators and regulators (SANCO/1/2009)*. List of Country Profiles. (undated: 41)

40 cf. Braeseke et al. (undated: 21)

6. Finland

6.1. Official title

In Finland two occupational groups exist that can be compared to *health care assistants*. One is called *licensed practical nurse* (LPN), the other *care assistant*. *Care assistants* have no official education and may therefore not use the official occupational title. However, many of them did undergo parts of the practical nursing education course and decided to enter working life directly (which is possible in Finland).

6.2. Education and Training

The training of LPNs includes a basic understanding of the life situation of their patients. What is required here is that patients are receiving support in everyday life; this includes handling matters with authorities as well as applying for and using welfare services and attaining peer support organisations. Intercultural knowledge is also necessary.

The training duration is expected to be three years of full-time study. The majority of LPNs work in hospitals and nursing homes caring for old people, but they can specialize in work in kindergartens and schools for children with special needs as well.

The official curriculum of the National Board of Education indicates the following aspects of education. It is divided into practical and theoretical parts. The practical part takes half a year.

During the first two years the participants are trained in “support and guidance; nursing and care; rehabilitation support”.⁴¹

In the third year participants are given the opportunity to choose from nine different vocational parts:

1. Emergency care
2. Rehabilitation
3. Children's and youth care and education
4. Mental health and substance abuse welfare work
5. Nursing and care
6. Oral and dental care
7. Care for [persons with disabilities]
8. Care for the elderly
9. Customer services and information management.⁴²

6.3. Possibilities of higher education

After three years of education and completion of the status as LPN one is qualified “to apply for studies at universities and polytechnics.”⁴³

6.4. Tasks and duties

Tasks and duties of LPNs are as follows:

1. guide patients on issues relating to nutrition, healthy lifestyles, and maintenance of functional capacity
2. provide pharmaceutical care
3. promote individual patients' interaction in activities of daily living
4. be able to work ergonomically and to function proactively in a quality-conscious, service-oriented manner
5. have language skills in one foreign language and both national languages
6. act in a holistic, humane, and tolerant manner.

41 EU-Project: *Creating a pilot network of nurse educators and regulators (SANCO/1/2009)*. List of Country Profiles. (undated: 51)

42 *ibid.* 51

43 *ibid.* 56

6.5. Regulation and Registration

The education of *licensed practical nurses* is regulated. The qualification is recognized nationally and a licence is required to use the occupational title of LPN. Compulsory registration for LPNs exists.

The higher-level institution implementing the regulation is the National Supervisory Authority for Welfare and Health (Valvira). In addition, there are Regional State Administrative Agencies in all provincial territories that guide and supervise the activities of health care workers.⁴⁴ Laws that conduct the regulation of LPNs are the following:

1. Vocational Education and Training Act (630/1998)
2. Vocational Education and Training Decree (811/1998)
3. Vocational Adult Education Act (631/1998);
4. Vocational Education Decree (812/1998) Curriculum.⁴⁵

6.6. EU mobility

Currently, there is a lack of LPNs in Finland. However, in 2008, only 3 per cent of foreigners worked in the social and healthcare profession. Requirements for labour migration to Finland are recognition of the applicant's education by the National Supervisory Authority for Welfare and Health which grants the applicant to use the title of LPN. Additionally, non-EU citizens need an official language certificate in Finnish that has to be accepted by Valvira, EU citizens do not need such a certificate.⁴⁶

44 cf. *ibid.* 49

45 *ibid.* 48

46 cf. *ibid.* 55; cited after www.valvira.fi/en/licensing/professional_practice_rights/licensed_practical_nurses

7. France

7.1. Official title

The official title for HCAs in France is *aide-soignant(e)*.

7.2. Education and Training

Education takes between eight months and one year.

7.3. Regulation and Registration

Vocational training as *aide-soignant(e)* is subject to common regulations nationwide; there is a curriculum to provide the minimum content.

7.4. Possibilities of higher education

Following the training as an *aide-soignant(e)* an additional qualification for geriatric care can be acquired.⁴⁷

7.5. Tasks and duties

Aide-soignant(e)s often work in hospitals; only 7.5 per cent are employed in the home care environment. *Aide-soignant(e)s* work under the instruction of nurses.⁴⁸

7.6. EU mobility

Due to the high unemployment rate there is no shortage of *aide-soignant(e)s* in France.⁴⁹

47 cf. Waldhausen et al. (2014: 18)

48 cf. *ibid.* 19

49 cf. *ibid.* 20

8. Germany/North Rhine-Westphalia

The 16 German federal states regulate the education of HCAs themselves. The legislator is the corresponding Federal Ministry of Health. The training duration takes between one and two years depending on the specific federal state.⁵⁰

8.1. Official title

In North Rhine-Westphalia the official title relating to HCA is *geriatric health care assistant*. In Lower Saxony, the target group is titled *certified care assistants*. In Brandenburg, the title *health care assistant* is used.

In the following the example of North Rhine-Westphalia is used to describe education and training of HCAs in Germany.

8.2. Education and Training

Common components of the education of *geriatric health care assistants* are basic care of elderly people in stable care situations; assistance in preventative health care; assistance in collecting patient data and documentation, and assistance in enabling independent living.

The education as *geriatric health care assistant* has a duration of 12 months in full-time, and up to 24 months in part-time. It comprises 750 hours of theoretical and 900 hours of practical training.

8.3. Possibilities of higher education

Geriatric health care assistants can acquire post-education specialization that enable them to perform tasks usually performed by registered nurses (but for lower remuneration).

Geriatric health care assistants can partake in further education programmes to become geriatric nurses.

8.4. Tasks and duties

There are no specifically defined tasks of *geriatric care assistants*. However, common tasks and duties are treating and nursing of people; helping with personal hygiene; nutrition; administration of medicine in compliance with a physician's instruction; assistance in everyday situations, for example going to a doctor; organizing leisure time activities and social programmes; supporting relatives. Owing to the increasing number of people with dementia in care homes, dealing with this group is a basic competence. *Geriatric care assistants* work under the supervision of a certified caregiver.

8.5. Regulation and Registration

Although a compulsory curriculum does not exist, training and examination regulation do exist. The training of *geriatric care assistants* is regulated by the Federal Law of Execution of the Act for Geriatric Care and Education in Geriatric Care Assistance. Training facilities are responsible for proper conduct of the practical training.

8.6. EU mobility

No information on EU mobility in either direction is available.

50 cf. Bundesministerium für Bildung und Forschung (2014: 145)

9. Italy

9.1. Official title

The official title for the care support staff in Italy is *operatore socio-sanitaria (OSS)*. Health care assistants are known as *auxiliary staff*. At the time of the *SANCO/1/2009* project the education of OSS had not started anywhere in Italy. The *SANCO/1/2009* project predicts a trend of having more OSS and less nurses' work in the institutions.

9.2. Education and Training

The goals of education include social values, communication skills, household-keeping, making beds, washing patients, helping them to mobilize, and assisting them in social activities. Vocational training takes 1.000 hours full-time, which means one year in average. It consists of theoretical components (550 hours), which take place in schools, and practical components (450 hours), which are to be completed within health or social structures.

The official curriculum focuses on "nursing for basic needs, psychology, sociology, organization of the national health system and management, ethics, health legislation, [and] social care."⁵¹

9.3. Possibilities of higher education

OSS workers can take a next step in qualification and become specialised support workers. To achieve this qualification they have to undergo 300 hours of additional study of theory. No bridging courses enabling the target group to enter into nursing studies are available; however, the political institution Ipasvi (Board for Registered Nurses) tries to build such bridges. In the meantime about 10-15 per cent

of the OSS become Registered Nurses after further studies at an academic level.

9.4. Tasks and duties

Tasks and duties of OSS are mainly:

1. [...] observe skin condition and report any abnormalities to the nurse in charge
2. [...] assist patients [...] with dressing and grooming [...]"⁵²
3. assist patients with personal hygiene
4. assist patients with nutrition
5. assist with safe mobility of patients within and outside the institution
6. assist with achieving maximum independence
7. help promote social contacts with peers and family
8. be confidential
9. assist with cleaning the room
10. interact in an "effective manner with the practice team"⁵³
11. respect every individual's uniqueness and dignity
12. "assist in general nursing duties on and in the assessment of a set standard competence level and under the supervision of nurses, [e.g.] take temperatures, weight [and] height, blood pressure measurements, recording."⁵⁴
13. OSS only work under supervision of staff with higher qualifications, mainly nurses.

51 ibid. 95

52 ibid. 96

53 ibid. 97

54 ibid. 96-97

9.5. Regulation and Registration

In Italy compulsory educational preparation as well as compulsory registration is required. Licensing is regulated by regional authorities. Responsible for the curriculum are the Ministry of Health, the Ministry of Work and Social Politics and the Conference of the Italian regions.

The *auxiliary staff* and the *OSS* are regulated by law, the main document is the Decree stated by the Agreement of February 22nd 2001 between the “Ministry of Health, the Ministry of Work and Social Politics and the Conference of the Italian regions”⁵⁵. This decree declares the official profile of the OSS and defines the curriculum for the training.

9.6. EU mobility

Italy has a high unemployment rate, so few HCAs from other countries come to Italy. No information is available on Italian workers leaving the country. To enter the Italian job market from another country, the employee needs to prove his or her language skills to the employer and his or her qualification must be recognized by the Ministry of Health.

10. The Netherlands

10.1. Official title

In the Netherlands three groups of employees are part of the target group: *individual health carers* (Verzorgende IG, EQF-level 3), *health and welfare assistants* (Helpende zorg en welzijn, EQF-level 2), and *care assistants* (Zorghulp, EQF-level 1). The higher the level, the more responsibility the respective employee has to carry. Nurses are referenced on levels 4 and 5.⁵⁶

10.2. Education and Training

The education of *individual health carers* include:

1. providing care and support based on the care plan [...]
2. supervising the care recipient, based on the care plan [...]
3. performing organization and profession-related tasks.⁵⁷

The education of *health and welfare assistants* includes:

1. providing care and support based on a work plan [...]
2. supporting independent functioning.⁵⁸

The education of *care assistants* includes:

1. providing home care [...]
2. providing help with daily tasks and activities.⁵⁹

55 ibid. 93, 95

56 cf. ibid. 100; cf. Waldhausen et al. (2014: 18)

57 EU-Project: *Creating a pilot network of nurse educators and regulators (SANCO/1/2009)*. List of Country Profiles. (undated: 102)

58 ibid.

59 ibid. 102-103

For *individual health carers* (level 3) the training lasts three years, either full time (40 hours a week) or with a 24-hour employment contract on the basis of an acknowledged apprenticeship with an institution and additional education days.

Training of *health and welfare assistants* (level 2) lasts two years, training of the care assistants one year. All training includes theoretical as well as practical parts. Trainees with little Dutch language skills can undergo the training as *care assistants* in 1.5 years.⁶⁰

For each level of training a curriculum exists. Areas of employment are all accredited health institutions, especially hospitals, nursing homes, and child and youth care institutions.

10.3. Possibilities of higher education

Bridging courses enable them to gain access to nursing studies.

10.4. Tasks and duties

Tasks and duties of *individual health carers* include the “provision of care and support [...], making a care plan, support[ing] in basic personal care, providing palliative care, support for household and living”⁶¹ etc.

Tasks and duties of *health and welfare assistants* include “providing care and support based on a work plan [...], creating a work plan based on the care-, living- [and] activity plan, giving household support, giving support with personal care [...]”⁶²

Tasks and duties of *care assistants* are provision of “home care, working according to a work

[...] plan, keeping the living space [...] clean, maintaining working material, provision of food and drinks, taking care of [...] laundry, simple repairs of clothing [...], and maintenance of footwear.”⁶³

Employees with qualification on level 3 are also responsible for nursing tasks “like medication, injections, feeding tubes”⁶⁴. Workers with qualification levels 1 to 3 work under the supervision of registered nurses.

10.5. Regulation and Registration

Training of the three assistant health care professions is regulated. Determining the content of the training falls within the competence of the Ministry of Education, Welfare and Sports. The institute Calibiris is responsible for the regulation of education.

The employment of *health care assistant* workers is regulated by law. The *SANCO/1/2009* project states there is a law to regulate the quality of the care given; to regulate the quality of all health care providers; and to regulate risky procedures that may only be performed by professionals with a specific registration. The use of official titles is regulated by law. No mandatory registration is available for *health and welfare assistants* and *care assistants*, but *individual health carers* (level 3) are required to register in the BIG register, as they have to perform more comprehensive tasks.

