Literature Review

Introduction

The *Institute of Medicine of the National Academies* (2011) reports that the nursing workforce can effect wide reaching change, and can function to bridge the gap between coverage and access. As well, the *Commission on the Reform of Ontario's Public Services* (2012) advocates that physician role functions that also fall within nursing scope of practice should be performed by nurses, in order to enhance nurses' roles and to control public expenditures. A search of the literature has identified the need and importance of nurses working to their full scope of practice. With health care professional shortages, recruitment and retention issues, and waning job satisfaction, now is the time to shift the focus to maximizing nurses' full scope of practice[i].

Underutilisation of nursing skills and knowledge may result in compromised quality of care[ii]. Therefore, it is vital that nurses strive to practise to full scope, and efforts to minimize practice barriers should be addressed[iii]. Research has revealed the benefits of a maximized scope of practice for nurses, however, several studies have found that nurses are still underutilized in the healthcare system[iv]. Allard et al. (2010) found that 61% of RNs surveyed felt they were working to full scope, and it has been noted that researchers, providers, and managers feel that now is the time for change[v]. A Cochrane review found that nurses with the appropriate education can provide the same high quality care as primary care physicians and produce the same patient outcomes[vi]. In addition to nurses, the public also appears ready for such a change[vii]. Their readiness may be due to the level of trust placed in nurses and their acceptance of nurses providing routine care[viii]. It is important to note that maximizing the scope of the nursing role serves to complement, rather than replace the roles of other health professionals[ix].

Method

This review focused on identifying relevant articles and papers related to maximizing nurses' full scope of practice in primary care settings. The search strategy involved the use of four electronic databases (CINAHL, Medline, PubMed, and Google Scholar) using key terms such as "nurse", "scope", "practice", "RN", "RPN", "maximize", "primary care", and "full scope". This search was supplemented through the hand searching of relevant articles, advisory team and research expert colleague recommendations, citation searching, and footnote chasing. This literature search, although thorough, cannot be considered systematic.

Literature gaps

In order to maximise full scope of practice utilisation, it is important to understand what full scope of practice is, why it is important, and what are the potential barriers and facilitators to the process[x]. The literature review revealed that there were critical gaps identified in the literature. Specifically, the conceptual understanding of scope of practice and the factors influencing it were noted. The majority of the literature focused on the roles of advanced practice nurses such as clinical nurse specialists and nurse practitioners, as well as acute care nurses practicing in the hospital setting. Consistent with the findings of others[xi], there was limited literature focused on the roles of registered nurses (RN) and registered practical nurses (RPN) practising in primary care settings. Thus, in order to enhance the

understanding about the factors influencing full scope of practice, this literature will be consulted. It is important to consider that the generalizability of study findings from this literature review may be limited; thus, application of findings to the primary care setting should be made with a lens of caution.

The literature related to the conceptual understanding of scope of practice is more descriptive in nature, and focuses on role functions, nurses' abilities to perform delegated tasks, or issues regarding role overlap[xii]. There is both a lack of definition in scope of practice terminology, as well as a lack of consistency[xiii]. White et al. (2008) distinguish between scope of practice, which is understood as the expectations of the nursing role that nurses are educated and legislated to perform, and role enactment, which is the performance of tasks associated with that role. There is also a gap in the literature with respect to the barriers and enablers to maximizing nurses' full scope[xiv] and limited emphasis on how these factors affect full scope of practice maximisation from the perspective of health care professionals themselves working in primary care[xv].

Outcomes

The potential positive outcomes of full scope of practice utilization for primary care nurses extend to patients, employers, health professional teams (including nurses) and the health care system as a whole[xvi]. Overall, maximising nursing full scope of practice utilisation addresses current and predicted nursing and healthcare professional shortages (Oelke et al., 2008), increases role satisfaction (Jowett et al., 2001), and may improve health-care cost-effectiveness[xvii]. Full scope of practice utilisation supports continuity of care, and results in expanded service provision, and therefore increases access for patients (Pringle, 2009). Patients have also reported increased satisfaction with care, and feeling better equipped to cope with their illnesses (Besner et al., 2011). Just as job satisfaction decreases as scope of practice is limited, working to fuller scope of practice results in significantly higher level of satisfaction and autonomy ($p<0.005$), with comprehensive patient care being the primary determinant[xviii].

