



Workload, Task Allocation, and Role Clarity of Health Care Assistants in Hospital Settings

Alruqi, Abdulrahman Abdullah S^{1*}, Saud Farhan A Alanazi², Turki Hamed Hasawi Alanazi³, Alhanouf Khalaf Aiad Alanazi⁴, Reema Saleh Farhan Almulla⁵, Eiman Abdullah M Alenazy⁶, Abdullatif Mudshir M Alenezi⁷, Sultan Hadi S Alqahtani⁸, Badr Ali Saeed Alghamdi⁹, Shouq Khidhran Saeed Alghamdi¹⁰, Abdullah Awad J Alsawat¹¹

¹Health Assistant (Health Care Security) – Health Surveillance Center at Taif Airport, Taif Health Cluster, Ministry of Health, Taif, Makkah Region, Saudi Arabia

* **Corresponding Author Email:** D7mi335@gmail.com - **ORCID:** 0000-0002-0407-7850

²Health Assistant (Health Care Security) – Erada Complex and Mental Health, Northern Borders Health Cluster, Ministry of Health, Arar, Northern Borders Region, Saudi Arabia

Email: saudfarhan91@gmail.com- **ORCID:** 0000-0002-0047-0950

³Health Assistant (Health Care Security) – Long-Term Care Hospital, Northern Borders Health Cluster, Ministry of Health, Arar, Northern Borders Region, Saudi Arabia

Email: Talanazi34@moh.gov.sa- **ORCID:** 0000-0002-0047-1150

⁴Health Assistant (Health Care Security) – Long-Term Care Hospital, Northern Borders Health Cluster, Ministry of Health, Arar, Northern Borders Region, Saudi Arabia

Email: aalanazi576@moh.gov.sa- **ORCID:** 0000-0002-0047-1250

⁵Health Assistant (Health Care Security) – Maternity and Children Hospital, Northern Borders Health Cluster, Ministry of Health, Arar, Northern Borders Region, Saudi Arabia

Email: rsalmulla@moh.gov.sa- **ORCID:** 0000-0002-0047-1350

⁶Health Assistant (Health Care Security) – Maternity and Children Hospital, Northern Borders Health Cluster, Ministry of Health, Arar, Northern Borders Region, Saudi Arabia

Email: eaalenazy@moh.gov.sa- **ORCID:** 0000-0002-0047-1450

⁷Health Assistant (Health Care Security) – North Medical Tower Hospital, Northern Borders Health Cluster, Ministry of Health, Arar, Northern Borders Region, Saudi Arabia

Email: adltef1212@gmail.com- **ORCID:** 0000-0002-0047-1550

⁸Health Assistant (Health Care Security) – Imam Abdulrahman Alfaisal Hospital, Riyadh First Health Cluster, Ministry of Health, Riyadh, Riyadh Region, Saudi Arabia

Email: suhalqahtani@moh.gov.sa- **ORCID:** 0000-0002-0047-1650

⁹Health Assistant (Health Care Security) – Maternity and Children Hospital, Al-Kharj, Riyadh First Health Cluster, Ministry of Health, Al-Kharj, Riyadh Region, Saudi Arabia

Email: badrghamdi32@gmail.com- **ORCID:** 0000-0002-0047-1750

¹⁰Health Assistant (Health Care Security) – Erada Complex and Mental Health, Tabuk Health Cluster, Ministry of Health, Tabuk, Tabuk Region, Saudi Arabia

Email: Shkhalghamdi@moh.gov.sa- **ORCID:** 0000-0002-0047-1850

¹¹Health Assistant (Health Care Security) – Maabadah Primary Health Care Center, Makkah Health Cluster, Ministry of Health, Makkah, Makkah Region, Saudi Arabia

Email: Abalsawat@moh.gov.sa - **ORCID:** 0000-0002-0047-1950

Article Info:

DOI: 10.22399/ijcesn.4680
Received : 01 February 2024
Accepted : 28 February 2024

Keywords

Health Care Assistants;
Nursing Assistants;
Workload Management;
Task Allocation;
Delegation;
Role Clarity

Abstract:

The interrelated challenges of workload, task allocation, and role clarity fundamentally shape the effectiveness and sustainability of Health Care Assistants (HCAs) within hospital settings. Excessive and unmanaged workload, encompassing physical, emotional, and cognitive demands, leads to burnout and high turnover, directly compromising patient safety and quality of fundamental care. This burden is exacerbated by haphazard and inequitable task allocation, often governed by informal delegation rather than transparent systems, which fosters team discord and creates gaps in continuity. At the core lies pervasive role ambiguity, where a disconnect between formal job descriptions and enacted duties places HCAs in a vulnerable position, blurring accountability and stifling professional identity. Together, these factors form a vicious cycle that undermines workforce stability, jeopardizes patient outcomes, and highlights an urgent need for systemic interventions focused on acuity-based staffing, structured delegation models, and the professionalization of the HCA role to ensure a resilient and high-performing healthcare team.

