

Health Assistants at the Intersection of Patient Care and Health Security: A Theoretical Perspective on Professional Identity, Preparedness, and Integrated Practice

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ABSTRACT

Health assistants work where the ordinary continuity of patient care meets the exceptional demands of protection, disruption management, and emergency readiness. Yet their contribution is often described through narrow task lists that separate bedside support from health-security functions. This narrative-theoretical review develops an integrated account of Health Assistant - Health Care and Health Assistant - Health Security roles. It draws on patient-safety science, professional identity formation, workforce governance, human factors, resilience engineering, interprofessional collaboration, primary health care, infection prevention, and health-emergency preparedness. The review uses published scholarship and authoritative international frameworks for conceptual synthesis; it does not collect primary data, test hypotheses, calculate effects, or use statistical software. The synthesis identifies six connected functions: relational care, surveillance and early recognition, environmental protection, controlled access and safe flow, emergency support, and closed-loop escalation. Three mind maps organize the results around an Integrated Health Assistant Role Architecture, a Professional Identity Formation model, and a Preparedness and Resilience Cycle. The central argument is that the two designations should be integrated through shared purpose and interoperable routines while their authorization boundaries remain explicit. Professional identity becomes safer when assistants are recognized as accountable team members, receive role-specific supervision, understand the downstream consequences of their observations, and can speak up without being asked to perform outside competence. Preparedness is strengthened when routine care practices become the foundation for emergency action rather than a separate activity activated only during crises. The proposed Patient Care-Health Security Interface Framework

connects role clarity, competency assurance, communication, situational awareness, ethical safeguards, and organizational learning. It offers a theoretical basis for workforce policy, education, supervision, and future empirical evaluation in hospitals, primary care, public-health facilities, and other complex service environments.

Keywords: *Health Assistants; Patient Care; Health Security; Professional Identity; Emergency Preparedness; Integrated Practice; Patient Safety; Workforce Governance.*

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1. INTRODUCTION

Safe care depends on work that is clinically meaningful even when it is not classified as autonomous diagnosis or treatment. Health assistants help patients move, communicate, maintain comfort, follow instructions, reach services, and remain visible to the clinical team. Assistants assigned to health-security functions support controlled access, environmental awareness, safe movement, incident recognition, and orderly response. These responsibilities appear different when written as job descriptions, but they converge in the lived environment of care. A confused visitor, an agitated patient, an infectious exposure, an evacuation, a missing person, or a sudden surge can require care sensitivity and security discipline at the same moment.

The World Health Organization (WHO, 2021) frames patient safety as an organized system of activities rather than the absence of individual mistakes. The same systems logic underpins health security: capacities must detect threats, communicate information, coordinate action, and preserve essential functions. The International Health Regulations establish prevention, surveillance, notification, and response obligations for public-health risks that may cross borders (WHO, 2016). At facility level, these broad duties become practical routines involving identification, observation, infection prevention, access management, communication, escalation, and protection of continuity.

The conceptual difficulty is that role integration can be misunderstood in two opposite ways. Fragmentation treats the health-care assistant and health-security assistant as unrelated workers, allowing information and accountability to fall between them. Overexpansion assumes that integration authorizes each worker to perform all functions, thereby obscuring competence, licensure, and supervision. A defensible model must integrate purpose, communication, and preparedness while protecting scope boundaries. This article addresses that need through a theoretical synthesis focused on professional identity, preparedness, and integrated practice.

1.1 Aim and Review Questions

The aim is to explain how health-care and health-security assistants can form a coordinated workforce layer that strengthens safe, person-centered, and resilient services. The review asks: What is the distinctive contribution of each role? Which interfaces connect their work? How can professional identity support both belonging and boundary discipline? Which preparedness mechanisms convert routine observation into timely protective action? What governance arrangements make integration reliable without transferring responsibilities beyond competence?

1.2 Significance and International Relevance

Health systems are under simultaneous pressure from workforce shortages, service complexity, infectious hazards, violence, disasters, cyber and infrastructure disruption, misinformation, and public expectations of dignified care. WHO's workforce strategy emphasizes availability, accessibility, acceptability, and quality, while the Working for Health agenda links workforce investment to health-system resilience and socioeconomic development (WHO, 2016; WHO, ILO, & OECD, 2022). Assistants are relevant to each dimension because they expand the practical capacity of teams, connect patients with formal services, and often observe changes before professionals who interact intermittently.

International relevance does not imply that one job description can be exported unchanged. Titles, legal authority, training pathways, and employment arrangements vary widely. Healthcare support workers may provide direct personal care under delegation in one jurisdiction, facility support in another, or public-health outreach in a third. Health security may refer to emergency preparedness and population protection, to safety and security within healthcare facilities, or to a combination of both. The theoretical value of an interface model is therefore functional rather than occupational: it identifies what must

be achieved while allowing national regulators and employers to assign tasks appropriately.

