National Review of the Scope of Nursing and Midwifery Practice Framework

Final Report

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on behalf of

The Nursing and Midwifery Board of Ireland
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GLOSSARY OF TERMS

**Code of Professional Conduct for each Nurse and Midwife**
The *Code of Professional Conduct for each Nurse and Midwife* is a document published by An Bord Altranais in 2000. The purpose of the Code is to provide a framework to assist the nurse to make professional decisions, to carry out his/her responsibilities and to promote high standards of professional conduct.

**Competence**
A complex and multidimensional phenomenon and is defined as the ability of the Registered Nurse to practise safely and effectively, fulfilling his/her professional responsibility within his/her scope of practice (ABA 2005)

**Decision-making Framework**
The Decision-Making Framework is the decision tree algorithm (or process) on page 11 of the *Scope of Practice Framework* document. It sets out a series of steps to be taken when making a decision the scope of one’s practice.

**Expanded Role**
A change in the role of an individual nurse or midwife to include areas of practice that have not previously been within his/her scope of practice, but are within the overall scope of practice of the nursing and midwifery professions

**The Framework**

**Professional role**
The function or position that an individual nurse or midwife holds.

**Project Steering Committee**: The Committee with responsibility for the governance and oversight of the pilot

**Project Team**
The Team of researchers commissioned by the Nursing and Midwifery Board to provide research and consultation activities for the review of the Scope of Nursing and Midwifery Practice

**Registrants**
Nurses and midwives whose names are entered on to the active register of nurses and midwives maintained by the Nursing and Midwifery Board of Ireland

**Scope of Practice**
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 Framework**
The *Scope of Practice Framework* is a document published by An Bord Altranais, which provides principles that 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 and thereby ensure the protection of the public and the timely delivery of quality healthcare.
EXECUTIVE SUMMARY

Introduction
Nurses and midwives in Ireland are knowledgeable and highly skilled resource in the Irish health system. Therefore a key challenge for the Irish health services is to ensure that the nursing and midwifery resource is deployed to optimal advantage, to ensure optimal health care delivery and to ensure that the valuable and costly resource is not underutilised or inappropriately utilised. It is partly for this reason that nurses and midwives need to be empowered to act within the full range of their scope of professional practice and to expand their scope of practice as and when patient and service needs dictate.

First published in 2000, the *Scope of Nursing and Midwifery Practice Framework* document provides a practical guide for nurses and midwives in decision making about their scope of practice (An Bord Altranais 2000a). The Framework document defines scope of nursing and midwifery practice, sets out principles for determining scope of practice and presents a decision-making algorithm with which practitioners may review and expand their professional practice.

Since it was first published, several developments have occurred in nursing and midwifery in Ireland; these include the advent of graduate-level entry to practice and considerable role expansion through clinical specialist and advanced practitioner grades, supported by expansion of continuing professional development opportunities. In addition, the Nurses’ and Midwives’ Act 2011 introduced the requirement for registered nurses and registered midwives to maintain professional competence on an on-going basis.

In light of these developments, the Nursing and Midwifery Board instituted a national review of the Scope of Practice Framework. This review involved several elements, including a review of other regulatory authorities’ frameworks, stakeholder consultation through a national survey and 28 qualitative data collection events, an analysis of the NMBI enquiries database and two case studies of expanded practice. The review was completed in spring 2014.

Background and context
The *Scope of Nursing and Midwifery Practice Framework* (An Bord Altranais 2000a) is designed to be an effective and rational mechanism for decision making by which Irish nurses and midwives and other healthcare professionals may evaluate and negotiate traditional role
boundaries. The framework promotes self-reliance among nurses and midwives in determining the boundaries and scope of their professional role (An Bord Altranais 2000a). It supports clinical judgement and decision making around factors such as competence, accountability and autonomy, and legislation and policy requirements. The Framework also supports the principle that role expansion must be in the context of the values of nursing and midwifery and be in the best interest of patients (An Bord Altranais 2000a). The Framework is predicated on the practitioner being familiar with legislation and guidelines that regulate and control practice and that may enable or prohibit role expansion.

The Framework fulfils several functions in guiding and supporting practitioners in relation to the scope and boundaries of their practice. It acts as a basis for independent decision making related to nurses’ and midwives’ everyday practice, it assists in the identification of nurses’ and midwives’ professional development needs and it provides a basis for the expansion of nursing and midwifery roles. As an enabling framework, it also emphasises nurses’ and midwives’ individual accountability in making decisions about their roles and responsibilities and is, therefore, a basis for practitioner empowerment (An Bord Altranais, 2000a).

Scope of professional practice is closely associated with notions of professional conduct, accountability and self-governance and expanded practice. Professional regulatory bodies for nurses and midwives in developed countries have issued policies and/or guiding frameworks that address scope of practice. The Scope of Nursing and Midwifery Practice Framework is one such framework, which offers practitioners a set of guiding principles with which to review and, where appropriate, expand the parameters of their practice, thereby promoting self-reliance among nurses and midwives in determining the boundaries of their professional practice (An Bord Altranais, 2000a).

**Design of the review**

The design of the review, including the overall review strategy and the data collection methods, was influenced by current thinking on evaluation theory and by the principles of partnership. The main elements of the Donabedian model (2005) were also adopted, which addressed structure, process and outcomes elements of the Framework and its use in the world of professional practice. The evaluation strategy was also based on a number of key operating principles, including consultation with key stakeholders; clarification of outcomes of the
evaluation with the stakeholders and the sponsor; discussion of the purpose of the evaluation and how the information will be used and the use of multiple methods to gather information.

The review strategy incorporated a mixed methods approach in which a combination of complementary quantitative and qualitative data collection methods was used; these included a national survey of registrants to examine variables related to self-reported scope of practice and use of the Framework, focus groups and interviews with key stakeholders, case studies of the Framework in use, analysis of in-situ documentary evidence retained by the Nursing and Midwifery Board of Ireland and a documentary review of the Scope of Practice Framework document.

**Research into scope of practice**

Empirical studies have tended to examine scope of practice from the perspective of practitioners, usually through self-reports of their practices and/or by eliciting their opinions and perceptions. The focus of empirical studies has been on the extent to which the nursing resource, including the range of nursing skills, is optimally utilised in practice and on the facilitators and barriers that nurses and midwives encounter when expanding their scope of practice. In empirical studies, nurses may describe their scope of practice with reference to key nursing roles, functions and actions, or in the case of expanded roles, through descriptions of technical competence in the performance of medically-delegated clinical tasks.

Scope of practice has also been studied from the perspective of expanded roles and functions and also more directly by measuring actual scope of practice through self-reports. The research literature on scope of practice points to enduring difficulties, including the difficulty of balancing practice restriction with practice expansion and the differences in defining scope of practice for both generic and specialist roles, coupled with environmental and client-specific contextual factors.

**Findings: Defining and regulating scope of practice**

Scope of practice is a concept that several professions use in the context of their professional regulation and sets out the procedures, actions and processes that are permitted for the individual who is registered or licenced to practice. The individual practitioner’s scope of practice is determined by a range of factors, including professional education and competence. These, in turn, give the practitioner authority to perform a particular role or task. Individual jurisdictions
have enacted laws, established regulatory authorities and published regulations that prescribe the requirements for training and education and guidelines that define scope of practice for the profession.

The competent statutory regulatory authority is responsible for defining the scope of practice of nurses and midwives, but the individual practitioner is also responsible to practice within the established norms and professional codes that attend to their professional role. The principle that the individual practitioner is self-regulating underpins scope of practice. Despite the benefits of expanded nursing and midwifery roles to both patients and health services, there is evidence that many nurses and midwives do not practise to the full extent of their education, training, and competence. This is, in part, related to barriers such as lack of opportunity and lack of clarity regarding professional roles and role boundaries.

**Findings: International guidelines and decision-making frameworks**

Internationally, policies and frameworks that address scope of professional practice generally offer guidance for decision making and suggest practice boundaries within which practitioners can or should operate. When the scope of practice frameworks of other regulatory authorities are examined, it is evident that determining scope of practice is part of everyday professional practice and individual decision making and accountability are central to this. Scope of practice and decision-making frameworks in nursing and midwifery are underpinned by concepts and principles and, while a degree of commonality in these principles is evident, two somewhat distinct framework types are evident, one that emphasises legislation and rules and one that emphasises individual accountability.

Frameworks that seek to define tasks and activities to be carried out and/or to be avoided emphasise policy and legislation and are typically behaviour driven and somewhat restrictive of individual autonomy in the decision-making process. They tend to advise the practitioner to seek advice, typically from a manager or regulatory body when unsure of how to proceed. Frameworks that emphasise the accountability of the individual practitioner are somewhat more enabling in that they promote autonomous decision, collaboration and communication when consulting and tend to leave the final decision about how to act with the individual practitioner.
Findings: Documentary review of the Scope of Practice Framework document
A documentary review of the Framework document indicates that overall the document was fit for purpose and valid. The analysis resulted in the consensus among the research team was that overall the document was of a high quality, in terms of content, suitability as a guiding framework, consistency in use of constructs, validity, in terms of reflecting real-world situations in which nurses and midwives operate when using the document, clarity of statements of principles and good quality of layout and design.

Findings: NMBI education department enquiries database
Analysis of up to 1,000 enquiries contained within the database maintained by NMBI indicates that enquiries were concerned with three main areas: medication management, changing and evolving scope of practice, and professional role boundaries. Each of these areas reflected concerns that arose in practice situations and circumstances in which the nurse or midwife was required to practice outside of his/her self-determined scope of practice. These situations and circumstances were frequently related to the fit between the individual practitioner’s registration status and associated skill set and the demands of the service. Other concerns were related to expectations on the part of the registered nurse or midwife to take responsibility and accountability for others, including support staff and agency nurses. Delegation of nursing roles and tasks to non-registered care staff represented a particular concern in this regard.

The context for many enquiries was service developments, staff shortages, as well as uncertainty about role expansion and professional accountability. Efforts by employers to maximise the skill mix of their staff and optimally deploy staff to meet service needs and/or address gaps in service represented the service context from which many enquiries arose. Enquiries were received from registered nurses, registered midwives, service managers and other health care professionals including medical personnel.

Findings: Results from the national survey
A national survey of registered nurses and midwives was conducted as part of the stakeholder consultation component of the review. The purpose of the survey was to examine registrants’ self-reported current scope of practice, and their use of the Framework and other resources to develop and support their professional practice and their experiences of expanded practice. The survey was conducted using the Scope-Q, a 64-item self-report questionnaire designed specifically for the study. The sample consisted of 2,354 registrants on the active part of the
Register of nurses, selected by a stratified random sampling procedure. The response rate was 45.1 per cent, a high response rate for a postal survey.

Sample characteristics
Over two-thirds of the sample (68.5%) was aged 40 years and older and over one third (37%) of the sample was ≥50 years of age. Less than 10 per cent of the sample was under the age of 30 years. The majority of the respondents was female (93.3%), with the proportion of males at just 6.7 per cent. The educational attainments of the respondents showed that 39.3 per cent had a bachelor’s degree and 12.1 per cent held a master’s degree. The majority (85.4%) were registered in the general nurse division of the Register and almost one third (31.0%) was registered in the midwifery division. The largest proportion of respondents (59.2%) was employed at the level of staff grade, one fifth at the clinical manager 1 and 2 grades (20.3%) and fewer than 10 per cent (7.8%) at the managerial grades. The sample was representative of a wide range of areas of practice, including general nursing (41.6), children’s nursing (5.7%), midwifery (7.4%), psychiatric nursing (9.5%), intellectual disability nursing (6.6%), and public health/community nursing (11.0%). Other areas of practice were also represented in smaller proportions, such as practice nursing and occupational health.

Self-reported scope of practice
Approximately one quarter of respondents (24.2%) reported that they rarely or never used the Scope of Practice Framework document when making a decision about the scope of their professional practice. Over half (59.6%) of respondents frequently or always consulted professional colleagues and half (50.3%) consulted their line manager when making a decision about the scope of their professional practice. The majority of respondents (60.7%) reported that they relied on their own professional judgement and a majority (62.3%) also reported rarely or never relying on the direction of others when making a decision regarding their scope of practice. Most respondents (95.8%) indicated that they would act only when they believed that they were competent to perform a new task, role or function and most (92.4%) indicated that they recognised when they were not competent to do so. The majority (85.4%) also reported that they acknowledged to others the limitations in their own competency.

With regard to taking on a new expanded task, role or function, the majority of respondents (90.3%) reported that they frequently or always assessed the task, most (82.4%) considered the impact on service delivery, and most (95.9%) considered the clinical outcomes. The majority
reported that they accepted accountability (87.2%) and recognised their accountability (75.3%) when delegating a task, role or function to another.

Respondents in the older age category were significantly less likely to consult a line manager and to recognise their own accountability more when making a decision to delegate when compared to their younger counterparts. Conversely, younger respondents were significantly more likely to consult with their line manager and less likely to recognise their accountability when making a decision to delegate than their older counterparts.

**Enablers and barriers to expanded practice**

The majority of respondents (88.9%) agreed that nurses and midwives wishing to expand their scope of practice are aware of the *Scope of Practice Framework* document. The majority also agreed that nurses or midwives wishing to expand their scope of practice are supported in doing so by their organisation or employer (60.8%) and by their colleagues (75.8%), and have access to continuing professional development (88.9%). However, fewer than half (45.1%) agreed that they are supported in doing so by other health professionals.

Half of the respondents (50.6%) agreed that nurses and midwives have few workplace opportunities to expand their scope of practice. Half (50%) also agreed that nurses or midwives are reluctant to expand their practice because they do not wish to take on additional responsibilities and just over half (51.8%) agreed that nurses and midwives are reluctant to expand their practice as they believe they are taking on other professionals’ work. The majority (74%) agreed that nurses or midwives are reluctant to expand their scope of practice because they do not receive additional salary for doing so and a majority (57.1%) also agreed that nurses and midwives are fearful of potential legal consequences of expanding their scope of practice.

Statistically significant associations were observed between the grade of respondent in respect of their experiences of enablers and barriers to expanding scope of professional practice. Specifically, an association was found between the respondents’ grade and their perceptions of support from their organisation or employer and the availability of workplace opportunities for expanded practice; respondents in the senior manager grades were significantly less likely than respondents in the other grade categories to see these two factors as barriers to expanded practice. Staff grades were significantly more likely to agree that nurses and midwives are reluctant to expand their practice as they are uncertain if it would be approved by external audit.
Hence, senior manager grades are more likely to believe that nurses and midwives are supported by their organisation and have workplace opportunities when expanding their scope of practice and a less likely to see the need for approval by external audit as a barrier to expanding practice than their lower grade counterparts.

When barriers and enablers were examined in their totality, the data showed a significant difference in perceptions of barriers between the staff grade and senior manager grades, with the staff grade respondents generally perceiving a greater number of barriers than their counterparts in senior manager grades. Similarly, senior manager grades were more likely to perceive enablers to expanded practice than staff or clinical manager grade respondents.

In summary, perceptions of enablers and barriers to expanded scope of practice appeared to be related to age and grade in the current sample, with younger respondents tending to perceive greater barriers than those in the older age categories. Senior manager grades also tended to perceive fewer barriers and more enablers than either the staff or clinical manager grade respondents, although the effect sizes in each case were small.

Resources for professional practice
The study respondents reported the resources that they used within the previous three years to support their professional practice. Fewer than half of respondents (41.6%) reported consulting workplace resources and just a quarter (26.2%) consulted a professional organisation. The most frequently-used resource was the Code of Professional Conduct (63.3%), followed by the Scope of Practice Framework document (59.6%), and just over a half of respondents (51.3%) consulted the NMBI website. These various resources were mainly consulted in relation to the respondents’ own professional practice. Approximately half of the respondents (49%) used at least one resources provided by the Nursing and Midwifery Board of Ireland in the previous three years. Respondents in the youngest age category were significantly more likely to use resources than their older age counterparts. However, significantly more respondents in the senior manager grades used more resources than all the other grades. A statistically significant positive association was found between the number of resources used and the extent to which respondents perceived enablers to expanded scope of practice; specifically the more resources used the greater was the perception of enablers to scope of practice.
Professional role
Demographic data from the study sample indicated that the vast majority of respondents (96.0%) had the word ‘nurse’ or ‘midwife’ in the title of their current professional role. Most respondents (91.7%) worked directly with patients/service-users and most worked as part of a multidisciplinary team (85.5%). The majority (90.1%) reported to a nurse or midwife as their line manager. Most (63.3%) reported that they frequently delegated tasks and duties to more junior colleagues and three quarters (72.7%) were required to expand the scope of their practice since taking up their current role, with two thirds (66.8%) receiving training specific to their expanded role. The majority (69.2%) used local policies/guidelines and over half (53.9%) used the Scope of Practice Framework document when expanding the scope of their professional practice.

Findings: Stakeholder consultation, interviews, focus groups
A total of 28 data collection events were conducted, involving 113 participants. The participants contributed to thirteen focus groups and thirteen interviews. Two case examples of expanded practice were also conducted. The focus groups, interviews and case examples generated a large body of narrative data on the participant’s understanding and perceptions of the scope of their individual practice. Use of the decision-making Framework (DMF) and recommendations for change were also explored in the group discussions and interviews. The data also provided information on expanding scope of practice, professional competencies and the practice setting and context within which scope of practice was applied, as well as a critique of the actual documentation itself. Analysis of the qualitative data yielded six major themes, as follows (Figure 6.1): Evolution of the nursing and midwifery professions and practice; Scope of practice: understanding and use; Expanding scope of practice; Professional competence; Practice setting and context; Reflections on the current Framework (DMF). Each theme consisted of two or more themes.

Theme 1: Evolution of nursing and midwifery professions and practices
Focus group and interview discussions regarding the scope of nursing and midwifery practice occurred against a backdrop of a number of changes in nursing and midwifery roles and practices, as this theme highlighted. Participants noted the changes in pre- and post-registration education, and the introductions of advanced practitioner roles and increasing numbers of nurse- and midwifery-led services. Significant changes in the roles of nurses and midwives were highlighted across all practice settings, as well as difficulties in negotiating role boundaries, both
with other healthcare professionals, as well as with other nurses and midwives. Participants of all grades and across several settings were mindful of the importance of continuing to provide nursing care while also noting the demands placed upon them by changing patient profiles and increased complexity of care. This evolution of roles provided an important context to the discussions of scope of practice.

Theme 2: Scope of practice: understanding and use
Participants in the focus groups and interviews spoke about scope of practice as something internalised, something that is often not consciously considered. Others understood scope of practice to be about guiding and defining nursing and midwifery roles. Several participants linked scope to competency, training, level of knowledge, evidence-based practice and professional conduct. Of key importance for participants was the consideration of how patient safety, quality of care and a client-led approach underpins a nurse’s or midwife’s scope of practice. Many participants indicated that they used scope of practice every day while others reported that they used scope on a ‘needs’ basis. Some nurses and midwives discussed scope of practice as a reflective tool or as a guide to patient care during team meetings, while others used it in student training and induction programmes. Some participants noted that the use of scope of practice was related in some way to the nurse or midwife seeking permission from service managers to carry out particular tasks or roles. Scope of practice was considered as either enabling and empowering or restricting for nurses and midwives. Some considered that scope of practice could be used as an excuse not to carry out some role or task. Finally, participants highlighted the perceived lack of knowledge, among nursing and midwifery staff and other healthcare professionals, around the concept of scope of practice.

Theme 3: Expanding scope of practice
Nurses and midwives indicated their willingness to expand their scope of practice, but expressed concern around the impact that role expansion could have on patient care. Many participants working in the areas like mental health, intellectual disability, midwifery and private practice made the link between expansion of practice and level of role autonomy. A number of negative aspects of expanding practice were identified, including the lack of monetary incentive, lack of recognition, increased workload without support, and the expectation that expanded scope means working ‘outside of scope’. A number of positive aspects of expanded practice were also identified. These included improved patient care, improvement in overall quality of nursing standards and an increased job satisfaction. Identified barriers to expanded practice included lack
of resources, staff shortages, lack of time for training, lack of organisational support and motivation and the disposition of the individual nurse or midwife. Enablers to expanded practice included access to training and appropriate support from individuals and the organisation.

**Theme 4: Professional competence**

Competence in nursing and midwifery practice was seen as being about more than just tasks, skills and roles; it was seen to encompass critical thinking along with a certain amount of documentation, auditing and continuous monitoring and updating on the part of the nurse or midwife. Maintaining competence was viewed as essential in ensuring safety and protection for the nurse and midwife as well as for the patient. Participants generally believed that competence should not consist of a list of tasks and roles that a nurse or midwife completes; rather, it should be about knowledge, experience and critical thinking to enable a nurse or midwife to make safe decisions for the patient and themselves in clinical practice.

Participants considered that competencies are attained through accessing appropriate training; however the challenge was keeping them up-to-date. Participants linked competence and confidence; building competencies increased confidence and having confidence allowed nurses and midwives to take on new competencies. Participants also highlighted that fact that the practitioner is responsible for judging his/her level of competence. Competency was seen to be about the nurse or midwife taking ownership for his/her practice.

**Theme 5: Practice setting and context**

Nurses and midwives highlighted the importance of having relevant legislation, local and national policies and guidelines, and regulation to support them in their practice. Concerns associated with the practice context that impacted on practitioners’ capacity to practice effectively included staff redeployment and lone working. These concerns related to a lack of understanding on the part of service managers of practitioners’ scope of practice when practitioners in instances of redeployment and a lack of resources, supports and reporting structures for practitioners who are lone working.

**Theme 6: Reflections on the current Framework**

Participants were in general agreement that the *Scope of Nursing and Midwifery Practice Framework* is a good document; however, many suggested that, as it was published in 2000, it
was in need of updating to take account of the many changes that had occurred in nursing and midwifery practice since the *Framework* was first published.

Several participants were of the opinion that any revised *Framework* should reflect the responsibilities of the organisation or the employer and should take student internships into consideration. Others stated that the *Framework* needed to reflect the fact that many nurses and midwives now work as part of a multi-disciplinary team and that there was a need to educate other health professionals about the nursing and midwifery scope of practice.

Some participants viewed the scope *Framework* as a ‘generalist’ document, a resource more suited to students and recently qualified nurses and midwives while others suggested it could act as the ‘scaffolding’ upon which advanced practitioners could expand their decision making. A few participants discussed the possibility of having a separate *Framework* document for nurses and midwives, but the general consensus was that this was not necessary. Many suggestions were made for amendments to the *Framework* document and the decision-making algorithm.

**Conclusions from stakeholder consultation**

Based on the findings from the national survey of registrants there is evidence that most practitioners consult the *Framework* document, although a sizeable proportion never does so. When making a decision about the scope of their professional practice, most consult other resources, including professional colleagues and their line manager and most rely on their own professional judgement when making a decision regarding their scope of practice. Additionally, most practitioners believe they were competent to perform a new task, role or function and recognise when they were not competent to do so and most accept accountability when delegating a task, role or function to others. Older practitioners are less likely to consult a line manager and to recognise their own accountability more when making a decision to delegate when compared to their younger counterparts.

Several enablers and barriers exist in relation to expanding practice. Enablers include having access to continuing professional development, support from the practitioner’s organisation and professional colleagues, and, to a lesser extent, support other health professionals. Factors that act as barriers to expanding practice include reluctance on the part of practitioners, based on not wishing to take on additional responsibilities, the belief that they are taking on other professionals’ work, lack of remuneration for the additional work and responsibilities that comes
with role expansion, and fear of potential legal consequences of expanding their practice. The age and the grade of the practitioner is significantly associated with experiences of enablers and barriers to expanding professional practice, with the staff grades and younger practitioners generally perceiving a greater number of barriers to expanded practice than senior manager grades and older practitioners.

Practitioners consult a wide variety of resources in relation to the scope of their own professional practice, including the *Code of Professional Conduct*, the *Scope of Practice Framework* document and the NMBI website. Younger practitioners are more likely to consult resources than their older age counterparts. Use of resources is related to the experience of enablers of expanded practice, with a greater use of resources leading to a greater perception of enablers to support expanded practice.

Nurses and midwives are aware of the context of their professional practice and the factors that impact on their scope of practice. These include changes in the health services, such as changing patient profiles and increased complexity of care, and factors in their own immediate work setting, including difficulties in negotiating role boundaries, both with other healthcare professionals and with other nurses and midwives.

Practitioners are aware of and understand the scope of professional practice. They demonstrate a variety of understandings of scope of practice, including the idea of something that is often not consciously considered, that guides and defines their practice, that is concerned with competence to practice and that is concerned with patient safety and quality of care. While some practitioners see scope of practice as enabling and empowering others see it as potentially restrictive in the way that it may be used as a way of avoiding taking on new roles and duties.

Nurses and midwives are generally willing to expand their scope of practice, and see it as resulting in improved patient care, improvement in overall quality of standards and increased job satisfaction. Those who express concern about expanding practice do so with reference to lack of monetary incentive, lack of recognition, increased workload without support, and the expectation that expanded scope means working ‘outside of scope’. Enablers to expanded practice included access to training and appropriate support from individuals and the organisation.
Related to scope of practice and practice expansion is competence and practitioners are aware that competence relates to several capacities in a practitioner, including skills and critical thinking, as well as updating knowledge and skills. The practitioner is held to be responsible for maintaining their competencies and this is viewed as essential in ensuring safety and protection for the nurse and midwife as well as for the patient.

Nurses and midwives place importance in having relevant legislation, local and national policies and guidelines, and regulation to support them in their practice. For some, there are particular practice issues that can impact on their scope of practice and their capacity to practice effectively; these included staff redeployment and lone working.

**Recommendations**

The following recommendations are made based on the findings from the review.

**Recommendation 1**

A single generic scope of practice framework should continue to be used as the basis for guiding nurses and midwives in relation to their scope of professional practice. The framework should continue to be ‘an enabling framework’ that provides guidance on how the practitioner should act in circumstances of uncertainty; emphasises individual accountability; and promotes autonomy and self-reliance in the decision-making process. The framework should enable role expansion within and with reference to the core functions and values of nursing and midwifery and the best interest of the patient. The framework should retain a decision-making algorithm and should continue to be based on core principles.

**Recommendation 2**

The current Framework document should be revised and updated, through the relevant committee and governance structures within the Nursing and Midwifery Board and should be informed by the key findings of this review, where appropriate, and by the relevant legislation and rules. When revising the Framework document, the NMBI should consider the following:

- Include explicit reference to the most pertinent legislation and guidelines that regulate and control professional practice, including role expansion, in Ireland
Include a new section on expanded roles, containing a statement of NMBI policy and supports for expanded practice and appropriate guidance on the clinical specialist, advanced practitioner roles as well as a clear statement on prescriptive authority

Include a paragraph or section on the context of professional practice, which recognises the diversity and range of services and settings in which practitioners work (and are likely to work) and make reference to the responsibilities of the health service provider and/or employer in relation to scope of practice and expanded practice roles and functions across all settings

Include a paragraph or section on interprofessional and multidisciplinary working, to include reference to the responsibilities of the individual practitioner and other professionals within this context

Include a statement on patient choice as an element of evidence-based practice

Include a paragraph or statement as to the practitioner’s responsibilities and possible responses in circumstances in which no explicit policies or guidelines exist

Include updated in-text citations and references throughout the document, to demonstrate the provenance and evidence base of the framework document as a guiding document for practice

Ensure that the revised Framework document has a distinct branding, in terms of its general visual appearance. While the current branding is clear and distinct, it might be worth considering a new and distinct appearance, to create renewed awareness among practitioners

Review the concepts of autonomy, responsibility, accountability, authority and delegation to ensure that they are clear and consistent with contemporary understandings of these concepts

Consider including a more detailed and precise statement about quality, safety and risk assessment and risk management to ensure the provision of quality, safe health care
Expand on the discussion and guidelines on ‘emergency situations’.

**Recommendation 3**

Review and revise the decision-making algorithm, with the aim of ensuring that it continues to provide a clear decision tree, which practitioners can use when reviewing their scope of practice and making decisions about expanding their practice. Consider the following:

- Chose a new colour that will be associated with the new Framework and avoid confusion with the older version.
- Using more than a single colour in the revised algorithm, for example, use of red, amber and green to denote ‘stop’, ‘wait/consider’ and ‘go’, respectively, and to provide clear and immediate visual cues.
- Make reference to evidence-based decision making.
- Make reference to the need for risk-assessment in the decision-making process.
- Include a ‘step for action’ at the end of the algorithm if practitioner still ‘Unsure’.

**Recommendation 4**

Case examples, similar to those presented in Chapter 6 should be developed and used in the dissemination of and education about the Framework.

**Recommendation 5**

The Nursing and Midwifery Board should consider novel ways of disseminating information about the *Scope of Practice Framework* and information on issues associated with scope of practice. This might include a regular item in the Board’s monthly e-zine that incorporates a link to the *Framework* document. The production of an A4 laminated version of the algorithm should be considered as an additional resource for use in every day practice situations. The e-learning programme on the NMBI website should also be available on HSEland.
Recommendation 6

The Nursing and Midwifery Board should consider novel ways of disseminating information about drug management and administration, to inform practitioners of their role and responsibilities in the matter as it applies to their scope of practice. This might include a regular item in the Board’s monthly e-zine that incorporates a link to the NMBI’s ‘medication management’ page on the website.

Recommendation 7

The system of recording entries into the Nursing and Midwifery Board’s enquiries database should be reviewed. The following points should be considered in any review:

The clinical setting or site of the enquirer should be recorded as part of the entry

Only information that is deemed relevant to the database should be recorded

A template for recording enquiries should be developed to ensure standardisation of the presentation of the enquiries

Consideration should be given to moving from a system of manual and telephone recording to an online method of recording that would also incorporate a decision-making algorithm that could provide online and real time advice and guidance to the enquirer as part of the response

The option for telephone enquiries should continue to be available to enquirers and the responder could use the online template to record the enquiry and guide the caller using the decision-making algorithm

Conduct regular monitoring and evaluation of the enquiries received in order to ensure that emerging and abiding issues are reviewed with the relevant authorities, where appropriate, and appropriate action taken to address the issue(s).

Recommendation 8

The Nursing and Midwifery Board of Ireland should consider the merits of entering into discussions with other regulatory authorities for healthcare professionals in Ireland, including
the Medical Council, with the view to establishing if there are shared elements in scope of practice guidelines that might be incorporated into their respective guidelines, and with the aim of increasing multidisciplinary awareness of the scope of practice framework.

**Recommendation 9**

The Nursing and Midwifery Board of Ireland should consider the system of recording names on the active part of the Register, with the view to ensuring that active part of the Register truly reflects the actual number of registrants in practice. Consider confirming an up-to-date address and using the following categories for gathering information on the status of registrants at the annual renewal date: Active in nursing or midwifery practice in Ireland; Retired; On leave of absence, for example, maternity leave, unpaid leave, career break; Not actively practising as a nurse or midwife in Ireland (for example, out of the country, working in another capacity) and Other.
Chapter 1

INTRODUCTION AND BACKGROUND

1.1 Introduction
The Scope of Nursing and Midwifery Practice Framework document (An Bord Altranais 2000a) was first published in 2000 following a process of consultation with nurses and midwives throughout Ireland. The Framework acts as a guide for nurses and midwives in making decisions about their scope of practice, by providing key principles and a decision-making algorithm with which nurses and midwives may review and expand the parameters of their professional practice. The Framework has been in use for approximately fourteen years and in the period since its publication, several developments have occurred in nursing and midwifery practice, including the advent of graduate-level entry to practice and substantial role expansion, including the development of a range of clinical specialist and advanced practitioner grades. In addition, the Nurses’ and Midwives’ Act 2011 has introduced the requirement for registered nurses and registered midwives to maintain professional competence on an on-going basis.

The developments in the intervening period since the Framework was first published represent a greatly altered practice landscape for nurses and midwives, resulting in the need for a national review of the Framework. In 2013, the Nursing and Midwifery Board of Ireland commissioned a team of researchers to conduct such a review. The review consisted of several elements, including: an analysis of definitions of scope of practice, a review of international regulatory authorities’ scope of practice frameworks, an analysis of the queries that the NMBI received concerning scope of practice and stakeholder consultation using mixed methods research. This chapter examines developments in the Irish healthcare system that impact on the scope of professional practice in Ireland and the international drivers of practice development and expansion. The chapter outlines the methods and findings of selected international studies that have examined scope of practice.

1.2 Background
Registered nurses and midwives are a valuable resource in the Irish health system. The development of a highly educated and skilled workforce of nurses and midwives was explicitly incorporated into Government policy with the publication of the report of the Commission on Nursing in 1998 (Government of Ireland 1998) and continues to be supported through funding
for preparatory and continuing education. The academic preparation of nurses and midwives and, in particular, the development of post-registration training for specialist and advanced practitioner roles, has resulted in the development of a more knowledgeable and skilled nursing and midwifery workforce in Ireland (Begley et al. 2010).

A key challenge for the Irish health services is to ensure that the nursing and midwifery resource is deployed to optimal advantage, so as to ensure optimal health care delivery. Conversely, with practice becoming more focused on care activities that demand the use of high-level skills of highly educated nurses and midwives, it is important that the nursing and midwifery resource is not underutilised or inappropriately utilised (D’Amour et al. 2012). It is partly for this reason that nurses and midwives must be empowered to act within the full range of their scope of professional practice and to expand their scope of practice as and when patient and service needs dictate.

1.3 Scope of practice: The Irish context
The reform of health services in Ireland is driven by increased complexity of treatments and demand on services, and a key concern is improving the quality of and access to care while controlling costs to the taxpayer. Since the economic crash of 2008, successive national service plans of the (Irish) Health Service Executive (HSE) have been shaped, in much part, by the need to minimise the cost of health care and therefore treat individuals at the site closes to where they live, while at the same time, ensuring quality and extending access to specialist care when needed. The Programme for Government (2011) and several policy documents, including Health Strategy Quality and Fairness: A Health System for You (DoHC 2001a), Primary Care: A New Direction (DoHC 2001b), A Strategy for Cancer Control in Ireland (DoHC2006a), A Vision for Change: Report of the Expert Group on Mental Health (DoHC 2006b), Tackling Chronic Disease: A Policy Framework for the Management of Chronic Diseases (DoHC 2008a), and Changing Cardiovascular Health: National Cardiovascular Health Policy 2010–2019 (DoHC 2010), have established the priorities of the Irish health system and provide a blueprint for the future direction of health care services, including nursing and midwifery roles that impact on scope of professional practice.

Priorities for the delivery of health services are further shaped by a quality-driven agenda supported by the Report of the Commission on Patient Safety and Quality Assurance (DoHC 2008b) and guidelines issued by the Health Information and Quality Authority (2010). Against
this backdrop of exceptional health care reform in Ireland is a demand from policy makers for
greater flexibility and the development of new nursing and midwifery roles, with significant and
unprecedented levels of role expansion. In the context of its reform agenda, the Department of
Health and Children, through the Strategic Framework for Role Expansion of Nurses and
Midwives (DoHC 2011) sought to achieve role expansion in order to support the attainment of
health care priorities using six steps: 1) service need analysis; 2) skill mix assessment; 3)
decision on role expansion; 4) examination of impact on service delivery; 5) review of Scope of
Practice; 6) evaluation of clinical outcomes.

Enthusiasm for role expansion in Ireland is apparent, with evidence emerging of the benefits and
opportunities of role expansion as demonstrated in the National Evaluation of Clinical
Nurse/Midwife Specialist and Advanced Nurse/Midwife Practitioner Roles (SCAPE) (Begley et
al. 2010). Benefits include reduced morbidity and improved access to specialist care with greater
usage of evidence-based guidelines and protocols (Begley et al. 2010). In addition, the
introduction of prescriptive authority for nurses and midwives in Ireland has been embraced
positively with high levels of patient confidence in nurses and midwives due to their enhanced
specialist knowledge and availability (Drennan et al. 2009).

Despite the evidential benefits of expanded scope of practice, some ambivalence has been
detected among the Irish nursing workforce as to the real benefits of role expansion (Wells et al.
2009). There is some unease regarding the unprecedented movement in health care roles with
issues of consensus around role boundaries (Drennan et al. 2009), professional and educational
requirements and clinical autonomy (Begley et al. 2010). There is also concern about the
potential erosion of nursing values (Mc Kenna et al. 2006; Mc Kenna et al., 2008), increased
vulnerability to litigation (Drennan et al. 2009), and exploitation and undermining of nursing
values (Lockwood and Fealy 2008; McKenna et al. 2008). There is also reported disappointment
with the over emphasis on biomedical tasks rather than a full understanding of nursing work
(Nevin 2005) and some frustration among nurses that role expansion may be dictated by the
workforce needs of the medical profession and by the need for cost savings (Mc Kenna et al.
2006; Mc Kenna et al. 2008). Physician resistance to role expansion has been reported in some
instances, with concern regarding potential overlaps in service, competence and expertise, and
increased risk of liability (Drennan et al. 2009).
McConnell et al. (2013), who examined role typology and scope of practice among emergency nurse practitioners (ENP) in Northern Ireland, reported that the ENP was a relatively homogenous group, in which the clinical aspect of the role dominated; this involved assessment and management of patients in the emergency department. While the individual practitioner’s knowledge and skills determined how the role was expressed, the role was largely determined by external factors beyond the ENPs control, including the patient’s wishes, protocols, and the wishes of medical staff and referral rights.

A study of nurses in advanced roles conducted in twelve OECD countries, including Ireland, suggested that anticipated cost savings through increased use of advanced nursing roles may be less than anticipated, due to longer consultations, increased referrals and the use of more diagnostic tests (Delamaire and Lafortune 2010). However, this concern was not borne out in the National Evaluation of Clinical Nurse and Midwifery Specialist and Advanced Nurse/Midwife Practitioner Roles (SCAPE), which reported that the introduction of such roles was, at the very least, cost neutral (Begley et al. 2010). The difficult task of estimating the economic contribution of such advanced roles towards controlling cost in the management of chronic illness has yet to be fully evaluated.

1.4 The Scope of Nursing and Midwifery Practice Framework

Published in 2000, the Scope of Nursing and Midwifery Practice Framework (An Bord Altranais 2000a: 1) presented nurses and midwives in Ireland with a series of principles with which they could ‘review, outline and expand the parameters of [their] practice’. The scope of professional practice framework provided for the expansion of practice and represented the expression of a number of principles that included professional conduct, accountability and self-governance. The Framework aimed to ‘support and promote best practice for all nurses and midwives’, in order to ensure both the protection of the public and the delivery of quality healthcare (An Bord Altranais 2000a: 1).

The Scope of Nursing and Midwifery Practice Framework (An Bord Altranais 2000a) is designed to be an effective and rational mechanism for decision making by which Irish nurses and midwives and other healthcare professionals may evaluate and negotiate traditional role boundaries. The framework encourages self-reliance among nurses and midwives in determining the boundaries and scope of their professional role (An Bord Altranais 2000a). It provides an algorithm to support judgement and decision making around factors such as competence,
accountability and autonomy, and legislation and policy requirements. Central to the Framework is the principle that expansion must be in the context of the values of nursing and midwifery and be in the best interest of patients (An Bord Altranais 2000a) and should be cognisant of the legislation and guidelines that may enable or prohibit such role expansion in addition to the full evaluation of the competence and professional development requirements.

The Framework fulfils several functions; it acts as a basis for independent decision making related to nurses’ and midwives’ everyday practice, it assists in the identification of nurses’ and midwives’ professional development needs and it provides a basis for the expansion of nursing and midwifery roles. As an enabling framework, it also emphasises nurses’ and midwives’ individual accountability in making decisions about their roles and responsibilities and is, therefore, a basis for practitioner empowerment (An Bord Altranais 2000a).

The publication of the Framework document coincided with major developments in nursing and midwifery education, policy and practice in Ireland in the early 2000s. These included the advent of graduate-level entry to practice and the development of a structured clinical career pathway for nurses and midwives through the introduction of the clinical specialist and advanced practitioner grades, which came in the wake of the Report of the Commission on Nursing (Government of Ireland 1998). These developments led to an expansion in the provision and range of taught graduate clinical courses by the higher education sector, which was in response to the growing demands of nurses and midwives and their service managers for new and enhanced knowledge and skills for a wide range of new expanded roles and service developments.

A more recent development has been the significant changes in the regulatory framework for nursing and midwifery, which were brought about with the enactment of the Nurses’ and Midwives’ Act 2011. In addition to the constitution of a new regulatory authority, the Nursing and Midwifery Board of Ireland (NMBI), a key provision of the Act was the requirement for registered nurses and registered midwives to maintain professional competence on an on-going basis and to demonstrate competence to the satisfaction of the new Board. In addition, the Board is required to develop, establish and operate schemes ‘for the purposes of monitoring the maintenance of professional competence by registered nurses and registered midwives’ (An Bord Altranais 2011: 72).
1.5 The scope of nursing and midwifery practice: International perspectives

The World Health Organisation (1986: 32) has advocated ‘a general definition [of nursing, which] . . . can accommodate new nursing functions as they are justified by expanding education or improved technology’. The International Council of Nurses (ICN) has been influential in formulating codes to guide nursing practice with the first code being presented in 1953. The ICN identifies scope of practice as being dynamic and responsive to health care needs (ICN 2004). The most recent ICN Code of Ethics for Nurses (2012) identified the fundamental responsibilities of nurses to promote health, prevent illness, restore health and alleviate suffering. The code acknowledged the universal need for nursing, which adds to the challenges of determining the scope of professional nursing practice.

Factors such as the international fiscal crisis of 2008, the aging demographics of developed countries, the gap between health care supply and demand in certain countries, the perception that nurses and midwives do not work to their full potential and the policy pledges to expand health care provision have necessitated changes in the scope of practice frameworks over time (Fairman et al. 2011; Riegel, Sullivan-Marx and Fairman 2012).

Professional nursing codes and frameworks offer a system of rules and principles by which the nursing profession is expected to regulate its members and demonstrate its responsibility to society. Nightingale provided the basis for the first code of conduct for clinical nursing practice by identifying the need for holistic and safe care of the patient, competence in specific and skilled nursing tasks, continuing education for nurses, and accurate documentation concerning the care delivered (Dolan et al. 1983). Nursing practice has evolved from a biomedical model to a more humanistic basis where ethical decision making is paramount (Meleis 1991). Nevertheless, both nursing and midwifery practice remain closely aligned with medical practice and, while nurses and midwives practice under their respective regulatory frameworks, interdisciplinary practice remains largely interdependent. In some countries, medicine continues to hold pre-eminence in determining both the professional training and the scope of practice of nurses and midwives (Fealy et al. 2009).

Nursing organisations and regulatory entities in Canada, the United States of America, Australia, the United Kingdom and Ireland have sought to guide nurses in the determination of their scope of practice within an evolving social, fiscal and ethical context. Common among these various frameworks is the process used for the development and evaluation of the scope of practice.
Most professional organisations have sought to: elucidate the determinants and professional parameters that shape the scope of practice; develop a decision making framework for nurses using both Delphi methods and consensus building approaches; and subsequently validate the relevance and usefulness of the framework in the practice context (Davies and Fox-Young 2000). Such evaluations have taken varying forms, most especially surveys of practitioners and other stakeholders and interviews with practitioners.

1.6 Scope of practice and decision making frameworks: Overview of empirical studies
The body of empirical research specifically on scope of practice is somewhat limited, with a search of CINAHL and MEDLINE (2005 to date) returning 288 records, based on the following search terms: (nurs* OR midwi*) AND (“scope of practice”) AND (evaluation OR review). For the purpose of this review of literature, only records reporting empirical studies of reviews of scope of practice were appraised, thereby excluding non-research and anecdotal reports. Publications were included if they reported the findings generated through data collected from field work, such as surveys, interviews and so forth. In this way, twelve published studies were identified through the literature search and included for review.

Studies that have examined scope of practice have tended to examine the phenomenon from the perspective of practitioners, usually through self-reports of their practices and/or by eliciting their opinions and ‘perceptions’. Much of the early research examined scope of practice through studies of the expanded role of advanced practitioners or practice nurses who were operating in a range of clinical settings, with a focus on descriptions of biomedical role functions and technical competence in the performance of medically-delegated clinical tasks (White et al. 2008).

While surveys and other structured instruments have been used to examine perspectives on scope of practice (e.g. Cronie et al. 2012), other methods have also been deployed, either singly (Schulter et al. 2011; Fox-Young and Ashley 2010) or in combination (Lubbe and Roets 2014; Hoodless and Bourke 2009; An Bord Altranais 2000a; Drennan et al. 2009; Fagerström 2009). The focus of empirical studies on scope of practice has been on the extent to which the nursing resource, including the range of nursing skills, is optimally utilised in practice (D’Amour et al. 2012; Oelke et al. 2009; White et al. 2008) and on the facilitators and barriers that nurses and midwives encounter when expanding their scope of practice (Oelke et al. 2009; Jowett et al. 2001). In empirical studies, nurses may describe their scope of practice with reference to key nursing roles, functions and actions, like teaching patients and families (D’Amour et al. 2012),
assessment and care coordination (White et al. 2008) and safeguarding the patient (Schluter et al. 2011).

1.6.1 Perceptions of scope of practice
According to White et al. (2012), research on scope of practice is not well established, with a focus on the use of qualitative methods, which require rigorous data handling, particularly where large volumes of qualitative data are generated. Relying on qualitative data alone can be at the expense of more systematic objective measures of nurses’ and midwives’ actual scope of practice. On that basis the authors employed a mixed-methods approach to study Canadian nurses’ perceptions of the meaning of ‘working to full scope of practice’ (White et al. 2008). They reported that nurses’ perceptions of the meaning of ‘working to full scope of practice’ were represented in their descriptions of particular nursing activities, which they undertook; these activities included patient assessment and care coordination.

Schluter et al. (2011) examined qualitatively how nurses conceived their scope of practice. Using a critical incident technique within a constructivist methodology, Schuler et al. (2011) examined how a sample of Australian hospital nurses perceived their scope of practice in response to the available grade and skill mix. Focusing on significant clinical events, participants were asked to consider whether patient care activities should be delegated to a lower grade, such as an enrolled nurse, or performed by a higher level of care provider. The idea of negotiation was a central pattern in the study data, whereby participants believed that some nursing work associated with direct care could be delegated to support staff. The authors reported that some participants equated ‘good nursing’ to working in ‘proximity to patients providing total patient care’. However, this ability to practice in proximity to patients could be restricted by factors like the increasing use of support health care staff to provide direct patient care, decreased length of stay in hospital, patient acuity levels, staff shortages, augmented indirect care responsibilities and perceived difficulties in interpreting core nursing roles which could not be delegated (Schluter et al. 2011).

As part of a study to examine the impact of the UK’s Central Council for Nursing, Midwifery and Health Visiting (UKCC) Scope of Professional Practice, Jowett et al. (2001) surveyed several stakeholder groups, including practitioners, managers and educators, drawn from diverse organisations and agencies, including medical and professional bodies, consumer groups, government departments and health service providers from across the UK. The authors used a
structured questionnaire to elicit opinions and perspectives from respondents concerning the Scope of Practice, including aspects of expanded role, concerns about role expansion and perceived advantages and disadvantages of role expansion (Jowett et al. 2001). The authors reported interest among the stakeholders in developing innovative systems of delivering nursing and midwifery care, so long as the necessary safeguards and supports were in place and appropriate training for those taking on extended practice roles was provided. Additionally, most respondents viewed the Scope of Practice document as enabling, as offering useful boundaries for practice, and as a valuable way of optimising the skills and contribution of nurses, midwives and health visitors (Jowett et al. 2001).

Oelke et al. (2008: 61) used in-depth interviews to examine nurses’ and other stakeholders’ understandings and perceptions of the scope of professional practice, the extent to which nurses were ‘practising to scope’ and the barriers and facilitators to practising to scope in three western Canadian health regions. Oelke et al. (2008) reported that nurses had difficulty in describing their scope of practice, with a tendency to do so in terms of tasks and activities that they performed. Additionally, while nurses reported that they were working to full scope, many experienced barriers to expanded practice roles (Oelke et al. 2009).

1.6.2 Actual scope of practice

Scope of practice has also been examined more directly by measuring actual scope of practice through self-reports (Cronie et al. 2012; D’Amour et al. 2012). Cronie et al. (2012) examined the diversity and scope of practice of hospital-based midwives in the Netherlands, using an online national survey. The unit of analysis was the country’s maternity hospitals and maternity units and the survey addressed several aspects of scope of midwifery practice, including the clinical midwife’s involvement in managing births. The authors reported that 40 per cent of all births were managed solely by the midwife and 44 per cent of the clinical midwives autonomously prescribed medications, such as night sedation, although this was not within their official scope of practice. Overall, the hospital-based midwives reported a high level of practice autonomy (Cronie et al. 2012).

D’Amour et al. (2012) similarly studied actual scope of practice, using a bespoke instrument, the Actual Scope of Practice (ASCOP) questionnaire. The authors measured the extent to which nurses actually work to their full scope of practice or ‘apply the breadth of their professional preparation in daily practice’ (D’Amour et al. 2012: 254). Through the instrument, they
measured role enactment in six dimensions of scope of practice as follows: assessment and care planning; teaching of patients and families; communication and care coordination; integration and supervision of staff; quality of care and patient safety; and knowledge updating and utilization. While the focus of D’Amour et al.’s study (2012) was on the development of a valid instrument to measure actual scope of practice, the authors reported that nurses practiced at ‘less than their optimal scope’ in key dimensions of professional practice, including communication and care coordination, integration and supervision of staff, quality of care and patient safety, and knowledge updating and utilization (D’Amour et al. 2012: 248).

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

As a prelude to the publication of the present Scope of Nursing and Midwifery Practice Framework, An Bord Altranais conducted a consultation process among stakeholders in four distinct phases, as follows: a public call for submissions, consultative workshops, a national survey targeting all nurses and midwives on the active register and individual meetings with ‘key groups’ (An Bord Altranais 2000b). Following a stakeholder consultation process to determine Scope of Nursing and Midwifery Practice Framework, An Bord Altranais identified several ‘key issues’ to emerge concerning the scope of practice. Among these were: the varied and diverse nature of both practice and the caring; the unplanned and reactive nature of changes in scope of practice; the varied influences on the scope of practice; difficulties in defining scope of practice; and the need for structured decision making in determining scope of practice (An Bord Altranais 2000b). The report concluded that key concepts in relation to the development of the scope of practice included the notions of specialist and advanced practice, accountability and autonomy, competence, supervision, continuing professional development and delegation.

1.6.3 Expanded roles

The scope of practice has also been studied from the perspective of expanded roles and functions (Drennan et al. 2009; Fagerström 2009; Hoodless and Bourke 2009). Fagerström (2009)
examined the needs of advanced nurse practitioners in Finland with reference to their scope of practice and educational needs, using a combination of focus groups with ANPs and a survey questionnaire administered to nurse managers. Based on the study data, the author found that the role of the ANP required advanced clinical skills for aspects of the practice role, such as tertiary prevention in chronic illness, secondary prevention in the care of older people and assessment and prescriptive skills in acute care, including the authority to order laboratory tests and x-rays. The ANPs’ nurse managers had clear expectations of the ANP role, including the ability to practice independently within an expanded scope of practice. Hoodless and Bourke (2009) examined the experiences of enrolled nurses’ (ENs) working in rural Victoria, Australia, in relation to their expanded scope of practice in the area of medication administration using a job satisfaction questionnaire combined with complementary individual interviews that further explored job satisfaction and expanded scope of practice. The authors reported that ENs who had received training in medication administration had improved job satisfaction (Hoodless and Bourke 2009).

In an evaluation study to examine the practice-level effectiveness of introducing one particular aspect of expanded practice, the introduction of independent nurse and midwife prescribing, Drennan et al. (2009) deployed a range of evaluative methods. These included surveys, audit of prescriptions and patient records and qualitative interviews, and data were collected from several stakeholder representatives, including clinical nurses and midwives, managers and administrators, pharmacists, academics, physicians, representatives of regulatory and policy bodies. The authors reported that the majority of nurses and midwives who expanded their scope of practice to incorporate independent prescribing agreed that they could prescribe safely and effectively, had the requisite skills and training for their expanded role and were aware of their scope of practice and the issue of accountability associated with a prescribing role (Drennan et al. 2009).

In summary, the literature points to enduring difficulties in relation to scope of practice, including the difficulty of balancing practice restriction with practice expansion and the differences in defining scope of practice for both generic and specialist roles, coupled with environmental and client-specific contextual factors.
1.7 Conclusions
Scope of professional practice is closely associated with notions of professional conduct, accountability and self-governance and expanded practice. Professional regulatory bodies for nurses and midwives in developed countries have issued policies and/or guiding frameworks that address scope of practice. The *Scope of Nursing and Midwifery Practice Framework* is one such framework, which offers practitioners a set of guiding principles with which to review and, where appropriate, expand the parameters of their practice, thereby promoting self-reliance among nurses and midwives in determining the boundaries of their professional practice (An Bord Altranais, 2000a). Internationally, policies and frameworks that address scope of professional practice generally offer guidance for decision making and suggest practice boundaries within which practitioners can or should operate.

Much of the empirical research into scope of practice is concerned with examining practitioners’ perspectives on particular frameworks or their experiences of expanding their practice. Much of the research is predicated on a concern to establish the extent to which there is optimal deployment and/or minimal utilisation of the nursing and midwifery resource. The evidence from the research suggests that frameworks are generally helpful in guiding practitioners, but that local circumstances often determine and delimit practitioners’ scope of practice. Practitioners are generally open to role expansion, so long as there are sufficient safeguards and resources to support independent decision making and expanded role activities. Notwithstanding local constraints, a continuing challenge is to ensure that scope of practice frameworks are readily applicable in varied practice contexts, sufficiently effective to guide practitioners so that they may work to their optimum capabilities, while at the same time ensuring safe and effective practice. In other words, frameworks and guidelines should be fit for purpose.

1.8 The current study
*The Scope of Practice Framework* is a central step in the process of role expansion, and considerable resources have underpinned its development and implementation for the last fourteen years. However, to date the Framework has not been formally evaluated. In the fourteen years since its publication, developments in the Irish health service and in nursing and midwifery roles have led to further expansion of the scope of nursing and midwifery practice, including the advent of nurse and midwife-led care and the institution of prescriptive authority for specially-trained nurses and midwives. The Nursing and Midwifery Board of Ireland instituted a series of measures in response to these developments, in order to revise the *Code of Professional Conduct*.
Code of Professional Conduct for each Nurse and Midwife (An Bord Altranais 2000c) and to review and revise the Scope of Nursing and Midwifery Practice Framework (An Bord Altranais 2000a).

In October 2013 the Nursing and Midwifery Board of Ireland commissioned a team of researchers from four of Ireland’s nursing schools (University College Dublin; University of Limerick; Trinity College Dublin; University College Cork) to undertake a review of the Scope of Practice Framework. Conducted within an evaluation methodology framework, the outcomes of this review are intended to inform national policy on professional regulation for nurses and midwives.
2.1 Introduction
The *Scope of Nursing and Midwifery Practice Framework* (An Bord Altranais 2000a) provides nurses and midwives in Ireland with a set of principles with which they can review, outline and expand the parameters of their professional practice and expand their scope of practice. Several major developments have occurred in nursing and midwifery practice, education, policy and regulation in Ireland since the publication of the *Scope of Nursing and Midwifery Practice Framework*, including the advent of graduate-level entry to practice and the development of clinical specialist and advanced practitioner grades, as well as the enactment of the Nurses’ and Midwives’ Act 2011. Given these developments and the fact that the *Framework* has not been reviewed since it was first published in 2000, the Nursing and Midwifery Board considered it timely to conduct a review of the *Framework*. This chapter describes the methods used to conduct the review, which was based on an evaluation methodology framework.