1. Introduction

The contemporary hospital is a complex, high-stakes ecosystem where the delivery of safe, effective, and compassionate patient care is the paramount objective. This delivery is fundamentally reliant on a multidisciplinary team, a carefully orchestrated ensemble of professionals with distinct yet interdependent roles. Within this team, the Health Care Assistant (HCA), known also as Nursing Assistant, Patient Care Technician, or Auxiliary Nurse, occupies a position of immense practical importance and growing complexity. Tasked with providing fundamental, hands-on care, HCAs form the backbone of direct patient interaction, often spending more time at the bedside than any other member of the clinical staff. Their responsibilities, which traditionally included basic hygiene, mobility assistance, feeding, and vital signs monitoring, have expanded considerably in response to evolving healthcare demands, financial constraints, and advanced nursing roles. This evolution, however, has not been uniformly matched by systematic evaluation and redesign of their working conditions, leading to a precarious operational nexus defined by three interlinked and critical factors: excessive and unmanaged workload, haphazard and inequitable task allocation, and pervasive ambiguity regarding role clarity. The interplay of these factors constitutes a significant, yet often overlooked, determinant of hospital performance, influencing not only the well-being of the HCA workforce but also the safety, quality, and experience of patient care [1, 2]. Understanding the HCA role requires a historical and contextual lens. The position emerged from the traditional "nursing aide" role, created to support registered nurses (RNs) by taking on less-skilled duties, thereby freeing RNs for more complex clinical tasks. For decades, this hierarchical division was clear, if not always equitable.

However, the late 20th and early 21st centuries brought transformative pressures to healthcare systems globally: aging populations with multiple chronic conditions, technological advancements, rising patient acuity, and relentless economic pressures to enhance efficiency and reduce costs. One strategic response has been "skill mix" changes, where tasks are delegated downwards from physicians to advanced practice nurses, and from registered nurses to HCAs. Consequently, HCAs now frequently perform procedures once reserved for RNs, such as electrocardiogram (ECG) recording, phlebotomy, wound care dressings, and catheter care, often with minimal formal training for these extended duties [3, 4]. This expansion has occurred in an ad-hoc manner, driven more by immediate unit needs and individual RN delegation styles than by standardized protocols or robust competency frameworks. The result is a role in flux, its boundaries porous and inconsistently defined across and even within individual hospital wards. The issue of workload for HCAs is multifaceted and intense. Quantitatively, HCAs are frequently assigned patient loads that are unsustainable, a situation exacerbated by chronic staff shortages and high patient turnover. The physical demands are relentless: constant bending, lifting, transferring, and ambulating patients, which leads to one of the highest rates of musculoskeletal injuries in any industry. The emotional and psychological workload is equally taxing. HCAs provide intimate care for patients who are vulnerable, frightened, and often in pain or distress. They form close, continuous bonds with patients and their families, yet they typically lack the formal training and structured support systems available to registered nurses to process grief, trauma, and ethical dilemmas. Furthermore, their work is characterized by frequent interruptions, multitasking, and the need to respond to the needs of multiple patients

and nurses simultaneously, creating a state of chronic cognitive strain and time pressure [5, 6]. This combination of physical, emotional, and cognitive overload is a direct pathway to burnout, absenteeism, and high staff turnover, creating a vicious cycle that further depletes the workforce and intensifies the burden on those who remain.

Compounding the problem of sheer volume is the manner in which work is distributed—task allocation. In many hospital settings, task allocation for HCAs lacks transparency, consistency, and fairness. It is often governed by informal patterns, personal relationships, and the implicit authority of senior nurses or charge nurses, rather than by objective patient acuity tools or collaborative planning. Some HCAs may find themselves consistently assigned to the most dependent, heavy-care patients, while others may be tasked primarily with clerical or supply duties. This inequity breeds resentment, perceived injustice, and team conflict. Moreover, allocation is frequently reactive and fragmented; an HCA may be pulled from one essential task to address an urgent need elsewhere, leaving prior tasks incomplete and forcing them to mentally juggle competing priorities. This "task-switching" environment is inefficient and error-prone. Crucially, the delegation process itself is often flawed. Registered nurses, themselves under tremendous pressure, may delegate tasks without adequate explanation of the clinical context, desired outcomes, or red-flag warnings, leaving the HCA to perform procedures in an information vacuum. This not only risks patient safety but also undermines the HCA's sense of professional competence and integration within the care team [7, 8].

