ORIGINAL RESEARCH: EMPIRICAL RESEARCH – QUALITATIVE

Nurses’, midwives’ and key stakeholders’ experiences and perceptions of a scope of nursing and midwifery practice framework

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Abstract
Aim. This paper reports on the qualitative findings from a national review of a nursing and midwifery scope of practice framework.

Background. Scope of professional practice frameworks offers a system of rules and principles to regulate its members and demonstrate its responsibility to society. Key issues in reviewing the scope of practice include notions of specialist and advanced practice, accountability, autonomy, competence, supervision, continuing professional development and delegation. Evaluation of scope of practice frameworks has particular application value to nurses, midwives, regulatory bodies and healthcare employers across the globe.

Design. A mixed methods approach was used. This included a national survey of nurses and midwives and focus groups and interviews with key stakeholders. The qualitative data are reported in this paper.

Methods. Focus groups and interviews were conducted among a convenience purposive sample of key stakeholders, including nurses and midwives working in the widest range of services and settings in 2014. The participants contributed to thirteen focus groups and thirteen interviews.

Findings. Six global themes, as follows: Evolution of the nursing and midwifery professions and practice; Scope of practice: understanding and use; Expanding scope of practice; Professional competence; Practice setting and context; Reflections on the current framework.

Conclusion. Practitioners understand the scope of professional practice and while some see it as empowering others see it as potentially restrictive. Nurses and midwives are generally willing to expand their scope of practice and see it as resulting in improved patient care, improvement in overall quality of standards and increased job satisfaction.

Keywords: experiences, framework, midwifery, nursing, professional practice, qualitative research, scope of practice, stakeholder, thematic analysis
Introduction

A clearly defined nursing and midwifery scope of practice framework provides clarity in relation to the role competencies and accountabilities of the nurse and midwife, while being cognizant of the emerging needs of patients and health services. Factors such as the international fiscal crisis of 2008, the ageing demographics of developed countries, the gap between healthcare supply and demand in certain countries, the perception that nurses and midwives do not work to their full potential and the policy pledges to expand healthcare provision have necessitated changes in the scope of practice frameworks (Fairman et al. 2011, Riegel et al. 2012). These ongoing developments and the substantial role expansion, including the development of a range of clinical specialist and advanced practitioner grades have become more global. Hence, there is a growing need for Registered Nurses and Registered Midwives everywhere to maintain professional competence on an ongoing basis and, in Ireland for example, this is enshrined in the Nurses’ and Midwives’ Act 2011. Nursing organizations and regulatory entities in Canada, the USA, Australia and the UK have also sought to guide nurses in the determination of their scope of practice in an evolving social, fiscal and ethical context. These developments herald a need for continuous review of the scope of practice.

Most professional organizations have sought to: elucidate the determinants and professional parameters that shape the scope of practice; develop a decision-making framework for nurses using both Delphi methods and consensus building approaches; and subsequently validate the relevance and usefulness of the framework in the practice context (Davies & Fox-Young 2002). Such evaluations have taken varying forms, most especially surveys of practitioners and other stakeholders and interviews with practitioners. A continuing challenge is to ensure that scope of practice frameworks are readily applicable in varied practice contexts, sufficiently effective to guide practitioners so that they may work to their optimum capabilities, while at the same time ensuring safe and effective practice. In other words, frameworks and guidelines should be fit for purpose.

Background

Regulation of scope of practice can take many forms, from listing of services, individual interventions or competencies, to statements of broader roles and functions such as health promotion or injury prevention (Bigham et al. 2013) to decision-making frameworks that assist the practitioner in making self-regulated decisions about practice actions (An
Bord Altranais 2000a). Scope of professional practice is closely associated with concepts of professional conduct and accountability, self-governance and expanded practice. Professional regulatory bodies for nurses and midwives in developed countries have issued policies and/or guiding frameworks that address scope of practice. These frameworks offer a system of rules and principles by which the nursing profession is expected to regulate its members and demonstrate its responsibility to society. Nightingale provided the basis for the first code of conduct for clinical nursing practice (Dolan et al. 1983) and the International Council of Nurses (ICN) developed the first code in 1953. The ICN identifies scope of practice as being dynamic and responsive to healthcare needs (ICN 2004). The most recent ICN Code of Ethics for Nurses (2012) identified the fundamental responsibilities of nurses to promote health, prevent illness, restore health and alleviate suffering which adds to the challenges of determining the scope of professional nursing practice.