2.2 Review aims and objectives
The aim of this study was to conduct a review of the *Scope of Nursing and Midwifery Practice Framework* (An Bord Altranais, 2000a) on behalf of the Nursing and Midwifery Board of Ireland (NMBI). The objectives of this study were to:

- Conduct a critical review of the relevant national and international literature, research and policy documents relating to the establishment and definition of nurses’ and midwives’ scope of practice
- Undertake a comparative analysis of other regulators’ and professional nursing and midwifery associations’ scope of practice
- Conduct a thematic analysis of the NMBI Education Department Enquiries database queries pertaining to the scope of nursing and midwifery practice
- Conduct a critique of the current *Scope of Practice Framework* document, to include proposed recommendations for updating the *Scope of Practice Framework* document published in 2000
- Consult with key stakeholders through a range of complementary methods of inquiry, including a national survey of nurses and midwives, interviews and focus groups with key stakeholders and a public call for submissions
2.3 Study design
The study design, including the overall review strategy and the data collection methods, was influenced by current thinking on evaluation theory and reflected an eclectic and valid approach, which permitted the use of complementary methods to generate both qualitative and quantitative data for the evaluation and review (hereafter evaluation) process. The strategy was also informed by the principles of partnership, which have been successfully deployed elsewhere (Casey 2008, Ford et al., 2008), and by illuminative evaluation principles (Fealy et al., 2000). In order to capture information on the content, operation and effectiveness of the Scope of Practice Framework (An Bord Altranais 2000a), key elements of the Donabedian model (2005) were adopted, which addressed structure, process and outcomes elements of the Framework and its use in the world of professional practice.

The evaluation strategy was also based on a number of key operating principles, as follows: consultation with key stakeholders; clarification of outcomes of the evaluation with the stakeholders and the sponsor; discussion of the purpose of the evaluation and how the information will be used and the use of multiple methods to gather information (Hannun et al., 2007). The strategy ensured that relevant data was generated on registrants’ experiences of using the Framework, including extant evidence of nurses’ and midwives’ expressed concerns, as recorded in the NMBI Education Department Enquiries Database, and other key stakeholder perspectives and experiences.

2.3.1 Review strategy and data collection methods
The evaluation strategy incorporated a mixed methods approach in which a combination of complementary quantitative and qualitative data collection methods was used. These included a national survey of registrants to examine variables related to self-reported scope of practice and use of the Framework, focus groups and interviews with key stakeholders, case studies of the Framework in use, analysis of in-situ documentary evidence retained by the Nursing and Midwifery Board of Ireland and a documentary review of the Scope of Practice Framework document itself. The main data collection methods for stakeholder consultation are summarised in Figure 2.1.
2.3.2 Reviewing the Framework document and arrangements: Structural element

The structure aspect of the Framework refers to all the resources (human, material and fiscal) necessary for the Framework to be used in practice. The evaluation of the structure element involved analysis of the pre-specified aims of the Framework, the decision-making algorithm contained within the Framework and the extent to which the health systems and services are conducive to and have the capacity to enable the decision-making framework to be enacted by individual practitioners. The evaluation of the structure elements of the Framework involved data gathering and analysis related to the following:

- The content of the Framework document with reference to the Nurses and Midwives Act, 2011
- The procedures for communicating the Framework to each registered nurse and midwife
- The content of the Framework document, including the constructs used and the decision-making algorithm and documents and materials supporting the framework
- The regulatory structures and protocols for addressing questions related to the Framework
- The structures and protocols in place in health services to enable the effective operation of the Framework
- The Framework model with reference to other nursing and midwifery professional regulatory bodies’ scope of practice and associated decision-making frameworks
Information about these key structure elements was generated through the national survey of nurses and midwives, focus groups and individual interviews, case studies and the documentary review.

2.3.3 Reviewing the Framework in use: Process element

The Scope of Professional Practice Framework is a document that gives rise to decision making and actions on the part of a nurse or midwife and, as such, it also constitutes a process. Accordingly, the process aspects of the Framework were examined with reference to the individual’s experiences of practising within the parameters of the Framework, the perspective of the service provider, the service user and the regulator. This involved investigating how practitioners, service administrators and regulators experience the use of the Framework and consultation with the public, through representative groups of service users. It also involved analysis of the NMBI Education Department Enquiries Database of queries pertaining to the scope of nursing and midwifery practice. Hence, the process elements of the evaluation involved data gathering and analysis related to the following:

- Nurses’, midwives’ and service managers’ experiences of using the Framework
- Other key stakeholders’ experiences
- Thematic analysis of the NMBI Education Department Enquiries Database
- Case studies of the Framework in use

Information about the process elements was generated through the national survey of nurses and midwives, the focus groups, individual interviews and the two case studies.

2.3.4 Reviewing the Framework in use: Outcomes element

Reviewing the outcomes element of the Framework involved ascertaining whether it is a fit-for-purpose document and a reliable and effective guide that a nurse or midwife can use in the decision-making process related to their scope of professional practice. It involved data gathering and analysis related to the following:

- Nurses’ and midwives’ self-reported experiences of using the Framework, with particular reference to decisions and actions informed by the decision-making algorithm contained in the Framework
- Case study accounts of the outcomes of using the Framework
Information about the outcomes element was generated through the national survey of nurses and midwives, the focus groups and individual interviews and the two case studies.

2.3.5 Summary of the major elements of the evaluation

The aims and objectives of the review of the Framework gave rise to the evaluation strategy that, in turn, informed the study design and the range of complementary data collection methods that were used to examine structure, process and outcomes elements of the Framework. The major data collection activities were as follows:

- A literature review, involving a comprehensive critical review of the literature pertaining to scope of practice and decision-making frameworks, including review and evaluation studies; this activity informed elements of the design for stakeholder consultation, as well as informing the review overall
- A comparative analysis of other nursing and midwifery regulatory and professional bodies’ scope of practice and associated decision-making frameworks
- A documentary review and critique of the current Scope of Nursing and Midwifery Practice document
- A thematic analysis of the NMBI Education Department Enquiries Database of queries pertaining to scope of nursing and midwifery practice for the period October 2003 (inception date) to June 2013
- Focus group discussions and individual interviews with key stakeholders, including nurses, midwives, service managers, policy personnel, regulatory personnel and service users, NMBI representatives
- Case studies of the Framework in use
- A national survey of nurses and midwives relating to self-reported scope of practice
- A public call for submissions from stakeholders and the public in relation the Scope of Practice Framework and a thematic analysis of responses received.

2.4 Review of the relevant national and international literature

This part of the study involved a critical review of the relevant national and international literature, research, regulatory and policy documents relating to the establishment and definition of nurses’ and midwives’ scope of practice. The review was conducted according to best-practice in the design and conduct of literature reviews and the findings are presented using the narrative synthesis method.
Search strategies were designed with broad eligibility criteria to source the maximum amount of literature relating to the topic area. Quality assessment of sourced materials was considered; however due to the nature and type of materials sourced this was not considered practicable.

Information garnered from multiple sources, including empirical studies (e.g. surveys, qualitative descriptive interviews, case studies), policy documents and regulatory frameworks are often considered to provide a lower level of evidential support within evidence-based practice hierarchies. However, information gathered using these approaches provided valuable and valid insights into the evolution of the notion that nurses and midwives should have a defined scope of practice and that the expansion of the scope of practice enables the development of expanded clinical, specialist, and advanced practice roles.

The three-step approach to searching the literature included:

1. An initial preliminary search of MEDLINE and CINAHL to identify the keywords, subject headings, alternate terminology associated with the topic area
2. A comprehensive search of the following databases Cumulative Index to the Nursing and Allied Health Literature (CINAHL), PubMed (MEDLINE), Education Resources Information Center (ERIC), SCOPUS, WEB of Knowledge, Embase, PsycINFO, AMED, Cochrane, Web of Science, was conducted using all of the identified key words. The search included the descriptive, discursive and empirical literature. Searches of Google and Google scholar (including GrayLit Network (<http://graylit.osti.gov/>) were also conducted to access grey literature (i.e. materials not indexed by major databases); these included policy documents, reports and regulatory frameworks. Standard Boolean operators AND, OR, NOT were used to combine search terms. Search strategies were adopted for each database as appropriate. In order to include early examples of regulatory authorities’ frameworks, no date limits were set.
3. Hand searching of the reference list of identified reports, polices, articles was also conducted for additional information sources.

The search strategy resulted in 79 relevant citations and sources as outlined in Figure 2.2.
Figure 2.2 Search Strategy Report (Identification, screening, eligibility, included studies)

Search Terms
Scope of Practice OR Professional Practice OR Provision of Nursing Care OR Parameters of Practice OR Scope of Practice Guidelines OR Role definition OR Service Parameters OR Sphere of Practice OR Legal Scope of Practice OR Scope Principles OR Practice Roles OR Clinical Governance OR Professional Responsibilities OR Professional Accountability OR Standard of Practice OR Professional Standards OR Clinical Parameters of Practice Code of Nursing ethics’ OR ‘Code of Professional Practice’ OR ‘Code of Professional Conduct’ OR ‘Code of Conduct’ OR ‘Code of Ethical Practice’ OR ‘Ethical Code’ OR ‘Scope of Practice’ OR ‘Decision-Making’ OR ‘Practice’ OR licensure OR certification AND Nurse OR Nursing OR Midwi*OR ‘Nurse-Midwives’

Records identified through database searching (n = 4450)

Additional records identified through other sources (n =3007)

Records screened (n = 7457)

Records excluded (n = 7378)

Publications, websites, studies included in analysis/narrative synthesis (n = 79)
Initially the bibliographic records from the pertinent searches (titles, abstract and description of link) were screened by a member of the research team to assess their match to the defined inclusion criteria (Table 2.1).

Data was abstracted from the publication according to the key descriptions of: definition of scope of nursing practice; contextual information relating to the scope of practice definition; and source of description. The narrative synthesis is an approach to the synthesis of review findings from multiple sources in textual format providing an integrated interpretation of the topic area and an understanding of the chronological development of practices and processes in the area. The synthesis was informed by the guide provided by Popay et al., (2006) and Barnett-Page et al. (2009) (Table 2.1).

<table>
<thead>
<tr>
<th>Approach</th>
<th>Technique</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) How the definition of the scope of nursing and midwifery practice developed: how they work, why and for whom</td>
<td>Provide textual description of the included citations</td>
</tr>
<tr>
<td>2) Develop a preliminary synthesis: the parameters included in the scope of practice, factors which have influenced these over time, barriers and enablers to expanding scope of practice</td>
<td>Group and cluster definitions; create table; transform data into a common rubric, e.g. ideas webbing Conduct thematic analysis and explore relationships in data (e.g. similarities and differences in definitions, triangulation of concepts)</td>
</tr>
<tr>
<td>3) Explore the factors mediating changes in scope of practice</td>
<td>Critically reflect on the synthesis process</td>
</tr>
<tr>
<td>4) Assessing the robustness of the synthesis</td>
<td>Critically reflect on the synthesis process</td>
</tr>
</tbody>
</table>

### 2.5 Comparative analysis of other nursing and midwifery regulatory and professional bodies’ scope of practice and associated decision-making frameworks

The overall aim of this element of the review was to conduct a comparative analysis of professional nursing and midwifery associations’ scope of practice and associated decision-making frameworks. The intention was to apply the principles of the systematic review, the gold standard in research synthesis, to this comparative analysis. The systematic review methods advocated by the Cochrane Collaboration (2008) and Scottish Intercollegiate Guideline Network (SIGN 2011) were modified to facilitate the review of regulators’ and professional nursing and midwifery associations’ scope of practice and associated decision-making frameworks (DMF). These documents are mainly available on-line and supported by a series of position papers, policy documents and letters.
In the initial stages a subject librarian was consulted and conducted a key word search strategy using databases such as CINAHL and EMBASE. This initial search resulted in limited outcomes. Therefore a manual searches were used to search and follow up web links on the International Council of Nursing (ICN) website, which provides links to the regulatory and nursing associations of several countries of the world. Despite the limitations of this approach, the key attributes of the systematic review process were employed (Figure 2.3).

2.5.1 Inclusion criteria

Papers which detailed the scope of practice for the jurisdiction and associated DMF were included. The screening question ‘is this paper about expansion of practice for registered nurses and midwives?’ was used to ensure that relevant papers were reviewed. Position statements, letters and policy guidelines, which did not provide specific guidance, were excluded. Papers from the year 2000 onwards were reviewed as this timescale corresponds to that of the Scope of Nursing and Midwifery Practice in Ireland (An Bord Altranais 2000a).

A manual search was completed and 143 sources and documents saved in Endnote where documents and/or URLs were available. Of the identified 143 sources and documents retrieved, six were excluded on the basis of relevance, leaving 137 sources for review in the first instance. Australia, New Zealand, Canada and Europe were included as these jurisdictions were judged to be most relevant to the Irish context. Information from the USA was also included at this stage due to the volume of sources which existed, but professional regulation of nurses in that country is somewhat complex and this is explained in more detail later in this report. A total of 79 papers were reviewed in full and this was reduced to 12 regulatory frameworks following a detailed review of their content and relevance to the present review (Appendix 1). The process of reducing the papers to a final number of 12 for inclusion is detailed Table 2.2.
Table 2.2 Summary of initial findings

<table>
<thead>
<tr>
<th>Nursing regulatory associations*</th>
<th>No. of hits</th>
<th>Reviewed</th>
<th>Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>15</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td>New Zealand</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>International/Global</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Europe</td>
<td>11</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Middle East and Gulf states</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Canada</td>
<td>27</td>
<td>16</td>
<td>2</td>
</tr>
<tr>
<td>Africa</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>United States of America</td>
<td>76</td>
<td>44</td>
<td>2</td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td><strong>143</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excluded (Middle East, Gulf states, Africa, global)</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>137</strong></td>
<td><strong>79</strong></td>
<td><strong>12</strong></td>
</tr>
</tbody>
</table>

* Source: International Council of Nurses (2014)

2.5.2 Approach to data synthesis

Following agreement on the 12 frameworks for inclusion, key information was extracted and summarised. The papers were then combined and this resulted in eight summaries as set out in Table 2.3 (see also Appendix 2).

Table 2.3 Framework types

<table>
<thead>
<tr>
<th>Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decision making frameworks (DMF)</td>
<td>3 (2 nursing, 1 midwifery)</td>
</tr>
<tr>
<td>Combined guidance and DMF</td>
<td>4</td>
</tr>
<tr>
<td>Guidance only</td>
<td>1</td>
</tr>
</tbody>
</table>

This process helped to clarify and refine emerging issues and assisted with the interpretation of other jurisdictions’ scope of practice frameworks and decision making-frameworks.

2.6 Documentary Review of the Scope of Nursing and Midwifery Practice Framework document

The Scope of Nursing and Midwifery Practice Framework document (An Bord Altranais 2000a) was subjected to a descriptive documentary review. A bespoke descriptive documentary review instrument (Appendix 3) was adapted from an instrument developed to review documentary materials used in the National Clinical Leadership Development Programme (Fealy et al. 2012). The instrument contained a list of 34 statements about the general content and suitability of the Framework document and the decision-making algorithm as well as the layout and design of the document. Each statement in the instrument was set alongside a five-point Likert scale and eight members of the research team were asked to indicate their level of agreement with the statements from ‘strongly disagree’ (1) to ‘strongly agree’ (5). This method permitted an
objective description the *Framework* document by members of the Project Team with reference to the language used to represent key constructs and ideas. Data from the documentary review of the *Framework* document were summarised using standardised data collection spread sheets and reported in a narrative report with supporting tables, as appropriate.

### 2.7 Content Analysis of NMBI Education Department Enquiries Database

#### 2.7.1 Introduction

The NMBI Education Department holds a database of inquiries made by registered nurses and midwives; the database contains a record of queries dating back to 2001. Part of the review design involved an analysis of the data entries that were related specifically to the scope of nursing and midwifery practice. An initial meeting was held in December 2013 with the NMBI to establish the parameters of the database and to arrange access following the signing of a confidentiality agreement, after which access to the database was granted to the NMBI Education Department Enquiries Database. The database was made available to the project team in MS Excel format.

The database contained 9,818 entries containing a description of the enquiry, the date of the enquiry and a general classification of the enquiry; classification terms used included ‘fitness to practice’, ‘medication management’ and ‘ethics’. The initial review of the database revealed that there was a marked stylistic difference in the nature of the entries and the level of detail collected over the period January 2001 to end of July 2013. Some of the early entries reflected general enquires that were adjudged to be not relevant to the present review. In addition, the approach to categorisation in the data entries has changed over time with some inconsistencies noted. It was agreed that an extensive data cleansing procedure of the database was necessary prior to analysis.

#### 2.7.2 The data cleaning process

Much of the literature on cleaning databases is related to large numerical datasets and involves use of computerised algorithms (Aye 2011); however, this approach was not suitable for the database in question. In order to approach the cleaning of the database in a systematic way, the Knowledge Discovery in Databases (KDD) process described by Fayyad *et al.* (1996) was adopted. A key feature of the KDD process is the use of prior knowledge about the topic under investigation so that important data fields and relationships between data are already known. With a background in nursing and midwifery, and an understanding of the scope of practice, the
research team possessed the relevant knowledge necessary to carry out this process. The KDD process involved the following key steps: identifying the goal of the KDD process from the client’s perspective; creating a target data set; data cleaning; data reduction; choosing the data reviewing strategies; data reviewing; and consolidating data found (Fayyad et al. 1996). Each of these stages is outlined in more detail below:

*Identifying the goal of the KDD process from the client’s perspective*

The review was focussed on those queries that were related specifically to scope of practice. After an initial review of the queries, it was decided that ‘scope of practice’ would be interpreted in a way consistent with the An Bord Altranais Framework document (An Bord Altranais 2000a), namely: competence, accountability and autonomy, continuous professional development, support, delegation and emergency situations.

*Creating a target data set*

This stage involved selecting the relevant data categories that would be used in the review. The key data categories were: date of the query, practice area from which the query arose, division of register of the person submitting the query and the query description.

*Data cleaning*

This stage involved recoding the practice area to fill in missing data and correct some of the existing entry information. The decision on which practice area to use for each individual entry was based on the questions of those making the enquiry and, where this was not possible to ascertain, using the default NMBI practice area code. ‘Practice area code’ represented the area of nursing to which the query was related, for example, practice, community or psychiatric nursing. This was not recorded for all entries. In addition, the date of the enquiry entry was recoded based on a number of key publications from NMBI, such as the *Introduction of Nurse and Midwife Prescribing in Ireland* (An Bord Altranais 2005), *Guidance to Nurses and Midwives on Medication Management* (An Bord Altranais 2007), *Nurses Rules* (An Bord Altranais 2010) and the Nurses and Midwives Act 2011. The final timescale categories used were pre-2005, 2005–2007, 2008–2011 and 2011 to July 2013.

*Data reduction*

This stage involved, what Fayyad et al. (1996: 84) refer to as, ‘finding useful features to represent the data depending on the goal of the task’. In order to reduce the data, the ‘category of
query’ and ‘sub-category of query’ were used to enable a quick decision about which queries were of little or no relevance to ‘scope of practice’. Approximately half of the 9,818 entries were deleted at this stage.

Choosing the data reviewing strategies
At this stage, the remaining entries were manually reviewed based on a number of strategies. Initially, a key word search was conducted using the following key words: ‘role’, ‘scope’, ‘practice’, ‘SOP’, S of P’, ‘responsibility’, ‘union’, ‘competent’, ‘competence’, ‘development’, ‘professional’, ‘delegate’ and ‘accountability’. Relevant entries were colour coded in order for a decision to be made about inclusion and non-relevant entries were eliminated. Two members of the research team ‘double’ coded the reviewed queries to ensure that consistency on the strategies agreed upon was maintained.

Data reviewing
The remainder of the entries, those that were non-colour coded, were read so that a decision could be made as to whether they should be eliminated or included in the analysis.

Consolidating data found (discovered knowledge)
After the cleaning process was complete the database contained a total of 978 entries that were deemed to be relevant to the review of the scope of nursing and midwifery practice. This number did not represent those entries in the database that could be considered to be solely related to ‘scope of practice’, but instead represented those entries selected following the cleaning process and the inclusion and deletion criteria. The knowledge discovery in databases process is an iterative process and can involve loops between any of the stages involved (Fayyad et al. 1996). During the cleaning process members of the research team communicated regularly about the inclusion and exclusion criteria during the various stages with the ‘data cleaning’ and ‘data reduction’ stages being re-visited on several occasions. Once agreement was reached on the ‘consolidated data’ stage, the next step involved an in-depth analysis of the ‘new’ consolidated database so that key themes could be identified.

2.7.3 Data analysis
It was decided to conduct content as opposed to thematic analysis on the database as it became clear during the cleaning process that some level of quantification would be necessary in reporting the findings. Based on the distinction provided by Vaismoradi et al. (2013: 398), the
main difference between content and thematic analysis ‘lies in the opportunity for quantification of data’ when using content analysis. The text of the actual query was imported into NVivo 10 software (QSR Int. PTY Ltd.) for data handling and content analysis and selected data were then imported into SPSS V20 (SPSS Inc. Chicago IL) for analysis.

2.8 Stakeholder consultation: National survey of nurses and midwives

A key part of the review of the Scope of Practice Framework was stakeholder consultation that included a national survey of nurses and midwives, which was conducted to examine self-reported experiences of scope of practice. A self-report questionnaire, the Scope-Q, was designed specifically for this purpose (Appendix 4). It was developed from a review of the literature on the scope of nursing and midwifery practice, and the structures and supports available to nurses and midwives to aid them in the development of their scope of professional practice.

2.8.1 Scope-Q Survey Instrument

The Scope-Q is a sixty-four item questionnaire, designed to gather self-report information on nurses’ and midwives’ current scope of practice, as well as their use of the Framework and other resources to develop and support their professional practice. The decision-making algorithm, found on page 11 of the original Scope of Nursing and Midwifery Practice Framework document, was reproduced on the inside cover of the questionnaire booklet, to act as a memory aid for respondents.

The Scope-Q is set out in five main categories: my scope of practice; enablers and barriers to expanded scope of practice; resources for my professional practice; my professional role and demographic information (Table 2.4).

<table>
<thead>
<tr>
<th>Section</th>
<th>Category</th>
<th>No. of items</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>My scope of practice</td>
<td>15</td>
</tr>
<tr>
<td>B</td>
<td>Enablers and barriers to expanded scope of practice</td>
<td>19</td>
</tr>
<tr>
<td>C</td>
<td>Resources for my professional practice</td>
<td>9</td>
</tr>
<tr>
<td>D</td>
<td>My professional role</td>
<td>13</td>
</tr>
<tr>
<td>E</td>
<td>Demographic information</td>
<td>8</td>
</tr>
</tbody>
</table>

Section A contains fifteen items relating to respondents’ current professional role and the scope of their professional practice, including competence, delegation and accountability. Respondents are asked to indicate the frequency with which they engage in a list of activities relating to their
professional practice on a Likert scale ranging from 1=Never to 5=Always. Examples of the items are listed in Table 2.5 below.

<table>
<thead>
<tr>
<th>Item</th>
<th>In my current professional role...</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I use the Scope of Practice Framework document when making a decision about the scope of professional practice</td>
</tr>
<tr>
<td>6</td>
<td>I act under the direction of others when making decisions about my competence to perform a new task, role or function</td>
</tr>
<tr>
<td>9</td>
<td>I recognise when a task, role or function falls outside the scope of practice of the nursing or midwifery profession</td>
</tr>
<tr>
<td>14</td>
<td>When I undertake a delegated task, role or function, I accept accountability for the performance of that task, role or function</td>
</tr>
</tbody>
</table>

Section B consists of nineteen items relating to the potential barriers and enablers a nurse or midwife may experience when expanding the scope of their professional practice, including organisational guidelines and support and access to relevant training. Respondents are asked to indicate, with reference to their own experiences, whether they strongly agree, agree, disagree, strongly disagree or have no opinion Table 2.6 lists sample statements from Section B of the Scope-Q survey instrument.

<table>
<thead>
<tr>
<th>Item</th>
<th>Nurses of midwives...</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>who wish to expand their scope of practice are supported in doing so by their organisation or employer</td>
</tr>
<tr>
<td>24</td>
<td>have few opportunities in the workplace to expand their scope of practice</td>
</tr>
<tr>
<td>32</td>
<td>are reluctant to expand their scope of practice because they are fearful of potential legal consequences of doing so</td>
</tr>
</tbody>
</table>

Section C comprises nine items related to respondents’ use of resources to support their professional role, including the actual Scope of Practice Framework document, the Code of Professional Conduct for each Nurse and Midwife, the resources on the NMBI website and so forth. Items are presented in a yes/no forced-choice format and filter questions ask respondents to indicate (Table 2.7) reasons for using a particular resource, relating either to the respondent’s own professional practice, the professional practice of others, or both. A three-year timeframe was selected to facilitate more recent recollection on the part of the respondents.
Table 2.7 Scope-Q sample items Section C: Resources for my professional practice

<table>
<thead>
<tr>
<th>Item</th>
<th>Within the past three (3) years...</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>35</td>
<td>I consulted a professional organisation (e.g. trade union, nursing association) for advice concerning the scope of my professional practice</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>39</td>
<td>I consulted the Scope of Practice Framework document published by An Bord Altranais in 2000</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Section D contains thirteen items asking respondents to describe their current professional role, role expansion, including questions on delegation, team working, and continuous professional development, as well as aspects of their role that have involved expanded elements. Respondents are presented with a dichotomous yes/no choice, with filter questions included to measure additional variables related to use of resources to support expanded practice.

Section E of the Scope-Q contains eight items that collected demographic information, including age, gender, educational attainments, current registration(s) and type of care setting. The Scope-Q is designed as a self-completion instrument.

2.8.2 Survey Population and Sampling Frame

The total population of interest was defined as all nurses and midwives whose names are entered onto one or more divisions of the active register of nurses and midwives maintained by the Nursing and Midwifery Board of Ireland. At the time of sampling this number was 66,888 registrants and this figure constituted the sampling frame.

2.8.3 Sample Size Calculation

Based on the total population of 66,888 registrants on the active Register of Nurses and Midwives, it was calculated that a sample size of 1,060 respondents would provide a confidence interval of +/-3%, according to the following sample size formula (Figure 2.4).

\[
SS = \frac{Z^2(p)(1-p)}{C^2}
\]

Where:
- \(Z^2 = 1.96\) (for a 95% confidence level)
- \(p = 0.5\) (worst case scenario percentage picking choice)
- \(C = 0.03\) (Confidence interval expressed as decimal +/- 3%)

Figure 2.4 Sample size calculation based on complete sampling frame

2.8.4 Sampling procedure for national survey

A stratified random sampling technique was employed. This involved dividing the survey
population into a number of groups or strata, and drawing a random sample from within each stratum (Robson 2002). The divisions of the NMBI register of nurses and midwives formed the strata for this purpose. This procedure ensured that individuals within each of the registration categories of the Register (Table 2.8) were represented in the study sample (de Vaus 2002). Table 2.8 indicates the distribution of nurses and midwives across the nine registration categories.

<table>
<thead>
<tr>
<th>Division</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced midwife practitioner (AMP)</td>
<td>4</td>
</tr>
<tr>
<td>Advanced nurse practitioner (ANP)</td>
<td>109</td>
</tr>
<tr>
<td>Children’s nurse (RCN)</td>
<td>4,220</td>
</tr>
<tr>
<td>General nurse (RGN)</td>
<td>55,433*</td>
</tr>
<tr>
<td>Intellectual disability (RNID)</td>
<td>4,727</td>
</tr>
<tr>
<td>Midwife (RM)</td>
<td>11,850</td>
</tr>
<tr>
<td>Nurse prescriber (RNP)</td>
<td>481</td>
</tr>
<tr>
<td>Psychiatric nurse (RPN)</td>
<td>9,223</td>
</tr>
<tr>
<td>Public health nurse (RPHN)</td>
<td>2,402</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>88,449</strong></td>
</tr>
</tbody>
</table>

*The actual number included for sampling purposes within the general nursing category was 45,327.

As the table illustrates, a total of 88,449 registrations are held by the 66,888 nurses and midwives on the active register, yielding a surplus of 21,561 registrations. A decision was made to consider a reduced number of general registrations for sampling purposes, to ensure better representation of some of the smaller registration categories in the study sample. It was estimated that the number of registrants with only one registration was equal to the total number of registrants on the active register (66,888), less the number of surplus registrations (21,561), yielding a population of 45,327 for the general category for the purpose of drawing the quota sample.

Based on a desired sample size of 1,060 and a response-rate estimate of 45%, a stratified random sample of 2,354 was drawn from the adjusted total number of registrations (Table 2.9). This method ensured adequate representation of registrants within each registration category in the final study sample. The purpose of the survey instrument was to examine aspects of the scope of practice among a representative sample of all nurse and midwives on the active Register of Nurses and Midwives. It was therefore not intended to elicit the experiences and perspectives of individual divisions of the Register or individual practice settings.
Table 2.9 Stratified sampling distribution

<table>
<thead>
<tr>
<th>Registration category</th>
<th>Adjusted number of registrations (N)</th>
<th>Percentage of total number of registrations (%)</th>
<th>Sample distribution based on population proportions (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced midwife practitioner</td>
<td>4</td>
<td>0.01</td>
<td>1</td>
</tr>
<tr>
<td>Advanced nurse practitioner</td>
<td>109</td>
<td>0.14</td>
<td>3</td>
</tr>
<tr>
<td>Children’s nurse</td>
<td>4,220</td>
<td>5.39</td>
<td>127</td>
</tr>
<tr>
<td>General nurse</td>
<td>45,327</td>
<td>57.86</td>
<td>1361</td>
</tr>
<tr>
<td>Intellectual disability</td>
<td>4,727</td>
<td>6.03</td>
<td>142</td>
</tr>
<tr>
<td>Midwife</td>
<td>11,850</td>
<td>15.13</td>
<td>356</td>
</tr>
<tr>
<td>Nurse prescriber</td>
<td>481</td>
<td>0.61</td>
<td>14</td>
</tr>
<tr>
<td>Psychiatric nurse</td>
<td>9,223</td>
<td>11.77</td>
<td>277</td>
</tr>
<tr>
<td>Public health nurse</td>
<td>2,402</td>
<td>3.06</td>
<td>72</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>78,343</strong></td>
<td><strong>100</strong></td>
<td><strong>2,354</strong></td>
</tr>
</tbody>
</table>

An estimated response rate of 45% would result in 1,060 returned questionnaires, yielding 80% power for a two-tailed independent samples t-test at a 95% confidence level and an estimated medium effect size of 0.5 (Cohen 1988). However, in order to undertake an independent samples comparison of means, for example, to compare registration categories on other variables of interest, at least 60 observations was needed within each category. Accordingly, the predicted sample size of 1,060, distributed across the nine registration categories (Table 2.8), precluded certain sub-group analyses, such as comparisons between two or more categories of registrants. An officer of the Nursing and Midwifery Board of Ireland generated the stratified random sample of 2,354 registrants; the research team was blind to this procedure.

2.8.5 Pilot testing

In an effort to ensure a good degree of face validity and reliability, the Scope-Q was subjected to pilot testing (Baker 1994: 182–3; de Vaus 2002: 116). The pilot test was conducted at a university school of nursing and midwifery among a mixed cohort of students taking a taught graduate programme. A purposive sample of 16 students was invited to complete the questionnaire, drawn from a range of different clinical sites and settings. Having completed the questionnaire the respondents were then asked to comment on the instrument, with particular reference to its content and layout. This procedure was informed by the cognitive interview method of pretesting questionnaires prior to their distribution to the sample of interest. The cognitive interview is useful in establishing how respondents comprehend, interpret and respond to questions, thereby providing the respondent’s perspective and not that of the researcher, thereby functioning to identify sources of response error in questionnaires (Drennan 2003).

Respondents spoke about their experiences of completing the questionnaire and about individual categories ad items. The outcome was that respondents viewed completing the questionnaire as a
positive experience and reported no major difficulties with completing the instrument. The feedback generated by the pilot resulted in some minor technical changes to the layout of instrument prior to its final administration.

2.8.6 Data collection procedure

The Scope-Q questionnaires were administered to the sample of 2,354 registrants, through a commercial mailing service. The data collection procedure was based on best practice evidence concerning the distribution of postal questionnaires (Edwards et al. 2002; Dillman 2000). A modified Dillman method, using three contacts with the sample, was utilised to maximise the response rates from the study sample (Dillman 2007). This involved an initial personalised letter informing respondents of the study and alerting them to expect the questionnaire (contact 1; Appendix 5), the mailed Scope-Q with a return freepost envelope (contact 2; Appendix 6) and a reminder letter with a second copy of the questionnaire (contact 3; Appendix 7). The timing between contacts was 7–10 days.

2.9 Stakeholder consultation: qualitative interviews, focus groups and case examples

Focus groups and interviews were conducted among a purposive sample of key stakeholders, including registered nurses and midwives from across all grades. In order to obtain data from nurses and midwives working in the widest range of services and settings, the sampling strategy focused on the type of service and not the clinical grade of the nurses and midwives. Additionally, focus groups and interviews were conducted among other key stakeholder categories, including service user representatives, representatives from trade unions, representatives from the Department of Health and from nursing and midwifery policy and regulation. A total of 28 data collection events were conducted, as follows: thirteen focus groups (Table 2.10) and thirteen interviews, and two case examples of expanded practice were also conducted (Table 2.11).
Table 2.10 Data collection: focus groups

<table>
<thead>
<tr>
<th>Setting (service or role type)</th>
<th>Source of informants</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>General public hospital (CNS, ANP, RNP)</td>
<td>HSE South</td>
<td>1</td>
</tr>
<tr>
<td>General public hospital (staff and CNM)</td>
<td>HSE West/HSE South</td>
<td>2</td>
</tr>
<tr>
<td>General private hospital (all grades)</td>
<td>HSE South</td>
<td>1</td>
</tr>
<tr>
<td>Community (Public health nurse (PHN)/ community RGN)</td>
<td>Through ICHN(^1) (national sample)</td>
<td>1</td>
</tr>
<tr>
<td>Education</td>
<td>Through 3rd level institution</td>
<td>1</td>
</tr>
<tr>
<td>Maternity hospital (all grades)</td>
<td>HSE South</td>
<td>1</td>
</tr>
<tr>
<td>Mental health service (all grades)</td>
<td>HSE Dublin North East</td>
<td>1</td>
</tr>
<tr>
<td>Occupational health</td>
<td>Through OHNA(^2) (national sample)</td>
<td>1</td>
</tr>
<tr>
<td>Research</td>
<td>Through IRNN(^3) (national sample)</td>
<td>1</td>
</tr>
<tr>
<td>Residential care (private)</td>
<td>HSE South</td>
<td>1</td>
</tr>
<tr>
<td>Residential care (public)</td>
<td>HSE West</td>
<td>1</td>
</tr>
<tr>
<td>Patient advocacy group</td>
<td>Service user advocacy group</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>

Table 2.11 Data collection: Interviews and case studies

<table>
<thead>
<tr>
<th>Interviews</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community: GP services (practice nurse)</td>
<td>2</td>
</tr>
<tr>
<td>Intellectual disability (all grades)</td>
<td>2</td>
</tr>
<tr>
<td>Forensic Service and prison service</td>
<td>1</td>
</tr>
<tr>
<td>Medical education</td>
<td>1</td>
</tr>
<tr>
<td>Nursing and midwifery policy and regulation</td>
<td>2</td>
</tr>
<tr>
<td>Professional regulation</td>
<td>2</td>
</tr>
<tr>
<td>Professional associations</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Case Studies</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwifery practice</td>
<td>1</td>
</tr>
<tr>
<td>Nursing practice</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2</strong></td>
</tr>
</tbody>
</table>

2.9.1 Recruitment procedures for focus groups and interviews

Purposive sampling was used to generate a sample of participants for the focus groups and individual interviews. Focus group and interview participants were recruited using a combination of direct and proxy methods. The target number of participants in each focus group was eight to ten and, to that end, over-sampling for each group was deployed at the stage of sample recruitment. Once each data collection site was selected, the relevant director of nursing or midwifery was contacted and informed of the study’s purpose, and invited to nominate up to twelve individuals to participate in a focus group. Each letter was followed up by telephone and/or e-mail contact, in order to negotiate a suitable time and venue for the planned focus group. To promote interest in the study among stakeholders and prospective participants, directors of nursing and midwifery were also provided with an information leaflet. Every effort

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\(^1\)Institute of Community Health Nursing.
\(^2\)Occupational Health Nurses Association.
\(^3\)Irish Research Nurses Network.
was made to ensure that the timing and location of the focus groups caused minimal disruption to individual participants and to the services in which the focus groups took place.

Once nominees were identified, the Project Team wrote to them individually with details of the focus group and invited them to participate. The letter of invitation included an information sheet, a consent form (Appendix 8), and details of the venue and time of the focus group. Prospective participants were assured of their prerogative to decline to take part without prejudice.

Focus group participants representing research nurses, occupational health nurses, nurse tutors, public health nurses and community RGNs were recruited through their respective national professional associations. Individual interviews were also conducted with the following: a forensic service nurse, a prison service nurse, two practice nurses and two nurses employed in an intellectual disability service. Three individual interviews were also held with professional representative associations; these were recruited by direct invitation to the respective associations’ general secretaries. Several interviews were also conducted with representatives from nursing and midwifery policy and regulation. Finally, one focus group was conducted with representatives of service users’ advocacy groups.

2.9.2 Data collection procedures
Prior to the commencement of each focus group and interview, participants were provided with an information sheet explaining the purpose of the study and were then asked to give written informed consent prior to participating. All participants were assured that their anonymity would be preserved in reporting the study findings and that their confidentiality would be maintained throughout.

Each focus group discussion and interview was facilitated by a moderator and, in the case of some focus groups, with the assistance of an observer, acting as a support to the moderator. Each group was conducted according to a topic guide, which was standardised with reference to categories for discussion (Appendix 10). In this way, discussion in each group was directed towards the participants’ understanding and experiences of the scope of practice.

Modifications to the topic guide were made for the patient advocacy group. For the individual interviews, the topic guide was adapted in order to address scope of practice issues associated
with the particular role of each participant. The topic guide was subjected to pilot testing initially at the level of the research team and minor modifications were made. Each focus group participant was asked to complete a short demographic questionnaire. All group discussions and interviews were recorded, with permission, and transcribed verbatim for analysis. Detailed notes were taken at some focus groups and were used to augment the transcribed data and inform the analysis stage.

Each focus group comprised up to thirteen participants, and took place over a period of sixty minutes approximately. The method of data collection resulted in the production of candid views that might not otherwise emerge in other forms of questioning. Validity was enhanced by the preparation of the aforementioned topic guide based on the literature review, by analysis of the data as it was generated, and by judicious group moderation in order to reduce the risk of opinions being overly influenced by individuals and/or by other group dynamics. The thirteen focus groups and fourteen individual interviews were conducted over a period of two months.

2.9.3 Qualitative data handling and analysis

Demographic data for participants were entered into SPSS for data handling and presentation purposes. Qualitative data generated from the focus groups were transcribed after each group was completed. Analysis followed the well-known stages of data reduction, exploration and synthesis common to most qualitative research designs, regardless of their specific methodological commitments (Attride-Stirling 2001). Each transcript was read closely and tentative themes were noted using thematic network analysis, which assisted in unearthing latent themes in the textual data at different levels; the method is best understood as a ‘web-like illustrations that summarise the main themes constituting a piece of text’ (Attride-Stirling 2001: 388). The analysis resulted in a network starting from basic themes and working inwards towards a global theme. A coding frame (Appendix 11) was developed from the basic, organising and global themes and the resultant codes provided a conceptual lens through which to begin interpretation of the data (Figure 2.5).
Figure 2.5 Example of the structure of a thematic network

The coding frame was generated as a result of an iterative interplay between concepts pervading the theoretical and empirical literature, the research question and the themes and patterns gleaned from the data as well as the researcher’s experience of the topic under study. As exploration of the data deepened, the coding frame was modified and used to refine the structure of the global themes until the research team was satisfied that the maximum amount of data was accounted for. The aim was to move through increasing levels of abstraction in order to transform the mass of raw data into a concise conceptual description and interpretive explanation of the phenomenon of interest (Sandelowski and Barroso 2003). The coding frame was then imported into NVivo 10 software (QSR Int. PTY Ltd.) where free nodes were created to represent the key codes identified and new free nodes were created where necessary. Once coding was completed, relationships between these free nodes were identified and further explored, and a tree node structure was devised to represent the key themes emerging.

2.9.4 Case examples of expanded practice

In order to augment the data from stakeholder experiences, two purposively-selected case studies of expanded practice were included to provide a more in-depth view of how the Framework is utilised by individual practitioners. The method of data collection for the case studies involved in-depth semi-structured interviews with the two practitioners. They were provided with an information sheet explaining the purpose of the study and their role in the study and were then asked to give written informed consent prior to participating. The practitioners were asked to discuss their scope of practice in general and then to provide case study accounts of how they used the decision-making algorithm in their respective fields of practice. Interviews were
recorded, with permission, and later transcribed for analysis. Interactional narrative analysis (Kohler Riessman 2003) was conducted to produce case examples. Each participant reviewed the case example to ensure it was consistent with the evidence that they provided in the course of the interview.

2.10 Stakeholder consultation: Call for submissions

As part of the review and evaluation, the research team engaged in public consultation with key stakeholders, such as nurses and midwives, individuals, group and organisations that have an interest in the Scope of Nursing and Midwifery Practice Framework. A notice was placed on the websites of the schools of nursing and midwifery at University College Dublin, Trinity College Dublin, University College Cork and University of Limerick. The NMBI also placed a notice on its website and included the call for submissions in an edition of their e-zine online publication. The call for submissions incorporated a final date for receipt of written submissions (Appendix 12). A total of six submissions were received from nurses and other agencies. The information provided in these submissions was incorporated into the qualitative analysis where appropriate.

2.11 Ethical review

The data collection procedures for the stakeholder consultation elements of the review were subject to review by the UCD Human Research Ethics Committee (HREC) of University College Dublin, the host institution for the fieldwork element of the review. The detailed procedures for the conduct of the postal survey, the focus groups and the individual interviews were submitted in the application for exemption from full ethical review using a standard procedure of notification to the Committee. Ethical approval was granted.

All focus group participants and interviewees were asked to give written informed consent prior to their participation, no names of individuals or their organisation were recorded during the focus group or identified in the report and all data were stored securely at the UCD Nursing and Midwifery Research Unit. The return of completed postal questionnaires was taken to indicate consent to participate in the postal survey. Access to the NMBI Enquiries Database was granted subject to the signing of a confidentiality agreement by the research team member responsible for that element of the review.
Chapter 3

FINDINGS: REVIEW OF LITERATURE AND SCOPE FRAMEWORK DOCUMENT

3.1 Introduction

New and emerging patterns of health care and service delivery models coupled with expanded levels of autonomy, skills and decision making mean that there is some confusion in the health service community internationally about the professional role and scope of both the generalist and advanced practice nurse or midwife (Gardner et al. 2007). The overriding principle of professional regulation, therefore, is to ensure that practitioners are able to practice effectively and safely to the full extent of their capabilities.

The scope and standards of professional practice are articulated in a variety of formats internationally, providing guidance and practice boundaries for both generic and specialist practice roles (American Nurses Association 2010). However factors have necessitated changes in the scope of practice frameworks over time, including the international fiscal crisis in 2008, the ageing demographic profile of many developed countries, the gap between supply and demand of nurses in certain countries, the perception that nurses do not work to their full potential and the policy pledges to expand health care provision (Fairman et al. 2011; Riegel et al. 2012).

The World Health Organisation (1986: 32) has previously advocated ‘a general definition [of nursing, which] . . . can accommodate new nursing functions as they are justified by expanding education or improved technology’. The International Council of Nurses (ICN) identified scope of practice as being dynamic and responsive to health care needs (ICN 2004). Nursing organisations and regulatory bodies in Canada, the United States of America, Australia, the United Kingdom and Ireland have sought to guide nurses in determining their scope of practice while identifying that the role and responsibilities of the nurse must adapt and change according to the evolving practice context.

Difficulties which continue to emerge in relation to scope of practice include balancing restriction with expansion of practice, the differences in defining scope of practice for both generic and specialist roles along with environmental and client-specific contextual factors (Davies et al. 2001; White et al. 2008; Schluter et al. 2011; D’Amour et al. 2012). The
continuing challenge is to ensure that the scope of practice framework is enabling and readily applicable in varied practice contexts while at the same time ensuring the safety of the patient and the ability of the nurse or midwife to work to his/her optimum capabilities.

This chapter presents the findings from a critical review of the relevant national and international literature, research, and regulatory and policy documents relating to the establishment and definition of nurses’ and midwives’ scope of practice. The chapter also presents the results of a comparative analysis of other nursing and midwifery regulatory and professional bodies’ scope of practice and associated decision-making frameworks. The results of a documentary review of the quality, layout and internal structure of the Framework document itself are also presented.

3.1.1 Outline of the review

The review findings relating to the establishment and definition of nurses’ and midwives’ scope of practice are presented under a number of general headings, as follows: 1) Scope of practice: the broad context; 2) Regulation of the scope of nursing and midwifery practice: the Irish context; 3) Working within and through a scope of practice; 4) The change in articulation of scope of practice; and 5) Facilitators and barriers to working to a full scope of practice. The analysis of the definitions of scope of practice revealed that regulation of the scope of practice occurs on a continuum. The continuum reflects both the restrictive-permissive approaches to regulation, and the varying levels of practice of the nurse and midwife.

3.2 Scope of practice: The broad context

In the literature the term ‘scope of practice’ is used by national agencies and regulatory authorities to define the parameters of a professional’s activities, which are inclusive of the procedures, actions and associated processes that a licenced individual is permitted to perform. Specific statements regarding education, training and competencies are usually included within the definition of a scope of practice. In addition, some definitions make reference to the practice of the health care professional and the type of patients/clients for whom the professional can provide care and the context in which such care should be provided. In their totality, these definitions delineate the activities that a professional is educated and authorised to perform. The rationale for such scope of practice definitions for health care professionals include protection of the public, a general societal understanding of the role and functions of the practitioner, and the need for role clarity to ensure that practitioners can practice to the full extent of their capabilities.
and thereby optimise their contribution to the provision of an effective and safe public health service.

With reference to nursing and midwifery, registration legislation and professional regulation determine: the definition of the nurse and midwife within a jurisdiction; the nature and duration of educational programmes for entry to the professional register; and the scope of professional practice of the nurse or midwife. In turn, the scope of practice of the individual nurse or midwife is influenced by a myriad of contextual factors including: the environment of practice (evolving government policy, the health care system, the clinical practice setting); governance (local guidelines, polices, evidence base); nurse-level factors (education, professional competence); the multidisciplinary team (collaborative teamwork, shared understanding of roles and responsibilities); and patient-level factors (client safety, needs and desires).

Regulation of nursing and midwifery should be seen as part of a broader system that is striving to find the correct balance between the quality of health and social services and the cost of service provision, while maintaining easy and equitable access to those services (International Council of Nurses 2009). The phrase ‘protecting the public’ is prevalent in most discourses regarding regulation of professional practice; this is related to the fact that the public need to be confident that qualified, competent practitioners provide health care services.

The evolution of nursing regulation dates back to the late nineteenth century when New Zealand became the first country to pass legislation for nursing licensure (Rider et al. 2004). In contrast the regulation of midwifery has had a somewhat more tortuous history in that the practice of midwifery was regulated in some countries under the title ‘nurse’. In Ireland, the Report of the Commission on Nursing (Government of Ireland 1998) recommended that nursing and midwifery should be seen as distinct professions; consequently, the Nurses and Midwives Act 2011 provided the legislative framework that established them as distinctly different.

3.3 The definition of nursing and midwifery
Definitions of nursing and midwifery vary. One of the most widely-used definitions was developed by the International Council of Nurses (ICN 2010):
Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.

In 2000, in response the Bologna Declaration that aimed to achieve international co-operation and academic exchange, several European Union countries developed the Tuning Educational Structures in Europe pilot project. The European Union’s Tuning Group (2011: 20) adopted a working definition for the ‘first cycle registered nurse’:

This registered nurse is a professional person achieving a competent standard of practice at first cycle level following successful completion of an approved academic and practical course. This registered nurse is a safe, caring and competent decision maker willing to accept personal and professional accountability for his/her actions and continuous learning. [He/she] practices within a statutory framework and code of ethics delivering nursing practice (care) that is appropriately based on research, evidence and critical thinking that effectively responds to the needs of the individual clients (patients) and diverse populations.

This definition makes reference to the idea of different levels of practice and differential competency requirements. Similarly, definitions of midwifery make reference to specific competency requirements. The International Confederation of Midwives (ICM) (2011: 1) defines a midwife as:

A person who has successfully completed a midwifery education program that is duly recognised in the country where it is located and that is based on the ICM essential competencies for basic midwifery practice and the framework of the ICM global standards for midwifery education; who has acquired the requisite qualifications to be registered and or legally licensed to practice midwifery and use the title ‘midwife’ and who demonstrates competence in the practice of midwifery.

A registered nurse can also be defined in legal terms as a person ‘whose name is entered in the nurses division of the register’ and a registered midwife is defined as a person ‘whose name is entered in the midwives division of the register of nurses and midwives’ (Nurses and Midwives Act 2011 [Pt1, no 41 of 2011]).

In summary, definitions of nursing and midwifery vary and can generally be framed around the requirements of pre-registration education and training, registered nurse or midwife competencies, codes of professional conduct and codes of ethics for nurses and midwives in
individual countries. In many jurisdictions the scope of practice of the nurse and midwife is
detailed in specific publications, many of which make reference to other associated supporting
documents that address codes of practice, codes of ethics and competencies required for
professional registration.

3.4 Regulation of the scope of nursing and midwifery practice in Ireland

In Ireland, nursing and midwifery are self-regulating professions. The Nurses’ and Midwives’
Act 2011 provides the legislative framework relating to the roles and functions of The Nursing
and Midwifery Board of Ireland (NMBI), the statutory professional regulatory body in Ireland.
Prior to the publication of the formal *Scope of Nursing and Midwifery Practice Framework* in
2000, changes in nursing and midwifery practice were facilitated through a process of
certification for individual role extensions. In Ireland ‘scope of practice’ refers specifically to:

[The] range of roles, functions, responsibilities and activities, which a registered nurse,
or 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 (An Bord Altranais 2000a).

Regulation governing scope of practice provides guidance for nurses and midwives in relation to
the expansion of roles and responsibilities. Expansion of scope of practice occurs in the context
of both generalist and specialist practices.

3.5 Evolution of specialist and advanced practice roles

The growth of specialist practitioner roles in nursing can be traced to several developments,
including a response to perceived specialist needs of patients, for example the need for specialist
trauma nurses during global conflicts or a nursing service in rural outposts (Kaasalainen *et al.*
2010). Specialist practitioner roles also grew out of increased interest in defining the niche
requirements of specialist nursing, in terms of regulation and formal recognition of specialist and
advanced practice nursing and midwifery roles (Government of Ireland 1998; ICN 2009a,
2009b; ICN 2005; Institute of Medicine 2010; Kaasalainen *et al.* 2010).

Global health targets have been articulated through the WHO ‘millennium goals’ (WHO 2010).
The challenges to health service delivery in Europe include the changing population
demographics, in particular the increase in the aging population (WHO 2009), and a greater
focus on primary health care and disease prevention (Chiang Mai Declaration 2008; WHO
Additionally, there is an increasing need to link episodes of care and the emergence of the concept of person-centeredness with increased flexibility and client-centred care packages. These developments have led to an increasing focus on enabling nurses to practice to the full scope of their practice and the development of specialist and advanced practice roles. In the last fifteen years, in particular, there has been considerable growth and variation in the range of specialist and advanced practice roles undertaken by nurses and midwives. Much of this change has occurred concomitant with health service reform and political and governmental support. Nurses and midwives have been expanding their roles in some areas of practice and at the same time delegating roles in other areas.

Expansion of the scope of professional practice of nurses and midwives has been linked to either the performance of particular activities, such as prescription of drugs, use of various medical devices, and performance of a particular task or procedure, or to a more specialist expanded role with defined patient groups or defined clinical contexts, often termed clinical nurse specialist or advanced nurse practitioner. With the evolution of such advanced practice roles, nurse- and midwife-led services have gained momentum (Shiu, Lee and Chau 2011). Various nomenclatures have been used to describe advanced practice roles, including advanced practice nurse/midwife, advanced nurse/midwife practitioner and nurse/midwife practitioner. The term ‘specialist generalist’ role has also been used in the context of the developing role of the family health nurse (Martin et al. 2013, Parfitt 2007).

Greater clarity has emerged over time regarding the clinical career pathways for nurses and midwives and the differentiation between the roles of clinical nurse/midwife specialists and advanced nurse/midwife specialists and associated concepts of autonomy, expert practice and professional and clinical leadership (National Council for the Professional Development of Nursing, and Midwifery 2008, 2010). The role of the clinical nurse specialist has a strong patient focus, which may incorporate case management, the care of a defined patient group and limited decision making. The advanced nurse practitioner role can include several elements including assessment, diagnostics and treatment planning, substitution for defined medical roles, autonomy and decision making within defined parameters, and research and audit (Schneider and Faithfull 2011). However, advanced practice roles are frequently under the supervision of medical physicians. This has been criticised on the grounds that leadership roles should not be based on hierarchical divisions emerging from historical interprofessional relationships, but on the
situation in which practice occurs (Common Ground 2011). The International Council of Nurses (2002) defines the advanced practitioner role as follows:

A nurse practitioner-advanced practice nurse is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A master's degree is recommended for entry level.

In Ireland, the National Council for the Professional Development of Nursing and Midwifery (2008: 5) later expanded on this definition:

[Advanced nurse practitioners are] autonomous, experienced practitioners who are competent, accountable and responsible for their own practice … grounded in the theory and practice of nursing/midwifery and [incorporating] nursing/midwifery and other related research, management and leadership theories and skills in order to encourage a collegiate, multidisciplinary approach to quality patient/client care.

The scope of practice associated with the advanced practitioner role incorporates a broad range of practice activities. These include advanced promotion of wellness, health assessment, diagnosis, disease management, health education and promotion, referral ability, prescribing diagnostic procedures, medications and treatment plans, admitting and discharging privileges, patient caseload management, collaborative practice, care coordination, evaluation of healthcare services and research (ICN 2005; The National Council for the Professional Development of Nursing 2008; Sheer and Wong 2008; Pulcini et al. 2010). Additionally, the role requires that nurses and midwives demonstrate the requisite knowledge and skills for their expanded role activities and participate in formal evaluation of the outcomes of their expanded practice role in such areas as clinical audit (Nursing Council of New Zealand 2011). However, the many and varied roles and functions of advanced practice nurses and midwives have caused confusion for healthcare professionals and patients for some time (Gardner et al. 2007; Lowe 2010; Nutt and Hungerford 2010; Kleinpell et al. 2011; Lowe et al. 2012; National Governors Association 2012). In addition variance in roles and functions has created difficulty in terms of defining scope of practice for such advanced roles. Clarity of nursing and midwifery roles and their associated scope of practice provide for greater opportunities to develop consistent measures to evaluate the impact of such roles on healthcare outcomes across healthcare settings (Lowe et al. 2012).
Referring to the nurse practitioner role in Australia, Gardner and Gardner (2005) recommended that nurse practitioners should have the opportunity to develop the role, such that the nurse’s scope of practice should evolve with the role rather than commence with an *a priori* scope of practice for the role. Key to the global development of the nursing and midwifery workforce is the development of new and advanced practice roles with established career pathways (WHO 2013).

In summary, central to the concept of professional regulation of specialist and advanced practice roles are educational preparation, competence, accountability and scope of practice for individual nurses and midwives.

### 3.6 Regulation of the scope of practice occurs on a continuum

Regulation of the scope of practice occurs on a continuum from very prescriptive and restrictive, through lesser degrees of prescription, to permissive (International Council of Nurses 2010).

