Natural Resources for Human Health
eISSN: 2583-1194

Original Research

Received 12 Oct 2025
Revised 18 Nov 2025
Accepted 25 Dec 2025

Natural Resources for Human Health 2025, Vol. 5 (4): 944–954

KEYWORDS:
health care assistants, nursing assistants, unlicensed assistive personnel, early identification, clinical deterioration, change detection, baseline observation.

Contribution of Health Care Assistants to Early Identification and Reporting of Changes in Patients' Basic Care Needs

Alanazi.Ahmed Mohammed H[1], Ibrahim Mushahhina Alanazi[2], Alanazi, Hamoud Abdullah B[3], Rakan Mansour Mohammad ALharbi[4], Khalid Othman M Alruwaili[5], Mohammed Refai S Alenezi[6], Alowaydhah, Nawaf Saleh A[7], Laila Jahz S Almutairi[8], Nawdh Mutair A Almajdi[9], Hamad Hoori Alrawili[1]

[1]Health Assistant – Health Care Security – Ministry of Health – Arar – Northern Borders Region – Saudi Arabia
Email: Iiiahmdiii78@gmail.com
[2] Health Care Security Assistant – Eradah and Mental Health Complex – Northern Borders Health Cluster – Ministry of Health – Arar – Northern Borders Region – Saudi Arabia
Email: Alngze@hotmail.com
[3] Health Assistant – Health Care Security – Ministry of Health – Arar – Northern Borders Region – Saudi Arabia
Email: hmood.alenzy@gmail.com
[4] Health Assistant – Health Care Security – Qassim Health Cluster – Ministry of Health – Al Bukayriyah – Al Qassim Region – Saudi Arabia
Email: ralharbi125@moh.gov.sa
[5] Health Care Security Assistant – Al-Hamidiyah Primary Health Care Center – Al Jouf Health Cluster – Ministry of Health – Al Qurayyat – Al Jouf Region – Saudi Arabia
Email: khotalruwaili@moh.gov.sa
[6] Health Care Security Assistant – Mental Health Hospital – Northern Borders Health Cluster – Ministry of Health – Arar – Northern Borders Region – Saudi Arabia
Email: hkj12@hotmail.com
[7] Health Assistant – Eradah and Mental Health Hospital, Al Jouf – Al Jouf Health Cluster – Ministry of Health – Sakaka – Al Jouf Region – Saudi Arabia
Email: NALOWAYDHAH@MOH.GOV.SA
[8] Health Assistant – Health Care Security – Hafar Al-Batin Health Cluster – Ministry of Health – Hafar Al-Batin – Eastern Region – Saudi Arabia
Email: laialy200541@gmail.com
[9] Health Care Security – Maternity and Children Hospital – Hafar Al-Batin Health Cluster – Ministry of Health – Hafar Al-Batin – Eastern Region – Saudi Arabia
Email: Nmalmajdi@gmail.com
[10] Health Assistant – Health Care Security – Al-Salihiya Middle Primary Health Care Center – Northern Borders Health Cluster – Ministry of Health – Arar – Northern Borders Region – Saudi Arabia
Email: Hamad5559@hotmail.com

ABSTRACT: Health care assistants occupy a distinctive position in the care continuum because they are present during the moments when subtle changes most often first appear—mealtime, bathing, mobilizing, toileting, and the quiet intervals between formal

assessments. Their proximity and continuity of contact allow them to notice deviations from a patient's usual baseline: reduced appetite, altered gait, a new reluctance to weight-bear, skin changes, confusion, or diminished engagement in previously enjoyed activities. These observations are often qualitative and cumulative rather than captured by scheduled screening tools, which makes the assistant's tacit knowledge of "what is normal for this person" a genuinely irreplaceable clinical resource.The value of this contribution, however, depends on the mechanisms that surround it. Recognition alone does not improve outcomes; it must be translated into timely, structured reporting that reaches the right person with enough detail to prompt action. This requires clear escalation pathways, a shared vocabulary for describing change, documentation systems that are quick enough to use in real time, and a workplace culture in which assistants feel psychologically safe raising concerns without fear of being dismissed as overstepping their role. Where these conditions exist, assistants function as an early-warning layer that can reduce avoidable deterioration, prevent hospital admissions, and shorten the interval between the first sign of decline and clinical response. Where hierarchies are steep or reporting is informal and undocumented, potentially significant observations are lost—an educational and organizational gap rather than a failure of individual diligence.

