

All nurses should re-examine the concept of advanced and advancing practice and help to determine the future of their practice and profession

ADVANCED NURSING PRACTICE: PART 2 OF 2

A new vision for advanced nursing practice

In this article...

- › Advanced practice compared with advanced practitioners
- › The concept of practice innovation units
- › Shifting the emphasis from individual to team practice

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Part one of this series suggests that the post-Francis era requires a perspective on advanced nursing practice that emphasises, celebrates and rewards the development of core nursing skills, values and attitudes rather than extending the role of the nurse into medical territory.

This article offers some thoughts and ideas that attempt to move the focus away from the notion of advanced practice as the development of a particular role towards the idea of advancing practice as a team of like-minded professionals working together in practice innovation units for the benefit and wellbeing of patients.

Part one of this series (Rolfe, 2014), traced the history of advanced nursing practice from the 1965 introduction of the nurse practitioner in the US, through its introduction into the UK in the 1980s and the debate about extended and expanded roles in the 1990s, to the competency-driven, role-based model currently favoured by most professional organisations.

We must bear in mind that history is written by the victors; it is never impartial. It is also, by definition, composed in retrospect. For example, Silver and Ford's (1965) medicalisation of the nursing role in the 1960s, when they introduced the nurse

practitioner to a paediatric service in the US, is only regarded as a significant moment in the history of the advanced nurse practitioner in light of the current conception of advanced practice. Had the role developed in a different direction, its history might be told differently, with different heroes and different significant moments. As discussed in part 1, advanced nursing practice very nearly did develop in a quite different direction (Rolfe, 2014).

An alternative history

An alternative history of advanced nursing practice might locate its origin not in the emergence of specialist nursing in the US during the 1930s and 1940s but in 1952 with Hildegard Peplau's book *Interpersonal Relations in Nursing* (Peplau, 1952).

It might identify the birth of advanced nursing practice not in the medical extension of the nursing role by Silver and Ford but with Lydia Hall's seminal paper *Nursing: What Is It?* and her introduction of nursing beds at the Loeb Center for Nursing and Rehabilitation in New York (Hall, 1964). It might also identify the origins of the introduction of the role into the UK not in Barbara Stilwell's nurse practitioners but in Alan Pearson's nursing development unit at Burford in 1981 and his subsequent clinical nursing unit in Oxford, and with Stephen Wright's nursing development unit at Tameside (Wright, 1990; Pearson, 1983).

The authorised account is a history of the development of the role of the nurse, whereas the alternative story is of a history of the development of nursing or, perhaps, of the development of a particular philosophy and vision for nursing.

5 key points

1 After the Francis report, the concept of advanced nursing practice needs to be reconsidered

2 This should be considered in terms of core nursing values rather than medical and technical skills

3 Advancing nursing practice is best done by a team of practitioners, educationalists researchers and managers

4 Nursing practice can be advanced in practice innovation units

5 Practice innovation units encourage therapeutic nursing



Advancing practice depends less on what nurses do than on how that they do it

While the authorised account focuses on the role and career development of individuals, the alternative is concerned with the development of teams, clinics and units. The authorised account focuses primarily on a role that was initiated by doctors and driven by shortages; the alternative has its origins in a nurse-led unit as a means of addressing patient needs for nursing care that doctors are unskilled and unqualified to meet. The authorised account can be described as the history of a push outwards by the profession into new territory; the alternative turns the focus inwards to the core attitudes, values, knowledge and skills that are fundamental to nursing.

Advanced practitioners and advancing practice

As discussed in part 1 (Rolfe, 2014), the United Kingdom Central Council for Nursing, Midwifery and Health Visiting initially favoured the expanded model aimed at strengthening the core values and practices of nursing as most deserving of the accolade “advanced”.

