

Ontario Nurses' Association Position Statement on The Generic Health-Care Worker

(June 1995)

“A more attractive and cost-saving development in the area of multi-skilling and cross-training is the creation of a whole new breed of generic health care worker. This worker would be partially trained in all health care work and well-skilled in none. This new generic health care worker would not have to be licensed and her job description would fit into none of the existing job classifications nor within any of the traditional health care bargaining units. She would be a little bit of a nurse, a little bit of a lab tech, a little bit of a physiotherapist, a little bit of a perfusionist, a little bit of a housekeeper, a little bit of a clerk, a little bit of a porter and a big bit tired.”

- Trudy Richardson,

“Patient-Focused Care: A United Nurses of Alberta Study,”

February 1994

The following is a brief statement and corresponding rationale to explain ONA's position on the use of generic health-care workers. Because patient populations, acuity of illness, current staffing mix, working conditions and supervision differ so much between the three sectors - hospitals, long-term care and community care - the manner in which health-care workers other than registered-nursing personnel may be most effectively used will differ markedly.

Consequently, ONA's position on the use of generic health-care workers will differ within each of the three sectors.

Hospital/acute-care settings

Statement:

ONA will accept the addition of a category of generic health-care workers in hospital/acute-care settings, if the following criteria are met:

- 1. No nursing jobs will be lost as a result of the addition of a category of generic health-care worker.*
- 2. Generic workers will perform no nursing functions, except where they are assisting a Registered Nurse or Registered Practical Nurse who is physically present.*

3. *A provincially standardized education program is available which will adequately train generic workers for the tasks they will be expected to perform.*
4. *A supervisory system is put into place, which will ensure that patients are properly assessed before a generic worker is assigned to them, and that the generic workers are performing only the tasks they have been trained to do, and are performing them appropriately.*
5. *The Employer and the Union will develop a system to be put into place, which sets out clearly to whom the generic worker is accountable, and where they are to receive assistance and support. Registered nurses and registered practical nurses will not be expected to take responsibility for the work of generic workers.*

*** Definition of nursing functions:** In acute-care/hospital settings, because of the acuity level of the patient population, nursing functions are defined as any nursing action which involves direct contact with the patient. In practical terms, this definition implies, for example, that a generic worker could assist an RN or RPN to get a patient up in the chair, assist to make an occupied bed or feed a patient if there is an RN or RPN present in the room. On the other hand, the generic worker could not remove a bedpan, transfer a patient into a chair or give a bed bath without an RN or RPN physically present.

Rationale

The increased acuity level of patients in the hospital sector in recent years has been well documented and current forecasts indicate that this will continue to be a feature of our health-care system in the future. Factors which have contributed to increased acuity levels are changes such as increased use of same day or short-stay surgery, earlier discharges, admission of only the most compromised patients and a focus on keeping potential hospital patients in their own homes.

Statistics show that even though hospital beds and even entire units have been closed, the actual number of patients being admitted and discharged through hospitals has increased. Productivity has also increased. These trends are present in every service, from obstetrics, to surgery, to medical floors.

It has also been observed and documented that the new, more acutely compromised patient population needs a caregiver with a relatively advanced and broad skill set to care for them effectively. Ten years ago, on the average medical/surgical floor, for example, there were patients with needs ranging from minimal help with bathing, toileting and feeding to very ill post-operative patients. It was then usually straightforward to divide patient assignments among RNs and RPNs, for example, according to skills and patient needs. Now, in many facilities it is increasingly difficult to find enough stable patients on a floor to assign to a RPN. Hospitals which have found RPNs not to be effective caregivers in that environment, have chosen to replace RPNs with an all-RN staff.

Given increased acuity levels and a concomitant increase in nursing needs of these patients, it is impossible to find an appropriate direct caregiving role for a generic worker, other than to assist a more highly trained worker. Even while performing tasks as mundane as bedpans, bed baths and feeding patients, important assessment, treatment and patient education functions are done.

It is often during the delivery of this kind of care that a well-trained nurse will note significant changes in a patient's condition and be able to act on them. It is unreasonable to ask a worker who may have had two to four weeks of on-the-job training to be able to assess and report subtle but significant indicators of medical status.

At the same time as patient acuity levels have been increasing, fiscal constraints have led many hospitals to begin to pare down existing auxiliary health-care staff. Orderlies, porters, housekeeping and dietary staff have all been cut back or phased out in many facilities. Tasks, previously performed by these workers, for the most part, still need to be done. Patients still need to be transported to different departments for tests and heavy patients still need to be bathed and helped up into chairs. Meal trays still need to be distributed into patient rooms from the cart in the hallway, even if there is no longer dietary staff to perform this function. Garbage needs to be emptied, bedside units cleaned and dirty laundry hampers emptied, whether or not there is any housekeeping staff to do it. In most cases, nursing staff has reluctantly filled the void, recognizing that all of these functions ultimately contribute to the recovery of their patients.

