Maltese Nurses' Perception of their Expanded Role

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Declaration

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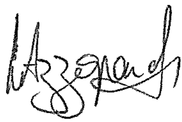

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Abstract

The study aimed to identify if nurses are aware of the benefits and risks, and the legal implications of their expanded role. A descriptive research design was used to reach the aims of the study. All staff nurses working on the purposively chosen Surgical and Medical Wards, the Intensive Therapy Unit, the Coronary Care Unit and the Accident and Emergency Department and met the pre-set criteria constituted the sample population. Self-report questionnaires (n=107) were distributed with a response rate of 79% (n=83). Analysis of results was performed using descriptive and inferential statistics.

From the results it appears that nurses are willing to expand their role. They also hold a moderately positive attitude towards role expansion that was interpreted as a cautious approach. Statistical significance was achieved between the attitude mean score of surgical nurses and the nurses working in the Intensive Therapy Unit. Responses show that the term expanded role was not clear to some nurses. However, expanded activities are being performed regularly, sometimes ignoring the hospital's policy. It also appears that nurses are inclined to learning and keep updated about their role. A worrying result was that, some nurses are undertaking expanded activities when they do not feel competent in carrying out such activities. The legal knowledge about the expanded role is distorted, as related answers proved very inconsistent. Nurses appear to be in favour of certification and to work in the parameters of guidelines.

A number of recommendations were put forward based on the findings of the study. Also further studies were suggested to explore more in depth various elements that emerged form the study.

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Chapter 1

1 - Introduction

Nurses are becoming more involved in complex tasks that have previously been the domain of other professions. As some of these complex tasks were not taught in the nurses' basic training, nurses may feel more threatened when asked to account for their actions when harm occurs to patients. Maltese people are becoming more open to information, more educated and privately insured. This development has led to an increase in the number of patients who seek judicial redress for breach of their rights while receiving health care.

These problems could be minimized if the hospital management introduced regulations to guide staff during their course of duty. Since these guidelines are lacking, the nurse has no parameters that indicate when to be involved in activities beyond basic training and which paths are to be followed to be able to perform extended or expanded role activities. Although, both these terms imply the activities performed by nurses that were not covered in their basic training, they refer to different concepts.

Job enlargement, which is similar to role extension, is seen as added tasks with increased responsibility to further accommodate the organisation but with little value for employees (Hellriegel, Slocum, & Woodman, 1998). Job enrichment correlates more to job expansion where upgrading of responsibility, scope and challenge in work is deliberately demanded by the employee (Hersey & Blanchard, 1977). Although expanded and extended roles indicate different concepts, a study by Bowler and Mallik (1998) reveals that the nursing and medical respondents could not differentiate between expanded or extended activities since tasks under each respective category

were not included in basic training. Therefore, for the purpose of the study to avoid confusion of terms, the word **expanded role** was used to mean both terms.

The Maltese Nursing and Midwifery Board, which is the local regulating board, unlike boards in foreign countries has not issued documents to regulate the expanded role locally. The DHSS document, *The Extending Role of the Nurse* (1989) had very rigid rules that would hinder rather than promote progress. This document was superseded by the UKCC's document *The Scope of Professional Practice* (1992) which liberated practice from the need for certification of competence to a self determined competence based on the *Code for Professional Conduct* (1992). In Malta *The policy for administration of intravenous medications by qualified nurses* [Farrugia, Abdilla, & Borg, 1995 (Appendix 1)], which was issued for the local hospital 'St. Luke's', resembles the DHSS document (1989). It states, that nurses should only practise expanded role activities if they were adequately trained and certified. However, in a local study undertaken by Pace (1999) about intravenous drug administration, it was found that some nurses administered intravenous drugs without the needed course demanded by the policy. Therefore, it appears that the policy is being ignored and nurses who were not formally trained and assessed were administering intravenous drugs. Such behaviour may have adverse repercussions on the employee and the employer should a patient be harmed in the exercise of their duties. Nurses who decide to be engaged in expanded role activities should be aware of the legal implications because if harm comes to a patient they may have to answer to the following:

1. The employer and face disciplinary action,
2. The profession and be accused of professional misconduct,

3. The patient and be sued for breach of civil law rights,
4. The public and face criminal charges (Furlong & Glover, 1998).

However, the organization is also at stake because according to the Master / Servant principle (Dimond, 1995), the master will have to accept responsibility for the actions of the servant. When applied to the health services, this principle involves the central administration as the master and its employees as the servants. Therefore, the employees' performance will affect the organization's reputation, as well as having possible financial repercussions.

In view of these circumstances, the study will identify how aware nurses are of the benefits and risks of their expanded role as well as the legal implications. The research questions of the study are the following:

1a. What typical activities are considered as expanded?
1b. How frequently are these activities performed?

2a. Do nurses hold a positive or a negative attitude towards the expanded role?
2b. Are there socio-demographic differences on attitudes of the expanded role?

3a. In what manner do nurses keep updated about their nursing duties?
3b. Is there a relationship between nurses' perceived attitudes with nurses who are currently involved or undergone training?

4. What does competence mean to Maltese nurses?

5. Are nurses well informed regarding the legal aspects of the expanded role?

This study is important because it will explore the perception of the nurses towards the expanded role and their awareness of the implications the role entails. As it is the first study of its nature in Malta, the hospital management who is vicariously liable for the employees' actions will acknowledge the reality of the nurses' expanded role issue. Recommendations will be addressed to improve the approach for this controversial issue. This study was also undertaken to fulfil the requirements of the Masters Degree in Health Service Management.

Chapter 2

2 - Literature Review

2.1 Introduction

A list of articles and studies published in English were compiled following a thorough search on the Internet, CINAHL and MEDLINE databases. Internet was also utilized to trace relevant articles or studies not found in local libraries. Nine studies which are directly related to the nurses' expanded role were found. Almost all the studies were undertaken after the publication of the UKCC's document *The Scope of Professional Practice* (1992). Four of the studies are very recent, three studies were carried out in the Intensive Care Unit (ICU) and one local study regarding intravenous drug administration was carried out with nurses and junior doctors. An overview of the studies is given in Table 1. Most of the information was obtained from primary sources, however, secondary sources had to be considered when original articles could not be obtained.

