The expanded role of the registered nurse: studying nurses’ perceptions

Expanded roles for nurses have developed in the UK over the past 25 years and are now commonplace in most clinical settings. However, considerable confusion and difference of opinion exist about the role and its implications for practice. Shelagh Leonard describes a study undertaken to ascertain how the registered nurses who carry out expanded role activities perceive their role.

OVER THE last 25 years, nurses have moved away from the rituals of nursing towards the implementation of research-based, holistic practice (Walsh and Ford 1992). There has also been a natural process of growth that has widened the extent of nursing responsibilities (Hunt and Wainwright 1994). Furthermore, the nursing profession has been developing its own theories and producing its own experts and autonomous practitioners (Brooking 1991, Lempp 1995). The result has been an expanding, evolving role for nurses, a process that looks set to continue.

The extent to which nurses’ roles have been expanded includes not only more frequently performed activities, such as the administration of intravenous drugs or venepuncture, but also such duties as stripping veins for cardiac surgery (Woodhead 1995), working as autonomous nurse practitioners (Devine 1995), and even substituting for junior medical staff in certain specialties (Dowling et al 1995, Griffiths 1997).

The geographical isolation of the Isle of Man means that a high degree of self-sufficiency is required. The opportunity for nurses to expand their role is great and includes unusual areas such as aviation nursing. This exacting role involves transferring patients to specialist centres in the UK and might involve a lengthy flight and subsequent ambulance journey. Therefore, the skill and expertise of a practitioner with an expanded portfolio of clinical skills is required.

Despite growing acceptance of, and familiarity with, expanded role activities, the issue remains confused both in clinical practice, when nurses show uncertainty over expanded role activities, and also in the growing correspondence on the issue in professional journals. These factors prompted the researcher to undertake a literature review to assess the potential for a major research project into the subject.

Literature review

Traditionally, every nurse who extended his or her role was required to undertake a period of education, supervised clinical practice and assessment before being issued with a certificate of competence. The UKCC, in its document The Scope of Professional Practice (1992), rejected the concepts of extended role and certification of competence stating that these limited, rather than extended, the parameters of practice. The Scope of Professional Practice places particular emphasis on knowledge, skill, responsibility and accountability, clearly defining the precepts that underpin any broadening of role (Box 1).

In addition, for registered nurses to benefit from employers’ vicarious liability, the duty must have been approved as one which is suitable to be delegated to them, and to which the employing authority agrees specifically (DHSS 1977, Dimond 1995).

Since 1977 when the way was paved for nurses to expand their role (DHSS 1977), nurses have disagreed on the principle of role expansion (Rowden 1987). Even the nurse theorists of the 1990s have failed to agree (Castledine 1996, Salvage 1995). Some see role expansion as a natural progression which can only benefit patients by the prompt delivery of consistently high quality nursing care (Alderman 1996), while others are concerned that vital aspects of nursing will be lost if nurses begin to undertake functions which were once considered to be the exclusive domain of doctors (Wright 1991).
Rapid advances in medicine, surgery and social services have led to pressure being exerted on nurses to do more. However, pressure for nurses to expand their role has not always been solely in the best interests of the patients. Some authors believe that nurses could, for example, be used to reduce the hours of employment of junior doctors (NHSME 1990).

Other changes in the NHS have enabled the nursing profession to appraise its current role in order to be able to respond to the complex health needs of society in the 1990s and into the 21st century. These have included education targets such as the introduction of national vocational qualifications (NVQs) for healthcare assistants (HCAs), an increased demand for nurse education to be widely available at both diploma and degree level (Hopkins 1996), and political targets such as the introduction of the NHS and Community Care Act (DHSS 1992), the Patient’s Charter (DoH 1991a), and the Health of the Nation (DoH 1991b).

