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Preface

It gives me great pleasure to present this Final Report of the Review of Scope of Practice for Nursing and Midwifery in Ireland. This report contains the results of a detailed review of nursing and midwifery practice both nationally and internationally, which has provided the basis for the formulation of the Scope of Nursing and Midwifery Practice Framework contained in this document. This framework has far-reaching and important implications for nurses and midwives and for health service delivery in Ireland.

Irish nurses and midwives have a long-standing reputation for providing excellent and quality healthcare. The professions have reviewed and expanded their practice many times in response to the healthcare needs of the population. In the past this review and expansion has occurred without a guiding framework to provide support and leadership. An Bord Altranais is now presenting the Scope of Nursing and Midwifery Practice Framework which provides both opportunity and guidance for the determination, review and expansion of nursing and midwifery roles. As healthcare needs, knowledge and technology develop, this framework will guide nurses and midwives in independent decision making regarding changes in their scope of practice and facilitate them in developing new skills to meet patients'/clients' needs. This guidance is provided in an enabling and flexible manner in order that nurses and midwives can be empowered to respond in an appropriate and timely manner to the healthcare needs of the population. The framework emphasises that expansion of practice should take place with the patient's/client's best interests foremost and in the interest of promoting and maintaining best quality health services for the population.

The publication of the Scope of Nursing and Midwifery Practice Framework is the beginning of a new and empowering phase in Irish nursing and midwifery practice. I believe that this framework provides challenges and opportunities to the nursing and midwifery professions. Irish nurses and midwives in clinical practice are challenged to embrace this framework in order that their practice continues to be of paramount importance to healthcare throughout this new century. The challenge for nursing and midwifery managers is to provide the support, leadership and encouragement necessary in this new period of nursing and midwifery practice.

The success of this project is due to the commitment of many people.

I would like to thank the steering committee who provided guidance and support for the project. An Bord Altranais is indebted to the many nurses and midwives who participated in this project and provided a wealth of information in relation to nursing and midwifery practice in Ireland. An Bord appreciates the individuals, groups and organisations who made written and oral submissions. Particular thanks are extended to Project Officer, Kathleen Mac Lellan and Project Assistant, Mary Farrelly for their enthusiasm, hard work and professionalism.

An Bord acknowledges the support of the Executive Staff, Eugene Donoghue, Chief Executive Officer; Yvonne O’Shea, Chief Education Officer and other officers with particular expertise in midwifery, competence, psychiatry, mental handicap and community who supported the work of the project.

Sheila O’Malley
President, An Bord Altranais
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ANP</td>
<td>Advanced Nurse Practitioner</td>
</tr>
<tr>
<td>CNA</td>
<td>Canadian Nurses Association</td>
</tr>
<tr>
<td>CNS</td>
<td>Clinical Nurse Specialist</td>
</tr>
<tr>
<td>FIGO</td>
<td>International Federation of Gynaecology and Obstetrics</td>
</tr>
<tr>
<td>ICM</td>
<td>International Confederation of Midwives</td>
</tr>
<tr>
<td>ICN</td>
<td>International Council of Nurses</td>
</tr>
<tr>
<td>NP</td>
<td>Nurse Practitioner</td>
</tr>
<tr>
<td>PHN</td>
<td>Public Health Nurse</td>
</tr>
<tr>
<td>RGN</td>
<td>Registered General Nurse</td>
</tr>
<tr>
<td>RM</td>
<td>Registered Midwife</td>
</tr>
<tr>
<td>RMHN</td>
<td>Registered Mental Handicap Nurse</td>
</tr>
<tr>
<td>RNT</td>
<td>Registered Nurse Tutor</td>
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<tr>
<td>RPN</td>
<td>Registered Psychiatric Nurse</td>
</tr>
<tr>
<td>RSCN</td>
<td>Registered Sick Children’s Nurse</td>
</tr>
<tr>
<td>UKCC</td>
<td>United Kingdom Central Council for Nursing, Midwifery and Health Visiting</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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Steering Committee Membership

Ms Sheila O’Malley
   President of An Bord Altranais and Chairperson of Steering Committee
Mr Jim Brown
   Representing the CEO Group of the Health Boards
Mr John Byrne
   Vice-President of An Bord Altranais
Dr Brid Corkery
   Representing the Irish Medical Council
Ms Mary Courtney
   Representing the Association of Irish Nurse Managers
Ms Antoinnette Doocey
   Board Member
Ms Mary Durkin
   Board Member
Ms Maeve Dwyer
   Board Member
Ms Geraldine Feeney
   Board Member
Dr Linda Hamilton
   Representing the Irish College of General Practitioners
Ms Eileen Kelly
   Board Member
Ms Annette Kennedy
   Representing the Alliance of Nursing Unions
Ms Veronica Kow
   Board Member
Mr Con McCarthy
   Board Member
Ms Ann McGee (up to June 1999)
   Representing the Pharmaceutical Society of Ireland
Mr Matthew Lynch (June 1999-April 2000)
   Representing the Pharmaceutical Society of Ireland
Ms Nora Mansell-Quirke
   Board Member
Ms Ann Martin
   Board Member
Ms Jacinta Mulhere
   Board Member
Ms Lasarina O’Connor
   Representing Post Registration Nurse Tutors
Ms Breege O’Neill
   Board Member
Ms Peta Taaffe
   Representing the Department of Health and Children

In Attendance

Mr. Eugene Donoghue
   Chief Executive Officer
Mr.Vincent Breheny
   Education Officer
Ms. Margaret Carroll
   Education Officer
Ms. Naomi Elliott
   Education Officer
Ms. Catherine Griffin
   Education Officer
Ms. Marie Neary
   Education Officer
Ms. Kay Shine

Project Team

Ms. Yvonne O’Shea
   Chief Education Officer
Ms Kathleen MacLellan
   Project Officer
Ms Mary Farrelly
   Project Assistant
Ms. Sarah McCormack
   Administrative Support
SECTION 1

Introduction
1.1 Project Background and Terms of Reference

This document provides a detailed account of the work carried out under the terms of reference of the Review of Scope of Practice for Nursing and Midwifery Project. The project was initiated by An Bord Altranais in October 1998 against a background of the changing socio-economic environment within which nursing and midwifery in Ireland are practiced. The ever-changing demographic and epidemiological profile of the Irish population has implications for both the management and the delivery of healthcare services. Given that nurses and midwives currently account for 40% of the health services workforce, their role and the scope of their practice within these services continues to be of paramount importance to the success of healthcare provision in Ireland. Nursing and midwifery practice needs to be responsive and dynamic, in order to effectively contribute to health and social gain among the population. The project occurs therefore, at an opportune and useful time and will serve to provide information and support for the nursing and midwifery professions in relation to the determination of the scope of nursing and midwifery practice.

The terms of reference that were agreed for the project were as follows:

• A review of current practice, identifying relevant issues
• A review of appropriate international considerations in relation to scope of practice issues
• A review of the legislation governing the practice of nursing and midwifery
• A review of the intra-professional boundaries and their implications for practice
• Consideration of the future delegation and supervision role of nurses and midwives
• Consideration of the future expansion of the role of nurses and midwives
• Consideration of educational developments needed to support expanded roles.

The Board considered that widespread consultation was essential to the success of this project. The consultation process consisted of four phases –

• Public submissions were called for based on the terms of reference of the project - 169 were received from a cross section of nurses, midwives and other interested parties
• Fifty - five consultative workshops for nurses and midwives were held in nine locations throughout the country
• A survey of all nurses and midwives on the live register was conducted using a questionnaire published in the newsletter of An Bord Altranais
• A number of representative groups of nurses, midwives and others were invited to meet with the project team.

Further details of the consultation process are provided in appendices 1-3.

In October 1999 an interim report of the project was published which provided a summary of the issues that arose during the consultation process (An Bord Altranais 1999a). Based on consideration of these issues and a review of the international literature, key concepts pertaining to the scope of nursing and midwifery practice were identified and further examined. This formed the basis for the formulation of the Scope of Nursing and Midwifery Practice Framework, which provides an empowering decision-making framework to support and guide nurses and midwives in the determination of their scope of practice. The Scope of Nursing and Midwifery Practice Framework has been circulated to all nurses and midwives on the live register and is also presented in section 5 of this report. This Final Report of the Review of Scope of Practice for Nursing and Midwifery provides an overview of the entire project.

1.2 Outline of Report

The report consists of six sections –

• Section 2, provides background information on the regulation of nursing and midwifery. The rationale for the production of a scope of practice document is provided and reference is made to the legislative and regulatory history of nursing and midwifery both nationally and internationally.
• Section 3, highlights the key issues, which were identified during the consultation process.
• Section 4, reviews the key concepts related to scope of practice. These include a consideration of the development of the scope of nursing and midwifery practice, specialist and advanced practice, accountability and autonomy, competence, continuing professional development, support for practice and delegation.
• Section 5, presents the Scope of Nursing and Midwifery Practice Framework.
• Section 6, outlines implications, recommendations and decisions arising from the project.
SECTION 2
Regulation and the Scope of Nursing and Midwifery Practice
Regulation and the Scope of Nursing and Midwifery Practice

In determining the scope of nursing and midwifery practice it is necessary to refer to the way in which the professions are regulated. The nursing and midwifery professions in Ireland enjoy the privilege of self-regulation. This means that certain responsibilities for regulation are granted by the state through legislation to a professional regulatory body. It is the legal definition of nursing and midwifery practice, which is included in professional legislation, that establishes the basis for the scope of practice in which a registered nurse or midwife may engage. Each country has its own method of regulating and authorising nursing and midwifery practice. Such authorisation generally includes the educational preparation for nursing and midwifery, the protection of titles and systems for licensing or registration. It is important to note that in some countries nursing and midwifery are legislated for separately, in others there is no distinction made and midwifery is subsumed under nursing.

This section of the report is divided into two parts. The first part, provides a description and analysis of different approaches to the regulation of nursing and midwifery internationally. The second part, reviews different approaches to the definition of the scope of practice for nursing and midwifery.

2.1 The Regulation of Nursing and Midwifery Practice

Regulation of nursing and midwifery varies depending on the regulatory mechanism and its purposes. The ICN defines regulation as the: “forms and processes whereby order, consistency, and control are brought to an occupation and its practice” (ICN 1985, p.7). The WHO augments this by stating that this occurs “through the establishment of guidelines, rules, and procedures for the implementation of a statute, for the monitoring of practice, and for the initiation of appropriate corrective action” (WHO 1986, p.58).

The primary purpose of regulation is the protection of the public by ensuring that qualified and competent practitioners provide nursing care. The benefits to individual practitioners and the profession as a whole, which may accrue from professional regulation, are secondary to this overriding principle. If regulation is to achieve its stated purpose of protecting the public, it must include the regulation of nursing education and training, the maintenance and updating of knowledge, skills and attitudes, the definition of scope and standards of practice and the mechanisms for disciplinary actions by reason of personal or legal disability, infractions of standards of practice, or unprofessional conduct (Storey et al 1988).

The distinction between internal and external regulation may not always be clear or may not always exist. Some countries regulate externally to the profession by laws enacted and some regulate solely within the profession by a named regulatory body. Examples of regulatory mechanisms include legislation, licensure, registration, certification, accreditation or approval of educational programmes and facilities and rules of health authorities, institutions or employment agencies.

The primary purpose of professional legislative acts and accompanying regulations is to ensure safe, competent and ethical care and to protect the public from unskilled or ill-intentioned providers. As such these acts are legislative recognition of the importance of the services provided by a profession (Hadley 1995).

The first efforts toward the regulation of nursing began in England in the late 19th century. In 1901, New Zealand became the first country to enact a nursing licensing law (Sheets 1996). The regulation of midwifery practice has undergone much change throughout the 20th century. The authority to practice as an autonomous midwife was revoked in many countries and midwifery as an autonomous profession declined. Midwifery was regulated in some countries under the title nurse. Some of the ground lost was however regained late in the 20th century, with many countries now in the process of reviewing regulation or having enacted legislative change. For example, in New Zealand legislation was enacted in August 1990 to allow midwives to take responsibility for the care of a woman throughout pregnancy, labour and the postnatal period (Fleming 1996). It was only in the 1990s that legislation and education programmes for midwifery re-emerged across Canada, reversing the decline of the Canadian midwife (Fleming 1992). Midwives in the USA tend to be described as certified nurse midwives and have responsibility for providing well-woman, gynaecological and low-risk obstetrical care including prenatal, labour and delivery, and post-partum care (American Nurses Association 1993). In Ireland, the Report of the Commission on Nursing (1998) has recommended that the title of the current act (Nurses Act 1985) which regulates both nurses and midwives in Ireland, be amended to The Nurses and Midwives Act. The Commission also recommended the restoration of a separate statutory midwives committee.
The following are descriptions of the history and current status of regulation in the USA, Canada, Australia, Europe, United Kingdom and Ireland.

2.1.1 United States of America

The year 1873 has been referred to as the beginning of the modern era in American nursing, because three ‘Nightingale’ schools opened that year (Bullough, 1975, p.8-9). In the United States by the early 1900’s, nursing practice had developed and matured to a point where laws and regulations became necessary to establish minimum standards for entry into the profession. The first nurse registration act was made law in North Carolina in March 1903 with New Jersey, New York and Virginia also passing registration laws in that year. The early registration laws were viewed as a way of providing for the legal recognition of nursing and, through title protection, to provide a mechanism for the establishment and examination of educational standards, and thus were intended to protect the public. The laws were permissive, did not define nursing practice, and were diverse and inconsistent from state to state (Sheets, 1996).

By 1923 every state had some type of nurse registration law. In 1938 New York State passed the first mandatory Nurse Practice Act, a law which established two levels of nursing: licensed registered nurse and licensed practical nurse. This Practice Act mandated that only professionals licensed under the act could practice nursing. Other states followed with similar laws. By 1952, all the states, the District of Columbia and all U.S. territories had enacted nurse practice acts. Since these early years of legislative activity, numerous significant changes have occurred, including changes in the definition of nursing practice. States now recognize expanded nursing roles; some states also regulate certified nursing assistants. Every nurse practice act is designed to protect the public by broadly defining the legal scope of practice. The nursing practice act of each state controls education and practice (Kelly and Joel, 1995, p.402).

The National Council of State Boards of Nursing, Inc., (NCSBN Inc.) is an organization whose membership is comprised of the boards of nursing in the 50 states, the District of Columbia, and five United States territories. The National Council has developed two licensure examinations used by its Member Boards to test the entry-level nursing competence of candidates for licensure as registered nurses and as licensed practical/vocational nurses. These examinations, the NCLEX-RN® and NCLEX-PN® examinations, are administered with the contractual assistance of a national test service (NCSBN Inc, 2000).

Almost all of the American State Boards have regulations to govern three types of advanced practice registered nurses (Certified Registered Nurse Anaesthetist, Certified Nurse Midwife and Nurse Practitioner) which set out scope of practice, regulation and requirements for legal recognition (NCSBN Inc, 1997). Nurse-midwifery emerged in the USA in the late 1920’s as traditional midwifery declined (Scoggin 1997). Plans are underway to revamp nursing regulation in the USA, from the current single-state licensure model to a mutual recognition model, as proposed by the NCSBN Inc. (Chaffee 1998).

A number of states, either via nursing regulatory bodies or professional organizations, have published separate scopes of nursing practice to augment the nurse practice acts. The American Nurses Association states that a nurse’s scope of practice is dynamic and evolves in line with changes in the phenomena of concern, with knowledge about the effects of various interventions on patient or group outcomes, or with the political environment, legal conditions and cultural and demographic patterns in society (American Nurses Association 1995).

2.1.2 Canada

Professional legislation governing nursing practice in Canada is a provincial rather than a federal responsibility and regulation is via separate acts in each of the ten provinces and two territories. These acts grant self-governance to the nursing profession, define a scope of practice and establish mechanisms for registration and quality assurance (Hadley 1995).

In Canada licensing examinations are nation-wide and conducted under the auspices of the Canadian Nurses Association (CNA) Testing Service. Licensing is therefore reciprocal between the ten provinces and two territories. The CNA offer programmes of certification in several areas of specialisation, however certification does not preclude anyone who is not certified from performing the services in question (Hadley 1995).

In 1985 midwifery practice was only legal in one province, Newfoundland. However, currently several provinces in Canada are in the process of obtaining midwifery legislation designed to strengthen, support and legalise the practice of midwifery. Ontario has passed such legislation (Relyea 1992).

The CNA states that a profession’s scope of practice encompasses the activities its practitioners are educated and authorised to perform. The association states further that the overall scope of practice for the profession sets the outer limits of practice for all practitioners, and that the scope for individual practitioners is influenced by the settings in which they practice, the requirements of the employer and the needs of their patients or clients (CNA 1993). Like the USA some of the provinces, either via nursing regulatory bodies or professional organisations, have produced scope of practice documents to augment legislation.

2.1.3 Australia

Each of the six states and two territories in Australia has a nurse regulatory authority, which maintains its own register of registered and enrolled nurses. It is a legal requirement under the Nurses’ Acts of each state and territory that nurses be registered or enrolled in the state or territory in which they intend to practice. Requirements for registration or enrolment may vary between the different states and territories. Once registered in one state or territory, mutual recognition laws in Australia provide for recognition of certain categories of registration across state boundaries. This means that a nurse who has registration in one state or territory may apply for registration with the nursing board in the second state or territory under mutual recognition, and may be eligible for registration provided there is a similar registration category in that state (Australian Nursing Council Inc. 2000).

There are two levels of nurses in Australia, the registered nurse and the enrolled nurse. The Australian Nursing Council Inc. has published competency standards for registered and enrolled nurses that are core competencies which all nurses must possess (Australian Nursing Council Inc. 1994). They assist in indicating the scope of nursing practice. There is no uniform method of describing a nursing activity or the scope of nursing practice. The nursing boards of Tasmania (Nursing Board of Tasmania 1997) and...
Queensland (Queensland Nursing Council 1998) have produced scope of practice documents to augment nursing acts.

2.1.4 Europe

All European countries have legislation to determine the practice of health professions. Legislative and regulatory practices and mechanisms vary between and within countries (Salvage and Heijnen 1997). The Council of the European Union produces directives from time to time, which have direct implications for nursing and midwifery practice. These relate to mutual recognition of qualifications, advisory committees on the training of nurses and midwives, knowledge and clinical experience necessary for nursing and midwifery practice and the activities of a midwife. The scope of midwifery practice is outlined within the EEC Council Directive 80/155/EEC of 1980. This directive concerns the coordination of provisions laid down by law, regulation or administrative action in respect of the activities of midwives. It outlines the minimum knowledge and clinical experience necessary for midwifery and outlines the activities that midwives are entitled to take up and pursue.

