CHATHAM-KENT Health Alliance

CKHA POLICY

Title:	Patient Care Assistants (PCA)		**Document Number:** PTC-1-075
Approved by:	Senior Leadership Team (SLT)	**Date Revised:**	February 28, 2020
Policy Owner:	Professional Practice	**Date of Origin:**	February 28, 2020

BACKGROUND

Patient care assistants (PCA) are unregulated care providers, meaning they are not licensed or regulated under the *Regulated Health Professions Act* (RHPA) or by a professional regulatory body. Unlike registered or licensed professionals, PCAs do not have a legislated scope of practice, a protected title, mandatory education requirement, a set of professional standards for practice or a professional conduct review process. Their key characteristics are that they assist many professions, are known by numerous titles, work in a variety of settings and perform various functions (CNA, 2005).

OUTCOME

The purpose of this policy is to guide and support PCAs as they work collaboratively with regulated care providers to deliver high quality patient care.

POLICY

PCAs employed by Chatham-Kent Health Alliance (CKHA) work within a CKHA standardized and defined scope of practice (Appendix A) under the supervision of a regulated care provider (i.e. Registered Nurse (RN)/Registered Practical Nurse (RPN)). Regulated care providers will supervise the care provided by PCAs by observing the PCAs (direct supervision) and/or having the PCAs report regularly to them regarding observations, interventions and outcomes (indirect supervision).

When more than one PCA is working on a unit, consideration will be given to assigning the PCAs to routine and variable work (see Table 1). Allocating PCAs in this manner will help minimize interruptions and optimize workflow (Advisory Board, 2016).

Table 1 - Examples of Routine vs Variable Work Assignments

Routine Work PCA	Variable Work PCA
- Rounding - Feeding patients - Turning patients - Bathing patients - Ambulating patients	- Call lights - Assisting Nurses with unexpected needs - Preparing patients for tests/transfer/discharge

PCA Competency

A nurse who assigns elements of patient care to a PCA is expected to verify the competence of the PCA. Nurses also need to ensure that the PCA understands:

a. the extent of his/her responsibilities in performing the care activities;
b. when and who to ask for assistance;
c. when, how and to whom to report the outcome of care activities (CNO, 2013).

Assigning and Delegating

When assigning or delegating a task to a PCA, regulated care providers must first have the necessary knowledge and judgement to assign the care. Regulated care providers also need to assess the client's situation and condition, the activity and associated risk, and the environmental supports before assigning or delegating (CNO, 2013). Nurses can only delegate those controlled acts which they have authority to perform. A nurse who delegates a controlled act is responsible for the decision to delegate the controlled act. They cannot delegate an act that has been delegated to them. (CNO, 2018).

Documentation

PCAs are expected to document observations, actions taken and the response. "The recording of accurate, complete, and truthful notes during patient interactions are essential to ensuring that the highest level of client care is being provided. The PCA is expected to take all necessary steps to ensure that records are not falsified or compromised. Examples of how this can be achieved include only documenting care that is provided, ensuring that all documentation is accurate and complete, and including all relevant encounters with the patient. While it may not be possible to document all care provided to a patient at the exact moment it is occurring, PCAs are expected to document their interactions and care provided to patients at the earliest time available to ensure the accuracy and applicability of the patient's care plan" (Personal Support Worker Registry of Ontario, 2018 pp. 3,4). "Falsification of client records violates the fundamental trust that underpins the relationship between patients and PCAs." (Personal Support Worker Registry of Ontario, 2018, p.7). Documentation is to be completed by the individual who performed the action or observed the event (CNO, 2008). The principals of documentation as outlined in policy HTI-1-003: Clinical Documentation must be followed when applicable. In addition to documenting, PCAs are also required to verbally report to the primary nurse whenever they observe something abnormal, or are unsure of something. When documentation occurs on a log or progress note, those notes will be filed in a patient's chart as they are considered a part of the legal record.

Direct/Constant Supervision

If observing a patient who is at risk for suicide, and/or who is in restraints, care provision and documentation will occur according to the related CKHA policies (see policy PTS-1-036: Suicide Risk Screening and Levels of Observation and PTS-1-012: Restraint Policy.

As direct/constant supervision is resource intensive and can be considered a physical restraint, fair consideration must be given before assigning a CKHA care provider to this task (see

Appendix B). Alternative measures must be considered and attempted prior to assigning 1:1 observation (see Appendix C).

Prior to implementing the use of a PCA for 1:1 observation, a request must be made to the Unit Manager or delegate for approval and documentation of alternatives attempted must be completed. Once approved, observation can be implemented and documentation on the appropriate tool (i.e. restraint log, observation log) must be completed.

DEFINITIONS

Delegation – delegation is a formal process through which a regulated health professional (delegator) who has the authority and competency to perform a procedure under one of the controlled acts delegates the performance of that procedure to another individual (delegatee) (CNO, 2018).