10.6. EU mobility

Only a few foreigners are employed within the target group, originating mainly in non-EU countries and working as care assistants (level 1). A valid diploma as well as Dutch language proficiency is required.

60 cf. *ibid.* 103-104

61 *ibid.* 106

62 *ibid.*

63 *ibid.* 107

64 *ibid.*

11. Poland

11.1. Official title

In Poland the official title relating to the target group of *health care assistants is medical carer*.

11.2. Education and Training

Since 2012 there has been a decree that regulates the education of *medical carers*. Content-related this decree is based on the European Qualification Framework. It includes three modules:

1. general educational objectives for all professions [...]
2. educational objectives for students in [the] socio-medical [field]
3. specific educational objectives for specific professions.⁶⁵

The general skills of *medical carers* are: “recognizing and solving problems of sick and dependent [...] persons in different stages of sickness and age; helping sick and disabled persons in satisfying their physical, psychological and social needs; assisting a qualified nurse and other medical personnel during nursing; conservation and disinfection of [instruments] used during nursing procedures; [...] cooperating with [the] therapeutic team [when caring] for a sick and disabled [...] person.”⁶⁶

“The minimum curriculum scheme for vocational education” of *medical carers* includes “400 hours of basic education [...] –and additionally 320 hours of education in care services [...]”.⁶⁷ Training can be done full-time, part-time or at evening schools. The curriculum for *medical carers* is based on legislation from September 2012.

General employment areas for *medical carers* are “hospital wards, hospices, medical care facilities, health care teams [or] sanatoriums”⁶⁸.

11.3. Possibilities of higher education

The profession of *medical carer* is not regarded as part of nursing, hence there are no bridging possibilities to proceed with studies to become a nurse.

11.4. Tasks and duties

Tasks and duties of *medical carers* include “identifying and resolving problems in caring for an ill or dependent person [...]; helping an ill and dependent person in meeting biological, psychological[,] and social needs; assisting [nurses] during treatment; maintenance and disinfection of utensils [...] used during treatments; cooperation with a caring and therapeutic team [...]”⁶⁹.

11.5. Regulation and Registration

The occupational group of *medical carers* was introduced by the Ministry of Health in 2007. There has been no compulsory education or registration; however, regulation of the educational objectives has existed since 2011.

People without secondary education can attend special medical carer courses without the need for secondary education; however, those courses do not entitle them to use the professional title of medical carer.

11.6. EU mobility

There are no statistical data available on how many employees leave or enter the Polish healthcare system from foreign countries.

65 ibid. 114

66 ibid. 116

67 ibid. 122

68 ibid. 124

69 ibid. 125

12. Slovenia

12.1. Official title

The official titles accorded to *health care assistant* in Slovenia are *health care technician* and *practical nurse*.

12.2. Education and Training

There is a national curriculum issued by the Institute for Vocational Education and Training (CPI). General objectives of *health care technicians/practical nurses* are:

1. undertaking “health and nursing interventions”⁷⁰ independently
2. “following doctors’ and nurses’ instructions”⁷¹
3. performing “health care of adult patients, children and young persons”⁷²
4. administering “first aid, emergency medical aid and basic resuscitation procedures”⁷³
5. using “health care appliances and apparatuses” etc.⁷⁴

The training for *health care technicians/practical nurses* takes four years, leading to a qualification at Level 5 of the European Quality Assurance Reference Framework. The education takes place in special secondary level vocational education facilities.

12.3. Possibilities of higher education

Health care technicians/practical nurses can specialise in their field. After a training of four years they are able to enter nursing colleges and attain a diploma in nursing.

70 *ibid.* 143

71 *ibid.*

72 *ibid.*

73 *ibid.*

74 *ibid.* 136, 143

12.4. Tasks and duties

Common areas of employment are “community health care centres, hospitals, private health care organizations, nursing homes for elderly and other social institutions, home care and [...] private care.”⁷⁵

12.5. Regulation and Registration

The institution of Health Services Act is responsible for the regulation of health workers in general. The *SANCO/1/2009* report states that “health services can be provided by health workers who have appropriate professional education, are adequately qualified for independent practice of their profession, and meet other criteria set by the law and other regulations.”⁷⁶

The Nurses and Midwives Association of Slovenia is authorized to regulate the compulsory registration as well as the licensing of *health care technicians/practical nurses*. The regulation of *health care technicians/practical nurses* is controlled by CPI (Institute for Vocational Education and Training), by the Council of Experts for Vocational and Professional Education of the Republic of Slovenia, and by the Ministry of Education, Science, Culture and Sport.

12.6. EU mobility

There is no information on HCAs from other countries working in Slovenia, but it is common for *health care technicians/practical nurses* to work in Austria and Germany. One condition under which foreign target groups may work in Slovenia is that their education must be recognized by the Ministry of Education. Language skills and a work permit are also required.

75 *ibid.* 142

76 *ibid.* 132

13. Spain

13.1. Official title

The official title of the target group in Spain is *nursing assistant* (técnico en cuidados auxiliares de enfermería).

13.2. Education and Training

An official curriculum, regulated by law, exists for *nursing assistants*. The corresponding law is R.D. 558/1995. The training duration for *nursing assistants* is one to two years full-time, which means 1.400 hours.⁷⁷ The first year consists of theoretical training; the second year includes a three-month period of practical training. This translates into 960 hours of theoretical training and 440 hours of practical education.

The main employment areas for nursing assistants are hospitals or primary health care centres.

13.3. Regulation and Registration

For *nursing assistants* no compulsory licence is required. However, there is a compulsory educational preparation which is recognized nationwide and concludes with acquisition of the official title. Those so-called Middle Grade Training Cycles are regulated by the Ministry of Education.

The tasks and duties of nursing assistants are regulated by law. Two laws are central to organisation and regulation of nursing assistants, first the R.D. 546/95, which regulates the minimum educational criteria and second, R.D. 558/95, which regulates the official education curriculum.

No compulsory registration for nursing assistants is needed.

13.4. EU mobility

0.2 per cent of the workforce consist of workers from foreign countries.

⁷⁷ cf. *ibid.* 149-150; cf. Waldhausen et al. (2014: 32)

14. Sweden

14.1. Official title

The official title relating to *health care assistant* in Sweden is *Undersköterska*. One qualification level below HCA is *Vardbiträde*.⁷⁸

14.2. Education and Training

Qualification as an *Undersköterska* can be achieved by different means. In the Swedish school system students can choose a vocationally orientated programme of three years after having finished primary school after nine years. Among others are the *Vard och omsorgsprogrammet*, which corresponds to vocational education for HCAs. Another possibility is in-service training for adults.⁷⁹

The education and training as a *Vardbiträdes* takes one year.⁸⁰

As for geriatric health care workers *Vardbiträdes* are most likely to be found (46 per cent), 44 per cent being *Undersköterskas*.⁸¹

14.3. EU mobility

In Sweden there is a lack of junior health professionals. This shortage also affects *Undersköterskas* and *Vardbiträdes*.⁸² Apart from improving working situations Sweden is eager to employ an increasing number of migrant *health care workers*.⁸³

78 cf. Waldhausen et al. (2014: 28)

79 cf. *ibid.* 28, 29

80 *ibid.*

81 *ibid.*

82 cf. *ibid.* 30

83 *ibid.*

15. Switzerland

15.1. Official title

In Switzerland the official titles for the target group are *Fachfrau/Fachmann Gesundheit EFZ der Sekundarstufe II*; *Assistentin/Assistent Gesundheit und Soziales EBA*; *assistant en soins et Santé Communautaire ASSC*. Those titles correspond to the title *health care assistant*.

15.2. Education and Training

To become a *health care assistant* three years of vocational education and training are necessary. After that the trainee reaches VET secondary II level, which replaces the former Swiss Red Cross (SRC) courses of one or two years.

Health care assistants work under the supervision of nurses.

At the time of the *SANCO/1/2009* report an official curriculum had not been developed. The content of the former one-year vocational education training includes “Hygiene, Safety, Care assistance, Medical technical tasks, Organization of daily life, Logistics, Administration, Work planning, Nutrition, Clothing, Washing of clothes, Focus on clients, family, and social environment, and Emergencies.”⁸⁴ Locations where training takes place include “hospitals, clinics, nursing homes, care homes, disabled people homes, rehabilitation centres”, and ambulatory care.⁸⁵

84 cf. EU-Project: *Creating a pilot network of nurse educators and regulators (SANCO/1/2009)*. List of Country Profiles (undated: 158-159)

85 *ibid.* 159-160

15.3. Possibilities of higher education

Fifty per cent of health care students wish to undertake further education in nursing or physiotherapy.

15.4. Tasks and duties

Tasks and duties of health care assistants include supervision and caring for patients, taking into consideration “religion, culture, age and gender of [...] patients”⁸⁶, helping with daily personal care, supporting patients with nutrition, encouraging patients’ agility etc.

15.5. Regulation and Registration

The education of *health care assistants* is loosely regulated by an edict on education (Bildungsverordnung). The responsibility for defining and supervising the practice of *health care assistants* lies with the employer. No licence is required. Responsibility for the regulation of *health care assistants* no longer rests with the Swiss Red Cross, but with the Federal Office for Professional Education and Technology (OPET).

15.6. EU mobility

Owing to the geographical position, 22 per cent of the entire working population of Switzerland is foreign, but the statistics do not reveal the origins of *health care assistants*.

16. The UK

16.1. Official title

The terminology of *health care assistant* (HCA, England) or *healthcare support worker* (HSW, Scotland) is most common in the UK. A number of other titles are also used (e.g. *nursing assistant*) that describe essentially the same role. The level of qualification, according to the National Health Service (NHS), is 2 and 3. The EQF reference-level is 3.⁸⁷

The term *assistant practitioner* (AP) is used to describe higher level support workers. APs differ from HCAs in their higher level of responsibility at work. They work at level 4 of the NHS career framework, whereas registered nurses work at level 5. The EQF reference-level of registered nurses is 4.⁸⁸

16.2. Education and Training

Vocational training takes two years. As there had not been any nationally recognized curriculum until very recently, the national vocational qualification system was replaced by the Qualifications and Credit Framework in England and Northern Ireland, the Credit and Qualifications Framework in Wales and the Scottish Credit and Qualifications framework in Scotland. In this context courses in health and social care are available, but not mandatory, for all HCAs. “Training for support workers [includes] both theoretical and practical elements.”⁸⁹ The ratio between them depends on the individual course being taught. Some training takes place at the workplace, some at educational colleges or higher education facilities. When the project

87 cf. Waldhausen et al. (2014: 18)

88 cf. *ibid.*

89 EU-Project: *Creating a pilot network of nurse educators and regulators (SANCO/1/2009)*. List of Country Profiles (undated: 171)

86 *ibid.* 160

drew to a close “no formal examinations for HCAs in the UK”⁹⁰ existed.

The project concludes that the candidate is primarily instructed by his or her employer. Vocational qualifications are held by verifiers who have to assess candidates’ work at their workplaces and look at their portfolios.

From April 2015 onwards new standards for education and employment of HCAs have to be applied.

16.3. Tasks and duties

Basics tasks in healthcare include for HCAs and APs:

- “core caring skills, communication, knowledge of confidentiality, consent, record keeping, infection prevention and control, dignity awareness and compassion.”⁹¹

Clinical skills that belong to the qualification of an HCA include among others:

- “taking of physiological measurements (BP, pulse, MBI, temperature) [...], ECG recording, [...] lung function testing, wound care, administration of medication [...], administrative tasks[,] e.g. stock control, call and recall for clinics”⁹².

HCAs work in primary and secondary care and are supposed to work under the delegation and supervision of registered nurses. It is mentioned, however, that HCAs are obliged to resume responsibilities beyond their qualifications. As pointed out in the GesinE Survey, France and Great Britain are especially concerned with this issue.⁹³

The Royal College of Nursing (RCN) also considered this situation as a problem in their published *Position statement on the education and training of HCA* (2012). The fact that HCAs undertake tasks for which they are not trained, is attributed to the fact that there were, at least until April 2015, “no national standards for the education, training and support of this group of workers across the UK” according to the RCN.⁹⁴

Since April 2015 a national code of conduct has been in effect in the UK, the effect of which cannot be foreseen at present. It is expected, however, that specific instructions for education as well as a national common code of conduct will ensure a certain level of reliability concerning tasks for HCAs.