The tendency of nursing to fill these gaps emerges from the historical understanding of nursing as "women's work" and of nurses as "doctors' handmaidens." Historically, before auxiliary staff were brought into the hospitals, nurses performed many of these tasks as part of their job. And even after auxiliary staff were added, nurses had often performed their jobs on night and evening shifts, weekends and holidays, or whenever a task had to be done quickly in order to care for a patient. So as the numbers of porters, orderlies and others were cut, many nurses grudgingly assumed these duties. However, in recent years, especially during the "nursing shortage" of the late 1980s, nurses throughout the province demanded that "non-nursing tasks" be taken away from nursing to let nurses do the job they have been educated to do, and the job they wanted to do. Nurses asked why they were portering patients, cleaning floors, filling patient charts, replacing water jugs, running specimens to the labs - why could these jobs not be done by others, leaving nurses to do their own jobs?

At first glance, proposals for the creation of generic health-care workers appear to be in response to those demands by nursing. In fact, however, in most cases where generic workers have been introduced, the intent is not to create a group of workers to perform non-nursing functions to free nurses to do nursing; the intent is to save money by replacing RNs with generic workers. The result is a "deskilling" of a previously highly skilled workforce. This shift raises serious issues about the ability of the restructured system to provide safe, adequate patient care. It also raises questions about the future of nursing, if the job is taken apart and assigned, task by task, to unskilled workers. For example, St. Joseph's Hospital in London is now introducing a generic-worker classification called "Patient Care Partners."

The introduction of these workers, plus other restructuring initiatives, has resulted in layoff notices for 96 ONA members. Obviously, the goal is not to provide trained registered nurses with the assistance necessary to perform their jobs more effectively; the goal is to replace highly skilled more expensive workers with untrained, inexpensive workers. Similar initiatives are taking place at other hospitals in the province, under the guise of improving patient care and allowing RNs to be relieved of non-nursing duties.

This goal could only be achieved if there was a guarantee that no nursing jobs would be lost and that there was no intention to replace RNs or RPNs with unskilled workers. Of course, no facilities are willing to give that guarantee.

ONA could accept and even welcome the prospect of a generic health-care worker, if it was understood that these workers would perform only non-nursing tasks. The idea that workers from one job classification (generic workers) could perform a variety of tasks such as portering, clerical work and assisting RNs and RPNs, appears attractive. Certainly these jobs might be more interesting and rewarding than previous job descriptions, which encompassed only a small number of tasks. These workers would have a better idea of how the various parts of systems fit together, and consequently, have a better understanding of the importance of what sometimes appear to be “menial” tasks.

Another issue that has received little attention in the discussion of generic workers in the hospital sector is training of these workers. To date, the Ontario hospitals that are beginning to introduce these workers appear to intend to train the workers themselves to meet the particular needs and job descriptions of that facility. Consequently, generic workers at each facility will have different training, and will be prepared to perform different functions. This situation might be acceptable if these workers were not expected to perform patient care. However, this is not the case; facilities that are hiring or planning to hire generic workers intend them to care for patients.

ONA cannot accept the use of generic workers to perform patient-care functions that RNs used to perform, when these workers have received no formalized or standardized training. If RNs are expected to delegate some of their tasks to these generic workers, they must be confident in the skills and abilities of these workers, and that they have been trained to perform the tasks assigned.

Long-term care settings

Statement:

ONA does not accept the introduction of a category of generic health-care workers into long-term care facilities. Currently, these facilities are staffed with a mixture of RNs, RPNs and Health Care Aides (HCAs). ONA sees no justification for the addition of another category of staff with less training than HCAs.

Rationale

As patient-acuity levels have increased in the hospital sector, there has been a parallel development in the long-term care sector. Reports from this sector tell of increasingly frail and ill patients with more sophisticated care needs. This situation arises in part from an increased emphasis on keeping the elderly in their own homes for much longer, so if and when they are institutionalized, they are often quite debilitated. Also, modern medicine has succeeded in keeping elderly people with multiple health problems alive much longer, so staff in long-term care facilities find themselves caring for patients with a multitude of needs. In addition, because of the pressure on acute-care facilities to discharge patients quickly, a long-term care resident that is admitted to a hospital for a specific problem, may be discharged back to their long-term care facility while still requiring intensive care. These needs must then be met by the staff in the long-term care facility.

Currently, the complaints which ONA receives from its members about these facilities are not just that they are short-staffed, but that the current non-professional staff is not skilled enough or well trained enough to care for fragile patients adequately. For the most part, many of these facilities are staffed primarily with Health Care Aides, workers who have received, on average, between seven and 10 weeks of training. Even though many of these workers are working to the best of their abilities and using all of their training, they are not always able to deliver the care that is needed. The RNs are asking for more highly trained staff and for more RNs to adequately supervise existing staff. The introduction of a new category of even less-prepared staff is a mistake, given that the patient population they are to care for will become even more complex and need even more sophisticated care. In the long-term care facilities where generic workers have been introduced, it has been at the expense of existing staff. RNs, RPNs and HCAs have been laid off to be replaced by generic workers.

