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WHAT TYPES OF CONTINUING PROFESSIONAL DEVELOPMENT TRAINING COURSES DO HEALTHCARE ASSISTANTS EMPLOYED IN COMMUNITY CARE SETTINGS THINK SHOULD BE CONDUCTED FACE-TO-FACE OR ONLINE?

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ABSTRACT: ***Aim:*** *This study was undertaken to explore what types of continuing professional development (CPD) clinical training courses Healthcare Assistants think should be conducted by face-to-face or online methods.*
Methodology: *A purpose-built piloted questionnaire was utilised to collect data. A total of 71 completed questionnaires were included in the data analysis. The participants were all consenting adults aged between 20 - 61 years.*

Results: *The face-to-face learning method was thought of as the preferred method by 45/71 (63%) of the participants while 9/71 (14%) of the participants thought of online learning as their preferred method. Interestingly, 17/71 (23%) thought of blended learning as their preferred method. Among 20 popular CPD courses, participants preferred 16/20 (80%) for the face-to-face training method and 3/20 (15%) of the courses for online training methods. There was an equal preference for 1/20 (5%) course.*

Conclusion: *The face-to-face training/learning method remains the dominant preference for HCAs, but online training/learning is gaining popularity, especially among younger computer-literate learners. A blend of the two methods may satisfy proponents of traditional teacher-centric training/learning styles on one hand and those supporting digitally aided student-centric training/learning on the other.*

KEYWORDS: CPD, Healthcare Assistant, Blended, Face-to-face, Online learning, Support Worker.

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INTRODUCTION

Continuing Professional Development.

Continuing professional development (CPD) according to The Chartered Institute of Personnel and Development (CIPD, 2024), has been defined as learning experiences that develop and improve employees' professional practice. This includes building on employees' strengths and developing them where they have capability gaps in their knowledge and practice. CPD has also been ascribed other names including Continuing Professional Education (CPE), Continuing Nursing Education (CNE), and Lifelong Learning or LLL (Royal College of Nursing, RCN 2021). In healthcare, CPD is promoted because active participation in learning activities develops and maintains clinical competence thus enhancing safe professional practice.

In England, United Kingdom (UK), continuing professional development is a key requirement set by professional and regulatory bodies like the Nursing and Midwifery Council (NMC, 2018), Health and Care Professionals Council (HCPC, 2024); and other government bodies including the Care Quality Commission (CQC) that have regulatory powers to monitor health and social care organisations. The International Council of Nurses (ICN) in their code of ethics states that nurses must carry personal responsibility and accountability for ethical nursing practice and for maintaining competence by engaging in CPD and lifelong learning (ICN, 2021).

Generally, CPD training falls into two main categories – statutory and mandatory training. Mandatory training is compulsory training that is determined as essential by an organisation for the safe and efficient delivery of services as this aims to minimise risks by ensuring that agreed policies, guidelines, and regulatory frameworks are complied with by staff (RCN, 2022). Examples include Fire Awareness Training and specific clinical skills training including diabetes management, dysphagia awareness, epilepsy care, and medication management for HCAs.

Statutory training is those that an organisation must provide to its employees as required by law. Employers are obliged to provide their employees with the stipulated training based on a specific piece of legislation. For example, The Health and Safety at Work Act, 1974 and Management of Health and Safety at Work Regulations, 1999 stipulate the provision of CPD training on Infection prevention and control, sharps training, and spill kit training for all healthcare workers employed in acute and community-based nursing or care home institutions.

Rationale for this study

Research on the effectiveness of online learning compared to face-to-face learning for healthcare staff has focused more on higher education (Claudia *et al*, 2020), medical or paramedical training (Chumley-Jones *et al*, 2002; Suppan *et al* 2020), and registered nurse or midwifery training working in the acute care settings (Beckett, 2020; Ramos-Morcillo *et al*, 2020). There is a paucity of published research information on the study topic targeted at Healthcare Assistants (HCAs) especially those employed within the community in nursing or residential care homes.