This focus also corrects an imbalance in teamwork literature. Interprofessional frameworks often concentrate on regulated professions meeting in formal clinical forums. Important safety work, however, occurs in corridors, entrances, waiting areas, transport routes, isolation boundaries, and repeated bedside contacts. Workers positioned in these spaces may detect weak signals that are absent from the electronic record. Recognizing that knowledge does not erase hierarchy or accountability; it makes the system more capable of hearing and acting on relevant information.

1.3 Core Definitions

Patient care means supportive activities that preserve dignity, comfort, access, observation, and continuity under authorized plans. Health security means organized protection of people and essential health functions from hazards, including facility incidents and wider public-health emergencies. Integrated practice means coordinated contribution to a shared outcome through explicit boundaries and connected routines. Professional identity is the evolving understanding of who a worker is, what the role values, how it relates to others, and what responsible conduct requires. Preparedness is the continuous capability to anticipate, prevent, respond to, recover from, and learn about disruption.

1.4 Conceptual Boundaries

This paper does not redefine health assistants as nurses, emergency managers, infection-prevention specialists, law-enforcement personnel, or independent clinicians. Integration is not substitution. The safe assistant recognizes, protects, communicates, and escalates within authorization; the responsible organization defines when another professional must assess, decide, or intervene. The distinction is especially important when observations concern clinical deterioration, mental-health crisis, suspected abuse, hazardous materials, violence, confidentiality, or restrictions on movement.

The paper also distinguishes security from coercion. A therapeutic environment requires proportionate protection, respect for rights, trauma-informed communication, and the least restrictive response compatible with immediate safety. Security measures that disregard dignity can damage trust and discourage care-seeking. Conversely, person-centered language cannot replace controls that are necessary to protect patients, staff, visitors, medicines, information, equipment, or essential services. Ethical integration holds care and protection together.

1.5 Theoretical Premise

The premise is that health assistants occupy a boundary-spanning position. Boundary spanners translate local information, connect separated groups, and help a system respond across formal divisions. Their value arises less from independent authority than from proximity, recurrence, and relational access. Because they repeatedly encounter patients and environments, they can notice changes in behavior, mobility, cleanliness, crowding, identification, access, supplies, or communication. These signals become protective only when the organization supplies shared language, trusted reporting routes, responsive supervision, and feedback.

The theoretical synthesis combines Donabedian's structure-process-outcome logic, the Systems Engineering Initiative for Patient Safety (SEIPS), relational coordination, high-reliability organizing, resilience engineering, and professional identity formation. Donabedian (1988) links organizational capacity to processes and outcomes. SEIPS locates performance within interactions among people, tasks, tools, organization, and environment (Carayon et al., 2006; Holden et al., 2013). Relational coordination explains how shared goals, shared knowledge, mutual respect, and problem-solving communication connect interdependent work (Gittell, 2016). High-reliability and resilience perspectives direct attention to weak signals, adaptive capacity, recovery, and learning (Weick & Sutcliffe, 2015; Hollnagel et al., 2015). Professional identity scholarship explains how participation, reflection, role models, and organizational recognition shape responsible membership (Cruess et al., 2015).

2. LITERATURE REVIEW

2.1 Health Assistants in the Workforce Architecture

Support roles are created when health systems distribute work across occupations to improve access, responsiveness, and continuity. Their effectiveness depends not merely on headcount but on design. The WHO guideline on community health worker programmes emphasizes selection, competency-based education, supportive supervision, integration into health systems, remuneration, and clear relationships with other workers (WHO, 2018). Although facility-based assistants are not identical to community health workers, the governance principles are transferable: workers require defined responsibilities, reliable support, supplies, information, and referral pathways.

Delegation is a relationship, not a one-time transfer. The delegating professional remains accountable for decisions that cannot lawfully or safely be transferred, while the assistant is accountable for accepting only tasks for which authorization and competence exist. Safe delegation requires a stable match among patient condition, task complexity, worker capability,

supervision, and context. When staffing pressure becomes the dominant logic, assistants may receive tasks without the training or access to information needed to perform them safely. Role ambiguity then becomes a latent system hazard rather than a personal deficiency.

The Cavendish Review highlighted wide variation in preparation and support for healthcare assistants and argued for common standards of fundamental care (Cavendish, 2013). Subsequent research in acute hospitals found that training, assessment, and support can be weakened by inconsistent expectations, limited protected learning time, and dependence on local supervisors (Sarre et al., 2018). These findings support a structural conclusion: an assistant workforce cannot be made reliable through goodwill alone. Competence must be visible, assessed, maintained, and connected to escalation.

2.2 Patient Care as Relational and Observational Work

Patient care is often reduced to a sequence of physical tasks, but the quality of assistance depends on relationship, interpretation, and timing. Supporting hygiene, mobility, nutrition, comfort, and navigation gives the assistant repeated opportunities to observe changes. A patient who eats less, becomes newly confused, walks differently, withdraws from conversation, or appears frightened may be expressing a clinical or safety problem before conventional measurements capture it. Observation becomes useful when assistants know what changes matter, how urgently to report them, and who must respond.