At the heart of these challenges lies the profound issue of role ambiguity. Role clarity refers to the degree to which an individual understands the expectations, responsibilities, and limits of their position. For HCAs, this clarity is frequently absent. There is a stark dissonance between the *espoused* role (as defined in formal job descriptions, which are often outdated and vague) and the *enacted* role (what they actually do on a shift-by-shift basis). This ambiguity manifests in several ways: uncertainty about the scope of practice (what they are and are not permitted to do), confusion about reporting lines and supervision, and a lack of understanding of how their contributions fit into the wider therapeutic goals for the patient. This "grey zone" of practice places HCAs in an untenable position. They may feel pressured to perform tasks beyond their competency for which they are not legally accountable, or conversely, they may be underutilized, leading to frustration and wasted potential. The lack of clear boundaries also fuels

inter-professional tension, as RNs may be uncertain about what they can legitimately delegate, and HCAs may resent being asked to perform what they perceive as "nursing work" without commensurate pay, recognition, or training. This ambiguity is not merely an administrative concern; it is a stressor that erodes job satisfaction, commitment, and psychological safety, making HCAs less likely to speak up about concerns or errors [1, 7].

2. The Multifaceted Burden: Analyzing HCA Workload in Hospitals

2.1 Physical and Quantitative Overload

The workload of Health Care Assistants is first and foremost characterized by a sheer quantitative and physical burden that is among the most severe in the healthcare sector. Patient assignment ratios for HCAs are frequently high and rarely adjusted using validated acuity tools that account for patient dependency. An HCA may be responsible for the direct personal care of eight, ten, or even more patients per shift, each with needs for assistance with activities of daily living (ADLs) such as washing, toileting, dressing, and eating. The physicality of this work cannot be overstated. Manual patient handling—lifting, turning, repositioning, and transferring—remains commonplace despite the widespread knowledge of ergonomic risks. This leads to alarmingly high rates of chronic back pain, shoulder injuries, and other musculoskeletal disorders, which are a primary cause of sickness absence and attrition among HCAs [9, 10]. The work environment itself adds to the physical strain, involving long hours of walking and standing on hard floors, managing heavy equipment, and working at a pace that precludes adequate rest breaks. This unrelenting physical demand is not only a personal health issue for workers but also an organizational one, resulting in significant direct and indirect costs related to injury compensation, temporary staffing, and reduced productivity [11].

2.2 Emotional and Psychological Labour

Beyond the physical toll, HCAs engage in profound emotional and psychological labour, a facet of their workload that is frequently invisible and unsupported. Their role places them in sustained, intimate contact with patients during moments of extreme vulnerability, fear, pain, and confusion. They are often the primary listeners to patient and family anxieties, the witnesses to suffering and decline, and the providers of compassionate touch and reassurance. However, unlike registered nurses

or social workers, HCAs typically receive little formal training in therapeutic communication, grief counselling, or boundaries for emotional involvement. They are expected to manage this emotional labour intuitively, which can lead to compassion fatigue, emotional exhaustion, and a sense of being overwhelmed by the human tragedy they encounter daily [12, 13]. Furthermore, HCAs often navigate complex ethical terrains—observing care they perceive as inadequate, dealing with abusive or confused patients, or feeling caught between patient requests and nursing instructions—without clear channels for debriefing or ethical guidance. This psychological burden is compounded by their relatively low status in the hospital hierarchy, which can leave them feeling that their emotional insights and contributions are undervalued by the clinical team [14].

2.3 Cognitive Demands and Interruptions

The cognitive workload of the HCA is also substantial and poorly accounted for in traditional workload measures. Their work is inherently interrupt-driven and requires constant task-switching. A typical sequence might involve: starting to assist a patient with a shower, being called to answer another patient's call bell, being asked by a nurse to urgently collect a specimen from a third patient, then returning to the first patient, all while mentally keeping track of which patients have been turned, fed, or toileted. This fragmented workflow imposes a high cognitive load related to memory, prioritization, and situational awareness. HCAs must constantly monitor multiple patients for subtle changes in condition, remember a myriad of specific instructions for different individuals, and adapt plans dynamically in response to shifting ward priorities [15]. This cognitive strain is exacerbated by factors such as inadequate handover processes, poor documentation systems that are not designed for their use, and a lack of access to comprehensive patient information that would allow them to understand the "why" behind their tasks. When cognitive load exceeds capacity, the risk of errors—such as missing a critical observation, confusing patient instructions, or omitting a key care task—increases significantly, with direct implications for patient safety [16].

2.4 Consequences of Excessive Workload

The cumulative effect of this physical, emotional, and cognitive overload is severe and multidimensional. For the HCA individually, it manifests as chronic stress, burnout, physical

injury, and poor work-life balance. Burnout, characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment, is endemic in this population and is a key predictor of intention to leave the job [17]. For the organization, the consequences include high rates of absenteeism, presenteeism (working while sick), and staff turnover. The constant cycle of recruiting and training new HCAs is costly and destabilizing, perpetuating a state of understaffing that further intensifies the workload on remaining staff. Most critically, from a patient perspective, excessive HCA workload is correlated with adverse outcomes. Research has linked higher HCA-to-patient ratios to increased rates of hospital-acquired infections (e.g., from rushed hygiene practices), patient falls, pressure ulcers, and medication errors (where HCAs are involved in prompting or administration) [18, 19]. Furthermore, the relational, compassionate care that is central to patient experience—having time to talk, to provide comfort, to attend to details—is the first casualty of an overwhelmed HCA, leading to lower patient satisfaction scores and a diminished sense of dignity in care [20].

