

An Examination of the Changes in the Professional Role of the Nurse outside Ireland

Report Prepared for The Commission on Nursing

July 1998

By

ELLEN B. SAVAGE

RGN, RM, RSCN, RNT, BNS, MEd

College Lecturer, Department of Nursing Studies
National University of Ireland, Cork

Edited by

DR. GERALDINE McCARTHY-HASLAM

RGN, RNT, MEd, MSN, PhD

Director, Department of Nursing Studies
National University of Ireland, Cork

| | |
|-----------|-------------------|
| LIBRARIES | |
| Acc. No. | _____ |
| Class | _____ |
| Invoice | Gov. Pub. 2117627 |
| Price | £7.00 |
| Date | 25-1-99 |

ISBN 0-7076-6129-9

BAILE ÁTHA CLIATH
 ARNA FHOILSIÚ AG OIFIG AN tSOLÁTHAIR
 Le ceannach díreach ón
 OIFIG DHÍOLTA FOILSEACHÁN RIALTAIS,
 TEACH SUN ALLIANCE, SRÁID THEACH LAIGHEAN, BAILE ÁTHA CLIATH 2,
 nó tríd an bpost ó
 FOILSEACHÁN RIALTAIS, AN RANNÓG POST-TRÁCHTA,
 4 - 5 BÓTHAR FHEARCHAIR, BAILE ÁTHA CLIATH 2,
 (Teil: 01 - 6613111 - fo-líne 4040/4045; Fax: 01 - 4752760)
 nó trí aon díoltóir leabhar.

DUBLIN
 PUBLISHED BY THE STATIONERY OFFICE
 To be purchased directly from the
 GOVERNMENT PUBLICATIONS SALE OFFICE,
 SUN ALLIANCE HOUSE, MOLESWORTH STREET, DUBLIN 2,
 or by mail order from
 GOVERNMENT PUBLICATIONS, POSTAL TRADE SECTION,
 4 - 5 HARCOURT ROAD, DUBLIN 2,
 (Tel: 01 - 6613111 - ext. 4040/4045; Fax: 01 - 4752760)
 or through any bookseller.

£7.00

PREFACE

On March 21st 1997, the Minister for Health, Mr. Michael Noonan, T.D., established the Commission on Nursing. The terms of reference were: to examine and report on the role of nurses in the health service including:

- the evolving role of nurses, reflecting their professional development and the overall management of services;
- promotional opportunities and related difficulties;
- structural and work changes appropriate for the effective and efficient discharge of that role;
- the requirements placed on nurses, both in training and the delivery of services;
- segmentation of the grade;
- training and educational requirements; and
- the role and function of An Bord Altranais generally, including, *inter alia*, education and professional development, regulation and protection of the citizen.

As part of the preparatory work a number of reports were commissioned. This report entitled "An Examination of the Changes in the Professional Role of the Nurse Outside Ireland" has been prepared by Ellen Savage and edited by Dr. Geraldine McCarthy-Haslam.



Ms. Justice Mella Carroll
Chair of the
Commission on Nursing

July 1998

TABLE OF CONTENTS

| | <i>Page</i> |
|--|-------------|
| Preface | iii |
| List of Figures and Tables | viii |
| Introduction | xi |
| Chapter 1: Nursing: Historical Perspectives | |
| Introduction | 1 |
| 1.1 The Evolution of Nursing as a Discipline | 1 |
| 1850s – 1950 | 1 |
| 1950 – 1997 | 2 |
| 1.2 Influence of Nursing Theories: An International Perspective | 4 |
| North America, Canada and Australia | 4 |
| United Kingdom and Other European Countries | 5 |
| 1.3 Branches of Nursing and Educational Preparation | 6 |
| General Nursing | 6 |
| Psychiatric Nursing | 8 |
| Paediatric Nursing | 9 |
| Mental Handicap Nursing | 10 |
| Public Health Nursing | 11 |
| Midwifery | 13 |
| 1.4 Specialist and Independent Practitioner Nursing | 14 |
| Specialist Nursing | 14 |
| Independent Practitioner Nursing | 15 |
| Summary | 17 |

| | <i>Page</i> |
|--|-------------|
| Chapter 2: The Practice of Nursing | |
| Introduction | 19 |
| 2.1 Benner's Model of Skill Acquisition | 19 |
| Novice Practice | 20 |
| Advanced Beginner Practice | 20 |
| Competent Practice | 20 |
| Proficient Practice | 20 |
| Expert Practice | 21 |
| The Influence of Benner's Theory | 21 |
| 2.2 The Practice of Nursing: International Trends and Issues | 21 |
| North America | 21 |
| Canada | 24 |
| Australia | 25 |
| United Kingdom | 27 |
| Summary | 29 |
| Chapter 3: The Professional Role of the Nurse | |
| Introduction | 31 |
| 3.1 The Concept of Role | 31 |
| Role Theory | 31 |
| Role Expectations: Influential Factors | 31 |
| An Introduction to the Professional Role of the Nurse | 32 |
| 3.2 The Primary Level Nurse: Role Dimensions and Expectations | 33 |
| The Helper Role | 33 |
| The Teacher/Educator Role | 36 |
| The Patient Care Manager Role | 37 |
| 3.3 The Specialist Level Nurse: Role Dimensions and Expectation | 39 |
| The Clinician Role | 40 |
| The Educator Role | 41 |
| The Manager/Leader Role | 42 |
| The Consultant Role | 43 |
| The Researcher Role | 44 |
| Summary | 46 |

| | <i>Page</i> |
|---|-------------|
| Chapter 4: The Professional Role of the Nurse: Difficulties and Consequences | |
| Introduction | 47 |
| 4.1 Professional Latitude | 47 |
| Restricted Authority and Autonomy | 47 |
| Lack of Recognition | 51 |
| Restricted Continuing Education | 54 |
| 4.2 Work Environment | 55 |
| Organisational Structures | 55 |
| Nursing Care Delivery | 57 |
| 4.3 Role Problems and Consequences | 61 |
| Role Problems: Definition of Terms | 61 |
| Role Strain and Role Overload | 61 |
| Role Conflict | 63 |
| Role Ambiguity | 65 |
| Summary | 66 |
| Chapter 5: Recommendations | |
| Introduction | 69 |
| 5.1 The Disciplinary Body of Nursing Knowledge | 69 |
| 5.2 Nurse Education Reform | 69 |
| 5.3 Framework for the Practice of Nursing | 70 |
| 5.4 The Role Dimensions of the Nurse | 70 |
| 5.5 The Role of the Nurse in the Workplace | 70 |
| Work Redesign | 70 |
| Practice Development | 74 |
| Staff Development | 77 |
| Management Support and Commitment | 78 |
| Summary of Recommendations | 79 |
| Conclusion | 83 |
| References | 85 |
| Appendix 1 | |
| ANC Inc National Competencies for the Registered and Enrolled Nurse | 101 |
| Appendix 2 | |
| Role Titles Identified in the Literature | 106 |

LIST OF FIGURES AND TABLES

| | <i>Page</i> |
|---|-------------|
| Figure 1.1 Key Attributes of Nursing | 4 |
| Figure 4.1 The Role of the Nurse: Difficulties and Consequences | 8 |
| Figure 4.2 Professional Self Concept versus Bureaucratic Norms | 64 |
| | |
| Table 1.1 The Evolution of Definitions/Descriptions of Nursing | 3 |
| Table 1.2 Minimum Education Standard for Entry as a General Nurse in North America | 7 |
| Table 1.3 International Routes of Entry for Branches of Nursing other than General Nursing | 8 |
| Table 1.4 List of Specialisations in the EU | 16 |
| | |
| Table 2.1 Practice Requirements for Renewal of Registration in Canada | 24 |
| Table 2.2 Examples of Activities cited as Extended Tasks in the UK | 27 |
| | |
| Table 3.1 Nurses' Values Associated with Professional Identity and Meaningful Nursing Practice | 32 |
| Table 3.2 Benner's Domains of Nursing Practice | 34 |
| Table 3.3 The Helping Role: Competencies and Expectations | 34 |
| Table 3.4 Descriptions of Different Types of Helpers | 35 |
| Table 3.5 The Teacher/Educator Role of the Nurse | 36 |
| Table 3.6 Role Expectations of the Patient Care Manager Role | 39 |
| Table 3.7 Role Titles of Clinical Nurse Specialists and Nurse Practitioners in Relation to Specific Groups of Patients | 41 |
| Table 3.8 Clinical Nurse Specialist Titles | 41 |
| Table 3.9 The Educator Role of Specialist Level Nurses: Role Expectations | 41 |

| | | <i>Page</i> |
|-------------------|---|-------------|
| Table 3.10 | Co-ordinating Experiencing of Specialist Level Nurses' Manager Role | 42 |
| Table 3.11 | The Leader Role of the Specialist Level Nurse: Role Expectations | 43 |
| Table 3.12 | The Consultant Role of the Specialist Level Nurse: Role Expectations | 44 |
| Table 3.13 | Levels of Research Involvement for the Specialist Nurse | 45 |
| Table 4.1 | Professional Latitude: Issues Relating to (a) Authority and Autonomy and (b) Lack of Recognition | 49 |
| Table 4.2 | Disadvantages of Clinical Ladders | 52 |
| Table 4.3 | Grading Characteristics of Registered Nurses with different Participation Level in Continuing Education | 54 |
| Table 4.4 | Difficulties Encountered by Nurses seeking Continuing Education | 55 |
| Table 4.5 | Average Percentage of Time Spent in Activities by Registered Nurses | 58 |
| Table 4.6 | Issues Identified in the Literature on which Nurses Seek Support | 60 |
| Table 4.7 | Personnel Involved in Inter-Role Conflict | 63 |

INTRODUCTION

The background to this report lies with the establishment of the Commission on Nursing in Ireland by the Department of Health in 1997. The aim of the report is to examine the changes in the professional role of the nurse outside Ireland. An international perspective on the changing professional role of the nurse is presented, concentrating on North America, Canada, Australia, New Zealand, and Europe. The greater weighting of the literature review on Europe rests with the United Kingdom (UK).

To understand the changes that have taken place in the professional role of the nurse, a reflective analysis of the history of nursing is presented in Chapter 1. In this chapter, the extent to which the nursing profession is developing its disciplinary knowledge base, and developing its educational base for practitioners is analysed. Nursing as a practice based discipline is the focus of Chapter 2. Practice issues such as levels and scope of practice, and criteria for entry into practice are critically analysed. Against the background of Chapters 1 and 2, the professional role of the nurse is presented in Chapter 3. This is addressed in the contexts of primary level and specialist level nurses. The role dimensions and associated expectations for each level are illuminated. Having established the role of the nurse, a critical review of the difficulties encountered by nurses in fulfilling their role is presented in Chapter 4. In the fifth and final chapter, recommendations are made to alleviate the difficulties identified with the role of the nurse in nursing practice.

CHAPTER 1

NURSING: HISTORICAL PERSPECTIVES

Introduction

Tracing the history of a discipline helps to clarify its meaning as a social phenomena and confirms the legitimacy of the service provided by the discipline (Maggs, 1996; Nolan, 1993). In this chapter, historical perspectives on nursing are described. The discipline of nursing as it has evolved over the past century is presented at the outset. From this the key attributes of nursing are identified. An overview of the influence of emergent theories from an international perspective aims to illustrate the contribution of theory development to the nursing profession. The historical developments of the various branches of nursing are traced from the late 1900s to the present day. Finally developments in specialist and independent practitioner nursing are traced since the 1950s.

1.1 The Evolution of Nursing as a Discipline

A discipline is “a unique perspective, a distinct way of viewing all phenomena, which ultimately defines the limits and nature of its inquiry” (Donaldson and Crowley, 1978, p. 13). Prior to the mid 1800s nursing was not organised into any professional discipline (Doheny, Cook and Stopper, 1997). Nursing represented the caring and nurturing role of women in the family, society and church (Baly, 1980). Since the 1850s, nursing has slowly evolved as a discipline, which can be traced over two historical eras.

1850s – 1950

Florence Nightingale (1820-1910) is viewed as the founder of modern nursing which originated in the United Kingdom (UK). Her experiences in the Crimean war greatly influenced her concept of nursing. Although she did not refer to a theory of nursing, she did have views and beliefs on what constituted nursing (Doheny et al., 1997). She described nursing in terms of ‘sick nursing’ (or nursing proper) and ‘health nursing’ both of which were “to put the patient in the best condition for nature to act upon him” (Nightingale, 1992, p. 74). According to Nightingale the ‘best conditions’ related to elements in the physical environment, such as, fresh air, light, warmth, and hot water. The goal of Nightingale’s ideal of nursing represented preventative and health-oriented care which she claimed was distinct from medicine, since the latter focused on curing illnesses (Reed and Zurakowski, 1996).

However, Nightingale seemed to contradict her ideology that nursing was distinct from medicine. In 'Notes on Nursing' she stated that "the art of nursing, as now practised, seems to be expressively constituted to unmake what God had made disease to be, viz., a reparative process" (Nightingale, 1992, p. 6). Nightingale's prescribed curriculum for student nurses from the 1860s onwards represents a further contradiction. In addition to being taught environmental studies such as public health and sanitation, students were taught subjects such as medicine and surgery and the physical care of the sick (Doheny et. al., 1997; Lobo, 1995). Not surprisingly then, the disciplinary status of nursing up to the 1950s "paralleled medicines focus on disease" (Shaw, 1993, p. 1653) and thus a biomedical model of care.

Nonetheless, Nightingale was committed to the importance of the environment to the health of individuals and its centrality to nursing. This view of nursing, with the emphasis on the physical environment, remained the dominant focus of nursing until the mid 1900s. Nightingale is credited with laying the foundations for the development of nursing as a science (Chin and Kramer, 1995). The person-environment-health link is clearly evident in most nursing theories today.

1950 – 1997

Since the 1950s, notable advances in the disciplinary status of nursing are evident. Numerous nurse theorists have emerged, most of whom have stemmed from North America. Hilgaard Peplau, from a psychiatric nursing background, is credited with formulating the first contemporary nursing theory. Peplau focused on the importance of purposeful patient-nurse interaction in a therapeutic healing process (Belcher and Fish, 1995). Peplau's concept of 'interpersonal relationships' became a basis for many subsequent nursing theories which mushroomed in the 1960s and 1970s. Such was the growth of nursing theories in the mid 1960s, that the American Nurses Association stated that theory development was one of the most important goals of the nursing profession (McKenna, 1997).

The upsurge of theory development raised many questions about the nature of nursing. A definition of nursing became essential to the formulation of legislation regarding nursing practice in the United States (US) (Doheny et. al., 1997). The most distinguished definition on the nature of nursing which gained international recognition is that of Virginia Henderson (1966, cited in Furukawa and Howe, 1995). According to Henderson:

The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do so in such a way as to help him gain independence as rapidly as possible (p. 15).

With the rapid growth of nursing theories up to 1980, and their continued refinement in the 1980s and 1990s, numerous definitions and descriptions of nursing have evolved (Table 1.1). In these theoretical definitions the client/patient is viewed as central to nursing, rather than the environment as viewed by Nightingale.

The traditional biomedical model of nursing evident in the first half of the twentieth century fell prey to much criticism. Its task oriented ethos with an emphasis on the physical aspects of nursing, was considered to be atomistic, reductionistic, mechanistic, and dualistic. Furthermore, it was considered to be an authoritarian approach to nursing patients (Lowenburg, 1989). The introduction of the nursing process was intended to

define nursing in general holistic terms. This resulted in a move towards individualised care planning through the adoption of a systematic approach to care (Boschma, 1994).

The adherence to any one definition over others would fail to capture the complexity and diversity of the discipline of nursing (McKenna, 1997). That is not to suggest that theoretical definitions of nursing should be discarded. Rather, the definitions when viewed collectively contribute to explaining the meaning of the phenomenon 'nursing'. Based on an analysis of the definitions of nursing in Table 1.1, the key attributes of the discipline, as they have evolved over the second half of this century are presented in Figure 1.1.

TABLE 1.1. The Evolution of Definitions/Descriptions of Nursing since 1950

| Theorist | Theory Focus | Definition of Nursing |
|---|------------------------------------|---|
| 1950s Peplau | <i>Interpersonal relationships</i> | Nursing is a significant, therapeutic interpersonal process which functions cooperatively with other human processes that make health possible for individuals in communities (Peplau, 1952 in Belcher and Fisher, 1995). |
| 1960s Abdellah | <i>Nursing problems</i> | Nursing is an art and science which is broadly grouped into 21 problem areas to guide nursing care of individuals, sick or well, in coping with their health needs (Abdellah, 1960 in Falco, 1995). |
| Orlando | <i>Nurse-patient relationships</i> | The basic core of nursing is that it is an interpersonal process which helps to meet an individual's needs through the development of nurse-patient relationships. Nursing is unique and independent (Orlando 1961, 1972. In Leonard and George, 1995). |
| Henderson | <i>Principles of nursing</i> | The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible" (Henderson, 1966, p. 15). |
| Johnson | <i>Behavioural Systems</i> | Nursing "is concerned with man as an integrated whole and this is the specific knowledge of order we require" (Johnson, 1968, p. 207 in George) |
| 1970s/1980s/1990s Orem (1971-1991) | <i>Self care</i> | Nursing is a human service designed to overcome individual's limitations in self care actions for health related reasons. To this end, nursing may be wholly compensatory, partly compensatory, and supportive-educative (Orem, 1991). |
| Roy 1976-1991 | <i>Adaptation</i> | Nursing is a scientific discipline that is practice oriented in promoting adaptation for the purpose of affecting health positively (Roy, 1976. 1984, Roy and Andrews, 1991). (1976- 1991) |
| Neuman 1994-1995 | <i>Systems</i> | Nursing is a unique profession concerned with the total person (i.e. all the variables that may affect an individual's response to stressors). The main focus of nursing is to help the client system attain, maintain or retain system stability (Neuman, 1974, 1989, 1995) |
| King | <i>Open systems</i> | Nursing is a process of human interaction between nurse and client whereby each perceives the other and the situation and through communication they set goals, explore means, and agree to achieve goals (King, 1981, 1989) |

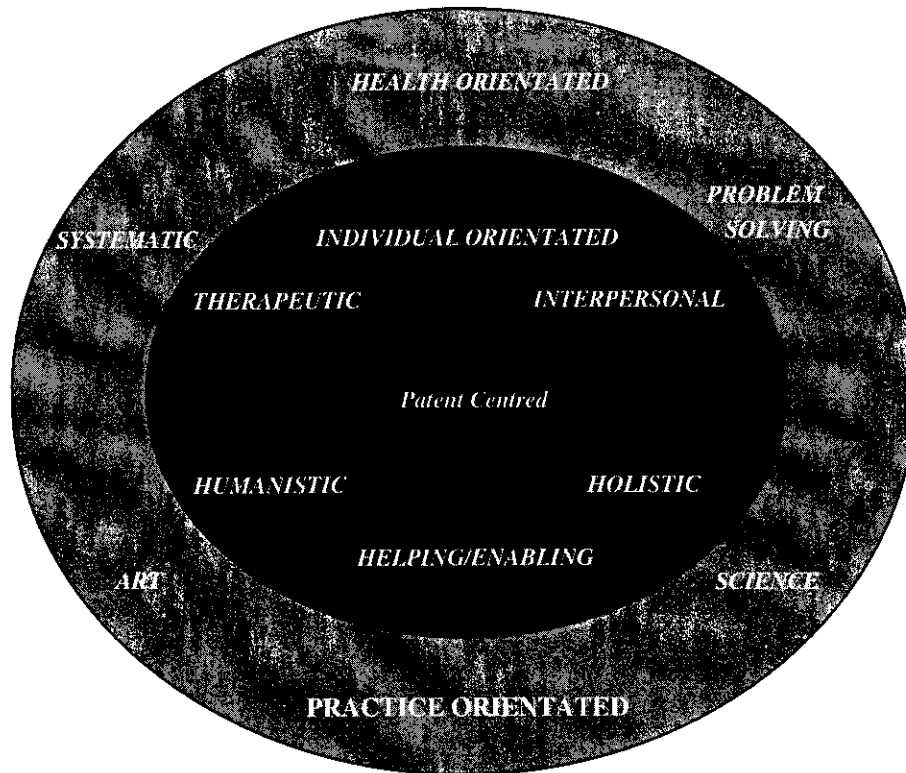


FIGURE 1.1 Key attributes of nursing derived from theoretical definitions/descriptions of nursing

1.2 The Influence of Nursing Theories: An International Perspective

North America, Canada and Australia

The development of theories in the 1960s and 1970s had a major impact on the nursing profession in its country of origin, North America (US). The US government funded nurses to pursue doctoral studies which contributed to further development of nurse theorists and nursing theory (McKenna, 1997). The initial impact of nursing theories was on nurse education. In 1972, the National League of Nursing specified an accreditation criterion emphasising that nurse education curricula should be based on nursing theory (Meleis, 1991).

Since the 1980s the development of new theories has slowed down. The emphasis has been on refining existing theories for practice utilisation. The use of nursing theories to guide nursing practice has gained increasing acceptance in the United States since the 1970s. A wealth of literature has since been published on the application and utilisation of nursing theories across a variety of practice settings (McKenna, 1997).

Efforts to move away from the prevailing task orientated biomedical model of nursing resulted in the implementation of the nursing process, a systematic approach to patient care (Boschma, 1994). A further endeavour to digress from the biomedical culture, was the development of diagnostic categories of health problems amenable to nursing care. In 1982, the North American Nursing Diagnosis Association (NANDA) was established. Through this association, Nursing Diagnosis Classification systems were established and these continue to be revised and updated (Doheny et al., 1997). A nursing diagnosis is as

actual or potential problem that nurses are capable and licensed to treat as a result of their education and experience (Gordon, 1987).

The development of the nursing diagnosis movement marked an important turning point in the history of nursing in the US. The concept of nursing diagnosis required that nurses accept responsibility and accountability for autonomous nursing practice, symbolising the hallmark of a true professional. This is an ideology that continues to permeate the profession into the 1990s (Doheny et al., 1997; Moloney, 1992).

The perspectives on the discipline of nursing that emanated from North American nurse theorists strongly influenced developments in other countries such as Canada and Australia (Huch, 1995; Beynon and Laschinger, 1993; Thomas, 1987). For example in Canada, professional associations have mandated theory based nursing as a practice standard (Beynon and Laschinger, 1993).

Nursing theories have been developed to bestow respectability and credibility on the nursing profession. They have helped to give nursing a professionalizing stance which defines and sets it apart from other health care disciplines (Hardy, 1986). Nursing theories have also provided the impetus for nursing professionals to "think" nursing and to challenge the traditional mode of practice, i.e. the routinised, fragmented and task oriented approach to care delivery. Consequently, new methods of organising nursing care emerged such as patient allocation, case management and primary nursing (Doheny et al., 1997). Primary nursing in particular, has gained increasing momentum since its inception in the US in the 1960s. Developed by Manthey (1970), primary nursing was designed to establish a one-to-one nurse-patient relationship whereby a registered nurse would assume primary responsibility for a patient. Primary nursing was designed to enhance the professional status of the nurse by fostering responsibility, accountability and autonomy to registered nurses in the delivery of nursing care (Moloney, 1992). The implementation of primary nursing in Canada and Australia further illustrates the influence that nursing developments in North America have on these countries (e.g. Richard and Stern, 1991; Merritt, Walker and Fehring, 1989).

United Kingdom and Other European Countries

Although modern nursing originated in the United Kingdom (UK) with Nightingale, it does not have a history of theory development. There appears to have been a general acceptance of Nightingale's ideology which was not founded on a theoretical basis. This also appears to be the case in other European countries (McKenna, 1997).

Unlike Canada and Australia, nursing theories from the US had little impact on nursing practice in Europe prior to the 1980s. Attempts to introduce American initiatives such as the nursing process and nursing models were met with resistance in clinical settings in the UK (Booth, 1992). However, nurse educators acknowledged the significance of nursing theories to the development of nursing as a discipline. There was broad agreement amongst educators in the profession that nurse education and training should be grounded in nursing theory (Roberts, 1985; Smith, 1982).

Throughout the 1980s, the UK nursing literature became saturated with debate on nursing theories, nursing models and the nursing process. Questions continued to be raised about the suitability of theories and concepts from the American culture. Consequently, European models of nursing are being developed (Arets and Slevin, 1995) but appear to be at an embryonic stage of theory development.

Although US theories met with little acceptance initially, there is little doubt that these developments have influenced nursing practice in the UK and throughout Europe. The application of nursing theories such as the: Orem Self Care Model, Neuman System Model, King Open System Model and the Roy Adaptation Model is evident in numerous publications (Tolson and McIntosh, 1996; Nyqvist and Sjoden, 1993; Haggart, 1993; van Achterber et al., 1991; Knight, 1990; Paunonen and Haggman-Latila, 1990). Similarly, primary nursing is widely practised in the Netherlands, Finland and the UK to name but a few countries (Melchior et al., 1996; Kivimaki, Voutilainen, and Koskinen, 1995; Audit Commission, 1991). The nursing diagnosis movement has also reached Europe and the first European Conference of Nursing Diagnosis was held in Copenhagen in 1993 (Mortensen, 1995).

1.3 Branches of Nursing and Educational Preparation

The profession of nursing is characterised by diversity and spans a wide variety of settings within the health care services in general. It comprises of six branches:

- General Nursing
- Psychiatric Nursing
- Paediatric Nursing
- Mental Handicap Nursing
- Public Health Nursing
- Midwifery

Each branch of the profession has undergone a number of changes in relation to education and practice since the turn of the century. Social, economic, political and professional factors have collectively influenced the numerous changes that each branch has experienced.

General Nursing

Historically, the branch of general nursing has dominated within the profession. The first schools of nursing in the late 1800s, both in the UK and North America, predominately focused on general “hospital” nursing. This continued throughout the first half of the 20th century. The need for nurses in hospital settings was influenced by the growth of medical knowledge which resulted in hospital medicine attaining a central place in the health care system (Boschma, 1994; Baly, 1980). In the 1990s, hospitals remain the primary work area for registered nurses. In the US, for example, more than two thirds (67.9%) of registered nurses work in hospital settings (Flanagan, 1994). Similarly in Europe, most nurses in the European Union (EU) are general nurses and work in hospital settings (Versieck, Bouten and Pacolet, 1995).

Educational preparation of general nurses has undergone notable changes since the era of Florence Nightingale and her counterparts. Initial aspirations for nurse education were that schools of nursing would be independent of hospitals, and that students would not be part of the service (Baer, 1984). Although attempts to move nurse education to tertiary

level can be traced back to the late 1800s in both Canada and North America, no substantial progress was made until the 1950s. In a medical dominated system and a patriarchal society, such aspirations were lost although not forgotten. Hospital based apprenticeship training was therefore the dominant mode of nurse education until the second half of the twentieth century (Doheny et al 1997).

Pre-registration nurse education reform centres around two major issues: the transition from hospital based programmes to tertiary education institutions, and the development of the generalist nurse. The transition from hospitals to tertiary level has resulted in multiple routes of entry into nursing across countries and within some countries (Table 1.2). In Australia and Canada, the diploma programmes are being phased out with baccalaureate degrees becoming the minimum standard for entry to practice (Duffield et al., 1995; McQueen and Grenier, 1993). In the EU, Denmark is the only country that has a baccalaureate programme as the minimum standard of education for registration as a nurse. The minimum standard for entry to practice in the UK is Diploma preparation, offered through the Project 2000 programme. The UK Project 2000 transition commenced in 1989 and was completed by the mid 1990s (Quinn and Russell, 1993).

TABLE 1.2 Minimum Education Standard for Registration as a General Nurse in North America, Canada, Australia, New Zealand, and European Countries. (Number of years duration in brackets)

| Country | Certificate | Diploma | Associate Degree | Bachelor's Degree |
|----------------|-------------|-----------|------------------|-------------------|
| North America | | X (3) | X (2) | X (4) |
| Canada | | **X (2/3) | | X (4) |
| Australia | | **X (3) | | X (3) |
| New Zealand | *X(3) | | | |
| United Kingdom | | X (3) | | |
| Belgium | | X (3) | | |
| Denmark | | | X (3.75) | |

* New Zealand – This seems to be at certificate level since Registered Comprehensive Nurses can pursue an undergraduate diploma in nursing studies.

**Diploma programmes are being phased out in these countries.

Sources: Nursing in the World (1993); Quinn and Russell (1993).

Moloney (1992) is critical of the diversified systems of nurse education that have evolved and suggests that it compares unfavourably with other professions. She argues that unless a unified system of education that is grounded in the disciplinary knowledge of nursing exists, nurses may experience difficulty in joining other health professions to influence health care.

The second issue central to education reform is the preparation of a generalist nurse. The traditional option of four entry points (i.e. general, paediatric, psychiatric, mental handicap) to register as a nurse is declining in Europe and obsolete in the US, Canada, Australia and New Zealand. The paediatric, psychiatry, and mental handicap (not available in all countries) nursing branches are post basic programmes in almost all countries (Table 1.3).

TABLE 1.3 International Routes of Entry for Branches of Nursing other than General Nursing.

| Country | Branch of Nursing | | | | |
|-----------------|-------------------|------------|-----------------|-----------|---------------|
| | Psychiatric | Paediatric | Mental Handicap | Midwifery | Public Health |
| North America | PB | PB | | DE | PB |
| Canada | PB | PB | | | — |
| Australia | PB | PB | | | — |
| New Zealand | PB | PB | | DE | — |
| United Kingdom | CF-BR | CF-BR | CF-BR | DE & PB | PB |
| Belgium | CF-BR | CF-BR | | CF-BR | PB |
| Denmark | * | * | | DE | PB |
| Italy | PB | DE | | PB | PB |
| The Netherlands | DE | PB | DE | PB | PB |

Programmes vary from diploma to Master's level. Generally, if diploma is offered for pre-registration programmes, post basic programmes are at higher diploma or degree level. If pre-registration programmes are at baccalaureate level, post basic programmes tend to be at Masters e.g. Denmark, America.

*In Denmark Masters programmes are offered in Clinical Nursing but are not branch specific.

Codes: PB = Post basic programmes; DE = Direct entry; CF-BR = Branch from Common Foundation Programme.

Sources: *Nursing in the World* (1993); Quinn and Russell (1993).

The movement towards generalist nurse education parallels health care reform, in particular the primary health care movement. It is suggested that generalist nurses with a broad educational base encompassing general, mental health, child health, mental handicap and community health, are better equipped to meet the demands of a rapidly changing society (Rowden, 1993). Registered nurses from generalist programmes are prepared to work in all primary, secondary and tertiary settings, and with clients of all ages. According to Stallknecht (1993) in Denmark, generalist nursing allows for a more cohesive health care system and facilitates resource allocation from the secondary to the primary health care sector. The concept of generalist nursing has received intergovernmental support and it is viewed as having an important contribution to meeting the World Health Organisation's (WHO) targets of "Health for All by the Year 2000". In 1988, WHO proposed that "all basic programmes of nursing education should be restructured, reoriented and strengthened to produce generalist nurses" (cited in Barr and Sines, 1996, p. 274).

Despite the international trend towards generalist basic nurse education, there appears to be little published literature debating its advantages and disadvantages to the profession, and society at large. Most debates have centred around concerns specific to individual branches, for example, dilution of skills and recruitment problems. Furthermore, there appears to be little research carried out examining the contribution of generalist nursing to the health care services.

Psychiatric/Mental Health Nursing

The origins of psychiatric nursing lie with the "attendants" of asylums in the 1800s. The primary responsibilities of these attendants was to keep institutions clean and tidy and maintain order by controlling the inmates. They were also servants to medical superintendents, with responsibility for carrying out their orders (Nolan, 1993).

Florence Nightingale as founder of modern nursing did not have psychiatric nursing as part of her plan (Nolan, 1993). The origins of modern psychiatric nursing stem from the US. The first psychiatric schools of nursing opened in 1889 and were similar to general

nursing programmes. At the turn of the century however, nurse leaders identified psychiatric nursing as a specialised branch that required a specialised educational programme. Subsequently, psychiatric nurse training and education diverged from the general nursing system (Church, 1986). In the 1920s, postgraduate courses in psychiatric nursing became available to general registered nurses. Developments in the UK lagged behind the US, and psychiatric nursing as a branch with specific educational requirements did not emerge until the 1920s (Nolan, 1993).

Historically, psychiatric nursing was based in institutional settings. Advances in chemotherapeutic interventions and societal forces in the 1950s sparked the community health movement. The rise of this movement towards the 1970s paralleled a decline in institutional care of persons with mental illnesses (Bowers, 1992; Church, 1986). Consequently, there has been a dramatic rise in the numbers of community psychiatric nurses, which White (1990) found in a UK survey to be approximately 5000.

The community health movement has resulted in an increased emphasis on preventative and educative functions of psychiatric nursing (Butterworth, 1995; Jimerson, 1986). This is reflected in the term "mental health nursing" which is increasingly being used to describe the field of psychiatric nursing (Butterworth, 1995; Nolan, 1993). The core of psychiatric nursing however, represents a therapeutic healing ethos, grounded in nurse-patient interpersonal relationships (Wilshaw, 1997; Belcher and Fish, 1995). Peplau's theory on interpersonal relationships has been most influential and has gained international recognition within psychiatric nursing (Belcher and Fish, 1995).

Prior to nurse education reforms, psychiatric nursing remained largely separate from general nursing. However, in light of the generalist nurse movement, this segregation is narrowing. As shown in Table 1.3, the international trend is that psychiatric nursing is increasingly becoming a post basic speciality. This trend has fuelled much concern about the future of psychiatric nursing. In 1995, Butterworth reported on a survey conducted by the International Council of Nurses on 23 out of 101 of its member associations. A disturbing finding is that many countries are experiencing a marked decline in the number of recruits into nurse education at the basic level and an even greater decline into post basic psychiatric nursing programmes. Consequently, a rethinking of the agenda for the future of psychiatric nursing is being deliberated by many authors in the current literature (Butterworth, 1995; Nolan, 1993; Porter, 1993; Lowery, 1992).

Paediatric Nursing

Similar to psychiatric nursing, paediatric (children's) nursing has traditionally remained apart from general nursing. Although Nightingale suggested that the ability to nurse a sick infant was a real test of a nurse, she was referring to general nurses and not specifically to children's nurses (Glasper, 1995). Children's nursing did not emerge in Nightingale's plan for modern nursing. The development of this branch lies with Catherine Wood who founded the first school for sick children's nursing at Great Ormonde Street hospital in London. In 1888, Wood claimed that "Sick children require special nursing, and, ... sick children's nurses require special training" (cited in Miles, 1986, p. 85).