2.1.5 United Kingdom

Midwives were first regulated in the UK in 1902 with an act to secure better training of midwives and to regulate their practice. This act applied to England only and did not extend to Ireland or Scotland even though both were under UK rule at the time. Nurses became regulated via the Nurses Registration Act, 1919. The UK is the only European country to date that has produced a scope of practice document. This document sets out principles governing the scope of practice, which apply to nursing, midwifery and health visiting (UKCC 1992).

2.1.6 Ireland

The legislative history of Irish nursing and midwifery dates back to the early 1900s. The first legislation relating to nursing in Ireland was the Nurses Registration Act, 1919, which established the General Nursing Council for Ireland. The Act specified that there be a register to consist of general nurses and a supplementary register for male nurses, nurses trained in the nursing and care of persons suffering from mental diseases and nurses trained in the nursing of sick children.

The first legislation relating to midwifery in Ireland was the Midwives Act, 1918. This act established the Central Midwives Board and the first register for midwives in Ireland, which was called the Roll of Midwives. The next legislation to apply directly to midwives was the Midwives Act, 1931. This was an act to provide for attendance at childbirth and midwife badges. This was followed by the 1944 Midwives Act, which was an act to make further and better provision for the enrolment, certification, control and training of midwives. The rules regarding training, examination and registration of midwives were contained in this act. Regulation and supervision of midwives practicing in the district of any local supervising authority was provided for in this act.

The Nurses Act, 1950 brought together the General Nursing Council and the Central Midwives Board and established An Bord Altranais. The Nurses Act, 1961 revoked parts of the 1950 Act. The Nurses Act, 1985 replaced all other acts and is the current statutory framework for the regulation of nursing in Ireland. It introduced major changes in the evolution of regulation of nursing and enhanced the role and function of An Bord Altranais. The act states that ‘nurse’ means a woman or man whose name is entered on the register and that ‘midwife’ means a person whose name is entered in the midwives division of the register. In this act midwifery has been subsumed under the title ‘nurse’, stating that the term ‘nurse’ includes ‘midwife’. The Act provides for the establishment of An Bord Altranais in its current form.

The function of An Bord Altranais is to provide for the registration, control and education of nurses and to provide for other matters relating to the practice of nursing and the persons engaged in such practice. The general concern of An Bord is to promote high standards of professional education and training and professional conduct among nurses (Nurses Act 1985). There are currently seven divisions of the register: general nurses, psychiatric nurses, sick children’s nurses, mental handicap nurses, midwives, public health nurses and nurse tutors. There were 51,281 nurses registered on the active file with An Bord Altranais in March 2000. Many nurses have more than one qualification registered. Qualifications registered are outlined in Table 1.

Table 1. Qualifications registered with An Bord Altranais, March 2000

<table>
<thead>
<tr>
<th>DIVISION</th>
<th>TOTAL</th>
<th>ACTIVE</th>
<th>INACTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>51,593</td>
<td>42,616</td>
<td>8,977</td>
</tr>
<tr>
<td>Midwives</td>
<td>15,667</td>
<td>13,023</td>
<td>2,644</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>10,611</td>
<td>9,157</td>
<td>1,454</td>
</tr>
<tr>
<td>Sick children’s</td>
<td>4,054</td>
<td>3,392</td>
<td>662</td>
</tr>
<tr>
<td>Mental handicap</td>
<td>3,800</td>
<td>3,393</td>
<td>407</td>
</tr>
<tr>
<td>Public health</td>
<td>2,075</td>
<td>1,811</td>
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<td>Tutors</td>
<td>479</td>
<td>408</td>
<td>71</td>
</tr>
<tr>
<td>Other</td>
<td>619</td>
<td>395</td>
<td>224</td>
</tr>
</tbody>
</table>


The education and training of nurses and midwives is currently undergoing radical change. Currently all schools of nursing in all three basic disciplines of nursing (general, psychiatric and mental handicap nursing) offer a registration/diploma programme in a linked third-level institution. In line with the Report of the Commission on Nursing (1998) it is planned that by the beginning of the academic year 2002, nurse education and training leading to registration in general, psychiatric and mental handicap nursing will consist of a four-year degree programme. The Nurse Education Forum is currently developing a strategy for this transition.

Midwifery students, following successful completion of a two-year post-registration higher/postgraduate diploma programme, qualify for midwifery registration with An Bord Altranais. The Report of the Commission on Nursing (1998) recommended the piloting of a direct-entry midwifery course by An Bord, which commences in June this year. The Commission recommended that this programme be provided initially at diploma level but should move to a degree programme in 2002.

1. The active file refers to those nurses who have not deemed themselves to be inactive.
Sick children's nurses qualify for registration following successful completion of an 18-month third-level programme leading to a Higher Diploma in Paediatric Nursing. Successful completion of a Higher Diploma in Public Health Nursing qualifies public health nurses for registration.

From time to time An Bord Altranais provides guidelines on various practice issues which provide guidance and support for nurses and midwives in Ireland. These include:

- The Code of Professional Conduct for each Nurse and Midwife (1988b)
- Guidelines for Midwives (1994b)
- Guidance to Nurses and Midwives on the Administration of Medical Preparations (1998b)
- Guidance for Nurses and Midwives with Serious Contagious/Infectious Diseases (1997a)
- Guidance to Nurses and Midwives on the Management of Violence and Challenging Behaviour (1997b)

2.2 The Scope of Nursing and Midwifery Practice

The scope of nursing/midwifery practice is defined as the range of roles, functions, responsibilities and activities, which a registered nurse/midwife is educated, competent, and has authority to perform in the context of a definition of nursing/midwifery.

Nurses and midwives in Ireland are operating within a healthcare environment that is influenced by legislation, health policy and a changing demographic and epidemiological profile of patients/clients. Work trends are constantly changing and the healthcare services are striving towards a consumer-responsive service that is cost-effective. Reference is made to the scope of nursing and midwifery practice in the Report of the Commission on Nursing (1998, p.56-58). The Commission highlights the need for a framework that will enable nurses and midwives to develop their practice within safe parameters. It considers that nurses need to be empowered to a greater extent to make professional decisions, rather than having narrowly focused prescriptive guidelines in certain areas.

The role of nurses or midwives in the health service structure of a country is determined by national or subnational legislation on the practice of the health-related professions. Statutes on the practice of medicine, nursing and pharmacy and regulations pursuant to these statutes, as well as public health laws and regulations, define what the nurse or midwife can do and under what circumstances. When determining what a nurse or midwife may legally do, the statutory definitions of nursing and midwifery practice have to be considered, and also the regulations of the nursing board, of the ministry of health, the ethical standards set out for the nursing and midwifery professions and also local individual hospital policy (WHO 1986).

Scope of practice in Ireland is currently defined by legislation, social policy, national and local guidelines, education and individual levels of competence. International developments, and in particular EU directives, contribute to the definition of the scope of practice. Legislation specifically relating to nurses and midwives is via the Nurses Act (1985). However other acts define practice parameters or have specific implications for nurses and midwives and should be considered when making decisions about the scope of nursing and midwifery practice. Social policy relates to documents and strategies developed on a national basis which may have implications for nursing and midwifery practice. Shaping a Healthier Future (Department of Health 1994) and A Plan for Women's Health (Department of Health 1997) are examples of such social policy. National guidelines, such as the Guidelines for the Safe Administration of Cytotoxic Medical Preparations in the Treatment of Patients with Cancer (Department of Health 1996), or Guidance to Nurses and Midwives on the Administration of Medical Preparations (An Bord Altranais 1998b), are important when defining the boundary of scope of practice. On a regional basis, locally defined policies, protocols and guidelines outline care within a particular setting.

It is recognised that the scope of practice of the nursing and midwifery professions is broader than that of the individual nurse or midwife (CNA 1993). The outer limits are set by legislation, policy and guidelines as outlined above, within which individuals need to make decisions about their own level of competence. Registration education programmes allow nurses and midwives to register in a particular division of the register maintained by An Bord Altranais and thus practice in that discipline. Post-registration education programmes provide nurses and midwives with in-depth knowledge and skills for particular practice fields. Nurses and midwives are advised by An Bord Altranais to practice within the limits of their training, education and competence. Individually nurses and midwives must consider their own accountability and duty of care as they practice on a day-to-day basis and make decisions with regard to their scope of practice.

Many countries and states have published scope of practice documents throughout the 1990s to augment or clarify legislation. These include:

- UKCC 1992
- Alberta Association of Registered Nurses 1992
- Saskatchewan Registered Nurses Association 1992
- Association of Registered Nurses of Newfoundland 1995
- Registered Nurses Association of British Columbia 1995
- Pennsylvania State Board of Nursing 1996
- Nursing Board of Tasmania 1997
- New Zealand Nurses Organisation 1997
- Arkansas State Board of Nursing 1998
- ICN 1998
- Queensland Nursing Council 1998
- QUIN Council for Nursing (Florida) (undated)
- Thai Nursing Council (undated)
- Texas State Board of Nurse Examiners (undated).
In general, these scope of practice documents have been developed and published by nursing regulatory bodies, however some originate from professional organisations. The documents vary in their orientation. Some are restrictive, outlining lists of practices, while others are more flexible and are presented as decision-making frameworks. Certain issues emerge that are common to many of the documents published. These include:

- A definition for the term scope of practice
- A definition of nursing and midwifery practice
- A definition of health
- The importance of the national or sub-national legislation that governs nursing and midwifery practice, in the determination of the scope of practice
- The relevance of the code of conduct or code of ethics that exists to guide practice
- The role of local policies and guidelines in guiding decisions regarding scope of practice
- The centrality of individual competence in determining scope of practice
- The individual accountability of the nurse or midwife
- The importance of education and continuing professional development
- A consideration of the development of practice in terms of extension or expansion of roles
- Advanced practice roles
- The basis on which to make decisions regarding scope of practice in the form of a decision making framework or principles on which to base decisions.

There is a trend towards broad, enabling scope of practice frameworks, which empower nurses and midwives as professionals to make decisions about their scope of practice and a general shift away from an emphasis on certification for tasks. Limited evaluation would appear to have taken place on the effect on practice of scope of practice frameworks. Some studies suggest that empowering frameworks, such as that of the UKCC (UKCC 1992) are perceived as having a positive influence on practice, providing liberation for practitioners in relation to role development and contribution to social and health care provision (Land et al 1996) and enabling the development of skills and the promotion of confidence, reflection and self awareness (Jowett et al 1997). The UKCC commissioned independent research into the application and impact of their Scope of Professional Practice (Jowett et al 2000). Although the research did not evaluate patient/client care it was interesting to note that the study found that in developing their practice nurses felt that they were able to offer a seamless, more continuous service as a result of having a scope of professional practice document.

### 2.3 Conclusion

To date no formalised statement has been made in relation to the scope of nursing and midwifery practice in Ireland. The scope of practice for nurses and midwives in Ireland has been defined with reference to EU directives, contemporary legislation, social policy, national and local guidelines, education and individual levels of competence.

Nurses and midwives need a scope of practice decision-making framework that will provide them with the flexibility to review and expand their practice in a way that best meets patients’/clients’ needs.
SECTION 3

Key Issues Arising from the Consultation Process
3.1 Nursing

The issues that emerged in relation to the scope of nursing practice are dealt with under the following headings:

• The current scope of nursing practice
• The changing scope of nursing practice
• Difficulties in defining the scope of nursing practice
• Future developments in the scope of nursing practice
• Decision-making regarding the scope of nursing practice.

3.1.1 The current scope of nursing practice

Throughout the consultation process, the scope of nursing practice was recognised as varied and diverse, depending on patient profile, location of care and the type of service in which the nurse worked. Aspects of the role that were seen as the norm in some care settings were seen as the exception in others. Nursing was described as a health profession primarily involved in caring. The principal differences that were highlighted among the different divisions of the register were in relation to the type and focus of care that was delivered to patients.

The diversity of the nurse’s role was seen as both a strength and a weakness. The strength lay in the ability of the nurse to provide care in a flexible and responsive manner in many varied situations. The weakness related to the general feeling that the role of the nurse was often misunderstood by other professionals and by the public. Nurses stated that the lack of boundaries in nursing resulted in difficulties for nurses in deciding what was actually within their remit. This, they felt, was a major cause of stress within the profession.

Nurses described their current scope of practice with reference to the following: caring for patients, education and development, patient advocacy, working within a team, management and non-nursing duties. A common theme that spanned these categories was the importance of communication and communication skills.

Key Issues

• The scope of nursing practice was recognised as varied and diverse, depending on patient profile, location of care and the type of service in which the nurse works.
• The current scope of practice of nurses was described with reference to the following: caring for patients, education and development, patient advocacy, working within a team, management and non-nursing duties.
• Caring was seen as a core function of nursing. Caring was identified as encompassing physical, psychological, social and spiritual aspects of the person, incorporating both technical and interpersonal skills. It was felt that nurses strive to deliver care that is holistic.
• The focus of care differed depending on the particular area of nursing practice described.

3.1.2 The changing scope of nursing practice

Nurses identified themselves as a profession currently in a state of transition due to the educational, management and practice changes occurring at present. They felt that in some way these changes are happening too quickly to be assimilated, and hence fear is being engendered. While it was identified that nurses are taking on new roles in a variety of settings, it was also recognised that they are not shedding old roles at an equivalent rate, hence they are doing more work than ever. It was considered important to identify what is leading these changes.

Key Issues

• Changes in the scope of nursing practice to date have been reactive and unplanned, often without due consideration and support and made on an ad hoc basis.
**SECTION 3: KEY ISSUES ARISING FROM THE CONSULTATION PROCESS**

- Influences on scope of practice include social change, technological innovation, the nursing profession itself and the work practices of other groups of healthcare workers.

- The scope of nursing practice was seen to have been influenced too much in the past by the work practices of other professions or groups of staff.

- Changes occurring in nursing include changes in the method of care delivery, including increased specialisation, accountability, autonomy, and increased emphasis on patient needs, changes in location of care delivery and emerging new roles.

### 3.1.3 Difficulties in defining the scope of nursing practice

Nurses acknowledged that, because they work in a dynamic healthcare environment, their role and function must evolve and change to meet patient needs and incorporate service needs. Many nurses felt that they were isolated when making scope of practice decisions. This has implications for the quality of patient care and the profession of nursing.

The provision of a 24-hour service by nurses means being responsive to many complex situations in order to act in the patient’s best interests. This often places them in situations where they feel unsure about their legal and professional scope of practice. Nurses felt that at times they are working in ‘grey’ areas, and did not feel confident that they were ‘covered’. Nurses clarified that ‘being covered’ meant working within their legal and professional scope of practice. An example described related to emergency situations, which by their nature warrant immediate action to save a person’s life. Nurses in such situations, although competent, felt that at times they were acting outside their usual scope of practice.

It was acknowledged that in some cases decisions about the scope of nursing practice are planned based on reflection, consultation, standards and evidence and with due reference to international and national developments. However, it was felt that generally decision-making regarding the scope of practice is reactive, and is only discussed when something goes wrong. Nurses felt that their difficulties with scope of practice highlight the ad hoc manner in which these issues have been managed in the past. Thus nurses often felt pressurised and ill prepared to expand their scope of practice. Nurses expressed concern that their previous experience has been that when they do something once it suddenly becomes ‘their job’.

Nurses recognised that in order to facilitate professional decision-making about scope of nursing practice, it is necessary to have a framework on which to base such decisions. It is therefore important to examine the difficulties that nurses experience in making decisions about the scope of nursing practice. Nurses identified situations in which they felt that they were acting without due preparation. The main areas of difficulty in relation to defining the scope of nursing practice were in relation to competence, local and national policy, legislation and inter- and intra-professional boundaries.

An issue that emerged in the final stage of the consultation process related to the Mental Health Bill, 1999. Section 22 provides that certain professionals can prevent a voluntary patient in an approved centre from leaving if they are of the opinion that the person is suffering from a mental disorder. The professionals referred to in the Bill are, a consultant psychiatrist, a registered medical practitioner or a registered nurse. Psychiatric nurses generally feel that the specified nurse should be a registered psychiatric nurse due to their particular competence in the discipline of mental health care.

### Key Issues

- Nurses felt that they were working in ‘grey’ areas at times, and did not always feel confident that they were ‘covered’.

- Extension of practice through the collection of certificates was seen as outdated and unhelpful in responding to an ever-changing healthcare environment.

- Local and national policy is often over-prescriptive and thus restricts the expansion of nursing practice in the interest of quality patient care.

- Nurses felt restricted by being unable to administer non-prescription medications to patients.

- Nurses felt that in certain circumstances they should be able to prescribe prescription only medications for patients.

- Nurses expressed concern that there is an expectation that they take on roles that are being discarded by other professionals in the interest of cost-effectiveness.

- Nurses felt that in many cases they did not have the autonomy to make decisions about the nursing care of patients.

### 3.1.4 Future developments in the scope of nursing practice

Nurses supported the development of their role, but they were clear that the ad hoc/unstructured developments that have occurred to date are neither desirable nor helpful. They stated that development of the role should be structured in line with an identified framework that would encompass the distinct characteristics of each division of the register.

Consideration was given to the issues that should lead the development of nursing practice, the direction in which the nurse’s role should develop, and how nurses should make decisions about their scope of practice.

### Key Issues

- Nurses felt strongly felt that population and health needs and thus service need, coupled with a regard for patients’ rights, should lead nursing to develop.

- Nurses should lead the development of nursing practice.

- Good leadership and vision are needed.

- There is a necessity for a philosophy of nursing to underpin any development of the nurse’s role.

- Nurses agreed that development of the nurse’s role involved expansion. They clarified that expansion meant becoming more expert, competent, reflective practitioners developing skills to meet patients’ needs.

- There was general support for the proposed clinical pathway outlined in the Report of the Commission on Nursing (1998, p.104)
• Nurses should be autonomous in relation to the practice of nursing.

3.1.5 Decision-making and the scope of nursing practice

Scope of practice decisions, it was felt, should be made on three levels. The first level relates to national guidelines and legislation. The second level relates to nurses making decisions with due regard to their location of work and organisational culture. The third level relates to nurses making decisions on an individual basis. The three levels interact to support and facilitate each other and therefore should not be considered as independent of each other.

Key Issues

• Decisions about the scope of nursing practice need to be structured and based on an identified framework.

