An evaluation of the preparation and role of Emergency Care Practitioners in Dorset

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Acknowledgements

We would like to thank all the Emergency Care Practitioners who gave up their time to take part in this survey.

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Background

The Emergency Care Practitioner (ECP) is a new role which is being introduced nationally to enhance patients' experiences through their emergency care journey and to provide care that is patient-focused, rather than system-focused. It is aimed at enabling ECPs to make autonomous decisions based on sound clinical assessment and judgement, to complete episodes of care in a range of settings including the out-of-hospital setting when it is safe to do so, and to arrange referrals when it is not (NHS Modernisation Agency 2003b).

Bournemouth University, in conjunction with the Dorset Ambulance Trust, has been involved with preparing practitioners for this role. This report is an evaluative summary of the views and comments of the first intake of students to undertake the preparation and subsequently work as ECPs.

Aims of this study

- To evaluate the ECP programme and its ability to prepare practitioners for the ECP role;
- To explore the views ECPs have about adjusting to their new role;
- To explore issues of acceptance of the new role by other healthcare professionals;
- To use information gained from ECPs to inform any further support that may be needed for them to pursue this role.

Findings

- The perceptions and experiences of ECPs in their new role so far show the role to be of benefit to patients;
- The course is a good start for the preparation of the role, and feedback from participants is being used responsively by the course team to improve the delivery;
- There are transitional challenges in consolidating the role of the ECP on a number of levels in practice:
  - Protected time;
  - Named mentors;
  - Exposure to experiences;
- There is a general lack of clarity about the actual role of the ECP by both ECPs and other health care personnel;
- The role would benefit from more operational guidance.

Recommendations

- A definition of the role of the ECP and its operational context should be made available to all ECPs, GPs and others involved in the service they provide;

- There should be on-going evaluations of the university course to inform the structure and content of future courses;
- Protected time should be made available for ECP students to consolidate their practice under the supervision of a suitably experienced mentor (GP/nurse practitioner). This should be organised prior the student exiting the university course;
- ECP students should not be expected to undertake tasks unsupervised until they achieve competency in the task;
- Protocols/guidelines should be made available for clinical tasks, and Patient Group Directives should be revised to cover the necessary drugs and conditions;
- Greater resources (internet, books, etc.) should be available at treatment centres;
- Consideration should be given for two personnel to attend patients, to avoid chaperone/'dangerous' patient issues;
- Academic support should be more rigorous while students are consolidating practice.

The Survey

Introduction

The Emergency Care Practitioner (ECP) role is one of the most innovative approaches to reforming emergency care that has emerged in years. Although other roles are also being tested and developed, the ECP role is at the forefront, having undergone the greatest degree of trialling and refinement (NHS Modernisation Agency 2003b).

In 2001, the Joint Royal Colleges Ambulance Liaison Committee and the Ambulance Trust Association first raised the concept of the 'Practitioner in Emergency Care'. The role they envisaged was focused on developing a 'Paramedic Practitioner' within the Ambulance Trust. The Department of Health became interested in taking the idea forward and requested that the chosen practitioners be drawn from a range of professional backgrounds.

The Changing Workforce Programme (CWP) was tasked by the Department of Health to develop the role of the 'Emergency Care Practitioner' (ECP) as part of an emergency care development (Wintle 2003).

Emergency Care Practitioners will be the first point of contact for many patients with a wide range of health problems. To prepare ECPs for this role, a programme was designed by the NHS Modernisation Agency to equip participants with an enhanced range of skills in history taking and physical assessment for them to be able to undertake patient assessment in a range of clinical settings (NHS Modernisation Agency, 2003a). Furthermore, the CWP viewed the programme not only in terms of enhancing patient care, but also in providing career development opportunities for the personnel involved.

Development of the ECP programme was based on the competencies needed to deliver the ECP role, and was piloted in the Coventry and Warwickshire Health Community in 2002. Since then, some 17 health communities have prepared personnel for the role, including the Dorset Ambulance Trust in partnership with Bournemouth University.

This study explores the preparation for the ECP role within Dorset. The first programme locally commenced in March 2004 and followed guidelines issued by the Modernisation Agency. Thirteen practitioners enrolled on the programme; three were registered nurses and ten were

trained paramedics. The course comprised 15 weeks at Bournemouth University, with a further six months' consolidation of practice experience in various patient areas. The first cohort of participants was included in this study and their views gained via interview and questionnaire on their preparation for the role, and their experiences of the role within their six months' consolidation period.