90 ibid. 172

91 ibid. 173-174

92 ibid. 174

93 cf. Bundesministerium für Bildung und Forschung (2014)

94 cf. Royal College of Nursing (2012: 3)

16.4. Regulation and Registration

There are no common standards for the education of HCAs in England, although there are regulations in Scotland and Wales. Scotland has “mandatory induction standards, a code of conduct for *healthcare support workers* and a code of practice for employers”⁹⁵ that work in the NHS. In Wales there are “assurance codes [that include the] code of conduct for [HCAs] and [the] code of practice for employers, but [...] no mandatory induction standards.”⁹⁶ Northern Ireland has an “independent health and social care regulatory body, the Regulation and Quality Improvement Authority”⁹⁷, but has no regulation for HCAs.

The Francis Report highlights the lack of compulsory registration for HCAs and demanded in 2013 a “compulsory registration scheme for healthcare support workers, and the imposition of common standards of training and a code of conduct”.⁹⁸ According to a survey of the BJHCA that followed the Francis Report, 93 per cent of support workers agreed that there should be a code of conduct and compulsory registration.⁹⁹ Education up to the age of 16 is required for this training.

95 EU-Project: *Creating a pilot network of nurse educators and regulators (SANCO/1/2009)*. List of Country Profiles (undated: 169-170)

96 *ibid.* 170

97 *ibid.*

98 Francis Report Summary (2013: 14)

99 *cf.* Bradley (2013: 164)

Key Projects and their influence on training and everyday working practice of HCAs

With regard to training and regulation of day-to-day-work much has been achieved over recent years. A decisive contribution was made by the Cavendish Review¹⁰⁰ (2013) in the UK – which resulted in the introduction of the Care Certificate in the UK on 1 April 2015.¹⁰¹ The Cavendish Review examines the regulation standards and codes of conduct for HCAs in the UK. One of the aspects the Cavendish Review remarks strongly on is that both registered nurses and HCAs feel unsure about what tasks can be delegated and taken over because of the lack of a guiding code of conduct.

The Cavendish Review therefore recommends creation of basic rules to ensure that patients receive good care. It is assumed that the Care Certificate will “raise standards, improve transparency, reduce duplication [of training], raise the status of caring, and bridge divides in the system” by facilitating career opportunities.¹⁰²

In Germany the GesinE-Study¹⁰³ (2009-2012) was launched by the German Federal Ministry of Education and Research (BMBF). The aim of the survey is to gain a basic understanding of education, qualification, and tasks of training professions in health care in Europe.

Covering Europe the pilot network of nurse educators and regulators (SANCO/1/2009)¹⁰⁴ (2010-2013) is important. The project report gives a broad overview of the current situation in education, training, and employment for HCAs as well as a comparison of different countries regarding further aspects such as registration and regulation, field of operation, required skills and competences, tasks and duties, labour market situation or EU-wide mobility. Key recommendations of the report are 1) that training of HCAs should lead to a “recognised certificate”, 2) that training should enable “HCAs to progress to higher qualifications”, 3) that HCA education should prepare for EU-mobility, and 4) that HCAs should be registered.¹⁰⁵

These projects helped modify training and working regulations of HCAs in the EU.

Below all key projects during the last four years are listed. The list includes both the projects already mentioned above and other projects.

The literature review follows the chronological order of the date of publication of the project surveys, as some of them relate to each other. For example the *Francis Report*¹⁰⁶, which was published early in 2013, led to the *Cavendish*

100 Cavendish (2013)

101 Royal College of Nursing. RCN work on regulation. www.rcn.org.uk/development/health_care_support_workers/professional_issues/regulation (last visited: April 30th 2015)

102 Cavendish (2013: 53)

103 Bundesministerium für Bildung und Forschung (2014): *Bestandsaufnahme der Ausbildung in den Gesundheitsfachberufen im europäischen Vergleich (Gesinde)*. Band 15. www.bmbf.de/pub/berufsbildungsforschung_band_15.pdf (last visited: February 13th 2016)

104 EU-Project: *Creating a pilot network of nurse educators and regulators (SANCO/1/2009)*. List of Country Profiles.

105 Filkins J. *Putting HCAs on the map*. Nursing Standard 29(25), 2015: 68-69. www.journals.rcni.com/doi/pdfplus/10.7748/ns.29.25.68.s58 (last visited February 21th 2016). (2015: 69)

106 The Mid Staffordshire NHS Foundation Trust Public Inquiry. Chaired by Francis, Robert. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. February 2013. Volume 1-3.

*Review*¹⁰⁷ finished mid-July 2013, which initiated the design of the Care Certificate.¹⁰⁸ Unfortunately not all project and survey reports reveal their publication date. In this case the bibliographical references are used to draw conclusions as to the publication date.

1. Challenges and opportunities associated with the introduction of assistant practitioners supporting the work of registered nurses in NHS acute hospital trusts in England (2011)¹⁰⁹

Subject: The survey investigates the role of Assistant Practitioners (APs) in acute hospital trusts. APs are defined as “‘higher level’ support workers”¹¹⁰. At the time of the survey APs were not “registered or regulated by a professional body, but [future regulation had been] widely debated”¹¹¹. APs undertake formal training for foundation degrees, which take two years and combine academic study with workplace learning or through attaining a work-related, competence-based qualification. APs are expected to operate “at level 4 on the Career Framework [...] and [are] usually banded at level 4 under the NHS Agenda for Change Frame-

work”, one level below RNs.¹¹²

It is possible for HCAs to obtain higher-level appointments by becoming APs. In many cases long-time HCAs become “nominated by their ward manager to [pursue] training for [...] the role of AP.”¹¹³ However, APs had not been registered at the time of the study, and because former HCAs are often promoted to APs, who stay in their old work environment, their new status might not have been taken into consideration in the everyday routine. Only very occasionally do APs from outside obtain job offers.¹¹⁴

Method: The study collects data “using sequential quantitative and qualitative methods”¹¹⁵. Case studies were sampled in three NHS acute hospital trusts. Interviews were conducted with APs, RNs, HCAs, ward managers and other health-care professionals and staff from senior nursing management to explore the development of the role of APs.¹¹⁶

Aim: The study showed that relatively few APs are employed within the assistant workforce. The figure is somewhere between 5 and 10 per cent in respect of wards the examined. According to the study this is the result of a “lack of suitability for the clinical speciality and patient population; lack of requirement for a role crossing professional boundaries; lack of distinction between senior health care assistant (HCA) and AP role descriptions; reluctance to replace RNs with APs; and financial restraints.”¹¹⁷

107 Cavendish (2013)

108 cf. Health Care Education England, Skills for Care, Skills for Health. *The Care Certificate Standards*. www.skillsforcare.org.uk/Learning-development/Care-Certificate/Care-Certificate.aspx (last visited: February 13th 2016)

109 Spilsbury K, Adamson J, Atkin K et al (2011): *Challenges and opportunities associated with the introduction of assistant practitioners supporting the work of registered nurses in NHS acute hospital trusts in England*. Journal of Health Services Research and Policy 16(1), pp. 50-56. www.ncbi.nlm.nih.gov/pubmed/21460350 (last visited: February 15th 2016).

110 *ibid.* 51

111 *ibid.*

112 *ibid.*

113 *ibid.* 54

114 *ibid.* 55

115 *ibid.* 52

116 *ibid.*

117 *ibid.*

2. Survey of the Training of Health Professional Care. A European Comparison. (Bestandsaufnahme der Ausbildung in den Gesundheitsfachberufen im europäischen Vergleich (GesinE)) (2012)¹¹⁸

Subject: The GesinE-Study was launched by the German Federal Ministry of Education and Research (BMBF) as there were only a few international and comparative studies on this issue of training and qualification for jobs in the health care sector in general. The GesinE-Study is supposed to shed light on these issues.

Project Duration: 12/2009 – 11/2012.

Aim: The aim of the survey is to acquire a basic understanding of education, qualification, and tasks of training professions in health care. Existing regulations in Germany are compared with those in France, the UK, the Netherlands, and Austria. The training of health care assistants is covered by part of one chapter in the survey.

In every country surveyed HCAs are employed in the care sector. Training models differ between countries. In the UK it is possible to undergo extra-occupational training. In Germany length and content of training vary between federal states. However, France, the Netherlands, and Austria have nationwide common standards and a code of conduct regarding education and tasks of HCAs.

In France and the UK a relatively high proportion of nursing staff consists of HCAs. In France *aide-soignant(e)s* account for 50 per cent of the regular nursing staff. In Germany and Austria HCAs constitute less than 10 per cent of the regular nursing staff. The Netherlands

takes a middle position. Unlike in Germany, French *aide-soignant(e)s*' qualifications are regulated by common standards that enable *aide-soignant(e)s* to work to a large extent independently.¹¹⁹

3. EU-Project: Creating a pilot network of nurse educators and regulators (SANCO/1/2009) (2010-2013)¹²⁰

Duration: The EU-Project: Creating a pilot network of nurse educators and regulators (SANCO/1/2009) took place from Dec 2010 – Dec 2013.¹²¹

Aim: The aim of the study is to set up a pilot network and knowledge database on the education, regulation and employment situation of "persons working [in] healthcare with a qualification below the standard of registered nurses defined by the EU Directive 2005/36/E".¹²² The project report gives a broad overview of the current situation in education, training, and employment for HCAs as well as a comparison of different countries regarding further aspects like registration and regulation, field of operation, required skills and competences, tasks and duties, labour market situation or intra-EU mobility. 15 countries were included: Austria, Belgium, Bulgaria, the Czech Republic, Denmark, Finland, Germany, Ireland, Italy, the Netherlands, Poland, Slovenia, Spain, the United Kingdom, and Switzerland.

119 *ibid.*

120 EU-Project: *Creating a pilot network of nurse educators and regulators (SANCO/1/2009)*. List of Country Profiles. www.hca-network.eu/downloads/ALL%20Country%20Profiles%20131004.pdf (last visited: February 15th 2016).

121 Braeseke et al. (undated: 4)

122 EU-Project: *Creating a pilot network of nurse educators and regulators (SANCO/1/2009)*. List of Country Profiles.

118 Bundesministerium für Bildung und Forschung (2014)

Key findings of the report are 1) that training of HCAs lead to a recognised certificate, 2) that training enables HCAs to progress to higher qualifications, 3) that HCA education prepares EU-mobility, and 4) that HCAs are registered.¹²³

Project partners are CONTEC GmbH; IEGUS – European Institute for Healthcare Research and Social Economy; DBfK Deutscher Berufsverband für Pflegeberufe (Berlin); Medical University Wroclaw (Wroclaw, Poland); Jacqueline Filkins (Cumbria, UK); Preusker Healthcare Ltd OY (Vantaa, Finland); ZAB Zentrale Akademie für Berufe im Gesundheitswesen GmbH (Gütersloh, Germany).¹²⁴

Method: The project used literature researches and empirical data.¹²⁵

Subject: In the light of, first, the continuously increasing average age of persons in need of care, and second of a severe shortage of care assistance staff, the project *Creating a pilot network of nurse educators and regulators (SANCO/1/2009)* was launched. It is assumed that Europe expects “a shortage of 1.000.000 health workers by 2020”¹²⁶. Increasing mobility within Europe may solve this problem, but may also cause a problem of care drain. Health workers especially from Eastern European countries and new EU Member States, in particular from countries like “Estonia, Hungary, Poland, Slovakia and Romania”, are looking for jobs abroad.¹²⁷ Consequently, the question

of how to deal with different education norms should be given priority. Therefore the primary aim of the project is “to initiate a Europe-wide exchange about educational standards and legal regulations of employment for assistant staff within the healthcare sector”.¹²⁸ The target groups are HCAs as well as care staff below the qualification level of nurses according to Directive 2005/36/EC.¹²⁹

As regards training courses for HCAs, some extreme differences in complexity, instruction material, and content across countries are noted, but there are also similarities between many countries. Denmark has the shortest period of training with eight months, whereas in the Czech Republic and Slovenia training takes four years and Ireland has no regulation at all on the length of training.¹³⁰ In seven out of 15 countries HCAs, as well as their education, are regulated (Austria, Bulgaria, the Czech Republic, Denmark, Finland, Italy and Slovenia). All countries except the UK have an official curriculum for HCA education and training.¹³¹

Under the terms of the curricula of most countries theoretical as well as practical components have to be completed in equal proportions or at a ratio of two-thirds to one-third. For example, in Austria and Belgium the proportion is 50/50, in the Czech Republic it is a closely similar 40/60. In Spain, the relation is 960 hours of theory to 440 hours of practice, similar to the situation in Germany (e.g. Lower Saxony: 1,800 hours theory to 960 hours praxis). Only in Poland is the focus put mainly on theory (720 hours) with the practical part requiring only 160 hours.