Restrictive approaches to the definition and regulation of scope of practice provide clear delineations of professional role boundaries. Such approaches frequently feature lists of authorised activities, i.e. activities that are permitted or, in some cases, not permitted. Some such documents set out the standards, limits and conditions related to scope of practice (e.g. College of Registered Nurses of British Columbia, 2013). The advantages of such approaches are that they provide clarity for the practitioner by defining the common practices associated with the role of registered nurse or midwife and clearly delineate restricted practices or practices associated with advanced practice roles only. Such approaches place strict boundaries on the scope of practice of a nurse or midwife, and in so doing, potentially limit opportunities for role expansion. Given the demands of a changing health care environment, the diversity of client groups and the range of patient needs that require effective clinical care, restrictive approaches may ultimately disadvantage both practitioners and patients.

Permissive approaches to the definition and regulation of scope of practice are less prescriptive in that professional responsibility and associated accountability are seen to rest principally with the individual nurse or midwife and their employer. In setting out ‘the range of roles, functions, responsibilities and activities which a registered nurse/midwife is educated, competent, and has authority to perform’ (An Bord Altranais 2000a), the current *Scope of Practice Framework* for nurses and midwives in Ireland typifies this more permissive approach (ICN 2010) The
regulatory authority for nurses, midwives and health visitors in the UK, the Nursing and Midwifery Council (NMC), has provided a position on role boundaries, which similarly typifies the more permissive approach to scope of practice. In its statement on role boundaries, the Council (NMC 2014) declares:

The NMC accepts that through meeting post registration education and practice (prep) standards, registered nurses and midwives will develop their knowledge, skills and competence beyond their initial registration throughout their careers. For this reason, The NMC does not place any boundaries on the roles of nurses or midwives in relation to the parts of the register and fields of practice.

However, the Council points to a clear restriction on a nurse or midwife in relation to midwifery practice by declaring that –‘only a registered and practicing midwife who has notified their intention to practice to a local supervising authority may provide midwifery advice and care’ (NMC 2014). The Council entreats nurses and midwives to recognise the limits of their own competence:

Nurses and midwives must always be aware of the limits of their ability and role boundaries, acknowledge their professional limitations and make accountable decisions about their ability to practise in a safe and effective manner. As a nurse or midwife they are accountable for the care they give as well as the decisions they make.

By placing the responsibility on the nurse or midwife to self-determine their competence to practice the Council is clearly placing scope of practice within an enabling framework. In its statement on expanded roles, the Council also invokes The code: Standards of conduct, performance and ethics for nurses and midwives (NMC 2008), which highlights the need for knowledge and skill for safe practice and the nurse or midwife’s responsibility to continually develop their knowledge and skills for practice.

In addition to self-regulated practice, limits can be placed indirectly on scope of practice through several mechanisms, including lists of prescribed activities, the absence of skills training for specific roles and tasks, employment legislation, the prerogative of physician supervisors in restricting practitioner roles and functions, and employer policies and guidelines.

3.7 Working within and through a ‘scope of practice’

Defining scope of practice for practitioners provides them with clarity regarding the boundaries of role and function. However, some nurses do not work to the full range of their scope of
practice, in terms of using their full range of competencies (D’Amour et al. 2012). Examples of activities which can be construed as inappropriately using the nursing and midwifery resource include: restocking medications, supply resourcing, moving beds, answering telephones, clerical work, housekeeping and repetitive follow up on requests (Schluter et al. 2011). Hence, while scope of practice denotes the outer limits of the professional’s practice, for many nurses the reality is that actual clinical practice is generally much narrower than that which is allowable (Association of Registered Nurses of Newfoundland and Labrador 2006).

A key element of the scope of practice guidance provided in most jurisdictions is that the nurse or midwife needs to be aware of their professional limits and know their own ability and associated role boundaries. In addition, nurses are accountable for the decisions they make and the care that they provide. The UK Nursing and Midwifery Council (NMC) does not place boundaries on the roles of nurses or midwives in relation to ‘the parts of the register and fields of practice’; however, the accountability of the nurse or midwife is reflected through the enactment of the NMC Code (2008), which refers to having the requisite knowledge and skills, recognising limits of competence, keeping knowledge and skills updated, and partaking in activities to remain updated. Accordingly, it is the individual nurse or midwife who places the boundaries on their professional practice. However, nurses in the generalist, specialist, or advanced nurse practitioner practice contexts can be unclear as to their own scope of practice (Kleinpell et al. 2011). This lack of clarity relates to role boundaries and to the expansion of practice to include roles and responsibilities that may have previously been seen as medical roles.

3.8 The change in articulation of scope of practice

Early scope of practice documents focused primarily on providing guidance relating to practice expansion and delegation. Expanded practice concerned issues like meeting patient needs, improving health outcomes, consultation as an antecedent to role expansion, enhancing an aspect of professional practice, being lawful, and the importance of competence in role expansion. Delegation addressed issues such as the need for assessment of the patient, the ability of the person to whom a role is delegated to carry out the role, and the importance of feedback and follow-up.

In its Scope of Professional Practice document, published in 1992, the United Kingdom Central Council (UKCC) replaced the term ‘extended nurses’ roles’ in favour of the idea of expanded practice to meet the needs of patients. The Scope of Professional Practice document was seen as
being the key to a ‘more responsive, liberal and dynamic nursing service’ (Castledine 1993: 6). The WHO Regional Director for Europe, Dr Marc Danzon, has argued that good health workforce planning should include ‘robust yet permissive regulatory frameworks which ensure protection of the public but allow role expansion; and appropriate recognition and reward’ (Cited in Buscher et al. 2009).

Nurses are being asked to proactively identify areas where an expansion in their scope of practice, closely aligned with service need, would lead to improvements in patient outcomes and in the quality and range of available services (HSE 2012). In 2011 the Irish Health Service Executive published A Strategic Framework for Role Expansion of Nurses and Midwives: Promoting Quality Patient Care (HSE 2011). The Framework provided guidance as to whether role expansion lies within the remit of nurses and midwives, clinical nurse specialists and clinical midwife specialists or advanced nurse and advanced midwife practitioners, with reference to differentiation in the levels of decision making required. The Framework included the statement that ‘the level of clinical decision making associated with the expanded role will indicate at what stage of the clinical career pathway it should occur’ (HSE 2011: 29). However, nurses’ and midwives’ practice is increasingly influenced by employers through organisational policies and procedures and, at the same time, regulation is being reconceptualised to ensure protection of the citizen and quality patient care while maintaining equal access to affordable healthcare (ICN 2009a).

In empirical studies, nurses may describe their scope of practice with reference to their daily activities, such as ‘assessment and care coordination’ (White et al. 2008), teaching patients and families, communication and care coordination, integration and supervision of staff, and activities associated with quality of care, patient safety and knowledge updating and utilisation (D’Amour et al. 2012). Nurses also describe their scope of practice with reference to core nursing actions that are supported by critical thinking and ‘synthesising cues’ and include prioritising care, coordinating patient care and safeguarding the patient (Schluter et al. 2011).

Definitions of the scope of nursing and midwifery practice provide for a collective understanding of activities, roles and responsibilities of nurses and midwives and the parameters that are considered important in making scope of practice decisions. Key issues that emerge from such definitions also include level of education and training; competency; authorisation and authority; accountability and responsibility; autonomy; and delegation.
Scope of practice documents increasingly emphasise the importance of patient-level factors, environment or contextual factors, practitioner-level factors and wider national-level factors. Patient-level factors include the central role of the patient in decisions relating to their care and the educated patient as a partner in care decisions, and as a part of a support network, family and community. Hence, scope of practice and professional regulation are underpinned by patient safety and quality care.

Environmental or contextual factors include organisational governance processes for quality and safety, such as quality and risk-management frameworks, policies and guidelines, and organisational culture. These factors also include difficulties with the differentiation in roles and responsibilities of the various healthcare team members, whilst also acknowledging the benefits of teamwork and collaboration. The blurring and overlapping of role boundaries between health care professionals is exacerbated by the lack of clarity regarding the role boundaries of nurses and midwives; however such overlap may simply reflect the overlap that occurs in the real world of practice.

Nurse and midwife level factors include the practitioner’s professional competence, that is the quantum of critical thinking, knowledge, including systems knowledge, judgement, skill and practice, as well as metacognition, or knowing one’s cognitive strengths or weaknesses in relation to particular tasks and activities. Competence is not seen as static but as a continuum; movement on this continuum is influenced by education, frequency of clinical exposure, years of experience and length of experience in a particular clinical context. In addition, nurses need to be aware of the risks and consequences of not performing in a safe manner, which links competence and patient safety. Expanding the boundaries of nursing or midwifery practice is associated with increased accountability and responsibility. Guidance on the scope of practice thus allows for the full range of practice roles and activities that a nurse or midwife can undertake. However, the empirical evidence suggests that individuals usually practice within a narrower scope of practice, given the many other parameters that influence practice decisions.

At a national level, health and social care are continually evolving. Thus the influence and effectiveness of nurses and midwives working in varying contexts, for example primary care, should be enabled through scope of practice frameworks reflecting the varying domains of competency/skills requirements and the increasing focus on the social-cultural context of care. In facilitating this expansion of the role of the nurse and midwife, the ICN has emphasized the
importance of self-regulation of scope of nursing and midwifery practice whilst valuing the contributions of others to that definition of scope of practice. Furthermore expanded nursing and midwifery practice should occur as a component part of a professional (nursing and midwifery) strategic response to a changing health care need. In addition a formal plan or roadmap to facilitate role expansion, inclusive of further education, assessment of competence and potentially credentialing, is required.

National decision-making frameworks reflecting a whole of the workforce perspective offer the potential of a generic approach to definitions of scope of practice and decision making frameworks (Nursing and Midwifery Board of Australia 2007). This can be facilitated through the use of commonly understood shared terminology.

3.9 Facilitators and barriers to a full scope of practice
A number of empirical studies have provided evidence of the facilitators and barriers that exist in relation to nurses’ and midwives’ scope of practice. Buscher et al. (2010) reported the results of a World Health Organisation-commissioned survey that suggested that several obstacles exist in relation to nurses working to their full scope of practice, including limited financial resources, health care systems’ hierarchical arrangements with associated medical domination, and difficulties in articulating the professional roles of nurses and midwives. An Australian survey of enrolled nurses (ENs) revealed that lack of opportunity to expand scope of practice was linked to a lack of opportunity for role expansion or lack of support from management, budget restrictions and the nature of the EN grade (Davies and Fox-Young 2002). However, the majority of survey respondents noted that the scope of practice decision-making framework was an enabler in that it helped them to map role relationships among healthcare team members.

The Institute of Medicine (IOM) in the United States has suggested that the existence of ‘overly restrictive scope-of-practice regulations for advanced-practice registered nurses (APRNs) that vary by state’ act as a barrier to expanded practice (IOM, 2010). Such restrictions are associated with a decreased number of nurse practitioners per capita in states that have more restrictive approaches to regulation for scope of practice (Reagan and Salsberry 2013; Iglehart 2013).

Regional variability in the supply of healthcare professionals within the workforce and increased demands for services have provided the impetus for nurses to expand their scope of practice. The proliferation of new healthcare roles, the diversity of skill mix, the variety of clinical settings,
reduced staff numbers and the changes to the role of the nurse over time have compounded the ‘blurring’ of professional boundaries (Schluter et al. 2011).

Registration or licensure legislation restricts the practice of nursing to those registered as nurses; therefore the delegation of nursing care requires supervision by registered nurses (Nurses and Midwives Act 2011, Nurses Rules 2004). In some countries, a differentiation between the scope of practice of the enrolled nurse and registered nurse is facilitated through the use of a scope of practice decision-making framework (e.g. Queensland Nursing Council 2005; Department of Health Western Australia 2005). For example, the framework of the Queensland Nursing Council lists roles and responsibilities that cannot be delegated to enrolled nurses, such as the interpretation of assessment data (Queensland Nursing Council 2005). However, the framework also makes reference to the expanded role of the Nurse Practitioner, permitting direct referral of patients to other healthcare professionals, prescribing medications and the ordering of diagnostic investigations (Queensland Nursing Council 2005).

In a study of how Australian nurses conceive their scope of practice, Schluter et al. (2011) reported that some nurses equated ‘good nursing’ to working in ‘proximity to patients providing total patient care’. However, this ability to practice in proximity to patients can be restricted by factors like the increasing use of support staff to provide direct patient care, decreased length of stay in hospital, patient acuity levels, staff shortages, augmented indirect care responsibilities and perceived difficulties in interpreting core nursing roles that cannot be delegated (Schluter et al. 2011). Hence, clarity regarding what constitutes core nursing or midwifery roles and functions would help in defining scope of practice and associated decisions regarding the delegation of roles and tasks. The difficulty in defining what constitutes scope of nursing practice is also related to the rapid pace of change in the healthcare context (Lowe et al. 2012). Medico-legal concerns as well as a lack of systematic outcome data have also been cited as a barrier to practice expansion. Ways of overcoming these barriers include active engagement by nurses and midwives in health policy formulation, nurturing professional relationships within the multidisciplinary team, and demonstrating empirically the improved health outcomes of expanded practice (Neft et al. 2013).

Evidence suggests that where nurses are better educated, nursing-sensitive patient outcomes are better (Aiken et al. 2014). Similarly, expanded nursing and midwifery practice results in improved patient outcomes (National Council for Professional Development of Nursing and
Midwifery 2010). Hence, the quality of care provided by nurses and midwives working in expanded roles provide a convincing argument to support expanded practice (Eibner et al. 2013).

3.10 Defining scope of practice: Summary and conclusions

Scope of practice is a terminology used in the regulation of various professions. It defines the procedures, actions and processes that are permitted for the individual who is registered or licenced to practice. The individual practitioner’s scope of practice is determined by the professional’s education and competence, which, in turn, give authority to perform a particular role or task. Individual jurisdictions have enacted laws, established regulatory authorities and published regulations that prescribe the requirements for training and education as well as guidelines that define scope of practice for the profession.

Regulation of scope of practice can take many forms, from listing of services, individual interventions or competencies, to statements of broader roles and functions such as health promotion or injury prevention (Bigham et al. 2013), to decision-making frameworks that assist the practitioner in making self-regulated decisions about practice actions (An Bord Altranais 2000a). A clearly defined scope of practice provides clarity to all stakeholders in relation to the role competencies and accountabilities of the nurse and midwife, while being cognisant of the emerging needs of patients and health services.

The responsibility for defining the scope of practice of nurses and midwives lies with their statutory regulatory authority (An Bord Altranais 2000a; ICN 2004), but also with the individual nurse to practice within their established scope of practice. The principle that individual nurses are self-regulated underpins scope of practice (Canadian Nurses Association 2007), with self-regulation being fundamental to the healthy evolution and advancement of nursing and midwifery (ICN 2009).

Despite the benefits of expanded nursing and midwifery roles to patients and health services, it appears that many nurses and midwives are not practising to the full range of their scope of practice. This is partly related to a number of barriers, such as lack of opportunity and lack of clarity regarding professional roles and role boundaries, as well as medico-legal concerns.
3.11 A comparative analysis of other nursing and midwifery regulatory and professional bodies’ scope of practice and associated decision-making frameworks

The comparative analysis of other nursing and midwifery regulatory and professional bodies’ scope of practice and associated decision-making frameworks was based on 12 selected published frameworks, selected on the basis of a systematic search and inclusion criteria, as outlined in Chapter 2. The analysis identified two main approaches to the regulation of the scope of practice and associated decision-making frameworks. The first approach is policy and regulation driven. The second approach is based on notions of professionalism and accountability. The two approaches are not mutually exclusive, but have similar elements with a different emphasis (Figure 3.1).

![Figure 3.1: Approaches to decision-making frameworks](image)

The words ‘scope’, ‘standards’ and ‘competencies’ tend to be used interchangeably, while frameworks address both preparatory undergraduate training and post-registration specialist roles, with a particular focus on the expansion of practice beyond initial registration. All frameworks incorporate a decision-making algorithm, with the exception of one (CRN Nova Scotia 2009, 2013), which lists criteria for performing a task or role.
There appears to be limited information about how the various scope of practice frameworks were developed. The frameworks of the UK, Australia and New Zealand contain the most detailed information on scope of practice and decision making. The relevant information dates from 2009, with earlier versions being superseded by those included in this analysis.

The following observations emerged from the comparative analysis (Figure 3.1):

- All scope of practice and decision-making frameworks are underpinned to some extent by policy and regulation
- Accountability is a key feature and varies from being explicit to being veiled in other concepts
- Two main approaches are used to guide decision making for nurses and midwives; one driven by policy and regulation, the other by professional accountability

Approach 1 reflects policy and regulations which govern nursing and midwifery practice. In this approach to decision making the focus is on informing the behaviours and actions of the nurse or midwife. The framework of the North Carolina Nursing Board (2013) typifies this model, as the following extract illustrates:

Is the activity prohibited by the Nursing Practice Act, Board Rules, Statements, or by any other law, rule, or policy? If the answer is ‘yes’ the advice is ‘stop’ or if unsure to refer to nursing admin or Board.

Approach 2 links professional decision-making to a framework of accountability, which is aligned to traditional nursing and midwifery practice, where the role of the practitioner is seen to be autonomous and therefore self-regulating. This approach identifies the patient as central to the practitioner’s professional activities and reflects the expectations on the part of the nurse or midwife in taking responsibility for individual decision-making. Typical of this is the type of question contained in the decision-making framework of the Australian Nursing and Midwifery Council 3.13 (2013): ‘Is this activity within the current/contemporary scope of nursing practice?’ The nurse or midwife is prompted to assess their level of competence, confidence and accountability, while taking cognisance of organisational capacity, risk assessment and their educational preparation.

The scope of nursing and midwifery roles is more limited at the individual level than that of the profession as a whole. This means that individual practitioners work within boundaries that are
determined by a number of factors, including their knowledge and educational preparation, their acquired competencies and skills, and the environment in which they work. The role of the nurse and midwife is underpinned by public expectations and a legal, moral and ethical code of conduct. These components are visible within scope of practice guidelines and decision-making frameworks from a number of jurisdictions. However discrete differences exist in emphasis, as suggested in the two main approaches. This suggests two major themes within the content of the scope of practice and decision-making frameworks reviewed: 1) the prominence of legislative frameworks; and 2) general principles and criteria.

3.12 Prominence of legislative frameworks

In a number of jurisdictions, mainly in North America, scope of practice and decision-making frameworks emphasise the individual confidence, competence and accountability of the practitioner in the process of decision making. This is to ensure that the task or activity is permitted by legislation and supported by professional standards and education at the outset. These frameworks fit with Approach 1, reflecting a focus on the policy and regulation governing nursing and midwifery practice. Documents from the College of Registered Nurses (CRN) of British Columbia (2013), College of Registered Nurses (CRN) of Nova Scotia (2009), the North Carolina Board of Nursing (2013) and the Virginia Board of Nursing (2012) reflect this approach. For example, the Scope of Practice for Registered Nurses, Standards, Limits and Conditions College of Registered Nurses of British Columbia (CRNBC 2013) identifies four criteria for determining scope of practice. These are termed ‘controls on nursing practice’, with four levels of controls set out as follows:

1. Nurses (Registered) and Nurse Practitioners Regulation, which sets out the scope of practice in fairly broad strokes (lists of tasks)
2. CRNBC standards, limits and conditions, which complement and further define and limit the scope of practice set out in the Regulation
3. Employer policies, which may restrict registered nurses’ practice in a particular agency or unit
4. An individual registered nurse’s competence to carry out a particular activity (CRNBC 2013: 2–3).

These are framed hierarchically where regulation, standards and policies underpin decisions linked to individual competencies. The framework differentiates between ‘acting with an order’ and ‘acting without an order’ and provides details of restricted and unrestricted tasks and
activities and sets very clear guidance about the need for policies and procedures to underpin activities.

Delegation, as a role of the registered nurse, is a prominent feature of scope of practice frameworks in North America, where the Licenced Practice Nurse role exists. The scope of practice exemplified in Approach 1 uses a particular language which includes key words like ‘activity’, ‘task’, ‘prohibited’ and ‘order’. The frameworks represented in Approach 1 typically require the practitioner to clearly define the activity or task and to identify if there is evidence to support it. The following extract from the framework of the North Carolina Board of Nursing (2013) illustrates this approach:

- Define, identify, describe, and clarify the activity or task
- Is the activity prohibited by the Nursing Practice Act, Board Rules, Statements, or by any other law, rule, or policy?
- Education, policies, competence
- Is activity indicated as routine in nursing literature? Does documented evidence support activity?
- Would a reasonable prudent nurse perform this activity in this setting?

While legislation features in scope of practice frameworks categorised within Approach 2, it is less prominent than references to individual accountability in decision-making. For example, in the framework of the Nursing Council of New Zealand (2010) the first question in the decision-making framework is linked to the benefits and outcomes for patients, and is followed by the question: ‘Is the role or activity supported by any legislation or professional standards?’ Where the answer is ‘no’, the practitioner is prompted to ‘refer to appropriate health practitioner or health care provider and collaborate for on-going care’. This places the decision-making within the context of the practice setting and emphasises the patient needs and benefits. Within this framework, the practitioner is given indicators as to the next steps beyond contacting a manager or regulatory body.

3.13 General principles and criteria

Five main principles for decision making underpinning the scope of professional nursing and midwifery practice emerged from the analysis, which may be couched as questions:

- Is there legislated authority or restrictions on professional practice?
- What are the professional standards and expectations of practice?
What is the evidence for practice?

What is the practitioner’s individual capability, in terms of knowledge, skills and competence, for practice?

Is there contextual or organisational support for the practice?

As already noted, some jurisdictions, particularly in North America, define scope of practice through lists of tasks and activities that a practitioner may or may not undertake. However, there has been a significant movement towards limits of practice being determined by the knowledge and skills required for safe and competent performance, and towards practitioners being accountable for whatever tasks or actions they decide to perform. For example in its guidelines for expanded practice, the Nursing Council of New Zealand (2010: 11) provides key principles for self-regulated practice that illustrate the approach in which accountability is a central tenet:

Ensuring patient safety is the primary consideration when determining if expansion of practice is appropriate. Expansion of the scope of practice is based on appropriate consultation and planning, educational preparation and a formal assessment of the nurse’s competence to undertake an expanded scope of practice. All nurses are accountable for their decisions about whether an activity is beyond their own capacity or scope of practice and for consulting with or referring to other health professionals.

Historically the guidelines and frameworks governing scope of practice in the United Kingdom have reflected the approach that emphasises accountability in decision-making. However, at the time of writing the Nursing and Midwifery Council (NMC) in the UK was undertaking a major review of its Code of Conduct for practicing nurses, midwives and health visitors. These developments are part of the NMC response to the Francis Report (2013), which pointed to serious failings in care at the Mid-Staffordshire Hospital that were the result of ineffective or absent leadership (Francis 2013). The UK is moving towards a process of revalidation, which will require practitioners to provide third-party verification of eligibility to practice. The present Code (NMC 2008: 2) is central to the scope of nursing practice, emphasising the accountability and responsibility of the individual nurse:
As a professional, you are personally accountable for actions and omissions in your practice, and must always be able to justify your decisions. Accountability is integral to professional practice. Nurses and midwives make judgements in a wide variety of circumstances, and use their professional knowledge and skills to make a decision based on evidence for best practise and the person’s best interests. Nurses and midwives need to be able to justify the decisions they make … They are professionally accountable to the NMC, as well as having a contractual accountability to their employer and are accountable in the law for their actions.

In its ongoing review, the UK regulatory authority has moved from a decision-making framework format towards a more integrated source of reference and information for practitioners to help them clarify their scope of practice. Practitioners are provided with access to ‘regulation in practice topics’, on-line resources ‘to help nurses and midwives apply their professional judgement, putting regulatory principles into practice’ (NMC 2014). These resources address several practice issues that fall within or at the margins of professional role boundaries, such as mixing medications, obtaining consent and free-birthing. Further, these practice issues are linked to the standards expected in the Code, and provide definitions and set out expectations of the practitioner. They also provide links to appropriate legislation and other relevant sources of information. These resources for regulation in practice accentuate the accountability of the individual practitioner.

The scope of practice and decision-making frameworks of the UK, Australia and New Zealand each emphasise the needs of the patient and the accountability of the practitioner in determining what activities they can undertake. While the Australian framework identifies the context and organisational support for scope, these considerations are not prominent in frameworks of the other two jurisdictions, and may be important to emphasise given current fiscal constraints.

3.14 Comparative analysis of other regulatory frameworks: Summary and conclusions
Determining scope of practice is an element of professional nursing and midwifery practice and individual decision making is central to this. Core concepts and principles underpin scope and decision-making frameworks in nursing and midwifery practice. While there is a degree of commonality in these principles, two somewhat distinct framework types are evident, one emphasising legislation and rules and the other highlighting individual accountability. These two types are influenced by the context in which nurses and midwives work and their perceived roles and responsibilities.
Frameworks in Approach 1 seek to define tasks and activities to be carried out and emphasise policy and the regulatory framework at the outset. Within this approach the decision-making framework is typically behaviour driven, arguably reductionist and may restrict the decision-making process to ‘stopping the behaviour’ or advising the decision maker to seek advice, typically from a manager or regulatory body.

Frameworks in Approach 2 emphasise the accountability of the individual nurse or midwife and place the needs of patients at the forefront of the decision-making process. In this way the approach is enabling; it promotes collaboration and communication concerning who to consult or whether to refer to other health professionals, and leaves the final decision about how to act with the nurse or midwife.

The two approaches overlap and are not mutually exclusive, but emphasise the status of nursing and midwifery practice in a given jurisdiction. Neither emphasises patient choice, which is a fundamental principle of evidence-based practice. Hence this aspect and related contextual aspects of scope of practice and decision-making might be usefully incorporated into future frameworks.

### 3.15 Documentary review of the Framework document

The *Scope of Nursing and Midwifery Practice Framework* document (An Bord Altranais 2000a) was subjected to a descriptive documentary review, using a bespoke documentary review instrument. The instrument contained a list of 34 statements, presented as seven scales, about the content and suitability of the *Framework* document and the decision-making algorithm as well as the general layout and design of the document. Each statement was presented in a five-point Likert scale, with which each member of the research team indicated their level of agreement from ‘strongly disagree’ (1) to ‘strongly agree’ (5). This method permitted an objective description the *Framework* document with reference to the language used to represent key constructs and ideas and the suitability of the document as a guiding framework.

### 3.16 Narrative description and ratings of the Framework document

The *Scope of Practice Framework* document is presented as an A5 booklet comprising 12 pages, including references. It is also available online in portable document format (PDF). The document is presented in five main sections, as follows: Introduction; Defining scope of nursing practice; Defining scope of midwifery practice; Important considerations in determining the
scope of nursing and midwifery practice; Principles for determining scope of practice. In addition the document contains a decision-making algorithm, a diagrammatic representation of the step-by-step procedure that the nurse or midwife should follow when making a decision about scope of practice. The algorithm is set out on a single page.

Section 1 Introduction
Section 1 is presented as a short introduction, which describes the role of An Bord Altranais, the regulatory authority, the meaning of scope of practice, the function of the framework document and the professional context within which it exists. The Introduction also sets out the structure of the Framework document.

The research team rated seven statements (Table 3.1) that described the general content and suitability of the document. Responses indicated that the document was rated as a suitable resource to inform nurses/midwives about the concept of ‘scope of practice’ (statement 5), with evidence of the origins/authorship of the document (statement 3) and consistent use of the key constructs throughout (statement 4). Two statements in the scale (statements 1 and 2) were based on the AGREE II criteria for assessing guidelines (Brouwers et al 2010). Responses to these two statements indicated there was no consensus among the team that the content of the document was based on best-available evidence at the time of publication or that it was prepared through a consultation process. The majority agreed that the document enables expansion of practice (statement 6) and encourages the practitioner to question the boundaries of his/her practice (statement 7).

Table 3.1 Ratings for general content and suitability

<table>
<thead>
<tr>
<th>Section A – General content and suitability</th>
<th>Strongly Disagree n (%)</th>
<th>Disagree n (%)</th>
<th>No Opinion n (%)</th>
<th>Agree n (%)</th>
<th>Strongly Agree n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 The content is based on the best-available evidence at the time of publication (e.g. review cited)</td>
<td>2 (25.0)</td>
<td>2 (25.0)</td>
<td>0 (25.0)</td>
<td>2 (25.0)</td>
<td></td>
</tr>
<tr>
<td>2 It is evident that the content of the document was prepared through a consultation process</td>
<td>2 (25.0)</td>
<td>3 (37.5)</td>
<td>1 (12.5)</td>
<td>0 (25.0)</td>
<td></td>
</tr>
<tr>
<td>3 There is evidence to indicate the origins/authorship of the document</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>1 (12.5)</td>
<td>4 (50.0)</td>
<td></td>
</tr>
<tr>
<td>4 In general, the key constructs are used consistently throughout the document</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>7 (87.5)</td>
<td>1 (12.5)</td>
<td></td>
</tr>
<tr>
<td>5 In general, the document is a suitable resource to inform nurses/midwives about ‘scope of practice’</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>6 (75.0)</td>
<td>2 (25.0)</td>
<td></td>
</tr>
<tr>
<td>6 In general, the document inhibits the nurse or midwife in expanding the scope of his/her practice</td>
<td>1 (12.5)</td>
<td>6 (75.0)</td>
<td>1 (12.5)</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>7 In general, the document encourages the practitioner to question the boundaries of his/her practice</td>
<td>0 (12.5)</td>
<td>1 (12.5)</td>
<td>7 (87.5)</td>
<td>0 (0)</td>
<td></td>
</tr>
</tbody>
</table>

(N =8)
**Sections 2 and 3: Defining scope of nursing and midwifery practice**

Sections 2 and 3 of the *Framework* document contain statements defining the scope of nursing and midwifery practice. In Section 2, the definition of the scope of nursing practice is followed by three definitions of nursing based on WHO and ICN definitions. The section also contains a list of six values that guide the way nursing care is delivered; these values include the need to promote high standards based on best-available evidence, and the need to promote the patient’s best interest, patient advocacy and patient empowerment.

Section 3 contains a definition of the scope of midwifery practice, a definition of midwifery and a list of eleven activities that midwives ‘are entitled to take up and pursue’. The section also contains a list of eight values that guide the way in which midwives deliver care; these values speak of childbirth as a normal process and the focus of the midwife’s role, as well as the midwife’s role in promoting best evidence, partnership in the midwife-mother relationship, and the individuality of the woman and her family. Both Sections 2 and 3 refer to the *Code of Professional Conduct for each Nurse and Midwife* and Section 3 also refers to the *Guidelines for Midwives* produced by An Bord Altranais.

The research team rated three statements for Sections 2 and 3 (Table 3.2). There was majority agreement that the *Framework* document provides a clear definition of the scope of nursing practice (statement 8), midwifery practice (statement 9) and that the definitions of each were clearly distinguishable (statement 10).

<table>
<thead>
<tr>
<th>Section B – General content and suitability</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>No Opinion</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>8</td>
<td>Section 2 provides a clear definition of the concept of scope of nursing practice</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>(N =8)</td>
<td>9</td>
<td>Section 3 provides a clear definition of the concept of scope of midwifery practice</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>The definitions of the scope of nursing and midwifery practice are clearly distinguishable</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

**Section 4: Important considerations in determining the scope of nursing and midwifery practice**

Presented in two pages, Section 4 of the *Framework* document contains discussion of six ‘important considerations in determining the scope of nursing and midwifery practice’, as follows: competence; accountability and autonomy; continuing professional development; support for professional nursing and midwifery practice, delegation and emergency situations.
Within each of the six sections the construct under discussion is defined and this is followed by a discussion of the implications of the construct as it applies to scope of practice. Also contained under the discussion of delegation is a list of seven principles that should inform a nurse or midwife’s decision to delegate.

The section on emergency situations is presented as a short disclaimer, which declares that ‘nothing in this document will be construed as preventing a nurse or midwife from taking appropriate action in the case of an emergency’ and this is followed by a statement on the responsibility of the nurse or midwife in promoting the best interests of the individual in such situations.

The research team rated seven statements (Table 3.3) concerning ‘important considerations in determining the scope of nursing and midwifery practice’. Overall, the majority of the team agreed or strongly agreed that the following items for consideration appeared valid, in terms of reflecting real-world situations: the important considerations overall (statement 11), competence (statement 12), accountability and autonomy (statement 13), continuing professional development (statement 14), delegation (statement 16) and emergency situations (statement 17). However, just half of the team agreed that consideration of ‘support’ in determining the scope of practice appeared valid (statement 15).

Table 3.3 Ratings for important considerations

<table>
<thead>
<tr>
<th>Section C – Important considerations</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>No Opinion</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 Overall the ‘important considerations’ in determining the scope of practice appear valid, i.e. reflect real-world situations</td>
<td>0 (12.5%)</td>
<td>1 (12.5%)</td>
<td>0</td>
<td>7 (87.5%)</td>
<td>0</td>
</tr>
<tr>
<td>12 The consideration of ‘competence’ in determining the scope of practice appears valid, i.e. reflect real-world situations</td>
<td>0 (12.5%)</td>
<td>1 (12.5%)</td>
<td>0</td>
<td>5 (62.5%)</td>
<td>2 (25.0%)</td>
</tr>
<tr>
<td>13 The consideration of ‘accountability and autonomy’ in determining SOP appears valid</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6 (75.0%)</td>
<td>2 (25.0%)</td>
</tr>
<tr>
<td>14 The consideration of ‘continuing professional development’ in determining the scope of practice appears valid</td>
<td>0</td>
<td>0</td>
<td>1 (12.5%)</td>
<td>7 (87.5%)</td>
<td>0</td>
</tr>
<tr>
<td>15 The consideration of ‘support’ in determining the scope of practice appears valid, i.e. reflect real-world situations</td>
<td>0 (12.5%)</td>
<td>1 (12.5%)</td>
<td>3 (37.5%)</td>
<td>4 (50.0%)</td>
<td>0</td>
</tr>
<tr>
<td>16 The consideration of ‘delegation’ in determining the scope of practice appears valid, i.e. reflect real-world situations</td>
<td>0 (25.0%)</td>
<td>2 (25.0%)</td>
<td>0</td>
<td>5 (62.5%)</td>
<td>1 (12.5%)</td>
</tr>
<tr>
<td>17 The consideration of ‘emergency situations’ in determining the scope of practice appears valid</td>
<td>0 (25.0%)</td>
<td>2 (25.0%)</td>
<td>1 (12.5%)</td>
<td>4 (50.0%)</td>
<td>1 (12.5%)</td>
</tr>
</tbody>
</table>

(N = 8)
Section 5: Principles for determining scope of practice

Section 5 of the Framework document contains a list of eight principles for determining scope of practice. These principles relate to expansion of practice (principles 1 to 3, 6), competence (statements 4 and 5), delegation (principle 7) and accountability (principle 8). With the exception of principle 7, each statement of principle is generally presented in no more than one or two sentences.

The research team rated nine statements, eight referring to the clarity of each statement and one referring to the overall clarity of the section (Table 3.4). In the case of all nine statements, the majority of the team agreed or strongly agreed that, overall, the list of eight principles for determining the scope of practice was clearly stated (statement 18) and that each of the principles was clearly stated (statements 19 to 26).

<table>
<thead>
<tr>
<th>Table 3.4 Ratings for important considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section D – Important considerations</td>
</tr>
<tr>
<td>18 Overall, the ‘list of eight principles for determining the scope of practice’ are clearly stated</td>
</tr>
<tr>
<td>19 ‘Principle 1’ for determining the scope of practice is clearly stated</td>
</tr>
<tr>
<td>20 ‘Principle 2’ for determining the scope of practice is clearly stated</td>
</tr>
<tr>
<td>21 ‘Principle 3’ for determining the scope of practice is clearly stated</td>
</tr>
<tr>
<td>22 ‘Principle 4’ for determining the scope of practice is clearly stated</td>
</tr>
<tr>
<td>23 ‘Principle 5’ for determining the scope of practice is clearly stated</td>
</tr>
<tr>
<td>24 ‘Principle 6’ for determining the scope of practice is clearly stated</td>
</tr>
<tr>
<td>25 ‘Principle 7’ for determining the scope of practice is clearly stated</td>
</tr>
<tr>
<td>26 ‘Principle 8’ for determining the scope of practice is clearly stated</td>
</tr>
</tbody>
</table>

Section 6: Decision-making algorithm

The Framework document contains a decision-making algorithm, entitled ‘the nurse/midwife scope of practice decision making framework’. This is presented on a single page of the document as a diagrammatic representation of the step-by-step procedure that the nurse or midwife should follow when making a decision about their scope of professional practice. The diagram contains a series of incremental procedural steps of the nature of rules for solving a problem in a finite number of steps.
The research team rated three statements about the clarity of the algorithm (Table 3.5). The majority of the team agreed or strongly agreed that the algorithm presents a clear guide for decision-making in everyday midwifery practice situations (statement 27), presents a clear guide for decision-making in everyday nursing practice situations (statement 28) and that the statements/directions in the decision-making algorithm (page 11) are clear.

### 3.17 Layout and design of the Framework document

The research team rated five statements about the layout and design of the document (Table 3.6). The team agreed or strongly agreed that overall the document was finished to a high standard (statement 30), the majority agreed that the use of ‘white space’ worked well to create contrast and balance (statement 31), that the A5 format was user friendly (statement 32), and that the colour clearly distinguished the document from other documents (statement 34). Just half of the research team agreed that the typeset and font size made the document easy to read (statement 33).
**Summed scores and general comments**

The responses yielded from the documentary analysis rating instrument were analysed using measures of central tendency and dispersion of scores, specifically the median score and the inter quartile range, respectively. Generated independently by eight reviewers, the individual reviewers’ rating scores for each section were summed (Table 3.7).

| Table 3.7 Summed scores from rating instrument |
|-----------------|-----------------|-----------------|-----------------|
| Section | No. items | Range | IQR | Median |
| A       | 7         | 20–29  | 20.25–28.0 | 23.0          |
| B       | 3         | 11–13  | 12.0–13.0   | 12.0          |
| C       | 7         | 22–31  | 24.3–28.0   | 26.5          |
| D       | 9         | 31–45  | 34.3–42.0   | 37.0          |
| E       | 3         | 10–14  | 12–14       | 12.5          |
| F       | 5         | 14–23  | 16–21       | 19.5          |

The median scores for each section yielded from the responses provided by the individual members of the research team showed that overall there was a high level of agreement with the statements. These summed scores may be interpreted as indicating that the consensus view of the research team was that overall the document was of a high quality, in terms of content, suitability as a guiding framework, consistency in use of constructs, validity, in terms of reflecting real-world situations, clarity of statements of principles and good quality of layout and design.

**3.18 Documentary review: summary and conclusions**

The items in the documentary review instrument gave rise to some discussion among the members of the team and some additional comments and recommendations were proffered. There was agreement that any revisions of the *Scope of Practice Framework* document would benefit from the following addenda: updating of in-text citations and references; a section on expanded roles, specifically the advanced practitioner role and also a statement on prescriptive authority; a section on the practice context and the responsibilities of the health service provider/employer; a section on interprofessional working and the multidisciplinary team and the responsibilities of the practitioner within this context. In addition, while the decision-making algorithm includes reference to the availability of ‘guidelines/protocols or supports, this section could be further expanded in any revised document, to include guidelines as to the practitioner’s responsibilities and responses in circumstances in which no explicit policies or guidelines exist. The Nursing and Midwifery Board of Ireland might also usefully consider the merits of entering into discussions with other regulatory authorities for health professionals in Ireland, with the
view to establishing if there are shared elements in scope of practice guidelines that might be incorporated into their respective guidelines.
Chapter 4

FINDINGS: NMBI EDUCATION DEPARTMENT ENQUIRIES DATABASE

4.1 Introduction
This chapter presents the findings arising from an analysis of enquiries to the Nursing and Midwifery Board of Ireland (NMBI). The database contained a total of 9,818 enquiries recorded by NMBI staff during the period January 2001 to the end of July 2013. All entries to the database were assessed for inclusion and exclusion criteria as set out in Chapter 2. The sources of enquiries to the NMBI and the timing of the enquiries are outlined. The findings from the analysis of the relevant queries within the database are presented as major themes and sub-themes. The chapter also provides a summary of the observations about the database that may be of relevance to its future development.

After the data cleaning process was complete the database contained a total of 978 entries that were deemed to be relevant to the scope of nursing and midwifery practice. Of the 978 queries received, the highest proportion, approximately one fifth (20.6%), was from nurses working in a general or children’s nursing setting. Others practice areas from which relatively high levels of queries were received included psychiatric and intellectual disability settings (13.7%) and public health and community nursing (14%) (Table 4.1).

<table>
<thead>
<tr>
<th>Practice Area</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>General nursing and children’s nursing</td>
<td>201</td>
<td>20.6</td>
</tr>
<tr>
<td>Public health nursing and community</td>
<td>137</td>
<td>14.0</td>
</tr>
<tr>
<td>Psychiatric/ID (including Community and ID residential care)</td>
<td>134</td>
<td>13.7</td>
</tr>
<tr>
<td>Nursing home</td>
<td>86</td>
<td>8.8</td>
</tr>
<tr>
<td>Midwifery (incl. community MW)</td>
<td>64</td>
<td>6.5</td>
</tr>
<tr>
<td>Practice nursing</td>
<td>62</td>
<td>6.3</td>
</tr>
<tr>
<td>Agency, independent practitioner/private sector</td>
<td>54</td>
<td>5.5</td>
</tr>
<tr>
<td>School (incl. care home)</td>
<td>23</td>
<td>2.4</td>
</tr>
<tr>
<td>Occupational health nursing (including private setting)</td>
<td>23</td>
<td>2.4</td>
</tr>
<tr>
<td>Private hospital</td>
<td>17</td>
<td>1.7</td>
</tr>
<tr>
<td>Prison service</td>
<td>15</td>
<td>1.5</td>
</tr>
<tr>
<td>Management of service</td>
<td>14</td>
<td>1.4</td>
</tr>
<tr>
<td>Uncategorised</td>
<td>55</td>
<td>5.6</td>
</tr>
<tr>
<td>Other (including voluntary organisations and. education)</td>
<td>93</td>
<td>9.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>978</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

The nature and detail of information entered into the database during the review period varied and changed over time. In the earlier years the database contained records concerning day-to-day
practice and issues of concern to the wider profession and were relatively short entries. In more recent years entries contained more detailed information and incorporated enquiries from clinicians, service managers and members of the public. Analysis of the database indicted that a small number of enquiries were submitted as a way of venting frustration with issues at work and did not constitute a legitimate enquiry concerning the scope of the practice. The highest proportion of calls was made in the period 2008–2011, which corresponds with a period when some key publications were prepared by NMBI, for example, The Implementation of the Review of Nurses and Midwives in the Prescribing and Administration of Medicinal Report (An Bord Altranais November 2008) and Professional Guidance for Nurses working with Older People (An Bord Altranais 2009) (Table 4.2).

Table 4.2 Breakdown of enquiries by selected periods

<table>
<thead>
<tr>
<th>Timescale</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-2005 (4 years)</td>
<td>253</td>
<td>25.9</td>
</tr>
<tr>
<td>2005–2007 (2 years)</td>
<td>206</td>
<td>21.1</td>
</tr>
<tr>
<td>2008–2011 (4 years)</td>
<td>365</td>
<td>37.3</td>
</tr>
<tr>
<td>2012–July 2013 (2.5 years)</td>
<td>154</td>
<td>15.7</td>
</tr>
<tr>
<td>Total</td>
<td>978</td>
<td>100</td>
</tr>
</tbody>
</table>

Over one third (36%, n=352) of all queries concerned medication management, either directly or indirectly. The majority of these came from practitioners in the community with over half of these (53.1%, n=187) dating from the period pre-2007. In the period 2008–2011, a surge in enquiries was evident from practitioners in the community (12.5%, n=123); however only a very small proportion of these queries (n=10) mentioned ‘nurse prescribers’ specifically.

The analysis of the 978 queries within the data resulted in the emergence of three main themes that were labelled as: ‘Medication management: Are we covered?’; ‘Evolving scope of practice: Where do I stand?’ and ‘Professional role boundaries’ (Table 4.3). Each major theme was made up of a number of sub-themes, each representing a distinct aspect of the major theme.
Table 4.3 Scope of Nursing and Midwifery Practice – overview of enquiries

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
<th>Key issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication management: Are we covered?</td>
<td>Are we covered?</td>
<td>Practice innovation, Protocols, Dispensing, Repeat prescriptions/transcription, Emergent/First aid response</td>
</tr>
<tr>
<td></td>
<td>Non-nurse administration</td>
<td>Accountability, Developing policy and education of support staff</td>
</tr>
<tr>
<td></td>
<td>Independent practice</td>
<td>Insurance</td>
</tr>
<tr>
<td>Professional boundaries</td>
<td>Eligibility</td>
<td>To provide Maternal care, To provide nursing service</td>
</tr>
<tr>
<td></td>
<td>Voluntary service</td>
<td></td>
</tr>
</tbody>
</table>

4.2 Medication management: Are we covered?

This theme describes the enquiries concerning medication management, the category that appeared most frequently in the database (n =353) and reflected An Bord Altranais position on the matter, which states: ‘the professions’ responsibilities, activities and accountability involving medications are intrinsically linked to the individual’s scope of practice’ (An Bord Altranais 2007: 5). These emerged largely from clinical settings where practitioners work alone for the most part, including: as public health nurses in the community; as practice nurses; in long-term residential care; in palliative care; as school nurses and occupational health nurses; as first aiders; and those working in independent practice.

Issues around the introduction of prescriptive authority did not feature prominently among enquiries to the NMBI database, with relatively few relating to prescribing (n=10). Some practitioners appeared fixed in their view of scope of practice and to not fully appreciate the level of individual decision making around scope of practice. In some instances the questions around scope appeared misplaced and related to an inadequate understanding of the guidelines on administration of medication and the relevant legislation that underpins their practice. Examples of queries posed under scope were related to issues around knowledge of medication management principles, such as verbal orders or administration of controlled drugs. This lack of familiarity with the medication management principles indicated misplaced concern over scope of professional practice, as this extract illustrates:
Nurse wants to know if it is requirement for two people to check MDA\textsuperscript{4}'s for med administration; there is only one nurse on duty and a care assistant (Nursing Home 2011).

The theme contained two sub-themes, as follows: ‘Are we covered’ and ‘Non-nurse administration’.

4.2.1 Are we covered?
This sub-theme describes questions that reflected concern around the risk to registration in making scope of practice decisions around medication. Many staff working in situations where they practiced alone reported this concern and sought support and guidance from the Board around issues pertaining to medication management. Many of the queries arose from services which may not have the benefit of organisational policies to underpin practice in the administration of medications, for example in community services, nursing homes and prison services.

Innovation in practice
Queries around the use of medication indicate that practitioners are confronted with complex issues associated with titrating medication, first dose IVs, unfamiliar drugs, complex regimes being delivered in non-acute settings, and off label or unlicensed medications. There were a number of enquiries from practitioners working in the cosmetic industry such as queries relating to the administration of Botulinum-A toxin (‘Botox’) and fillers. Innovations in treatment modalities and pressure from employers, service demand, and demands from other health professionals appeared to be influencing scope of practice around medication management and some enquirers sought reassurance that their actions are permissible:

I am a clinical nurse specialist[working] in community palliative care and part of our remit is the provision of palliative care in nursing homes and the education of their staff … if we are in a nursing home educating staff in setting up a syringe pump, are we allowed/covered to sign their controlled drug book as the second person checking out the medication? Also, would we be allowed/covered to administer a ‘sub cut’ injection in nursing homes using their medication and documentation (Community Palliative Care 2013).

Some practitioners reported pressure to participate in activities that were not consistent with NMBI guidance (An Bord Altranais 2007) around medications. In some instances service

\footnote{Controlled medicinal products under Misuse of Drugs Act 1977, 1984.}
management structures were the source of such pressure and practitioners sought support from the NMBI to add credence to their concerns:

Work in a nursing home on nights. We are now being asked by management to prepare patients’ meds for a.m. and leave at patients’ lockers for the day staff to administer to patients (Nursing Home 2008).

A number of queries suggest that practitioners wanted an immediate solution to a practice issue that confronted them in relation to medication management. The nature of practice in the community presented challenges for practicing nurses and midwives in adhering to NMBI guidance on the administration of medication, as reflected in some of the queries received. The following extract suggests that practitioners may be drawn into finding solutions to real-life difficulties in promoting patients’ ability to remain in their home with limited resources at their disposal:

An assistant director of nursing, looking at medication policy in community [is] inquiring as to whether it is acceptable practice for public health nurse to draw up insulin in syringe and leave for administration by client or carer [and] she cites increasing numbers of IDDM\(^5\) clients in community – [the] public health nurse [is] not always available to be in home to administer insulin (PHN/Community 2011).

The practicalities of service delivery may bring pressure to find creative solutions that can place nurses in a state of uncertainty around the scope of their practice, as the following enquiry suggests:

I am currently working … in an in-patient detox unit where there is only one nurse covering the shift at any one time. My shift is from this evening at 21.30 to tomorrow at 09.30. My manager is off sick tomorrow and they have been unable to find a replacement nurse. Our current medicine policy is written in accordance with An Bord Altranais guidelines. The medicine keys must only be handled by a qualified nurse. The senior manager who is non-clinical has asked me to lock the keys in the safe tomorrow until the nurse comes on duty at 17.00. The ward will not be covered by a clinically qualified person/nurse from 09.30 to 17.00. What should I do? Please call me urgently (Psychiatry institutional care setting 2011).

Medication protocols
The Medication Protocol Framework was developed as part of the Medication Management Guidance document (An Bord Altranais 2007) to support the development and implementation

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\(^5\) Insulin dependent diabetes mellitus.
of medication protocols. This document appeared to have a positive effect in the period after its publication when there were fewer queries around medication management. However there was evidence that the policy and accountability of nurses and midwives in supplying drugs in this manner was not well understood by some practitioners and concern continued to be expressed in the smaller number of enquiries that were recorded after 2007.

Some enquirers reported confusion around the difference between patient group directives and medications protocols. Enquiries were submitted from service managers and staff charged with practice development and reflected existing and everyday activities such as the administration of the over-the-counter medications by school nurses or flu vaccines by practice nurses. There were several enquiries from school nurses, with many related to the administration of over-the-counter medications in the absence of protocols. Other enquiries suggest that innovations in service delivery were bringing about increased usage of protocols, for example, the administration of medications in the emergency department triage process prior to medical assessment or in response to patient deterioration. Newer practice initiatives designed to enhance access to specialist advice also gave rise to some concerns, as this extract from the database illustrates:

A protocol has come across my desk on the management of oral anticoagulant dosage adjustments for maintenance of target INR\(^6\) by the anticoagulant nurse in the … hospital anticoagulant clinic … Nurse analyses the computer suggested doses taking into consideration for example, if patient is on antibiotics as this interferes with warfarin absorption. If the nurse deems it appropriate they may adjust the computer’s suggested dosing using guidelines from the British Society of Haematology to inform their decision … The nurse than writes and signs what dosage a patient is to take in their warfarin book as well as giving verbal instructions to patient on same and date for next INR check is discussed. The anticoagulation nurse does not give patients a prescription for warfarin this is obtained by the patient from their general practitioner. The protocol outlines specific circumstances when a patient is to be referred for further assessment to the Haematologist. Please advise on whether dose adjusting under protocol is an acceptable nursing practice, as no reference is made in the Guidance to Nurses and Midwives on Medication Management July 2007 (General nurse hospital 2008).

This extract suggests that clarity was sought around the permissibility of a practice that was accounted for in the Medication Management Guidance document (2007).

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\(^6\) International normalised ratio.
Dispensing medication

Dispensing medication represents an extension to the role of the nurse or midwife that is only undertaken in exceptional circumstances and should be underpinned with organisational policy, appropriate training and quality assurance measures (An Bord Altranais 2007). A recurrent concern expressed over the course of the period under review related to dispensing medications when there are gaps or irregularities in a particular service. The demands and practicalities of everyday nursing work meant practitioners were expected to cooperate in response to demands to engage in dispensing, but experienced uncertainty as to their scope of practice in this area:

Caller is assistant director of nursing/supervisor on weekends with responsibility to dispense/supply medications to various units throughout hospital on off hours and weekends as no pharmacist is available. She is concerned about scope of practice with this practice, as no additional training has been provided and [she] believes this is unsafe practice and [believes she] does not possess competency to do this even though she states this is part of written job description to provide this service. She would like to pursue with nursing management and pharmacy an examination of this with [the] objective of ending this function. What advice do we have? (General Nursing- hospital 2007).

Evidence from the enquiries received from long-term residential care settings and smaller hospitals suggest that nurses, particularly those in management roles, were routinely acting in the role of pharmacist in dispensing medications in the absence of a pharmacist outside of Monday to Friday hours. There also appeared to be conflicting messages from pharmacists, managers and regulators as the following enquiry illustrates:

Recent HIQA\(^7\) inspection which raised concerns about dispensing of meds by assistant director of nursing (ADON) when stock needed on wards, pharmacist serves hospital on Mon and Thurs only so other times the ADON provides meds to the wards, pharmacy is okay with this and there is a policy in effect for this along with an education package being delivered to all staff involved. Is this acceptable practice? (Community long-term residential care 2010).

It appeared that resource constraints were causing practitioners to act in ways that were at variance with the best practice guidance on medication management (An Bord Altranais 2007). This was a common concern for those working in out-of-hours situations, in rural or in long-term residential care, but it also applied to others, for example to palliative care nurses:

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\(^7\) Health Information and Quality Authority.
Hospice has clients who have difficulty getting meds dispensed from pharmacy, some in rural areas, drugs not in stock etc., wants to know if nurses can dispense/supply from stock in hospice. Some meds would be MDAs … inpatient pharmacist says this [is] not acceptable (Palliative care hospice 2007).

The database also indicated that those working in long-term residential care settings and in prisons routinely dispensed medication to facilitate service delivery during times when a pharmacist was not available.

**Repeat prescriptions and transcription**

One of the recurring concerns entered into the enquiries database was related to the role of nurses in issuing repeat prescriptions. Community nurses, in particular, are called upon to extend the services provided by general practitioners (GPs). Such services include issuing repeat prescriptions and the process around this appeared to impact on the scope of practice of nurses working in these situations. Some entries to the database suggested that there was pressure on practice nurses in particular to engage in this extended role, providing follow-up assessments for patients with chronic illness who require repeat prescriptions:

Works in multi-GP practice where docs and office manager want the practice nurse to print repeat prescriptions (rx) from computer system after assessing [the] patient and have docs review rx who will then sign rx and give to the practice nurse to provide to patient. Caller [is] concerned about scope of practice does not want to undertake this activity; she states the nurses in the practice have nothing to do with patient’s medications at all [and that this is the] role of doctor, does not believe competent to undertake this, wants An Bord Altranais support in stating this is not role for nurse (Practice Nursing 2007).

Concerns around the transcription of prescriptions arise from long-term residential care settings where the practicalities of nursing service delivery mean it is necessary to transcribe prescriptions in order to facilitate the recording of drug administration to each patient. In some instances GPs reported insufficient time to transfer their written prescription to the drug administration kardex⁸:

A query received from an intellectual disability service as follows: Can a nurse transcribe a written prescription instruction into the service’s medication kardex? The GP is saying she does not have the time to do this (Psychiatric and intellectual disability, long-term residential 2012).

⁸ The trademark for a card-filing system that allows quick reference to the patient’s medications.
Added to the uncertainty as to whether transcription was acceptable within scope of practice was the concern that guidelines on the matter were unclear and conflicting:

Works in a nursing home - issue of transcribing of prescriptions onto medication administration record; is this permissible? Conflicting information from HIQA and medications management document from An Bord Altranais not clear (Nursing Home 2011).