However, it later attempted to steer opinion towards a more extended medical role, underpinned by “advanced competencies”, despite earlier misgivings that such a move “demonstrates an ignorance of nursing care and an effort to deny society knowledgeable nursing services” (Castledine, 1998). In defence of this U-turn, it must be pointed out that the UKCC found itself with two separate and not necessarily compatible aims: to promote the profession of nursing; and to safeguard the public. The move towards competencies can be interpreted as a shift in emphasis from the former to the latter.

The UKCC turned its attention away from the nebulous concept of advanced practice towards nurse practitioners and clinical nurse specialists and, when the Nursing and Midwifery Council reignited the debate on advanced nursing practice several years later, it referred to these roles. Although the Royal College of Nursing and other professional and academic organisations pointed out that the UK and international literature defines “advanced” as a level of practice rather than a role or a job title, the NMC continued to insist that:

“Advanced nursing practice is an umbrella term, which is used to describe a number of specialist roles including clinical nurse specialist and nurse practitioner” (NMC, 2010).

Unfortunately, this confusion between roles and levels is widespread. For example, the Framework for Advanced

Nursing, Midwifery and Allied Health Professional Practice in Wales states both that: *“Advanced practice should be viewed as a ‘level of practice’ rather than a specific role”* and that: *“Within Wales, advanced practice is to be defined as a role...”* (National Leadership and Innovation Agency for Healthcare, 2010).

Until we completely disentangle the ANP role from the concept and possibilities of advanced nursing practice, we will continue to go round in ever-decreasing circles, driven by political issues of regulation, cost-cutting and role boundaries.

As Dickon Weir-Hughes, the former chief executive and registrar of the NMC, pointed out:

“We [the NMC] don’t exist to serve nurses and midwives.... We’re here for patients and patient safety so in terms of our mission, whether nurses like us or not is more or less irrelevant” (Santry, 2010).

However, if it is the NMC’s position that it does not exist to serve nurses, then its role in steering the professional agenda of nursing is similarly “more or less irrelevant”; its primary function in relation to the nursing profession is regulatory. Now that the NMC has been forced to back away, perhaps indefinitely, from the issue of regulation and registration of advanced practice, the nursing profession has an opportunity to apply some creative thinking to the subject, free from the constraints of the NMC’s agenda. At the very least, it is important that the NMC’s remit for control, constraint and regulation is counter-balanced by a creative, free-thinking, practice-oriented alternative.

As well as refocusing on the ideas and concepts of practice rather than on the role and competencies of the practitioner, it might be fruitful to turn our thinking away from the idea of advanced practice as an objective that can be defined, benchmarked and measured and, instead, think about advancing practice – moving forward and making progress; we should think about it as a process rather than an outcome, a journey rather than a destination.

Once we free our thinking from the concept of advanced nursing practice as a competency-based role, job title or higher level of registration, it becomes easier to imagine the idea of “advancing nursing practice” as a team effort that does not depend on identified individuals. In other words, it might be productive to think of advanced/advancing nursing practice not in terms of individual role development,

nor even of professional development, but as an approach to practice development.

Rethinking advanced nursing practice

Einstein is reported to have said that imagination is more important than knowledge. Let us, then, imagine advanced (or perhaps advancing) nursing practice as it might have been and as it might yet become.

Hildegard Peplau’s (1952) simple but profound idea was that nursing is, in essence, the relationship between the nurse and the patient. Each party contributes to and participates in that relationship and, most importantly, the relationship itself is or has the potential to be therapeutic in and of itself.

The advancement of nursing practice is therefore founded first and foremost in the development of the person of the nurse and nurses’ ability to build relationships with each of their patients and work together to solve patients’ problems. Advancing nursing practice does not depend on:

- » Developing new technical or specialist skills (although these might be important in certain areas of practice);
- » Achieving and demonstrating competencies (although, again, these might be relevant in some settings);
- » Job titles, roles and registration.

Advancing practice depends less on what nurses do than on how that they do it. For example, the technical procedure of carrying out a physical examination can be performed by a nurse or by a doctor, it can be performed well or poorly by either and it can be performed at a novice, competent or expert level. Although it might be tempting to describe a nurse who achieves a prescribed level of competence in this task as an ANP, we might be reluctant to describe a competent doctor performing the same task as an advanced doctor. Indeed, if we look again at the list of tasks set out by the NMC (Rolfe, 2014), what is expected of an ANP also describes more or less the role of a relatively junior medical practitioner.