• Scope of practice decisions should be made on three levels – national, organisational and individual. The three levels, it was felt, should interact to support and facilitate each other and therefore should not be considered as independent of each other.

• Decision-making on a national basis is influenced and guided by legislation, social policy, An Bord Altranais, education and professional organisations.

• Organisational decision-making should be supported and guided by management and policies, protocols and guidelines.

• Nurses felt that individual decision-making should be based on education, clinical experience, expertise, knowledge, competence and skills.

• Nurses felt that guidance from An Bord Altranais on scope of practice, in the form of a decision-making framework was critical for the development of the nursing profession.

• A scope of practice framework, it was felt, should be empowering which would support and guide nurses in a practical and contemporary manner.

3.2 Midwifery

The issues that emerged in relation the scope of midwifery practice are dealt with under the following headings:

• Current and future practice

• Difficulties in defining the scope of midwifery practice

• Scope of midwifery practice decision-making.

3.2.1 Current and future midwifery practice

Midwives were clear that they wanted to be viewed as a profession distinct from nurses. They supported the proposed legislative changes to the 1985 Nurse’s Act as recommended by the Report of the Commission on Nursing (1998, p.65-66) which will confirm midwifery as a separate profession from nursing, restoring the midwives’ statutory committee and revising fitness to practice procedures. Midwives recognised the challenge of the Commission report for midwifery practice, acknowledging that it has made midwives reflect on their roles and functions.

WHO/ICM/FIGO (1992) issued a statement on the definition of a midwife, which reads as follows:

“A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the new-born and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child-care. She may practice in hospitals, clinics, health units, domiciliary conditions or in any other service.”

Throughout the consultation process, midwives wished to clarify that their scope of practice is already outlined within this definition and the EEC Council Directive 80/155/EEC of 1980. This directive concerns the coordination of provisions laid down by law, regulation or administrative action in respect of the activities of midwives. It outlines the minimum knowledge and clinical experience necessary for midwifery and outlines the activities that midwives are entitled to take up and pursue. Midwives emphasised that they were anxious to participate in the full activities of the midwife as defined within the directive. Midwives expressed frustration with their current role and functions, but felt that midwifery practice internationally and the return of midwives educated and trained abroad will challenge current midwifery practice and organisation of maternity services in Ireland.

Some midwives argued that a midwife who is functioning as defined by WHO/ICM/FIGO (1992) working within the EEC Directive (1980) was practising at advanced practice level. However, others felt that to practice as defined by the EEC Directive was a requirement for all midwives at the point of registration and thus was normal practice for the midwife. Some sub-specialisation in midwifery was, however, identified. Concern was expressed, however, that midwives should be providing more holistic care rather than becoming specialised, for example as a labour ward midwife or a postnatal ward midwife. They were concerned that such specialisation could lead to loss of skills and reduced continuity of care, as has happened in the past. However, others viewed such specialisation as advantageous.

Key Issues

• Midwives wish to be viewed as a profession distinct from nurses.

• Midwives wish to practice as defined by the definition of a midwife (WHO/ICM/FIGO 1992).

• Midwives wish to clarify that their scope of practice is already outlined within the EEC Council Directive 80/155/EEC of 1980. Some midwives felt that to practice at this level was normal practice, while others felt that it was advanced practice.

• In general, midwives felt that pregnancy and childbirth should be considered normal which is contrary to the present medical model of childbirth.
Midwives stated that currently many policies are obstetric led and not midwifery led.

Recommendations for midwifery developments included outlying clinics, DOMINO schemes (Domiciliary Care In and Out of Hospitals), team midwifery, home deliveries and more independent midwives.

3.2.2 Difficulties in defining the scope of midwifery practice

Midwives felt that a major difficulty with their scope of practice was that although their scope of practice was outlined in both the EEC directive (1980) and the definition of a midwife (WHO/ICM/FIGO 1992), they found themselves unable to practice at this level. Midwives felt that currently their scope of practice decision-making was centred on the way in which health services are delivered. Midwives have difficulty with the medicalisation of maternity services. They view the function of the midwife in maternity care as the normal care of women throughout pregnancy, labour and the postnatal period. Midwives outline that the current care that they give is in contrast to their defined role and function. This can create differences of opinion between midwives and obstetricians. The midwife feels that at times his/her role is only to facilitate, or is perceived as being only to facilitate, the obstetrician.

Key Issues

- Midwives are unable to practice to their scope of practice as outlined by the EEC directive (1980) due to the way in which maternity services are structured.

- The Misuse of Drugs Regulations (1988) outlines the regulations relating to the possession or administration of any medical preparation, which contains pentazocine or pethidine. The regulations do not allow midwives practicing in a hospital setting to administer these medications without prescription.


- Midwives stated that there were certain prescription-only medications that in the course of their practice they need to be able to prescribe and administer without reference to a medical practitioner.

- Stringent hospital policies hamper midwives from fulfilling their role.

- Scope of midwifery practice is currently location-based.

- Lack of leadership prevents midwives from fulfilling their role.

- An Bord Altranais Guidelines for Midwives (1994b) is not seen as giving sufficient professional guidance.

3.2.3 Decision-making and the scope of midwifery practice

Midwives highlighted that the midwife’s scope of practice involves working within legislation, adhering to An Bord Altranais guidelines and being cognisant of local policies and guidelines. Midwives felt that they should be empowered and enabled to make scope of practice decisions with due regard to the above. Certain supports need to be in place to facilitate midwives in determining their scope of practice.

Key Issues

- The importance of appropriate, timely, referenced, enabling local policies and guidelines (midwife-led), which guide and support scope of practice decisions, was emphasised.

- Midwifery practice should be supported and underpinned by an appropriate educational structure that is ongoing and will enable midwives to practice to the full extent of their scope of practice.

- Further scope of practice workshops are necessary to discuss professional issues.

- The importance of appropriate supervision as a support was emphasised.

- The importance of management support and leadership was emphasised.

- A review of An Bord Altranais Guidelines for Midwives (1994b) to provide more professional guidance for midwives is needed.

3.3 Conclusion

It is evident following consideration of the key issues identified by nurses and midwives that there are a number of important concepts to consider in relation to the determination, review and expansion of scope of practice. These concepts are: the development of the scope of nursing and midwifery practice, specialist and advanced practice, accountability and autonomy, competence, supervision, continuing professional development and delegation. Section 4 examines and discusses these concepts and their implications for the scope of nursing and midwifery practice in Ireland.
SECTION 3: KEY ISSUES ARISING FROM THE CONSULTATION PROCESS
SECTION 4

Important Concepts in Determining the Scope of Nursing and Midwifery Practice
4.1 Development of the Scope of Nursing and Midwifery Practice

4.1.1 Nursing

There is little doubt that the role of the nurse has evolved over the last century. The dynamic nature of the demographic and epidemiological profile of populations has impacted on both the management and delivery of healthcare services. There have been radical reforms in health care delivery, technological advances and a growth of nursing research and knowledge. Additionally, there have been cultural, educational and legal changes (Hunt and Wainwright 1994, p.x–xi). Nurses’ scope of practice in Ireland has changed, evolved and developed over the years and is continuing to change (An Bord Altranais 1999a).

Castledine (1992) describes development of nursing practice in the context of general practice, specialist practice and advanced nursing practice. General practice is described as general experience across traditional specialist domains of nursing. Specialist practice includes specific expertise in particular fields of practice and advanced nursing practice, significant input of direct clinical work, research, teaching, evaluation, case work, consultation, leadership and management. Shewan and Read (1999) however view development of the role of the nurse as less defined and outline four categories of role development for the nurse: discrete new roles, creeping role development, specific intervention and policy-led role development. Discrete new roles are outlined as nurse practitioners (NPs) and clinical nurse specialists (CNS’s). The creation of these roles is seen as a movement towards ‘nurse-led’ care. Creeping role development is described as the addition of a new skill or task to the workload of the nurse. Specific interventions relate to the addition to a nurse’s role of a clinical treatment or investigation formerly performed by doctors or the introduction of a new nursing intervention. Policy-led development is where the emphasis of nurses’ work is altered by centrally determined policies.

It is evident that role development for nurses can occur at many levels, not just in the context of specialist and advanced practice. Hunt and Wainwright (1994, p.xiv) outline two ways of increasing the responsibilities of nurses. One way is growth by mechanical addition of parts (extension) and the other way is organic growth of whole (expansion). Mitchinson and Goodlad, (1996) describe the extended role as one that involves tasks borrowed from other professions; these tasks are used by the nurse at the discretion and convenience of others and involve training, supervision and certification by other professions. The expanded role is described as involving a higher level of nursing practice within existing boundaries of nursing. This is as a result of the development of knowledge from research, experience and continuing education and incorporating new skills from this knowledge base.

Wright (1995) states that at its most simple, role extension refers to nurses carrying out tasks not included in their normal training for registration. The fundamental difference between extension and expansion of practice would appear to lie in the value base that underpins the change in practice. Role extension has been described as ‘counter-holism’ (Magennis et al 1999), whereas role expansion is a holistic process both in relation to the needs of patients/clients and the development of the nurse. The UKCC (1992) asserts that a concentration on ‘activities’ can detract from the importance of holistic nursing care and therefore considers that the terms extended or extending roles are no longer suitable since they limit, rather than extend the parameters of practice. The guiding principles outlined in the UKCC Scope of Professional Practice (UKCC 1992) emphasise the nurse’s professional accountability and reflect the belief that practice is based on principles and not tasks delegated from doctors (Tolley 1994). This ideological shift towards nurses regulating their own practice is seen as a step towards autonomy. This new approach is less about changing practice than about changing the way nurses think (Carlisle 1992). Role expansion is considered preferable to role extension in relation to the development of nursing practice and more consistent with a holistic approach to patient/client care.

1The contribution of Ms. Margaret Carroll is acknowledged. 2The contribution of Ms. Catherine Griffen is acknowledged.

This section of the report reviews and discusses key concepts relevant to the determination of scope of practice. These are –

- Development of the scope of nursing and midwifery practice
- Specialist and advanced practice
- Accountability and autonomy
- Delegation
- Competence
- Continuing professional development
- Supervision and clinical supervision

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Irish nurses also suggest that expansion is preferable to extension. Role extension was described as a limiting mechanism whereby nurses require certification for skills for taking on new tasks. Expansion on the other hand involves becoming more competent, reflective, autonomous practitioners and developing expertise and skills to meet patients’ nursing needs (An Bord Altranais 1999a, p.24-31).

Concern has been expressed both nationally and internationally that nursing care could become fragmented as a result of nurses taking on roles in an ad hoc manner. Some of these roles are perceived as areas of practice, which other health care professionals are shedding. It is clear from the literature that nurses working in specialist and advanced practice roles, as well as those in other clinical posts frequently do take on roles/activities that have been within the remit of doctors. Due to the nature of health care the boundaries between medical and nursing care are often blurred, making it at times difficult to ascertain what particular aspect of care belongs within the remit of a particular profession. Strict role delineation may not serve the interests of holistic patient/client care. Due to the multiplicity of groups contributing to patient/client care, changing practice to meet changing health care needs requires flexibility and collaboration. Studies that have examined expanded nursing practice have identified that collaboration and communication with other members of the health care team is vital (Wilson 1996, UKCC 1997). Each member of the health care team has a unique contribution to make to patient/client care. There are also aspects of care that may be shared. However, the expansion of nursing practice must not take place at the expense of fundamental nursing care of patients/clients. It is therefore important that nursing is defined and the values underpinning care are made explicit to act as a guide for nurses faced with decisions about expansion of role.

4.1.2 Midwifery

There is a dearth of midwifery literature discussing extended and expanded roles and the concept of specialist and advanced practice. The emphasis for development of the midwifery profession has been on the promotion of autonomous midwifery practice without reference to a doctor. Different ways of delivering maternity care are being developed and promoted such as DOMINO schemes (Expert Group on Domiciliary Births undated, O'Connor 1994).

Internationally midwifery practice is changing and developing. In New Zealand midwifery practice changed in August 1990 when legislation was enacted to allow midwives to take responsibility for the care of a woman throughout pregnancy, labour and the postnatal period (Fleming 1996). The decline in the role of the traditional midwives’ role and secondly the acquisition of new skills such as screening and health promotion (Hunt and Wainwright 1994, p.154).

4.1.3 Conclusion

An Bord Altranais recognises that both nursing and midwifery roles are evolving and recommends that as method of evolving the term expansion of practice rather than extension of practice be adopted.

Expansion encompasses becoming more competent, reflective practitioners, developing expertise and skills to meet patients’/clients’ needs in a holistic manner.

Expansion may refer to a change in the overall scope of practice of the professions to include areas of practice that have not hitherto been within the remit of nurses or midwives; or it may refer to a change in the scope of practice of an individual nurse or midwife to include areas of practice that have not been within his/her scope of practice but are within the overall scope of practice of the nursing and midwifery professions.

Expansion of the scope of nursing and midwifery practice should always be made with the patient’s/client’s best interests foremost and in the interest of promoting and maintaining best quality health services for the population.

Expansion of nursing/midwifery practice must be made in the context of the definitions of nursing/midwifery and the values that underpin nursing/midwifery practice.

4.2 Specialist and Advanced Practice

Much has been written describing and discussing advanced practice, specialist practice, clinical nurse specialists (CNS), advanced nurse practitioners (ANP) and nurse practitioners (NP). The discussion regarding both specialist and advanced practice is complex given the divergent historical growth of roles, responsibilities and educational preparation for advanced practice nurses. There is clear lack of delineation of roles internationally. Advanced practice encompasses specialist practice in some deliberations but not in others (Castledine 1992, Berger et al 1996, WHO 1996). Many titles are used for specialist and advanced roles without clear definition of role or educational preparation (Dowling 1995, Cahill 1996, Elcock 1996). For example, nurse practitioners have been described as physician assistants, physician extenders, expanded role nurses, physician associates (Denton et al 1983), nurse educators and nurse consultants (Dyson 1997). There is a call for amalgamation of roles and standardisation regarding scope, skills and educational preparation of expanded roles (Briody 1996, Deane 1997, Dunn 1997). There is support for a distinction between specialist nursing practice and the advanced practitioner (Castledine et al 1996, The Nursing Research Unit, University of Central England 1998). Much of the literature available is related to nursing rather than midwifery.

4.2.1 Specialist nurses

As early as 1910 nurses were designated as specialists. For the first half of the 20th century the term ‘specialist’ denoted a nurse with extensive experience in a particular area of nursing, a nurse who completed a hospital-based ‘postgraduate’ course, or a nurse who performed with technical expertise (Hamric and Spross 1989, p.4).
Sometimes ‘specialty’ was used to identify a particular facility or disease and frequently ‘specialist’ meant doing something in nursing especially well (Smoyak 1976). The term clinical nurse specialist was first used in 1938 (Peplau 1965). Peplau subsequently developed the first clinical nurse specialist course in 1954 in New Jersey (Smoyak 1976).

The role of the CNS evolved in clinical areas of nursing practice for many reasons including the reduction of doctors’ hours (Fish 1995). Posts developed in order to manage resources effectively, to promote interaction between education, expert practitioners and the clinical setting (Mc Sharry 1995), to initiate research and to reduce the theory practice gap (Montemuro 1987).

A review of CNS practice across the USA identified role categories in relation to practice:

fo. Patient care/consultation (includes clinical practice, case manager, patient advocate, change agent, consultant, role model and development of patient care standards, policies and procedures).

• Education (includes general staff, patient, special projects, program development and student mentorship).

• Administration (includes general administrative activities, committee work, budget, quality assurance activities).

• Research and professional development (Mc Fadden and Miller 1994).

The essential functions of CNS’s have been outlined as research, clinical leadership, development of nursing knowledge, acting as a consultant, educator, change agent and evaluating care (Mc Gee 1992).

The ICN in 1987 defined the nurse specialist as a nurse who is prepared beyond the level of a nurse generalist and authorised to practice as a specialist with advanced expertise in a branch of the nursing field. Titles for nurse specialists include the designation nurse modified by the name of the specialty (ICN 1987).

4.2.2 Advanced practice nurses

The UKCC (1994) outlines advanced practice as adjusting the boundaries for the development of future practice, pioneering and developing new roles responsive to changing needs and with advancing clinical practice, research and education to enrich practice as a whole. Advanced practice nurses are described as professionals with specialised knowledge and skills that are applied within a broad range of patient populations in a variety of practice settings (American Association of Colleges of Nursing 1996). It is suggested that the scope of the role encompasses clinical practice, management, teaching and research. The advanced nurse practitioner (ANP) integrates these elements into a whole, while acting as a consultant to the profession and others (Elliott 1995). Advanced practice nurses work in a variety of settings from community-based primary care clinics to surgical suites and critical care units (Carroll and Fay 1997). Castledine (1998, p.3-7) suggests that ANPs should demonstrate autonomy, should be experienced and knowledgeable, should be researchers and evaluators of care and should be able to conduct a comprehensive health and nursing assessment. The emphasis of the role should be on case management and ANPs should act as consultants and educators.

The NP role originated in the USA with Henry Silver and Loretta Ford in 1965 (Winson and Fox 1995). The role was said to develop due to the number of people in the USA who were without health care or who were being treated in an inadequate manner (Peterson Sinclair 1997). Historically NP practice has been associated with primary care (Cronenwett 1995). Since then the NP role has expanded to include many other patient populations (Price et al 1992). The first recognised NP program was initiated at the University of Colorado in 1965 (Smoyak 1976). Currently in the USA the advanced practice nurse is an umbrella term given to a registered nurse that has met advanced educational and clinical practice requirements. Under this umbrella fall four principal types of advanced practice nurses: nurse practitioners, certified nurse midwives, clinical nurses specialists and nurse anaesthetists (American Nurses Association 1992, American Academy of Nurse Practitioners 1993). Canadian nurses saw the NP role as an opportunity to expand their scope of practice (Bajnok and Wright 1993). New South Wales in Australia began a process of introducing NPs in 1997 (New South Wales Health Department 1998).

Reiter (1966) who first used the term ‘nurse-clinician’ described this role as a master practitioner; competent in care, knowledgeable about care, perceptive about human motivation, and committed to the profession of the highest quality. However this author acknowledges that the term nurse-clinician which is used widely in the literature does not mean the same thing to everyone. The definition of a nurse clinician used at the University of Liverpool in its MSc in Clinical Nursing is a first level nurse who has completed an appropriate course of study at master’s level. This nurse functions independently or within a clinical team of doctors or alongside a single medical practitioner with agreed protocols. Competence is demonstrated by the nurses in a wide range of skills complementary to the doctor’s role in the delivery of health care in primary, community and secondary areas (Barnes 2000).