One entry suggested that nursing service managers were attempting to provide structure and guidance around this activity, but they too had concerns regarding issues of legality, indemnity and accountability:

I am [a] director of nursing of a … nursing home. We have various GPs visiting, [and] my query concerns nurse transcribing. The GP’s writing can be very difficult to read, and I want to know if it is within my scope of practise to transcribe the medication list from an original prescription to the drug prescription book [that] we use? This transcription would be signed by a registered nurse, witnessed and signed by a second registered nurse, and checked and signed by [the] GP. No drugs are administered until GP signs the prescription (Nursing Home 2010).

**Emergent/first aid response**

The practice of nurse practitioners working in the emergency department and in primary care frequently involves telephone triage, in which they are required to respond to callers who provide information on signs, symptoms and details of injuries. First aid scenarios also produced concern for some practitioners around their scope of practice.

Some enquiries suggest that practitioners perceived that their capacity to act was limited and curtailed by uncertainty as to their role boundaries in such situations. Some contrasted their scope of practice with that of paramedics, who are perceived as having a wider professional scope. Examples in the database included concerns around scope of practice in first scenarios involving advice on the administration of over-the-counter medications, such as aspirin during a suspected cardiac event and in telephone triage giving instruction on patient self-management in relation to self-administration of over-the-counter medicines. There were also a number of enquiries from school nurses who sought clarification as to what was permissible within their scope of practice in relation to over-the-counter medications:
Caller works as school nurse in boarding school seeking advice re use of over the counter medication dispensing and administering, describing process in use at school is this acceptable (School Nurse 2010).

4.2.2 Non-nurse medication administration
The second sub-theme under the theme ‘medication management’ was concerned with the practice of permitting non-registered carers to administer medications. This sub-theme is labelled ‘non-nurse medication administration’ and reflects concern around the nurse’s accountability in delegating. The enquiries in this category came from nurses working in community-based intellectual disability services, in residential care for older people and in community settings, where complex care in a person’s home is delivered. In these situations health care assistants (HCA) or other support staff may administer medications when a nurse is not available. Recurring enquiries throughout the ten years related to concerns about the administration of medication by health care assistants or support staff. These enquiries were received mainly from registered nurses and were more numerous in recent years. The enquiries suggest that there was uncertainty as to the degree of autonomy and discretion at the disposal of the registered practitioner and that there was a perceived need for reassurance that one is ‘covered’ when delegating.

These enquiries changed over the course of the period under review, with initial enquiries coming from public health nurses who reported concerns regarding their role in filling dossettes and compliance aids. This practice has been somewhat universally replaced by pharmacy blister packing. Other enquiries came from nurses working in community home care where there has been an increased reliance on health care assistants and these enquiries indicate a lack of clarity around reporting relationships and accountability.

Accountability
Enquiries suggest uncertainty regarding delegation of nursing work, such as medication administration and, in particular, concern regarding individual accountability in an environment where employers are actively promoting the use of care workers in service delivery. The following query illustrates this concern:

How responsible is the nurse on duty if an error occurred by a non-nurse when the nurse was not on duty, i.e. the next day or on an opposite shift. If a nurse is employed in the same programme would they be held responsible for the administration of medication by non-nurses even if they are not present at that point in time? (Uncategorised 2003).
The provision of community care service is reliant on facilitation and planning by registered nurses, yet there appeared to be uncertainty as to their level of authority, with some expressing concern that practices are being imposed by health care managers without appropriate consultation:

Caller has outlined that management has requested that nurses would assess care staff in the administration of medication using a competency tool devised by management. They feel that this practice is unsafe and that it does not comply with their code of conduct. They would like advice on the matter (Intellectual disability long-term residential care 2003).

There was a sense that some nurses perceived themselves as passive rather than active participants in the delegation of this nursing function. Some found this practice alien and a potential erosion of their role and a risk to their registration status, as this enquiry illustrates:

Are care staff who receive training allowed to administer medications? Is this not the remit of a registered nurse? (Psychiatric/ID residential care 2004).

This also suggested a recurrent concern over the boundaries of the scope of nursing practice when providing training and oversight to the non-licensed support staff who are actively administering medications. While many of the enquiries were received from registered nurses, some health care assistants also submitted enquiries about their role in administering medications, indicating that the practice was not just a concern for registered practitioners:

Caller is working as care staff in intellectual disability with children, has been asked by employer to administer medications, has received no training and does not feel competent to do so, looking for clarification as to legal responsibility for administer medications. Is it registered nurse authority only not care staff, what should she consider to bring back to employer? (Psychiatric/ID 2006).

*Developing policy and education*

Registered nurses retain accountability in the supervision and oversight of medication administration and changes in service provision indicate that they are being required to develop guidelines and protocols to underpin the practice of medication administration by support staff and to assure patient safety. One enquiry suggests that the policy and training process around this activity does not appear to be uniform and to be ad hoc in nature:
I am looking for some guidance on the provision of education and training for health care assistants in Intellectual Disabilities. I have been approached by Senior Management to teach the safe administration of medication to care assistants who work in the community mental handicap service. I have read the report ‘Guidance to Nurses and Midwives on Medication Management’ (An Bord Altranais, 2003). I am still concerned about working beyond the boundaries of my scope of practice (Psychiatric/ID 2004).

Enquiries also suggest that some nurses are unclear as to their level of accountability around the education of support staff or family in relation to the administration of medication and have sought guidance from the NMBI:

Working in intellectual disability sector has been asked to assist in teaching care staff drug administration to clients what should he consider for this responsibility (Community ID residential care 2010).

4.3 Evolving scope of nursing and midwifery practice: Where do I stand?
The range of activities undertaken by nurses and midwives continues to evolve, as evidenced in the enquiries received in the period since the publication of the Scope of Practice Framework. Service innovations and technology have impacted on nurses’ and midwives’ scope of practice and have presented some practitioners with concerns about the boundaries of their practice role. Enquiries have also come from practitioners working in healthcare settings in which they do not have the support structure of a large organisation to verify and validate their practice activities. Practice nursing is one area where nursing has a greatly expanded role, with nurses engaged in both expanded and extended role activities such as conducting cervical smears and providing family planning services. While these practices have brought opportunities for role expansion they have presented potential additional risks and concerns and many nurses have sought reassurance as to whether these extended functions are permissible within the nursing role.

Given the changing profile of hospitalised patients, care activities that were formerly the preserve of the acute setting are now being performed by nurses working in community and in residential care settings. Activities such as venepuncture and phlebotomy are a source of concern to some practitioners, as reflected in enquiries received in the previous decade. Other concerns submitted to the Board were related to the professional authority of a nurse or midwife to share test results with patients and the practice of conducting telephone assessments.
Competence

There were numerous and diverse enquiries that reflected concerns about competence. These concerns suggested that many enquirers experienced discomfort when undertaking certain roles and care activities or when they were redeployed from one practice setting to another. Some enquiries also indicate that practitioners had concerns when they delegated tasks to others.

Registered general nurse employed in the intellectual disability sector. Manager has informed her that she will be transferring her into another. Nurse does not feel that she is competence to work in the specific area proposed. (Psychiatric/ID 2012)

Nurse working in Central supply department for past decade, now asked to provide relief nursing in various units across hospital. Concern re: her scope of practice and competence to do so for this redeployment (General nurse, hospital 2011)

Outside my comfort zone

Some enquiries indicated that individual practitioners were unable to judge their competence in the absence of a colleague or a more senior practitioner. Since competence is not static, the individual practitioner is challenged to continually re-evaluate their competence when faced with new practice situations, as the following extract illustrates:

Recently our intensive care unit (ICU) lost a staff member and I have been told that we will be covering over there more frequently in the coming weeks. I have been told by management that I am competent to look after any of the patients who are not ventilated. I am wondering if this is outside of my scope of practice. Most of the time I do feel competent to look after the patients over there, but I have no ICU training and prior to working in this hospital have never worked in ICU … My question is: am I covered to be working over there? … I’m very confused as to what to do. Obviously the call to go over is coming from my clinical nurse manager and at the weekend from the nursing supervisor and I don’t want to refuse until I know whether it is within or outside my scope. Maybe you could help me with this? (General nurse, acute hospital 2012).

Even in situations where nurses felt competent they could be restricted by a local policy in expanding their role; for example some nurses employed as agency nurses reported restrictions on their scope of practice by local policies, which required local certification of roles and tasks. Some reported that although they felt competent in performing tasks like administering intravenous drugs and had completed certification elsewhere, they were prohibited from engaging in such tasks and were required to retake training and competency assessment. For these practitioners, this represented an unnecessary waste of the nursing resource, as the process
of certification required not only attendance at training but also working under supervision for a period of time.

The database also contains evidence of practitioners’ concerns that they are required to compensate for the absence or shortage of medical or other health care personnel in order to meet a service demand. This tended to occur during evenings and weekends or in more isolated healthcare settings. Some of the queries received in this regard were submitted by physicians who were concerned with a nursing colleague’s limited scope of practice or with restrictions on a nurse’s scope of practice, such as not accepting a telephone instruction except in a medical emergency. This reflected a concern on the part of medical practitioners that a service could only be provided when they were available in person.

Re-deployment
The issue of re-deployment appeared as a recurrent concern for nurses and midwives. The context appeared to be related to staffing shortages, which gave rise to numerous entries that reflected concerns regarding competence to practice in new settings.

Has been working in central supply/sterilisation section of hospital for many years now being asked to work in medical/surgical units, concern about her scope of practice with this redeployment also issue of competency to practice in this environment (General nurse, hospital 2011)

Issue of redeployment within the hospital works in outpatient department, presently believes she may not have certain competencies for areas of redeployment (General nurse, hospital 2012)

Delegation
Given the emphasis on integrated care and the demand for flexibility in care delivery (Brady 2010), delegation of nursing tasks to support staff and the supervision of support staff comprise a large part of nursing work. This aspect of the nursing role has resulted in some uncertainty for practitioners, as reflected in the growing number of enquiries to the NMBI. Enquiries in this regard were submitted from nurses working in community services in the main and, as the following extract suggests, these concerns reflect unease with the idea of health care assistants taking on what are seen as nursing responsibilities:
I am training co-ordinator for … a private nursing home. I have been asked by one of our directors of nursing to organise training for care attendants in taking blood pressure. I would be grateful if you could confirm whether this practise would be acceptable under your regulations? My feeling is that it wouldn’t, but I would like to double check. I look forward to hearing from you (Nursing home 2012).

**Governance and accountability**

Evidence from enquiries submitted suggests that practitioners require clarity regarding governance arrangements and lines of accountability in community nursing services. A number of enquiries suggest that there is a lack of clarity concerning the reporting relationship and communications between registered nurses and health care assistants, particularly those employed through agencies. The following extract illustrates this:

> Working as public health nurse ... A patient being discharged to community requiring ventilatory support who is being cared for by family and agency nurses; she is worried about competency of agency nurses to care for patient and governance structure and communication between agency nurses and public health nursing (PHN/Community 2010).

The Health Service Executive is increasingly subcontracting agency services to provide patient care in the community and this practice has given rise to concerns from registered nurses. A public health nurse expressed discomfort about having overall responsibility for the care of a ventilated patient in the community, where the care was also supplied by an agency:

> Caller is assistant director of nursing in public health services there is a client with motor neurone disease, intubated and ventilated needs 24-hour nursing care. [The] Health Service Executive (HSE) provides public health nurse support and agency nursing staff is used for 24-hour coverage. She has said she is being held responsible for making sure there is adequate coverage for client, not the agency, as the HSE is providing/paying for the services. She feels she is in an uncomfortable situation as she does not believe she should be responsible for staffing as the public health service has intermittent nursing care for client, her director of nursing is not supportive of her concerns, she feels she is being compromised and is upset about current situation (2011PHN/Community).

The enquiries database also indicates that delegation gave rise to a particular concern about accountability and governance:

> Working as assistant director of nursing in public health, has current clinical issue of public health nursing assessments and link with home care services for delegation and supervision of carers who are under home care services remit and not public health nurse. [Is] concern[ed] as to how to marry both for accountability and governance (PHN/Community 2011).
Independent practice

The NMBI received a number of enquiries from nurses and midwives working as independent practitioners, specifically nurses engaged in the provision of services involving cosmetic products, and some midwives providing antenatal classes, breastfeeding and other postnatal support. Some enquiries indicated that some practitioners sought confirmation that expansion of nursing and midwifery functions to work independently in the private sector was permissible within scope of practice. This indicates that enquirers were aware of the issue of professional indemnity and public liability insurance should they choose to practice independently. Some practice nurses who were employed in GP practice in the private sector also enquired about the issue of indemnity insurance.

4.4 Professional boundaries

The third major theme was named ‘role boundaries’ and reflected practitioners’ concerns with the limits of the nursing or midwifery role. Among the issues identified were authority to practice in particular settings and the authority to provide care on a voluntary basis. The enquiries suggest that some nurses and midwives are operating in situations in which they are filling gaps in services where other health professionals are not available, such as in remote settings or in services that close in evenings and weekends. This was evidenced in enquiries about medication management, as outlined above, but also in other situations in which practitioners felt obliged to provide a service in response to a particular need. The following two extracts illustrate this concern:

Concern that nurse treated person with number of verbal orders for meds, including IM9 Lasix for a period of a few hours with GP assessing person via phone and giving directions, issues of competence, definition of emergency situations etc. questioned (Prison Service 2012).

Works as consultant psychiatrist has been told by director of nursing that telephone and fax orders are not accepted even in emergency situations and doctors will have to come in and assess and prescribe. She states the director of nursing has cited An Bord Altranais standards [that] do not allow for fax/telephone orders, she has practiced in other settings where this is allowed. What does the Board advise? (Psychiatric/ID long-term residential care 2008).

Conflict and uncertainty arises for nurses and midwives as they find themselves operating beyond what is determined to be acceptable in their professional roles. Medical colleagues can

9 Intra Muscular.
become frustrated with a lack of willingness on the part of nurses to extend their role and there is potential for this to negatively impact on the patient’s care experience. This is not exclusively a concern for nurses but also for midwives where shortages of staff have resulted in greater pressure on midwives to triage and filter patients to maximise the use of medical staff time. The enquiries suggest that nurses and midwives are challenged to define the parameters of their professional practice and this challenge was particularly felt in relation to authority to provide a maternal care service and authority to provide a nursing service outside the context of that required as an employee.

**Eligibility to provide maternal care**
Evidence from the database suggests that community-based maternity services, in particular those using the combined care model, are presenting a challenge to midwives, practice nurses and public health nurses. The document *Guidance to Midwives* (An Bord Altranais 2002) stipulates that only registered midwives can provide antenatal and postnatal care. There is evidence that this requirement is presenting a difficulty for practice nurses who are not registered midwives and who are being requested by their GP employers to engage in antenatal care activities, as the following extract illustrates:

Registered general nurse (RGN) working in GP practice. GP has commenced combined care and has requested the RGN to carry out BP and urinalysis on maternity patients. Is this within scope of practice? (Practice Nursing 2013).

Another aspect of authority to practice arose in relation to enquiries related to the position of nurses and midwives whose names were on a particular division of the active register, but were not actively practising in that division. For some this concerned the issue of maintaining competence. These enquiries arose in the context of service managers seeking to maximise employees’ transferable skills. One example was registered nurses working in general nursing being called to provide cover in maternity units. This was a particular concern for the scope of practice of some general nurses, since obstetrical emergencies can arise intermittently and unpredictably.

**Eligibility to provide nursing services**
Similar concerns regarding scope of practice in relation to midwifery care were also recorded with regard to the provision of nursing care. These were evident in particular from nurses working in long-term residential care, and concerned eligibility to provide older person care.
Recruitment of RNID and RPN nurses in long-term residential care gave rise to concerns among existing staff and service managers regarding eligibility of these registrants to practice in a ‘general’ nursing context, as this extract illustrates:

Clinical nurse manager II in care of the elderly ward is getting new staff member who is a RPN; how does she know is this individual is competent as she is not an registered general nurse (General Hospital 2005).

Similarly, the requirement to meet the care needs of a patient with health problems for which a registered general nurse was unqualified also presented a concern for a service manager:

Care of older person setting now going to accept clients with psychiatric conditions, caller believes caring for these individuals is outside her SOP as she is not a[n] registered psychiatric nurse, [and is] seeking view of An Bord Altranais (Nursing home 2010).

Another service manager reported a concern with a nurse wishing to expand the scope of his/her practice:

Working in palliative care with dementia patients, is registered in psych nursing wants to expand her practice in palliative care, does Board have any restrictions for this; wanting to educate self re syringe drivers etc. [that are] used in care setting (Nursing Home 2011).

There were also some enquiries in the database from unemployed midwives wishing to know if they were eligible to work in a residential care setting.

Voluntary provision of nursing services

Nurses are often called upon to utilise a wide range of skills to serve their community, for example through providing assistance to older neighbours, providing first aid at sports or scouting events, or providing a voluntary nursing service to religious pilgrimages. These requests to provide nursing services on a voluntary basis have presented some nurses with concerns in relation to their scope of practice. For example, one general nurse working in an acute hospital was presented with a request, for which she sought guidance:

Works in cardiac unit in hospital, recently asked to by her GAA\(^{10}\) club to perform health screening for members, concerned about taking on this role (Other 2013).

---

\(^{10}\) Gaelic Athletic Association.
Many nurses who are no longer practising as nurses, but are working in a related field, retain their status as registrants on the Active Register. Those working outside of nursing, but in situations in which a demand for nursing skills arise, can find themselves called upon to act in a nursing role, as this extract shows:

I work in the Intellectual Disability field as a clinical nurse manager and we are currently reviewing our medication policy. In our organisation we have a number of qualified registered nurses who are employed as social care workers and social care leaders … I have been asked to clarify if a person is a registered nurse but is employed as a social care worker/leader are they covered to administer an intramuscular injection (Psychiatric/ID 2013).

Among the enquiries were a number submitted by special needs assistants. Students with complex care needs are enabled to attend school though the use of special needs assistant support. The role of the special needs assistant is focused on the educational needs of the child. In some instances special needs assistants, although not employed as nurses, are asked to provide nursing services:

Special needs assistant [is] required to give insulin injections. Can she get involved as is intellectual disability trained? (Uncategorised 2012).

In summary, several entries in the database indicate that nurses and midwives encountered situations and circumstances that raised issues for their scope of practice. Several enquiries concerned scope of practice where the nurse or midwife was not employed in an official capacity as a nurse or midwife. These issues were associated with their eligibility to practice in particular setting and/or to provide care to a particular client group. These issues, in turn, gave rise to concerns about the boundaries and jurisdiction of professional practice and the related concern about professional indemnity.

4.5 Summary of findings
Analysis of the 978 queries contained within the database maintained by NMBI indicates that enquiries were concerned with three main areas: medication management, changing and evolving scope of practice, and professional role boundaries. Each of these areas reflected concerns that arose in practice situations and circumstances in which the nurse or midwife was required to practice outside of his/her self-determined scope of practice. These situations and circumstances were frequently related to the fit between the individual practitioner’s registration status and associated skill set and the demands of the service. Other concerns were related to
expectations on the part of the registered nurse or midwife to take responsibility and accountability for others, including support staff and agency nurses. Delegation of nursing roles and tasks to non-registered care staff represented a particular concern in this regard.

The context for many enquiries was service developments, staff shortages, as well as uncertainty about role expansion and professional accountability. Efforts by employers to maximise the skill mix of their staff and optimally deploy staff to meet service needs and/or address gaps in service represented the service context from which many enquiries arose. Enquiries were received from registered nurses, registered midwives, service managers and other health care professionals including medical personnel.
Chapter 5

FINDINGS OF STAKEHOLDER CONSULTATION: NATIONAL SURVEY

5.1 Introduction
A major element of the review of the Scope of Practice Framework document was stakeholder consultation involving a national survey of nurses and midwives. The purpose of the survey was to examine self-reported experiences of scope of practice. A self-report questionnaire, the Scope-Q, was designed specifically for this purpose (Appendix 4). The Scope-Q was a sixty-four item questionnaire, which aimed to gather information on nurses’ and midwives’ current scope of practice, as well as their use of the Framework and other resources to develop and support their professional practice.

The questionnaire was administered by a postal survey to a national sample of registered nurses and midwives, whose names were entered onto the Active Register of nurses and midwives. The sample consisted of 2,354 registrants, selected by a stratified random sampling procedure. This chapter presents the findings from the national survey. Results are presented in sections that correspond to the sections of the Scope-Q.

5.2 Data analysis
Data obtained using the Scope-Q survey instrument were analysed using SPSS Version 20.0 (SPSS Inc. Chicago IL). Calculations of frequency distributions, measures of central tendency and measures of variability were conducted to summarise data. Chi-square analyses were used to identify group differences on variables of interest. Linear principal components analysis (CATPCA), a data reduction technique, was used to allow a large number of related variables to be reduced to a smaller number of uncorrelated components (Linting, Meulman, Groenen and van der Kooij 2007). This technique is particularly useful when a large number of variables prohibits effective interpretation of relationships of interest (Meulman and Heiser 2010), allowing a smaller number of components to be used in subsequent analyses instead of the individual items. For more information on this technique, please see Appendix 14.

5.2.1 Missing data
The vast majority of respondents completed the survey questionnaire in its entirety, with approximately 10 responses (~1.0%) missing for each variable. Given these small numbers, it
was considered unlikely that missing values would introduce a bias in the analysis; thus, listwise
deletion of missing values was used, whereby any case with missing data on any one of the
variables in the analysis is eliminated (de Vaus 2002). This approach has been widely
recommended as appropriate when there are few cases with missing values (Howell 2007, de

5.3 Response rate
The Scope-Q was administered in two waves and the total number of questionnaires returned
from both waves was 1,135, representing a response rate of 48.2 per cent. Of these, 125 were
incomplete and classified as unusable for analysis. Reasons for non-completion are listed in
Table 5.1. This resulted in 1,010 valid questionnaires, yielding an adjusted response rate of 45.1
per cent.

<table>
<thead>
<tr>
<th>Unusable category</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blank</td>
<td>13</td>
<td>10.4</td>
</tr>
<tr>
<td>Emigrated</td>
<td>4</td>
<td>3.2</td>
</tr>
<tr>
<td>Incorrect address</td>
<td>27</td>
<td>21.6</td>
</tr>
<tr>
<td>Non-practicing11</td>
<td>36</td>
<td>28.8</td>
</tr>
<tr>
<td>Retired</td>
<td>35</td>
<td>28.0</td>
</tr>
<tr>
<td>Other</td>
<td>10.0</td>
<td>8.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>125</td>
<td>100</td>
</tr>
</tbody>
</table>

This response rate compares very favourably with other large-scale national postal surveys
among nurses and midwives in Ireland. For example, the National Clinical Leadership Needs
Analysis Study (Fealy et al. 2009) reported a response rate of 31.0 per cent, while the Review of
Nurses and Midwives in the Prescribing and Administration of Medical Products study (An
Bord Altranais 2005) yielded a response rate of 35.0 per cent. From a postal survey of 4,000
nurses and midwives for the Experiences of Empowerment study, Scott et al. (2003) reported
replies at 46 per cent and a response rate of usable questionnaires of 33.1 per cent. The Report
on the Continuing Professional Development of Staff Nurses and Staff Midwives (NCNM 2004)
reported a usable response rate of just 20 per cent from a survey of 10,000 nurses, albeit from a
proxy method of questionnaire administration. A full breakdown of survey responses from both
waves is included in Appendix 13.

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11 This category includes those that have been categorised as non-practicing but have indicated that they work as
nurse attendant, work as skills instructor/education, are on sick leave (long and short-term), are not practicing in
ROI, N/A in their current role, are on leave of absence (others just indicated ‘non-practicing’).
5.4 Sample characteristics

5.4.1 Age

The final sample consisted of 941 (93.3%) female respondents and 68 (6.7%) male respondents (Table 5.2). The largest proportion of respondents was aged between 40 and 49 years (31.6%, n=319), while 84 (8.3%) were over 60 years of age. No respondents were aged less than 20 years.

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>N</th>
<th>%</th>
<th>Female</th>
<th>N</th>
<th>%</th>
<th>Total</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>20–29</td>
<td>4</td>
<td>0.4%</td>
<td>58</td>
<td>5.7%</td>
<td>62</td>
<td>6.1%</td>
<td>1009</td>
<td></td>
<td>100.0%</td>
</tr>
<tr>
<td>30–39</td>
<td>27</td>
<td>2.7%</td>
<td>228</td>
<td>22.6%</td>
<td>255</td>
<td>25.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40–49</td>
<td>22</td>
<td>2.2%</td>
<td>297</td>
<td>29.4%</td>
<td>319</td>
<td>31.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50–59</td>
<td>11</td>
<td>1.1%</td>
<td>278</td>
<td>27.6%</td>
<td>289</td>
<td>28.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;60</td>
<td>4</td>
<td>0.4%</td>
<td>80</td>
<td>7.9%</td>
<td>84</td>
<td>8.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>6.7%</td>
<td>941</td>
<td>93.3%</td>
<td>1009</td>
<td>100.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In order to avoid problems of small cell sizes and to simplify subsequent analyses, age was recoded into fewer categories. Accordingly, the categories 30–39 and 40–49 were combined to create a larger single category containing those respondents aged between 30 and 49 years; this recalculation indicated that over half of the sample (56.9%, n=574) was in the age range 30–49 years. Similarly, the categories 50–59 and 60+ were combined to create a larger single category of those aged 50 years and over. This recalculation indicated that well over one-third of the sample was aged ≥ 50 years (37.0%, n=373). The category 20–29 was retained and showed that the smallest proportion of the sample (6.1%, n=62) was in this age category.

5.4.2 Educational attainment

The educational attainments of the sample are summarised in Table 5.3.

<table>
<thead>
<tr>
<th>Academic Award</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Certificate</td>
<td>527</td>
<td>52.5%</td>
</tr>
<tr>
<td>Diploma</td>
<td>370</td>
<td>36.9%</td>
</tr>
<tr>
<td>Higher Diploma</td>
<td>319</td>
<td>31.8%</td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>394</td>
<td>39.3%</td>
</tr>
<tr>
<td>Graduate Diploma</td>
<td>142</td>
<td>14.2%</td>
</tr>
<tr>
<td>Master’s Degree (taught)</td>
<td>86</td>
<td>8.6%</td>
</tr>
<tr>
<td>Master’s Degree (research)</td>
<td>35</td>
<td>3.5%</td>
</tr>
<tr>
<td>Doctor of Philosophy</td>
<td>8</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

Of the total sample 39.3 per cent (n=394) had a bachelor’s degree while 12.1 per cent (n=121) held either a master’s degree, either taught or by research. Approximately half of the
respondents (n=527, 52.2%) had two or more qualifications. The educational attainment of survey respondents is illustrated in Figure 5.1.

![Figure 5.1 Educational attainment of the sample](image)

**5.4.3 Divisions of Register**

Table 5.4 lists the distribution of the sample by divisions of the Register in which respondents were registered.

<table>
<thead>
<tr>
<th>Division of the Register</th>
<th>Number*</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>General nursing (RGN)</td>
<td>857</td>
<td>85.4%</td>
</tr>
<tr>
<td>Psychiatric nursing (RPN)</td>
<td>141</td>
<td>14.1%</td>
</tr>
<tr>
<td>Midwifery (RM)</td>
<td>311</td>
<td>31.0%</td>
</tr>
<tr>
<td>Intellectual disability nursing (RNID)</td>
<td>81</td>
<td>8.1%</td>
</tr>
<tr>
<td>Children’s nursing (RCN)</td>
<td>110</td>
<td>11.0%</td>
</tr>
<tr>
<td>Public health nursing (PHN)</td>
<td>100</td>
<td>10.0%</td>
</tr>
<tr>
<td>Advanced practitioner (ANP/AMP)</td>
<td>10</td>
<td>1.0%</td>
</tr>
<tr>
<td>Registered nurse prescriber (RNP)</td>
<td>33</td>
<td>3.3%</td>
</tr>
<tr>
<td>Nurse tutor (RNT)</td>
<td>17</td>
<td>1.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,660</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

*Note: N=1,003
The majority of respondents (85.4%, n=875) were registered in the general nurse division. Upwards of one third of the sample (31.0%, n=311) was registered in the midwifery division and only ten respondents (1.0%) were registered as advanced nurse/midwife practitioners (ANP or AMP).

A total of 1,660 registrations were held by 1,003 respondents. Half of respondents (50.7%, n=508) were registered in one category only, approximately one third (34.8%: n=348) were registered in two categories, while 12.5% (n=124) were registered in three or more categories.

Table 5.5 compares sample respondents with the total population of nurses and midwives registered with the Nursing and Midwifery Board of Ireland. As Table 5.5 illustrates, respondents in the current sample held more registrations per person than the national population of nurses and midwives, resulting in an over–representation of each category.

Table 5.5 Comparison of the study sample with the total national population by divisions of the Register

<table>
<thead>
<tr>
<th>Division of Register</th>
<th>National population (N=66,888)</th>
<th>Study sample (N=1,003)</th>
<th>Percentage difference (+ or –)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>General nursing (RGN)</td>
<td>55,433</td>
<td>62.7</td>
<td>857</td>
</tr>
<tr>
<td>Psychiatric nursing (RPN)</td>
<td>9,223</td>
<td>10.4</td>
<td>141</td>
</tr>
<tr>
<td>Midwifery (RM)</td>
<td>11,850</td>
<td>13.4</td>
<td>311</td>
</tr>
<tr>
<td>Intellectual disability nursing (RNID)</td>
<td>4,727</td>
<td>5.3</td>
<td>81</td>
</tr>
<tr>
<td>Children’s nursing (RCN)</td>
<td>4,220</td>
<td>4.8</td>
<td>110</td>
</tr>
<tr>
<td>Public health nursing (PHN)</td>
<td>2,402</td>
<td>2.7</td>
<td>100</td>
</tr>
<tr>
<td>Advanced practitioner (ANP/AMP)</td>
<td>113</td>
<td>0.1</td>
<td>10</td>
</tr>
<tr>
<td>Registered nurse prescriber (RNP)</td>
<td>481</td>
<td>0.5</td>
<td>33</td>
</tr>
<tr>
<td>Nurse tutor (RNT)</td>
<td>N/A</td>
<td>N/A</td>
<td>17</td>
</tr>
<tr>
<td><strong>Total number of registrations</strong></td>
<td><strong>88,449</strong></td>
<td><strong>1,660</strong></td>
<td></td>
</tr>
</tbody>
</table>

5.4.4 Current grade

Table 5.6 summarises the distribution of the sample according to the respondents’ current grade. The largest proportion of the sample, 590 respondents (59.2%, n=590), was employed at staff grade level, followed by the clinical nurse/midwife manager grade (14.0%, n=139). Just less than one per cent of the sample (0.9%) was at the grade of advanced nurse or midwife practitioner.
Table 5.6 Distribution by current grade

<table>
<thead>
<tr>
<th>Grade</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff grade or equivalent</td>
<td>590</td>
<td>59.2</td>
</tr>
<tr>
<td>CNM1/CMM1 or equivalent</td>
<td>61</td>
<td>6.1</td>
</tr>
<tr>
<td>CNM2/CMM2 or equivalent</td>
<td>139</td>
<td>14.0</td>
</tr>
<tr>
<td>CNM3/CMM3 or equivalent</td>
<td>15</td>
<td>1.5</td>
</tr>
<tr>
<td>ADON or equivalent</td>
<td>39</td>
<td>3.9</td>
</tr>
<tr>
<td>DON or equivalent</td>
<td>23</td>
<td>2.3</td>
</tr>
<tr>
<td>CNS/CMS</td>
<td>55</td>
<td>5.5</td>
</tr>
<tr>
<td>ANP/AMP</td>
<td>9</td>
<td>0.9</td>
</tr>
<tr>
<td>Tutor or lecturer</td>
<td>21</td>
<td>2.1</td>
</tr>
<tr>
<td>PHN</td>
<td>35</td>
<td>3.5</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>0.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>996</td>
<td>100</td>
</tr>
</tbody>
</table>

Missing: n= 14

In order to avoid problems of small cell sizes and to simplify subsequent analyses, grades were recoded into fewer categories. Accordingly, the categories CNM1/CMM1 and CNM2/CMM2 were combined to create a larger CM1/CM2\(^{12}\) category; this recoding indicated that one fifth of the sample (20.3%, n=200) was in this category. Similarly, the ADON/M, DON/M and CNM3/CMM3 categories were merged to create a larger category pertaining to senior management positions; less than 10 per cent of the sample was in this category (7.8%, n=77).

The categories CNS/CMS and ANP/AMP were also combined to create a larger category of CS/AP, indicating that just 6.5 per cent (n=64) of the sample was represented in this category. The PHN grade was recoded into staff or equivalent grade for the purposes of subsequent analyses indicating that close to two-thirds (63.3%, n=652) of the sample was in the staff grade category. The remainder of the sample (3.0%, n=30), including tutor, lecturer and other, was recategorised as ‘Other’ (Figure 5.2).

\(^{12}\) For simplicity, the acronyms CM, AP, CS etc. will be used to refer to both nurses and midwives of those grades.
5.4.5 Area of current employment

Table 5.7 summarises the sample with reference to the main areas in which employment.

<table>
<thead>
<tr>
<th>Area</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>General nursing</td>
<td>416</td>
<td>41.6</td>
</tr>
<tr>
<td>Children's nursing</td>
<td>57</td>
<td>5.7</td>
</tr>
<tr>
<td>Midwifery</td>
<td>74</td>
<td>7.4</td>
</tr>
<tr>
<td>Education</td>
<td>16</td>
<td>1.6</td>
</tr>
<tr>
<td>Prison/forensic service</td>
<td>5</td>
<td>0.5</td>
</tr>
<tr>
<td>Practice nursing (with GP)</td>
<td>47</td>
<td>4.7</td>
</tr>
<tr>
<td>Practice development</td>
<td>9</td>
<td>0.9</td>
</tr>
<tr>
<td>Policy</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td>Research nurse</td>
<td>5</td>
<td>0.5</td>
</tr>
<tr>
<td>Agency/bank nursing</td>
<td>8</td>
<td>0.8</td>
</tr>
<tr>
<td>Psychiatric nursing</td>
<td>95</td>
<td>9.5</td>
</tr>
<tr>
<td>Intellectual disability nursing</td>
<td>66</td>
<td>6.6</td>
</tr>
<tr>
<td>Public health/nursing/community</td>
<td>110</td>
<td>11.0</td>
</tr>
<tr>
<td>School nursing</td>
<td>8</td>
<td>0.8</td>
</tr>
<tr>
<td>Occupational health</td>
<td>4</td>
<td>0.4</td>
</tr>
<tr>
<td>Independent practitioner</td>
<td>4</td>
<td>0.4</td>
</tr>
<tr>
<td>Service management (e.g. DON)</td>
<td>14</td>
<td>1.4</td>
</tr>
<tr>
<td>Regulation</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td>Academic research</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td>Care of the elderly</td>
<td>35</td>
<td>3.5</td>
</tr>
<tr>
<td>Palliative care</td>
<td>6</td>
<td>0.6</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
<td>1.9</td>
</tr>
<tr>
<td>Missing</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,010</td>
<td>100</td>
</tr>
</tbody>
</table>

In order to facilitate comparisons among the largest groups, and to avoid problems of small cell sizes in subsequent analyses, this variable was subsequently recoded. The categories of general nursing (41.6%, n=416), children’s nursing (5.7%, n=57), midwifery (7.4%, n=74), psychiatric nursing (9.5%, n=95), intellectual disability nursing (6.6%, n=66), and public health/community nursing (11.0%, n=110) were retained. As the remaining categories could not meaningfully be combined, these were recoded as missing for bivariate analyses involving this variable. Respondents in the remaining categories are included in the full sample for all other analyses (e.g. descriptive statistics, bivariate analyses not including area of employment).

5.5 My scope of practice (Scope-Q, Section A)

Section A of the Scope-Q contained 15 statements relating to respondents’ current professional roles and the scope of their professional practice. Respondents were asked to read each statement and to indicate the frequency with which they engaged in activities related to their professional practice on a scale from 1 (never) to 5 (always). Table 5.8 displays the frequency distribution of respondents in respect of each response in the section. The most frequent response for each
statement is displayed in bold using the mode as the measure of central tendency. The responses to these statements are presented under a number of separate headings, with selected responses highlighted.

**Table 5.8 My scope of practice (Scope-Q Section A)**

<table>
<thead>
<tr>
<th>In my current professional role...</th>
<th>Never n (%)</th>
<th>Rarely n (%)</th>
<th>Sometimes n (%)</th>
<th>Frequently n (%)</th>
<th>Always n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 I use the Scope of Practice Framework document when making a decision about the scope of my professional practice</td>
<td>71 (7.1%)</td>
<td>172 (17.1%)</td>
<td><strong>288 (28.7%)</strong></td>
<td>221 (22.0%)</td>
<td>252 (25.1%)</td>
</tr>
<tr>
<td>2 I consult with professional colleagues when making a decision about the scope of my professional practice</td>
<td>14 (1.4%)</td>
<td>69 (6.9%)</td>
<td>322 (32.1%)</td>
<td><strong>400 (39.9%)</strong></td>
<td>198 (19.7%)</td>
</tr>
<tr>
<td>3 I consult with my line manager when making a decision about the scope of my professional practice</td>
<td>26 (2.6%)</td>
<td>119 (11.9%)</td>
<td><strong>352 (35.2%)</strong></td>
<td>309 (30.9%)</td>
<td>194 (19.4%)</td>
</tr>
<tr>
<td>4 I rely mainly on my own professional judgement when making a decision about the scope of my professional practice</td>
<td>38 (3.8%)</td>
<td>98 (9.8%)</td>
<td>258 (25.7%)</td>
<td><strong>438 (43.6%)</strong></td>
<td>172 (17.1%)</td>
</tr>
<tr>
<td>5 I rely mainly on the direction of others when deciding about my competence to perform new tasks, roles or functions</td>
<td>247 (24.7%)</td>
<td><strong>377 (37.6%)</strong></td>
<td>273 (27.2%)</td>
<td>75 (7.5%)</td>
<td>30 (3.0%)</td>
</tr>
<tr>
<td>6 I act under the direction of others when deciding about my competence to perform a new task, role or function</td>
<td>228 (22.9%)</td>
<td><strong>298 (30.0%)</strong></td>
<td>248 (24.9%)</td>
<td>138 (13.9%)</td>
<td>82 (8.2%)</td>
</tr>
<tr>
<td>7 I act only when I believe I have the competence to perform a new task, role or function</td>
<td>3 (0.3%)</td>
<td>7 (0.7%)</td>
<td>32 (3.2%)</td>
<td><strong>207 (20.6%)</strong></td>
<td>754 (75.2%)</td>
</tr>
<tr>
<td>8 I recognise when I am not competent to perform a new task, role or function that falls within the scope of my practice</td>
<td>2 (0.2%)</td>
<td>19 (1.9%)</td>
<td>55 (5.5%)</td>
<td>223 (22.2%)</td>
<td><strong>706 (70.2%)</strong></td>
</tr>
<tr>
<td>9 I recognise when a task, role or function falls outside the scope of practice of the nursing or midwifery profession</td>
<td>2 (0.2%)</td>
<td>2 (0.2%)</td>
<td>85 (8.5%)</td>
<td>291 (29.0%)</td>
<td><strong>624 (62.2%)</strong></td>
</tr>
<tr>
<td>10 I acknowledge to others when I recognise limitations in my competence to perform a task, role or function</td>
<td>3 (0.3%)</td>
<td>12 (1.2%)</td>
<td>131 (13.0%)</td>
<td>325 (32.2%)</td>
<td><strong>535 (53.2%)</strong></td>
</tr>
<tr>
<td>11 When I consider expanding the scope of my professional practice, I first assess the new expanded task, role or function</td>
<td>6 (0.6%)</td>
<td>12 (1.2%)</td>
<td>79 (7.9%)</td>
<td><strong>285 (28.4%)</strong></td>
<td>620 (61.9%)</td>
</tr>
<tr>
<td>12 When I consider expanding the scope of my professional practice, I consider the impact on service delivery (e.g. skill mix)</td>
<td>16 (1.6%)</td>
<td>22 (2.2%)</td>
<td>139 (13.9%)</td>
<td>352 (35.2%)</td>
<td><strong>472 (47.2%)</strong></td>
</tr>
<tr>
<td>13 When I consider expanding the scope of my professional practice, I consider the clinical outcomes (e.g. effects on patients)</td>
<td>7 (0.7%)</td>
<td>1 (0.1%)</td>
<td>33 (3.3%)</td>
<td><strong>246 (24.6%)</strong></td>
<td>714 (71.3%)</td>
</tr>
<tr>
<td>14 When I undertake a delegated task, role or function, I accept accountability for the performance of that task, role or function</td>
<td>0 (0.0%)</td>
<td>1 (0.1%)</td>
<td>17 (1.7%)</td>
<td><strong>111 (11.1%)</strong></td>
<td>875 (87.2%)</td>
</tr>
<tr>
<td>15 When I delegate a task, role or function to another, I recognise that I am accountable for the decision to delegate</td>
<td>4 (0.4%)</td>
<td>9 (0.9%)</td>
<td>49 (4.9%)</td>
<td><strong>185 (18.5%)</strong></td>
<td><strong>754 (75.3%)</strong></td>
</tr>
</tbody>
</table>
5.5.1 Resources for decision-making
As Table 5.8 illustrates, approximately one quarter of respondents (24.2%, n=243) indicated that they ‘rarely’ or ‘never’ use the Scope of Practice Framework document when making a decision about the scope of their professional practice (Statement 1). Just over half of respondents (59.6%, n=598) stated that they ‘frequently’ or ‘always’ consult with professional colleagues when making a decision regarding their scope of practice, with an approximate further third (32.1%, n=322) indicating that they ‘sometimes’ do so (Statement 2). Similarly, half of the respondents (50.3%, n=503) reported that they ‘frequently’ or ‘always’ consult their line manager when making a decision about the scope of their professional practice (Statement 3), and a further one third approximately (35.2%, n=352) stated that they consult their line manager ‘sometimes’.

5.5.2 Autonomy
Respondents were also asked to report the frequency with which they relied on their own professional judgement when making a decision regarding their scope of practice, with 60.7% (n=610) stating that they do so ‘frequently’ or ‘always’ (Statement 4). The majority of respondents (62.3%, n=624) stated that they ‘rarely’ or ‘never’ rely on the direction of others when deciding on their competence to perform new tasks, roles or functions (Statement 5). Less than a quarter of the sample (22.1%, n=220) reported ‘frequently’ or ‘always’ acting under the direction of others when making decisions regarding their own competence to perform new tasks, roles or functions (Statement 6).

5.5.3 Competence
The vast majority of respondents (95.8%, n=961) indicated that they would ‘frequently’ or ‘always’ act only when they believed that they had the competence to perform a new task, role or function (Statement 7). Similarly, most respondents (92.4%, n=929) indicated that they ‘frequently’ or ‘always’ recognise when they are not competent to perform a task, role or function (Statement 8). The majority (85.4%, n=860) also reported that they ‘frequently’ or ‘always’ acknowledge to others the limitations in their own competency to perform a task, role or function (Statement 10).

5.5.4 Expanding the scope of practice
The majority of respondents (90.3%, n=905) reported that they ‘frequently’ or ‘always’ assess a new expanded task, role or function when considering expanding the scope of their professional
practice (Statement 11). A large proportion of respondents (82.4%, n=824) reported that they ‘frequently’ or ‘always’ consider the impact on service delivery when considering expanding the scope of their professional practice (Statement 12). The vast majority (95.9%, n=960) also reported that they ‘frequently’ or ‘always’ considered the clinical outcomes (e.g. effects on patients) when they considered expanding their scope of professional practice (Statement 13).

5.5.5 Delegation

Most of the respondents (87.2%, n=875) reported that they ‘always’ accept accountability for the performance of a task, role or function that has been delegated to them (Statement 14). Three-quarters (75.3%, n=754) of the sample reported that they ‘always’ recognise their own accountability for a decision to delegate a task, role or function to another (Statement 15).

5.5.6 Associations between self-reported scope of practice and age, grade and area of employment

In order to examine the associations between age, grade, area, and a number of the responses to the fifteen statements in Section A of the Scope-Q, a series of chi-square analyses was conducted. In order to avoid the problems associated with small cell sizes, and to facilitate subsequent analyses, for Statements 1 to 5 both the ‘never’ and ‘rarely’ response choices were combined to create a new response category of ‘rarely or never’. Similarly, both ‘frequently’ and ‘always’ response choices were combined to create a new response category of ‘frequently or always’. The response category of ‘sometimes’ was retained. Given the small number of respondents reporting that they never, rarely or sometimes accept accountability for the performance of a delegated task, role or function (Statement 14), or that they never, rarely or sometimes accept accountably for the decision to delegate (Statement 15), these categories were subsequently collapsed to meet the assumptions of chi-square analyses. Therefore, for these two statements, one response category of ‘never, rarely or sometimes’ was created. The categories of ‘frequently’ and ‘always’ were retained. A Bonferroni adjusted α-level of \( p < .007 \) (.05/7) was used to compensate for multiple comparisons. Table 5.9 displays the associations between age, grade, area, and a number of items from Section A of the Scope-Q.

\[\text{No cells with expected frequencies less than one, not more than 20\% of cells with expected frequencies <5.}\]
When Chi-square tests were performed on the variables and responses to pre-selected statements, a number of statistically-significant associations were observed. There was a statistically significant negative association between age and how frequently respondents reported consulting with their line manager when making a decision about their scope of practice [Statement 3; \( \chi^2(4) = 25.936, p < .001 \)], with older respondents consulting with their line manager less frequently than younger respondents. According to guidelines provided by Cohen (1988), this represents a small effect [Somers’ d = −.090, \( p = .004 \)]. Respondents aged 50 years and over were significantly more likely to report ‘rarely or never’ consulting with their line manager when compared with respondents in the age categories 20–29 or 30–49. Similarly, respondents aged 20–29 were significantly more likely than those in the age categories 30–49 and ≥50 to report consulting their line manager ‘sometimes’, ‘frequently or always’. The differences observed between respondents aged 30–49 and those aged ≥50 were not significant. Thus, the data indicates that younger nurses and midwives reported consulting with their line managers regarding their scope of practice more frequently than their older counterparts.

There was a statistically significant association between age and the frequency with which respondents reported recognising their own accountability for a decision to delegate a task, role or function [Statement 15: \( \chi^2(4) = 22.231, p < .001 \)], with older respondents reporting that they recognise their own accountability more frequently than their younger counterparts.
[Somer’s $d = .114$, $p < .001$]; this represented a small effect (Cohen 1988). Respondents aged $\geq 50$ were significantly more likely to report always recognising their accountability for a decision to delegate, when compared with respondents aged 20–29 and 30–49. Respondents in the middle age categories were significantly less likely than those in the older age category, but significantly more likely than those in the youngest category, to report ‘always’ recognising their accountability for a decision to delegate (Statement 15). Additionally, respondents in the age category 20–29 were significantly more likely to report rarely, never, sometimes or frequently recognising their accountability for a decision to delegate when compared with older respondents. Thus, the data indicate that older nurses and midwives are more likely than their younger counterparts to report ‘always’ recognising their own accountability when making a decision to delegate.

There was no statistically significant association between age and any of the other Section A statements examined (Table 5.9). Similarly, no significant associations were found between the statements contained in the SCOPE-Q and the grade of respondents, or their area of employment. Thus, it appears from the data that responses to most of the Section A statements were independent of a respondent’s age, grade or gender.

### 5.6 Enablers and barriers to expanded scope of practice (SCOPE-Q, Section B)

Section B of the Scope-Q contained nineteen statements about factors that may enable or hinder nurses or midwives when expanding their scope of practice. Respondents were asked to indicate, with reference to their own experience, whether they agreed, strongly agreed, disagreed, strongly disagreed, or had no opinion. Table 5.10 summarises the frequency distribution of responses in each response category for each of the nineteen statements. The most frequent response for each statement is displayed in bold using the mode as the measure of central tendency. The responses to these statements are presented under the headings Enablers and Barriers.
Table 5.10 Enablers and barriers to expanded scope of practice (Scope-Q Section B)

<table>
<thead>
<tr>
<th>Nurses or midwives …</th>
<th>Strongly disagree n (%)</th>
<th>Disagree n (%)</th>
<th>No opinion n (%)</th>
<th>Agree n (%)</th>
<th>Strongly Agree n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 who wish to expand their SOP are supported in doing so by their organisation or employer</td>
<td>36 (3.6%)</td>
<td>278 (27.7%)</td>
<td>79 (7.9%)</td>
<td>515 (51.3%)</td>
<td>95 (9.5%)</td>
</tr>
<tr>
<td>17 who wish to expand their SOP are supported in doing so by their nursing/midwifery colleagues</td>
<td>14 (1.4%)</td>
<td>135 (13.4%)</td>
<td>94 (9.4%)</td>
<td>647 (64.4%)</td>
<td>115 (11.4%)</td>
</tr>
<tr>
<td>18 who wish to expand their SOP are supported in doing so by other health professionals</td>
<td>32 (3.2%)</td>
<td>249 (24.9%)</td>
<td>269 (26.6%)</td>
<td>399 (39.9%)</td>
<td>52 (5.2%)</td>
</tr>
<tr>
<td>19 who wish to expand their SOP have access to continuous professional development</td>
<td>35 (3.5%)</td>
<td>187 (18.7%)</td>
<td>84 (8.4%)</td>
<td>571 (57.1%)</td>
<td>123 (12.3%)</td>
</tr>
<tr>
<td>20 who wish to expand their SOP are aware of the SOP Framework document published by ABA</td>
<td>4 (0.4%)</td>
<td>44 (4.4%)</td>
<td>64 (6.4%)</td>
<td>564 (56.1%)</td>
<td>330 (32.8%)</td>
</tr>
<tr>
<td>21 who wish to expand their SOP are motivated by the professional satisfaction that they get</td>
<td>11 (1.1%)</td>
<td>50 (5.0%)</td>
<td>81 (8.1%)</td>
<td>581 (57.8%)</td>
<td>282 (28.1%)</td>
</tr>
<tr>
<td>22 who wish to expand their SOP are motivated by a desire to enhance promotional opportunities</td>
<td>11 (1.1%)</td>
<td>143 (14.3%)</td>
<td>133 (13.3%)</td>
<td>531 (53.0%)</td>
<td>184 (18.4%)</td>
</tr>
<tr>
<td>23 who wish to expand their SOP are motivated by a desire to meet the service needs of patients</td>
<td>3 (0.3%)</td>
<td>29 (2.9%)</td>
<td>37 (3.7%)</td>
<td>574 (57.1%)</td>
<td>393 (39.1%)</td>
</tr>
<tr>
<td>24 have few opportunities in the workplace to expand their scope of practice</td>
<td>37 (3.7%)</td>
<td>356 (35.5%)</td>
<td>103 (10.3%)</td>
<td>393 (39.1%)</td>
<td>115 (11.5%)</td>
</tr>
<tr>
<td>25 are reluctant to expand their SOP as they do not wish to take on additional responsibilities</td>
<td>54 (5.4%)</td>
<td>364 (36.2%)</td>
<td>86 (8.6%)</td>
<td>403 (40.1%)</td>
<td>98 (9.8%)</td>
</tr>
<tr>
<td>26 are reluctant to expand their SOP as they believe they are taking on work of other professionals</td>
<td>52 (5.2%)</td>
<td>325 (32.4%)</td>
<td>106 (10.6%)</td>
<td>381 (38.0%)</td>
<td>138 (13.8%)</td>
</tr>
<tr>
<td>27 are reluctant to expand their SOP because they frequently do not receive additional salary</td>
<td>26 (2.6%)</td>
<td>166 (16.5%)</td>
<td>69 (6.9%)</td>
<td>425 (42.3%)</td>
<td>319 (31.7%)</td>
</tr>
<tr>
<td>28 are reluctant to expand their SOP because there are no guidelines to support them in doing so</td>
<td>27 (2.7%)</td>
<td>283 (28.2%)</td>
<td>173 (17.2%)</td>
<td>387 (38.5%)</td>
<td>135 (13.5%)</td>
</tr>
<tr>
<td>29 are reluctant to expand their SOP because they are uncertain about which activities are permissible</td>
<td>38 (3.8%)</td>
<td>408 (40.6%)</td>
<td>143 (14.2%)</td>
<td>344 (34.2%)</td>
<td>73 (7.3%)</td>
</tr>
<tr>
<td>30 are reluctant to expand their SOP because they are uncertain if it will be approved by external audit</td>
<td>45 (4.5%)</td>
<td>389 (38.7%)</td>
<td>256 (25.5%)</td>
<td>239 (23.8%)</td>
<td>75 (7.5%)</td>
</tr>
<tr>
<td>31 are reluctant to expand their scope of practice because they lack the professional autonomy</td>
<td>48 (4.8%)</td>
<td>374 (37.5%)</td>
<td>169 (16.9%)</td>
<td>331 (33.2%)</td>
<td>76 (7.6%)</td>
</tr>
<tr>
<td>32 are reluctant to expand their SOP because they are fearful of potential legal consequences</td>
<td>34 (3.4%)</td>
<td>310 (30.9%)</td>
<td>86 (8.6%)</td>
<td>404 (40.2%)</td>
<td>170 (16.9%)</td>
</tr>
<tr>
<td>33 are reluctant to expand their SOP because they believe their contribution is not valued by others</td>
<td>65 (6.5%)</td>
<td>303 (30.3%)</td>
<td>110 (10.9%)</td>
<td>322 (32.0%)</td>
<td>116 (11.5%)</td>
</tr>
<tr>
<td>34 are reluctant to expand their SOP because they believe the additional processes are time-consuming</td>
<td>41 (4.1%)</td>
<td>263 (26.1%)</td>
<td>119 (11.8%)</td>
<td>436 (43.3%)</td>
<td>148 (14.7%)</td>
</tr>
</tbody>
</table>
5.6.1 Enablers

Over half of survey respondents (60.8%, n=610) agreed or strongly agreed that nurses or midwives who wish to expand their scope of practice are supported in doing so by their organisation or employer, while a further 31.1% (n=314) ‘disagreed’ or ‘strongly disagreed’ with this statement. Three quarter of respondents (75.8%, n=762) ‘agreed’ or ‘strongly agreed’ that nurses or midwives who wish to expand their scope of practice are supported in doing so by their nursing or midwifery colleagues. Somewhat fewer than half of the respondents ‘agreed’ or ‘strongly agreed’ that nurses or midwives were supported by other health professionals when expanding their scope of practice (45.1%, n=451), while over two-thirds (69.4%, n=694) ‘agreed’ or ‘strongly agreed’ that nurses and midwives who wish to expand their scope of practice have access to continuing professional development. The majority of respondents (88.9%, n=894) ‘agreed’ or ‘strongly agreed’ that nurses and midwives wishing to expand their scope of practice are aware of the Scope of Practice Framework document.

5.6.2 Barriers

Half of respondents (50.6%, n=508) ‘agreed’ or ‘strongly agreed’ that nurses or midwives have few opportunities in the workplace to expand their scope of practice, while 39.2% (n=393) disagreed or strongly disagreed with this statement. Similarly, just half of the respondents (49.9%, n=501) ‘agreed’ or ‘strongly agreed’ that nurses or midwives are reluctant to expand their scope of practice because they do not wish to take on additional responsibilities, while a substantial proportion 41.6% (n=418) ‘disagreed’ or ‘strongly disagreed’ with the statement. Just over half of respondents (51.8%, n=519) ‘agreed’ or ‘strongly agreed’ that nurses and midwives are reluctant to expand their scope of practice as they believe they are taking on the work of other professionals. Nearly three quarters of the sample (74.0%, n=744) ‘agreed’ or ‘strongly’ agreed that nurses or midwives are reluctant to expand their scope of practice because they do not receive additional salary for doing so. Almost one third (31.3%, n=314) ‘agreed’ or ‘strongly agreed’ that nurses and midwives are reluctant to expand their scope of practice because they are uncertain if it will be approved by external audit, while well over half of the sample (57.1%, n=574) ‘agreed’ or ‘strongly agreed’ that nurses and midwives are fearful of potential legal consequences of expanding their scope of practice.
5.6.3 Associations between enablers and barriers to expanded practice and age, grade and area of employment

In order to examine the associations between age, grade, area of employment and pre-selected items from Section B of the SCOPE-Q instrument, chi-square analyses were conducted. In order to avoid the problems associated with small cell sizes, and to simplify subsequent analyses, both ‘strongly disagree’ and ‘disagree’ response choices, and ‘strongly agree’ and ‘agree’ choices were recoded to, respectively, create two new response categories, ‘strongly disagree or disagree’, and ‘strongly agree or agree’. The response choice ‘no opinion’ was retained. Table 5.9 summarises the associations between age, grade, area, and a number of items from Section B of the Scope-Q. A Bonferroni adjusted $\alpha$-level of $p<.004 (.05/12)$ was used to compensate for multiple comparisons.

