Nursing Workforce Utilization: An Examination of Facilitators and Barriers on Scope of Practice

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Abstract

Several reports have highlighted the need to address underutilization of health human resources, but barriers to and facilitators of role optimization for nurses are poorly understood. The purpose in this study was to understand the perceptions of

nurses – Licensed Practical Nurses (LPNs), Registered Nurses (RNs) and Registered Psychiatric Nurses (RPNs) – of the extent to which they can work to full scope of practice and identify barriers and facilitators in optimizing their roles. As part of a mixed-methods study, semi-structured interviews were conducted with 167 acute care nurses (RNs, LPNs, RPNs and nurse managers) in three western Canadian health regions. Approximately 48% of all nurses interviewed felt they were working to full scope, at least some of the time. Barriers to working to full scope included heavy workload, high patient acuity, lack of time, poor communication and ineffective teamwork. Identified facilitators were working as a team, management and leadership support and support for continuing education. Barriers need to be addressed in light of nursing shortages, as these are closely related to job satisfaction and directly affect the retention and recruitment of all groups of nurses. Policies and strategies based on these findings must be developed to ensure that nurses can work to their full scope of practice.

Introduction

Numerous reports have highlighted the need to address the underutilization of heath human resources (e.g., Romanow 2002). Ensuring that nurses and other healthcare providers are able to work to their full scope of practice is an important retention strategy that is crucial to resolving workforce shortages. Barriers to and facilitators of role optimization for nurses are poorly understood. Although the concepts "nursing scope of practice" and "role enactment" are widely used, the terms are often not clearly defined, despite the fact that understanding these concepts is essential to effective utilization of the workforce (Besner et al. 2005).

In this study, we made a distinction between nursing scopes of practice (predefined expectations of the role that all nurses are educated and legislated to perform at entry to practice) and role enactment (actual performance of tasks and activities associated with nurses' roles, as delimited by legislation, employer policies, experience, context of practice, competence, etc.). We employed a mixed-methods approach to understand the perceptions of nurses – Licensed Practical Nurses (LPNs), Registered Nurses (RNs) and Registered Psychiatric Nurses (RPNs) – of their scope of practice (i.e., their knowledge and skills) and to identify perceived barriers and facilitators in applying that knowledge optimally in their day-to-day work (i.e., role enactment). Nurses in acute care settings in three western Canadian health regions participated in the study. In this paper, we report on the facilitators and barriers described by nurses as having an impact on their ability to use the full extent of their knowledge, skills and capabilities (i.e., ability to work to their full scope of practice) in performing their work.

Research Questions

The primary purpose in this study was to elicit the perceptions of nurses (LPNs, RNs, and RPNs) of the extent to which they are able to work to full scope and to identify perceived barriers and facilitators in optimizing their roles. Research questions to be addressed in this paper included the following: (1) To what extent do nurses perceive themselves to be "working to scope"? (2) What are the personal, professional and organizational barriers and facilitators in maximizing scopes of practice? and (3) To what extent do contextual factors, such as patient complexity, provider characteristics, workload and organizational supports, appear to influence nurses' ability to work to full scope of practice?

Background

Scope of practice and role enactment

Within the nursing profession, significant questions are still asked about the scope of nursing practice (Baranek 2005; CNA 1993; Long et al. 2003). Despite considerable effort to clarify the definition of nursing scope of practice in the United Kingdom, lack of clarity among nurses continues (UKCC 2000). In Australia, Jones and Cheek (2003) attempted to gain better insight into the work of nurses. They found that a "typical" workday for nurses was impossible to describe. Nurses needed to be flexible and to adapt constantly to ongoing changes in providing nursing care. In one UK study exploring nurses' perceptions of expanding roles, several nurses described themselves as a "jack of all trades" (Edwards 1995). In another UK study (Perry et al. 2003: 500), registered general nurses (RGNs) in nursing homes commented that "RGNs do anything and everything" and thus find it difficult to define their actual role. The lack of ability to articulate a clear description of scope of practice is apparent. Nurses have difficulties in describing their scope of practice (Lillibridge et al. 2000) beyond providing a list of daily activities they perform (Thompson 1997).