Nursing practice has evolved from a biomedical model to a more humanistic basis where ethical decision-making is paramount (Meleis 1991). Nevertheless, both nursing and midwifery practice remain closely aligned with medical practice and, while nurses and midwives practice under their respective regulatory frameworks, interdisciplinary practice remains largely interdependent and shared governance presents challenges. Key issues in relation to developing and reviewing the scope of practice include notions of specialist and advanced practice, accountability and autonomy, competence, supervision, continuing professional development and delegation (An Bord Altranais 2000b). The benefit of a scope of practice framework is that it defines the procedures, actions and processes that are permitted for the individual who is registered or licensed to practice. Evaluation of scope of practice frameworks would have particular application value to nurses, midwives, regulatory bodies and healthcare employers across the globe.

As part of a study to examine the impact of the UK’s Central Council for Nursing, Midwifery and Health Visiting (UKCC) Scope of Professional Practice, Jowett et al. (2001) surveyed several stakeholder groups using a structured questionnaire to elicit opinions on perceived advantages and disadvantages of role expansion and reported that practitioners were willing to expand their practice, so long as there were the necessary safeguards and supports and appropriate training in place for those taking on extended roles. A mixed methods study by White et al. (2008) of Canadian nurses reported that their perceptions of the meaning of ‘working to full scope of practice’ were represented in their descriptions of particular nursing activities, which they undertook; these activities included patient assessment and care coordination. Nurses’ and other stakeholders’ understandings and perceptions of the scope of professional practice, the extent to which nurses were ‘practising to scope’ and the barriers and facilitators to practising to scope in three Canadian health regions was examined using in-depth interviews by Oelke et al. (2008). They reported that nurses had difficulty in describing their scope of practice and did so in terms of tasks and activities that they performed. Additionally, while nurses reported that they were working to full scope, many experienced barriers to expanded practice roles (Oelke et al. 2008).

Fagerström (2009) examined the needs of advanced nurse practitioners (ANPs) in Finland with reference to their scope of practice and educational needs, using a combination of focus groups with ANPs and a survey questionnaire administered to nurse managers. The author found that the role of the ANP required advanced clinical skills for aspects of the practice role, such as tertiary prevention in long-term illness, secondary prevention in the care of older people and assessment and prescriptive skills in acute care, including the authority to order laboratory tests and x-rays. The ANPs’ nurse managers had clear expectations of the ANP role, including the ability to practice independently within an expanded scope of practice.

Research relating to the experiences of enrolled nurses’ (ENs) working in rural Victoria, Australia, in the area of medication administration using a job satisfaction questionnaire combined with individual interviews was undertaken by Hoodless and Bourke (2009). These authors reported that ENs who had received training in medication administration had improved job satisfaction. Using a critical incident technique within a constructivist methodology, Schluter et al. (2011) examined how Australian hospital nurses perceived their scope of practice in response to the available grade and skill mix. The authors reported that some participants equated ‘good nursing’ to working in ‘proximity to patients providing total patient care’. However, this ability to practice in proximity to patients could be restricted by factors like the increasing use of support healthcare staff to provide direct patient care, decreased length of stay in hospital, patient acuity levels, staff shortages, augmented indirect care responsibilities and perceived difficulties in interpreting core nursing roles which could not be delegated (Schluter et al. 2011).

More recently, Lubbe and Roets (2014) examined the scope of practice among nurses in South Africa through a retrospective quantitative audit of patient files. The authors analysed the risk assessment scores completed by nursing students and enrolled nurses in such areas as tissue
malnutrition and neurological deficits. They found that enrolled nurses and nursing students, when unsupervised, may engage in practices that place patients at risk and concluded that nurses with limited formal theoretical training are not adequately prepared to perform tasks unsupervised.