Table 5.11 illustrates that there were no statistically significant associations between age and any of the enablers or barriers to expanded scope of practice when examined at the adjusted $\alpha$-level of $p<.004$, suggesting that respondents’ self-reported experiences of enablers and barriers were not associated with respondents’ age.

<table>
<thead>
<tr>
<th>Nurses or midwives…</th>
<th>Age</th>
<th>Grade</th>
<th>Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 who wish to expand their SOP are supported in doing so by their organisation or employer</td>
<td>$\chi^2 (4)$: 12.158, $p$: .016*</td>
<td>$\chi^2 (6)$: 28.588, $p$: &lt;.001***</td>
<td>$\chi^2 (10)$: 11.603, $p$: .313</td>
</tr>
<tr>
<td>17 who wish to expand their SOP are supported in doing so by other health professionals</td>
<td>$\chi^2 (4)$: 1.453, $p$: .853</td>
<td>$\chi^2 (6)$: 7.145, $p$: .308</td>
<td>$\chi^2 (10)$: 13.615, $p$: .191</td>
</tr>
<tr>
<td>18 who wish to expand their SOP have access to continuous professional development (CPD)</td>
<td>$\chi^2 (4)$: .820, $p$: .936</td>
<td>$\chi^2 (6)$: 15.396, $p$: .017*</td>
<td>$\chi^2 (10)$: 14.525, $p$: .150</td>
</tr>
<tr>
<td>20 have few opportunities in the workplace to expand their scope of practice</td>
<td>$\chi^2 (4)$: 3.253, $p$: .516</td>
<td>$\chi^2 (6)$: 7.136, $p$: .309</td>
<td>$\chi^2 (10)$: 12.325, $p$: .264</td>
</tr>
<tr>
<td>24 are reluctant to expand their SOP as they do not wish to take on additional responsibilities</td>
<td>$\chi^2 (4)$: 11.956, $p$: .018*</td>
<td>$\chi^2 (6)$: 30.748, $p$: &lt;.001***</td>
<td>$\chi^2 (10)$: 20.842, $p$: .002**</td>
</tr>
<tr>
<td>25 are reluctant to expand their SOP as they believe they are taking on the work of others</td>
<td>$\chi^2 (4)$: 9.849, $p$: .043</td>
<td>$\chi^2 (6)$: 10.488, $p$: .106</td>
<td>$\chi^2 (10)$: 6.758, $p$: .748</td>
</tr>
<tr>
<td>26 are reluctant to expand their SOP because they do not receive additional salary</td>
<td>$\chi^2 (4)$: 15.151, $p$: .004**</td>
<td>$\chi^2 (6)$: 7.519, $p$: .276</td>
<td>$\chi^2 (10)$: 27.943, $p$: .002**</td>
</tr>
<tr>
<td>27 are reluctant to expand their SOP because they do not receive additional salary</td>
<td>$\chi^2 (4)$: 12.285, $p$: .015</td>
<td>$\chi^2 (6)$: 3.419, $p$: .755</td>
<td>$\chi^2 (10)$: 13.105, $p$: .218</td>
</tr>
<tr>
<td>30 are reluctant to expand SOP because they are uncertain if it will be approved by audit</td>
<td>$\chi^2 (4)$: 7.675, $p$: .104</td>
<td>$\chi^2 (6)$: 33.682, $p$: &lt;.001***</td>
<td>$\chi^2 (10)$: 10.486, $p$: .399</td>
</tr>
<tr>
<td>32 are reluctant to expand their SOP because they are fearful of legal consequences</td>
<td>$\chi^2 (4)$: 3.195, $p$: .526</td>
<td>$\chi^2 (6)$: 11.654, $p$: .070</td>
<td>$\chi^2 (10)$: 10.124, $p$: .430</td>
</tr>
<tr>
<td>33 are reluctant to expand their SOP because they believe their contribution is not valued</td>
<td>$\chi^2 (4)$: 5.481, $p$: .241</td>
<td>$\chi^2 (6)$: 16.046, $p$: .014*</td>
<td>$\chi^2 (10)$: 16.801, $p$: .079</td>
</tr>
</tbody>
</table>

Note: *$p<.05$, **$p<.01$, ***$p<.001$
There was a statistically significant association between the respondent grade and the extent to which they agreed that nurses or midwives are supported by their organisation or employer in expanding their scope of practice [Statement 16, $\chi^2 (6) = 28.588, p < .001$]. Respondents in the senior management category (AD/D/CM314) were significantly less likely than respondents in the other categories (staff grade, CM1/CM2, CS/AP) to strongly disagree or disagree with this statement. Similarly, assistant directors, directors and CM3s were significantly more likely to agree or strongly agree that nurses or midwives are supported by their organisation or employer in expanding their scope of practice. There were no differences between the other grades. According to guidelines by Cohen (1988), this represents a small effect ($\text{Cramer's } V = .122, p < .001$). Thus, senior manager grades generally believe that nurses and midwives are supported by their organisation in expanding their scope of practice.

There was a statistically significant association between the grade of participant and the extent to which they agreed that nurses or midwives have few opportunities in the workplace to expand their scope of practice [Question 24, $\chi^2 (6) = 30.748, p < .001$]. Staff grade respondents were significantly more likely to agree or strongly agree with this statement, when compared to CM1s/CM2s grades or CS/AP grades. No significant differences were observed between staff grades and senior management grades (AD/D/CM3), or senior management grades and CM1/CM2 or CS/AP grades. Similarly, staff grades were significantly less likely to disagree or strongly disagree that nurses or midwives have few opportunities in the workplace to expand their scope of practice, compared to other grades. This represents a small effect ($\text{Cramer’s } V = .126, p < .001$) (Cohen (1988). Thus, respondents in the staff grades were more likely to perceive a lack of opportunities in the workplace as a barrier to nurses or midwives expanding their scope of practice than respondents from other grades.

A chi-square analysis was conducted to examine the association between grade and the extent to which respondents agreed that nurses or midwives are reluctant to expand their scope of practice because they are uncertain if it will be approved by external audit (Statement 30). This association was statistically significant [$\chi^2 (6) = 33.682, p < .001$]. Senior management grades (AD/D/CM3) were significantly more likely to disagree or strongly disagree with this statement, compared with all other grades. Similarly, CM1/CM2 grades were significantly more likely to strongly disagree or disagree with this statement than either staff or senior management grades.

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14 For simplicity, ADON/ADOM, DON/DOM, CNM3/CMM3 etc. are here referred to as AD, D, CM3 etc. to reflect both nurses and midwives at those grades.
Further, staff grades were significantly less likely to disagree or strongly disagree that nurses or midwives are reluctant to expand their scope of practice because they are uncertain if it will be approved by external audit, compared with CM1/CM2 grades and AD/D/CM3 grades. There were no differences between respondents of different grades on whether they agreed or strongly agreed. Hence, the data indicated a statistically significant association between grade and the extent to which respondents disagreed that nurses or midwives were reluctant to expand their scope of practice as they were uncertain it would be approved by external audit. This represents a small effect (Cramer’s V=.132, p<.001) (Cohen 1988). Table 5.11 above also demonstrates that there were no other statistically significant associations between respondent grade and responses to several statements concerned with enablers and barriers to expanded scope of practice.

5.6.4 Categorical principal components analysis of enablers and barriers to expanded scope of practice

In order to reduce the number of items from Section B of the Scope-Q to a smaller number of components that could effectively summarise the information contained in the 19 variables and be used in further analyses, a categorical principal components analysis (CATPCA) was performed, as outlined in Section 5.2. Performing CATPCA is a dynamic process which typically consists of several steps in which analysis results are evaluated and options revised (Linting and van der Kooij 2012). The various steps taken and decisions made in the CATPCA are described in more detail in Appendix 14.

The nineteen items of Section B of the Scope-Q were subjected to a categorical principal components analysis, specifying the extraction of two components. This two-component solution accounted for 42.76 per cent of the total variance, with component 1 accounting for 26.66 per cent (Cronbach’s α=.847), and component 2 for 16.13 per cent (Cronbach’s α=.711) of the variance, respectively. Table 5.12 presents the factor loadings for the 19 enabler and barrier items, all of which can be considered significant according to guidelines proposed by Stevens (2002). The items that cluster on the same component suggest that component 1 represents barriers to expanded scope of practice, while component 2 represents enablers. The Cronbach’s α values indicate that the items loading on each factor can be considered to form a reliable scale (Cronbach 1951; Field 2009).
Table 5.12 Component loadings for CATPCA on 19 enablers and barriers items

<table>
<thead>
<tr>
<th>Nurses and midwives…</th>
<th>Component 1 Barriers</th>
<th>Component 2 Enablers</th>
</tr>
</thead>
<tbody>
<tr>
<td>who wish to expand their scope of practice are supported in doing so by their organisation or employer</td>
<td>.558</td>
<td></td>
</tr>
<tr>
<td>midwives who wish to expand their scope of practice are supported in doing so by their professional nursing/midwifery colleagues</td>
<td>.580</td>
<td></td>
</tr>
<tr>
<td>who wish to expand their scope of practice are supported in doing so by other health professionals</td>
<td>.567</td>
<td></td>
</tr>
<tr>
<td>who wish to expand their scope of practice have access to continuing professional development (CPD)</td>
<td>.596</td>
<td></td>
</tr>
<tr>
<td>who wish to expand their scope of practice are aware of the Scope of Practice Framework document published by ABA</td>
<td>.564</td>
<td></td>
</tr>
<tr>
<td>who wish to expand their scope of practice are motivated by the professional satisfaction that they get from doing so</td>
<td>.585</td>
<td></td>
</tr>
<tr>
<td>who wish to expand their scope of practice are motivated by a desire to enhance their promotional opportunities</td>
<td>.580</td>
<td></td>
</tr>
<tr>
<td>who wish to expand their scope of practice are motivated by a desire to meet the service needs of patients/service users</td>
<td>.528</td>
<td></td>
</tr>
<tr>
<td>have few opportunities in the workplace to expand their scope of practice</td>
<td>.507</td>
<td></td>
</tr>
<tr>
<td>are reluctant to expand their scope of practice because they do not wish to take on additional responsibilities</td>
<td>.640</td>
<td></td>
</tr>
<tr>
<td>are reluctant to expand their scope of practice because they believe they are taking on the work of other professionals</td>
<td>.664</td>
<td></td>
</tr>
<tr>
<td>are reluctant to expand their scope of practice because they frequently do not receive additional salary for doing so</td>
<td>.613</td>
<td></td>
</tr>
<tr>
<td>are reluctant to expand their scope of practice because there are no local/organisational guidelines to support them in doing so</td>
<td>.655</td>
<td></td>
</tr>
<tr>
<td>are reluctant to expand their scope of practice because they are uncertain about which activities are permissible</td>
<td>.655</td>
<td></td>
</tr>
<tr>
<td>are reluctant to expand their scope of practice because they are uncertain if their expanded practice will be approved by external audit</td>
<td>.646</td>
<td></td>
</tr>
<tr>
<td>are reluctant to expand their scope of practice because they lack the professional autonomy to do so</td>
<td>.615</td>
<td></td>
</tr>
<tr>
<td>are reluctant to expand their scope of practice because they are fearful of potential legal consequences of doing so</td>
<td>.666</td>
<td></td>
</tr>
<tr>
<td>are reluctant to expand their scope of practice because they believe their contribution is not valued by other healthcare professionals</td>
<td>.659</td>
<td></td>
</tr>
<tr>
<td>are reluctant to expand their scope of practice because they believe that the additional processes are too time-consuming</td>
<td>.592</td>
<td></td>
</tr>
<tr>
<td>Cronbach’s α</td>
<td>.847</td>
<td>.711</td>
</tr>
<tr>
<td>Variance explained</td>
<td>26.66%</td>
<td>16.13%</td>
</tr>
</tbody>
</table>

As the categorical principal components analysis (CATPCA) indicated, the items from Section B of the Scope-Q formed two components, one relating to enablers to expanded scope of practice and one to barriers. Further, Cronbach’s α suggests that each of these components performs well as a scale. Accordingly, responses to items 16–23 and 24–34 were summed to produce a total enablers and a total barriers score, respectively. The original variables, rather than the transformed variables produced by the categorical principal components analysis, were used for this purpose, as the transformed variables are calculated in such a way that their means equal zero, which can be more difficult to interpret. Further, correlations between the total scores
based on the original variables and the transformed variables were \( r = 0.987 \) for barriers to expanded scope and \( r = 0.830 \) for enablers to expanded scope, indicating very strong associations between the total scores based on the transformed and untransformed variables.

### 5.6.5 Enablers and barriers to expanded scope of practice: Total scores

Total enablers scores ranged from 14 to 40, with a mean of 30.09 (SD=4.08). Higher scores on this variable indicate a higher number of enablers, as perceived by respondents. Total barriers scores ranged from 11 to 55, with a mean of 35.43 (SD=8.05). Higher scores on this variable indicate a higher number of barriers, as perceived by respondents. There was a statistically significant negative association between total enablers and total barriers scores \( [r = -0.352; p < 0.001] \), suggesting that respondents who reported more enablers also perceived fewer barriers.

Total scores for enablers and barriers were compared for respondents in the different age categories. There was a significant difference in perceptions of barriers to expanded scope of practice between the different age groups \([F^1(2, 180.682)=5.425, p=.002] \). Post-hoc contrasts using the Games-Howell procedure indicated that there were statistically significant differences between the barriers perceived by those in the group aged 20–29 years (M=37.98, SD=6.26) and those in the group aged 30–49 years (M=35.58, SD=8.17) and in those aged ≥50 years (M=34.76, SD=8.05), with respondents in the younger age categories generally perceiving greater barriers than those in the two older age categories; this represents a small effect (eta squared =.009) (Cohen 1988). There were no statistically significant differences in perceptions of enablers between the different age groups.

Total scores for enablers and barriers were also compared for respondents of different grades. There was a statistically significant difference in perceptions of barriers to expanded scope of practice between the different grades \([F(4, 973)=5.150, p<.001] \). Post-hoc comparisons using the Games-Howell procedure indicated that there was a significant difference in perceptions of barriers between the staff grade (including PHN) (M=36.06, SD=7.96) and senior management grades (M31.84, SD=7.85), with the staff grade respondents generally perceiving a greater number of barriers than their senior management counterparts. Significant differences were also found in perceived barriers between CM1/CM2 grades (M=35.14, SD=7.85) and senior management grades, with CM1/CM2 grades tending to perceive more barriers than their AD/D/CM3 counterparts; this represents a small effect (eta squared =.021) (Cohen 1988).

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15 This value is based on Welch’s F as Levene’s \( p < 0.05 \)
Similarly, there was a statistically significant difference in perceptions of enablers to expanded scope of practice between the different grades \([F(4, 973)=3.638, p=.006]\). Post-hoc comparisons using the Games-Howell procedure indicated that there was a significant difference in perceptions of enablers between senior management grades (M=31.45, SD=3.45) and staff grade (including PHN) (M=29.84, SD=4.16) and CM1/CM2 (M=30.00, SD=3.77), with senior manager grades more likely to perceive enablers than staff or CM1/CM2 grade respondents; this represents a small effect (eta squared =.015) (Cohen 1988).

Enablers and barriers total scores were also compared for respondents working in different health care settings. There were no statistically significant differences in perceived enablers \([F(5, 802)=2.147, p.058]\) or barriers \([F(5, 802)=1.731, p=.125]\) between nurses or midwives working in different health care settings.

Hence, perceptions of enablers and barriers to expanded scope of practice appeared to be related to age and grade in the current sample, with younger respondents tending to perceive greater barriers than those in the older age categories. Senior management grades also tended to perceive fewer barriers and more enablers than either the staff or CM1/CM2 grade respondents. However, the effect sizes in each case were small.

5.7 Resources for my professional practice (SCOPE-Q, Section C)

Section C of the Scope-Q instrument asked respondents to indicate the resources which they used within the previous three years to support their professional practice. Table 5.13 summaries the frequency of responses. The table indicates that approximately a quarter of respondents (26.2%, n=263) reported consulting a professional organisation for advice concerning their scope of professional practice in the past three years. While few respondents noted seeking advice from a legal professional (2.6%, N=26), 415 sample respondents (41.6%) reported consulting other workplace resources such as practice development or risk management staff.

<table>
<thead>
<tr>
<th>Table 5.13 Resources used</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Within the past three years...</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>35 I consulted a professional organisation (e.g. trade union, nursing association) for advice concerning the scope of my practice</td>
</tr>
<tr>
<td>36 I sought advice from a legal professional (e.g. solicitor) concerning the scope of my professional practice</td>
</tr>
<tr>
<td>37 I sought advice from workplace resources (e.g. practice dev./risk management staff) concerning the scope of my practice</td>
</tr>
</tbody>
</table>
Table 5.14 presents the frequency with which respondents consulted a number of resources provided by the Nursing and Midwifery Board of Ireland (NMBI) within the previous three years. The most frequently-used resource in this category was the *Code of Professional Conduct*, which was consulted by upwards of two-thirds of the respondents (63.3%, n=636). More than half of the respondents (59.6%, n=590) reported consulting the *Scope of Practice Framework* document, while approximately half of the respondents (51.3%, n=511) reported that they had consulted the NMBI website within the past three years.

Table 5.14 NMBI resources used

<table>
<thead>
<tr>
<th>Within the past three years...</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>38 I consulted (i.e. read or referred to) the Code of Professional Conduct for each Nurse and Midwife</td>
<td>636 63.3</td>
<td>369 36.7</td>
</tr>
<tr>
<td>39 I consulted the Scope of Professional Practice Framework document</td>
<td>590 59.6</td>
<td>400 40.4</td>
</tr>
<tr>
<td>40 I consulted the website of the Nursing and Midwifery Board for the purpose of obtaining information related to policies and guidelines</td>
<td>511 51.3</td>
<td>485 48.7</td>
</tr>
<tr>
<td>41 I consulted (i.e. wrote to, spoke with) a staff member for the purpose of obtaining information related to the scope of practice</td>
<td>136 13.6</td>
<td>865 86.2</td>
</tr>
<tr>
<td>42 I completed the free online programme, entitled ‘Scope of Practice’ on the website of the Nursing and Midwifery Board</td>
<td>119 11.9</td>
<td>877 88.1</td>
</tr>
<tr>
<td>43 I consulted the online CPD Directory on the website of the Nursing and Midwifery Board</td>
<td>259 25.8</td>
<td>744 74.2</td>
</tr>
</tbody>
</table>

Table 5.15 indicates whether these resources were consulted, mainly, in relation to the respondent’s own professional practice, the professional practice of others, or both. Of the respondents who reported using these resources, the majority indicated doing so in relation either to their own practice, or both their own practice and that of others. Fewer respondents used these resources solely in relation to the practice of others, as shown in Table 5.15 below.

Table 5.15 Reasons for accessing resources

<table>
<thead>
<tr>
<th>I mainly...</th>
<th>My own professional practice</th>
<th>The professional practice of others</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>38(b)</td>
<td>consulted the Code document in relation to</td>
<td>330 33.1</td>
<td>60 6.0</td>
</tr>
<tr>
<td>39(b)</td>
<td>consulted the Framework document in relation to</td>
<td>354 36.3</td>
<td>48 4.9</td>
</tr>
<tr>
<td>40(b)</td>
<td>consulted the website of NMBI in relation to</td>
<td>296 29.8</td>
<td>31 3.1</td>
</tr>
<tr>
<td>41(b)</td>
<td>consulted a staff member of the Board in relation to</td>
<td>64 6.4</td>
<td>28 2.8</td>
</tr>
<tr>
<td>42(b)</td>
<td>completed the SOP e-Learning programme in relation to</td>
<td>92 9.3</td>
<td>2 0.2</td>
</tr>
<tr>
<td>43(b)</td>
<td>consulted the CPD directory in relation to</td>
<td>205 20.4</td>
<td>9 0.9</td>
</tr>
</tbody>
</table>
Table 5.16 below illustrates that the majority of respondents used at least one of the resources listed in Section C of the Scope-Q instrument.

<table>
<thead>
<tr>
<th>Total number of resources used</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No resources</td>
<td>133</td>
<td>13.2</td>
</tr>
<tr>
<td>1–3 resources</td>
<td>493</td>
<td>48.8</td>
</tr>
<tr>
<td>4–6 resources</td>
<td>336</td>
<td>33.3</td>
</tr>
<tr>
<td>7–9 resources</td>
<td>48</td>
<td>4.8</td>
</tr>
<tr>
<td>Total</td>
<td>1,010</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Almost half (48.8%, n=493) reported using between one and three resources, while one third (33.2%, n=336) reported using between four and six resources. Fewer than fifty respondents (4.8%, n= 48) reported using between seven and nine resources. The mean number of resources used by the sample as a whole was 2.93 (SD=1.99). The number of resources is illustrated in Figure 5.3.

![Resources used](image)

Figure 5.3 Number of resources used when expanding scope of practice

There were significant differences in the number of resources used between the different age groups [F(2, 1006)=3.25, p=.041], with respondents in the youngest age category tending to report the use of more resources than those in the older age categories. Post-hoc comparisons using the Games-Howell procedure indicated that average use of resources for those aged 20–29 years (M=3.53, SD=1.66) was significantly higher than for those aged 30–49 (M=2.86, SD=1.97) and ≥50 (M=2.92, SD=2.04). However, the actual difference in mean use of resources
between the age groups was very small; the effect size, calculated using eta squared, was .006 (Cohen, 1988).

There were statistically significant differences in the number of resources used between respondents in different health care settings [F(5, 812)=2.377, p=.037]. The actual difference in mean use of resources was very small, ranging from 2.37 (SD=1.84) for children’s nursing to 3.26 (SD=1.91) for midwifery. Post-hoc comparisons using the Games-Howell procedure did not demonstrate any significant differences between any of the individual health care settings; the effect size, calculated using eta squared, was quite small (.014; Cohen 1988).

There was a statistically significant difference in the number of resources used between different grades [F(4, 982)=6.725, p<.001]. Post-hoc comparisons using the Games-Howell procedure indicated that there were significant differences between the mean number of resources used by senior management grades (AD/D/CM3; M=3.97, SD=2.11) and all of the other categories of grade (CM1/CM2 M=3.01, SD=1.91; staff grade/PHN M=2.76, SD=1.96; CS/AP M=2.95, SD=2.05; Tutor/Lecturer M=2.67, SD=1.56). Assistant Directors, Directors, and CNM/CMM3s reported using significantly more resources than all the other grades. However, the actual difference in mean use of resources between all the grades was quite small; the effect size, calculated using eta squared, was .027 (Cohen, 1988).

There was a statistically significant positive association between the number of resources used and the extent to which respondents perceived enablers to expanded scope of practice, with an increase in number of resources used related to an increased perception of enablers to scope of practice [Spearman’s r=.073, p=.020]. While this association was statistically significant, the effect size was small ($R^2=.005$) (Cohen, 1988). There was no statistically significant association between number of resources used and perceptions of barriers to expanded scope of practice.

5.8 My professional role (Scope-Q, Section D)
Section D of the Scope-Q survey instrument measured several variables related to the respondents’ professional role. The vast majority of respondents reported that the word ‘nurse’ or ‘midwife’ was contained in the title of their current professional role (N=964, 96.0%, n=964). Job titles of the remaining respondents varied and included 'allocations liaison officer’ (n=2),
‘clinical facilitator’ or ‘clinical placement coordinator’ (n=4), ‘early years inspector’ (n=2), ‘health promotion manager’ (n=1) and ‘leadership advisor’ (n=1). Most of the respondents (91.7%, n=867) reported that they worked directly with patients/service-users and a majority also reported that they worked as part of a multidisciplinary team (85.5%, n=811). The majority of respondents (90.1%, n=857) indicated that their line manager was a nurse or midwife.

Almost two-thirds of respondents (63.3%, n=600) reported that they frequently delegated tasks and duties to more junior nursing/midwifery or non-nursing colleagues. Nearly three quarters of the sample (72.7%, N=720) indicated that they had been required to expand the scope of their professional practice since taking up their current role; of these, 66.8 per cent (n=661) reported having undertaken training specific to their expanded role. A large proportion of the sample (69.2%, n=682) reported having used local policies/guidelines to guide them when expanding the scope of their professional practice and over half (53.9%, n=530) indicated that they had used the *Scope of Practice Framework* document when expanding the scope of their professional practice.

### 5.9 Summary of findings from the national survey

A national survey of registered nurses and midwives was conducted as part of the stakeholder consultation component of the review. The purpose of the survey was to examine registrants’ self-reported current scope of practice, and their use of the *Framework* and other resources to develop and support their professional practice and their experiences of expanded practice. The survey was conducted using the Scope-Q, a 64-item self-report questionnaire designed specifically for the study. The sample consisted of 2,354 registrants on the active part of the Register of nurses, selected by a stratified random sampling procedure.

Three points of contact with the sample yielded a response rate of 45.1 per cent. This was high for a postal survey of the type used in the stakeholder consultation and, when compared with other national surveys of Irish nurses and midwives, was higher than that the response rates achieved in most other referent national studies in the past decade.

### 5.9.1 Sample characteristics

Over two-thirds of the sample (68.5%) was aged 40 years and older and over one third (37%) of the sample was ≥50 years of age. Less than 10 per cent of the sample was under the age of 30 years. The majority of the respondents was female (93.3%), with the proportion of males at just
6.7 per cent. The educational attainments of the respondents showed that 39.3 per cent had a bachelor’s degree and 12.1 per cent held a master’s degree. The majority (85.4%) were registered in the general nurse division of the Register and almost one third (31.0%) was registered in the midwifery division. The largest proportion of respondents (59.2%) was employed at the level of staff grade, one fifth at the clinical manager 1 and 2 grades (20.3%) and fewer than 10 per cent (7.8%) at the managerial grades.

The sample was representative of a wide range of areas of practice, including general nursing (41.6), children’s nursing (5.7%), midwifery (7.4%), psychiatric nursing (9.5%), intellectual disability nursing (6.6%), and public health/community nursing (11.0%). Other areas of practice were also represented in smaller proportions, such as practice nursing and occupational health.

5.9.2 Self-reported scope of practice
Approximately one quarter of respondents (24.2%) reported that they rarely or never used the Scope of Practice Framework document when making a decision about the scope of their professional practice. Over half (59.6%) of respondents frequently or always consulted professional colleagues and half (50.3%) consulted their line manager when making a decision about the scope of their professional practice. The majority of respondents (60.7%) reported that they relied on their own professional judgement and a majority (62.3%) also reported rarely or never relying on the direction of others when making a decision regarding their scope of practice. Most respondents (95.8%) indicated that they would act only when they believed that were competent to perform a new task, role or function and most (92.4%) indicated that they recognised when they were not competent to do so. The majority (85.4%) also reported that they acknowledged to others the limitations in their own competency.

With regard to taking on a new expanded task, role or function, the majority of respondents (90.3%) reported that they frequently or always assessed the task, most (82.4%) considered the impact on service delivery, and most (95.9%) considered the clinical outcomes. The majority reported that they accepted accountability (87.2%) and recognised their accountability (75.3%) when delegating a task, role or function to another.

Respondents in the older age category were significantly less likely to consult a line manager and to recognise their own accountability more when making a decision to delegate when compared to their younger counterparts. Conversely, younger respondents were significantly
more likely to consult with their line manager and less likely to recognise their accountability when making a decision to delegate than their older counterparts.

5.9.3 Enablers and barriers to expanded practice
The majority of respondents (88.9%) agreed that nurses and midwives wishing to expand their scope of practice are aware of the Scope of Practice Framework document. The majority also agreed that nurses or midwives wishing to expand their scope of practice are supported in doing so by their organisation or employer (60.8%) and by their colleagues (75.8%), and have access to continuing professional development (88.9%). However, fewer than half (45.1%) agreed that they are supported in doing so by other health professionals.

Half of the respondents (50.6%) agreed that nurses and midwives have few workplace opportunities to expand their scope of practice. Half (50%) also agreed that nurses or midwives are reluctant to expand their practice because they do not wish to take on additional responsibilities and just over half (51.8%) agreed that nurses and midwives are reluctant to expand their practice as they believe they are taking on other professionals’ work. The majority (74%) agreed that nurses or midwives are reluctant to expand their scope of practice because they do not receive additional salary for doing so and a majority (57.1%) also agreed that nurses and midwives are fearful of potential legal consequences of expanding their scope of practice.

Statistically significant associations were observed between the grade of respondent in respect of their experiences of enablers and barriers to expanding scope of professional practice. Specifically, an association was found between the respondents’ grade and their perceptions of support from their organisation or employer and the availability of workplace opportunities for expanded practice; respondents in the senior manager grades were significantly less likely than respondents in the other grade categories to see these two factors as barriers to expanded practice. Staff grades were significantly more likely to agree that nurses and midwives are reluctant to expand their practice as they are uncertain if it would be approved by external audit. Hence, senior manager grades are more likely to believe that nurses and midwives are supported by their organisation and have workplace opportunities when expanding their scope of practice and a less likely to see the need for approval by external audit as a barrier to expanding practice than their lower grade counterparts.
When barriers and enablers were examined in their totality, the data showed a significant difference in perceptions of barriers between the staff grade and senior manager grades, with the staff grade respondents generally perceiving a greater number of barriers than their counterparts in senior manager grades. Similarly, senior manager grades were more likely to perceive enablers to expanded practice than staff or clinical manager grade respondents.

In summary, perceptions of enablers and barriers to expanded scope of practice appeared to be related to age and grade in the current sample, with younger respondents tending to perceive greater barriers than those in the older age categories. Senior manager grades also tended to perceive fewer barriers and more enablers than either the staff or clinical manager grade respondents, although the effect sizes in each case were small.

5.9.4 Resources for professional practice
The study respondents reported the resources that they used within the previous three years to support their professional practice. Fewer than half of respondents (41.6%) reported consulting workplace resources and just a quarter (26.2%) consulted a professional organisation. The most frequently-used resource was the Code of Professional Conduct (63.3%), followed by the Scope of Practice Framework document (59.6%), and just over a half of respondents (51.3%) consulted the NMBI website. These various resources were mainly consulted in relation to the respondents’ own professional practice. Approximately half of the respondents (49%) used at least one resources provided by the Nursing and Midwifery Board of Ireland in the previous three years. Respondents in the youngest age category were significantly more likely to use resources than their older age counterparts. However, significantly more respondents in the senior manager grades used more resources than all the other grades. A statistically significant positive association was found between the number of resources used and the extent to which respondents perceived enablers to expanded scope of practice; specifically the more resources used the greater was the perception of enablers to scope of practice.

5.9.5 Professional role
Demographic data from the study sample indicated that the vast majority of respondents (96.0%) had the word ‘nurse’ or ‘midwife’ in the title of their current professional role. Most respondents (91.7%) worked directly with patients/service-users and most worked as part of a multidisciplinary team (85.5%). The majority (90.1%) reported to a nurse or midwife as their line manager. Most (63.3%) reported that they frequently delegated tasks and duties to more
junior colleagues and three quarters (72.7%) were required to expand the scope of their practice since taking up their current role, with two thirds (66.8%) receiving training specific to their expanded role. The majority (69.2%) used local policies/guidelines and over half (53.9%) used the Scope of Practice Framework document when expanding the scope of their professional practice.
Chapter 6

FINDINGS: STAKEHOLDER CONSULTATION, INTERVIEWS, FOCUS GROUPS
AND CASE EXAMPLES

6.1 Introduction
In addition to a national survey of nurses and midwives, the review of the Scope of Practice Framework document included consultation with key stakeholders through individual interviews and focus groups. Participants included registered nurses and midwives from a wide range of services and from across all grades, service user representatives, representatives from trade unions and representatives from the Department of Health and from nursing and midwifery policy and regulation. Two case studies of expanded practice were also included in order to provide a more in-depth analysis of how the Framework is utilised by individual practitioners. Furthermore, the research team engaged in public consultation, through a call for written submissions from nurses and midwives, individuals, groups and organisations that have an interest in the Scope of Nursing and Midwifery Practice Framework.

This chapter presents the findings from the stakeholder consultation process. The views of all participants, as provided in the focus groups, individual interviews, case examples and in written submissions are presented here. The chapter contains extracts from the narrative data to illustrate themes and sub-themes. Where two extracts from the same practice area are presented consecutively, these refer to different individuals within that specific practice area.

As three focus groups were held with nurses from general public hospitals extracts from this setting occur frequently throughout the chapter, but they do not relate to a single focus group. To protect the anonymity of participants, the verbatim quotes attributed to ‘Policy, Regulation and Other’ includes the following: representatives from, nursing and midwifery policy and regulation, professional regulation, professional associations and the medical profession.

6.2 Demographic information of participants
A total of 28 data collection events were conducted, involving 113 participants. The participants contributed to thirteen focus groups and thirteen interviews. Two case examples of expanded practice were also conducted. Table 6.1 summarises of the individual events and number of participants.
Table 6.1: Data collection events

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

The total number of nursing and midwifery participants in the focus groups was 94 and the range of participants for individual groups was 5 to 10. Of the 94 participants in the thirteen focus groups, 88 were female and 6 were male. The age range of participants in the focus groups is outlined in Table 6.2.

Table 6.2: Demographic information of nurses and midwives in focus group

<table>
<thead>
<tr>
<th>Age range</th>
<th>20–29 N</th>
<th>30–39 N</th>
<th>40–49 N</th>
<th>50-59 N</th>
<th>&gt;60 N</th>
<th>Total16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>9</td>
<td>22</td>
<td>25</td>
<td>14</td>
<td>1</td>
<td>71</td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>10</td>
<td>24</td>
<td>26</td>
<td>15</td>
<td>1</td>
<td>76</td>
</tr>
</tbody>
</table>

The majority of the nurses and midwives (n=69) were registered in the general division of the Register and 19 were registered midwives. Other registrations included psychiatric nursing.

16 In total 76 participants provided their age category, demographic questionnaires were not completed for two groups (18 individuals).
(n=10), children’s nursing (N=8), advanced practitioner (n=2), registered nurse prescriber (n=1) and nurse tutor (n=1).

Table 6.3: Current grade of focus group participants

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

With regard to their current grade, almost one third of nurses and midwives (30.7%, n=23) were staff grade or equivalent, approximately one third (32%, n=24) were CNM2/CMM2 or equivalent. The remainder (n=28) were drawn from the other grades as follows: CNM1/CMM1 or equivalent (n=9), ADON or equivalent (n=4), CNS or CMS (n=3), nurse/midwife tutor (n=2), CNM3/CMM3 (n=1), DON/DOM (n=2), ANP/AMP (n=2) and other (n=5) (Table 6.3).

The focus groups, interviews and case examples generated a large body of narrative data on the participant’s understanding and perceptions of the scope of their individual practice. Use of the decision-making Framework (DMF) and recommendations for change were also explored in the group discussions and interviews. The data also provided information on expanding scope of practice, professional competencies and the practice setting and context within which scope of practice was applied, as well as a critique of the actual documentation itself. Analysis of the qualitative data yielded six major themes, as follows (Figure 6.1):

- Evolution of the nursing and midwifery professions and practice
- Scope of practice: understanding and use
- Expanding scope of practice
- Professional competence
- Practice setting and context
- Reflections on the current Framework (DMF)

Each theme consisted of two or more themes. The case examples developed from the case study interviews are presented separately at the end of the chapter.
6.3 Theme 1: Evolution of nursing and midwifery professions and practices

Theme 1 describes participants’ perspectives on the role of the nurse or midwife in a ‘diversity of practice settings’ (Policy, Regulation and Other), as well as the changes and developments that have occurred within and around nursing and midwifery practice over time. These include educational changes and changes and expansions in nursing and midwifery roles, role boundaries, and professional autonomy. It also describes their perspectives on environmental factors that have necessitated changes in nursing and midwifery practice, such as changes in technology and therapeutics, an ageing population with more complex care needs, and the move from hospital-based to community-based care. This theme also highlights the difficulties experienced by nurses and midwives in all settings in balancing new and expanded roles with the need to continue to provide ‘basic patient care’ (General public hospital), and the blurred role boundaries that overlap with the roles of other healthcare professionals. The theme provides the context and background to the discussion of the Scope of Practice Framework and expanded scope of practice. Three sub-themes related to the evolution of nursing and midwifery profession and practice were identified: ‘changes in nursing and midwifery education and practices’, ‘the evolving roles of nurses and midwives and negotiating role boundaries’, and ‘changes in care delivery’ (Figure 6.2).
6.3.1 Changes in nursing and midwifery education and practices

Discussions of the Scope of Practice Framework occurred against a backdrop of significant changes in the education and practices of nurses and midwives, as the following quote illustrate:

I’m conscious of the Scope of Practice… emerging in and around the same time as the nursing degree. It would have been that era of nursing… when we were moving nursing on significantly at a point in time… we were sort of unlocking nursing from a very prescriptive approach to its education and to its practice, to a more autonomous route … Where people … could then make more autonomous decisions about their practice (Policy, Regulation and Other).

Another participant noted that these ‘educational changes… have driven practice changes’. Hence, changes in education and training had contributed to the evolution of the nursing and midwifery as professional disciplines, as one nurse stated:

Postgrad education I think gives us the currency to sit at the table with other members of the multidisciplinary team (Residential care public).

Another change in the landscape of nursing and midwifery practice was the introduction of advanced practitioner roles and the proliferation of nurse- and midwifery-led services:
When they evaluated the midwifery-led services in ’04 and ’06, the midwives themselves felt they needed an expert practitioner to enable and guide their practice. They needed somebody that would clinically supervise them… so they were one of the main areas as why the AMP was developed in the first place (Midwifery).

It would be nurse led, obviously you would call the doctor but we set up the whole thing and you would obviously have medical input at all stages but it would be nurse led, nurse run… five day a week (General public hospital).

Related to these services and developments has been autonomy in nursing and midwifery practice, with nurses and midwives in a number of settings seeing their practice as being more autonomous:

Within gerontology nursing itself the competencies are higher because we don’t have, unlike the acute side, the doctor here 24/7, we don’t have other interdisciplinary team members. So… we are taking and making a lot more decisions (Residential care public).

I have to decide whether this patient is going to the hospital or not. I think more judgement is happening here than in the hospital, by the nurse (Residential care private).

Similarly, some nurses working in an intellectual disability service highlighted that ‘ID nurses are massively autonomous’, while midwives considered themselves to have ‘more autonomy and more accountability’ than nurses in some health care settings would have. Practice nurses spoke of ‘episodes of care’ that may not involve the GP at all.

6.3.2 Evolving roles of nurses and midwives and negotiating role boundaries

This sub-theme arose from discussions of the myriad roles and functions carried out by nurses and midwives in a variety of settings, and the role changes and role expansions that have occurred over time. These changes have been triggered to a large extent by ‘all the technological advances and all the new skills that are coming on board’ (Education), as well as changes in regulation and legislation. Thus, participants from all practice settings spoke of changes in nursing and midwifery practice, as highlighted by a nurse working in a private residential setting: ‘we’ve gone from a predominantly medical nursing model to a social model’ and a policy and regulation representative similarly remarked: ‘there was no philosophy of the recovery process in mental health nursing back in 2000’.

Occupational health nurses spoke about how their roles have ‘evolved a lot’, from essentially providing a basic level of service to a more comprehensive service: ‘20 or 30 years ago, there is
a little cough bottle and it is given out to whoever has a cold or a cough and the plasters and whatever … where now it is] about more case management and actually rehabilitating people and getting people back into work and health promotion’ (Occupational health). Similarly, nurses working in the community and in GP practices highlighted that their roles had ‘changed hugely’ and this was also identified by nurses in other settings:

The practice nurses would have started doing bloods, and ECGs, and injections … they’re running a midwifery clinic if they’re midwives, or they’re doing family planning clinics, they're doing insertion of contraception devices, they’re doing … a huge amount of chronic disease management, with diabetes, cardiovascular, respiratory … they’re doing nurse-led clinics for immunisation (Practice nurse).

I suppose the roles are changing … there is more emphasis here in the hospital, nurses taking bloods for instance, or now you can see that there would be more male catheterisations (Residential care public).

Midwives discussed how their ‘role is hugely expanding at the moment … midwives are doing things we never dreamed of doing ten years ago and it is going to get bigger and bigger’. Changes in nursing and midwifery roles were generally seen as positive and ‘fantastic’ for patients; however, some participants noted that the changes and expansions in the practice of some nurses and midwives could be a source of workplace tension:

That sometimes can lead to a little animosity amongst those who have not had the opportunity or may have had the opportunity and are not willing to take up the opportunity to further their education or take up that skill (Residential care public).

Several participants spoke of the fact that changes in the roles and practices of nurses and midwives have led to a re-distribution of functions across healthcare disciplines. Issues associated with negotiating such changing role boundaries were highlighted by some participants, as one nurse observed: ‘It is difficult in this hospital to figure out who does what or who is responsible for what, it is a minefield’ (General public hospital). A nurse working in a private general hospital noted that, ‘even cannulating, years ago people would say that was the doctor’s job’. Another nurse reflected:

You might have ten people with a [peripherally inserted central catheter] PICC line that is ten people who need their bloods done every morning… so that is a job for a nurse where it was the phlebotomist's job before (General private hospital).
While these expanded role functions were seen as a positive by many participants, others argued that nurses ‘shouldn’t be taking more roles from the doctors, we should be working together as a team’ (General public hospital). The growth of healthcare support staff in recent years was also noted as a concern for the development of nursing and midwifery and a number of participants highlighted the difficulties in negotiating role boundaries with other professions. For example, a nurse working in mental health stated:

No matter what setting I was in, whether it be acute or community or whatever, I find that… the blurred kinda thing, we’re slightly an occupational therapist, slightly CBT, slightly psychology, we do absolutely everything, from prescribe to care, you know we do absolutely everything… I think we just multi-task so much that we, we cover into everybody’s work, and we liaise and we communicate with every other professional but we’re also slightly doing bits of their job you know as well (Mental health).

Occupational health nurses spoke of the difficulties in clearly defining their role in the presence of several related professions, including ‘occupational health specialists … occupational health advisors, occupational health technicians.’ The difficulty in negotiating role boundaries was evident even within the discipline of nursing, as one participant pointed out: ‘you have to be very clear, are you working as a clinical nurse specialist or are you working at advanced practice level?’

Many participants linked role expansion and the perceived level of autonomy that they considered they could exert in their current role. These nurses and midwives recognised that accountability and responsibility came with autonomy, as the following three extracts illustrate.

Because there’s a push in my job and in different hospitals around for us to be much more autonomous, and I’m not sure that it’s driven from a fact that they suddenly realise that we’ve got all these skills (Mental health).

Here if anything goes wrong I have to take the decision what I’m going to do. I have to communicate with the family, it’s me, the whole thing I have to look…on behalf of the doctor, we have to do the things. I have to decide whether this patient is going to the hospital or not. I think more judgement is happening here than in the hospital (Residential care private).

I would see that ID nurses are massively autonomous but with that comes responsibility, with autonomy comes accountability and that’s one reason why it would great if competence was first because there’s no point if you can’t do it, if you lack competence (Intellectual Disability).
6.3.3 Impacts on care delivery

Participants across all care settings spoke of the importance of the patient in any consideration of scope of practice and of the fact that ‘the patient should remain the central focus’ (General private hospital) regardless of what practice- or service-level changes were implemented. Some concern was voiced about the increased emphasis on documentation and administration, due to the changes in nursing roles, which was seen to take nurses away from the ‘bedside’. One nurse observed that ‘the documentation has really grown’ (General private hospital). Another participant indicated that ‘nurses are actually burdened by documentation … it doesn’t free them up to be at the bedside’ (Education). While nurses and midwives had taken on roles and functions that have previously been carried out by other professionals, many stated that this should not be done at the expense of providing ‘basic nursing care’ as indicated in the following extract:

What tasks are we losing in order to take those on? Are they really very important? I think here we were very lucky, we have both sides, we have nurses caring at a bedside and watching patients… giving really good quality nursing care and you don't want to lose that to take on all these tasks which are important as well (General private hospital).

One of the major contributors to the changes in nursing and midwifery practice and care delivery noted by participants was the change in the profiles of their patients and the increasing complexity of care, given greater levels of acuity. This was observed in community as well as hospital settings:

The type of patient and the complexity of the patients and the life expectancies of patients, oncology patients and the treatment options that they have is so vast and varied now (General private hospital).

[Cases are] becoming more and more complicated. There are people now with more complications coming out of the hospital that are living longer (General public hospital).

Public health nurses in particular reflected on the difficulties associated with ‘transferring all of the care into the community’:

It actually becomes really visible when you go in for a discharge and you have a complex case coming into the community, particularly the elderly if they are very complex… they come out into the community and there is one Public Health Nurse… and the home help are not nurses and you are trying to explain… and [the patient and family] are going ‘we were promised this in the hospital, we were told this’ (PHN/Community RGN).
The importance of cultural sensitivity and being aware of cultural differences among patients was also highlighted by a number of participants:

I think we need to also remember that there’s cultural diversity… we can be looking after a very different population… there are diversities for us that I think our values have to actually change on that (General public hospital).

We have all the different races now coming to us, which is great, but a lot of them would have very different values and things that they bring along with them that might be different to what we have been used to and that we have to take into account as well and respect their individuality and cultural beliefs (Midwifery).

**Summary of findings, Theme 1: Evolution of nursing and midwifery professions and practices**

Focus group and interview discussions regarding the scope of nursing and midwifery practice occurred against a backdrop of a number of changes in nursing and midwifery roles and practices, as this theme highlighted. Participants noted the changes in pre- and post-registration education, and the introductions of advanced practitioner roles and increasing numbers of nurse- and midwifery-led services. Significant changes in the roles of nurses and midwives were highlighted across all practice settings, as well as difficulties in negotiating role boundaries, both with other healthcare professionals, as well as with other nurses and midwives. Participants of all grades and across several settings were mindful of the importance of continuing to provide nursing care while also noting the demands placed upon them by changing patient profiles and increased complexity of care. This evolution of roles provided an important context to the discussions of scope of practice.
6.4 Theme 2: Scope of practice, understanding and use

This theme describes the participants’ understanding of the Framework for practice. The theme reflects their knowledge and use of and their perspectives on the scope of practice Framework. The theme contains three sub-themes: ‘understanding my scope of practice’, ‘use of scope of practice framework’ and ‘aspects of scope of practice’ (Figure 6.3). The data were derived from both the focus group discussions and the individual interviews.

Figure 6.3 ‘Theme’: Scope of practice, understanding and use

6.4.1 Understanding my scope of practice

Many participants spoke about scope of practice as something internalised, something that is ‘conscious and unconscious’, ‘always in your mind no matter what you’re doing in your work’ and that is grounded in ‘stuff that you do just automatically every day’. One midwife stated:

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

Others remarked that the setting within which a nurse or midwife was practicing could impact on how scope of practice was understood. One research nurse stated that: ‘[We] have to be especially careful that we are always working within our scope of practice, we always have to
think twice about it (Research), while a nurse working in a residential care home observed: ‘each person knows I think their capacity and capability and that the scope, what they can do, and if I’m not confident, of course, I will not do it (Nursing care private). Other nurses and midwives stated that they understood their scope of practice to be about guiding and defining nursing and midwifery roles and the expectations of the nurse or midwife, as these two extracts illustrate:

It’s about clearly defining the roles, in a role profile and people, nurses by nature want to work on a continuum where they improve their practice and widen their scope cause that’s in our nature, we just want to be better (Intellectual Disability).

I understand is quite simplistically, scope is what would the nurse do, what is the definition, what is the expectations of the nurse and my idea is that there are certainly expectations for what we do so what is the scope for what we do and sometimes we need to amend or adjust or expand that scope in a safe way (General public hospital).

Several participants related scope of practice to competence, training, levels of knowledge, evidence-based practice and professional conduct, as indicated by the following extracts:

For me I’ll say is knowing what I’m capable of doing with a patient, and knowing where my knowledge is, at this time in terms of my practice, so it kind of gives me guidelines and confirms what I’m aware of and then what is likely to … so it gives me a bit of insight on to where I am in terms of my professional life (Mental health).

I suppose to me it’s a framework that is to guide your practice and your decision making the whole way along. And whether you are saying, it’s to do with your competency level as well and how competent you are to make a decision. And … have you got the training and the evidence behind that level of competence, to go ahead and make a decision (Midwifery).

One nurse remarked that ‘comfort zone is another word for scope’ and that often, when working in a new area, she considered herself to be outside her comfort zone, outside her scope of practice. Another nurse stated that he looked at the scope of practice Framework as a guide that enables him to know when to stop in the treatment of a patient:

It’s a guide for me to understand my limitations, because all the other nurses are going on the possibilities that I could have the experience, but unfortunate for me personally and my practice, I still have to know when to stop (Mental health).

Throughout the discussions on the understanding of scope of practice many nurses and midwives made specific reference to the importance of considering patient safety, quality of care and a
client-led approach to care and how this should underpin scope of practice, as the following extracts illustrate:

I suppose primarily it is for patients, the mechanism for patient safety, isn't it really, that at that point do they [the nurses and midwives] then recognise the need for more training and take that up, autonomously follow that up themselves? (PHN/Community RGN).

We have to remember that the patient is entitled to safe, quality care at a minimum risk and the scope of practice I believe was put in place so that nurses worked the scope, the framework so that they did that for the patient and we lose sight of that and time and time again the nurse focuses too much on what is their scope rather than what is required by the patient ...the importance of having a framework is a little bit lost (General public hospital).

One of the participants in the patient advocacy group similarly spoke about how the scope could help nurses and midwives to be responsible for their work and practice safely:

[With the scope] … you can say to people, you know, it’s your responsibility to make sure that you’re, you know that you’re being cared for as well that your feel confident and that you feel safe in your work environment…and by being safe in your work environment it means that you know what your scope is and that you know that you can ask questions (Patient advocacy).

6.4.2 Use of scope of practice Framework

In exploring how the scope Framework was used by nurses and midwives in their clinical practice, many participants commented that due to the nature of their work and the area in which they worked, they used the scope on a day-to-day basis. Others indicated that they used the scope on a somewhat ‘needs’ basis and suggested that they should perhaps refer to it more frequently:

For most of my clientele and my caseload I would be working from an autonomous view and you’re putting pathways of care in place. So you’re making decisions around absolutely everything and you’re asking yourself every single time … is this in my scope, am I working in a grey area, am I working outside of it, have I got the evidence to back up what I am doing, does the woman understand, and what are going to be the outcomes. So that, to me endorses the framework the whole way along (Midwifery).

Subconsciously you are making decisions all of the time that would be based on your knowledge and your experience and the skills that you are working with…and it is up on the wall, I am not too sure that I got to it often enough and say, OK I have been asked to do this, and you go down along, I could hold my hand up and say I don't do that as often as perhaps I should do (Residential care public).
Use of the *Framework* was linked to the realities of day-to-day work for many participants as the following extracts indicate:

But it is only when something comes up or something happens that it focuses the mind back to the scope of practice because as [my colleague] said you are running faster now than you were 20 years ago (Residential care public).

I think there is an inhuman expectation of nursing on a day-to-day basis, there is huge demand and I think it puts a strain on the scope of practice and the nurse. That you can work within your scope but there are so many other aspects that go on, on a day-to-day basis (General public hospital).

Related to the realities of work were ‘out of the ordinary’ and emergency situations. Some participants reported that not enough reference was made to emergencies within the *Framework*, while others remarked that the *Scope of Practice Framework* could be helpful to nurses or midwives in emergency situations, particularly when trying to maintain patient safety:

But I think a lot of times as well it is when the hospital is in crisis and there is a shortage of staff… the patients are so ill and all of a sudden it comes up to a crisis point and then people are put into positions at very short notice…. So yes this would have been a very useful tool to identify what needs to be put in place in order to keep that patient safe (General public hospital).

Some participants stated that students and newly-qualified graduates would tend to use the *Framework* more than more experienced staff:

I think that depends on your years of qualification or the level that you are at. If you are early on or newly qualified you probably have to toy with that a lot in your head, whereas when you are actually more experienced it doesn't become an issue because you know straight away whether something is within your scope of practice or not (General private hospital).

If you delegate a job out to a junior member of staff you have to make sure that they have the capacity or the competency to carry it out … and to ensure that they are working within their scope of practice because there are different levels of scope of practice for student nurses. It is very different once you have graduated to your scope when you are a student and your scope is a slightly different (General public hospital).

One recently-graduated nurse who did not train in Ireland, was very positive about having the scope of practice *Framework* to guide her practice, stating: ‘We didn’t have this scope of practice [where I was training], it is all new to me … So I think it is quite good that you have something to go by (General public hospital).
However, there was some criticism of the *Framework* as a teaching tool, with some participants suggesting that it was ‘very much into … the physical aspects, and that it did not… cover the dimensions of health, like emotional health or mental health or whatever’ (Education). Some nurses and midwives indicated that they used the *Framework* document as a tool to educate their students and enable them to understand the concept and how it would be applied in practice:

For our first year students we have a professional issues subject in year 1 as part of a wider module, and students would be introduced to the framework…we would give them copies of the booklet and we’d talk about the general principles of it, and I suppose mostly it is used with the first years from the point of view of like…saying this is a framework to encourage you to be safe in your practice (Education).

The scope *Framework* document was also used as a tool to inform nurses and midwives moving from different care settings and cultures:

This framework we use on the induction, and I know when they go into [hospital name] it makes sure that they really understand it…So the framework is being used certainly in the classroom here quite a lot, to get them to understand when to say no. And to feed it back up the line (Residential care private).

Several participants noted that the use of scope of practice was related in some way to the nurse or midwife seeking permission from service managers to carry out some task or role based on the ‘tradition and culture’ of nursing in Ireland and the increasingly litigious nature of nursing and midwifery practice:

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

It is about nurses understanding decision making and their role and accountabilities and authorities within decision making. And I suppose this is where the landscape for nursing becomes complicated because so much of the tradition and the culture that we have come up through has this thing of looking for permission (Policy, Regulation and Other).

Sometimes you go to scope when you need permission to do something … permission for yourself … midwifery is such a litigation field that some days, you worry is that enough, that yeah I said to myself is that OK (Midwifery).

Several other uses of the scope *Framework* were highlighted by participants. Some indicated that it was used in team meetings ‘when we are dealing with difficult cases’ (Occupational
health); others stated that the scope ‘should be a protective tool for the nurse as well, that keeps her on the straight and narrow, although this was viewed as somewhat limited; ‘at times I think it could be a bit more specific … [so] that you are a bit more protected (Midwifery).

One participant from regulation and policy stated that generally nurses and midwives had a good understanding of their scope of practice, but that those who are more aware of their ‘professional responsibilities’ and who have a supportive working environment would possibly use the Framework more than others:

I think people have a good understanding what nursing and midwifery is about. So I don’t think they’re necessarily hung up on that. I think it’s the local guidelines, it’s the authority, it’s, ‘they’re asking me to do something, now I’m not really sure about’. And ‘where, where is the support that I have as a practitioner from that organisation’ (Policy, Regulation and Other).

While there were many ways in which nurses and midwives used their scope of practice, there was general consensus that Framework was a very useful resource:

It is a fantastic framework if you use it and have the confidence to use it and the support to use it. But we are a profession…this [scope] supports all of that and it should be used [for] the safety of the patient at the end of the day (General public hospital).