Except for Ireland, the Netherlands, Poland and Slovenia the practical training for HCAs

123 Filkins (2015: 69)

124 Braeseke G, Hernández J, Dreher B et al: Final Report on the Project. *Development and Coordination of a Network of Nurse Educators and Regulators (SANCO/1/2009) to the European Commission*, DG SANCO. www.ec.europa.eu/health/workforce/docs/pilot_netw_nurse_educators_fin_rep_def_en.pdf (last visited: February 15th 2016) (undated: 4-6)

125 ibid. 5

126 ibid. 4

127 ibid.

128 ibid.

129 ibid.

130 ibid. 21

131 ibid. 28; 25

takes place in facilities of various kinds. HCAs are trained in “acute care [...], rehabilitative and long-term care [...], hospitals, nursing homes, rehabilitation centres, ambulatories, dental clinics or private practices.”¹³²

This project was started because of the heterogeneous directives in connection with regulation, education, and examination of HCAs within Europe. As a result, EU-wide accepted educational standards and work descriptions are needed. Recommendations for common standards regarding education and employment of HCAs are as follows:

1. “The Structure of HCA Education and Training (duration, theory/practice balance, use of IT/ electronic learning support)
2. Curriculum for HCA education (nationwide core curriculum? Theory and practice [...])
3. Methods of Assessments (methodology of assessment for theoretical and practical work, ongoing assessment or examination, who performs the assessment [...])
4. Access, Development and Progression Opportunities [...]
5. Registration [...]
6. Competences (Does the HCA education meet the needs of today’s and future health [care] systems? [...])
7. Relationship between HCA and RN [...]
8. Guidance and support of informal carers by HCA [...]
9. EU mobility for HCA.”¹³³

132 *ibid.* 29

133 *ibid.* 50

4. NHS Standards of Health Care Regulation in Scotland, Wales and Northern Ireland (2011-2015)¹³⁴

Subject: The National Health Service (NHS) of the UK consists of four independent organisations: National Health Service (NHS) in England, NHS Wales, NHS Scotland and Health and Social Care (HSC) in Northern Ireland.

As regards recent years, the implementation of Health Care Regulation Standards in the UK is well advanced. For NHS employers standards regarding regulation and codes of conduct for Health Care Assistants and Assistant Practitioners have existed in Scotland since 2011.

Regarding the Regulation of Health Care Support Workers (HCSWs) in Scotland, NHS Education for Scotland has developed the *Healthcare Support Workers Toolkit. Support role development in NHS Scotland*¹³⁵ which has been in place since 2011. The toolkit includes the Scottish government’s mandatory induction standards for HCSWs, and a code of conduct. Furthermore it gives advice on how to develop a clear HCSW role, including good practice examples.

134 NHS Wales. *Code of Practice for NHS Wales Employers*. www.wales.nhs.uk/sitesplus/documents/829/Final%20-%20NHS%20Employers%20Booklet%20ENG.pdf (last visited February 13th 2016); NHS Wales. *Code of Conduct for Healthcare Support Workers in Wales*. www.wales.nhs.uk/sitesplus/documents/829/Final%20-%20NHS%20HSCW%20Booklet%20ENG.pdf (last visited: February 15th 2016); NHS Wales. *Principles of Induction for Health Care Support Workers (HCSW)*. www.weds.wales.nhs.uk/sitesplus/documents/1076/Doc%20FINAL%20Principles%20of%20Induction%20for%20Health%20Care%20Support%20Workers%20%28HCSW%29.pdf (last visited: February 13th 2016).

135 NHS. *Education for Scotland*. www.hcswtoolkit.nhs.uk (last visited: April 30th 2015)

For NHS Wales employers a *code of practice*¹³⁶ as well as a *code of conduct*¹³⁷ and *Principles of Induction for Health Care Support Workers (HCSW)*¹³⁸ have been developed.

In Northern Ireland there is no clear distinction between health care and social care services. The *Northern Ireland Social Care Council* is the regulatory body for the *social care* workforce in total, including care assistants working in nursing homes. Workforce regulation and induction standards are therefore in place for all social care workers.¹³⁹ The Royal College of Nursing stresses that HCAs should be regulated alongside registered nurses by the Nursing and Midwifery Council.¹⁴⁰

5. Francis Report (2013)¹⁴¹

Duration: The Francis Report was published on 6 February 2013. The public inquiry on which it is based took place between January 2005 and March 2009.

Subject: The Francis Report is the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. The aim of the report is to increase the safety of patients who are dependent on care.

Recommendations of the Francis Report regarding HCAs/health care support workers (HCSW) are as follows:

- Employers should review the work ethic regarding nursing activity in the selection of HCAs: “Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess candidates’ values, attitudes and behaviours towards the well-being of patients and their basic care needs, and care providers should be required to do so by commissioning and regulatory requirements.”¹⁴²
- A better distinction is needed between nurses and HCAs for the patients, therefore “[t]here should be a uniform description of healthcare support workers, with the relationship with currently registered nurses made clear by the title.”¹⁴³
- On registration of HCAs: “A registration system should be created under which no unregistered person should be permitted to provide for reward direct physical care to patients currently under the care and treatment of a registered nurse or a registered doctor (or who are dependent on such care by reason of disability and/or infirmity) in a hospital or care home setting.”¹⁴⁴

136 NHS Wales. *Code of Practice for NHS Wales Employers*.

137 NHS Wales. *Code of Conduct for Healthcare Support Workers in Wales*.

138 NHS Wales. *Principles of Induction for Health Care Support Workers (HCSW)*.

139 Northern Ireland Social Care Council.
www.niscc.info/index.php
(last visited: April 30th 2015)

140 Royal College of Nursing. RCN work on regulation.
www.rcn.org.uk/development/health_care_support_workers/professional_issues/regulation
(last visited: April 30th 2015)

141 The Mid Staffordshire NHS Foundation Trust Public Inquiry. Chaired by Francis, Robert. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. February 2013. Volume 1-3. (last visited February 15th 2016); The Mid Staffordshire NHS Foundation Trust Public Inquiry. Chaired by Francis, Robert. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Executive Summary. February 2013.

142 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Executive Summary (2013: 105)

143 *ibid.* 107

144 *ibid.*; Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Volume 3 (2013: 1697)

- A code of conduct for HCAs is recommended and well as a “common set of national standards for the education and training of healthcare support workers.”¹⁴⁵

6. Francis Report Summary (2013)¹⁴⁶

Subject: The Francis Report Summary took place in 2013. The key recommendation is introduction of compulsory registration for support workers. The Francis Report Summary indicates the lack of compulsory registration for HCAs and demands a “compulsory registration scheme for healthcare support workers, and the imposition of common standards of training and a code of conduct”.¹⁴⁷ The Francis Report Summary recommends – alongside the RCN¹⁴⁸ – the Nursing and Midwifery Council (NMC) as the regulatory body. A registration scheme should include reasons for dismissals of HCAs to ensure good care for patients and care receivers. Furthermore, the Francis Report summary requests that HCAs should be “clearly identified, including by uniform, as distinct from registered nurses.”¹⁴⁹

According to a survey of the BJHCA that followed the Francis Report, 93 per cent of support workers agreed there should be a code of conduct and compulsory registration.¹⁵⁰

7. Support workers after the Francis Report – a BJHCA survey (2013)¹⁵¹

Project duration: Following the Francis Report the BJHCA started an online survey in the spring of 2013 addressing HCAs. The survey was conducted by the British Journal of Healthcare Assistants (BJHCA) from 15 February to 2 April 2013.

Subject: The survey details are as follows: “The British Journal of Healthcare Assistants (BJHCA) conducted an anonymous online survey [...]. By the closing date, 385 responses had been received. The survey will remain open and BJHCA will do an updated report if the responses warrant it. The survey can be accessed here:

www.healthcare-assistants.co.uk.”¹⁵²

The survey identified “shortage of staff” as the main reason for poor patient care. Further key findings of the survey were that a large majority (97 per cent) supports implementation of common standards. 93 per cent declared themselves in favour of a code of conduct and compulsory registration for HCAs. Most of them (67 per cent) also said they would be prepared to pay an annual fee for registration. More than half felt appreciated for their work, but even so 16 per cent felt ignored, underappreciated, and criticised at work.¹⁵³

145 *ibid.*

146 Francis Report Summary (2013). CoG 07/13. www.healthwatchhillingdon.org.uk/wp-content/uploads/downloads/2013/10/Francis_Report_Summary_of_recommendations.pdf (last visited: February 15th 2016)

147 Francis Report Summary (2013: 14)

148 Royal College of Nursing. RCN work on regulation. www.rcn.org.uk/development/health_care_support_workers/professional_issues/regulation (last visited: April 30th 2015)

149 Francis Report Summary (2013: 14)

150 Bradley P: Support workers after the Francis Report – a BJHCA survey. British Journal of Healthcare Assis-

tants 7(4): 2013: 163-167. www.magonlinelibrary.com/doi/abs/10.12968/bjha.2013.7.4.163 (last visited: February 15th 2016).

151 *ibid.* 164

152 *ibid.* 167

153 *ibid.* 167

8. Cavendish Review (2013)¹⁵⁴

Project duration: The project took 2.5 months and was completed in mid-July 2013. The Cavendish Review was published in July 2013.

Subject: After the Francis Report had drawn attention to the lack of compulsory registration for HCAs, Camilla Cavendish was asked by the Secretary of State for Health to review and make recommendations on recruitment, education, training, management, and support of HCAs and social care support workers. The result was the *Cavendish Review*.

The *Cavendish Review* recommends a “Certificate of Fundamental Care”¹⁵⁵ for HCAs, before they can work unsupervised. Furthermore the *Cavendish Review* recommends a curriculum for HCAs, which should be inspired by the practical nursing degree curriculum.¹⁵⁶

The *Cavendish Review* looks into the regulation standards and codes of conduct for HCAs in UK. One of the aspects on which the *Cavendish Review* remarks strongly is that both registered nurses and HCAs feel unsure about what tasks can be delegated and taken over because of the lack of a guiding code of conduct. Some surveys indicate that HCAs have the impression of being responsible for similar tasks as are RNs. Against this background concerns rise about “skill mixes [that] were being diluted

by the expanding, uncontrolled use of non-registered and often untrained staff to carry out tasks previously the domain of registered nurses. Patients are often unaware of the level and qualifications of staff caring for them. These rapidly, locally driven modifications in the shape and functions of nursing workforce include valuable innovations, but are sometimes poorly implemented and not evaluated, raising concerns about public protection”.¹⁵⁷

Aim: The aim of the *Cavendish Review* is to create basic rules to ensure that patients receive good care. A “Certificate of Fundamental Care” is recommended to realise common basic knowledge and skills. Under these conditions, the tasks of HCAs may be carried out unsupervised.¹⁵⁸

In 2013 approximately 1.3 million unregistered HCAs and support workers were employed in the UK. Owing to a large number of different job titles, it is not possible to arrive at a more exact estimate. Because of, first, nurses being overloaded with work, second, an increasing number of people being in need of care, and third, the lack of clear job descriptions, additional tasks have to be done by HCAs without having received proper training. Moreover their wages do not correspond to the level of responsibility they take on. HCAs are being paid at band 2, three levels below a nurse.¹⁵⁹

Regular tasks of HCAs are “making beds, helping patients to eat and bathe, monitoring and recording patients’ glucose tests, temperature, pulse, respiration and weight, carrying out simple dressings and escorting patients to theatre.”¹⁶⁰ Because of the overwork of nurses the *Cavendish Review* reports that “some HCAs

154 Cavendish C (2013): *The Cavendish Review. An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings*. www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf (last visited: February 13th 2016)

155 *ibid.* 5

156 *ibid.* 55; cf. Health Care Education England, Skills for Care, Skills for Health: The Care Certificate Standards. www.skillsforcare.org.uk/Learning-development/Care-Certificate/Care-Certificate.aspx (last visited: February 13th 2016)

