# Nursing Scope of Practice: Descriptions and Challenges

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**Abstract**

The nursing workforce is faced with shortages of near crisis proportions, yet little is understood about the optimal utilization of various categories of nurses – Licensed Practical Nurses (LPNs), Registered Nurses (RNs) and Registered Psychiatric Nurses (RPNs). The primary purpose in this study was to elicit the perceptions of nurses (RNs, LPNs, and RPNs) of what "working to full scope of practice" meant to them.

Participants included acute care nurses in three health regions in western Canada. A key finding from the study was the fact that nurses most often discussed scope of practice by reference to the tasks they perform, rather than the roles they play in healthcare delivery. Assessment and coordination of care were two components of nursing work that most differentiated the three nursing roles. Nonetheless, insufficient role differentiation among nurses and between nurses and other healthcare professionals leaves some nurses feeling devalued and not respected for their contribution to healthcare delivery.

## Introduction

Employers are currently dealing with shortages of many healthcare professionals, and the nursing workforce in particular is facing shortages of near crisis proportions. Yet, a number of recent reports on the Canadian health system (e.g., Fyke 2001; Romanow 2002) suggest that healthcare professionals are not being effectively utilized, a situation that is potentially contributing to low staff satisfaction and aggravating retention and recruitment problems. These reports have highlighted the need to optimize the roles of healthcare professionals. Before optimization can occur, it is critical to understand the scope, boundaries and potential overlap in roles of various categories of nurses, as well as the facilitators or barriers that might account for differences in enactment of nursing roles across settings.

Although the term "scope of practice" is often used in policy and professional documents, it is difficult to find a consistent definition of the concept (Baranek 2005). The meanings of scope of practice vary among healthcare professionals. For some, it refers to standards of practice or professional competencies; for others, it encompasses the legal base of practice; still others equate it with the components of the clinical parameters of practice (Schuiling and Slager 2000). More broadly, scope of practice has been defined in regulatory documents as the full range of roles, responsibilities and functions that nurses are educated, competent and authorized to perform (CMA et al. 2003; College of Licensed Practical Nurses of Alberta 2003).

The literature search that preceded this study, as well as subsequent review of the literature (2002–2006), revealed relatively little research on scope of practice as a general concept. More specifically, research has been descriptive in nature and has primarily focused on advanced practice and nurse practitioner roles in such areas as oncology (Cleary 2002), acute care (Cummings et al. 2003), paediatrics (Kahir and Madge 2002), pain management (Musclow et al. 2002), sexual health (O'Keefe and Gardner 2003), heart failure clinics (Staples and Earle 2004) or outpost

settings (Nelson and Purkis 2004). Often such discussion focuses on a description of the biomedical role functions and technical competencies in the performance of medically delegated tasks of the advance practice and nurse practitioner roles (Donnelly 2003) rather than expected nursing competencies that encompass knowledge and skills related to the enhancement of health and wellness. A secondary theme consistent across the studies is a voiced frustration by nurses of the role overlap or "shared practice boundaries" among nurses and other providers (Scholes and Vaughan 2003). Daly and Carnwell (2003) suggest that there has been an unprecedented movement to creating "new roles or titles" for nursing providers without an understanding or consensus regarding differences among the various roles and a mapping of the boundaries of practice, levels of clinical autonomy and preparation for these roles.

Examination of studies about the organization and distribution of nursing work again reveals a predominant focus on the biomedical tasks (treatments, personal care), often described as direct care and indirect care activities such as documentation, delivering and retrieving supplies and communication of information (Pelletier and Duffield 2003; Urden and Roode 1997; Elbright et al. 2003). While the studies provide useful information about workflow, there is no discussion about the relevance or relationship of these activities or tasks to roles, responsibilities and functions that nurses are educated to perform. Tiedeman and Lookinland (2004) note that much of the literature with respect to professional practice models or alternative service delivery models is descriptive in nature about types of nursing tasks, or else it focuses on conceptual descriptions of the service delivery model and delegation of tasks among nursing providers.

Scope of practice is also presented in the literature in relation to factors that address working conditions or organizational characteristics in the environments where nurses work (Ball and McElligot 2003). Depending on the focus of the research, the authors argue for expanding or extending the functional aspects of the nursing role (acknowledging primarily medically designated tasks) (Masterson 2002) and the potential risks of doing so (Melling and Hewitt-Taylor 2003). It is important to understand how nurses themselves describe what it means to work to full scope of practice and what they recommend as strategies that will enable them to be better utilized (Lundgren and Segesten 2002).

