Entrustables and Entrustment: Through the Looking Glass at the Clinical Making of a Nurse Practitioner

L. Antoinette Bargagliotti, PhD, RN, FAAN, and
Doris Davenport, DSN, PNP

ABSTRACT

Entrustable professional activities (EPAs) formally address the supervision level required for nurse practitioner (NP) skills of students and fellows. Entrustment is the decision to entrust students and fellows with the responsibility to practice professional skills without direct supervision. EPAs offer the promise of consistency within and among NP programs about the expected skills of NP students and fellows and how and when they are acquired. EPAs highlight how and when the supervision and entrustment decisions are made. Their use in medical and graduate medical education suggests that EPAs would provide a common vocabulary among NP students, fellows, and physician colleagues.

Keywords: Entrustables, entrustable professional activities, nurse practitioner evaluation, nurse practitioner skills, nurse practitioner transition

In the clinical making of a nurse practitioner (NP), faculties or preceptors decide to *entrust* selected aspects of advanced nursing practice to NP students because they believe that the student can safely and competently perform an advanced task. NP faculties have identified the need for a framework for the evaluation of NP student capabilities.[1] The purpose of this article is to suggest that what faculties or preceptors allow NP students to do are *entrustables* that are tacitly known to nursing faculty and preceptors within and among nursing programs. What remains tacit knowledge among nursing educators and preceptors is when and to some extent how we entrust these activities to students. However, this tacit knowledge is used every day to decide when a student requires supervision. An entrustable is the step beyond being *checked off* in a simulation laboratory or an NP intensive with standard patients or simulators and then being observed clinically. Entrustment is the formal decision to give students the opportunity for independent practice of a skill.

BACKGROUND

In the formation of physicians and advanced practice nurses, there is always an education practice gap because practice evolves in additive ways. Nonstandardized performance evaluation tools do not address in a meaningful way the education to practice gap that exists for NP students. Operationalizing competencies with entrustable professional activities (EPAs) standardizes evaluation because EPAs are discrete, measurable, observable activities stated in easily understood ways.[2] For example, the formulation of a differential diagnosis, the interpretation of diagnostic tests, a physical examination, and the Subjective, Objective, Assessment, Plan (SOAP) note are EPAs for NP programs. For an adult gerontology acute care NP program, endotracheal intubation, performing a lumbar puncture, and insertion of a central line might be EPAs. The development of standardized EPAs across NP programs will enhance the reliability of NP skills that new NP graduates, physician colleagues, and the consuming public can count on. The fundamental premise underscoring the use of standardized EPAs is patient safety and the accountability of educational programs to NP students and the consuming public.

The various governing bodies of graduate medical education in the United States, the Netherlands, Canada, and the United Kingdom sought to bridge

the education and practice gap by delineating entrustables or EPAs as "those professional activities that together constitute the mass of critical elements that operationally define a profession."[3(p544)] After a great deal of work, US medical schools and medical specialty associations delineated EPAs for medical students and physician residents at different milestone points in their graduate medical education programs.[4–8] In the fluid process that emerged as multiple medical schools and medical specialty associations took on the task of delineating EPAs specific to areas of practice, the terms EPAs, milestones, and outcomes were sometimes used interchangeably.[5] However, an EPA is the professional activity that requires skill, judgment, and supervision of learners performing the activity. In contrast, milestones represent the marker points (competencies) in a curriculum when EPAs should be or should have been accomplished.

EPAs and the Medical Education Practice Gap

Medical educators used the concept of entrustables and EPAs to address an education practice gap that began with graduate medical education programs indicating that medical graduates were not entering residencies with the necessary skills to be successful. Medical residency directors had similar problems with residents who were not completing residencies with the skill sets for practice. Medicine now has the domains of competencies for physicians and EPAs that lead learners to those competencies in undergraduate medical programs (medical school) and graduate medical programs (residencies).

The 13 EPAs and 4 procedures expected of medical school graduates entering a residency[9] are familiar to nurse educators because several of these are accomplished by bachelor of science in nursing students (giving/receiving handoffs, contributing to a culture of safety by recognizing system failures, documenting a patient encounter, and collaborating with the interdisciplinary team). The remainder (obtaining a history and physical, prioritizing differential diagnoses, and recommending and interpreting laboratory data) are accomplished with the completion of the direct care core in NP programs (advanced pathophysiology, pharmacology, and health assessment).

The Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties have adopted 6 competencies that all physicians should attain (medical knowledge, patient care and procedures, practice-based learning and improvement, system-based practice, interpersonal and communication skills, and professionalism).[10] The residency EPAs each address more than 1 of these 6 competencies and their subcompetencies (usually 10-12). For example, an internal medicine EPA is to manage transitions of care. These are written in table form with the EPA and the 4 specific tasks (such as anticipate expected course of disease and barriers), the numbers of the 6 medical competencies the EPA addresses, and the assessment method/tools (chart audit, direct observation, and multisource feedback) that can be used to assess proficiency with the EPA.[11] A family medicine EPA is "diagnose and manage acute illness and injury."[4] Pharmacy has recently developed EPAs for graduates that include items such as "collects information to identify a patient's medication-related problems and health related needs."[12]

EPAs and the Nursing Education Advanced Practice Gap

The National Organization of Nurse Practitioner Faculties in collaboration with the American Association of Colleges of Nursing developed NP competencies that are required to be addressed in all NP programs.[13] However, how students reach those has not yet been standardized. Programs have successfully used simulation, standardized patients in advanced health assessment courses, Objective Structured Clinical Examinations (OSCEs) in clinical courses, and intensives with skills practice.

Complicating the acquisition of NP skills is the use of different preceptors in different practice sites every semester and limited practice hours that vary between 500 and 950 hours across programs. Although doctor of nursing practice programs have extended practice hours to a minimum of 1,000 hours over a longer period, time does not offer a solution to the lack of specificity or standardization across programs.

There are a growing number of postgraduate fellowship programs for new NP graduates.[1,14–16]