The expanded role is an issue that aroused a lot of discussion for many years. In the light of the search carried out, the literature review on nurses' expanded role was divided into the following sections:

- Background,
- The Scope of Professional Practice,
- The Notion of Competence,
- Legal Aspects,
- Clinical Guidelines,
- The Local Situation,
- Summary.

Table 2.1 - Overview of the studies

Date & Author	Aim of the study	Area of study	Number, *type of sampling* & response rate	Research Methods	Limitations / Strengths
1989 Olade	To identify responsibilities and the perceptions of users of health care regarding the expanded role in Nigeria	Institutional clinics in Nigeria	17 nurses & 55 customers from different classes, *various categories of clients* Response rate 100%	2 questionnaires – 1 for nurses and 1 for clients – that included open and closed ended questions	• Small sample • Study undertaken in urban areas • Nurses worked on their own- difficult to be judged
1992 Last, Self, Kassab, & Rajan.	To investigate important aspects of the role of nurses working in intensive care units	Intensive Care Units in the United Kingdom, the Channel Islands & the Isle of Man	1440 nurses in 288 working in Intensive Care Units *5 nurses randomly chosen in each unit.* 61.5% response rate	Questionnaire with closed and open ended questions	• Total population not known • Sample randomly chosen, • Very large sample, • Population sample homogenous.
1995 Barrett	Identify the opinions of nursing and medical staff regarding the extended roles	Neonatal units from South West Region of England	290 nurses & 27 consultants in different neonatal units – *purposive sampling (non-probability sampling*) 61% and 51% respectively	2 Questionnaires – 1 for nurses & 1 for consultants	• Moderate response rate, • Bias as the probability is that those in favour of the expanded role are morel likely to participate.
1995 Edwards	To explore nurses' views on broadening their scope of practice	Different specialities and health authorities in U.K.	17 nurses of varying experience *Type of Sampling- not available* Response rate 100%	Semi-structured interviews	• Small Sample • Bias from interviewer, • Different specialities yield broader views.
1998 Bowler & Mallik	To investigate issues surrounding role extension or expansion in intensive care nursing.	17 bedded Intensive Care Unit in a large teaching hospital in U.K.	5 senior intensive care nurses & 5 consultant anaesthetists - *Non-probability purposive sample* Consultant response rate 3	Semi-structured interviews	• Small selective sample • Interviewer bias • In depth probing of participants

Table 1 – Overview of the studies (*Continued*)

Date & Author	Aim of the study	Area of study	Number, *type of sampling* & response rate	Research Methods	Limitations / Strengths
1999 Magennis	Nurses' attitudes to the extension and expansion of their clinical roles	Cardiology Unit, Intensive Care Unit, Medical Ward in an British General Hospital	32 nurses *Random Sampling* 100% response rate	Self-administered survey postal questionnaires	• Small Sample • Randomly chosen • Good response (80%) • Appropriate tool to measure attitudes (Likert Scale)
1999 Leonard	The expanded role of the registered nurse: studying nurses' perceptions	Acute medical unit in the Isle of Man	70 registered nurses – *Convenience sampling* 30 nurses responded the questionnaires & 2 attended the interviews	Self-administered questionnaires and face-to-face interviews.	• Low response rate, • Lessen generalisation. • Manifold interpretation of non-respondents • Purposively sample
1999 Hind, Jackson, Andrewes, Fulbrook, Galvin, & Frost.	Explore the current role of the critical care nurses and the potential to expand their practice	Critical Care Unit in a large district general hospital	18 nurses & 5 consultants *Focus group sampling* Response rate 100%	Semi-structured interviews for focal groups and individuals & questionnaires	• Small sample, • Interview bias, • Broad data collection, • Participants probing.
1999 Pace	Perception of registered nurse and junior doctors working in surgical wards on the nurses, extended role of intravenous drug administration	Surgical wards in a General Hospital in Malta	8 registered nurses & 10 junior doctors *Convenient sample* 100% response rate	2 different questionnaires - 1 for registered nurse & 1 for junior doctors	• Small Sample, • Interviews could have resulted in deeper investigation, • 100% response rate

2.2 Background

The role of the nurse is becoming more complex and nurses are performing new activities that fall within the domain of other professions (Dowling, 1997). These activities have evolved from a nurse taking a blood pressure (Mechanic, 1988; Briffa, 1999), to performing an appendicectomy (Dimond, 1998) and assisting in heart bypass operations (Shepherd, 1993). Thus, the nursing role can be said to be enlarged by the inclusion of new activities.

Most of the nurses are in favour of role expansion *only* when it is for the benefit of the patients as expressed in the studies undertaken by Last, Self, Kassab and Rajan (1992), Barrett (1995), Edwards (1995), Bowler and Mallik (1998) and Magennis, Slevin and Cunningham (1999). Although these studies have similar findings, they have been carried out in speciality areas and therefore the findings in these studies cannot be generalized to all nurses. However, this similarity in findings gives an indication that nurses are willing to increase their responsibility only for the welfare of their patients.

Another positive point, which emerged in a study undertaken in an ICU by Last et al. (1992), was that from role expansion, the patient will benefit more while it was instrumental to strengthen the inter-professional relationship between healthcare professionals. This finding was supported by Leonard's (1999) study which indicated that patients will receive holistic care safely and in time and the multidisciplinary team approach will be enhanced through better relationship amongst professionals. A good working relationship amongst health carers may be highly solicited by managers

as it instils the concept of teamwork, which results in better output for the patients' advantage (Hellriegel & Slocum, 1996).

However, it appears that nurses are concerned that, when undertaking activities usually performed by doctors, the increased workload will lower standards of care. Bedside nursing may have to be delegated to less qualified personnel (Edwards, 1995; Bowler & Mallik, 1998) who will do the real nursing thus compromising the quality of care (Shepherd, 1993; Higgins, 1997). In this way nursing may loose its character as the real nursing is done by the nursing aides while nurses will be more receptive to activities other health carers would like to shed. Finding from a local study by Schembri (1998) emerged that nursing aides are already performing nursing activities while Hind et al. (1999) and Magennis et al. (1999) found that the nursing participants in their studies felt that they were intruding on the doctors' areas of practice, thus being considered as mini-doctors.