INTRODUCTION

Health care assistants, also described in the international literature as nursing assistants, certified nursing assistants, health care support workers, or unregulated care providers, occupy a distinctive position within contemporary health and social care systems. They are the staff group with the most sustained, intimate, and continuous contact with patients across hospital wards, nursing homes, residential facilities, and patients' own homes. A systematic review of activities undertaken by nursing assistants identified more than two hundred activities delegated to this staff group across eight countries and concluded that over thirty-one per cent of these activities required skills and comprehension beyond the level of training that nursing assistants typically receive [1]. This finding confirms that health care assistants are performing observation, monitoring, and reporting functions of genuine clinical complexity, while also exposing a structural gap between the responsibilities they carry and the preparation they are given [1]. In hospitals, health care assistants have been described as the indispensable frontline safeguard against omissions in fundamental care and as critical hubs for informational and relational continuity [2]. In emergency departments, the health care assistant has been conceptualised as the guardian of fundamental care and continuous presence, ensuring dignity, comfort, and hygiene while simultaneously feeding observational data back to the wider team [3]. The evidence base for their observational contribution is longstanding. In a foundational observational cohort study conducted in a nursing home, nursing assistants completed a standardised instrument on seventy-four residents over four weeks; residents with an instrument-recorded change were 4.1 times more likely to develop an acute illness within seven days, and documentation of signs of illness by nursing assistants preceded chart documentation by an average of five days [4]. This five-day lead time is one of the most powerful empirical justifications for investing in health care assistant observation and reporting [4]. The same principle has been recognised in improvement work on the "softer signs" of deterioration, where carers often notice subtle cognitive and functional changes that herald illness before significant physiological deterioration is apparent in recorded observations [5]. In hospice settings, aides have described themselves as "the eyes and the ears" of the service while reporting that they do not "have a voice," limited access to records, and little opportunity to contribute to team discussions [6]. A Swedish study of homecare workers similarly found that staff were often unsure whether a client needed urgent admission, could not reach primary care for advice, and received little or no feedback on the reports they made [7]. These findings establish the central argument of this article: the contribution of health care assistants to early identification and reporting is neither peripheral nor merely supportive; it is a foundational mechanism of patient safety, a determinant of timely clinical intervention, and an essential component of continuity of care [8].

The pathway from observation to action is not a single act but a chain of interdependent steps: noticing, interpreting, documenting, reporting, escalating, and following up. The barriers and enablers of recognition and response to deteriorating patients have been shown to operate at individual, interpersonal, organisational, and cultural levels, and they determine whether an observation becomes clinically actionable [8]. When an initial report is not acted upon, guidance for nursing home staff emphasises that the reporter must persist, document the concern, and escalate through the appropriate chain rather than

assuming that silence is an adequate response [9]. Structured communication tools such as SBAR, which organises a report into Situation, Background, Assessment, and Recommendation, and CUS, which provides a graded assertiveness script of Concerned, Uncomfortable, and Safety, have been developed precisely to make escalation clearer and more resistant to hierarchy [10]. Condition-specific tools have also been designed for health care assistant use; the Stop and Watch Early Warning Tool prompts carers to recognise and articulate signs of deterioration, and its implementation in a nursing home project was associated with a reduction in readmission rates from twenty-five per cent to eighteen per cent, although longer-term trend data were still required [11]. In a skilled nursing facility, a sepsis pathway incorporating education for nurses and certified nursing assistants was associated with an increase in sepsis recognition from fifty-six per cent to eighty-six per cent and a reduction in sepsis-related hospital transfers from sixty-eight per cent to forty-four per cent [12]. A study comparing nursing assistants and licensed nurses in the recognition of delirium in nursing home residents with dementia found that nursing assistants made observations about mental status changes that were as accurate as those made by licensed nurses, but that both groups recognised delirium and its subtypes less than fifty-three per cent of the time [13]. A multicentre study of nursing assistant trainees found that most trainees perceived safety concerns and were willing to speak up, but that common barriers included fear of negative repercussions for their training and uncertainty about how to articulate their concerns [14]. The Care Certificate was introduced in the United Kingdom to equip health and social care support workers with the knowledge and skills needed to provide safe and compassionate care, and it is intended to form part of a robust induction for staff new to care [15].

The Royal College of Nursing guidance is clear that delegation is the transfer of authority to perform a specific task to a competent individual, and that the registered nurse remains accountable for the decision to delegate and for the appropriate supervision of the delegated care [16]. A European overview of health care assistant roles notes that regulation and mandatory structured education are not universal and that delegation arrangements vary considerably between countries [17]. A large retrospective study of vital signs monitoring in thirty-two English hospital wards found that late and missed observations were frequent, particularly in high-acuity patients, and that lower levels of nursing assistant staffing were associated with higher rates of missed observations [18]. The BEACH course for unregistered healthcare staff teaches a structured and prioritised approach to assessment, care, and handover of a deteriorating patient, and is explicitly designed to give health care assistants increased confidence, skills, and knowledge to recognise, respond to, and interpret physiological changes [19]. The AWARE programme similarly provides a developmental framework for healthcare support staff to improve recognition and response to deteriorating patients, using case studies, role-play, group discussion, and competency assessment [20]. Early warning scores such as NEWS2 provide an objective language for deterioration that both health care assistants and registered nurses can use, reducing reliance on subjective impressions and hierarchical permission [21]. Practical guidance on noticing changes that matter emphasises that detection depends on all nursing staff, including assistive personnel, and that observations must be interpreted against the patient's usual baseline [22].