Up until the 1960s however, children's nursing was not viewed on equal parity with general nursing. The boom of hospital medicine for the adult population which gave rise to the rapid growth of general nursing shadowed the contribution of children's nursing up to this time. Concerns regarding the welfare of children in hospital, prompted by psychological research in the 1940s and 1950s, marked a turning point for children's

nursing. In 1959, the UK government published the Platt Report as government policy on the welfare of children in hospital; a report which gained international recognition (Stenbak, 1986). A key recommendation of the Platt Report was that children had the right to be cared for by suitably qualified staff thus raising the status of children's nursing (Glasper, 1995; Cleary, 1992).

Traditionally, children's nurses have predominately worked in hospital settings. While this may still be the case, community children's nurses are more visible since the late 1980s. The numbers are small however when compared to other branches of nursing in the community. In referring to a 1996 National Health Service document, Whiting (1997) states that there are only 400 community children's nurses in employment in the service. Since children are being discharged from hospital "sicker and quicker", as evident in the Audit Commission (1993), the need for greater numbers of suitably qualified nurses in the community, i.e. children's nurses is called for (Whiting, 1997).

A second source of concern within the children's branch of nursing is the international trend towards generalist nurse education. It is argued that the breadth of children's nursing cannot be captured in a generic programme or a child health branch such as in Project 2000. Glasper (1995) claims that a broad educational base is required for preparation as a registered children's nurse. He argues that while "the all singing and all dancing" generalist nurse may be appealing to the NHS managers, it may not be adequate to care for the nursing needs of children as a specific group of health care clients.

Mental Handicap Nursing

In contrast to other branches, the literature on mental handicap (or learning disability) nursing is sparse.¹ Mental handicap nursing seems to have evolved in line with the provision of services under the Mental Deficiency Act of 1913 in the UK (Baly, 1980). Prior to the 1980s, nursing individuals with a mental handicap was predominately carried out in long stay hospitals and was based on a medical model of care (Sines, 1995).

The movement towards deinstitutionalising persons with a mental handicap began in the 1970s. In preparation for this movement, the National Health Service staffing of mental handicap residential centres was examined within the Jay Report in 1971. An important finding in the Jay Report was that mental handicap nurses were inadequately prepared for their educational and social roles (Baly, 1980). A Certificate in Social Services was recommended as a more appropriate qualification for working with mental handicapped individuals in the community. This was not viewed favourably by the nursing profession (Baly, 1980).

Over 20 years later, the philosophy of community care, grounded in the principle of normalisation, is increasingly becoming a reality for individuals with a mental handicap (Barr, 1995). There has been more than a 50% reduction in the number of mental handicapped persons living in long stay hospitals (Rose, 1995; Sines, 1995). In the 1990s, while mental handicap nurses continue to work in institutional settings, there are an increasing number working in local authorities, community teams, GP practices, special schools and in the private and voluntary sector (Rose, 1995).

The mental handicap branch is also encountering change in light of education reform. Similar to both psychiatric and children's nurse education in the UK, a branch programme is offered on mental handicap nursing on the completion of the Project 2000 eighteen month Common Foundation Programme. While the Project 2000 programme is viewed

¹ The writer was unable to locate literature on this branch from countries other than the UK.

with scepticism (McMillan, 1995), it is also viewed positively in that it creates opportunities to share learning across the branches of nursing (O'Byrne, 1994).

The idea of shared learning with other professionals as recommended in two documents published by the Department of Health in 1994 ("Nursing, Midwifery and Health Education – A Statement of Strategic"; and "The Future of Learning Disability/Mental Handicap Nursing") is supported by a number of authors (Hebron and Rose, McCray, 1995; O'Byrne, 1994). Since 1991, joint education programmes to prepare practitioners in mental handicap and social work are developing. In some universities, these programmes are validated at degree level awarding graduates a BA in Health and Social Care, as well as the professional qualifications Registered Mental Handicap Nurse (RMHN) and Diploma in Social Work (DipSW) (McCray, 1995). Interestingly, as shown on Table 1.3, there is no reference to mental handicap nurse education in a number of countries. A speculative conclusion is that joint education initiatives may have been developed and that programmes exclusively for mental handicap nursing have been phased out.

This development in the educational preparation of mental handicap nurses rests on the premise that they work at the interface of social care as well as health. There appears to be optimism for the future of mental handicap nursing in that its contribution to the multidisciplinary delivery of services is being addressed. However, O'Byrne (1994) emphasises the need to expand shared learning to other members of the multidisciplinary team such as occupational therapists, speech and language therapists, and special education teachers. Another deficit in the system is a lack of commitment from central government and professional bodies to fund a research evaluation of projects that would promote collaboration and co-operation with interested parties involved with mental handicap client groups (Juke, 1994).

Public Health Nursing

Historically, the importance of providing care for people in their homes, known as district nursing, has been valued by society. To this day, the term district nursing is still used to describe home nursing in the UK, Australia, United States, Canada, New Zealand and parts of Europe.²

In tandem with district nursing, health visiting as a public health nursing service evolved in the UK. The origins of health visiting lie with sanitary engineering and not nursing. In the 1850s, "health missionaries", subsequently called "health visitors" voluntarily worked "to teach the laws of health" to families to improve sanitary conditions. By 1900, there was growing concern about child and maternal health and mortality rates. A maternal and child welfare scheme was established to educate on health issues and this became the primary function of health visiting. Health visitors were required to hold a qualification in medicine, or nursing or midwifery. At this point, health visiting became established as a branch of nursing. It was referred to as "health nursing" by Nightingale, thus distinguishing it from nursing proper i.e. sick nursing (Baly, 1980).

To this day, health visiting is the legal term employed for public health nursing in the UK (Caraher and McNab, 1996). The term health visiting is not commonly used in other European countries reviewed herein. More common terms used are public health nursing and/or community health nursing (Quinn and Russell, 1993). Similarly, in North America and Canada, the terms public health nursing and community health nursing are used. In

² This is evident by combining the textword 'district nursing' with respective countries in CINAHL.

Australia and New Zealand, the term community health nursing is used (Nursing in the World, 1993).

The term public health nursing was coined by Lillian Wald in the US in the late 1800s. Although influenced by Nightingale's view of "health nursing", Wald, along with other American nurse leaders, had more radical plans in mind. Influenced by the politics of the progressive era, Wald became an advocate of economic and social reform. In progressive politics, education and social services are closely linked. Wald envisaged a new and independent social role for nurses as health educators in the community, therefore moving beyond the family focus (Boschma, 1994; Buhler-Wilkinson, 1993). In order to prepare nurses for their new social role, nurse leaders sought a more progressive education than the traditional hospital system for general nurses. By the turn of the century, university programmes were on offer to public health nursing students in the US (Boschma, 1994).

The boom of hospital medicine up to the 1950s stifled the aspirations and progress of public health nursing (Buhler-Wilkinson, 1993). After the 1950s, there was an upsurge in the public health movement. A revolt against the established order emerged which stemmed from fears of a technocratic and dehumanised social system. There was a major emphasis on self awareness and self help grounded on the belief that individuals were responsible for their own health and well-being (Boschma, 1994). Consequently, health education and health promotion became the basis of public health (Caraher, and McNab, 1996). In the 1970s, the paradigm shift towards primary health care received international recognition as a result of the World Health Organisation establishing the goal of "Health for All by the Year 2000" (Clarke, Beddome and Whyte, 1993).

The strategic position of public health nursing within the primary health care paradigm is well documented in the Canadian, US, and UK (health visiting) literature (Kuss et al., 1997; Caraher and McNab, 1996; Clarke et al., 1993; Royal College of Nursing, 1994). According to Kuss et al. (1997), public health nursing is a subspecialty of nursing with a specialised function in health promotion and illness prevention through population based interventions. These authors emphasise the need to clearly distinguish the function of public health nursing from that of community health nursing.

The term community health nursing is used to define all nurses working in scattered community settings (Kuss et al., 1997) and based on this literature review would appear to encompass all branches of nursing. It is community based and involves the delivery of personal care services to specific groups such as, families and individuals. It is argued that public health nursing differs from community health nursing in that it represents population based health education and promotion, and does not involve the delivery of personal care services (Kuss et al., 1997; Salmon, 1993).

Based on the literature from the US, Canada and the UK, the ideology of public health nursing does not seem to have been realised in these countries. The function of public health nursing largely reflects the ethos of community health nursing which Salmon (1993) claims has resulted in a case of mistaken identity. This dilemma is currently generating much debate in the literature on the future of public health nursing.

Educational preparation for public health nursing is offered at post basic level in all countries reviewed (Table 1.3). In countries where pre-registration baccalaureate programmes are in place, for example, Canada, US, and Denmark, students are prepared at Bachelor and Master degree levels for both public health nursing and community health nursing (Cuss et al., 1997; Selby et al., 1990). In most EU countries, diploma programmes are offered for community/public health nursing (Quinn and Russell, 1993). A recent development in the UK is the establishment of a degree programme on community health

nursing, which is replacing the district nursing and health visiting diplomas (Lawton, 1993). In both Australia and New Zealand, specific programmes for public health nursing do not appear to be on offer. For these countries, public health nurses are not referred to in the profiles on health care personnel presented in *Nursing in the World* (1993). It appears that education for community health nursing is incorporated into generalist programmes (*Nursing in the World*, 1993).

Midwifery

The branch of midwifery has its origins in lay midwifery which was practised independently in home settings. Pressures from the medical profession at the end of the 19th century resulted in midwifery practice being regulated by legislation. This required that all practising midwives be formally trained (Lops, 1988). Legislation permitting independent midwifery practice was first introduced in Europe (Fleming, 1996). Similarly in the US, midwifery practice was legislated in the early 1900s (Lops, 1988). In Canada, Australia, and New Zealand, legislation for independent midwifery practice has been initiated only since the 1990s (Page, 1996; Fleming, 1996; Relyea, 1992).

The fundamental ethos of midwifery has always been that of primary care provision through independent practice (Shaw, 1993). In Germany, a midwife is "authorised to assist a women during labour and birth without having to call a doctor" and doctors are obliged to seek the presence of a midwife (Markfort, 1994, p. 53). The midwife as a primary care giver is also recognised in the Netherlands where midwifery care is subsidised, but not care by medical personnel (Mander, 1995). Midwifery practice in other countries has not been afforded the same autonomy and recognition.

The literature on the historical evolution of midwifery presents a strong theme of struggle for identity and survival. Since the beginning of the 20th century, the independent and primary care ethos of midwifery has met with numerous obstacles, most notably the dominance of the medical profession (Scoggin, 1997; Lops, 1988). Midwives experienced erosion of their practice as the science of obstetrics proliferated, and childbirth in hospitals became the norm (Ernst, 1994). Consequently, most midwives practised in hospitals either by assisting obstetricians, or working under their supervision (Scoggin, 1997; Fleming, 1996).

In the US, midwives' attempts to gain increasing recognition and autonomy were met with unified resistance from the medical profession. Thus midwives remained relatively stifled in their practice until the 1970s. The consumer movement in the 1960s paved the way for greater recognition of US midwives. Childbearing women sought alternative services to the traditional technological and hospital orientation of care. The movement towards natural delivery in the home setting increased the demand for independent midwives (Scoggin, 1997). Midwives continue to gain recognition and acceptance in the US (King, 1996). Similarly in New Zealand and in some Canadian states, independent midwifery practice is gaining recognition since 1990. The consumer movement, as well as the collective action of midwives with feminist groups have been most influential in these countries (Fleming, 1996; Relyea, 1992).

In Europe, midwives have enjoyed greater autonomy than their counterparts in the aforesaid countries (Fleming, 1996). The situation seems more favourable in some countries (e.g. Germany and the Netherlands) than in others (e.g. UK). In the UK, midwives claim that they have been the victims of medical dominance (Sandall, 1995). The hospital era of childbirth delivery resulted in most midwives practising in hospital

settings. However, many midwives continued to practice independently in the community (Baly, 1980). A detrimental turning point emerged for midwifery in the early 1950s. The National Health Service entitled all women to free maternity care under the care of medical practitioners which resulted in a decline in independent midwifery (Baly, 1980). This was further exacerbated by a decline in home births which was influenced by a number of government reports, recommending that all births take place in hospital (Department of Health, 1993).

Midwives in the UK have continued to challenge the traditional boundaries of midwifery and medicine in an attempt to develop their role as primary care providers that reflects continuity and choice (Sandall, 1995). The UK government publication "Changing Childbirth" seems optimistic in that it presents midwives as primary care providers on par with general practitioners in the community (Department of Health, 1993). However, midwives are still faced with a number of unresolved difficulties. These difficulties are discussed further in Chapter 4.

In addition to medical dominance, midwives claim that their association with nursing has stifled their professional status (Scoggins, 1996). Historically, individuals entering midwifery were first required to be registered general nurses. According to Ernst (1994) nurse education promulgates the medical model of pregnancy as an illness, and birth as a medical event. Furthermore, general nurses develop subservience to medical doctrine which stifles their potential for independence. Efforts to separate midwifery from nursing have taken the form of political debate to legislate for midwifery as a distinct profession from nursing. This is evident in both the US and the UK (Winship, 1996; Ernst, 1994). The move towards direct entry education is another and more prominent strategy to develop midwifery as a distinct discipline to nursing. As shown in Table 1.3, direct entry midwifery education is now on offer in a number of countries.

1.4 Specialist and Independent Practitioner Nursing

Specialist Nursing

Specialisation is not a new concept in the nursing profession. As early as 1900, various groups of nurses were designated "specialists". In the first half of the 20th century, the term "specialist" represented a nurse with experience in a particular area of nursing (Hamric, 1989). Nurses who qualified in branches of nursing other than the general branch, traditionally called themselves "specialists". General hospital nurses also considered themselves specialists on acquiring specialised knowledge and skills in a specific area of practice such as theatre nursing and intensive care nursing. However, clinical specialisation was mainly acquired through practice and on-the job instruction. In the 1930s and 1940s, short post registration courses for specific areas of general nursing practice emerged (Stafford and Appleyard, 1994).

During the second world war, there was a marked reduction in the numbers of nurses in hospital settings. Consequently, there was a growth in the employment of nurses aides, licensed practical nurses, and other types of nursing assistants. Increasingly, registered nurses were removed from bedside care and were given administrative and supervisory roles and responsibilities. Many nurses sought positions outside clinical settings in the areas of education and administration (Moloney, 1992).

The fall in nursing standards of patient care became a prime concern for the profession. The need to retain and return experienced nurses to "really practice nursing" with advanced knowledge and skills became paramount (Montemuro, 1987). In the 1940s, Reitter coined the term "nurse clinician" in the US to describe the nurse with advanced education and clinical competence who remained actively involved in clinical practice.

A marked rise in specialist nursing was not visible until the 1960s. The need to respond to advancing technology and increasing complexity of the health care system placed pressures on the profession to develop specialisation (Berger et al., 1996). In both the US and Canada, federal funding became available to nurses, and by the early 1960s specialist nursing programmes began to mushroom (Stafford and Appleyard, 1994; Montemuro, 1987). The rise in specialist programmes in the EU has not propelled with the same speed. As shown in Table 1.4., most specialist courses that are legally recognised in the EU relate to branch programmes. Unlike Canada and the US, the programmes are not state funded, and the costs are borne by nurses themselves or their employing authorities (Advisory Committee on Training in Nursing, 1994). This Committee has recommended that specialist courses for clinical practice be developed in all countries in line with EU directives.

Traditionally, the locus of practice of specialist nursing has been in acute care settings with responsibility for groups of patients (Wells et al. 1996) for example, critical care nursing, cancer nursing, and accident and emergency nursing. However, since the 1980s the orientation towards primary health care has resulted in increasing numbers of nurses from branches other than public health nursing to be employed in the community (Nolan, 1993, Brocklehurst, 1996).

In addition to broader specialist areas of nursing referred to above, subspecialty roles have evolved in the context of body system problems such as diabetic nurse, stoma care nurse, pain care nurse, and wound care nurse. These nurses have traditionally been referred to as clinical nurse specialists (Montemuro, 1987). The origin of this title rests with Reitter's concept of the "nurse clinician" in the 1940s (Bousefield, 1997), as referred to above. The fundamental ethos of clinical nurse specialism is the delivery of expert knowledge and clinical practice in a well delineated aspect of patient care (Hamric, 1989).

The initial growth of clinical nurse specialists was most notable in the US and Canada. The most important impetus for this movement was an increase in clinical career pathways in the 1970s in an attempt to recognise, reward and retain nurses with high levels of expertise in the clinical area (Balasco and Black, 1988). Access to federal funding made it possible for many nurses to seek advanced clinical preparation at masters degree level (Moloney, 1992). In Australia, the UK and other EU countries, the clinical nurse specialist role was slow to develop until the 1980s. Similar to the US and Canada, the outgrowth of clinical specialists was primarily influenced by the introduction of career structures such as clinical ladders and clinical grading (Buchanan et al., 1989 in Bousefiel, 1997; Appel, Malcolm and Nahas, 1996).

Independent Practitioner Nursing

In tandem with the clinical nurse specialist movement, another category of nurse emerged in the mid 1960s in the US: the nurse practitioner. The nurse practitioner movement was developed primarily in response to a scarcity of family practice physicians in rural areas, falling standards of health care, escalating health care costs, and the rise in specialism. To address these issues, federal funding and pilot schemes became available

TABLE 1.4 List Of The Nursing Specialisations in EU Countries Legally recognised by Diploma or Certificate following the Award of a General-Care Nursing Qualification accordance with Directive 77/452/EU

| Nursing specialisation* | Belgium | Denmark | France | Germany | Greece | Ireland | Italy | Luxembourg | Netherlands | Portugal | Spain | UK |
|------------------------------|---------|---------|--------|---------|--------|---------|-------|------------|-------------|----------|-------|----|
| Pediatrics | X | X | X | | X | X | X | X | X | X | X | X |
| Psychiatry | X | X | | X | X | X | | X | X | X | | |
| Public and Community Health | X | X | | X | | X | X | X | X | X | X | X |
| Anaesthesia | | X | X | XICU | | | | XICU | | | | X |
| Intensive Care | | | | | | X | | | X | | | X |
| Operating Theatre | X | X | X | X | | X | X | X | X | X | X | X |
| Midwifery/obstetrics | X | | | | | X | X | X | X | X | X | X |
| Infection control | | X | | | | X | | | | | | X |
| Psycho-geriatric care | | | | | | X | | | | | X | |
| Care of mentally handicapped | | | | | | X | | | | | | X |
| Occupational Medicine | | | | | | X | | | | | | X |
| Critical care/ICU | XICU | | | | | X | | | X | | | X |
| Oncology | X | X | | | | X | | | X | | | X |
| Hygiene | X | | | X | | | | | | | | |
| Medical nursing | | | | | X | | | | | X | | |
| Surgical nursing | | | | | X | | | | | | | |
| Mental Health | | | | | | | | | | | X | |
| Haemodialysis | | | | | | | | | X | | | |
| Masscur | | | | | | | | X | | | | |
| Medical radiology/imaging | X | | | | | | | X | | | | |
| Rehabilitation | | | | | | | | | | X | | |
| Nursing instructor | X | X | X | X | | X | X | X | X | | | X |
| Management/administration | X | X | X | X | | | X | X | | X | X | X |

The titles of the specialisations listed may not correspond exactly to those legally recognised in the Member States.
Source adapted from: Advisory Committee on Training in Nursing (1994)

to prepare nurses as practitioners in community settings. Nurses therefore began to fill the medical labour shortage and worked in independent practice, either complimenting medical services or providing the only medical service in a poorly served area (Fenton and Brykczynski, 1996; Pickersgill, 1995; Moloney, 1992).

At the outset of the 1960s, nurse practitioners served a diversity of groups in the community. Since the 1970s, they have become increasingly specialised in terms of client groups such as the family, the elderly, and children. Also, in the 1970s, an increasing number of nurse practitioners became employed in acute care settings, mainly as a consequence of shortages in junior hospital doctors and regulation of their long hours (Knaus et al., 1997; Nemes, 1996).

The nurse practitioner movement has been slower to develop in countries outside the US. In the 1970s, on reviewing the changing role of the nurse, Canadian nurses viewed the nurse practitioner role as an opportunity to expand the role of the nurse (Bajnok and Wright, 1993). However, the surplus of general practitioners in communities, financial disincentives to employ nurse practitioners, and patient unawareness of the role stifled this movement (Spitzer, 1984). Since the mid 1980s, there has been a growth of nurse practitioners, mainly in acute care settings. Overall however, the nurse practitioner movement in Canada has been unsuccessful (Bajnok and Wright, 1993; Mitchell et al., 1991), primarily because of legislation which as further discussed in Chapter 2.

In Australia, nurse practitioners did not emerge until the early 1990s and are mainly in rural primary care settings (Smith, 1996). In the UK, the nurse practitioner movement made slow progress until the mid 1980s with a more notable growth since the 1990s. The shortage of junior hospital doctors and regulation of their long work hours was the main impetus for the growth of nurse practitioners in this country. Most nurse practitioners in the UK are therefore employed in hospital settings (Leifer, 1995).

While clinical nurse specialists and nurse practitioners evolved as two separate roles, the most recent debate in the literature is concerned with merging the two roles into a unified advanced nursing practice role (Briody, 1996; Schroer, 1991). Consequently new role titles are emerging with "Advanced Practice Nurse" being used in the US (Briody, 1996), and "Advanced Nurse Practitioner" being used in Australia and the UK (McGee, Castledine and Brown, 1996; Sutton and Smith, 1995). In all countries reviewed the development of clinical nurse specialists and nurse practitioners have generated much debate and continue to be contentious issues. These will be discussed in more detail in the next chapter.

Summary

As this chapter unfolded, it was noted that from the 1950s onwards there was a paradigm shift in the philosophy of nursing from the centrality of the environment to the centrality of the person receiving nursing care. The emergence of numerous theories and definitions of nursing have afforded nursing a disciplinary status. Key attributes were identified from the theoretical perspectives in an attempt to illustrate the meaning of the phenomenon nursing. The initial impact of nursing theories was on education. The subsequent impact of theories on nursing practice has resulted in innovations such as the application of conceptual models to guide patient care, and new work methodologies such as primary nursing.

Traditionally, the profession of nursing has been characterised by diversity, as represented by six clinical branches. The general branch emerged as the most dominant

in which case each of the other branches have historically sought to establish its own identity and ethos. It was noted that attempts to establish a more unified basis to the profession through the generic nurse education movement is not viewed favourably by members of a number of the branches. All branches of the nursing profession appear to be at a critical juncture of reflection and review in an attempt to seek out the most appropriate pathway for the future.

Finally in this chapter, the rise in specialist and independent practitioner nursing was outlined. It was shown that these movements have varied across countries in terms of pace and acceptability. While nursing theories formed the agenda for debate up to the 1980s, both the clinical nurse specialist movement, and the nurse practitioner movement have been instrumental in changing the focus of debate to practice issues in nursing. In the next chapter, a discussion on international trends and issues regarding the practice of nursing is presented.

CHAPTER 2

THE PRACTICE OF NURSING

Introduction

Nursing has always been proclaimed a practice based discipline and few would dispute this today. However, inquiries into the nature of the practice of nursing did not meet with the same zeal or tempo as theory development on the discipline of nursing. Consequently, the practice of nursing became subordinate to nursing theory (Darbyshire, 1994). It was not until the 1980s that a growth of inquiry on the practice of nursing emerged. A North American landmark study, "From Novice to Expert: Excellence and Power in Clinical Nursing Practice", by Benner (1984) has been most influential. The attraction of Benner's work lies with its emphasis on clinical practice and the development of clinical practitioners to the level of expert practice in the context of direct patient care. Her initial theory has been further substantiated in a more recent study (Benner, Tanner and Chesla, 1996).

In this chapter, an overview of Benner's (1984) theory on the development of novice to expert practice is presented. Against the background of Benner's (1984) theoretical framework, the practice of nursing is described from an international perspective. The trends and issues regarding nursing practice that have arisen in each country are analysed.³

2.1 Benner's Model of Skill Acquisition

Benner's (1984) study involved the application of the Dreyfus Model of Skill Acquisition to clinical nurses in hospital settings. This model was originally developed by Dreyfus and Dreyfus in the late 1970s, and involved the study of skill acquisition amongst chess players. Five developmental levels of skill acquisition were identified. These were novice, advanced beginner, competent, proficient, and expert levels.

Benner, through in-depth interviewing and observations, identified that nurses pass through the same stages of skilled performance in clinical practice. Nurses progress from the level of novice to expert as they obtain more experience in a specific area. This represents a shift from rule guided "knowing that" to experienced based "knowing how". Experience is therefore a critical element in the development of expert practice (Benner, 1984).

³ New Zealand and European countries (other than UK) are not included due to paucity of literature.

Novice Practice

Novice practice is characterised by a reliance on objective rules and facts and direct instruction to guide action. Practice tends to be compartmentalised and does not represent a holistic approach to care. Also, prioritisation is not demonstrated in novice practice. Practitioners at this stage are inexperienced (Benner, 1984).

Advanced Beginner Practice

Nursing practice at the advanced beginner level represents a time of extraordinary transition in terms of knowledge, situatedness in the practice environment, and self-awareness as a nurse. Practice becomes less reliant on rules, facts, and direct instruction. With repeated real life situation experiences, advanced beginner practice becomes more context-free than the novice level (Benner et al., 1996).

However, practitioners at this level continue to be largely dependent on the resource environment. They are acutely aware of the limitations of their practice, and therefore actively role model more experienced nurses, and seek their advice on the management of patients. In facilitating this level of practice, the importance of preceptorship, environmental support, and resource identification is emphasised. Furthermore, the advanced beginner level of practice is an important landmark for practitioners to explore their role as nurses (Benner et al., 1996; Benner, 1984).

Competent Practice

Competent practice emerges following one and a half to three years experience on the same or similar clinical setting. Nursing practice at this level is planned and evolves on the basis of long term goals and prioritisation. However, competent practice lacks the speed and flexibility of the proficient level. The importance of precepting by proficient-to-expert nurses continues to be important (Benner et al., 1996; Benner, 1984).

In contrast to the advanced beginner level however, competence is characterised by a sense of role mastery and an ability to cope and manage many contingencies of clinical nursing. The competent level represents a time of consideration to one's career and therefore is a critical developmental step in becoming an expert nurse. (Benner et al., 1996; Benner 1984).

Proficient Practice

At the proficient level, practice is based on a holistic and deep understanding of situations. The hallmarks of proficient practice are increased perceptual acuity and responsiveness to particular situations. It represents a transition to expertise and requires an experiential base with a particular client group. Specialisation is necessary since skill development at this level depends on a perceptual grasp of qualitative distinctions, which can only be acquired by seeing and contrasting many similar and distinct clinical situations over time. A sense of salience is developed so that the most important aspects of a situation are given priority and addressed. Increasingly, practice at this level is guided by good outcomes. The proficient level presents a critical juncture for further education which compliments the process of turning education into clinical expertise (Benner et al., 1996; Benner, 1984).

Expert Practice

Expert practice is based on a large reserve of experience and is characterised by an intuitive grasp of the most salient aspect of each situation with the minimum number of cues. Unlike the proficient level, there is no detached decision making, deliberation or contemplation at the competent level of practice. Clinical grasp is inextricably linked with clinical response. Expert practice represents the essence of clinical judgement and is the pinnacle of clinical performance from the most knowledgeable members of the profession (Benner et al., 1996; Benner, 1984).

The Influence of Benner's Theory

Benner's (1984) theory on the practice of nursing is an important contribution to further understanding the evolving discipline of nursing. Although Benner's theory is not without critique (e.g. Cash, 1995; English, 1993), the greater consensus in the literature is that it has uncovered the richness and complexity of skilled nursing practice. It has been adopted enthusiastically across a number of settings and has gained international credence (Darbyshire, 1994; Gatley, 1992; McGregor, 1990). From this, it could be expected that international trends in nursing practice reflect Benner's model of practice.

However, there is considerable variance across countries on a number of trends and issues in nursing practice, especially in relation to advanced nursing practice. This variance includes the defining characteristics of levels and scope of practice, the criteria for advanced nurse practitioner roles, educational preparation, professional regulation and licensing. For the purpose of clarity, these trends and issues are examined in the context of individual countries.

2.2 The Practice of Nursing: International Trends and Issues

North America

Traditionally, levels of practice have been described in North America (US) as generalist and specialised practice. Nurses who were not specialised were referred to as generalists. The widespread use of the term "advanced nursing practice" by both the profession and the public resulted in the revision of the American Nurses Association's (ANA) 1980 social policy statement. By 1995, following consultation with nursing organisations, the terms generalist and specialist were replaced by basic and advanced practice respectively (Cronenwett, 1995).

There was general agreement that nurses at both basic and advanced levels could focus on a specialised area of practice and progress from novice to expert within each level, therefore reflecting Benner's (1984) theory. The distinguishing feature between both levels is that, in addition to specialisation, advanced practice involves expansion and advancement. Defining characteristics of the ANA 1995 draft statement (cited in Cronenwett (1995, p. 115) are as follows:

- *Specialisation* is concentrating or delimiting one's focus to part of the whole field of nursing.
- *Expansion* refers to the acquisition of new practice knowledge and skills, including knowledge and skills that legitimize role autonomy within areas of practice that overlap the traditional boundaries of medical practice.
- *Advancement* involves both specialisation and expansion and is characterised by the integration of a broad range of theoretical, research based, and practical knowledge that occurs as part of graduate education in nursing.

The advanced nursing practice movement has resulted in a diversity of role titles which encompass clinical nurse specialist, nurse practitioner, nurse anaesthetist, and nurse-midwife (Cronenwett, 1995). The titles, clinical nurse specialists and nurse practitioners, dominate the literature on advanced nursing practice. Since the demarcation between the roles of clinical nurse specialists' and nurse practitioners' is dissolving, the current trend is to use the term "advanced practice nurse", thus representing a merger of role titles. The trend towards merging both roles is also reflected in the movement towards a common core educational base for advanced nursing practice (Sparacino, 1991; Fenton and Brykczynski, 1993).

As yet, there appears to be no uniform educational criteria for entry into advanced practice. Most advanced nurse education programmes in the US confer a Masters degree on graduates (Berger et al., 1996; Mundinger, 1994), although this is not the norm in a minority of states (Sinclair, 1997). This is likely to change in light of the 1993 publication "Nursing Education's Agenda for the 21st Century" which states that advanced nursing practice requires graduate education (Cronenwett, 1995). Similarly there appears to be no criteria regarding the number of years of experience required for entry to advanced practice. As suggested by Benner et al. (1996), it takes one and a half to three years to develop competence in a given area of nursing practice following which a nurse can progress towards proficient and expert practice.

The clinical ladders introduced in the 1970s were seen as a structure for nurses to advance in clinical practice. Clinical ladders are defined as a hierarchy of criteria intended to provide a means for evaluating and/or developing nurses providing direct nursing care to patients (del Bueno, 1982). However, clinical ladders were developed as a recruitment and retention strategy to deal with staff turnover rates rather than a proactive plan to advance nursing practice. Furthermore, the initial introduction of ladders lacked a developmental theoretical framework on advancing nursing practice (Sanford, 1987). Since the publication of Benner's work in 1984, many institutions have incorporated the novice to expert framework into clinical ladders. However these endeavours reflect local institutional initiatives. Consequently, there is considerable variance across clinical ladder programmes in the US (Corley et al., 1994). A number of other problems have been identified with clinical career ladders which will be discussed further in Chapter 4.

Perhaps the most contentious issue regarding advanced nursing practice is that multiple legal and regulatory inconsistencies exist across states (O' Malley, Cummings and King, 1996). To register and be licensed to practice as a nurse, all graduates from basic education programmes must complete a State Board of Nursing Examination. Standardisation of state licensure has only been solved in recent years (Moloney, 1992).

Certification by the American Nurses Association for specialty and advanced practice is another mechanism of credentialing nurses. This became necessary in the 1970s because of pressures from patients and the public for additional evidence of the competence of nurses to take on greater responsibilities for more complicated levels of care (Moloney, 1992).

In 1993, the National Council of State Boards of Nursing adopted a position in support of a second license for advanced practice. This is a source of much dissent within the profession. In most states, nursing associations along with the American Nurses Association, argue for one license for registered nurses, and a minimum statutory language for advanced practice. It is argued that because the boundaries of nursing are constantly changing, it is risky to commit distinct scopes of basic and advanced practice to statutory language. Rather, scopes of practice should be addressed in the contexts of rules and

regulations (Cronenwett, 1995). This debate on a second license for advanced practice versus one scope of practice license for registered nurses with minimum statutory language regarding advanced practice nursing remains unresolved (O'Malley et al., 1996).

Given that there are no standard criteria for advanced nursing practice, it is not surprising to find that there are wide variations across states in relation to titles, scope of practice, practice agreements, and use of protocols (O'Malley et al., 1996). A further inconsistency is that, in addition to being regulated by a Board of Nursing, advanced practice nurses may also be regulated by a Board of Pharmacy, Board of Medical Examiners, or Board of Medicine, which may have sole or joint authority (O'Malley et al., 1996). In many states for example, nurse practitioners' practice is dependent on physicians' approval, direction and/or supervision. This has curtailed the extent to which advanced practice nurses can practice as independent practitioners (Stafford and Appleyard, 1994). This seems reflected in the wide variation between states in the numbers of practising nurse practitioners. Interestingly, greater numbers of nurse practitioners are found in rural areas in the west and south west states where there is a shortage of physicians (Winson and Fox, 1995).

Another issue that may impact on the licensing and regulation of nursing practice in North America is the Pew Health Professions Commission, completed in 1995. This commission convened a national task force to establish the ideal licensure and regulatory system for healthcare professionals. The Commission recommendations, referred to in an anonymous "International Nursing Review" article in 1996 and of significance to nursing are summarised herein as follows:

- Standardised language should be used across all states for health professions regulation.
- Entry to practice requirements should be standardised across all states and limited to competence assessments in order to facilitate physical and professional mobility of health professions.
- There should be continuing assessment of health professionals' competence to practice which allows for different professions to share overlapping scopes of practice.
- States should redesign health professional boards and their functions to reflect the interdisciplinary and public accountability demands of the changing healthcare system.
- States should develop evaluation tools to assess the objectives, successes and shortcomings of their regulatory systems and the bodies to best protect and promote the public's health.