Historically, any duties that were carried out by nurses but not covered in basic training for the UKCC Register, were considered to be extended roles (Rowden 1987). During the past 25 years, there has been much debate regarding definitions of extended and, latterly, expanded roles (Briggs 1972, Buckles 1990, DHSS 1977, Hughes 1996). Despite the publication of The Ministerial Group on Junior Doctors’ Hours (NHSME 1990), and Junior Doctors – The New Deal (NHSME 1991), expansion of nurses roles remained slow until The Scope of Professional Practice (UKCC 1992) was published. It was intended to clarify the situation regarding the expanded role and ensure that practice and education remained dynamic, sensitive, relevant and responsive to the changing needs of patients or clients. It emphasised nurses’ professional accountability and placed decisions about the boundaries of practice in the hands of individual practitioners (Carlisle 1992).

Some authors agree that, in principle, the concept of role expansion has its merits. Denner (1995) discussed the arguments for and against nurses taking on more medical tasks and noted the advantages were varied and included such factors as the ability to deliver high quality holistic care, increase patient satisfaction, reduce error, and reduce the frequency of intervention by other professionals. The disadvantages included a lack of clear direction regarding the role, a predisposition to neglect the nursing role, the exploitation of nurses as a cheap source of labour (nurses being paid less than doctors), and the subsequent reinforcement of the ‘handmaiden’ stereotype. Denner (1995) also considered that concentrating on certification detracts from the importance of holistic care and provides no guaranteed protection of the patient from a poor practitioner, or of the practitioner from poor teaching.

Overall, authors have welcomed the expanded role of the registered nurse, albeit with some reservations. However, any expansion should be driven by the needs of patients, not staff, mutual respect between professionals should prevail, and employers must agree that extension is desirable (Rowden 1987).

Although nurse theorists have written extensively on the question, little is available from practitioners themselves. However, useful insight can be gleaned from letters written to the nursing press. As with the nurse theorists and leaders, opinions appear to be split. Some authors call for a degree of separation between medicine and nursing (Nicholas 1996, Roberts 1995), while others extol the virtues of role expansion in the guise of advanced and specialist practice (Holyoke 1996, Jones 1996). Some appear to be disconcerted by the wealth of opinion currently available and are seeking further views on the subject (Chaffer 1996).

Significantly, most interest has been shown in the more widely accessible nursing journals, while the subject has received little coverage in the more academic journals. This suggests that the subject is currently of more practical than academic importance.

In addition to the debate about the expanded role, there are many directions in which nurses’ expanded roles could progress in the future. These might include nurse practitioner (Marsden 1995), advanced practitioner (UKCC 1990), specialist practitioner (UKCC 1994), nurse substitution (Dawling et al. 1995, Salvage 1995), and physicians’ assistants (Peyser 1996). Nurse academics are calling for increased collaboration between doctors and nurses (Brooking 1991) and there are even calls for a period of joint education for doctors and nurses (Leifer 1995) in order to create a new healthcare professional for the future.

Wright (1991) has, however, urged caution, warning that if nurses choose to accept an expansion of role into what was once considered the exclusive domain of doctors, it should only be when all parties are convinced that other aspects of nursing do not suffer as a consequence. This is a view held by both theorists (Castledine 1996, Hopkins 1996, Rowden 1987) and practitioners (Nicholas 1996, Roberts 1995). However, there still appears to be a large gap in the background and knowledge of this subject, particularly the belief and opinion of the practitioners themselves.

Box 1: Principles for adjusting the registered nurse’s scope of practice.

The proposed expansion of role must:

- Be directed towards meeting the needs and serving the best interests of the patient
- Not fragment existing care delivery
- Be undertaken only by registered nurses who possess sufficient skills and knowledge to undertake such duties safely

(UKCC 1992)
Research study
The aims of the research were to:

- Determine registered nurse understanding and perceptions of the existing role.
- Explore registered nurse belief about the concept of role expansion.
- Determine registered nurse perceptions of the benefits and detriments of role expansion on patients, practitioners and other healthcare professionals.
- Ascertain registered nurse perceptions of the implications for current and future practice.
- Ascertain registered nurse perceptions of any existing or potential problems associated with the nurses’ expanded role.

Method
A mixed method of self-administered questionnaires and face-to-face interviews was used on a volunteer convenience sample of 70 registered nurses working in an acute medical unit. The questionnaire ascertained practitioner perception of the role, role boundary and expanded role of the registered nurse, while the interviews explored the rationale behind the beliefs held.