4.2.3 The Irish context

Historically within the Irish context no framework has existed for the creation or recognition of nurse specialists. The Working Party on General Nursing (1980) recommended that specialist nurses should be developed. These nurses, it was felt, should be developed to enhance the quality of care, to provide a specialist nursing service in certain areas, to provide specialist advice to other nurses and to enable more nurses to pursue a career in clinical nursing. A large number of nurses consider themselves to be ‘specialists’ in particular areas of nursing practice. These ‘specialist’ nurses are however graded at a variety of levels and there is little coherence in the recognition of the posts (Commission on Nursing 1997, p.41).

Irish midwives expressed mixed views with regard to whether midwives should remain as generalist midwives or whether midwifery should develop specialist and advanced practice. Some midwives argued that a midwife who is functioning as defined by WHO/ICM/FIGO (1992) working within the EEC Council Directive 80/155/EEC of 1980 is practicing at advanced practice level. However, others felt that to practice as defined by this Directive is a requirement for all midwives at the point of registration and thus is normal practice for the midwife. Some sub-specialisation in midwifery was, however, identified. Examples outlined included midwives in the neo-natal unit, family planning, ultrasound and domiciliary midwifery (An Bord Altranais, 1999a, p.46). Midwifery care in Ireland was described as being fragmented with care being provided separately in the antenatal, the postnatal...
and the labour ward. This approach to care was felt has resulted in many midwives functioning as obstetric nurses (An Bord Altranais 1999a, p.42). Daly and Sugre (2000) argue that the term enhanced is more appropriate than specialist in the context of midwifery practice.

The Commission on Nursing in Ireland has provided a framework for the future use of titles, development and educational requirements for the roles of clinical nurse and midwife specialist and advanced nurse and midwife practitioner in Ireland (Commission on Nursing 1998, p.104-106). The use of the titles ‘clinical nurse or midwife specialist’ or ‘advanced nurse or midwife practitioner’, must involve the appointment of a nurse or midwife to a particular post. Practice of the clinical nurse or midwife specialist should include clinical practice, teaching, research implementation and advisory roles. The advanced nurse or midwife practitioner is described as a nurse/midwife who exercises higher levels of judgement, discretion and decision making in the clinical area above that expected of the clinical nurse or midwife specialist.

Research into CNS and ANP roles has been mostly descriptive and relatively little systematic evaluation has been reported. Some studies have suggested positive outcomes as a result of nurses/midwives working in advanced or specialist roles:

- Safe and effective care (Spitzer et al 1974, Sakk et al 1982, Sakk et al 1999)

4.2.4 Conclusion

Common to both ANP’s and CNS’s is the fact that they increase their levels of responsibility, develop skills and expertise, become more competent in particular practice areas and in some situations take on roles that would previously not have been within the scope of individual nursing or midwifery practice. In other words they review and expand their practice. This is not unique to specialist and advanced practice; all nurses and midwives review and expand their practice. Appropriate review and expansion requires an empowering scope of practice framework to enable nurses and midwives to practice safely, with flexibility and to be fully accountable and autonomous.

4.3 Accountability and Autonomy

In articulating the responsibilities of a nurse, the WHO has stated that “the nurse is an autonomous practitioner of nursing, accountable for the care she or he provides.” (WHO 1991, p.3)

As the body that regulates the practice of nursing and midwifery in Ireland and in doing so provides protection for the public, An Bord Altranais provides guidance for the professions through the Code of Professional Conduct (1988b). In relation to accountability the Code of Professional Conduct states: “the nursing profession demands a high standard of professional behaviour from its members and each registered nurse is accountable for his or her practice”.

4.3.1 Responsibility

It is well established in the literature that the concepts of autonomy, authority, responsibility and accountability are linked. Accountability and responsibility are often confused. Responsibility is defined as: “a charge for which one is answerable” (Batey and Lewis 1982, p.14). The focus is on the charge. Responsibility connotes the action, the performance of a task. Accountability suggests that the outcomes of the actions will be judged against some outcome criteria (Moloney 1992, p.254). It has been noted that nurses in the past often accepted responsibility for charges that did not fall within the domain or scope of nursing practice (Batey and Lewis 1982). Therefore in defining areas of responsibility for which nurses and midwives are accountable, consideration must be given to the appropriateness of the responsibility to nursing and midwifery practice. This is particularly important in the context of a changing health care environment, changing patient/client needs and increases in new technology resulting in demands for nurses and midwives to expand their range of responsibilities.

4.3.2 Autonomy

If nurses and midwives are expected to be held accountable for the areas of patient/client care for which they hold responsibility, they need to have the necessary autonomy to practice according to their professional judgement. Autonomy has been defined as: “freedom to make discretionary and binding decisions consistent with one’s scope of practice and freedom to act on those decisions” (Batey and Lewis 1982, p.15). Thus the importance of defining the scope of nursing and midwifery is explicit in this definition. If nurses and midwives are to exercise their autonomy they must first decide what the parameters of their practice are.

Nurses and midwives have expressed a desire to be autonomous in the practice of nursing and midwifery (An Bord Altranais 1999a). While nurses have identified that autonomy is an issue that has been pursued by nurses, unsuccessfully in most cases, midwives have identified that they have always been entitled to practice autonomously as midwives, but that due to the medicalisation of childbirth and the organisation of the maternity services, the practice of midwifery has largely not been autonomous in the recent past.

Although autonomy was identified by a large number of nurses and midwives as desirable for the development of patient care and the profession, some have identified that a fear of autonomy often acts as a barrier to nurses and midwives expanding their practice (An Bord Altranais 1999a). A study carried out by Lewis and Batye (1982) suggested that the extent to which nurses had autonomy to act varied; directors of nursing reported that even when they had negotiated with other groups for nurses to be autonomous in their responsibility for a particular charge, the nurses tended to avoid doing so out of fear. Fourteen per cent of nurses and midwives who responded to the scope of nursing and midwifery practice survey, identified fear of autonomy as a barrier to expansion of their practice (An Bord Altranais 1999a, p.86).

4.3.3 Authority

Authority, “the legitimate power to fulfil a responsibility” (Batey and Lewis 1982), is a necessary pre-requisite for nurses and midwives to practice autonomously in fulfilling their responsibilities. There are three types of authority outlined in the literature. Authority of the situation involves the rightful power to act in an emergency situation that would not be allowed in usual circumstances.
Authority of expert knowledge is conferred by society through regulation of a profession by a regulatory body (for example An Bord Altranais) and comes from the competent application of sound research-based knowledge, according to the standards of the profession (ICN 1998). Authority of position is related to a position that a person holds rather than to the person themselves (Lewis and Batey 1982). Nurse have often not fully used their authority of situation or of expert knowledge and what tends prevail in health care organisations is authority of position, where decisions that effect clinical practice are taken by managers (both nursing, midwifery and others) by virtue of their administrative position.

As nurses and midwives mostly work within health care organisations, the environment in which they practice has enormous bearing on the extent to which they have authority. It has been noted that in most organisations the authority is embedded in the hierarchy of agency administration thus inhibiting decision making at grass roots level (Jackson 1983). Individual accountability for practice cannot be achieved if the individual practitioner does not have the necessary authority to act in accordance with his/her professional judgement. This presents a challenge to health care organisations to develop systems that will enable them to devolve decision making to clinical practitioners while maintaining accountability for the overall provision of health care services.

**4.3.4 Accountability**

The freedom for nurses and midwives to act in accordance with their professional judgement in relation to areas within their scope of practice, brings with it the principle consequence of accountability for one’s decisions and actions (Snowdon and Rajach 1993). Accountability has been defined as: “the fulfilment of a formal obligation to disclose to referent others the purposes, principles, procedures, relationships, results, income and expenditures for which one has authority. This disclosure is systematic, periodic, and carried out in consistent form... Initiating the disclosure is the responsibility of the one accountable and not of others” (Lewis and Batey 1982, p.10).

To be accountable is to be called to account for one’s practice and decisions made therein. Professional accountability requires that the nurse or midwife weighs up the interests of patients or clients in complex, changing situations, using his/her professional knowledge, skills and judgement to make a decision enabling them to account for their actions (UKCC 1996). Accountability is a concept that is very much in the public arena in the past two decades.

The question to whom is the nurse or midwife accountable? is often asked. The nurse or midwife is legally accountable to patients, to the public, to the employer and to the profession. This accountability can be enforced in a variety of arenas. Accountability to the patient is enforced in civil or criminal law. Accountability to the public is enforced in criminal law. In civil law the nurse or midwife is accountable to the courts to provide care to a certain standard, once it has been established that a duty of care exists. The standard against which care is judged has been established in case law to be that which would be provided by an ordinary skilled man exercising and professing to have that special skill (known as the Bolam principle) (Dimond 1995, p.30). Also established in case law is that in addition to the above, the standard should be determined in the context of particular posts rather than the general rank or status of the people filling the posts. This means that the standard expected is that of an ordinary practitioner in a particular grade and that therefore inexperience is no defence to action for negligence (Dimond 1995, p.44). This is particularly relevant to nurses or midwives who are taking responsibility for or carrying out tasks that have previously been carried out by other professional groups. They will be judged in law against the standard expected of the professional who would usually carry out the task or responsibility (Tingle 1990).

**4.3.5 The Fitness to Practice Process**

Accountability to the profession in Ireland is administered via the Fitness to Practice Process of An Bord Altranais, as outlined in the Nurses Act (1985). The Fitness to Practice Committee is a statutory committee of An Bord. An Bord or any person, may apply to the Fitness to Practice Committee for an inquiry into the fitness of a nurse or midwife to practice nursing or midwifery on the grounds of alleged professional misconduct or alleged unfitness to engage in such practice by reason of physical or mental disability. Where the Fitness to Practice Committee, after consideration of the application, is of the opinion that there is a prima facie case for holding an inquiry or has been given a direction by An Bord to do so, the Committee shall proceed to hold an inquiry into the fitness of the nurse or midwife to practice. The Fitness to Practice Committee for the purposes of the inquiry, has the powers, rights and privileges vested in the High Court or a High Court Judge in respect of the enforcement of the attendance of witnesses and their examination on oath or otherwise and the compelling of the production of documents. Following an investigation and subsequent report to An Bord if a nurse has been found guilty of professional misconduct, or has been found unfit to practice by reason of physical or mental disability or has been convicted in the courts of an offence triable on indictment, An Bord may decide to impose any of the following sanctions:

(a) Decide that the name of such person should be erased from the Register

(b) Decide that during a period of specific duration the registration of the person’s name on the Register should not have effect

(c) Decide to attach such conditions as it thinks fit to the retention in the Register of the person

(d) Decide to advise, admonish or censure such person in relation to his/her professional conduct (Nurses Act 1985).

Sanctions (c) or (d) can be imposed by An Bord following such an inquiry even if there is not a finding of professional misconduct or unfitness to practice on health grounds. Guidelines to nurses and midwives on professional conduct are provided by the Board in *The Code of Professional Conduct for each Nurse and Midwife* (An Bord Altranais 1998b).

The Report of the Commission on Nursing has recommended reforms to the legislation governing the fitness to practice process. It was recommended that the 1985 Nurses Act be amended to provide for the setting up of three ad hoc sub-committees drawn from the membership of the Fitness to Practice Committee. Any complaint made against a nurse or midwife would be investigated by an ad hoc preliminary screening sub-committee. If a complaint is related to a health issue the Commission recommended that an ad hoc health sub-committee investigate the issue. If a complaint related to a misconduct issue, an ad hoc professional conduct sub-
SECTION 4: IMPORTANT CONCEPTS IN DETERMINING THE SCOPE OF NURSING AND MIDWIFERY PRACTICE

4.4.1 The nature of competence

Being competent is more than being able to do a specific task or being able to practice at a specific skill level. Competence includes many components and attributes of a person, which results in effective and/or superior performance (Australian Nursing Council Inc. 1994). The common components and attributes are described as:

- Practical and technical skills
- Communication and interpersonal skills
- Organisational and managerial skills
- The ability to practice safely and effectively utilising evidence-based practice
- Having a problem-solving approach to care utilising critical thinking

4.4.2 Determining competence

In determining his/her scope of practice the nurse or midwife must make a judgement as to whether he/she is competent to carry out the role/activity. Insight into one’s own abilities and capabilities is required to assess one’s own competence and this may be achieved through reflection on and in practice (Schon 1983, 1987). Reflection on the assessment of one’s own competence encompasses:

- The recognition of one’s own abilities
- Practicing to the limit but not beyond the scope of practice
- Practicing within the limits of one’s own abilities and qualifications.

This insight into individual competence may be achieved by independent, comprehensive and accurate reflection on one’s own practice. This recognition of one’s own competence allows consultation with other nurses/midwives, or other health care professionals which enhances the professional development of the individual and of others whilst maintaining independence. Competence also includes the requirement of the registered nurse or registered midwife to practice in accordance with legislation and The Code of Professional Conduct (An Bord Altranais 1988b).

4.4.3 Maintaining competence

The maintenance of competence and ensuring its continuing development may be achieved by identifying areas where professional growth can occur and by recognising the importance of the need for continuing education. The participation in professional activities enhances the professional development of the individual and others. The recognition of the value of research to the contribution of care for the client/patient contributes to the maintenance and development of competence.

The notion of competence, as outlined above, is a complex multidimensional phenomenon, so too is its achievement.
development and maintenance. There is no fixed point in a professionals’ life where it is possible to say for each and every nurse or midwife “...that competence has been fully accomplished with respect to every aspect of nursing or midwifery” (Phillips et al 1994, p.17). Competence is not static, it is always developmental.

4.4.4 Conclusion

Competence is the ability of the registered nurse/midwife to practice safely and effectively, fulfilling his/her professional responsibility within his/her scope of practice.

In determining his/her scope of practice the nurse/midwife must make a judgement as to whether he/she is competent to carry out the role/function.

The nurse/midwife must acknowledge any limitations in competence. The nurse/midwife must take measures to develop and maintain the competence necessary for professional practice.

4.5 Continuing Professional Development

4.5.1 The nature of continuing professional development

The development of new roles and structures and the demands of advanced practice, result in greater pressure being brought to bear on nurses and midwives. These changes must be embraced by systems of working which offer safety and opportunity for continuous professional development (Butterworth et al 1997 p.3). The WHO identified that education is key to the development of excellence in nursing practice. It supports innovative approaches to curriculum planning and teaching/learning methods so that nursing education programmes are based on the most recent assessment and forecasts of a country’s health needs and of the nursing services required to meet them (WHO 1996, p.18). An Bord Altranais provides guidance for the development of flexible, innovative practice-oriented registration programmes to third level institutions and health care institutions involved in the education and training of nurses and midwives (An Bord Altranais 1999c, 2000). Registration education programmes allow nurses and midwives to register on a particular division of An Bord Altranais register and thus practice in that discipline.

Continuing professional development following registration is essential for nurses and midwives if they are to acquire new knowledge and competence that will enable them to practice effectively in an ever-changing health care system. Professional development has been described as including all the experiences, activities and processes that help develop an individual as a professional. This means it is a lifelong process of learning, both structured and informal (Oulton 1997).

According to the WHO, in order to maintain high quality in nursing practice nurses must be lifelong learners (WHO 1996). An Bord Altranais mirrored this view in 1997 and stressed that continuing professional education is required in order to maintain and enhance professional standards and to provide the highest quality of health care; it should also contribute to the nurse’s and midwife’s personal development (An Bord Altranais 1997c).

Continuing education is defined by An Bord Altranais as “a lifelong professional development process which takes place after the completion of the pre-registration nurse education programme. It consists of planned learning experiences which are designed to augment the knowledge, skills and attitudes of registered nurses [and midwives]” for the enhancement of nursing [and midwifery] practice, patient/client care, education, administration and research” (An Bord Altranais 1994c, p.xi). The Commission on Nursing (1998, p.100) formally adopted this definition.

Nurses, according to Benner, pass through five levels of skill performance in clinical practice. These are characterised as: novice practice, advanced beginner practice, competent practice, proficient practice and expert practice. Experience is seen as the critical element in the progression of a nurse through the levels of practice. Benner’s theory reflects the progression of nursing practice and recognises the concept, not unique to nursing that there are different levels of practice, based on experience and education. Benner stresses that staff development programs need to promote clinical knowledge development so that each nurse learns from clinical experience. She suggests the importance of diverse approaches to skills acquisition (Benner 1984).

4.5.2 Report of the Commission on Nursing and continuing professional development

The Commission on Nursing saw the need to develop and strengthen the availability of professional development for all nurses and midwives and suggested that it might be helpful to consider professional development under the following three broad headings (Commission on Nursing 1998):

• In-service training - which might, for example, consist of education on occupational health issues and work orientation programmes

• Continuing education - which might consist of education on developments in nursing and the treatment of patient groups; and

• Specialist training - which would consist of dedicated educational programmes and experience, supporting a nurse seeking to practice at an advanced level.

Education for specialist and advanced practice will be the responsibility of the National Council for the Professional Development of Nursing and Midwifery. The Council was established via statutory instrument (S.I. No. 376 of 1999) and held its first meeting in January 2000.

The functions of the council include:

• To monitor the on-going development of nursing and midwifery specialties, taking into account, changes in practice and service need

• To formulate guidelines for the creation of specialist nursing and midwifery posts by health service providers

• To support additional developments in continuing nurse education by health boards and voluntary organisations.

The commission envisaged that the National Council would approve courses to ensure accessibility, a geographic spread in the provision of specialist courses, as well as maximise the use of educational resources. The National Council would also develop a comprehensive database in relation to the provision of specialist post-registration nursing and midwifery education. It would also determine the appropriate level of qualification and experience for entry into specialty practice.

In-service education and continuing education will remain of paramount importance to nurses’ and midwives’ scope of practice.
The Commission on Nursing envisaged that part of the role of the Nursing and Midwifery Planning and Development Units would include overseeing the provision of continuing nursing and midwifery education for the health board area. Such provision could range from running day seminars within individual institutions, to supporting nurses and midwives to undertake specialist education on courses accredited by the National Council. The Nursing and Midwifery Planning and Development Units are to submit development plans to the National Council when applying for additional development funding to support continuing nursing and midwifery education (Commission on Nursing 1998, p.101).

