



What work do assistant practitioners do and where do they fit in the nursing workforce?

Assistant practitioners were introduced at band 4 to fill a workforce gap. But are trusts expecting unregistered staff to act as autonomous practitioners?

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ABSTRACT Wakefield A et al (2010) What work do assistant practitioners do and where do they fit in the nursing workforce? *Nursing Times*; 106: 12, 14-17.

Aim To understand where assistant practitioners fit in the workforce and examine the roles they are asked to undertake, by comparing their job descriptions with the policy vision.

Method A total of 27 job descriptions from three acute trusts were analysed to highlight similarities and differences between the documents. The analysis focused on how clinical tasks related to the level of responsibility APs were expected to assume as part of their role.

Results The analysis revealed the following categories for APs' job descriptions: fully assistive (one description); supportive/assistive (nine); supportive/substitutive (nine); substitutive/autonomous (seven); and fully autonomous (one). This revealed a number of inconsistencies in the form of different organisational expectations about the AP role.

Conclusion This study highlights that it is still not clear what managers and workforce planners want from the AP role as it does not have a clearly defined position in the clinical hierarchy, despite being located at level four on the Skills for Health (2008) framework.

BACKGROUND

Nursing shortages are not a just concern for British healthcare policy (Buchan, 2008; NHS Modernisation Agency, 2007), but present a significant challenge for healthcare providers across the world (Needleman et al, 2006; Buchan and Dal Poz, 2002).

As a result of spiralling workforce gaps, a new kind of practitioner was introduced into the UK healthcare system, called the assistant practitioner (AP). These staff have also been referred to as senior support workers, advanced nursing assistants, lead

healthcare assistants or by other titles indicating the role's more advanced but supportive nature.

The rationale for introducing this role was to help sustain effective, efficient healthcare services across the NHS and to free up registered nurses to take on new or expanding roles.

Reinforcing this, NHS Employers (2009) said: "The Workforce Review Team forecasts indicate that the qualified nursing workforce will be proportionally smaller in the future and therefore the role of the healthcare assistant and assistant practitioner become even more crucial to ensuring that patients continue to receive high quality care."

As a result of the changes taking place in healthcare, occupational boundaries are being redefined and renegotiated, with clinical tasks being transferred or redistributed between different members of the team (Skills for Health, 2008). For example, nurses are shifting their work boundaries both upwards and downwards. They are taking on increasingly complex medical tasks (upwards) while also redistributing what they consider to be "mundane" work by passing this down to an increasingly expanded supportive healthcare workforce; in this case APs (Nancarrow and Borthwick, 2005).

If we consider Nancarrow and Borthwick's (2005) framework, the changes taking place between nurses and APs could be likened to "vertical substitution", where roles once undertaken by a discipline higher up the occupational ladder are delegated to those of lower occupational status.

Nevertheless, this role substitution results in a blurring of boundaries, meaning that on occasions APs may be considered responsible for a particular task one day, while the following day RNs may want to retain the area of work they had delegated.

A major consequence of vertical

PRACTICE POINTS

- Occupational boundaries between nurses and assistant practitioners are becoming blurred.
- A lack of clarity over the APs' role can cause conflict and confusion.
- Without AP regulation and clarity over the role, standards of care cannot be guaranteed.

substitution is the potential for role conflict, role confusion and, perhaps more alarmingly, professional disputes (Abbott, 1988). For example, when nurses delegate unwanted tasks to APs, this can have a detrimental effect on working relationships, with APs often feeling used and/or taken for granted (Wakefield et al, 2009; Mackey and Nancarrow, 2005). On the

other hand, APs could be perceived as a threat to nurses, since they are taking over and, indeed, being overtly assigned work that was once nurses' domain (Wakefield et al, 2009).

APs' scope of practice

Despite the issues discussed above, policy documents published when APs were introduced envisaged this new type of healthcare worker would have an assistive, supportive role in the healthcare team (House of Commons Health Committee on Workforce Planning, 2007; Skills for Health, 2007).