Furthermore, some nurses feel that performing activities beyond basic training is a means for the organization to save money as nurses are less paid than doctors (Leonard, 1999). Nurses appear to be reluctant to be used as an alternative and as a form of cheap labour (Vaughan, 1990). On the other hand, some nurses may welcome the expansion of their role as it is viewed to improve their image and esteem and an opportunity for career advancement (Leonard, 1999).

However, Scott (1996) claims that nurses need to adopt good nursing based on research to improve their image rather than take up the activities other professions are eager to renounce. This is the way nursing standards will improve, not by being the mechanical hands of other professions and performing their dropped tasks. Moreover,

clear guidelines or boundaries should be given for those nurses who perform activities beyond their training which will protect them from facing legal or disciplinary proceedings (Quinn & Thompson, 1995).

Also, nurses seem to agree that the activities beyond basic training may be performed on voluntarily basis even if trained (Barrett, 1995; Edwards, 1995). Although the concept to expand voluntarily may increase the bargaining power of the nurses, it may also disrupt the smooth running of the unit should someone abruptly choose to withdraw from being involved in a particular task.

Given these apparent differences of opinion on the nurses' role expansion it is important for the management to explore if expanded role activities need to be encouraged. If so, nurses or their representatives should be included in the discussions for the implementations of such activities to gain the nurses' co-operation and reduce resistance, after the nurses' feelings towards role expansion were examined. Dowling et al., (1996) stated that whilst nurses must willingly accept taking on new roles, the employer should provide the necessary conditions including clear guidelines, the necessary training and management support. Policy documents may be issued to guide those nurses who decide to be involved in activities beyond their basic training to ascertain safe practice. The issue of policy documents will be discussed in the next section.

2.3 The Scope of Professional Practice

The British authorities issued policy documents that outlined the legal and ethical implications of role expansion, to guide nurses in practice who decide to perform duties that fall under the expanded role. Two documents, namely *The Extending Role*

of the Nurse (DHSS, 1989) and *The Scope of Professional Practice* (UKCC, 1992) directly address this issue.

The concepts in the DHSS (1989) document are that: nurses had to be adequately trained before agreeing to undertake new activities; training had to be recognised as satisfactory by the employing authority; the new activity had to be recognised by the profession and by the employing authority as an activity which may be properly delegated to a nurse; and the delegating doctor had to be assured of the competence of the individual nurse concerned. These concepts are all in line with the American regulations (Mechanic, 1988) and still the practice in the Massachusetts' (The Board of Registration in Massachusetts, 23/4/2000) regulations governing the practice of nursing in the expanded role. The local policy for administering intravenous drugs (Farrugia et al., 1995) also holds these principles.

The DHSS document gives nurses a sense of protection from any disciplinary action if activities were carried out competently (Dimond, 1996). However, professional development was seen as incremental, task oriented and often delegated from other health care professionals, usually medical, because it is these professionals who will dictate what nurses can do (Dimond, 1995). Moreover, nurses may need to attend several courses on one task if they change jobs because what is acceptable for one authority may not be enough or accepted by another (Wright, 1995) leading to wastage of resources.

Redfern (1997) also claimed that such a policy encourages a fragmented task-based approach that loses the holistic care patients want and need. Nurses who were capable but not certified had to refrain from carrying out certain activities related to

patients' care and wait for other professionals to perform them. Patients may benefit more if someone whom they already know and trust carries out a procedure.

Certificates demonstrate that a person has attended some kind of training in a particular area but are not a guarantee that mistakes cannot happen. Boylan (1984) and Wainwright (1996) indicated that if nurses consider themselves as professionals they do not need a certificate for every task they undertake as true professionals undergo a natural growth in their role. This is confirmed by Olade (1989) who showed that the nurses' aptitude in her study came from experience.

The nurses in Olade's study were reported to manage infectious diseases, minor accidents and performed minor surgery. The reason for shouldering so much responsibility was the shortage of doctors that existed in the clinics where the nurses in the study worked. Eighty two percent (n = 14) of the nurses in the study perceived their level of competence as high, though they felt that they would improve even more if they were provided with the necessary equipment and attended refresher courses at regular intervals. The nurses' self-confidence was also exhibited by their patients who rated a high acceptance of the nurse practising the expanded role activities. Although the sample population was not large enough to generalize findings, it clearly indicated that though the nurses were not certified to carry out certain activities, they still performed them with a good outcome to the satisfaction of their patients. Nurses in Olade's study had to develop their role to the needs and benefits of their patients not by obtaining certificates but by practising what they had experienced. However, these nurses worked on their own making it difficult to appraise their performance.

The DHSS (1989) document issued very rigid regulations that may result in nurses attending more courses than attending patients especially when nurses are performing a number of expanded role activities for which nurses have to undertake different courses. Last et al. (1992) identified 54 activities that are considered as expanded roles. Last et al.'s study, which had a response rate of 61.5%, was carried out with a population sample of 1440 in 288 different Intensive Care Units in the United Kingdom, the Channel Islands and the Isle of Man. However, as this study was carried out with nurses who work in intensive care and these may be involved in more expanded role activities than general nurses, the findings could not be generalized to the whole population of nurses in spite of the large sample.

However, some nurses favour the need for certification before being engaged in activities not covered in basic training. This was strongly expressed in the studies carried out by Last et al. (1992), Barrett (1995), Edward (1995), and Magennis et al. (1999). Findings from these studies, which were held in Intensive Care, Neonatal and other different specialities respectively, revealed that nurses show apprehension about the legal implications, accountability and responsibility when something goes wrong. Nurses consider certification as their shield and refuge, as they would be more amply prepared and can prove their competency when faced with disciplinary boards. On the other hand, irrespective of whether the nurse is certified competent or not, if something goes wrong the nurse would still be accountable for any harm done, irrespective whether the harm results from the expanded role or from normal or routine 'nursing activities'.