The Pew Health Professions commission also pointed out that the various states should acknowledge the links, overlaps and conflicts between their healthcare workforce regulatory system and other systems that affect the education, regulation and practice of healthcare practitioners and develop partnership to streamline regulatory structures and processes.

The American Nurses Association supports the recommendations on consistency and clarity on regulatory terms and criteria. However, it does not support the recommendations on sharing scopes of practice, since this would reduce standardisation of regulation of health professionals. It is also opposed to interdisciplinary boards on the grounds that this would lead to renewed efforts by medicine to control nursing practice and limit its scope. Finally, while the American Nurses Association supports the concept of assessing nurses' competencies beyond initial registration, the methods of achieving this goal in a profession such as nursing, with its broad range of specialties, setting and roles, is problematic and requires further exploration (Anonymous, 1996).

While the practice of nursing appears to be in a state of flux and turmoil in the US, there is confidence that the issues and trends currently being debated create a wealth of opportunity to strengthen and expand nursing's leadership position in future health care reform (Briody, 1996; O' Malley et al., 1996).

Canada

In the Canadian literature, there appears to be no uniform language to describe levels and scope of practice. In contrast to the US, debate in the Canadian literature on issues and trends on the practice of nursing was found to be sparse.

Under the 1867 British North American Act, professional legislation is a provincial/territorial responsibility rather than a federal responsibility. The professional nursing association in each province/territory (except Ontario⁴) is the registering/licensing/certifying body. Licensing examinations are nation-wide and are reciprocal between the ten Canadian provinces and two territories (Hadley, 1995).

On advancing post basic knowledge to a specialised area, nurses are certified. There is variance across provinces/territories in that certification may be non-statutory or may be legislated, granting exclusive right to a title (Hadley, 1995). There is also variance in relation to scope of practice. In some provinces the scope of practice is exclusive and in others it is not defined at all. Legislation specifying "exclusive nursing practice" inhibits the performance of tasks in the medical domain (Anonymous, 1996; Hadley, 1995) which may be a factor contributing to the slow progress in the nurse practitioner movement in Canada. Few nurses or midwives practice independently (Relyea, 1992; Fleming, 1992).

Registered nurses are personally responsible for their continuing education and maintenance of competency. In all jurisdictions, except Ontario and Quebec, there is a requirement that nurses work a minimum number of hours over a specified time frame to maintain active registration. (Table 2.1). This reflects Benner's (1984) theory in terms of competence being grounded in experience. In Quebec, competency of professionals is assessed through audit regimes and this is required by law. A similar programme has been developed in Ontario and is supposedly being implemented since 1997 (Hadley, 1995). According to Cutshall (1996), the current health care reform in Canada is likely to result in increasing attention being placed on continuing competency rather than credentials, in which case nursing must find a common competency language.

TABLE 2.1 Practice Requirements For Renewal Of Registration in Canada

| No. of Provinces/Territories | Required hours | Time Frame (years) |
|------------------------------|----------------|--------------------|
| 1 | 1200 | 5 |
| 6 | 1125 | 5 |
| 1 | 1125 | 5 |
| | or 480 | 2 |
| 1 | 750 | 5 |
| 1 | 450 | 3 |
| 2 | No requirement | |

Source: Hadley (1995).

Similar to the US, there are legal and regulative inconsistencies across the provinces/territories of Canada. An array of subtitles in relation to clinical nurse specialists

⁴ In Ontario, the College of Nurses of Ontario is the statutory body responsible for registration of all nurses.

roles have emerged. There appears to be no criteria specified for entry into specialist practice, either in terms of education or years of experience. However, most nurses pursuing a specialty in nursing undertake a Masters degree programme since the minimum requirement to enter practice at basic level is a bachelor's degree (Bramadat and Chalmers, 1989). Uniformity in professional regulation and legislation is called for in order to ensure consistency, clarity, ease of communication, greater mobility and equity (Cutshall, 1996). The 1990s therefore appears to be an era of awakening for nurse professionals in Canada to address the divergent and seemingly divisive pathways of the past.

Australia

Although the terms "generalist", "specialist" and "advanced" nursing practice are well documented in the Australian literature, there is criticism that the various "types of nursing practice have received minimal discussion in Australia" (Sutton and Smith, 1995, p. 1037). There is also criticism that the scope of nursing practice in Australia lacks definition and clarity with professional regulatory bodies. Each Australian state or territory has its own registration authority (Smith, 1996). This is likely to change in light of the most recent trend towards national competencies for registration of nurses.

The competency movement springs from the 1980s, when federal government applied pressure on industry and the professions to adopt a competency based approach to education, staff development, and performance appraisal. A national co-ordinating body was established to ensure a consistent national framework for developing competency standards. A second government body was established specifically to develop strategies towards recognition of overseas qualifications in Australia (Sutton and Arbon, 1994).

In 1986, the Australian Nurse Registering Authorities Conference began to develop competencies for the registration of nurses. By 1990, there was national acceptance of minimum competencies for practising nurses at the point of registration and beyond. These initial competencies were validated through observation of new graduates in practice and through workshops, following which the competencies were further refined in 1994 (Australian Nursing Council Inc., 1994; see Appendix 1).

According to Sutton and Arbon (1994), the competency movement has moved Australian nursing closer to establishing a national registration system. Although the initial impetus for competency based education and practice arose from federal government, the nursing profession in Australia appear to be highly motivated towards this movement which has led to the development of level and field specific competency formulation (Sutton and Arbon, 1994). These authors are sceptical however, and suggest that competencies will establish only minimal standards and cannot be used to truly reflect the complexity of nursing practice.

In line with the competency movement, the nursing profession has gradually implemented clinical career structures for registered nurses in each state/territory. This was prompted primarily by staff shortages in the 1980s, particularly specialised nurses in acute care hospitals (Duffield et al., 1995). Hence, it is only in the past decade that clinical nurse specialist positions have been formally established in Australia. A recent initiative in South Australia is the implementation of a number of projects on career development for clinical nurses. These projects are sponsored by the Health Commission (Arbon et al., 1993).

This formal recognition of nursing specialisation has resulted in an outgrowth of clinical specialist nurses. This is reflected in the numbers of clinical speciality groups throughout

Australia with 28 nationally organised groups, and 47 groups organised at state level (Smith, 1996). Parallel to this outgrowth, various descriptions of what specialised nursing practice means have evolved within the profession (Pratt, 1995). Standardised criteria for educational preparation, entry to specialised practice and credentialing have not been established in many states (Smith, 1996).

The failure to establish standardised criteria for specialised practice represents a paradox given the national competency movement. However, progress has been made in some areas. For example, in New South Wales, nurses seeking clinical nurse specialist positions are required to have attained a minimum of twelve months experience in the specialty area as well as a relevant post-basic specialty qualification. Alternatively, four years of post registration experience is required, three of which must be in the specialised clinical area (Smith, 1996). A further specification is that hospitals must have a distinct unit or health service for the specialty in order to appoint respective clinical nurse specialists (Appel et al., 1996). These criteria arose from industrial award specifications following much unrest in the mid 1980s about the status and remuneration of nursing's clinical work force (Duffield et al., 1995).

In some ways, the aforesaid criteria reflect Benner's (1984) theoretical position on advancing nursing practice. There is an emphasis on experience which Benner claims is the platform from which specialised nursing develops. However, the specification of twelve months experienced in the first criterion above falls short of Benner's recommendation of one and a half to three years. Nonetheless, this first criterion seems more appropriate than the second criterion in which case specific educational preparation is not mandated. According to Benner (1984) educational preparation is necessary to translate experience into more advanced nursing practice.

Although educational criteria for entry into specialist practice is not standardised, most clinical specialist nurses have completed diplomas in their respective speciality with an increasing number pursuing Masters degrees (Appel, et al, 1996). Since pre-registration nurse education has progressed to baccalaureate level, the trend towards Masters degrees for specialist education is growing, although the demand far exceeds the supply (Mascord, 1992).

While the clinical nurse specialist movement has gained momentum and recognition in Australia, this is not the case with nurse practitioners. The nurse practitioner movement which began in the 1990s has generated much controversy and debate because it involves extending the scope of nursing practice into the terrain of medicine. In New South Wales, the Department of Health has funded pilot projects to examine the role of the nurse practitioner in contexts of Area/District Health Services, General Practice Services, and Remote Area Services. The outcome of these projects is expected to have implications for new policy formulation and legislative change (Sielgloff, 1995). In a number of states, discussion papers are being distributed to the profession by registering authorities and departments of Health, making recommendations on the scope of nursing practice and associated legislative changes, accreditation, and evaluation criteria (Smith, 1996; Coxhead, 1995). According to Smith (1996), the changing nature of nursing practice in Australia poses challenges for the nursing profession to develop a policy on the scope of practice that is congruent with the community and profession's expectations regarding current and future health care needs.

United Kingdom

Since 1990, the UK literature is replete with discussion on nursing practice trends and issues. Similar to other countries, discussions in the UK centre around "clinical nurse specialist" and "nurse practitioners" roles, as well as levels and scope of practice. The first formal recognition of levels of nursing practice lies with the "Post Registration Education and Practice Project" (PREPP), initiated in the late 1980s by the profession's registering authority, the United Kingdom Central Council (UKCC) (Gatley, 1992). The PREPP framework set out to improve post-registration education and to recognise different and advancing levels of clinical practitioners (Elliot, 1995).

Following consultation with various sectors of the nursing profession, the UKCC proposed three levels of nursing practice: primary, specialist, and advanced practice. There was general acceptance of the primary level of nursing proposed which was defined as "being able to accept responsibility with confidence, in co-operation with other practitioners and disciplines as required" (UKCC, 1990, cited in Gatley, 1992, p. 89). Definitions of specialist and advanced practice were not so readily accepted. The defining characteristics proposed for these levels reflected the function of the nurse rather than characteristics of different levels of practice and thus evoked criticism (Brown, 1995; Castledine, 1995a).

The UKCC has continued its consultation process with the profession in an attempt to seek definitive agreement on both specialist and advanced nursing practice. The most recent position states that "there are neither agreed definitions of advanced practice nor criteria against which standards for advanced practice can be set" (UKCC, 1997a, p. 5). The UKCC, while fully supporting the concept of advanced practice, has stated that explicit standards for this level of practice will not be set (UKCC, 1997a). The current emphasis is on specialist practice and the UKCC has recently announced that a working group is being set up to further develop the work on specialist practice. The remit of this working group is to examine how specialist practice can embrace clinical nurse specialists and nurse practitioners, so that specialist practice will be "as inclusive as possible" (UKCC, 1997b, p. 5).

TABLE 2.2 Examples of Activities cited as Extended Tasks in the UK

| | | |
|----------------------|---------------------------|-------------------------------------|
| Venepuncture | Venous cannulation | Removal of foreign bodies from eyes |
| Intubation | Extubation | Treatment of warts and verrucae |
| Syringing of ears | Defibrillation | Intravenous administration of drugs |
| Male catheterisation | Suturing | Administration of cytotoxic drugs |
| Vaccinations | Fitting breast prosthesis | Prescribing medications* |
| Lumbar Puncture | Chest Drain Insertion | Suprapubic catheterisation |

*Since 1992, nurses can legally prescribe drugs from a Nurses' Formulary (Andrews, 1994).

Sources: Dillon and George (1997); Dimond (1994); Last et al. (1994).

In addition to levels of practice, the scope of nursing practice has been the focus of much deliberation in the UK. Similar to other countries, the traditional boundaries of nursing are changing, and nurses are taking on extended tasks that were traditionally in the domain of medicine (Table 2.2). This extension in scope of practice seems to be more characteristic of the nurse practitioner role than the clinical nurse specialist role. As mentioned in Chapter 1, the nurse practitioner movement was sparked by a shortage of junior hospital doctors and the regulation of their long working hours (Leifer, 1995).

Although the nurse practitioner movement has not developed at the same pace as that of the clinical nurse specialist movement, Darley (1996) claims that nurse practitioner roles are gaining prominence and are here to stay. Increasingly, nurse-led clinics are emerging and a number of hospitals and trusts are experimenting with nurse-led services in inpatient and outpatient areas (Darley, 1996).

It was inevitable that the extending role of the nurse would have implications for the regulation of nursing practice. Prior to the 1990s, the practice of nursing was controlled by rules and regulation from the UKCC (Fox, 1995) with a system of certification for specified or "extended" tasks not taught in pre-registration education (Lunn, 1994). Since 1992, the UKCC has heralded a change in practice through its publication of "The Scope of Professional Practice" which represents "principles of practice".

With "The Scope of Professional Practice" the terms "extended" or "extending" are no longer appropriate since they limit the parameters of practice, thus preventing nurses from fulfilling their potential for the benefit of patients (UKCC, 1992). Consequently, responsibility for practice and the decision on whether or not to take on "extended" roles was entrusted to registered nurses themselves (Denner, 1995; Gee, 1995). "The Scope of Professional Practice" requires that nurses "acknowledge any limitations in (their) knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner" (UKCC, 1992, p. 5). To address competence and knowledge deficits, nurses are obliged to remain professionally updated (UKCC, 1992).

"The Scope of Professional Practice" has met with mixed responses. The positive stance is that it provides a regulatory framework for nurses to become flexible, responsive, and independent service providers (Darley and Rumsey, 1996; Castledine, 1995b). A negative and cautionary stance revolves around fundamental nursing, legal, and educational issues. At a fundamental nursing level, there is concern that the adoption of medical tasks will turn nurses into doctors' accessories (McKenna, 1993). Moreover, nurses may lose sight of basic nursing and its inherent caring ethos (Hoover and van Ooijen, 1995). These authors suggest that clinical nurse specialist and advanced nurse practitioner roles are "leading nursing away from its essential caring role" (p.42). On a similar vein, Gee (1995) claims that the liberal extension of nurses' activities changes nursing practice but does not advance it.

From a legal perspective, it is suggested that "The Scope of Professional Practice" places nurses in a vulnerable position (Rieu, 1994). As already mentioned the onus is on each nurse to identify limitations with his/her own and competency. This raises the question on what competency means and who is the recognised authority on it. It also raises questions regarding the measures required to ensure uniformity of nursing practices. Rieu (1994) emphasises the importance of policy formulation on extended roles by employing authorities. Without such policies nurses may find themselves defenceless under the umbrella of vicarious liability. In other words, the employing authority may not accept liability if a nurse extends his/her role outside the parameters of an agreed policy (Derrick, 1990).

Concerns about the educational implications of "The Scope of Professional Practice" have also been raised. With the removal of certification for extended tasks, a situation has arisen whereby some employing authorities have not provided any formal training for such tasks (Last et al., 1994). There seems to be no standard educational or experiential criteria for the performance of extended tasks. However, educational criteria for entry

into both clinical nurse specialist and nurse practitioner roles are being addressed, and this has implications for extended nursing practice (Castledine, 1994).

By 1998, educational programmes designed to meet UKCC requirements for the specialist nurse practitioner qualification will be in place throughout the UK. These programmes, some of which are already in place, will be the only route of entry to attain a specialist qualification with the title of "specialist practitioner". Transitional arrangements are in place for nurses currently working in specialist positions and wishing to use this title (UKCC, 1996a). The programmes are being developed to baccalaureate level, with some courses on offer at Master's level (Allison, 1995; Wallace and Gough, 1995). This reflects the educational trend in other countries reviewed in this chapter.

Undoubtedly, nursing practice in the UK is in a dynamic state of change which seems to have been propelled by "The Scope of Professional Practice" (UKCC, 1992). Concerns about the lack of research on the effectiveness of "The Scope of Professional Practice" on the practice of nursing have soared. To this end, the UKCC initiated a major research project in 1996 throughout the UK. This research, through extensive consultative processes, aims to analyse the impact of the Scope of Professional Practice. The project, which is due to be completed in 1998, is intended to facilitate the UKCC to produce "evidence-based policy" on regulating professional nursing practice in the future (Darley, 1996, Darley and Rumsey, 1996).

Summary

Historically, the practice of nursing was perceived as subordinate to nursing theory. It was not until the 1980s that the practice of nursing became a focal point for inquiry, with Benner's (1984) work being most influential. Stemming from Benner's skill acquisition model, the concept of developing from novice to expert practice is widely acknowledged in the international literature. Benner's research has uncovered the richness and complexity of skilled nursing practice and offers a coherent framework for developing nursing practice. However, the extent to which international trends in nursing practice follow a coherent framework such as that of Benner's, is minimal.

In this chapter it was noted that emerging trends in the practice of nursing have been the focus of much debate and disparity. This debate and disparity evolves around issues such as definitive agreement on levels of practice, legislation for advanced practice, criteria for entry to specialised/advanced practice, and the scope of professional practice. The literature leaves little doubt that the practice of nursing is a complex phenomenon and in the process of evolution.

CHAPTER 3

THE PROFESSIONAL ROLE OF THE NURSE

Introduction

The evolutionary changes in both the discipline of nursing and the nature of nursing practice as described in the previous chapters, present challenges for defining the professional role of the nurse. According to Jacox et al. (1990), the many changes in nursing highlight the need for nurses to be confident in defining their role and contribution to patient care. These changes relate not only to the theory and practice of nursing, but also to the demand for high quality care. In a climate of economic constraints and cost effectiveness, nurses are being challenged more than ever before to define their professional role and justify their contribution to the health care services (Chang and Twinn, 1995). In this chapter, the international literature on the professional role of the nurse is reviewed. First, an overview of role theory and definition of terms are presented.

3.1 The Concept of Role

Role Theory

The study of 'role' is referred to as role theory and represents a collection of concepts and hypotheses that suggest how people behave in a certain societal role (Biddle and Thomas, 1979). Role theory can be viewed from two perspectives: structural-functional, and symbolic interactional (Hardy and Conway, 1987). In the former, role theory assists in exploring the function of a given societal role. The functional perspective is based on the premise that societal roles are fixed and hold certain expectations and demands. In the symbolic interactional perspective, role theory assists in explaining the process of interaction between different societal roles (Hardy and Conway, 1987).

According to Biddle (1985), one of the problems with role theory is that it has generated a plethora of terminology which can be ambiguous. Interpretations and definitions vary from author to author which is found to be a source of confusion when attempting to understand the role of the nurse (Chang and Twinn, 1995). Hence, for this report, the following definition of terms are employed:

- *A Role* is a goal directed behaviour that comprises of functions performed by a person occupying a certain societal role (Leddy and Pepper, 1993; Biddle and Thomas, 1979).

- *Role Behaviours* are the anticipated set of behaviours that are normatively defined for the occupant of a given societal position. Role behaviours are anticipated by the individual and by the society. (Biddle, 1985; Nye and Gegas, 1976).
- *Role Expectations* are the anticipated behaviours for a given role (Biddle, 1985).
- *Role Concept* is the image of ideal positional obligations and rights received by a position incumbent (Corwin and Taves, 1962, cited in Ahmadi, Speedling and Kun-Weissman, 1987).

A classification of roles was proposed by Linton in 1945 (cited in Flynn, 1995) which consists of ascribed roles and achieved roles:

- *Ascribed Roles* are allocated to individuals without reference to their innate differences and abilities
- *Achieved Roles* are acquired through competition and individual effort.

Role Expectations: Influential Factors

According to Biddle and Thomas (1979), an individual's personal attributes and socialisation experiences influences their role expectations. Personal attributes that affect role expectations include personality, knowledge levels, communication and interpersonal skills, and previous experiences. Socialisation experiences facilitate learning of roles from generation to generation and these roles evolve as society evolves (Topham, 1987). Values and value commitments have been identified as structurally essential components of the socialisation process which are used as the major frameworks underpinning actions in the social context (Gecas, 1991). Values held by nurses have been found to be "other" or patient oriented, and "self oriented" (Table 3.1). These values contribute to professional identity and meaningful nursing practice (Fagermoen, 1997).

TABLE 3.1 Nurses' Values Associated with Professional Identity and Meaningful Nursing Practice.

| Patient oriented values | Self-oriented values |
|--|---|
| Human dignity Rights of individuals Rights to privacy Trust Hope | Autonomy Intellectual stimulation Personal stimulation Creativity Achievement |

Source: Fagermoen (1997).

A number of role problems have been identified in the context of role theory. These include role strain, role overload, role conflict, and role ambiguity. These problems are defined and discussed further in Chapter 4 in relation to difficulties encountered by nurses in their professional role.

An Introduction to the Professional Role of the Nurse

According to Chang and Twinn (1995), most of the literature on the role of the nurse is based on expert opinion rather than the findings of empirical studies. The writer supports this viewpoint on the basis of this review of the literature. It was also noted that while there is ample reference to the role of the nurse in the literature, the extent to which in-depth discussion and analysis is presented is generally small and fragmented.

According to Clifford (1996) any given role in society such as "nurse" can be described in component parts. The component parts represent the dimensions or sub roles of the main role title. Delineating the dimensions of a given role is an important step towards its clarification and operationalisation (Chang and Twinn, 1995). To this end, through the process of thematic content analysis of the literature, the varying dimensions of the role of the nurse and associated expectations are presented in this chapter. The role of the nurse relates to registered nurses in both primary level and specialist level nursing. For the purpose of this review, primary level nurses are those practising in a generic context in their respective branch of nursing. The role of the nurse at specialist level relates to nurses who have advanced beyond primary level. In the literature, nurses in this category represent advanced nurse practitioners to include both clinical nurse specialists and nurse practitioners.

3.2 The Primary Level Nurse: Role Expectations and Dimensions

As already mentioned, the literature presents a fragmented view of the role of the nurse, in particular that of the primary level nurse. Few attempts are made to clearly delineate the dimensions and associated expectations of the nurse's role at this level. Numerous interpretations were gleaned from the literature (Appendix 2). According to Clifford (1996) such a plethora of interpretations tend to mystify rather than clarify the role of the nurse.

In an attempt to give a more coherent and meaningful perspective on the role of the primary level nurse, the writer coded and categorised the labels that emerged from the literature into three dominant role dimensions: the helper role, the teacher/educator role, and the patient care manager role (Appendix 2). These represent the ascribed roles of the nurse and were found to be applicable to primary level nurses in all branches of nursing.

The Helper Role

Given that 'caring' is claimed to be synonymous with nursing (Leninger, 1984) and represents the central core of nursing (McKenna, 1993), it was surprising to find the dimension 'helper' cited more frequently than 'carer' at a ratio of 2:1⁵ in the literature reviewed. However, on analysing the concept of caring, it becomes apparent that role expectations for the 'carer' role and 'helper' role are similar (Kyle, 1995; Morrison, 1989).

In Benner's (1984) study, analysis of detailed narratives on patient care episodes yielded seven domains of nursing practice (Table 3.2), one of which was "the helping role" of the nurse. According to Benner (1984), in a technological era, human pain and suffering can easily be reduced to "problems to be solved". This may result in a reductionist approach to care whereby physical and psychosocial care are viewed separately. However, Benner (1984) observed that a holistic approach to care can exist in the practical context of a committed nurse-patient relationship and this is characteristic of the helping role of the nurse.

⁵ This analysis is based on the literature that specifically addresses or reflects the role of the nurse. It does not include the literature on the concept of caring since this would give a biased view.

TABLE 3.2 Benner's Domains of Nursing Practice.

The helping role
The teaching - coaching function
The diagnostic and patient-monitoring function
Effective management of rapidly changing situations
Administering and monitoring therapeutic interventions and regimens
Monitoring and ensuring the quality of health care practices
Organisational and work-role competencies

Source: Benner (1984)

Benner (1984) identified seven competencies for the helping role of the nurse (Table 3.3). These competencies represent role expectations for the helping domain of nursing. Creating a climate for and establishing a commitment to a healing relationship seems a fundamental expectation of the nurse's helper role. The concept of a healing relationship is more frequently referred to as a therapeutic relationship and is evident in the literature pertaining to all branches of nursing (e.g. Kirby, 1995; Wilshaw, 1997; Rushton, McEnhill, and Armstrong, 1996). The centrality of a therapeutic relationship in the helping role of the nurse is captured in the following definition:

[Nursing] therapy is the process of helping involved in an interpersonal relationship within which the clear intention is to promote the health and well-being of the whole person in his/her physical, psychological, spiritual and social contexts and within which the helping may take the form of physical, psychological and social interventions, or consist of the helping nature of the relationship itself. In its truest sense it incorporates curative (treatment) and carative (caring) elements in a striving towards holistic healing, personal growth and well being, or peaceful death. By virtue of its helping nature [nursing] therapy involves a helper (the nurse) and a client (a patient in need) (Slevin, 1995; p. 412).

TABLE 3.3 The Helping Role of the Nurse:

1. The healing relationship: creating a climate for and establishing a commitment to healing
 2. Providing comfort measures and preserving personhood in the face of pain and extreme breakdown
 3. Presencing: Being with the patient
 4. Maximising the patient's participation and control in his or her own recovery
 5. Providing comfort and communication through touch
 6. Providing emotional and informational support to patient's families
 7. Guiding patients through emotional and developmental change
-

Source: Benner (1984)

A therapeutic nurse-patient relationship is the bedrock of the helper role of the nurse and is grounded in compassion, sincerity, authenticity, empathy, and personal involvement (Kirby, 1995; Appleton, 1993). It serves as the medium through which other expectations of the helper role can be realised. For example, nurses as helpers are expected to demonstrate a "way of being with" rather than "doing for" patients (Appleton, 1993), which Benner (1984) refers to as "presencing". This necessitates a person to person relationship whereby a partnership is established (Wilshaw, 1997). To be effective helpers, nurses are expected to enable patients and act as patient advocates (Dunst and Trivette, 1996; Arthur, 1995; Chambers et al., 1994). According to the American Nurses' Association (1985, cited in Rushton et al., 1996), advocacy on behalf of patients and their families is central to the practice of nursing. Advocacy generally implies acting on behalf of another and advancing their interests with the goal of enabling the patient, family, and

significant others to adjust to changes in the patient's health in their own unique way (Rushton et al, 1996).

The process of enabling involves facilitating a nurse-patient partnership relationship (Clarke et al., 1993) that fosters a participatory experience for the patient (Dunst and Trivette, 1996). Enabling is an empowering process of helping people assert control over the factors which affect their lives (Gibson, 1991). The expectations of enabling and advocacy inherent in the helper role of the nurse are consistent with Benner's (1984) competency 'Maximising the patient's participation and control in his or her own recovery' (p. 58).

Good communication skills are another expectation of the helper role. Fitzpatrick, While and Roberts (1992) emphasise the importance of using appropriate communication skills in facilitating the development of caring and therapeutic relationships with patients. Good communication skills are characteristic of effective helpers (Dunst and Trivette, 1996). The need to develop professional communication skills to deal with varying patient situations is highlighted in the literature (Dunn, 1991; MacCleod Clark, 1988).

As already mentioned, an individual's personal attributes may influence role expectations. A number of researchers have attempted to identify personality characteristics of helpers in various work settings, although this seems minimal in the area of nursing. One study of relevance to nursing is Burke's (1982), which examined the relationship of two aspects of personality: self esteem and locus of control, and several aspects of self image with helping activities. A semantic differential (SD) of 60 bipolar adjectives was administered to 136 nurses. Data analysis gleaned descriptions of ineffective helpers and effective helpers. These descriptions are consistent with those of other authors in the literature (Table 3.4).

TABLE 3.4 Descriptors of Different Types of Helpers.

| Effective helpers | Ineffective helpers |
|---------------------|-------------------------|
| Emotional warmth | Emotional coldness |
| Assertive | Abrasive |
| Flexible | Ineffectual |
| Perceptive | Timid |
| Patient | Inflexible |
| Social extroversion | Impatient |
| Self-confident | Overbearing |
| Honest/sincere | Extreme self-confidence |
| Supportive | |

Sources: Dunst and Trivette (1996); Burke (1982).

The desire to help and care for others has always been a major factor motivating individuals to enter the profession of nursing (Chapman, 1983; Pratt, 1980). This seems to have changed little over the years. In a 1991 US nation-wide mail survey conducted by the American Nurses Association, 1,193 registered nurses were questioned about why they entered nursing. The motivation for choosing nursing as a career was reported by 71% (n = 847) of the sample to be a desire to help people, with an interest in health care being the next most important reason as reported by 63% (n = 751) of respondents (Flanagan, 1994).

The helper role of the nurse, as described herein, seems to reflect the "values embedded in meaningful nursing practice". Many of these values are 'other-oriented', (e.g. upholding

humanness and fostering trust) and contribute to nurses' professional identity (Fagermoen, 1997, p. 434). It is also worth noting that patients' experiences of the helper role of the nurse are found to have positive outcomes in terms of quality care and patient satisfaction (Fitzpatrick and Taylor, 1994; Price, 1993). According to Appleton (1993), understanding the importance of the art of nursing, and its integral helper role, deepens the significance of the profession because it makes an emancipatory difference in the present health care system.

The Teacher/Educator Role

The teacher/educator role as a dimension of the nurse's role is well articulated in the literature, irrespective of the branch of nursing. According to Benner (1984), teaching and learning transactions demand great skill especially when the learner is threatened and ill. Benner identified a number of teaching-coaching competencies (Table 3.5) which the writer equates with the expectations of the teacher/educator role of the nurse. However, Benner's (1984) competencies relate to acutely ill patients rather than individuals in varying contexts. Furthermore, they represent "only a fraction of the teaching-coaching competencies" required of nurses (Benner, 1984, p. 93). In reviewing the literature, a number of additional competencies or expectations were identified which are also presented in Table 3.5.

TABLE 3.5 The Teacher/Educator Role of the Nurse: Competencies and Expectations.

| Benner's (1984) Teaching-Coaching Competencies | Expectations gleaned from the literature |
|--|--|
| Capturing a patient's readiness to learn | Providing knowledge of health promotion activities, disease-related conditions, and specific treatments (Doheny et al. 1997) |
| Assisting patients to integrate the implications of illness and recovery into their lifestyles | Assessing and planning for individual learning needs (Hinchcliffe, 1996) |
| Eliciting and understanding the patient's condition and giving a rationale for procedures | Implementing teaching strategies and education based programmes to meet learning needs (Bailey et al. 1995). |
| Providing an interpretation of the patient's condition and giving a rationale for procedures | Evaluating learning outcomes and educational interventions (Kruger, 1991). |
| Coaching: Making culturally avoided aspects of an illness approachable and understandable | Designing teaching/educational materials and programmes that will maximise patients' potential for health (Karpiuk, Fjerestad and Young, 1994; Kruger, 1991) |

Patient education on health care has been gaining value and emphasis in all aspects of the health care services. The benefits of patient education are documented in numerous studies, for example:

- gaining in knowledge on health care (Hill, 1987)
- fewer symptoms from illness (Wilson-Barnett, 1981; Hartfield and Carson (1981)
- improved self care performances (Luker et al. 1995; Nieweg, Griednas and de Vries, 1987)
- patient adherence /compliance to treatment regimes (Deccache, 1995; Kerr, 1985).

The aforesaid benefits are paramount when one considers the changing orientation of health care. Increasingly, hospital stays are shorter with patients being discharged earlier to care for themselves in their own homes (Kruger, 1991). Similarly, as mentioned in Chapter 1, with the community health movement individuals are moving out of institutions to live in community settings. If individuals are expected to be self caring they must have access to the relevant knowledge and skills through patient education (Noble, 1991).

Undoubtedly, all professions in the health care sector have an obligation to teach and educate patients in the course of their work. However, Tones (1980) has suggested that the main responsibility for educating patients should lie with those who have closest contact with them, which according to Smith (1979) are nurses. More recently, Kruger (1990) highlights the substantial contribution of nurses to the health of patients through development of education materials and programmes.

The importance of education to the health and well-being of individuals is acknowledged by many nurses and is held as a high expectation of their role. This was evident in Kruger's (1991) US study involving a stratified random sample ($N = 1,230$) of staff nurses, nurse administrators and nurse educators. However the findings of this study show that the teacher/educator role of the nurse needs to be strengthened. This concurs with Taunton and Ottemans' earlier US study in 1986. These researchers found that patient teaching was not well integrated into staff nurses ($n = 581$) practice in hospital settings. A number of difficulties encountered by nurses must be resolved if they are to realise their teacher/educator potential and thus this invaluable contribution to health care. These difficulties are discussed further in Chapter 4.

The Patient Care Manager Role

Numerous terms emerged from the literature that reflect a managerial function for primary level nurses in the context of patient care. The writer proposes the sub role title of "patient care manager" to categorise the plethora of terms into a coherent structure, and also to differentiate this role from the 'manager' role of ward sisters or charge nurses.

A comparative analysis of the various terms employed in the literature suggests that the patient care manager role encompasses two broad expectations. These are: the delivery of direct patient care and the co-ordination of patient care. In delivering of direct patient care, primary level nurses are expected to adopt a systematic approach to nursing. This involves assessing, planning, implementing and evaluating in relation to individual patient's nursing and health care needs. Nurses are expected to incorporate research findings into nursing practice, and to foster a quality improvement approach to care (Table 3.6a – Delivery of Direct Patient Care).

In co-ordinating patient care, the primary level nurse is expected to effectively bring together all aspects of care involving other health care professionals and services. The expectations of the co-ordinating function of the patient care manager role fall into three broad categories: resource management, delegation, and liaison and collaboration (Table 3.6b – Co-ordinating Patient Care). This co-ordinating function emerged as a dominant theme from the US literature.

It appears that devolving responsibility for co-ordinating patient care to primary level nurses has changed the role of head nurses/charge nurses. According to Karpiuk, Fjerestad, and Young (1994), the function of charge nurses has changed to that of clinical care co-ordinator with responsibility for nursing services rather than patient care. On a similar vein, Blauwet and Bolger (1990) state that the co-ordinating function of primary

level nurses has negated the need for charge nurses to manage patient care, with this position evolving more as a resource person. The co-ordinating function of primary level nurses is discussed by the aforesaid authors in the contexts of case management and primary nursing.

To fulfil the expectations of the patient care manager role, the nurse requires a number of technical/clinical, interpersonal, and intellectual skills, as well as a sound knowledge base. Technical/clinical skills relate to procedural interventions (Hackbarth et al., 1995) such as wound care, pain management, skin and pressure area care, and monitoring vital signs (Hortin, 1995). These physical oriented aspects of patient care do not stand in isolation in the care delivery process but are incorporated into a holistic framework to include psychosocial aspects of nursing (Doheny et al., 1997). Patient care delivery is mediated through the nurse-patient therapeutic relationship that arises from the helper role of the nurse (Slevin, 1995). The intellectual skills necessary for the effective fulfilment of the patient manager role of the nurse include problem solving, decision making, creative, reflective and critical thinking (Fitzpatrick et al, 1992; Simpson, 1989). In essence, to effectively manage patient care, the nurse is required to be a knowledgeable 'thinker' and 'doer'.

