

ENROLLED NURSE SKILL EXTENSION: METROPOLITAN MYTH OR RURAL REALITY?

Nicole Blay, RN, BHA, Senior Nurse Manager, Acute Care Nursing Professorial Unit, St. George Hospital, Sydney, Australia.

blayn@sesiahs.health.nsw.gov.au

Judith Donoghue, RN, PhD, Professor of Acute Care Nursing, St. George Hospital and Faculty of Nursing, Midwifery and Health, University of Technology, Sydney, Australia.

Accepted for publication August 2006

Key words: advanced practice, enrolled nursing, legal authorisation, surgical nursing

ABSTRACT

Objective:

The objective of this study was to examine whether the position of 'after hours clinical support enrolled nurse' is embracing clinical skill extension in the acute surgical area.

Design:

Experienced enrolled nurses employed in a supernumerary capacity documented all activities with which they were engaged over a six-month period.

Setting:

Six surgical wards within a tertiary referral hospital, Sydney, Australia.

Subjects:

Enrolled nurses working after hours in an extended support role in a supernumerary capacity.

Results:

Data demonstrated that, in this study, the 'after hours clinical support enrolled nurse' was primarily performing routine nursing activities. Although the number of extended skills (n=13) performed could be considered diverse for an enrolled nurse, many were seldom performed. The most frequently performed extended skills were patient escorts and undertaking bladder ultrasounds with a mobile scanner. Medication administration was rarely performed.

Conclusion:

The role primarily incorporates basic nursing care with minimal scope for extended skills. The paper recommends that basic nursing practices be delegated to assistants in nursing to enable the 'after hours

clinical support enrolled nurse' to effectively support registered nurses and extend their own practice.

INTRODUCTION

Nursing work has changed dramatically over the years leading to increased professionalism and more diverse and complex roles (Magennis et al 1999). Many factors have contributed toward this change including: increased health-care costs; technological advancement; the ageing population (O'Connell and Ostaszkiewicz 2005; Finlayson et al 2002); shorter hospital lengths of stay; increasing patient acuity (Finlayson et al 2002); community expectations; and medical practitioner reluctance toward some service provision (Pearson and Peels 2002), leading to nurses taking on tasks previously undertaken by doctors and other health professionals (Kenny and Duckett 2004; Pearson and Peels 2002). The effect of these factors on nursing is greater specialisation and advanced practice.

The shift in registered nursing work has opened avenues for enrolled nurses (ENs) to extend their own practice. More ENs are specialising in acute care areas (Milson-Hawke and Higgins 2004) and undertaking (often at their own discretion) additional nursing activities (Bunt and Gibbs 2004). Considering recent curricula changes to EN training endorsing medication administration (for example, NSW Health 2005) and the proposed national competencies, examination of EN extended practice is timely.

LITERATURE REVIEW

Much literature has been published in Australia and the United Kingdom (UK) examining EN status, role responsibilities (Milson-Hawke and Higgins 2004; Iley 2004; Kimberley et al 2004; Bunt and Gibbs 2004; Stubbings and Scott 2004; Gibson and Heartfield 2003;

Milson-Hawke and Higgins 2003) and reasons for or barriers to registered nurse (RN) conversion (Kenny and Duckett 2005; Iley 2004; Webb 2001; Webb 2000) but few have examined which extended skills are being embraced by ENs.

The Australian EN role was considered restrictive (Pearson 2002) and has subsequently expanded to incorporate medication administration, patient assessment and treatment provision (Duckett 2005). Variation exists however between practice and delegated responsibilities depending upon employment conditions and geographical location (Kimberley et al 2004; Gibson and Heartfield 2003; Milson-Hawke and Higgins 2003; Webb 2000) with rural ENs having greater responsibility (Kenny and Duckett 2005; Kenny and Duckett 2003) compared to their metropolitan counterparts. However there is also practice disparity within hospitals, on individual wards (Bunt and Gibbs 2004) and according to staffing levels (Kenny and Duckett 2005; Milson-Hawke and Higgins 2003).