When COVID-19 restrictions were imposed in the UK during the global pandemic, the mode of delivery of clinical CPD training was suddenly switched from face-to-face to online learning

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using virtual platforms to host/deliver courses. As the COVID-19 restrictions have been relaxed, questions are being asked whether CPD training for HCAs would return to pre-pandemic full-time face-to-face mode, continue with online training, or use a blended approach. Those HCAs who previously experienced mostly face-to-face training, have over the three years that COVID-19 restrictions were in place been exposed to online learning for completing their CPD training courses. Their perception as to which mode of learning HCAs should use needs to be explored as this will furnish CPD training providers and nursing care home managers valuable information to aid decisions in choosing the best learning delivery methods that will enhance learners' experience and promote knowledge transfer. Hence the key rationale for this study was to investigate the types of clinical CPD training that HCAs think should be conducted either face-to-face, online, or as a blend of the two.

LITERATURE REVIEW

Distance learning for delivery of CPD training

Online learning is a form of distance learning where the learner and the teacher may not be physically present at the same location but seamlessly interact in the learning process like they were in a face-to-face classroom. According to Dash *et al* (2022) and Dhawan (2020), distance learning has many benefits including its adaptability and interactivity aided with cleverly incorporated functionality tools.

Comparing face-to-face and online learning

The divide between face-to-face learning and online learning attracted researchers' attention during the COVID-19 pandemic under various themes including those comparing the learners' attitudes to both forms of course delivery, those comparing the learner-centredness, teacher-centredness or online-centredness of the learning experience and those comparing their advantages/benefits and the disadvantages/challenges to the learners (Regmi & Jone, 2020; Sadeghi, 2019 and Alsaaty *et al* 2016). These papers highlighted that there is no homogenous class or group of learners, especially adult learners and that by adopting an eclectic inclusive approach, learners will benefit from a more inclusive learning experience.

Online learning offers flexibility to learners, and it has been proven to be a convenient means of delivering learning to comparatively many more students at a particular given time (Gherhes 2021). With the right equipment including computer/laptop/mobile phone hardware and appropriate software, a learner can engage with online classes from anywhere if a reliably active internet connection is available. This makes it possible to offer CPD training to a wider reach of learners who would otherwise find it difficult to access learning besides face-to-face classes that require travel to a fixed venue outside the learners' home or workplace. Such learners would include those with physical disabilities (Berndt *et al* 2017), those with childcare responsibilities (Cheris, 2015), and those with personalities that make learning in large groups unsettling (McCutcheon *et al*, 2018). Learners with greater commuting distances to face-to-face training venues value the flexibility of online delivery (Cole *et al*, 2014; Williams 2006).

Possessing good information communication technology (ICT) skills is vital to achieving a positive experience in online learning sessions. Previous exposure to and having confidence in using electronic equipment effectively aids online learning engagement. This promotes a better

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online learning experience as it removes the fear factor, especially in those learners with minimal exposure to using modern electronic gadgets. Those learners with previously acquired ICT skills gained through work and/or academic learning experiences are well suited for online learning and self-directed study (Clement, 2020). They tend to report positive learning experiences on course feedback/evaluation. Generations Y and Z for example, are arguably savvy online learners as these millennial learners have grown up with ICT and have in the process mastered the skills of the ever-growing electronic gadgets technology to engage with and complete tasks virtually ranging from everyday activities like personal online banking or shopping but also including supervised or self-directed CPD mandatory/statutory courses (Kuleto *et al*, 2021). For such learners, the online format can provide an acceptable alternative to face-to-face learning thus allowing learners to study from the comfort of their homes (Ozerbas and Erdogan, 2016).

However, O'Doherty (2018) cautioned that though online learning offers many benefits with multiple applications, it comes with challenges that need to be addressed to maximise the highlighted benefits. They cite that as learners and teachers are located at a distance, the learner may easily become distracted, lose concentration, and become demotivated which can affect their learning or the achievement of the taught competency. Lemay *et al* (2021) assert that positive online learning correlates with reliable technology the learner is using, especially internet connectivity and familiarity with the learning platform being used. In the UK, internet connectivity though dependable, has remained quite variable across regions depending on infrastructural development and the service provider capabilities. Over the years, telecommunication providers have erected effective transmission masts and laid down communication cables including fibre optics throughout the country. The bigger urban cities like London, Birmingham, Liverpool Glasgow, Cardiff, and Belfast now have strong/reliable internet signals as wireless and fibre optics technology have become widely available there. In smaller towns or rural communities where many HCAs may reside, the reliability of internet connectivity can pose a challenge and those learners residing there may struggle to get reliable internet connections resulting in frustration and negative learning experience.