Person-centered care requires recognition of the patient as a partner with preferences, values, and rights. The WHO framework on integrated people-centred health services places coordinated services, empowered people and communities, and supportive governance at the center of system redesign (WHO, 2016b). For assistants, person-centeredness appears in privacy, respectful address, explanation before action, accessible communication, cultural sensitivity, and refusal to treat security status as a reason to disregard dignity.

Continuity also depends on information. Assistants may not author the full clinical plan, but they must receive the portion necessary for safe action and must have a route to add relevant observations. Excluding them from huddles or denying access to role-relevant information can create preventable blind spots. At the same time, minimum-necessary access and confidentiality remain essential. Integration therefore requires information governance that is role-based, purposeful, auditable, and compatible with privacy.

The literature on missed nursing care demonstrates that omission is a system phenomenon related to staffing, prioritization, teamwork, and resource conditions (Ball et al., 2018). The lesson for assistant roles is not that all omitted nursing work can be transferred. It is that supportive work must be deliberately designed, supervised, and connected to the clinical plan; otherwise, invisible omissions can accumulate while formal indicators appear satisfactory.

2.3 Health Security from Global Capacity to Facility Practice

Health security is commonly defined through protection from events that threaten population health across geographical or political boundaries. The International Health Regulations require countries to build core capacities for surveillance and response (WHO, 2016a). The COVID-19 pandemic demonstrated that formal plans are insufficient when supply, workforce protection, communication, trust, and service continuity are weak. Haldane et al. (2021) found that resilience depended on governance, financing, workforce, medicines and technology, information, and service delivery acting as a connected system.

At facility level, health security is more concrete. It includes access control, identification, crowd and traffic management, protection of vulnerable areas, recognition of suspicious behavior or unattended items, support for infection-control boundaries, incident communication, evacuation, and continuity during utility or technology failures. It also includes the ability to recognize when a local event may have wider public-health significance. Assistants do not independently classify an outbreak or lead a major incident unless formally authorized, but their observations and early notifications can affect response time.

Preparedness should not be conceived as an emergency binder separate from ordinary work. Kruk et al. (2015) describe resilient health systems as those capable of absorbing, adapting, and transforming when exposed to shocks. Routine reliability creates this capacity: accurate identification, clean handoffs, maintained communication devices, clear routes, working personal protective equipment, known supervisors, and practiced escalation. When these foundations are weak in normal operations, crisis conditions magnify the weakness.

The 2024 amendments to the International Health Regulations and the continuing evolution of global emergency governance reinforce the importance of equitable access, coordination, and sustained capacity. For workforce design, the implication is that preparedness responsibilities must be institutionalized through training and practice rather than added informally when an incident occurs.

2.4 Professional Identity, Recognition, and Role Clarity

Professional identity is both internal and relational. Workers develop a sense of role through education, practice, feedback, role models, organizational language, and the way other professions respond to them. Cruess et al. (2015) depict identity formation as an interaction among individual development, communities of practice, and socialization. Although much identity literature concerns regulated professions, its central mechanisms apply to assistants: belonging, recognition, reflection, responsibility, and alignment between stated values and workplace behavior.

Role clarity supports identity by answering four questions: What am I expected to do? What must I not do? When must I seek help? How will others respond? Vague job descriptions cannot answer situational questions. Workers need operational protocols and supervised rehearsal for high-risk boundaries. Clarity also protects against status-based silence. If assistants are described as team members but their reports are routinely dismissed, the organization communicates that their knowledge is not legitimate.

Interprofessional collaboration depends on understanding the expertise and constraints of others. Suter et al. (2009) identified role understanding, communication, patient-centered care, leadership, and conflict resolution among core competencies of collaborative practice. Reeves et al. (2017) concluded that interprofessional interventions may improve selected practices and outcomes, although evidence and implementation vary. These findings caution against treating collaboration as a slogan. Integration requires concrete routines, authority, and feedback.

Identity can also become unsafe if it is built around heroic overreach. An assistant may feel pressure to demonstrate value by accepting unfamiliar tasks, managing an aggressive event alone, or withholding uncertainty. A mature identity normalizes boundaries and escalation. Saying 'this requires clinical assessment' or 'security leadership must take command' is not avoidance; it is competent recognition of the system's differentiated authority.

2.5 Communication, Psychological Safety, and Closed Loops

Communication fails when a message is transmitted but not received, interpreted, or acted upon. Closed-loop communication requires a clear sender, identified receiver, confirmation, and documented or observable resolution. It is particularly important when an assistant reports deterioration, infection risk, identification discrepancy, unauthorized access, missing equipment, environmental hazard, or behavioral escalation. The system should specify urgency language and alternative routes when the first receiver is unavailable.

Hospital communication is shaped by hierarchy, workload, professional boundaries, and technology. Gleeson et al. (2023) found that effective interprofessional communication relies on relational and organizational conditions, not simply individual skill. Psychological safety—the shared belief that interpersonal risk can be taken without punishment—helps team members raise concerns and admit uncertainty (Edmondson, 1999). In health services, speaking up must also be connected to response accountability. An invitation to report is hollow if reports disappear without acknowledgement or learning.