Existing literature has focused on the role of clinical nurse specialist and nurse practitioners rather than the role of registered nurses (RNs) without advanced practice degrees, licensed practical nurses (LPNs) and registered psychiatric nurses (RPNs). Given existing shortages and the need to optimize the roles of all professionals, this research is an important step in redesigning nursing work to achieve an optimal staff mix.

In this study of nursing scopes of practice, we differentiated between nursing roles (predefined expectations of nurses' contribution based on professional education and role) and role enactment (actual practice as delimited by legislation, employer policies, experience, context of practice, etc.). The primary purpose of this research was to elicit the perceptions of nurses (LPNs, RNs, RPNs) on what constitutes their full scope of practice and the extent to which they are able to work to full scope.

## Methods

A mixed-methods design (Johnson et al. 2007), with both qualitative and quantitative methods, was used for this study. Qualitative methods followed a qualitative descriptive approach to obtain an in-depth understanding of nurses' and other stakeholders' perceptions of scope of practice, whether and how they were practising to scope and barriers and facilitators. The research was conducted in acute care facilities in two health regions in Alberta (Calgary and Edmonton) and one in Saskatchewan (Saskatoon). To ensure variability in sampling, patient care units ($n$=14) from hospitals of various intensity and type (acuity, medicine, surgery, intensive care), organizational characteristics (level of hospital) and variability in type of nursing provider (proportional ranges of RNs, LPNs and RPNs – 65% RN/35% LPN; 100% RN; 50% RN/50% RPN) were selected.

Information about nursing roles was obtained through face-to-face semi-structured interviews conducted with a purposive volunteer sample of nurses (RNs, LPNs and RPNs). Detailed guidelines for the semi-structured interviews can be found in the final report (Besner et al. 2005). Patient care managers, nurse educators and clinicians were also interviewed in order to obtain information about care delivery models, perceptions of whether nursing staff on their unit worked to full scope and the factors that facilitate or hinder maximizing the roles of all nursing personnel. This information was seen as important to redesign nursing work and to foster better utilization of the knowledge and skills of all members of the healthcare team. To better understand perceived boundaries or potential overlaps between nurses and other professionals, interviews were also conducted with members ($N$=53) of the interdisciplinary healthcare team such as: social workers ($n$=7), pharmacists ($n$=4), physician ($n$=1), physical therapists ($n$=6), physiotherapist ($n$=3), speech pathologists ($n$= 2), respiratory therapist ($n$=2), dietitians ($n$=2), recreation therapist ($n$=3), chaplain ($n$=1), administrative health support ($n$=4) and occupational therapists ($n$=7).

Quantitative data were collected for participants' demographics and corporate information. To augment description of the context within which scope of practice was examined, nurse participants were invited to complete three validated instruments that captured nursing workload, autonomy and control in prac-

tice and job satisfaction. Analysis of corporate and instrument data will not be addressed in this paper.

A thematic analysis was conducted of interview transcripts: categories and themes were identified and defined, relationships between categories and themes were explicated and themes from various data sources were compared and contrasted (Morse and Richards 2002). Several iterations of the categories evolved during analysis. N6™ computer software was used to facilitate analysis.

Trustworthiness of the data (Guba and Lincoln 1989) was ensured through a variety of methods throughout the study. Both interviewers and coders received extensive training; regular meetings were held throughout the coding process to discuss coding categories and emerging themes. A selection of transcripts was reviewed by experienced qualitative researchers, and an external audit of the research study was conducted by an expert qualitative researcher. Themes identified in the study were corroborated in the external audit.

Consent was sought prior to conducting interviews. All data collection tools developed for this study were pilot tested. Ethics approval was received from the research ethics board of each participating health region.

## Results

### Description of nurse participants

A total of 167 interviews were conducted with staff RNs ($n$=85), LPNs ($n$=31), RPNs ($n$=11), patient care managers (PCMs)/assistant PCMs ($n$=19) and nurses in specialized roles ($n$=21). The mean age of nurse participants was 42.1 years (SD=10.7), with an average of 16.4 years of nursing experience (SD=11.3). About 39% of the respondents had a baccalaureate degree in nursing and 4% had a master's degree. Most participants were employed in permanent full-time (59%) or part-time positions (31%), while about 10% were in temporary or casual positions. Over 90% of respondents were female. Specific to the staff nurses interviewed, the mean age was 41.0 years (SD=11.3), with an average of 14.4 years (SD=11.3) of nursing experience. Approximately 51% ($n$=65) indicated they were in a permanent full-time position. Thirty-five per cent ($n$=45) indicated they were in a permanent part-time position and approximately 13% ($n$=16) identified themselves as temporary or casual. In terms of age, the sample of nurses interviewed was comparable to the profession as a whole, whereas the distribution of nurses in full- and part-time positions was slightly lower (CIHI 2002a,b,c). A comparison of RN, LPN and RPN health region interviewees to provincial staffing percentages revealed that with the exception of the Capital Health Region, the proportion of RPNs interviewed was higher than provincial percentages, the RNs'

distribution was slightly lower than provincial staffing percentages and the LPNs' distribution was higher (CIHI 2002a,b,c).