The employer, in some cases, rehires the laid-off RNs and RPNs into the new job classifications with a pay cut. Patient care may not suffer at first because the rehired workers may continue to perform the same tasks they did in their previous job description. Even though these tasks are no longer assigned to them, this situation becomes more complicated for staff who are registered with the College of Nurses, because they remain accountable to their professional standard. Patient care will begin to suffer, however, when the employer begins to hire true generic workers who have minimal training, if any.

ONA could accept cross-training of workers that could perform a mixture of clerical and auxiliary functions, such as stocking shelves, housekeeping, portering and assisting to set up meal trays. The goal should be to allow existing categories of health-care workers to perform their own assigned duties, in order to provide good patient care. Unfortunately, the goal of long-term care employers appears to be to demote existing workers, pay them less and assign them to do the same or more work. This is unacceptable to ONA.

Community Care

Statements:

ONA supports the use of generic health-care workers known as Personal Support Workers (PSW) and Personal Attendants (PA) to deliver care in clients' homes if the following criteria are met:

- 1. No Registered Nurses' jobs in the community will be lost as a result.*
- 2. A provincially standardized education program is available which will adequately train these workers for the tasks they will be expected to perform.*
- 3. A supervisory system is put into place which will ensure that patients are properly assessed before a generic worker is assigned to them, and that the generic workers are performing only the tasks they have been trained to do and that they are performing them appropriately.*

4. *A system will be put into place which sets out clearly to whom the PSW or PA is accountable and where they are to receive assistance and support.*
5. *Registered Nurses and Registered Practical Nurses will not be expected to take responsibility for the work of PSWs who they never see practice and with whom they have very little contact.*

Rationale:

ONA is not prepared to see RN jobs disappear from the community-health sector, especially since the acuity level of many of the patients being cared for will only be increasing. The move to use generic workers in the community sector is not as advanced as it is in the hospital sector. However, in some areas, ONA has seen a dramatic shift in the ratios of RNs to RPNs. For example, in some Victorian Order of Nurses units, the percentage of RPNs on staff has risen from approximately 10-15 per cent to 32-35 per cent. RNs have lost jobs as the change has been implemented.

Although there are not yet any concrete plans to reduce the professional level of nursing staff any further, this may be the first step. Because agencies such as VON and St. Elizabeth are experiencing funding cuts, they will be looking for ways to deliver care more cheaply - generic workers may seem to be the answer.

In mid-March (1995), ONA responded to the final "Report on Personal Support Worker Training." This report addressed issues and made proposals around the training and use of Personal Service Workers in the community. It appears these two groups of workers will perform a wide range of tasks for clients in the community that may be similar in their scope and lack of specific definition to those performed by generic workers in the hospital and long-term care sectors. As in the other two sectors, it also appears that clients being cared for in the community will have more serious health problems and sophisticated care needs than ever before.

Currently, the focus in the community-health sector appears to be the formalization of job classifications and standardization of training of non-professional health-care workers. This differs from initiatives in the other two sectors, where individual employers, on the advice of consultants, are creating job classifications specific to their own facilities, and providing their own on-the-job training. Consequently, in those sectors, ONA's response to such initiatives may differ from facility to facility, depending on actual job descriptions and layoffs.

The rationale for the criteria listed above can be found in ONA's submission of March 17, 1995 to the Ministry of Health, in response to the Report on Personal Support Worker Training. ONA's critique is briefly summarized here:

1. *ONA supports a standardized education/training program for PSWs.*
2. *ONA has serious concerns that the expectations placed on the PSW are unrealistic, and that there is not enough accountability within the existing systems to ensure that adequate care will be delivered to clients.*

3. *ONA believes that the training which is proposed is too short to allow PSWs to meet the expectations that will be placed on them.*
4. *Issues around client choice of care providers and client ability to direct the delivery of care have not been dealt with.*
5. *The impact of the implementation of the Report recommendations is further deskilling of nursing care. Although this Report deals only with training needs of PSWs to work in the community, the impact on nursing and on the quality of care delivered will be similar to that discussed above in the sections on hospitals and long-term care. The same assumptions are used - nursing can be broken down into a series of discrete tasks which any worker can learn to perform correctly without the benefit of a theoretical background and a more complete education. ONA does not believe these assumptions are well founded or in the interest of health-care consumers.*

This position paper is produced by the Ontario Nurses' Association, a union representing over 45,000 registered nurses and allied health personnel in hospitals, nursing homes, homes for the aged, public health units and industries in Ontario.

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