In addition to personal attributes there are a number of organisational factors that promote the patient care manager role of the nurse. These relate to work design and management structure. The nurse's work should be designed to allow optimal contact with patients thus facilitating the delivery of direct patient care (Wright, 1994). The management structure should allow the transfer of decision making power to the level of the nurse thus fostering autonomy and responsibility in both direct patient care, and co-ordination of care (Blauwet and Bolger, 1990).

The role dimensions of the nurse presented in this section are mutually inclusive, In other words, the role of the primary level nurse in the societal context of health care represents interwoven functions of helping, teaching/educating, and managing patient care. At this point, it is worth reflecting on the key attributes of nursing presented in Chapter 1 (Figure 1.1). In light of these attributes, the writer suggests that the role dimensions and expectations of the nurse, as described herein, seem very fitting for the social construct of nursing. For example, the core helping role of the nurse mirrors the core attributes of nursing: holistic, therapeutic, interpersonal, humanistic, enabling, and individualism. The teaching/educator role is consistent with the health orientated goal of nursing. Finally, the patient care manager role correlates with the systematic problem solving nature of nursing care. The writer suggests that the fulfilment of role expectations of the primary level nurse represents the practice orientated art and science of nursing.

Role fulfilment for primary level nurses requires that they become expert practitioners. According to McGregor (1990), nurse managers and educators have a responsibility to develop staff nurses (or primary level nurses) beyond the basic level of competence to the level of expertise. This concurs with the theoretical positions of Benner (1984) and Benner et al. (1996) in that nurses in direct and continuous patient care have the potential to practice at an expert level. However, the literature on advanced nursing practice transmits a clear message that expert practice is in the domain of advanced nurse practitioners, namely clinical nurse specialists and nurse practitioners. The role dimensions and associated expectations of nurses under the auspices of advanced nursing practice are discussed in the next section.

TABLE 3.6 Role Expectations of the 'Patient Care Manager' Role.

| (a) Delivery of Direct Patient Care | (b) Co-ordinating Patient Care |
|---|--|
| <p><i>Systematic Approach to Care</i></p> <p>(a) Assessing: Collecting data to identify health care needs. Organising and analysing health pattern data to develop nursing diagnosis.</p> <p>(b) Planning: Establishing short and long term goals in collaboration with patient and hence developing a holistic and comprehensive nursing plan from admission to discharge (or equally from the point of first contact with the service to the point of exit).</p> <p>(c) Implementation: Implementing the planned care plan based on nursing diagnoses for health promotion.</p> <p>Monitoring patient responses to nursing and non-nursing (e.g. medical, physiotherapy) interventions and regimes.</p> <p>(d) Evaluation: Evaluating the nursing care delivered and promoting goal directed change to meet individual patient health care needs.</p> <p><i>Research Approach to Care:</i></p> <p>Incorporating research findings into the practice.</p> <p>Consulting with nurse researchers regarding identified nursing problems in order to enhance practice.</p> <p><i>Quality Improvement Approach to Care</i></p> <p>Incorporate professional standards into practice.</p> <p>Identify quality indicators from patients</p> <p>Use a quality improvement plan in delivering patient care</p> | <p><i>Resource Management</i></p> <p>Prioritising, planning and organising the delivery of comprehensive nursing care using time, personnel and other resources effectively and efficiently.</p> <p>Coping with staff shortages and high patient turnover</p> <p>Acting as a resource person for information and consultation directly relating to patient care.</p> <p>Acting as a resource person to influence policy formulation, research projects, and Quality Improvement plans affecting patient care.</p> <p><i>Delegation</i></p> <p>Delegating aspects of care to others e.g. nursing colleagues, student nurses, support workers (nurse attendants/aides), in order to meet clients needs, consistent with their level of education and experiences in order to meet patients' needs and maximise staff performance.</p> <p><i>Liaison and Collaboration</i></p> <p>Initiating referral to appropriate professionals, departments and agencies to provide services and promote the continuity of care.</p> <p>Communicate and work with other health professionals to meet the identified health care needs of patients.</p> <p>Communicate and work with patient family members and significant others to meet the identified health care needs of patients.</p> <p>Building and maintaining a team to provide optimal health care for patients.</p> |

This table was compiled by integrating the literature from a number of sources.

Key sources: Doheny et al. (1997); Hackbarth et al. (1995); Karpiuk et al. (1994); Blauwet and Bolger (1990); Benner (1984).

3.3 The Specialist Level Nurse: Professional Role Dimensions and Expectations

In contrast to primary level nurses, the professional role dimensions of specialist nurses are more clearly delineated in the literature. Furthermore, the professional role of clinical nurse specialists has been the focus of more discussion in the literature than the role of nurse practitioners. In this review, it is not intended to compare and contrast both roles given the increasing evidence that they are more similar than different (e.g. Williams and Valviedeso, 1994; Fenton and Brykczynski. 1993). Rather, a unified description of the role of the nurse at a more specialised and advanced level than that of primary level is presented. Specific reference is made to clinical nurse specialists and/or nurse practitioners where appropriate.

While a number of authors present an abundance of terms in defining the role of specialist/advanced nurses, the overwhelming majority focus on five key role dimensions. These are clinician, educator, manager/leader, consultant, and researcher. It is within this framework that the role of specialist level nurse is discussed.

The Clinician Role

The clinician role has always been considered the core aspect of the specialist level nurse (Hazleton, Boyum and Frost, 1993; Koetters, 1989). As mentioned in Chapter 1, the clinical nurse specialist role was first developed to retain nurses in direct patient care. However, the extent to which specialist nurses are currently involved in direct patient care seems variable.

Studies that have addressed similarities and distinctions between clinical nurse specialist and nurse practitioner roles indicate that the latter spend more time in patient care that is holistic and continuous (Williams and Valdivieso, 1994; Fenton and Brykczynski, 1993). Nurse practitioners in these studies were mostly working in specific patient population settings, whereas clinical nurse specialists were mostly working in the context of specific clinical situations. It could be argued that nurse specialists working with specific patient populations such as those presented in Table 3.7 are also likely to be engaged in holistic and continuous patient care.

The 'clinician' role of the specialist level nurse relates to two focal points. Firstly, it involves the extended role of the nurse which consists of carrying out tasks that were traditionally in the medical domain. A sample of tasks that may be expected of nurses in this context is already presented in Chapter 2 (Table 2.2). Similarly, the debate and concerns surrounding this role expectation is addressed in Chapter 2.

The second focal point of the 'clinician' role of the specialist/advanced nurse relates to specific clinical problems and systems of the body. Most nurses in this category are specifically referred to as 'clinical nurse specialists' in the literature, and work in secondary and tertiary care settings. As shown in Table 3.8, the focus of clinical nurses specialist job titles is on physical aspects of care, reflecting a biomedical model, which according to Sparacino (1991) fragments patient care.

An expectation of the specialist level nurse's clinician role is to have in-depth knowledge on a very specific clinical aspect of patient care. Fenton and Brykczynski, (1993) found that clinical nurse specialists were expected to make nursing diagnosis and recommend appropriate nursing interventions specific to their area of expertise. Furthermore, in the event of an illness crisis, clinical nurse specialists were called upon and asked to intervene. This is reflective of Benner's (1984) concept of expert practice whereby clinical grasp is inextricably linked with clinical response, and the practitioner can identify the most salient aspects of a situation with minimal cues. Unquestionably, this level of expertise is of utmost importance in the event of a patient crisis situation.

The expectation that nurses who are specialised in clinical aspects of patient care can be expert clinicians is questionable. A number of studies illustrate that clinical nurse specialists' contact time with patients is intermittent rather than continuous. For example, the amount of time spent in direct patient care for clinical specialist nurses in two studies was found to 33% (Williams and Valdivieso, 1994), and 39% (Buchanan, 1992). This limited contact time with patients may therefore preclude the development of clinical expertise.

TABLE 3.7. Role Titles of Clinical Nurse Specialists and Nurse Practitioners in relation to Specific Groups of Patients.

| Nurse Specialist Titles | Nurse Practitioner Titles |
|---|---|
| Clinical specialists in community health nursing | Family nurse practitioner |
| Clinical specialist in gerontological nursing | Paediatric nurse practitioner |
| Clinical specialist in medical-surgical nursing | Gerontological nurse practitioner |
| Clinical specialist in adult psychiatry and mental health nursing | Midwife practitioner |
| Specialist nurse in palliative care | Neonatal nurse practitioner |
| | Accident and Emergency nurse practitioner |

Sources: Moloney (1992); McGee et al. (1996).

TABLE 3.8 Clinical Nurse Specialist Titles.

| Relationship to Body System Dysfunction | | |
|---|-------------------------------|-------------------------|
| Stoma Care Nurse | Incontinence Nurse Specialist | Pain Care Nurse |
| Wound Care Specialist | Diabetic Nurse Specialist | Infection Control Nurse |
| Asthma Nurse Specialist | Respiratory Medicine Nurse | Rheumatology Nurse |
| Breast Care Nurse Specialist | Haematology Nurse Specialist | |

Key Source: McGee et al. 1996.

The Educator Role

Traditionally, a sub role of the specialist level nurse has been that of educator (Reid-Priest, 1989). This role involves teaching patients and their families (Miller, 1995; Reid-Priest, 1989) with expectations similar to those described for the primary level nurse in Table 3.4. Reid-Priest (1989) points out that similar expectations in this regard results in overlap with nurses in primary level roles.

TABLE 3.9. The Educator Role of Specialist Level Nurses: Role Expectations.

| Staff Education | Educational Resource Person |
|--|-----------------------------|
| Preceptor | Resource for; |
| Inservice Education | Information |
| Continuing Education | Guidance |
| Programme planner and Implementer of Hospital & Unit wide education | Clinical solutions |
| Co-ordination of departmental/hospital/community education programmes. | Mentor |
| Hospital wide Lecturer in undergraduate & graduate programmes. | |

Note: Refer also to Table 3.5.

Key sources: Davies and Hughes (1995); Boyd et al. (1992); Reid-Priest (1989).

Interestingly, the title 'teacher' is not frequently used in the literature as a dimension of the specialist level nurse's role. The emphasis on the 'educator' role reflects a different set of expectations. Although specialist level nurses are involved in teaching, the expectation is that of a broader educational remit. For example, specialist nurses are expected to be involved in staff education. In addition, they are considered to be in a unique position to capitalise on educational needs identified by health care agencies and organisations throughout the community (Hazleton et al. 1993). The expectations of the specialist level nurse's educator role are presented in Table 3.9.

Despite the emphasis placed on the educator role, studies that have documented the activities of specialist level nurses reveal that the amount of time spent in the educational component of their role is generally low, ranging from 12% of time to 29% (Knaus et al, 1997; Boyd et al., 1995; Williams and Valviedeso, 1994; Buchanan, 1992).

The Manager/Leader Role

Since the inception of specialist nurses in the 1940s, their manager role was intended to be in the direct management of patient care (McGann, 1975). This does not emerge as a dominant picture in the literature today. While there is evidence to suggest that specialist nurses continue to manage patient care, much of this is in a co-ordinating and administrative function (Knaus et al., 1997; Boyd et al., 1991). The co-ordinating function of the manager role of specialist level nurses seems best recognised in the context of case management (Wells, Erickson and Spinella, 1996; Schroer, 1991).

Case management is conceptualised as a system with many elements which focuses on the patient for the entire duration of care and crosses all health care settings (Doheny et al., 1997; Schroer, 1991). While traditionally a recognised mode of care delivery in the community settings with public health and community health nurses, case management has extended into acute care settings in both the US and Canada since the mid 1980s (Petryshen and Petryshen, 1992; Schroer, 1991). Factors influencing the introduction of case management in acute settings centre around economic issues such as reducing health care costs, reducing length of hospital stays, decreasing readmission rates (Gibbs et al. 1995).

TABLE 3.10 Co-ordinating Expectations of Specialist Level Nurses' 'Manager' Role (in additional to those cited for the primary level nurse).

| Liaison and Collaboration | Change Agent | Resource Management |
|---|--|----------------------|
| <p>Team Builder</p> <p>Communicating medium across all health care settings for patients in case load</p> <p>Directs multidisciplinary conferences re: patient care</p> | <p>Planning, implementing and monitoring change e.g Quality Assurance, Shared Governance</p> <p>Chairing/committee member on Governing/policy formulation bodies</p> | <p>Staff Support</p> |

Sources: McGee et al. (1996); Miller (1995); Boyd et al. (1991); Schoers (1991).

The co-ordinating function of the specialist nurse manager role, as described in the literature, typically reflects the expectations of primary level nurses (Boyd et al., 1991; Schroer, 1991), as presented in Table 3.6. This suggests an overlap in expectations for

nurses at both levels. However, there are some co-ordinating expectations of the specialist level nurse documented in the literature that did not emerge for nurses in primary roles (Table 3.10).

Another dimension of the specialist nurse's role is that of leader. However, this sub role does not receive the same reference in the literature as the manager role of specialist level nurses. Gournic (1989) is critical of some authors for using the terms manager and leader interchangeably. While these two roles are complimentary and interrelated, a distinction must be made between both and their associated expectations. In Table 3.11 the expectations gleaned from the literature regarding the leader role of specialist nurses are presented. There is evidence to suggest that specialist level nurses value leader roles. The qualitative findings of Bousfield's (1997) phenomenological study using a purposive sample of seven clinical nurse specialists, illuminated that these nurses were enthusiastic about a leadership role in their position. That specialist nurses value their leader role is an important consideration given the potential of this role to change and improve nursing practice.

TABLE 3.11 The Leader Role of the Specialist Level Nurse: Role Expectations.

| Expectations | |
|--|--|
| Creating a vision for future practice | Challenging ritual and routine practices |
| Developing innovative approaches to practice | Creating opportunities for change |
| Influencing others towards a shared vision | Accomplishing organisational goals |

Key sources: Bousefields (1997); Davies and Hughes (1995); Hazleton et al. (1993).

The Consultant Role

The consultant role is considered to be an important dimension of the role of specialist nurses (Barron, 1989). The consultative capacity of nurses was first recognised in the 1960s in the psychiatric branch of nursing and evolved as a liaison role (Rogers and Trimnell, 1987). The consultant subtitle has since been applied to specialist nurses in other branches of nursing (Barron, 1989).

The kernel of the consultant role appears to be that of resource person. According to Ponte et al. (1993) specialist level nurses as consultants are recognised for their expertise as resource persons. The expectations of the consultative role relate mainly to patient centred and nurse centred consultations. A third broad expectation relates to administrative consultation (Roger and Trimnells, 1987). It is also suggested that specialist level nurses act as consultative resource persons to non-nursing members of the health care team (Berger et al., 1996; Gibbs et al., 1995).

The consultant role expectations gleaned from the literature portrays a highly complex and demanding view of the overall role of specialist level nurses, incorporating patient, nurse, and administrative dimensions (Table 3.12). According to Berger et al (1996), the actualisation of this role requires expertise in consultation theory and process, systems theory, and organisational dynamics. This consultative function seems to hold great potential for positive outcomes on patient's health, staff development, and organisational goals. However, the true potential of specialist nurses' consultative role is rarely, if ever actualised.

TABLE 3.12. The Consultant Role of the Specialist Level Nurse: Role Expectations.

| Patient Centred Consultation | Nurse Centred Consultation | Administrative Centred Consultation |
|--|--|---|
| Application of expert knowledge and skill to help consultees (e.g. patients, families, clinical staff) better understanding and development of comprehensive care plans. Advising on nursing interventions specific to complex patient needs. Maximising integration of research knowledge into clinical practice. Promoting the latest technology, products, procedures in a specific area of health care. | Promoting staff development to maintain high standard of care. Providing advise on career promotion, speciality education to nursing personnel. | Applying expertise to assist an individual and/or groups with programme planning, implementation, and evaluation. Enhancing consultee's capacity to resolve difficulties in achieving organisational or management goals. Application of expert knowledge of communication and problem solving to complex systems. Acting as a leader in the management of change. Facilitating multidisciplinary project team work, research and care improvement initiatives. Provision of clinical nurse research consultations. Facilitate the acquisition of funding for clinical nursing research. Generating revenue. |

This table was compiled by integrating the literature from a number of sources.

Key sources: Berger et al (1996); Gibbs et al. (1995); Boyd et al., (1991); Barron (1989); Rogers and Trimmell (1987).

A number of US studies investigating the work activities of specialist nurses reveal that they spend as little as 6 % to 8% of time in a consultative capacity (Williams and Valdivieso, 1994; Boyd et al., 1991; Robichaud and Hamric, 1986). Some authors advocate that specialist nurses be given exclusive consultative responsibilities (Berger et al. 1995). This paves the way for Clinical Nurse Consultants which are in place in Australia (Smith, 1996; Duffield et al., 1995) and in some parts of the US (Berger et al. 1996). In Australia, Smith (1996) describes this position at Level 3 on the career structure for nurses. It parallels that of Nurse Managers and Nursing Unit Managers, and is one level above that of Clinical Nurse Specialist.

The Researcher Role

The involvement of clinical nurses in research is viewed as critical to the profession in terms of developing the discipline of nursing and advancing nursing practice (Berger et al., 1996;). The writer suggests that external economic, social, and political pressures impacting on the health care services, also highlight the need for nurses to be involved in research, thus validating best nursing practice and patient outcomes.

In the literature, the specialist level nurse is proposed as a key figure in the research process in nursing (Miller, 1995; Hazleton et al., 1993). Hence, a further dimension of the specialist nurse is that of researcher. According to McGuire and Hardwood (1989), research involvement is "generally accepted as one of the major components of the clinical nurse specialist" role (p. 169). This assertion is doubtful however, given the evidence that specialist nurses spend least time engaged in their research role, which has been found to be as low as 2% to 6% of time (Williams and Valdivieso, 1994; Buchanan, 1992; Robichaud and Hamric, 1986). Furthermore, in William and Valdiviesos' (1994) study,

clinical nurse specialists and nurse practitioners ranked the researcher component of their role as being relatively unimportant compared to other aspects of their role.

A number of authors present a diversity of expectations regarding the research role of specialist nurses. Few authors differentiate between different levels of research. McGuire and Harwood (1989) argue that it is unrealistic to expect all specialist nurses to be interested and involved in the highest level of research. These authors propose three levels of research involvement depicting advancing expectations (Table 3.13). Similar expectations are cited by other authors (e.g. Berger et al., 1996; Hazleton et al., 1993) but are not as complete, or developmentally sequenced in McGuire and Harwoods' framework (1989).

In concluding this section on the role dimensions and expectations of specialist level nurses, the writer notes that while the dimensions are clearly delineated in the literature, there is considerable overlap of expectations across sub roles. For example, similar expectations on education, staff development, change management, research, and being a resource person are straddled across the educator, manager/leader, consultant, and researcher roles. This overlap is presented, not only by different authors but also by the same authors in a given publication (e.g. Miller, 1995; Hazleton et al., 1994).

TABLE 3.13 Levels Of Research Involvement For The *Specialist Nurse.

****Role Expectations**

Level 1

1. Identifies nursing practice problems and translates them into research questions.
2. Enhances the clinical relevance and quality of research findings through collaboration with researchers.
3. Facilitates the research of nurses and others in the clinical setting.
4. Assists others to apply scientific knowledge in practice.

Level 2

1. Conducts investigations to monitor or assess the quality of nursing practice in the clinical setting.
2. Conducts virtual replication studies of others' research.
3. Tests the research findings of others in the clinical setting and applies the findings when appropriate.
4. Participates in collaborative research, assuming responsibility, for minor aspects of the research process.

Level 3

1. Conducts independent nursing research.
 2. Participates in collaborative research, assuming responsibility, for major aspects of the research process.
 3. Serves as a research preceptor or advisor for student or other researchers.
 4. Seeks out sources of financial support for research and writes grant applications for such funds.
-

* These authors were specifically referring to Clinical Nurse Specialists.

**The authors did not specifically use the term 'role expectations in their framework'.

Source: McGuire and Harwood (1989, p. 174).

According to Berger et al. (1996), nurses in advanced practice positions must have clearly delineated roles if they are to maximise their contribution to the health care system of the future. These authors oppose the diversity of sub roles expected of nurses in "advanced practice roles". Instead, the authors propose distinct and unique roles for nurses that encompass different positions in the health care services. These proposals include for example, Patient Care Manager, Case Manager, Clinical Educator, Clinical Consultant, and Clinical Researcher. Berger et al. (1996) conclude that effective use of "advanced practice nurses" can optimise patient outcomes, and at the same time foster cost-effectiveness.

Summary

In this chapter the role of the professional nurse at two levels of practice was identified. It was noted that a paucity of research exists on the role dimensions of nurses, especially at primary level. To this end, the plethora of role labels identified in the literature were thematically analysed to yield three mutually inclusive role dimensions of the primary level nurse: the helper role, the teacher/educator role, the patient care manager role. The helper role emerged as the core aspect of primary level nurses' role of the nurse. It is through the helper dimension that the teacher/educator and patient care manager roles are channelled. The role of the primary level nurse, as presented in this chapter, seems typical of the ascribed role for all registered nurses entering into practice. It was highlighted that for each dimension the nurse has the potential to progress from novice to expert at primary level. It was concluded that the role dimensions of nurses at primary level practice are consistent with the ideology of nursing identified in Chapter 1.

The role of the nurse at specialist level was noted to be more clearly delineated in the literature. The general consensus is that it comprises of five sub roles: the clinician, the educator, the manager/leader, the consultant, and the researcher. The specialist nurse represents an achieved role that is considered to be characteristic of expert practice. The extent to which specialist nurses can demonstrate expertise in direct patient care was questioned, given the multiplicity and complexity of role expectations demanded of them across five sub roles. A number of role expectations of nurses at specialist level were noted to overlap with those of nurses at primary level, especially in relation to direct patient care, and teaching. The sub roles of researcher, consultant and the broader remit of education were noted to mark a clear distinction from the primary level role. However, it was noted that specialist nurses spend minimal time engaged in these sub roles. In concluding, it was proposed that each sub role may represent distinct positions in the health care services.

CHAPTER 4

THE PROFESSIONAL ROLE OF THE NURSE: DIFFICULTIES AND CONSEQUENCES

Introduction

In the interest of quality services, consumer demand, professionalism and cost effectiveness, it seems critical that nurses present a clear description and account of the service that nursing offers in the health care services. In Chapter 3, the professional role and expectations of the nurse are described. In this chapter, the difficulties that nurses may encounter in exercising their role are discussed. In the literature, there is outstanding consistency regarding the difficulties encountered by nurses in fulfilling their role, irrespective of branch, level (primary or specialist), or country. The writer perceives that these difficulties may be grouped into three broad and interrelated categories: professional latitude, work environment, and role problems. These difficulties are illustrated by the writer in Figure 4.1. Role problems emerge as outcomes of difficulties that nurses encounter with professional latitude and work environment, which ultimately have detrimental consequences for nurses, patients and employing organisations (Figure 4.1).

4.1 Professional Latitude

Latitude is defined in "The Oxford Reference Dictionary" as "freedom from restriction in action or opinion" (Hawkins, 1986, p. 455). This definition captures a number of difficulties that nurses encounter in their professional roles. As shown in Figure 4.1, restrictions that nurses encounter in their role relate to issues of authority and autonomy. The lack of recognition from significant others has also been found restrictive for nurses. Restricted continuing education is a further source of difficulty encountered by nurses in the context of professional latitude.

Restricted Authority and Autonomy

The concepts of authority and autonomy are inextricably linked within the broader concept of empowerment. However, these concepts represent two distinct phenomena. Authority is defined as sanctioned or legitimate power delegated to an individual within an organisation, thus permitting the individual to perform role related functions (Mintzberg, 1983). Autonomy, on the other hand, is an individual's ability to independently perform the responsibilities of a given position without close supervision. To be autonomous, individuals must first be given authority (Raelin, 1984). For nurses, a number of issues emerge in the literature relating to restricted authority and autonomy (Table 4.1).

Difficulties Encountered in the Role of the Nurse

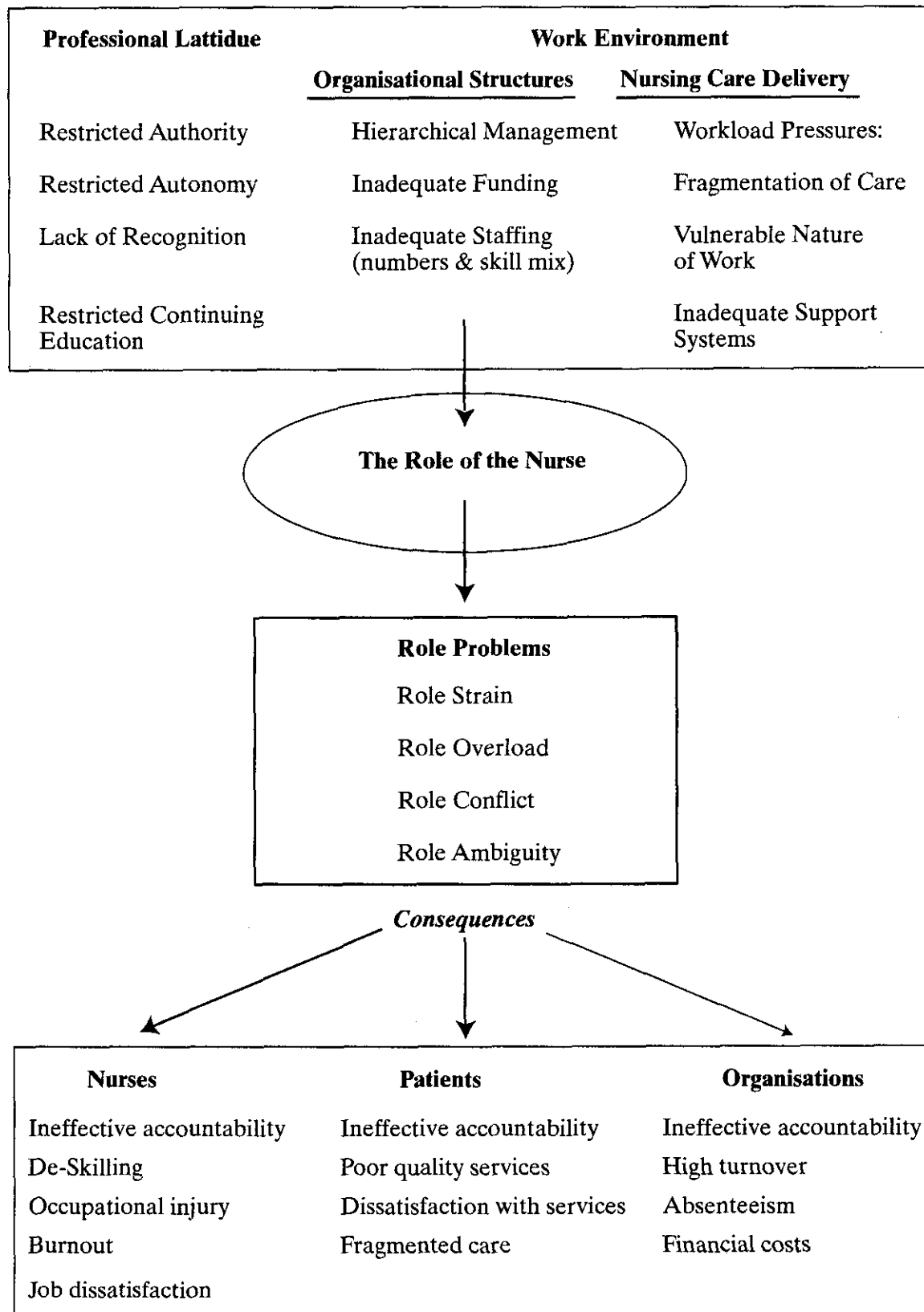


FIGURE 4.1 The Role of the Professional Nurse: Difficulties and Consequences

TABLE 4.1 Professional Latitude: Issues Relating to (a) Authority and Autonomy and (b) Lack of Recognition.

| Authority and Autonomy | Lack of Recognition |
|---|---|
| Legislation Hierarchical position in the organisation Locus of work Ineffective Accountability | Professional Image Clinical ladders Clinical grading Recognition from others (Medical profession and managers) De-skilling |

Legislative Issues

Already in Chapter 2, legislative barriers surrounding advanced and independent practice were discussed. To recall, there are no authorising statutes to support advanced and independent practice in the countries reviewed. Midwifery is an exception to this. While the absence of legal authorisation may have impeded the growth of independent practitioners, it has not stifled it entirely. Nonetheless, Briody (1996) claims that legislative authority is necessary if high levels of autonomy are to be experienced by nurses in advanced practice.

Although authorisation is a prerequisite to autonomous practice, autonomy does not always follow authority. The literature is replete with detail on the lack of autonomy afforded to nurses who are legitimately authorised to perform their roles. Research illustrates that nurses value autonomy, and want and need more autonomy and power for professional practice (Blanchfield and Biordi, 1996; Reutter and Ford, 1996). Power in this context relates to legitimate and expert bases (Blanchfield and Biordi, 1996). This seems an admirable demand given that expert practice is the pinnacle of clinical performance (Benner, 1984).

Hierarchical Position

A nurse's position in the organisation is found to influence his/her experience of autonomy. In a Canadian study, Laschinger and Shaimans' (1994) investigated staff nurses' and nurse managers' perceptions of job-related empowerment. They found that staff nurses (n = 112) rated their access to power and opportunity in their jobs lower than nurse managers (n = 27) did. Interestingly, in another study from the US, nurse managers (n = 88) perceived staff nurses to have greater levels of autonomy than staff nurses (n = 511) themselves experienced (Blanchfield and Biordi, 1996). The writer acknowledges the imbalance in sample sizes between staff nurses and nurse managers in both studies.

In the UK, clinical nurses in more senior positions to staff nurses, such as nurse specialists, have also been found to experience restrictions in autonomous practice (Bousefield, 1997). However, despite the proclamations of advanced nursing practice being the cornerstone to greater autonomous practice, there appears to be little published research that has investigated nurses' perceptions of autonomy at specialist level.

Lower levels of autonomy could be expected, and perhaps be more acceptable for the most junior registered nurses. As suggested by Benner (1984), nurses progressing from novice to expert are largely dependent on the resource environment. However, there is evidence that graduate nurses are not permitted autonomy appropriate to the level of practice that they are prepared for (Horsburgh, 1989).

Locus of Work

In addition to nurses' positions, autonomy seems influenced by locus of work. In a US study, nurses working in Intensive Care units and Emergency Departments, were found to have greater authority and autonomy than nurses working in more broadly defined areas (Blanchfield and Biordi, 1996). In the same study, nurses on night duty were granted greater autonomy than those on day duty, and this seemed attributed to a more flattened hierarchical management structure. In a UK study, community nurses reported greater levels of autonomy than hospital nurses (Melhuish et al., 1993). However, evidence from Canada suggests that public health nurses have little control in shaping public health policies (Clarke et al., 1993), yet health promotion is the long standing mission of public health nursing (Zerwekh, 1993).

As discussed in Chapter 1, while the midwifery branch of the nursing profession has made greater inroads in the field of autonomous and independent practice, it is marred by the dominance of the medical profession. For example in the UK, since the inclusion of maternity services in "GP fundholding", midwives are dependent on general practitioners to purchase their services in the community (Tyler, 1996a). An issue of great concern to midwives in the UK is the Royal College of Midwifery's withdrawal of insurance indemnity policies for self employed independent midwives (Tyler, 1996b). This calls to question the extent to which the autonomy and parity with GPs, afforded to midwives in the government report "Changing Child Birth" can be realised (Department of Health, 1993). This situation is not unique to midwives in the UK, or indeed to the general body of independent nurse practitioners. For example, in the US, relatively few nurse practitioners get contracts with Health Maintenance Organisations or indemnity plans (Sinclair, 1997), thus limiting their freedom of autonomy. A similar situation is evident in Australia (Smith, 1996).

Implications for Accountability

Both the lack of authority and autonomy have consequences for the status of accountability for nursing practice. Accountability is concerned with holding professionals answerable for the outcome of their practice (Moloney, 1992). Internationally, the principle of accountability is enshrined in professional codes of practice, and in guidelines regarding the scope of professional practice (Kelly and Joel, 1995; UKCC, 1992; Pyne, 1992).

According to Moloney (1992) the ultimate accountability for nursing service delivery rests with nurse administrators. However, this should not negate or lessen individual nurses' professional obligation to be accountable for their practice. As evident from Chapter 3, responsibility as primary caregiver in the nursing services is incumbent in the role of the nurse, particularly at primary level. Furthermore, it was shown that fulfilment of the nurse's role requires that responsibility and decision making authority be devolved to the level of the nurse. This is particularly the case for the evolving "patient care manager" role of the nurse.

Professional accountability implies authority and autonomy at the practitioner level. In order to be accountable the nurse must have the authority relevant to their role (Moloney, 1992). Without the reinforcement of authority and autonomy, nurses cannot be expected to be accountable for their practice. Accountability is of little worth and in fact ineffective if practitioners are restricted in terms of authority and autonomy (Moloney, 1992).

Lack of Recognition

According to Ruetter and Ford (1996), autonomy implies that one's judgement is credible, and hence autonomy may be closely related to being valued. Kanter (1979) claims that all individuals, irrespective of the work environment, have a fundamental need to feel important, useful, and part of a successful and worthwhile enterprise. This scenario with nurses being recognised and influential in the workplace does not permeate the nursing literature (Table 4.1).

Professional Image

As illustrated in Chapter 1, the history of nursing reads as an arduous struggle for recognition. Negative and stereotyped images, such as 'ministering angels', and "doctor's handmaidens" have haunted nurses (Dahl, 1992). It is suggested that this image has stifled professional recognition (Moloney, 1992).

However, there is a growing body of evidence that nurses are valued and recognised by the general public, in particular by those who have encountered nursing services (Walizer, 1996; Walker, Hall and Thomas, 1995). Furthermore, there is evidence that nursing services contribute to quality patient outcomes that are cost-effective (Boyd et al., 1994; Deal, 1994; Buchanan and Ball, 1992). However, research in this areas is still in its infancy. In Clarke et als' (1993) Canadian study, public health nurses voiced the need for more research on the qualitative aspects of health and nursing outcomes. A research basis to the service would establish the credibility of public health nurses and raise the profile of public health nursing. The writer suggests that this is equally applicable to all branches of nursing.