The Distinctive Position of the Health Care Assistant in the Care Team

The scale and composition of the unregulated care workforce explain why its contribution cannot be treated as incidental. The systematic review of nursing assistant activities across acute and primary healthcare settings confirms that this staff group is not confined to domestic or hygiene tasks but is involved in monitoring, reporting, and supporting clinical processes [1]. The review warned that patient safety is placed at risk when roles expand without commensurate education and supervision [1]. The contribution of health care assistants to early identification must therefore be understood not as an argument for unlimited role expansion, but as an argument for recognising, formalising, and supporting the observational work that health care assistants already perform [1]. In hospitals, their prolonged contact with patients allows them to notice deviations from an individual's normal pattern of eating, sleeping, moving, speaking, and interacting, and they function as critical hubs for informational and relational continuity [2]. In emergency departments, their continuous presence ensures dignity, comfort, and hygiene while feeding observational data back to the wider team [3]. This dual function is important: the health care assistant is not simply delivering care tasks in parallel with observation; the delivery of care is itself the context in which observation occurs [2]. Assisting a patient to eat reveals dysphagia or loss of appetite; assisting with washing reveals new skin lesions or bruising; assisting with mobilisation reveals new weakness, imbalance, or reluctance to move [3]. The observational contribution is thus embedded in the caring relationship rather than added to it [2].

The Nature of Changes in Patients' Basic Care Needs

To appreciate what health care assistants detect, it is necessary to specify what counts as a change in basic care needs. Basic care needs are not confined to hygiene and comfort. They encompass nutrition and hydration, elimination and continence,

mobility and positioning, skin integrity, thermoregulation, rest and sleep, communication, and psychological and emotional security [2]. Changes in these domains may be gradual or abrupt, subtle or obvious, transient or sustained [4]. They may be physiological in origin, such as the onset of infection, dehydration, constipation, urinary retention, or a pressure injury [4]. They may be functional, such as a new inability to bear weight, a loss of grip strength, or an increased dependence in dressing [3]. They may be behavioural or cognitive, such as withdrawal, agitation, confusion, reduced eye contact, or altered sleep patterns [13]. They may be social or environmental, such as a patient refusing food because of pain, fear, or an inability to reach the tray [7]. The taxonomy of relevant changes is broad precisely because basic care needs are interconnected: a urinary tract infection may present first as confusion or incontinence; dehydration may present first as lethargy or a dry mouth; a pressure injury may present first as a change in skin colour or a reluctance to lie on one side [4]. The evidence from nursing homes shows that instrument-recorded changes by nursing assistants have meaningful predictive validity and can precede formal chart documentation by several days [4]. Improvement work on the softer signs of deterioration reinforces that subtle cognitive and functional changes may herald illness before significant physiological deterioration is apparent in recorded observations [5]. In hospice and homecare settings, the changes that matter most are often those that deviate from the patient's usual pattern and that are best known to the carer who sees the patient repeatedly [6][7]. Table 1 summarises the principal categories of change that health care assistants are positioned to detect, together with illustrative indicators and their clinical significance.

Table 1. Categories of Change in Basic Care Needs Detectable by Health Care Assistants

Domain of basic care need	Illustrative indicators	Why early detection matters
Nutrition and hydration	Reduced appetite, food left untouched, difficulty swallowing, dry lips, concentrated urine, reduced fluid intake	May signal infection, depression, dysphagia, dehydration, or deterioration in general condition
Elimination and continence	New incontinence, frequency, urgency, constipation, abdominal discomfort, changes in stool or urine	May indicate urinary tract infection, faecal impaction, medication effects, or neurological change
Mobility and positioning	New weakness, reluctance to mobilise, unsteadiness, inability to bear weight, increased dependence	May precede falls, pressure injury, delirium, or acute illness
Skin integrity	Redness, blanching, bruising, breaks, moisture lesions, changes in temperature or texture	Early pressure injury or skin failure can be prevented from progressing with timely intervention
Behaviour and cognition	Withdrawal, agitation, confusion, reduced communication, altered sleep, loss of interest	Delirium, pain, infection, and hypoxia often present first as behavioural change
Vital signs and physiological observations	Changes in temperature, pulse, respiration, blood pressure, oxygen saturation, blood glucose	Provide objective evidence of deterioration and trigger escalation protocols
Pain and comfort	Facial grimacing, guarding, restlessness, refusal of care, moaning	Untreated pain impairs mobility, appetite, sleep, and recovery

From Observation to Report: The Communication Chain

The value of health care assistant observation is realised only when observations are transmitted accurately and acted upon. Reporting is therefore not a clerical afterthought; it is the translational step that converts caring knowledge into clinical action [8]. The literature on recognition and response to deteriorating patients identifies several features of effective communication: timeliness, specificity, reaching a clinician with authority to respond, documentation, and feedback to the reporter [8]. Vague statements such as "she's not herself" are less actionable than descriptions of what has changed, when it changed, and how it differs from the patient's usual baseline [22]. Detecting change depends on all nursing staff, and the quality of the interface between observers and decision-makers determines whether early identification translates into early intervention [23]. When an