In order to support their scope of practice nurses and midwives will have to embrace a variety of methods of professional development, both formal and informal. Methods that are both innovative and flexible should be encouraged and embraced in order that nurses and midwives are enabled to prepare for practice. Examples of systems that would support professional practice include reflection on practice, journal clubs, case-conferencing, clinical supervision, learning sets, preceptorship, mentorship, workshops, distance learning, accessing and sourcing information.

4.5.3 Supervision and clinical supervision

Much has been written in the literature regarding clinical supervision as a means of developing professional practice. Nurses and midwives mentioned clinical supervision frequently throughout the consultation process, and there was evidence of confusion and ambiguity regarding the term and concept (An Bord Altranais 1999a). As such it warrants further consideration.

It was apparent throughout the consultation process that the use of the term supervision was problematic in the Irish context (An Bord Altranais 1999a). The boundaries between managerial supervision and clinical supervision are often blurred, and there is evidence of confusion between the two processes among practitioners, together with a concern that the promotion of personal and professional development which is central to clinical supervision could become a form of surveillance associated with management (Yegdich 1999). It is clear that while the introduction of clinical supervision must be supported and facilitated by management, it needs to be differentiated from managerial supervision. In commenting on the relationship between managerial and clinical supervision, Yegdich (1999) asserts:

"Clinical supervision can only function on a foundation of managerial supervision, staff welfare and support, and education. It is achieved by the fact that managerial supervision already occurs, a fact that nurses should take for granted. Clinical supervision should be considered a particular form of clinical teaching within a supportive relationship used for the specific purpose of learning therapeutic skills. It is concerned with and limited to professional development that subsumes pre-existing accountability and autonomy which managerial protocols, policies and agreed professional standards and codes of conduct determine. It is limited to an isolated area of experience-professional life? (p.1201).

Clinical supervision has been defined as: "an exchange between practising professionals to enable the development of professional skills" (Butterworth and Faugier 1992, p.12).

Much debate is evident in the literature regarding the role of clinical supervision as a support for practice. While anecdotal evidence would indicate that nurses and midwives find clinical supervision, when it is provided, useful as a means of reflecting on their practice and an important component of their professional development and beneficial to patient care, there has been little or no empirical evidence to indicate its effects on patient outcomes.

A range of benefits have been ascribed to clinical supervision in the literature, however the research into these has been scanty. Evaluative research has tended to focus on outcomes for practitioners rather than for patients (Cutliffe and Burns 1998). A large scale study commissioned by the UK Department of Health found that levels of emotional exhaustion and depersonalisation increased among staff when they were not involved in clinical supervision but that these stabilised and in some cases reduced when clinical supervision was introduced (Butterworth et al 1997). This study found that the primary areas addressed during clinical supervision and mentorship were organisational and management issues, clinical casework, professional development, educational support, confidence building, interpersonal problems and personal matters. The authors concluded that:

"There is ample evidence from this research that clinical supervision and mentorship provides that much needed opportunity for reflection on practice, advancement of skills and that it provides a vital vehicle for support and development. Clinical supervision and mentorship is seen as supportive and developmental by an overwhelming number of participants in this study" (p.28).

Another large scale study (Bishop 1998), which outlined clinical supervision activity within NHS trusts in England, found that the following benefits were perceived to be gained by the introduction of clinical supervision within organisations:

- Reflection on practice/staff confidence
- Support and valuing of staff
- Improved clinical practice/competence
- Enhanced service provision
- Personal and professional growth
- Happier staff/improved morale
- Reduced risk to staff and patients
- Increased staff motivation/commitment
- Potential to assist with staff recruitment and retention
- Reduction in sickness rates
- Improved and increased communication
- Reduced stress level.

This study highlighted the importance of training for those being supervised in order that maximum benefit could be obtained from clinical supervision, and of training and ongoing support for supervisors. It was identified in the study that although a large proportion of managers planned that there should be protected time for nurses to engage in clinical supervision, this was not always achieved due largely to resource difficulties. The findings of the study suggest that centres, which had a dedicated co-ordinator, had a more comprehensive implementation strategy for clinical supervision.
Although there is scope for further research into the effectiveness of clinical supervision as a means of developing clinical practice and clinical practitioners, and improving patient outcomes, the evidence that exists suggests that it is a useful means of improving the job satisfaction of staff and provides them with a means of reflection on practice, which can benefit patient care.

4.5.4 The supervision of midwives

The supervision of midwives warrants particular mention as there is legislation governing the supervision of midwives practicing independently. The Nurses Act (1985) states:

“Where a midwife, who is not employed by a health board, or by a hospital authority providing maternity services or by a maternity home authority, is practising or proposes to practice midwifery, he shall notify the health board, or health boards, as the case may be, in whose functional area he practices or intends practising of such practice or proposal to practice (Section 57:1).

It shall be the duty of a health board in whose functional area a midwife of the type referred to in subsection (1) of this section is practising or proposes to practice to exercise, in accordance with regulations made by the Minister, general supervision and control over such midwife” (Section 57:2).

Currently within the health boards superintendent public health nurses exercise the supervisory function in relation to independent midwives but the evidence suggests that this appears not to incorporate clinical support and is more aligned to managerial supervision (An Bord Altranais 1999a).

In the UK the Nurses, Midwives and Health Visitors Act (1997) makes provision for the supervision of all practising midwives by local supervising authorities (health authorities, health boards etc.). A supervisor is appointed by the local supervising authority who should be a practicing midwife (UKCC 1998). This supervisor of midwives would appear to have both a managerial and clinical supervisory role.

During the consultation process, midwives generally expressed a need for systems that would enable them to develop professionally. It is clear that there is a need for clinical support for practising midwives, particularly those practising independently in isolated settings. What form this support should take and on what basis it should be provided are issues that warrant further debate. Both independent midwives and superintendent public health nurses are dissatisfied with the supervision arrangements that exist. There is also a concern that supervision, which is statutory in nature and linked to a management function, may not be conducive to the open and frank communication that is necessary for clinical support. Consideration of the types of supervision necessary for midwives in both hospital and community settings is needed.

4.5.5 Conclusion

Continuing professional development following registration is essential for nurses and midwives in order that they can acquire new knowledge and competence that will enable them to practice effectively in an ever-changing health care system. The nurse or midwife has responsibility to develop himself or herself as a professional.

Health care organisations have a responsibility to assess the professional development needs of their staff and to provide appropriate support for staff to practice to high standards in the interests of quality patient/client care.

Consideration of the types of supervision necessary for midwives in both hospital and community settings is needed.

4.6 Support for Professional Nursing and Midwifery Practice

It is recognised that in order for nurses and midwives to practice competently and to realise their potential in the interests of quality patient/client care, certain supports may need to be in place. The Scope of Nursing and Midwifery Practice Framework will be a major source of support for all nurses and midwives in determining both the overall scope of practice of the professions and the range of individual roles and responsibilities. There are however additional supports that warrant consideration.

4.6.1 Managerial support

The support of managers for nurses in expanding their practice is of paramount importance (Wilson 1996). Nurse and midwife managers need to ensure that there are systems in place that will provide support for nurses and midwives in determining and expanding their scope of practice. This support may vary from organisation to organisation depending on need and resources available and should be determined collaboratively between all concerned parties.

4.6.2 Policies, guidelines, protocols

A vast amount of literature has amassed in the wake of publication of scope of practice frameworks internationally. Although most of it is descriptive in nature, providing opinions or describing local initiatives, it is apparent that in situations where expansion of practice has been most successful, certain supports have been present and are considered essential. These include guidelines, policies or protocols that have been developed collaboratively with practising nurses and midwives with reference to legislation and research based literature where this is available (Castledine 1993, Wilson 1996, Land et al 1996, Naish 1997, UKCC 1997). The importance of local guidance and support was given high priority by nurses and midwives in Ireland during the consultation process (An Bord Altranais 1999a).

4.6.3 Review of legislation

In order to ensure that nursing and midwifery practice is responsive to changes in healthcare need, the legislation governing practice needs to support such changes. There are many statutes that influence nursing and midwifery practice. In particular it is evident that changes in legislation need to be made to support the introduction of nurse and midwife prescribing of medical preparations in appropriate circumstances.

4.6.3.1 Nurse and midwife prescribing of medical preparations

The issue of nurse and midwife prescribing has been raised both nationally and internationally. Many nurses and midwives feel that empowering them to prescribe in appropriate circumstances would reduce fragmentation of care and increase continuity of care, thus improving the quality of care.

There have been developments internationally in relation to nurse/midwife prescribing which are of interest. The inability of nurses and midwives to prescribe a limited range of medications has been described as inhibiting the delivery of safe, accessible, cost-effective and quality care (Biester and Collins 1991). Studies that have
evaluated nurse prescribing have indicated that nurses have the ability to prescribe appropriately (Rosneaur et al. 1984, Feeney Mahoney 1994, Cox et al. 1995).

In 1989 the Crown Report (Department of Health (UK) 1989) examined the practicalities of nurse prescribing in the UK. The report recommended that certain groups of nurses working in the community be authorised to prescribe from a limited list of products and to supply medicines, or vary their timing and dosage within agreed protocols. The report put forward proposals for the introduction of nurse prescribing and suggested a timetable for the necessary education and training of nurses and the legislative changes required. Legislation was enacted to make provision with respect to medicinal products prescribed or otherwise ordered by registered nurses, midwives and health visitors. Implementation was carried out in eight demonstration sites in England (Jones and Gough 1997). A further review of prescribing, supply and administration of medicines was established in March 1997. The Secretary of State announced in April 1998 plans to implement nationally the current prescribing scheme in England (Department of Health (UK) 1999). Following a review of nurse prescribing it was concluded that where nurse prescribing had been introduced it was readily accepted by both patients and other professionals (Luker et al. 1997).

Almost all of the American State Boards have regulations to govern three types of advanced practice registered nurses. Each state regulates prescriptive authority for advanced practice registered nurses. In some states prescriptive authority is automatically granted to advanced practice registered practitioners; others require application for prescriptive authority or apply restriction to the prescriptive authority. Each state outlines the level of prescriptive authority and prescription of controlled substances (NCSBN Inc. 1997).

Until recently the issue of nurse prescribing in New Zealand was unresolved (Ministry of Health 1998). The Minister of Health has indicated support for extending prescribing rights to nurses (and other health professionals) under certain conditions. The Minister has also asked the Ministry of Health to begin work on the introduction of limited prescribing rights to nurses working in two particular scopes of practice: child/family health and aged care.

Following review of international trends and consideration of the circumstances in which Irish nurses and midwives practice consideration needs to be given to the establishment of pilot sites to initiate and evaluate nurse and midwife prescribing of prescription-only medications and non-prescription medications in appropriate circumstances. This will necessitate review of current legislation and guidelines governing medication prescription and definition of appropriate circumstances, educational preparation, policy formation and record keeping necessary to ensure best practice.

### 4.6.4 Conclusion

Expansion of practice must only be made with due consideration of legislation, national policy, local policy and guidelines. If necessary at local level appropriate policies/protocols and guidelines should be devised.

The support of managers for nurses and midwives in their determination, review and expansion of practice is of paramount importance.

Consideration needs to be given to the establishment of pilot sites to initiate and evaluate nurse and midwife prescribing of prescription-only medications and non-prescription medications in appropriate circumstances.

### 4.7 Delegation

#### 4.7.1 The nature of delegation

The National Council of State Boards of Nursing define delegation as: “transferring to a competent individual the authority to perform a selected nursing task in a selected situation” (NCSBN Inc. 1995). The Queensland Nursing Council refers to delegation, as the conferring of authority to perform activities on a person whose role does not normally encompass them (QNC 1998).

Delegation should not be confused with assigning a task or role to another. When assigning a task to a colleague a nurse or midwife is asking this colleague to do something that is normally within their responsibility. Delegation on the other hand is giving another a task that is normally within the responsibility of the delegator (Neuman 1989). Thomas and Hume (1998) highlight lack of preparation in undergraduate programmes and Poteet (1984) cites lack of knowledge of the delegation process and fear of losing control as barriers to efficient and effective delegation.

#### 4.7.2 Decision-making and delegation

Conger (1999) states that the delegator should ask whether the task is within the educational preparation, the scope of practice and the job description of the person to whom it is being delegated, but goes on to state that delegation decisions cannot be made solely on the basis of the nature of the task. Each task must be considered in the light of the associated patient problem. Irish nurses concur, stating that each decision about delegation must be made based on the individual merits of the situation and the people involved (An Bord Altranais 1999a). The National Council of State Boards of Nursing suggests that decisions related to delegation of nursing tasks must be based on the fundamental principle of protection of the health, safety and welfare of the public (NCSBN Inc. 1995). The Queensland Nursing Council cautions that if a nurse receives a delegated function beyond the current scope of practice of the nurse, the nurse will need to consider the appropriateness of this delegation. This consideration should include: review of the motivation for the delegation, consultation and planning, a process for education and assessment of competence of the delegated function and the lawfulness of the function (QNC 1998).

Poteet (1984) suggests that any task to be delegated must be identified in sufficient detail so that it can be described to the person to whom it is being delegated. If there are potential problems, these should also be described. Objectives and results expected should be agreed. Neumann (1989) states further that the lines of communication must be kept open and the delegator must be available to help and support the person to whom the task is delegated. He suggests that you cannot delegate safely unless you know each individual’s level of competence.

Communication of the delegated function involves ensuring clarity as to why the task or role is being delegated and clarification of the function itself. Reporting channels need to be identified and it is necessary to clarify who maintains responsibility and accountability.

Five rights of delegation are described: the right task, the right circumstance, the right person, the right directions or instructions
and the right supervision (Davidson and Scott 1999). The right task is one that is capable of being delegated for a specific patient. The right circumstances are the appropriate patient setting, available resources and other relevant factors. The right person ensures that the right person is delegating the right task to be performed by the right person. The right direction/communication relates to clear, concise description of the task, including its objective, limits and expectations. Right supervision ensures appropriate monitoring, evaluation, intervention as needed and feedback (NCSBN Inc. 1995).

4.7.3 Delegation and accountability

It is important to consider the issue of accountability in relation to delegation. Delegation is referred to in the Code of Professional Conduct (An Bord Altranais 1988b), which states that: “The nurse must not delegate to junior colleagues tasks and responsibilities beyond their skill and experience”… and … “The nurse must acknowledge any limitations of competence and refuse in such cases to accept delegated functions without first having received instruction in regard to those functions and having been assessed as competent.”

The delegator and the person receiving the delegated role or function have accountability for their actions. The delegator is accountable for ensuring that the delegated role/function is appropriate and that support and resources are available to the person to whom it is delegated. In delegating, the nurse must ensure appropriate assessment, planning, implementation and evaluation. The person to whom the role or function is delegated is accountable for carrying out the function appropriately and must inform the delegator if he/she is not competent to perform the function (NCSBN Inc. 1995).

4.7.4 Conclusion

Delegation is the transfer of authority by a nurse or midwife to another person to perform a particular role/function.

The nurse or midwife who is delegating (the delegator) is accountable for the decision to delegate. This means that the delegator is accountable for ensuring that the delegated function is appropriate and that support and resources are available to the person to whom it is being delegated.

The nurse or midwife (or other person) receiving the delegated role/function is accountable for carrying out the delegated role/function. This means that the accountability of the nurse or midwife, on acceptance of a delegated role/function is to carry out the role/function appropriately.
SECTION 5

The Scope of Nursing and Midwifery Practice Framework
This section outlines the scope of nursing and midwifery practice framework as developed by An Bord Altranais. The framework was developed following consideration of national and international developments in nursing and midwifery practice. The consultation process informed the framework with regard to the present scope of nursing and midwifery practice in Ireland. The historical evolution of nurses’ and midwives’ scope of practice both nationally and internationally and subsequent decision making with regard to scope of practice was examined. The framework was thus developed to guide and support nurses and midwives in their determination, review and expansion of their scope of practice. This guidance is provided in an enabling and flexible manner in order that nursing and midwifery practice can respond in an appropriate and timely manner to the healthcare needs of the population while protecting the public. Decisions about the scope of nursing and midwifery practice must always be made with the patient’s/client’s best interests foremost and in the interest of promoting and maintaining best quality health services for the population.

5.1 Introduction

An Bord Altranais is the statutory body responsible for the regulation of the practice of nursing and midwifery in Ireland. The general concern of An Bord Altranais is the promotion of high standards of education, training and professional conduct among nurses and midwives. The purpose of this document is to provide nurses and midwives with professional guidance and support on matters relating to clinical practice. It introduces a decision-making framework to assist nurses and midwives in making decisions about the scope of their clinical practice.

The term scope of practice refers to the range of roles, functions, responsibilities and activities, which a registered nurse or a registered midwife is educated, competent, and has the authority to perform. Scope of practice for nurses and midwives in Ireland is determined by legislation, EU directives, international developments, social policy, national and local guidelines, education and individual levels of competence.

This framework provides principles, which should be used to review, outline and expand the parameters of practice for nurses and midwives. The framework aims to support and promote best practice for all nurses and midwives which will ensure the protection of the public and the timely delivery of quality healthcare in Ireland. The healthcare services and the work trends of nurses and midwives are undergoing continuous change, driven by the demand for a consumer-responsive service that is cost-effective and responsive to the changing demographic and epidemiological profile of the Irish population. The role and scope of practice of nurses and midwives must respond to these changes in a dynamic way. For this reason, the framework provided in this document is enabling and aims to support nurses and midwives in determining their scope of practice and, in so doing, to practice with flexibility and innovation.

To date, changes in nursing and midwifery practice have been driven by a process of certification of extended roles. The emphasis has been on the mechanical addition of tasks to the nurse’s or the midwife’s role and the provision of certification of his/her ability to fulfil that role. This approach has been based on the notion that any task that goes beyond what is learned in pre-registration training requires official sanction by certification.

It is appropriate that nursing and midwifery practice should develop to meet the ever-changing needs of the population and the health service. An Bord Altranais considers that this should take place by an organic expansion of roles based on informed professional discretion and guided by certain fundamental principles, rather than by mechanical extension based on certification. Expansion encompasses becoming more competent, reflective practitioners, developing expertise and skills to meet patients’/clients’ needs in a holistic manner. Expansion may refer to a change in the overall scope of practice of the professions to include areas of practice that have not hitherto been within the remit of nurses and midwives. It may also refer to a change in the scope of practice of an individual nurse or midwife to include areas of practice that have not been within his/her scope of practice, but are within the overall scope of practice of the nursing or midwifery professions.