### Description of scope of practice

In this study, many nurses understood "scope of practice" to mean the tasks they perform in day-to-day work. None of the respondents appeared to differentiate between the meaning of "full scope of practice" (a role that is reflected in the knowledge base of the profession) and "role enactment" (the application of knowledge within parameters defined by legislation, experience, competence and contextual factors in the environment) (Besner et al. 2005). Two key themes in nurses' descriptions of their scope included assessment and coordination of care.

**Assessment**

Assessment emerged as central to nursing work and was one key element that also differentiated the three nursing groups. All LPNs spoke of assessment as part of their scope of practice. They tended to speak about assessing vital signs, hydration/elimination, glucose levels, etc.: "… and we just go in and assess them … [their] state of mind, mood, skin colour, pain, wounds, activities of daily living, bowels, bladder, circulation" (LPN). RPNs spoke more holistically about patient assessment than did a number of RNs, although what RPNs considered physical assessment was rarely described:

> … our first priority is to do a mental assessment … for hallucinations, delusions, their emotional state, their suicidal risk … then we also go into their social, cultural background, their development … and then we also do the physical assessment. (RPN)

RNs were more likely to speak of assessment using such terms as neurological, respiratory, cardiovascular or pain assessment and determination of the effects of medications: "My role is to assess the patient and to use my knowledge and skills … to address the needs of the patient" (RN). Description of systems assessment was often linked to various aspects of care such as medication administration. Unlike LPNs and RPNs, RNs saw and described assessment as key in prevention of a variety of situations, providing a basis for identifying changes in the patient's condition. Assessment is required for "monitoring and looking for changes in the patient's status. … I start to pick out the things that need some intervention" (RN). Both RPNs and RNs identified the importance of integrating other sources (charts, others' assessments, patient and family comments) to inform assessment. An additional component of assessment for RNs and RPNs was determining the need for involvement of other disciplines (e.g., physicians, physiotherapists, social workers) in service delivery. While LPNS made reference to involving RNs or

RPNs in helping them respond to patient needs: "My role is to assess the patient … and then use my knowledge to figure out who should be coming to address the needs of the patient" (RN).

**Coordination of care**

The idea of the nurse as the "go-between" or the "hub of the wheel" for the patient/family and other healthcare providers was also a theme in nurses' descriptions of their roles. The fact that nurses are with patients 24 hours a day facilitated their ability to coordinate care. While some LPNs did not perceive they had a role in coordinating care, others spoke about organizing care around scheduled treatments and services performed by other members of the healthcare team: "… sometimes I have to juggle to accommodate others. … It takes coordinating [care] between the two of us [occupational therapist]" (LPN). RNs and RPNs referred to coordination in the context of involving others and ensuring that patient needs were met by appropriate members of the healthcare team:

> I think the nurse is kind of the central person who gets to organize all the little teams that are around the patient, the nurse makes sure that we've got everybody there. Nursing is absolutely responsible for the coordination of patient care. (RN)

Coordination was also linked to patient advocacy, with RNs and RPNs acting on behalf of patients, mediating between them and other professionals, updating physicians and others on the patient's status, interpreting for patients but also having input into planning care: "[We] plan with patients and refer them to any community group … talk to the docs and decide where the person belongs or is best suited" (RPN). RNs, and to a lesser extent RPNs, discussed discharge planning as an important component of care coordination: "We all should be working together to coordinate care to help the patient return to their previous, [or] their highest level of wellness for the earliest discharge" (RN). LPNs, on the other hand, spoke mainly of their role in discharge as getting everything ready that the patient needed before leaving hospital and ensuring that charting was current.