Structured tools such as SBAR can create a common grammar for escalation, but scripts should support rather than replace judgment. An assistant may communicate situation, background known within role, observation, and requested response without making a diagnosis. Read-back is useful when identities, locations, instructions, or urgent facts could be misunderstood. During security events, plain language may be preferable to codes that are inconsistently understood.

Communication design must include patients and families. Security-related instructions should explain what is happening, what cooperation is requested, and how rights and privacy will be protected. People with language, sensory, cognitive, or mobility needs require adapted communication. The assistant's relational position can reduce confusion, but only if messages are accurate and aligned with the authorized incident lead.

2.6 Human Factors, Environment, and Technology

The SEIPS model treats safety as an outcome of interactions among persons, tasks, tools and technologies, organizational conditions, and the physical environment (Carayon et al., 2006). This perspective prevents organizations from blaming an assistant for predictable difficulties produced by poor signage, inaccessible alarms, conflicting instructions, understaffing, obstructed routes, or communication equipment that fails in noisy environments. It also shows why health care and health security cannot be designed independently: both roles operate within the same space and depend on the same information and infrastructure.

Environmental design influences aggression, falls, infection transmission, privacy, and evacuation. Waiting time, crowding, unclear queues, restricted visibility, and confusing access points can create risk before any individual behaves unsafely. Assistants may compensate informally, but recurring workarounds are data about system design. Human-factors governance asks why adaptation was necessary and whether the workaround transfers risk elsewhere.

Digital technologies create additional boundaries. Electronic identification, visitor systems, surveillance tools, messaging platforms, electronic records, and access-control devices can improve traceability but may also create exclusion, alert fatigue, privacy concerns, and single points of failure. Technology is safe only when roles, training, downtime procedures, cybersecurity, and human review are considered across the life cycle. WHO's digital health strategy emphasizes governance, interoperability, people-centered design, and capacity rather than technology adoption alone (WHO, 2021b). For assistants, minimum-necessary access must be paired with maximum-necessary clarity. A worker should not receive unrestricted clinical or security data, but lack of relevant information can make authorized tasks unsafe. Role-based access, secure authentication, privacy training, audit trails, and rapid escalation during system downtime offer a balanced approach.

2.7 Infection Prevention and Environmental Protection

Infection prevention is a shared property of the care environment. Standard precautions, hand hygiene, appropriate personal protective equipment, respiratory etiquette, cleaning interfaces, waste pathways, and isolation controls depend on coordinated behavior. The WHO core components for infection prevention and control emphasize programmes, guidelines, education, surveillance, multimodal strategies, monitoring, workload, staffing, and the built environment (WHO, 2016c). Assistants contribute when these components are translated into daily movement and contact.

Health-care assistants may support hygiene, mobility, transport, specimen movement, or room turnover within authorized duties. Health-security assistants may manage entrances, queues, restricted zones, or movement during outbreaks. Their interface becomes critical when protective controls affect access. A security rule that creates crowding may increase infection risk; an infection-control restriction that is poorly communicated may provoke conflict or cause inappropriate exclusion. Joint planning can anticipate these tradeoffs.

Occupational protection is equally important. The International Labour Organization and WHO emphasize protecting health workers from biological, ergonomic, psychosocial, and physical hazards. Assistants may be highly exposed because of proximity and repeated public contact while having less organizational power to request resources. Competency, vaccination policy, personal protective equipment, post-exposure pathways, violence-prevention measures, rest, and psychosocial support are therefore elements of ethical preparedness.

Environmental protection also includes recognition of spills, waste, damaged barriers, blocked exits, unsafe crowding, or unusual odors. The assistant's role is typically to secure the immediate area, prevent additional exposure, communicate accurately, and summon specialized response. Training should distinguish observation and initial protection from technical remediation.

2.8 Ethics, Equity, and Proportionate Security

Security practices in healthcare affect autonomy, privacy, access, and trust. Ethical practice requires necessity, proportionality, non-discrimination, accountability, and the least restrictive effective measure. These principles are particularly important for people experiencing mental-health crises, disability, cognitive impairment, pain, grief, intoxication, homelessness, migration-related vulnerability, or communication barriers. Behavior that appears noncompliant may reflect unmet clinical or accessibility needs.

Trauma-informed practice asks workers to recognize that control, search, restraint, surveillance, or authoritative language may reproduce fear. It does not prohibit protective action; it changes how action is prepared, explained, and reviewed. Assistants can preserve dignity by using calm introductions, offering understandable choices where possible, protecting privacy, avoiding unnecessary audiences, and involving clinical leadership early when behavior may have a medical cause. Equity also concerns access during emergencies. Scarcity and surge conditions may lead to stricter flows and prioritization. Assistants should apply authorized criteria consistently rather than improvise eligibility. They need a rapid route to request reasonable accommodation or clinical review when a standard process would create disproportionate harm. Documentation should record the reason for exceptions without exposing unnecessary personal information.

Confidentiality crosses both roles. Health-care assistants may encounter diagnoses, conversations, and bodily care; health-security assistants may see identities, movements, incidents, or surveillance. Ethical integration requires shared privacy principles, role-specific access, secure communication, and prohibition of informal disclosure. Trust is a security asset because patients who expect respectful treatment are more likely to share information and seek help early.