157 Cavendish (2013: 12)

158 *ibid.* 9

159 *ibid.* 14, 19, 28, 31

160 *ibid.* 18

are now doing a wide range of more advanced tasks traditionally undertaken by registered nurses. These include female catheterisation, cannulation [...], applying complex dressings, monitoring diagnostic machines, setting up infusion feeds, giving injections, preparing medication and administering it to patients, making ECG tracings, taking blood samples, liaising with medical staff, relating medical information to relatives, and developing and updating care plans.”¹⁶¹

Inconsistent qualification standards are criticised by the *Cavendish Review*: “Training is neither sufficiently consistent, nor sufficiently well supervised, to guarantee the safety of all patients and users in health and social care. In domiciliary care, we have heard of instances of staff being sent unsupervised into clients’ homes with no training.”¹⁶² Attested by a “Certificate of Fundamental Care” minimum training standards can be implemented, and thus public opinion of care can be improved.¹⁶³

The Cavendish Review notes that structural improvements are made when implementing education standards, but that they are not consistently realised everywhere.¹⁶⁴

The lack of realization also applies to the Common Induction Standards (CIS), which were developed by Skills for Care in 2005. CIS includes “three days’ training in first aid, moving and handling, infection prevention, dementia awareness, nutrition and hydration, and dignity.”¹⁶⁵ Working should only be allowed when CIS is completed. However, the *Cavendish Review* reports that “employers and Skills for Care have told us that completion of CIS is not always

verified by inspectors. The United Kingdom Healthcare Association (UKHCA) told us that the guidance is ‘only a recommendation with no commitments on what training standards and timescales should be.’”¹⁶⁶

Additionally the *Cavendish Review* highlights a wide variety of opportunities for training and further education which, however, are not subject to quality standards, and only certify qualifications in a non-binding way. Therefore “[l]ack of faith in the quality of some of the training on offer has led many organisations to develop their own in-house training. Some of this is excellent, but it leads to duplication, with employers retraining new staff irrespective of what they have learned elsewhere.”¹⁶⁷

The “Certificate of Fundamental Care” will “raise standards, improve transparency, reduce duplication [of training], raise the status of caring, and bridge divides in the system” by facilitating career opportunities.¹⁶⁸ In addition to the certificate, CIS training has to include “a probationary period, clear job descriptions, supervision and continuous assessment over time”.¹⁶⁹

Method: Methods used were interviews with staff in hospitals and care homes, and meetings with domiciliary care workers, HCAs, personal assistants, nurses, and registered managers as well as contacts with distinguished health and social care organisations for best practice examples.¹⁷⁰

161 *ibid.*

162 *ibid.* 36

163 *ibid.*

164 *ibid.* 38

165 *ibid.*

166 *ibid.*

167 *ibid.* 41

168 *ibid.* 53

169 *ibid.* 54

170 *ibid.* 12

9. Geriatric Care Education in Europe. A comparison (2014)¹⁷¹

Overview (survey) care assistance, duration of training and job title – sorted by country

European Qualifications Framework (EQF)	Country	Occupational title	Duration of training	Training
	France	Aide-soignant	8 months to 1 year	
	France	Aide auxiliaire de vie sociale	< 1 year	no education/training required, though DEAVS (diplôme d'État d'auxiliaire de vie sociale) is common
	France	Assistant de soins de Gériatrie	140 hours	Additional training as aide-soignant
3	Denmark	Social- og sundhedshjælper	1 year and 2 months	
4	Denmark	Social- og sundhedsassistent	1 year and 8 months	Following the qualification as Social- og sundhedshjælper
1	The Netherlands	Zorghulp	1 year	
2	The Netherlands	Helpende Zorg & Welzijn	1-2 years	
3	The Netherlands	Verzorgende-Individuele Gezondheidszorg	2-3 years	
	Austria	Heimhelfer	200 hours theory and 200 hours practice	
	Austria	Pflegehelfer	1 year (1,600 hours)	
	Austria	Sozialbetreuer mit Schwerpunkt Altenarbeit	2-3 years	Following the qualifications as Health Care Assistant (Pflegehelfer)
	Austria	Personenbetreuer/-in	No qualification needed	Constitutes largest group in domiciliary care
	Poland	Caregiver for people in need of support		
Not defined	Sweden	Undersköterska	3 years	Extra-occupational training or recognition of competences gained while working may qualify
	Sweden	Vardbiträde	< 1 year	Not a protected occupational title
	Spain	Técnico en cuidados auxiliares de enfermería/auxiliares de enfermería	1,400 hours	
3-4	The UK	Healthcare Assistant (HCA), also health care support workers, auxiliary nurses		No common educational standard until 2014
3-4	The UK	Assistant practitioner	2 years	Foundation degree in health and social care

Source: Waldhausen 2014, p. 18

171 Waldhausen A, Sittermann-Brandtsen B, Matarea-Türk L (2014): (*Alten*)*Pflegeausbildungen in Europa. Ein Vergleich von Pflegeausbildungen und der Arbeit in der Altenpflege in ausgewählten Ländern der EU.* Abschlussbericht. Beobachtungsstelle für gesellschaftspolitische Entwicklungen in Europa. www.beobachtungsstelle-gesellschaftspolitik.de/uploads/tx_aebg-publications/PflegeEU_Aug2014_01.pdf (last visited: February 15th 2016)

Project duration: In August 2014 the final report of the project *Geriatric Care Education (Training) in Europe. A comparison of health care training and health care work in chosen countries in the EU* was published by Beobachtungsstelle für gesellschaftspolitische Entwicklungen in Europa (The Observatory for Sociopolitical Developments in Europe).

Subject: The study examines current training formats of health care workers and nurses in geriatric nursing within Europe. Countries covered are Denmark, France, the UK, the Netherlands, Austria, Poland, Sweden and Spain. The study takes place in the context of reform plans for health care training in Germany.

The aim was to provide an overview of job profiles and care work in the area of geriatric care in Europe. The study underlines difficulties in comparing assistant jobs within the EU owing to different qualification standards, training structures, and task profiles. The study therefore focuses on duration and content of the training.¹⁷²

In most countries the training of health care assistants takes one year (in Austria, Spain, France and the UK). In Denmark training for *Social- og sundhedshjælper* (social and health assistants) takes one year and two months, on which the training for health care assistants is built, taking another year and eight months. In the Netherlands they have different levels of training; the first is reached after one year. In Sweden they have a three-year vocational school programme leading to the qualification as an *Undersköterska* (health care assistant).

This qualification can also be achieved by other means. After their training health care assistants can obtain further qualifications; for

example in Austria there are further training opportunities in geriatric care, while in France there is the possibility of becoming an *Assistant de soins en Gériatrie*. Apart from the medical approach there are training opportunities in social care, as the *auxiliaire de vie sociale* in France or the *técnico de atención sociosanitaria* in Spain.¹⁷³

Medical assistance occupations assume responsibility for nursing care close to the body as well as for support in everyday life. In such cases unskilled nursing staff can be employed (a high proportion in Spain and the UK).¹⁷⁴

172 *ibid.* 9

173 *ibid.* (2014: 9-10); NHS. Health Education England. The Care Certificate. www.hee.nhs.uk/work-programmes/the-care-certificate-new (last visited: April 30th 2015)

174 Waldhausen (2014: 15-35)

10. Regulation of Health Care Support Workers in the UK (2015)¹⁷⁵

Date: In England the *Care Certificate* has been implemented since 1 April 2015. It replaces the *Common Induction Standards and the National Minimum Training Standards*.¹⁷⁶

Subject: The prior lack of common standards in England (although not in Wales and Scotland) was a major concern that ran throughout the literature. For example, the Royal College of Nursing highlights that “[t]he RCN believes all health care assistants (HCAs) and assistant practitioners (APs) should be regulated in the interests of public safety and is committed to supporting steps towards mandatory regulation. This has been a major policy position for the RCN for many years and campaigning for regulation continues to be a priority for the organisation going forward.”¹⁷⁷

11. Details regarding the Care Certificate Standards: Health Education England about regulation and related issues (2015)¹⁷⁸

Date: Health Education England (HEE) was established in June 2012 as a Special Health Authority (SpHA). Since 1 April 2015 HEE constitutes a Non-Departmental Public Body.

Subject: HEE wants to create high-quality education and training standards in health workforces. Every employer is expected to ensure the implementation of Care Certificates. To prepare for the official launch of the Care Certificate Health Education England (HEE), Skills for Care and Skills for Health provide employers with the Care Certificate Workbook available online without charge.¹⁷⁹

The 15 standards in the Care Certificate according to HEE are: “Understand your role; Your personal development; Duty of care; Equality and diversity; Work in a person centred way; Communication; Privacy and dignity; Fluids and nutrition; Awareness of mental health, dementia and learning disability; Safeguarding adults; Safeguarding children; Basic life support; Health and safety; Handling information; Infection prevention and control”.¹⁸⁰

175 Royal College of Nursing. RCN work on regulation.

176 Skills for Care. Care Certificate. www.skillsforcare.org.uk/Standards/Care-Certificate/Care-Certificate.aspx (last visited: April 30th 2015)

177 Royal College of Nursing. RCN work on regulation. www.rcn.org.uk/development/health_care_support_workers/professional_issues/regulation (last visited: April 30th 2015); cf. also Bradley (2013: 164)

178 NHS. Health Education England. The Care Certificate. www.hee.nhs.uk/work-programmes/the-care-certificate-new (last visited: April 30th 2015)

179 *ibid.*

180 *ibid.*; for further information see Health Education England, Skills for Care, Skills for Health: The Care Certificate Standards.

Ongoing projects

Ongoing projects with focus on HCAs are predominantly concerned with the training of HCAs. This is done with an emphasis on comparability of training and working skills of HCAs across Europe – the Dutch project NIVEL following the *Pilot network of nurse educators and regulators* is developing a “Common Training Framework (CFT)”¹⁸¹, which should help standardise knowledge, skills and competences in nursing. The aim is to achieve increased cross-border mobility of HCAs and thus avoid care shortages in European countries.

In Berlin, too, the question of establishing a chamber of care (‘Pflegekammer’) to represent the interest of care professionals is of great importance. The study of Alice Salomon University of Applied Sciences is conducting a representative survey among more than 1,000 qualified care workers, inquiring whether a ‘Pflegekammer’ should be established in Berlin.

An argument in favour of a ‘Pflegekammer’ is, among others, that nursing tasks and competences can be clearly defined and – as a result – may lead to better defined tasks in daily work, thereby upholding a certain standard of work in the care sector.¹⁸²

Under the aspect of “Can Healthcare Assistant Training improve the relational care of older people?” Health Education England examines in a study in how far ‘values-based’ training of HCAs might lead to more kind, compassionate, and respectful communication with elderly patients, which is assumed to improve their well-being.¹⁸³

Especially in the UK questions about working conditions have become more and more prominent. Several projects on the topics of education and training of HCAs¹⁸⁴ and 12-hour shifts¹⁸⁵ are carried out.

181 NIVEL - Netherlands institute for health services research. Project “Support for the definition of core competences for healthcare assistants (CC4HCA). www.nivel.nl/en/cc4hca (last visited: September 1st 2015).

182 Alice Salomon University of Applied Sciences. Chamber Study. A study on the acceptance of a Chamber of Care Workers in Berlin. www.ash-berlin.eu/forschung/forschungsprojekte/kammer-studie.

183 Health Education England (2013-2015): *Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values*. Project research. www.gov.uk/government/uploads/system/uploads/attachment_data/file/203332/29257_2900971_Delivering_Accessible.pdf (last visited: February 13th 2016)

184 Royal College of Nursing (2012): *Position statement on the education and training of health care assistants (HCAs)*. <https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2014/february/pub-004214.pdf?la=en> (last visited: February 13th 2016)

185 Ball J, Maben J, Murrells T et al. (2015): *12-hour shifts: Prevalence, views and impact*. National Nursing Research Unit. www.england.nhs.uk/6cs/wp-content/uploads/sites/25/2015/06/12-hour-shifts-report.pdf (last visited: February 13th 2016)

1. Project “Support for the definition of core competences for healthcare assistants (CC4HCA)”¹⁸⁶

Institute

NIVEL - Netherlands Institute for health services research

Project title

Support for the definition of core competences for healthcare assistants (CC4HCA)

Project description

NIVEL - Netherlands Institute for Health Services Research is responsible for the implementation of the project “Support for the definition of core competencies for health care assistants (CC4HCA)”. The goal of the study is “to explore the interest among all EU Member States of the European Union in developing a common position on the skills, knowledge and competences of health care assistants (HCAs) in Europe.”¹⁸⁷

Especially in the context of the increasing importance of HCAs in nursing practice the study designs a “Common Training Framework (CFT)”, which helps standardise knowledge, skills and competences in nursing. The aim is to achieve increased cross-border mobility of HCAs and thus avoid work shortages in European countries.