The traditional apprenticeship type education of nurses has militated against their professional recognition. As illustrated in Chapter 1, all countries reviewed in the literature have undergone education reform in an attempt to enhance the professional status of nurses. Another factor that reflects poor recognition of nurses, relates to pay and remuneration for services offered. Historically, nurses' work has been synonymous with women's work, and therefore has been underpaid and thus undervalued (Delamothe, 1988a; Delamothe, 1988b). Nurses' pay has been a major political issue in many countries, with salary compression being a particular source of dissatisfaction for senior clinical nurses (Gavin, 1995; Corley et al., 1994). Attempts to address this problem include the introduction of clinical ladders and clinical grading systems.

Clinical Ladders and Clinical Grading

It was noted in Chapter 2 that clinical ladders were first introduced in the US in the 1970s as a retention and recruitment strategy to deal with the high turnover rates of clinical nurses. Clinical ladders have since been employed in many organisations. More recently clinical career structures have been introduced to Australia (Duffield et al., 1995). Clinical ladders have evolved as structures for recognising and rewarding excellence in clinical practice. The reward takes the form of clinical promotion and increased remuneration (Lomurno and Downing-Janus, 1997).

It is purported that clinical ladders differentiate levels of practice and thus offer a methodology for structuring roles and functions according to experience, demonstration of clinical competence, and in some instances education (McClure, 1991). Clinical ladders

are claimed to be yardsticks by which nurses' performance can be measured (Snyder, 1997).

While the fundamental ideology of clinical ladders is commendable, research on their effectiveness is limited. Corley et al's (1994) review of the literature noted that most reports on clinical ladders were mainly in the form of case studies presenting success stories with little supportive data. There are a number of aspects of clinical ladders that seem worthy if utilised effectively e.g. feedback mechanisms, role negotiation, and peer review.

However, the general impression gleaned from this literature review is that the disadvantages or difficulties surrounding clinical ladders outweigh any evidence to support their merits (Table 4.2). Clinical ladders are described in the literature as "quick-fix" measures to recruit nurses and it is suggested that they do not serve the purpose of recognising clinical excellence in nursing (Snyder, 1997).

TABLE 4.2 Disadvantages of Clinical Ladders.

| |
|---|
| Cumbersome to develop (Lomurno and Downing-Janus, 1997). |
| Complexity of defining clinical competencies (Sanford, 1987; Del Bueno, 1982) |
| Complexity of defining advancing nursing practice (Sanford, 1987) |
| No correlation between clinical ladder level and performance (Snyder, 1997) |
| No notable impact of retention rates (Lomurno and Downing-Janus, 1997; Corley et al., 1997; del Bueno, 1982). |
| Perpetuate a system of hierarchical worth (del Bueno, 1982). |
| Organisations cannot offer unlimited promotions or financial rewards (Snyder, 1997) |

Similar to the US, a structure for recognising and rewarding nurses clinical expertise was introduced in the UK in the late 1980s, known as clinical grading. Nine clinical grades in total were identified (A to I, with registered nurses starting at C). However, it must be emphasised that the UK clinical grading is a direct outcome of the 1988 pay round (Gavin, 1995), and not related to a retention and recruitment strategy as in the US. Unlike the US "success stories" referred to above, clinical grading in the UK has been subject to repeated criticism in the nursing press. A great sense of sheer frustration and anger emerged from the literature reviewed.

From the outset, a central objective of clinical grading was to reward nurses in clinical practice. A paradox emerged however, in that clinical grading was based on job descriptions or qualifications rather than on standards of clinical performance (Gavin, 1995; Andrew, 1993). Trade unions seem to have been the main pressure group in this regard in that they were "absolutely wedded to grading the job" (Gavin, 1995; p. 380). This resulted in a "logjam" of appeals by nurses who disputed the grade awarded to them by management (Tattam, 1990; Davidson, 1990). A national survey reveals that within a fifteen month period of introducing clinical grading in the UK, 25% (n = 135), of nurses had lodged appeals against their grades (Gaze, 1990). In addition to the grading start-up bill of 1 billion pounds, it was estimated by Carlisle in 1992 that the cost of each appeal was approximately £1,000. As a policy for recognising and rewarding clinical practice, clinical grading has failed to realise its objectives (Gavin, 1995).

Recognition from Others

While nurses call for formal mechanisms of recognition, the need for recognition and influence in everyday practice in the work place seems more immediate. In a Canadian study, Laschinger and Haven (1996) found that staff nurses ($n = 127$) in hospital settings were fundamental to the provision of patient care. However, the findings revealed that neither the position of staff nurse nor the staff nurses themselves received the visibility or recognition commensurate with the centrality of their role in achieving organisational goals relating to patient care. This finding concurs with evidence from other studies (Melhuish et al., 1993; Horsburgh, 1989).

Lack of recognition from the medical profession is found to be an important source of stress amongst nurses. In a UK study by Melhuish et al. (1993), both hospital and community nurses reported that doctors neither respected nor valued autonomous nurses and tended to treat nurses as inferior beings. Similarly, Williamson (1993) found that a major source of dissatisfaction amongst neonatal nurses was a lack of recognition of their skills and expertise, in particular from medical staff. Nurses have reported little control over treatment and ethical decisions concerning patient care (Fowler, 1989; Edwards and Haddad, 1988), yet nurses, because they work closest to patients are often the first to note subtle and sudden changes in their conditions (Collins, 1996).

With regard to recognition from others however, it appears that nurses' greatest difficulty lies with management. In Melhuish et al.'s (1993) study, while nurses were critical of doctors, they were more critical of general managers. Few nurses felt they could influence general managers, with the more junior nurses feeling least influential. In another UK study, mental health hospital staff nurses ($n = 144$) reported little recognition from managers. Included in the top ten stressors reported by respondents, were "not being notified of changes before they occur" and "lack of consultation from management about influential structural changes" (Carson et al., 1995, p. 482). Another characteristic of nurse managers' lack of recognition of staff is their failure to give them timely positive feedback, a finding evident in Laschinger and Haven's (1996) study. Collins (1996) cautions that without recognition from nurse managers, nurses are likely to feel undervalued and dissatisfied, leading to detrimental consequences such as burnout.

De-Skilling

Failure to recognise and acknowledge clinical nurses' skills and expertise may result in de-skilling. This seems to be a particular problem for nurses in primary level roles. The increasing employment of unskilled aides or patient care technicians in substitution for temporary or full time registered nurses is a fundamental issue. Increasingly, unskilled personnel are assuming the role of direct patient carer resulting in registered nurses' clinical skills being under-utilised. In a nation-wide survey in the US, nurses ($n=7560$) throughout the country reported their concerns about the de-skilling of registered nurses directly involved in patient care (Shindul-Rothschild, Berry, and Long-Middleton, 1996). Clifford (1992) maintains that although registered nurses must supervise nursing assistants, they must always be in a position to use their knowledge and expertise on behalf of patients. Clifford's argument is that clinical decision making and expert judgement can neither be delegated nor substituted by lesser prepared personnel.

It is suggested that clinical nurse specialists also contribute to de-skilling. Although not extensively researched, this is a concern expressed by nurses in a number of UK studies. In McGee et al.'s (1993) study, chairpersons and chief nurse respondents ($n = 230$) from

National Health Service trusts were concerned that nurses who become too focused on a particular speciality may lose generic nursing skills. It may also lead to de-skilling of the generalist nurse of specialised knowledge and expertise. These findings are supported by other studies (Griffiths and Luker, 1994; Wade and Moyer, 1989). According to Burn and Tonges (1993), nurses potential to develop clinical skills and knowledge must be recognised, and they must be allowed to use their knowledge and skill in the direct care of patients.

Restricted Continuing Education

Education is considered to be the cornerstone of professional development and the key to empowering nurses (Clay, 1992). Although research evaluating the impact of continuing education is scarce and inconclusive to date, evidence is emerging that continuing education has the potential to improve patient care through the enhanced clinical performance of nurses (Ferguson, 1994; Waddell, 1992; Bignell and Crotty, 1988). Despite the paucity of substantial evidence on the impact of continuing education on nursing practice, it has been mandated for registered nurses in a number of countries, for example in most states in the US (Peden, Rose and Smith, 1992), and in the UK (UKCC 1996b).

While continuing education seems promising in terms of enhancing professional latitude, planned and equitable opportunities for all registered nurses are not apparent. In a recent UK study, the provision and uptake of continuing education was found to be arbitrary and random (Barriball and While, 1996). Hospital nurses practising in elderly care, learning disabilities, and mental health were found to have the lowest uptake of continuing education. Conversely, a higher uptake was found amongst nurses practising in paediatrics, maternity care, general medical/surgical units, and community care. The study also revealed that participation in continuing education was lowest for nurses on evening/night shifts, and amongst temporary nurses (Barriball and While, 1996).

An interesting finding is that a consistent association was found between the clinical grade of registered nurses and their level of participation in continuing education. Participation was found to be least amongst registered junior nurses (Barriball and While, 1996) (Table 4.3). A similar finding is evident in a US study, whereby head nurses' participation in continuing education was greater than staff nurses (DeHaven, 1990).

TABLE 4.3 Grading Characteristics of Registered Nurses with Different Participation Levels in Continuing Education (CE).

| | 5 or more CE study days attended | Less than 5 or no CE study days attended | % of nurses who participated (CE) |
|-----------------------|----------------------------------|--|-----------------------------------|
| <i>Clinical Grade</i> | | | |
| H or higher | 28 | 1 | 97% |
| G | 62 | 7 | 89.9% |
| F | 38 | 1 | 97.3% |
| E | 55 | 14 | 79.7% |
| D | 47 | 19 | 71.2% |
| C | 6 | 7 | 58.3% |
| | (n=237) | (n=48) | |

Source: Barriball and While (1996).

Irrespective of country, nurses report numerous difficulties within the work environment in accessing further education beyond mandatory requirements. As shown

in Table 4.4 these difficulties are mostly related to structural issues within the work environment. If continuing education is to afford optimum positive outcomes for clients, nurses and services, then these structural difficulties must be resolved (Barriball and While, 1996). Furthermore, the writer suggests that if education is the key to empowerment and professional latitude for the nursing profession, the resolution of these difficulties seems paramount.

TABLE 4.4 Difficulties Encountered by Nurses Seeking Continuing Education (CE).

| | |
|--|--------------------------------|
| Inadequate study leave | Low staffing levels |
| Lack of commitment and support from managers | Lack of funding |
| Personal/domestic circumstances | Late notification of CE events |

Key Sources: Barriball and While (1996); Yeun (1991).

4.2 Work Environment

The difficulties that nurses encounter in their work environment are multiple, and as illustrated in Figure 4.1, centre around two interrelated issues: organisational structures, and nursing care delivery. Difficulties relating to organisational structures include hierarchical management style, inadequate funding, and inadequate staffing (numbers and skill mix). These structural issues encroach on the role of the nurse in delivering quality nursing care. Difficulties that nurses encounter at the operational level of nursing care delivery include workload pressures, fragmentation of care, vulnerable nature of work, and inadequate support in their role.

Organisational Structures

Hierarchical Management

The detrimental effects of hierarchical management structures on nurses' professional latitude in the workplace have already been referred to in this chapter. The literature leaves little doubt that rigid and rule-bound hierarchical structures moulds nurses into passive, subservient and unthinking doers (Laschinger and Havens, 1996; Moloney, 1992). Unless nurses are intellectually stimulated and encouraged to "think", they cannot be expected to advance nursing practice. To reflect on Chapter 3, it was noted that intellectual stimulation is a self oriented value held by nurses in relation to meaningful practice (Fagermoen, 1997).

Inadequate Funding

Organisational issues at the broader level relate to the continuous increase in health care expenditure trends since the 1960s. For example, in the UK, the total health care expenditure as a percentage of GDP rose from 3.95% in 1960 to 6.6% in 1991 (Versieck et al, 1995). The knock on effect of this trend has been a restructuring of health care services. For many nurses, restructuring of health services is synonymous with cut backs or "downsizing", as evident in Shindul-Rothschild et al's (1996) nation-wide study in the US. Similarly in Canada, limiting government funding in an effort to cut health care costs in the 1980s has resulted in shortages of equipment and materials, staff shortages, ward

closures with resultant overcrowding, and a reduction of in-service education at a time when the acuity and complexity of patient care is increasing (Lindsey and Attridge, 1996).

Inadequate Staffing Numbers

Of all resource cut backs, the most notable difficulty lies with staff shortages, particularly registered clinical nurses. In the US, between 1993 and 1994, there was an average loss of 90 full time equivalent registered nurses (FTE RN) per 100,000 population throughout the country, with the loss in some areas as high as 161 FTE RNs per 100,000 population (Shindul-Rothschild et al, 1996). These researchers refer to long term employment forecasts for the US which predict that by the year 2005, the percentage of nurses employed in hospitals will have fallen from 63.8% to 57.4% while the percentage of nurses in the community will increase. Despite the increase in community nurses in most countries, staff shortages remain a problem (Reutter and Ford, 1996; Clarke et al., 1993).

The registered nurse shortage "crisis" found in acute care settings in both the US and Canada has not yet hit Europe (EU). To the contrary, marginal increases in the numbers of registered nurses employed in all EU countries were noted in a recent country-comparative survey (Versieck et al., 1995). This increase is in response to specialisation, the development of community nursing services, and the need to meet the intensifying nursing demands of more rapid patient turn over in hospital settings. However, nurses in a number of countries (e.g. Belgium, France and Portugal) claim that there is a shortage of nurses, and that the numbers employed are not adequate to meet nursing demands (Versieck et al., 1995).

Inadequate Staff Skill Mix

Inappropriate skill mix of staff is a further difficulty encountered by nurses. A survey in the UK – "The Virtue of Patients: Making Better Uses of Ward Nursing Resources" found wide discrepancies across comparable units regarding staffing norms (Audit Commission, 1991). Similar findings are evident in an EU survey (Versieck et al, 1995). Recommendations from this survey included the need for more efficient use of nursing skills, and the need to establish staffing norms.

Two areas that seem to require particular attention in relation to skill mix are ratios of nursing assistants to registered nurses, and ratios of inexperienced registered nurses to experienced registered nurses. The upsurge of paranursing grades such as nursing assistants, unlicensed assistive personnel, and health care assistants (nursing assistants hereon), most notably in the US, coupled with a shortage of registered nurses has resulted in delegation of many nursing responsibilities to this grade of personnel. Examples of nursing responsibilities delegated to nursing assistants include basic bedside nursing care, and technical/clinical procedures such as pressure area care, wound care, and monitoring vital signs (Barter et al., 1996; Taunton and Otterman, 1986). To recall from Chapter 3, these activities represent expectations pertaining to the helper role and patient care manager role of the nurse. A similar situation is evident in the UK with nursing assistants taking on many of the responsibilities that were traditionally in the domain of nursing (Hunt and Evans, 1994; Thomas, 1992).

Apart from the risk of de-skilling referred to earlier, there is evidence that the minimal training received by nursing assistants does not prepare them for the complexity of nursing. Out of a sample of 171 staff nurses and team leaders across three hospitals in the

US, Barter et al. (1996) found that only 11% (n = 17) of nurses were satisfied with the ability of nursing assistants to perform delegated tasks. Furthermore, only 35% (n = 60) expressed satisfaction with nursing assistants' abilities to differentiate important from unimportant clinical information, and to communicate changes in patient conditions.

Inadequate numbers of nursing assistants is also problematic for nurses in realising their role expectations. In the absence of nursing assistants, nurses find themselves taking on non-nursing duties in the areas of housekeeping, clerical work and transportation, as evident in a number of EU countries such as Belgium, Denmark, and Portugal (Versieck et al., 1995). Ironically, despite the increasing numbers of nursing assistants in the UK, non-nursing duties are common amongst nurses (Audit Commission, 1991).

Inadequate ratios of experienced to inexperienced registered nurses further compounds the skill mix situation. When units are staffed with a greater ratio of inexperienced nurses, research has shown that they are required to take on more complex responsibilities than should be expected of them (Holsburgh, 1989; Ahmadi, Speedling and Kuhn-Weissman, 1987). Graduates of generic programmes are particularly vulnerable, and are found to be least prepared for clinical practice in acute care settings (Holsburgh, 1989; Kramer, 1974). In Australia, graduates have reported that the demands of the situation dictated the responsibilities allocated to them. Often during evening shifts when the numbers of experienced staff were decreased, new graduates were allocated sole responsibility for a group of patients (Holsburgh, 1989).

The writer speculates that the situation may be somewhat different in the EU, than in countries such as Canada, Australia and New Zealand. Unlike these countries, generic education is not the norm in most of the EU. More importantly, in accordance with EU directives on nurse education and training, student nurses are required to have no less than 2300 hours in clinical placements (An Bord Altranais, 1994), which is greater than that required in Canada (1500 hours), Australia (890 hours), and New Zealand (1500 hours) (Nursing in the World, 1993). Keeping in mind Benner's (1984) theory, the writer suggests that newly registered nurses in the EU may be more competent to practice in acute care settings. However, emergent evidence from Project 2000 indicates that graduate nurses continue to need the guidance and direction of more experienced nurses (Jasper, 1996), thus reiterating the importance of appropriate skill mix and establishing staff norms.

Nursing Care Delivery

Workload Pressures

The overriding and immediate effect of staff shortages is best described as a "speed up" service (Shindull-Rothschild et al. 1996). Nurses are described as working "around the clock and against the clock", carrying heavy workloads and responsibilities (Lindsey and Attridge, 1989, p.15). These responsibilities are greater still with inappropriate skill mix staffing levels, in which case there may be increased supervisory and delegation demands of senior nurses, or inappropriate allocation of responsibility to junior nurses (Barter et al., 1996; Holsburgh, 1989).

Fragmentation of Care

The "speed up" work phenomenon results in fragmentation of nursing care. In Shindull-Rothschild et al's (1996) study, 55% (n = 4128) of registered nurse respondents across the US reported a decline in the continuity of care in nursing practice. Most nurses (73%, n =

5518) reported less time for teaching patients and their families. An almost equal percentage of respondents (74%, n = 5594) reported less time to talk to and comfort patients. Less time to provide basic patient care was reported by 69% of respondents (n = 5216) (Shindull-Rothschild et al. 1996).

The aforesaid findings leave little doubt that nurses are spending less time in patient care. This calls to question, how do nurses use their time? This question was addressed in a US study by Hendrickson, Dottato and Kovner (1990). These researchers carried out a non participant observational study in six units of a large metropolitan hospital. The aim of the study was to identify how registered nurses spend their time on a typical 8 hour shift. A summary of these findings are presented in Table 4.5.

TABLE 4.5 Average percentage (%) of Time Spent in Activities by Registered Nurses on a Typical 8 Hour Shift.

| Direct Patient Care | Indirect Patient Care | Non Nursing | Miscellaneous |
|---------------------|---|--|----------------------------------|
| 31% (2.5 hours) | 45% (3.6 hours) Charting (11%) Preparing therapies (10%) Changing shift (9%) Checking physicians orders (3%) Miscellaneous e.g counting narcotics (3%) | 10% (48 minutes) Paperwork (4%) Phone communications (3%) Looking for/Obtaining supplies (3%) | 13% (1 hour) e.g meals/breaks |

Source: Hendrickson et al. (1990).

The time spent in specific activities was fairly consistent across the seven days of the week (Hendrickson et al, 1990). This contrasts with Sabo's (1990) study which found that nurses working on evening shifts and at weekends spent more time in non-nursing duties. Non nursing duties included clerical work, stocking, and cleaning. The major variation in times spent by nurses in Hendrickson et als' (1990) study related to time frames spent with each patient, rather than overall time spent with each patient per shift. The researchers found that the time frame spent with each patient varied from 38 minutes in the paediatric unit to 18 minutes in the surgical unit. The variation in times spent with patients seemed related to nurse/patient ratio with more favourable ratios permitting greater time being spent with a patient at a given time. The average case load per nurse ranged from 4 to 10 patients, with greater caseloads in the evening times.

Hendrickson et als' (1990) quantitative study gives credence to nurses' claims that increased workloads result in fragmented care. As shown in Table 4.5, the majority of nursing time is spent in indirect patient care, with only 31% of time in direct care activities. The researchers highlighted that this percentage of time is less than that found in previous studies carried out in an era prior to staff shortages. With lack of continuity and a fragmented approach to care, nurses report that patients receive only the essential functional aspects of patient care (Hendrickson and Doddato, 1989).

Continuity and fragmentation of patient care is also a concern raised by nurses in community settings, in particular public health nurses, and midwives. The concerns expressed by these nurses lie not so much with staff shortages, but with fragmentation of the health services overall. In Clarke et als' (1993) Canadian study, public health nurses voiced the need for integration of community health services within public health departments and among physicians, hospitals and community. Public health nurses further

emphasised that, to ensure recognition, public health nurses need to define their role in the context of an integrated service.

Similarly, midwives have expressed dissatisfaction with the lack of continuity of care for expectant mothers. Flint and Poulengeris (1987, cited in Hundley et al., 1995) sought the experiences of midwives in the UK "Know Your Midwife" scheme. They found that fragmentation of care was one of the main factors contributing to low job dissatisfaction amongst midwives. Thomson (1980) claims that because midwives seldom see a woman through the complete process of childbearing, they may have difficulty envisaging factors which effect the experience and this reduces a sense of purpose in their work. The findings of Hundley et al's more recent study in 1996 continue to support the view that continuity of care is an important factor in midwives' job satisfaction.

Vulnerable Nature of Nursing

A number of authors claim that the vulnerable nature of nursing is an important source of stress for nurses. Nursing is often associated with unpleasant sights and odours, human pain, suffering, and death, which in the hospital setting is in an atmosphere that is often noisy, brightly lit and highly technical (Lindsey and Attridge, 1989). In Sullivan's (1993) UK study on occupational stress in psychiatric nursing, violent incidents, potential suicide, and continuous observation of patients on a one-to-one basis were reported to be the most frequent stressors for respondents. The lack of manpower resources to maintain safe levels of observation, the inadequate competence of relief staff and bank nurses, and the lack of management support, further exacerbated these stressors (Sullivan, 1993).

Vulnerable situations have also been identified for nurses working in the community. These include, working with bereaved families, and high risk families (e.g. suspected non-accidental injury, mental illness, socially and economically disadvantaged) (Reutter and Ford, 1996; Fletcher, Jones and McGregor-Cheers, 1991). However, these Canadian and UK researchers respectively, found that public health nurses/health visitors valued their work and generally found their jobs satisfactory. The analysis of the qualitative data gleaned from Canadian public health nurses (n = 28) revealed that the stressful aspects of their work relate to structural problems, such as workload and time pressures, rather than the actual nature of the work itself (Reutter and Ford, 1996). The UK study presents similar findings with a significant number of health visitors under strain, mainly because of structural difficulties. According to these health visitors, a supportive work environment is a crucial factor in offsetting stressors (Fletcher et al. 1991).

Inadequate Support System

Given the difficulties that nurses encounter in the course of their work, the need for support in the work environment seems paramount. There is ample evidence in the literature that social support can ameliorate the negative effect of stress on nurses working in various contexts, to include critical/intensive care units (Cronin-Stubb and Rooks, 1985; Lindsey and Attridge, 1989), medical-surgical units (Laschinger and Havens, 1997), acute care psychiatric units (Sullivan, 1993), health visitors/public health nurses (Reutter and Ford, 1996; Fletcher et al., 1991), and clinical nurse specialism (Bousefield, 1997).

All of the researchers referred to above emphasise the importance of support from management. Laschinger and Havens (1997) found that supportive work environments which provided opportunities to learn, grow, and develop creative approaches to work, were health promoting. Lack of support in the work environment was found to be detrimental to staff nurses' occupational mental health.

Generally, research findings present an unfavourable view of the support offered to nurses by nurse managers in the work environment (e.g Laschinger and Havens, 1997, Lindsey and Attridge, 1989). In the studies reviewed, it appears that all nurse managers were in positions above the level of ward sisters/head nurses. In fact, ward sisters/head nurses along with peers seemed to be an important source of support for nurses. In both acute care and community settings peers were found to be the main source of support in a number of studies (Sullivan, 1993; Fletcher et al, 1991; Lindsey and Attridge, 1989). This type of support was reported to be informal and interpersonal in nature such as "the chance to talk to colleagues at break or lunchtime" (Fletcher et al., 1991, p. 1081). While this type of informal support is valued by nurses, there still remains a number of formal issues on which nurses seek support in the work environment, in particular from nurse managers/management (Table 4.6).

TABLE 4.6 Issues identified in the Literature on which Nurses seek Support.

| |
|--------------------------|
| Control over their work |
| Feed back on performance |
| Educational leave |
| Resources |
| Personal Circumstances |
| Change process |

Sources: Bousefiel, (1997); Laschinger and Havens (1997); Lindsey and Artirdge (1989).

Nurses are reported to feel unsupported in attempting to seek greater control over their work, especially in acute care settings (Bousefield, 1997; Laschinger and Havens, 1997; Lindsey and Attridge, 1989). This finding is closely aligned to the lack of recognition given to nurses, referred to in relation to professional latitude. On a similar vein, nurses who do not have their performance recognised through feedback from nurse managers feel unsupported (Laschinger and Havens, 1996). Nurse managers failure to recognise and meet the educational needs of nurses further generates an unsupportive culture (Waddel, 1992).

The call for better resources from nurses has been found to often go unnoticed and without support from nurse managers (Sullivan, 1993; Lindsey and Attridge, 1989). Interestingly, lack of support in the work environment has a considerably greater impact on nurses' occupational mental health than lack of resources (Laschinger and Havens, 1997). These researchers highlighted the importance of this finding for nurse managers in today's resource-constricted healthcare climate.

Another area where nurses perceive a lack of support from nurse managers relates to flexibility to attend to personal circumstances. According to Kane and Kartha (1992) little has been done to compensate nurses for the competing demands of both career and family. This writer proposes job sharing or flexible working times as a viable solution. However, in an earlier publication, Anderson and Forbes (1989) point out that personal financial circumstances may militate against this option for some nurses. The need for flexible scheduling to support the demands of nurses' personal circumstances is called for (Vernengo, 1996).

As indicated in Table 4.6, the literature reveals that nurses also feel unsupported in the process of change. For example, in Sullivan's (1993) study, psychiatric staff nurses reported that their organisation had been in a constant state of change over the previous 10 years. However, themes of poor information, lack of consultation, and minimal communication

regarding the changes permeated the qualitative aspects of data in this study. With reference to Antonovsky's work, Ruetter and Ford (1997) write that working in a climate of uncertainty can lead to a decreased sense of manageability and/or meaningfulness at work. Manageability is contingent on comprehensibility and thus consistent, structured and clear information on the nature of change is important (Ruetter and Ford, 1997). Such a scenario was not evident in a number of studies in the literature (Laschinger and Havens, 1997; Fletcher et al., 1991).

4.3 Role Problems and Consequences

Invariably, unresolved difficulties relating to professional latitude and work environment result in role problems for nurses. As briefly mentioned in Chapter 3, role problems include role strain and overload, role conflict, and role ambiguity. These problems if unresolved have adverse consequences for nurses, patients, and the organisation as a whole (Figure 4.1).

Role Problems: Definition of Terms

Drawing on role theory, the following definitions of role problems apply herein:

- *Role Strain* is a subjective phenomenon caused by multiple conflicting obligations and organisational demands which leads to feelings of frustration and tension (Biddle and Thomas, 1979).
- *Role Conflict* occurs within the role occupant when there is no congruence with the expected role behaviours and available time, resources, or capabilities or expectations of others (Biddle and Thomas, 1979; Doheny et al, 1997).
- *Role Ambiguity* stems from uncertainty about what is expected in a given role. It results from a lack of clarity about responsibilities, authority, allocation of time, and relationships with others (Biddle and Thomas, 1979).
- *Role Overload* occurs when expectations and demands exceed the ability of the role occupant to respond. Overload frequently appears in situations which are ambiguous (Biddle and Thomas, 1979).

Role problems arise when tasks and activities are not allocated specifically to the role occupant (Barter et al. 1997). Another factor which greatly contributes to role problems is the extent to which boundary-spanning activities are expected. Individuals engaged in boundary-spanning activities are those in co-ordinating positions with interdisciplinary and cross-functional activities both within and across organisation boundaries (Miles, 1976).

Role Strain and Role Overload

Occupations that increase stress hormone levels are those in which employees have little control over their work and/or must complete psychologically demanding expectations. These occupations are high-strain jobs, including nursing (Saego and Faucett, 1997). In Saego and Faucett's (1997) study on "job strain among registered nurses and hospital workers", the psychological demands of the work environment contributed to greater job strain amongst nurses than lack of control. The difficulties encountered in the work environment such as heavy and diverse workloads, time pressures, poor staffing

and skill mix, inflexible scheduling, and vulnerable situations, all contribute to increasing psychological demands on the nurse. A number of studies have correlated these demands with role stress and role strain (Hipwell, Tyler, and Carson, 1989; Dewe, 1988).

Apart from environmental stressors, the multiple dimensions expected of a given role may lead to role strain and overload (Taunton and Otteman, 1986). On reflecting on the role of the nurse at primary level, as presented in Chapter 3, the writer suggests that there may be too much expected in the context of "the patient care manager" role (Table 3.6). The expectations of co-ordinating patient care are very complex, and it is questionable if any one nurse could meet this expectation in addition to direct patient care delivery and the two other sub roles, namely the helper and the teacher/educator. Similarly, the role dimensions of nurses at specialist level are multiple and diverse. Each sub role comprises very demanding expectations and according to Berger et al (1996) cannot be expected of any one person.

When expectations and demands of a given role exceed the abilities of the role occupant, role overload ensues (Biddle and Thomas, 1979). Workload problems are an important daily element in the role of the nurse in the context of strained human resources (Dolan et al., 1992). These researchers statistically correlated workload problems with propensity to quit amongst nursing staff in 40 general hospitals, the majority of whom were nurses in primary level roles (74%, $n = 915$). However, the correlation was weak when compared to other stressors such as professional latitude (Dolan et al., 1992).

Nurses who continue to be subjected to role strain and overload stressors are at risk of detrimental physical, and psycho-social consequences (Saego and Faucett, 1997). These researchers, in referring to the Karasek Job Strain Model, state that job strain results in increased heart rates, depression, sleep problems, exhaustion, use of medication, and illnesses such as cardiovascular disease and hypertension. This reference is in the context of employees in general and not specifically to nurses. Nonetheless, the immediate and long term effects of role strain and overload on nurses is well documented in the literature. These relate to occupational injuries and burnout.

In Shindul-Rothschild et al's (1996) survey, 44% ($n = 3326$) of US nurses reported that the "speed up" phenomenon and increased workload demands associated with cut-backs, had resulted in an increase in occupational injuries. The two dominant occupational injuries reported by nurses were found related to violence in the workplace and mobilising patients. Nurses working in psychiatric units, emergency departments, and in primary care reported a greater increase in workplace violence. Increases in musculo-skeletal injury were also reported, most notably by nurses in operating theatres, neurology departments, and orthopaedic units (Shindul-Rothschild et al. 1996). Back pain and injury is the most major occupational injury experienced by nurses overall (Kane and Parahoo, 1994). It is the greatest contributor to sick leave and this has enormous financial implications for employing authorities (Sedgley-Roach, 1992).

The long term consequences of role strain and overload is burnout which contributes to job dissatisfaction, absenteeism, and turnover. The essential elements of burnout are described by Dolan (1987) as follows:

Decreased energy, shown by the inability to keep up with the work pace: decreased self esteem manifested in a sense of personal failure related to work: output exceeding input, whereby the individual perceives a greater expenditure of him/herself into the job for an even smaller profit or reward; a sense of helplessness/hopelessness and being unable to see alternative ways of functioning: cynicism, negativism in relation to self, others, the job, institutions, etc; and a feeling of self depletion (p.3).

Burnout is the consequences of specific social and situational factors that can be changed. Social support in the work place is a critical mechanism for offsetting burnout in nurses (Lindsey and Attridge, 1989).

Role Conflict

Role conflict is another source of job dissatisfaction, absenteeism, and burnout. Conflicting expectations on the role of the nurse arise within individual nurses (intra-) and between nurses and others (inter-) (Taunton and Otteman, 1986). Intra-role conflict arises when an individual nurse's professional role conception differs and is incongruous with the expectations of a bureaucratic organisation (Ahmadi et al., 1987). The writer has constructed Figure 4.2, to illustrate examples of these conflicting paradigms as they relate to the role of the nurse at primary level.

The conflict between professional self concept and bureaucratic norms has been found most acute in the initial socialisation process into the profession, that is, on qualifying and registering as a nurse. This is an area that is well researched in the US from where the term "reality shock" originates to describe new graduates initial experiences of role conflict on taking up employment (Kramer, 1974).

Evidence from longitudinal studies indicate a steady decline in graduates' professional conception and a parallel increase in bureaucratic conception (Taunton and Otteman, 1986; Corwin, 1961 cited in Ahmadi et al., 1987). This finding is not supported by other studies, which show that nurses continue to experience professional-bureaucratic role conflict beyond the initial socialisation period (Ahmadi et al., 1987; Taunton and Otteman, 1986).

A consistent finding in a number of studies is that conflicting ideals on authority and autonomy are the most likely aspects of role conception to give rise to professional-bureaucratic role conflict in nurses (Taunton and Otteman, 1986; Kramer, 1974). In Dolan et al's (1992) Canadian study, lack of professional latitude was found to be the strongest predictor of propensity to quit for nurses in emergency units, and intensive care units. Lack of professional latitude has also been identified as an inevitable source of inter-role conflict in the workplace (Taunton and Otteman, 1986). Inter-role conflict involves a diversity of personnel as presented in Table 4.7.

TABLE 4.7 Personnel Involved in Inter-Role Conflict.

Junior and senior primary role nurses (Horsburgh, 1989)
 Primary role nurse and lower level nurses e.g licenced practice nurse, enrolled nurse (Chang and Twinn, 1995)
 Primary role nurses and nursing assistants (Barter et al., 1987)
 Primary role nurses and nurse managers (Melhuish et al., 1993)
 Primary role nurses and medical personnel (Melhuish et al., 1993)
 Primary role nurses and nurse specialists (Griffiths and Luker, 1994)
 Nurse specialists and nurse managers (Bousefield, 1997)
 Nurse specialists and medical personnel (Bousefield, 1997).