**Resources used in decision making**

Participants in the focus groups discussed the resources that they draw on when making decisions in their clinical practice and on which they relied to support them in expanding their scope of practice. The most commonly stated resource was ‘colleagues’, ‘managers’ or the ‘clinical team’; this was evident across all groups who took part in the review. While these groups were generally viewed as an excellent resource, one nurse pointed out that this was not necessarily always the case:

Sometimes that can be the worst thing to do, cos they go ‘no listen you’ll be grand, you’ll be grand go ahead and do it’, and you end up going, well I still don’t feel comfortable in that but they’re looking over my shoulder and, I’m under pressure now again (Mental health).

Many other resources were named and these are illustrated in Figure 6.4.
Some nurses and midwives working in areas of nursing other than general nursing noted that they used policies, procedure and legislation specific to their field of practice. One participant from the field of mental health pointed out that he ‘would go for clinical supervision … without supervision [I] really felt pushed at times into making decisions [I] really wasn’t comfortable with’.

Participants employed as research nurses pointed out that they often referred to the ‘sponsor’ of the clinical trial or consulted ‘sister sites’ to fill the information gaps about scope of practice that arose for them Others relied on their ‘instinct’, based on their ‘knowledge of a particular thing’ when making a decision about patient care and scope of practice (Residential care nurse). One midwife stated that the role often involves having to ‘educate the woman about what you are doing … to try and strike a deal between what she wants and what the hospital wants’ (Midwifery).

6.4.3 Aspects of scope

One participant from policy and regulation viewed the scope of practice Framework as ‘an enabling process that provides the nurse with a confidence that when she makes her decision I
have done it within this framework’ and remarked that thinking about scope should be ‘more challenging than saying, does this support a definition of nursing [and] does this support a value of nursing?’ The same participant also commented that nurses and midwives should be able to draw on evidence to support their decisions: ‘It actually needs to say: ‘right is there an evidence base there, [evidence] that I can draw on that says this is the best possible thing I can do for my patient?’’ (Policy, Regulation and Other).

The perspective of the nurses and midwives was a little different, as during the focus group discussions it emerged that participants considered scope of practice as a concept that could be viewed as either enabling or restricting for nurses and midwives:

I think overall it would enable nurses to do things, but again without the support to talk it through and figure it out, there is responsibility that some nurses abuse it and say ‘oh that’s not within my scope’, without figuring out how it can be within their scope (Practice Nurse).

One nurse spoke about scope of practice preventing him from doing something rather than enabling him to act:

I think it’s probably something that you would think about when, it prevents you from doing something, when I think about this, any time I’d think about like it’s something that prevents me from doing something. You know, you always think, is this within my remit…when I think of this, I think I always think about it in that sense like, of it being outside my remit. I never think of this when I think about something being inside my remit (Forensic).

Several participants viewed scope of practice as something that could be ‘abused’ by some nurses and midwives, who could use it as an excuse not to carry out some role or task and to abdicate their responsibility. The extracts below illustrate these views:

I do think that as the services in the community become very complex that so too must our skills or we must adapt them to meet the population need. And I think it is abused in that term in the sense that there is a bit of a stalemate into what I qualified in 2000 and what I actually practice today. There is an abuse of it as much as there is an enhancement of it (PHN/Community RGN).

Nurses can abdicate their level of responsibility and their accountability by virtue of the current framework because the current framework gives you an out to go to your manager, gives you an out to not to have to make the hard decision yourself (Policy, Regulation and Other).
While participants noted the possibility of scope of practice being ‘abused’ they also suggested that action should be taken by the organisation and the individual if they find that nurses and midwives are regularly indicating tasks and roles to be outside their scope of practice. Each has an obligation to act:

I think the important part is if somebody is saying ‘no’ a lot of the time that something is outside of their scope, well what are they doing about it or what is the organisation doing about it and how is that being communicated and dealt with? (General private hospital).

I don’t think they’ve actually looked through the whole framework. So I think it’s the lazy man way out. You know: ‘oh I don’t have a policy’. OK, stop right there, so maybe you shouldn’t be doing it. But what do you need to develop that policy. Because obviously there may be, there’s some consideration what the service need is (Policy, Regulation and Other).

One participant, from professional education, suggested that the scope of practice of nurses and midwives should be ‘monitored’ to ensure that nurses and midwives develop to their full potential. When the patient advocate group were asked if they considered the Framework to be enabling or restricting for nurses and midwives, one participant remarked: ‘mistakes are made … or conflict arises when people don’t feel enabled to make a decision that they feel comfortable with and they feel unsupported within the organisation’.

One practice nurse described the aspects of scope of practice as follows:

Some of them will use the scope of practice as a way of identifying where their gaps are and will say ‘OK I need to be educated in this’… others, rather than an opportunity for expansion they will see it as you know ‘No scope of practice says I can’t do this’ so it’s like a … just like an order, you cannot do this (Practice nurse).

While the dual aspects of the scope of practice were highlighted by nurses and midwives, ‘scope’ was also ‘about interpretation that this document has both the ability to be enabling and limiting, depending on how it’s perceived’ (Education). One nurse stated that ‘the ultimate decision [is] with the nurse who’s on the register and who’s going to be judged by the nursing board’ (Education) while another participant observed: ‘a strong nurse will make it her own, if you make it your own and put your own slant on it and be able to stand over what you are doing you can use it very well’ (Intellectual Disability).
Several participants believed the *Framework* could be empowering, providing nurses and midwives with the power to say ‘look I am not happy here’ (General public hospital), while others stated that it enabled nurses and midwives to identify gaps in clinical competence that needed to be addressed:

I think it’s very empowering cause … for me if I was re-deployed as an AMP 2 on the pay scale of a CNM2, but I don’t have those skills as a manager so if I was asked to go down and manage a unit I would be incompetent and the in itself would facilitate me to say, you know: ‘I’m not refusing to do it but I have reservations about it and my clinical competence isn’t up to scratch so you need to put things in place’ … so I think it’s quite an empowering document (Intellectual Disability).

So it gives you that piece of [mind], you know, to go back to the night sister or whoever is in charge to say: ‘I am not happy to be here, either move me or move somebody else more senior who knows the run of the place.’ I have no problem. Before you used to, say, be very blasé and say ‘oh I am not happy to move.’ But now you have something there that is a framework that is there to say ‘look … and that we are not happy to work in that environment because we are putting ourselves and, most importantly, the patient, at risk under our care if anything goes wrong (General public hospital).

The view that the scope of practice *Framework* was empowering was not limited to nurses and midwives. The patient advocate representatives also considered this to be the case, as one of them stated:

It enables people, it empowers people…when [as a nurse] I have a graph that can maybe outline steps that you can take to assist with my remint, am I doing my best for the patient…to me, I must feel it’s a good tool to have (Patient advocacy).

*Education on scope of practice*

Many participants highlighted the perceived lack of knowledge, among nursing and midwifery staff and other healthcare professionals, around the scope of practice. One practice nurse stated: ‘I know from working with nurses that they don’t understand it … don’t understand … the background to it’. Other participants indicated that nurses and midwives need to be more aware of how important scope of practice is for their continuing registration:

They also need to be aware of the fact that they’re registrations is very important and a lot of the times they don’t realise how important it is ‘cause that’s their livelihood … we need to make nurses a lot more aware of the kind of things that they could lose their registration (General public hospital).
Some participants suggested that nurses and midwives should be educated to become clinical decision makers and stressed the importance of educating nurses and midwives about the scope of practice and making it part of ‘mandatory training’. Some also suggested that the training should emphasise the empowering nature of the Framework and also the need to address empowerment in professional training: ‘I think, part of the training as well should be about empowering staff’ (Education). A research nurse proposed the need for education about the scope of practice in the context of the research nurse’s role.

Several participants referred to the need for other healthcare professionals and service managers to be educated about the scope of nursing and midwifery practice, as a one participant remarked: I think there needs to be an appreciation from the other professions as to what the scope of practice means (Policy, Regulation and Other). Another suggested that it was important for ‘our employers and managers need to know’ (General public hospital) about and understand the concept of scope in order to appreciate the legitimacy of nurses’ and midwives’ concerns when they are being pressurised to work outside their scope of practice.

Summary of findings, Theme 2: Scope of practice: understanding and use
Participants in the focus groups and interviews spoke about scope of practice as something internalised, something that is often not consciously considered. Others understood scope of practice to be about guiding and defining nursing and midwifery roles. Several participants linked scope to competency, training, level of knowledge, evidence-based practice and professional conduct. Of key importance for participants was the consideration of how patient safety, quality of care and a client-led approach underpins a nurse’s or midwife’s scope of practice. Many participants indicated that they used scope of practice every day while others reported that they used scope on a ‘needs’ basis. Some nurses and midwives discussed scope of practice as a reflective tool or as a guide to patient care during team meetings, while others used it in student training and induction programmes. Some participants noted that the use of scope of practice was related in some way to the nurse or midwife seeking permission from service managers to carry out particular tasks or roles. Scope of practice was considered as either enabling and empowering or restricting for nurses and midwives. Some considered that scope of practice could be used as an excuse not to carry out some role or task. Finally, participants highlighted the perceived lack of knowledge, among nursing and midwifery staff and other healthcare professionals, around the concept of scope of practice.
6.5 Theme 3: Expanding scope of practice

Theme 3 is entitled ‘expanding scope of practice’ and it describes participants’ accounts of their experiences of expanding their practice, including their accounts and perspectives on perceived barriers and enablers to expanded scope of practice. The theme contains three sub-themes, as follows: ‘expanded scope’, ‘barriers to expanded scope’, and ‘enablers of expanded scope’ (Figure 6.5).

![Figure 6.5 ‘Theme’: Expanding scope of practice](image)

6.5.1 Expanded scope

This sub-theme describes some of the issues that participants discussed in relation to expanding their scope of practice.

Conflict between expanded scope and patient care

Participants discussed how nurses and midwives were open and keen to expand their scope of practice but find that there ‘are so many other roles [we] have to take on and it is just expanding and expanding and expanding’ and there was a real concern around the impact this expansion could and is having on patient care. One participant stated that she did not want to ‘compromise the other areas of care’ (General public hospital) and another highlighted the need to consider ‘what impact does [expanded roles] have on the care of the patient at the bedside, good or bad?'
(General private hospital). A nurse in a general hospital setting stated that due to the increased workload it was becoming increasingly difficult to look after basic patient needs:

> [With] the workload is such that we can’t, even though the patients would benefit [from expanded scope] but you have to concentrate as well on the essential elements of care… it is important that patients get their medication, get their pressure area care, get to the toilet, these basic attentions. Your workload is definitely a limitation (General public hospital).

Several participants expressed concern about the requirements for expanding scope of practice and the need to be ‘mindful’ of how this commitment could impact on patient care:

> With regards to the extended role of the nurse, I think that’s always been, it’s been very interesting, very challenging, great for patients. But it can be extremely dangerous, because where is the demarcation line, you know, where you want to care for the patient and you want to help the patient, you want to help the doctor … so when you’re thinking of taking on any further role, you need to be very, very mindful of that, you know, where’s the line in the sand…cos the care is constantly compromised (Residential care private).

Many participants stressed that they were very keen to expand their scope of practice but acknowledged that having done the appropriate training did not necessarily ensure that they would expand their scope, as one observed:

> I mean we would all love to be doing it, I have done the training but I don't have the time. I can't compromise other care, and the hospital has paid, we have been let go from the ward to do the training and it has probably gone out of date now (General public hospital).

**Motivation to expand scope**

Participants discussed aspects of expanded practice that could be considered somewhat negatively. These included the lack of monetary incentive, lack of recognition, increased workload without support and the expectation that expanded practice could mean working ‘outside of scope’, as the following extracts illustrate:

> [There is] no incentive to go and do extra training and widen scope of practice. Nurses are not only motivated by money but lack of incentive…salary increment based on your year in role and not necessarily related to competencies (General public hospital).

They’re expected to do their job as well as do 22 bloods, or ten bloods on a day. You know, that financial reward is, I know I have to say is, when someone is paid solely to take bloods, and true it enhances our practices and it enhances our knowledge to be able to do that, but I feel it shouldn’t be condition…it shouldn’t be left to us to carry it as part of our daily duty, that’s how I feel (Mental health).
One participant suggested linking continuing professional developments (CPD) points to the expansion of scope of practice:

I often wonder about, you know the way you see CPD in lots of different things, and you have, in family therapy you have to have your CPD points, and I often wonder in nursing if there was a way of introducing in some ways, because you get paid the same, whether you do it or you don’t, in a lot of ways … It would be nice to think, after all the slogging and the studying that you do and different bits … now I think the onus would be up to you to prove that you’re keeping your standards (Mental health).

A number of positive aspects of expanding one’s scope of practice were identified. The most frequently cited aspect was improved patient care noted an improvement in overall quality of nursing standards:

I think that is probably almost a positive that shows people aren't doing it for money. There isn't a monetary gain or for an easier life or for a plaque over a door that says whatever, I can run a private clinic here and make a load of money. They are doing it for the best outcome for their patients and that is a really good sign to see I suppose (General private hospital).

I’m trained in phlebotomy and I quite like being trained because it makes my daily life a bit easier, and I can just do take bloods from somebody. And like we’re running Clozaril clinics, like and I can do that… it depends on your role really (Mental health).

Several participants also made reference to the increase in nurses’ and midwives’ level of job satisfaction as a result of their expanded roles:

We do virtually everybody’s job including ourselves. And you know, you really want to do that because you, to your own satisfaction and you feel that you’ve really contributed to that person’s recovery… I feel that if I’m not doing it that means I’m not looking after the patient as I should (Mental health).

6.5.2 Barriers to expanded practice

Many barriers to expanding scope of practice were identified by the participants, including lack of resources and staff shortages, lack of time, lack of support from the organisation, lack of support from healthcare staff, service-led barriers and the attitude of individual nurses and midwives.
**Lack of resources and staff shortages**

One of the main barriers to expanding scope identified by participants was the lack of funding to support expanded role development:

> You have lots of people in agencies so they are not getting proper training. It is quite difficult for junior staff to get experience or to even get onto a course because it is difficult, the money isn't there. From a national point of view there is cut backs, there is less staff and it is difficult (General public hospital).

> There’s not enough funding for training in this area. As much as I would love to have done the phlebotomy courses, there’s no shortage of places and stuff like, so it’s only the funding really (Mental health).

Access to appropriate training was seen as another barrier and was seen to impact on nurses’ and midwives’ ability to expand their scope of practice. Some pointed out that some areas of nursing are dependent on the public service to provide the training and this has been reduced due to the difficult economic situation. Having to complete mandatory training also impacts on nurses’ or midwives’ ability to access other training:

> And we’re kinda’ dependent on the public service at a whim to get on those courses to expand our scope. Because it’s not something we can expand internally. There are structured courses very much laid out by the HSE and basically… so you’re always trying to wait and get the next batch expanded (Residential care private).

> They are being asked to do all this extra bit of work, the complex cases, discharges from hospital, keeping them away from the hospital in the first place and yet they have not been facilitated to get up to speed with the IT, with the training (PHN/Community RGN).

Some participants stated that due to staff shortages and the lack of support staff, it was difficult to expand their scope, get time off for training or prepare guidelines where required:

> The majority of staff are actually very good and we will undertake some of these training days on their time off, but that is not fair because if it is part of your work you should be able to get off for the training from your work environment (Residential care public).

> One participant indicated that she would not take time off in order to attend a training course because she believed that she would be leaving her colleagues to cope in her absence: ‘I know that my colleagues are just going to be on their knees so I won’t do it’ (Intellectual Disability).

Staffing levels were not only seen to impact on expanding scope of practice, but there was also...
concern that the moratorium on hiring staff had impacted on the nurses’ and midwives’ overall well-being and their ability to expand their skill set, as one educator remarked: ‘We haven’t got enough staff and … it’s not just your economic downturn … there’s a staff moratorium on, so where am I going to get staff? (Education).

Lack of time and lack of support

Most of the participants made reference to a lack of time as a key barrier in expanding scope of practice. Concern about releasing people for training and having adequate and safe cover was raised, as was the need to amend training courses to fit with nurses’ and midwives’ limited availability. The concerns around the lack of time are highlighted in the following extracts:

We’ve stopped running full days because it’s hard for practice nurses to get a whole day off. So you know if we can do an afternoon session, 2 or 3 hours in the afternoon, that’s what we’ll focus on and that’s what we’ll run with [training] (Practice Nurse).

What the service demands is spreading and spreading and there is nothing to facilitate us expanding our scope of practice. Because when we don’t get this time, people are refusing to do the study days because they don’t get the time back and why should they come in? (Midwifery).

Linked to the lack of time was the issue of administration and documentation and the amount of time that needed to be allocated to this task. This was seen as a barrier to expanding scope, as one midwife remarked:

[It’s a] massive barrier with all the paper work … people are afraid to take on the study days because of the work they have to do afterwards … like ten signatures for a cannulation … it could take a year to get that … [they are] afraid to take it on cause of all the other work and it does put a barrier on their scope (General public hospital).

Lack of support also emerged as a barrier to expanded scope. Nurses who were working outside an ‘organisational’ structure outlined their concerns about the perceived lack of support from An Bord Altranais and their desire for some form of recognition and support network:

Like if you were ever challenged for malpractice or whatever, where would our support lie with An Bord Altranais? And they don’t have a definition for us, they don't know what our scope of work is. They don’t understand occupational health (Occupational Health)
A lot of research nurses have no reporting structure through the nursing management structure of the hospitals. And in a lot of cases they’re not interested in knowing about us. You know there would be resistance to establishing a formal relationship. I think some barriers have broken down in recent years, but you know it’s not that we don’t want to report to them, it’s that actually the structures aren’t there (Research).

Others noted the lack of support at the level of their own organisation and among the profession more generally. One practice nurse spoke about a recent development in which practice nurses would no longer be able to obtain indemnity insurance from the insurance company that had heretofore provided it; this also applied to registered midwives working as practice nurses. The participant expressed concern that this would impact directly on practice nurses’ scope of practice, limiting the range of diagnostic and therapeutic functions that they could perform and this had resulted in ‘a very bad feeling’ among practice nurses, who were restricted in their ability to provide antenatal care. Several nurses spoke of a lack of support from colleagues and this was viewed as impacting on the desire and ability to expand scope of practice: ‘I have been accused of breaking the good will of the hospital if I refused to do something’ (General public hospital).

Attitudes of individual nurses and midwives
Several participants spoke of the importance of the attitude of the individual nurse or midwife towards the expansion of his/her own scope of practice. Some suggested that not every nurse or midwife wants to expand their scope of practice and no amount of pushing them to do so will be effective:

I suppose not everybody is willing to expand either so you have to either appreciate that or try to bring them along. So a lot of the time, I suppose, in oncology people are very pro learning a new skill, but not everybody is and you have to take that into account as well (General private hospital).

The fact that some practitioners are willing to expand their practice and others are unwilling can adversely impact of the team cohesion:

I also think that you can have very proactive nurses who are willing to engage to meet that need, but then you have ones that haven’t. So you have got a team where it is half working and half not and that drives a bit of animosity within a team, so it can cause an awful wedge in a team and I think it has been witnessed in practice (PHN/Community RGN).
6.5.3 Enablers of expanded scope

Participants highlighted many factors that they believed enabled them to expand their scope of practice, including access to training, support from colleagues and their organisation and the disposition of the individual nurse or midwife towards role expansion.

Access to training

Access to appropriate training emerged as the most significant enabler of expanded scope among participants in the interviews and focus groups, as one participant pointed out: ‘if you have the training then you have the scope to do something … you’ve been signed off [to] do it’ (Midwifery).

The importance of training and further education in enhancing the confidence of nurses and midwives and enhancing the service as a whole and, specifically, patient care was highlighted:

I think it just adds more information and it adds more confidence and it adds more skills to the workforce. And if it does then that is automatically transferred onto the service that the client receives (Residential care public).

Several participants gave examples of specific training courses that they had attended and the necessity and benefits of this training in enabling them to expand their scope of practice, as one occupational health nurse remarked:

One of the training courses that I found to be very helpful which is directly associated with An Bord Altranais is the medicines management course online. That to me was very good and that was directly associated within my role (Occupational health).

Participants spoke about the personal input that was required from both practitioners and their employers in order to attain the appropriate training that would enable them to expand their scope of practice, as this extract illustrates:

The GP would ... have the understanding to say, well, perhaps the nurse has offered, but while it’s not within my scope now, we could work together to make it within my scope, by becoming competent and educated (Practice Nurse).

One nurse spoke about ‘promoting e-learning a lot’ in order to overcome the barriers of cost and time that act as an impediment for many practice nurses trying to access training. While the importance of access to appropriate training was highlighted, for some participants, trying to
access training could be difficult and some commented that it was difficult to access courses listed on the NMBI website, as they were ‘still not updated’.

**Support from individuals and the organisation**

Several participants noted that support in the form of policies and guidelines and team meetings with colleagues were a source support for nurses and midwives wishing to expand their scope of practice:

> And having you know competency isn’t just a particular task, it includes the support such as documentation, for example the guidelines and policies, and it can be very hard when you’re working in practice individually and you’re privately employed, to really push this agenda (Practice Nurse).

> I think our CNM meetings, when we meet and have a conversation around the table, if you have an issue, at least you feel you have the support of your colleagues. That can be very enabling, because there is so much expertise amongst ourselves that we kind of forget sometimes (Residential care public).

One participant spoke about the importance of managers spending time with staff and getting to know about their specific ‘role profile’ thereby enabling expansion of scope of practice:

> I don’t think there is enough emphasis on role profiles [be]cause if you know what your role profile is … if managers spend time with their staff they know exactly what their role profile is, what they are accountable for, what their responsibility is…it lessens I suppose animosity about your role and therefore you will actually develop your scope (General public hospital).

One patient advocate representative also indicated that support from within the organisation was implicit for the expansion of nursing and midwifery roles and expected that such support would be available and accessible to all nurses and midwives:

> I’m just surprised … that people might be a little bit worried about going to their superiors. I just assumed that you would always go to your superior, you know, for advice (Patient advocacy).

Expanding practice was also contingent on the level of commitment of individual nurses and midwives who are motivated to give their time to expand their scope in order to provide enhanced patient care and who could act as role models for others. One community RGN spoke of her experiences of the ‘very highly motivated’ public health nurses, who had motivated her to ‘to do the PHN course and jump through the extra modules and hurdles’. Another general nurse
remarked that ‘a lot of people are quite willing to give up their own time to do courses because most of the courses people do have to do in their own time’. One nurse spoke of the need for practitioners to be willing to ‘increase your capacity and your willingness to change’ and expand their practice in order to improve standards and be ‘more accountable and improve your standards’ (Mental health).

Summary of findings: Theme 3: Expanding scope of practice

Nurses and midwives indicated their willingness to expand their scope of practice, but expressed concern around the impact that role expansion could have on patient care. Many participants working in the areas like mental health, intellectual disability, midwifery and private practice made the link between expansion of practice and level of role autonomy. A number of negative aspects of expanding practice were identified, including the lack of monetary incentive, lack of recognition, increased workload without support, and the expectation that expanded scope means working ‘outside of scope’. A number of positive aspects of expanded practice were also identified. These included improved patient care, improvement in overall quality of nursing standards and an increased job satisfaction.

Identified barriers to expanded practice included lack of resources, staff shortages, lack of time for training, lack of organisational support and motivation and the disposition of the individual nurse or midwife. Enablers to expanded practice included access to training and appropriate support from individuals and the organisation.
6.6 Theme 4: Professional competence

Theme 4 is named ‘professional competence’ and describes the views of the participants on competence in nursing and midwifery practice, including their understanding of competence as well as the link between competency and confidence. Three sub-themes were identified: ‘what is competence?’, ‘gaining and maintaining competence’ and ‘competency and the practitioner’ (Figure 6.6).

![Figure 6.6 'Theme': Professional competence](image)

6.6.1 What is competence?

Competence was spoken about in a number of ways. One participant spoke of ‘a blurring around the understanding of competence and authority’ (Maternity). Competence in nursing and midwifery practice was seen as being about more than tasks, skills and roles and was seen to encompass a certain amount of documentation, auditing and continuous monitoring and updating on the part of the nurse or midwife and ‘not just about … the actual task’ (Midwifery):

> Competence was also seen as the ability of nurses and midwives to critically assess circumstances and know how best to apply their skills and ‘critically think things through’ (General private hospital).
For one manager, competence played a key role in delegation:

I suppose the main thing is really when you do ask a staff member to do something for you that you will ask them do they feel comfortable and are they competent to do it. And if they say ‘yes’ [then] that is fine and if they don’t then you have to send somebody else who can, and then they have to be educated to be able to do the task (Residential care public).

Maintaining competence was viewed as essential in ensuring safety and protection for the practitioner so as to ‘mind your own self’ (General public hospital) and to ‘not to jeopardise your registration’ (Residential care public). Competence was also seen as essential for the wellbeing of the patient, in order to ‘demonstrate that we are practising safely and that it is safe for the public to come into our services’ (Residential care public).

For some participants, competence should not consist of a list of tasks and roles that a nurse or midwife completes; rather it should be about knowledge, experience and critical thinking to enable a nurse or midwife to make safe decisions for the patient and themselves in clinical practice. One participant saw competence as ‘the ability to be proficient and skilled in practice and have the ability in every way … [and] not just clinical skills (Intellectual disability) and another remarked that to be competent one needed to be ‘a strong decision maker and stated:

I think it’s, it’s obviously your education, but obviously your experience, your learning, and your knowing as well (Residential care private).

6.6.2 Gaining and maintaining competence

Participants suggested that gaining competencies was achieved through ‘gaining the acquired knowledge’ and accessing the appropriate training. One nurse explained that in order to attain relevant competencies, she had to ‘[go] back to the drawing board of gaining that acquired knowledge and on how to do it, [how to] carry out a comprehensive assessment (Residential care private). Another nurse explained how having gained competencies in a particular area, she had expanded her scope of practice and patients have benefited from her skills:

So I have gone and done training and I can do blood cultures … and I feel well within my scope that I can do it because I have been trained to do it My manager is happy for me to do it … but the patient isn’t waiting now, the patient is getting what they need at the right time and that is what it is all about (General public hospital).

While gaining competence requires the acquisition of certain skills and involves ‘certification’, ‘full’ competence might not be achieved without the support from other staff members:
Certification is mechanical, I could go on a study day and come back and still not be able to do what I am supposed to do [without] more support to be competent (General public hospital).

One participant drew attention to the fact that in the near future, competence would be part of the pre-requisition for registration, observing that ‘we now have the EU directive, which outlines a list of competencies that has to be adhered to now … [and] whether we like it or not we have to adhere to the EU directive (Policy, Regulation and Other).

Having attained the relevant competencies, maintaining them and keeping them up to date posed challenges for some nurses and midwives; one nurse spoke about becoming ‘de-skilled … unless there is continuous assessment or continuous training going on in each unit’ (General public hospital). An occupational health nurse spoke about the how the ‘onus’ is on her to show that she has the competencies to carry out her role, commenting that this can be both ‘very daunting… [and]…very worrying … because you are there telling your employer that you are competent, that you have all the necessary qualifications to do the job as in the job spec’.

6.6.3 Competence and the practitioner

Several participants noted that the practitioner is responsible for judging his/her level of competence. It was highlighted that while a service manager or an employer may believe that a nurse or midwife is competent to carry out a particular task or role, the practitioner may or may not consider this to be the case, as these extracts illustrate:

Well people, their own judgement for their competence might be different to their manager’s judgement and there is the expectation of what level of competence is needed. (General public hospital)

[T]he organisation may not believe that you as a registrant are covered to complete a task; however your scope, your knowledge, and indeed your education and learned experience from another area may lead you to believe that you are covered (Policy, Regulation and Other).

Until you as an individual know that you are competent and maybe it’s that piece of paper … you have, you know…competence; what does that mean? Does that mean the form has been signed or does that mean I’m comfortable with myself?’(General public hospital).

Participants recognised that competence should be reviewed and evaluated regularly and to have ‘an assessment of competence as well as a declaration … some sort of measuring tool to say [I am competent]’ (General hospital public). One participant called for ‘an appraisal for every
member of staff … [and] a competency review on a yearly basis’ (Residential care private). This same participant linked regular review to self-protection: ‘it’s just a good way of being safer I think, legally’.

Competency was viewed as ‘very much about the ownership of your practice … so when you cannot perform a role or a function you do have to take ownership … [and] is about up-skilling, go about up-skilling yourself’ (General public hospital).

Some participants linked competence to the individual practitioner’s level of confidence. Building competencies was seen to increase nurses’ and midwives’ confidence and having confidence allowed them to develop new competencies. One midwife remarked that confidence was a changing state and that each midwife needed to be aware of their responsibility in maintaining the competencies they had attained and ‘we need to remember that it’s our responsibility you know to maintain our competency … we can’t be leaning on other people’ (Midwifery).

One nurse expressed concern that they have to be careful not to over-step ‘the fine line’ between confidence and competence and expressed caution saying that ‘confidence does not always mean competence’ (General public hospital). For another nurse, the key to competence was assessing a task, knowing that you have the knowledge and skills to deal with it and then proceeding ‘bit by bit’:

Every nurse, will say, ‘I can do a dressing.’ But if you present somebody with major burns, somebody who has the whole of their body burned and it is, ‘but I can't do this.’ But actually the knowledge is there [and] we have the skill; it is just that it is overwhelming when you see somebody who has the whole front of them burned and you say, ‘I can't do this.’ But actually you take it bit by bit and you do it and it is no different, you are using more materials but they are the same materials (General public hospital).
Summary of findings, Theme 4: Professional competence

Competence in nursing and midwifery practice was seen as being about more than just tasks, skills and roles; it was seen to encompass critical thinking along with a certain amount of documentation, auditing and continuous monitoring and updating on the part of the nurse or midwife. Maintaining competence was viewed as essential in ensuring safety and protection for the nurse and midwife as well as for the patient. Participants generally believed that competence should not consist of a list of tasks and roles that a nurse or midwife completes; rather, it should be about knowledge, experience and critical thinking to enable a nurse or midwife to make safe decisions for the patient and themselves in clinical practice.

Participants considered that competencies are attained through accessing appropriate training; however the challenge was keeping them up-to-date. Participants linked competence and confidence; building competencies increased confidence and having confidence allowed nurses and midwives to take on new competencies. Participants also highlighted that fact that the practitioner is responsible for judging his/her level of competence. Competency was seen to be about the nurse or midwife taking ownership for his/her practice.
6.7 Theme 5: Practice setting and context

Theme 5 is entitled ‘practice setting and context’ and describes the participants’ perspectives and experiences of the practice setting and the wider context in which they practice. It relates to service and setting factors associated with scope of practice, including the relevant national and international legislation governing practice, local and national policies, guidelines, regulation, and organisational factors such as redeployment and lone working. Two sub-themes were identified: ‘legislation, policies, guidelines and regulation’ and ‘practice concerns’ (Figure 6.7).

![Figure 6.7 ‘Theme’: Practice setting and context]

6.7.1 Legislation, policies, guidelines and regulation

Most participants in the interviews and focus groups stressed the central importance of relevant local, national and international legislation, policies and guidelines governing nursing and midwifery practice. For example, a participant working in practice nursing highlighted graphically the many guidelines and policies that were needed in order for a practice nurse to be able to administer a flu vaccine in a person’s own home:

You can’t just do it … where’s your insurance, where’s your cover for going into the home, where’s your guideline to put into the home, where’s your guideline for working alone, where’s your guideline for the transportation of the flu vaccine under the cold chain? Where’s your consent, if you’re giving the flu vaccine, where’s your anaphylaxis kit if you’re outside the practice, is your anaphylaxis up to date, have you got your basic life support? (Practice nurse).
The specific policies and guidelines varied according to the practice setting, with occupational health nurses, for example, citing the Health and Safety at Work Act, ‘European directives’, and the Health and Safety Authority (HSA): ‘I would refer to the HSA a lot’. Research nurses spoke of the International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use Good Clinical Practice guidelines (ICH GCP) as ‘the legislation governing anything to do with research or clinical trials’. Research nurses also stated that they referred frequently to the Irish Medicines Board: ‘you just have to be very careful that that way of administering the drug has been approved by the Irish Medicines Board’. A nurse working in a forensic setting highlighted the importance of legislation to his practice: ‘I would say that the Mental Health Act 2001 and the Criminal Law Insanity Act 2006 probably governs … my scope of practice more than anything else’ (Forensic). Participants also mentioned other policies and guidelines that governed the scope of their practice, including policies issued by the Health Information and Quality Authority (HIQA), the Irish Medicines Board (IMB) and by international bodies like the National Institute for Health and Care Excellence (NICE) and the Food and Drug Administration (FDA).

Participants generally viewed policies and guidelines as protective and enabling, as the following quote illustrates:

The IV medications, the fact that the document was there gives a certain amount of safety because we then ... we were able to say we want training in this and we want a pilot scheme going and we want to be able to feed into it (General public hospital).

Some participants spoke about creating their own policies as a way of ensuring that their practice was being conducted within explicit parameters. One private hospital nurse mentioned putting ‘policies and procedures in place’ in order to ensure effective communication between nurses, rotating doctors and consultants. An occupation health nurse described how ‘a lot of the times it is actually the occupational health nurse [who] writes their own policy and guidelines within the role that they are [in] and added:

So it would be in regard to pre-employment screening, report writing, case management, absence management, alcohol and drug testing. So we would write our own policies (Occupational health).

While participants generally welcomed the development of policies, some raised concerns about the time required to develop and implement a single policy, which, in the view of one
participant, could take ‘a year, if not longer’ (General public hospital). Working in the absence of supporting policies was also a concern and this could often leave nurses and midwives in a difficult position as one nurse suggested:

I’ve been left in a very vulnerable position, making the call myself simply because I felt I’d no other choice and was probably in a very grey area on the call I made because there wasn’t the policy in place. I felt vulnerable because of a policy not being there (Education).

National and local policies could also give rise to difficulties for practitioners, as one midwife observed:

We had an example of that recently where the patient had read the national guideline on the particular procedure … and within the guideline it had written that hospitals adapted their local policies, which we had here, but the woman was questioning why weren’t we following the national guideline and why did we perform this particular procedure that wasn’t following current practice (Midwifery).

In addition to policies and guidelines, professional regulation was also cited as an important factor in governing practice, as one nurse commented:

I mean, the other thing is we’re heavily regulated compared to other sectors, so we must be seen to be using the best evidence-based practice, we must be seen to be using the full list of comprehensive assessments for older people (Residential care private).

Another participant from education spoke of the importance of regulation, as exemplified in the scope Framework:

I think we would get in to a very dangerous space if we didn’t have some guidance, whatever it is, from the Nursing Board, to determine how do we, how can we safely decide what we can and we can’t do (Education).

6.7.2 Practice concerns
The second sub-theme identified as relating to practice setting and context describes participants’ perspectives and experiences that gave rise to particular concerns. Redeployment was a concern for many participants, particularly those working in public general hospitals, as highlighted in this extract:
In principle I don’t have a problem but that’s not where my skill set is that’s not where my experience is, how am I going to be of any use … when I haven’t stood on a ward in 20 years, you know, is that the best use of my time?... to be sent and to be re-deployed to another area was very distressing for staff (General public hospital).

One participant believed that scope of practice would protect her if she was re-deployed from her current role:

For myself, if I was to be re-deployed in the morning I feel that scope of practice would protect me cause I haven’t been on clinical area, it wouldn’t be that I would be refusing to do anything, but I would certainly need up skilling and that would support me (Intellectual Disability).

Another participant referred to an attitude of ‘a nurse is a nurse is a nurse’, which was prevalent in organisations and which demonstrated a lack of recognition and understanding of the variety of roles and competencies that are required for different practice settings. This appeared to be a particularly salient issue for midwifery practice, due to the presence of ‘specifically trained direct entry midwives who are… pure midwives… and then we have the dual qualified and there is such a mix of us and it is actually quite confusing’. One midwife highlighted this concern:

We have a new cohort of patients recently that have … palliative care and pain issues, which we really don’t have the training or the competence for. And sometimes the attitude … is that you are being told ‘well you are a nurse and a midwife so just get on with it’ (Midwifery).

Another concern associated with specific practice settings was lone working. One of the difficulties reported was the fact that practitioners in such circumstances do not have recourse to an organisation and its supports, as one practice nurse explained:

‘Nurses working individually, and alone … are not as aware of new things from the [Nursing and Midwifery] Board as nurses in larger institutions, where there’s notices and notice boards and people are talking over coffee and there’s somebody in professional development or practice development who’s bringing it to their attention’ (Practice nurse).

These experiences of lone working and the difficulties they presented for scope of practice were particularly relevant for nurses and midwives who were either not part of a larger organisation or hospital, such as public health nurses, or those who worked largely without the support of other colleagues or a line manager, such as occupational health nurses, practice and school nurses, as these extracts show:
[Practice nurses] could be working … one or two nurses job-sharing, or one to a GP, and that’s it, there’s no other nurse that’s working in the practice, there’s no nursing line management, there’s no nursing support … So many nurses… not just practice nurses, but there would be school nurses… occ[upational] health nurses, many privately employed nurses who are working individually that don’t have somebody [for support] (Practice nurse).

A lot [of nurses] in the community are a lone worker and you have an area to cover, there is no one to refer to so you have to get on with it (PHN/Community RGN).

A research nurse also spoke about the how research nurses ‘work very much in isolation’ of a nursing structure and drew the distinction between ‘nurses who are working individually’ and ‘a nurse in a big hospital who has ten colleagues and can go to her line manager and say: ‘I want to talk to you about this’. Another research nurse similarly referred to ‘the difficulties … in terms of feeling isolated and not within [a] nursing reporting structure within the hospital’. This sense of being isolated from the wider profession was also considered to be an issue for prison nurses:

[Prison nurses are] straddled between what is nursing, as a healthcare service, their role in providing … healthcare services in a prison in a very controlled environment, and even their reporting structure back. Okay, there’s a director of nursing, [but] it’s ultimately back to the Department of Justice, it’s not the Department of Health (Policy, Regulation and Other).

Some participants spoke of the difficulties of negotiating relationships when working outside of traditional medical and nursing reporting structures, as highlighted by a nurse working in the community setting, who spoke of not having the [consultant] coming along and… telling me what to do in relation to this patient’, but instead having different GPs who are ‘independent practitioners, they are not being monitored, so you tell me one thing, and you tell me something else’ (PHN/Community RGN). This sense of not having a support structure to guide one in practice was not confined to nurses lone working, but could also be experienced by hospital nurses working outside of regular working hours, as one nurse explained:

It is the 3 in morning and 4 in the morning when you don’t have your management support structures then and it is at the weekends … that is when the problem does arise, it is not Monday to Friday, 9-5 unfortunately (General public hospital).
Summary of findings, Theme 5: Practice setting and context

Nurses and midwives highlighted the importance of having relevant legislation, local and national policies and guidelines, and regulation to support them in their practice. Concerns associated with the practice context that impacted on practitioners’ capacity to practice effectively included staff redeployment and lone working. These concerns related to a lack of understanding on the part of service managers of practitioners’ scope of practice when practitioners in instances of redeployment and a lack of resources, supports and reporting structures for practitioners who are lone working.
6.8 Theme 6: Reflections on the current Framework

A key element of the review included a reflection on the current Framework document. Theme 6 is entitled ‘reflections on the current Framework’ and reflects participants’ comments and observations on the Framework document and related matters. Participants were asked to comment on the document and to discuss possible amendments, if any, that they believed might improve and enhance the Framework. This theme is presented in three sub-themes, each of which represents particular ideas and reflections on the document as a whole, the possible changes that could be made to individual sections of the document, and recommended changes to the decision-making algorithm. The three sub-themes are ‘general thoughts on the current Framework’, ‘comments on individual sections of the Framework’ and ‘nurse/midwife scope of practice decision-making Framework (DMF)’ (Figure 6.8).

![Figure 6.8 'Theme': Reflections on the current Framework](image)

6.8.1 General thoughts on the current Framework

Most participants spoke positively about the Framework document, one observing that it is ‘probably a very good framework’ (Forensic) and another remarking that it is ‘a very useful, succinct document’ (Policy, Regulation and Other). One participant remarked that the document was ‘one of the best pieces of legislation or direction that came out’ (Intellectual Disability) and another observed:
I thought it was a fabulous document … particularly the framework and the flowchart … I know there’s a review of it, [but] I wouldn’t like that to be changed. I think it’s very clear, it’s a very clear teaching tool … I think a review is good because sometimes it concentrates people on it again (Residential care private).

A patient advocacy representative remarked that ‘any kind of scope is excellent because … [it] guides you, it’s very useful to have, it helps you to make a decision if you’re beginning to have a doubt’

However, one participant commented that it was ‘less than specific’ and did not ‘appear to be very ambitious’ (Policy, Regulation and Other). Another participant was ‘mindful that it was published in 2000, and life has progressed a lot since then’ and another similarly commented that ‘in the last 14 years we have had the introduction of so many roles in nursing … [and] people are crying out for an updated framework’ (General public hospital).

Several participants noted that the Framework document was aimed at the individual and made no reference to the responsibility of the organisation or employer, in ensuring that nurses and midwives work within their scope of practice. Some suggested that the Framework should reflect this is some way, as one representative from policy and regulation commented:

In terms of responsibilities of the employer, in my respect, it’s a bit open, and thinking in terms of the review of the Act requires that the employer shall require … that nurses achieve continuing professional development … So that would be one area that it [the scope Framework] needs to sync with … the scope now would need to sync with the current legislation (Policy, Regulation and Other).

This same participant also stated that the overall document needed to take student internships into consideration: … ‘I think the scope needs to be mindful of the internship piece of undergrads, and how the framework could be looked at or tweaked or informed’ (Policy, Regulation and Other). Any new Framework would also need to ‘take into account … and respect [patient] individuality and cultural beliefs’ (Midwifery) and the possible ‘language barrier’ experienced by some nursing and midwifery staff (Residential care public). One practice nurse noted that nursing ‘values have to actually change’ based on the degree of cultural diversity in Ireland. Another participant pointed out that any changes in the Framework document should take account of the needs of practitioners working more in isolation.

There was some discussion around the scope Framework being a ‘generalist’ document, a
resource more suited to students and recently-qualified nurses and midwives. Some suggested that the one Framework could act as the ‘scaffolding’ upon which advanced practitioners could expand their decision making:

I don’t necessarily think that we need another decision-making framework at advanced practice … I think the one framework, whatever decision-making tools we set out, now there may be other bits and pieces in it that you’d have to add in to advanced practice, but the basic scaffolding would be the same (Policy, Regulation and Other).

While a small number of participants discussed the possibility of having a separate Framework document for nurses and midwives the consensus view was that individual nurses and midwives have individual experiences that will influence their decision making in practice and that the ‘generalist’ framework allows for this individuality to be applied:

It is very individualised … look at all the experience we have around the table and we all have different individual experiences as well in empowering our decision making and our practice … That is what is so good about the Framework, that you can apply it just to you as well as to what is different (Midwifery).

Another participant made reference to the future development of the healthcare professions and the possibility of a shared framework being developed for all healthcare professionals, explaining:

If it happens to be that a scope of practice framework is being considered … before it’s reviewed by any of the professions it needs to be … adapted by each of the professions as they see it … [Many elements of the Framework are] … common to all professions so there is no need to re-invent the wheel … but it could be that there are some things that are peculiar to a group … some bits and pieces that are going to be professional specific … and these would need to be articulated (Policy, Regulation and Other).

Personally I think that any kind of scope is excellent because … [it]… guides you, it’s very useful to have, it helps you to make a decision if you’re beginning to have a doubt … this guides people, well yeah it’s OK for me to go to the next level and get advice or it’s OK for me to question is it within my scope of competence, that’s just, I feel it’s just good (Patient advocacy).
6.8.2 Comments on individual sections of the Framework

Sections 1, 2 and 3 (Introduction and definitions)

Based on the focus group discussions, the individual interviews and the written submissions, several comments specific to sections 1, 2 and 3 of the Framework document were noted. The overall emphasis of the Scope Framework was questioned in a submission received:

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. This statement requires review and may no longer be relevant (Written submission).

One lacuna in the Framework was seen to reside in its lack of definition of particular nursing roles, such as occupational health nursing: ‘they don’t have a definition for us, they don’t know what our scope of work is’. Other areas that were identified as requiring amendment included the roles and values of nursing and midwifery, which needed to ‘take the changes from 2000 into consideration’ and some participants suggested the Framework should demonstrate an increased emphasis on collaborative working between nurses, midwives and multi-disciplinary teams.

Sections 4 and 5 (Important considerations and principles for determining scope)

In the course of focus groups and interviews and from submissions received, many suggestions were proffered about Section 4 (‘important considerations’) and Section 5 (‘principles of determining scope’) of the Framework, which are summarised in the Table 6.4 below.
### Table 6.4: Comments on section 4 and Section 5 of Framework document

<table>
<thead>
<tr>
<th>Important consideration</th>
<th>Comments and suggestions</th>
</tr>
</thead>
</table>
| Competence                       | • This section needs to highlight that only the ‘individual’ can evaluate their competency; it can vary from individual to individual and from task to task  
• Include a definition of competence  
• Need to address EU directives around competence                                                                                                                                  |
| Accountability and autonomy      | • Clarification is still necessary in relation to autonomy, authority, responsibility and accountability, as these terms can create ‘grey’ areas at times, and nurses and midwives do not always feel confident that they are ‘covered’ in their scope of practice                                                                                           |
| Delegation                       | • The piece on ‘delegation’ needs to be addressed; who should/can delegate to who  
• The inclusion of examples illustrating delegation would be helpful here                                                                                                                                                                                                                         |
| Emergency situations             | • Expand this section to provide more clarity                                                                                                                                                                                                                                                                                                               |
| Principles for determining scope of practice | • Core principles should remain the cornerstone by which to assess scope  
• Point 6 should also include reference to collaboration with stakeholders in the expansion of practice. Suggest the inclusion of reference to quality, safety and risk management in this section to ensure the provision of quality, safe health care. Clear direction around expanded roles since 2000 and also incorporate more around for example the CNS, ANP, nurse prescribing  
• Make reference to the core values of nursing, ensuring that ‘primary care needs’ are met before expanding scope                                                                                      |

**Nurse and midwife scope of practice decision-making Framework**

During the course of the data collection all participants were provided with copies of the decision-making algorithm and asked to discuss its usefulness and highlight possible changes that could improve or enhance it. The views on the decision-making algorithm varied, with some participants saying that it was clear and that all the questions seem relevant and appropriate, and others stating that it was not fully understood. One nurse in forensic services commented: ‘[the algorithm] straightforward and it’s quite well laid out … and easy to follow with the arrows and stuff, but I’m still not quite sure. I mean I don’t know if nurses, I think this type of thing that nurses glance at, don’t think about it (Forensic).

One participant stated that the algorithm did not reflect the setting in which she practiced as her decision making processes would not be ‘that linear, it doesn’t flow that well because of all the variables that can affect us in a normal knock on the door and walk through the door’ (PHN/Community RGN). Another stated that ‘the centrality of the patient’ should be the starting point upon which the rest of the decision making should be built:

If you were to start from here again I would think, okay, what is in the best interest to the patient here? How is the patient presenting? And then I would have the thing about legislation and national guidelines further along’ (Policy, Regulation and Other).
One nurse suggested that the question, ‘Do you have the necessary competence to perform this role/function?’ should be moved further up in the algorithm, stating: ‘if nurses or midwives do not have the competency then they should not be attempting to complete the task or role even if there is a policy in place’. For this participant, autonomy and accountability were key issues and confidence was not viewed as being the same as competence: ‘It would be great if competence was first because there’s no point if you can’t do it, if you lack competence’ (Intellectual Disability).

Several references were made to the final line of the algorithm Framework, which reads: ‘Unsure?: Discuss with line manager/An Board Altranais.’ One nurse pointed to an inherent limitation in this aspect of the algorithm, stating: that ‘as it stands … you can discuss with your line manager forever [and] nothing changes and so there should be a step for action here’ (Education). It was also suggested that this final instruction was ‘too broad’ and that it might be better to include a more precise instruction, such as ‘discuss with a nurse manager. Other suggested changes to individual aspects of the decision-making algorithm) as well as suggestions for dissemination are summarised in Table 6.5 below.

Table 6.5: Suggested changes to scope of nursing and midwifery decision-making Framework

<table>
<thead>
<tr>
<th>Aspect of decision-making Framework</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colour</td>
<td>Keep the colour the same; it is recognisable as ‘scope’ document from An Bord Altranais</td>
</tr>
<tr>
<td></td>
<td>Change the colour – blue?</td>
</tr>
<tr>
<td></td>
<td>Use green and red colours to indicate ‘go’ and ‘stop</td>
</tr>
<tr>
<td>General content</td>
<td>The Framework for nurse prescribing is more user-friendly</td>
</tr>
<tr>
<td></td>
<td>Make it look less complicated</td>
</tr>
<tr>
<td></td>
<td>It is too generic; it needs to be more specific</td>
</tr>
<tr>
<td></td>
<td>Need to highlight somewhere that the decision needs to be evidence based</td>
</tr>
<tr>
<td>Specific content</td>
<td>Should add useful evidence based resources such as care plans to the question ‘Is there any legislation…relating to this role/function?’</td>
</tr>
<tr>
<td></td>
<td>Should make reference to the need to conduct risk-assessment when considering ‘What are the implications?’</td>
</tr>
<tr>
<td>Suggestions for enhancement/dissemination</td>
<td>Would be useful as a smart phone application, although it was recognised that nurses and midwives are not permitted to use their mobile phones at work</td>
</tr>
<tr>
<td></td>
<td>Make more obvious the link to scope Framework on NMBI website</td>
</tr>
<tr>
<td></td>
<td>Have hyper-links to relevant policies and legislation (relevant to all settings)</td>
</tr>
<tr>
<td></td>
<td>Set up a Blackboard type online forum where questions could be answered</td>
</tr>
<tr>
<td></td>
<td>Change the language somewhat, for example, the use of the phrase ‘the nurse must’ could be replaced by the term ‘the nurse should’</td>
</tr>
<tr>
<td></td>
<td>Prepare examples/case studies for various areas of nursing and midwifery to provide a better understanding</td>
</tr>
<tr>
<td></td>
<td>Produce on A4 size and laminate and place it in all clinical departments</td>
</tr>
</tbody>
</table>
Summary of findings, Theme 6: Reflections on the current Framework

Participants were in general agreement that the Scope of Nursing and Midwifery Practice Framework is a good document; however, many suggested that, as it was published in 2000, it was in need of updating to take account of the many changes that had occurred in nursing and midwifery practice since the Framework was first published.

Several participants were of the opinion that any revised Framework should reflect the responsibilities of the organisation or the employer and should take student internships into consideration. Others stated that the Framework needed to reflect the fact that many nurses and midwives now work as part of a multi-disciplinary team and that there was a need to educate other health professionals about the nursing and midwifery scope of practice.

Some participants viewed the scope Framework as a ‘generalist’ document, a resource more suited to students and recently qualified nurses and midwives while others suggested it could act as the ‘scaffolding’ upon which advanced practitioners could expand their decision making. A few participants discussed the possibility of having a separate Framework document for nurses and midwives, but the general consensus was that this was not necessary. Many suggestions were made for amendments to the Framework document and the decision-making algorithm.
6.9 Summary of findings

Focus group and interview discussions regarding the scope of nursing and midwifery practice occurred against a backdrop of a number of changes in nursing and midwifery roles and practices. Significant changes in the roles of nurses and midwives were highlighted across all practice settings, as well as difficulties in negotiating role boundaries, both with other healthcare professionals, as well as with other nurses and midwives. Participants of all grades and across several settings were mindful of the importance of continuing to provide nursing care while also noting the demands placed upon them by changing patient profiles and increased complexity of care.

Participants in the focus groups and interviews spoke about scope of practice as something internalised, something that is often not consciously considered. Others understood scope of practice to be about guiding and defining nursing and midwifery roles. Several participants linked scope to competency, training, level of knowledge, evidence-based practice and professional conduct. Of key importance for participants was the consideration of how patient safety, quality of care and a client-led approach underpins a nurse’s or midwife’s scope of practice.

Many participants indicated that they used scope of practice every day while others reported that they used scope on a ‘needs’ basis. Some nurses and midwives discussed scope of practice as a reflective tool or as a guide to patient care during team meetings, while others used it in student training and induction programmes. Some participants noted that the use of scope of practice was related in some way to the nurse or midwife seeking permission from service managers to carry out particular tasks or roles. Scope of practice was considered as either enabling and empowering or restricting for nurses and midwives. Some considered that scope of practice could be used as an excuse not to carry out some role or task. Finally, participants highlighted the perceived lack of knowledge, among nursing and midwifery staff and other healthcare professionals, around the concept of scope of practice.

Nurses and midwives indicated their willingness to expand their scope of practice, but expressed concern around the impact that role expansion could have on patient care. A number of negative aspects of expanding practice were identified, including the lack of monetary incentive, lack of recognition, increased workload without support, and the expectation that expanded scope means working ‘outside of scope’. A number of positive aspects of expanded practice were also
identified. These included improved patient care, improvement in overall quality of nursing standards and an increased job satisfaction. Identified barriers to expanded practice included lack of resources, staff shortages, lack of time for training, lack of organisational support and motivation and the disposition of the individual nurse or midwife. Enablers to expanded practice included access to training and appropriate support from individuals and the organisation.

Competence in nursing and midwifery practice was seen as being about more than just tasks, skills and roles. Participants generally believed that competence should be about knowledge, experience and critical thinking to enable a nurse or midwife to make safe decisions for the patient and themselves in clinical practice. Participants considered that competencies are attained through accessing appropriate training; however the challenge was keeping them up-to-date. Participants linked competence and confidence; building competencies increased confidence and having confidence allowed nurses and midwives to take on new competencies. Participants also highlighted that fact that the practitioner is responsible for judging his/her level of competence. Competency was seen to be about the nurse or midwife taking ownership for his/her practice.

Nurses and midwives highlighted the importance of having relevant legislation, local and national policies and guidelines, and regulation to support them in their practice. Concerns associated with the practice context that impacted on practitioners’ capacity to practice effectively included staff redeployment and lone working.

Participants were in general agreement that the Scope of Nursing and Midwifery Practice Framework is a good document; however, many suggested that, as it was published in 2000, it was in need of updating to take account of the many changes that had occurred in nursing and midwifery practice since the Framework was first published. Several participants were of the opinion that any revised Framework should reflect the responsibilities of the organisation or the employer and should take student internships into consideration. Others stated that the Framework needed to reflect the fact that many nurses and midwives now work as part of a multi-disciplinary team and that there was a need to educate other health professionals about the nursing and midwifery scope of practice.
6.10 Case examples of expanded practice

Considering the nature of the case studies and the topic being reviewed – the Scope of Practice Framework - the most suitable method of presenting the findings, derived from the interviews with the midwifery and nursing practitioners, was in the form of case examples or ‘stories’ (Bailey and Tilley 2001). The purpose of these case examples is to demonstrate how nurses and midwives made sense of the decision-making algorithm and utilised it in their practice. Outlined below are the two case examples.

6.10.1 Case example of midwifery practice

Mary is a senior midwife and works on a ward with Anne a midwife who has one year’s experience. Mary stated that the Framework is a part of her ‘natural practice’, it is internalised, but in order to explain how she would use the decision-making algorithm she gives an example of a case where Joan presented to the ward with uterine pains. She would have been considered to be a low-risk woman, that is, she was having her first baby, was full-term (forty weeks gestation) and gave a history of regular, possibly uterine, contractions. Anne had decided, after the whole of the admission procedure, that the woman was not actually in labour and the woman indicated that her preference was to go home. The decision to be made was whether or not Anne should allow this woman to go home.

Using the algorithm in the Framework document, Mary takes us through the process and explains how Anne (and Mary) came to their final decision.