The Royal College of Radiologists and the Society and College of Radiographers (2007) gave what could perhaps be considered the strongest steer about APs' scope of practice: "There is no delegation or transference of care to assistant practitioners. These are supervised roles."

If this comment was taken at face value, APs would simply be expected to report a problem to RNs or other registered practitioners for the latter to then manage the situation. However, Sargent (2006) had already contradicted the RCR/SCR's (2007) statement when defining the AP role as part of his written evidence to the House of Commons Select Committee on Health. In this definition, an AP was expected to deliver care to patients "with a level of knowledge and skill beyond that of the traditional healthcare assistant or support worker [and]

FIG 1. AGENDA FOR CHANGE FRAMEWORK

Band 9	More senior staff	Registered practitioners
Band 8	Consultant practitioners	
Band 7	Advanced practitioners	
Band 6	Senior/specialist practitioners	
Band 5	Registered practitioners	
Band 4	Assistant/associate practitioners	Support/assistant staff
Band 3	Senior healthcare assistants/technicians	
Band 2	Healthcare assistants/support workers	
Band 1	Initial entry level jobs	

Source: DH (2004a)

TABLE 1. ASSISTANT PRACTITIONER SPECIALTIES AND JOB DESCRIPTIONS

Site 1	
Clinical specialty	Number of job descriptions
Medicine and rehabilitation	5
Surgical care services	4
Radiology	1
Critical care services	3
Dermatology	1
Maternity care services	2
Total	16
Site 2	
Clinical specialty	Number of job descriptions
Radiology	4
Critical care services	2
Total	6
Site 3	
Clinical specialty	Number of job descriptions
Surgical care services	2
Critical care services	1
Medicine and rehabilitation	1
Unknown – not stated	1
Total	5

undertake clinical work in domains... previously... the remit of registered professionals... transcend[ing] many... boundaries that have hitherto been strictly demarcated between different professions".

This definition clearly advocates that role encroachment and role transgression was expected and, to some extent, actively encouraged so that boundaries between registered practitioners and what could be considered traditional assistant roles were expected to be redefined.

For this reason, the AP role was located firmly within band 4 on the Agenda for Change framework (Department of Health, 2004a) and subsequently situated at level 4 on the Skills for Health (2007) careers framework. As Fig 1 shows, band 4 equates to a higher level support worker, yet this role is clearly situated beneath registered practitioners, reinforcing the notion that APs should be considered as having lower occupational status than nurses so should not be expected to take on nurses' roles (DH, 2004a).

However, the policy vision clearly indicates that APs would be able to "do more" than "traditional" healthcare assistants by taking on some of nurses' duties, freeing up the latter to achieve better patient outcomes (Wakefield et al, 2009; Sargent, 2006).

Consequently, the AP role was introduced to deliver protocol based care tailored to the needs of a particular ward or clinical area, and thus expected to be supervised by a registered practitioner (Skills for Health, 2007; Sargent, 2006).

The rationale for expanding the supportive workforce has to some extent been underpinned by Buchan and Dal Poz's (2002) findings; they suggested that changes to the supportive healthcare workforce have

often led to increased organisational effectiveness.

Yet, if AP roles are to be effective, these workers need clear and unambiguous job descriptions that reflect the supportive nature of their work (Wakefield et al, 2009; Sandall et al, 2007).

AIM

This article aims to highlight some of the occupational uncertainties APs are exposed to as part of their role.

By definition, job descriptions provide a framework within which practitioners are expected to work (DH, 2004a; 2004b). When job descriptions are unclear, it becomes more difficult to establish definitive occupational boundaries, while the reverse – that is, rigid job descriptions – stifles creativity and flexibility, which undermines the reason why APs were introduced.

Furthermore, when roles are not clearly delineated, this can lead to exploitation, disquiet and dissatisfaction, which can have a negative impact on patient care (Wakefield et al, 2009).

METHOD

This article draws on data taken from 16 AP job descriptions representing all clinical nursing divisions in one acute trust in the UK, supplemented by 11 job descriptions from two other acute trusts (see Table 1).