The ability to work to full scope is defined through a variety of mechanisms, one being provincial and national legislation, which in turn is interpreted by regulatory bodies. At the regulatory level, policy papers, principles and standards all contribute to the definition and interpretation of scope of practice and facilitating or limiting scope of practice. Employers – through policy, among other means – can also have a significant impact on role enactment, influencing whether one is able to practise to full scope or a portion thereof (Baranek 2005). Competency and continuing competence also affect nurses' ability to work to full scope. Legally, healthcare professionals must show competence to practise in today's work environment (Basford and Orr 2005). Occupational standards must be merged with professional competency for nurses to attain total competence, which includes knowledge, skills, experience and the requirements of the employment setting, as well as the educational (basic and continuing education) content (Basford 2003).

A search of the literature revealed that there has been relatively little research on scope of practice as a general concept, and no prior research was found examining and contrasting the practice of RNs, LPNs and RPNs simultaneously. Research on scope of practice has largely involved RNs in specialty roles – e.g., oncology (Cleary 2002) – and nurse practitioners (Cummings et al. 2003).

Barriers and facilitators in practising to scope

Consistent with the general lack of research on scope of practice, there is limited information in the literature on barriers to and facilitators of nurses' ability to work to full scope of practice, although there is some discussion of factors that influence nurses' ability to carry out their practice. Barriers include organizational change, inadequate staffing, lack of time, poor communication, role ambiguity and lack of resources. A survey conducted in New York (Crosby et al. 2000) revealed that changes in healthcare delivery systems (e.g., downsizing), short staffing and lack of opportunities for learning had a moderately negative impact on nursing practice, as did lack of management support. Hedberg and Larsson (2004) found that time, or the lack of it, affected nurses' decision-making ability. Conflict, poor communication (Wieck et al. 2004) and lack of clarity in boundaries and roles among providers (Pearson 2003) also acted as barriers to the practice of nurses. Surveys conducted with nurses in the United Kingdom revealed that lack of resources, including training, prevented nurses from providing care in the manner they felt was most desirable. On the other hand, providing care in the desired manner was facilitated by effective teamwork and management support. Working as a team with other healthcare professionals assisted nurses in providing care for their patients (Jackson 2005; Masterson 2002; Pearson 2003; Wieck et al. 2004). Collaboration and the development of trust with other healthcare professionals were most beneficial to nursing practice (Crosby et al. 2000). Organizational and management support and lack of time constraints also enhanced nurses' practice (UKCC 2000).

Although the literature provides some information on barriers and facilitators in nursing practice, it is unclear whether these same factors are perceived by nurses as inhibiting their ability to work to their full scope and enact their role. In this paper, we provide a beginning understanding of perceived barriers and facilitators to working to full scope of nursing practice in the acute care setting and will compare these perceptions to nurses' ability to enact their roles as outlined in the literature.

Methodology

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. Quantitative data were collected for participants' demographics, workload and job satisfaction measures and corporate information. Both qualitative and quantitative approaches were used to provide a complete picture of the nursing scope of practice and role enactment, considering multiple perspectives (Johnson et al. 2007) and triangulation of data (Morse and Richards 2002). Only qualitative results are reported in this paper. Research protocols were reviewed and approved by the research ethics boards at the three participating sites.

Data were collected on 14 acute care units (medicine, surgery, intensive care, rehabilitation and psychiatry) in the three health regions, with variability in the mix of nursing providers (LPNs, RNs and RPNs) across units and sites. A total of 236 interviews were completed, with nurses involved in 167 of these interviews (RNs, 85; RPNs, 11; LPNs, 31; unit managers/other, 40). Although the number of RPNs recruited into this study was small, they were proportionately well represented, as were all three nursing groups that make up the total nursing workforce. Only a small number of RPNs are graduated, and only in western Canada; thus, they make up just a fraction of the nurses employed in these settings.

Face-to-face, semi-structured interviews were conducted with volunteer participants from each of the units. The Nursing Role Effectiveness Model (Irvine et al. 1998), whose components are structure (nursing experience, knowledge, skills, staff mix, nurse–patient ratios and patient characteristics), process (independent, interdependent and medical care–related roles) and outcomes (clinical, functional status, knowledge, satisfaction and costs), guided the interview process. Interview guides incorporated such questions as: What does it mean to practise according to the roles and responsibilities defined by your profession? Have you been able to use the full range of your education, knowledge and skills as a nurse? Why or why not? Are there factors that act as a barrier in allowing you to practise to the full extent of your skills and knowledge?

