Getting the mix right: Assistants in Nursing and skill mix

One of the current issues dominating the nursing profession is skill mix. It is well documented throughout the literature of the relationship between staffing levels, skill mix and adverse events.

At an open forum with 56 registered nurses (RNs) from various Australian states, the role of assistants in nursing (AlfNs) was a burning issue; for those RNs already working with AlfNs within their career structure and for those who would be in the future. The following discussion highlights a few of the issues highlighted by RNs working in the acute care setting, and how these issues correlate to current literature on skill mix and quality patient care.

Discussions at the forum were held within an online learning space at an Australian regional university with registered nurses carrying out postgraduate studies in acute care. The focus of the forum was on the increasing extent of AlfNs in the acute care setting. The registered nurses within the forum were from a variety of Australian states including Tasmania, New South Wales, Queensland and Victoria; they were all made aware of the intent to make public the outcomes of the discussion.

Whilst Carrigan (2009) mentions a proportion of AlfNs are undergraduate nursing students as does Dinsdale (2005), the general opinions and experiences of RNs in acute care consider this is not an adequate reason to use them in substitution of RNs. The constraints of the AlfN position prevent undergraduate nursing students from using skills they have learned and practised during the course of their studies and clinical placements, for example, medication administration. Rationalising the use of undergraduate nursing students as AlfNs as a safety measure comes with multiple issues. Although recent studies suggest that using nursing undergraduates as AlfNs as a possible way to combat the challenges tertiary institutions face.
The premise that increasing the numbers of AINs in acute care settings is a viable alternative to increasing the numbers of RNs is a micro political health issue. From the observations and experiences of a group of RNs working in acute care settings in a variety of states in Australia, this directly impacts on the provision of both patient care and nurses’ work.

Using the search term ‘assistants in nursing’ revealed there is a paucity of research, particularly recent research, in relation to AINs and their roles in the acute health care team. In the United Kingdom alone, it is estimated there are possibly over 300 different job titles for nursing assistants (Spilsbury and Meyer 2004). In order to find sufficient research data, the search parameters were expanded to include health care assistants, certified nursing assistants, and nursing assistants, all who share similar position descriptions to those of an AIN.

The shortage of RNs has been a focal point of research for many years (Cowin and Jacobsson 2003; Duffield et al 2010; Hogan et al 2007; Keenan 2003; Walker et al 2007). The forum discussions echoed sentiments of ANF Senior Federal Industrial Officer Nick Blake (cited in Carrigan 2009) that one of the primary reasons AINs are employed in substitution of RNs is as a cost cutting exercise. However, Needleman et al (2006) found the cost of employing RNs as opposed to lesser skilled workers is self-recouping. Carrigan (2009, p25) cites NSW Nurses and Midwives’ Association General Secretary Brett Holmes’ view that AINs should not be employed ‘at the expense of registered or enrolled nurse positions’, a point previously made by Burns (2006). Despite this, there has been an increase of approximately 20% in the employment of AINs and a decrease in the employment of RNs over the same time (Carrigan 2009).

Cost cutting

There were a number of RNs in the forum who claimed the replacement of an absent RN with another RN rarely occurs in their facilities, despite this being documented in the Public Health System Nurses’ and Midwives’ (State) Award (NSW Health 2011). One RN stated: “More often than not, we are informed that there is no available nurse of the same classification and we will be sent an AIN, regardless of the unreasonable workload this will place on the RN.”

This same award specifies that workloads are to be reasonable for nurses and that this is the responsibility of the employer (NSW Health 2011). It would appear that, regardless of these specifications, the practice of replacing RNs with AINs is well established and likely to continue unabated.

The addition of AINs to the skill mix is not new. Indeed, Walker et al (2007) conducted research at St Vincent’s Private Hospital in Sydney, which introduced AINs in 2002. Employment of RNs was reduced as a result of increased numbers of AINs and noted that communication levels needed to be significantly improved. The timely intervention of care when a patient is deteriorating was cited as one area of communication needing improvement (Walker et al 2007). The authors determined that skill mix did have drawbacks, but, to compensate for decreased numbers of RNs, the inclusion of AINs in staffing allocations is likely to stay. Likewise, Gravlin and Bittner (2010) reached the same conclusion based on cost saving measures.
The RNs at the forum reported, and research supports, clarification of duties, together with increased education opportunities for AINs, are necessary to facilitate the safe care of patients.

**Education/training**

McKenna et al (2007) also determined that AINs are now incorporated as part of the health care team and are entitled to further education. O’Shea (2009) concluded that accessible educational courses are necessary for safe patient care. Some of the RNs in the forum considered an enhanced knowledge base would increase their confidence of ENs leading to an increase in their job satisfaction. Castle (2010, p218) substantiates this belief when he observes that satisfaction with their jobs could well have ‘important implications for quality of care’. There is an element of discontent in relation to their job requirements (Castle 2010), and some AINs are not forthcoming about their position. Many of the RNs in the forum gave examples they had seen in their practice, one RN stated: “In the acute care hospital which I work one AIN known to me often wears an RN shirt and does not display her AIN identification badge in clear view. She is frequently thought to be an RN by the patients.”

