



MONASH University



# The UK role of the Emergency Care Practitioner: Clinical and collaborative components?

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# ECP Background

- ECP developments have been influenced by:
  - Targets (response times and waiting times)
  - Workforce gaps
  - Changing working practices/hours
  - Patient demographics
  - Expectations of care
  - Tyranny of distance
  - Tyranny of traffic
  - With the aim of right skill, right time, right place.

# ECP definition

- Definition: "A healthcare professional (*paramedic or nurse*) who works to a medical model, with the attitude, skills and knowledge base to deliver holistic care and treatment within the pre-hospital, primary and acute care settings with a broadly defined level of autonomy"<sub>1</sub>

# Education

- Bachelors degree (Level 3) covering for example:
  - Issues in emergency care
  - Mentorship
  - Leadership and management
  - Applied skills
    - Patient assessment
    - Investigations
    - Treatment (e.g. prescribing, wound closure)
- Certificate level (Level 1) (3 months)
  - Covering clinical skills

# Aim of this study

- To identify contemporary ECP practice and performance including:
  - Clinical and
  - Collaborative components

*Collaboration defined as:*

*Working in positive association with others*

# Setting

- SW of England
  - Population 5 million
  - Land mass equivalent to south/eastern Victoria
- Tyranny of traffic/time

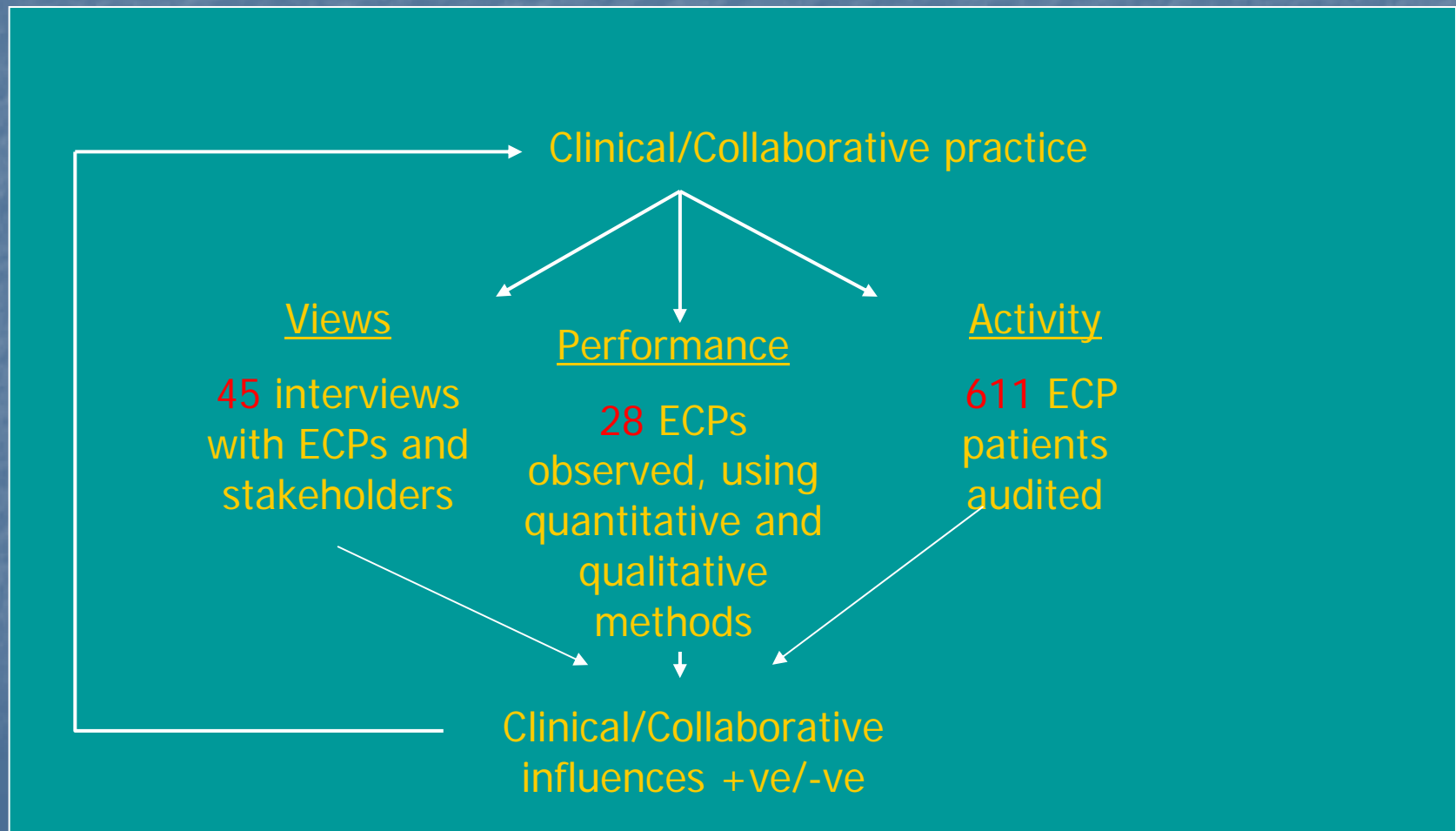


# Sample

- Study period 2005-6
- ECP staff [n=29] in SW of England (urban and rural settings)
- Recruitment n=24 (83%)
- 4 ECPs observed twice i.e. 28 observations