Other obstacles to online learning relate to its impact on the physical and mental health of learners and teachers. Fleming and Mills (2017) describe four key learning styles used in education - visual, aural, read/write, and kinesthetics. These are popularly abbreviated as VARK. In online learning the teacher makes greater use of the visual, aural, and read/write styles - displaying prepared slides on a screen and using his/her voice on the microphone. This means learners remain sedentary in their seats for longer periods in front of the display screen/monitor. The long sitting sessions can lead to boredom (Akpina, 2021) and cause back or joint pains in some learners (Baltà-Salvador *et al* 2021), while the long staring at display screens/monitors can lead to eye/sight complications and mental health issues including depression or stress in both the learners and their teacher **(**Azmi *et al*, 2022).

STUDY DESIGN

This was a cross-sectional study undertaken to explore what types of clinical training HCAs think should be conducted either face-to-face or online. The target population was those HCAs employed in community-based institutions such as nursing/residential care homes in England. A piloted questionnaire created using Microsoft Forms® was used to collect data. Generally, questionnaires have been used as data collection tools to capture both qualitative and

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quantitative data in healthcare research (Rowley, 2014). The main advantages of questionnaires are cost-effectiveness, the possibility of anonymity as they could be self-administrated without the presence of the researcher and generate data that is comparatively uncomplicated to collate or analyse (Polit & Beck, 2021 and Moule, 2021).

This study aimed to explore:

- What is the perception of HCAs about the effectiveness of face-to-face compared to online learning on:
    - Increasing participants' clinical skills knowledge.
    - Increasing participants' theoretical knowledge.
    - Increasing participants' confidence to apply the clinical skills learned in the classroom in their clinical work settings.
- What are the participants' preferred methods of CPD course delivery?
- What courses out of twenty (20) popular CPD courses should be offered face-to-face or online?

Participants population and sample size.

The selected study population was adult HCAs who were employed in a community-based healthcare institution. HCA is a generic job title and includes carer, support worker, auxiliary nurse or nursing assistant but excludes registered nurses (RNs) on or waiting to join the Nursing and Midwifery Council (NMC) register. The potential recruits were identified from attendance registers for learners who have completed either face-to-face or online clinical skills training sessions contracted by registered nursing/care homes or General Practitioners (GP) for their staff and conducted by an employed Clinical Trainer. The study period was between January and September 2023. A non-probabilistic convenient target sample size of one hundred participants was initially agreed upon. However, 71/100 (71%) fully completed questionnaires were returned in the stipulated period. This represents above the 30 - 70% threshold which is considered as a good response rate for online questionnaires in social research (de Vaus, 2014).

Ethics Committee approval process and consent.

The University of Cumbria Research Ethics Committee approval was sought and granted for this work. The author’s employer also granted permission to proceed with the data collection work. As participants' personal data was going to be collected, strict adherence to the relevant regulation which is Regulation 2016/679 of the UK General Data Protection Regulation (GDPR, 2018) was observed. All the participants were required to give their voluntary informed consent for participation in this study. This was facilitated by providing the participants with adequate information about the study (approved participant information leaflet), providing adequate opportunity for the participants to consider the options of participating or not to participate and responding to participants' questions. Obtaining the participants' voluntary agreements prior to enrolling them in research involving human subjects is mandatory (Gov.uk, 2018).

Study participants' recruitment process and sampling technique.

This study was restricted to a single private healthcare provider in south-east England, UK. It was advertised in the author’s employer’s staff information bulletin and at training meetings.

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The study documents including the participants' information sheet, consent form and the study questionnaires were made available to potential recruits at training sessions and online.

Data protection considerations.
All participants' information was treated in strict adherence to the GDPR (2018) regulation. When participants submitted their completed questionnaire online, the form was automatically deposited into a secure password-protected folder on a multi-factor authentication (MFA) secure storage platform at the author's work head office without any link or connection with the email address of the participant. This is important to maintain anonymity and prevent the researcher from contacting the participant to exert any undue influence on the participant.

RESULTS

Data in this study was analysed using the IBM SPSS package (Version 29.0.2.0). A total of seventy-one (71) consenting adult participants completed and returned the study questionnaires which met the full inclusion criteria. The biographic details of the study participants are displayed in **Table 1.** Of these, 54 (76%) participants self-reported their gender as female, 16 (23%) participants as male, and 1 (1%) participant preferred not to state their gender.

