**In this article...**
- History and background of the role of nursing associate
- Experience of a critical care unit supporting a nursing associate trainee
- Skills required from future nursing associates joining a critical care nursing team

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**Developing the nursing associate role in a critical care unit**

**Key points**

- The role of nursing associate (NA) was created to fill the gap between healthcare assistants and registered nurses.
- Future NAs can be trained in specialist areas of nursing practice, such as critical care.
- Training future NAs requires an understanding of the scope of practice and staff engagement.
- There is freedom to tailor NA training to area-specific needs.
- NAs can strengthen the nursing team but it is too early to determine their value.

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**Abstract** The role of nursing associate (NA) was originally created as a generic nursing role to bridge the gap between healthcare assistants and registered nurses. When it was launched, there was no guidance on how it could be incorporated into specialist areas of nursing such as critical care; however, this meant there was freedom to tailor its training to area-specific needs. This article looks at the experience of a small critical care unit in North Devon in taking on an NA trainee. It explores the background of the new role, the challenges faced and the development of skills priorities specific to critical care. This early experience is encouraging, but it is still too early to determine the overall value of NAs, and their future in critical care is an open book. For NAs to thrive in that setting, their role will need to be incorporated into national competency frameworks and standards for safe staffing.

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Nurse shortages have been well publicised in recent years. Many organisations have struggled to recruit and retain enough nursing staff to meet the recommended nurse-patient ratios. Following publication of the Francis report, the need for nationally recognised safe staffing levels was identified (Francis, 2013). In 2014, the National Institute for Health and Care Excellence published guidance on safe staffing for nursing in adult inpatient wards in acute hospitals (NICE, 2014) and, in 2016, the Faculty of Intensive Care Medicine and Intensive Care Society updated its guidance on safe staffing in critical care, publishing the first version of its Guidelines for the Provision of Intensive Care Services; these guidelines have recently been updated (FICM and ICS, 2019).

Today it is estimated that, across the UK, there are 41,000 vacant nursing positions in the NHS (Dolton et al, 2018), in addition to the 5,000-10,000 shortfall in nursing staff as a result of Brexit that has been predicted by the National Institute of Economic and Social Research (Dolton et al, 2018). Creative thinking into how the NHS nursing workforce can continue to provide safe, effective and good-quality care will be a national priority over the next few years.

**Birth of a new role**

Building tiers within professions and bridging gaps between them by developing different roles – such as assistant practitioners and advanced practitioners – is not a new concept in the NHS, but there had never been a focus on nursing. In 2015, the government announced the creation of a new role, that of nursing associate (NA), which was identified as an additional tier in the nursing profession that would fill the gap between healthcare assistants (HCAs) and registered nurses (RNs). The new role would create a pathway for career progression and an additional route to becoming an RN.

In October 2016, Health Education England announced that 1,000 future NAs
would start training in December that year – soon to be followed by a further 1,000 trainees – and that 11 pilot sites had been identified to train the first wave (HEE, 2016). An outcome-based curriculum had been created: future NAs were to undergo a two-year foundation degree academic programme covering eight key domains (HEE, 2017). Those eight key domains have been outlined in Box 1, while Box 2 outlines the core structure of the national NA training programme.

The concept of the academic programme had thus been laid out, but many aspects of the NA role were still being worked on, including value, professional accountability, skills, competences and scope of practice. In addition, there was no national template to support the introduction of NAs in specialist areas of nursing. While this ‘one size fits all’ approach could produce generic NAs, it did not allow for creativity in specialist areas of practice. This was acknowledged by Vanson and Beckett (2018) who, in their evaluation of the introduction of the role, suggested freedom should be given to tailor certain aspects of NA training to local needs.

**Trialling the role in critical care**

Northern Devon Healthcare NHS Trust was one of the 11 identified pilot sites and, in December 2016, a first cohort of 13 NA trainees started training with us. To support implementation and iron out initial concerns, the trust appointed a project lead and established consultation between departments. Focus groups on mentoring, academic domains, scope of practice and professional regulation were regularly held. This led people at the trust expressing an interest in exploring the NA role in a more specialist field – that of critical care.

For many years, the critical care unit at the trust had had a stable workforce, comprised predominately of RNs supported by a small number of HCAs. Due to the small size of the unit – it has eight beds, an average of 500 patients a year and 37 whole-time-equivalent RNs – assistant practitioner and advanced practitioner roles had not been felt necessary.

However, between October 2017 and October 2018, the unit experienced an increased turnover of RNs and struggled to recruit for vacant posts. Turnover increased from 5% to 15% due to career progression, personal lifestyle choices and retirement. Although the unit had helped former nurses come back into nursing, invested in newly qualified nurses and offered its staff opportunities for development, creative thinking was now essential to futureproof the service.