From Peplau’s perspective, the defining criterion of advanced nursing practice for a nurse who competently carries out a physical examination is whether the technical procedure is undertaken within a therapeutic nursing relationship; this is the added value the nurse brings to the procedure and what distinguishes nursing practice from medical practice. Of course, the technical procedure must be performed to the desired level of competence to ensure patient safety, but that merely defines the baseline level of practice; above and beyond technical competence, the examination

must be carried out therapeutically – “therapeutically” refers to everything that happens in conjunction with the technical procedure. By the same token, advanced nursing practice may be demonstrated in core nursing activities such as giving a bed bath or even serving meals, activities now thought of merely as tasks and often allocated to unregistered staff.

It could be argued that building a therapeutic relationship is itself a competence similar to carrying out a physical examination, and it is true the NMC proposed an entire domain – the nurse-patient relationship – which included competencies such as “creates a relationship with patients that acknowledges their strengths and knowledge” and “communicates a sense of ‘being there’ for the patient, carers and families” (NMC, 2005). However, it is difficult to imagine how we might measure and accredit a nurse’s ability to communicate a sense of “being there”, or even what a competent level of “being there” might look like. The simple fact of the matter is that what counts and what can be counted are often quite separate matters and, if we attempt to reduce what counts to something measurable, we tend to lose it in the process.

If we reimagine advanced/advancing nursing in terms of the values, attitudes and knowledge with which nurses go about the core activities of nursing, we can see that advanced practice is not determined by the grades and job descriptions of individual nurses nor by the specialisms or nature of their clinical areas. It is, however, dependent to some extent on how care provision is organised in their workplace, their ward’s philosophy of nursing and the values and attitudes of their colleagues. Nursing can best be advanced in places where:

- » Values and philosophies are oriented specifically to the development of practice;
- » Therapeutic nursing is encouraged and expected;
- » Patient-centred care is the norm;
- » Nurses have a primary responsibility and a level of autonomy conducive to exercising those values, philosophies and practices.

There was a flurry of activity during the 1980s and 1990s, which centred on clinical nursing units, nursing development units, nursing beds, primary nursing, therapeutic nursing, key working and team working. With only one or two exceptions, the focus of attempts to advance practice in this way was on systems, organisations, theories and philosophies, rather than roles and job titles. Nursing development units were based on the assumption that therapeutic

nursing was the province and responsibility of all nurses, and the most important consideration was to develop attitudes, structures and working practices conducive to the advancement of the core values and practices of nursing.

Practice innovation units

I have argued the case for looking at the idea of advanced nursing practice differently, for returning to an earlier concept that emphasises the process of advancing practice rather than the role and activities of the advanced practitioner.

With the UK government withdrawing its support for the idea of a centralised system of regulation, accreditation and protected status for the “advanced nurse practitioner” title, nursing appears to have run itself yet again up a blind alley. Let us pause and think, then, about what it might mean to turn away from roles, competencies, job titles, courses, accreditation and frameworks for advanced practitioners and think instead about the structures, support mechanisms, philosophies and values that need to be put in place to advance practice at a ward, unit or hospital level.

I refer to places where practice is advanced in this way as practice innovation units. I have chosen this title because it does not use the words “advanced” or “advancing”, which carry a great deal of conceptual baggage. I have avoided the more common terms – nursing development unit and practice development unit – because, as with “advanced practice”, they are most often associated with one approach and philosophy. I am not claiming that PIUs are the only places where practice is advanced, nor am I claiming that individual practitioners do not advance practice in isolation; I am using PIUs simply as an example of an approach to advancing practice that I have witnessed and that I know to be effective (Gardner et al, 2013).