Table 1.

Study Participants' Biographic Details.

Variable	Category	Frequency n=71	Percentage (% = 100)
Gender	Female	54	76
	Male	16	23
	Preferred not to say	1	1
Age (years)	20 – 30	15	21
	31 – 40	24	34
	41 – 50	12	17
	>50	20	28
Length of Employment (years)	1 – 5	54	76
	6 – 10	14	20
	>10	3	4
Job Title	Carer	24	34
	Health Care Assistant	33	46
	General Practice Assistant	4	6
	Support Worker	10	14

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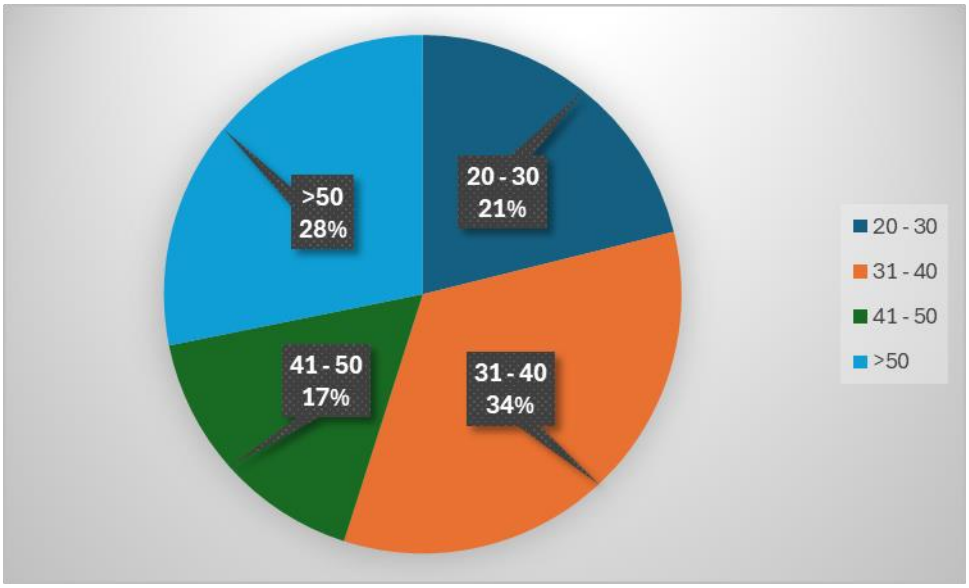
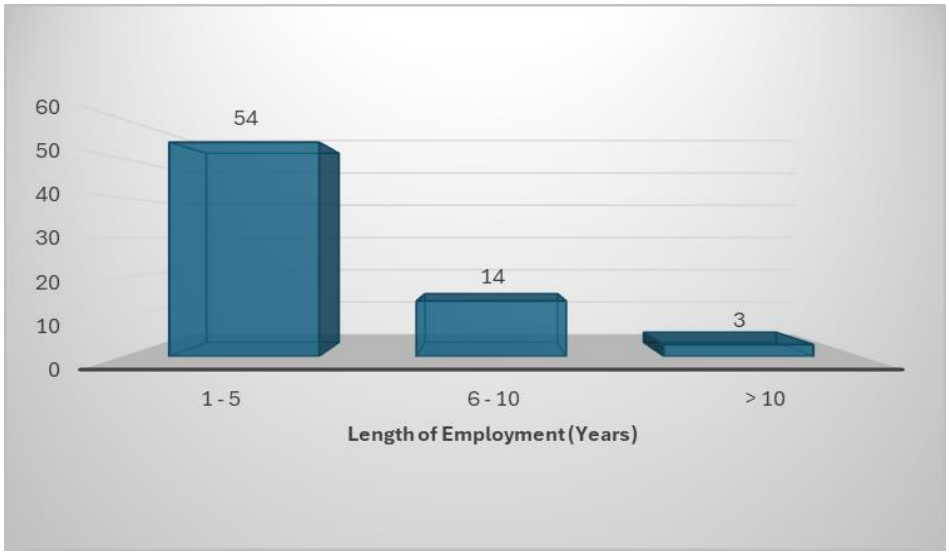
The ages of the participants ranged from 20 to 61 years with a median of 38 years. When these ages were grouped into four convenient categories of 20 – 30 years, 31 – 40 years, 41 – 50 years, and > 50 years, the proportional representations of these age groups were calculated as 21%, 34% 17%, and 28%, respectively as displayed in **Graph 1**.