initial report is not acted upon, guidance emphasises that the reporter must persist and escalate rather than assume that silence is an adequate response [9]. Structured communication tools have been developed to support these requirements. The SBAR framework, comprising Situation, Background, Assessment, and Recommendation, is widely used to organise escalation conversations, while the CUS tool, comprising Concerned, Uncomfortable, and Safety, provides a graded assertiveness script for situations in which a concern has not been acted upon and the risk appears to be escalating [10]. For nursing assistants reporting a detected change, the most important elements are the situation and the background: what has been noticed, and what the patient's usual state and relevant history are [10]. The assessment and recommendation components are primarily the responsibility of the registered nurse or other licensed clinician, although an experienced health care assistant may offer a recommendation to request review [16]. Condition-specific tools have also been developed for health care assistant use. The Stop and Watch Early Warning Tool consists of prompts designed to help carers recognise and articulate signs of deterioration, and it has been used to support the "gut instinct" of staff who know the patient well [11]. In a nursing home implementation project, the geriatric nursing assistant was identified as the frontline provider best placed to notice subtle behavioural changes, and the tool provided a method for communicating those changes to the licensed provider; readmission rates fell from twenty-five per cent before implementation to eighteen per cent afterwards, although the authors cautioned that longer-term trend data were required [11]. Disease-specific pathways have produced similar findings. In a skilled nursing facility, a sepsis pathway incorporating education for nurses and certified nursing assistants was associated with an increase in sepsis recognition fro m fifty-six per cent to eighty-six per cent and a reduction in sepsis-related hospital transfers from sixty-eight per cent to forty-four per cent [12]. These results do not prove that health care assistants alone produced the improvement, but they demonstrate that when health care assistants are included in structured recognition and reporting systems, the system as a whole performs better [12]. Early warning scores such as NEWS2 provide an objective language that both health care assistants and registered nurses can use, reducing reliance on subjective impressions and hierarchical permission [21]. When the health care assistant can say that the NEWS score is five and the respiratory rate has risen from sixteen to twenty-four, the conversation with the registered nurse is anchored in shared data rather than in a contest of intuition [21]. Table 2 summarises structured communication and escalation tools relevant to health care assistant reporting.

Table 2. Structured Communication and Escalation Tools Relevant to HCA Reporting

Tool	Components	Primary use	HCA contribution
SBAR	Situation, Background, Assessment, Recommendation	Escalation of a change in condition to a registered nurse or clinician	States the situation and background clearly; provides baseline and observed change
ISBAR	Identification, Situation, Background, Assessment, Recommendation	Handover and escalation in acute and community settings	Identifies self, patient, and concern; supplies focused observational data
CUS	Concerned, Uncomfortable, Safety	Graded assertiveness when a concern is not being addressed	Repeats and escalates the concern using explicit safety language
Stop and Watch	Structured prompts covering behaviour, eating, mobility, elimination, skin, and vital signs	Early warning in nursing homes and care homes	Records and communicates subtle changes from the resident's normal pattern
NEWS2 / early warning scores	Aggregated physiological parameters with trigger thresholds	Objective detection of deterioration	Records observations accurately and reports trigger scores promptly

Barriers to Early Identification and Reporting

Despite the strength of the observational contribution, the pathway from health care assistant observation to clinical action is frequently obstructed. The barriers are individual, interpersonal, organisational, and cultural, and they interact in ways that can silence precisely the information that is most needed [8]. The most extensively documented barrier is hierarchical and relational. Health care assistants often feel that their knowledge is not valued and that their reports are dismissed or unwelcome [6]. In a

qualitative study of hospice aides, participants described themselves as "the eyes and the ears" of the service but reported that they did not "have a voice"; they felt that they had the least background information about patients, limited access to electronic records, and little opportunity to contribute to team discussions [6]. The phrase "we have no voice" captures a structural problem that is not resolved by exhorting health care assistants to speak up [6]. If the culture of the team communicates tha t only licensed staff are entitled to interpret and report, health care assistants will learn to withhold or minimise their observations [8]. A study of homecare workers in Sweden similarly found that staff were often unsure whether a client needed urgent admission, could not reach primary care for advice, and received little or no feedback on the reports they did make; in the absence of feedback and medical information, they were uncertain about which signs and symptoms should prompt concern [7]. The consequence was either inappropriate escalation to emergency services or failure to escalate at all [7]. A multicentre study of nursing assistant trainees found that most trainees perceived safety concerns and were willing to speak up, but that common barriers included fear of negative repercussions for their training and uncertainty about how to articulate their concerns [14]. These findings suggest that speaking up is not simply a personality trait but a skill and a culturally permitted act [14]. Where senior staff respond dismissively, or where no structured language for escalation exists, the default response is silence [14].

A second barrier is role ambiguity and inconsistent delegation. Health care assistants frequently measure vital signs and perform other observational tasks as part of an expected routine rather than following an explicit, patient-specific delegation from a registered nurse [16]. This routinisation can be efficient, but it can also mean that the health care assistant does not receive clear guidance about which observations matter most for a particular patient, what thresholds should trigger a report, and to whom the report should be made [16]. When delegation is implicit, accountability becomes blurred: the registered nurse may assume that the health care assistant will report anything important, while the health care assistant may assume that the registered nurse will review the observation chart and notice the change [16]. The Royal College of Nursing guidance is clear that delegation is the transfer of authority to perform a specific task to a competent individual, and that the registered nurse remains accountable for the decision to delegate and for the appropriate supervision of the delegated care [16]. In practice, however, delegation is often informal and undocumented, particularly in understaffed environments [17]. A European overview of health care assistant roles notes that regulation and mandatory structured education are not universal and that delegation arrangements vary considerably between countries [17]. This variation creates inconsistency in what health care assistants are expected to observe, how they are prepared to interpret it, and whether their reports are formally recognised [17].