# Sample (continued) and Methods

## A 12 month clinical case study



# Quantitative Rating scales

- Observational ratings based upon:
  - Leadership Behaviour Description Questionnaire (LBDQ)
  - Communication Competence Questionnaire (CCQ)
  - Emergency Team Dynamics (ETD)

*Cronbach's alpha >0.80 for all the scales (including >0.94 for the previously untested ETD)*

# ECP Demographics

## ECP Demographics

- 21 male 3 female
- All over 31 years
- 3 had primary qualifications as nurses, 21 as paramedics and 2 dual qualified
- 15 qualified at certificate level, 7 at bachelors and 2 at masters
- Mean years as a health care professional =19 (range 10-33)
- Mean years as an ECP 1.8 (range 1-3)

# Results

# Quantitative Results-Observation

- Significant correlation between all the rating scales ( $p=0.01$ ). Better leaders were better communicators and team workers.
- However, range was large on all the scales e.g. 29% to 100% on LBDQ. Some ECPs were very poor leaders & communicators.

# Quantitative Results-Observation

- More highly educated ECPs had a higher mean rating on all the scales reaching significance in the leadership ratings ( $p=0.05$ ).
- Significant +ve correlation between years as a HCP and leadership ability ( $p=0.023$ ).
- Women's mean ratings were all higher than men's (but not significantly)?

# Results-Patient Audit

- 6 Week audit of 25 ECPs patients from across the region - n=611 patients

## Results

- ECPs treated a wide range of conditions but predominantly minor.
- 49% of patients were over 65 years
- Mean response time 17 mins (range 1min – 13 hours)

# Results-Patient Audit

- Mean time on scene 47 mins (range 1 min – 4.5 hours)
- Only 30% patients were seen out of hours
- 62% patients not-conveyed to hospital
  - Previous reports ... 50% for ECPs, 36% for paramedics.
- In training ECPs conveyed significantly more patients ( $p=0.04$ )

# Qualitative Findings: Influences on Collaboration

- Theme 1: ECP Role Perception
  - See/treat/refer clinical role
  - To bridge build
  - To reduce response times
  - To fill out of hours gaps
  - As an educator (patients & staff)
  - Holism of care
    - But the quality of communication was limited by a 'restricted ambulance code'

# Qualitative Findings: Influences on Collaboration

- Theme 2: Cultural influences on the ECP role
  - Emergency service v National Health Service
  - Blue collar v white collar professionalism
  - Management, ambulance and ECP silos

# Qualitative Findings: Influences on Collaboration

- Theme 3: Education and Training
  - Graduate education v skills training
  - De-skilling & standby
  - CPD desire
  - Minor Injury Units for skills development
  - Clinical supervision

# Recommendations for this region

- Graduate multi-professional education
- Leadership, communication and teamwork training
- Clinical supervision (especially trainees) for safe lone working
- Focussed clinical practice (e.g. minor injury/illness and the elderly)
- ECP Clinical leads
- Multi-professional experience

# Evidence for ECPs?

- A 2008 literature review (*Cooper & Grant*) of international pre-hospital roles showed:
  - Quantitative studies
    - 1 cluster randomised trial of paramedic practitioners
    - 1 ECP patient satisfaction survey
  - Mixed method studies
    - 6 evaluation studies of ECP practice and performance.
- All papers identified positive impacts of ECP practice, but there is opinion and comment which challenges this. There is some evidence of cost effectiveness.

# References

1. Skills for Health (The ECP Team) (2007). The Competence and Curriculum Framework for the Emergency Care Practitioner. Skills for Health
  - **Cooper S.** O'Carroll J. Jenkin A. Badger B. (2007) Collaborative practices in unscheduled emergency care. The role and impact of the Emergency Care Practitioner (ECP): Quantitative Findings. *Emergency Medical Journal.* 24; 630-633.
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  - **Cooper S.** O'Carroll J. Jenkin A. Badger B. (2008). Emergency Care Practitioners (ECP): Practice and Performance in the UK Westcountry? *International Emergency Nursing* 16, 3, 180-184.



**ANY  
QUESTIONS?**