The focus of empirical studies on scope of practice has been on the extent to which the nursing resource, including the range of nursing skills, is optimally used in practice (Oelke et al. 2008, White et al. 2008, D’Amour et al. 2012) and on the facilitators and barriers that nurses and midwives encounter when expanding their scope of practice (Jowett et al. 2001, Oelke et al. 2008). The scope of practice has also been studied from the perspective of expanded roles and functions (Drennan et al. 2009, Fagerström 2009, Hoodless & Bourke 2009). Difficulties which continue to emerge in relation to scope of practice include balancing restriction with expansion of practice, the differences in defining scope of practice for both generic and specialist roles along with environmental and client-specific contextual factors (White et al. 2008, Schluter et al. 2011, D’Amour et al. 2012).

In Ireland, the Scope of Nursing and Midwifery Practice Framework (An Bord Altranais 2000a) encourages self-reliance among nurses and midwives in determining the boundaries and scope of their professional role. It provides an algorithm designed to be an effective and rational mechanism for decision-making around factors such as competence, accountability and autonomy, legislation and policy requirements. The developments in Ireland since the framework was published in 2000, represent a greatly altered practice landscape resulting in the need for a review of the scope of practice framework for nurses and midwives.

The study

Aim

To conduct a review of the Scope of Nursing and Midwifery Practice in Ireland.

Design

A mixed methods approach (Creswell & Plano Clark 2007) using a national survey of nurses and midwives and focus groups and interviews with key stakeholders. The evaluation strategy was informed by the principles of partnership (Casey 2008), however, only the qualitative data are reported in this paper.

Participants

Focus groups and interviews were conducted among a convenience purposive sample (Collins et al. 2007) of key stakeholders, including nurses and midwives working in the widest range of services and settings. The sampling strategy focused on the type of service and not the clinical grade of the nurses and midwives. Additionally, to ensure that key stakeholders with ‘different perspectives on the central phenomenon’ (Creswell & Plano Clark 2007, p. 112) were included, focus groups and interviews were conducted with nursing representatives from trade unions, government departments and from nursing and midwifery regulatory boards and service user representatives. In total 13 focus groups and 13 interviews involving 113 participants were conducted. Table 1 summarizes the individual events and number of participants.

Data collection

Data collection took place between January–March 2014. A topic guide was used for each focus group which was standardized with reference to categories for discussion. Modifications to the topic guide were made for the patient advocacy focus group. For the individual interviews, the same topic guide was adapted to address scope of practice issues associated with the particular role of each participant. The topic guide was pilot tested, at the level of the research team and minor modifications were made. Each participant was asked to complete a short demographic questionnaire and all focus groups and interviews were held in private, recorded with permission and transcribed verbatim for analysis. The focus groups comprised of up to ten participants lasting from 40–60 minutes approximately. The interviews lasted from 35–50 minutes.

Ethical considerations

The data collection procedures for the stakeholder consultation were subject to review by the UCD Human Research Ethics Committee (HREC) of University College Dublin. All participants received an information sheet about the purpose of the study and written consent was obtained prior to participation in the study.

Data analysis

Demographic data for participants were entered into Statistical Package for the Social Sciences© (SPSS version 20) software (SPSS Inc., Chicago, IL, USA) for data handling. Qualitative data generated from the focus groups and
interviews were transcribed after each was completed. Analysis followed the stages of data reduction, exploration and synthesis common to most qualitative research designs, regardless of their specific methodological commitments (Attride-Stirling 2001). Each transcript was read closely and tentative themes were noted using thematic network analysis. This method is best understood as a ‘web-like illustrations that summarize the main themes constituting a piece of text’ (Attride-Stirling 2001, p. 388). The analysis resulted in a network starting from basic themes and working inwards towards organising themes which led to the emergence of six superordinate or global themes. A coding frame was developed from the basic, organising and global themes and the resultant six global themes provided a conceptual lens through which to begin interpretation of the data. The coding frame was then imported into NVivo 10 (2012) software where a tree node structure was devised to represent the emerging global themes.