3. METHODOLOGY

3.1 Design

A narrative-theoretical review was selected because the objective was to integrate concepts from several bodies of knowledge rather than estimate an intervention effect. The article follows the structure and scholarly tone of the supplied 25-page narrative review while addressing a different workforce problem. It is interpretive and non-empirical: no

participants were recruited, no database of patient-level observations was created, and no statistical program was used.

3.2 Source Domains

Sources were drawn from peer-reviewed literature and authoritative institutional frameworks concerning patient safety, health workforce governance, healthcare support workers, professional identity, delegation, interprofessional collaboration, human factors, psychological safety, infection prevention, primary health care, emergency preparedness, health-system resilience, occupational safety, and the International Health Regulations. Foundational works were retained when they define theories still central to the synthesis; recent WHO and peer-reviewed sources were used to represent contemporary policy and preparedness.

3.3 Eligibility and Conceptual Extraction

A source was conceptually eligible when it clarified at least one of five questions: role contribution, boundary risk, identity formation, preparedness capacity, or integration mechanism. Sources were not treated as a statistical sample. Concepts were extracted into a matrix containing the actor, task or function, dependency, potential failure, enabling mechanism, and ethical constraint. Similar mechanisms were grouped and tested for coherence across routine and disrupted care.

3.4 Analytical Strategy

The synthesis proceeded through four moves. First, the distinctive purposes of the two assistant designations were separated. Second, shared interfaces were identified. Third, theoretical lenses were used to explain why those interfaces succeed or fail. Fourth, the mechanisms were assembled into a conceptual framework and three mind maps. The results are therefore conceptual findings supported by literature, not empirical estimates.

3.5 Scholarly Quality and Contextual Applicability

Priority was given to identifiable original publications, systematic reviews, and official reports with stable bibliographic details. The synthesis was designed for international relevance while respecting differences in legislation, licensure, accreditation, organizational policy, and training. Its concepts can therefore support contextual adaptation without imposing one national job description on all health systems.

4. RESULTS: CONCEPTUAL SYNTHESIS

4.1 Distinctive and Shared Contributions

The synthesis identifies a complementary division of contribution. Health Assistant - Health Care is oriented toward supportive contact with the patient, continuity of authorized care, observation, comfort, mobility, navigation, and communication with clinical teams. Health Assistant - Health Security is oriented toward protective awareness, controlled access, safe movement, environmental vigilance, incident reporting, and support for emergency procedures. Both roles depend on respectful communication, accurate identification, infection prevention, situational awareness, documentation, and escalation.

The shared domain is not a merged job description. It is an interface consisting of six functions. First, relational care maintains dignity and reduces confusion. Second, surveillance and early recognition convert proximity into useful warning. Third, environmental protection limits exposure to hazards. Fourth, controlled access and safe flow connect security with clinical priorities. Fifth, emergency support sustains ordered action under pressure. Sixth, closed-loop escalation ensures that observations reach an authorized decision-maker and produce a verified response.

Four recurring failure patterns were also identified. Role ambiguity causes duplication or omission. Information discontinuity prevents one role from understanding why a restriction or care need matters. Status hierarchy suppresses assistant voice. Preparedness separation allows emergency procedures to become detached from daily practice. Each failure is organizationally governable through defined boundaries, shared briefing, response protocols, supervision, and learning.

4.2 Patient Care-Health Security Interface Framework

The proposed framework contains six governance elements: shared purpose; explicit scope and delegation; competency assurance; interoperable communication; ethical and proportionate action; and continuous learning. It operates across macro policy, meso organizational design, and micro encounters. Its core rule is that integration should increase continuity without increasing unauthorized practice. The framework treats an escalation as complete only when responsibility is accepted and the next action is known.