### Working to full scope

There were differences among RN participants in their interpretation of what it meant to work to full scope. Ability to apply the full range of their knowledge and skills depended on the type of unit and the range, acuity or complexity of the patient population. RNs were more likely to report "working to full scope" in highly technical areas such as intensive care. "Full scope" was seen as the ability to provide comprehensive care (biological, psychological, social and spiritual assessment, working with families, patient teaching, advocacy, discharge planning and coordination of care) from admission to discharge:

> I guess every time a patient is admitted … we have to employ our full range of skills to assess them physically, mentally, emotionally, spiritually … then use that information to determine what needs the patient has. (RN)

Although degree-prepared RNs appeared more likely to discuss their practice in holistic terms, it was difficult to detect any other consistent pattern that clearly differentiated degree- from diploma-prepared RNs in this study. Those nurses with less experience felt they could practise to fuller scope once they had gained more experience: "I think you become less task oriented and just a bit more noticing the big picture" (RN).

Of the three groups of nurses, RPNs were most likely to report working to full scope, although a majority (73%) reported not being fully utilized at least some of the time. RPNs believed they were well utilized when they worked as part of an extended treatment team; were able to provide holistic care, patient and family education, counselling and psychotherapy; and engaged in goal setting with patients. Being able to address the patient's mental health needs, especially when others had not, was seen as working to full scope. The emphasis for RPNs was on the importance of talking and building rapport with the patient and others in the patient's life.

Fewer than 20% of the LPNs reported unequivocally that they were working to full scope. LPNs made reference to what they were allowed to do when explaining whether or not they felt well utilized. Some LPNs reported that they felt limited and frustrated, both by others who were resistant to their working to full scope and by unmet expectations related to what they were educated to do versus what they were in fact permitted to do: "… sometimes it's kind of frustrating, because you learn all these skills, but then you don't get to practise them" (LPN). Not being allowed to work to full scope was perceived as a lack of respect for LPNs by their colleagues.

Working to full scope was most often described as "just total care" (LPN), meaning basic care, vital signs, settling patients, paperwork and transfers. Some LPNs reported feeling more rewarded in their work when they were involved in decision-making with physicians or other team members and using higher-level skills for procedures such as inserting nasogastric tubes, changing dressings and monitoring IVs.

Overall, about half of the RNs reported that they were appropriately utilized. PCMs and nurses in specialized roles felt that RNs, RPNs and LPNs were not fully utilized and that system, unit and personal factors prevented nurses from having a more meaningful role. RPNs were seen to have more expertise and knowledge about human behaviour and therefore were considered more appropriate than

either RNs or LPNs for dealing with mental health issues. However, RNs were seen to have a strong "medical background" (PCM), and therefore both RNs and RPNs were needed in areas where patients had concurrent medical and psychological issues. It is important to note that a majority of PCMs and nurses in specialized roles felt that RNs were overly task focused and not working to their full capability.

### Role confusion

In nurses' description of scope of practice and in their perceptions of whether they worked to full scope, a strong theme was the considerable role confusion among the three groups of nurses, and between nurses and other healthcare professionals, who were interviewed for this study. Nurses' approach to describing their scope of practice was very similar across the three occupational nursing groups. Generally, RNs were perceived as having expertise in the medical aspects of nursing care and in conducting comprehensive health assessments, but they were viewed as lacking the depth of psycho-social skills possessed by RPNs. Both RNs and RPNs reported overlap with LPNs with respect to basic skills, and LPNs described blurred boundaries between their role and that of RNs. Overlap in scope of practice was most often described in terms of specific activities (i.e., psychomotor skills and patient assessments) that were shared: "We're doing the medications like they are … the only difference [is] that the RN does intravenouses" (LPN). The focus on task performance by many RNs appears to have narrowed the gap in perceived scopes of practice between LPNs and RNs. With the recent expansion in the LPN scope of practice, RNs question what that means to their role: "The LPNs moved to full scope of practice and we needed to move the RNs ahead at the same time. And that hasn't happened" (RN).

The lack of role differentiation and the focus on describing professional roles in terms of "technical" skill sets without acknowledgement of the differences in depth or breadth of knowledge resulted in some nurses devaluing their own contribution ("I have my degree in nursing. I feel I could be doing more. I feel that I'm doing essentially the same tasks as the LPN" [RN]) or the contribution of other colleagues ("the LPNs do a lot of the grunt work" [RPN]). Several RPNs spoke of the failure to recognize their unique knowledge base and expressed concern about their inability to practise in all healthcare settings: "An RN can walk into psych, no problem, but a psych nurse can't walk onto a medical unit, yet we do medical–surgical" (RPN).