Graph 1: Age distribution of participants (Years).

The employment history of the participants ranged from 2 weeks (Carer) to 23 years (Senior Healthcare Assistant). When the length of participants' employment (in years) was grouped into three convenient categories, a greater number 54/71 (76%) of the participants have been employed between 1 – 5 years in their care job role with 14/71 (20%) employed for 6 – 10 years while 3/71 (4%) were employed for more than 10 years. The results of participants' length of employment are displayed in **Graph 2.**



Graph 2: Participants' length of employment.

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Information and Communication Technology (ICT) Competency

The various variables relating to all the recruited participants' ICT skills are summarised and presented in **Table 2** below.

Table 2.

Study participants' IT Competence Variables.

Variable	Category	Frequency N=71	Percentage %=100
IT competency	Full IT competency	28	39
	Moderate IT competency	39	55
	Minimal IT competency	4	6
Previous IT training	Yes	38	54
	No	33	46
IT equipment ownership	Employee-owned	46	65
	Employer-provided	25	35
Preferred online learning platform	MS Teams	9	12
	Zoom	29	41
	Both	34	47
IT equipment used	Mobile phone	23	33
	Laptop/Tablet	25	35
	Projected on a TV	8	11
	Desktop	15	21
Accessed Training venue	At home using my own device	37	52
	At home using work provided device	6	8
	At work using my own device	11	16
	At work using work provided device	17	24

Of the 71 participants, 28/71 (39%) said they had full IT competency which meant the participant could use digital equipment to log on and complete either tutor-led or online CPD learning unaided. Another 39/71 (55%) self-assessed themselves as possessing moderate ICT proficiency while 28/71 (39%) reported having full ICT proficiency. Moderate proficiency means a participant possesses essential computer skills including the ability to switch on the computer and, a basic understanding of emails or word processing but requires some assistance to engage with online learning platforms. The remaining 4/71 (6%) reported having minimal

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IT competency. Minimal competence in this context meant only being able to use the mobile phone to make calls and send/receive text messages and would require assistance with logging on or interacting with a learning platform for CPD learning purposes.

The participants' ICT needs were assessed through the ownership of ICT equipment/devices and the venue where the learners accessed the CPD training. This showed that 46/71 (65%) of the employee HCAs privately/personally owned the electronic devices used while 25/71 (35%) used their employers' provided devices. Furthermore, 43/71 (61%) of the participants accessed the training from their homes, which saved them the travel/commuting time to a training venue. Some 28/71 (39%) of the participants logged on to the CPD training at their work venue, with some participants moving straight from the 10-hour night duty shift and deciding to stay at their workplace to complete their statutory/mandatory CPD training before travelling home. Reasons given for this included internet challenges at home, making use of a dedicated IT support staff at work, not having time to allocate for the CPD study when they get home because of other competing needs on their time, and wanting to get the CPD training completed to avoid a query from their manager.

To support employees, HCA-employing organisations now include ICT training as part of staff induction programs including additional ongoing ICT development training. In this study, 38/71 (54%) participants reported having no previous ICT training while 33/71 (46%) reported that they had previous ICT training. However, all HCAs were allocated online training sessions and expected to engage with and complete these training sessions.

Various online platforms have sprung up to assist virtual delivery of CPD courses. Two online platforms used for course delivery were MS Teams® developed by Microsoft as part of their Microsoft 365® family of products and Zoom Meetings® developed by Zoom Video Communications®. Both MS Teams® and Zoom Meetings® applications software can be downloaded and installed on desktop computers and mobile devices including laptops, tablets, Android phones, or Apple iPhones. There are other online platforms available but were not used in this study. Preference for the two online platforms used showed that 9/71 (12%) of participants preferred MS Teams®, 29/72 (41%) preferred Zoom®, and 34/71 (47%) participants preferred using both to complete their CPD training. In some cases, participants logged on with a laptop device and then projected the training session on a television with a larger screen rather than using the computer devices with smaller screens.

Direct Comparisons of Face-to-face and Online Training.