### Dependability, reliability and credibility

Dependability of the focus groups and interviews was enhanced by the use of a topic guide that was developed based on relevant literature. Dependability was further enhanced by confining the analysis to four members of the research team and seeking consensus and the use of a coding frame that was developed through the data reduction and synthesis process and verified by these members. Reliability of the data was gained through the quality of the transcripts where details of ‘intonation and prosody’ were included (Silverman 2006, p. 289) and opportunity for participants to read their transcript was also provided. Credibility was achieved by reading each transcript closely, coding the data into basic, organising and global themes and finally into a coding frame where all the data could eventually be accounted for based on similarity of content and substance and thereby providing internal consistency. This coding structure was agreed by all eight members of the team.

### Findings

The total number of nursing and midwifery participants in the focus groups was 94 and the range of participants for individual groups was 5–10. The age range of participants in the focus groups is outlined in Table 2. In total 76 participants provided their age category, demographic questionnaires were not completed for two groups (18 individuals). The majority of the nurses and midwives (n = 69) were registered in the general division of the register and 19 were registered midwives.

### Table 1

<table>
<thead>
<tr>
<th>Data collection events</th>
<th>Focus groups</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>General public hospital × 3 groups (nurses)</td>
<td>3</td>
<td>28</td>
</tr>
<tr>
<td>General private hospital (nurses)</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Public health nursing/community nurses</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Education (Nurses)</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Maternity hospital (all grades of midwives)</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Mental health service (all grades of nurses)</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Occupational health nurses</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Research nurses</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Residential care (private) nurses</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Residential care (public) nurses</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Patient advocacy group</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>97</td>
</tr>
<tr>
<td>Individual interviews</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community: GP services (practice nurse)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Intellectual disability</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>(2 participants in interview)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forensic service (nurses)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Prison service (nurses)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Medical education</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nursing and midwifery policy and regulation (nurses)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Professional regulation (nurses)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Professional associations (nurses)</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Midwifery practice</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nursing practice</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total overall number of events and participants</td>
<td>28</td>
<td>113</td>
</tr>
</tbody>
</table>

### Table 2

<table>
<thead>
<tr>
<th>Age range (N)</th>
<th>20–29</th>
<th>30–39</th>
<th>40–49</th>
<th>50–59</th>
<th>&gt;60</th>
<th>Total*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>9</td>
<td>22</td>
<td>25</td>
<td>14</td>
<td>1</td>
<td>71</td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>24</td>
<td>26</td>
<td>15</td>
<td>1</td>
<td>76</td>
</tr>
</tbody>
</table>

*In total, 76 participants provided their age category, demographic questionnaires were not completed for two groups (18 individuals).
With regard to their current grade, almost one-third of nurses and midwives (30.7%, n = 23) were staff grade or equivalent and one-third (32.0%, n = 24) were a clinical manager grade CNM2/CMM2 or equivalent (Table 3).

Six global themes were identified from the data: (1) evolution of the nursing and midwifery professions and practice; (2) scope of practice: understanding and use; (3) expanding scope of practice; (4) professional competence; (5) practice setting and context; and (6) reflections on the current decision-making framework. These six global themes and their associated organizing themes are summarized in Figure 1.

**Table 3 Current grade of focus group participants.**

<table>
<thead>
<tr>
<th>Grade</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff grade or equivalent</td>
<td>23</td>
<td>30.7</td>
</tr>
<tr>
<td>CNM1/CMM1 or equivalent</td>
<td>9</td>
<td>12.0</td>
</tr>
<tr>
<td>CNM2/CMM2 or equivalent</td>
<td>24</td>
<td>32.0</td>
</tr>
<tr>
<td>CNM3/CMM3 or equivalent</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>ADON or equivalent</td>
<td>4</td>
<td>5.3</td>
</tr>
<tr>
<td>DON or equivalent</td>
<td>2</td>
<td>2.7</td>
</tr>
<tr>
<td>CNS/CMS</td>
<td>3</td>
<td>4.0</td>
</tr>
<tr>
<td>ANP/AMP</td>
<td>2</td>
<td>2.7</td>
</tr>
<tr>
<td>Tutor or lecturer</td>
<td>2</td>
<td>2.7</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>6.6</td>
</tr>
<tr>
<td>Total</td>
<td>75</td>
<td>100</td>
</tr>
</tbody>
</table>

Theme 1: Evolution of nursing and midwifery professions and practice

Participants noted the changes in pre- and postregistration education in Ireland and the introductions of advanced practitioner roles and increasing numbers of nurse- and midwifery-led services;

When they evaluated the midwifery-led services in ’04 and ’06, the midwives themselves felt they needed an expert practitioner to enable and guide their practice...so they were one of the main areas as why the AMP was developed in the first place (Midwife).