The ever rising criticism for the DHSS (1989) document obliged the UKCC to issue a new document to supersede it (Wainwright, 1996). *The Scope of Professionals*

Practice (1992) was launched and its bedrock is endorsed in *the Code of Professional Conduct* (1992) paragraphs 1 to 4 which behold that the interest of the patient must come first. Therefore, nurses must maintain and expand their knowledge, skill and competence and acknowledge their limitations. Moreover, nurses must ensure that any widening of practice does not jeopardise standards of care and must fully observe the *Code of Professional Conduct* while recognising their direct and indirect personal accountability and avoid inappropriate delegation that might compromise the interests of patients.

The Scope of Professional Practice (UKCC, 1992) is a regulatory framework to encourage nurses to expand and enhance their role as safe, autonomous practitioners (Darley & Rumsey, 1996). This document was regarded to have liberated the development of nursing from its previous reliance upon certification for tasks, towards an acceptance that should be limited only by the individual accountable practitioner's own knowledge and competence (UKCC, 2000).

Campell and Lunn (1997) stated that *The Scope of Professional Practice* (1992) document stresses on the responsibility of individual nurses to develop skills in accordance with their own needs and those of their patients. However, this document does not oblige nurses to widen their skills but will leave them to decide whether or not to enlarge practice (Denner, 1995). Dimond (1996) pointed out that it is part of the professional development of the individual nurse to keep up to date, although certification of competence is no longer asked as a proof. Although it is true that the need for certification was eliminated, the document does not illustrate how knowledge and competence are to be achieved. Dimond (1996) queries how a nurse will be

protected if accused of incompetence or who is going to certify competency - nurses themselves, the profession, the employer or the civil/criminal courts.

To declare oneself competent is very subjective and depends on individual perceptions and self-confidence. While some nurses may be very self-disciplined and strict with themselves when practising new activities, others may take it lightly and perform such activities due to peer or other pressure. The latter may adopt an accommodating behaviour as they are not assertive enough to say no and so perform whatever is passed on them irrespective of whether they feel that they are competent or not. Last, et al. (1992) stated that nurses' leaders need to ascertain that all nurses are safe to enlarge their professional practice. Therefore, the hospital management has to provide all the necessary opportunities and learning environment where knowledge and competence will be continuously developed and monitored. Furthermore, performance will also be continuously assessed and endorsed in the individual's professional profile, thus demonstrating a more tangible evidence of competence.

In spite of the importance of *The Scope of Professional Practice* (1992) document, the a recent UKCC's study revealed that only about two thirds of the 10,000 respondents were aware of *The Scope of Professional Practice* (1992) document. The UKCC's study, which used interviews, questionnaires and observations, showed that not all the participants had read all or part of the document although mostly agreed that it offered useful guidance on professional practice. About 20% of the participants were of the opinion that it should be written more clearly and more than 50% were certain that the document helped to develop their role. Respondents showed their preoccupation that this document could lead to increased workloads and accountability rather than to

practice development. Nurses have a tight schedule of work and any added activities or tasks may increase their burden that may decline the quality of care they deliver.

Moreover, from the UKCC study emerged that effective safeguards for patients are lacking. In fact, more details and guidelines were deemed as necessary and it was also widely acknowledged that more flexibility was needed in how the principles inscribed in the UKCC document are going to be incorporated into practice.

An important document, which effect the work of a profession such as nursing, should be a priority for nursing boards and employers to deliver its message to all their members and employees in order to prevent unnecessary misunderstandings. This was recognised by the UKCC who in its study recommended that the nursing managers should be more familiar with *The Scope of Professional Practice* document and its potential. Misunderstandings, lack of awareness and concerns expressed should be addressed, especially the clarification of the balance of responsibility between individual practitioners and the organization for which they work. Certainly, to be successfully implemented, the document needs the full active support of the employers, managers and nurses.

However, UKCC's study also indicated the benefits gained from *The Scope of Professional Practice* document. Practitioners increased their level of job satisfaction and accountability for their practice while patients received high quality care minimising anxiety, frustration or inconvenience. It is explicit that there is room for improvement that includes management support, continued education and training, and for change to be patient-led rather than management driven. However, organizational support was seen as important in enabling registered nurses to

incorporate the principles outlined in the UKCC's document (1992) into their work, whilst lack of resources was viewed as the most significant barrier to implement the document's principles. Meanwhile, the notion of competence, which will be discussed in the next section, continues to be the mostly obscure point in *The Scope of Professional Practice* (1992) document.

2.4 The Notion of Competence

The Maltese Code of Ethics for Nurses and Midwifes (Nursing and Midwifery Board [NMB], 1997) and the British *Code of Professional Conduct* (UKCC, 1992) demands that nurses should maintain and improve their professional knowledge and competence. Therefore it is not appropriate for nurses to refuse to develop their practice beyond the level reached when registered (Dimond, 1995). Professional competence is developmental and has to be linked to lifelong learning (Eraut, 1996).

Bowler and Mallik (1998) and Hind et al. (1999) pointed out that competence need to be maintained and improved. It is not enough to have formal or non-formal training but it is also essential to have sufficient opportunity to carry out the skills learned. Practitioners, although trained, may feel insecure to undertake an activity that is only done occasionally. Practising may transform an individual into an expert in that field of practice. This was exhibited by nurses in Bowler and Mallik's (1998) study who agreed that only experienced nurses should be allowed to perform expanded activities.

The level of competence should be on a graduated scale where competence is a position on a continuum from novice to expert as described by Benner (1984) or on a binary scale where a person is judged to be either competent or not competent. Eraut (1996) pointed out that before a person can be judged as competent, there need to be

an agreement on what constitutes that profession, what will be the scope of any statement of competence, what criteria will be used and what will be regarded as sufficient evidence. Participants in Hind et al.'s (1999) study indicated that to be really competent they needed to be well versed to be capable to deal with complications should they arise after attempting new skills. This study was conducted in Critical Care Unit with a sample of 18 nurses and 5 consultants using semi-structured interview and questionnaires to collect data. Although, generalization of findings was not possible due to the small sample size, the respondents made an attempt to define how competency can be determined.