Participants were asked three questions with the aim to directly compare face-to-face training and online training using a 5-point Likert scale. This scale was built on an increasing strength of likelihood with a score of 1 representing the lowest and 5 the highest. A score of 3 was the median.

The first comparison question asked participants about the effect of the training delivery method on increasing their clinical skills knowledge. The interquartile range (IQR) for face-to-face was 4 (3, 5), and for online: 5 (4, 5). Using the Wilcoxon signed rank test *($z = -5.272$)* showed that the online training recorded a better understanding of clinical skills, and this was highly statistically significant, $p < 0.0001$.

The second comparison question asked the participants about the effect of the training delivery method on increasing their theoretical knowledge. The IQR for face-to-face was 5 (4, 5), and

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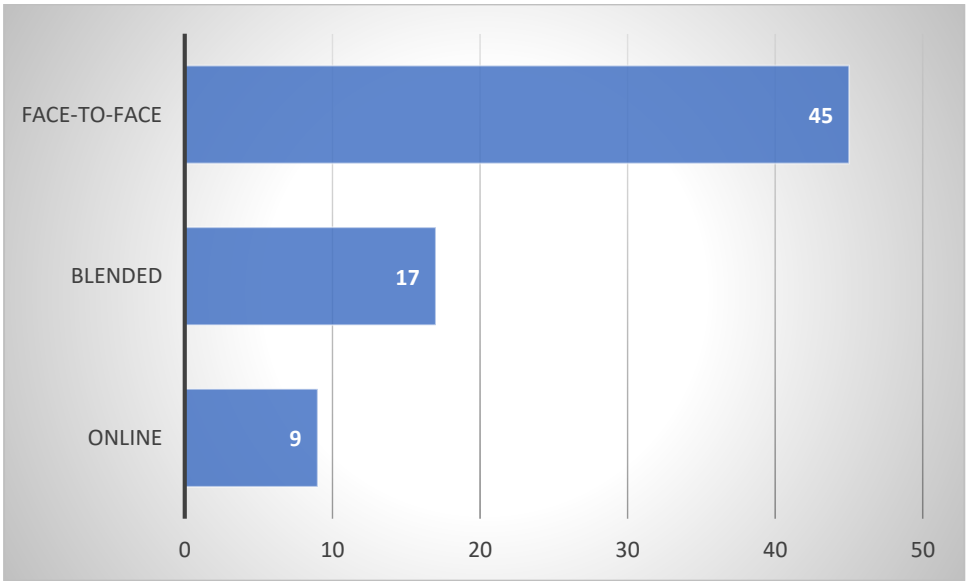
for online 4 (3, 5). Using the Wilcoxon signed rank test *(z = 4.993)* showed that the face-to-face training gave a better understanding of theoretical knowledge, which was highly statistically significant, $p < 0.0001$.

The third question asked participants about the effect of the training delivery method on increasing their confidence to apply the clinical skills learnt in the classroom in their clinical work settings. The IQR for face-to-face was 5 (4, 5), and for online 4 (3, 5). Using the Wilcoxon signed rank test *(z = 5.090)* showed that the face-to-face training participants led to better application of skills learnt and this was highly statistically significant, $p < 0.0001$.

Participants preferred the CPD course training method.

Participants were asked to indicate their preferred CPD course delivery method. The first question in this regard required the participants to indicate their preferred method of training between face-to-face, online, or blended learning. The participants' responses are displayed in **Graph 3**. A majority of participants preferred face-to-face training with 45/71 (63%) and 9/71 (13%) preferred online training. The face-to-face method was preferred over the online method by a ratio of 5:1 interestingly, 17/71 (24%) of the participants preferred a blended training method which is nearly twice more than online.



Graph 3: Participants preferred CPD course training method.

The second question asked the participants to choose their preferred CPD course training method for 20 of the most popularly booked CPD courses sourced by training managers from the author's employer. The responses are summarised in **Graph 4**. Most of the participants, 16/20 (80%) preferred the face-to-face training method as opposed to 3/20 (15%) preferring the online method. The three courses preferred for online delivery were Delirium Care, Nutrition & Hydration, and Safeguarding the Vulnerable Adults. There was an equal choice for 1 (5%) course (Infection Prevention and Control) in which 30 participants each chose face-to-face and online. Unfortunately, the participants were not able to state their reasons for the choices as closed questions were used, a limitation of the questionnaire.