A third barrier is training and confidence. The systematic review of nursing assistant activities found that a substantial proportion of delegated activities exceeded the training of the staff performing them [1]. This is not an argument against health care assistant involvement in observation; it is an argument against expecting complex interpretation without structured education [1]. Health care assistants may be able to record a respiratory rate accurately but may not know that a rising respiratory rate in an older patient can be an early sign of pneumonia, acidosis, or sepsis [19]. They may recognise that a patient is "not right" but lack the vocabulary and framework to describe what is wrong in clinically meaningful terms [22]. The BEACH programme for unregistered healthcare staff was established precisely because recognition of deterioration by clinical staff is often delayed or not escalated in a timely manner, and because health care assistants are undertaking vital sign observations far more frequently than their education to interpret those observations would justify [19]. The AWARE programme similarly provides a developmental framework for healthcare support staff to improve recognition and response to deteriorating patients [20]. The absence of a coherent national training standard for health care assistants in many countries compounds this problem [17]. The Care Certificate provides a foundation in the United Kingdom, but it is not in itself sufficient to prepare health care assistants for the interpretive demands of deterioration recognition [15]. Additional training in physiological observation, early warning scores, delirium recognition, sepsis awareness, and structured communication is required, and this training should be competency-based rather than merely attendance-based [15].

A fourth barrier is workload and time. When staffing is stretched, observation becomes a task to be completed rather than a process to be thought about [18]. A large retrospective study of vital signs monitoring in thirty-two English hospital wards found that late and missed observations were frequent, particularly in high-acuity patients, and that lower levels of nursing assistant staffing were associated with higher rates of missed observations [18]. A health care assistant who is responsible for the hygiene, nutrition, and mobility needs of a large number of patients may have little time to document a subtle change, to find the registered nurse, or to persist when the first report is not acted upon [18]. The problem is not a lack of concern; it is a lack of slack in the system [18]. The same workload pressure can make it difficult for registered nurses to provide the supervision and feedback that delegation requires [16]. Table 3 summarises the barriers and facilitators identified across these levels.

Table 3. Barriers and Facilitators to HCA Identification and Reporting

Level	Barriers	Facilitators
Individual	Lack of confidence; uncertainty about what to report; fear of being wrong	Clear observation frameworks; training in recognition and communication; positive feedback
Interpersonal	Hierarchy; dismissive responses from senior staff; fear of repercussions	Respectful team culture; named responsible clinician; closed-loop communication
Organisational	Implicit delegation; unclear reporting pathways; workload and time pressure; limited record access	Explicit delegation; standardised escalation protocols; adequate staffing; accessible documentation systems
Educational	Training gaps in interpretation and escalation; variable induction standards	Competency-based training; simulation; Care Certificate or equivalent; refresher training
Cultural	"No voice" perception; low status of caring work; blame-oriented response to error	Leadership valuing fundamental care; recognition of HCAs as team members; learning culture

Facilitators and Enablers of Effective Contribution

The barriers described above are not immutable. The literature also identifies a range of facilitators that can strengthen the health care assistant contribution and integrate it more reliably into clinical workflows [8]. The first facilitator is a structured observation and reporting framework that is designed for health care assistant use rather than retrofitted from professional nursing practice [11]. The Stop and Watch tool is an example of a deliberately simplified instrument that prompts the carer to notice changes in behaviour, eating, mobility, elimination, skin, and vital signs, and to communicate them to the licensed provider [11]. The tool does not replace clinical judgement; it scaffolds it [11]. Similarly, early warning scores provide an objective language for deterioration that both health care assistants and registered nurses can use, reducing reliance on subjective impressions and hierarchical permission [21]. When the health care assistant can say that the NEWS score is five and the respiratory rate has risen from sixteen to twenty-four, the conversation with the registered nurse is anchored in shared data rather than in a contest of intuition [21].

The second facilitator is explicit, patient-specific delegation with clear reporting expectations [16]. The Royal College of Nursing guidance emphasises that delegation must be to a competent individual, must be appropriate to the patient's needs, and must be accompanied by supervision [16]. In practice, this means that the registered nurse should communicate not only what is to be observed but also why it matters, what change should prompt a report, and how urgently the report should be made [16]. When health care assistants understand the clinical rationale for an observation, they are more likely to notice meaningful deviations and less likely to record data mechanically [19]. The evidence from the barriers literature supports this: health care assistants who anticipated that registered nurses would be receptive and helpful were more willing to escalate subtle signs, whereas those who anticipated dismissal were more likely to hesitate [8]. The relationship is therefore reciprocal: the registered nurse creates the conditions in which the health care assistant can observe and report safely, and the health care assistant supplies the granular, longitudinal knowledge of the patient that the registered nurse needs to make informed decisions [16].

The third facilitator is education that is pitched at the right level and delivered in a format that respects the health care assistant's working context [19]. The BEACH course teaches a structured and prioritised approach to assessment, care, and handover of a deteriorating patient, and is explicitly designed to give health care assistants increased confidence, skills, and knowledge to recognise, respond to, and interpret physiological changes [19]. The AWARE programme similarly provides a developmental framework for healthcare support staff to improve recognition and response to deteriorating patients, using case studies, role-play, group discussion, and competency assessment [20]. These programmes are effective precisely because they do not attempt to turn health care assistants into substitute nurses; they equip health care assistants to perform their existing observational role with greater precision and to communicate their findings in a language that clinical teams can act upon [19][20]. The Care Certificate provides a foundation for induction, but it must be supplemented by condition-specific and observation-specific training if health care assistants are to contribute reliably to early identification [15].