The theoretical element of the course, run by Bournemouth University, was developed by taking the intended learning outcomes and curriculum outline laid down by the Modernisation Agency and devising a 15-week course to include the above. The course speakers were drawn from a variety of clinical backgrounds and included specialists in their fields. The course was led by a nurse consultant in rural medicine who had close liaison with the ambulance service.

As with all courses run by the University, students were asked to evaluate their experiences, and their comments were scrutinised by the course team and changes made for the next course. The evaluation took the form of discussion and written comments. This is an ongoing process with each Emergency Care Practitioner course that has been delivered (three to date, with a further two planned). The evaluation process was particularly important for the course reviewed in this study as it was the first of its kind to be developed and run locally.

Students were given a comprehensive outline of the course on commencement, and a 'profile' of the competencies they were expected to achieve during their six-month consolidation period. These were to be practised under supervision and 'signed off' by their mentor in practice as they achieved competency in them. They subsequently formed the basis of their assessment of practice. The format of the profile document was taken from the Modernisation Agency.

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Methodology

Data Collection

A combination of qualitative and quantitative methods was used in this study. Initially, a purposeful sample, comprising five participants from the first cohort of the Emergency Practitioners programme, was interviewed. They were selected from different centres across Dorset and one from Hampshire (see Table 1). The centres they worked from included rural areas, semi-rural areas and towns. Four of the participants were registered paramedics and one a registered nurse. Data were collected using semi-structured interviews to gather their in-depth views. The questions were focused on the aims of the course, but allowed the participants to describe the situation in their own words and in their own time.

Table 1: Summary of characteristics of sample group interviewed.

Profession		**Gender**		**County**		**Locality**	
Nurse	1	Female	1	Dorset	4	Rural	2
Paramedic	4	Male	4	Hampshire	1	Semi-rural	2
						Town	1

The data were analysed and put into themes representing the views of the participants. From this analysis, a Likert-style questionnaire was designed and distributed to all 13 participants to confirm the information gained from the initial interviews. A response rate of 23% (n=3) was achieved (see Quantitative Data section).

Ethical Approval

Approval from the Head of Research at the Institute of Health & Community Studies, Bournemouth University, was gained for this study. All participants who agreed to be interviewed confirmed their agreement and consented for the data collected to be used for this study and for no other purpose. The semi-structured interviews were taped and the tapes destroyed following transcription and analysis.

All participants were sent an explanation of the study, together with a consent form which was duly signed. They were given the right to withdraw at any time. A copy of the proposal was sent to the director of the Dorset Ambulance Trust and Workforce Development Directorate prior to the study commencing.

Findings

Qualitative Data

The qualitative element of this evaluation of the Emergency Care Practitioner's role revealed that the five participants all held very similar views on a number of topics. There was some variance in the views of the nurse, which differed from the paramedic perspective, and also in the participant who worked in Hampshire as opposed to those who worked in Dorset. On the whole, the geographical area in which they worked did not influence their views, although their experiences varied.

Preparation for the role

University course

All those interviewed enjoyed the three-month course at Bournemouth University, although they found studying hard as some had not undertaken academic work before, or if they had it was many years ago:

> *It was hard work, but I enjoyed it.* (Participant 2)

Comments that the course team were unaware of the depth paramedics had studied to in the past meant that some sessions (e.g. anatomy and physiology) were pitched at an inappropriate level. Also, comments that the sequence of study days could be made more logical have since been addressed by the course team:

> *It needs to be structured so that we have the A&P, then the systems, then the illness/problem, then the assessment, then the treatment, and that we go through each system this way. It was a bit disjointed doing all the A&P together and then not relating it to the clinical problems for a couple of weeks.* (Participant 5)

There was also concern that the paediatric element was more hospital orientated than assessing and treating children in their homes. Other comments included:

- More sessions on paediatric problems needed;
- Less 'in-depth' aspects of mental health;
- More clinical examination sessions needed;
- More GPs to lecture: 'The odd GP we had was great and they're the people we will be working with' (Participant 1);
- More minor ailment sessions needed.

The participants all acknowledged that this was the first course to be run locally and that there would be 'teething troubles'. They also acknowledged that much of what they said had already been addressed by the course team for future courses. The complexity of the number of different speakers involved was welcomed, but did cause administrative problems on occasions.

Change to the service for patients

All participants believed the concept of the Emergency Care Practitioner to be of great benefit to patients. One participant stated that he was able to treat 50% of the patients he was called out to at home and therefore prevent the need for an ambulance or admission to an Accident and Emergency (A&E) department. Another simply stated that 'patients get a better deal' (Participant 5).