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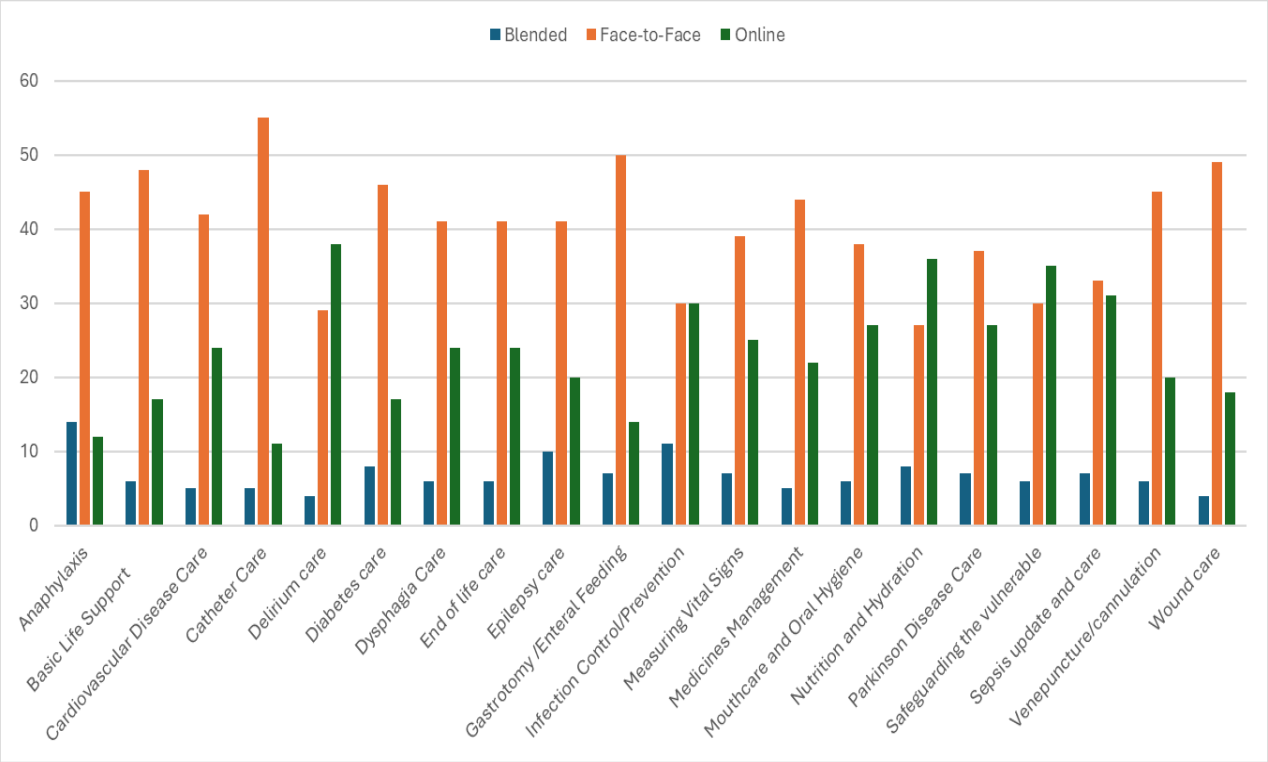

Graph 4: Participants' choice of CPD training method for 20 popular courses.

DISCUSSIONS

Comparing and contrasting face-to-face and online learning.

Historically, traditional face-to-face learning has proved useful for learner interaction with the teacher/trainer present in person, participants learning together with colleagues in person which promotes learner confidence, learners not worrying about IT/internet connection issues, promotes learner motivation to get to the venue and offering the learner an opportunity to practice, discuss or collaborate with other learners in a classroom setting supported by a teacher/trainer (Gherhes, 2021). However, though face-to-face learning has many advantages its limitations can be a challenge to some learners. These include incurring travel fare/time commuting to travel to CPD training venues, attendance times that may be inconvenient or restrictive, rigid schedules, intimidating classroom experiences that can bring back uncomfortable memories of school days for some and interfere with learners' work-life balance (Bucata, 2023).