The American National Council of State Boards of Nursing (cited in Sheets, 1999) defined competence as 'The application of knowledge and the interpersonal decision-making, and psychomotor skills expected for the nurse's practice role, within the context of public health, welfare and safety'. This definition is in line with Ashworth and Morrison (1996) reasoning that competence is the outcome of behaviour as well as a mental skill. They continue to argue that the more knowledgeable and understanding nurses are the more they can adapt to different situations by exhibiting their ability to cope flexibly and effectively with new challenging situations. In fact, Benner (1984) stated that really competent nurses will comprehend a given situation as a whole rather than judging by appearance and their performance is guided by principles.

Eraut (1996) explains that expertise is based on being experienced. However, there is no sure way of knowing that a person is competent and it is s/he who has to decide when s/he is competent. However, sometimes it is difficult to know what nurses do not know and whether they do not know what they ought to know. Intuition and tacit knowledge, supposedly the essence of what counts as competence are by their nature

not susceptible to objective methods of testing, and indeed, may mislead the practitioners in an over optimistic view of their own competence so ignoring the real danger of fallibility of judgement (Eraut, 1996). Therefore, it is important that practitioners will have role boundaries and guidelines to enable them to recognise the limits they have to reach and the paths they have to follow.

The American National Council (cited in Sheets, 1999) developed standards of competence to be used by boards of nursing and individual nurses. These include the application of knowledge and skills at the level required for a particular situation, demonstration of responsibility and accountability for practice and decisions, and the implementation of professional development activities based on assessed needs.

However, Sheets (1999) implied that attaining, maintaining and advancing competence is a joint responsibility amongst the individual nurse, licensing boards, employer, educators and the profession. Table 2 shows the responsibility each party should hold to ensure competency as defined by Sheets (1999).

Table 2.2: Responsibilities of each party to ensure competency

- **Boards** can provide a framework for competence – identification of standards, expectations, a means of tracking activities and evaluations – as well as taking disciplinary action when practice is proven unsafe.
- The **employer** can determine on an ongoing basis whether or not nurses can perform in their assigned nursing role.
- **Educators**, in addition to competence development of nursing students, can support continued professional development by supporting the enhancement and expansion of the knowledge and skills of licensed nurses.
- The **profession** as a whole, through its professional organization, can promote the evolution of nursing practice, identify standards of excellence and provide opportunities for professional development.
- The **individual nurse** must be accountable for practice and implement professional development activities based on assessed learning needs.

(Sheets, 1999)

All these parties play an important role in assuring competence but the individual nurse must be accountable and responsible for his/ her practice and decisions. Rieu (1994) pointed out that to ensure that nurses are competent to perform expanded roles, strict regulations should be applied. Rieu continued that this would prevent errors occurring and protect nurses from legal liabilities. Dimond (1995) pointed out that withdrawing the need for certification of competence creates uncertainty for the individual nurse, the employer and the profession to determine the competence and knowledge needed to undertake activities not covered in pre-registration training. Certificates of competence may be necessary to the employer and the public to demonstrate that they are employing and cared for by qualified persons.

A mistake performed by nurses due to lack of knowledge, skill or excess of self-confidence of their capabilities may result in fatal consequences. Certified or not, the nurses' competence will only be challenged when it fails and it is only then that nurses have to prove that they acted competently. At this stage it is the law or disciplinary boards who become the final arbiter and define competence (Bradshaw, 1998). The legal implications of competence will be discussed in the next section.

2.5 Legal Aspects

When a patient suffers harm, the nurse may have to answer to four different courts or tribunals, namely:

- The employer and face disciplinary action,
- The profession and be accused of professional misconduct,
- The patient and be sued for breach of civil law rights,
- The public and face criminal charges (Dimond, 1995; Furlong & Glover, 1998).

Tingle (1990) stated that if nurses unintentionally breach the law, they cannot be exempted because of ignorance, as ignorance is no excuse, otherwise the law will cease to operate effectively. Therefore, Tingle continued to argue that nurses need to be aware of the legal aspects of their practice to avoid potential legal consequences and expensive litigation. Awareness of litigation had clearly emerged in the studies by Last et al. (1992), Barrett (1995), and Bowler and Mallik (1998). Participants in these studies demonstrated concern in regard to legal litigation when performing activities that were not covered in basic training.

Another legal aspect to be referred to is the question of experience. Dimond (1995) stated that although much more is expected from a senior nurse in relation to a junior nurse, the patient is entitled to receive the accepted standard of care whoever provides it, even from a beginner (Dowling et al. 1996). This is reflected in *Wilsher v Essex Area Health Authority* (1986). The Lord Justice Glidewell stated that the law requires the trainee or learner to be judged by the same standard as his/her more experienced colleagues because if it did not, experience would frequently be urged as a defence to an action for professional negligence. This implies that whenever nurses undertake a task, they should be certain of their competency as standards do not change with experience. Moreover, patients will expect that the practitioners who were engaged to perform an activity on them have the necessary knowledge and experience to do it, as patients deserve the best quality of carc.

However, according to the case of *Philips v William Whitely Ltd* (cited in Tingle, 1990), it could be argued that if a patient is aware that the treatment given by the nurse was an expanded role, s/he should only expect that the nurse acts as a reasonable nurse. Tingle (1990) remarked on this case that most often patients do not have real

choice over who will deliver care as they are usually directed to a health professional who will either be a doctor or a nurse but presumably one who is competent to give them the necessary care.