Significant changes in the roles of nurses and midwives were highlighted across all practice settings:

The practice nurses would have started doing bloods and ECGs and injections...they’re running a midwifery clinic if they’re midwives, or they’re doing family planning clinics, they’re doing insertion of contraception devices, they’re doing...a huge amount of chronic disease management... (Practice nurse).

Theme 2: Scope of practice: understanding and use

Participants spoke about scope of practice as something internalised, something that is often not consciously considered. Others understood scope of practice to be about guiding and defining nursing and midwifery roles. Several participants...
linked scope to competency, training, level of knowledge, evidence-based practice and professional conduct:

So the framework should be part of what you do. If you’re saying you’re autonomous in clinical practice, you’re saying you don’t have to think about this (Midwife).

Others remarked that the setting in which a nurse or midwife was practicing could impact on how scope of practice was understood. One research nurse stated that:

[We] have to be especially careful that we are always working within our scope of practice, we always have to think twice about it (Research Nurse)

while a nurse working in a residential care home observed:

each person knows I think their capacity and capability and that the scope, what they can do and if I’m not confident, of course, I will not do it (Nurse).

Of key importance for participants was the consideration of how patient safety, quality of care and a client-led approach underpins a nurse’s or midwife’s scope of practice. Some participants noted that the use of scope of practice was related in some way to the nurse or midwife seeking permission from service managers to carry out particular tasks or roles:

When I was working as a staff nurse I wouldn’t have had to use the scope because I would have had my managers. So I would go to them, [asking] whether, ‘is that within my scope’ and then they would give me ‘no’, or ‘yes, you can go ahead (Nurse in the residential care private setting).

Scope of practice was considered as either enabling and empowering, or restricting for nurses and midwives. Participants also highlighted the perceived lack of knowledge among nursing and midwifery staff and other healthcare professionals around the concept of scope of practice.

Theme 3: Expanding scope of practice

Nurses and midwives indicated their willingness to expand their scope of practice, but expressed concern around the impact that role expansion could have on patient care and also highlighted that increased workload was a limitation to role expansion:

[With] the workload is such that we can’t, even though the patients would benefit [from expanded scope] but you have to concentrate as well on the essential elements of care...Your workload is definitely a limitation (Nurse in a general public hospital).

Nurses and midwives working in areas like mental health, intellectual disability, midwifery and private practice made the link between expansion of practice and level of role autonomy. Several negative aspects of expanding practice were identified, including the lack of monetary incentive, lack of recognition, increased workload without support and the expectation that expanded scope means working ‘outside of scope’. Several positive aspects of expanded practice were also identified. These included improved patient care, improvement in overall quality of nursing standards and an increased job satisfaction.

Theme 4: Professional competence

Maintaining competence was viewed as essential in ensuring safety and protection for the nurse and midwife and for the patient. Participants generally believed that competence should not consist of a list of tasks and roles that a nurse or midwife completes; rather, it should be about knowledge, experience and critical thinking to enable a nurse or midwife to make safe decisions for the patient and themselves, in clinical practice:

Competence was also seen as the ability of nurses and midwives to critically assess circumstances and know how best to apply their skills and ‘critically think things through (Nurse in a general private hospital).

Participants considered that competencies are attained through accessing appropriate training; however, the challenge was keeping them up-to-date. Participants also highlighted that the practitioner is responsible for judging his/her level of competence. Competency was seen to be about the nurse or midwife taking ownership for his/her practice:

Until you as an individual know that you are competent and maybe it’s that piece of paper...Does that mean the form has been signed or does that mean I’m comfortable with myself’(Nurse in a general public hospital).

