

The advanced nurse practitioner role should be re-examined to ensure it advances nursing skills rather than plugging gaps created by a shortage of doctors

ADVANCED NURSING PRACTICE: PART 1 OF 2

Understanding advanced nursing practice

In this article...

- › Why we must debate the concept of advanced nursing practice
- › The history of advanced practice
- › Controversy of the development of the advanced nursing role

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Articles published in *Nursing Times* in 2012 presented the role of the advanced nurse practitioner as an extension into the territory of junior doctors in response to pressures in healthcare resources. This article traces the history of advanced practice and suggests that a more appropriate model, post Francis report, should focus on fundamental skills and core nursing values. Rather than attempting to plug a gap created by a shortage of doctors by developing medical skills, nurses should value and promote advanced nursing practice, which is driven by patients' needs for the care that doctors are unable and unskilled to provide.

In September 2012, the chief nursing officer for England introduced the "5Cs for nursing": compassion, competence, communication, courage and commitment. Care was later included as a sixth. The CNO said:

"I believe these five areas define nursing as a profession and, by focusing on these values, we can achieve our aims of improving care for our patients and strengthening the profession" (Cummings, 2012).

Several months later, the Francis (2013) report called for a structure of fundamental standards and improved support for caring,

compassionate and committed nursing. In light of these and subsequent events, it is time to reconsider the following:

- » How we think about, and define, nursing;
- » What we hold up as "best" or "advanced" practice;
- » How we might set about encouraging and preparing aspiring advanced nurse practitioners (ANPs) as the future leaders of our profession.

Shortly before the CNO announced her "new vision for nursing", *Nursing Times* published a series of articles discussing the development, governance and future of advanced nursing (Barton et al, 2012a; 2012b; 2012c), in which the authors argued that the development of the ANP role is important in "a health service facing severe threats, in terms of both resource restriction and dramatic changes in health demography" (Barton et al, 2012c).

Although the authors suggested the extension of the nurse's role into medical territory was necessary to plug the gap in junior doctors' hours, they overlooked a projected shortfall of nearly 50,000 nurses by 2016 (Lintern, 2012) – a gap that will probably be filled by healthcare assistants. As such, although promoting the ANP role could help the nursing profession take on some of the roles and duties of junior doctors, this might be at the expense of the core roles and duties of the nurse.

The title of ANP is one to which many nurses aspire, suggesting these practitioners are at the pinnacle and forefront of their profession. The question we have to ask is whether the current move to develop an ANP role that straddles the

5 key points

1 When the idea of advanced nursing practice was introduced in the UK, the consensus was that it focus on the core skills, values and attitudes of nursing

2 Currently advanced nursing practice is thought of in terms of medical skills, such as carrying out physical examinations or prescribing medicine

3 The Francis report and the chief nursing officer for England have called for a return to the core skills, values and attitudes of nursing

4 The advanced nursing practice role should not aim to compensate for a shortage in doctors

5 It is timely to think again about what nursing should be promoting as advanced practice

nurse–doctor interface is the most appropriate nursing innovation for this post-Francis age.

As we have seen over the past few years, the most severe threats to the health service, and to nursing in particular, are not concerned simply with resources or demography but with a serious and sustained crisis of confidence in nursing. With the call for a return to the core caring role of the nurse, coupled with the predicted shortage of hands-on “essential” nursing care, perhaps it is time for the nursing profession to reconsider the idea of “advanced” nursing, not in terms of extending nurses’ medical skills, but as a return to our core values and aspirations.

This article examines how our current ideas about advanced nursing practice originated, and discusses how we might have taken a different approach to professional development. To do this, it first revisits the history and development of advanced practice.

Advanced practice in the 21st century

Advanced nursing practice, as it has come to be understood is concerned predominantly with advancing the skills, knowledge and role of the nurse beyond the traditional professional boundaries. Most descriptions seek to identify the activities and roles that are taken on by advanced nurses, above and beyond the traditional scope of nursing practice. For example, the Nursing and Midwifery Council suggested a number of possible roles for ANPs; these are outlined in Box 1. There are several interesting observations to be made about the NMC’s description:

- » It takes the form of a self-contained list of tasks that an advanced practitioner is expected to be able to do;
- » The activities describe a generic role that could be performed by any of the professions related to medicine;
- » Although the NMC identifies these as advanced roles, there is no mention of the quality or level at which these additional activities are performed, beyond a basic assumption of competence.