The fourth facilitator is a culture of feedback and recognition [6]. Health care assistants who receive positive validation for appropriate escalation are more likely to repeat the behaviour [6]. In the barriers and enablers study, a health care assistant

described the effect of being told by a nurse that a patient had been saved because of the health care assistant's quick action: "Next time I do more" [8]. This is not a trivial point about morale. Feedback closes the loop between observation and outcome, and it teaches the health care assistant which observations are clinically significant [8]. By contrast, the absence of feedback, documented in the hospice aide and homecare studies, leaves the health care assistant unable to calibrate their judgement and uncertain whether their reports are valued [6][7].

The fifth facilitator is documentation that is accessible, contemporaneous, and designed for multidisciplinary use [24]. The health care assistant needs to be able to record what has been observed in a way that is legible to the registered nurse, the physician, and the next shift [24]. Guidance on clinical documentation emphasises recording the patient's exact words where relevant, documenting concerns and the actions taken, and ensuring that late entries are clearly labelled [24]. When documentation systems are cumbersome or inaccessible to health care assistants, the observation may remain in the health care assistant's memory or in an informal verbal report, and the likelihood that it will be lost increases [24]. Guidance on escalating a change in a home care client stresses that the reporter should use a clear framework, state what has changed, and persist if the response is inadequate [25].

Training, Competence, and Professional Development

The contribution of health care assistants to early identification is inseparable from the question of competence. Competence is not a fixed attribute; it is developed through induction, structured training, supervised practice, and continuing education [15]. In the United Kingdom, the Care Certificate was introduced following the Cavendish Review to equip health and social care support workers with the knowledge and skills needed to provide safe and compassionate care [15]. It comprises a set of standards underpinned by learning and assessment criteria covering duty of care, person-centred working, communication, and other essential domains, and it is intended to form part of a robust induction for staff new to care [15]. The Care Certificate provides a foundation, but it is not in itself sufficient to prepare health care assistants for the interpretive demands of deterioration recognition [19]. Additional training in physiological observation, early warning scores, delirium recognition, sepsis awareness, and structured communication is required, and this training should be competency-based rather than merely attendance-based [19][20]. The BEACH course and the AWARE programme are examples of training that is tailored to the health care assistant role rather than generic [19][20]. The evidence on delirium illustrates both the potential and the limits of health care assistant competence. A study comparing nursing assistants and licensed nurses in the recognition of delirium in nursing home residents with dementia found that nursing assistants made observations about mental status changes that were as accurate as those made by licensed nurses, but that both groups recognised delirium and its subtypes less than fifty-three per cent of the time [13]. The conclusion is not that health care assistants are unreliable observers; it is that all staff require further education, particularly in the recognition of hypoactive delirium, which may present as quiet withdrawal rather than agitation [13]. The study recommended that multifaceted educational interventions, including case studies and live videos, be included in mandatory education for all nursing home staff, including nursing assistants [13]. This is a model of how to think about health care assistant competence: not as a binary threshold of adequacy, but as a developmental trajectory that can be improved through targeted, context-relevant education [13][20].

The Role of Registered Nurses and the Ethics of Delegation

Any discussion of the health care assistant contribution must avoid two errors. The first is romanticisation: the claim that health care assistants can or should replace the clinical judgement of registered nurses [16]. The second is dismissiveness: the claim that because health care assistants are not registered, their observations are of secondary importance [16]. The evidence supports a third position: health care assistants are essential observers and reporters, and registered nurses are essential interpreters and decision-makers [16]. The two roles are complementary, and the quality of the interface between them determines whether early identification translates into early intervention [23]. The ethics of delegation are therefore central. The Royal College of Nursing guidance is unambiguous that registered nurses are accountable for the appropriate delegation and supervision of care provided by others in the team, and that delegation must be to a competent individual in a specified situation [16]. This means that the registered nurse cannot simply allocate observation tasks and assume that the health care assistant will manage the interpretive and escalation components without support [16]. It also means that the health care assistant must be honest about the limits of their competence and must report changes even when they are unsure of their significance [14]. The relationship is therefore reciprocal: the registered nurse creates the conditions in which the health care assistant can observe and report safely, and the health care assistant supplies the granular, longitudinal knowledge of the patient that the registered nurse needs to make informed decisions [16]. In settings where this relationship is strong, health care assistants function as extensions of the

registered nurse's clinical gaze; where it is weak, health care assistants function as isolated task-performers whose knowledge is disconnected from clinical decision-making [23].

