Who or what is an unregulated care provider?
The term unregulated care provider (UCP) was just one of several titles used to describe an unregulated worker who performs a variety of tasks, some of which may traditionally have been performed by regulated health care professionals (RHCPs). Some of the other popular titles include generic worker, multi-skilled worker, personal support worker, nursing aide, nurse extender, and unlicensed assistive personnel.

Where does the concept come from?
The UCP concept has been instituted to various degrees for various reasons which include:
1. To deal with shortages of RHCPs. It is assumed that employing UCPs to perform the simpler tasks often performed by professionals will allow the professionals to focus on the complex aspects of their work.
2. To cut costs. Even when there are ample supplies of RHCPs, employing lower-cost multi-skilled workers allows institutions to serve the same number of people with fewer higher-paid professional care providers.
3. To implement "patient-focused care." Patient-focused care is an American reengineering phenomenon that changes processes within institutions to make them more patient-friendly. It eliminates departments and results in the provision of multiple services at the ward level by individuals who are trained in multiple skills.

What do research articles tell us about the use of UCPs?
Fewer than 25% of the articles reviewed were research studies. Most of the studies used small, American, convenience samples which may not generalize to Canadian health care. The implementation of UCPs is often done in conjunction with other interventions which makes it difficult to determine which outcomes are related to UCPs alone. Also, the different ways UCPs have been used in studies make them difficult to compare. The following questions were asked while reviewing the research articles:

a. Does the use of UCPs save money?
   • the salaries of UCPs are lower than the salaries of RHCPs. Most institutions have not evaluated the cost-effectiveness of using UCPs beyond salaries.
   • there are costs associated with increases in the need for equipment (eg. IV infusions pumps to accommodate less RN monitoring time), RN overtime, high absenteeism, high turnover, UCP down time, staff injuries and legal liability
   • the institutional cost of training a UCP is estimated to be $4000 (U.S.) (Barter, McLaughlin & Thomas, 1994).

b. Does the use of UCPs affect the quality of care?
   • most studies suggest when the ratio of RNs to patients or RNs to other care providers decreases, there are increases in the mortality rate, average length of stay, and rate of rehospitalization.
   • studies measuring patient satisfaction, patient accidents, and complications are inconclusive about a relationship to UCPs.
   • studies of RHCP time suggest they spend more time in supervision, but less time in direct patient care when working with UCPs.
c. Are there any problems with using UCPs?
• there are no regulations for UCPs so patients cannot be assured of any standard of education or practice in this group of workers.
• registered nurses indicated that there are no tasks that can always be delegated to a UCP safely because patient care is individualized and patient acuity changes rapidly.
• continuous supervision of UCPs is needed to avoid large amounts of unproductive time.
• anecdotal reports suggest that UCPs sometimes make independent decisions which they are inadequately prepared to make and which can result in patient harm.
• job enlargement (ie. knowing how to do many tasks but mastering none) is associated with job dissatisfaction, high absenteeism and high turnover.

How should UCPs be implemented?

a. The process of reengineering to create the role
• measure costs and quality of care before and after implementation.
• include all levels of staff in the planning.
• provide a channel for regular communication to and from staff.
• prepare staff to deal with change and uncertainty.
• decide which services/tasks that your institution provides which could legally and ethically be delegated to a UCP. In the literature there are numerous examples of tasks that have been delegated (eg. stocking cupboards, venipuncture, taking vital signs).
• decide how the UCP could be integrated (ie. assigned to a ward, part of a care team or partnered with a RHCP).
• define the roles of the RHCPs and the UCPs.

b. Recruitment, education and training
• select individuals who are mature, flexible, and willing to learn. There are mixed suggestions about hiring individuals with prior experience in a similar position.
• most institutions use a combination of classroom instruction and clinical preceptorship over a period of one to four weeks, where the preceptorship is conducted by a RHCP.
most institutions provide RHCPs with an average of zero to three hours of in-service training on their new role as preceptor and supervisor.

• most institutions provide checklists for preceptors to evaluate UCPs in their performance of various skills.

c. Supervision and competency maintenance

• RHCPs must be trained and given the authority to delegate and supervise.
• delegation must be done appropriately to comply with the standards of professional practice set out by the Colleges of the regulated health care professions.
• there must be means for ongoing performance evaluation and skill maintenance to ensure the RHCPs that the UCPs are competent.

Conclusion
The implementation of UCPs can take many forms and the role can be filled by many different types of people. The results of studies are inconclusive concerning many of the outcomes largely because of individual variables. The implementation of UCPs may allow some institutions to save money while preserving quality of care, but these results cannot be guaranteed based on the research to date. There is a need for a rigorous study of the outcomes of using UCPs including costs and quality indicators such as mortality, length of stay, patient accidents, nosocomial infections, and skin breakdown.

Prepared by Donna Gill, RN, MSc

References upon request

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