Despite findings that EN work is similar to that of RNs (Webb 2000; Francis and Humphreys 1999) EN training was discontinued in the UK (and temporarily in New Zealand) in preference for a single level, diploma qualified RN, to enhance nursing professionalism (Francis and Humphreys 1999). Career limitations have also been broached in the Australian literature with suggestions for a degree qualification (Duckett 2005) or two-year traineeship to broaden skills and ultimately increase EN staffing levels (Duckett 2000). Kimberley et al (2004) however, argue that despite activity similarities, gaps remain between ENs' and RNs' knowledge depth, and capacity for assessment and decision-making.

EN Demographics

ENs comprised 19% of full time equivalent (FTE) nurses in the Australian nursing labour force in 2004. While employed FTE ENs increased by 7.4% from 1999-2004, the ratio of ENs to RNs declined from previous years as the number of employed RNs has increased (Australian Institute of Health and Welfare 2006).

Victoria has the highest supply of ENs, followed by South Australia and the ACT. The majority of ENs (53%) are employed in major cities, while approximately 42.3% work in regional or remote areas (Australian Institute of Health and Welfare 2006).

Employed ENs are overwhelmingly female (91%) with an average age of 43.6 years. The proportion of enrolled nurses who were male increased from 6.7% in 1999 to 9.1% in 2004. Data from 2004 demonstrated that the majority of ENs (92.3%) worked in a clinical capacity, primary medical or surgical (34.3%) and aged care (31.3%) (Australian Institute of Health and Welfare 2005).

OBJECTIVE

This study aimed to determine if experienced ENs working in a supernumerary capacity, within a tertiary level metropolitan hospital are practising skill extension in the surgical environment.

METHOD

Sample

This study examined the role of After Hours Clinical Support Enrolled Nurses, hereafter called After Hour ENs (AH ENs) in a tertiary metropolitan hospital from January to June 2004. The study was part of a formal role evaluation as the after hours (AH) role was initially implemented for a trial period of one year. The AH team consisted of experienced ENs and RNs who provide clinical support to ward nurses, weekdays from 1700-2300hrs. Both the EN and RN role is job shared by part-time nurses.

The nurses, considered to be experienced, primarily cover six surgical wards, incorporating the specialties of orthopaedics, cardio-thoracic, gastro-intestinal, neuro-surgery, vascular, urology, high dependency and head, neck and plastics.

Instrument

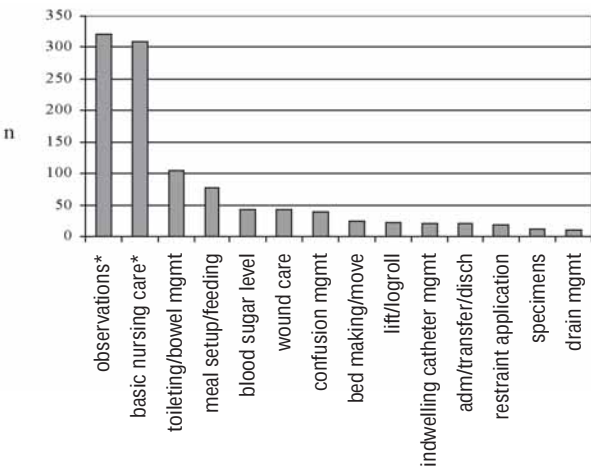
The AH ENs documented chronologically in an A4 diary all activities with which they were involved during the nursing shift. Documentation included the time activity commenced and designation of staff member being assisted (if applicable). These activities were then coded and analysed utilising Microsoft Access software.

RESULTS

The results demonstrated that the AH EN was involved with a diverse range of clinical nursing activities ranging from basic nursing care to more advanced practices over the six-month period.