4.3 Integrated Role Architecture

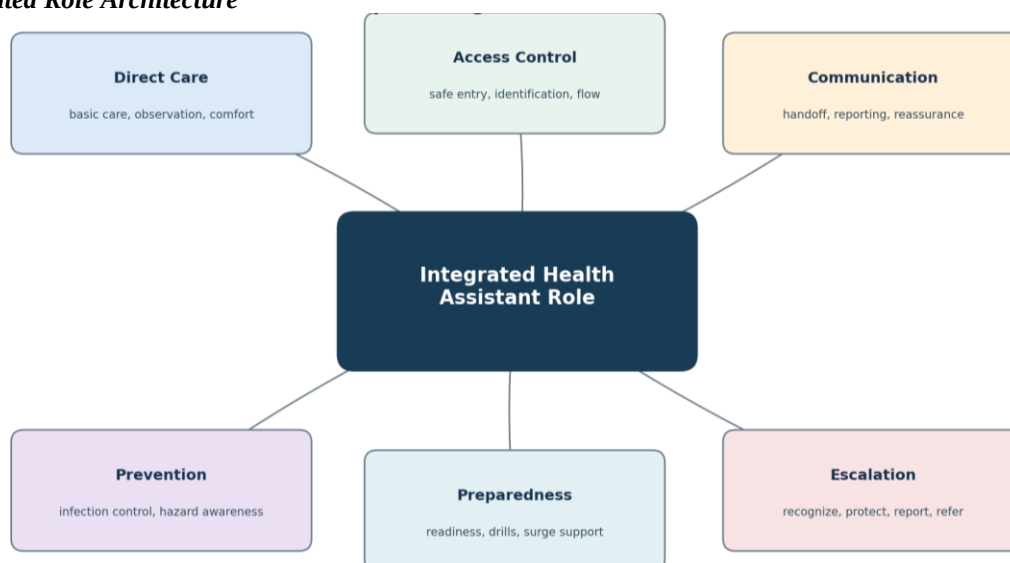


Figure 1. Mind map of the Integrated Health Assistant Role Architecture. Source: Authors' conceptual synthesis.

The first mind map positions the integrated role at the center of six branches. Direct care captures authorized supportive activities and observation. Access control protects patients and services while remaining responsive to clinical need. Communication connects patient experience with operational action. Prevention joins infection control and hazard awareness. Preparedness translates routine competence into surge and emergency support. Escalation defines the safe endpoint of assistant judgment: recognizing when authority or expertise must pass to another professional.

The map shows that integration is created by relationships among functions. For example, access control without communication can delay care, while direct care without environmental awareness can expose a patient or worker to danger. Escalation links every branch because neither assistant designation should carry unresolved risk alone. This architecture is compatible with SEIPS: the role is shaped by tasks, technologies, organization, and environment rather than by personal attributes alone (Holden et al., 2013).

A practical implication is that orientation should be partly shared and partly role-specific. Shared modules can address identity, dignity, confidentiality, identification, infection prevention, hazard recognition, communication, and escalation. Role-specific modules must define authorized patient-care tasks, access procedures, incident responsibilities, equipment, and supervision. Competency assessment should use realistic scenarios at the interface, including a deteriorating person at an entrance, an agitated relative in a clinical zone, or an evacuation involving mobility limitations.

4.4 Professional Identity Formation



Figure 2. Mind map of professional identity formation for health assistants. Source: Authors' conceptual synthesis.

The second mind map identifies six identity conditions. Competence gives the worker a legitimate foundation for action. Boundaries define what responsible practice excludes. Belonging makes the assistant a recognized team member rather than an invisible helper. Ethics connect authority to dignity, confidentiality, and fairness. Voice legitimizes reporting and speaking up. Development ensures that identity can mature through supervision, reflection, and continuing learning.

Identity is weakened when any one condition is missing. Competence without belonging may produce silence; belonging without boundaries may encourage overreach; voice without response may become performative; and development without ethical grounding may strengthen technical performance while leaving inequity unexamined. The model therefore treats identity as a safety mechanism, not only a matter of morale.

Organizations shape identity through titles, uniforms, access permissions, induction, team introductions, documentation privileges, supervisor behavior, and the response to concerns. If policy calls assistants essential but meetings and systems exclude them, the enacted message contradicts the formal one. Relational coordination suggests that shared goals and mutual respect must be accompanied by shared knowledge and timely problem-solving communication (Gittel, 2016).

The model supports reflective supervision. Brief post-event conversations can ask what the assistant noticed, what action was taken, which boundary was encountered, how others responded, and what should change. Reflection must remain non-punitive while distinguishing acceptable adaptation from unsafe deviation. This helps workers learn that escalation and asking for help are positive identity practices.

4.5 Preparedness and Resilience Cycle

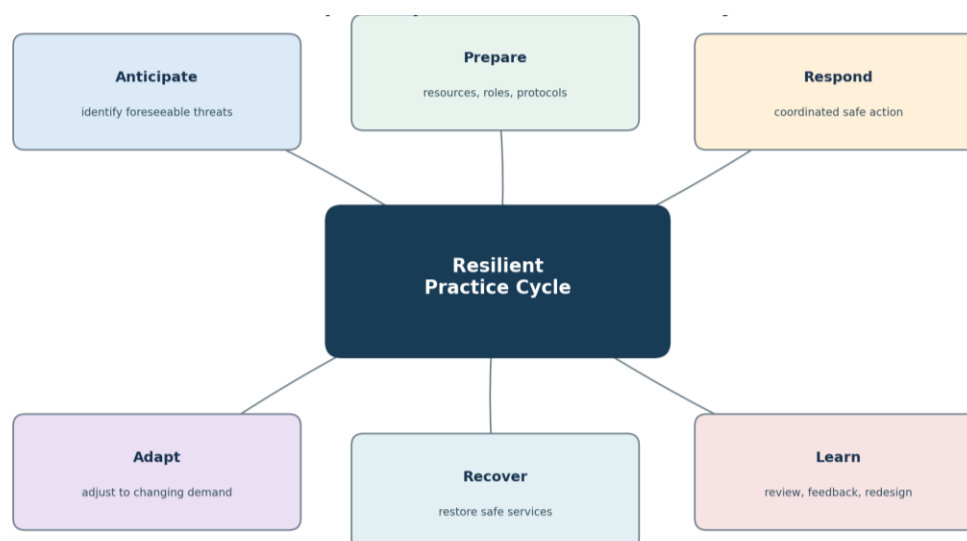


Figure 3. Mind map of the preparedness and resilience cycle. Source: Authors' conceptual synthesis.