The study follows up on earlier work on a pilot network of nurse educators and regulators (‘Creating a Pilot Network of Nurse Educators and Regulators’ (SANCO/1/2009)) which concluded in 2013.

Project duration

The study has been designed to last 18 months – starting in spring/summer 2015 – and consists of four main steps:

- “The current situation of health care assistants in all Member States will be mapped, building on previously collected data (spring/summer 2015)
- Representative national and European professional organisations (or competent authorities) will be approached to identify the stakeholders interested in working on a suggestion for a common training framework for HCAs (spring/summer 2015)
- A Delphi study will be conducted among professional organizations (or competent authorities) to explore the shared vision on the core skills, knowledge and competencies of health care assistants (autumn 2015)
- The results of this study will be taken further into a two-day workshop organized in spring 2016 in Brussels.”¹⁸⁸

Funder

The study is funded by the European Commission’s Health Programme 2014.

Contact

Ronald Batenburg (CC4HCA study leader),
r.batenburg@nivel.nl

Country

The Netherlands

¹⁸⁶ NIVEL - Netherlands institute for health services research. Project “Support for the definition of core competences for healthcare assistants (CC4HCA).

¹⁸⁷ *ibid.*

¹⁸⁸ *ibid.*

2. Chamber Study. A study on the acceptance of a Chamber of Care Workers in Berlin¹⁸⁹

Institute

Alice Salomon University of Applied Sciences

Project title

Kammer-Studie. Studie zur Akzeptanz einer Pflegekammer im Land Berlin (Chamber Study. A study on the acceptance of a Chamber of Care Workers in Berlin)

Project description

The ASH study is conducting a representative survey among more than 1,000 qualified care workers on whether or not a 'Pflegekammer' should be established in Berlin. However, HCAs are not explicitly taken into account, yet they will be concerned because of the design of their education and training as well as the implementation of their daily work if a 'Pflegekammer' is established.

An argument in favour of a 'Pflegekammer' is, among others, that nursing tasks and responsibilities can be clearly defined and – as a result – may lead to more defined responsibilities at daily work and a constant standard of work in the care sector.

On the other hand, a strong argument against a 'Pflegekammer' is the added bureaucratic burden, which is already making work more difficult in nursing facilities.

Project duration

15/08/2014 to 14/08/2015

Funder

The study is funded by the Senate of Berlin for Health and Social Affairs.

Further information

www.rbb-online.de/politik/beitrag/2015/04/Studie-Pflegekammer-Ergebnisse-2015-04-14.file.html/Studie-Pflegekammer-Ergebnisse.pdf

Contact

kammer-studie@ash-berlin.eu

Country

Germany

189 Alice Salomon University of Applied Sciences. Chamber Study. A study on the acceptance of a Chamber of Care Workers in Berlin. www.ash-berlin.eu/forschung/forschungsprojekte/kammer-studie.

3. NHS England Call to Action¹⁹⁰

Institute

NHS England

Project title

NHS England Call to Action

Project description

In July 2015 NHS England published “The NHS belongs to the people – A call to action”.¹⁹¹ Taking into account an ageing society and an increasing demand for long-term care, the NHS has initiated ‘Call to Action’. The aim is to find lower-cost solutions for care work structures. The description by the NHS itself reads as follows: “harnessing technology to fundamentally improve productivity; putting people in charge of their own health and care; integrating more health and care services [...]”.¹⁹²

Through its ‘Call to Action’ the NHS encourages both staff members and patients to discuss their ideas and give feedback: “The information you share will help local commissioners understand what things are good about local services, what needs to change and where funding would have more impact. This might mean providing more care outside of hospitals, in community settings, giving better access to GP services and investing more in interventions, such as services for stopping smoking and helping people to lose weight and make healthier choices.”¹⁹³

Patients and staff have the opportunity to make contact either online or through a local Clinical Commissioning Group (CCG).

Link to brochure

“The NHS belongs to the people – A call to action”:

www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf

Country

United Kingdom

190 NHS England. NHS England Call to Action. www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction (last visited: September 1st 2015).

191 *ibid.*

192 NHS England. The NHS belongs to the people – A call to action. www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf (undated: 4)

193 NHS England. NHS England Call to Action. www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction

4. Perceptions of 12-hour shifts on Health Care Assistants¹⁹⁴

Institute

NHS England

Title

The NHS England has put a project out to tender entitled “Perceptions of 12 hour shifts on Health Care Assistants”.

Project description

Until now only the invitation to tender has been made public. Aims of the project are:

- “To organise and coordinate two live listening evidence gathering events involving Health Care Assistants, Health/ Care professionals, people we care for and other key stakeholders from a range of NHS care provider settings to discuss findings from the reviews of the impact of 12 hour shifts on Health Care Assistants.
- To facilitate group discussion in the events around areas of divergence and convergence from the findings and engage with participants to identify associated emergent issues and proposed actions for future consideration.

- To use case studies/vignettes for groups to discuss and validate emergent issues from the scoping review and findings from the focus groups and interviews.
- To produce an action plan identifying key actions to be addressed as part of a short term delivery plan, and actions to be addressed as part of a longer term work-force strategy.”¹⁹⁵

The project includes interviews with Healthcare Assistants.

Contacts

Mike Daw, m.j.daw@mmu.ac.uk, also h.pile@unison.co.uk.

Country

United Kingdom

194 NHS England. Perceptions of 12 hour shifts on Health Care Assistants. www.mmuresearchblog.wordpress.com/2015/02/02/perceptions-of-12-hour-shifts-on-health-care-assistants/ ; <http://www.unison.org.uk/news/new-research-what-do-healthcare-assistants-think-about-12-hour-shifts> (last visited: September 1st 2015).

195 *ibid.*

5. 38th Annual National Nursing Assistants Week¹⁹⁶

Institute

National Network of Career Nursing Assistants

Title

38th Annual National Nursing Assistants Week

Description

The National Network of Career Nursing Assistants organised the 38th Annual National Nursing Assistants Week from 11 to 18 June 2015. This event is not a research project, but a regular annual event which focuses on the working conditions of HCAs, for example decreasing work injuries as well as networking: “Nursing Assistants Week provides a venue to bring folks together to create partnerships, projects and programs that will continue throughout the year for the benefit of all.”¹⁹⁷

Country

USA

6. RCN Knowledge and Innovation Action Plan for 2014 – 2018¹⁹⁸

Institute

Royal College of Nursing

Project title

Knowledge and Innovation Action Plan for 2014 – 2018

Project description

The Knowledge and Innovation Action Plan determines the priorities of the RCN for the coming five years. A main topic is how caring can be improved and how newly gained knowledge can be put into practice.

With regard to HCAs this means:

- “Patients, service users and carers express the value and positive difference nursing knowledge and skills makes to their experience of care
- Nursing care is person centred, safe and effective, wherever delivered or received, because registered nurses (RN) and health care support workers (HCSW) in partnership with the people they care for, make decisions and take action based on the best available evidence
- RNs and HCSWs contribute to the continuing development of nursing knowledge nationally and internationally, and patients, service users and carers are active partners with us in developing health and social care research evidence
- RNs and HCSWs are decision makers locally, nationally and internationally, whose

196 National Network of Career Nursing Assistants. 38th Annual National Nursing Assistants Week. www.cna-network.org (last visited: September 1st 2015).

197 *ibid.*

198 Royal College of Nursing. RCN Knowledge and Innovation Action Plan for 2014 - 2018. www.rcn.org.uk/development/research_and_innovation (last visited: September 1st 2015).

use of evidence and knowledge in making decisions is consistent and valued

- RNs, HCSWs, the public, patients, service users and carers choose the RCN as a preferred and trusted source of nursing knowledge
- The RCN is identified as a champion of excellence in research and innovation in nursing and their translation into practice.”¹⁹⁹

Further information

www.rcn.org.uk/development/research_and_innovation/rcnknowledgeandinnovationaction-plan

www.rcn.org.uk/development/research_and_innovation/rcnknowledgeandinnovationaction-plan/our_vision

Country

United Kingdom

7. NAHCA National Association of Health Care Assistants National Conference²⁰⁰

Institute

National Research Corporation

Conference description

The National Research Corporation announced the conference “NAHCA National Association of Health Care Assistants National Conference” in Canada on 10-11 June 2015. The brief announcement was as follows: “Powerful information is essential to empowering your healthcare organization for success. And understanding research findings and improvement best practices first-hand truly makes a difference - that’s why National Research Corporation attends and presents at healthcare conferences and tradeshow throughout the year.”²⁰¹

Country

Canada

¹⁹⁹ *ibid.*

²⁰⁰ National Research Corporation. NAHCA National Association of Health Care Assistants National Conference. www.nationalresearch.com/events/archive/?articlesid=432 (last visited: February 15th 2016).

²⁰¹ *ibid.*

8. Can Healthcare Assistant Training improve the relational care of older people? A development and feasibility study of a complex intervention (feasibility RCT)²⁰²

Institute

University of East Anglia in collaboration with King's College London and the University of Nottingham

Project title

Can Healthcare Assistant Training improve the relational care of older people? A development and feasibility study of a complex intervention (feasibility RCT)

Project description

The basic assumption of the study is that, especially for elderly people, kindness, compassion, and respectful communication on the part of the hospital staff is essential for their well-being. HCAs do much “hands-on” care with patients, but their training might not take sufficient account of the possible need for social skills. For this reason research at three NHS hospitals trusts is carried out. Part of the study includes ‘values-based’ training of HCAs, the aim of which is to maintain the dignity of older patients and afford respectful care.

As a second step the study aims “to conduct-²⁰³ sibility cluster RCT to assess the feasibility of a definitive study to formally compare the effectiveness and cost effectiveness of a new training intervention for healthcare assistants against current training”.²⁰⁴

Project duration

March 2015 to October 2015

Funder

National Institute of Health Research under their Health Services and Delivery Research programme (NIHR 12/129/10) (UK)

Contact person

Professor Antony Arthur,
antony.arthur@uea.ac.uk

Country

United Kingdom

202 University of East Anglia. Can Healthcare Assistant Training improve the relational care of older people? A development and feasibility study of a complex intervention (feasibility RCT). www.public.ukcrn.org.uk/search/StudyDetail.aspx?StudyID=16330 www.isrctn.com/ISRCTN10385799?q=&filters=conditionCategory:Not%2Applicable.ageRange:Senior&sort=&offset=7&totalResults=86&page=1&page-Size=10&searchType=basic-search (last visited: September 1st 2015).

203 ibid

204 ibid.

9. Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values²⁰⁵

Institute

Health Education England

Project title

Delivering high quality, effective, compassionate care: developing the right people with the right skills and the right values.

Project duration

April 2013 to March 2015

Project description

Since 1 April 2013 the Secretary of State for Health has a statutory duty to ensure that an adequate education and training system is in place for the National Health Service (NHS) and public health system. This mandate follows the recently published Education Outcomes Framework (EOF). Their five main issues are focused on:

1. excellent education
2. competent and capable staff
3. flexible workforce, receptive to research and innovation
4. NHS values and behaviours
5. widening participation²⁰⁶

With regard to HCAs the mandate states the importance of developing the care assistant workforce. The goals are to improve the capability of the HCA workforce and the standard of training they receive. To achieve this Health Education England should develop a plan on minimum training standards based on the Cavendish Review, Skills for Health and Skills for Care. The plan should include “job roles, recruitment, induction, training standards and transparency as well as identifying opportunities for career progression [e.g. into nursing].”²⁰⁷

Funder

Government to Health Education

Country

UK

205 *Health Education England. Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values.* (last visited: February 13th 2016). (undated: 6)

206 *ibid.* 6

207 *ibid.* 20-21

10. PACE. Comparing the effectiveness of palliative care for elderly people in long-term care facilities in Europe²⁰⁸

Institute

Vrije Universiteit Brussel (VUB)

Project title

PACE. Comparing the effectiveness of palliative care for elderly people in long-term care facilities in Europe.