The majority of nursing activities performed by the AH EN were those traditionally associated with the EN role (Gibson and Heartfield 2003). Figure 1 demonstrates that patient observations (n=322) were the most frequently performed activity over the six-month period followed by basic nursing care (washing, pressure area care etc) (n=310). Patient toileting (n=104) and meal tray set-up and/or feeding (n=78) were also frequently undertaken. It should be noted that patient observations and basic nursing care as depicted in figure 1 refers to episodes of care and not patient numbers as these activities are customarily performed on multiple patients in several patient rooms.

Figure 1: Number of self-documented nursing activities performed by the AH EN

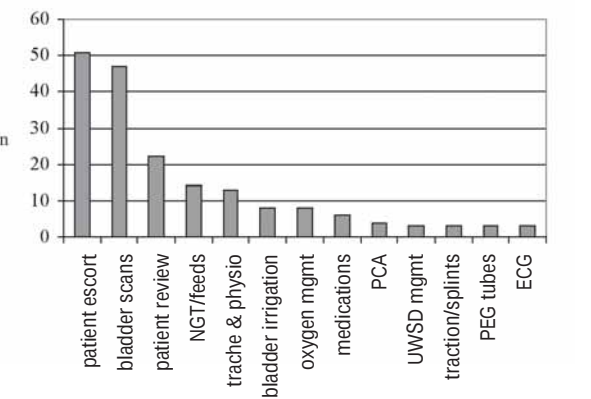


Blood sugar levels (n=44) and wound care (n=42) were performed relatively frequently. More specific nursing practices eg indwelling catheter management (n=21) and admitting, transferring or discharging patients (n=21) were performed on average less than once per week. Management of postoperative drains were documented as being performed on ten occasions (refer to figure 1).

The AH EN performed a diverse range of advanced nursing practices however in the majority of cases these were not undertaken frequently (refer to figure 2).

The most frequently performed extended practices were patient escort (n=51) primarily escorting patients from the post-anaesthetic care unit (PACU) to wards and conducting bladder scans using a mobile ultrasonographical scanner (n=47). Anecdotal evidence of repeated machine malfunction led to this investigative procedure being restricted to specialist urology nurses and AH ENs within the surgical division at this hospital and thus has been classified as an extended practice in this paper. Twenty-four instances of bladder retention or residual urine were identified following bladder scans. By contrast, attending to bladder irrigation was much less frequent (n=8).

Figure 2: Number of self-documented extended practice activities performed by AH EN

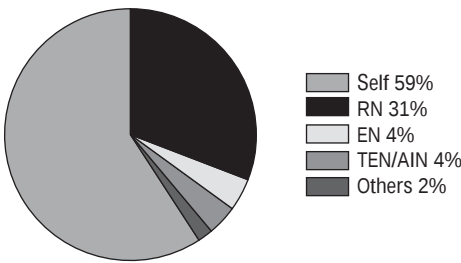


The EN reviewed and assessed 22 post-operative patients in response to requests by RNs to check individual patients. This includes requests by medical and oncology ward staff for advice on surgical outliers (n=5).

Medication administration, a relatively recent addition to the role of the EN within NSW, was undertaken on six occasions. Some practices common to surgical specialities were also infrequently performed eg oxygen management, observations related to patient controlled analgesia (PCA) and underwater seal drainage (UWSD).

Figure 3 demonstrates that although AH ENs primarily worked alone they assisted RNs (n=137) with workload to a much greater extent than they assisted other ENs (n=19) and trainee enrolled nurses (TENs) (n=15). The ‘other’ category includes nurse managers, medical officers and security personnel.

Figure 3: Pie chart demonstrating the designation of staff assisted by the AH EN.



DISCUSSION

This research project concentrated on the role of the after hours EN and their participation in advanced practices. The role requires broad nursing knowledge and expertise to work in such a diverse range of areas. The findings from this study indicate that while AH ENs are exposed to a range of surgical specialities, their participation with extended nursing practices is limited.