3. The Chaotic Distribution: Systems and Pitfalls of Task Allocation

3.1 Informal and Inequitable Delegation Practices

The process by which tasks are assigned to Health Care Assistants is often the operational weak link in ward management. In the absence of standardized, transparent systems, task allocation frequently defaults to informal mechanisms. These are influenced by a range of non-clinical factors, including the personal rapport between an RN and an HCA, the perceived "efficiency" or "willingness" of certain assistants, the shift patterns of senior staff, and even unconscious biases. An HCA who is seen as exceptionally capable or compliant may become the "go-to" person for the most complex or unpleasant tasks, leading to an inequitable distribution of labour and eventual resentment [21]. This informal system lacks objectivity and fails to consider the holistic workload of each HCA. It also undermines team cohesion, fostering perceptions of favouritism and unfairness. New or less assertive HCAs may be left with simpler but more numerous tasks or relegated to non-clinical duties, hindering their skill development and sense of value. The lack of a visible, fair system means that HCAs have little recourse to challenge allocations they perceive as

unreasonable, reinforcing power imbalances within the team [22].

3.2 The Delegation Dilemma: Communication and Context

The act of delegation from RN to HCA is a critical juncture for patient safety and professional respect, yet it is often poorly executed. Effective delegation involves not only the transfer of responsibility for a task but also the transfer of authority to perform it and the provision of sufficient information and context for its safe completion. In practice, delegation to HCAs is often transactional and time-pressured: "Can you do obs on bed 10?" or "Get a urine sample from the lady in bed 5." This approach omits crucial information. Why are the observations needed more frequently? What specific parameters would warrant immediate reporting? What is the clinical suspicion behind the urine sample? Without this context, the HCA is operating blindly, unable to exercise judgment or notice subtle anomalies because they don't know what to look for [23, 24]. This constitutes a safety risk. Furthermore, poor delegation communicates a lack of trust and respect; it frames the HCA as a pair of hands rather than a thinking member of the care team. It also absolves the RN of their ultimate accountability for the task, as they have not ensured the delegatee is fully prepared. When errors occur in this context, blame is often misplaced onto the HCA for "not reporting," while the systemic failure of inadequate delegation goes unaddressed [25].

3.3 Fragmentation and Lack of Continuity

A predominant model of task allocation for HCAs is the "task-oriented" or "functional" model, where individuals are assigned specific duties (e.g., all vital signs, all hygiene care) for a large group of patients. This model, often adopted in the name of efficiency, is fundamentally flawed. It fragments patient care, reducing it to a series of disconnected procedures delivered by a parade of different workers. For the patient, this is depersonalizing and confusing, as they cannot build a relationship with a primary caregiver. For the HCA, it prevents the development of a holistic understanding of any single patient's condition, needs, or progress. They become experts in taking blood pressure but may have no idea why the patient is hypertensive or whether a particular reading represents a change from baseline [26]. This fragmentation also destroys continuity and accountability. If no single HCA is responsible for the overall care of a patient, small but important details—a loss of appetite, a new complaint of pain, a slight change in

behaviour—can easily fall through the cracks. It also makes coordination more difficult, as communication must occur among multiple HCAs and nurses about each patient, increasing the likelihood of miscommunication and omitted information during handovers [27].

3.4 The Impact on Team Dynamics and Morale

Inequitable and opaque task allocation systems have a corrosive effect on team morale and dynamics among HCAs and between HCAs and RNs. Among the HCA cohort, it can create a competitive or resentful atmosphere, where individuals may hoard easier tasks or avoid helping overburdened colleagues. It stifles the development of a collaborative team spirit where the workload is shared as a collective responsibility. Between HCAs and RNs, poor allocation and delegation practices erode mutual respect. HCAs may feel used, exploited, or treated as subordinate labour rather than colleagues. They may perceive that RNs are "dumping" undesirable tasks on them without appreciation. Conversely, RNs, frustrated by what they perceive as a lack of initiative or competence, may micromanage or avoid delegating meaningful tasks, thus underutilizing the HCA workforce [28]. This dysfunctional dynamic creates a negative feedback loop: poor communication leads to mistrust, which leads to poorer collaboration, which in turn compromises patient care and increases stress for all parties. A team that does not function as a cohesive unit, with clear and respectful processes for distributing work, is a team at risk of failures in care [29].