Many examples of care given in the home were cited, particularly stressing that patients were seen more speedily than having to wait in an A&E department. One participant was able to take bloods and, via telephone referral to a Care of the Elderly consultant, treat a patient in a nursing home rather than admit them to an acute ward.

One participant, on visiting a patient with chest pain, stated:

> *Yes, I've kept them out of hospital, but it was scary at first – as a paramedic I would have taken it in.* (Participant 5)

Two participants were more reticent, stating that, in time, the difference would be greater when there was a wider understanding of their role. One viewed their out-of-hours role as:

> *Safety-netting people – making sure they're safe until in-hours.* (Participant 4)

However, all those in Dorset had forged links between themselves and set up their own 'referral' system where they sought help and advice from each other, and emailed each other on a regular basis. They had also forged links with other healthcare professionals:

> *I see the role as enhancing communication between healthcare groups to ensure a smooth experience for patients, but we're still short on numbers and still trying to develop our own skills.* (Participant 5)

Participant 5 went on to say:

> *I think we're going to have to specialise within our role, we can't all possibly know everything about everything – we need to be more like nurse practitioners and have our own special fields.*

Consolidated practice

Concern was expressed by all the participants about the quality of their consolidated practice period. One participant summed his experience up with the words: 'well let's have some' (Participant 5). At interview for the course, the participants had been told (by the ambulance service) that they would have a period of 'protected' supervised practice where they could consolidate the new skills and knowledge they would need to be an Emergency Care Practitioner, and that this would be for a period of six months.

Following completion of the university course, the paramedics in Dorset went straight back to work as paramedics on 999 calls for the first three months due to staffing shortages:

> *Everything has to be done within the operational needs of the ambulance service.* (Participant 5)

In October 2004, the Dorset Ambulance Service won the contract for out-of-hours working and the paramedics who had been on the ECP course were then used to staff this service.

Without exception, all paramedics stated that they did not get time to consolidate, and that they had to arrange any consolidation themselves, mostly in their off-duty times. One participant had been offered overtime pay to cover this consolidation period. Participants believed the ambulance service should address these issues:

> *I couldn't do it in six months, too many restrictions from my employer.* (Participant 2)

> *We thought we'd have six months, but in the back of my mind I thought 'no, this is the ambulance service – it can't be real'.* (Participant 3)

> *They did tell us that we were going to have six months in which to consolidate. I suppose all of us, naïvely believed it, but soon realised it wasn't going to happen.* (Participant 1)

> *I've had to put my own time in, but that's the ambulance culture.* (Participant 3)

> *Directly you become operational there is a tension between the needs of the ECP student and the ambulance service – operational management don't understand our needs.* (Participant 5).

> *The planning is lax – there is no-one to organise it.* (Participant 4)

> *Service has got to think past the first three months.* (Participant 1)

The exception to this was a nurse who was working with a Primary Care Trust in Hampshire:

> *I had to find my own support and experience, but have been given the time to do it. My employer said I could take as long as it took.* (Participant 2)

Equally, participants all had to find their own mentors in practice, which proved difficult as they were the first group of ECPs to emerge and they didn't know who to ask:

> *I had ideas of what I wanted to do, but didn't know anyone, and when I did find someone I didn't have the time to meet up with them.* (Participant 3)

> *I went to Accident & Emergency, but got called out more-or-less straight away to go on a 999 call. It's not fair on me or the mentor or the patient who I was trying to treat.* (Participant 4)

The main concern about the lack of supervised practice was that participants could not consolidate their clinical skills before being expected to undertake procedures on patients. The nurse in the group expressed concern over consolidating different skills from the ones paramedics had reported:

> *A paramedic has different skills and levels of knowledge that they bring to the course. I found pharmacology and clinical skills easier as I'd been doing it all my working life, whereas I was struggling with emergency work like intubation.* (Participant 2)

Change to role of the ECP

The participants were experiencing some difficulty about their change of role and felt that it was being muddled with servicing the out-of-hours contract. They also stated that neither the ambulance service nor general

practitioners understood their new role. This was not helped by the fact that four of the five interviewed had not received an updated job description (from that of a paramedic) and the nurse had had to write her own:

> *Nobody knew what the role was.* (Participant 5)

> *People don't understand the role – it's a different doctrine from treat and go – I knew exactly where I was as a paramedic and suddenly I'm doing something completely new* (Participant 3)

> *The ambulance service are still treating us as paramedics, there's a perceived threat in the term Emergency Care Practitioner…because they are still treating us as paramedics, I don't think they get full value from us.* (Participant 1)

> *I'm not sure what my role is.* (Participant 5)

> *I do what comes along.* (Participant 2)

One participant was more positive:

> *Now most people have been in their role for a while they can see how things work.* (Participant 4)

However, all agreed that their role had changed. The biggest change appeared to be the responsibility and accountability they now carried. The thought of litigation was uppermost in their minds, and the fact that they have to make their own decisions and act on them. All commented on the wide range of liaison they now have with other healthcare professionals, which was to the benefit of their patients.