The depletion of the critical care nursing workforce coincided with the arrival of the first cohort of NA trainees. This led the trust to decide to trial the NA role in critical care and review its workforce plans for the unit. While this was not an immediate solution to workforce gaps, it enabled us to review the composition of the nursing team in critical care. Today, it is more in line with NHS England’s (2019) The NHS Long-term Plan.

**Initial challenges**

The critical care unit started supporting its first NA trainee in January 2017 as part of the trust’s second cohort. The trainee was an HCA already working in the unit – as such, they had a good level of knowledge of critical care. We encountered initial challenges in four areas:

- Relation to RNs;
- Scope of practice;
- Scope of training experience;
- Levels of skills and knowledge.

**Relation to RNs**

There were concerns the NA role could be used to dilute the RN workforce but HEE’s intention was that NAs would support RNs, not replace them. The aim is to strengthen the workforce and increase the depth of its knowledge so nursing teams can continue providing safe, good-quality care.

The RN and NA roles have different scopes of practice and the NA role cannot exist without support from RNs. As there is no national recognised staffing model to support the introduction of NAs in critical care, we were working outside of national staffing recommendations and had to be very careful how we approached this.

**Scope of practice**

Because the NA role was still under development, it was difficult to fully clarify queries about its scope of practice. Identifying the key differences between NAs and RNs was a good starting point: NAs directly provide and monitor care, safety and quality, and contribute to integrated care while RNs are the decision makers, responsible and accountable for planning and evaluating care, along with leading, managing and coordinating it. Both roles are equally accountable and responsible for their acts and omissions (Nursing and Midwifery Council, 2018). These distinctions gave us a basis on which to decide how tasks should be allocated.

**Scope of training experience**

The two-year level 5 curriculum developed by HEE (HEE, 2017) uses a work-based learning model that enables NA trainees to

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**Box 1. NA national training programme: eight key domains**

- **Domain 1:** professional values and parameters of practice
- **Domain 2:** person-centred approaches to care
- **Domain 3:** delivering care
- **Domain 4:** communication and interpersonal skills
- **Domain 5:** team working and leadership
- **Domain 6:** duty of care, candour, equality and diversity
- **Domain 7:** supporting learning and assessment in practice
- **Domain 8:** research, development and innovation

**Source:** Health Education England (2017)

**Box 2. NA national training programme: core structure**

- Full-time course with 3,000 practice hours over two years
- Trainees work as a band 3 and are released one day a week to attend taught sessions
- Trainees are allocated a number of supernumerary shifts to develop clinical skills and shadow registered nurses or other health professionals
- Each trainee has a ‘home ward’ with an overall mentor
- Trainees rotate placements every two to three months
- Placements cover hospital, close-to-home and home settings
- Placements use different care providers, such as hospitals, general practices, hospices, nursing homes, ambulance services etc

**Source:** Health Education England (2017)
gain technical knowledge alongside hands-on experience. To broaden their experience, rotating placements expose trainees to different healthcare settings, different patient populations and different medical/surgical conditions.

One of the initial challenges we encountered was explaining that future NAs cannot be trained to work only in one setting, department or specialty. Like the training for future RNs, that for future NAs needs to expose students to a variety of clinical situations and settings so they can develop a wide range of skills and competencies.

**Level of skills and knowledge**

A two-year level 5 foundation programme cannot provide the same level of theoretical knowledge and clinical skills as a three-year level 6 programme (which is what RNs go through). In the critical care team, people raised concerns about the depth and detail of future NAs’ knowledge of anatomy, physiology and pharmacology, and their consequent ability to monitor patients, interpret and act on visual signs, adjust treatments, give medication and undertake procedures.

Trainees have a practice assessment document (PAD) that supports the eight key domains identified by HEE. To some extent, the PAD can be adapted to suit area-specific needs; equally, during training, the depth and breadth of knowledge expected can be shifted to match the individual’s stage of learning. However, we had to convince the critical care nursing team that the NA training could not focus only on the development of critical care skills.

**Long-term challenges**

Overcoming these challenges and gaining the confidence and support of the nursing workforce were essential to make the trainee NA role work. Alongside holding question and answer sessions with staff, identifying a mentor interested in supporting the role was also pivotal. We sought advice and support from our regional network (South West Critical Care Network) but found out that no other critical care units in the region were supporting the NA training programme.