Patients, who suffer harm due to health carers' negligence, are more frequently seeking legal redress (Tingle, 1990; Dimond, 1998; Green, 1999). Therefore, negligence is another issue to be addressed when discussing legal aspects. The Maltese criminal law, although not explicitly referring directly to the expanded role, counsel service providers. If service providers cause harm through imprudence or unskilfulness in their profession or due to failure to follow regulations, they shall on conviction, be liable to imprisonment or a fine (Laws of Malta, 20/2/2001). Negligence, according to Green (1999), can simply be defined as carelessness and irresponsibility. Three components constitute a negligent action in law. These are: **duty of care** – when it is foreseeable that omission of an action owed to the patient caused harm; **breach of duty** – when the standard of care owed is infringed; **resultant damage** –when the breach has caused reasonably foreseeable and avoidable harm (Dimond, 1995; Green, 1999). This is all based on the neighbour principle that evolved from the case of *Donoghue vs. Stephenson* (cited in Furlong & Glover, 1998). This principle holds that everyone has a duty of care in the course of their actions to prevent harm, which could be reasonably foreseen, to another person. Thus, nurses have a duty of care to patients on account of the nurse/patient relationship that they and patients enter into (Furlong & Glover, 1998).

However, nurses are not deemed to be negligent when they act in the same way as any reasonable member of their profession as reflected by the Bolam Principle (1957). This holds that nurses are safe if they act according to an accepted practice by a

responsible body at the time and if they prove that they have acted as an ordinary competent practitioner exercising that activity. Therefore, the Bolam principle is a test which legally enshrines a standard of accepted care and clinical judgement formed by scientific evidence and professional experience (Hurwitz, 1999). Experts in the field will be called to state in court what is the reasonable standard of care expected by the patient and if this was lacking, whether there was an acceptable reason for their absence.

Another principle is that if nurses carried out their duties below the standard of professional practice resulting in damage to patients, then it is their employers who will be sued for negligence (Lunn, 1994). The employer is vicariously liable (indirect liability) to his employees' deeds performed in the course of their employment (Dimond, 1995). Dimond continued to imply that employers might still be vicariously liable even if their employees acts against their employers' orders. The essential principle in vicarious liability is that the master is in control of the servant where the master is the employer and the nurse is the servant (Dimond, 1995). However, the employers have always the possibility to recover damages from the negligent nurse, although this is rarely sought (Dimond, 1995).

In view of the vicarious liability principle, the employer has to clarify whether or not the nurse should undertake a specific activity as part of his/her role (Dimond, 1998) and only according to the approved policy (DHSS, 1989). The employer should formally acknowledge any work being delivered revising the job description as necessary (Dowling et al., 1996).

The use of properly drafted clinical guidelines is recommended as they may serve to reduce health litigation and complaints (Tingle, 1997).) Guidelines provide information about the care for a particular condition, including options, and makes recommendations based on researched evidence, which can be adapted locally to suit a particular situation and patient (McClarey & Duff, 1997). The issue of guidelines will be discussed in the next section.

2.6 Clinical Guidelines

Clinical guidelines should guarantee that the treatment patients receive will attain the desired outcomes (Shekelle, Woolf, Eccles, & Grimshaw, 1999). Moreover, with the aid of guidelines patients will be cared for in the same manner regardless of where or by whom they are treated (Woolf, Grol, Hutchinson, Eccles, & Grimshaw, 1999). Also, clinical guidelines can improve the quality of clinical decisions offering clear recommendations for uncertain clinicians, overturn beliefs of outdated practices and provide sound counsel about the best of treatment policies. The Massachusetts' Board of Registration in Nursing (23/4/2000) defines guidelines as written instructions and procedures describing the methods that nurses practising in an expanded role are to follow in managing a health care situation. Thus, clinical guidelines may be developed for activities that are labelled as expanded role after considering feasibility issues that include time, skill, staff and equipment necessary for the nurse to carry out the recommendations (Shekelle et al., 1999). Before adopting guidelines, it is imperative that their validity will be appraised to avoid harm to patients or waste of resource (Feder, Eccles, Grol, Griffiths, & Grimshaw, 1999). Also, the target

population for the guidelines are clearly defined and areas not covered by the guidelines are clearly stated (Royal College of Nursing [RCN], 22/01/2001).

Tingle (1997) stated that in an environment where litigation and complaints are on the increase, it is necessary that nurses are aware of the legal and clinical risk management of guidelines. Participants in Leonard's study (1999) were in favour of written guidelines as they would protect and give security to practitioners. However, Tingle (1997) continued to imply that clinical guidelines must reflect a responsible body of nursing opinion to be viewed as proper in a legal contest. A well-developed evidence-based, valid guidelines will help ascertain that the care delivered by nurses is in accordance with current knowledge and possibly the most effective (McClarey & Duff 1997). It was pointed out by Tingle (1996) that the whole concept of guidelines will become discredited if clinical guidelines are not based on sound research with no reflective review of world literature or existing evidence. Shekelle et al., (1999) sustained that guidelines could be revised whenever new relevant evidence is published. Furthermore, Tingle (1997) implied that clinical guidelines must be reasonably achievable and regularly reviewed as circumstances, skill mix, resource levels, the science and technique may all change. Therefore, clinical guidelines are not an easy task to achieve and maintain, especially when it is known that what is written can serve as evidence and challenged in courts or disciplinary boards.

2.7 The Local Situation

In Malta the only policy that exists, as regards the expanded role, is that for the administration of intravenous drugs (Farrugia et al., 1995), which is considered an activity beyond the nurses' basic training. A local study on the administration of

intravenous drugs which was undertaken by Pace (1999) merits to be analysed on its own as it is the only study undertaken locally that relates closely to the nurses' expanded role. Using a sample of 8 registered nurses and 10 doctors who worked in surgical wards, Pace aimed to investigate nurses' perception of the expanded role when administering intravenous drugs. For this purpose 2 different structured questionnaires were distributed one for each sample with a response rate of 100%.

The doctors in this study were in favour of nurses giving intravenous drugs to the patients' benefit. While not considering this task as a medical task, but very risky, doctors argued that treatment will be given on time, nurses know their patients better making them less apprehensive and nurses will be present after administration. Besides, doctors pointed out that they are more prone to mistakes due to not being familiar with the ward environment especially during the night. Furthermore, doctors maintain that the nurses' image will improve while reducing their (doctors) workload but increase minimally nurses' work. Improving the image by doing the doctors' work may mean that doctors perceive nursing as a profession of lower status. However, there are many other nursing activities that when performed properly will improve the nursing image.