One conclusion that might be drawn from reading the NMC’s list is that advanced nursing practice is neither advanced nor particularly concerned with nursing.

The origins of advanced nursing practice

Barton et al (2012a; 2012b; 2012c) provide an overview of the evolution of advanced nursing practice in terms of the history of



Better nursing skills, not new medical ones should be at the core of advanced practice

the development of a professional role, mostly in response to a combination of internal professionalising drivers and external political ones.

In the first of their articles (Barton et al, 2012a), the authors locate the earliest manifestations of the ANP role: the introduction of the nurse specialist in the US during the first half of the 20th century. However, they point out that these specialist practitioners only truly became advanced when the role moved beyond the traditionally understood domains of nursing practice, which they refer to as “professional boundary transgression”.

For Barton et al, as for many others, the advent of advanced nursing practice can be traced quite precisely to 1965 when a doctor, Henry Silver, and a nurse, Loretta Ford, introduced the “nurse practitioner” into a paediatric service. As Barton et al (2012a) pointed out, the rationale for this new role was partly a professionalising agenda for nursing, but mostly it was in response to “the need... from social issues of the time, such as shortage of paediatricians”.

This nurse practitioner role was brought to the UK by Barbara Stilwell in the 1980s and later developed into what Barton et al (2012a) described as a maturing and widely accepted concept of the ANP, shaped at least in part by the patient-protection agenda, which argued that advanced practitioners should be able to demonstrate certain “advanced” competencies.

There are several important points to note about this widely accepted view of advanced nursing practice:

- » Its defining and distinguishing feature and its claim to the title “advanced” is that it advances the role of the nurse into new and uncharted territory. As Barton et al (2012a) stated, the clinical

activities of specialist nurses “lie comfortably within the traditionally understood domains of nursing practice” but these nurses only become truly advanced when they extend their scope of practice into new (often medical) territory.

- » Advanced practice is usually described in relation to a list of skills, knowledge and competencies that are beyond those normally expected from a nursing role but which must be achieved before nurses can describe their practice as advanced.
- » The word “advanced” is not being used in this context as a description of a level of practice but rather of a field of practice. When the NMC described advanced practice in terms of a list of skills and competencies, it was clearly using the word “advanced” to describe an additional skillset rather than a higher level of existing nursing skills.

According to this use of the term, an ANP is one who moves beyond the boundaries of the profession. Advanced practice describes an attempt to push outwards as much as, or more than, pushing upwards, to develop competence in new skills rather than becoming more accomplished in existing ones.

As Barton et al (2012c) pointed out, the path to becoming an advanced practitioner can be seen in terms of ascending a “hierarchy of skill and expertise”, beginning as a novice ANP, progressing to competent and finally to expert. Indeed, the concept of a novice ANP only makes sense if advanced practice is regarded as distinct and separate from ordinary, or non-advanced, practice, and if it means starting from the beginning at something new, rather than advancing ordinary practice to a higher level.

Only by regarding the term “advanced” as a separate domain of practice is it possible, without any hint of contradiction, to progress from being an expert ordinary nurse to a novice advanced nurse. Consequently, although the idea of an ANP as pioneering new medical roles and extending into new domains is useful and important in the development of the profession, it might be somewhat confusing for patients and relatives.

It is perhaps inevitable that patients will assume an ANP will provide advanced or expert practice but, in reality, newly appointed ANPs may be no more than competent at the so-called “advanced” elements of their job; in addition, although the professional perspective on advanced nursing practice is of extending the scope

BOX 1. ADVANCED NURSING PRACTITIONER SKILLS

Advanced nurse practitioners are highly skilled nurses who can:

- Take a comprehensive patient history
- Carry out physical examinations
- Use their expert knowledge and clinical judgement to identify the potential diagnosis
- Refer patients for investigations
- Make a final diagnosis
- Decide on and carry out treatment
- Use their extensive practice experience to plan and provide skilled and competent care to meet patient's health and social care needs, involving other members of the healthcare team as appropriate
- Ensure the provision of continuity of care, including follow-up visits
- Assess and evaluate the effectiveness of the treatment and care
- Work independently
- Provide leadership
- Make sure each patient's treatment and care is based on best practice.

