The assistant practitioner role in healthcare

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Assistant practitioners can free nurses to focus on advanced practice but there are concerns about delegation of care to an unregulated workforce.

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The assistant practitioner role is intended to free up nurses to make better use of their professional skills and improve patient outcomes. However, it can be perceived as a threat to nurses because it involves handing over clinical aspects of their work to unregistered and unregulated support workers. This article looks at how the role is developing, and the implications for nursing and quality of patient care.

Increasing demand for healthcare, downward pressure on NHS resources and a shortage of registered clinicians is causing occupational boundaries to be redefined, with clinical tasks transferred or redistributed between different team members to make more efficient and cost effective use of staffing (Royal College of Nursing, 2010; Wakefield, 2010; Spilsbury, 2008). Nurses are taking on expanded roles, including some medical tasks, while relinquishing essential nursing care to support workers. This has mostly been in acute care, use of APs in community and primary care settings is growing.

Assistant practitioners deliver protocol-based care, tailored to particular wards or clinical areas and supervised by registered practitioners (Skills for Health, 2009), but are semi-autonomous, accountable to themselves, their employer and patients (Miller et al, 2015). This involves working within clear parameters defined by their employer, and only delivering activities they are signed off as competent to undertake (Miller et al, 2015).

These roles vary hugely in terms of numbers, job remit and preparation for practice (Spilsbury, 2011; RCN, 2010). Typically, APs are trained while working as HCAs (Miller et al., 2015; Spilsbury, 2012); formal training is usually required, such as a foundation degree, national vocational qualification or the more recent advanced apprenticeships (Skills for Health, 2015). Most who train to be APs stay in the role, but it can be used as a stepping stone to train as a registered practitioner (Miller et al, 2015).

While the benefits of the AP role are increasingly recognised (Miller et al, 2015), creating a new grade of unregistered worker also has “potential for role conflict,
Development of the role
A review undertaken for Skills for Health found a continuing increase in numbers of APs and the range and scope of the role, driven by cost efficiencies, shifts in policy and changes to service delivery agreements (Miller et al, 2015). It found APs working in a range of clinical, community and laboratory settings, and expanding from the traditional realm of the hospital into primary and community care, including across health and social care.

A survey of 381 APs in acute hospital wards in England suggested 80% of roles were introduced to fill a skills gap, 79% to better meet patient needs and 44% to substitute for a registered nurse (Spilsbury, 2011). Miller et al (2015) found posts were more usually a cost-effective way to increase capacity in the face of nurse recruitment and retention problems and improve patient services, rather than primarily to replace nurse posts, with some created as additional posts to help meet waiting time targets. They also found new roles emerging from the design of new services and patient pathways, and the shift towards more community provision and integrated health and social care, helped by the semi-autonomous nature of the role and its ability to work across professional boundaries (Miller et al, 2015).

Barriers
Where AP roles enhance skill mix, benefits included, improvements in quality, productivity and efficiency (Miller et al, 2015). However, barriers remained, including lack of clarity and confidence about the role and its supervision, particularly among nurses, who worry about delegating tasks to unregistered staff; lack of clarity about who is accountable if things go wrong; and problems identifying suitable education, training and mentoring. A lack of consensus regarding the clinical areas in which APs are able to practise both between and within organisations was also identified.

Miller et al (2015) also found recent National Institute for Health and Care Excellence guidance on safer staffing was serving to ”dampen enthusiasm for further extension of support roles in acute inpatient settings” because of its emphasis on numbers of registered staff rather than overall skill mix (NICE, 2014).

While some nurses accepted APs as valued, even essential, members of the healthcare team, others felt threatened, seeing them as a cost-cutting exercise that devalued the nurse’s professional role and risked compromising patient care (Miller et al, 2015).

Scope of practice
Spilsbury’s (2011) survey of hospital APs found 49% employed in medical or surgical wards, 76% solely supporting registered nurses, and 22% registered nurses and other professionals. As many as 97% provided direct patient care, 75% continuity of care and 65% case assessment and planning; 61% wrote reports for the medical team and 59% discussed care with patients and relatives. Only 6% were involved in medicines administration.

The APs in the survey had an average of 12 years’ NHS experience, 69% as HCAs on the same ward; 92% also had a qualification for the post, usually a foundation degree (43%) or NVQ (33%). Many had supervisory or mentoring roles, 64% supervising HCAs, 38% newly registered or appointed nurses and 42% student nurses. More recently, Miller et al (2015) found the role expanding across different healthcare settings, with APs often working independently and across professional boundaries in hospitals and the community.