A number of respondents also reported overlap in roles with other healthcare professionals: "I think there is overlap with social work; they deal with families in crisis. In my mind, that is very much our role" (RN). Many of the RPNs reported an overlap with social work, occupational therapy and recreational therapy, and saw these professions as having taken away some aspects of the RPN role (e.g.,

counselling and group therapy). Nurses suggested that role overlap with other healthcare providers was partially the result of nurses working 24/7 and needing to take on others' activities:

> … on evenings, they're not here, PT and OT, so we just continue where they left off; getting people up walking … we suction the same as respiratory … we overlap because we do some of the same things they do. (LPN)

In describing overlap with other providers, nurses offered little recognition of the differences that exist in the educational preparation, knowledge base and expertise of various professionals that account for differences in how they should be utilized. The focus was on task overlap, and it was therefore difficult to determine whether nurses or other professionals truly perceive that there is overlap in the depth, breadth or content of professional education, knowledge and skill among members of the interprofessional team. Differences in roles were certainly not clearly articulated by any of the respondents in this study.

## Discussion

Central to understanding the optimal utilization of the nursing workforce is acknowledgement that nursing care is not merely a collection of tasks but must consider the context of care (e.g., organizational supports, unit activity, workload, patient complexity), population health needs and the number, mix and knowledge base of providers available to meet those needs (Besner et al. 2005). In this research, as in much of the research focusing on advanced practice (Tolhurst et al. 2004), nursing tended to be described more often on the basis of "functional tasks" rather than "functional roles."

Consistent with research conducted in the United Kingdom (Perry et al. 2003; Cowman et al. 2001), this research revealed substantial role confusion and perceived role overlap within nursing and between nursing and other professional groups employed in acute care settings. Role ambiguity is a serious and costly phenomenon (Duffield et al. 1994) because it contributes to tension in the workplace and potentially results in underutilization of the workforce, a situation we can ill afford in light of current and future shortages of healthcare professionals.

It is not surprising that nurses (LPNs, RPNs, RNs) identified overlaps in the tasks and activities they perform, but it is disappointing that they experienced such difficulty in differentiating among their roles. While entry-to-practice requirements for LPNs, RPNs and RNs differ, there is but one

discipline of nursing; therefore, we should expect that the three occupational groups share a considerable amount of knowledge. Nonetheless, given differences in the length, content and approach to education among the three regulated nursing groups, there should be differences in the roles they are expected to perform when providing nursing care. Those differences were not clearly articulated by any of the participants in this study. If, in fact, differences in roles cannot be described, that raises the question of whether there should continue to be separate regulatory requirements and such distinct differences in educational approach across the three occupational nursing groups.

Baranek (2005) suggests that perceived overlap in roles leads to competition among providers, workplace tension, lack of trust among professionals, ineffective teamwork, diminishing professional identity and under- or overutilization of professionals. On the other hand, collaborative practice models are recognized as important elements of health system redesign and a potential solution to shortages in the healthcare workforce. Effective interprofessional practice requires the right mix of providers whose areas of expertise complement rather than duplicate others, as well as practice environments in which providers have a clear appreciation of one another's roles, competencies and capabilities (Spilsbury and Meyer 2001; Pearson 2003).

This research indicates that substantial work is required to clarify roles and responsibilities, improve understanding of the education, competencies and skill base of all health team members and provide increased opportunities for meaningful collaboration in healthcare delivery. In a rapidly changing healthcare environment, effective human resources planning depends on understanding and agreeing about not only who does what, but also who should perform certain functions and why.

## Conclusion

Clearly defining and articulating the role of nurses, and clarifying what is unique to nursing practice and what is shared with other healthcare professionals, pose significant challenges to the profession at this time. We must be able to describe nursing practice in terms of the knowledge and principles that underpin nurses' roles. If nurses are unable to explain the theoretical basis for their practice, they may find themselves unable to articulate what motivates their actions. It is difficult indeed to document accountability for one's practice without an explanatory framework within which to evaluate practice.

Nurses are experiencing pressure from a number of sources to clarify their scope of practice. Much of the pressure is coming from nurses themselves, who understand the importance of re-examining their roles in view of changes occurring in the healthcare system. Governments are also calling for a review and modification of existing scopes of practice in order to permit flexibility in staffing and optimize the use of existing professional resources (Scholes and Vaughan 2002). Nurse leaders, educators and practitioners must make greater effort to explicate the manner in which nursing "adds value" in the health system. They must collaborate in articulating the distinct and shared responsibilities of the three nursing occupational groups in order to improve role clarity and enhance quality of care. Continuing education of the current nursing workforce will be an important strategy towards clarifying the distinct roles of RNs, RPNs and LPNs in our evolving healthcare system. The time for action is now.

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