The role of the manager in undertaking research in her or his own sphere of responsibility is not without its problems. Participants might, in the absence of a well-defined research strategy, perceive pressure or be pressured, into participating in a study. Additionally, if anonymity is not ensured, participants might feel compelled to give the responses they feel the researcher is expecting, rather than those they themselves consider to be correct, thus affecting the findings of the study.

Therefore, the researcher ensured participants’ anonymity (as well as that of those who chose not to participate) by using a self-administered questionnaire, completion of which was voluntary. Practitioners were also invited to participate in a follow-up face-to-face interview to explore the rationale for their belief. In this way the participants themselves were the ones to determine the amount of involvement they had in the study.

All registered nurses within the medical unit at the time of the study were invited to participate and all were given an individual pack with a copy of the questionnaire, a letter explaining the nature of, and necessity for, the study and a return envelope (pre-addressed to the researcher). In addition, instructions were contained in the event that practitioners wished to participate in the face-to-face interviews following completion of the questionnaires. A strict protocol was devised to ensure that in this circumstance, although the respondent’s identity would be known to the researcher, this knowledge would be protected and the respondent would not be identified by any information or detail contained within the interviews. Approval for the study was granted by the Island’s local research and ethics committee.

Results
Thirty of the 70 questionnaires (43 per cent) were returned. This is higher than the expected 25-30 per cent response rate (Burns and Grove 1995) and reflects practitioner interest in the subject. Of the 30 respondents, two came forward for the follow-up (face-to-face) interview phase of the study.

Role and boundary issues When asked their views about the registered nurses’ role, only 19 of the respondents (66 per cent) believed their role to be defined clearly. However, all respondents believed that boundaries to the role existed, defined mainly by UKCC guidelines and local policies. One individual, however, felt that others would be aware of role boundaries by some form of trial and error process, suggesting a degree of risk taking in clinical practice. Eight respondents (26 per cent) felt that other healthcare professionals were not aware of registered nurses’ role boundaries, and only two respondents (7 per cent) felt that the role boundaries were respected by other healthcare professionals. This was demonstrated when registered nurses were asked to practise outside their roles, and when other healthcare professionals disagreed with nurses, questioning their practice.

Twenty-two practitioners (93 per cent) felt that boundaries to the role should exist and that the existence of such boundaries would afford practitioners some degree of protection. The solution proposed most often by respondents was the formulation of clear, written guidelines within which all practitioners could practise.

Expanded role issues There was a level of agreement among practitioners that expanded role activities could be defined as ‘duties over and above those learnt in pre-registration education and for which further training was required.’

Twenty-six respondents (87 per cent) gave the example of administration of intravenous medication and 19 respondents (63 per cent) mentioned venepuncture, although aviation nursing was also cited by 12 respondents (40 per cent). Twenty-six practitioners (87 per cent) already undertook some expanded roles; those who did not were awaiting training. All respondents agreed that registered nurses should, in principle, undertake expanded role activities and cited a rationale which reflected an improvement in the holistic care received by the patients.

All respondents believed that the registered nurses’ expanded role held benefits for the patients, especially the delivery of safe, timely, holistic care. Twenty-eight respondents (93 per cent) felt that it held benefits for other healthcare professionals, citing doctors in particular. The reported benefits to other healthcare professionals included a decrease in their workload, an improvement in working relationships among professionals and an improvement in the delivery of multidisciplinary care.

Twenty-eight respondents (93 per cent) believed that the expanded role held benefits for nurses
they believe, into undertaking the role in the future. 

When considering implications for practice, 28 respondents (93 per cent) considered there to be implications for current practice. Of these, 16 (57 per cent) felt that the role was detrimental for nurses themselves and cited an increase in workload and pressure, a reduction in the available time to perform direct nursing care and an increase in responsibility. Only 11 respondents (37 per cent) perceived there to be any detriment to other healthcare professionals. However, detrimental effects reported included confusion regarding role, a reduction in patient contact and, ultimately, in clinical skills.