In addition to issues relating to authority and autonomy, boundary crossing of various roles seems a fundamental source of inter-role conflict. For example, the primary role nurse may experience inter-role conflict when another role occupant such as nurse specialist or nursing assistant, performs role expectations that they perceive to belong to their role (Barter et al., 1997; Griffiths and Luker, 1994)

**FIGURE 4.2 Professional Self Concept versus Bureaucratic Norms:
Examples of Role Conflict**

| Conflicting Paradigms | |
|---|---|
| Professional Self Concept | Bureaucratic Norms |
| <p>The Helping Role e.g.</p> <ul style="list-style-type: none"> - Presencing/being with - Personal involvement - Providing comfort measures - Developing interpersonal/therapeutic relationship - Guiding patients through emotional and developmental changes - Maximising patients participation/control in his/her recovery. | <p>Work Environment e.g.</p> <ul style="list-style-type: none"> - Workload Pressures - Inadequate Staffing (numbers & skill mix) - Fragmented Care |
| <p>The Patient Care Manager Role</p> <ul style="list-style-type: none"> - Systematic and Holistic Approach to Care - Quality Improvement Approach to Care - Resource Management - Delegation - Liaison & Collaboration - Research Approach to Care | <p>Work Environment</p> <ul style="list-style-type: none"> - Workload Pressures - Inadequate Staffing - Fragmented Care <p>Professional Latitude</p> <ul style="list-style-type: none"> - Restricted Authority - Restricted Autonomy - Lack of Recognition - Restricted Continuing Education |
| <p>The Teacher/Educator Role e.g.</p> <ul style="list-style-type: none"> - Capturing a patients readiness to learn - Assisting patients to intergrate the implications of illness and recovery into their lifestyles - Assessing and planning for individual learning needs - Providing knowledge of health promoting activities, disease-related conditions, and specific treatment | <p>Work Environment</p> <ul style="list-style-type: none"> - Workload Pressures - Inadequate Staffing (numbers & skill mix) - Fragmented Care <p>Professional Latitude</p> <ul style="list-style-type: none"> - Restricted Authority - Lack of Recognition - Restricted Continuing Education |

For nurse specialists, who are perceived to cross the boundaries of medicine, the greater source of inter-role conflict lies with medical personnel (Bousefield, 1997). Another type of role conflict experienced by specialist nurses relates to boundary spanning activities. It appears from the literature that many specialist nurses practice in diverse settings within the same organisation, and have co-ordinating roles (Bousefield, 1997; Smith, 1996; Montemuro, 1987). Boundary spanning persons who co-ordinate interdisciplinary or cross-functional activities within or across organisations are at increased risk of role conflict (Miles, 1976).

Role Ambiguity

The literature presents evidence that many nurses are unclear on what is expected of them in their roles within their organisations. This is applicable to both primary role nurses and specialist nurses, and is articulated by nurses in all branches of nursing (Bousefield, 1997; Melhuish et al., 1993; Butterworth, 1995; Taunton and Otteman, 1986; Clarke et al., 1993). Three factors identified in the literature that contribute to role ambiguity relate to educational preparation, job descriptions, and policies on scope of practice.

According to Olsson and Gullberg (1988) development of the nursing profession is an essential goal of nurse education. Inherent in this goal is the development and clarification of the professional role of the nurse. However, as already illustrated above, the professional ideals conveyed in nurses pre-registration programmes do not always match the reality of what is expected of them in practice. Furthermore, the importance of continuing education is emphasised to nurses and even mandated by regulatory bodies, but is found to be more rhetoric than reality for many nurses (Barriball and While, 1996; Yuen, 1991).

Without educational preparation for various sub roles, nurses claim that they are unclear of what is expected of them, in which case they may choose to opt out of a particular sub role. This is evident in Taunton and Ottemans' (1986) study, where staff nurses who felt unprepared for teaching patients choose not to practice this dimension of their role. Research from Australia on specialist nurses also revealed that educational programmes do not prepare them adequately for the multiple dimensions of their role (Appel et al., 1996; Duffield et al., 1995). While a Masters degree is the minimum educational standard recommended for specialist nurses by some authors (Berger et al., 1996), others (e.g. Collins, 1992) claim that nurses should be prepared at doctoral level to engage in clinical nursing research. This may further explain why specialist nurses are found to spend least time in their researcher sub role.

Job descriptions that articulate expected and progressive levels of competence in nursing from "a theoretical and practical perspective" have been found to clarify nurses' roles and associated expectations (Gordon, 1986). Taunton and Otteman, (1986) found that in the absence of job descriptions nurses have experienced role ambiguity. Role boundaries become readily permeable if the parameters of a given role are not clearly delineated. This permeation of boundaries contributes to inter-role conflict and creates threats of role deprivation (Barter et al., 1997; Taunton and Otteman, 1986).

Nurses have been found to experience role deprivation from nursing assistants (Barter et al. 1997), and from less qualified nurses (i.e not registered, e.g enrolled nurses) (Chang and Twinn, 1995). In the latter study, enrolled nurses carried out 86.3% of the same activities as registered nurses. Based on their findings, the researchers advocate the UK's

strategy of phasing out the enrolled nurse, and they recommend one grade of nurse in clinical settings (Chang and Twinn, 1995).

In Taunton and Ottemans' (1986) study, staff nurses in hospital settings identified the importance of policy statements as a mechanism for clarifying expectations in relation to "job boundaries". Such policies should be based on standards set by the profession. This has implications for clearly delineating the scope of professional practice which calls to question the current trend by the UKCC to offer professions loosely bound principles on the scope of professional practice. According to Moloney (1992), professional regulatory authorities have an obligation to set standards for nurses in the interest of public safety, accountability, and optimal professional practice.

Summary

Against the background description of the professional role of the nurse in Chapter 3, this chapter set out to discuss the difficulties encountered by nurses in fulfilling their respective role dimensions. Difficulties were found to evolve around three broad areas: professional latitude, work environment, and role problems. It was noted that role problems are an inevitable outcome of professional latitude and work environment difficulties. Collectively, these difficulties were identified to have detrimental consequences for nurses, patients, and employing organisations.

The most remarkable finding in the literature regarding professional latitude is that registered nurses with lower positional status in an organisation perceive themselves to have least autonomy and recognition. A number of factors were identified regarding nurses' perceptions of lack of recognition. The most immediate factors seemed directly related to the workplace, rather than broader issues such as professional image and financial remuneration. The most notable finding in this regard was the lack of recognition from medical personnel, and management personnel, with the latter group being a greater source of difficulty. Closely aligned with lack of recognition from management personnel is the lack of support that they offer nurses in the work place. This was found to manifest in various ways, for example, in relation to coping with the change process, facilitating educational leave, and provision of resources.

The lack of both human and material resources were found to contribute to difficulties in the work environment, in particular inadequate staffing numbers and inappropriate skill mix, with the latter seemingly more problematic than the former. It was noted that inadequate staffing norms and inappropriate skill mix inhibited the role of the nurse in the delivery of direct and continuous nursing care, resulting in functional and fragmented patient care.

A number of role problems were identified, namely, role strain and overload, role conflict, and role ambiguity. The psychological and physical working conditions for nurses in an era of "cut-backs" was found to be a major factor contributing to role strain and overload. However, the overriding factor contributing to role strain and overload was found to be lack of management support.

Role conflict was found to arise when nurses professional self concept was incongruous with bureaucratic norms. This seemed most problematic for graduate nurses entering into practice for the first time. A further source of conflict was identified in relation to nurses inter role relationships. The variety of nursing personnel involved in patient care emerged as the most likely source of conflict. These personnel were found to be nursing assistants, nurse specialists, primary level and nurses with lower qualifications (e.g. enrolled nurses,

licensed practice nurses). Role conflict in this regard was found to be a greater difficulty for primary level nurses than specialist nurses.

Role deprivation and subsequent de-skilling were identified as consequences of having numerous layers of staff. It was noted that nurses with lower qualifications (e.g enrolled nurses, licensed practice nurses) and nursing assistants carried out activities considered integral to primary level nurses' role in direct patient care. Similarly the emergence of nurse specialists was found to create conflict in that primary level nurses perceived their potential to develop clinical expertise to be stifled.

The crossing of inter role boundaries was found to be attributed to role ambiguity. It was noted that role ambiguity arises when job descriptions of various personnel are poorly *defined or non-existent*. The need for policy statements was also identified with particular reference to clarifying the scope of professional nursing practice. Lack of educational preparation was also identified as a contributing factor to role ambiguity. Furthermore, lack of educational preparation was identified as an important factor militating against nurses fulfilling role dimensions and expectations such as those identified in Chapter 3.

The findings of the literature review specific to this chapter further illuminates the complexity of nursing which has implications for the effective functioning of nurses in meeting the expectations of both ascribed and achieved roles. The literature review in the preceding chapters forms a basis for making recommendations towards resolving the difficulties incumbent in the role of the nurse and these recommendations are presented in the next chapter.

CHAPTER 5

RECOMMENDATIONS

Introduction

In this final chapter, recommendations are made in relation to developing the professional role of the nurse. In keeping with the literature review, recommendations relate to: the disciplinary body of nursing knowledge, nurse education reform, a framework for nursing practice, the role dimensions of the nurse, and the role of the nurse in the work place. Although the recommendations stem from the international literature, they are of relevance to the Irish nursing context.

5.1 The Disciplinary Body of Nursing Knowledge

As illustrated in Chapter 1, the second half of the twentieth century has been a period of growth in terms of the development of nursing theories. Nursing theories contribute to the development of the disciplinary body of nursing knowledge. A disciplinary body of knowledge is a fundamental criterion for professional status. It is therefore recommended that the profession of nursing continues to develop and refine its theoretical basis. An important consideration in this regard is the availability of funding to facilitate Irish nurses in the development of nursing theories relevant to the practice of nursing in Ireland.

5.2 Nurse Education Reform

In Chapter 1, it was demonstrated that the international trend in nurse education reform is towards a Bachelors degree as the minimum standard of pre-registration education for general nursing. In a number of countries there has been a move towards generic nurse education programmes. Specialist branches such as psychiatric nursing and paediatric nursing are at post basic level education in a number of countries. For nurses entering specialist or nurse practitioner roles, a masters degree programme is becoming a prerequisite in a number of countries.

Ireland is currently on the threshold of educational reform, in particular at pre-registration level. It is therefore recommended that a strategy for the future development of nurse education in Ireland be planned. This strategy should be coherent and developmental in its orientation thus enabling nurses to develop a career pathway. Government funding should be made available to pilot educational programmes.

5.3 Framework for the Practice of Nursing

In Chapter 2, international trends and issues relating to the practice of nursing were discussed. The concept of advanced nursing practice has been the focus of much debate and disparity in many countries. For example, definitive agreement on advancing levels of practice, experiential and educational criteria for entry to advanced/specialist levels of nursing practice have not been reached in a number of countries. Furthermore it was noted that few countries have a coherent framework in place to develop and guide the practice of nursing.

It is recommended that Benner's (1994) research on skill acquisition should be considered as a basis for developing the practice of nursing. Benner's framework has the potential to develop nurses through increasingly complex levels of practice: novice, advanced beginner, competent, proficient, and expert. A framework for the practice of nursing should articulate the competencies required of nurses to advance their level of practice. In Ireland, consideration should be given to the Australian Nursing Council's (1994) initiative to develop national competencies for registered nurses (Appendix 1).

5.4 The Role Dimensions of the Nurse

As pointed out in Chapter 3, the literature presents a fragmented view of the role dimensions of the nurse, in particular at primary level practice. In order to articulate the nursing profession's contribution to the health services it seems paramount that the role dimensions of the nurse are clearly defined. As synthesised in Chapter 3, it is recommended that the role dimensions for primary level nurses are: the helping role, the teacher educator role, and the patient care manager role. The role dimensions of nurses at specialist level practice are more clearly delineated in the literature. These are: the clinician, the educator, the manager/leader, the consultant, and the researcher. However, it was noted that the extent to which specialist level nurses are able to perform all of the aforesaid sub roles is questionable given the complex demands inherent in each of the sub roles. It is recommended that each of the aforesaid sub roles of the specialist level nurse have the potential to represent distinct positions held by nurses in the health care services.

5.5 The Role of the Nurse in the Workplace

In Chapter 4, difficulties encountered by nurses in the workplace were discussed with reference to how these difficulties impinge on the role of the nurse. The difficulties were categorised into three broad categories: professional latitude, work environment, and role problems. The writer recommends that the difficulties encountered by nurses in performing their role may be ameliorated by focusing on four interrelated areas in the workplace. These are: work redesign, practice development, staff development, and managerial support and commitment.

Work Redesign

Work redesign is a term used to broadly describe the process an organisation uses to examine how work is being carried out, to analyse the efficiency and effectiveness of work practices, and to alter work practices in the interest of best meeting the needs of the organisation and the client (McGillis Hall, 1997). According to Madden and Lawrenz (1990, p. 4), work redesign has the potential to:

- reduce conflict and unnecessary competition
- develop a customised patient care model
- promote collaboration and respect among nursing staff and between departments
- increase job satisfaction
- reduce stress
- improve overall organisational communication
- reduce costs
- create a shared sense of purpose.

In reviewing the literature work redesign seems to fall into two categories relating to management style and patient delivery systems. These are addressed below in the contexts of shared governance, primary nursing, and professional practice partnership model.

Shared Governance

The concept of shared governance, which originated in the US in the late 1970s, is considered to be one of the most significant changes in moving away from the traditional bureaucratic and hierarchical management style (Geoghegan and Farrington, 1995). Broadly defined, shared governance is a nursing management style that legitimises nurses' decision making control over professional practice (Bernreuter, 1993). Shared governance represents a participative management style in an organisation with decision making powers decentralised to nurses at the operational level of patient care (Przechrzelski, 1987). Furthermore, shared governance provides a structure for nurses to be involved in decision making at all levels of an organisation such as participating in problem solving teams, organisational committees, and policy formulation committees (Westrope et al., 1995). These researchers found that following the implementation of a shared governance model in a hospital setting, staff nurses were more satisfied and more committed to their jobs and the hospital organisation. Increased participation in decision making was found to be associated with greater control over nursing practice and more meaningful work (Westrope et al., 1995). The shift of responsibility to nurses at the operational level of care has implications for change management and staff development. This is discussed later in the context of staff development.

Primary Nursing

Primary nursing is a care delivery system that fosters continuity of care and increases direct patient contact time (Wright, 1994). As indicated in Chapter 4, a number of studies revealed a functional approach to patient care. Patient care was found to be fragmented with registered nurses spending less than one third of their working time in contact with patients (Hendrickson et al., 1990). According to Fralic (1992), when introducing new care delivery systems the essence of professional practice must be preserved. A further consideration in redesigning patient care delivery systems is that it must facilitate maximum use of clinical expertise (Clifford, 1992).

In the US in the 1960s, criticisms of functional fragmented approaches to care resulted in the introduction of primary nursing as a care delivery system (Moloney, 1992). Since

then, primary nursing has permeated many countries internationally (Wright, 1994). Numerous authors and government publications support the utilisation of primary nursing as the preferred method of organising high quality patient care (e.g. Wright, 1994; National Health Service Management Executive, 1993; Moloney, 1992; Audit Commission, 1991). Recent evidence from the UK reveals that the primary nurse is very much a hands-on total patient care practitioner. Primary nursing was found to enhance the helping enabling role of the nurse with patients noted to be actively encouraged to participate in their own care (Leach, 1993).

With primary nursing, the total care of a given patient is co-ordinated by a registered nurse designated the primary nurse. A primary nurse has full responsibility for a group or caseload of patients. The primary nurse works with a number of associate nurses who are delegated patient care responsibilities within the ethos of total patient care (Wright, 1994).

In the literature, there appear to be no clearly defined criteria for assessing a nurse's suitability as a primary nurse. According to Manthey (1970), both the experiences and educational status of a nurse must be taken into consideration. In keeping with Benner's (1984) theory referred to in Chapter 2, it would appear that once a nurse has progressed beyond the level of competence to the level of proficiency, the position of primary nurse might be assumed. This implies that a nurse has at least one and a half years of experience in a given clinical setting before becoming a primary nurse (Benner, 1984). The position of associate nurse is allocated to less experienced nurses, for example, newly qualified nurses, and student nurses.

According to Hegyvary (1982, cited in Wright, 1994), primary nursing is both a philosophy of nursing care and an organisational design. It is a way of viewing nursing as a professional, patient centred practice. Wright (1994) claims that primary nursing offers a professional model for practice in that it fosters accountability, autonomy, co-ordination, and comprehensive patient care. It is a system of nursing that facilitates a high level of quality care by enabling and empowering individuals to perform at their maximum capacity (Manthey, 1980). To facilitate responsibility and accountability, Moloney (1992) emphasises the need for autonomy and a decentralised structure for decision making. Furthermore, nurses must be given the authority necessary to fulfil their responsibilities. Most importantly, to be operationally effective, nursing administrators must be supportive and committed to the ideology of primary nursing (Moloney, 1992).

Professional Practice Partnership Model

The professional practice partnership model is described in the US literature as a mechanism that combines a redesign of both management style and patient care delivery systems simultaneously (Hastings and Waltz, 1995). The concept of partnership represents a core business unit consisting of the staff and manager responsible for a designated clinical programme, a defined scope of practice, and associated resources. A department governance structure unifies the partnership. This structure provides opportunities for staff nurse participation in decision making and the development of professional practice (Hastings and Waltz, 1995). According to these authors, the goal of each professional practice partnership is to design and deliver services in a way that will achieve clinical, service quality goals, as well as the business goals of the organisation.

In the model implemented by Hastings and Waltz (1995), each partnership focused on three major areas. These included strengthening the nursing care delivery system to effectively meet the needs of patients within a practice setting, management of unit level

governance, and support of career advancement for staff members. Each partnership was granted autonomy to develop systems and adapt practices to achieve its goals.

The professional practice partnership model in some ways seems representative of primary nursing. It involves a core group of experienced staff, designated full partners with responsibility for delivering expert patient care, managing patient outcomes, and developing clinical practice at unit level. Full partners are also charged with the development of the group practice and monitoring unit performance. There is a senior partner role which is a unit-level leadership position. With this model, the traditional nurse manager role shifts to a manager partner with responsibility for unit outcomes and developing a highly effective team (Hastings and Waltz, 1995).

An associate partner role is designated to newly qualified nurses, nurses new to a speciality, and also to nurses in part time employment (Hastings and Waltz, 1995). This associate role supports the call for greater flexibility in working hours and appears to accommodate the principle of job sharing referred to in Chapter 4. Furthermore, the designation of an associate role to newly qualified nurses or part time nurses supports Benner's (1984) view that such nurses are not as well grounded in experience thus precluding them from being designated roles more appropriate for expert practice.

According to Lengacher et al. (1993), the implementation of a professional practice partnership model takes time and careful planning. These authors emphasise the use of a collaborative process in designing the model, in guiding its implementation, and the importance of staff participation throughout the implementation and evaluation process.

The professional practice partnership model has been found to yield strong correlation between general job satisfaction and organisation commitment ($r = 0.64$), between general job satisfaction and intent to leave ($r = 0.75$), and between general job satisfaction and the specific aspects of control/responsibility ($r = 0.62$) (Hastings and Waltz, 1995). The credibility of these findings lie with the fact that the results were statistically significant and were based on a respondent sample size of 863 nurses. The researchers Hastings and Waltz (1995) emphasise the importance of continued research to identify work group outcomes, unit outcome in the areas of clinical quality, patient satisfaction, and financial performance.

Staffing Numbers and Skill Mix

In Chapter 4, staffing shortage and inadequate skill mix emerged as work environment resource difficulties for nurses. In the UK, the Audit Commission (1991) investigated the management of ward nursing in acute general hospitals. It was proposed that nursing staff and managers collaborate on agreed staffing levels consistent with the delivery of a high standard of care. Periodic review of staffing numbers should be determined by work load assessment. According to Mackay et al. (1997) staffing numbers should be proportioned to nursing units' patient acuity. More stable ward staffing was recommended by the Audit Commission (1991). Mackay et al (1997) found that using part time and float nurses adds to the work load of full time staff unless they are fully orientated to the nursing unit.

To address inadequate skill mix, a collaborative approach between managers and ward unit nurses on an agreed approach to skill mix is recommended by the Audit Commission (1991). Skill mix should be determined on the basis of ward activity patterns that reflect variance across shifts. Changes in skill mix must be evaluated to ensure that nurses are used appropriately and that the intended improvements in patient care are actually achieved (Audit Commission, 1991).

Two types of staff mix models are described in the literature, and are based on their relationship with the nursing role (Mackay et al. 1997). These are complementary models and substitution models. The substitution model uses unlicensed personnel/nursing assistants as ancillary support staff with responsibility for some nursing care and functions (Mackay et al., 1997). As pointed out in Chapter 4, the crossing of boundaries by nursing assistants into nursing activities is a source of role conflict for nurses, and also raises concerns about de-skilling. The complimentary staff mix model uses unlicensed personnel as ancillary support staff for nurses, usually to perform nonnursing tasks (Mackay et al., 1997). There is unanimous support in the literature for the employment of support staff to relief nurses of non nursing tasks (Salmond, 1997; Audit Commission, 1991; Hendrickson et al, 1990). However, on the basis of experiences in the US, the Audit Commission (1991) cautions that the provision of extra support workers does not automatically lead to registered nurses spending more time in patient related activities, thus reiterating the need to evaluate the effectiveness of the skill mix employed in nursing units.

Another issue that emerged from the literature regarding skill mix is the emphasis on employing qualified nurses (McKenna, 1995; Hancock, 1992), on the evidence that a rich skill mix of mostly qualified nurses is necessary for the provision of high quality nursing care (Buchanan and Ball, 1992; Royal College of Nursing, 1992; Pearson et al., 1987). It must be pointed out however that there is a general paucity of research evaluating the effectiveness of skill mix models which Mackay et al., (1997) claim must be addressed in the context of quality care, patient satisfaction, and cost-effectiveness.

Role Clarification

As pointed out in Chapter 4, lack of role clarity contributes to role conflict and role ambiguity. Fundamental to any work redesign initiative is the collection of data on the impact of changes on the functions and roles of nurses, the relationship of nursing function to the role of patient care, and role definition and redefinition (Madden and Lawrenz, 1990). It is evident in the literature that nurses seek clarification both in the form of job descriptions and policy statements delineating the scope of professional practice (Taunton and Otteman, 1986).

Gordon (1986) cautions that job descriptions often become idle bureaucratic tools reflecting unrealistic statements of ideals. Job descriptions that represent a checklist of nursing behaviours contribute to a minimalist view of nursing. However, in an analysis of job descriptions, Gordon (1986) found that if they are structured within a theoretical and practical framework, they effectively articulate the expectations and progressive levels of competence to nurses. Furthermore, they were used to demark the boundaries of nursing. In this case job descriptions were contextualised in Benner's novice to expert framework. Gordon (1986) found that these job descriptions served as a locus of control for nurses.

Practice Development

Practice development models have evolved in the US from the clinical ladder movement. A criticism of clinical ladders referred to in Chapter 2, is that they were designed as a retention and recruitment strategy rather than specifically to advance nursing practice (Sandford, 1987). Furthermore they were not designed within a theoretical framework (Sandford, 1987) thus contributing to their lack of credibility and relevance to clinical nursing practice (Schultz, 1993). In contrast, practice development

models focus on the sequential development of advancing nursing skills used to contribute to quality patient care outcomes (Nuccio et al. 1996). According to Lomurno and Downing-Janos (1990, p.10) practice development models have the potential to:

- enhance quality care,
- enhance clinical excellence by establishing specific criteria,
- maintain and increase the professional's motivation toward clinical excellence,
- support staff productivity and job satisfaction and
- provide an in-house core of recognised clinical resource nurses.

Themes emerging from the literature on practice development models are levels of nursing practice, performance appraisal, and practice development and research co-ordination.

Levels of Nursing Practice

Already in section 5.3, Benner's (1984) novice to expert framework for developing the practice of nursing was recommended. Furthermore, it was recommended that a national framework for developing the competencies of registered nurses be considered in Ireland. In addition to a national framework for the development of nursing practice, local initiatives in the workplace congruent with a national framework are recommended. Practice development models, although yet at an embryonic stage of implementation, seem to hold potential for structuring both national and local frameworks on levels of nursing practice.

A positive feature of practice development models is the acknowledgement of the professional socialisation needs of novice nurses. The literature leaves little doubt that newly qualified nurses experience numerous difficulties on entering professional practice. Internship programmes have been developed for new graduates in the US which seem to vary from three months to one year. In these programmes newly qualified nurses work alongside preceptors (Carioselli-Karinja et al., 1988; Dear et al., 1982). Internship programmes have also been developed as a pathway to enhance nursing practice for nurses at all levels of practice (Verhey et al., 1992)

Similarly in the UK, in light of Project 2000 and as part of the PREPP project the UKCC has introduced a three to six month preceptorship programme to facilitate the professional orientation of newly qualified nurses (Ashton and Richardson, 1992). The UKCC also requires that qualified nurses, who have taken a career break of five years or more, have a preceptorship period on return to practice (Morton-Cooper and Palmer, 1993).

Preceptorship represents a one to one working relationship whereby a newly qualified nurse works alongside a preceptor, that is, a more experienced nurse who acts as a role model (Shamian, and Inhaber, 1985). The concept of preceptorship seems compatible with work redesign initiatives such as primary nursing and professional practice partnership models already referred to, with the primary nurse or full partner nurse being suited to preceptor role. Preceptorship is also compatible with the role of advanced nurses. As illustrated in Chapter 3, preceptoring is an expectation of the educator role of nurses at specialist levels of practice.

Performance Appraisal

Fundamental to practice development initiatives is the idea of performance appraisal (Hamric et al., 1993). According to Moloney (1992) mechanisms for monitoring and

evaluating care must be established to ensure quality nursing care within the contemporary health care system. The need for performance appraisals seems paramount given the increasing demand for accountability within the health services. Performance appraisals are identified as an important means of recognising the achievements of staff (Moloney, 1992). Furthermore, performance appraisals are a means of identifying the educational needs of staff (Audit Commission, 1991). Mechanisms used to facilitate performance appraisal and thus evaluation of care include peer reviews, individual nurse appraisals, portfolios, and nursing audits (Hamric et al., 1993; Moloney, 1992).

As pointed out in Chapter 2, the assessment of professional competence is increasingly becoming a focal point of debate in a number of countries with Australia being the only country to have established a national framework in this regard. Although practice level competencies are an inherent component of practice development models in the US (Hamric et al., 1993; Rodriguez, 1992) they do not form part of a national framework and therefore vary across models. Another issue for consideration is the extent to which competencies are linked to the role dimensions of the nurse. This is not apparent in some of the practice development models cited in the literature (Nuccio et al, 1996; Rodriguez, 1992). The writer suggests that if competency and performance appraisals are to be valid, criteria must be developed to reflect the role dimensions and associated expectations of the nurse.

Practice Development and Research Co-ordination

In reviewing the literature on practice development initiatives, it becomes clear that this requires expertise, time, money, and research. Practice development programmes resulting in positive outcomes were found to be headed by experienced and advanced nurses (Nuccio et al., 1996; Verhey et al., 1992). To reflect on the role of specialist nurses presented in Chapter 3, the role expectations of the consultant dimension seem most appropriate for the position of practice development nurses. As suggested by Hazleton et al (1993), the consultant nurse specialist is involved in programme development at agency level.

Given the three focal points of consultation depicted in Table 3.12 that is patient centred, nurse centred, and administration centred, the writer suggests that practice development nurses have a key role in facilitating the evaluation outcomes relating to patient satisfaction, quality nursing care, and organisations goals. Practice development nurses in their consultative position would seem to be key players in establishing nursing development units. Nursing development units are specially designed to develop nursing practice with the aim of improving patient care (Graham, 1996).

A primary role as consultant practice development nurse also seems necessary given the complexity of implementing changes in nursing practice. The time implications of changing and developing nursing practice (Hamric et al., 1993) further supports the need to develop full time positions for practice development nurses. Given the international trends towards masters degree education for nurses in advanced practice, the writer recommends that practice development nurses should be funded to facilitate masters level preparation for their role.

In light of the rapid changes in the health care environment numerous innovations have evolved in nursing practice. This is evident in the literature review presented in this project. However, a concern pertaining to the implementation of practice initiatives is that few have been systematically evaluated (Hastings and Waltz, 1995). Most studies on

practice initiatives tend to focus on their impact on job satisfaction and turnover rather than their impact on organisational performance or work unit effectiveness. Hastings and Waltz (1995) emphasise that with increasing pressures to justify the implementation of resource intensive practice model innovations, evaluation of their effectiveness through research is essential.

As identified in Chapter 3, specialist nurses spend least amount of time in the researcher role. This may explain why practice initiatives have not been the focus of substantial research projects. Berger et al. (1996) recommend that positions of clinical nurse researchers should be established. The writer suggests that this should be a separate position to the practice development nurse described above. While the practice development nurse should be involved in research the writer proposes that this should be at level 2 as described by McGuire and Harwood (1989) and presented in Table 3.13 of this report. In this way, practice development nurses facilitate staff in utilising research findings, and in participating in the research process as required.

The key persons in designing clinical research projects should lie with the position of a clinical nurse researcher who should be prepared at doctoral level (Collins, 1992). It is recommended that the role of clinical nurse researchers should reflect McGuire and Harwoods' (1989) third level of research involvement presented in Table 3.13. Nurse researchers should work closely with practice development nurses and clinical nurses. Indeed, the successful implementation of research based practice innovations is dependent on a collaborative relationships (Lengacher et al., 1993). According to Berger et al (1996) the role of nurse researcher offers an ideal position from which to advance the discipline of nursing practice, as well as improving quality of patient care. The writer suggests that nurse researchers should also engage in interdisciplinary research projects so that the practice of nursing is articulated to other health professionals, and also be given the recognition and credence that it merits.

If practice development innovations are to be effectively implemented and evaluated through research, financial resources must be available. The funding of a number of projects in some Australian states referred to in Chapter 2 is commendable (Arbon et al., 1993). Similarly the UK Department of Health has made £3.2 million available for the establishment of nursing development units to develop nursing practice (Draper, 1996). Given that nursing practice is at an evolutionary stage, the injection of financial resources into practice innovations seems a necessary stimulus for its growth and development.

Staff Development

The availability of carefully planned staff development education programmes for nurses at all levels has been identified as a hallmark to the successful implementation of work redesign and practice development initiatives in organisations (Lengacher et al., 1993; Hamric et al., 1993). This is a fundamental consideration in nursing organisations given the evidence cited in Chapter 4 that continuing education for clinical nurses represents a piecemeal and inequitable approach.

The need for education programmes to be grounded in role dimensions of the nurse is identified in the literature (Cotton, 1993 cited in Hastings and Waltz, 1995; Lengacher et al., 1993). Hastings and Waltz (1995) on identifying educational deficits in the implementation of a professional practice redesign, emphasise the need for core curricula design that target various roles of nurses. The focus on role based education seems a viable solution to the difficulties referred to in Chapter 4 regarding role ambiguity

stemming from inadequate role preparation of nurses. In line with international trends in post registration education, clinical nurses should be facilitated and supported in pursuing further studies at baccalaureate and masters levels. The development and implementation of policies that support study leave and funding for nurses, and that reflect the principles of accessibility and equity is recommended (Audit Commission, 1991; Przestzelski, 1987).

The appointment of a clinical nurse educator is also recommended as a strategy for the successful implementation of changes in nursing practice in that it facilitates the role development of nurses (Lengacher et al., 1993). This paves the way for the development of the educator sub role of specialist nurses to evolve as a primary role in nursing organisations. According to Berger et al. (1996) the clinical educator is responsible for co-ordinating all educational activities in an organisation. A more complete description of the role expectations of clinical nurse educators is presented in Chapter 3 (Table 3.9).

Management Support and Commitment

As indicated in Chapter 4, one of the most fundamental solutions to alleviating difficulties encountered in the role of the nurse is management support. According to Clifford (1992) nurse managers demonstrate their supportive role by listening to nurses, asking questions and talking to them in order to obtain their perspectives of the work environment. In this way nurse managers can gain valuable insights into the realities of nursing practice environments. Nurse managers' visibility at all levels of the organisation is indicative of their support for nurses at the operational level of patient care (Laschinger and Havens, 1996). Hastings and Waltz (1995) found that nurses who experienced management support reported higher scores for rewards and recognition, and perceptions of work group effectiveness, compared to their counterparts who did not experience management support. These researchers concluded that managers require further skill development to enable them in their supportive role.

In addition to being supportive, nurse managers are expected to be committed to develop the role of the nurse in light of evolving changes such as work redesign and practice developments. The need for the genuine commitment of nurse managers towards a shared vision of fostering empowerment in the role of the nurse is emphasised by Laschinger and Havens (1996). Indeed it may be counterproductive to empower people in an unaligned organisation (Senge, 1990 cited in by Laschinger and Havens, 1996). Laschinger and Havens (1996) conclude that management support and commitment is fundamental to the development of a more efficacious work group and improved patient care.

Summary of Recommendations

In summary, the recommendations drawn from the literature review are as follows:

Chapter 1

Disciplinary Body of Nursing Knowledge:

- The profession of nursing should continue to develop and define its theoretical knowledge base. To this end, government funding should be made available.

Nurse Education Reform

- A strategy for the future development of nurse education should be developed to guide nurse education reform. Government funding should be made available to guide educational reform.

Chapter 2

Framework for the Practice of Nursing

- Benner's (1994) framework of novice to expert practitioners is recommended as a basis for developing the practice of nursing.
- A framework for developing national competencies for registered nurses in Ireland is recommended.

Chapter 3

The Role Dimensions of the Nurse

- It is recommended that the role dimensions of nurses at various levels of practice are clearly delineated and articulated.