Theme 5: Practice setting and context

Nurses and midwives highlighted the importance of having a framework for practice relevant legislation, local and national policies and guidelines and regulation to support them in their practice:

I think we would get in to a very dangerous space if we didn’t have some guidance, whatever it is, from the Nursing Board, to determine how do we, how can we safely decide what we can and we can’t do (Nurse working in education context).
Concerns associated with the practice context that impacted on practitioners’ capacity to practice effectively included staff redeployment and lone working. These concerns related to a lack of understanding on the part of service managers of practitioners' scope of practice in instances of redeployment and a lack of resources, supports and reporting structures for practitioners who are lone working.

Theme 6: Reflections on the current Framework

Participants were in general agreement that the scope of practice framework (An Bord Altranais 2000a) is a good document; however, many participants suggested that any revised framework should reflect the responsibilities of the organization or the employer and should take student internships into consideration. Others stated that the framework needed to reflect that many nurses and midwives now work as part of a multi-disciplinary team and that there was a need to educate other health professionals about the nursing and midwifery scope of practice. Some participants viewed the scope framework as a ‘generalist’ document, a resource more suited to students and recently qualified nurses and midwives while others suggested it could act as the ‘scaffolding’ on which advanced practitioners could expand their decision-making. Several participants discussed the possibility of having a separate framework document for nurses and midwives, but the general consensus was that this was not necessary.

Discussion

Evolution of nursing and midwifery profession and understanding scope of practice

Practitioners demonstrate understanding of their scope of practice with reference to core actions, supported by critical thinking and ‘synthesising cues’ that support activities such as prioritising and coordinating care and safeguarding the patient (Schluter et al. 2011). The rapid pace of change in the healthcare context can make it difficult to define what constitutes scope of practice (Lowe et al. 2012). The perspectives in this review reflect an awareness of the functions of the framework and an understanding that, although the professional practice landscape is considerably altered since 2000, practice will still need to be guided by judicious decision-making that, ultimately, rests with the individual practitioner.

The Irish algorithm sits closer the more restrictive end of the spectrum as opposed to Australia. This is because the Irish scope has ‘stop’ signs and refers the decision maker to the Nursing Board or manager. The Australian algorithm requires the decision maker to make the final decision about where to refer to and this includes a broader range of options. The North American decision-making frameworks are restrictive and very influenced by the legal context. Jowett et al. (2001) found that most stakeholders viewed the UKCC Scope document as enabling, offering useful boundaries for practice and as a valuable way of optimising the skills. However, since April 2002, guidance on the scope of professional practice in now incorporated in the Nursing and Midwifery Council’s code through Post registration education preparation (PREP). Their present Code is central to the scope of nursing practice, emphasising the accountability and responsibility of the individual nurse, however it does not employ a framework. Instead it has moved towards a more integrated source of reference and information to assist nurses and midwives to clarify their scope of practice and apply their professional judgement in practice.

Some participants in this study viewed the scope of practice as empowering and others as restrictive and it appears that some nurses were willing to assume responsibility for conducting technical tasks, like venepuncture and administering intravenous drugs. This emphasis on the performance of single technical tasks suggests that, like the study by Oelke et al. (2008), participants had a tendency to describe scope of practice in terms of tasks and activities that they could perform.

Expanding scope of practice and professional competence

The advanced practitioner and clinical nurse specialist grades in Ireland, along with the introduction of prescriptive authority for senior practitioners, best exemplify expanded roles in the Irish health services. Another area where role expansion has developed in Ireland has been in practice nursing, where a cadre of over 1,500 practitioners are providing a unique and significant contribution to primary care through expanded role activities that encompass direct clinical care, elements of chronic disease management and administration of immunizations (McCarthy et al. 2012). The capacity of nurses and midwives to expand their practice and/or to practice to the maximum extent of their training and competence is contingent on several factors, which act as either enablers or barriers. Some practitioners recognize that their scope of practice can be determined by their own competence and by factors beyond their control, such as the patient’s wishes, protocols and the wishes of
medical staff (McConnell et al. 2013). Critical to safe and effective practice is clinical competence and being able to recognize the limits of one’s competence. There is evidence that when unsupervised, junior staff may take on roles and tasks beyond their competence and thereby place patients at risk (Lubbe & Roets 2014). Some participants also recognized the importance of competence in making decisions about scope of practice, including knowing the competence of those to whom they were delegating roles and tasks. Findings indicate that participants hold professional judgement to be important in decision-making and that, while an employer might believe that a practitioner was competent to carry out a particular task or role, the practitioner might not consider her/himself to be competent.

