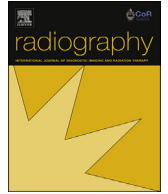




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Assistant radiographer practitioners: Creating capacity or challenging professional boundaries?

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ABSTRACT

Introduction: Over the last 2 decades the assistant radiographer practitioner (ARP) role has been introduced into NHS diagnostic imaging departments as a strategy to expand the workforce and create capacity. This skill mix initiative has not been implemented in a standardised way and there is limited knowledge of the current role scope within general radiography (X-Ray).

Method: An electronic survey of ARPs working within UK diagnostic imaging departments was conducted. Both open and closed questions sought information regarding basic demographic data (age category; gender; geographic region), scope of practice (patient groups; anatomical regions; imaging outside of the diagnostic imaging department), limitations placed on practice, supervision and additional roles.

Results: A total of 108 responses, including 13 trainees, were received. Most sites employ three or less ARPs in general radiography ($n = 43/66$; 65.2%), although 11 sites have five (range 1–15). The majority undertake imaging of both adults and children ($n = 85/108$; 78.7%), although limitations on age were described. Their scope of practice covers a broad anatomical range and included some non-ambulant patients. The level of supervision varied with some sites empowering ARPs to check the referral prior to examination ($n = 25$) or images post acquisition ($n = 32$) (both $n = 20/66$; $\chi^2 = 16.003$; 1df; $p = 0.000$).

Conclusion: ARPs are helping to maintain capacity in imaging departments but we suggest there is further scope for expansion. The practice described by the post holders suggests that many are working beyond the scope envisaged by the radiography professional body.

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Introduction

The assistant radiographer practitioner (ARP) role was formally embedded into diagnostic imaging in the early 2000's after being piloted for a review of the skill mix of the NHS radiography workforce.¹ The specific aim of the skill mix strategy was to expand the imaging workforce by implementing a four-tier structure, from assistant to non-medical consultant. This was seen as a way to cope with burgeoning demand, providing a development route for support staff and enabling the expansion of the role of registered radiographers.^{1–3} Within healthcare, assistant practitioners are defined as:

'A worker who competently delivers health and social care to and for people ... able to deliver elements of health and social care and undertake clinical work in domains that have previously only been the remit of registered professionals'⁴

Assistant practitioners are expected to deliver protocol-based care under the direction of a registered professional.² Usually educated to Level 4 or 5,^{5,6} a foundation degree or other similar academic award, alongside the completion of work based training in the clinical environment. However, the role and scope of assistant practice have been found to vary between health professions and employers, with tension between policy definitions and implementation.^{3,7} Cancer workforce plans announced in 2017⁸ announced plans for in excess of 2000 additional diagnostic radiographers and a further 300 more advanced practitioners by 2021, therefore opportunities to grow the entire imaging workforce are needed. A lack of local workforce planning has hindered benefit realisation in the utilisation of ARPs⁹ and therefore there is a need

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to identify the purpose of this tier and its' contribution to greater imaging capacity across all levels.

There is limited knowledge of current assistant practitioner numbers or the breadth of their role in contemporary practice. Previous research identified supervisory issues, limitations on departmental flexibility and impact on undergraduate student training.^{7,9–13} This article reports on a national survey to explore their role and scope of practice within imaging. This article has a specific focus on general radiography (X-Ray) and aims to provide insight into the role and post holders. Further discussion of the ARP role across all imaging modalities will be presented in a separate paper. For clarity the term *assistant radiographer practitioner* has been used throughout this paper to distinguish the role from posts created at this level within other health professions or clinical settings.

Method

This study was a UK survey of radiography ARP practice within diagnostic imaging departments utilising an electronic survey tool (Bristol Online Survey®, Bristol, UK). An initial invitation was distributed as a paper letter to radiology managers of all UK NHS Trusts (or Health Boards) identified from Government statistics and national hospitals databases (n = 218). Although there are a number of independent sector providers of imaging services, the authors are cognisant of the expectations of the Cancer Workforce Plan⁸ in relation to imaging capacity and radiographer number growth, so therefore the survey was directed at NHS provision. No formal ARP database exists, thus a snowball sampling method was adopted whereby radiology managers and ARPs were asked to share the invitation with other ARPs known to them. Additional strategies to increase recruitment were initiated including a notice in the monthly radiographer professional journal (Synergy News) and through social media. All mailings provided an introduction to the purpose of the research, information regarding voluntary participation, data to be collected (including its management) and a link to the survey.