Data analysis was facilitated through N6™ computer software to manage the large volume of data collected through interviews. 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). Consistent with qualitative methods, several iterations of the themes evolved over time, with a final round of analysis conducted following the completion of all data collection and initial analyses. 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.

Results

Although this research drew primarily on qualitative data obtained from interviews, considerable quantitative data were also collected to describe the patient care units sampled. In this paper, we report only on qualitative findings related to barriers and facilitators in working to full scope of practice. In another paper (see page 44) we discuss other qualitative data obtained through interviews in this study.

The average age of nurse participants in the study was 42.1 years, with an average of 16.4 years of nursing experience. About 39% had a baccalaureate degree in nursing and 4% had a master's degree. Most participants (57%) had an RN or RPN diploma or LPN certificate. Just over half (59%) of those interviewed worked full time, 31% worked part time and 10% worked in temporary or casual positions. Over 90% of respondents were female.

Nurses in all three occupational groups had difficulty describing their scope of practice: "Don't know what scope of practice is. I guess I'm not really sure exactly what my roles and responsibilities are" (RN). Clearly, many nurses and other healthcare professionals understand "scope of practice" in terms of what they do in performing day-to-day work. None of the respondents appeared to differentiate between the meaning of "full scope of practice" (predefined expectations of the role determined by education and legislation) and "role enactment" (performance of tasks and activities delimited by legislation, policies, experience, competence and environmental contextual factors). Participants described their scope of practice as the tasks and activities they performed while delivering care: "As an LPN, I'm responsible for a lot of things – bedside care, assessments, patient care, ADLs, assessment for pain control and IVs and all that stuff" Approximately half of the RNs interviewed perceived that they were working to full scope. RPNs were most likely to report working to full scope, although many felt they were not fully utilized. Few LPNs perceived they were working to full scope.

Barriers

Participants across the three occupational groups discussed similar factors that negatively affected their ability to work to full scope. Key themes are presented below.

Workload, acuity and time

Heavy workload, high patient acuity and lack of time were commonly identified themes by all participants, although less so by RPNs. The high acuity levels created

heavy workloads, preventing nurses from providing the care they felt patients needed and that nurses wanted to give:

> I think sometimes you're overwhelmed, in which case it does cloud your judgment. And you just feel like you're running all the time and you never get caught up. (LPN)

> Patient load and whatever else will prevent you from doing things as thoroughly as you would like to or really feeling like you have completely grasped the whole situation with your six or 12 patients. (RN)

Staff shortages, and perceptions of inappropriate staff mix (e.g., replacing an RN with an LPN) or nurse-to-patient ratio, were perceived to increase workloads and to interfere with nurses' ability to work to full scope.

Lack of time was a major barrier to these nurses' ability to work to full scope of practice. They were concerned about not having enough time to perform the work required or to complete work to the level that was needed and desired:

> … at some point you would eventually use your full scope of responsibilities. Very rarely, because [of] maybe time frame or lack of time available. (RPN)

> It [lack of time] affects [our practice] because we can't do everything that the patient wants us to do. We just have to do priorities. (RN)

Lack of time prevented nurses from conducting in-depth assessments, creating concerns about the quality of care provided, as well as patient safety. When time was an issue, nurses were unlikely to attend to patients' psychosocial needs:

> … it's a shame with time constraints when we find we are just focusing on maybe the first two priorities, rather then maybe the 10 possibilities that we could be doing, as our role within our scope. (RN)

LPNs commented that expansion of their scope of practice over the last 10 years sometimes contributed to their inability to provide the care they felt was needed: "We still have the same workload, but we've added more onto it. There are definitely times when you can't do these extra things" (LPN). The lack of time prevented LPNs from fully enacting their roles and from maintaining competence in some of their more advanced skills.