Interesting to note that none of the doctors had received formal training to administer drugs intravenously although performing this procedure regularly. This is another point to be deeply looked into as while other professions do not need certification for new activities that are needed in their course of duty, nurses, according to the policy by Farrugia et al. (1995) have to be certified competent to carry out such tasks.

The respondents in this study agreed with the role transfer but with caution as they are conscious of the increased responsibility and do not feel adequately protected from the authorities. Should a patient be harmed, nurses fear that they will have to pass through unnecessary turbulence. However, if trained to do a particular activity, they should be accountable for their deeds, although nurse participants still felt doubtful in spite of receiving formal training. Besides, to get involved in performing expanded role activities, nurses were in favour of formal training, which correlate with other studies in this literature review. It should be pointed out that 3 nurse participants still performed intravenous drug administration although no formal training was undertaken. This could be either because they were not aware of the legal implication or they based their competence on experience.

In her study, Pace found that there is still confusion on the legal implications and responsibility when delegating or performing expanded activities. Some held that both nurses and doctors should be held responsible while others did not know. However, adherence to the local policy on intravenous drug administration, which resembles the DHSS document (1989) is very limited. Doctors hardly know that the document exists while only nurses who attended the intravenous drug administration course knew about the policy.

Pace's study, whose sample size limits generalization, gives an insight of the perception of Maltese nurses and doctors on the nurses' expanded role. Findings correspond to most of foreign studies and opinion articles on the subject. However, with a small sample, Pace would have taken more in depth information from the participants.

2.8 Summary

The review of the literature shows that nurses are willing to expand and evolve their role as long as basic nursing care is not compromised and is addressed to the patients' benefit, but not because other professions shed it on them. These changes in role seem to be inevitable due to increased advances in technology. However, the administration needs to support, train and motivate its employees who are engaged in such activities. Besides, most nurses need a sense of security in a form of a certificate for competence to perform activities not covered in basic training, sometimes irrespective of what professional bodies propose. Removing the need for certification does not solve the problem. The hospital management and other professional bodies have to indicate what need to be done, to be deemed competent. Thus, arise the need for clinical guidelines that should be professionally acceptable, legally defensible, economically affordable and administratively feasible. Nurses may feel more secure and legally protected when activities not covered under basic training will be regulated and indicate the limits and boundaries they have to perform in and the paths they have to follow for the benefit of the patients they serve and themselves. It is also to the management's advantage to provide safe working regulations that may prevent costly litigation.

The issues that emerged from the literature review on the expanded role make this study very important for the welfare and safety of the patients being the customer, nurses as service providers and management as the employer. Also, the perception of the local nurses towards their expanded role need to be explored so that informed decisions may be taken about the nurses' role expansion if the need arises.

The methodology of the study will be explained in the next chapter.

Chapter 3

3 - Methodology

3.1 Aim and Objectives

The aim of the study is to identify if nurses are aware of the benefits and risks, and legal implications of the expanded role. The objectives of the study are the following:

1. To identify what activities nurses consider as an expansion of their role,
2. To determine how often they perform these activities,
3. To explore how nurses feel about having an expanded role,
4. To explore how nurses keep abreast in nursing,
5. To define what competence means to nurses,
6. To verify if nurses know the legal implications regarding to the expanding role.

3.2 Operational Definitions

The following definitions of terms are provided to prevent misconceptions:

- A **nurse** refers to a registered nurse who is registered with the Maltese Nursing and Midwifery Board after completion of basic nursing training either traditionally, at diploma or degree level.
- **Expanded roles** refer to the activities undertaken by nurses that go beyond their basic nursing training.

3.3 Research Design

The perception of the Maltese nurses working in St. Luke's Hospital regarding their expanded role is under study and no hypothesis is tested. Since the nurses' expanded role has not been previously explored in Malta, a descriptive design as opposed to non-descriptive was considered to be an efficient and effective means of collecting

large amount of data about this area (Polit & Hungler, 1995). Furthermore, descriptive surveys mainly demonstrate certain opinions and characteristics of members of the population (Oppenheim, 1992) and also facilitates the investigation of an established setting in which a number of phenomena can be explored (Treece & Treece, 1986; Polgar & Thomas, 1991). Therefore a descriptive design was deemed appropriate to address the aims and objectives.

3.4 Site Description

Malta is a small island in the middle of the Mediterranean Sea, south of Sicily with a population of 380,000 inhabitants. This study was conducted in St. Luke's Hospital, which is the main acute state hospital in Malta where 321 staff nurses have full time employment (Health Division, 1999). St Luke's Hospital, which has a bed capacity of 850, provides a full range of secondary and tertiary medical services (Health Division, 1999). Thus, it is equipped with general wards and many other specialities.

It is worth noting that in St. Luke's Hospital a senior medical assistant and other doctors will be in attendance in the specialized units while medical on call facilities are available after 14.30 hours for the medical and surgical wards. Therefore, nurses working in specialized units have immediate support of a medical officer while general wards have to rely on the services of a junior doctor on call.

3.5 Research Sample

The research sample consisted of all the staff nurses (n = 107) working in the following purposively chosen units:

⇒ the Intensive Care Unit (n = 43),

⇒ the Coronary Care Unit (n = 8),

⇒ the Accident and Emergency Department (n = 13),

⇒ all the Medical Wards i.e. 8 wards (n = 26),

⇒ all the Surgical Wards i.e. 5 wards (n = 17).

The eligibility criteria are that participants:

1. are registered with the Maltese Nursing and Midwifery Board and followed either a traditional, diploma or degree course,
2. are involved directly with patients and nursing care,
3. work in the adult Surgical and Medical wards, Coronary Care Unit (CCU), Accident and Emergency Department (A&E) and Intensive Therapy Unit (ITU).
4. have at least one year nursing experience.

To prevent bias, staff nurses who worked in the same ward of the researcher were excluded from participating in the study.