Source: Nursing and Midwifery Council (2006)

of practice into new and innovative roles, the patients' experience might simply be of someone different performing the same fairly routine and standard tasks. The term "advanced" is, therefore, practitioner-focused rather than patient-centred.

A brief history of advanced nursing practice

Although there is now a single generally agreed and accepted understanding of the term "advanced nursing practice" as extending the role of the nurse into medicine and other technical procedures, this has not always been the case.

Up until the early 1990s two very different ideas about the function, purpose, philosophy and future development of nursing existed side by side. Some writers and theorists advocated the extension of the nursing role into the domain of medicine, as exemplified by the emerging nurse-practitioner movement (Salvage, 1991); others focused on the expansion of nursing through holistic patient care and a focus on what makes nursing different from medicine (Hunt and Wainwright, 1994). Indeed, it was only when the United Kingdom Central Council for Nursing, Midwifery and Health Visiting first introduced the concept and terminology of advanced nursing practice in 1990 (UKCC, 1990) that the two sides each began to position themselves as the natural heirs to the title.

The Scope of Professional Practice (UKCC, 1992), published two years later, appeared to favour the holistic concept of the expanded role over the more medical extended role. Thus:

"The Council considers that the terms 'extended' or 'extending' roles which have

been associated with this system are no longer suitable since they limit, rather than extend, the parameters of practice. As a result, many practitioners have been prevented from fulfilling their potential for the benefit of patients. The Council also believes that a concentration on 'activities' can detract from the importance of holistic nursing care" (UKCC, 1992).

The triumph of the integrated holistic model over the attempt to extend nursing activities across the professional boundaries into the sphere of medicine appeared complete when George Castledine, one of the architects of *The Scope of Professional Practice*, stated:

"To attempt to persuade professionally educated nurses that they should take on medical tasks and function at a lower level in the field of medicine represents an unbelievable human and intellectual waste. What is more, it demonstrates an ignorance of nursing care and an effort to deny society knowledgeable nursing services.

"Expanding the scope of professional nursing practice means developing the scope of nursing care, not moving into medicine or any other field of technical care or manipulation of machinery. Medical knowledge - no matter how relevant to medical practice - is not a substitute for the nursing knowledge that is essential to nursing practice" (Castledine, 1994).

However, when the UKCC eventually formalised the definition of advanced nursing practice (UKCC, 1994), it described it simply as:

"... concerned with adjusting the boundaries for the development of future practice, pioneering and developing new roles [...]

and with advancing clinical practice, research and education to enrich professional practice as a whole" (UKCC, 1994).

Such was the vagueness of the language that it could be seen as applying equally to expanded or extended roles, and effectively reignited the contest to claim the title of advanced nursing practice. As Castledine was later to admit:

"I would probably be one of the first to point out that we 'fudged' the issue somewhat, and left nursing and midwifery to contemplate on the possibilities" (Castledine, 1998).

In retrospect, this "fudging" can be seen as a turning point in how the profession thought about advanced practice and the beginnings of a realisation by the UKCC that the demand for accreditation of ANPs required them to demonstrate something rather more tangible than adjusting boundaries, pioneering new roles and enriching professional practice as a whole.

As a result, in 1996 the UKCC conducted a national "listening exercise" to collate the profession's views on the way forward for advanced nursing practice. In reality, however, it appeared to have already decided the accreditation of advanced practitioners should be subject to achieving a set of "advanced competencies", and the role of the participants in the listening exercise was simply to identify from a pre-prepared list of competencies those that constituted "advanced" and those that did not. Many of the participants who had attended the exercise expecting to be listened to refused to cooperate, and the entire process fell apart. The interim report noted diplomatically that:

"There was a split regarding understanding of advanced practice... Broadly, the first group saw advanced practitioners within a doctor substitution model and thought therefore that advanced practice required a high-level knowledge base founded predominantly in the biological sciences, physical health assessment skills, [and which is] evidence based and supported by assertiveness and communication skills training... In the second group, the knowledge base suggested [advanced practice] was eclectic and more process oriented" (UKCC, 1996).