Data relied on self-documentation and therefore inaccuracies from under reporting may have occurred, particularly during busy periods. Conversely, previous observational studies of clinical ENs found limited evidence of extended EN practice (Blay 2005; Gibson and Heartfield 2003) despite nurses’ verbal reports indicating otherwise (Milson-Hawke and Higgins 2004; Kimberley et al 2004; Gibson and Heartfield 2003). The AH EN may have been hesitant to document practices that could be seen to be beyond their legal authority.

Variation exists between hospitals as to what nursing activities are considered advanced practice or an extension of skills. It is of concern that ENs may be accredited to practice specified skills in some metropolitan hospitals while comparable hospitals within the same area health service have policies restricting ENs using those same skills. In contrast the literature demonstrates that rural ENs practice to a higher level with limited RN supervision.

Another possible reason for infrequent practice of some skills by the AH EN is that some practices are restricted to the ward that has accredited them (St. George Hospital and Community Health Service 2005) thus limiting the scope of the AH team. One potential advantage of EN national nursing competencies as proposed by the National Enrolled Nurse Project (NSWNA 2005) is the standardisation of EN practice between States and hospitals, ameliorating these discrepancies. Managers' and colleagues' attitudes toward advanced RN roles impact on their implementation (Lloyd Jones 2005) and while opinions on the extended EN role have not been sought it could be assumed that within some organisations and/or clinical areas opposition may prevail. Focus groups conducted with trainee enrolled nurses (TENs) undertaking medication administration accreditation have highlighted negative attitudes toward them on some wards (Reardon 2005).

The EN legally remains under the direct or indirect supervision of an RN. Therefore it is not surprising that the AH EN worked predominantly with RNs. The majority of time the AH EN worked alone even though they were meant to be supernumerary for the purpose of the pilot. In this situation the 'floating' nurse might be allocated miscellaneous tasks converse to team nursing or patient allocation. Only 8% of the AH EN activities were in conjunction with other ENs and/or TENs.

The AH ENs are performing routine nursing practices that in some organisations are undertaken by health care assistants (Iley 2004). The delegation of tasks to health care assistants has been described by ENs as an erosion of their role (Kenny and Duckett 2005). However basic task delegation is becoming a necessity as the number of admissions of older people and people with chronic illness increase (Duckett 2005; O'Connell and Ostaszkiwicz 2005).

The use of health care assistants or assistants in nursing will free qualified nurses, particularly ENs, to attend to more complex treatments and practices. It is certainly not advocated that health care assistants and/or assistants substitute for ENs in nursing but that they are employed as an adjunct to the ward team. Indeed, much has been written regarding the deterioration in care and patient outcomes with changing skill-mix and a reduction in nurse-patient ratios particularly the number of qualified RNs (Stanton 2004; Sochalski 2004; Duffield and O'Brien-Pallas 2002). However, as both metropolitan and rural ENs freely admit to practicing beyond their legal responsibilities (Kenny and Duckett 2005; Blay 2005; Bunt and Gibbs 2004), without adequate education and/or accreditation it is likely that patient safety is currently being compromised. In the words of rural ENs:

'Without a doubt as an enrolled nurse in a rural hospital we frequently undertake duties that are really RN roles' (Kenny and Duckett 2005, p.427).

'They are happy for ENs to do things when there is none [sic] else around that is beyond their legal scope of practice...' (Kenny and Duckett 2005, p.427).

This last comment implies that the individual EN is not responsible for their actions as 'they' (management or RNs?) are 'indirectly encouraging' the practice. This raises some interesting concerns as to whether organisations are knowingly permitting unauthorised practice, if ENs have verbalised (and/or documented) any apprehension and whether ENs are performing these tasks under supervision.

Evidence has demonstrated that ENs who were dissatisfied with their role and had an interest in technical skills were more likely to convert to RNs (Iley 2004) perhaps indicating that these ENs are more mindful of legislative repercussions. Indeed, in line with proposed national competencies perhaps a full review of the ENs scope of practice is necessary.

The results demonstrate that the AH ENs embarked on skill extension for specific practices. The EN is comprehensively assessing post-operative patients (n=22) and giving management advice to clinical nurses within other specialties. This is an important aspect of surgical nursing and should be embraced by ENs caring for post-operative surgical patients.