The third mind map converts preparedness from a static plan into a six-stage cycle. Anticipation identifies foreseeable threats and vulnerable interfaces. Preparation assigns roles, resources, communications, and alternatives. Response coordinates action under an incident structure. Adaptation addresses changing demand without abandoning ethical or scope boundaries. Recovery restores safe service and supports affected people. Learning turns experience into redesigned practice.

Health assistants contribute at every stage. Their routine observations inform anticipation; participation in drills strengthens preparation; proximity supports rapid communication during response; knowledge of patient and environmental needs supports adaptation; assistance with orderly return to service supports recovery; and frontline accounts enrich learning. This contribution should be specified in emergency plans rather than assumed.

Resilience is not an expectation that workers absorb unlimited pressure. Kruk et al. (2015) and Haldane et al. (2021) locate resilience in system capacities, governance, workforce protection, information, and service organization. An assistant asked to compensate indefinitely for missing staff, equipment, or authority is experiencing system fragility, not demonstrating sustainable resilience. The cycle therefore includes escalation of capacity constraints and leadership responsibility for correction.

The model also integrates routine and exceptional safety. Identification, hand hygiene, route knowledge, respectful communication, and closed-loop reporting are daily practices that become critical during emergencies. Drills should test these ordinary dependencies under stress and include realistic patient needs, not only security movement.

4.6 Theoretical Propositions

The synthesis supports a coherent set of theoretical propositions. Patient care and health security become mutually reinforcing when they share a person-centered safety purpose while retaining distinct authorization boundaries. The protective value of assistant observation increases when communication follows a closed escalation loop and responsibility is explicitly accepted. Professional identity supports safety when competence, belonging, ethical responsibility, voice, and boundary discipline develop together. Preparedness becomes more reliable when emergency functions rest on routine care practices and rehearsed interdisciplinary relationships.

The framework further proposes that role clarity distributes responsibility fairly and protects assistants from being asked to absorb unresolved organizational risk. Technology and access controls contribute to security when they remain compatible with clinical urgency, accessibility, privacy, and dependable downtime procedures. Ethical proportionality strengthens trust, communication, and timely access, while organizational learning becomes more complete when incident review includes assistants who directly observed the environment and the handoff between functions.

4.7 Governance Across Levels

Level	Primary focus	Illustrative mechanisms
Macro	Regulation, workforce standards, emergency policy	Recognized titles; scope standards; competency requirements; protected reporting
Meso	Organizational design and resources	Joint governance; role profiles; supervision; drills; access and information design
Micro	Patient and facility encounters	Identification; respectful communication; observation; initial protection; closed-loop escalation

5. DISCUSSION

5.1 Integration Without Role Dilution

The synthesis reframes integration as connected responsibility rather than interchangeable labor. Health-care assistants and health-security assistants can share goals, language, situational awareness, and escalation processes while performing different authorized tasks. This distinction matters because workforce shortages can make integration rhetoric a vehicle for unsafe substitution. A strong framework makes boundaries more visible, not less.

The framework also expands the recognized care team. Many safety signals arise before a formal clinical encounter or outside a treatment room. Workers at entrances, waiting areas, corridors, transport routes, and repeated bedside contacts observe the conditions in which care succeeds or fails. Their inclusion can improve system awareness, provided that concerns are routed to professionals who can evaluate and act.

5.2 Identity as Safety Infrastructure

Professional identity is frequently discussed as personal development, yet the findings show that it is infrastructure. A worker who knows the role, belongs to the team, understands ethical duties, and expects a response is more likely to identify and communicate risk. Conversely, inconsistent titles, informal delegation, and dismissive supervision create uncertainty that can remain hidden until an event occurs.

Recognition must be paired with accountability. Assistants should document or communicate within policy, maintain confidentiality, participate in competency assessment, and disclose uncertainty. Leaders should respond to concerns, investigate systemic obstacles, and prevent retaliation. This reciprocity converts voice into a dependable safety process.

5.3 Care-Security Tensions

Care and security can conflict around access, privacy, surveillance, movement, and control. The framework does not remove these tensions; it provides principles for managing them. Clinical urgency, rights, necessity, proportionality, accessibility, and least-restrictive action should guide joint decisions. When immediate danger requires rapid control, subsequent review should examine both protective effectiveness and patient experience.

5.4 Preparedness as Everyday Capability

The preparedness cycle argues against treating emergencies as rare exceptions managed only by specialized leaders. Major

incidents still require command structures and expert authority, but response quality depends on thousands of ordinary capabilities: knowing routes, identifying patients, using protective equipment, communicating locations, maintaining calm, assisting people with mobility or sensory needs, and escalating accurately. Assistants can strengthen these capabilities because they are embedded in the daily environment.