The job descriptions were examined to identify similarities and differences in their content and gain a better understanding of what APs were expected to do as part of their role. For this reason we focused our attention mainly on the clinical roles and responsibilities APs were asked/expected to undertake.

In addition, we examined the extent to

which APs were used in a truly assistive capacity, as envisaged by policy, to establish whether they were expected to assist nurses, act as their substitute or take on a totally independent role.

The job descriptions were developed before Agenda for Change (DH, 2004a) and national job profiles (DH, 2004b) were implemented. The study therefore highlighted any potential inconsistencies in role expectations across diverse clinical specialties to reveal possible deviations from the policy vision (DH, 2004b).

Ethics and analysis

Job descriptions used in this analysis were coded to protect trusts' anonymity, in line with the requirements of the National Research Ethics Service's approval process.

Two members of the research team first examined each job description from a

practice research report

BOX 1. HEADINGS USED FOR ANALYSIS

- Job description
- Role summary statement orientation
- Clinical task
- Clinical task orientation
- Comments: evidence for conclusions drawn

general perspective to establish similarities and differences, in line with Hammersley and Atkinson's (2003) recommended analytical framework.

Each document was scrutinised individually, in that each statement was examined to identify exactly what the AP was expected to do in relation to their job title and clinical specialty. When analysing the documents, we took into consideration each item listed in Box 1. This enabled us to adopt a clear and consistent strategy on which to base our search for role categories and from this, find the necessary evidence to support why a particular job description should be assigned to a specific role category.

Once each clinical task statement had been examined, each job description was then re-examined more generally to identify the definitive overarching role category that should be assigned to each job description, denoting the extent to which the role was assistive or autonomous.

RESULTS

Five role categories were isolated from the data. Each role descriptor definition is also supported by an example of the type of statement found in the job description, and assigned to a particular category (in italics).

● **Fully assistive:** the AP worked in a similar way to traditional HCAs. This notion was reflected by statements such as: "Under the direction of the registered nurse, at the appropriate level, as detailed in the unit clinical training programme for healthcare support workers."

● **Supportive assistive:** the AP supported and assisted the nurse's work, shown by comments such as the AP would "work under the direction of the qualified staff in the unit, by assisting in the admission and assessment processes, including the utilisation of clinical skills to deliver care aimed at improving the patient journey".

● **Blended supportive assistive/substitutive:** the AP undertook mostly supportive and/or assistive tasks but the AP would take the RN's place when needed, demonstrated by task statements such as

"referral to appropriate professional and implement recommendation".

● **Substitutive/autonomous:** the AP took the nurse's place and, on occasion, would work completely independently making her/his own decisions without reference to the nurse, as noted in statements such as: "Check patient's inhalation techniques and implement education."

● **Fully autonomous/independent practitioner:** the AP functioned as a completely independent practitioner, shown by comments such as: "Take referrals from GPs, dermatology nurse practitioner or consultant dermatologists for patients assessed to be suitable and would benefit from treatment for lymphoedema."

Table 2 shows the number of job descriptions in each category.

DISCUSSION

In this first systematic analysis of AP job descriptions, several tensions existed between the policy vision and the AP role as it has been implemented to date. For example, APs were originally intended to:

- Deliver protocol based clinical care previously associated with registered practitioners;
- Deliver care under the direction and supervision of a registered practitioner (Skills for Health, 2007; Sargent, 2006; DH, 2003).

However, the comments above show there were times when APs were clearly expected to do more than simply assist or support nurses, contravening what could be deemed protocol driven care.

In the more autonomous categories, APs were expected to become much more independent and substitute for RNs. As a result of this ambiguity, it is still not clear where APs fit into the organisational hierarchy.

In effect the role in its current form does not have boundaries, in that its form and scope is constantly shifting to accommodate changes in circumstance as they arise in practice. This ambiguity is not helped by

Skills for Health's (2008) level 4 career framework descriptors (Table 3) in which it states that level 4 practitioners should "develop self directed work practices" and "make judgements requiring comparison of options". In essence these comments are at variance with the concept of assisting, which is more often associated with the notion of helping. However, making judgements and/or comparisons about a patient's care is much more complex than simply helping. Likewise, being self directed is more akin to autonomy, which can be defined as self governance or in this context being able to practise independently, which AP roles were not originally designed to do.