Q. Is there any legislation, national or local guidelines prohibiting Anne’s role or function?
A. No as there is a midwifery discharge guideline in place for such cases. Straight away Anne can go to the next question. If there were no guidance or policy here then Mary believed that Anne would have to stop as there would be no legislation guiding her decision.

Q. Will the decision maintain Joan’s best interests and promote and maintain best quality health services for the population?
A. Yes. From research (in the literature) and previous experience Anne knows that women ‘labour better’ in their home environment. This is better for the baby, the mother

17 Names have been changed in order to maintain the interviewee’s anonymity.
and the husband/partner and has better outcomes. Sending Joan home is also better ‘for
the population’ as longer stays in hospital can result in more intervention and more risks
– again based on research and experience.

Q. Does Anne’s role fit with the definitions and the values that underpin midwifery?
A. Yes, the Nursing and Midwifery Board of Ireland looks towards a philosophy of
midwifery that is woman-led and women-centred. Pregnancy and birth with a low-risk
woman like Joan fits with the definition and values of midwifery.

Q. Is there any legislation, national or local guidelines/policies relating to Anne’s
function/role as a midwife?
A. Yes, the discharge guideline that Mary mentio
ned earlier. The question is does Joan
fit the criteria and she does. What about the implications? According to Mary, in this
case there few implications as Anne is working within best practice guidelines. However,
when considering the implications a risk assessment should be carried out. Risk
assessment is a key part of midwifery. Mary pointed out that at this stage she would be
expecting Anne to be coming to her saying that she is happy to discharge the woman
with a pathway of care, she would not be delegating the decision to Anne.

Q. Do local policies/guidelines/protocols or supports need to be put in place?
A. No – guidelines for this case are already in place and signed off by an obstetrician.

Q. Does Anne have the necessary competence to make the decision?
A. As a midwife working in the labour ward, Mary would expect Anne to have the
competence and knows she has from working with her regularly. Mary explained that if
Anne had felt that the task was not ‘within her scope of practice’ and she felt happier
admitting Joan, she would ask the question ‘why’ and allow Anne to go through her
rationale. In doing this, they work through the whole clinical assessment and get at the
core of why Anne was not feeling competent and what would be needed to make her
become more competent. She would ask Anne leading questions, reflecting the scope
questions back to her so that she could work out her own decision.
Q. Is Anne willing to accept accountability for her decision?

A. Yes. Mary stressed that it was important that Anne was willing to be accountable for her decision – she was not asking Mary for permission to send Joan home but just informing her of the decision. If permission is being sought, this ‘muddies the water’ as it is unclear who is taking responsibility.

Action: An evidence-based decision was made to send Joan home with a ‘pathway of care’ as she lived close to the hospital and would be able to return when she felt she needed to.

While Mary was able to use the Framework to demonstrate the example and explain how the algorithm could be used, she did not feel that it was very useful in its current format. She believed that the Framework did not reflect what was ‘happening on the ground’ and suggested that it was somewhat ‘ideal’. She was also of the opinion that the organisations where midwives were employed need to provide a more supportive role for the Framework, in the form of risk assessment and relevant policies. Mary and Anne’s case example is presented in a visual format in the figure below. Using the decision-making algorithm as a template their process is tracked.

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18 Joan went home with an understanding of why she was being sent home and the knowledge about when to come back and who to contact.
Figure 6.9 Midwifery Case Example Algorithm
6.10.2 Case example of advanced practice: Reflective tool

Karen is an advanced nurse practitioner and works as part of a multi-disciplinary team in a busy general hospital. Karen spoke about how she has internalised the *Scope of Practice Decision-making Framework* so she believes that there is no need to refer to it on a daily basis in her practice as an Advanced Nurse Practitioner. She also noted that there is a separate framework for advanced nurse practitioners with ‘core competencies and very specific post competencies’, which can be linked to the competency aspect of the nursing and midwifery *Framework*.

In this case example, she had made a decision about an element of patient care where there was no specific protocol in place. This was the first time such a decision needed to be made by her. John had been attending Karen for a course of treatment and she had built a ‘therapeutic relationship’ with him. On this occasion when he attended, she found that John’s description of his condition had changed somewhat and after her advanced assessment, Karen believed that the best course of action would be to withhold the current treatment (prescribed by a medical consultant) and refer John for further examination. This is what she decided to do and the outcome was positive for John, he received alternative appropriate treatment.

After the decision was made and action was taken, she said that she did a lot of ‘teasing out’ in her mind because she felt very ‘vulnerable’ and was wondering what would have happened if her action had not had the desired outcome. She took out the decision-making *Framework* and went through each of the key components.

Using the algorithm in the *Framework* document, Karen takes us through the process and explains how she came to her final decision.

*Q. Was there any legislation, national or local guidelines prohibiting Karen’s role or function?*

A. No. There were no prohibiting guidelines in place but there was no specific protocol either. Karen proceeded to evaluate the decision she made using the *Framework*.

*Q. Would the decision maintain her patient’s best interests and promote and maintain best quality health services for the population?*

A. Yes. Karen’s decision was made based on her advanced assessment of John and her knowledge and experience as an advanced practitioner.

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19 Names have been changed in order to maintain the interviewee’s anonymity.
Q. Did Karen’s role fit with the definitions and the values that underpin nursing?
A. Yes. She was advocating for the patient, she had been treating John for some time and he trusted and would trust the decision that she made.

Q. Was there any legislation, national or local guidelines/policies relating to Karen’s function/role as an Advanced Nurse Practitioner?
A. Yes. To maintain the patient safety at all times and to maintain practitioner safety at all times. At this stage, Karen would have considered the implications of her decision for John, would it have resulted in a good or bad outcome?

Q. Did local policies/guidelines/protocols or supports need to be put in place? (If yes, consider what needs to happen to put these in place.)
A. Yes. But when making her decision, Karen chose to go along with the protocol to maintain patient safety at all times. After the event, Karen called a case conference and a new appropriate protocol was put in place by her.

Q. Did Karen have the necessary competence to make the decision?
A. Yes. There is a Framework for advanced practice with core competencies and very specific post competencies and Karen had the knowledge and experience to make this decision.

Q. Was Karen willing to accept accountability for her decision?
A. Yes. An evidence-based decision was made which had a good outcome for John. Karen believes that it is very important that decisions and action come from an evidence-based perspective.

Karen believed that she had learned so much from the experience. The fact that at some stage, decisions will have to be made and action will have to be taken for the first time and often there will be an element of ‘immediacy’ about the decision to be made. In these circumstances, boundaries would have to be pushed.

Looking at the Framework in hindsight as a reflective tool, she realised that in her case it would have been quite restrictive. If she stuck rigidly to it, she would not have taken the action she did at the time. She was confident, however, that having made the decision based on her ‘advanced
assessment of the patient’ she had worked ‘within her parameters’ and acted in the best interests of her patient. Karen’s case example is presented in a visual format in the figure over the page. Using the decision-making algorithm as a template her process is tracked.
Figure 6.10 Reflective Case Example Algorithm
Chapter 7

DISCUSSION

7.1 Introduction
In the fourteen years since the Scope of Nursing and Midwifery Practice Framework (An Bord Altranais (2000a) was first published, several developments have occurred in nursing and midwifery in Ireland, notably the advent of graduate-level entry to practice, expansion of continuing professional development opportunities, and role expansion through the introduction of clinical specialist and advanced practitioner grades. More recently, the Nurses’ and Midwives’ Act of 2011 introduced the requirement for registered nurses and registered midwives to maintain professional competence on an on-going basis. In light of these developments, the Nursing and Midwifery Board considered it timely to commission a national review of the Scope of Practice Framework. The review consisted of several elements, including a review of other regulatory authorities’ frameworks, stakeholder consultation through a national survey and 28 qualitative data collection events, an analysis of the NMBI enquiries database and two case studies of expanded practice. The findings from this evaluation are discussed here.

7.2 Self-reported scope of practice

Competence and decision making
Some practitioners recognise that their scope of practice can be determined both internally by their own competence and externally by factors beyond their control, such as the patient’s wishes, protocols, and the wishes of medical staff (McConnell et al. 2013). The data from the focus groups and interviews indicated that participants held professional judgement to be important in decision making and that, while an employer might believe that a practitioner was competent to carry out a particular task or role, the practitioner might not believe her or himself to be. This idea was supported in the findings from the national survey, which indicated that the majority of respondents reported that they relied on their own professional judgement when making a decision regarding their scope of practice and rarely relied on the direction of others when deciding on their competence to perform new tasks, roles or functions.

The findings from the national survey indicate that approximately a quarter of the study respondents reported ‘rarely’ or ‘never’ using the Scope of Practice Framework document when making a decision about the scope of their professional practice. Conversely, upwards of half
reported frequently using the Framework. Data from the interviews and focus groups also indicated that many participants used the Framework, sometimes in team meetings or to guide student training, although for many it was used only when circumstances demanded. While there is an expectation that all registrants should consult the Framework document from time to time, the numbers not using it is possibly reflective of the reality of everyday practice and two possible reasons may account for why practitioners might not use the Framework: they may not be presented with situations that require them to consult the Framework or they may lack awareness of the Framework. This latter reason is, however, unlikely, as the vast majority of respondents believed that nurses and midwives wishing to expand their scope of practice are aware of the Framework document.

Critical to safe and effective practice is clinical competence and, importantly, being able to recognise the limits of one’s competence. There is evidence that when unsupervised, junior staff may take on roles and tasks beyond their competence and thereby place patients at risk (Lubbe and Roets 2014). The vast majority of respondents to the national survey reported that they would not perform a new task, role or function unless they believed themselves to be competent and most reported that they would acknowledge the limitations of their competence. Some participants in the focus groups also recognised the importance of competence in making decisions about scope of practice, including knowing the competence of those to whom they were delegating roles and tasks. The NMBI enquiries database indicated uncertainty regarding delegation of nursing work, in areas such as medication administration, and concern regarding individual accountability in an environment where employers are actively promoting the use of care workers in service delivery. The Framework provides guidance regarding delegation, stating that ‘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 and … ensure appropriate assessment, planning, implementation and evaluation of the delegated role/function’ (An Bord Altranais 2000: 7). Effective delegation depends on the right task being assigned to the right person within the right circumstances and is dependent on appropriate communication and supervision (Brady 2010).

This unwillingness to step beyond the bounds of one’s competence was particularly evident in the inquiries submitted to the NMBI enquiries database, as exemplified by several inquirers who sought clarification as to whether they were ‘covered’ to perform a particular task. This particular finding is noteworthy, given the level of individual decision making and judgement
that is afforded in the Framework document and may suggest that nurses and midwives seek external reassurance or endorsement, in order to be convinced they are operating within the boundaries of their scope of practice.

However, some of the evidence generated in the focus group discussions suggests that some nurses were willing to assume responsibility for conducting technical tasks, like venepuncture and administering intravenous drugs; some of the nurses in question were based in areas like long-term residential care and mental health. This emphasis on the performance of single technical tasks suggests that, like the participants in the study by Oelke et al. (2009), the participants had a tendency to describe scope of practice in terms of tasks and activities that they could perform.

During the focus group discussions participants spoke about their understanding of the idea of scope of practice; some viewed the idea as enabling – ‘it’s a guide for me to understand my limitations’ – others as restrictive – ‘it is about clearly defining the roles’. Jowett et al. (2001) similarly reported that most stakeholders viewed the UKCC Scope document as enabling and as offering useful boundaries for practice and as a valuable way of optimising the skills and contribution of nurses, midwives and health visitors. However, Jowett et al. (2001) also reported that practitioners were willing to expand their practice, so long as there were the necessary safeguards and supports and appropriate training in place for those taking on extended practice roles. This sense of caution when expanding practice was conveyed by several study participants who believed that the Framework should act to protect the practitioner, what one participant described as ‘a protective tool … that keeps her on the straight and narrow’.

Clinical decision-making is influenced by several factors, including the type of knowledge used to make a decision (evidence- or practice-based), the use of clinical guidelines, care pathways, the time available to make decisions and the surrounding context (Kilpatrick 2013). Interviewees and focus group participants reported that colleagues, managers and the clinical team were the resource to which they most likely turned to support them in decision making. The national survey results indicated that older respondents were significantly less likely to consult a line manager and to recognise their own accountability more when making a decision to delegate than their younger counterparts. Conversely, younger respondents were significantly more likely to consult with their line manager and less likely to recognise their accountability when making a decision to delegate than their older counterparts. This finding is not surprising and suggests
that older practitioners and, by definition, more experienced practitioners are more self-assured about nursing or midwifery functions associated with the scope of their practice than their younger counterparts. It may also imply that younger practitioners are more cautious when it comes to decision making.

**Scope of practice and autonomy**

The level of practitioner autonomy is both a key principle underpinning scope of practice and a practical consideration in determining an individual’s ability to work to optimal scope of practice, given their level of competence. In practice, autonomy is partly a function of the extent of a practitioners’ control of their own role, which is, in turn, influenced by their knowledge and skills. Accordingly, factors that negatively impact on autonomy, in turn, impact on scope of practice, particularly in relation to practice expansion. McConnell (*et al.* 2013) found that the greatest obstacles to autonomy were lack of role progression, control of the role by others and the domination of the practitioner’s clinical workload.

Autonomy does not imply acting alone, but relates to the practitioner’s capacity, actual and perceived, to make professional decisions based on judgements and to act on those decisions. The majority of respondents to the national survey reported that they relied on their own professional judgement when making a decision regarding their scope of practice and data from the interviews and focus groups also indicate that many practitioners experienced their practice role as relatively autonomous. These findings may be interpreted in a number of ways that are interrelated. They may suggest that practitioner roles and their associated grade levels are somewhat well defined and that practitioners are capable of functioning within these delineated and delimited role boundaries. Conversely, they may suggest that practitioners are empowered to act autonomously through professional knowledge and skills. Corbally *et al.* (2007: 177) found that education for practice was ‘a clear antecedent to inherent empowerment beliefs’ among Irish nurses and midwives and observed that being educated to practice effectively is an antecedent condition for empowerment. These authors also found that Irish nurses’ and midwives’ experience of empowerment was related to having general support from professional bodies, having a clearly defined role and a clear scope of practice. Begley *et al.* (2010) found that advanced practitioners in Ireland had a lot of autonomy in decision making in areas like referral and treatment, but that within the role collaborative decision making also occurred among the multidisciplinary team.
Referring to the scope of practice of emergency advanced nurse practitioners in Northern Ireland, McConnell et al. (2013) write that most care delivered remains protocol-led, indicating little individual autonomy in decision making. While this finding relates to a small sample of advanced practitioners in a particular context, it points to the pre-eminence of protocols and guidelines in directing the practice decisions of practitioners. While using protocols and guidelines may be interpreted as reflecting limited autonomy in clinical decision making, their use may be viewed as reflecting due prudence and an aid to decision making. Guidelines, protocols and policies were cited as important resources for decision making by most participants in the focus groups. Additionally, over two thirds of the national survey sample reported using local policies and guidelines to guide them when expanding the scope of their professional practice and over half reported that they had used the Scope of Practice Framework document when expanding the scope of their professional practice. Hence, policies and guidelines may be viewed as a vehicle for judicious decision making and for informing scope of practice and supporting expanded practice.

7.3 Expanding practice: Enablers and barriers
The healthcare reform agenda in Ireland has for over a decade included explicit plans to develop and expand primary care as a key part of service development (Department of Health and Children 2001). The advanced practitioner and clinical nurse specialist grades in Ireland, along with the introduction of prescriptive authority for senior practitioners, best exemplify expanded roles in the Irish health services. Another area in which role expansion has developed in Ireland has been in practice nursing, where a cadre of over 1,500 practitioners are providing a ‘unique and significant contribution’ to primary care through expanded role activities that encompass direct clinical care, elements of chronic disease management and administration of immunisations (McCarthy et al. 2012). Role expansion also occurs within the context of all grades, as evidenced in the present study, wherein almost three quarters of the sample, in the national survey, reported that that they were required to expand the scope of their professional practice since taking up their current role, with two thirds reporting having undertaken training specific to their expanded role.

The capacity of nurses and midwives to expand their practice and/or to practice to the maximum extent of their training and competence is contingent on several factors, which act as either enablers or barriers. The scope of professional practice is influenced by both practitioner-level and organisational-level factors and these factors can act as enablers or barriers to practitioners’
capacity to operate to their optimal scope or to expand their practice. A number of authors have reported the existence of barriers to expanded practice (Begley et al. 2010; Drennan et al. 2009; D’Amour et al. 2012; Lubbe and Roets 2014; Hoodless and Bourke 2009).

The findings from the national survey of registrants indicated that enablers to expanding practice included support from colleagues, support from the organisation and having access to continuing professional development. The support from other health professionals was also an enabler, although this was reported to be less of an enabler than the others, with fewer than half of the respondents agreeing that support from other health professions was an enabler. Resistance from physicians was also identified as one of the main barriers to the development of more advanced nursing roles by the National Council for the Professional Development of Nursing and Midwifery in its evaluation of clinical specialist and advanced practitioner roles in Ireland (Begley et al. 2010). However, the National Council report found ‘considerable support’ from medical personnel who worked alongside clinical specialists and advanced practitioners (Begley et al. 2010). McCarthy et al. (2012) similarly reported that in the area of general practice, the vast majority of GPs believed that practice nurses should extend their role into areas such as chronic disease management. O’Shea (2008) also found that the medical profession had a positive view of the clinical specialist and advanced practitioner roles.

In the national survey, more respondents from the senior grades were significantly more likely to agree that nurses or midwives are supported by their organisation or employer in expanding their scope of practice than junior grades. More junior grades were statistically more likely to agree that nurses or midwives have few opportunities in the workplace to expand their scope of practice.

Drennan et al. (2009) found that the principal barriers to the further development of nurses’ and midwives’ prescribing practice included issues associated with the prescribing of unlicensed medications and restrictions placed on the prescribing of controlled drugs. While these same authors reported some resistance from pharmacists, they did not report resistance from physicians. Nevertheless, physician resistance to nurses’ expanding their practice remains a barrier to expanded scope of practice (Lowe et al. 2012); this is particularly evident in the United States, although the Institute of Medicine in that country has advocated expanded scope of practice in primary care (Fairman et al. 2011).
Since advanced practitioner roles, including nurse and midwife-led care, have become more widespread in developed western countries, much of the literature on expanded scope of practice focuses on the role of the advanced practitioner. In the United States, state-based regulatory restrictions constitute critical factors in limiting nurse practitioners’ capacity to practice to the full extent of their education, training, and competence (Fairman et al. 2011). As the review of other regulatory authorities’ scope of practice frameworks indicated, these same factors are less evident as barriers to expanded practice in Ireland and the UK, with regulation acting to enable rather than restrict expanded practice. This enabling function of the regulation was confirmed, in part, by the fact that the vast majority of the respondents to the national survey agreed that nurses and midwives wishing to expand their scope of practice were aware of the Scope of Practice Framework document and upwards on three quarters used the Framework either sometimes or frequently when taking on new tasks, roles or functions.

Critical to the attainment of expanded practice is support from key stakeholders (Drennan et al. 2009). Begley et al. (2010) found that a lack of support to manage workload efficiently and have sufficient time for patients were barriers to expanded practice. Findings from the national survey showed that respondents in the younger age categories and respondents at the staff grade perceived a greater number of barriers than older respondents or respondents in senior grades. Hence, perceptions of enablers and barriers to expanded scope of practice appeared to be related to age and grade in the current sample. The findings from the focus groups and interviews indicated that the barriers to expanding practice included limited opportunities in the workplace, reluctance on the part of practitioners to expand their scope of practice because they do not wish to take on additional responsibilities or because they are not sufficiently remunerated for doing so, and the belief that they are taking on the work of other professionals.

Respondents to the national survey also reported the fear of potential legal consequences as a barrier to expanded practice. Some participants in the focus groups also noted the increasingly litigious nature of nursing and midwifery practice in Ireland as a factor influencing scope of practice and role expansion. The fear of litigation runs counter to the evidence from the Irish experience of expanded practice, which demonstrates that the development of clinical nurse specialist and advanced practitioner roles has resulted in decreased litigation, a finding previously noted in an evaluation of the clinical nurse specialist and advanced practitioner roles in Ireland (NCNM 2005). Nevertheless, Drennan et al. (2009) showed that some nurses and
midwives with prescriptive authority reported a fear of litigation as a barrier to expanded role as a prescriber.

The literature points to the difficulty that practitioners experience in balancing practice restriction with practice expansion and the differences in defining scope of practice for both generic and specialist roles, coupled with environmental and client-specific contextual factors (Davies and Fox-Young 2000; Jowett et al. 2001; White et al. 2008; Schluter et al. 2011; D’Amour et al. 2012). Currently Irish health policy is designed to increase efficiency and cost control in service delivery. The recent shift in emphasis to integrated rather than institutional or community care creates demand for flexibility in care delivery patterns (Brady 2010). There is increasing usage of non-nursing personnel in the delivery of care (DOH 2001) and this has the potential to impact on scope of nursing and midwifery practice.

Scope of practice concerns
The analysis of the 978 enquiries within the NMBI database indicated that concerns associated with medication management were a particular and abiding concern for registrants over the course of the past thirteen years. The volume of enquiries concerning drug management related to aspects such as dispensing, transcribing in the case of repeat prescriptions and drug administration in first aid situations. These particular concerns are perhaps unsurprising, since drug administration is predominately a nursing responsibility and one that carries the risk of drug errors, which can have serious consequences for both the patient and the nurse (Brady et al. 2009). Drennan et al. (2009) showed that even in the case of nurses and midwives with prescriptive authority supported by formal education and training, concerns about medication management and scope of practice persist, with ‘a substantial minority’ of registered prescribers expressing concern at the possibility of litigation associated with their role as prescribers.

Quality patient care is achieved by nurses being able to function effectively within nursing and inter-professional teams, and safe drug administration is contingent on the practitioner being able to describe their own scope of practice and to function competently within their own scope of practice as a member of the health care team (Cronenwett et al. 2007). While factors involving the health care system, the patient’s condition and the drug prescription all contribute to drug administration errors, neglect on the part of a practitioners is a leading factor in medication errors (Tang et al. 2007). Other factors associated with errors include failure to follow procedures, poor quality of prescriptions, poor knowledge on the part of the practitioner and inadequate drug distribution systems (Brady et al. 2009).
The number of enquiries in the NMBI database relating to medication management was fewer following the issuing of the Medication Protocol Framework, which was developed as part of the Medication Management Guidance by An Bord Altranais (2007). Therefore, the availability of clear guidelines to support the development and implementation of medication protocols appears to have been an important factor in providing clarification in the area of medication management. Several participants in the focus groups spoke about drug administration and generally viewed policies and guidelines as protective and enabling.

7.4 Scope of practice and role boundaries
Professional boundaries matter when it comes to professional and disciplinary identity (McNamara et al. 2011) and they also matter in the practicum, where role clarity is a necessary condition for clarity around responsibility and accountability for care. If health care is to be improved through expanded practitioner roles then role clarity is essential (Lowe et al. 2012). During focus group discussions, participants spoke of role boundaries that overlap with the roles of other healthcare professionals – ‘it is difficult in this hospital to figure out who does what or who is responsible for what, it is a minefield’ – and some participants highlighted the difficulties in negotiating role boundaries with other professions. Some of this difficulty was attributed to the ways in which services and associated roles have evolved in areas such as primary care, mental health and occupational health and in the field of research nursing, which was reported to be ‘constantly evolving’. The difficulties that nurses and midwives experience in relation to role clarity and role boundaries are, in much part, a function of the difficulty that they experience in defining and articulating a distinct disciplinary domain and perspective (Meleis 2007; McNamara et al. 2011).

Related to role clarity is the ability of nurses and midwives to know and articulate their distinct disciplinary role and contribution in a multidisciplinary context (McNamara and Fealy 2011). McNamara et al. (2011) reported that nurses and midwives in Ireland experience difficulty in articulating their specific and distinctive contribution to patient outcomes. The authors found that much of the work of nurses and midwives in Ireland is concerned with ‘coordinating and orchestrating care and other administrative functions of the multidisciplinary team’, a phenomenon that they referred to as ‘compensatory action’. In the present study, some participants in the interviews and focus groups also spoke of this type of compensatory activity in the way that they found themselves taking on roles and functions ‘that have previously been carried out by other professionals’, often at the expense of providing ‘basic nursing care’.
Working in this ‘compensatory mode’ interacts with the difficulties in articulating the disciplinary contribution and this, in turn results in ‘a blurring of disciplinary boundaries and the systematic effacement of nurses’ distinctive contributions to patient care’ (McNamara et al. 2011: 3509).

Practising in this compensatory mode can also result in practitioners failing to optimally practice to the maximum extent of their training and competence and practitioners may practice at less than their optimal scope in key dimensions of their professional practice, such as communication and care coordination, and integration and supervision of staff (D’Amour et al. 2012: 248). As already observed, the ability of practitioners to work to their maximum scope of practice is related to both individual and organisational factors (McConnell et al. 2013).

In this same connection, it is noteworthy that many participants in the focus groups and interviews highlighted the perceived lack of knowledge of other healthcare professionals around the scope of practice and several participants referred to the need for other healthcare professionals and service managers to be educated about the nursing and midwifery scope of practice Framework. This could result in greater clarity around roles among the multidisciplinary team and facilitate the use of a commonly-understood and shared perspective. It could also promote a whole-workforce perspective and offer the potential for the development of a generic approach to definitions of scope of practice and decision making frameworks (Nursing and Midwifery Board of Australia 2007). Nurturing professional relationships within the multidisciplinary team and demonstrating empirically the improved health outcomes of expanded practice are important ways of addressing barriers to expanded practice (Neft et al. 2013), such as the perceived difficulties in interpreting core nursing roles (Schluter et al. 2011).

7.5 Perspectives on the Framework
Participants in the focus groups and interviews discussed the Framework document and possible ways that it might be improved. Several spoke in positive terms about the document – ‘[it is] probably a very good framework’; ‘a very useful, succinct document’. Nevertheless, some spoke about its limitations, including the fact that it was published fourteen years ago, it contained no reference to the responsibility of the organisation or employer, and the fact that that the document needed to reflect both the changing makeup of the population using the health services and the changing landscape of practice, where many practitioners were likely to be working alone in providing service. Some saw the Framework document as being a ‘generalist’ resource.
more suited to students and recently-qualified nurses and midwives, while others saw it acting as a framework upon which advanced practitioners could build and expand their practice. However, there was broad consensus that a generic enabling framework, as represented in the current Framework document, is best suited to the majority of practitioners who must ultimately make individual decisions in individual circumstances.

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

7.6 Strengths and limitations of the study design
The overall strategy in designing this study was to review the Scope of Professional Practice Framework using an evaluation framework; however the study design was not without limitations. Foremost among these was the limitation inherent in the using self-reports to examine practice experiences. In relying on self-reports and respondents’ opinions, the Scope-Q did not provide direct empirical evidence of the actual work of nurses and midwives, including their decision-making processes around scope of practice. The inclusion of a scale-based instrument, such as that developed by D’Amour and colleagues (D’Amour et al. 2012), could have provided an empirical description of key practitioner roles, functions and actions; nevertheless, such an instrument would merely equate to a proxy description of actual scope of practice. Several other studies examining scope of practice among nurses and/or midwives have included self-reports of practice, including descriptions of actual practice (e.g. Schluter et al. 2011; White et al. 2008), practitioner ‘perceptions’ of their scope of practice (e.g. Davies and Fox-Young 2002; Jowett et al. 2001) and examinations of expanded practice roles (e.g. McConnell et al. 2013, Begley et al. 2010). Like several studies that examined scope of practice using two or more data collection methods in combination (Lubbe and Roets 2014; Hoodless and Bourke 2009; An Bord Altranais 2000; Drennan et al. 2009; Fagerström 2009), the present study deployed several methods to generate data for the purpose of stakeholder consultation.
This ensured that the approach was broad and comprehensive and did not rely on a single data source, but incorporated both qualitative methods and more systematic objective measures of nurses’ and midwives’ perspectives and experiences in relation to scope of practice (White et al. 2012). Similar to Begley et al. (2010), Oelke et al. (2009) and Jowett et al. (2001), data were also collected to examine the enablers and barriers to expanding scope of practice.

The evaluation framework used to conduct the review of the Scope of Practice Framework examined the broad structure, process and outcomes elements of the Framework. It did not examine the more micro-level aspects of scope of practice in the real world of practice, such as the ways that nurses and midwives engage in decision making and whether they actually practice to the maximum extent of their training and competence. The use of observational methods within an ethnographic framework could have provided a more nuanced analysis of actual scope of practice. However, the use of the case examples gave some important insights as to how the Framework is actually used by practitioners.

The evaluation strategy and its associated design and data collection methods are well supported in the literature. Informed by contemporary ideas on evaluation theory, the evaluation framework on which the review was based ensured that the phenomenon of interest was thoroughly examined from several perspectives. Hannum et al., (2007) advocate the adoption of a number of key operating principles when conducting evaluation studies, including: consultation with key stakeholders; clarification of outcomes of the evaluation with the stakeholders and the sponsor; discussion of the purpose of the evaluation and how the information will be used and the use of multiple methods to gather information. These principles were particularly relevant to the present review, since stakeholder consultation, including close engagement with the sponsor, were critical to the effective development and successful operationalisation of the review.

The use of the Donabedian model (2005) as a way of structuring the review is also widely supported in the literature and ensured that the review was both comprehensive and multi-dimensional, addressing structure, process and outcomes elements of the Framework. The data triangulation approach used to gather information was also important in ensuring that the perspectives of all the relevant key stakeholder groups were included and that each element of the data complemented each other element in informing the review. Additionally, the overall strategy and elements of the methods used in the present study were used with success in
previous studies conducted by members of the research team (Casey et al. 2013, Fealy et al. 2014, Fealy et al. 2012, Carney et al. 2005) and in other national studies involving the nursing and midwifery resource (Begley et al. 2010, Drennan et al. 2009). The evaluation design used in the present study is also supported in similar international studies of scope of practice; the present study incorporated similar methods to those used in studies reported by Schluter et al. (2011), D’Amour et al. (2012), Oelke et al. (2009) and White et al. (2008).

The use of focus groups and interviews to generated rich descriptive accounts on individual and group experiences is advocated in evaluation studies (Krueger and Casey 2010, 2009). Each focus group was conducted according to best-practice guidelines concerning the conduct of focus groups for social research (Krueger and Casey 2009) and interviews were standardised according to a topic guide informed by the literature.

The adjusted response rate of 45.1 per cent, yielded from an actual response rate 48.2 per cent, was high for a postal survey of the type used in the stakeholder consultation. As indicated in Chapter 5, this response rate compares very favourably with other large-scale national postal surveys among nurses and midwives in Ireland, which reported response rates ranging from 20 per cent (NCNM 2004) to 35 per cent (An Bord Altranais 2005); the response rate was higher than that yielded in four out of five referent national studies (Scott et al. 2003; NCNM 2004; An Bord Altranais 2005; Fealy et al. 2009).

A sizeable proportion of respondents to the survey returned uncompleted questionnaires, declaring that they were retired and several respondents also contacted the research team directly to indicate that they were no longer practising and had retired. Additionally, a small number of questionnaires were returned via the postal service, indicating that the named registrant was no longer living at the postal address to which the questionnaire was posted. Fealy et al. (2009) reported similar anomalies when surveying a national random sample of nurses and midwives using a similar sample size. This suggests that the active part of the Register may not truly represent the number of nurses and midwives currently in practice. If the proportion of returned questionnaires – 3.1 per cent – is extrapolated to the total number of registrants on the active Register, it is possible that in excess of 2,000 registrants on the active Register are not currently in practice, assuming that the study sample is representative of the total population of registrants. While outside the scope of the present review, the NMBI might consider the advisability of developing a means of ensuring that the active part of the Register truly reflects the actual
number of registrants in practice. This may require a part of the Register for registrants who are retired, but who wish to maintain their registration status and associated professional title(s).

On the basis of the pilot study and the very small proportion of missing variables in the returned questionnaires, it appeared that the instrument had a good degree of face validity. The reliability of the barriers scale contained in the instrument was also high, based on the categorical principal component analysis procedure (Linting, et al. 2007), which yielded Cronbach’s $\alpha$ scores of .847 and .711 for the barriers and enablers components of the instrument, respectively.

The method used for the documentary analysis was another limitation of the study design. Specifically, the validity of the bespoke documentary analysis instrument was not established. In particular, the individual items in each of the subscales of the instrument do not carry equal weight in terms of measuring the quality and content of the Framework document under review. Additionally, while individual ratings were conducted independently, consensus scores were used to report on the ‘quality’ of the documents.

A further strength of the review was that the reviews of literature were conducted according to rigorous methods for systematic reviews and examined national and international literature, research and policy documents, and empirical studies associated with scope of practice. The comparative analysis of professional nursing and midwifery associations’ scope of practice and associated decision-making frameworks was informed by methods advocated by the Cochrane Collaboration (2008) and the Scottish Intercollegiate Guideline Network (SIGN) (2011). The review of literature on definitions of scope of practice included systematic and comprehensive searches of published works indexed in databases such as CINAHL, PubMed, ERIC, SCOPUS, WEB of Knowledge, and so forth. The approach to the analysis of the NMBI enquiries database incorporated a rigorous process of data cleaning, which was informed by the Knowledge Discovery in Databases (KDD) process described by Fayyad et al. (1996).

In summary, the review of the *Scope of Nursing and Midwifery Practice Framework* included the following elements: a literature review, comparative analysis of other nursing and midwifery decision-making frameworks, documentary review and critique of the current Framework document, thematic analysis of the NMBI Education Department Enquiries Database, focus group discussions and individual interviews, case studies of the Framework in use, a national survey of nurses and midwives, and a public call for submissions from stakeholders and the
public. The key issues addressed were ‘self-reported scope of practice’, including competence and decision making and scope of practice and autonomy; ‘expanding practice’, including enablers, barriers and scope of practice concerns; ‘scope of practice and role boundaries’ and finally, ‘perspectives on the current Framework’, all of which have been discussed in this chapter.
Chapter 8

CONCLUSIONS AND RECOMMENDATIONS

8.1 Introduction

Registered nurses and midwives are a valuable resource in the Irish health system. The academic preparation of nurses and midwives and the development of post-registration training for specialist and advanced practitioner roles have resulted in the development of a knowledgeable and highly skilled nursing and midwifery workforce in Ireland. Therefore, a key challenge for the Irish health services is to ensure that the nursing and midwifery resource is deployed to optimal advantage, to ensure optimal healthcare delivery, and that the valuable and costly resource is not underutilised or inappropriately utilised. It is partly for this reason that nurses and midwives must be empowered to act within the full range of their scope of professional practice and to expand their scope of practice as and when patient and service needs dictate.

Scope of professional practice is closely associated with notions of professional conduct, accountability and self-governance and expanded practice. Professional regulatory bodies for nurses and midwives in developed countries have issued policies and/or guiding frameworks that address scope of practice. Issued by An Bord Altranais in 2000, the Scope of Nursing and Midwifery Practice Framework is one such guiding framework (An Bord Altranais 2000a).

In Ireland, the Framework exists within the context of considerable changes in the landscape of professional practice. These include developments in the configuration and delivery of health services, a changing profile of service users, and a nursing and midwifery resource that has demonstrated its willingness to develop practice through specialist and expanded roles and through continuing professional development. In the wake of the Nurses’ and Midwives’ Act 2011, registered nurses and registered midwives will be required to maintain professional competence on an on-going basis.

8.2 The Scope of Practice Framework

The Scope of Nursing and Midwifery Practice Framework document provides a practical guide for nurses and midwives in decision making about their scope of practice (An Bord Altranais 2000a). The Framework document defines scope of nursing and midwifery practice, sets out principles for determining scope of practice and presents a decision-making algorithm with
which practitioners may review and expand their professional practice. It offers practitioners a set of guiding principles with which to review and, where appropriate, expand the parameters of their practice, thereby promoting self-reliance among nurses and midwives in determining the boundaries of their professional practice (An Bord Altranais, 2000a). The Framework is designed to be an effective and rational mechanism for decision making by which Irish nurses and midwives may evaluate and negotiate traditional role boundaries.

The Framework supports clinical judgement and decision making around factors such as competence, accountability and autonomy, and legislation and policy requirements. It also supports the principle that role expansion must be in the context of the values of nursing and midwifery and in the best interests of patients (An Bord Altranais 2000a). The Framework is predicated on the practitioner being familiar with legislation and guidelines that regulate and control practice and that may enable or prohibit role expansion.

The Framework fulfils several functions in guiding and supporting practitioners in relation to the scope and boundaries of their practice. It acts as a basis for independent decision making related to nurses’ and midwives’ everyday practice, assists in the identification of nurses’ and midwives’ professional development needs, and provides a basis for the expansion of nursing and midwifery roles. As an enabling framework (An Bord Altranais, 2000a) it also emphasises nurses’ and midwives’ individual accountability in making decisions about their roles and responsibilities and is, therefore, a basis for practitioner empowerment.

8.3 The Scope of Practice Framework in context

Scope of practice is a concept used in the regulation of various professions. It defines the procedures, actions and processes that are permitted for the individual who is registered or licenced to practice. The individual practitioner’s scope of practice is determined by professional education and competence, which, in turn, give authority to perform a particular role or task. Individual jurisdictions have enacted laws, established regulatory authorities, and published regulations that prescribe the requirements for training and education as well as guidelines that define scope of practice for the profession.

Regulation of scope of practice can take many forms, from listing of services, individual interventions or competencies, to statements of broader roles and functions such as health promotion or injury prevention, to decision-making frameworks that assist the practitioner in
making self-regulated decisions about practice actions. A clearly-defined scope of practice provides clarity to all stakeholders in relation to professional role, competencies and accountability.

The responsibility for defining the scope of practice of nurses and midwives lies with the statutory regulatory authority. However, the individual practitioner also has a responsibility to practice within the established norms and professional codes of their professional role. The principle that individual practitioners are self-regulating underpins scope of practice, with self-regulation being fundamental to the healthy evolution and advancement of nursing and midwifery. Despite the benefits of expanded nursing and midwifery roles to patients and health services, it appears that many nurses and midwives are not practising to the full range of their scope of practice. This is partly related to a number of barriers, such as lack of opportunity and lack of clarity regarding professional roles and role boundaries, as well as medico-legal concerns.

*International guidelines and decision-making frameworks*

Internationally, policies and frameworks that address scope of professional practice generally offer guidance for decision making and suggest practice boundaries within which practitioners can or should operate. When the scope of practice frameworks of other regulatory authorities are examined, it is evident that determining scope of practice is an element of professional practice and individual decision making is central to this. Core concepts and principles underpin scope of practice and decision-making frameworks in nursing and midwifery practice internationally. While there is a degree of commonality in these principles, two somewhat distinct framework types are evident, one emphasising legislation and rules (Approach 1), the other highlighting individual accountability (Approach 2). These two types are influenced by the context in which nurses and midwives work and their perceived roles and responsibilities.

Frameworks in Approach 1 seek to define tasks and activities to be carried out and emphasise policy and the regulatory frameworks at the outset. Within this approach, the decision-making framework is typically behaviour driven, arguably reductionist and may restrict the decision-making process to ‘stopping the behaviour’ or advising the decision maker to seek advice, typically from a manager or regulatory body. Frameworks in Approach 2 emphasise the accountability of the individual nurse or midwife and place the needs of patients at the forefront of the decision-making process. In this way the approach is enabling, by promoting collaboration
and communication concerning who to consult or whether to refer to other health professionals, and leaves the final decision about how to act with the individual nurse or midwife.

The two approaches overlap and are not mutually exclusive, but emphasise the status of nursing and midwifery practice in a given jurisdiction. Neither approach emphasises patient choice, which is a fundamental principle of evidence-based practice. Hence, this and related contextual aspects of scope of practice and decision-making might be usefully incorporated into future frameworks.

**Empirical research**

Empirical research into scope of practice is largely concerned with examining practitioners’ perspectives on particular frameworks or their experiences of expanding their practice. Much of the research is predicated on a concern to establish the extent to which there is optimal deployment and/or minimal utilisation of the nursing and midwifery resource. The evidence from the research suggests that frameworks are generally helpful in guiding practitioners, but that local circumstances often determine and delimit practitioners’ scope of practice.

Research evidence demonstrates that practitioners are generally open to role expansion, so long as there are sufficient safeguards and resources to support independent decision making and expanded role activities. Notwithstanding local constraints, a continuing challenge is to ensure that scope of practice frameworks are readily applicable in varied practice contexts, sufficiently effective to guide practitioners so that they may work to their optimum capabilities, while at the same time ensuring safe and effective practice. In other words, frameworks and guidelines should be fit for purpose.

**8.4 Documentary review**

A documentary review of the *Framework* document indicates that overall the document was fit for purpose and valid. The consensus among the research team that overall the document was of a high quality, in terms of content, suitability as a guiding framework, consistency in use of constructs, validity in terms of reflecting real-world situations in which nurses and midwives operate when using the document, clarity of statements of principles, and good quality of layout and design.
8.5 Enquiries to NMBI about scope of practice

Almost one thousand logged enquiries to the Nursing and Midwifery Board Enquiries database were examined. Enquiries were received from registered nurses, registered midwives, service managers and other health care professionals including medical personnel. Analysis revealed that enquiries were concerned with three main areas: medication management, changing and evolving scope of practice, and professional role boundaries. Each of these areas reflected concerns that arose in practice situations and circumstances in which the nurse or midwife was required to practice outside of his/her self-determined scope of practice. These situations and circumstances were frequently related to the fit between the individual practitioner’s registration status and associated skill set and the demands of the service. Other concerns were related to expectations on the part of the registered nurse or midwife to take responsibility and accountability for others, including support staff and agency nurses. Delegation of nursing roles and tasks to non-registered care staff represented a particular concern in this regard.

The context for many enquiries was service developments, staff shortages, as well as uncertainty about role expansion and professional accountability. Efforts by employers to maximise the skill mix of their staff and to optimally deploy staff to meet service needs and/or address gaps in service represented the service context from which many enquiries arose.

8.6 Findings from stakeholder consultation

A national survey of registered nurses and midwives was conducted to examine self-reported current scope of practice, and use of the Framework and other resources to develop and support professional practice, as well as experiences of expanded practice. In addition, 28 qualitative data collection events were held with key stakeholders, including registered nurses and midwives from across all grades. The participants provided valuable information concerning their current scope of practice, their use of resources in supporting their practice and their perceived barriers and enablers to expanding practice.

Findings indicate that most practitioners who participated in the review consult the Framework document, although a sizeable proportion never does. When making a decision about the scope of their professional practice, most practitioners consult other resources, including professional colleagues and their line manager. Most rely on their own professional judgement when making a decision regarding their scope of practice. Additionally, most practitioners believe they are competent to perform a new task, role or function and recognise when they were not competent
to do so. Most accept accountability when delegating a task, role or function to others. Older practitioners are less likely to consult a line manager, and recognise their own accountability more when making a decision to delegate when compared to their younger counterparts.

Several enablers and barriers exist in relation to expanding practice. Enablers include having access to continuing professional development, support from the practitioner’s organisations and professional colleagues, and, to a lesser extent, support from other healthcare professionals. Factors that act as barriers to expanding practice include reluctance on the part of practitioners, based on not wishing to take on additional responsibilities, the belief that they are taking on other professionals’ work, lack of recognition and remuneration for the additional work, the responsibilities that comes with role expansion, and fear of potential legal consequences of expanding their practice. The age and the grade of the practitioner is significantly associated with experiences of enablers and barriers to expanding professional practice, with the staff grades and younger practitioners generally perceiving a greater number of barriers to expanded practice than senior manager grades and older practitioners.

Practitioners consult a wide variety of resources in relation to the scope of their own professional practice, including the Code of Professional Conduct for each Nurse and Midwife (An Bord Altranais 2000b) the Scope of Nursing and Midwifery Practice Framework (An Bord Altranais 2000a) document and the NMBI website. Younger practitioners are more likely to consult resources than their older counterparts. Use of resources is related to the experience of barriers and enablers, with greater use of resources leading to a greater perception of enablers to support scope of practice.

Nurses and midwives are aware of the context of their professional practice and the factors that impact on their scope of practice. These include changes in the health services, such as changing patient profiles and increased complexity of care, and factors in their own immediate work setting, including difficulties in negotiating role boundaries, both with other healthcare professionals and with other nurses and midwives.

Practitioners are aware of and understand the scope of professional practice and, when talking about it, demonstrated a variety of understandings of scope of practice, including the idea of something that is often not consciously considered, that guides and defines practice that is concerned with competence to practice and with patient safety and quality of care. While some
practitioners see scope of practice as enabling and empowering, others see it as potentially restrictive in that it may be used as a means of avoiding taking on new roles and duties.

Nurses and midwives are generally willing to expand their scope of practice, and perceive this as resulting in improved patient care, improvement in overall quality of standards and increased job satisfaction. Those who express concern about expanding practice do so with reference to lack of monetary incentive, lack of recognition, increased workload without support, and the expectation that expanded scope means working ‘outside of scope’. Enablers to expanded practice included access to training and appropriate support from individuals and the organisation or employer.

Linked to scope of practice and practice expansion is competence. Practitioners are aware that competence relates to several personal capacities, including knowledge, skills and critical thinking, as well as updating and maintaining acquired skills. The practitioner is held responsible for maintaining his or her competencies and this is viewed as essential in ensuring safety and protection for the nurse and midwife as well as for the patient.

Nurses and midwives place importance on having relevant legislation, local and national policies and guidelines, and regulation to support them in their practice. For some, there are particular practice issues that can impact on their scope of practice and their capacity to practice effectively; these included staff redeployment and lone working.

8.7 Recommendations
The following recommendations are made based on the findings from the review. The recommendations relate mainly to the current Framework and how it could be revised, the NMBI enquiries database and the Register of Nurses and Midwives.

Recommendation 1
A single generic scope of practice framework should continue to be used as the basis for guiding nurses and midwives in relation to their scope of professional practice. The framework should continue to be ‘an enabling framework’ that provides guidance on how the practitioner should act in circumstances of uncertainty; emphasises individual accountability; and promotes autonomy and self-reliance in the decision-making process. The framework should enable role expansion within and with reference to the core functions and values of nursing and midwifery.
and the best interest of the patient. The framework should retain a decision-making algorithm and should continue to be based on core principles.

**Recommendation 2**

The current *Framework* document should be revised and updated, through the relevant committee and governance structures within the Nursing and Midwifery Board and should be informed by the key findings of this review, where appropriate, and by the relevant legislation and rules. When revising the *Framework* document, the NMBI should consider the following:

- Include explicit reference to the most pertinent legislation and guidelines that regulate and control professional practice, including role expansion, in Ireland.

- Include a new section on expanded roles, containing a statement of NMBI policy and supports for expanded practice and appropriate guidance on the clinical specialist, advanced practitioner roles as well as a clear statement on prescriptive authority.

- Include a paragraph or section on the context of professional practice, which recognises the diversity and range of services and settings in which practitioners work (and are likely to work) and make reference to the responsibilities of the health service provider and/or employer in relation to scope of practice and expanded practice roles and functions across all settings.

- Include a paragraph or section on interprofessional and multidisciplinary working, to include reference to the responsibilities of the individual practitioner and other professionals within this context.

- Include a statement on patient choice as an element of evidence-based practice.

- Include a paragraph or statement as to the practitioner’s responsibilities and possible responses in circumstances in which no explicit policies or guidelines exist.

- Include updated in-text citations and references throughout the document, to demonstrate the provenance and evidence base of the framework document as a guiding document for practice.
Ensure that the revised Framework document has a distinct branding, in terms of its general visual appearance. While the current branding is clear and distinct, it might be worth considering a new and distinct appearance, to create renewed awareness among practitioners.

Review the concepts of autonomy, responsibility, accountability, authority and delegation to ensure that they are clear and consistent with contemporary understandings of these concepts.

Consider including a more detailed and precise statement about quality, safety and risk assessment and risk management to ensure the provision of quality, safe health care.

Expand on the discussion and guidelines on ‘emergency situations’.

*Recommendation 3*

Review and revise the decision-making algorithm, with the aim of ensuring that it continues to provide a clear decision tree, which practitioners can use when reviewing their scope of practice and making decisions about expanding their practice. Consider the following:

Chose a new colour that will be associated with the new Framework and avoid confusion with the older version.

Using more than a single colour in the revised algorithm, for example, use of red, amber and green to denote ‘stop’, ‘wait/consider’ and ‘go’, respectively, and to provide clear and immediate visual cues.

Make reference to evidence-based decision making.

Make reference to the need for risk-assessment in the decision-making process.

Include a ‘step for action’ at the end of the algorithm if practitioner still ‘ Unsure’.
Recommendation 4
Case examples, similar to those presented in Chapter 6 should be developed and used in the dissemination of and education about the Framework.

Recommendation 5
The Nursing and Midwifery Board should consider novel ways of disseminating information about the Scope of Practice Framework and information on issues associated with scope of practice. This might include a regular item in the Board’s monthly e-zine that incorporates a link to the Framework document; the production of an A4 laminated version of the algorithm should be considered as an additional resource for use in every day practice situations; the availability of an e-learning programme on HSEland.ie similar to that on the NMBI website.

Recommendation 6
The Nursing and Midwifery Board should consider novel ways of disseminating information about drug management and administration, to inform practitioners of their role and responsibilities in the matter as it applies to their scope of practice. This might include a regular item in the Board’s monthly e-zine that incorporates a link to the NMBI’s ‘medication management’ page on the website.

Recommendation 7
The system of recording entries into the Nursing and Midwifery Board’s enquiries database should be reviewed. The following points should be considered in any review:

The clinical setting or site of the enquirer should be recorded as part of the entry

Only information that is deemed relevant to the database should be recorded

A template for recording enquiries should be developed to ensure standardisation of the presentation of the enquiries

Consideration should be given to moving from a system of manual and telephone recording to an online method of recording that would also incorporate a decision-making algorithm that could provide online and real time advice and guidance to the enquirer as part of the response
The option for telephone enquiries should continue to be available to enquirers and the responder could use the online template to record the enquiry and guide the caller using the decision-making algorithm.

Conduct regular monitoring and evaluation of the enquiries received in order to ensure that emerging and abiding issues are reviewed with the relevant authorities, where appropriate, and appropriate action taken to address the issue(s).

**Recommendation 8**
The Nursing and Midwifery Board of Ireland should consider the merits of entering into discussions with other regulatory authorities for healthcare professionals in Ireland, including the Medical Council, with the view to establishing if there are shared elements in scope of practice guidelines that might be incorporated into their respective guidelines, and with the aim of increasing multidisciplinary awareness of the scope of practice framework.

**Recommendation 9**
The Nursing and Midwifery Board of Ireland should consider the system of recording names on the active part of the Register, with the view to ensuring that the active part of the Register truly reflects the actual number of registrants in active practice. Consider confirming an up-to-date address and using the following categories for gathering information on the status of registrants at the annual renewal date:

- Active in nursing or midwifery practice in Ireland
- Retired
- On leave of absence, for example, maternity leave, unpaid leave, career break
- Not actively practising as a nurse or midwife in Ireland (for example, out of the country, working in another capacity)
- Other
REFERENCES


Australian Nursing and Midwifery Council (2013). Midwifery Practice Decision Flowchart
Australian Nursing and Midwifery Council


*Cochrane Handbook for Systematic Reviews of Interventions: Cochrane Book Serie.s* Edited by Julian PT Higgins and Sally Green


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Cronie D, Rijnders M, Buitendijk S (2012). Diversity in the Scope of Practice of Hospital-Based Midwives in the Netherlands. *Journal of Midwifery & Women’s Health* 57 (5): 469–75


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205


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North Carolina Board of Nursing (2013). Scope of Practice decision tree for the RN and LPN North Carolina Board of Nursing


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Nursing Council of New Zealand (2010). Guideline: expanded practice for registered nurses Nursing Council of New Zealand


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Scott PA, Matthews A, Corbally M (2003). *Nurses’ and Midwives’ Understanding and Experiences of Empowerment in Ireland* DOHC: Dublin


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APPENDICES

Appendix 1: Flowchart of included documents in the comparative analysis of international frameworks

Documents/URLs recovered from the search (n=143)

Documents and URLs excluded (n= 25)

Documents/URLs for consideration (n=118)

Documents/URLs deemed not related to the review question (n=39)

Potentially appropriate information relating to the review question (n=79)

Articles not relevant to the research question after reading the full text (n=67)

Finally included and analysed articles (n=12)*

*combined and reported as 8 summaries in table A.1

Figure A.1 Search results
# Appendix 2: Summary of included scope of practice and decision-making frameworks

<table>
<thead>
<tr>
<th>Titles and Authors:</th>
<th>Type of publication:</th>
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</table>

<table>
<thead>
<tr>
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<tbody>
<tr>
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Screening question: is this paper about expansion of practice for registered nurses and midwives?
- Yes * continue to review
- No * exclude and document reason for exclusion

<table>
<thead>
<tr>
<th>Reason for exclusion if applicable:</th>
</tr>
</thead>
</table>
Aims and approach
National approach to regulation of nurses and midwives in Australia was informed by policy and standards included the development of a National Framework for Decision Making by Nurses and Midwives on Scopes of Practice (National DMF). A consultative policy framework design was used. Review driven by legislative and technological change, altered community expectations, an increased emphasis on the safety and quality of health care, changes in models of care initiated by organisations or professional Groups, changes in other health professions, the emergence of new health care roles, changes in the structure and funding of education, changes in the numbers of available health care workers and an ageing workforce.

Decision Making Framework:
- Yes / No
- **Algorithm** or other format?
- Guidance on whether to expand or not practice **Yes** / **No**

Key components of DM framework
- Identify client need/benefit
- Reflect on scope of practice and nursing practice standards
- Consider context of practice/organisational support
- Select appropriate, competent person to perform the activity

Principles and key concepts of Scope
The National DMF is principle based and contained within template tools grounded in professional discretion. Differences in education, experience, individual competence and the context of practise are all considered when using the decision making tools. To guide nurses and midwives in making decisions about everyday practice and changes to practice over time to meet the health needs of the community. Facilitate planning, negotiation and implementation of practice change for individuals or groups of nurses and midwives to meet the health needs of the community. Acknowledge that the promotion and provision of quality health services for individual consumers and for the broader community are the drivers for change in practice.