Barriers and enablers

There were several factors identified in the literature that may impact the maximization of nurses' full scope of practice. Some of the key barriers included staff not feeling ready or willing to maximize their scope of practice[xix], a perceived lack of time, heavy patient workloads, staff shortages, inappropriate nurse to patient ratio, and high patient acuity[xx]. In addition, nurses are regularly involved in performing administrative or secretarial tasks, such as booking appointments and preparing clinic exam rooms, which should be delegated to non-nursing personnel[xxi]. Lack of time was also noted to result in safety and quality of care concerns[xxii]. Ineffective communication and teamwork was found to lead to workplace tension, which was underpinned by a lack of understanding of each other's competencies, skills, and roles[xxiii]. In addition, a lack of public awareness[xxiv], the local context and patient population of the practice[xxv], and a lack of clarity in role boundaries[xxvi] can act as barriers. Role ambiguity creates tension among providers, a lack of professional identity, stress, unproductive behaviour and ineffective communication. Role ambiguity should be addressed through a focus on developing role clarity and a mutual understanding of roles[xxvii]. Akeroyd et al., (2009) found that RNs in family practice were unsure of what their scope of practice actually consisted of. While some nurses felt that they were currently practicing at too narrow an aspect of scope of practice, other nurses felt that they were practicing too broadly. Donald et al (2005) found that a lack of professional awareness leads to ambiguous

expectations, turf protection, and concern about whether members are practising outside their scope of practice. There may also be worry that as nurses expand their scope of practice and role functions, in the case of an accident, liability will fall to the employer or physician[xxviii].

In addition to identifying factors that were perceived to act as barriers, factors perceived to act as enablers were also identified. These enablers included team work, collaborative practice, leadership, a non-hierarchical workplace, sharing common goals, orientation for new hires, having managerial and educational support (attending conferences was seen as beneficial), and role clarification. [xxix] . Staff who felt valued and who trusted and respected each other were more likely to be accepting of the idea of full scope of practice maximisation and more likely to practice interprofessional collaboration[xxx].

From this literature, and in consultation with experts in primary care, a list of 12 barrier and enabler categories were developed that were included on the RNAO/RPNAO Primary Care Toolkit survey administered to primary care employers and teams in Ontario (see below). The findings from the survey results confirmed that the following factors were perceived as relevant in the maximization of nurses' full scope of practice.

1. Staff readiness
2. Time available
3. Resources for education and mentoring
4. Organizational culture
5. Understanding rationale for full scope
6. Funding models
7. Team trust
8. Role clarity
9. Change management
10. Team communication
11. Liability considerations
12. Patient population

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[i] Baranek, 2005; Besner et al., 2005; 2011; Commission on the Reform of Ontario's Public Services; Fairman et al., 2011; Improving Access in Primary Care Working Group, 2011; Institute of Medicine of the National Academies, 2011; Romanow, 2002; White et al., 2008

[ii] Jowett, Peters, Reynolds & Wilson-Barnett, 2001; White et al., 2009

[iii] Baranek, 2005; Besner et al., 2005; 2011; Commission on the Reform of Ontario's Public Services, 2012; Fairman et al., 2011; Improving Access in Primary Care Working Group, 2011; Institute of Medicine of the National Academies, 2011; Romanow, 2002; White et al., 2008

[iv] Canadian Union of Public Employees, 2003; Saskatchewan Association of Licensed Practical Nurses, 2010; White et al., 2009;

[v] Allard et al., 2010; Jowett et al., 2001; Laurant et al., 2009

[vi] Laurant et al., 2009

[vii] Allard et al., 2010; Romanow, 2002

[viii] Laurant et al., 2009

[ix] The College of Family Physicians of Canada, 2009; Pringle, 2009

[x] White et al., 2008

[xi] Allard et al., 2010; White et al., 2008
[xii] Ackeroyd et al., 2009; Allard et al., 2010; Oelke et al., 2008; Tiedeman & Lookinland, 2004; White et al., 2008
[xiii] Baranek, 2005; Besner et al., 2005
[xiv] Oelke et al., 2008
[xv] White et al, 2008
[xvi] Allard et al., 2010, Besner et al., 2011; Oelke et al., 2008; Rashid et al., 2010; RNAO, 2012; White et al., 2008
[xvii] Jowett et al., 2001; Laurant et al., 2009; RNAO, 2012
[xviii] Allard et al, 2010; Rashid et al 2010
[xix] Besner, 2006; White et al, 2008
[xx] Besner et al., 2005; Kilpatrick et al., 2012; Oelke et al., 2008
[xxi] Allard et al., 2010; Mueller et al., 2012
[xxii] Oelke et al., 2008
[xxiii] Donald et al., 2005; White et al., 2008
[xxiv] DiCenso et al., 2003; 2007; Donald et al., 2005
[xxv] Kilpatrick et al 2012
[xxvi] Pearson, 2003
[xxvii] Akeroyd et al., 2009; Besner et al., 2011; Donald et al., 2005; LLyod Jones 2005
[xxviii] Cashin et al., 2009
[xxix] Besner et al., 2005; Canadian Union of Public Employees, 2003; Donald et al., 2005; Oelke et al., 2008
[xxx] Akeroyd et al., 2009; Besner 2005; Donald et al., 2005; Oelke et al., 2008; Pearson 2003, White et al., 2008; Wieck et al., 2004