PIUs can take many forms and be found in a wide variety of locations, including community nurse and health visitor teams. The word “unit” refers not to a place but to a group or a team of practitioners united by a common goal, vision or philosophy. The goal of PIUs, however it is expressed, has at its roots the desire to:

- » Make a positive difference to care;
- » Disseminate the processes that led to that improvement, where possible.

PIUs are not concerned with achieving normative standards or with prescriptive levels of excellence; they are inclusive rather than elitist. They have no agenda to be “the best”, only to be better than they are – that is, to move forward or advance their

practice. For example, I am working with a PIU in a mental health setting that had been the subject of a critical government report. All the staff are committed to improving care in small ways that nevertheless make big differences to patients’ quality of life.

Although the concept of advanced practice in a PIU is different from the usual idea of a role or level of individual practice, the two approaches share similarities. From the outset, concepts and definitions of advanced nursing practice have attempted to incorporate:

- » Clinical practice;
- » Research;
- » Education;
- » Leadership.

These components can be seen in most descriptions of advanced practice from the earliest definition by the UKCC through to the four pillars of the advanced practice toolkit (Scottish Government, 2008). However, while these four components are usually considered separately (that is, as four individual pillars holding up the edifice of advanced nursing practice), the PIU attempts to integrate them fully into a single idea of advancing practice by doing, thinking, learning, evaluating and leading.

In the PIU, this vision of advancing practice is best achieved by a team of professionals working together towards a common goal of innovating, developing and advancing nursing care and treatment. These professionals would include:

- » Nurse clinicians;
- » Educationalists;
- » Academics;
- » Researchers;
- » Managers.

Nurse educationalists, nurse academics, nurse researchers and nurse managers are, first and foremost, all nurses who have chosen education, scholarship, research and management as their specialisms. When nurse educationalists become involved in advanced/advancing practice in PIUs, they do so not as instructors, trainers, assessors or examiners but as teachers and learners alongside the other members of the PIU. When nurse researchers become involved, it is not with the intention of data mining or using the clinical areas as their personal research laboratory, complete with a ready supply of resident research assistants and subjects, but as partners in a critical examination and evaluation of the processes and outcomes of the PIU. When managers become involved, it is not with the intention of leading or taking control of the unit, but of ensuring the structures, resources and philosophies of care are in place to enable the team as a whole to



“I am absolutely a supporter of degree level preparation for nurses”

Jessica Corner ▶ p27

advance their practice. PIUs are patient-focused and practitioner-led.

The concepts of the ANP and the PUI are similar in that each has as its ultimate goals the improvement of care and the development of the nursing profession. However, we have seen they pursue these goals in different ways. In particular, many PIUs are made up of practitioners from across all the health disciplines, including medicine. They also often include healthcare assistants and other professionally unqualified practitioners, such as physiotherapy assistants, as part of the multidisciplinary team. While the aim of the ANP is, to some extent, to replace other professionals by performing tasks and demonstrating competencies beyond their traditional professional boundaries, nurses in PIUs develop their profession by focusing on the core elements of nursing and caring. There might well be a blurring of roles within the multidisciplinary PIU, but the ethos is based firmly on a team approach in which all members contribute according to their professional background and expertise.

Conclusion

The development of advanced practice in the UK since the introduction of the term

in 1990 has been driven and steered predominantly by our professional regulatory body. My argument is that the UKCC and NMC have been both the greatest catalysts for the idea of advanced practice and the greatest impediment to its realisation.

Two recent and significant developments have reignited the debate:

- » In the light of a number of recent care failures, the NMC has declared its primary mission is patient protection to the extent that, in the words of one of its former chief executives, it does not exist to serve nurses and midwives and what nurses think of it is irrelevant;
- » The UK government has stated the title and role of ANP will not be centrally regulated, accredited or protected.

Taken together, these two factors suggest the NMC now has only a marginal role to play in the debate. They should be seen as an invitation to all nurses to take a second look at the advanced and advancing practice concept and to play a more creative and influential role in determining the future of their own practice and profession. **NT**

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