The notion of "self direction" and the need to "make judgements and comparisons" are skills normally associated with registered practitioners' roles, so it is hardly surprising that a high level of role flexibility was seen in the job descriptions. Although many activities carried out in a given job do not simply reflect those listed in a job description, such documents are nevertheless produced to guide and define the scope of practice. Yet when job descriptions do not reflect the level or scope of practice expected, problems occur in relation to:

TABLE 2. NUMBER OF JOB DESCRIPTIONS IN EACH CATEGORY

Role category	Number of job descriptions assigned
Fully assistive	1
Supportive assistive	9
Blended supportive assistive/substitutive	9
Substitutive/autonomous	7
Fully autonomous/independent practitioner	1
Total	27

No fully substitutive category was identified from the data, which is why this category is not listed

TABLE 3. SKILLS FOR HEALTH (2008) CAREER FRAMEWORK DESCRIPTORS

Professional and vocational competence	Analytical/clinical skills and patient care	Organisational skills and autonomy/freedom to act
Demonstrates self directed development and work practice AND solves problems by integrating information from expert sources, taking account of relevant social and ethical issues	Performs clinical, technical, administrative or scientific procedures AND makes judgements requiring a comparison of options	Plans straightforward tasks AND work guided by standard operating procedures/protocols

- Clarity;
- Status;
- Pay for work done.

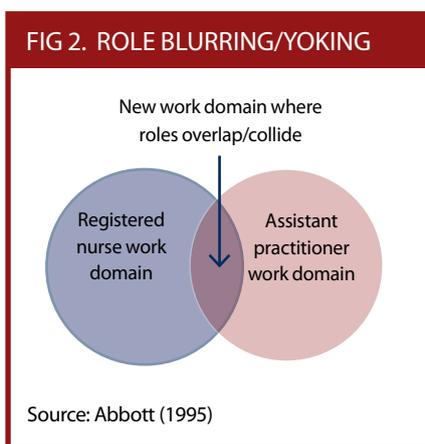
While role fluidity allows employers to create generic healthcare workers, it also creates role overlap and confusion together with inter and intraprofessional tensions, leading to a lack of understanding about what practitioners are expected to do as part of their new role.

Without clarity of purpose, new or novel boundaries emerge, become blurred and joined or what Abbott (1995) termed "yoked", where one side of each occupational boundary can be defined as being "inside" that of another (Fig 2).

Blurring boundaries

In the context of our study, yoking occurred when responsibilities normally undertaken by those of higher occupational status (RNs) were passed on to those further down the occupational hierarchy (APs). As a result, occupational responsibilities need to be redefined, so it is clear where role boundaries begin and end.

One way of achieving this is by generating robust, clear and publicly defined job descriptors (Rolfe et al, 1999). However, when job descriptions are ill thought out and do not reflect the realities of practice, they can undermine good working relationships, appropriate skill mixes, and leave practitioners professionally exposed,



culminating in poor patient experience. In our study, job descriptions did not clearly define APs' scope of practice. This led to confusion about what they could, should and/or did undertake as part of their role.

Our comparative analysis of AP job descriptions, policy documentation and other studies suggests it is vital for post holders to have accurate, clearly written job descriptions. This is particularly important for APs as this new role sits between two occupational spaces, one that is professionally regulated by registration and legislation, and the other unregulated (Masterson, 2002). Nevertheless, professional regulation is specifically designed to verify practitioners' competence to ensure clinical tasks can

be carried out safely for patients.

This lack of professional regulation is a dangerous and vulnerable space for APs to occupy, given they do not have clear directives to guide their actions or protect them when things go wrong, a factor that is even more apparent when the contents of their job descriptions are unpicked.

CONCLUSION

The AP role needs to be much more clearly defined as many NHS employers are still not sure what they want from this new type of healthcare worker, despite coming under increasing pressure to examine skill mixes. However, without clear role expectations and professional regulation, standards of care cannot be guaranteed. ●

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