Decisions about a nurse’s and a midwife’s scope of practice are complex and involve consideration of a number of important determining factors. These include the core definitions and values that underpin nursing and midwifery practice, the levels of competence, the channels of accountability and the supports and resources available. Individual nurses and midwives are responsible and accountable for making decisions about their own scope of practice. Nursing and midwifery managers, in planning, delivering and evaluating nursing and midwifery care services, are also responsible and accountable for making judgements about the overall scope of practice of nurses and midwives. In formulating the decision-making framework, all of these factors have been taken into account and are considered in the following sections.

Section 2, provides a definition of nursing practice and an outline of the values that should underpin nursing practice.

Section 3, focuses on the distinct identity of midwifery and provides a definition of the scope of midwifery practice and an outline of the values that should underpin midwifery practice.
In Section 4, the key determining factors that must be taken into account in deciding on the scope of practice of nursing and midwifery, are considered.

These include:

- Competence
- Accountability and Autonomy
- Continuing Professional Development
- Support for Professional Nursing and Midwifery Practice
- Delegation
- Emergency Situations.

Section 5, provides a summary of the principles that should guide individual nurses and midwives and nurse and midwife managers in determining scope of practice and provides a schematic outline of the decision-making framework that emerges from a consideration of these principles.

This Scope of Practice Framework has been produced to provide guidance and support to all nurses and midwives in determining their roles and responsibilities in relation to patient/client care. It should be considered in conjunction with the latest version of the Code of Professional Conduct for each Nurse and Midwife produced by An Bord Altranais and other guidance documents produced by An Bord from time to time.

5.2 Definition of the Scope of Nursing Practice

The scope of nursing practice in Ireland is the range of roles, functions, responsibilities and activities, which a registered nurse is educated, competent, and has authority to perform.

This definition of scope of nursing practice must be understood in the context of the following definition of nursing, which is based on the definitions provided by the World Health Organisation (WHO 1996) and the International Council of Nurses (ICN 1987):

“Nursing helps individuals, families and groups to determine and achieve their physical, mental and social potential, and to do so within the challenging context of the environment in which they live and work. The nurse requires competence to develop and perform functions that promote and maintain health [and comfort1] as well as prevent ill health. Nursing also includes the assessment, planning and giving of care during illness and rehabilitation, and encompasses the physical, mental [spiritual1] and social aspects of life as they affect health, illness, disability and dying.

Nursing promotes the active involvement of the individual and his or her family, friends, social group and community, as appropriate, in all aspects of health care, thus encouraging self-reliance and self-determination while promoting a healthy environment.

Nursing is both an art and a science. It requires the understanding and application of specific knowledge and skills, and it draws on knowledge and techniques derived from the humanities and the physical, social, medical and biological sciences.” (WHO 1996 p.4)

“Within the total health care environment, nurses share with other health professionals and those in other sectors of public service the function of planning, implementation and evaluation to ensure the adequacy of the health system.” (ICN 1987)

Nursing practice is underpinned by values that guide the way in which nursing care is delivered. An Bord Altranais considers that the following values should underpin nursing practice and provide the basis for the formulation of a philosophy of nursing:

1. In making decisions about an individual nurse’s scope of practice, the best interests of the patient/client and the importance of promoting and maintaining the highest standards of quality in the health services, should be foremost.
2. Nursing care should be delivered in a way that respects the uniqueness and dignity of each patient/client regardless of culture or religion.
3. Fundamental to nursing practice is the therapeutic relationship between the nurse and the patient/client that is based on trust, understanding, compassion, support and serves to empower the patient/client to make life choices.
4. Nursing practice involves advocacy for the individual patient/client and for his/her family. It also involves advocacy on behalf of nursing within the organisational and management structures within which it is delivered.
5. Nursing practice is based on the best available evidence.
6. Nursing practice should always be based on the principles of professional conduct as outlined in the latest version of the Code of Professional Conduct for each Nurse and Midwife produced by An Bord Altranais.

5.3 Definition of the Scope of Midwifery Practice

The scope of midwifery practice in Ireland is the range of roles, functions, responsibilities and activities which a registered midwife is educated, competent, and has authority to perform.

This definition of the scope of midwifery practice must be understood in the context of the EEC Directive on the activities of a midwife and the definition of a midwife as outlined by the WHO/ICM/FIGO (1992).

The scope of midwifery practice is outlined within the EEC Council Directive of 1980 (80/155/EEC). This directive, concerning the coordination of provisions laid down by law, regulation or administrative action in respect of the activities of midwives, outlines the minimum knowledge and clinical experience necessary for midwifery and outlines the activities that midwives are entitled to take up and pursue. It states:

“Member States shall ensure that midwives are at least entitled to take up and pursue the following activities:

1. to provide sound family planning information and advice;
2. to diagnose pregnancies and monitor normal pregnancies; to carry out the examinations necessary for the monitoring of the development of normal pregnancies;
3. to prescribe or advise on the examinations necessary for the earliest possible diagnosis of pregnancies at risk;
4. to provide a programme of parenthood preparation and a complete preparation for childbirth including advice on hygiene and nutrition;
5. to care for and assist the mother during labour and to monitor the condition of the foetus in utero by the

"Words in [ ] are not part of the original quote.
5.4 Important Considerations in Determining the Scope of Nursing and Midwifery Practice

5.4.1 Competence

Competence is the ability of the registered nurse or registered midwife to practice safely and effectively fulfilling his/her professional responsibility within his/her scope of practice. In determining his/her scope of practice, the nurse or midwife must make a judgement as to whether he/she is competent to carry out a particular role or function. He/she must also take measures to develop and maintain the competence necessary for professional practice. To be competent, it is not enough to be able to fulfill a specific role or function or even to be able to practice at a specific level of skill. A competent professional nurse or midwife possesses many attributes. These include practical and technical skills, communication and interpersonal skills, organisational and managerial skills, the ability to practice safely and effectively utilising evidence, the ability to adopt a problem solving approach to care utilising critical thinking, the ability to perform as part of a multidisciplinary team demonstrating a professional attitude, accepting responsibility and being accountable for one’s practice.

Competence is not static. One may learn a specific skill, but the knowledge underpinning that skill may change over time. This can affect the ability to practice the skill. In addition practice is affected by critical thinking, the ability to perform as part of a multidisciplinary team demonstrating a professional attitude, accepting responsibility and being accountable for one’s practice.

5.4.2 Accountability and Autonomy

Accountability is “the fulfilment of a formal obligation to disclose to referent others the purposes, principles, procedures, relationships, results, income and expenditures for which one has authority” (Lewis and Batey 1982). This means being answerable for the decisions made in the course of one’s professional practice. In the course of his/her professional practice, a nurse or a midwife must be prepared to make explicit the rationale for decisions they make and to justify such decisions in the context of legislation.

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Footnotes:

1. The female gender is referred to in this definition of a midwife, it should be interpreted as referring to either gender.
2. Definition of competence as agreed by the Focus Group for the Assessment of Clinical Competence set up by An Bord Altranais January 2000.
professional standards and guidelines, evidence based practice and professional and ethical conduct.

Accountability is the cornerstone of professional nursing and midwifery practice. Nurses and midwives are accountable both legally and professionally for their practice. Nurses and midwives are accountable to the patient/client, the public, their regulatory body, their employer and any relevant supervisory authority. It should be noted that accountability applies to both actions and omissions.

Accountability cannot be achieved unless the nurse or midwife has autonomy to practice. Nurses are autonomous in the practice of nursing and midwives are autonomous in the practice of midwifery. This means that nurses and midwives have the freedom to make discretionary and binding decisions in accordance with their scope of practice and act on those decisions (Batey and Lewis 1982). Inherent in the fulfilment of an autonomous role is authority to practice. Authority is “the legitimate power to fulfill a responsibility” (Batey and Lewis 1982).

### 5.4.3 Continuing Professional Development

Continuing professional development encompasses experiences, activities and processes that contribute towards the development of a nurse or midwife as a healthcare professional. This means it is a lifelong process of learning, both structured and informal. Continuing education is a vital component of continuing professional development and takes place after the completion of the pre-registration education programme for nurses and midwives. It consists of planned learning experiences that are designed to augment the knowledge, skills and attitudes of a registered nurse or registered midwife, for the enhancement of nursing or midwifery practice, patient/client care, education, administration and research.

It is essential for each nurse and midwife to engage in continuing professional development following registration in order to acquire the new knowledge and competence which will enable him/her to practice effectively in an ever-changing health care environment.

Continuing professional development is required in order to maintain and enhance professional standards and to provide the highest quality of health care; it should also contribute to the nurse’s and midwife’s personal development.

The individual nurse and midwife has a responsibility to develop himself/herself as a professional. Health care organisations have a responsibility to assess the professional development needs of their staff and to provide appropriate support for staff to enable them to practice to high standards in the interests of quality patient/client care.

Examples of activities that might contribute to a nurse’s and a midwife’s professional development include formal education programmes, reflective practice, journal clubs, case-conferencing, clinical supervision, learning sets, preceptorship, mentorship, workshops, distance learning, accessing and sourcing information.

### 5.4.4 Support for Professional Nursing and Midwifery Practice

In order for nurses and midwives to practice competently and to realise their potential in the interests of quality patient/client care, certain supports need to be in place. These include local and national guidelines, policies and protocols that have been developed collaboratively with practicing nurses and midwives and with reference to legislation and research-based literature, where this is available. Nursing and midwifery managers need to ensure that there are systems in place that will provide support for nurses and midwives in determining and expanding their scope of practice.

#### 5.4.5 Delegation

Delegation is the transfer of authority by a nurse or midwife to another person to perform a particular role/function.

Each registered nurse and midwife is accountable for his/her own practice. The nurse or midwife who is delegating (the delegator) is accountable for the decision to delegate. This means that the delegator is accountable for ensuring that the delegated role/function is appropriate and that support and resources are available to the person to whom the role/function has been delegated. The nurse or midwife (or other person) to whom the particular role/function has been delegated is accountable for carrying out the delegated role/function in an appropriate manner.

When delegating a particular role/function, the nurse or midwife must take account of the following principles:

1. The nurse or midwife must ensure that the primary motivation for delegation is to serve the interests of the patient/client.
2. The nurse or midwife must ensure that the delegation is appropriate with reference to the definitions and philosophies of nursing or midwifery as appropriate.
3. The nurse or midwife must take the level of experience, competence, role and scope of practice of the person to whom the role/function is being delegated into account.
4. The nurse or midwife must not delegate to junior colleagues, tasks and responsibilities beyond their skill and experience.
5. The nurse or midwife must ensure appropriate assessment, planning, implementation and evaluation of the delegated role/function.
6. The nurse or midwife must communicate the role/function in a manner understandable to the person to whom it is being delegated.
7. The nurse or midwife must decide on the level of supervision and feedback necessary.

A nurse or midwife to whom a particular role/function has been delegated should take account of the following principles:

1. The nurse or midwife must consider if it is within their current scope of practice. If the delegated role/function is beyond the current scope of practice of the nurse or midwife, the nurse or midwife will need to consider the appropriateness of this delegation. In this circumstance the nurse or midwife must refer to the An Bord Altranais Scope of Practice Framework.
2. The nurse or midwife must acknowledge any limitations of competence.
3. The nurse or midwife must provide appropriate feedback to the delegator.

#### 5.4.6 Emergency Situations

Nothing in this document will be construed as preventing a nurse or midwife from taking appropriate action in the case of an emergency. The best interests of the patient/client must be served by appropriate nursing or midwifery intervention in emergency situations.
5.5 Principles for Determining Scope of Practice

The following principles are the basis for making decisions with regard to the scope of practice for an individual nurse/midwife:

1. The primary motivation for expansion of practice must be the best interest of patients/clients and the promotion and maintenance of the best quality health services for the population.

2. Expansion of practice must be made in the context of the definitions of nursing/midwifery and the values that underpin nursing/midwifery practice.

3. Expansion of practice must only be made with due consideration to legislation, national policy, local policy and guidelines. If necessary at local level appropriate policies/protocols and guidelines should be devised and appropriate supports put in place.

4. In determining his/her scope of practice the nurse/midwife must make a judgement as to whether he/she is competent to carry out the role/function.

5. The nurse/midwife must take measures to develop and maintain the competence necessary for professional practice. The nurse/midwife must acknowledge any limitations of competence.

6. Expansion of practice must be based on appropriate assessment, planning, communication and evaluation.

7. The nurse/midwife who is delegating a particular role/function (the delegator) is accountable for the decision to delegate. This means that the delegator is accountable for ensuring that the delegated role/function is appropriate and that support and resources are available to the person to whom it has been delegated. The nurse/midwife (or other person) receiving a delegated role/function is accountable for carrying out the delegated role/function. This means that the nurse/midwife (or other person), on acceptance of a delegated role/function, is accountable for the appropriate performance of that role/function.

8. The individual nurse/midwife is accountable for his/her practice. This means that he/she is accountable for decisions he/she makes in determining his/her scope of practice. This includes decisions to expand or not to expand his/her practice.

The following framework is provided to assist nurses and midwives in determining their scope of practice.
CONSIDER THE NURSING/MIDWIFERY ROLE/FUNCTION

Is there any legislation, national or local guidelines prohibiting this role/function?

- **NO**

  Will the practice maintain the best interests of the patient/client and promote and maintain best quality health services for the population?

  - **NO**
  
  - **YES**

  Does this role/function fit with the definitions and the values that underpin nursing/midwifery!

  - **NO**

  - **YES**

  Is there any legislation, national or local guidelines/policies relating to this role/function?

  - **NO**

  - **YES**

  Do local policies/guidelines/protocols or supports need to put in place?

  - **NO**

  - **YES**

  - **NO**

  Do you have the necessary competence to perform this role/function?

  - **NO**

  - **YES**

  Are you willing to accept accountability for this role/function?

  - **NO**

  - **YES**

  Proceed with role/function in accordance with local policies/guidelines.

- **UNSURE**

  Discuss with your manager/An Bord Altranais (ABA).

- **STOP**

  - **YES**

  - **NO**

  - **NO**

  - **NO**

  - **YES**

  - **NO**

  - **YES**

  - **NO**

  - **YES**

  - **NO**

  - **YES**

  - **NO**

  - **YES**

  - **NO**

  What are the implications?

  - Following consideration of and action on the implications return to the decision-making framework.

  - Consider what needs to happen to put in place these policies/ guidelines/protocols/supports. Discuss with your manager.

  - Policies/guidelines/protocols/supports in place.

  - Policies/guidelines/protocols/supports not in place.

  - It is not within your scope of practice. Discuss with your manager/ABA.

  - It is not within your scope of practice. If appropriate, consider what measures you need to take to develop and maintain competence.

  - You need to consider the reasons why you feel unable to accept accountability. Discuss with your manager/ABA.
SECTION 6
Decisions and Recommendations Arising from the Project and Implications for Nurses and Midwives
The *Scope of Nursing and Midwifery Practice Framework* has far reaching implications for nurses and midwives at all levels and in all settings of the health services.

An Bord Altranais is concerned that this framework and the principles that underpin it are understood by nurses and midwives. It is with this in mind that An Bord Altranais has planned a six month program to profile and introduce the *Scope of Nursing and Midwifery Practice Framework*. Details of this programme are provided in section 6.1 below. The role of An Bord Altranais in providing on-going professional guidance to the nursing and midwifery professions is considered in section 6.2. Necessary amendments to other guidance documents from An Bord Altranais are outlined in section 6.3. Decisions and recommendations relating to the initiation and evaluation of nurse and midwife prescribing are provided in section 6.4. Finally, in section 6.5 implications for nurses and midwives and nurse and midwife managers are considered.

### 6.1 Introduction and implementation of the Scope of Nursing and Midwifery Practice Framework

It is recognised that the framework represents a change for nurses and midwives and will require much reflection and consideration.

#### 6.1.1 Decisions

6.1.1.1 The  *Scope of Nursing and Midwifery Practice Framework* will be circulated to all nurses/midwives via An Bord Altranais Newsletter (Summer 2000).

6.1.1.2 A national conference will be hosted in September 2000 to profile the framework.

6.1.1.3 A team from An Bord Altranais will host a number of familiarisation and training sessions in locations throughout the country. The purpose of these sessions will be to ensure the appropriate and timely implementation of the *Scope of Nursing and Midwifery Practice Framework*.

The training sessions will:

- Review current scope of practice issues
- Review current methods of decision making for scope of practice issues
- Ensure understanding of scope of practice
- Ensure understanding of the newly-devised scope of practice framework
- Provide training scenarios within which to review scope of practice decisions.

#### 6.1.2 Recommendations

6.1.2.1 An Bord Altranais recommends that health care organisations nominate a nurse or midwife who will be the designated person for education, advice and support for staff in relation to the scope of nursing or midwifery practice. This person will attend the training sessions referred to in subsection (6.1.1.3) above.

This should not take away from individual and organisational responsibility in relation to scope of practice. This person should act as a resource for clinical, managerial, research and educational staff in interpreting the *Scope of Nursing and Midwifery Practice Framework*. Directors of nursing and midwifery, chief nursing officers, directors of public health nursing and other senior nurse and midwife managers nationally, should nominate these facilitators. The training sessions will provide a training package, which will include the teaching and audio-visual material necessary for training on site.

The Nursing and Midwifery Planning and Development Units will have an important role in ensuring the timely and appropriate implementation of the *Scope of Nursing and Midwifery Practice Framework*.

### 6.2 Professional Guidance to Nurses and Midwives

An Bord Altranais will continue to provide guidance to the professions on issues relating to the scope of nursing and midwifery practice.

#### 6.2.1 Decisions

6.2.1.1 An Bord Altranais will respond to enquiries regarding scope of practice issues according to the principles of the *Scope of Nursing and Midwifery Practice Framework*.

6.2.1.2 An Bord Altranais will maintain a database of enquiries and responses given. This will aid the ongoing evaluation and review of the *Scope of Nursing and Midwifery Practice Framework*.

6.2.1.3 In line with the principles of the *Scope of Nursing and
6.3 Guidance Documents from An Bord Altranais

All professional guidance documents issued by An Bord Altranais will be in line with the principles of the Scope of Nursing and Midwifery Practice Framework. In order for nurses and midwives to respond to a developing health service and to provide seamless, quality care, certain amendments will be required to current An Bord Altranais guidelines. These include the:

- Code of Professional Conduct for each Nurse and Midwife
- Guidance to Nurses and Midwives on the Administration of Medical Preparations
- Guidelines for Midwives.

6.3.1 Decisions

6.3.1.1 The Code of Professional Conduct for each Nurse and Midwife (1988b) will be amended to provide for reference to the Scope of Nursing and Midwifery Practice Framework. The section which reads “The nurse must acknowledge any limitations of competence and refuse in such cases to accept delegated functions without first having received instruction in regard to those functions and having been assessed as competent” will be amended to reflect section 4.1 of the Scope of Nursing and Midwifery Practice Framework which describes competence.