Chapter 4

Work Redesign

- Organisational management styles should be analysed and redesigned to a shared governance model that increases participation, professional latitude, and accountability of nursing staff at the operational level of patient care delivery.
- Patient care delivery systems should be analysed and redesigned to enhance professional latitude, nurse patient contact time, and continuity of care, for example, primary nursing.
- Patient care delivery systems should provide a structure to accommodate varying levels of clinical expertise.
- Work redesign of both organisational management style and patient care delivery systems should be aligned to reflect a collaborative and partnership relationship.
- The effectiveness of work redesign should be evaluated in terms of outcomes relating to clinical quality, patient satisfaction, and financial performance
- Nurse managers and nursing staff at operational level should collaborate on agreed staffing numbers and skill mix consistent with high standards of patient care.

- Periodic reviews of work load should determine the norm staffing numbers within work settings
- Stable ward staffing should be established. Part time staff should be fully orientated to work settings that they are allocated to.
- Periodic review of work activities patterns should determine the skill mix within various work settings.
- Non nursing activities should be allocated to support personnel.
- Job descriptions that are structured within a theoretical and practical framework to articulate the role dimensions and associated expectations of nurses should be designed and utilised.
- Policy statements at both national and local level should be developed by members of the nursing profession to delineate the scope of professional practice, compatible with the role and functions of nurses.
- Job descriptions and policy statements should be reviewed periodically in line with changes in professional nursing practice and changes in the health services overall.

Practice Development

- National debates and consultation should take place between nursing professional organisations and nurses to establish a framework for practice development with particular reference to levels and scope of professional practice.
- Frameworks for practice development should be cognisant of the potential of all nurses at the operational level of patient care to advance their practice from novice to expert level.
- Preceptorship programmes should be developed to facilitate nurses to advance their clinical practice.
- Educational and experience criteria for entry into specialist/advanced practice should be established within a practice based theoretical framework.
- Mechanisms for performance appraisal should be employed. Criteria should be linked to job descriptions and thus reflect the role dimensions and associated expectations of nurses.
- Practice development nurses should be appointed as distinct positions within the nursing services. They should have a consultative function to facilitate nursing staff to implement practice development innovations. They should also have a key role in facilitating the evaluation of outcomes in terms of patient satisfaction, quality nursing care, and organisational goals. Practice development nurses should be prepared at masters level.
- Nurse researchers should be appointed as distinct positions within the nursing services, with responsibility for designing and co-ordinating research projects.
- Government funding should be made available to pilot and evaluate nursing practice developments

Staff Development

- Staff development programmes should be carefully planned to meet the need of the role dimensions and expectations of nurses.
- Staff should be facilitated and supported in pursuing further studies at baccalaureate and masters levels.
- Policy statements should be established and implemented to support leave and funding for nurses' continuing education to reflect the principles of accessibility and equity.

Management Support and Commitment

- Nurse managers should foster a supportive environment in the work place for nurses at the operational level of patient care, by seeking out and responding to their needs, and by acknowledging and recognising their contribution in the nursing services.
- Nurse managers should demonstrate commitment to developing the role of the nurse in line with work redesign and practice developments.
- Nurse managers should be facilitated to develop their skills to enable them in their supportive roles.

CONCLUSION

Considerable progress has been made over the past century in restructuring nursing. Nursing has made great strides in moving from a woman's occupation to a reputable profession. One of the major differences between an occupation and a profession is that members of a profession are committed to developing and advancing their practice (Moloney, 1992). The literature review presented in this project leaves little doubt that the profession has made progress in developing nursing practice. However, the literature also reveals that although progress has been made, developments in nursing practice have been inhibited for a number of reasons. These include the lack of practice based theoretical frameworks to guide practice developments, inadequate educational preparation, inadequate role development, lack of expertise amongst nurses to meet the demands of practice development, and a paucity of research specifically designed to develop nursing practice.

Notwithstanding the deficits of the past, the writer holds optimism for the future of nursing as a profession with a social mandate of providing optimal health care for society. The challenge for the profession of nursing is to develop practitioners' expertise at the operational level of patient care. Fundamental to this challenge is the development of the professional role of the nurse. In order to develop the role of nurses and realise the potential of nurses' role in the health services, the difficulties that nurses currently face must be addressed. The recommendations presented in Chapter 5 of this report represent a working framework towards developing the professional role of the nurse.

REFERENCES

- Aarnes, T. (1996) Norway – where legislation recognises the importance of midwives. *Midwives*. 109(1296), 8-10.
- Advisory Committee on Training in Nursing (1994) *Recommendations on Continuing and Specialist Education and Training*. Brussels, Belgium.
- Ahmadi, K., Speedling, E. and Kuhn, G. (1987) The newly hired hospital staff nurse's professionalism, satisfaction and alienation. *International Journal of Nursing Studies*. 24(2), 107-121.
- Allison, M. (1995) Education and professional development in specialist practice. *British Journal of Nursing*. 4(17), 1005-1008.
- An Bord Altranais (1994) *The Future of Nurse Education and Training in Ireland*. Dublin: An Bord Altranais.
- Anderson K. Forbes R. (1989) Job sharing ... part 1. *Canadian Journal of Nursing Administration*. 2(1), 11-4.
- Andrews, M. (1993) Clinical grading penalises some nurses. *British Journal of Nursing*. 2(2), 107-108.
- Andrews, S. (1994) Nurse prescribing. in Hunt, G. and Wainright, P. *Expanding the Role of the Nurse, The Scope of Professional Practice*. London: Blackwell Scientific.
- Anonymous. (1996) Emerging licensing issues in Canada and the US. *International Nursing Review*. 43(4), 113-120, 126.
- Appel, A., Malcolm, P., and Nahas, V. (1996) Nursing specialisation in New South Wales, Australia. *Clinical Nurse Specialist*. 10(2), 76-81.
- Appleton, C. (1993) The art of nursing, the experience of patients and nurses. *Journal of Advanced Nursing*. 18, 892-899.
- Arbon, P., Bowen, I., Cook, P., Rudge, T. and Sutton, F. (1993) A multi-generational staff development model for registered nurses. *Journal of Advanced Nursing*. 18, 144-149.
- Arets, J. and Slevin O. (1995) European nursing models. in Basford, L. and Slevin O. *Theory and Practice of Nursing, An Integrated Approach to Patient Care*. Edinburgh: Campion Press.
- Arthur, D. (1995) Measurement of the professional self-concept of nurses, developing a measurement instrument. *Nurse Education Today*. 15, 328-325.
- Ashton, P. and Richardson, G. (1992) Preceptorship and PREPP. *British Journal of Nursing*. 1(3), 143-146.
- Audit Commission (1991) *The Virtue of Patients, Making Best Use of Ward Nursing Resources*. London: HMSO.
- Audit Commission (1993) *Children First, A Study of Hospital Services*. London: HMSO.
- Baer, E. (1984) Nursing's divided house-an historical view. *Nursing Research*. 34(1), 32-38.
- Bailey, K., Hoepfner, M., Jeska, S., Schneller, M. and Wolohan, C. (1995) The nurse as an educator. *Journal of Nursing Staff Development*. 11(4), 205-209.

- Bajnok, I. and Wright, J. (1993) Revisiting the role of the nurse practitioner in the 1990s, a Canadian perspective. *AACN Clinical Issues in Critical Care Nursing*. 4(4), 609-610.
- Balasco, E. and Black, A. (1988) Advancing nursing practice, description, recognition, and reward. *Nursing Administration Quarterly*. 12(2), 52-57.
- Baly, M. (1980) *Nursing and Social Change*. 2nd edn. London: Heinemann.
- Barr, O. (1995) Normalisation, what it means in practice. *British Journal of Nursing*. 4(2), 90-94.
- Barr, O. and Sines, D. (1996) The development of the generalist nurse within pre-registration nurse education in the UK, some points for consideration. *Nurse Education Today*. 16, 274-277.
- Barriball, K. and While, A. (1996) Participation in continuing professional education in nursing, findings of an interview study. *Journal of Advanced Nursing* 23, 999-1007.
- Barron, A. (1989) The CNS as consultant. in Hamric, A. and Spross, J. 2nd edn. *The Clinical Nurse Specialist in Theory and Practice*. London: Saunders.
- Barter, M., McLaughlin F. and Thomas, S. (1997) Registered nurse role changes and satisfaction with unlicensed assistive personnel. *Journal of Nursing Administration*. 27(1), 29-38.
- Belcher, J. and Fish, L. (1995) Hildegard E. Peplau. in George, J. *Nursing Theories, The Base for Professional Practice* 4th edn. London: Prentice Hall.
- Benner, P. (1984) *From Novice to Expert, Excellence and Power in Clinical Nursing Practice*. Menlo Park: Addison-Wesley.
- Benner, P., Tanner, C. and Chesla, C. (1996) *Expertise in Nursing Practice, Caring, Clinical Judgement and Ethics*. New York: Springer.
- Berger, AM., Eilers, JG., Pattrin L., Rolf-Fixley, M., Pfeifer, BA., Rogge, JA., Wheeler, LM., Bergstrom, NI., Heck, CS. (1996) Advanced practice roles for nurses in tomorrow's healthcare systems. *Clinical Nurse Specialist*. 10(5), 250-255.
- Bernreuter, M. (1993) The other side of shared governance. *Journal of Nursing Administration*. 23(10), 12-14.
- Beynon, C. and Laschinger, H. (1993) Theory-based practice, attitudes of nursing managers before and after educational sessions. *Public Health Nursing*. 10(3), 183-188.
- Biddle, B. and Thomas, E. (1979) *Role Theory, Concepts, and Research*. New York: Kiegrer & Co.
- Biddle, B. (1985) *Role Theory, Expectations, Identities and Behaviours*. New York: Academic Press Inc.
- Bignell, A. and Crotty, M. (1988) Continuing education, does it make a difference? *Senior Nurse*. 7(4), 40-42.
- Blanchfield, K. and Biordi, D. (1996) Power in practice, a study of nursing authority and autonomy. *Nursing Administration Quarterly*. 20(3), 42-9.
- Blauwet, J. and Bolger, P. (1990) Differentiated practice in an acute care setting. in Mayer, Madden, M. and Lawrenz, E. *Patient Care Delivery Models*. Rockville, Maryland: Apsen.
- Booth, B. (1992) Nursing diagnosis, one step forward. *Nursing Times*. 88(7), 32-34.
- Boschma, G. (1994) The meaning of holism in nursing, historical shifts in holistic nursing ideas. *Public Health Nursing*. 11(5), 324-330.
- Bousefield, C. (1997) A phenomenological investigation into the role of the clinical nurse specialist. *Journal of Advanced Nursing*. 25, 245-256.
- Bowers, L. (1992) A preliminary description of the United Kingdom community psychiatric nursing literature 1960-1990. *Journal of Advanced Nursing*. 17(6), 739-746.
- Boyd, J., Stasiowski, S., Catoe, P., Wells, P., Stabl, B., Judson, E., Hartman, A., Lander, J. The merit and significance of clinical nurse specialists. *Journal of Nursing Administration*. 21(9), 35-43.
- Bramadat, I. and Chalmers, K. (1989) Nursing education in Canada, Progress – contemporary issues. *Journal of Advanced Nursing*. 14, 719-726.
- Briody, M. (1996) The future of the clinical nurse specialist in the USA. *International Nursing Review*. 43(1), 17-20, 31-32.

- Brocklehurst, N. (1996) Selling children's community nursing. *Paediatric Nursing*. 8(9), 6-7.
- Brown, R. (1995) The politics of specialist/advanced practice, conflict or confusion? *British Journal of Nursing*. 4(18), 944-948.
- Buchanan, L. (1992) A rehabilitation clinical nurse specialist, evaluation of the role in a home health care setting. *Holistic Nursing Practice*. 6(2), 42-50.
- Buchanan, J. and Ball, J. (1992) *Caring Costs*. Brighton: Institute of Manpower Studies.
- Buhler-Wilkerson, K. (1993) Bringing care to the people, Lillian Wald's legacy to public health nursing. *American Journal of Public Health*. 83(12), 1778-1785.
- Burke, R. (1982) Personality, self image and situational characteristics of effective helpers in work settings. *Journal of Psychology*. 112, 213-220.
- Burn, E. and Tonges, M. (1983) Professional nursing practice in acute care settings. *Nursing Administration Quarterly*. 8(1), 65-75.
- Butterworth, T. (1995) The current status and future challenges of psychiatric/mental health nursing. *International Journal of Nursing Studies*. 32(4), 353-365.
- Caraher, M., McNab, M. (1996) The public health nursing role, an overview of future trends. *Nursing Standard*. 11(10), 44-48.
- Carlisle, D. (1992) Hidden extras. *Nursing Times*, 88(42), 18-19.
- Caroselli-Karinja, M., McGowan, J. and Penn, S. (1988) Internship programs are safeguarding the future of psychiatric nursing. *Journal of Psychosocial Nursing*. 26(8), 28-31.
- Carson, J., Leary, J., de Villiers, N., Fagin I. and Radmall, J. (1995) Stress in mental health nurses, comparison of ward and community staff. *British Journal of Nursing*. 4 (10 British Journal of Mental Health Nursing), 579-582.
- Cash, K. (1995) Benner and expertise in nursing, a critique. *International Journal of Nursing Studies*. 32(6), 527-534.
- Castledine, G. (1994) Specialist and advanced nursing and the scope of practice. in Hunt, G. and Wainright, P. *Expanding the Role of the Nurse, The Scope of Professional Practice*. London: Blackwell Scientific.
- Castledine, G. (1995a) Will the nurse practitioner be a mini doctor or a maxi nurse. *British Journal of Nursing*. 4(16), 938-939.
- Castledine, G. (1995b) Defining specialist nursing. *British Journal of Nursing*. 4(5), 264-265.
- Chambers, L., Underwood, J., Halbert, T., Woodward, C., Heale, J. Isaacs, S. (1994) 1992 Ontario survey of public health nurses, perception of roles and activities. *Canadian Journal of Public Health*. 85(3) 175-9.
- Chang, A. and Twinn, S. (1995) Role determination in nursing – implications for service provision. *Journal of Nursing Management*. 3, 25-34.
- Chapman, C. (1983) The paradox of nursing. *Journal of Advanced Nursing*. 8, 269-272.
- Chin R. and Kramer, M. (1991) *Theory and Nursing, A Systematic Approach* 4th edn. St. Louis: C.V. Mosby.
- Church, O. (1986) From custody to community in psychiatric nursing. *Nursing Research*. 36(1), 48-55.
- Clarke, F., Beddome, G. and Whyte, N. (1993) Public health nurses' vision of their future reflects changing paradigms. Image, *Journal of Nursing Scholarship*. 25(4), 305-309.
- Clay, T. (1992) Education and empowerment securing nursing's future. *International Nursing Review*. 39(1), 15-18.
- Cleary, J. (1992) *Caring for Children in Hospital, Parents and Nurses in Partnership*. London: Scutari Press.
- Clifford, J. (1992) The myth of empowerment. *Nursing Administration Quarterly*. 16(3), 1-5.
- Clifford, C. (1996) Role, a concept explored in nursing education. *Journal of Advanced Nursing*. 23, 1135-1141.
- Collins, J. (1992) The myth of empowerment. *Nursing Administration Quarterly*. 16(3), 1-5.

- Corley, M., Farley, B., Geddes, N., Goodloe, L. and Green, P. (1994) The clinical ladder, impact on nurse satisfaction and turnover. *Journal of Nursing Administration*. 24(2), 42-48.
- Coxhead, J. (1993) United we stand – divided we fall. *Australian Journal of Rural Health*. 1(2), 13-18.
- Cronenwett, L. (1995) Molding the future of advanced practice nursing. *Nursing Outlook*. 43(3), 112-118.
- Cronin-Stubbs, D. and Rooks, C. (1985) The stress, social support, and burnout of critical care nurses, the results of research. *Heart and Lung* 14(1), 312-39.
- Cutshall, P. (1996) Megatrends in professional regulation – toward the year 2000. *International Nursing Review*. 43(4), 110-112.
- Dahl, M. (1992) Nurses, an image change still needed. *International Nursing Review*. 39(4), 121-126.
- Darbyshire, P. (1994) Skilled expert practice, is it all in the mind? A response to English's critique of Benner's novice to expert model. *Journal of Advanced Nursing*. 19, 755-761.
- Darley, M. (1996) The scope comes into clearer focus. *Nursing Management*. 2(8), 14-17.
- Darley, M. and Rumsey, M. (1996) The scope of professional practice, work to date. *Nursing Standard*. 11(4), 32-33.
- Davidson, L. (1990) Appealing anomalies. *Nursing Times*, 86(13), 44-45.
- Davies B. Hughes AM. (1995) Clarification of advanced nursing practice, characteristics and competencies. *Clinical Nurse Specialist*. 9(3), 156-60, 166.
- Deal, L. (1994) The effectiveness of community health interventions, a literature review. *Public Health Nursing*. 11(5), 315-323.
- Dear, M., Celentano, D. and Weisman, C. and Keen, M. (1982) Evaluating a hospital nursing internship. *The Journal of Nursing Administration*. 12(11), 16-20.
- Deccache, A. (1995) Teaching, training or educating patients?, influence of contexts and models of education and care on practice in patient education. *Patient Educational and Counselling*. 26(1-3), 119-29.
- DeHaven, M. (1990) Compliance with mandatory continuing education in nursing, a hospital based study. *Journal of Continuing Education in Nursing*. 21(3), 102-104.
- del Bueno, D. (1982) A clinical ladder? Maybe. *Journal of Nursing Management*. 12, 19-22.
- Delamothe, T. (1988a) Nursing grievances, women's work. *British Medical Journal*. 296, 345-347.
- Delamothe, T. (1988b) Nursing grievances, pay. *British Medical Journal*. 296, 120-123.
- Denner, S. (1995) Extending professional practice, benefits and pitfalls. *Nursing Times*. 91(14), 27-31.
- Department of Health (1993) *Changing Childbirth*. London: HMSO.
- Derrick, S. (1990). What are the legal implications of extended nurses roles? in Horne, E. and Cowan, T. *Staff Nurses' Survival Guide*. London: Wolfe.
- Dewe, P. (1988) Investigating the frequency of nursing stressors, a comparison across wards. *Social Science and Medicine*. 26(3), 375-380.
- Dillon, A. and George, S. (1997) Advanced neonatal nurse practitioners in the United Kingdom, where are they and what do they do? *Journal of Advanced Nursing*. 25, 257-264.
- Dimond, B. (1994) Legal aspects of role extension. in Hunt, G. and Wainright, P. *Expanding the Role of the Nurse, The Scope of Professional Practice*. London: Blackwell Scientific.
- Doheny, M., Cook, C. and Stopper, M. (1997) *The Discipline of Nursing, An Introduction*. Stamford: Appleton and Lange.
- Dolan, N. (1987) The relationship between burnout and job satisfaction in nurses. *Journal of Advanced Nursing*. 12, 3-12.
- Dolan, S., van Ameringen, M., Corbin S. and Arsenault, A. (1992) A lack of professional role problems as correlates of propensity to quit amongst nursing staff. *Journal of Advanced Nursing*. 17, 1455-1459.
- Donaldson, S. and Crowley, D. (1978) The discipline of nursing. *Nursing Outlook*. 26(2), 113-120.

- Dowling, S., Martin R., Skidmore, P. Doyal, L., Cameron, A., and Llyod. Nurses taking on doctors' work, a confusion of accountability. *British Medical Journal*. 312, 1211-1214.
- Draper, J. (1996) Nursing development units, an opportunity for evaluation. *Journal of Advanced Nursing*. 23, 267-271.
- Duffield, C., Pelletier, D. and Donoghue, J. (1995) A profile of the clinical nurse specialist in one Australian state. *Clinical Nurse Specialist* 9(3), 149-154.
- Dunn, B. (1991) Communication interaction skills. *Senior Nurse*. 11(4), 4-42.
- Dunst, C. and Trivette, C. (1996) Empowerment, effective helping practices and family centred care. *Paediatric Nursing*. 22(4), 334-337, 341.
- Edwards, B. and Haddad, A. (1988) Establishing a bioethics committee. *Journal of Nursing Administration*. 32(2), 20-32.
- Elliot, P. (1995) The development of advanced nursing practice, 1. *British Journal of Nursing*. 4(11), 633-6.
- English, I. (1993) Intuition as a function of the expert nurse, a critique of Benner's novice to expert model. *Journal of Advanced Nursing*. 18, 387-393.
- Ernst, E. (1994) Nurse-midwifery, a nursing challenge. in McCloskey, J. and Grace, H. *Current Issues in Nursing*. St. Louis: Mosby.
- Fagermoen, M. (1997) Professional identity, values embedded in meaningful nursing practice. *Journal of Advanced Nursing*. 25, 434-441.
- Falco, S. (1995) Faye Glenn Abdellah in George, J. *Nursing Theories, The Base for Professional Practice* 4th edn. London: Prentice Hall.
- Fenton MV. and Brykczynski, KA. (1993) Qualitative distinctions and similarities in the practice of clinical nurse specialists and nurse practitioners. *Journal of Professional Nursing*. 9(6), 313-326.
- Ferguson, A. (1994) Evaluating the purpose and benefits of continuing education in nursing and the implications for the provision of continuing education for cancer nurses. *Journal of Advanced Nursing*. 19, 640-646.
- Fitzpatrick, J., While, A. and Roberts, J. (1992) The role of the nurse in high-quality patient care, a review of the literature. *Journal of Advanced Nursing*. 17, 1210-1219.
- Fitzpatrick, B. and Taylor, R. (1994) A comparative study of quality criteria. *Nursing Standard*. 8(37), 25-29.
- Flanagan, L. (1994) Staff nurses, who are they, what do they do, and what challenges do they face?. in McCloskey, J. and Grace, H. *Current Issues in Nursing*. St. Louis: Mosby.
- Fleming, V. (1992) Midwifery in Canada. *Midwives Chronicle*. 105(1258), 338-340.
- Fleming, V. (1996) Midwifery in New Zealand, responding to the changing times. *Health Care for Women International* 17(4), 343-59.
- Fletcher, B., Jones, F. and McGregor, J. (1991) The stressors and strains of health visiting, demands, supports, constraints and psychological health. *Journal of Advanced Nursing*. 16, 1078-1089.
- Flynn, M. (1995) *The Role and Educational Preparation of Anaesthetic Nurses in Ireland*. Unpublished M.Ed. Thesis, Trinity College Dublin.
- Fowler, M. (1989). Moral distresses and the shortage of critical care nurses. *Heart and Lung*. 18(5), 314-315.
- Fox, P. (1995) Nursing developments, trust nurses' views. *Nursing Standard*. 9(18) 30-4.
- Fralic, M. (1992) Creating new practice models and designing new roles. *Journal of Nursing Administration*. 22(6), 7-8.
- Furukawa, C. and Howe, J. (1995) Virginia Henderson. in George, J. *Nursing Theories, The Base for Professional Practice*. London: Prentice Hall.
- Gateley, E. (1992) PREPP, from novice to expert. *British Journal of Nursing*. 1(2), 88-91.
- Gavin J. (1995). The politics of nursing, a case study – clinical grading. *Journal of Advanced Nursing*. 22, 379-385.

- Gaze, H. (1990) Fair deal on appeal, the forgotten fifty thousand. *Nursing Times*. 86(6), 28-31.
- Gecas, V. (1991) The self-concept as a basis for a theory of motivation. in Howard, J. and Callero, P. *The Self-Society Dynamic. Cognition, Emotion, and Action*. Cambridge: Cambridge Press University.
- Gee, K. (1995) Competency through being, the enemy within?. *British Journal of Nursing*. 4(11), 637-640.
- Geoghegan, J. and Farrington, A. (1995) Shared governance, developing a British model. *British Journal of Nursing*. 4(13), 780-783.
- Gibbs, B., Lonowski, L., Meyer, P. and Newlin P. (1995) The role of the clinical nurse specialist and the nurse manager in case management. *Journal of Nursing Administration*. 25(5), 28-34.
- Gibson, C. (1991) A concept analysis of empowerment. *Journal of Advanced Nursing*. 16(3), 354-361.
- Glasper, E. (1995) The value of children's nursing in the third millennium. *British Journal of Nursing*. 4(1), 27-30.
- Gordon, D. (1986) Models of clinical expertise in American nursing practice. *Social Science and Medicine* 22(9), 953-961.
- Gordon, M. (1987) *Nursing Diagnosis, Process and Application*. London: McGraw Hill.
- Gournic, J. (1989) Clinical leadership, management, and the CNS. in Hamric, A. and Spross, J. 2nd edn. *The Clinical Nurse Specialist in Theory and Practice*. London: Saunders.
- Graham, I. (1996) A presentation of a conceptual framework and its use in the definition of nursing development within a number of nursing development units. *Journal of Advanced Nursing*. 23, 260-266.
- Griffiths, A. and Luker, K. (1994) Community nurse attitudes to clinical nurse specialists. *Nursing Times*. 90(17), 39-42.
- Hackbarth, DP., Haas, SA., Kavanagh, JA., and Vlasses, F. (1995) Dimensions of the staff nurse role in ambulatory care, Part I – Methodology and analysis of data on current staff nurse practice. *Nursing Economics*. 13(2), 89-98.
- Hadley, M. (1995) Nursing practice in Canada, the influence of current and proposed legislation. *Journal of Advanced Nursing*. 22, 1210-1217.
- Haggart, M. (1993) A critical analysis of Neuman's systems model in relation to public health nursing. *Journal of Advanced Nursing*. 18(12), 1917-1922.
- Hamric, A. (1989) History and overview of the CNS role. in Hamric, A. and Spross, J. 2nd edn. *The Clinical Nurse Specialist in Theory and Practice*. London: Saunders.
- Hamric, A., Whitworth, T. and Greenfield, A. (1993) Implementing a clinically focused advancement system, one institution's experience. *Journal of Nursing Administration*. 25(9), 20-28.
- Hancock, C. (1992) Nurses and skill mix, what are the issues. Unpublished Paper presented at an Royal College of Nursing Conference – "Nurses and Skill Mix".
- Hardy, M. and Conway, M. (1987) *Role Theory, Perspectives for Health Professionals*. New York: Appleton Century Crofts.
- Hardy, L. (1986) Janforum, identifying the place of theoretical frameworks in an evolving discipline. *Journal of Advanced Nursing*. 11, 103-107.
- Hartfield, M. and Cason, C. (1981) Effect of information on emotional responses during barium enema. *Nursing Research*. 30(3), 151-155.
- Hastings, C. and Waltz, C. (1995) Assessing the outcomes of professional practice redesign, Impact on staff nurse perceptions. *Journal of Nursing Administration*. 25(3), 34-42.
- Hawkins, J. (1986) *The Oxford Reference Dictionary*. Oxford: Clarendon Press.
- Hazelton, JH., Boyum, CM., and Frost MH. (1993) Clinical nurse specialist subroles, foundations for entrepreneurship. *Clinical Nurse Specialist*. 7(1), 40-5.
- Hebron, C., Rose, S., and McCray, J. (1995) Marriage of convenience. *Nursing Times*. 91(49), 55-56.
- Hendrickson, G., Doddato, T. and Kovner, C. (1990) How do nurses use their time? *Journal of Nursing Administration*. 20(3), 31-37, 42.

- Hendrickson, G. and Doddato, T. (1989) Preferences and priorities, choices nurses make during shortages. *Nursing Outlook*, 37(6), 280-284.
- Hill, P. (1987) Effects of education on breastfeeding success. *Maternal and Child Nursing Journal*. 16(2), 145-156.
- Hinchliffe, S. (1992) *The Practitioner as Teacher*. London: Blackwell Scientific.
- Hipwell, P., Tyler, P. and Wilson, C. (1989) Sources of stress and dissatisfaction amongst nurses in four hospital environments. *British Journal of Medical Psychology*. 62(1), 71-9.
- Hoover, J. and van Ooijen, E. (1995) Back to basics. *Nursing Times*. 91(33), 42-43.
- Horsburgh, M. (1989) Graduate nurses' adjustment to initial employment, natural field of work. *Journal of Advanced Nursing*. 14, 610-617.
- Hortin R. (1995) Maintaining a safe environment. in Basford, L. and Slevin O. *Theory and Practice of Nursing, An Integrated Approach to Patient Care*. Edinburgh: Campley Press.
- Huch, M. (1995) Nursing and the next millennium. *Nursing Science Quarterly*. 8(1), 38-44.
- Hundley, V., Cruickshank, F., Milne, J., Glazener, C., Lang, G., Turner, M., Blyth, D. and Mollison, J. (1995) Satisfaction and continuity of care, staff views of care in a midwife-managed delivery unit. *Midwifery*. 11, 163-173.
- Hunt, G. and Evans, W. (1994) Health care assistants and accountability. in Hunt, G. and Wainright, P. *Expanding the Role of the Nurse, The Scope of Professional Practice*. London: Blackwell Scientific.
- Jacox, A. Pillar, B. and Redman, B. (1990) A classification of nursing technology. *Nursing Outlook*, 38, 81-85.
- Jasper, M. (1996) The first year as a staff nurse, the experiences of a cohort of Project 2000 nurses in a demonstration district. *Journal of Advanced Nursing*. 24(4), 779-790.
- Jimerson, S. (1986) Expanded practice in psychiatric nursing. *Nursing Clinics of North America*. 21(3), 527-535.
- Juke, M. (1994) A response to the statement on learning disability nursing. *British Journal of Nursing*. 3(11), 543.
- Kane, D. and Kartha, A (1992) Job sharing, impact on the general well-being of female nurses *Canadian Journal of Nursing Administration*. 5(1), 6-10.
- Kane, M. and Parahoo, K. (1994) Knowledge and use of lifting techniques among a group of undergraduate student nurses. *Journal of Clinical Nursing*. 3, 35-42.
- Kanter, R. (1979) Power failure in management circuits. *Harvard Business Review*. 57(4), 65-75.
- Karpiuk, K., Fjerestad, T. and Young, S. (1994) Integrated care at the bedside, job description consensus. *Nursing Management*. 25(8), 41-43.
- Kelly, L. and Joel, L. (1995) *Dimensions of Professional Nursing*. 7th edn. London: McGraw-Hill.
- Kerr, J. (1985) Adherence and self care *Heart and Lung*. 14(1), 24-31.
- King, C. (1996) Collaboration and the practice of nurse-midwifery *Advanced Practice Nursing Quarterly*. 1(4), 8-11.
- King, I. (1989) King's general systems framework and theory. in Riehl-Sisca, J. *Conceptual Models for Nursing Practice*. 3rd edn. Norwalk: Appleton and Lange.
- Kirby, C. (1995) The therapeutic relationship. in Basford, L. and Slevin O. *Theory and Practice of Nursing, An Integrated Approach to Patient Care*. Edinburgh: Campley Press.
- Kivimaki, M., Voutilainen, P. and Koslinen, P. (1995) Job enrichment, work motivation, and job satisfaction in hospital wards, testing the job characteristics model. *Journal of Nursing Management*. 3(2), 87-91.
- Knaus, V., Felton, S., Burton, S., Fobes, P. and Davis, K. (1997) The use of nurse practitioners in the acute care settings. *Journal of Nursing Administration*. 27(2), 20-27.
- Knight, J. (1990) The Betty Neuman systems model applied to practice, a client with multiple sclerosis. *Journal of Advanced Nursing*. 14(4), 447-455.

- Koetters, T. (1989) Clinical practice and direct patient care. in Hamric, A. and Spross, J. 2nd edn. *The Clinical Nurse Specialist in Theory and Practice*. London: Saunders.
- Kramer, M. (1974) *Reality Shock, Why Nurses Leave Nursing*. St. Louis: Mosby.
- Kruger, S. (1990) A review of patient education in nursing. *Journal of Nursing Staff Development*. 6(2), 71-4, 78.
- Kruger, S. (1991) The patient educator role in nursing. *Applied Nursing Research*. 4(1), 19-24.
- Kuss, T., Proulx-Girouard, L. (1997) A public health nursing model. *Public Health Nursing*. 14(2), 81-91.
- Kyle, T. (1995) The concept of caring, a review of the literature. *Journal of Advanced Nursing*. 21, 506-514.
- Laschinger, H. and Shamian, J. (1994) Staff nurses' and nurse manager's perceptions of job-related empowerment and managerial self-efficacy. *Journal of Nursing Administration*. 24(10), 38-47.
- Laschinger, H. and Havens, H. (1996) Staff nurse work environment and perceived control over nursing practice, conditions of work effectiveness. *Journal of Nursing Administration*. 26(9), 27-35.
- Laschinger, H. and Havens, H. (1997) The effect of workplace empowerment on staff nurses' occupational mental health and work effectiveness. *Journal of Nursing Administration*. 27(6), 42-50.
- Last, T. and Self, N. (1994) The expanded role of the nurse in Intensive care, a national survey. in Hunt, G. and Wainright, P. *Expanding the Role of the Nurse, The Scope of Professional Practice*. London: Blackwell Scientific.
- Lawton, S. (1993) The development of a BA in community health nursing/BA in nursing by distance learning. *Nurse Education Today*. 13(4), 310-314.
- Leach, M. (1993) Primary nursing, autonomy or autocracy. *Journal of Advanced Nursing*. 18, 394-400.
- Leddy, S. and Pepper, J. (1993) *Conceptual Bases of Professional Nursing*. Philadelphia: Lippincott.
- Leifer, D. (1995) Fellow profession or warring factions? *Nursing Standard* 9(47), 18-20.
- Lengacher, C., Mabe, P., Bowling, C., Heinemann, D., Kent, K. and Van Cott, M. (1993) Redesigning nursing practice, the partners in patient care model. *Journal of Nursing Administration*. 23(12), 31-37.
- Leininger, M. (1984) *Care, The Essence of Nursing and Health*. Detroit: Wayne State University Press.
- Leonard, M. and George, J. (1995) Ide Jean Orlando. in George, J. *Nursing Theories, The Base for Professional Practice* 4th edn. London: Prentice Hall.
- Lindsey E. and Attridge C. (1989) Staff nurses' perceptions of support in an acute care workplace. *Canadian Journal of Nursing Research*. 21(2), 15-25.
- Lomurno, A. and Downing-Janos, T. (1990) Retain expert nurses through clinical ladder alternatives. *The Journal of Continuing Education in Nursing*. 21(1), 5-10.
- Lobo, M. (1995) Florence Nightingale. in George, J. *Nursing Theories, The Base for Professional Practice* 4th edn.. London: Prentice Hall.
- Lops, V. (1988) Midwifery, past and present. *Journal of Professional Nursing* 4(6), 402-407.
- Lowenberg, J. (1989) *Caring and Responsibility, The Crossroads Between Holistic Practice and Traditional Medicine*. Philadelphia: University of Pennsylvania Press.
- Lowery, B. (1992) Psychiatric nursing in the 1990s & beyond. *Journal of Psychosocial Nursing and Mental Health Services*. 30(4), 7-13, 34-35.
- Luker, K., Beaver, K., Leinster, S., Owens, R., Degner, L. and Sloan, J. (1995) The information needs of women newly diagnosed with breast cancer. *Journal of Advanced Nursing*. 22(1), 134-141.
- Lunn, J. (1994) The scope of professional practice from a legal perspective. *British Journal of Nursing*. 3(15), 770-772.
- MacKay, R. Storey R., Maclean, L., Misick, J., Glube, R. and Pereira, L. (1987) Job design, matching jobs to staff nurses' interests. *Nursing Management* 18(4), 76-78. 80.
- Madden, M. and Lawrenz, E. (1990) Work redesign. in Mayer, G., Madden, M. and Lawrenz, E. *Patient Care Delivery Models*. Rockville, Maryland: Apsen.