Project duration

01/01/2014 – 01/01/2019

Project description

In view of an ageing European society attention must be paid to the fact that many elderly people will require long-term institutional care at the end of life. PACE's research aims can be defined as follows:

- map and classify existing palliative care systems in long-term care facilities in Europe;
- compare the effectiveness of health-care systems with and without formal palliative care structures in long-term care facilities in six EU countries (BE, UK, IT, FI, PL, NL) in terms of patient and family outcomes (quality of dying, quality of life), quality of palliative care, and cost-effectiveness, and in terms of staff knowledge, practices and attitudes;

- compare the impact of a health service intervention 'Route to Success' – aimed to improve the quality of palliative care in long-term care facilities – with traditional care (as control) in long-term care facilities in Europe, on patient, family and staff outcomes and on cost-effectiveness;
- develop products/tools to assist policy and decision-makers at national and international level in making informed and evidence-based decisions regarding best palliative care practices in long term care facilities.²⁰⁹

As a result two large scale studies are expected to arise.

In Study I PACE will compare "effectiveness of end-of-life care in long-term care facilities without formal palliative care structures (IT, PL, FI) and with formal palliative care structures (BE, UK, NL) by performing large-scale cross-sectional studies of deaths of residents in long-term care facilities in these six countries, obtaining representative nationwide data on dying in these facilities."²¹⁰

In Study II PACE will implement "the successfully tested complex health service intervention 'The Route to Success in long term care facilities' originally developed in the UK. The programme aims to enhance palliative care through facilitating organisational change and supporting staff to develop their roles around palliative care, aiming to ensure all residents receive high-quality palliative care."²¹¹

208 Vrije Universiteit Brussel (VUB). PACE. Comparing the effectiveness of palliative care for elderly people in long term care facilities in Europe. www.ec.europa.eu/research/health/public-health/health-systems/projects/pace_en.html

209 *ibid.*

210 European Association for Palliative Care (EAPC). Pace. www.eapcnet.eu/Themes/Policy/EUsupported-projects/PACE.aspx

211 *ibid.*

The study is intended to contribute to the patients' quality of life, better end-of-life care and cost-effective realisation.

Contact

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Countries

Belgium, UK, Italy, Finland, Poland, The Netherlands, Luxembourg

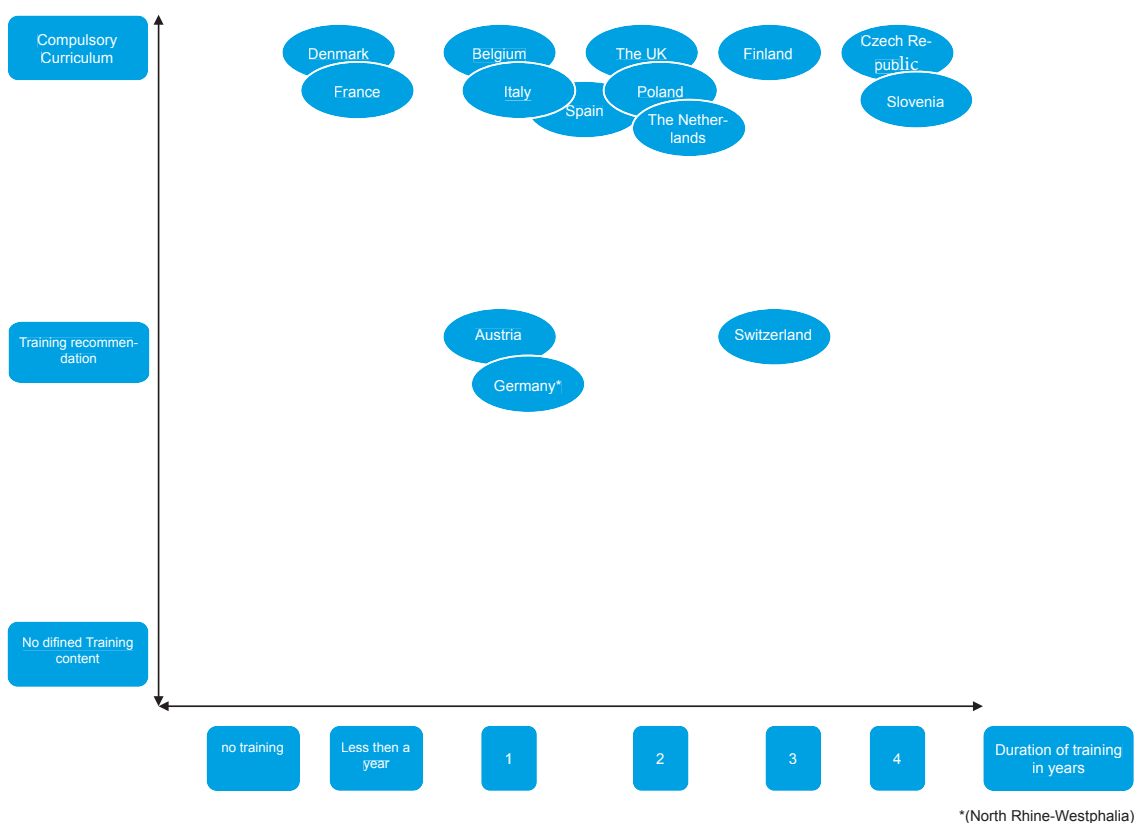
Main Results of Country Analysis

In the following overview the most important results of the country analysis are summarized: How long is the training in the countries and what are its contents? What are typical places of work and job descriptions for HCAs? What

requirements do prospective HCAs need to fulfill to be able to start training in the respective countries? The answers to these questions should help standardize the training and professionalization of HCAs in Europe.

1. Official curricula und duration of training

Figure 1 *Regulated education and duration of training*



*(North Rhine-Westphalia)

Source: own elaboration from section 2

As regards training courses for HCAs, some extreme differences in complexity, instruction material and content between countries are noted, but there are also similarities between many countries. A vast majority of the investigated countries have an official curriculum regulating education and training. Germany/North Rhine-Westphalia does not have a

compulsory curriculum. Regulation of HCAs education is at the discretion of the federal states resulting in a multitude of possible training and qualifications across the states.

Education mainly takes between one and three years. Exceptions are Denmark and France with a full-length education of only eight

months, and Finland and the Czech Republic with a duration of four years. For Bulgaria no information is available on the duration of training. In many countries the theoretical part of the education encompasses the following: ethics of care, care of elderly people, palliative care, hygiene and infectious diseases, nutrition and special dietary needs of the sick, introduction to gerontology and pharmacology, first aid, animation and motivation of patients to take part in leisure activities, introduction to rehabilitation and mobilisation, communication and conflict-solving as well as laws and regulations pertaining to the profession.

In Slovenia training standards are significantly higher than in the other reviewed countries (level 5 instead of level 2-4). It is unclear whether Sweden yet has an official curriculum (it had not by the end of 2012).²¹²

2. Common training contents

HCAAs in general are trained to work under the supervision of registered nurses, although in practice they often might be on their own carrying out day-to-day care. Therefore, in some curricula it is mentioned that HCAAs work “in structural support for nurses who delegate tasks to them”.²¹³

Typical content of training and duties in all or most countries include care assistance, nutrition, hygiene, first aid, safety and documentation. Various countries mention ethical sensitivity. In this matter Belgium is particularly specific – HCAAs have to “take into account factors such as religion, culture, age, gender, habits, living conditions, and the environment of the patient”.²¹⁴

Major differences can be found regarding the duration of training (8 months to 4 years) and the content of training. For example training of HCAAs in Slovenia is the longest (4 years) and ends at EQF reference level 5, which is above the average level of 2-4 for HCAAs. Because of their higher qualification HCAAs in Slovenia may work without being supervised by other practitioners.²¹⁵

212 *EU-Project: Creating a pilot network of nurse educators and regulators (SANCO/1/2009)*. List of Country Profiles (undated: 60)

213 cf. *ibid.* 22

214 cf. *ibid.* 21

215 cf. *ibid.*

3. European Qualifications Framework (EQF)

Over recent years discussions on the qualification standards of health care and social service workers have increased. This is also due to the increasing mobility of professional care staff across Europe. The EQF is a common European reference framework acting as a translation device in order to make qualifications acquired within the different education and training systems in Europe more readable and understandable. The levels of education are provided by the European Qualifications Framework (EQF) and were adopted in 2008 with the aim of translation between different systems.

In those countries where data is available the level of qualification for HCAs in respect of the European Qualifications Framework ranges between 2 and 4.²¹⁶

All in all there are eight reference levels. To be applicable to different systems of training and education the EQF reference levels focus on learning outcomes, that is what those trained know, understand and are able to do. Learning outcomes are knowledge, skills and abilities which can be acquired as part of a formal or informal education. Learning input, duration or type of education, institution of education, and so forth are not relevant.

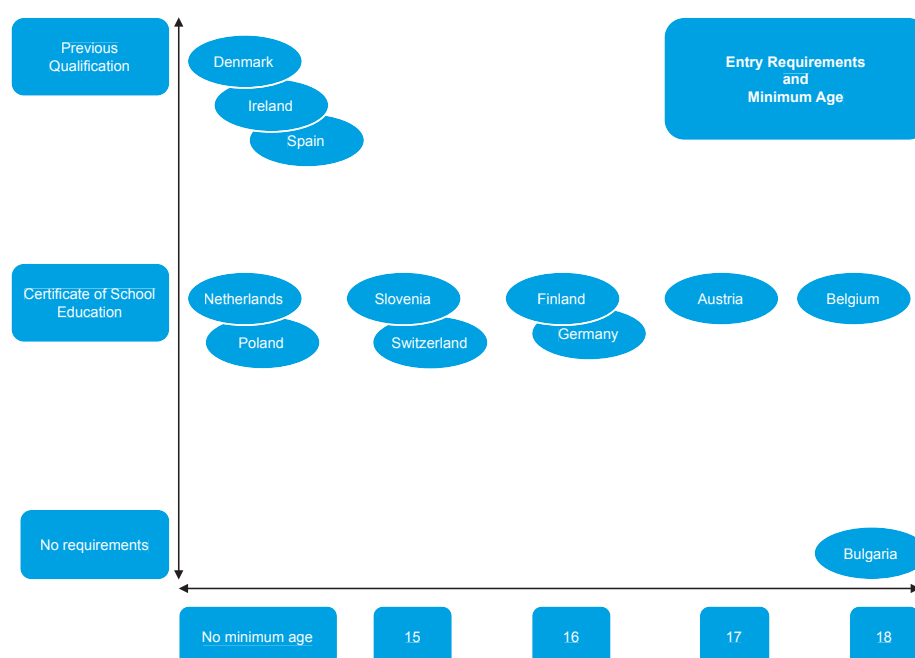
This allows an objective description of learning outcomes of education courses without making direct comparisons or having to refer to a country's qualification and educational system.²¹⁷

216 Waldhausen et al. (2014: 18); Bundesministerium für Bildung und Forschung (2014: 51)

217 cf. EQF project. EQF Referencing Process - Examples and Proposals - EQF-Ref March 2009 – February 2011. www.eqf-ref.eu (last visited: September 1st 2015); Matthies AL (2011): *Social Service Professions Towards Cross-European Standardisation of Qualifications*. sw&s 9(1). www.socwork.net/sws/article/view/9/31 (last visited: February 13th 2016)

4. Requirements to begin education

Figure 2 Entry requirements for education as HCA



Source: own elaborations from EQF project. EQF Referencing Process - Examples and Proposals - EQF-Ref March 2009 – February 2011. www.eqf-ref.eu; Matthies AL (2011): *Social Service Professions Towards Cross-European Standardisation of Qualifications*. sw&s 9(1). www.socwork.net/sws/article/view/9/31.

Most countries have a minimum age for the start of education and expect at least graduation from primary school.

Austria requires trainees to be at least 17 years of age. Trainees need to have their physical health attested by a physician, have no criminal record, and have successfully graduated from compulsory education.

In **Belgium** trainees need to be at least 18 years of age. 12 years of compulsory education are required. In **Bulgaria** trainees need to be at least 18 years of age. There are no further requirements regarding previous education.

In **Denmark** the completion of basic social and healthcare training (a year and two months) or a qualification through a combination of work

and training are required to begin the education as a *social health care assistant*. There is no minimum age requirement.