LINKS

HTI-1-003: Clinical Documentation
PTS-1-036: Suicide Risk Screening and Levels of Observation
PTS-1-012: Restraint Policy

REFERENCES

Canadian Nurses Protective Society. (2007). *Quality documentation: your best defence*. infoLAW, 1(1).

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Advisory Board. (2017). *Rising above the bottom line*. London, UK: Author.

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APPENDIX A: Scope of Practice- Patient Care Assistant

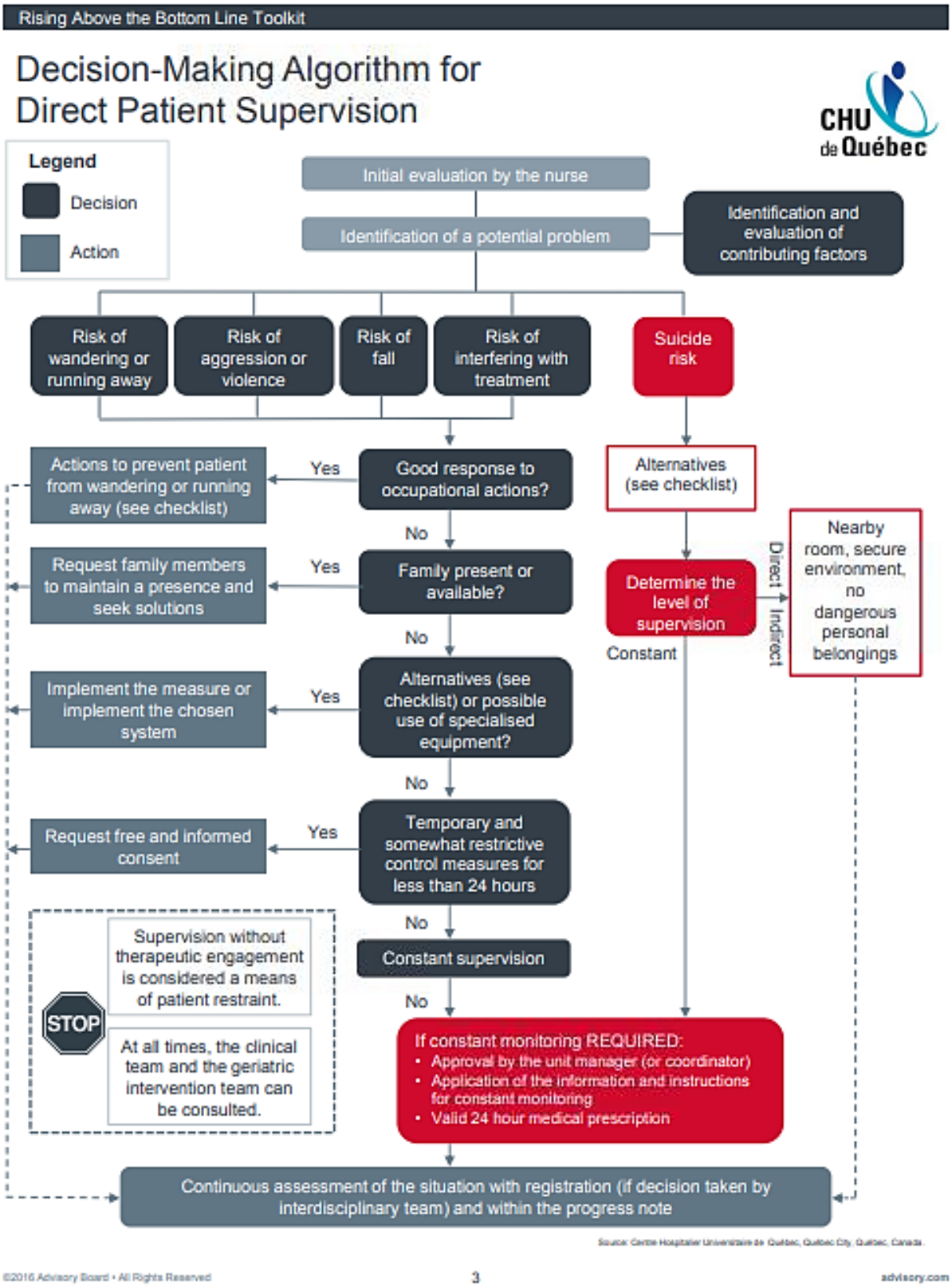
Patient Care

- Personal care needs of patients (bathing, feeding, oral care, toileting, incontinence care)
- Patient lifting, turning, repositioning, transfers, and ambulation
- Assists with set up and/or supervision of exercise routines
- Takes, records and reports patient weight
- Provides observation of patients who require close/constant care for safety (i.e. restraints, suicide risk) according to CKHA policies
- Performing and reporting of visual safety check rounding (side rails up, bed alarm on, call bell within reach, ID band on and visible)
- Gather equipment for nursing interventions (dressing tray) and assist under the supervision of a regulated health care provider
- Reapply oxygen mask/cannula where settings have been preset by RN/RPN
- Monitor, document and report patient intake and output as directed by the nurse
- Empty, measure, document and report ostomy and Foley catheter drainage bags and dispose of contents when directed by RN/RPN
- Perform cardio-pulmonary resuscitation (CPR) as required and according to current BLS guidelines
- Documents observations, actions taken and responses