5. The Blurred Boundaries: The Pervasive Crisis of Role Clarity

5.1 The Dissonance Between Formal and Enacted Roles

At the core of the challenges facing Health Care Assistants is a profound lack of role clarity, a disconnect that exists between the formal definition of their job and the reality of their daily practice. Formal job descriptions for HCAs are often generic, outdated documents created by human resources departments with limited clinical input. They tend to list broad categories of duties (e.g., "assist with patient care," "maintain a clean environment") without specifying scope, limitations, or competency requirements. In contrast, the enacted role on the hospital floor is shaped by immediate service pressures, the preferences of individual nurse managers and RNs, and historical unit norms. Consequently, an HCA in

one ward may routinely perform venepuncture and catheter care, while an HCA with the same job title in a neighbouring ward is strictly prohibited from doing so [30, 31]. This inconsistency creates confusion and professional insecurity. HCAs are left to navigate their boundaries shift by shift, unsure whether a requested task is within their remit, fearful of overstepping but also anxious about appearing uncooperative if they refuse. This ambiguity places them in legally and professionally vulnerable positions, as they may be performing activities for which they have not been assessed as competent and for which their employer may not provide indemnity.

5.2 Scope Creep and Accountability Gaps

The phenomenon of "scope creep"—the gradual, unplanned expansion of role boundaries—is particularly pronounced for HCAs. As RN roles have expanded into more advanced clinical areas, there has been a concomitant and often unofficial pushing of traditional nursing tasks down to the HCA level. This transfer is frequently driven by necessity on busy shifts rather than by strategic workforce planning. The danger of this ad-hoc expansion is that it occurs without parallel investment in three critical areas: standardized education and certification for the new tasks, clear legal and professional guidelines defining accountability, and appropriate adjustments to remuneration and status [32]. The accountability gap is the most perilous aspect. In most jurisdictions, the legal principle of "vicarious liability" holds the registered nurse (or employer) ultimately accountable for tasks they delegate, provided they have delegated appropriately to a competent individual. However, in an environment of chronic role ambiguity, the lines are blurred. HCAs may feel a moral obligation to perform a task when asked by a busy RN, even if they are unsure of their competency, creating a situation where they bear the practical risk without the formal authority or protection. This gap undermines the entire foundation of safe delegation and professional practice [33, 34].

5.3 Interprofessional Confusion and Tension

Role ambiguity does not exist in a vacuum; it directly fuels confusion and tension within the multidisciplinary team. Registered nurses are often uncertain about the full range of tasks they can legitimately delegate to HCAs on their particular unit. This uncertainty leads to inconsistency: one nurse may delegate a task freely, while another may never delegate the same task, leaving HCAs

confused about the "real" rules. Other professionals, such as physiotherapists or junior doctors, may also be unclear about the HCA's role, making requests or giving instructions directly that may be inappropriate or outside the HCA's scope [35]. This interprofessional confusion breeds frustration on all sides. HCAs feel disrespected and used when they receive conflicting instructions. RNs feel frustrated when HCAs cannot or will not perform tasks they believe are part of the assistant's role. This tension is detrimental to collaborative practice. Effective teamwork requires mutual understanding of each member's unique contribution, expertise, and limitations. When roles are opaque, collaboration is replaced by negotiation, conflict, and inefficient patterns of work where tasks are either duplicated or left undone because each professional assumes it is the other's responsibility [36].

5.4 Effects on Professional Identity and Job Satisfaction

The cumulative impact of persistent role ambiguity is a weak or negative professional identity for HCAs. A clear, valued, and understood role is a cornerstone of professional pride and satisfaction. When HCAs are unsure of what is expected of them, when their responsibilities shift unpredictably, and when their contributions are not formally recognized as distinct and valuable, they struggle to develop a strong sense of professional self. They may describe themselves simply as "just an aide" or "a pair of hands," internalizing their low status within the hierarchy [37]. This weak identity has direct consequences. It is associated with lower levels of job satisfaction, organizational commitment, and engagement. HCAs who do not feel a clear sense of purpose and place within the care team are more likely to view their work as a mere job rather than a vocation, increasing their susceptibility to burnout and their likelihood of leaving for other employment [38]. Furthermore, a lack of professional identity stifles advocacy. HCAs who do not see themselves as legitimate members of the clinical team are less likely to speak up about patient safety concerns, suggest improvements to care processes, or advocate for their own needs for training and support, perpetuating a cycle of silence and marginalization [39].

6. The Interconnected Web: How Workload, Allocation, and Clarity Influence Each Other

6.1 A Vicious Cycle of Dysfunction

The challenges of workload, task allocation, and role clarity are not isolated issues; they form a

tightly interlinked and self-reinforcing system of dysfunction within hospital wards. This interplay creates a vicious cycle that is difficult to break. It often begins with **excessive workload** driven by high patient acuity and understaffing. This overload pressures registered nurses to delegate tasks more rapidly and with less context, worsening the quality of **task allocation**. Simultaneously, the overwhelming volume of work forces HCAs to take on any task presented to them just to keep pace, blurring role boundaries and eroding **role clarity**. As role clarity diminishes, inefficient work patterns emerge. HCAs, uncertain of their remit, may either inappropriately perform tasks they are not prepared for (creating safety risks) or waste time seeking clarification for every request. This inefficiency further increases the perceived **workload** for both HCAs and RNs, as coordination becomes more burdensome. The RN, now even more pressured, resorts to even more inequitable and opaque **task allocation**, favouring HCAs they perceive as "no-fuss," which breeds resentment and team discord. This discord further muddies communication about roles and responsibilities, deepening **role ambiguity**. The end result is a stressed, demoralized team delivering fragmented, risky care, which in turn leads to poorer patient outcomes, higher staff turnover, and even greater staffing shortages, thus restarting and intensifying the cycle at the point of crippling **workload** [40, 41].