6.3.1.2 The Guidance to Nurses and Midwives on the Administration of Medical Preparations (1998b) will be amended to reflect Section 10, the Administration of Intravenous Preparations, makes reference to certification and competence. This will be amended in light of the principles of the Scope of Nursing and Midwifery Practice Framework.

Section 12 (b), Epidural Analgesia, makes reference to certification and competence. This will be amended in light of the principles of the Scope of Nursing and Midwifery Practice Framework.

6.3.1.3 A project to review the Guidelines for Midwives (1994b) will be implemented, with particular reference to the following points:

- The guidelines should include more guidance for independent midwifery care
- The guidelines should provide guidance in relation to situations where a midwife is concerned about the type of care that the mother is requesting
- Section 6 needs to be reviewed, particularly in relation to (6.1) defining the term accessible and (6.4) clarification of emergency procedures
- Sections 13, 14 and 15 need to be revised to reflect the decision-making framework in the Scope of Nursing and Midwifery Practice Framework
- Consideration of the types of supervision necessary for midwives in both hospital and community settings.

6.4 Initiation and Evaluation of Nurse and Midwife Prescribing

6.4.1 Decisions

6.4.1.1 A project will be established to initiate and evaluate nurse and midwife prescribing in relation to both non-prescription medications and prescription-only medications. This will involve:

- A review of the Guidance to Nurses and Midwives on the Administration of Medical Preparations (An Bord Altranais, 1998b) in order that Section 5.2 (a) which states that: “Medical preparations shall be administered in accordance with the direction of a practitioner given in writing, usually in the form of a prescription, which may be in the case note(s)” is amended to allow for nurses and midwives to administer ‘non-prescription medications’ without reference to a medical practitioner in appropriate circumstances.
- Definition of appropriate circumstances, educational preparation, policy formulation and record keeping necessary to ensure best practice
- Establishment of pilot sites to initiate and evaluate nurse and midwife prescribing in appropriate circumstances.

6.4.2 Recommendations

6.4.2.1 An Bord Altranais recommends that a review of legislation be conducted with a view to allowing nurse and midwife prescribing of ‘prescription-only’ medications in appropriate circumstances.

6.5 Implications of the Scope of Nursing and Midwifery Practice Framework for Nurses and Midwives

The Scope of Nursing and Midwifery Practice Framework has far-reaching and important implications for the professions.

In defining nursing and midwifery in the Irish context, and outlining the principles for defining scope of practice, the Scope of Nursing and Midwifery Practice Framework provides nurses and midwives with a basis for the review of current scope of practice. This will assist in the identification of the professional development needs of nurses and midwives and serve as a basis for service evaluation and definition of roles.

The Scope of Nursing and Midwifery Practice Framework provides scope for the expansion of nursing and midwifery roles. As health care needs and knowledge and technology develop, this framework will guide nurses and midwives in independent decision making regarding changes in their scope of practice and facilitate them in developing new skills to meet patients’/clients’ needs.
The Scope of Nursing and Midwifery Practice Framework emphasises the individual accountability of nurses and midwives in making decisions about their roles and responsibilities. This warrants careful consideration by members of the nursing and midwifery professions both on an individual and a collective basis. In particular, the issue of defining competence in the practice setting will be a challenge to nurses and midwives engaged in practice, management, education and research.

The publication of the Scope of Nursing and Midwifery Practice Framework is only the beginning of this new and empowering phase in Irish nursing and midwifery. The document provides the framework, and its success will lie with the way in which nurses and midwives use its principles to move patient/client care forward.
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REFERENCES


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Thai Nursing Council (undated) Scope of Nursing and Midwifery Practice in Thailand. Bangkok: Thai Nursing Council.


for Education and Practice following Registration. London: UKCC.


World Health Organisation/International Confederation of Midwives/International Federation of Gynaecology and Obstetrics (1992) Definition of a Midwife. The definition of a midwife was adopted by the International Confederation of Midwives (ICM) International Federation of Gynaecology and Obstetrics (FIGO), in 1972 and 1973 respectively and later adopted by the World Health Organisation (WHO). This definition was amended by the ICM in 1990 and the amendment ratified by the FIGO and the WHO in 1991 and 1992 respectively.


APPENDIX I

Consultation Process
The consultation process, which informed this report took place between October 1998 and January 2000. It consisted of a call for written submissions, participative workshops, survey questionnaire and meetings with key stakeholders. The process and methods utilised, together with demographic details of those who participated are described in this appendix.

**Written Submissions**

Public submissions were called for based on the terms of reference of the project via advertisement in national newspapers, An Bord Altranais Newsletter and through personal communication with nurse and midwife managers and professional organisations. In total, 169 written submissions were received. Sixty per cent of the submissions were from more than one person, and many represented large groups or organisations. Content analysis of the submissions was performed.

A list of individuals, and groups who made submissions to the project is provided in Appendix 2.

**Workshops**

In total 55 workshops were held in 9 locations throughout the country. The locations and dates of the workshops were as follows:

- 15/04/99 Tullamore
- 21/04/99 Limerick
- 27/04/99 Galway
- 28/04/99 Sligo
- 06/06/99 Carrickmacross
- 12/05/99 Dublin
- 18/05/99 Dublin
- 25/05/99 Waterford
- 26/05/99 Cork

In order to provide the participants with the opportunity to participate fully and appropriately, they were offered a choice of workshop in line with their area of practice. The choices offered were:

- General
- Mental handicap
- Sick children
- Education
- Psychiatry
- Public health
- Midwifery
- Specialities
- Management

Where possible, applicants were allocated their first preference workshop. There were sufficient numbers of nurses working in care of the elderly practice settings in several locations to justify dedicated workshops. Where there were not enough applicants to justify a group, mixed groups were organised; these groups were facilitated in a way that sought to maximise contribution from the participants.

In all 801 nurses and midwives participated in the workshops. The following tables and figures provide an outline of:

- The number and type of workshops held (table 2)
- Areas of practice of nurses and midwives who attended workshops (figure 1) and
- Employment grades of nurses and midwives who attended the workshops (table 3).

**Table 2. Number and type of workshops held**

<table>
<thead>
<tr>
<th>Group title</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health</td>
<td>7</td>
</tr>
<tr>
<td>General</td>
<td>7</td>
</tr>
<tr>
<td>Management</td>
<td>6</td>
</tr>
<tr>
<td>Midwifery</td>
<td>6</td>
</tr>
<tr>
<td>Specialities</td>
<td>6</td>
</tr>
<tr>
<td>Care of the elderly</td>
<td>4</td>
</tr>
<tr>
<td>Education</td>
<td>3</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>2</td>
</tr>
<tr>
<td>Sick children</td>
<td>2</td>
</tr>
<tr>
<td>Mental handicap</td>
<td>2</td>
</tr>
<tr>
<td>Mental handicap &amp; psychiatry</td>
<td>5</td>
</tr>
<tr>
<td>General &amp; specialities</td>
<td>2</td>
</tr>
<tr>
<td>Specialities and public health</td>
<td>1</td>
</tr>
<tr>
<td>General &amp; mental handicap &amp; psychiatry</td>
<td>1</td>
</tr>
<tr>
<td>Education &amp; specialties</td>
<td>1</td>
</tr>
</tbody>
</table>

**Total** 55

**Figure 1. Areas of practice of nurses and midwives who attended workshops (n=801)**

- Mental handicap: 7%
- Public health: 15%
- Sick children: 6%
- Psychiatry: 8%
- General: 53%
- Other: 2%
Table 3. Employment grades of nurses and midwives who attended workshops

<table>
<thead>
<tr>
<th>Employment grade</th>
<th>Frequency (n = 801)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff nurse/midwife</td>
<td>233</td>
<td>29.1</td>
</tr>
<tr>
<td>Ward sister¹</td>
<td>179</td>
<td>22.3</td>
</tr>
<tr>
<td>Assistant director of nursing²</td>
<td>70</td>
<td>8.7</td>
</tr>
<tr>
<td>Tutor</td>
<td>69</td>
<td>8.6</td>
</tr>
<tr>
<td>Public health nurse</td>
<td>64</td>
<td>8.0</td>
</tr>
<tr>
<td>Director of nursing³</td>
<td>41</td>
<td>5.1</td>
</tr>
<tr>
<td>Postgraduate student</td>
<td>26</td>
<td>3.2</td>
</tr>
<tr>
<td>Principal tutor</td>
<td>16</td>
<td>2.0</td>
</tr>
<tr>
<td>Unit nursing officer</td>
<td>12</td>
<td>1.5</td>
</tr>
<tr>
<td>College lecturer</td>
<td>10</td>
<td>1.2</td>
</tr>
<tr>
<td>Clinical teacher</td>
<td>5</td>
<td>0.6</td>
</tr>
<tr>
<td>Community psychiatric nurse</td>
<td>3</td>
<td>0.4</td>
</tr>
<tr>
<td>Deputy matron</td>
<td>3</td>
<td>0.4</td>
</tr>
<tr>
<td>Other</td>
<td>21</td>
<td>2.6</td>
</tr>
<tr>
<td>Not given</td>
<td>49</td>
<td>6.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>801</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

¹This grade includes both junior and senior sisters and nursing officers, deputy nursing officers, unit heads and clinical placement co-ordinators.

²This grade includes assistant chief nursing officers, senior public health nurses and nursing practice development co-ordinators.

³This grade includes chief nursing officers and superintendent public health nurses.

Workshop methodology

The aim of the workshops was to gather information from nurses and midwives that would guide An Bord Altranais in its development of a scope of practice document for nurses and midwives.

The workshop objectives were:

- To outline current nursing and midwifery roles and functions as they pertain to scope of practice issues
- To explore the expansion of nurses’ and midwives’ roles
- To identify support mechanisms for nurses and midwives in relation to scope of practice issues.

The workshops were organised at a variety of times in an attempt to facilitate nurses’ and midwives’ shift patterns. The format was as follows.

Introduction to workshop (30 minutes)

The project team gave a welcoming address and some background to the project. Participants were then divided into appropriate workshop groups. Group size depended on numbers attending. Individual workshop groups were colour-coded. At registration participants received a name badge with a sticker indicating a colour corresponding to their workshop.

Group workshop (150 minutes)

Each group was allocated a designated facilitator and a designated writer. The workshops lasted approximately 2½ hours. A series of questions were set out on posters for use by the facilitator during the workshop. These questions were developed from the terms of reference for the project and based on information from the submissions, and were designed to assist the facilitator in focusing the discussion in the workshops. The writer took notes on the main points discussed. The last half-hour of the workshop was used to sum up what had been said during the workshop using the writers’ notes as a guide. When the group work was over the workshop facilitator summarised the workshop contents using a dictaphone.

The facilitators of the workshops were chosen from the division on the register that the workshop participants were representing. In preparation facilitators’ workshops were organised. These workshops gave a background to the project, outlined the workshop process and prepared the facilitator for the workshop.

The facilitator was asked to:

- Focus the discussion around the questions, but not to direct the participants to respond in a particular way
- Provide clarification of the questions for the participants
- Ensure that each participant had an opportunity to participate
- Create an atmosphere in which participants felt comfortable contributing.

Data Management

A number of randomly selected workshop participants were asked to verify the content of the transcripts of the summation from their workshop. Their reports were examined and concurred with the summation of the facilitators except on one minor point in one workshop and changes were made accordingly. Content analysis of the transcripts was carried out.

Questionnaire

A survey questionnaire was circulated to all nurses and midwives on the live register via An Bord Altranais Newsletter. The questionnaire was developed based on a review of the literature and data from the submissions and the workshops. The aim of the questionnaire was to ascertain nurses’ and midwives’ views on the scope of nursing and midwifery practice. In addition demographic data was sought in order to provide a profile of the respondents. A copy of the questionnaire is provided in Appendix 3.

A number of checks were performed to ensure the readability and validity of the questionnaire. Firstly the questionnaire was pre-tested with a panel of experts. Following the pre-test a pilot study was performed with 180 nurses and midwives (response rate 68%) representing the following groups:

- General nurses
- Psychiatric nurses
- Managers
- Public health nurses
- Sick children’s nurses
- Educationalists
- Mental handicap nurses
- Midwives
- Specialist nurses.

A number of alterations were made based on comments received. Final date for receipt of returned questionnaires was 30 June, 1999. A total of 3,719 questionnaires were returned by this date, representing a response rate of 8%. Data was analysed using
Statistics Package for Social Sciences (SPSS). The following tables and figures provide an outline of:

- Areas of practice of respondents to questionnaire (figure 2)
- Employment grades of respondents to questionnaire (table 4)
- Work settings of respondents to questionnaire (figure 3)
- Length of time qualified in current area of practice of respondents to questionnaire (figure 4)
- Main focus of work of respondents to questionnaire (figure 5).

**Figure 2. Areas of practice of respondents to questionnaire (n = 3719)**

**Table 4. Employment grades of respondents to questionnaire**

<table>
<thead>
<tr>
<th>Employment grade</th>
<th>Frequency (n = 3719)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff nurse/midwife</td>
<td>2169</td>
<td>58.3</td>
</tr>
<tr>
<td>Ward sister&lt;sup&gt;4&lt;/sup&gt;</td>
<td>495</td>
<td>13.3</td>
</tr>
<tr>
<td>Assistant director of nursing&lt;sup&gt;3&lt;/sup&gt;</td>
<td>97</td>
<td>2.6</td>
</tr>
<tr>
<td>Tutor</td>
<td>72</td>
<td>1.9</td>
</tr>
<tr>
<td>Public health nurse</td>
<td>243</td>
<td>6.5</td>
</tr>
<tr>
<td>Director of nursing&lt;sup&gt;6&lt;/sup&gt;</td>
<td>65</td>
<td>1.7</td>
</tr>
<tr>
<td>Postgraduate student</td>
<td>58</td>
<td>1.6</td>
</tr>
<tr>
<td>Principal tutor</td>
<td>16</td>
<td>0.4</td>
</tr>
<tr>
<td>Unit nursing officer</td>
<td>47</td>
<td>1.3</td>
</tr>
<tr>
<td>College lecturer</td>
<td>13</td>
<td>0.4</td>
</tr>
<tr>
<td>Clinical teacher</td>
<td>19</td>
<td>0.5</td>
</tr>
<tr>
<td>Community psychiatric nurse</td>
<td>45</td>
<td>1.2</td>
</tr>
<tr>
<td>Deputy matron</td>
<td>10</td>
<td>0.3</td>
</tr>
<tr>
<td>Unemployed</td>
<td>74</td>
<td>2.0</td>
</tr>
<tr>
<td>Other</td>
<td>283</td>
<td>7.6</td>
</tr>
<tr>
<td>Not given</td>
<td>13</td>
<td>0.4</td>
</tr>
<tr>
<td>Total</td>
<td>3719</td>
<td>100</td>
</tr>
</tbody>
</table>

<sup>4</sup>This grade includes both junior and senior sisters, theatre sisters and night sisters and nursing officers, deputy nursing officers, unit heads and clinical placement co-ordinators.

<sup>5</sup>This grade includes assistant chief nursing officers, senior public health nurses and nursing practice development co-ordinators.

<sup>6</sup>This grade includes chief nursing officers and superintendent public health nurses.

**Figure 3. Work settings of respondents to questionnaire (n=3719)**

**Figure 4. Length of time qualified in current area of practice of respondents to questionnaire (n=3719)**

**Figure 5. Main focus of respondents work.<sup>7</sup>**

<sup>7</sup>This adds up to more than 100% as a small minority of respondents identified more than one main focus of work.
**Focussed Meetings with Key Stakeholders**

Following analysis of the data from the first three phases of consultation it was decided to invite a number of groups to meet with the project team and members of the steering committee.

These groups represented:

1. Nurses or midwives from specialties or sub-specialties that were under-represented in the initial phases of consultation
2. Key representative groups of nurses and midwives
3. Representatives of other professions allied to nursing and midwifery.