Impact on Patient Outcomes and Health System Performance

The ultimate test of the health care assistant contribution is whether it improves patient outcomes and health system performance. The evidence, while not exhaustive, is encouraging. The five-day lead time demonstrated in the nursing home cohort means that health care assistant observation can create a window for earlier treatment of acute illness, and the risk ratio of 4.1 for subsequent acute illness in residents with a recorded change suggests that health care assistant observations carry genuine predictive value [4]. The Stop and Watch implementation was associated with a reduction in readmission rates from twenty-five per cent to eighteen per cent, although the authors appropriately cautioned that longer-term data were needed [11]. The sepsis pathway that included certified nursing assistants in education and screening was associated with a substantial increase in sepsis recognition and a reduction in sepsis-related hospital transfers [12]. These findings converge on a single conclusion: when health care assistants are equipped with structured tools and included in recognition and escalation systems, the system detects deterioration earlier and intervenes sooner [11][12]. There are also economic and organisational implications. Early identification can prevent avoidable hospital admissions, reduce length of stay, and decrease the incidence of hospital-acquired complications such as pressure injuries and falls [4][11]. The health care assistant role in preventing missed basic care is directly relevant here: by consistently completing fundamental care tasks and reporting changes, health care assistants help to prevent the omissions that contribute to adverse outcomes [2]. This is not a marginal contribution to efficiency; it is a contribution to the sustainability of care systems that are under pressure to deliver more with constrained resources [2][18]. Recognising and supporting the health care assistant role is therefore not a soft human-resources gesture; it is a patient-safety and system-performance strategy [1][2].

Implications for Practice, Policy, and Future Research

Several implications follow from the analysis. First, health care organisations should formalise the observational and reporting component of the health care assistant role [1]. This means specifying, in job descriptions, competence frameworks, and delegation policies, that health care assistants are expected to observe, record, and report changes in basic care needs, and that they will be supported to do so [16]. Second, organisations should invest in training that is tailored to the health care assistant role rather than generic [19]. Training should cover the recognition of soft signs, the use of early warning scores, structured communication tools such as SBAR and CUS, delirium and sepsis awareness, and documentation [10][13][19]. It should be competency-based and refreshed regularly [20]. Third, organisations should ensure that reporting pathways are clear, accessible, and responsive [8]. A health care assistant who reports a concern should know who is responsible for receiving the report, what response to expect, and how to escalate if the response is inadequate [9][25]. Fourth, organisations should build a culture in which health care assistants are treated as legitimate members of the care team and in which their observations are actively solicited rather than merely tolerated [6]. This includes inviting health care assistants to contribute to handovers, safety huddles, and quality-improvement discussions [22][23].

For policy-makers, the evidence supports the development of national competence standards for health care assistants and the integration of health care assistant observation and reporting into patient-safety frameworks [17]. The variation in health care assistant regulation and training across countries is a source of inconsistency and risk [17]. While regulation is not a panacea, a clear minimum standard for observation, reporting, and escalation would reduce the likelihood that health care assistants are expected to perform complex observational work without adequate preparation [15][17]. For researchers, several gaps remain. There is a need for prospective studies that measure the impact of health care assistant-led observation and reporting on clinically important outcomes, including time to antibiotic administration, unplanned admission, length of stay, and mortality [4][11][12]. There is also a need for implementation research that examines how reporting pathways can be designed to be usable under real-world staffing pressures, and for qualitative work that explores how health care assistants experience the transition from observer to reporter in different cultural and organisational contexts [7][8]. Finally, there is a need for research that examines the interface between health care assistants and registered nurses, including the conditions under which delegation supports safe reporting and the conditions under which it undermines it [16][23].

CONCLUSION

The contribution of health care assistants to the early identification and reporting of changes in patients' basic care needs is substantial, evidence-based, and under-recognised. Health care assistants are not peripheral observers; they are the staff group

with the most continuous access to the patient's everyday functioning, and their observations often precede formal clinical recognition by days. The evidence from nursing homes, hospitals, and community settings shows that health care assistants can detect behavioural, functional, nutritional, cognitive, and physiological changes with meaningful predictive validity, and that structured tools and training can enhance their contribution. Yet this contribution is frequently constrained by hierarchy, role ambiguity, training gaps, workload pressures, and cultures that do not treat health care assistants as legitimate reporters. Addressing these constraints is not a matter of extending the health care assistant role beyond safe limits; it is a matter of supporting the observational work that health care assistants already do and ensuring that their reports reach clinicians who can act on them. The chain from noticing to acting is only as strong as its weakest link, and the health care assistant is the first link. Strengthening that link through training, explicit delegation, structured communication, accessible documentation, and a culture of feedback is therefore one of the most practical and consequential investments that health care organisations can make in patient safety.

REFERENCES

[1] Blay N, Roche MA. A systematic review of activities undertaken by the unregulated nursing assistant. Journal of advanced nursing. 2020 Jul;76(7):1538-51.

[2] Kagonya VA, Onyango OO, Maina M, Gathara D, English M, Imam A. Characterising support and care assistants in formal hospital settings: a scoping review. Human resources for health. 2023 Nov 27;21(1):90.

[3] Alhazmi SA, Alanazi SA, Alrawili EZ, Alshammari MM, Alruwaili MR, Alruwaili IM, Alrwili MZ. Immediate response in emergency departments: How the collaboration between emergency technicians and nurses contributes to providing high-quality care. Gland Surgery. 2024 Dec 26;9(2):472-80.

[4] Boockvar K, Brodie HD, Lachs M. Clinical Investigation-Nursing Assistants Detect Behavior Changes in Nursing Home Residents That Precede Acute Illness: Development and Validation of an Illness Warning Instrument. Journal of the American Geriatrics Society. 2000;48(9):1086-91.