6.2 The Impact on Patient Safety and Care Quality

The convergence of these three factors creates a perfect storm for patient safety incidents. Consider a scenario: An overworked HCA (high **workload**) is assigned by a harried nurse to monitor post-operative vital signs for several patients via a fragmented, task-oriented system (poor **task allocation**). The HCA is unsure if they are authorized to perform a basic neurological assessment on a patient who seems drowsy (low **role clarity**). Burdened with other tasks, they decide to just record the numbers and move on, assuming the nurse will check the patient. The nurse, overwhelmed with medication rounds, does not review the trends in time. This chain of failures—rooted in systemic issues of workload, allocation, and clarity—can lead to a delayed response to clinical deterioration. More broadly, the quality of fundamental care—hygiene, nutrition, mobility, comfort—which is the HCA's primary domain, suffers profoundly when this triad is out of balance. Rushed care due to overload leads to missed turns, incomplete hygiene, and inadequate

feeding. Inequitable allocation means some patients may receive inconsistent attention. Role ambiguity means HCAs may not feel empowered to spend the extra time providing emotional support or noticing subtle changes, as these "soft" skills are often not explicitly valued in their ambiguous role definition. The patient experience is thus directly degraded by this operational dysfunction [19, 20].

7. Strategies for Resolution: Building a Sustainable and Effective Model

7.1 Implementing Structured Workload Management Tools

Breaking the cycle requires deliberate, systemic intervention, starting with the management of workload. Hospitals must move beyond simple headcounts to implement validated patient acuity/dependency tools that are specifically designed to calculate the required HCA hours based on direct patient care needs. These tools should account for the full spectrum of HCA work: physical care, clinical monitoring, emotional support, and non-direct duties. The output must directly inform shift-by-shift staffing decisions, with a mechanism for real-time adjustment if acuity changes. Furthermore, workload management must encompass the physical environment. Mandatory, comprehensive safe patient handling programs with modern lifting equipment are not an optional luxury but a necessity to reduce injury-related absenteeism. To address psychological load, institutions must provide structured support, such as facilitated debriefing sessions after critical incidents, access to employee counselling services, and formal training in communication and resilience skills. Recognizing and legitimizing the emotional labour of HCAs is a critical step in reducing burnout [11, 16].

7.2 Designing Equitable and Transparent Task Allocation Systems

The informal "who's free?" model must be replaced with formal, transparent systems. One effective approach is the adoption of **patient allocation or partnership models**, where each HCA is assigned to a specific small group of patients for the duration of a shift, working in partnership with one or two RNs. This model promotes continuity, holistic understanding, and clear accountability. It allows the HCA to plan and prioritize care for "their" patients and builds therapeutic relationships. For this to work, assignment must be made equitably using the acuity data, and teams (RN+HCA) should be maintained consistently to build rapport.

Secondly, the process of delegation must be formalized through tools like **SBAR (Situation, Background, Assessment, Recommendation) for delegation**. When an RN requests a task, they should provide a brief context: *Situation* (what is needed), *Background* (why it is important for this patient), *Assessment* (what to look for), and *Recommendation* (when and to whom to report). This structured communication ensures safety, demonstrates respect, and integrates the HCA into the clinical thought process. Regular team huddles at the start and middle of shifts can also be used to collectively review patient needs and distribute tasks visibly and fairly [22, 27].

7.3 Establishing Clear, Standardized, and Respected Roles

Achieving role clarity requires a multi-level intervention. At the **national or regional level**, there is a strong argument for the formal regulation of the HCA role, including a standardized title, a defined and consistent scope of practice, mandatory minimum training and competency standards, and a requirement for registration. This would elevate the profession, protect the public, and provide a clear framework. At the **organizational level**, hospitals must develop precise, unit-specific job descriptions created in collaboration with practicing RNs and HCAs. These documents must delineate core duties, extended skills (with required certification), and absolute limitations. This must be paired with a robust **competency-based education and credentialing system**. Any task outside the core role requires formal training, supervised practice, and a sign-off process before an HCA can perform it independently. This closes the accountability gap and ensures safe expansion of scope. Finally, at the **team level**, role clarity must be actively negotiated and reinforced. Interprofessional education sessions where RNs and HCAs jointly explore scenarios of delegation and collaboration can build mutual understanding. Clearly visible role description boards in staff rooms and the inclusion of HCAs in patient care planning meetings can continually reinforce their valued and distinct place on the team [30, 34, 38].