- Maggs, C. (1996) A history of nursing, a history of caring. *Journal of Advanced Nursing*. 23, 630-635.
- Mander, R. (1995) The relevance of the Dutch system of maternity care to the United Kingdom. *Journal of Advanced Nursing*. 22, 1023-1026.
- Manthey, M. (1970) Primary nursing. *Nursing Forum*. 1X(1), 65-83.
- Manthey, M. (1980) *The Practice of Primary Nursing*. London: Blackwell.
- Markfort, E. (1994) Independent philosophy. *Nursing Times*. 90(32), 53.
- Mascord, P. (1992) The career structure and life long education. in Gray, G. and Pratt, R. *Issues in Australian Nursing*. Melbourne: Churchill Livingstone.
- McCleod Clark, J. (1988) Communication, the continuing challenge. *Nursing Times*. 84(23), 24-27.
- McClure, M. (1991) Differentiated nursing practice. *Nursing Outlook*. 39, 106-110.
- McCray, J. (1995) Twice the practitioner. *Nursing Times*. 91(49), 58-59.
- McGann, M. (1975) The clinical specialist from hospitals, to clinic, to community. *Journal of Nursing Administration*. 5, 33-37.
- McGee, P., Castledine, G., and Brown, R. (1996) A survey of specialist and advanced nursing practice in England. *British Journal of Nursing*. 5(11), 682-686.
- McGillis Hall, L. (1997) Staff mix models, complementary or substitution roles for nurses. *Nursing Administration Quarterly*. 21(3), 31-39.
- McGregor, R.J. (1990) Advancing staff nurse competencies, from novice to expert. *Journal of Nursing Staff Development*. 6(6), 287-90.
- McGuire, D. and Harwood, K. (1989) The CNS as researcher. in Hamric, A. and Spross, J. 2nd edn. *The Clinical Nurse Specialist in Theory and Practice*. London: Saunders.
- McKenna, G. (1993). Caring is the essence of nursing practice. *British Journal of Nursing*. 2(1), 72-75.
- McKenna, H. (1997) *Nursing Theories and Models*. London: Routledge.
- McKenna, H. (1995) Nursing skill mix substitutions and quality care, an exploration of assumptions from research literature. *Journal of Advanced Nursing*. 21, 452-459.
- McMillan, I. (1995) Learning curve. *Nursing Times*. 91(32), 16.
- McNally, S. (1995) The experience of advocacy. *British Journal of Nursing*. 4(2), 87-89.
- McQueen, M. and Grenier, F. (1993) Partnership in education, working toward the baccalaureate degree as entry to nursing practice in Canada. *Journal of Advanced Nursing*. 18, 1016-1022.
- Melchior, M., Philipsen, H., Abu-Saad, H., Halfens, R., van de Berg, A. and Gassman, P. (1996) The effectiveness of primary nursing on burnout among psychiatric nurses in long-stay settings. *Journal of Advanced Nursing*. 24(4), 694-702.
- Meleis, M. (1991) *Theoretical Nursing, Development and Progress* 2nd edn. Philadelphia: Lippincott.
- Melhuish, E., Maguire, B., Nolan, M. and Grant, G. (1993) The professional role of the nurse *British Journal of Nursing*. 2(6), 330-335.
- Merritt, S., Walker, B. and Fehring, G. (1989) Experiencing primary nursing, three perspectives. *Australian Journal of Advanced Nursing*. 6(4), 44-48.
- Miles, I. (1986) The emergence of sick children's nursing Part 1, sick children's nursing before the turn of the century. *Nurse Education Today*. 6, 82-87.
- Miles, R. (1976) Role requirements as sources of organisational stress. *Journal of Applied Psychology*. 61(2), 172-179.
- Miller, S. (1995) The clinical nurse specialist, a way forward. *Journal of Advanced Nursing*. 22, 494-501.
- Mintzberg, H. (1983) *Power in and Around Organisations*. London: Prentice Hall.
- Mitchell, A., Watts, J., Whyte, R., Blatz, S., Norman, G., Guyatt, G., Southwell, D., Hunsberger, M. and Paes, B. (1991) Evaluation of graduating neonatal nurse practitioners. *Paediatrics*. 88(4), 789-793.

- Moloney, M. (1992) *Professionalization of Nursing, Current Issues and Trends*. 2nd edn. London: Philadelphia.
- Montemuro, M. (1987) The evolution of the clinical nurse specialist, response to the challenge of professional nursing practice. *Clinical Nurse Specialist* 1(3), 106-110.
- Morrison, P. (1989) Nursing and caring, a personal construct theory study of some nurses' self-perceptions. *Journal of Advanced Nursing*. 14, 421-426.
- Mortensen, R. (1995) *Creating a European Platform, Proceeding of the First European Conference on Nursing Diagnosis*. Copenhagen: Danish Institute for Health and Nursing.
- Morton-Cooper, A. and Palmer, A. (1993) *Mentoring and Preceptorship, A Guide to Support Roles in Clinical Practice*. London: Blackwell Scientific.
- Mundinger, M. (1994) Advanced-practice nursing – good medicine for physicians. *The New England Journal of Medicine*. 330(3), 211-214.
- National Health Service Management Executive. (1993) *A Vision for the Future*. Leeds: NHSME.
- Nemes, J. (1994) Nurse practitioners in acute care units. *Nursing Standard*. 9(8), 37-40.
- Neuman, B. (1995) *The Neuman Systems Model* 3rd edn. Norwalk: Appleton and Lange.
- Nieweg, R., Griednas, J. and de Vries, E. (1987) A patient education programme for the continuous infusion regimen on an outpatient basis. *Cancer Nursing*. 10(4), 177-182.
- Nightingale, F. (1992) *Notes on Nursing, What it is and What it is not*. Philadelphia: Lippincott.
- Noble, C. (1991) Are nurses good patient educators? *Journal of Advanced Nursing*. 16, 1185-1189.
- Nolan, P. (1993) *A History of Mental Health Nursing*. London: Chapman and Hall.
- Nuccio, S., Lingen, D., Burke, L., Kramer, A., Ladewig, N., Raaum, J. and Shearer, B. (1996) The clinical practice model, the transition process. *Journal of Nursing Administration*. 26(12), 29-37.
- Nursing in the World Editorial Committee (1993) *Nursing in the World, The Facts, Needs and Prospects*. Tokyo: The International Nursing Foundation of Japan.
- Nye, F. and Gegas, V. (1976) The role concept, review and delineation. in Nye, F. *Role Structure and Analysis of the Family*. Beverly Hills: Sage.
- Nyqvist, K. and Sjoden, P. (1993) Advice concerning breastfeeding from mothers of infants admitted to a neonatal intensive care unit, the Roy adaptation model as a conceptual structure. *Journal of Advanced Nursing*. 18(1), 54-63.
- O'Byrne, L. (1994) Learning disability nursing, shared learning should be encouraged. *British Journal of Nursing*. 3(15), 752.
- Olsson, H. and Gullberg, M. (1988) Nursing education and the importance of professional status in the nurse role. Expectations and knowledge of the nurse role. *Nurse Education Today*. 25(4), 287-293.
- O' Malley, J., Cummings, S. and King, C. (1996) The politics of advanced practice. *Nursing Administration Quarterly*. 20(3), 62-72.
- Orem, D. (1991) *Nursing, Concepts of Practice*. 4th edn. St Louis: Mosby.
- Page, L. (1996) Impressions of midwifery in New Zealand & Australia. *Midwives*. 109(1299), 88-89.
- Parkes, R. (1994) Specialisation in nursing. *Australian Nursing Journal* 2(2), 25-28.
- Paunonen, M. and Haggman-Laitila, A. (1990) Life situation of aged home-nursing clients. *Journal of Community Health Nursing* 7(3), 167-178.
- Pearson, A., Punton, S. and Durant, I. (1987) *Nursing Beds, An Evaluation of the Effects of Therapeutic Nursing*. Harrow: Scutari Press.
- Peden, A., Rose, H. and Smith, M. (1992) Transfer of continuing education to practice, testing an evaluation model. *The Journal of Continuing Education in Nursing*. 23(4), 152-155.
- Petryshen, PR. and Petryshen, PM. (1992) The case management model, an innovative approach to the delivery of patient care. *Journal of Advanced Nursing*. 17(10), 1188-1194.
- Pickersgill, F. (1995) A natural extension? *Nursing Times*. 91(30), 24- 27.

- Ponte, P., Higgins, J., James, J., Fay, M. and Madden, M. (1993) Development needs of advanced practice nurses in a managed care environment. *Journal of Nursing Administration*. 23, 13-19.
- Porter, S. (1993) The determinants of psychiatric nursing practice, a comparison of sociological perspectives. *Journal of Advanced Nursing*. 18, 1559-1566.
- Pratt, R. (1980) A time to every purpose. *The Australian Journal of Nursing*. 10(3), 50-53, 56.
- Pratt, R. (1995) The challenge of specialisation, the Australian experience. *Collegian, Journal of the Royal College of Nursing, Australia*. 1, 6-13.
- Price, P. (1993) Parents' perceptions of the meaning of quality nursing care. *Advanced Nursing Science*. 16(1), 33-41.
- Przestrzelski, D. (1987) Decentralisation, are nurses satisfied. *Journal of Nursing Administration* 17(11), 23-28.
- Pyne, R. (1992) Accountability in principle and in practice. *British Journal of Nursing*. 1(6), 301-305.
- Quinn, S. and Russell, S. (1993) *Nursing, The European Dimension*. London: Scutari Press.
- Raelin J. (1984) An examination of the deviant /adaptive behaviours in the organisational careers of professionals. *Academy of Management Review*. 9(3), 413-427.
- Reid-Priest, A. (1989) The CNS as educator. in Hamric, A. and Spross, J. 2nd edn. *The Clinical Nurse Specialist in Theory and Practice*. London: Saunders.
- Reed, P. and Zurakowski, T. (1996) Nightingale, Foundations of Knowledge. in Fitzpatrick, J. and Whall, A. *Conceptual Models of Nursing, Analysis and Application*. 3rd edn. London: Prentice Hall.
- Relyea, J. (1992) The rebirth of midwifery in Canada, an historical perspective. *Midwifery*. 8, 159-169.
- Reutter, L. and Ford, J. (1996) Perceptions of public health nursing, views from the field. *Journal of Advanced Nursing*. 24, 7-15.
- Richard, J. and Stern, P. (1991) How primary nurses operationalise accountability. *Canadian Journal of Nursing Research*. 23(3), 49-65.
- Rieu, S. (1994) Error and trial, the extended role dilemma. *British Journal of Nursing*. 3(4), 168-174.
- Roberts, K. (1985) Conceptual frameworks and the nursing curriculum. *Journal of Advanced Nursing*. 10, 483-489.
- Robichaud, A. and Hamric, A. (1986) Time documentation of clinical nurse specialists activities. *Journal of Nursing Administration*. 16(1), 31-36.
- Rodriguez, L. (1992) Creating a clinical development plan for acute care nurses. *The Journal of Continuing Education*. 23(3), 105-109.
- Rogers, M. and Trimnell, J. (1987) Maximising the use of the clinical nurse specialist as consultant. *Nursing Administration Quarterly*. 12(1), 53-58.
- Rose, S. (1995) The last chance for learning disability nurses. *British Journal of Nursing*. 4(2), 85-86.
- Rowden, R. (1987) The extended role of the nurse. *Nursing*. 3(14), 516-517.
- Roy, C. and Andrews, H. (1991) *The Roy Adaptation Model, The Definitive Statement*. Norwalk: Appleton and Lange.
- Royal College of Nursing (1992) *The Value of Nursing*. London: Royal College of Nursing.
- Royal College of Nursing (1994) *Public Health, Nursing Rises to the Challenge*. London: Royal College of Nursing.
- Rushton, C., McEnhill, M. and Armstrong, L. (1996) Establishing therapeutic boundaries as patient advocates. *Paediatric Nursing*. 22(3), 185-189.
- Sabo, K. (1990) Protecting the professional role, a study to review non-nursing activities and recommendation for change. *Canadian Journal of Nursing Administration*. 3(4), 15-18.
- Saego, J. and Faucett, J. (1997) Job strain among registered nurses and other hospital workers. *Journal of Nursing Administration*. 27(5), 19-25.

- Salmon, M. (1993) Public health policy – The opportunity of a century. *American Journal of Public Health*. 83(12), 1674-1645.
- Salmond, S. (1997) Delivery of care systems using clinical nursing assistants, making it work. *Nursing Administration*. 21(2), 74-84.
- Sandall, J. (1995) Choice, continuity and control, changing midwifery, towards a sociological perspective. *Midwifery*. 11, 201-209.
- Sands, D. and Ismuert, R. Role alienation, staff nurses and powerlessness. *Nursing Management*. 17(5), 42J, 42L 42N.
- Sanford, R. (1987) Clinical ladders, do they serve their purpose? *Journal of Nursing Administration*. 17(5), 34-38.
- Schroer, K. (1991) Case management, clinical nurse specialist and nurse practitioner, converging roles. *Clinical Nurse Specialist*. 5(4) 189-94.
- Schultz, A. (1993) Evaluation of a clinical advancement system. *Journal of Nursing Administration*. 23(3), 13-19.
- Scoggin J. (1996) How nurse-midwives define themselves in relation to nursing, medicine, and midwifery. *Journal of Nurse-Midwifery*. 41(1), 36-42.
- Scoggin J. (1997) The historical relationship of nurse-midwifery with medicine. *Journal of Nurse-Midwifery*. 42(1), 49-52.
- Sedgley-Roach, T. (1992) Avoiding an unnecessary strain an examination of lifting practice. *Professional Nurse*. 7(7), 453-456.
- Selby, M., Riportella-Muller, R., Quade, D., Legault, C. and Salmon, M. (1990) Core curriculum for master's-level community health nursing education, a comparison of the views of leaders in service and education. *Public Health Nursing*. 7(3), 150-160.
- Shamian, J. and Inhaber, R. (1985) The concept and practice of preceptorship in contemporary nursing, a review of pertinent literature. *International Journal of Nursing Studies*. 22(2), 79-88.
- Shaw, M. (1993) The discipline of nursing, historical roots, current perspectives, future directions. *Journal of Advanced Nursing*, 18, 1651-1656.
- Shindul-Rothschild, and Middleton, E. (1996) Where have all the nurses gone?, final results of our patient care survey. *American Journal of Nursing*. 96(11), 25-39.
- Siegloff, L. (1995) The nurse practitioner project, Wilcannia, moving from anecdotes to evidence. *Australian Journal of Rural Health*. 3(3), 114-121.
- Simpson B. (1989) The role of the professional nurse, a report from the task force of the department of nursing at the Montreal General Hospital, Montreal, Quebec. *Canadian Journal of Nursing Administration*. 2(2),15-8.
- Sinclair, B. (1997) Advanced practice nurses in integrated health care systems. *Journal of Obstetric, Gynecologic and Neonatal Nursing*. 26(2), 217-223.
- Sines, D. (1995) Learning disability nursing. in Basford, L. and Slevin O. *Theory and Practice of Nursing, An Integrated Approach to Patient Care*. Edinburgh: Campion Press.
- Slevin O. (1995) Therapeutic intervention in nursing. in Basford, L. and Slevin O. *Theory and Practice of Nursing, An Integrated Approach to Patient Care*. Edinburgh: Campion Press.
- Smith, J. (1979) The challenge of health education for nurses in the 1980s. *Journal of Advanced Nursing*. 4, 531-543.
- Smith, L. (1982) Models of nursing as a basis for curriculum development, some rationales and implications. *Journal of Advanced Nursing*. 7, 117-127.
- Smith, S. (1996) Independent nurse practitioner, Advanced nursing practice in Brisbane, Australia. *Nursing Clinics of North America*. 31(3), 549-564.
- Snyder, M. (1997) Clinical ladders, do they reflect levels of competence?. *The Journal of Continuing Education in Nursing*. 28(2), 54-58.

- Sparacino, P. (1991) The clinical nurse manager specialist case manager relationship. *Clinical Nurse Specialist*. 5(4), 180-181.
- Spitzer, W. (1984) The nurse practitioner revisited, slow death or good idea. *New England Journal of Medicine*. 310, 1049-1051.
- Stafford, M. and Appleyard, J. (1994) Clinical nurse specialists and nurse practitioners. in McCloskey, J. and Grace, H. *Current Issues in Nursing*. St. Louis: Mosby.
- Stallknecht, K. (1993) *Denmark* in Quinn, S. and Russell, S. *Nursing, The European Dimension*. London: Scutari Press.
- Stenbak, E. (1986) *Care of Children in Hospital* Copenhagen: World Health Organisation.
- Sullivan, P. (1993) Occupation stress in psychiatric nursing. *Journal of Advanced Nursing*. 18, 891-901.
- Sutton, F. and Arbon, P. (1994) Australian nursing – moving forward? Competencies and the nursing profession. *Nurse Education Today*. 14, 388-393.
- Sutton, F. and Smith, C. (1995) Advanced nursing practice, new ideas and new. *Journal of Advanced Nursing*. 21, 1037-1043.
- Tattam, A. (1990) Logjam in the regions. *Nursing Times*. 29(35), 43.
- Taunton, R., and Otterman, D. (1986) The multiple dimensions of the staff nurse role conception, *Journal of Nursing Administration*. 16(10), 31-37.
- Thomas, S. (1987) Nursing diagnosis, what is it? *Australian Journal of Advanced Nursing*. 4(3), 41-48.
- Thomas, L. (1992) Qualified nurse and nurse auxiliary perceptions of their work in primary, team, and functional nursing wards. *Journal of Advanced Nursing*. 17, 372-382.
- Thomson, A. (1980) Planned and unplanned? Are midwives ready for the 1980s. *Midwives Chronicle and Nursing Notes*. 93(1106), 68-71.
- Tierney, M. J., Grant, L., and Mazique, S. (1990) Cost accountability and clinical nurse specialist evaluation. *Nursing Management*. 21(5), 26-31.
- Tolson, D. and McIntosh, J. (1996) The Roy adaptation model, a consideration of its properties as a conceptual framework for an intervention study. *Journal of Advanced Nursing*. 24(5), 981-987.
- Topham DL. (1984) Role theory in relation to roles of the clinical nurse specialist. *Clinical Nurse Specialist*. 1(2), 81-84.
- Tones, K. (1983) Getting across the facts of life. *Health and Social Services*. 93(4833), 170-173.
- Tyler, S. (1996a) Making GP fundholding work for midwives. *British Journal of Midwifery*. 4(8), 431-434.
- Tyler, S. (1996b) Independent midwives' insurance, the stance of the RCM. *British Journal of Midwifery*. 4(3), 151-152.
- Underwood, E., Woodcox, V., Van Berkel, C., Black, M. and Ploeg, J. (1991) Organizing public health nursing for the 1990s, generalist or specialist. *Canadian Journal of Public Health*. 82, 245-248.
- United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1992) *The Scope of Professional Practice*. London: UKCC.
- United Kingdom Central Council. (1996a) Transition arrangements – specialist practitioner title/specialist qualification. *Register*. 17, 14.
- United Kingdom Central Council. (1996b) PREPP – putting the record straight. *Register*. 18, 6-7.
- United Kingdom Central Council. (1997a) Advancing professional practice. *Register*. 19, 5.
- United Kingdom Central Council. (1997b) UKCC sets up group to look at specialist practice. *Register*. 20, 5.
- van Achterberg, T., Lorensen, M., Isenberg, M., Evers, G., Levin E. and Philipsen, H. (1991) The Norwegian, Danish and Dutch version of the appraisal of self-care agency scale, comparing reliability aspects. *Scandinavian Journal of Caring Sciences*. 5(2), 101-108.
- Verbey, M., Valentine, N. and Harrison, S. (1992) The carer development internship program, pathway to the enhanced nursing practice. *Journal of Nursing Administration*. 22(1), 46-49.

- Verengo, A. (1996) Time for change . . . self-scheduling and flexible rostering. *Nursing Standard*. 11(10), 26-27.
- Viersieck, K., Bouten, R. and Pacolet, J. (1995) *Manpower Problems in the Nursing/Midwifery Profession in the EC, Country-Comparative Report*. Leuven: Hoger Institute voor de Arbeid.
- Waddell, D. (1992) The effects of continuing education on nursing practice, a meta-analysis. *The Journal of Continuing Education in Nursing*. 23(4), 164-168).
- Wade, B. and Moyer, A. (1989) An evaluation of clinical nurse specialists, implications for education and the organisation of care. *Senior Nurse*, 9(9), 11-6.
- Walker, J., Hall, S. and Thomas, M. (1995) The experience of labour, a perspective from those receiving care in a midwife-led unit. *Midwifery*, 11, 120-129.
- Walizer, E. (1996) Family perspectives on the nurse's nurturing role. *Paediatric Nursing*. 22(6), 537-539.
- Wallace, M. and Gough, P. (1995) The UKCC's criteria for specialist and advanced nursing practice. *British Journal of Nursing*. 4(16), 939-944.
- Wells, N., Erickson, S. and Spinella, J. (1996) Role transition, from clinical nurse specialist to clinical nurse specialist/case manager. *Journal of Nursing Administration*. 26(11), 23-28.
- Westrope, R., Vaughn, M., Bott, M. and Taunton, R. (1995) Shared governance, from vision to reality. *Journal of Nursing Administration*. 25(12), 45-54.
- White, E. (1990) Surveying CPNs. *Nursing Times*. 86(31), 62-64.
- Whiting, L. (1997) Community children's nursing, a bright future. *Paediatric Nursing*. 9(5), 6-7.
- Williams CA. Valdivieso GC. (1994) Advanced practice models, a comparison of clinical nurse specialist and nurse practitioner activities. *Clinical Nurse Specialist*. 8(6), 311-318.
- Williamson, A. (1993) Job satisfaction and dissatisfaction amongst neonatal nurses. *Midwifery*. 9, 85-95.
- Wilshaw, G. (1997) Integration of therapeutic approaches, a new direction for mental health nurses. *Journal of Advanced Nursing*. 26, 15-19.
- Wilson-Barnet, J. (1981) Assessment of recovery, with special reference to a study with post operative cardiac patients. *Journal of Advanced Nursing*. 6, 435-445.
- Winship, E. (1996) The future of midwifery regulation. *British Journal of Midwifery*. 4(12), 653-656.
- Winson, G. and Fox, J. (1995) Nurse practitioners, the American experience. *British Journal of Nursing*. 4(22), 1326-1329.
- Wright, S. (1994) *My Patient – My Nurse, The Practice of Primary Nursing*. London: Scutari Press.
- Wright, S. (1995) The role of the nurse, extended or expanded? *Nursing Standard*. 9(33), 25-529.
- Yeun, F. (1991) Continuing nurse education, some issues. *Journal of Advanced Nursing*. 16, 1233-1237.
- Zerwekh, J. (1993) Going to the people – Public health nursing today. *American Journal of Public Health*. 83(12), 1676-1678.

APPENDICES

Appendix 1



NATIONAL COMPETENCIES FORTHE REGISTEREDAND ENROLLEDNURSE

January 1994

The Australian Nursing Council Inc. (ANCI) national nursing competencies have been accepted by Australian nurse registering authorities as the minimum competencies to be demonstrated by nurses for entry to the practice of nursing. The ANCI competencies, the role statements for registered and enrolled nurses, and the philosophy of nursing were adopted by all the nurse registering authorities in 1990, and it is expected that all nurses registered and enrolled will be able to demonstrate these competencies.

The Philosophy

The nurse registering authorities in Australia assert that:

- Nursing is a service which is authorised and valued by society.
- The focus of nursing care is health. Nurses are concerned with enabling people to remain healthy, return to a state of optimum function, behaviour or state of mind, and with assisting the dying to achieve a dignified death.
- Nursing addresses the complexity and uniqueness of the whole person in the environmental context.
- Nurses provide care, simultaneously attending to the biological, psychological, social and spiritual needs of the person, and by being acutely aware of the interrelationships between these needs.
- The effect of nursing care should be positive and should result in benefit, physically, emotionally and/or spiritually, to an individual or group.
- In circumstances of ill health, nurses focus on the response of individuals and groups to health problems, and their ability to contend with these responses.
- Nursing is an art and a science. The essence of nursing lies in a unique interplay of knowledge, intuitive and logical thought and compassion for others. The interaction of cognitive, affective and psychomotor skill is essential for nursing practice.
- Nursing knowledge is derived from qualitative and quantitative research and from the experience of nurses.

Statement Pertaining to the Role of the Enrolled Nurse

The enrolled nurse is a second level nurse who provides nursing care within the limits specified by education and the registering authority's licence to practise.

The major aims of education are the development of skill in providing care and comfort for individuals and groups; in supporting individuals and groups in the activities of daily living; in assisting meeting basic human needs, and in observing and reporting changes in individual or group behaviours.

The enrolled nurse works under the direction and supervision of the registered nurse. At all times, the enrolled nurse retains responsibility for his/her actions and remains accountable to the registered nurse for all delegated functions.

Supervision means the direction and guidance given by a registered nurse to an enrolled nurse. The supervision may be direct or indirect according to the nature of the work delegated to the enrolled nurse.

Registering authorities expect that on initial enrolment, the enrolled nurse may, with the supervision of a registered nurse, provide patient care in all relatively stable nursing situations and assist the registered nurse with patient care in less stable nursing situations.

The enrolled nurse practices with and under the direction and supervision of the registered nurse, and assists in the provision of nursing care. Enrolled nurses retain responsibility for their personal actions whilst remaining accountable to the registered nurse for all delegated functions.

Competencies for the Enrolled Nurse in Recommended Domains

Prerequisites for Enrolment

- Successfully completes an approved educational program
- Fulfils the assessment requirements of the nurse registering authority

Organisational and Work Role Competencies

1. Demonstrates a satisfactory knowledge base for safe practice.
2. Functions in accordance with legislation and common law affecting nursing practice.
3. Protects the rights of individuals/groups.

Organisation of Delegated Nursing Care of Patients/Clients

4. Contributes to nursing assessment of individuals and groups.
5. Implements those aspects of the nursing care plan delegated by the registered nurse.
6. Assists in the evaluation of progress toward expected outcomes.

The Helping Role

7. Demonstrates effective communication and interpersonal skills.
8. Assists in meeting the need for support, security and self esteem of individuals and groups.

Statement Pertaining to the Role of the Registered Nurse

The Registered Nurse is the first level nurse who is licensed to practise nursing in the field/s in which he/she is registered without supervision, and who assumes accountability and responsibility for his/her own actions. This nurse is also referred to as the professional nurse.

Pre-registration nursing courses are designed to prepare a beginning practitioner to provide safe, competent and responsible nursing care in a variety of health care settings.

The major aim of educational programs leading to registration is the development of knowledge and skill in providing nursing care for individuals and groups. This includes provision of care and comfort, support in activities of daily living, and meeting of basic human needs. The program aims to develop skills in assessment of health care needs, identification of goals; skills in problem identification and clinical decision making; and in the planning, implementation and evaluation of the care provided to individuals or groups.

The role of the registered nurse includes the following integrated components: clinician; care co-ordinator; counsellor; health teacher; client advocate; change agent; clinical teacher/supervisor. The role of the registered nurse includes the responsibility to examine nursing practice critically and to incorporate the results of personal action research or the research findings of others.

It is the registered nurse's responsibility to understand the role and function of enrolled nurses and to ensure that they are placed in situations where they are required to function only within the limits of their education and competence. The registered nurse determines, on the basis of client needs, whether nursing will be given by a registered nurse or an enrolled nurse.

Registering authorities expect that on initial registration, a beginning practitioner will have access to more experienced nurses. Registering authorities would not expect the beginning practitioner to take in-charge positions or function alone in areas where clinical decisions involve unpredictable outcomes or where the patient/client presents with multiple problems.

The nurse practises independently and inter dependently in accordance with professional standards, and employs a problem solving approach in practice.

Competencies for the Registered Nurse in Recommended Domains

Prerequisites for Registration

- Successfully completes an approved educational program
- Fulfils the assessment requirements of the nurse registering authority

Profesional/Ethical Practice

1. Demonstrates a satisfactory knowledge base for safe practice.
2. Functions in accordance with legislation and common law affecting nursing practice.
3. Protects the rights of individuals/groups.
4. Demonstrates accountability for nursing practice.
5. Conducts nursing practice in a way that can be ethically justified.

Reflective Practice

6. Recognises own abilities and level of professional competence.
7. Acts to enhance the professional development of self and others.
8. Recognises the value of research in contributing to developments in nursing and improved standards of care.

Enabling

9. Maintains a physical and psychological environment which promotes safety, security and optimal health.
10. Acts to enhance the dignity and integrity of individuals and groups.
11. Assists individuals or groups to make informed decisions.
12. Communicates effectively and documents relevant information.
13. Effectively manages the nursing care of individuals or groups.

Problem Framing and Solving

14. Carries out a comprehensive and accurate nursing assessment of individuals and groups in a variety of settings.
15. Formulates a plan of care in consultation with individuals/groups taking into account the therapeutic regimes of other members of the health care team.
16. Implements planned care.
17. Evaluates the progress toward expected outcomes and reviews plans in accordance with evaluation data.

Teamwork

18. Collaborates with the health care team.

Purposes of the Competencies

- To determine the eligibility for initial registration or enrolment of persons who have undertaken nursing courses in Australia.
- To determine the eligibility of nurses who have undertaken nursing courses outside Australia and who wish to practise in this country.
- To provide the basis for assessing nurses who wish to re-enter the work force after a period of absence defined by the registering authority.
- To assess qualified nurses who are required to show that they can demonstrate the minimum level of competence for continuing practice.

Background

- Competence of the beginning practitioner is a crucial issue, not only for professional groups but for employers, governments and the community at large. IN Australia it is the responsibility of the state and territory nurse registering authorities to assure patients and clients and the community that nurses licensed to practise nursing are able to provide a safe and competent level of nursing care. The registering authorities are entrusted by society with establishing and monitoring these standards of competence required for the purpose of registration and enrolment of nurses.
- Nursing competence is the ability of a person to fulfil the nursing role effectively and/or expertly. The ANCI competencies outline the scope of practice expected of beginning registered and enrolled nurses.
- The ANCI competencies, previously referred to as the ANRAC competencies, were initiated by the Australasian Nurse Registering Authorities Conference (ANRAC) in 1986. They were developed because of concerns expressed at this conference about the variations in requirements for nurse registration and enrolment in each state and territory in Australia. This created difficulty for nurses in Australia and from overseas. It was decided to identify minimum competencies for registered and enrolled nurses that would be accepted nationally.

- The research and development phase of the original competencies project started with the compilation of a list of competency statements. These were based on existing competency statements used by nurse registering authorities and other substantial Australian work on standards such as those developed by the Australian Nursing Federation. A philosophy of nursing and role statements for the registered and enrolled nurse were developed which underpin the competencies. Validation of the competencies was then undertaken through the observation of new graduates in the practice setting and through workshops, and this provided the data for refinement of the competencies.
- The competencies were adopted by all the nurse registering authorities in Australia at ANRAC in 1990. The implementation phase of the project which followed included promotion of the competencies, an issues paper and national seminars, and professional development workshops. These workshops assisted nurses to develop skills in the assessment of competency. A kit has also been produced for nurses to undertake self directed learning about the competencies and assessment.

Recommended Reading

ANRAC Nursing Competencies Assessment Project (1990). Report to the Australasian Nurse Registering Authorities Conference. Vols. 1-3. North Adelaide: ANRAC.

Australian Nursing Council (1993). National Competencies for the Registered and Enrolled Nurse in Recommended Domains. ANCI.

Australian Nursing Council (1993). A Self-Directed Learning Guide for Assessment of the National Nursing Competencies. ANCI.

Additional Information

Additional information in relation to the ANCI competencies and registration and enrolment, can be obtained from the nurse registering authority in your state or territory.

This brochure provides the philosophy and role statements which underpin the competencies, and the stem competencies in the recommended domains. While recommendations for further reading are included, a complete copy of the competencies can be purchased from:

Australian Nursing Council Inc.
GPO Box 1907
Canberra ACT 2601
Phone: (06) 257 7960
Fax: (06) 257 7955

APPENDIX 2

ROLE TITLES IDENTIFIED IN THE LITERATURE

| Role Dimensions Identified in the Literature for Generalist/Primary Level Nurses | | |
|--|--|---|
| Helper/helping role Carer/Caregiver Advocate Enabler Facilitator Communicator Interpersonal role Counsellor Surrogate Friend Teacher Educator Health Educator Educator/consultant | Teaching-coaching function Clinician Technical role Diagnostic & monitoring role Administering & monitoring therapeutic interventions Effective management of rapidly changing situations Manager Assessor Planner Evaluator Resource person Supervisor Nursing process | Co-ordinator Quality improvement role Case manager Organisational role Collaborator Researcher/evaluator Resource manager/planner/co-ordinator Researcher Professional role Health Promoter Policy formulator Marketing Leading Change agent |

| Categorisation of Role Dimension on the Role of the Nurse | | |
|--|---|--|
| Helper/helping role Carer/Caregiver Advocate Enabler Facilitator Communicator Interpersonal role Counsellor Surrogate Friend Health promoter | Teacher Educator Teaching-coaching Educator/consultant Health Educator Facilitator | Manager/Case manager Assessor, planner, evaluator Nursing process Resource person Resource manager/planner/co-ordinator Supervisor Co-ordinator Collaborator Organisational role Quality improvement role Diagnostic & monitoring role Administering & monitoring therapeutic interventions Effective management of rapidly changing situations Change agent Policy formulator Researcher |