Preparedness education should therefore use progressive scenarios. Foundational exercises can test notification and role recall; functional exercises can test interfaces; full-scale exercises can test coordinated movement and continuity. Debriefing should include assistants and patients' accessibility needs. Lessons should result in assigned actions, deadlines, and verification rather than general statements.

5.5 Implications for Leadership and Education

Leadership should create a shared core curriculum and separate role-specific competencies. Supervisors need preparation in delegation, feedback, psychological safety, and post-event reflection. Policies should identify primary and alternate escalation contacts, urgent wording, response expectations, and documentation rules. Information systems should support minimum-necessary access and reliable downtime processes.

Education should connect principles with boundary decisions. Learners should practice distinguishing observation from assessment, immediate protection from technical remediation, and supportive communication from unauthorized disclosure. Joint exercises can build shared knowledge without pretending that expertise is identical. Competency should be reassessed when duties, technology, hazards, or service models change.

5.6 Directions for Knowledge Development

The theoretical framework creates a constructive agenda for continued knowledge development. Future scholarship can explore how the model is adapted across national systems, clarify locally authorized meanings of the two job labels, and examine how education, supervision, communication, and preparedness interact in varied service environments. Qualitative inquiry, Delphi consensus, instrument development, observational research, and implementation evaluation can extend the conceptual contribution and examine outcomes for patients, staff, access, equity, incident response, and workforce retention.

6. CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

Health assistants contribute to the continuity and protection of care from different but connected positions. The Health Assistant - Health Care role supports the patient through authorized care, observation, comfort, navigation, and communication. The Health Assistant - Health Security role supports the safe environment through protective awareness, access and flow, incident recognition, and emergency procedures. Their intersection is a set of governed interfaces rather than a single undifferentiated occupation.

The Patient Care-Health Security Interface Framework connects shared purpose, explicit boundaries, competency, interoperable communication, ethical proportionality, and learning. Its three mind maps show how functions, identity, and preparedness reinforce one another. The principal conclusion is that integration is safest when assistants are visible members of the team, understand both their contribution and limits, and can transfer risk to an authorized responder through a closed loop.

6.2 Recommendations

Healthcare authorities and organizations should define both assistant roles through consistent competency profiles that explain responsibilities, professional boundaries, supervision, and escalation thresholds. A shared foundation curriculum should address patient safety, dignity, confidentiality, identification, infection prevention, hazard recognition, communication, and emergency awareness. This common preparation should be complemented by role-specific education and authorization for direct-care activities, access control, incident functions, equipment, documentation, and any restrictive measure governed by local law and policy.

Assistants should be included in safety huddles, preparedness exercises, debriefings, and incident reviews whenever their work intersects with the event. Closed-loop escalation should identify the responsible receiver, urgent terminology, expected response, alternate contacts, and feedback to the reporting worker. Supportive supervision, protected learning time, competency reassessment, and psychologically safe speaking-up routes should be treated as continuing features of workforce governance rather than occasional initiatives.

Organizations should regularly review access, surveillance, and protective practices for necessity, proportionality, privacy, accessibility, and equitable treatment. Workforce wellbeing, violence prevention, personal protective equipment, and post-incident support should be recognized as preparedness capacities. Continued scholarship should develop indicators for role clarity, escalation closure, interface reliability, patient experience, preparedness participation, and completion of learning

actions, thereby translating the theoretical framework into a mature international research agenda.

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Appendix A. Conceptual Interpretation Guide

Within this review, integrated practice describes coordinated contribution to a shared safety objective while preserving the authorized responsibilities of each role. It does not mean that Health Assistant - Health Care and Health Assistant - Health Security are interchangeable. The concept emphasizes connected communication, complementary awareness, and reliable transfer of responsibility. Patient care remains grounded in dignity, comfort, observation, navigation, and continuity, while health security remains grounded in protection, controlled movement, environmental awareness, incident support, and preparedness.

Professional identity refers to the way assistants understand their purpose, responsibilities, ethical commitments, membership within the health team, and obligation to seek support when a situation exceeds their authority. Identity is strengthened through competency-based education, role modeling, respectful supervision, meaningful participation, and feedback. In this framework, asking for clarification and initiating escalation are expressions of responsible practice because they preserve the relationship between competence and patient safety.

Preparedness is interpreted as an everyday organizational capability rather than a temporary response activated only during emergencies. Routine identification, infection prevention, route awareness, communication, documentation, accessibility, and workforce protection create the foundation for coordinated action during disruption. The resilience cycle therefore connects anticipation, preparation, response, adaptation, recovery, and learning. Each stage depends on defined leadership and on the timely contribution of workers positioned close to patients and service environments.

Closed-loop escalation means that a concern reaches an identified person with authority to respond, is acknowledged, produces a clear next action, and is followed through to resolution or formal transfer. Ethical proportionality means that protective measures are necessary, appropriate to the level of risk, respectful of dignity, attentive to accessibility, and no more restrictive than required. Together, these concepts provide a shared vocabulary for education, supervision, policy development, and future research across healthcare settings.