In **Finland** students have to be at least 16 years of age and have to have completed elementary education, which takes 9 years.

In **Germany** trainees have to be at least 16 years of age. They need to have their personal and physical health attested by a physician. Completed primary school education or an equivalent is demanded.

Ireland: there is no minimum age requirement. Candidates must have a certificate in health-care support or at least one year of work experience in healthcare settings.

The Netherlands: no requirements exist for level 1. Levels 2 and 3 need to have completed primary school. There is no minimum age requirement.

Slovenia: Trainees have to be at least 15 years old and need to have completed elementary education.

In **Poland** no minimum age is required, but 12 or 13 years of school education are expected.

In **Spain** trainees usually need to have completed secondary education and have to be certified technical assistants. They can also have access to training if they pass a special exam or have general access to university studies.

In **Switzerland** trainees have to have finished compulsory general education and a minimum age of 15 years is required.

The UK: no information on requirements for prospective HCAs is available.²¹⁸

5. How is the training of HCAs financed?

In most of the countries training is covered by public funding. This applies to Belgium, Bulgaria, Denmark, Finland, Germany, Ireland, the Netherlands, Poland, Slovenia, Spain and Switzerland.

In Austria and Italy mixed funding is in place. In Austria education is publicly funded by the labour market service (AMS) and the Vienna Employment Promotion Fund (WAFF), privately by the employer, and self-funded by the trainees. In Italy education is partially funded by Italian regions and also self-funded by trainees.

Exclusive self-funding by trainees is not required in any of the countries²¹⁹

In the UK, the education is privately funded by the employer.²²⁰

218 *ibid.*

219 *ibid.*

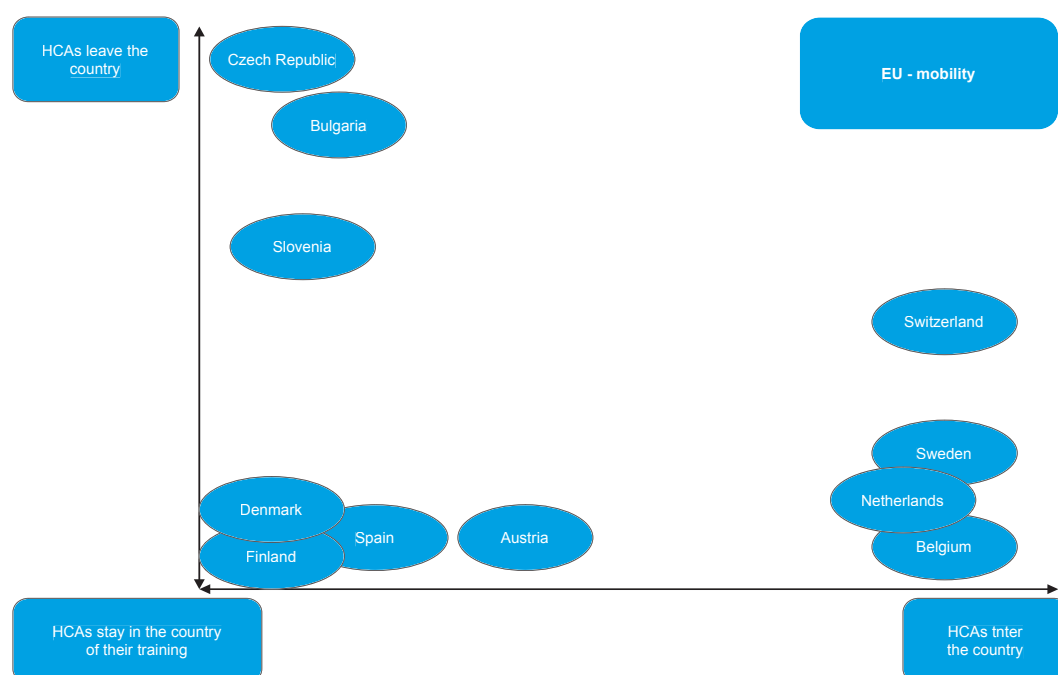
220 *ibid.* 172

6. EU-mobility

With regard to the continuously increasing number of persons in need of care and a severe shortage of care assistance staff the issue of qualified health care for old and very old people in need of care has become more and more important. It is assumed that Europe expects “a shortage of 1.000.000 health workers by 2020”.²²¹ Increasing mobility may solve the

problem of a shortage of health workers in Western Europe, but may also cause care drain in the health workers’ countries of origin. This might be especially true for Eastern European States and new EU member countries, in particular from countries like Estonia, Hungary, Poland, Slovakia and Romania, where – due to low pay or status – many health workers are looking for jobs abroad.²²²

Figure 3 In which countries HCAs leave to work abroad and which countries recruit them?



Source: own elaborations from section 2

221 Braeseke et al. (undated: 4)

222 ibid.

EU mobility differs in the different countries mentioned.

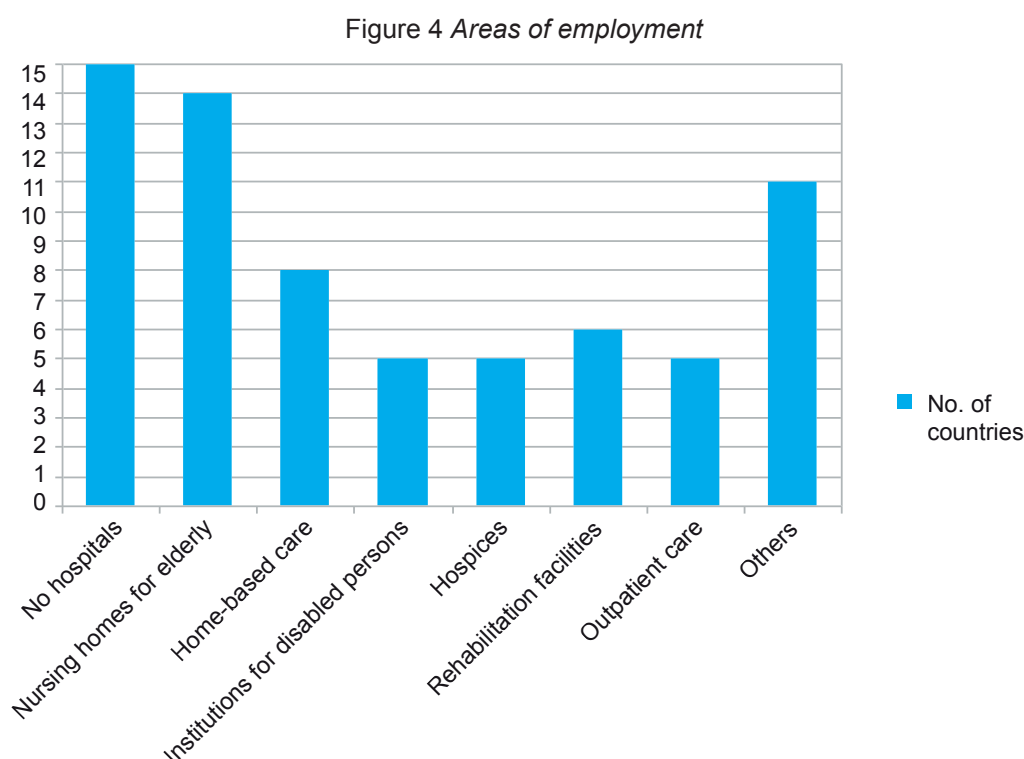
France, Poland and Italy are not listed as there is no information on the number of HCAs leaving their country and people from abroad working there. The same is also true for Germany and the UK.

The degree to which foreign workers enter seems to depend on working conditions in the relevant countries. The worse the working conditions and remuneration in their home

country, the higher their motivation to leave. The worse the working conditions or social status in the State of entry, the higher the motivation to recruit people from abroad as there is a lack of workers because of the rather unattractive training situation. This particular situation can be observed in Sweden, for example.

Another notable position is that of Switzerland: 20 per cent of the HCAs are foreign workers, but work migration to the neighbouring countries, Germany and Austria, also takes place. This is a result of the geographical location.

7. Areas of Employment



Source: own elaborations from section 2

As a result of the training and qualifications for HCAs, a wide range of various tasks is possible; it is emphasized, however, that HCAs are only allowed to work under the instruction and supervision of registered nurses or other practitioners such as doctors and physiotherapists. Even though this division of tasks is not strictly observed in the day-to-day working routine it has an effect on the work areas of HCAs as is shown below.

The countries surveyed are Austria, Belgium, Bulgaria, The Czech Republic, Denmark, Finland, Germany (North Rhine-Westphalia), Ireland, Italy, the Netherlands, Poland, Slovenia, Spain, Switzerland, and the United Kingdom.

In all these countries HCAs work in hospitals, with emphasis often being placed on geriatric and geronto-psychiatric wards. In most of these countries HCAs also work in nursing homes for elderly people. As regards home-based care

HCAs are only employed in half of the countries (8/15), a situation which is probably due to the fact that supervision by RNs or other practitioners is not guaranteed in this setting. For example, in Belgium and Spain HCAs are explicitly not allowed to do home-based care because of the lack of supervision.

In one-third of the countries employment is also possible in institutions for people with disabilities, hospices, rehabilitation facilities and outpatient care.

In many countries (11/15) HCAs sometimes work in other task areas such as child and youth care institutions, welfare service facilities, primary education facilities, community health care centres, maternity wards or the prison service .²²³

²²³ *ibid.*

Conclusions

As people live longer, the need for care increases. There is already a shortage HCAs as the profession is not attractive. The professional burden on caregivers is often high while the profession is hardly socially valued and pays little. These aspects make for low incentives to take up the profession of HCA.

A solution to alleviate the shortage of nurses in Europe is to enhance EU mobility. One tool to increase comparability of training and professional advancement is the European Qualification Framework (EQF) which has existed since 2008. The expansion of intra-European comparisons using the EQF is a promising approach. EQF is yet in its infancy, and so far information is only available for some countries.²²⁴ It is recommended that guidelines and national qualification frameworks referring to EQF be further developed. This approach would allow for a common basis for comparing the education and training requirements of HCAs.²²⁵

However, in increasing EU mobility one should take precautions against exacerbating the care drain that already takes place. For example, in Belgium most of the employed HCAs are from abroad, mainly from Eastern Europe (Romania, Bulgaria, Latvia, and some French-speaking African countries).²²⁶ It is therefore necessary to take steps to ensure that migration of HCAs does not only take place from poorer to richer countries. One solution for this may be to improve the reputation and prestige of HCAs in the respective countries. Care work is often socially undervalued, which is reflected in below-average wages. Higher

wages and better working conditions can add value to the profession so that more people seek a career in this field. Providing formal and better qualification can improve the reputation of the work of HCAs. In many countries the training is short and has a bad reputation. In Bulgaria, working as a HCA is so unattractive that the work is carried out by ex-prisoners.

Policies should also address the fact that HCAs in many countries have no or hardly any actionable opportunities for professional advancement. This lowers the prestige of the occupation and may also negatively affect work motivation.

Improving working conditions also entails development of clearly defined areas of activity. The Cavendish Review highlighted the problem in the UK that HCAs may only be allowed to work under the supervision of RNs in hospitals, whereas in practice the situation in everyday work is different, giving rise to personal overstrain.²²⁷

As society ages and life expectancy increases, the phases during which an elderly person requires care can be prolonged. In principle care should not aspire to merely keep people fed and clean but also take the quality of life into consideration. Therefore, a rethinking and restructuring of nursing practice is necessary. Also it is increasingly being taken into account that for the elderly there must be aspects of living other than care at home, in a care home or in a hospital. This might also require a general rethinking as regards housing for the elderly and care. Alternative living concepts, for example, such as self-organized housing projects for the elderly with an affiliated care provider. This increases the autonomy of the elderly and enhances quality of life, thereby creating care resources.

224 cf. Waldhausen et al. (2014: 18)

225 cf. Bundesministerium für Bildung und Forschung (2014: 51)

226 cf. EU-Project: [Creating a pilot network of nurse educators and regulators \(SANCO/1/2009\)](#). List of Country Profiles (undated: 23)

227 *ibid.* 22; Cavendish (2013: 18)

Acronyms

EQF = European Qualifications Framework

HCA = Health Care Assistant

NHS = National Health Service

RCN = Royal College of Nursing

RN = Registered Nurse

AP = Assistant Practitioner

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