The AH ENs are escorting patients to the ward from PACU at least twice weekly (n=51). The frequency of patient escorts is lower than expected, considering the number of operations performed and the fact that the AH EN has been actively encouraged (at this hospital) to escort patients thereby excluding the necessity for clinical nurses to leave wards and reducing collection delays from PACU.

The performance of bladder scans, as the second highest extended skill, is an interesting finding especially when comparisons are made with the number of occasions that the AH EN attended to indwelling catheters (n=21) and bladder irrigation (n=8). While bladder scans are useful for diagnosing urinary retention and some causes of urinary incontinence, they are not a replacement for physical assessment (Nickless et al 2002). Of those patients scanned, only 51% had bladder co-morbidities, possibly indicating that ultrasonography is utilised as the first measure or that clinical nurses are unfamiliar with bladder assessment. Further study into the judicial use of bladder scans is therefore advised.

Medication administration was carried out on six occasions by the AH ENs during the study period. Infrequent medication administration, with a risk of deskilling, was identified by Kimberley et al (2004) to be the result of the time-consuming supervision required by an RN. In this study, infrequent medication administration may be due to the floating nature of the role or simply that medications had previously been administered by ward nurses. The issue of deskilling is a major concern that could impact on patient safety, especially as this role is job shared by two individuals and many activities were performed on less than 10 occasions during the six months.

CONCLUSION

The study indicates that the AH EN, although considered to be working in a supernumerary and support role, is predominantly involved with traditional basic nursing care activities. Evidence of extended skills being performed regularly is limited even if the range of extended skills is diverse, with the potential for deskilling to occur.

Verbal reports by metropolitan and rural ENs indicating that they are frequently expected to carry out tasks beyond their legal jurisdiction in times of staffing need, is a major concern with the potential to affect patient outcomes. It raises further questions as to why the EN is willing to carry out these tasks and whether organisations are indirectly encouraging such practices.

In order for the AH EN to fulfil original role requirements and support surgical ENs and TENs it is necessary that basic nursing tasks be delegated to assistants in nursing, or health care assistants. Encouragement needs to be given toward supporting clinical ENs with skill extension, following appropriate education and accreditation.

