Is the Scope of Practice endangered by lack of vision?

When The Scope of Professional Practice was published in 1992 it was hailed as one of the UKCC’s most influential documents, with the potential to revolutionise nursing by extending the boundaries of practice. Is the Scope being implemented as originally visualised – or is it going to fail because of a lack of vision and imagination?
cusses contractual obligations, and says that an employer can not only control what an employee – in this case the nurse – does, but also the manner in which it is done. Lunn maintains that even if nurses feel that certain duties are not within their capabilities, the employer may still have a right to order these to be carried out. She believes that it would be difficult for nurses to resist acquiring new skills providing they were given appropriate training, but that there is a duty on employers to provide such training for their employees. Wilson et al (1996) agree that training is the cornerstone for successful development of roles, but that responsibility for competence is the practitioner's.

**Vicarious liability** If a nurse has carried out care to an appropriate standard, and the role in which he or she is acting has been properly developed with adequate training and accepted by his or her employers, the employers are likely to accept vicarious liability in law for the nurse's actions (Lunn 1994, Marsden 1995). Vicarious liability is the employer's responsibility in law for any negligence or incompetence by the employee, who is considered to be acting on the employer's behalf. It is in the interest of employers – usually NHS trusts – to listen to nurses' concerns about their levels of competence. Employers have a duty to provide training, and could be considered negligent if they employ nurses who are not competent to perform the tasks in question (Lunn 1994). This legal framework does not answer the following questions:

- Who assesses competence and how?
- Is competence something for which the employer contractually asks, providing training is given?
- Or is it based entirely on the practitioner's own assessment?

**Protocols** To assess competence, a standard needs to be set. Brebner et al (1996) suggest that this can be done by providing suitable training and initiating formal protocols. They do not say what form this training might take, nor do they attempt to define 'suitable'. They elaborate on various protocols, describing them as formal agreements which are strictly adhered to in the form of 'step by step' procedures. They include a requirement to refer a patient back for medical opinion. They refer to various protocols, they do not know (Dimond 1995b) and it seems to believe so, is not sufficient (Gee 1995).

The inexperienced are not always aware of what they do not know (Dimond 1995b) and it seems possible for any nurse, not only the inexperienced, to believe that they are competent for all sorts of reasons when they are not.

**Accountability**

Once nurses have achieved competence, they are accountable for their own practice. However, as Denner (1995) points out, while traditional extended roles and ‘certification’ were abolished, the Scope did not say how practitioners are to prove they have had any training in performing these tasks, or how to demonstrate evidence of skills and ability. The Scope generally accepts that nurses are to assess themselves – Lunn (1994) and Redfern (1997) talk of nurses recognising their own level of competence. Wilson et al (1996) specify a number of assessment strategies but particularly include 'self assessment and reflective evaluation'.

**Problems of self-assessment** There are a number of dangers inherent in relying on self-assessment for setting the required standard. Nurses may believe themselves competent to do a task that they are not.

People behave in ways that are consistent with their beliefs, and these beliefs are influenced by how others perceive them (Gross 1987) – but believing that one is competent, because others seem to believe so, is not sufficient (Gee 1995).

The inexperienced are not always aware of what they do not know (Dimond 1995b) and it seems possible for any nurse, not only the inexperienced, to believe that they are competent for all sorts of reasons when they are not.

Assessment is used for both personal development and professional selection, so the overriding need for assessment for professional purposes leads to a token attitude towards self assessment (Purdy 1997).

Purdy (1997) says that student nurses' self assessment is influenced by perceived expectations of tutors, so the clinical context can give significantly different self assessments. Purdy asks if judgements of performance, skills and attitudes arrived at by self assessment can be validly generalised across different clinical contexts.

If Benner’s model (1984) is applied in a way such as that described by Nicol et al (1996), then each of the levels in Benner’s model (1984) is fairly well defined in terms of psychomotor and cognitive...
skills. Although Nicol et al (1996) defined a way of applying Benner’s levels of skills that would seem to be appropriate, they acknowledge that their work is particularly in relation to pre-registration learners. But the principles can be applied at any level, since the skills range through ‘competent’ and ‘proficient’ up to ‘expert’ level. Purdy’s (1997) work was also with pre-registration nurses, and again the principles could be generalised from pre- to post-registration nurses and education (although Purdy discusses the unequal power relationship characterised in teacher-student relations).

The definition of proficient or expert is related to the task in question, and to who is accepted as the ‘owner’ of the role. Tingle (1990) suggests that if this is a delegated medical task, the standard expected will be that of a reasonably competent doctor rather than a nurse. This leads into issues of role ownership and direction (Mitchinson 1996, Shepherd 1993) as well as standards expected in law.

**Problems**

**Who judges competence** Within The Code of Professional Conduct (UKCC 1992b), nurses are accountable for their actions, but the Code specifies that they only undertake tasks for which they are competent and confident. The Code has not specified exactly who judges competence other than the individual nurse, and more specifically how the level of competence is assessed.

**Lack of structure** While the Scope removed the need for certificates of competence, it has not replaced them. The current arrangement appears to be a very informal and unstructured system of peer and self assessment, which are difficult to authenticate and transfer.

This lack of structure may lead to a return to the practice of issuing certificates of competence. Castledine (1995) warns that there are indications of this among some NHS trusts, while Wilson et al (1996) suggest that some nurses want this to happen. Tolley (1994) believes that the removal of the need for certification by other professions, along with the responsibility for competent practice being the practitioners’ own, may ‘open the floodgates for unsafe practice’.

**Protecting the public** One of the accepted functions of assessment is to protect an innocent public (Nicklin and Kenworthy 1995). But the Scope may have unintentionally introduced a system that fails to do this. The inexperienced may not always be aware of their own limitations (Dimond 1995b) – the most dangerous people are those who do not know that they do not know.

**Conclusion**

Will contractual pressures force nurses to extend their roles into areas where they may not always feel confident and competent (Lunn 1994)? Or would trusts and unit managers like to return to some kind of certification (Castledine 1995, Wilson et al 1996)? If you work for a different employer or as a bank nurse, you may be told ‘you probably are not covered until you have been assessed’ (Covered by whom, and for what?). If employers do not accept self and peer assessment – whether for legal reasons, or because they lack application, will or imagination – the principles of the Scope will not be implemented.

‘Where there is no vision the people perish’ (Proverbs 29:18). Is the Scope of Professional Practice about to perish for lack of vision?

**REFERENCES**


Dimond B (1995a) UKCC’s standards for incorporation into contracts. British Journal of Nursing. 4, 18, 1045-1046.


McGregor RJ (1990) Advancing staff nurse competencies, from novice to expert. Journal of Nursing Staff Development. 6, 6, 2 87-290.