Concern was expressed by some participants who were being asked to work outside their role. The expectation of GPs was that they could perform clinical tasks for which they had received 'theoretical' teaching, but had not had the opportunity to practice the skill (examples were given of being asked to catheterise and suture patients). One participant saw the danger of overstepping their role even if they were trying to do the best thing for their patients. Another participant was sent to review a patient he knew he didn't have the skills to treat and pointed this out, but was still expected to attend. Another was asked to administer drugs he was not covered to do. The consensus was that this was partly because GPs did not understand the role, and partly because some GPs saw them as being able to do things they would normally be called out to do.

Problems arose when participants were many miles from their base (up to 40 miles) and despite phone contact with the GP were not able to give the treatment required for the patients. This particularly occurred where locum GPs from Europe were unappreciative of the role and had different expectations of an ECP or, more widely, the culture of, and options available, within the NHS.

Protocols

All participants remarked on the lack of protocols available for the ECP role. The paramedics were used to protocols for emergency cases, but did not have any for the ECP cases. Likewise, the nurse was used to working with protocols and guidelines. The lack of guidelines was also raised by one of the teachers who was instructing in a clinical skill and wanted to know the protocols for their role surrounding that skill. Two participants stated they went on the internet prior to going out to visit patients to try to gain information they needed, while another spent over £400 on books which he kept in his car. The comments made surrounding this issue included:

> *We have no guidelines, we just think on our feet.* (Participant 1)

> *It's down to us to decide what to do and how to do it.* (Participant 4)

> *Nothing specific is written down, I use the handouts given to me on my course.* (Participant 3)

Patient Group Directives

Patient Group Directives (PGDs) also caused concern. One participant simply asked:

> *Well, are they legal? They don't cover the drugs we need to give, or enough conditions.* (Participant 1)

This was echoed by all participants. The participant in Hampshire had instigated a group for writing PGDs as they saw it key to the role, whereas participants in Dorset believed new ones were being written. However, as one participant stated:

> *They should have been in place a year ago.* (Participant 2)

Participants were often asked to administer drugs outside the PGDs, mainly because they held the 'doctor's box' with additional drugs in their car. One felt particularly frustrated as they could not complete the

treatment for a patient because they could not administer a specific drug – this caused particular problems as they were 30 miles from their base and a GP had to be called out.

Two participants expressed concern over being the sole person to visit patients:

> *I knew I was going to have to catheterise a female patient, and it was possible there would just be her and me – where did that leave me without a chaperone? At least GPs have a driver with them, and as a paramedic there would have been two of us.* (Participant 3)

Participant 1 was sent to a patient who was an alcohol and drug abuser and had been reported to be 'throwing things':

> *I went in there and actually he was reasonably quite, but with a risk assessment I should never have gone in there alone.*

Other views on the ECP role

Colleagues in the ambulance service

The paramedics reported differing views of their role from their colleagues in the ambulance service:

> *On the whole they view the role as a good one, it helps them with their role* [paramedic role]*, and keeps people out of A&E.* (Participant 3)

Whilst Participant 4 found*:*

> *There is resentment from colleagues – the perception is that we are doing what we like – a few people are against us.*

Participant 1 volunteered the information:

> *There are more ECPs off sick with stress than there are paramedics.*

The nurse in the group stated:

> *Some good, some bad reactions. Some nurses think we're mad to be taking on more responsibility.*

General practitioners

Their reporting of the views of general practitioners also varied:

> *Some are very helpful, others don't let you in the room.* (Participant 1)

> *Some are positive, some are negative – when I do an assessment they realise I've had to put in study to do this – I'm not just an ordinary nurse.* (Participant 2)

One participant stated they felt that some GPs used the ECPs as an opportunity to do less work, while others saw the ECP role as a threat. However, the GPs who were keen to see the role enhanced received favourable comments, although this centred more on the support for the consolidated practice:

> *One GP has taken it upon himself to organise training sessions for us – not in conjunction with the ambulance service.* (Participant 5)

> *I had good support – we went into a patient's home and he let me examine and treat the patient.* (Participant 3)

> *The GPs are keen to encourage us, I feel able to discuss things freely with them.* (Participant 4)

> *He asked me to assess a patient, but gave me his mobile number and said he would come out if I wanted him to at any time.* (Participant 2)

Nurse practitioners

One participant mentioned that the nurse practitioners were the best people to work with, but again he was talking about the consolidated practice.