The findings in this study showed that participants thought face-to-face training was their most popular choice. The results further showed that while online training recorded a statistically significantly better understanding of clinical skills taught, face-to-face training recorded a better understanding of theoretical knowledge and also led to better application of skills learned. Experience during the COVID-19 pandemic demonstrated that when face-to-face learning/training is severely restricted, other strategies like online learning/training could provide a viable alternative for clinical training. In this study, I have attempted to provide some initial findings on CPD training preferences of HCAs employed in community settings like care homes, nursing homes, or GP practices.

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With good planning, many CPD courses could be delivered to HCAs by the online method. Some of the challenges highlighted about online training in this study included inadequate ICT skills required to engage in effective online learning, availability or non-availability of the right electronic devices, and reliable internet connection. It was found that a significant number of the study participants 46/71 (65%) were using their personal ICT equipment i.e. Android phones, iPhones, laptops, tablets, or desktops to complete statutory and mandatory CPD courses. In the process, these learners may incur mobile telephone data connection charges/fees to access the internet. This disadvantages those learners who may not have appropriate electronic equipment or free access to internet connections to complete their online CPD courses from home. Training managers should therefore consider providing such HCA learners with protected time and computer facilities to enable them to complete their online CPD training.

Post the COVID-19 pandemic period, it is unlikely that employers will return to booking/delivering all required CPD courses for HCAs in full-time face-to-face mode. It also appears unlikely that CPD training will switch to full-time online training/learning mode. Some providers may opt to continue with online CPD courses while others will continue with face-to-face training/learning. It is more likely that an alternative medium may be adopted. That alternative medium lies in blended learning. Results in this study showed that although 63% thought face-to-face was their preference and 13% preferred online learning, a significant number of 24% thought of blended learning as their preference.

Online training methods have been shown to enhance learning as the learners can use ICT to record or make picture notes by engaging interactively within the sessions which are less intimidating for shy learners, promote learners' multi-tasking, remove the need to travel to a training venue with learners studying from the comfort of their homes (Reeves *et al*. 2017). However, with its dependence on ICT and internet connectivity, online learning has challenges, especially for HCAs residing in remote locations with poor telephony reception. The challenges recorded by participants with their online learning experiences included ICT issues making it difficult to access training (internet connection, device problems), comparative lack of learner motivation, less interaction with trainer/educator, social isolation from other learners, and learners may be situated inappropriate learning environment with distractions. These challenges may have been responsible for more of the participants choosing face-to-face learning as their preferred mode in this study.

CONCLUSION AND RECOMMENDATIONS

This study investigated what types of clinical training HCAs think should be conducted either face-to-face or online. The choice of the study topic was generated through undertaking a systematic literature review which highlighted a gap in the published research. There were few published primary research on the topic involving Healthcare Assistants especially those employed within community settings. Before the outbreak of the COVID-19 pandemic, CPD training was predominantly delivered via face-to-face method for HCAs. At the time when restrictions were imposed due to the global pandemic of COVID-19, alternative ways of CPD training delivery had to be implemented quickly. This was a steep learning curve for HCAs especially those with limited ICT skills or appropriate digital equipment.

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In summary, CPD training is a regulatory requirement for clinical skills validation and to demonstrate the maintenance of clinical skills competencies for safe practice. The face-to-face training/learning method remains the dominant preference for HCAs, but online training/learning is gradually gaining popularity, especially among younger computer-literate learners. A blend of the two methods may satisfy proponents of traditional teacher-centric or content-centric training/learning styles of pedagogy or andragogy on one hand and those supporting digitally aided student-centric training/learning of heutagogy on the other as society gradually edges into the digital era of Artificial Intelligence.

Study Limitations

This study was limited to a single private healthcare training provider and draws on participants from a limited population base. To make it more representative, participants from wider and more diverse groups including those employed in the private and public sectors would need to be recruited as study participants. Secondly, a non-probabilistic convenient sample was selected without statistical power analysis to determine the minimum required sample size. Hence a simple descriptive statistic strategy was used to analyse and summarise the research data.

Study significance and implications

Despite the above-mentioned limitations, this study provides a reasonably accurate assessment of face-to-face and online learning practices and associated factors in the study. The results generated in this study provide some initial findings that could be used to design further research studies that would produce findings that will offer guidance for Training Managers when they are choosing a mode of delivery for mandatory/statutory CPD or any other relevant clinical training for their Healthcare Assistant employees.

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