Enhance safety and quality when integrated with a comprehensive approach to managing risk.
Recognise and apply to all domains and contexts of practice

Overall Key messages:
- Legislative framework; acknowledges enablers and barriers to extending practice
- General principles and criteria: meeting the health needs of the community, ensuring safely and quality, CPD and ensuring role is matched to patient and community needs.
- Factors influencing individual decision making: professional discretion individual DM and accountability.
<table>
<thead>
<tr>
<th>Title and Authors:</th>
<th>Type of publication:</th>
</tr>
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<tbody>
<tr>
<td>Midwifery Practice Decision Flowchart (Part 1)</td>
<td>DMF</td>
</tr>
<tr>
<td>Nursing Practice Decision Flowchart (Part 2)</td>
<td></td>
</tr>
<tr>
<td>*Separate DMF for Nursing and Midwifery</td>
<td></td>
</tr>
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<td>Date of publication:</td>
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<td>Reason for exclusion if applicable:</td>
<td></td>
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<tr>
<td>Methods</td>
<td></td>
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<td>Already reported : consultative process</td>
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<tr>
<td>Key components of DM framework</td>
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</tr>
<tr>
<td>Focussed around desired and beneficial outcomes for clients/women/newborn</td>
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</tr>
<tr>
<td>Decision to extend scope might be at the level of individual, delegation to others or organisational</td>
<td></td>
</tr>
<tr>
<td>Ultimate point of DM lies with the practitioner as to next steps if necessary</td>
<td></td>
</tr>
<tr>
<td>Principles and key concepts of Scope.</td>
<td></td>
</tr>
<tr>
<td>Overall Key messages</td>
<td></td>
</tr>
<tr>
<td>Legislative framework: DMF accentuates the individual confidence, competence and accountability of the practitioner for DM to ensure activity is permitted by legislation and supported by professional standards and evidence.</td>
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</tr>
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<td>General principles and criteria: Focussed around desired and beneficial outcomes for clients/women/newborn.</td>
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<td>Factors influencing individual decision making: DMF accentuates the individual confidence, competence and accountability of the practitioner for DM.</td>
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</tr>
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<td>Title and Authors:</td>
<td>Type of publication:</td>
</tr>
<tr>
<td>-------------------</td>
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</tr>
<tr>
<td>Scope of Practice for registered nurses</td>
<td>Guidance document with a DMF (not in style of algorithm)</td>
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<td>College of registered nurses of British Columbia</td>
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<table>
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<tr>
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<tr>
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</tr>
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<td>Algorithm or other format? list of criteria for DM</td>
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</table>

<table>
<thead>
<tr>
<th>Key components of DM framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>Differentiates between acting with an order and acting without an order.</td>
</tr>
<tr>
<td>Accountability, confidence, client risk assessment and evidence informed practice – all activities informed by policy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Principles and key concepts of Scope.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The scope of practice for registered nurses reflects the reality of registered nurse practice.</td>
</tr>
<tr>
<td>Clear responsibility and accountability among health professionals is fundamental to the provision of safe and ethical client care by competent nurses.</td>
</tr>
<tr>
<td>Accept sole accountability for determining that the client’s condition warrants performance of the activity.</td>
</tr>
<tr>
<td>Assess client status and make a nursing diagnosis of a client condition that can be improved or resolved through nursing activities.</td>
</tr>
<tr>
<td>Ensure that the activity is within the scope of practice for registered nurses as set out in the Regulation congruent with any limits or conditions established by CRNBC within any restrictions imposed by organization policy.</td>
</tr>
<tr>
<td>Interpret and use current evidence from research and other credible sources to support both the activity and the decision to carry it out.</td>
</tr>
<tr>
<td>Have the competence to determine whether the client’s condition warrants performance of the activity, having considered: the known risks and benefits to the client, the predictability of outcomes of performing the activity, other relevant factors specific to the situation.</td>
</tr>
<tr>
<td>Carry out the activity safely and ethically</td>
</tr>
<tr>
<td>Manage the intended and unintended outcomes of the activity, having considered the safeguards and resources available in the circumstances to safely manage the intended and unintended outcomes of performing the activity.</td>
</tr>
<tr>
<td>Obtain client consent.</td>
</tr>
<tr>
<td>Registered nurses also request direction or orders from other health professionals when the activity is outside the scope of practice or their individual competence (e.g., from a physician for medical diagnosis and treatment orders or from a wound care clinician for direction on complex wound care).</td>
</tr>
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<table>
<thead>
<tr>
<th>Overall Key messages</th>
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<tbody>
<tr>
<td>Legislative framework: predominant in this scope and DMF. Clear cut yes/no decision making framework.</td>
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<tr>
<td>General principles and criteria: accountability, competence, client risk assessment and evidence informed practice</td>
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<tr>
<td>Factors influencing individual decision making: legislation and activities permitted without an ‘order’</td>
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</table>

215
<table>
<thead>
<tr>
<th>Title and Authors:</th>
<th>Decision Making Framework:</th>
</tr>
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<td>Discussion Paper on the Scope of Practice of Registered Nurses in Nova Scotia</td>
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<td><strong>Algorithm</strong> or other format?</td>
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<tr>
<td><strong>Type of publication:</strong></td>
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<td>Guidance document with DMF</td>
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<tr>
<td><strong>Date of publication:</strong> 2009</td>
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Screening question: is this paper about expansion of practice for registered nurses and/or midwives?

| **Yes** | continue to review |
| **No** | exclude and document reason for exclusion |

Reason for exclusion if applicable:

**Methods**

**Key components of DM framework**

**Accountability:** The degree of, accountability, responsibility, and authority that the health care provider assumes for the outcome of their practice including setting the direction & overseeing the outcomes where delegation has been made

**Education:** Consider the breadth, depth, and relevance of the health care provider’s education program taking into consideration provider certification and maintenance of competency

**Competency and standards of practice:** Consider the degree of knowledge, values, attitudes and skills of the provider group. Take into account clinical expertise, judgment, critical thinking, analysis, problem-solving, decision-making, leadership.

**Quality assurance and improvement:** Scopes of practice should reflect measures that have been implemented for the protection of the population served

**Risk assessment:** Includes taking into consideration risk to patients

**Evidence-based practices:** Degree to which practices are based on valid scientific evidence

**Setting and culture:** To be sensitive to place, context, and culture in which the practice occurs

**Legal liability & insurance:** Should reflect case law and the legal liability assumed by the health care provider including mutual professional malpractice protection or liability insurance coverage

**Regulation:** Should reflect the legislative and regulatory authority where applicable, of the health care provider

**Principles and key concepts of Scope.**

- Focus on the needs of the population served
- Flexibility
- Collaboration and cooperation
- Coordination of individual patient care
- Patient choice of health care provider

**Overall Key messages**

Legislative framework: legal liability and insurance, malpractice protection

General principles and criteria: accountability, education, competency within a clear legislative framework

Factors influencing individual decision making: setting and culture, patient choice
<table>
<thead>
<tr>
<th>Title and Authors:</th>
<th>Type of publication:</th>
</tr>
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<tbody>
<tr>
<td>Guideline: Expanded practice&lt;br&gt;for Registered Nurses (Part 1)&lt;br&gt;Decision making framework (Part 2)</td>
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Screening question: is this paper about expansion of practice for registered nurses and midwives?

| Yes * continue to review | No * exclude and document reason for exclusion |

Reason for exclusion if applicable:

**Methods**

**Decision Making Framework:**

<table>
<thead>
<tr>
<th>Yes /no</th>
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<tbody>
<tr>
<td>Algorithm or other format?</td>
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</table>

Guidance on whether to expand or not practice **Yes** / **No**

**Key components of DM framework**

- Informed by the Australian DMF.
- Outcomes for health consumers
- Legislation/professional standards
- Risk assessment
- Education and competence – links with other HCPs
- Monitoring and evaluation

If no then nurse/midwife is responsible for planning, consultation and referral.

**Principles and key concepts of Scope.**

The primary motivation for any decision about a health activity is to meet the consumer’s health needs or to enhance health outcomes. This may be an identified gap in health services which results in the public not having access to a service or a strategic initiative.

Ensuring patient safety is the primary consideration when determining if expansion of practice is appropriate.

Expansion of the scope of practice is based on appropriate consultation and planning, educational preparation and a formal assessment of the nurse’s competence to undertake an expanded scope of practice.

All nurses are accountable for their decisions about whether an activity is beyond their own capacity or scope of practice and for consulting with or referring to other health professionals.

**Overall Key messages**

- Legislative framework: actions informed by legislation and policy
- General principles and criteria: accountability is central concept alongside outcomes for patients and responsibility for monitoring and auditing outcomes
- Factors influencing individual decision making: ultimate accountability lies with nurse and decisions for consulting with or referring to other health professionals
## Decision Making Framework:

### Key components of DM framework

As a professional, you are personally accountable for actions and omissions in your practice, and must always be able to justify your decisions.

Accountability is integral to professional practice. Nurses and midwives make judgements in a wide variety of circumstances, and use their professional knowledge, and skills to make a decision based on evidence for best practise and the person’s best interests. Nurses and midwives need to be able to justify the decisions they make. Nurses and midwives hold a position of responsibility and other people rely on them. They are professionally accountable to the NMC, as well as having a contractual accountability to their employer and are accountable in the law for their actions.

### Principles and key concepts of Scope.

If a nurse or midwife is asked to deliver care they consider unsafe or harmful to a person in their care, they should carefully consider their actions and raise their concerns to the appropriate person. Nurses and midwives must act in the best interest of the person in their care at all times.

### Overall Key messages

- Legislative framework: code of conduct and professional accountability central to DM
- General principles and criteria: Revalidation with external/third party verification
- Factors influencing individual decision making: individual accountability
<table>
<thead>
<tr>
<th>Title and Authors:</th>
<th>Type of publication:</th>
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| North Carolina Board of Nursing  
Scope of practice decision tree for the RN and LPN | DMF and guidance document (1 document) |

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Screening question: is this paper about expansion of practice for registered nurses and/or midwives?

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<thead>
<tr>
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<th>No * exclude and document reason for exclusion</th>
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Reason for exclusion if applicable:

**Methods**

**Decision Making Framework:**

Yes / no

Algorithm or other format?

Guidance on whether to expand or not practice Yes / No

**Key components of DM framework**

Define, identify, describe, and clarify the activity or task

Is the activity prohibited by the Nursing Practice Act, Board Rules, Statements, or by any other law, rule, or policy?

Education, policies, competence

Is activity indicated as routine in nursing literature? Does documented evidence support activity?

Would a reasonable prudent nurse perform this activity in this setting?

Discuss with Nursing Admin. May want to consult with Board

**Principles and key concepts of Scope.**

Legislation and accountability around tasks

**Overall Key messages**

Legislative framework: predominant – refers nurse to admin or board

General principles and criteria: education, policies and competence for the task

Factors influencing individual decision making: evidence based practice, would a reasonable prudent nurse perform this activity?
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<tr>
<th>Title and Authors:</th>
<th>Type of publication: DMF</th>
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<td>Virginia Board of Nursing: A decision making model for determining RN/LPN scope of practice</td>
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<th>No * exclude and document reason for exclusion</th>
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Reason for exclusion if applicable:

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<th>Algorithm or other format?</th>
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<tr>
<td>Guidance on whether to expand or not practice</td>
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</table>

<table>
<thead>
<tr>
<th>Key components of DM framework</th>
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<tbody>
<tr>
<td>Are you prepared to assume professional accountability for safe, effective nursing practice (by accepting the consequences of your actions)?</td>
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</table>

<table>
<thead>
<tr>
<th>Principles and key concepts of Scope.</th>
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</thead>
<tbody>
<tr>
<td>Is task consistent with scope and consists of two of the following?</td>
</tr>
<tr>
<td>• Standards of practice of a national nursing organization.</td>
</tr>
<tr>
<td>• Established policy and protocol of employing agency.</td>
</tr>
<tr>
<td>• Nursing literature and research</td>
</tr>
<tr>
<td>• Reasonable, prudent nurse in similar circumstance.</td>
</tr>
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| Is the performance of the activity/task within the accepted “standard of care” that would be provided in similar circumstances by reasonable, prudent nurses with similar education, skills, and experience, consistent with appropriately established agency policies and procedures? |

<table>
<thead>
<tr>
<th>Overall Key messages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legislative framework: predominantly driven by policy- reasonable, prudent conduct</td>
</tr>
<tr>
<td>General principles and criteria</td>
</tr>
<tr>
<td>Factors influencing individual decision making; standards, policies, protocols, research literature and reasonable actions</td>
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Appendix 3: Documentary Review Tool

**Documentary Review Rating Instrument**  
(Adapted from Fealy *et al.* 2012)

*Scope of Nursing and Midwifery Practice Framework (April 2000)*

**DOCUMENTARY REVIEW**

Please rate the quality and content of the *Scope of Nursing and Midwifery Practice Framework* document (An Bord Altranais 2000) using the ratings scale provided. In the comments box you may make additional notes to support your scores if you feel these would be useful.

**Note:**
To select a rating for each statement, simply double click beside the tick box of your choice and a dialogue box will open. Then click on the choice 'checked'.
### SCOPE OF NURSING AND MIDWIFERY PRACTICE FRAMEWORK

Below is a list of statements about the content, layout and design of the *Scope of Nursing and Midwifery Practice Framework* document. Indicate the extent to which you agree or disagree with each statement on the list, using the scale: 1 = Strongly disagree; 2 = Disagree; 3 = No opinion; 4 = Agree; 5 = Strongly agree.

<table>
<thead>
<tr>
<th>General Content and Suitability</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>No Opinion</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 The content of the document is based on the best-available evidence at the time of publication (e.g. systematic review cited)</td>
<td></td>
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<tr>
<td>2 It is evident that the content of the document was prepared through a consultation process</td>
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<tr>
<td>3 There is evidence to indicate the origins/authorship of the document</td>
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<tr>
<td>4 In general, the key constructs (e.g. scope, practice, competent) are used consistently throughout the document</td>
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<tr>
<td>5 In general, the document is a suitable resource to inform nurses and midwives about the concept of ‘scope of practice’</td>
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<td>6 In general, the document inhibits the nurse or midwife in expanding the scope of his/her practice</td>
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<td>7 In general, the document encourages the practitioner to question the boundaries of his/her practice</td>
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<table>
<thead>
<tr>
<th>Section 2 and 3: Definitions</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>No Opinion</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 Section 2 provides a clear definition of the concept of scope of nursing practice</td>
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<tr>
<td>9 Section 3 provides a clear definition of the concept of scope of midwifery practice</td>
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<tr>
<td>10 The definitions of the scope of nursing and midwifery practice are clearly distinguishable</td>
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</table>

<table>
<thead>
<tr>
<th>Section 4: Important considerations</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>No Opinion</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 Overall the ‘important considerations’ in determining the scope of practice appear valid, i.e. reflect real-world situations</td>
<td></td>
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<tr>
<td>12 The consideration of ‘competence’ in determining the scope of practice appears valid, i.e. reflect real-world situations</td>
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<tr>
<td>13 The consideration of ‘accountability and autonomy’ in determining the scope of practice appears valid, i.e. reflect real-world situations</td>
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<td>14 The consideration of ‘continuing professional development’ in determining the scope of practice appears valid, i.e. reflect</td>
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<tr>
<td>15</td>
<td>The consideration of ‘support’ in determining the scope of practice appears valid, i.e. reflect real-world situations</td>
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<tr>
<td>16</td>
<td>The consideration of ‘delegation’ in determining the scope of practice appears valid, i.e. reflect real-world situations</td>
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<tr>
<td>17</td>
<td>The consideration of ‘emergency situations’ in determining the scope of practice appears valid, i.e. reflect real-world situations</td>
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<tr>
<td><strong>Section 5: Principles for determining scope</strong></td>
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<tr>
<td>18</td>
<td>Overall, the ‘list of eight principles for determining the scope of practice’ are clearly stated</td>
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<tr>
<td>19</td>
<td>‘Principle 1’ for determining the scope of practice is clearly stated</td>
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<tr>
<td>20</td>
<td>‘Principle 2’ for determining the scope of practice is clearly stated</td>
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<tr>
<td>21</td>
<td>‘Principle 3’ for determining the scope of practice is clearly stated</td>
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<tr>
<td>22</td>
<td>‘Principle 4’ for determining the scope of practice is clearly stated</td>
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<tr>
<td>23</td>
<td>‘Principle 5’ for determining the scope of practice is clearly stated</td>
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<td>24</td>
<td>‘Principle 6’ for determining the scope of practice is clearly stated</td>
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<tr>
<td>25</td>
<td>‘Principle 7’ for determining the scope of practice is clearly stated</td>
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<tr>
<td>26</td>
<td>‘Principle 8’ for determining the scope of practice is clearly stated</td>
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<tr>
<td><strong>Decision-making algorithm</strong></td>
<td></td>
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<tr>
<td>27</td>
<td>The decision-making algorithm (page 11) presents a clear guide for decision-making in everyday midwifery practice situations</td>
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<tr>
<td>28</td>
<td>The decision-making algorithm (page 11) presents a clear guide for decision-making in everyday nursing practice situations</td>
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<tr>
<td>29</td>
<td>The statements/directions in the decision-making algorithm (page 11) are clear</td>
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<tr>
<td><strong>Layout and design</strong></td>
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<tr>
<td>30</td>
<td>The overall document (e.g. paper and print quality, visual presentation, typescript etc.) is finished to a high standard</td>
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<td>32</td>
<td>The amount of ‘white space’ (space on a page used to create contrast and balance) works well in the document</td>
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<tr>
<td>33</td>
<td>The size of the document (A5) is more user-friendly than a larger document</td>
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<tr>
<td>34</td>
<td>The typescript and font size used make the document easy to read</td>
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<tr>
<td>35</td>
<td>The use of colour clearly distinguishes the Scope of Practice from other documents</td>
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</tbody>
</table>

In the space below, please provide additional comments on any aspect of the *Scope of Nursing and Midwifery Practice Framework* (April 2000) document.
Appendix 4: Scope-Q survey instrument

Bord Altranais agus Cnáimhseachais na hÉireann, 18/20 Ascaill Dhún Charúin, An Charraig Dhubh, Co. Bhaile Átha Cliath

Nursing and Midwifery Board of Ireland, 18-20 Carysfort Avenue, Blackrock, Co Dublin

Bord Altranais agus Cnáimhseachais na hÉireann

Nursing and Midwifery Board of Ireland

National survey of nurses and midwives for
The Review of the Scope of Nursing and Midwifery Practice Framework

on behalf of

The Nursing and Midwifery Board of Ireland
(Bord Altranais agus Cnáimhseachais na hÉireann)

Please return your completed questionnaire using the enclosed envelope to:
Professor Gerard Fealy
Room B113, UCD Health Sciences Centre
University College Dublin
Belfield
Dublin 4
**Nurse/Midwife Scope of Practice Decision-Making Framework**

**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?  
**YES**

Does this role/function fit with the definitions and the values that underpin nursing/midwifery?  
**YES**

Is there any legislation, national or local guidelines/policies relating to this role/function?  
**NO**

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

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

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

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

**UNSURE**

Discuss with your manager/An Bord Altranais (ABA)

Figure 1: The Decision-Making Framework
Scope of Nursing and Midwifery Practice Framework Questionnaire (SCOPE Q)

Please do not include your name or PIN on this anonymous questionnaire

PLEASE READ THESE SHORT DEFINITIONS BEFORE PROCEEDING

Scope of 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.

The Scope of Practice Framework
The Scope of Practice Framework is a document published by An Bord Altranais in 2000. It provides principles that 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 and thereby ensure the protection of the public and the timely delivery of quality healthcare.

Decision-Making Framework
The Decision-Making Framework is the decision tree algorithm (or process) on page 11 of the Scope of Practice Framework document (Figure 1). It sets out a series of steps to be taken when making a decision regarding the scope of one’s practice.

Code of Professional Conduct for each Nurse and Midwife
The Code of Professional Conduct for each Nurse and Midwife is a document published by An Bord Altranais in 2000. The purpose of the Code, which is currently under review, is to provide a framework to assist nurses and midwives to make professional decisions, to carry out their responsibilities and to promote high standards of professional conduct.

---

### SECTION A: MY SCOPE OF PRACTICE

Below is a list of statements about your current professional role and the scope of your professional practice. Please read each statement and indicate the frequency with which you engage in activities related to your professional practice using the scale: 1 = Never; 2 = Rarely; 3 = Sometimes; 4 = Frequently; 5 = Always.

*Please circle ONE number only for each statement*

<table>
<thead>
<tr>
<th>In my current professional role ...</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 I use the <em>Scope of Practice Framework</em> document when making a decision about the scope of my professional practice</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2 I consult with professional colleagues when making a decision about the scope of my professional practice</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3 I consult with my line manager(s) when making a decision about the scope of my professional practice</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4 I rely <em>mainly</em> on my own professional judgement when making a decision about the scope of my professional practice</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5 I rely <em>mainly</em> on the direction of others when deciding about my competence to perform new tasks, roles or functions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6 I act under the direction of others when making decisions about my competence to perform a new task, role or function</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7 I act only when I believe I have the competence to perform a new task, role or function</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8 I recognise when I am not competent to perform a task, role or function that falls <em>within</em> the scope of my professional practice</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9 I recognise when a task, role or function falls <em>outside</em> the scope of practice of the nursing or midwifery profession</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10 I acknowledge to others (e.g. colleague) when I recognise limitations in my competence to perform a task, role or function</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</tr>
<tr>
<td>11 When I consider expanding the scope of my professional practice, I first assess the new expanded task, role or function</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12 When I consider expanding the scope of my professional practice, I consider the impact on service delivery (e.g. skill mix)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13 When I consider expanding the scope of my professional practice, I consider the clinical outcomes (e.g. effects on patients)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14 When I undertake a delegated task, role or function, I accept accountability for the performance of that task, role or function</td>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
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<tr>
<td>15 When I delegate a task, role or function to another, I recognise that I am accountable for the decision to delegate</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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</tbody>
</table>
## SECTION B: ENABLERS AND BARRIERS TO EXPANDED SCOPE OF PRACTICE

Below is a list of statements about factors that **enable or hinder** nurses or midwives when expanding their scope of professional practice. When responding to each statement, please think of your own experiences, and indicate the extent to which you **agree or disagree** with each statement. *Please tick **ONE** box only for each statement.*

<table>
<thead>
<tr>
<th>Nurses or midwives…</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>No Opinion</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 who wish to expand their scope of practice are supported in doing so by their organisation or employer</td>
<td></td>
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<tr>
<td>17 who wish to expand their scope of practice are supported in doing so by their professional nursing/midwifery colleagues</td>
<td></td>
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<tr>
<td>18 who wish to expand their scope of practice are supported in doing so by other health professionals (e.g. medical practitioners, pharmacists)</td>
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<tr>
<td>19 who wish to expand their scope of practice have access to continuing professional development (CPD) provided either within or outside their organisation</td>
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<tr>
<td>20 who wish to expand their scope of practice are aware of the <em>Scope of Practice Framework</em> document published by An Bord Altranais</td>
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<tr>
<td>21 who wish to expand their scope of practice are motivated by the professional satisfaction that they get from doing so</td>
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<tr>
<td>22 who wish to expand their scope of practice are motivated by a desire to enhance their promotional opportunities</td>
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<tr>
<td>23 who wish to expand their scope of practice are motivated by a desire to meet the needs of patients/service users</td>
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<tr>
<td>24 have few opportunities in the workplace to expand their scope of practice</td>
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<tr>
<td>25 are reluctant to expand their scope of practice because they do not wish to take on additional responsibilities</td>
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<tr>
<td>26 are reluctant to expand their scope of practice because they believe they are taking on the work of other professionals (e.g. junior doctors, social workers)</td>
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<tr>
<td>27 are reluctant to expand their scope of practice because they frequently do not receive additional salary for doing so</td>
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<tr>
<td>28 are reluctant to expand their scope of practice because there are no local/organisational guidelines to support them in doing so</td>
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<td>29 are reluctant to expand their scope of practice because they are uncertain about which activities are permissible within their professional role</td>
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<td>30 are reluctant to expand their scope of practice because they are uncertain if their expanded practice will be approved by external audit (e.g. HIQA inspection)</td>
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<td>31 are reluctant to expand their scope of practice because they lack the professional autonomy to do so</td>
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<tr>
<td>32 are reluctant to expand their scope of practice because they are fearful of potential legal consequences of doing so</td>
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<tr>
<td>33 are reluctant to expand their scope of practice because they believe their contribution is not valued by other healthcare professionals</td>
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<td>34 are reluctant to expand their scope of practice because they believe that the additional processes are too time-consuming</td>
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</table>
# SECTION C: RESOURCES FOR MY PROFESSIONAL PRACTICE

This section asks about your use of resources to support you in your professional role.

*Please tick ✓*

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td><strong>Within the past three (3) years…</strong></td>
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<tr>
<td>35 I consulted a professional organisation (e.g. trade union, nursing association) for advice concerning the scope of my professional practice</td>
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<tr>
<td>36 I sought advice from a legal professional (e.g. solicitor) concerning the scope of my professional practice</td>
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<tr>
<td>37 I sought advice from other workplace resources (e.g. practice development or risk management staff) concerning the scope of my professional practice</td>
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<tr>
<td><strong>38 Within the past three (3) years …</strong></td>
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</tr>
<tr>
<td>(a) I consulted (i.e. read or referred to) the <em>Code of Professional Conduct for each Nurse and Midwife</em> published by An Bord Altranais in 2000</td>
<td></td>
<td></td>
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<tr>
<td>I <em>mainly</em> consulted the <em>Code</em> document in relation to (please tick <strong>ONE</strong> box only)</td>
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<td>(b) my own professional practice</td>
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<tr>
<td>(b) the professional practice of another/others</td>
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<td></td>
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<tr>
<td>(b) both</td>
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<tr>
<td><strong>39 Within the past three (3) years …</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) I consulted the <em>Scope of Professional Practice Framework</em> document published by An Bord Altranais in 2000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I used the decision-making <em>Framework</em> (reproduced on page 2 of this booklet) as the <em>main</em> guide in my decision to expand the scope of my professional practice</td>
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<td>I <em>mainly</em> consulted the <em>Framework</em> document in relation to (please tick <strong>ONE</strong> box only)</td>
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<td>(c) my own professional practice</td>
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<td><strong>40 Within the past three (3) years …</strong></td>
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<tr>
<td>(a) I consulted the website of the Nursing and Midwifery Board (An Bord Altranais) for the purpose of obtaining information related to policies and guidelines published by the Board</td>
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<tr>
<td>I <em>mainly</em> consulted the website of the Nursing and Midwifery Board in relation to (please tick <strong>ONE</strong> box only)</td>
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## SECTION C: RESOURCES FOR MY PROFESSIONAL PRACTICE

This section asks about your use of resources to support you in your professional role.

*Please tick ☒*

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<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td><strong>41</strong> <strong>Within the past three (3) years ...</strong></td>
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<tr>
<td>(a) I consulted (i.e. wrote to, spoke with) a staff member of the Nursing and Midwifery Board for the purpose of obtaining information related to the scope of professional practice</td>
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<th>Question</th>
<th>Yes</th>
<th>No</th>
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<td><strong>42</strong> <strong>Within the past three (3) years ...</strong></td>
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<tr>
<td>(a) I completed the free online programme, entitled ‘Scope of Practice’, which is available as an interactive e-Learning programme on the website of the Nursing and Midwifery Board</td>
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<tr>
<td>I mainly completed the ‘Scope of Practice’ e-Learning programme in relation to <em>(please tick ONE box only)</em></td>
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<td>(c) my own professional practice</td>
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<td><strong>43</strong> <strong>Within the past three (3) years ...</strong></td>
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<tr>
<td>(a) I consulted the online Continuing Professional Development/ Continuing Education (CPD) Directory, which is available on the website of the Nursing and Midwifery Board</td>
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<tr>
<td>I mainly consulted the Directory in relation to <em>(please tick ONE box only)</em></td>
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<td>(b) my own professional practice</td>
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SECTION D: MY PROFESSIONAL ROLE

This section asks about your current professional role. For this section ‘role’ is defined as the function or position that an individual nurse or midwife holds. An ‘expanded role’ is defined as a change in the role of an individual nurse or midwife to include areas of practice that have not previously been within his/her scope of practice, but are within the overall scope of practice of the nursing and midwifery professions.

Do note that it is possible to expand the scope of your practice without changing your role.

44. The word ‘nurse’ or ‘midwife’ is contained in the title of my current professional role
   □ Yes
   □ No. The title of my current professional role is: ________________________________

45. Since taking up my current professional role I have been required to expand the scope of my professional practice
   □ Yes (If yes please continue to 46)
   □ No (If No, Please skip to 49)

46. I have undertaken additional training specific to the expanded role that I perform
   □ Yes
   □ No

47. When expanding the scope of my professional practice, I used local policies and/or guidelines to guide me
   □ Yes
   □ No

48. When expanding the scope of my professional practice, I used the Scope of Practice Framework document to guide me
   □ Yes
   □ No

49. Before commencing in my current role, I undertook education and training specific to the role
   □ Yes □ No

50. Since commencing in my current role, I have undertaken continuing professional development (CPD) for the role
   □ Yes □ No

51. In my current role, I work directly with patients/service users
   □ Yes □ No

52. In my current role, I work mainly as part of a multidisciplinary team
   □ Yes □ No

53. In my current role, I work mainly as an independent practitioner
   □ Yes □ No

54. My line manager (i.e. the person to whom I report) is a nurse or midwife
   □ Yes □ No

55. My line manager is another professional (e.g. physician, GP, lay administrator)
   □ Yes □ No

56. In my current role, I frequently delegate tasks and duties to more junior nursing/midwifery/non-nursing colleague(s)
   □ Yes □ No
SECTION E: DEMOGRAPHIC INFORMATION

This final section asks you about yourself
Please answer ALL questions, as directed
Please tick ✔

57. Gender
☐ Male
☐ Female

58. Age (in years)
☐ <20
☐ 20-29
☐ 30-39
☐ 40-49
☐ 50-59
☐ >60

59. Educational attainment (academic awards)
Tick ALL that apply to you
☐ Hospital certificate
☐ Diploma in nursing
☐ Higher diploma
☐ Bachelor’s degree
☐ Graduate diploma
☐ Taught master’s degree
☐ Research master’s degree
☐ Doctor of Philosophy or equivalent
☐ Other (Please specify: _____________________________)

60. Additional professional training (specialist training with academic credits)
Tick ALL that apply to you
☐ Professional certificate
☐ Graduate certificate
☐ Professional diploma
☐ Stand-alone continuing professional development (CPD) module(s)
☐ Other (Please specify: _____________________________)

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## SECTION E: DEMOGRAPHIC INFORMATION

### 61. Division(s) of nursing or midwifery in which you are registered

Tick **ALL** that apply

- General nursing (RGN)
- Psychiatric nursing (RPN)
- Midwifery (RM)
- Intellectual disability nursing (RNID)
- Children’s nursing (RCN)
- Public health nursing (PHN)
- Advanced Practitioner (ANP/AMP)
- Registered nurse prescriber (RNP)
- Nurse tutor (RNT)
- Other (Please specify: ____________________________)

### 62. Current grade

Tick **ONE** box only

- Staff grade or equivalent
- CNM2/CMM2 or equivalent
- Assist. Director or equivalent
- CNS or CMS
- Nurse/Midwife tutor or equivalent
- Other (Please specify: ____________________________)

### 63. Area of nursing or midwifery in which you are mainly employed

(i.e. for more than 75% of your overall time)

Tick **ONE** box only

- General nursing
- Children’s nursing
- Midwifery
- Education
- Prison service/Forensic service
- Practice nursing (with GP)
- Practice development
- Policy
- Research nurse
- Agency/Bank nursing
- Psychiatric nursing
- Intellectual disability nursing
- Public health nursing/ Community nursing
- School nursing
- Occupational health (e.g. factory)
- Independent practitioner
- Service management (e.g. DON)
- Regulation
- Academic research
- Other (Please specify: ____________________________)

---

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Appendix 5: Initial letter of communication with the national survey sample

Bord Altranais agus Cnáimhseachais na hÉireann,
18/20 Ascaill Dhún Charúin,
An Charraig Dhubh,
Co. Bhaile Átha Cliath,
Nursing and Midwifery Board of Ireland,
18-20 Carysfort Avenue,
Blackrock,
Co Dublin

National survey of nurses and midwives
for
The Review of the Scope of Nursing and Midwifery Practice Framework
on behalf of
The Nursing and Midwifery Board of Ireland
(Bord Altranais agus Cnáimhseachais na hÉireann)

Date

Dear Colleague,

Since 2000, the Scope of Nursing and Midwifery Practice Framework has been a key part of the professional guidance issued by the Nursing and Midwifery Board of Ireland (NMBI).

The Board has commissioned a team of researchers from four of Ireland’s nursing and midwifery schools (University College Dublin; University of Limerick; Trinity College Dublin; University College Cork) to undertake a review of the Scope of Practice Framework. The review will inform national policy on regulation for nurses and midwives. As part of the review, the research team is conducting a national survey of nurses and midwives. This study has been approved by the NMBI Ethics Committee and the UCD Human Research Ethics Committee.

Your name has been randomly selected from the Register of Nurses maintained by the Nursing and Midwifery Board for inclusion in the national survey. You will receive a questionnaire by post in the next 7-10 days, along with a stamped-addressed envelope. All information collected will be handled anonymously.

I hope you will take the time to contribute to this important national study by completing the questionnaire. In the meantime, if you have any questions about the survey, please do not hesitate to contact me.

Yours Sincerely,

Gerard Fealy RGN, PhD
On behalf of the Research Team,

For further information, please contact:
Gerard Fealy, E-mail: gerard.fealy@ucd.ie Tel. 01 7166461
National survey of nurses and midwives for The Review of the Scope of Nursing and Midwifery Practice Framework on behalf of The Nursing and Midwifery Board of Ireland (Bord Altranais agus Cnáimhseachais na hÉireann)

Dear Colleague,

Since 2000, the Scope of Nursing and Midwifery Practice Framework has been a key part of the professional guidance issued by the Nursing and Midwifery Board of Ireland (NMBI). The Board directs nurses and midwives to use the Framework to inform and support them in their practice.

The Board has commissioned a team of researchers from four of Ireland’s nursing and midwifery schools (University College Dublin; University of Limerick; Trinity College Dublin; University College Cork) to undertake a review of the Scope of Practice Framework. The review will inform national policy on regulation for nurses and midwives. As part of the review, the research team is conducting a national survey of nurses and midwives.

Your name has been randomly selected from the Register of Nurses maintained by the Nursing and Midwifery Board for inclusion in the national survey. We now invite you to complete the enclosed questionnaire, which seeks information from you about your scope of professional practice.

The information collected using this questionnaire will be handled anonymously, and therefore you should not include your name or PIN. By completing the questionnaire you are indicating your consent to contribute to the study. This study has been approved by the NMBI Ethics Committee and the UCD Human Research Ethics Committee.

The questionnaire will take approximately 15 minutes to complete. Please take your time and ensure that you complete all questions. We would appreciate if you could return completed questionnaires to us as soon as possible. We thank you in anticipation for your contribution to this important national study.

Gerard Fealy RGN, PhD
On behalf of the Research Team

For further information, please contact:
Gerard Fealy, E-mail: gerard.fealy@ucd.ie Tel. 01 7166461
Appendix 7: Scope-Q cover letter for second round of questionnaire mail outs

Bord Altranais agus Cnáimhseachais na hÉireann, 18/20 Ascaill Dhún Charuín, An Charraig Dhubh, Co. Bhaile Átha Cliath, Nursing and Midwifery Board of Ireland, 18-20 Carysfort Avenue, Blackrock, Co Dublin

National survey of nurses and midwives for The Review of the Scope of Nursing and Midwifery Practice Framework on behalf of The Nursing and Midwifery Board of Ireland (Bord Altranais agus Cnáimhseachais na hÉireann)

Date

Dear Colleague,

Recently a questionnaire seeking your opinions and experiences regarding the Scope of Nursing and Midwifery Practice Framework was sent to you. Your name was drawn randomly from the register of nurses and midwives. If you have already completed and returned a questionnaire, please accept my sincere thanks, and note that you do not need to do so again. If you have not yet returned a questionnaire, or it was misplaced, please find enclosed another copy, which I hope you will fill out and return by Monday 24th February 2014.

I am especially grateful for your help, as it is only by asking registered nurses and midwives of all grades and working in all settings to share their experiences that the Scope of Nursing and Midwifery Practice Framework can be fully evaluated and reviewed.

Some people have written to say that the questionnaire does not apply to them as they are either retired or not currently in practice. If you share these concerns, please let me know on the cover of the questionnaire and return it in the enclosed envelope. Your answers are completely confidential, and the list of names and addresses used for this survey will be destroyed and never connected to the results in any way.

Once again, your time and help with this important national study are very much appreciated.

Sincerely,

Gerard Fealy RGN, PhD
On behalf of the Research Team

For further information, please contact:
E-mail: gerard.fealy@ucd.ie; Research Office Tel. 01 7166464
Appendix 8: Focus Group informed consent and information sheet

SCOPE OF NURSING AND MIDWIFERY PRACTICE REVIEW

FOCUS GROUP CONSENT FORM

I hereby consent to participate in a focus group, conducted as part of the Review of the Scope of Nursing and Midwifery Practice Framework, on behalf of the Nursing and Midwifery Board of Ireland (NMBI). I have read the accompanying Information Sheet and understand the purpose of the focus group.

Conditions of participation
My participation in the focus group is entirely voluntary. I am free to withdraw my consent without prejudice and discontinue my participation at any time, either prior to or during the focus group.

As part of this research project, audio recordings of the focus group discussion will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that the recordings may be studied by the research team for use in the research project.

The information that I provide in the focus group will be stored securely in the manner indicated in the Information Sheet and will be used solely for the purpose stated.

Name (Block Capitals) ________________________________________________________________

Signature ________________________________________________________________

Date ___/___/______
SCOPE OF NURSING AND MIDWIFERY PRACTICE REVIEW
INFORMATION SHEET

Introduction
Since 2000, the *Scope of Nursing and Midwifery Practice Framework* has been a key element of the professional guidance issued by the Nursing and Midwifery Board of Ireland (NMBI). The Board directs nurses and midwives to use the Framework to inform and support them in their practice. The Board has commissioned a team of researchers to undertake a review of the *Scope of Practice Framework*. The review will inform national policy on regulation for nurses and midwives.

Who is conducting the study?
A team of researchers from four of Ireland’s major nursing and midwifery schools (University College Dublin; University of Limerick; Trinity College Dublin; University College Cork) is conducting the study.

Why is this study important?
The *Scope of Nursing and Midwifery Practice Framework* (An Bord Altranais, 2000) presents nurses and midwives in Ireland with a series of principles with which they can ‘review, outline and expand the parameters of [their] practice’. These principles include professional conduct, accountability and self-governance. Since the *Framework* was first published, several developments in the health services and in the scope of nursing and midwifery practice have occurred, including the advent of nurse and midwife-led care and the institution of prescriptive authority for specially-trained nurses and midwives. In light of these developments and the publication of the Nurses’ and Midwives’ Act 2011, it is now timely to review the *Scope of Nursing and Midwifery Practice Framework*.

How can I contribute?
As part of the review, the research team is conducting a series of focus group discussions with registered nurses and midwives working in a wide range of health care settings. The purpose of these focus groups is to explore nurses’ and midwives’ experiences of developing their scope of professional practice. You can contribute by agreeing to take part in a focus group.

What do I have to do?
You will be invited to participate in a focus group, details of which will be sent to you once you have agreed to take part. You will then have the opportunity to discuss your own experiences.
Who will be conducting the focus groups?
The focus groups will be conducted by a member of the research team, with the support of a research assistant. The focus group discussions will be digitally recorded to ensure that all participants’ experiences and views are recorded.

What are the possible risks in taking part in this study?
There are no foreseeable risks to you in taking part in this study.

What are the benefits in taking part in this study?
While there are no immediate benefits to you, your participation will provide important information on nurses’ and midwives’ experiences of developing their scope of professional practice. The information will assist in the preparation of a detailed report that will reflect the views and experiences of all stakeholders.

What will happen after the focus groups and interviews are completed?
The research team will transcribe the information provided by you and the information will then be analysed along with that provided by other study participants, in order to provide a detailed descriptive understanding of nurses’ and midwives’ everyday experiences of developing their scope of practice.

How will the information be stored and used?
The information will be stored securely in digital form in a password-protected computer and as a written transcript in a locked filing cabinet in a locked office at the Research Unit of the UCD School of Nursing, Midwifery and Health System.

How will the information be used?
Once analysed, the information will be used in preparing the final report to be submitted to the Nursing and Midwifery Board. In due course, following submission of the final report some information may be used in the preparation of articles for publication in professional journals. No individuals or health care organisations will be identified in any reports or papers.

Has the study been approved by an ethics committee?
The study been approved by the Ethics Committee of the Nursing and Midwifery Board of Ireland (NMBI) and by the Life Sciences Human Research Ethics Committee (LS-HREC) of University College Dublin (Approval no. LS-E-13-164).

Where can I get further information about the study?
For further information, please contact:

Professor Gerard Fealy: gerard.fealy@ucd.ie
Tel. 01 7166461

Dr Mary Casey: mary.casey@ucd.ie
Tel. 01 7166473

Research Office: 01-7166464
Appendix 9: Interview consent forms and information sheet

SCOPE OF NURSING AND MIDWIFERY PRACTICE REVIEW

INTERVIEW CONSENT FORM

I hereby consent to participate in an interview, conducted as part of the Review of the Scope of Nursing and Midwifery Practice Framework, on behalf of the Nursing and Midwifery Board of Ireland (NMBI). I have read the accompanying Information Sheet and understand the purpose of the interview.

Conditions of participation
My participation is entirely voluntary. I am free to withdraw my consent without prejudice and discontinue my participation at any time, either prior to or during the interview.

As part of this research project, audio recordings of the interview will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that the recordings may be studied by the research team for use in the research project.

The information that I provide in the interview will be stored securely in the manner indicated in the Information Sheet and will be used solely for the purpose stated.

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<td>Date</td>
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</table>
SCOPE OF NURSING AND MIDWIFERY PRACTICE REVIEW

INFORMATION SHEET

Introduction
Since 2000, the Scope of Nursing and Midwifery Practice Framework has been a key element of the professional guidance issued by the Nursing and Midwifery Board of Ireland (NMBI). The Board directs nurses and midwives to use the Framework to inform and support them in their practice. The Board has commissioned a team of researchers to undertake a review of the Scope of Practice Framework. The review will inform national policy on regulation for nurses and midwives.

Who is conducting the study?
A team of researchers from four of Ireland’s major nursing and midwifery schools (University College Dublin; University of Limerick; Trinity College Dublin; University College Cork) is conducting the study.

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How can I contribute?
As part of the review, the research team is conducting a series of interviews with registered nurses and midwives working in a wide range of health care settings. The purpose of these interviews is to explore nurses’ and midwives’ experiences of developing their scope of professional practice. You can contribute by agreeing to be interviewed.

What do I have to do?
You will be invited to participate in an interview, details of which will be sent to you once you have agreed to take part. You will then have the opportunity to discuss your own experiences.
Who will be conducting the interview?
The interview will be conducted by a member of the research team. The interview will be digitally recorded to ensure that your experiences and views are recorded.

What are the possible risks in taking part in this study?
There are no foreseeable risks to you in taking part in this study.

What are the benefits in taking part in this study?
While there are no immediate benefits to you, your participation will provide important information on nurses’ and midwives’ experiences of developing their scope of professional practice. The information will assist in the preparation of a detailed report that will reflect the views and experiences of all stakeholders.

What will happen after the interview is completed?
The research team will transcribe the information provided by you and the information will then be analysed along with that provided by other study participants, in order to provide a detailed descriptive understanding of nurses’ and midwives’ everyday experiences of developing their scope of practice.

How will the information be stored and used?
The information will be stored securely in digital form in a password-protected computer and as a written transcript in a locked filing cabinet in a locked office at the Research Unit of the UCD School of Nursing, Midwifery and Health System.

How will the information be used?
Once analysed, the information will be used in preparing the final report to be submitted to the Nursing and Midwifery Board. In due course, following submission of the final report some information may be used in the preparation of articles for publication in professional journals. No individuals or health care organisations will be identified in any reports or papers.

Has the study been approved by an ethics committee?
The study been approved by the Ethics Committee of the Nursing and Midwifery Board of Ireland (NMBI) and by the Life Sciences Human Research Ethics Committee (LS-HREC) of University College Dublin (Approval no. LS-E-13-164).

Where can I get further information about the study?
For further information, please contact:

Professor Gerard Fealy: gerard.fealy@ucd.ie
Tel. 01 7166461

Dr Mary Casey: mary.casey@ucd.ie
Tel. 01 7166473
Appendix 10: Focus Group and Interview Topic Guide

Background information and welcome statement

[Hand out name labels and demographic sheet for participants to complete]

The Nursing and Midwifery Board of Ireland (NMBI) has commissioned a team of researchers from four of Ireland’s nursing and midwifery schools (University College Dublin; University of Limerick; Trinity College Dublin; University College Cork) to undertake a review of the *Scope of Nursing and Midwifery Practice Framework*. Since 2000, this Framework has been a key element of the professional guidance issued by the NMBI. The Board directs nurses and midwives to use the Framework to inform and support them in their practice. This review will inform national policy on regulation for nurses and midwives. As part of the review, the research team is conducting a series of focus group discussions and interviews with registered nurses and midwives working in a wide range of health care settings.

Before we commence, we would like to say a little about the focus group format. There is no right or wrong answer, everyone's views and input are valued in the review process. Also, can I ask you to respect the confidentiality of the group, which is to ask that people's views that are shared here today remain within the group and are not discussed outside of this setting.

Today, we will be discussing four key areas: 1) your understanding of ‘Scope of Practice’; 2) your use of the Scope of Practice framework; 3) expanding your scope of practice, including enablers and barriers and 4) resources and support.

- **Introduction**
  1. Could I ask each of you in turn to tell us a little bit about your background, the types of settings you have worked in and the work you are doing currently?
  2. What resources would you use to guide you in your work? Such as any documents, policies, guidelines etc.?

- **Understanding of scope of practice**
  I would like to move on to discussing the scope of nursing and midwifery practice.
  3. Can you discuss the term ‘scope of practice’ as you understand it?
    
    [Probe for: competence; taking responsibility for actions/decision-making; Accountability; continuing professional development; delegation; and emergency situations]

- **Use of Scope of Practice Framework:**
  4. Are you familiar with the Scope of Practice framework? [Display & hand out a copy]
  5. Could you discuss the circumstances in which you may have used the framework to make decisions about the scope of your professional practice?
    
    [Do you think the scope of practice framework is applicable to nurses or midwives working outside of clinical practice?]
6. Did you find the framework helpful in your decision-making?

- **Expanded scope of practice:**
  I would like to discuss your experience of an expanded scope of practice.

7. How did it come about and what were the positive and negative aspects of the experience?
   
   *Probe for: better patient care/skills utilised/increased job satisfaction/career opportunities; less hands-on/more accountable/impact on patient care/conflict with other healthcare professionals etc.*

8. Could we discuss some areas that would be considered **enablers** for an expanded scope?
   
   *Probe for: key motivations/access to continued professional development (CPD) inside or outside their organisation*

9. Could we discuss some areas that would be considered **barriers** for an expanded scope?
   
   *Probe for: lack of opportunity in the workplace/personal issues/lack of financial incentive/lack of autonomy in their current role*

- **Resources and supports**
  I would like to discuss the resources and supports that you have used or that you feel are available to you in expanding your scope of practice.

10. What resources, such as professional organisations, websites or documents, have you used?

11. Do you receive support from colleagues or employers in expanding your scope?

12. That’s all my questions, is there anything else, related to the scope of practice, that you feel is important to add?

13. Is there anything you would like to ask me?

Thank you for your participation in this focus group/interview. We are grateful that you have given your time today and your input into this project is very much appreciated.
Appendix 11: Qualitative Data Coding Frame

1. Evolution of the Nursing Profession and Practice – “the old style”
   - Education – move to University; CPD etc.
   - Autonomous Practice
   - Introduction of Advanced Practitioners
   - Nurse/midwife led teams/clinics
   - Social model of care
   - Emergence of MDTs
   - Advent of Evidence-Based Practice
   - Nursing as a “caring” profession

2. What is scope of practice?
   - Understanding of scope of practice
   - Use and experience of scope of practice
   - Duality of scope of practice – enabling vs. restrictive

3. Expanding the Scope of Practice – “you’d maybe aim to do a study day or do something on it so that you could become competent in it”
   - Conflict between taking on new expanded roles and maintaining traditional/“basic” patient care
   - Issues of service-level barriers – staff shortages, release off work to attend training, lack of available training
   - Support or lack of support from management/organisations
   - Lack of recognition by other healthcare professionals of expanded nursing roles
   - Lack of knowledge/understanding re: Scope of Practice document
   - Lack of support/recognition for specialist roles - “a nurse is a nurse is a nurse”; “we are just a number”
   - Resources available

4. Enablers to expanding the scope of practice
   - Access to training/education
   - Support from the organisation/management
   - Policies and legislation in place to support expanded role
   - Positive aspects of expanding scope of practice
   - Other resources

5. Barriers to expanding scope of practice
   - Lack of support from organisation/management
   - Lack of time – either to attend training or to carry out expanded roles
   - Staff shortages
   - Lack of appropriate policies in place
   - Lack of support from other nursing/non-nursing staff
   - Negative aspects of expanding scope of practice
6. Policies and legislation – “we are… governed either nationally or locally in anything that we do”
   - Local, national and international policies
   - Can work as a barrier or enabler
   - Writing/creating own local policies
   - National/international legislation governing nursing/healthcare practices

7. Supervision and Delegation - “I use it a lot with maybe junior staff”
   - Supervision of/by other nurses, doctors, healthcare assistants, students
   - Delegation to/by other nurses, doctors, healthcare assistants, students
   - Trust/suitability of qualifications/competence of self and others

8. Accountability and Responsibility
   - Related to supervision and delegation - conflict between being responsible for the actions of the person to whom one delegates, as well as one’s own actions when accepting a delegated task
   - Related to fear and confidence
   - Management and multidisciplinary team – communication, chains of command etc.

9. Competence

10. Confidence & Fear (personal factors?)
    - Confidence to act and make decisions autonomously
    - Confidence to take on new roles, tasks, functions
    - Confidence to say “no”
    - Uncertainty
    - ‘Am I covered?’
    - Fear of acting outside of one’s scope of practice
    - Fear of making mistakes and putting patients at risk
    - Fear of taking on new roles and responsibilities
    - “terrifying” – prospect of being struck off register
    - Risk-taking

11. Redeployment – “just move all the nurses around”
    - Issues of lack of skills and competence in a new area or area one hasn’t worked in for some time
    - Related to fear and confidence

12. Role Boundaries
    - Overlap with other healthcare professionals
    - Carrying out ‘non-nursing’ tasks
13. Patient safety – “what can I do that will keep me and the patient safe”
   o Patient-centred care
   o Conflict between taking on new expanded roles and maintaining traditional patient care
   o Lack of resources – staffing etc.
   o Risk assessment

14. Emergency/Crisis Situations

15. Setting/Context/Environment
   o Different issues reported in different settings
   o Reality of day-to-day work
   o Lone working

16. Recommendations for changes to current Scope of Practice Framework
Appendix 12: Call for Written Submissions

National Call for Written Submissions for
The Review of the Scope of Nursing and Midwifery Practice Framework

Bord Altranais agus Cnáimhseachais na hÉireann
Nursing and Midwifery Board of Ireland

Since 2000, the Scope of Nursing and Midwifery Practice Framework has been a key part of the professional guidance issued by the Nursing and Midwifery Board of Ireland (NBMI).

The Board has commissioned a team of researchers from four of Ireland’s nursing and midwifery schools (University College Dublin; University of Limerick; Trinity College Dublin; University College Cork) to undertake a review of the Scope of Practice Framework. The review will inform national policy on regulation for nurses and midwives.

As part of this review, the research team wishes to engage in public consultation with key stakeholders, particularly nurses and midwives, individuals, groups, agencies and organisations that have an interest in this matter.

The final date for the receipt of written submissions is 7th March 2014

Submissions should be marked ‘Scope of Nursing and Midwifery Practice Framework’ and sent to:
Professor Gerard Fealy or Dr. Mary Casey, Room B113
UCD Health Sciences Centre,
University College Dublin, Belfield, Dublin 4
Email: gerard.fealy@ucd.ie or mary.casey@ucd.ie
Project office: 01 716 6464
Appendix 13: Scope-Q survey response rates

At the end of the designated closing date for return of completed questionnaires at round 1, a total of 779 (33.09%) replies were received. Of this number, 723 questionnaires (30.7%) were returned completed and 56 (2.4%) were deemed to be invalid or incomplete. Round 2 yielded 356 (15.1%) replies, of which 287 (12.2%) were completed and 69 (2.9%) were returned incomplete. Accordingly, a total of 1,135 responses were received, of which 125 questionnaires were unusable for the purpose of data analysis. A total of 83 questionnaires were returned with an indication from respondents that they were either no longer working in nursing or midwifery, were retired, had emigrated or were ill. Another 27 questionnaires were returned as undeliverable. This resulted in a valid sample of 2,244 and a useable sample of 1,010 completed questionnaires, representing a cumulative response rate of 48.2% from the two rounds and a cumulative useable response rate of 45% for the purpose of data analysis.

The table below provides a breakdown of the returns by wave.

<table>
<thead>
<tr>
<th>Wave</th>
<th>N (n)</th>
<th>% response</th>
<th>(n)</th>
<th>% useable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wave 1</td>
<td>2,354 (779)</td>
<td>33.1%</td>
<td>(723)</td>
<td>32.2%</td>
</tr>
<tr>
<td>Wave 2</td>
<td>2,354 (356)</td>
<td>15.1%</td>
<td>(287)</td>
<td>12.8%</td>
</tr>
<tr>
<td>Cumulative Valid</td>
<td>2,244 (1,135)</td>
<td>48.2%</td>
<td>(1,010)</td>
<td>45.0%</td>
</tr>
</tbody>
</table>

20 Of this number, 110 were deemed to be invalid for the survey sample, representing 9.7% of valid returns. This would suggest that the sample contained other ‘invalid’ entries that we have no way of identifying, but could be estimated to be up to 10 per cent.
21 While this number represents the sample used in Wave 2, in total, only 1,911 questionnaires were posted out as individuals who had returned questionnaires by 7th February were not included in the 2nd mailing.
Appendix 14: Categorical Principal Components Analysis

Standard principal components analysis assumes linear relationships between numeric variables, and thus is not suited to the analysis of ordinal or categorical variables. Since a number of items from the Scope-Q survey instrument were recorded in ordinal (rank-ordered) categories, for example ranging from strongly disagree to strongly agree, non-linear principal components analysis, also known as categorical principal components analysis (CATPCA) was employed. In CATPCA, the categories of variables are assigned numeric values through a process known as optimal quantification, which replaces the category labels with category quantifications in such a way that as much of the variance in the quantified variables as possible is accounted for (Linting et al. 2007). Categories of variables with nominal and ordinal analysis levels are thus transformed to numeric values (Linting and van der Kooij 2014).

In order to test the suitability of the data for an ordinal analysis level, CATPCA was also run specifying a nominal analysis level for each variable. The transformation plots for this analysis displayed monotonic curves and thus did not vary markedly from the transformation plots for the ordinal analysis, indicating the suitability of the ordinal level analysis. A further option involves the specification of a monotonic spline analysis level, which requires not only that the categories of the variables be in the same order, but also that the transformations show a smooth curve (Linting et al. 2007). However, as Linting et al. (2007) suggest, the use of an ordinal analysis level is advisable when the number of categories is small. Since the variables in the current analysis only had five categories, ordinal analysis was used.

While the 19 items of Section B of the Scope-Q were developed to correspond to barriers and enablers to expanding scope of practice, no a priori assumptions about the potential number of principal components were made. Initially, a categorical principal components analysis, stipulating an ordinal analysis level for each of the 19 variables, was run specifying the extraction of 19 components – corresponding to the 19 variables in the analysis. Inspection of this 19-component solution revealed that only the first four factors had eigenvalues greater than 1 – one of the criteria for component selection used during standard principal components analysis that ensures that each component extracted explains more variance than one single item would on its own. Thus, the analysis was rerun specifying the extraction of four components. This four-component solution accounted for 58.14% of the variance in the nineteen items from Section B of the questionnaire. Inspection of the component loadings however indicated that all
of the 19 items loaded more heavily on one of the first three components than the fourth one. Thus, the analysis was re-run specifying the extraction of three components. This three-component solution accounted for 51.49% of the variance in the nineteen included items.

Component 1 included items Q24-Q34, relating to the ten statements designed to assess the perceptions of barriers to expanded scope of practice. Components 2 and 3 indicated items relating to enablers, but lacked interpretability as separate factors, with most items loading more heavily on component 2. In order to examine rotated component loadings, which can be easier to interpret, the quantified variables from the CATPCA were saved and subjected to a standard linear PCA using an orthogonal (Varimax) rotation (Linting & van der Kooij 2012). The rotated factor loadings indicated that items Q16-Q19 were associated with component 2, and items Q20-Q23 to component 3. Given that both components related to enablers for expanded scope of practice, and the small number of items split across the two components, it was decided that a two-component analysis would result in a more easily interpretable solution. This two-component solution is thus reported in the main text of this report.