Communication

Ineffective communication among providers was frequently reported by participants in this study. There were problems with communication on the unit among nurses, between managers and unit staff, with physicians and with other healthcare professionals. Of particular concern was the lack of communication among nursing staff from one shift to the next:

> A lot of the time it's so busy that you're filling in the basics and you're not getting to the details. (RN)

> … things aren't said that should be said. Sometimes information isn't passed on. (LPN)

All providers also identified written communication as being less than adequate, particularly the lack of comprehensive charting. Unfortunately, even when charting is adequate and complete, nurses said they had little or no time to read the chart, which further diminished the effectiveness of communication:

> I think time is a big thing. That sometimes you just feel really rushed. That at the end of the day you think, oh my gosh, I hope I did everything. And sometimes I tell them to call me if you find something I didn't do. Or chart on. Or the charting wasn't complete because you stopped to do something else. (RN)

Not working as a team

The inability to work as a team was described by RNs and RPNs as a barrier to full scope of practice. Concerns were expressed about the relationship between RNs and physicians. In particular, physicians' perceived lack of respect for assessment and input by nurses was felt to limit their capacity for contribution to patient care decisions: "… our input isn't valued and we're not being asked specifically what our opinion is or what our input is" (RN). Teamwork among nurses on the unit was also a concern. Negative attitudes about one another's capabilities and conflict among staff members were considered to limit nurses' ability to provide excellent care. Poor understanding of the roles of other healthcare professionals, role ambiguity within nursing and between nurses and other healthcare providers and "turf protection" were all identified as contributing to lack of collaboration among members of the team, limiting ability to work to full scope.

> … what gets in the way is what they believe is their role and what they believe they [should] be doing, and they're going to protect their job and they're going to protect their turf as we're going to protect ours. (RPN)

Facilitators

As was the case with barriers, participants described a large number of factors that enhanced their ability to enact their roles.

Working as a team

Working as a team was the facilitator most frequently cited by all three groups of nurses to enable them to work to full scope:

> The healthcare team is the biggest facilitator, although it's not perfect. But being able to delegate … and involve other people gives you more time to focus on your own skills. (RN)

Collaborative practice was described as teamwork within the nursing team, among members of the interdisciplinary team and between nurses and physicians. Nursing teamwork included collegial support, helping one another, providing guidance and consultation and sharing common goals:

> … we help each other. We really have a good team of nurses here. So if you need help or you're not sure about something, there is always someone you can go to. (RPN)

Being part of an interdisciplinary team was perceived to be essential to the care of these nurses' patients, and knowing other healthcare professionals was critical to building a good working relationship with them:

> … the trust factor that you build with … other healthcare providers. And when they realize your capability in performing tasks, they are comfortable in allowing you to do that. (RN)

Rounds and patient care conferences were seen as an important aspect of working effectively with other disciplines. While some nurses said they participated in conferences and rounds, others did not, although such participation was seen to be very important to provision of high-quality care. Nurses wanted to be seen as equal team members, be valued for their assessments and be able to contribute to care planning and decisions regarding patient care: "… working as a team member facilitates us all understanding the patient better" (RN).

RN participants commented that a well-functioning nurse–physician team was critical in helping them fulfill their role. Although the relationship between physicians and RNs was described as fairly good overall, many nurses commented that relationships between physicians and RNs were often difficult. Trust was perceived to be essential for good relationships between nurses and physicians, enhancing

nurses' perceptions of autonomy and, hence, positively influencing their ability to work to full scope. RNs wanted to be valued for their input and have their suggestions about patient care listened to: "Our chief doctor here … really values nursing and values the opinions that we have – and our skills … ." (RN)

Management and leadership support

RN and LPN participants commented on the importance of management and leadership support to facilitate working to full scope. A "good" manager possessed the following characteristics: knows the patients on the unit; is accessible and approachable; listens to the concerns of staff and has good communication skills. Managers need to be excellent mentors, teachers and a resource for staff:

> … if you've got good leadership … that filters down to your nurses to good patient care. … a manager who encourages you … doesn't say, well, this has to be done this way [but] encourages you to make independent and autonomous decisions. (RN)

Support for education/continuing competence

RN participants also noted that support for and access to educational activities, such as inservices, specialized training, workshops and certification, was an essential component of practising to full scope. Participants noted that up-to-date knowledge is necessary to provide the background and rationale for their work. Nurses want to be able to continually develop expertise in their areas of interest. Managers play a key role in supporting continuing education for staff, for example, by securing financial support for education:

> I think our manager is very supportive of education. She is trying to help people to further their knowledge base and skill expertise and still give good care. (RN)

The role of the nurse educator was also seen as a factor in facilitating RNs' ability to work to full scope, providing an excellent resource to fill gaps in knowledge and skills.