After the first year of training, a number of new questions and challenges emerged about the long-term development of the NA role in critical care. We found that:

- The rotating placements, while giving the trainee a more-rounded experience, had a negative effect on our ability to develop their area-specific skills;
- Staff found the frequent rotations disruptive to the trainee’s learning and development; they would have preferred the trainee to remain in critical care during placements;
- As no other regional critical care unit at the time was training future NAs, the team was unable to rely on the support of a network and so, sometimes, felt quite isolated;
- Critical care nurses thought it would be good to develop a formal competency document and assessment process.

**Critical care competency document**

Developing a training programme and competency document specific to critical care was challenging, notably due to the absence of a national template supporting the introduction of the NA role in specialist areas of nursing.

Critical care nursing is generally structured according to the well-established tiered competency framework of the Critical Care Networks – National Nurse Leads (CC3N) (Box 3, Bit.ly/CC3NCompetency-Framework), which, itself, is structured around the three levels of critical care for adults devised by the Intensive Care Society (Box 4). Recently, along with other critical care nursing organisations, CC3N has developed competencies for level 1 patients in enhanced care areas (CC3N, 2018). These competencies have a systematic approach, focusing on the A-E (airway, breathing, circulation, disability, exposure) assessment, recognition of deterioration, and the use of the SBAR (situation, background, assessment, recommendation) approach for communication and escalation.

Rather than trying to create something new, we used these competencies for enhanced care areas as a starting point, alongside their PAD, to put together our competency document. Box 5 shows the three sets of priorities we have established for our NA trainee based on the CC3N competencies for enhanced care areas. The NA trainee tackles each set of priorities, one after the other, over time.

The NA trainee is assessed by their mentor and/or the unit’s clinical educator to ensure consistency in education, information and assessment. After each assessment, the trainee’s new skills are shared with the nursing team; this helps the team support the trainee, allocate tasks and maintain safety.

The aim of the training is to equip the NA trainee with the background knowledge they need to acquire the skills specific to critical care. We now have a structured education document that supports the theoretical and practical aspects of the training. Clear priorities have been set, with a focus on the development of the broader knowledge (pharmacology, physiology and patient assessment) needed to develop critical-care skills.
Advice to others
We were the first critical care unit in our regional network to invest in the NA training programme. The feedback we gave at network meetings has been useful for regional units keen to explore the role.

This is our advice to others who may be keen to develop the NA role:
- Set a clear timeframe for development and clear clinical objectives;
- Engage with team members – their support will be key;
- Regularly meet the team and feed back to them to iron out any difficulties;
- Engage with people at senior executive/director level to gain their support;
- Identify NA-specific mentors who will support and drive the role;
- Provide weekly protected supernumerary time for trainees to work with mentors;
- Arrange placements predominantly in critical care to maximise training, but allow trainees to visit a variety of clinical settings so they acquire a more rounded experience;
- Establish a working model for the allocation of patient care;
- Incorporate the role into workforce plans and nursing strategies;
- Prepare a nursing model that supports the NA role in practice – this will be useful if a business case is required;
- Complete quality impact assessments – this will enable you to continuously review the impact the role has on patients, staff and finances, from development to implementation.

In the future
We are excited by the new role and the idea of developing its scope of practice. The fact that NAs are regulated by the NMC has increased public and health professionals’ confidence in the long-term plans for the role. There are minimal limitations to the development of its competencies and skill set, the major one being the administration of intravenous medication.

We hope, after registration, our NA will complete step 1 of the CC3N competency framework while we develop a training programme that will eventually allow them to perform the key skills involved with level 3 patient care. The trust plans to start training further NAs in May 2020 – we plan to be part of the selection process and would like to support one more NA.

The absence of a national template has allowed us to tailor training to area-specific requirements but national templates may be required as NAs develop further and are introduced in more clinical areas. It would be useful to see the role recognised in specialist fields of practice through the development of NA-specific competency frameworks and the incorporation of NAs into standards for safe staffing in critical care. This would help overcome challenges around establishment setting and funding, without losing registered nursing staff.

Conclusion
Although recruitment and retention of nursing staff will remain problematic for some time yet, the NA role can provide career progression for HCAs and give organisations the ability to ‘grow their own nurses’. Ultimately, increasing the depth of knowledge and strength in the profession can only have a positive effect on patient outcomes and experience.

It is still difficult to determine the exact value of NAs, but without taking risks we cannot innovate and without innovating we cannot find solutions to the nursing workforce crisis. Exploring how nursing can incorporate multiple health professionals into teams will ultimately improve patient outcomes in critical care.

References
National Institute for Health and Care Excellence (2014) Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals. nice.org.uk/5g1

Creating new roles in healthcare: lessons from the literature
Bit.ly/NTNurseRolesNew

For more on this topic online

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