The survey remained open for 12 weeks between August and October 2017, with a reminder letter addressed to the 'Assistant Radiographer Practitioners' at each organisation distributed 4 weeks before the closing date. Prospective participants were provided a contact email address for a member of the study team (DP) if there was any uncertainty about whether the survey was of relevance to their role. To ensure accurate response analysis, invitees were asked to complete the survey only once.

Following a review of the literature, the survey was developed to comprise both closed and open questions specific to general radiography, including basic demographic data (age category; gender; geographic region), scope of practice (patient groups; anatomical regions; imaging distant to the diagnostic imaging department), limitations placed on practice, supervision of practice and additional roles. Where appropriate, respondents were asked to provide additional free text comments. Relevant responses have been reported in the results with the unique identification (ID) number of the respondent. An initial pilot study was conducted using a small cohort of ARPs and radiographers which resulted in minor amendments to the questions to aid comprehension. This data was not included in final analysis and the ARPs involved were free to participate in the main survey if they wished.

The survey collected anonymised data, with only fundamental demographic information requested to assist in generating an overview of respondents. As this was an evaluation of current practice ethical approval was not required following Health Research Authority (HRA) guidance.¹⁴ However, ethical issues were considered following discussions with the local Research and

Development department and the study adhered to good research practice guidance. Respondents consent was considered to be implied by reading the study explanatory introduction and by completion of the survey.

Following closure of the survey response data were downloaded into Excel® (Microsoft Corporation 2010, USA) to allow for descriptive analysis and exploration of free text responses, further statistical analysis was performed using IBM SPSS (Version 24.0, Chicago, US).

Results

Demographics

A total of 108 responses, including 11 trainees, were received from ARPs working within general radiography. Although responses were received from all four home countries, the majority were from England (Table 1). All ARPs who have completed their training (qualified) confirmed they were paid at band 4 under Agenda for Change (AfC) with trainees at band 2 (n = 4), band 3 (n = 6), band 4 (n = 2) or through AfC Annex U agreements (n = 1). Two of the qualified ARPs stated they were undergraduate radiography students working as an ARP part time.

Most sites employ three or less ARPs in general radiography (n = 43/66; 65.2%), although 11 sites have five (range 1–15). Nearly two thirds of the qualified ARPs (n = 61/95; 64.2%) work full time (≥ 37.5 hrs per week), but only 22 (n = 22/95; 23.2%) work week-ends or evenings as part of their core hours. Although the majority of ARPs work alongside student radiographers with a radiographer in attendance, one third of the qualified ARPs (n = 33/95; 34.7%) indicate they work alone with students.

Scope of practice

The majority of ARPs examine adults and children (n = 85/108; 78.7%) although limits on children's age were often cited these varied (3–16years), with some suggesting that only babies or young children would not be included. The most common lower age limits were stated as 5 years (n = 12) or 12 years (n = 23), although this was seen to vary between organisations. Individuals described specific practice including: "able to xray on children from 12 to 18 -extremities only" (ID 25129682), or "can image from 6 years of age not below that" (ID 25154923). Whereas one stated that the "imaging of paediatrics under 16 require supervision from Radiographers" (ID 25813679). Additionally, for those who stated their scope to be limited to adults there was some debate as to the definition of 'adult', with some citing 16 years of age, whilst others suggested 18 years and the term 'Gillick competent' was also referred to by four respondents.

Most stated that they can undertake imaging of the chest, abdomen, appendicular and axial skeleton (n = 80/108; 74.1%), although almost half of these (n = 39/80; 48.8%) indicated specific limitations in relation to skull, face and dental examinations. The majority of ARPs (n = 101/108; 93.5%) stated they could examine non-ambulant patients, although many described restrictions, for example "patients in chairs or trolleys can [be] examined as long as the examination does not require modified technique" (ID 25182279) and "Non ambulant chest and extremities" (ID 25832900). A number also confirmed such patients were undertaken alongside a radiographer, "I work closely with qualified radiographers when examining non-ambulant and emergency patients" (ID 25698389), "Non ambulant patients that require assistance are carried out under the supervision of or assisting the radiographer" (ID 25186231).

When the specifics of supervision was sought 87.9% (n = 95/108), including eight trainees, confirmed it was usual to perform

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