Discussion

Considerable dissatisfaction was demonstrated in the apparent confusion still existing in the minds of both nurses and other healthcare professionals regarding expanded role issues. In addition to the personal impact which such confusion might cause, it may also cause conflict and disharmony in the workplace and, potentially, cause practitioners to act outside the limitations of their competence, endangering patient safety. A degree of role clarification is, therefore, required.

Fears were expressed that nurses would be ‘taken away from the patients’, that their workload would increase too much, or that they would, in some way, be pressured or expected to take part in such activities. Respondents spoke in terms of ‘frustration and guilt’ at their inability to deal with the ever-increasing ‘burden’ of work. Despite this, they also expressed great optimism when discussing collaborative care arrangements and opportunities for developing a full team approach to patient care.

There was no acknowledgement that an increase in nurses’ expanded role activities provides opportunities for nurses themselves to review the activities in which they participate, delegating some activities to other members of the healthcare team, for example, healthcare assistants. Nurses, not other healthcare professionals, should be the ones to make decisions about nursing practice.

At times, respondents appeared to contradict themselves when discussing specific beliefs about expanded role activities. One belief was that participation increases promotion prospects; however, as seniority in nursing increases, clinical activity decreases in favour of an increased management commitment, thus any perceived advantage is negated. This may be overcome in the future with the emergence of the specialist practitioner. Despite any confusion and apparent concern regarding expanded role activities, an air of optimism prevails. Respondents can identify benefits of expanded roles in nursing for patients, nurses, other healthcare professionals and for the profession as a whole.

Conclusion

Respondents were not only clear and candid about their perceptions of the issues and the implications of an expanded role, they were also very forthright with their solutions for these perceived problems. The most commonly suggested solution was that of a set of clearly written, enforceable guidelines for practice which were agreed locally and would be available for all healthcare professionals. At first glance, this might seem to be in conflict with the UKCC position (UKCC 1992) in which the ‘principles for practice’ ensure that practice remains dynamic and flexible to meet changing care needs; however, rather than simply relying on ‘rule books’, practitioners are calling for the development of guidelines to act as parameters within which all healthcare professionals could work. This would, they feel, decrease the present
confusion and engender harmonious collabora-
tive working arrangements with other healthcare
professionals.
Guidelines are far less prescriptive than policies,
yet still afford inexperienced staff protection by
determining the parameters within which they
may practice safely. They provide staff with the
protection of the organisation’s vicarious liability,
as practitioners would in these circumstances be
able to demonstrate not only their clinical compe-
tence in undertaking certain roles, but also the
organisation’s acceptance that in so doing, the
practitioner is acting as an ‘agent’ of the organi-
sation – the so-called ‘master/servant’ relationship
in law (Dimond 1995).
Opinions differ in the continuing debate in the
nursing press as to whether national or local
guidelines would be the most appropriate to
address the situation (Legge 1997). There are
fears that national guidance would be unduly
restrictive to practice – the very situation which
initially prompted the UKCC to issue the Scope
of Professional Practice (1992) and, subsequently,
to commission an investigation into its impact
(UKCC 1997), with examples of innovation in
practice which have benefited patients and prac-
titioners. It is acknowledged that solutions which
suit the circumstances of the UK will not neces-
sarily suit the needs of the small community of
the Isle of Man. Local guidelines would acknowled-
g the unique situation of the Isle of Man and
provide solutions appropriate to its environment.
In addition to determining a set of local guide-
lines for practice, other recommendations have
been suggested. These include a need to deter-
mine and implement methods to increase under-
standing by all healthcare professionals of the
roles of differing members of the multidisciplinary
team, and the provision of education for those
staff, nurses and other healthcare professionals,
who do not understand their colleagues’ roles.
In addition to this type of educational event, a con-
tinuing programme of professional education for
nurses themselves is required, to ensure that prac-
titioners remain competent and prepared to
adapt to changes in both technology and care
delivery into the 21st century.
Finally, the climate is right in nursing for nurses
to undertake an evaluation of the role of nurses,
of the activities in which they participate, and also
of the numbers of staff working in wards/department
s together with their skills and grade mix. Any
such review should be undertaken by the
professionals best able to understand the impact
of a change in nursing services, that is, nurses
themselves.

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