Consensus among the participants largely favoured the second view, and the interim report concluded that, "the nurse-practitioner model of doctor substitution either in acute or primary care was not felt to meet the criteria for advanced practice" (UKCC, 1996).

Despite the consensus that the idea of advanced nursing practice should be aligned to the holistic, expansive view of nursing, the final report failed to support this majority view. It concluded that:

“It was felt that there are neither agreed definitions of advanced practice nor criteria against which standards for advanced practice can be set. For these reasons, it was felt that the UKCC, whilst fully supporting the notion of advancing practice, should avoid setting explicit standards but should consider how specialist practice could embrace nurse practitioners and clinical nurse specialists” (UKCC, 1997).

The UKCC decided that, as advanced nursing practice could not be neatly summarised in a list of easily definable and measurable competencies, the prospect of accrediting and regulating it would be overly complex. It therefore abandoned the concept and turned its attention to practitioner and specialist models, which were far simpler to control and regulate.

History repeats itself

Eight years after the UKCC's inconclusive listening exercise, the NMC – which had replaced the UKCC – launched another consultation on the post-registration nursing framework (NMC, 2004) using a postal survey and an online questionnaire. The respondents were presented with a “consultation pack”, which set out the NMC's position, and were balloted on whether or not they agreed with it. As with the previous UKCC exercise, the NMC advocated a competency-based approach, this time comprising seven domains and 118 competencies. Participants were asked:

- » Whether or not they agreed with the NMC that a standard of proficiency should be set for a post-registration level of practice;
- » Whether it should be registered;
- » Whether it should be competency-based;
- » To what extent they agreed with proposed domains and competencies;
- » Whether the title for this level of practice should be “advanced nurse practitioner”, “specialist nurse practitioner” or “other”.

The questions all required a “yes”, “no”, “don't know” response and although some provided the opportunity for respondents who disagreed with the NMC's stated position to offer a brief explanation, there was no mechanism by which to vote for alternatives to the competencies approach.

After the consultation exercise, the

organisation that conducted it on the NMC's behalf warned of the limitations of a low response rate, a short time frame, evidence of block voting, lobbying from key stakeholders and multiple responses from individuals, concluding that:

“The consultation process is not an aggregation of an objectively derived cross-section of views, but gives those who care most about an issue a chance to speak up. Where a large group has a vested interest in the issue, they will clearly be represented (disproportionately to their less-interested colleagues) in the response” (Ball, 2005).

Despite this warning the NMC accepted the findings and subsequently announced the level of practice should be called advanced nursing practice and that this level of practice should be registered.

In accordance with the NMC's position, the UK government white paper, *Trust, Assurance and Safety*, advocated that:

“common standards and systems should be developed... This will encompass the development of standards for higher levels of practice, particularly for advanced practice” (Department of Health, 2007).

This was followed three years later by a prime minister's commission that called for regulation and registration of advanced practitioners in England based on achieving competencies (Prime Minister's Commission on the Future of Nursing and Midwifery in England, 2010). However, there followed a change of government in the UK, and the new administration responded to the commission with the view that additional statutory regulation was not required, arguing that “much of what is often called ‘advanced practice’ does not make additional statutory regulation necessary” (DH, 2011a) and that “a compelling case for further regulatory action has yet to be made” (DH, 2011b).

Conclusion

After nearly 25 years, we seem no further forward in terms of a national consensus on the nature, focus and regulation of advanced nursing practice, which is tied for political and professional reasons to the ANP role; that is to say, to issues of career frameworks, service design, regulation, accreditation, governance, resources and job titles. The current hiatus offers the nursing profession an ideal opportunity to rethink and re-imagine the concept of advanced practice for this century, focusing on core nursing skills and values rather than extending into a medical role. **NT**

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