Practice setting and context and perspectives on the Framework

Findings indicate that the scope of professional practice is influenced by both practitioner-level and organizational-level factors and these factors can act as enablers or barriers to practitioners’ capacity to operate to their optimal scope or to expand their practice. Critical to the attainment of expanded practice is support from key stakeholders. In the context of transitioning boundaries and role expansion, individual and organizational level factors directly relate to building clinical leadership capacity to participate fully in multidisciplinary teams, work in partnership and drive change (Casey et al. 2011). This study indicates that the barriers to expanding practice included limited opportunities in the workplace, reluctance on the part of practitioners to expand their scope of practice because they do not wish to take on additional responsibilities or because they are not sufficiently remunerated for doing so and the belief that they are taking on the work of other professionals. This supports previous findings by Drennan et al. 2009 and Begley 2010 that a lack of support to manage workload efficiently and insufficient time for patients were barriers to any considerations for expanded practice. Professional boundaries matter when it comes to professional and disciplinary identity (McNamara et al. 2011) and role clarity is a necessary condition for clarity around responsibility and accountability for care. If health care is to be improved through expanded practitioner roles then role clarity is essential (Lowe et al. 2012). Participants spoke of role boundaries that overlap with the roles of other healthcare professionals and some participants highlighted the difficulties in negotiating role boundaries with other professions. Some of this difficulty was attributed to the ways services and associated roles have evolved in areas such as primary care, mental health and occupational health and in the field of research nursing, which was reported to be ‘constantly evolving’.

Study limitations

The study is limited by the reliance on participants’ accounts of their experiences and this does not provide direct empirical evidence of the actual work of nurses and midwives, including their decision-making processes around scope of practice. The evaluation framework used to conduct the overall review of the scope of practice framework did not examine the more micro-level aspects of scope of practice in practice. This is essentially the challenge of capturing evidence of espoused action and action in use. The use of observational methods within an ethnographic framework could have provided a more nuanced analysis of actual scope of practice. Finally, the voluntary nature of participation could mean that only those interested and motivated participated in the research.

Conclusion

Nurses and midwives may experience scope of practice frameworks as either enabling or restrictive and different nurses interpret differently. For example CNMs talked about using it with more junior/new staff as part of the orientation process. Others used it individually or chose to discuss issues with managers and the more advanced nurses used it in a more reflective domain to confirm actions already discharged. Based on findings from this research, scope of practice frameworks are seen as valuable tools and should continue to be used as the basis for guiding nurses and midwives in relation to their scope of professional practice and in the best interest of patient safety. However, clinical decision-making lies within individual accountability and while this study strongly suggests that it is a useful framework there are limitations particularly around the context which is often outside the individual’s control. In this regard, the utility of the algorithm to individuals would appear to link with the perspective of the individual who may use it as both a permissive and restrictive framework. However, given some jurisdictions are moving away from algorithms, which have limitations for decision-making particularly around the aesthetic aspects of nursing work, there is a need for clarity around what might be a permissive or restrictive scope of practice.

While all stakeholders place importance on having relevant legislation, local and national policies and guidelines and regulation to support nurses and midwives in their
practice, there are particular practice issues that can impact on scope of practice and the capacity to practice effectively. It is noteworthy, however, that inclusion or consideration of ‘patient choice’, a fundamental principle of evidence-based practice, did not emerge at all in this study. This aspect and related contextual aspects of scope of practice and decision-making might be usefully incorporated into future frameworks as frameworks should enable role expansion within and with reference to the core functions and values of nursing and midwifery and the best interest of the patient. Without this consideration, there is a danger that expansion of practice is linked to complex clinical tasks rather than advancing nursing practice which combines practical, ethical and aesthetic components.

Frameworks should be enabling, providing guidance on how practitioners should act in circumstances of uncertainty. They should offer clarification to the expectations and responsibilities of the respective employer. Finally, frameworks should emphasize individual accountability and contain a decision-making algorithm to promote autonomy and self-reliance in the decision-making process.

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**References**


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