[5] Patel R. Nurse Expertise Saves Lives Through Early Recognition of Patient Deterioration (Doctoral dissertation, University of Auckland).

[6] Lai D, Cloyes KG, Clayton MF, Doyon K, Reblin M, Beck AC, Ellington L. We're the eyes and the ears, but we don't have a voice: perspectives of hospice aides. Journal of hospice and palliative nursing: JHPN: the official journal of the Hospice and Palliative Nurses Association. 2018 Feb;20(1):47.

[7] Bastholm-Rahmner P, Bergqvist M, Modig K, Gustafsson LL, Schmidt-Mende K. Homecare workers-an untapped resource in preventing emergency department visits among older individuals? A qualitative interview study from Sweden. BMC geriatrics. 2024 Apr 18;24(1):350.

[8] Smith D, Cartwright M, Dyson J, Hartin J, Aitken LM. Barriers and enablers of recognition and response to deteriorating patients in the acute hospital setting: A theory-driven interview study using the Theoretical Domains Framework. Journal of advanced nursing. 2021 Jun;77(6):2831-44.

[9] Lackore BK, Nehring RS, Cassivi MS, Donohue MJ, Deschamps MC, VanSuch MM, Naessens SJ. How best to measure surgical quality? Comparison of the Agency for Healthcare Research and Quality Patient Safety Indicators (AHRQ-PSI) and the American College of Surgeons National Surgical Quality Improvement Program (ACS-NSQIP) postoperative adverse events at a single institution. Surgery. 2011 Nov 1;150(5):943-9.

[10] Ashcraft AS, Owen DC. Comparison of standardized and customized SBAR communication tools to prevent nursing home resident transfer. Applied Nursing Research. 2017 Dec 1;38:64-9.

[11] Nesbitt-Johnson M. Decreasing Nursing Home Readmissions Using the Stop and Watch Early Warning Tool.

[12] Ahmed AM, Macapili E, Brenner MJ, Pandian V. Accelerating detection and intervention for sepsis in skilled nursing facilities using a sepsis pathway. Journal of nursing care quality. 2024 Jan 1;39(1):67-75.

[13] Steis MR, Behrens L, Colancecco EM, Mogle J, Mulhall PM, Hill NL, Fick DM, Kolankowski AM. Licensed nurse and nursing assistant recognition of delirium in nursing home residents with dementia. The annals of long-term care: the official journal of the American Medical Directors Association. 2015 Oct 28;23(10):15.

[14] Siebenförcher S, Schmied M, Hoffmann M, Schwarz C, Schwappach D, Sendlhofer G, Jäger M, Müller G. Safety concerns and speak-up in patient care from the perspective of nursing assistant trainees in Tyrol-a multicenter exploratory quantitative cross-sectional study. Zeitschrift für Evidenz, Fortbildung und Qualität im Gesundheitswesen. 2025;196:38-46.

[15] Turnpenny A, Hussein S. Migrant care workers and their future in the UK context. Migrant care workers and their future in the UK context. 2018 Oct 24.

[16] Sean Graffin RN. Nursing delegation in the United Kingdom. Online Journal of Issues in Nursing. 2010 May 1;15(2):1D.

[17] Conyard KF, Codd M, Metcalfe A, Corish S, Flannery J, Hannon P, Rusk B, Yeates S. Healthcare Assistants and Qualified Carers, A Trained, but Untapped Underutilised Resource: A population-based study in Ireland of skillset, career satisfaction, wellbeing and change across all sectors and care settings. UCD CSTAR & HCA & Carers Ireland; 2020.

[18] Redfern OC, Griffiths P, Maruotti A, Recio Saucedo A, Smith GB, Missed Care Study Group. The association between nurse staffing levels and the timeliness of vital signs monitoring: a retrospective observational study in the UK. BMJ open. 2019 Sep;9(9):e032157.

[19] Dresser S, Teel C, Peltzer J. Frontline Nurses' clinical judgment in recognizing, understanding, and responding to patient deterioration: A qualitative study. International Journal of Nursing Studies. 2023 Mar 1;139:104436.

[20] Etherington C. New Roles in General Practice and Primary Care: Working Together for Health Equity and Patient Empowerment. Jessica Kingsley Publishers; 2025 May 21.

[21] Shaw D, Fogarty AW. Is NEWS2 the optimal evidence-based surveillance tool for all respiratory patients or does it just represent the beginning of an iterative development process?. Thorax. 2025 Apr;80(4):197-201.

[22] Titler MG. The evidence for evidence-based practice implementation. Patient safety and quality: An evidence-based handbook for nurses. 2008 Apr.

[23] Savitz LA, Jones CB, Bernard S. Quality indicators sensitive to nurse staffing in acute care settings. Advances in patient safety: From research to implementation. 2005 Feb 1;4:375-85.

[24] Zimmer S, Gray C, Roy C, Semchuk WM. Departmental initiative to improve documentation in the medical record by acute care pharmacists. The Canadian Journal of Hospital Pharmacy. 2018 Apr 30;72(2):151.

[25] Australia's aged care COVID H. TOO-GREAT EXPECTATIONS.