Environmental

- Answer call bells
- Assists with delivery and set up of meal trays to patients
- Delivers water and nutritional snacks as directed by a RN/RPN
- Assist with room to room transfers and discharges
- Ensures a safe, tidy and comfortable environment for the patient/family
- Empty laundry and garbage bags as necessary
- Wiping down equipment
- Transport of equipment off or within unit (IV pumps, bladder scanner)
- Distributes supplies and/or stocks patient care areas as required
- Report all concerns voiced by the patients and their families to RN/RPN and manager as appropriate
- Alert team members immediately when any change or concern about the patient's condition occurs
- Contributes to the patient information collection and documentation process

APPENDIX B: Decision-Making Algorithm for Direct Patient Supervision



APPENDIX C: Alternatives for Direct Supervision

Alternatives for Direct Supervision

The following list of alternatives to 1:1 supervision come from Centre Hospitalier Universitaire (CHU) de Québec in Canada.

CHU de Québec

Risk of Wandering or Running Away

- If physical location permits, show them a walking route
- Ensure that the person has good shoes, accessible at all times
- Quickly treat the underlying reasons behind wandering: anxiety, pain, reaction to medication, etc.
- During care, try to respect the person's schedules and life habits
- Occupy the patient with activities s/he knows: reading, folding laundry, games, etc.
- Have them listen to music or watch television they like
- Eliminate or limit naps during the day
- Use magnetised doors or removable flexible half gates (when possible)
- Make sure the environment is safe (doors, windows, non-slippery floor)

Risk of Aggressiveness or Violence

- Have a calm, relaxed and respectable attitude
- Allow the patient to verbalise and express themselves (pacifying them)
- Use simple words and short sentences
- Encourage the use of strategies to reduce or channel feelings of irritability (reading, writing, listening to music , etc.)
- Specify limits and unacceptable behaviour
- Avoid confrontation and arguments
- Move slowly, avoid sudden and spontaneous gestures
- Do physical and breathing exercises (e.g., walking)
- Talk with a friend or friendly stranger, talk on the phone
- Reduce stimulation (lights, noise)
- Make contact with the patient through gaze, voice and touch (dementia)
- Use magnetised doors or removable flexible or unlocked half gates

Risk of Falls

- Give temporal (calendar), spatial (familiar objects, photos), and human landmarks (stable staff, at the bedside)
- Reorient the patient in time and space (physical orientation of places)
- Clearly identify the toilet
- Promote physical activities three times a day (favoring walking)
- Use reminders (e.g., to remind the patient to use their walker)
- Show the patient how to assess their limits and adapt their behaviours
- Teach safe behaviours
- Minimise mobility limitations (probe, nasogastric tub, IV drip)
- Use motion detectors (if available)
- Establish a schedule to meet the needs of the individual (ex. toiletting, hunger, thirst, etc.)
- Propose diversions (television, games, radio, etc.)
- Check for orthostatic hypotension
- Keep the bed in the lowest possible position (except during treatment)
- Use half-rails to help with transfers
- Respect as much as possible the patient's sleep routine

Source: Centre Hospitalier Universitaire de Québec, Québec City, Québec, Canada.

APPENDIX C: Alternatives for Direct Supervision (cont'd)

Alternatives for Direct Supervision (cont.)

The following list of alternatives to 1:1 supervision come from Centre Hospitalier Universitaire (CHU) de Québec in Canada.

CHU de Québec

Risk of Interfering with Care

- Control pain well
- Minimise mobility limitations (probe, nasogastric tube, IV drip)
- Camouflage a dressing by applying a protective bandage
- Involve the patient in their care (provides a sense of control over the situation)
- Keep the patient occupied by giving them something to do
- Coordinate care and medication to avoid interrupting sleep at night
- Respect as much as possible the patient's sleep routine
- Use non-pharmacological means to promote sleep: hot beverage (milk, herbal tea), relaxing music, massage
- Use a night light

Risk of Suicide

- Remove unused medical equipment
- Allow for the open expression of feelings without judgement
- Encourage the patient to contact family and loved ones
- Encourage the patient to call for help if suicidal thoughts intensify
- Identify with the patient ways to reduce stress and anxiety
- Accompany the patient in a problem-solving process