Discussion

This study was focused on nurses' perceptions of their ability to work to their full scope of practice. Lack of differentiation between nursing scopes of practice (expectations of practice based on education) and role enactment (actual practice) was noted. Evidence from the study indicated a gap between nurses' expectations of their role (working to full scope of practice) and what they

believed they were able to carry out (role enactment) (Besner et al. 2005).

The most common barriers cited by participants affecting their ability to work to full scope of practice were heavy workload, high acuity and lack of time, factors that are unfortunately a reality in today's work environment and are exacerbated by current staff shortages, which are predicted to worsen in the future. The findings from this research are not unlike those in prior studies of nursing practice (Crosby et al. 2000; Hedberg and Larsson 2004). Heavy workload, high acuity and lack of time also contribute to stress in the workplace, burnout and job dissatisfaction (Adams and Bond 2000; Collins et al. 2000) and are directly linked to patient safety. If nurses are unable to utilize all their knowledge and skills in caring for patients, there may be greater risk for potential errors to occur or for important information to be missed.

Not working as a team was also considered a barrier for nurses to be able to work to full scope of practice. Lack of collaboration was noted at all levels: nurses, physicians and other healthcare professionals. Unclear role definitions within nursing and between nurses and other professionals and turf protection resulted in conflict among team members. Participants in this study consistently reported that working as a team was the most important facilitator in being able to work to the full extent of their roles. Researchers have reported that working as an effective team has a significant impact on nursing practice (Jackson 2004; Masterson 2002; Pearson 2003), quality of care and patient safety (Wieck et al. 2004). Indeed, our study would suggest that role clarification and redesign of the work of healthcare professionals to enhance teamwork might well provide substantial opportunity to mitigate some of the workload pressures that inhibit these professionals from working to their full scope of practice. Job satisfaction is influenced by effective teamwork (Jackson 2004), integration among team members and feeling heard, listened to and valued (Collins et al. 2004). It is therefore highly likely that improving the quality of interprofessional relationships is an important retention strategy.

The importance of strong, supportive leadership (Crosby et al. 2000) by managers at all levels of the organization cannot be overstated as a factor in optimal utilization of the healthcare workforce. Strong leadership and organizational support can and must be applied to the development of policies and strategies that promote effective, collaborative practice and to enable all professionals to work to full scope of practice.

Continuing competence through the support of continuing and additional education opportunities was perceived as an important facilitator of role enactment, but only by RNs. Legislation and regulatory bodies affecting role enactment did not emerge as a theme in this study despite the importance placed on these components in the literature (Baranek 2005; Lahey and Currie 2005).

The findings of this study add to our understanding of factors that promote or inhibit enactment of professional roles for nurses and other healthcare providers. Although this research was limited to the acute care setting, discussion of the results with nurses and other professionals from various jurisdictions across Canada suggests that the findings represent a "current state" that potentially characterizes many healthcare settings. It would nonetheless be wise to conduct further research in non-urban settings, as well as in the community sector, to determine whether differences exist, as has been suggested by some informants. Given the current and predicted future shortage of nurses and other healthcare professionals, there is some urgency in addressing the full utilization of the healthcare workforce. There is no question that optimal enactment of professional roles is linked to the retention and recruitment of healthcare workers. Findings from this research indicate considerable task overlap and role ambiguity not only within nursing, but across other disciplines as well. The lack of clear understanding of differences in healthcare professional roles contributes to duplication of effort, underutilization of scarce human resources, tension in the workplace, less than ideal interprofessional relationships and potentially, the establishment of staff/provider mix models that may not always optimize quality of patient care or patient safety.

Canadian healthcare can ill afford to continue in this fashion. It is clear what needs to be done to improve the utilization of the healthcare workforce. It is time to move from talk to action: to introduce job redesign initiatives that begin to address these issues in nursing practice.

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