In all, 37 groups were invited to meet with the team. The 24 groups met with are outlined below:

- Association of Irish Nurse Managers
- Association of Psychiatric Nurse Managers
- Community Psychiatric Nurses
- Federation of Irish Nursing Homes Ltd.
- Hospital Pharmacy Association of Ireland
- Independent Domiciliary Midwives
- Institute of Obstetricians and Gynaecologists.
- Irish College of General Practitioners
- Irish Practice Nurses Association
- Mental Handicap Nurses
- Midwives Association of Ireland
- Midwives Section, Irish Nurses Organisation
- Nurse Practitioner
- Nursing Policy Unit, Department of Health and Children
- Office for Health Gain
- Occupational Health Nurses
- Operating Department Nurses Section, Irish Nurses Organisation
- Pharmaceutical Society of Ireland
- Psychiatric Nurses Association
- Psychiatric Nurses, Cavan/Monaghan Area
- Sick Children’s Nurses
- SIPTU General Nursing Council
- Superintendent Public Health Nurses Group
- Tutor’s Section, Irish Nurses Organisation

Some of the groups that were invited to meetings elected to make a written submission rather than attend a meeting. Key issues from these meetings and submissions were transcribed and circulated to the steering committee. This data served to augment and validate the data from previous consultation phases.
APPENDIX 2

List of Individuals and Groups Who Made Submissions
APPENDIX 2

List of Individuals and Groups Who Made Submissions

1. Anonymous
2. Ms Rena Harford, Dublin 8
3. Mr Michael Shannon, Sligo General Hospital
4. Ms Veronica Gavin, Royal Victoria Eye and Ear Hospital, Dublin 2
5. Ms Breda Brady, Royal Victoria Eye and Ear Hospital, Dublin 2
6. Ms Joan McDermott, D’Alton Community Nursing Unit, Co. Mayo
7. Mr John Farrell, St Loman’s Hospital, Dublin 20
8. Ms Aine O’Meara Kearney, Co. Meath
9. Ms Mary Courtney, Mr Steve Cooper and nursing staff, Portiuncla Hospital, Co. Galway
10. Mr David Kieran, St Anne’s, Sean Ross Abbey, Co. Tipperary
11. Ms Mary Sheridan, Cavan General Hospital
12. Ms Catherine Killilea and nursing staff, Care of the Elderly Service and Young Chronic Sick Unit, St Finbarr’s Hospital, Cork
13. Professor Roger Watson and staff, School of Nursing, Dublin City University
14. Ms Siobhan O’Halloran and Ms Anne-Marie Ryan, Dublin 14
15. Ms Mary Clemenger, Co. Meath
16. Ms Tanya Grandon and staff, Leopardstown Park Hospital, Dublin 18
17. Ms Anne Flood, Ms Anne McHugh and Mr Patrick Murray, Letterkenny General Hospital, Co. Donegal
18. Ms Rena Kennedy, staff nurses and ward sisters, St Luke’s General Hospital, Kilkenny
19. Ms Sinead Hanafin, Co. Cork
20. Mr Joe Gallagher and senior nurse managers, Donegal Mental Health Services
21. Ms Anna Savino, Practice Nurse Section, Irish Nurses Organisation
22. Mr Christian Huet, Royal Victoria Eye and Ear Hospital, Dublin 2
23. Ms Margaret Boland, Dublin 3
24. Ms M. Costelloe, Galway
25. Ms Noreen O’Connor, Dublin 6W
26. Cork Branch of the Association of Irish Nurse Managers
27. Nurse Practice Development Group, Mercy Hospital, Cork
28. Nursing staff, St Vincent’s Centre, Lisnagry, Co. Limerick
29. Ms Nicola Clarke, Dublin 11
30. Ms Trina Nolan, University College Hospital, Galway
31. Ms Joan Ryan, Hospital of the Assumption, Co. Tipperary
32. Siobhan Lingwood and nursing staff, Bons Secours Hospital, Cork
33. Ms Honor Nicholl and practitioners of paediatric nursing, The Children’s Hospital, Temple Street, Dublin 1
34. Hospital Pharmacists Association of Ireland
35. Nursing staff, Skibbereen Community Hospital, Co. Cork
36. Nurse cognitive behavioural psychotherapists, North Western Health Board
37. Mr Joe Wolfe, St Patrick’s Kilkenny
38. Public Health Nurses, Central Sector, North Cork Community Care Area
40. Public Health Nurses, Ballincollig Health Centre, Cork
41. Nursing Staff, District Hospital, Carlow
42. Ms Siobhan O’Brien, Co. Cork
43. Senior Nurse Managers, South Eastern Health Board
44. Ms Joan O’Connor, Cork
45. Registered Nurses in Mental Handicap, Moore Abbey, Co. Kildare
46. Ms Maureen Woodnutt, Association of Radiology Nurses
47. Irish Diabetes Nurse Specialist Association
48. Ms Mary Kemple, Department of Nursing Studies, University College Dublin
49. Ms Liz Dunbar, The Children’s Hospital, Temple Street, Dublin 1
50. Sr Celestine, Co. Cork
51. Home Birth Association of Ireland
52. Ms Judith Chavassse, Co. Dublin
53. Irish Association for Nurses in Oncology
54. Ms Sheila O’Reilly, Cork
55. Ms Kay Sullivan, Cork
56. Ms Anne Morrissy, Cork
57. Ms Agnes Higgins and nursing staff, St Frances Hospice, Dublin 5
58. Directors of Nursing, Acute Elderly and Learning Disability Services, Midland Health Board and Moore Abbey, Monasterevin
59. Donegal Branch of the Institute of Community Health Nursing
60. Ms Rita O’Shea and nursing staff, The Children’s Hospital, Temple Street, Dublin 1
61. Staff midwives, Our Lady of Lourdes Hospital, Co. Louth
62. Ms Imelda Coughlin, Cork
63. Domiciliary Midwives of Ireland
64. Nurse teachers, School of Nursing, St Vincent’s Hospital, Dublin 4
65. Nurse tutors, College of Nursing, Mater Misericordiae Hospital, Dublin 7
66. Department of Nursing, University College Cork
67. Ms Marion Kiernan, Cavan General Hospital
68. National Rehabilitation Hospital, Co. Dublin
69. Ms Marion Heffernan and Ms Josephine Murphy, Abbeycourt House, Cork
70. Review group, St Mary’s, Co. Louth
71. Nurse tutors, School of Nursing, Beaumont Hospital, Dublin 9
72. Ms Gerardina Harnett-Collins, Kerry Community Care
73. Ms Mary Harty, Kerry Community Care
74. Ms Mary B. O’Sullivan, Kerry Community Care
75. Ms Terese Morely, Kerry Community Care
76. Ms Nuala O’Connor, Kerry Community Care
APPENDIX 2: LIST OF INDIVIDUALS AND GROUPS MAKING SUBMISSIONS

78. Ms Rosaleen Murnane, Mater Misericordiae Hospital, Dublin 7
79. Ms Marie Keane and divisional nurse managers, Beaumont Hospital, Dublin 9
80. Midwifery tutors, National Maternity Hospital, Dublin 2
81. Ms Paula Lane, Waterford
82. School of Nursing and Midwifery, University College Dublin
83. Ms Mary Duff and nursing staff, Our Lady of Lourdes Hospital, Co. Louth
84. Operating Department Nurses Section, Irish Nurses Organisation
85. Practice Development Group and Professional Nurses Forum, Our Lady’s Hospital, Co. Meath
86. Anonymous
87. Bachelor of Nursing Studies (Nursing Theory and Practice Access Module, 1998 class), School of Nursing and Midwifery, University College Dublin
88. Ms Deirdre Daly, Dublin 6W
89. Ms Carmel Buckley, Co. Cork
90. Ms Kathleen Ward, Pennsylvania, United States of America
91. Ms Orla O’Reilly and Ms Christine Hughes, St Louise’s School of Nursing, St Joseph’s Hospital, Dublin 15
92. Association of Irish Nurse Managers
93. Ms Catherine Guihan and nursing staff, Mater Misericordiae Hospital, Dublin 7
94. Ms Mary McHugh and Ms Kay Collins, University College Hospital, Galway
95. Irish College of General Practitioners
96. Nurse Education Centre, St Patrick’s Hospital, Dublin 8
97. Irish Nurses Organisation
98. Ms Anne Hayes, Our Lady’s Hospital, Dublin 6
99. School of Nursing, St James’s Hospital, Dublin 8
100. Nursing Practice Development Unit and nurses working in specialised areas, Waterford Regional Hospital
101. Matrons of the Elderly Care Services in the Mid-Western Health Board
102. Sisters of La Sagesse Services, Cregg House, Sligo
103. Nursing Staff, James Connolly Memorial Hospital, Dublin 15
104. Mr Alvin McEvoy, St Mary’s, Co. Louth
105. Ms Anne Carrigy and the Intravenous Drug Administration Committee, Mater Misericordiae Hospital, Dublin 7
106. Nurse Education Committee, Sligo General Hospital
107. Midwife Teachers, College of Midwifery, St Finbar’s Hospital, Cork
108. Midwives, Erinville Hospital and St Finbarr’s Hospital, Cork
109. Ms Mary P Higgins, Erinville Hospital, Cork
110. Clinical Placement Co-ordinators, Galway Regional Hospitals
111. Ms Fatima Abeton, Stress Awareness Centre, St Vincent’s Hospital, Dublin 3
112. Midwives Section, Irish Nurses Organisation
113. Midwife Teachers, Rotunda Hospital, Dublin 1
114. Public Health Nurses, Kerry Community Care
115. Ms Margaret Buckley and nursing staff, Cork University Hospital
116. Nurse Managers (Community Hospitals), North Western Health Board
117. Faculty of Nursing, Royal College of Surgeons in Ireland
118. Nurse Tutors, Nurse Education Centre, Bons Secours Hospital, Cork
119. Teaching Staff, Education Centre, St Conal’s Hospital, Co. Donegal
120. Association for Improvements in the Maternity Services
121. Nursing Staff, The Adelaide and Meath Hospital Dublin, Incorporating the National Children’s Hospital, Dublin 24
122. St Louise’s School of Nursing, St Joseph’s Hospital, Dublin 15
123. Ms Patricia O’Dwyer, Cork
124. The Union of Students in Ireland
125. Nursing Staff of the National Children’s Hospital, Dublin 24
126. Infection Control Nurses Association
127. Clinical Nurse Specialists, Regional General Hospital, Limerick
128. Ms Valerie Small, St James’s Hospital, Dublin 8
129. Ms Emily Logan and nursing staff, Our Lady’s Hospital for Sick Children, Dublin 12
130. Nursing Staff, St Vincent’s Hospital and Area 7 Psychiatric Services, Dublin 3
131. Nurse Tutors, St Vincent’s Centre, Lisnagry, Co. Limerick
132. Mr Malachy Feely, Co. Meath
133. North Eastern Branch of Institute of Community Health Nursing
134. Nursing Staff, St James’s Hospital, Dublin 8
135. Midwives Association of Ireland
136. Mr Andy Cochrane, The Children’s Hospital, Dublin 1
137. The Nursing Practice Development Co-ordinators Association
138. Learning Disability Services, Moore Abbey, Co. Kildare
139. Psychiatric Nursing Practice Development Co-ordinators
140. Irish Society of Chartered Physiotherapists
141. Mr Ray Sweeney, Dublin 9
142. Association of Psychiatric Nurse Managers
143. Nurse Education Committee, St Brigid’s Hospital, Co. Louth
144. Mr Colum Bracken, Central Mental Hospital, Dublin 14
145. Ms Caroline Conaty, Anchorage, United States of America
146. Ms Mary Walsh, Sligo General Hospital
147. Ms Nuala O’Connell, Dublin 18
148. Ms Susan Carlan, Daughters of Charity Services for the Mentally Handicapped, Dublin 7
149. Mr Michael Shasby, Department of Psychiatry of Old Age, Eastern Health Board
150. Ms Mary Mannix, Psychiatry of Old Age Service, St Camillus Hospital, Limerick
151. Community Psychiatric Nurses, Midland Health Board
152. Community General Nurses, Kerry
153. Anonymous
154. Anonymous
155. Higher Diploma in Public Health Nursing, Class of 1998–99, Department of Nursing, University College Cork
156. Ms Margaret Freeney, Brothers of Charity Service, Limerick
157. Staff Nurses of Tuas Nua and Tara House Mental Health Day Centres, Community Care Area 7, Dublin
158. Irish Nursing Research Interest Group
APPENDIX 2: LIST OF INDIVIDUALS AND GROUPS MAKING SUBMISSIONS

159. Psychiatric Nurses Association of Ireland
160. Ms Ann O’Kelly, Dublin
161. Mr. David Kiernan, St. Annes, Sean Ross Abbey, Roscrea, Co. Tipperary
162. Ms. Mary Dermody, Dublin
163. Education Committee of the Erinville and St. Finbarr’s Hospital
164. Ms Brenda Crowley, Bantry General Hospital, Cork
165. Midwifery Students, Southern Health Board, April 1998
166. Irish Patient’s Association Ltd., Dublin
167. Irish Association of Critical Care Nurses
168. Occupational Health Nurses Association of Ireland
169. Association of Occupational Therapists of Ireland
Review of Scope of Practice
Nursing and Midwifery

An Bord Altranais is currently undertaking a comprehensive review of the Scope of Nursing and Midwifery Practice. The aim of this questionnaire is to gather information from nurses and midwives to guide An Bord Altranais in its development of a scope of practice document.

We invite you to participate in this review by returning the attached questionnaire in the PRE-PAID envelope provided.

Please return to An Bord Altranais by 30/06/99

It is very important that we hear YOUR responses to this review so that YOU can contribute to the project.

INSTRUCTIONS FOR COMPLETING QUESTIONNAIRE

♦ This questionnaire is anonymous, please do not sign your name
♦ Please use a BLACK BALL POINT pen
♦ Please MARK YOUR CHOSEN OPTION CLEARLY with an X (For computer purposes)
♦ This questionnaire has PRE-SET OPTIONS ONLY
♦ We will not be able to cater for any answers that are not within the pre-set options

If there is additional information you would like to send us or if you have any queries please address these to:

Scope of Practice Office
An Bord Altranais
31/32 Fitzwilliam Square
Tel: 01 6760226
Fax: 01 6763348
Email: mfarrel@nursingboard.ie

For the purposes of this questionnaire
THE SCOPE OF NURSING AND MIDWIFERY PRACTICE could be considered as:
the range of responsibilities which fall to individual nurses and midwives
APPENDIX 3: QUESTIONNAIRE

1. What division(s) of the An Bord Altranais register are you registered on?
   (Please mark appropriate box(es))
   - RGN
   - RNT
   - RSCN
   - RM
   - RPN
   - RMNH
   - PHN

2. What is your current job grading?
   (Please mark ONE option only)
   - Staff Nurse/ Staff Midwife
   - Junior Ward Sister
   - Deputy Nursing Officer
   - Ward Sister
   - Theatre Sister
   - Night Sister
   - Clinical Instructor
   - Community Psychiatric Nurse
   - Nursing Officer
   - Public Health Nurse
   - Unit Nursing Officer
   - Assistant Director of Nursing
   - Senior Public Health Nurse
   - Assistant Chief Nursing Officer
   - Nurse/ Midwife Tutor
   - Principal Nurse/ Midwife Tutor
   - College Lecturer
   - Night Superintendent
   - Theatre Superintendent
   - Deputy Director of Nursing
   - Director of Nursing
   - Chief Nursing Officer
   - Superintendent Public Health Nurse
   - Full-time postgraduate Student (Go to Question 12)
   - Not currently employed (Go to Question 12)
   - Other

3. Which setting do you work in?
   - Hospital
   - Community
   - Hospital and Community
   - University
   - Other

4. Which of the following best describes your area of practice?
   - General
   - Psychiatry
   - Paediatrics
   - Midwifery
   - Mental Handicap
   - Public Health
   - Occupational Health
   - General Practice
   - Other

5. How long are you qualified in the area of practice in which you are currently working?
   - < 2 years
   - 2-5 years
   - 6-10 years
   - 11-15 years
   - 16-20 years
   - 21+ years

6. What is the primary focus of your work?
   - Clinical Practice
   - Management
   - Education
   - Research

If part or all of your work involves CLINICAL PRACTICE PLEASE complete QUESTIONS 7-17.
If the main focus of your work is in MANAGEMENT OR EDUCATION OR RESEARCH PLEASE turn the PAGE to complete QUESTIONS 12-17.
7. Does your practice encompass the following activities?
(May mark MORE THAN ONE option)

- [ ] Case-load management
- [ ] Nurse/Midwife-led clinics
- [ ] Health assessments
- [ ] Referral of patients to other health professionals
- [ ] Counselling
- [ ] Health promotion
- [ ] Health education
- [ ] Complementary therapies
- [ ] Ordering diagnostic tests
- [ ] Venepuncture
- [ ] Ultrasound scanning
- [ ] Administering chemotherapy
- [ ] Intubation
- [ ] Male catheterisation
- [ ] Suturing
- [ ] Defibrillation
- [ ] Cannulation
- [ ] Applying Plaster of Paris
- [ ] Removing Plaster of Paris
- [ ] Vaccination programmes
- [ ] Death verification
- [ ] Other
- [ ] None of the above

8. Has the scope of your practice changed since you qualified?

- [ ] Yes
- [ ] No
- [ ] Do not know

If YES please answer questions 9 to 17
If NO or DO NOT KNOW please turn the page to question 12

9. Do you feel adequately prepared for these scope of practice changes?
(Please mark ONE option only)

- [ ] Yes, all of the time
- [ ] Yes, some of the time
- [ ] No, not at all
- [ ] Unsure

10. What has led to these scope of practice changes?
(May mark MORE THAN ONE option)

- [ ] Service need
- [ ] Personal initiative
- [ ] Medical consultant request
- [ ] Improvement of quality of patient care
- [ ] Cost-effectiveness
- [ ] Public demand
- [ ] Patient needs
- [ ] Management request
- [ ] Continuity of care
- [ ] Introduction of new technology
- [ ] Introduction of new treatments
- [ ] Advances in nurse education
- [ ] Other
- [ ] Do not know

11. What has prepared you for these scope of practice changes?
(May mark MORE THAN ONE option)

- [ ] Post-graduate course
- [ ] Short study course
- [ ] Study day
- [ ] Self directed preparation
- [ ] Supervised clinical practice
- [ ] Management support
- [ ] Local protocols/guidelines/policies
- [ ] National protocols/guidelines/policies
- [ ] Clinical experience
- [ ] Competency assessment
- [ ] No preparation
- [ ] Other
- [ ] Do not know
12. Should nurses/midwives expand their scope of practice?

- [ ] Yes
- [ ] No
- [ ] Do not know

13. If nurses/midwives expand their scope of practice, what should lead this expansion?

(May mark MORE THAN ONE option)

- Individual nurse/midwife initiative
- Medical consultant request
- Improvement of quality of patient care
- Provision of holistic care
- Development of the profession
- Advances in nurse education
- Cost-effectiveness
- Public demand
- Patient needs
- Management request
- Continuity of care
- Service efficiency
- Service need
- New technology
- New treatments
- Other
- Do not know

14. If nurses/midwives expand their scope of practice, what support is needed?

(May mark MORE THAN ONE option)

- Education
- Supervised clinical practice
- Management Support
- Competency assessment
- Financial support
- Local protocols/guidelines/policies
- National protocols/guidelines/policies
- Self preparation
- Clinical supervision
- Performance review/appraisal
- Peer support
- No support
- Other
- Do not know

15. If nurses/midwives expand their scope of practice, who is accountable?

(May mark MORE THAN ONE option)

- The individual nurse or midwife
- An Bord Altranais
- Department of Health
- The line-manager
- The employing agency
- Other
- Do not know

16. What do you think are the existing barriers to the expansion of scope of nursing/midwifery practice?

(May mark MORE THAN ONE option)

- A general lack of understanding of the role of the nurse/midwife
- Inappropriate skill mix
- Non-nursing duties taking up time
- Lack of inter-professional support
- Lack of adequate staffing levels
- Lack of management support
- Lack of research skills
- Fear of making a mistake
- Fear of increased responsibility
- Lack of remuneration
- Rigidity of workplace practices and policies
- Fear of fragmentation of nursing/midwifery practice
- Inappropriate skill mix
- Lack of national policies, protocols and guidelines
- Lack of local policies, protocols and guidelines
- Poorly defined inter-professional role boundaries
- Lack of educational courses
- Fear of litigation
- Lack of confidence
- Lack of peer support
- Lack of knowledge
- Lack of clinical skills
- Lack of time
- Lack of resources
- Lack of motivation
- Fear of autonomy
- Fear of change
- Other

17. How does current legislation influence the scope of nursing/midwifery practice?

(May mark MORE THAN ONE option)

- Enables clinical practice
- Informs clinical practice
- Restricts clinical practice
- Do not know