Future courses

Participants were asked about how they felt future Emergency Care Practitioners should be prepared for their role. Their answers included:

- The ambulance service need to decide what they want us to do;
- We should have protected time off work to consolidate;
- The consolidation needs to be organised with identified mentors;
- An explanation of the role should be given to all involved;
- There has been a lack of exposure to certain conditions and therefore I have been unable to complete my course outcomes and profile (all participants).

Quantitative Data

The response from the questionnaires sent out was disappointing, with only three being returned (see Table 2). However, on the whole the quantitative data confirmed the findings of the participants interviewed. Twenty-two questions were asked which required answers to be classified on a Likert-style scale, with responses ranging from strongly agree to strongly disagree. Two of the questions about course content were open ended, and three were yes/no answers. Limited demographic was also sought.

Table 2: Summary of characteristics of questionnaire respondents.

Profession		**Gender**		**Locality**	
Nurse	1	Male	3	Semi-rural	2
Paramedic	2	Female	0	Mixed	1

Participants indicated that some additional topics needed to be included in the university course, and conversely some needed to be scaled down – these are outlined in the section about the university course (above).

There was uniformity in the answers to questions relating to the consolidated practice period. All felt that their supervised practice had not allowed them to consolidate their knowledge and skills, and that they had to organise it themselves and find their own mentors. The two participants working for the ambulance service strongly disagreed that the ambulance service understood the importance of this protected time.

The ambulance personnel strongly agreed that the role of the ECP had been confused with out of hours working, while the nurse disagreed; but all agreed that the role had benefited patients by allowing them to be treated at home (where appropriate) and prevented unnecessary admissions to hospital.

All participants had patient group directives, and one of the participants believed them to cover a sufficient variety of patient conditions – the other two disagreed. With protocols, all participants claimed there were none in place. On the question as to whether they had a job description, two answered no, whereas one was not sure.

All three participants stated that they had received good support from doctors, and the nurse and one paramedic stated the support from their colleagues was good. One paramedic strongly disagreed that he had peer support.

The nurse believed they were not asked to undertake tasks beyond their role, whereas the two paramedics strongly believed this happened. Again, the two paramedics felt the ambulance service did not understand their role, but the nurse believed their employer did.

Finally, all agreed there could be more academic support while they were undertaking their consolidated period to complete their competencies.

Conclusion

Without exception, all participants believed the role of the Emergency Care Practitioner to be the way forward for delivering a quality service to patients in an out-of-hospital setting. As previously stated, one participant highlighted that he was able to treat 50% of the patients he was called out to at home and therefore prevented the need for an ambulance or hospital admission. The main 'plus' of the ECP role was that patients were treated more speedily than having to wait in A&E departments. Despite reservations on a number of issues, they were all enthusiastic about the role and wanted it to develop further. The initial course, on the whole, was accepted and issues from course evaluation at the time have influenced future courses.

The main problems appeared to stem from the consolidation period and the lack of organisational input into this, along with confusion about the role itself. It was apparent that participants had been left to sort out their own experiences and find their own mentors. Likewise, there was no uniformity in the role and in what ECPs were being asked to do by GPs or ambulance control. The belief was that, 'The ambulance service had not thought this through' (Participant 1), and that guidelines, protocols PGDs and job descriptions should have been in place before the role was introduced. In addition, GPs did not understand what the role entailed and how they could work with ECPs to enhance patient care. Differing expectations of the ECPs arose depending on where the ECP was based, i.e. rural or town location, and differing amounts of support were available for ECPs in different areas.

No participant has finished the course as yet because they have been unable to complete the competencies required due to problems accessing supervised consolidated practice. Three participants felt they would have benefited from more academic input into the way they presented their assignments. The expectation was that this cohort would have completed by January 2005.

Recommendations

- A definition of the role of the Emergency Care Practitioner and its operational context should be made available to all Emergency Care Practitioners, GPs and others involved in the service they provide;
- On-going evaluations of the university course should continue to inform the structure and content of future courses;
- Protected time should be made available for ECP students to consolidate their practice under the supervision of a suitably experienced mentor (GP/nurse practitioner). This should be organised prior to the student leaving the university course;
- ECP students should not be expected to undertake tasks unsupervised until they have reached competency in the task;
- Protocols/guidelines should be made available for clinical tasks, and Patient Group Directives should be revised to cover the necessary drugs and conditions;
- Greater resources (internet, books, etc.) should be available at treatment centres;
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References

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