REFERENCES

- Australian Institute of Health and Welfare. 2006. *Nursing and Midwifery labour force 2004*. AIHW Cat. No. HWL 38. Canberra: <http://www.aihw.gov.au/publications/index.cfm/title/10380>. (Accessed January 31, 2007).
- Australian Institute of Health and Welfare. 2005. *Nursing and Midwifery labour force 2003*. AIHW Cat. No. HWL 31. Canberra: <http://www.aihw.gov.au/publications/index.cfm/title/10146> (Accessed September 7, 2005).
- Blay, N. 2005. Shifting the Balance of Enrolled Nursing Practice. *Achievements in Nursing and Midwifery*. St. George Hospital and Community Health Service. 7:45-48.
- Bunt, S. and Gibbs, J. 2004. Enrolled Nurse Role Review: current and future practice at St. George Hospital. *Achievements in Nursing*. St. George Hospital and Community Health Service. 6:8-13.
- Duckett, S.J. 2005. Health workforce design for the 21st century. *Australian Health Review*, 29(2):201-210.
- Duckett, S. 2000. The Australian health workforce: facts and futures. *Australian Health Review*, 23(4):60-77.
- Duffield, C. and O'Brien-Pallas, L. 2002. The nursing workforce in Canada and Australia: two sides of the same coin. *Australian Health Review*, 25(2):136-144.
- Finlayson, B., Dixon, J., Meadows, S. and Blair, G. 2002. Mind the gap: the extent of the NHS nursing shortage. *British Medical Journal*, 325(7363):538-41.
- Francis, B. and Humphreys, J. 1999. Enrolled nurses and the professionalisation of nursing: a comparison of nurse education and skill-mix in Australia and the UK. *International Journal of Nursing Studies*, 36(2):127-35.
- Gibson, T. and Heartfield, M. 2003. Contemporary enrolled nursing practice: opportunities and issues. *Collegian*, 10(1):22-26.
- Iley, K. 2004. Occupational changes in nursing: the situation of enrolled nurses. *Journal of Advanced Nursing*, 45(4):360-370.
- Kenny, A.J. and Duckett, S. 2005. An online study of Australian enrolled nurse conversion. *Journal of Advanced Nursing*, 49(4):423-431.
- Kenny, A. and Duckett, S. 2004. A question of place: medical power in rural Australia. *Social Science and Medicine*, 58(6):1059-1073.
- Kenny, A. and Duckett, S. 2003. Educating for rural practice. *Journal of Advanced Nursing*, 44(6):613-622.
- Kimberley, A., Myers, H., Davis, S., Keogh, P. and Twigg, D. 2004. Enrolled nurse medication administration. *Contemporary Nurse*, 17(1-2):63-70.
- Lloyd Jones, M. 2005. Role development and effective practice in specialist and advanced practice roles in acute hospital settings: systematic review and meta-synthesis. *Journal of Advanced Nursing*, 49(2):191-209.
- Magennis, C., Slevin, A. and Cunningham, J. 1999. Nurses' attitudes to the extension and expansion of their clinical roles. *Nursing Standard*, 13(51):32-36.
- Milson-Hawke, S. and Higgins, I. 2004. The scope of enrolled nurse practice: a grounded theory study. *Contemporary Nurse*, 17(1-2):44-62.
- Milson-Hawke, S. and Higgins, I. 2003. The scope of enrolled nurse practice: A review of the literature. *Contemporary Nurse*, 14(2):129-137.
- Nickless, R., Burke, N. and Bolton, T. 2002. Using ultrasound to assess bladder function in aged care rehabilitation. *Australian Nursing Journal*, 9(10):suppl 1-3.
- NSW Health. 2005. Recommendations from the review of education, role and function of the enrolled nurse in NSW August 1991, Policy Directive PD2005_047, January 25.
- NSW Nurses' Association (NSWNA). 2005. Enrolled nurse position under threat: plan to 'dumb down' EN training and qualifications. *The Lamp*, 62(9):24-25.
- O'Connell, B.O. and Ostaszkievicz, J. 2005. Sink or swim: ageing in Australia. *Australian Health Review*, 29(2):146-150.
- Pearson, A. 2002. The composition of the nursing team [editorial]. *International Journal of Nursing Practice*, 8(4):175.
- Pearson, A. and Peels, S. 2002. The Nurse Practitioner. *International Journal of Nursing Practice*, 8(4):suppl 5-10.
- Reardon, S. 2005. Trainee enrolled nurse medication administration: the experience of the project coordinator. *Achievements in Nursing and Midwifery*. St. George Hospital and Community Health Service. 7:25-30.
- Sochalski, J. 2004. Is more better? the relationship between nurse staffing and the quality of care in hospitals. *Medical Care*, 42(2):suppl II 67-73.
- Stanton, M. 2004. Hospital nurse staffing and quality of care. *Research in Action*. Agency for Healthcare Research and Quality. 14:1-14 Publication No. 04-0029.
- St. George Hospital and Community Health Service, 2005. Nursing Practice Manual. <http://sesinfo/sgweb/pages/divisions/execdir/staffed/npm/maintoc.asp> (Accessed October 19, 2005).
- Stubbings, L. and Scott, J. 2004. NHS workforce issues: implications for future practice. *Journal of Health Organization and Management*, 18(3):179-194.
- Webb, B. 2001. An exploratory study in a community National Health Service Trust to understand why enrolled nurses choose not to convert to first-level registration. *Journal of Nursing Management*, 9(6):343-352.
- Webb, B. 2000. Enrolled nurse conversion: a review of the literature. *Journal of Nursing Management*, 8(2):115-120.