Many RNs in the forum viewed AINs as valuable members of the health care team, which is widely supported by research (Carrigan 2009; Deshong and Henderson 2010; Theze 2004; Walker et al 2010). However AINs’ knowledge/skills base is significantly less than that of an RN. Indeed, Deshong and Henderson (2010) recognise that AINs often work with patients who need acute care, without the required knowledge or skills to adequately cope. Clarke (2004, p67) also supports this view, adding that ‘educated and experienced nurses’ often make informed clinical decisions which lead directly to positive patient outcomes.

**Time management**

Attending to the fundamental needs of patients is recognised as the domain of AINs (Stockwell 2002). The RNs in the forum freely discussed their experiences working with AINs, many of them reported they had more than once encountered AINs who, coupled with their limited knowledge base, had very underdeveloped English language skills which impairs their ability to provide informed care and recognise signs and symptoms of a deteriorating patient. This lack of high calibre assistance is noted by Brooks and Anderson (2004) as a contributing factor to the excessive demands on RNs’ time and the ability to perform nursing tasks adequately. One RN stated: “As well as managing my own allocated patients, I must spend an inordinate amount of time double checking all work carried out by the AIN who is under my supervision and for whom I am legally accountable.” This issue has been well highlighted in the literature (Deshong and Henderson 2010; Jervis 2002). The RN went on to say with the support of her peers, that this negatively impacts time management, with research showing that proficient time management is paramount in the provision of the highest level of care (Willis et al 2005). The effect is amplified when the AIN is agency staff, particularly as research has found that the use of agency staff has a disruptive effect (Stockwell 2002).
Poor communication between AINs and RNs may lead to errors (Gravlin and Bittner 2010; Sorensen et al 2008). This was an interesting area of discussion in the forum where many RNs claimed of firsthand experience. One RN stated: “I did not immediately realise that the AIN I was working with had negligible English comprehension and inaccurate knowledge about the normal ranges for vital sign and observations.”

This incident was widely discussed in the forum; many participants agreed that clarification of the AIN’s ability to follow instructions and ascertaining one’s knowledge base should have been established at the outset. The presumption made by many RNs that AINs know what to do has been discussed in research (Spilsbury and Meyer 2004) as it is not uncommon. It is often only through the time consuming task of double checking the AIN’s work that problems are discovered. The RN further said: “I discovered my patient was febrile and very unwell after the AIN had charted his obs and told me they were going to lunch. I then had to go back and do all the work again that the AIN had done, that was meant to make my job easier.”

Many of the RNs at the forum who have been working with AINs for some time reported that whilst there is a position description which sets out clearly the requirements of AINs (NSW Health 2010b), they find that when allocated the care of eight to 10 patients with an AIN, they have the full care and responsibility of all patients for medication administration, vital observations, wound care, care planning and documentation; and the personal care (including showering, toileting and bed making) of at least four to five of these patients. The AIN assumes the personal care of the other four to five patients. One RN commented: “I have always found this to be an inequitable division of care, but the AINs I have worked with state that it is unreasonable to expect them to shower more than half of the allocated patients and make their beds.”

With this brief insight it would seem RNs working at the coalface consider there is a significant increase in the workload of an RN in this skill mix. The RNs at the forum reported, and research supports, clarification of duties, together with increased education opportunities for AINs, are necessary to facilitate the safe care of patients (McKenna et al 2004; Spilsbury and Meyer 2004), as is effective teamwork between RNs and AINs (Kalisch and Lee 2010). Klee (2009) recognises the need for the definition of position expectations in order to facilitate equitable teamwork, as did Burns (2006). AINs by definition are employed to assist the nurse in providing care (McKenna et al 2007). However, whilst the responsibilities of AINs are clearly delineated in the relevant health literature (NSW Health 2010) there does not appear to be any directives in relation to division of duties when sharing a patient load with an RN. The paucity of up to date research on the effectiveness of AINs in place of RNs within the health care team needs to be addressed. By asking RNs to reflect on experiences with AINs, the presumpation made by many RNs that AINs know what to do has been discussed in research (Spilsbury and Meyer 2004) as it is not uncommon. It is often only through the time consuming task of double checking the AIN’s work that problems are discovered. The RN further said: “I discovered my patient was febrile and very unwell after the AIN had charted his obs and told me they were going to lunch. I then had to go back and do all the work again that the AIN had done, that was meant to make my job easier.”

References
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