Expanding Nurses' Scope of Practice

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On April 9, 2009, the government of British Columbia announced that it was expanding the scope of practice of registered nurses, midwives and naturopathic physicians in the province. From now on, RNs will be able to "independently provide a broader range of health services including suturing, tuberculosis screening and managing labour in hospital when the primary care provider is absent. Registered nurses working triage will now be able to immediately order diagnostic ultrasounds and X-rays. Additionally, registered nurses will be able to dispense or administer prescription medications in urgent situations including severe allergic reaction, drug overdose, post-partum bleeding and for communicable disease prevention and management" (British Columbia 2009).

It is important to point out that it is RNs, not nurse practitioners, who will have these additional capacities. Let me begin by saying that I think the

expanded scope of practice is a good thing, but I recognize that there are a number of nurses whose opinions I respect who do not. Their position is that nurses are already fully engaged trying to fulfill the responsibilities that are currently within the scope of nursing. The shortage of nurses and the increased acuity of patients are stretching nursing human resources – so why add more tasks that have traditionally been the responsibility of physicians rather than concentrate our resources on doing what nurses must do as well as possible? It's a reasonable argument. On the other hand, responsibilities across health disciplines are constantly shifting. The example most commonly cited is the extension of blood pressure measurement to nurses' scope of practice back in the 1920s. A more recent example is the extension to practical nurses of responsibility for medication administration, which in Canada was previously completely within the purview of registered nurses.

I would rather see nurses' scope of practice expand than have their responsibilities expand under the mandate of standing physicians' orders. If nurses are going to assume responsibility for activities beyond their current scope of practice, then let nursing educators prepare them to do so, and to take full responsibility for these actions. However, the expansion of nurses' scope of practice has implications for practical nurses and, potentially, other healthcare providers. Expanding the scope of practice of any of the health disciplines makes no sense unless some elements of their responsibilities are added to the scope of other disciplines, and these other disciplines enact these expanded responsibilities. Otherwise, the situation is akin to continuing to blow up a balloon. At some point, the balloon must burst because it contains more air than it can accommodate.

The BC government's news release indicates that role expansion for midwives and naturopathic physicians applies only to those who have undertaken additional education and certification. Further, the ordering of diagnostic ultrasounds and radiographs will be assumed only by nurses who are working triage. It is not clear from the news release whether all nurses are expected to acquire the other competencies (suturing, TB screening, managing labour in hospital when a midwife or physician is not present, dispensing and administering identified prescription medications in urgent situations) as part of their basic skill set, or whether only nurses

with special preparation will be expected to attain them. I hope it is the former rather than the latter.

It is worth asking whether the additional competencies make sense for nurses to assume. The least acceptable rationale for adding any additional responsibilities to nurses' scope of practice is that physicians are too burdened. The best reason is that patients will have better care if one provider can manage a fuller range of activities required for a care episode. This approach should also reduce the waiting for both the nurse and the patient. It is worth recognizing that nurses have managed the responsibilities of suturing, TB screening and labour in numerous situations when a physician has not been available. Such situations usually arise in the middle of night in a small hospital, or involve a remote location. Nurses have acquired the competence through experience and mentoring from physician and nurse colleagues. The responsibilities for medication dispensing and administration make sense because they hold the potential for nurses to be able to intervene in emergencies to save patients' lives. However, it is these latter responsibilities that give me pause, not because I think nurses should not have them, but because we do not currently prepare nurses to assume them. My concern has been further aroused by two articles I read recently about how well acute care registered nurses performed in situations requiring decisions based on risk assessment under pressure of time.

The articles – by the same team of investigators, including British, Canadian and Dutch researchers – used the same sample of nurses undertaking two tasks related to clinical decision-making. The nurses were presented with 50 case studies with detailed clinical information based on real patients. A total of 245 nurses from acute care environments who came from Australia (50), Britain (95), Canada (50) and the Netherlands (50) participated. Their average age was 34, and they had an average of 11 years of experience, including almost nine years in their specialty area. Task one involved assessing whether the patients in the case studies were at risk for a critical event (Thompson et al. 2009). In the second exercise, nurses with only one year of experience were compared with those with three or more years of critical care experience in determining whether they would intervene by contacting a senior nurse or a physician. In 26 of the 50 cases, they were

put under time pressure, that is, they were given 10 seconds to make these decisions (Thompson et al. 2008). A clinical prediction rule, in this case the Modified Early Warning Score (MEWS), was used to determine in each scenario whether the patient was normal or not, and thus, whether intervention was warranted.

The nurses did not do particularly well. In the first scenario, despite the fact that they all received the same information, the nurses differed considerably in their risk assessments, and they tended to overestimate risk. While critical care experience was statistically associated with their estimates of risk, it was not associated with decisions to intervene. Interestingly, the nurses determined that intervention was necessary more frequently than the decision rule indicated (Thompson et al. 2009). While this finding may be acceptable from a risk reduction perspective, it has resource implications. In the second task, nurses with more critical care experience were significantly better able to identify the need to intervene than those with no experience or only one year; however, that difference disappeared when they had to make that decision under the pressure of time. In other words, time pressure negated the expected advantage of experience (Thompson et al. 2008). The authors point out that the nurses in their study did not use the linear reasoning necessary for making accurate risk assessments, nor did they use unique information in arriving at their judgments.

This study had a number of limitations. A relatively small sample of nurses was involved. The British nurses were randomly selected, but nurses from the other countries were self-selected. The nurses made their decisions in case studies of simulated, rather than actual, patients in live situations and thus lacked the benefit of context. The authors point out that the methodology they employed to determine the level of risk and whether intervention was needed – the MEWS – has limitations and may have overestimated the level of error. Nonetheless, I believe this was a well-conceived and well-executed study, the findings of which were published in highly respectable journals, i.e., *Nursing Research* and the *Journal of Clinical Nursing*. This work shines a needed light on an aspect of nursing about which we have little understanding: how nurses make clinical decisions.

The authors' conclusions pertain to nursing's current scope of practice and, certainly, to an expanded scope if it involves additional responsibilities to make critical patient decisions under the pressure of time:

> Nurses need to be taught the value of information, how to set appropriate decision-making criteria, and how to seek and use feedback on the success or failure of the application of their clinical judgment. ... Errors in judgment and decision-making by nurses, as with all healthcare professionals, are unavoidable and a direct consequence of the uncertainties of health and illness. Until nurses and society are trained for clinical *uncertainty* rather than *certainty*, then expectations on both sides will remain unrealistic. (Thompson et al. 2008: 309)

I think we are at or near that proverbial tipping point in preparing nurses to handle the clinical decision-making demanded by the increasingly challenging and high-pressured healthcare system. Fortunately, much research is underway (Banning 2008) to clarify how nurses reason and reach clinical decisions in both high- and low-risk situations, and how to apply this understanding in practice and education. Importantly, we have some 15 years of experience in educating nurse practitioners; we teach clinical reasoning differently in these programs than in undergraduate nursing education. NP programs have expertise that we can draw on. Additionally, advances in technology and measurement, and opportunities to use sophisticated simulated patients, are just a few of the factors that are driving the need and the ability to improve students' and practising nurses' adoption of a more systematic approach to clinical reasoning. Improvement will involve the application of decision-making rules to arrive at conclusions that more accurately convey patient status and the prescribed course of actions to keep patients as safe and well as possible. Nurses already make an enormous range of critical clinical decisions; as we expand nursing's scope of practice, more and different types of decisions will be involved. Let's be sure we are preparing nurses to do the most accurate risk assessments, and to reach the best decisions possible under the circumstances of clinical certainty and uncertainty.

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