7.4 Leadership, Culture, and Measurement

Sustainable change requires committed leadership and a cultural shift. Nurse managers and hospital executives must champion the professionalization of the HCA role. This includes advocating for competitive wages that reflect their expanded responsibilities, creating clear career progression pathways (e.g., to senior HCA or into nurse

training), and publicly recognizing their contributions. The culture must shift from one of hierarchy and task-orientation to one of teamwork, mutual respect, and patient-centeredness. Furthermore, what gets measured gets managed. Hospitals need to track metrics beyond just staffing numbers: HCA turnover and vacancy rates, injury rates, scores on role clarity and job satisfaction surveys, and patient outcome measures sensitive to nursing care (e.g., pressure ulcer rates, fall rates). These data should be used to drive continuous quality improvement in the deployment and support of the HCA workforce [39, 41].

8. Conclusion

The Health Care Assistant is an indispensable, yet frequently undervalued and systematically undermined, pillar of the modern hospital. Their daily work embodies the core of patient-centered care—the comforting touch, the vigilant observation, the fundamental act of preserving dignity. However, this essential contribution is jeopardized by a toxic interplay of excessive workload, chaotic task allocation, and profound role ambiguity. This triad does not merely represent operational inefficiencies; it constitutes a critical risk to patient safety, a primary driver of staff burnout and attrition, and a fundamental barrier to achieving high-quality, compassionate healthcare. As this analysis has demonstrated, these challenges are deeply interconnected, each one exacerbating the others in a vicious cycle that degrades both the working life of the caregiver and the care experience of the patient. Addressing them in isolation is futile. Reducing workload without fixing allocation merely redistributes chaos. Clarifying roles without managing workload sets up unrealistic expectations. The solution must be integrated and systemic. It requires a fundamental rethinking of how HCAs are conceptualized within the healthcare system: not as unskilled labour to be deployed reactively, but as a skilled, distinct, and regulated professional group that requires deliberate investment, clear boundaries, and structured support.

The path forward is clear, though not easy. It involves the implementation of acuity-based staffing, the adoption of patient-allocated partnership models, the standardization and regulation of the role, and above all, a cultural commitment to valuing the work of caring itself. Investing in the workload management, fair allocation, and role clarity of Health Care Assistants is not merely an act of staff welfare; it is a direct investment in patient safety, care quality, and the overall resilience of our hospital systems.

The time has come to move this critical workforce from the periphery to the center of healthcare strategy, ensuring that those who provide the most intimate care are empowered, supported, and clear in their vital purpose.

Author Statements:

- **Ethical approval:** The conducted research is not related to either human or animal use.
- **Conflict of interest:** The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper
- **Acknowledgement:** The authors declare that they have nobody or no-company to acknowledge.
- **Author contributions:** The authors declare that they have equal right on this paper.
- **Funding information:** The authors declare that there is no funding to be acknowledged.
- **Data availability statement:** The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

References

- [1] Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation. *Ann Intern Med.* 2018;169(7):467–473.
- [2] World Health Organisation. Task Shifting: Global Recommendations and Guidelines. In: Services HSa, editor. Geneva, Switzerland: WHO Document Production Services; 2008. p. 80.
- [3] Lizarondo L, Kumar S, Hyde L, Skidmore D. Allied health assistants and what they do: a systematic review of the literature. *J Multidiscip Healthc.* 2010;3:143–153.
- [4] Baratto MAM, Seidel EJ, Morais BX, Munhoz OL, Silva SCd, de Souza MCZTSB. Patient safety culture: perspective of health and support workers. *Acta Paul Enferm.* 2021;34(4):1–8.
- [5] World Health Organisation. Global strategy on human resources for health: Workforce 2030. In: Assembly tWH, editor. Geneva, Switzerland: WHO Document Production Services; 2016.
- [6] Munn ZA-O, Peters MDJ, Stern C, Tufanaru C, McArthur A, Aromataris E. Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach.
- [7] Griffiths P, Maruotti A, Recio Saucedo A, Redfern OC, Ball JE, Briggs J, et al. Nurse staffing, nursing assistants and hospital mortality: retrospective longitudinal cohort study. *BMJ Qual Saf.* 2019;28(8):609–617.
- [8] Cavendish C. The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings. online: Department of Health and Social Care; 2013 10 July 2013.
- [9] World Health Organization. Strengthening quality midwifery education: WHO meeting report, July 25–26, 2016. Switzerland: World Health Organization; 2017. Contract No.: WHO/FWC/MCA/17.12.
- [10] Chapman SA, Blash LK. New roles for medical assistants in innovative primary care practices. *Health Serv Res.* 2017;52(Suppl 1):383–406.
- [11] Fitzgerald L, Gathara D, McKnight J, Nzinga J, English M. Are health care assistants part of the long-term solution to the nursing workforce deficit in Kenya? *Hum Resour Health.* 2020;18(1):79.
- [12] Gerdtz MF, Nelson S. 5–20: a model of minimum nurse-to-patient ratios in Victoria, Australia. *J Nurs Manag.* 2007;15(1):64–71.
- [13] Vaughan S, Melling K, O'Reilly L, Cooper D. Understanding the debate around regulation of support workers. *British Journal of Nursing.* 2014;23(5):260–263.
- [14] World Health Organization. State of the world's nursing 2020: investing in education, jobs and leadership. Geneva: WHO; 2020. Contract No.: Licence: CC BY-NC-SA 3.0 IGO.
- [15] Ministry of Health Kenya. Kenya Health Workforce Report: The Status of Healthcare Professionals in Kenya, 2015. In: MOH, editor. Nairobi: The Task Force for Global Health; 2015.
- [16] The roles and impact of ward assistants on patient care in hospital settings: a scoping review protocol. *Open Science Framework.* 2022.
- [17] Beavis J, Davis L, McKenzie S. Clinical supervision for support workers in paediatric palliative care: a literature review. *Clin Child Psychol Psychiatry.* 2021;26(1):191–206.
- [18] Peters MDJ, Godfrey C, Mclnerney P, Munn Z, Tricco AC, Khalil H. Chapter 11: Scoping Reviews. 2020. In: JBI Manual for Evidence Synthesis. JBI. 2020.
- [19] Zeytinoglu IU, Denton M, Brookman C, Plenderleith J. Task shifting policy in Ontario, Canada: does it help personal support workers' intention to stay? *Health Policy.* 2014;117(2):179–186.
- [20] Deller B, Tripathi V, Stender S, Otolorin E, Johnson P, Carr C. Task shifting in maternal and newborn health care: key components from policy to implementation. *Int J Gynaecol Obstet.* 2015;130(Suppl 2):S25–31.
- [21] Aromataris E, Munn Z, editors. JBI Manual for Evidence Synthesis. 2020 ed. JBI; 2020.
- [22] The World Bank. World Bank Country and Lending Groups. Data. 2021.
- [23] World Health Organization. Global Strategy on human resources for health: workfoce 2030. In:

- WHO, editor. Geneva, Switzerland: WHO Document Production Services; 2016.
- [24] Mijovic H, McKnight J, English M. What does the literature tell us about health workers' experiences of task-shifting projects in sub-Saharan Africa? a systematic, qualitative review. *J Clin Nurs*. 2016;25(15–16):2083–2100.
- [25] Peters MDJ. In no uncertain terms: the importance of a defined objective in scoping reviews. *JB Evid Synthesis*. 2016;14(2):1–4.
- [26] Dawson AJ, Buchan J, Duffield C, Homer CS, Wijewardena K. Task shifting and sharing in maternal and reproductive health in low-income countries: a narrative synthesis of current evidence. *Health Policy Plan*. 2014;29(3):396–408.
- [27] World Health Organization. Health workforce requirements for universal health coverage and the sustainable development goals. Geneva: WHO; 2016.
- [28] Hewko SJ, Cooper SL, Huynh H, Spiwek TL, Carleton HL, Reid S, et al. Invisible no more: a scoping review of the health care aide workforce literature. *BMC Nurs*. 2015;14:38.
- [29] Thornley C. A question of competence? Re-evaluating the roles of the nursing auxiliary and health care assistant in the NHS. *J Clin Nurs*. 2000;9(3):451–458.
- [30] World Health Assembly 53. The World Health Report 2000: health systems: improving performance. WHO; 2000 29 March 2000. Contract No.: A53/4.
- [31] LUMIVERO, QSR International. NVIVO. In: Lumivero, editor. QSR International; 2023.
- [32] Gray MF, Coleman K, Walsh-Bailey C, Girard S, Lozano P. An-expanded-role-for-the-medical-assistant-in-priamary-care: evaluating a training pilot. *Perm J*. 2021;25(4):1–9.
- [33] Barken R, Denton M, Plenderleith J, Zeytinoglu IU, Brookman C. Home care workers' skills in the context of task shifting: complexities in care work. *Can Rev Sociol*. 2015;52(3):289–309.
- [34] Gathara D, Serem G, Murphy GAV, Obengo A, Tallam E, Jackson D, et al. Missed nursing care in newborn units: a cross-sectional direct observational study. *BMJ Qual Saf*. 2020;29(1):19–30.
- [35] 75th World Health Assembly. Seventy-fifth World Health Assembly - Daily update: 27 May 2022 [who.int/news](https://www.who.int/news); WHO; 2022.
- [36] Drennan IR, Blanchard IE, Buick JE. Opportunity for change: is it time to redefine the role of paramedics in healthcare? *Can J Emerg Med*. 2021;23(2):139–140.
- [37] Blay N, Roche MA. A systematic review of activities undertaken by the unregulated nursing assistant. *J Adv Nurs*. 2020;76(7):1538–1551.
- [38] Joanna Briggs Institute. Critical Appraisal Tools. Joanna Briggs Institute; 2020.
- [39] EndNote. EndNote 20. Clarivate; 2022.
- [40] Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ*. 2021;372:n71.
- [41] Needleman J, Shekelle PG. More ward nursing staff improves inpatient outcomes, but how much is enough? *BMJ Qual Saf*. 2019;28(8):603–605.