Many APs were responsible for specific areas including ward admissions and clinics, education and training and assessing other support staff (Miller et al, 2015). In one trust, they ran outpatient, phlebotomy and dressings clinics, in another they led the ophthalmology service, including pre- and post-operative counselling and removing sutures, and ran a fracture clinic, triaging and assessing patients. Others were working across traditional boundaries to improve community services, including new roles across health and social care, such as in the older adult care home liaison team. Roles in primary care included maternity services, dietetics and immunology.
Nursing Practice

Discussion

BOX 1. SIRONA CARE AND HEALTH

Sirona is a not-for-profit social enterprise providing community health and adult social care in Bath and North East Somerset and Gloucester. It increasingly uses assistant practitioners as a cost-effective way to enhance quality of care and manage the increasing number and complexity of patients cared for in the community.

APs work in specialist stroke services, with community matrons and district nurses, and in an integrated health and social care reability service. Tasks supervised by qualified staff include: delivering agreed care plans and pathways; health improvement; and clinical tasks within individual competency levels, such as catheterisation, wound or stoma care. Their ability to adjust care plans and refer individuals onto other services or agencies gives a more seamless and timely service.

David Read joined Sirona as an AP in March, working with Sarah Webb, the community matron. He completes initial assessments and refers clients on, reports back any physical changes and attends weekly team meetings with GPs.

Ms Webb says: “Feedback from clients has been positive as they appreciate the support David is able to offer. I can now concentrate on the most complex intensive clients, including practising my advanced clinical assessments and prescribing skills.”

“I did have reservations about delegation and accountability. However, it quickly became apparent these were not justified. It is about keeping an open mind, building up a level of trust, and letting go of the jobs that you don’t really need to do.”

Mr Read says: “It takes time to reassure nurses I am there to help and to only work within my assessed competencies. I have to respect that the pace at which that develops will vary from nurse to nurse.”

Sirona says roles succeed where boundaries are clear and fully understood, staff are confident the training gives the right competencies and skills, and robust workforce planning identifies these roles as part of the skill mix.

Benefits to patients

Miller et al (2015) concluded: “Support staff with ‘time to care’ can have immeasurable impact on quality and safety” and training in routine therapies can mean patients are seen more quickly. They suggested APs can improve patient experience and ensure services remain viable. Services struggling with a high turnover of nurses used APs to give a more stable workforce and reduce reliance on bank nurses, increasing consistency of care; nurses in one regional rehabilitation service were leaving because the work was “not at the pace they were looking for”, and so APs replaced some of these posts.

Opportunities for nurses

There is evidence of the role freeing up registered staff to do higher-level work (Box 1). Two stroke early supported discharge services in Nottingham used rehabilitation assistants to deliver repetitive everyday exercises, allowing more skilled staff to focus on more specialist rehabilitation (Miller et al, 2015). One AP talked about freeing up ward nurses to provide “more specialist care, for example give a controlled drug promptly when required”.

Miller et al (2015) said employers need to communicate much better “the opportunities these changes would bring for development and involvement in higher added value activities for the registered staff”;

however, freezing of vacant posts in the recent economic climate has sometimes meant “registered staff may see no benefit from such changes in terms of further development opportunities”.

Challenges

Lack of registration and regulation of AP roles remains the largest barrier to acceptance and raises concerns around delega-
tion and supervision (Miller et al, 2015). Nurses’ concerns included:

Uncertainty about supervision;

A misconception that the supervising nurse is accountable if an unregistered practitioner makes a mistake;

Concern about what tasks can be delegated and the associated risks;

Believing education or training not leading to registration lacks credibility.

The RCN has expressed concern that “APs are being asked to make clinical decisions that should only be undertaken by nurses” and called for the role to be registered (Miller et al, 2015).

In Spilsbury’s (2011) survey of APs, while 84% were clear about their role, only 47% believed it was understood by nurses, and 56% said their role fluctuated depending on the nurse on duty. It concluded: “AP posts succeed where their introduction...meets a clearly identified need and where the roles and responsibilities of the AP and the wider team are clear and understood”.

Organisations should start by “communicating the opportunities that will arise for registered staff from tasks being devolved downwards and how the role will be incorporated into existing teams” (Miller et al, 2015). A typical model would see APs “undertaking tasks for which it has previously been agreed that they are competent to do, possibly with sign off at the end by a registered practitioner... or reporting back to the supervisor if there any specific issues that need clarification or confirmation”.

Roles were also more likely to be successful “where their development is part of local workforce planning”, rather than, as tends to happen, “reactorion, responding mainly to a shortage of registered professionals or drives for cost-efficiencies”.

Conclusion

When APs are introduced to enhance skill mix they can increase the ability of healthcare teams to provide high-quality, efficient and cost-effective care. While most AP roles have been in acute care, attention is switching to their use in community and primary care settings. APs can free nurses to focus on higher-level work and take on new or expanded roles. However, concerns remain, particularly over handing over elements of clinical nursing care to an unregulated and unregulated workforce. NT

References


Royal College of Nursing (2010) Assistant Practitioner Scoping Project. Bit.ly/RCAssistantPractitioners