The specialized units were chosen because most of the studies reviewed were undertaken in Intensive Therapy Units and other specialized units. The ITU and the CCU are high-tech areas where nurses are expected to be involved in activities beyond their basic training, while nurses working in the A & E Department are involved in pre-hospital care where they are on their own and the nature of their work can be urgently demanding. The general medical and surgical wards were chosen to identify if expanded role activities were also practiced here where it is presumed that

in these areas only basic nursing care is required. All units and wards chosen catered for adults and paediatric wards were excluded to make the choice more homogenous. Operating theatres were also excluded because the nature of work in these areas is different from the ward settings. Moreover, this choice was deemed suitable for this study as it is the first study of its nature on the island and it had to view the perception of staff nurses regarding expanded role activities.

3.6 The Research Method

Both quantitative and qualitative methods of data collection could be used to perform this study. Quantitative research involves the systemic collection of numeric information, often under conditions of considerable control, using statistical procedures to analyse data (Polit & Hungler, 1995). On the other hand, qualitative research involves the systemic collection and analysis of more subjective collection and analysis of narrative materials, using procedures which limits the researcher's imposed control (Polit & Hungler, 1995).

Moreover, quantitative studies tend to emphasise deductive reasoning, the rules of logic and the measurable attributes of the human experience (Polit & Hungler, 1995). However, qualitative research is more inclined to stress the dynamic, holistic and individual aspects of the human experience and attempts to capture those aspects in their entirety. Moreover, contrary to qualitative studies, quantitative researches collect information through structured procedures and formal instruments. After considering the nature of both approaches, a quantitative approach was deemed more suitable for this study.

Also, the research tool chosen for this study is a structured questionnaire designed to reach the aims and objectives of the study. This was chosen after considering the three main methods of data collection that is questionnaires, interviews and observations. Observational methods were ruled out, as the data required, that is perceptions of nurses, for this study could not be gathered through observations.

Treece and Treece (1986) argued that questionnaires are preferred to interviews, as they are a simple method of obtaining data, yet rapid and efficient, inexpensive and less time consuming. Furthermore, considering the sensivity of the study, participants can remain anonymous, avoid the interviewer's bias and enable respondents to share sensitive information without the probing of personal contact. Treece and Treece continue to argue that in questionnaires, answers can be more mindful as respondents can take their time to respond. Other reasons in favour of questionnaires are that reliability and validity can easily be tested and measurement, analysis and interpretation of data are enhanced as all participants answer the same questions.

On the other hand, Treece and Treece argued negatively against questionnaires and in favour of interviews. In depth probing of the topic cannot be reached by questionnaires and information gathered can be limited to the participants' choice and preference. Participants, most often, can express themselves better while speaking than in writing. Moreover, respondents answer questions the researcher present them to answer, while other questions may not be fully comprehended or ignored. Treece and Treece continued to imply that response rates may be low with questionnaires, therefore the researcher has to do his utmost to collect as many

questionnaires as possible, as low response may introduce bias (Polit & Hungler, 1995).

Therefore, after careful consideration the researcher chose a quantitative approach using a self report questionnaire to collect data to reach the aims and objectives of the study.

3.7 The Research Tool

Following a review of the literature, a questionnaire (Appendix 2) was designed comprising thirty-nine questions in five sections. Each section was related to the objectives of the study. Most of the questions were of interval origin. Respondents had to read the statements provided and indicate their view on a scale of 5 points, ranging from strongly disagree to strongly agree. A few questions could not be scaled as they had no units or intervals but only required a binary answer of only yes or no, while another few open ended questions, that necessitated views of the participants, were also included.

Section A consisted of 4 demographic questions related to gender, experience, type of course followed and area of practice. A less than one year option was included to the question related to work experience in order to filtrate participants and sustain the exclusion criteria. Although Oppenheim (1992) stated that demographic information might put off participants if it is at the beginning of the questionnaire, the author deemed it more appropriate to ask the demographic questions in the first section as

this gave the participants a chance to answer primarily familiar questions and then continue with more detailed questions.

Participants were asked to write down those activities they consider to be as an expansion of their role in **Section B**. This section also included the frequency the named activity is performed by marking against each activity on a 5-point scale that ranged from 'very frequently' to 'very rarely'.

Section C consisted of 14 questions, from number 6 to number 19, to be graded on a Likert scale. Each question had a 5-point scale ranging from 'strongly agree' to 'strongly disagree' to form a composite scale to measure the nurses' attitudes towards the expanded role. This Likert scale was adapted by Magennis et al. (1999). Permission to use this tool was sought from one of the authors and granted (Appendix 3). Likert scales tend to perform very well when it comes to a reliable, rough ordering of people with regard to a particular attitude (Oppenheim, 1996). This tool consists of a pool of statements expressing favourable and unfavourable attitudes towards role expansion. The total maximum score, when all favourable items are added together, is 70 while the minimum score is 14. Therefore, a high mean score would reflect a positive attitude while a low mean score indicates a negative attitude. Oppenheim (1996) instructed that the number of attitude statements have been selected and put together from a much larger number of statements. Therefore, **the few chosen statements in a finished Likert scale should not be judged at their face value because they are the outcome of complicated process of item analysis.**

In fact, Magennis et al. (1999) stated that neutral statements or statements so extreme that everyone would either agree or disagree with them should be avoided. Also, to avoid bias, equal numbers of positive and negative items were used. This was completed in accordance with the scale design as advised by Polit and Hungler (1995) and Oppenheim (1996). Before computation of results, ratings for negative items were reversed. Questions 6 to 13 addressed areas related to quality of care, devaluation of basic nursing care, vulnerability to litigation, independence to decide and act in relation to role expansion and job satisfaction. While question 14 to19 addressed the potential risk to exploitation, quality of care, the threat of support workers, highlight the effects on the doctor nurse relationship and the need to respond to new needs in health care. This part of the questionnaire was already tested positively for validity and reliability by Magennis et al. (1999).

What competence meant to nurses was explored in **Section D** which included questions that inquired about the involvement of post registration training, courses completed and where. This section also asked for information regarding theory and research-based practice, how nurses keep adjourned, the notion of training and certificates and how nurses rate themselves when performing expanded role activities.

Questions related to the awareness of nurses' legal implications of the expanded role were inquired in **Section E**. These included questions regarding the knowledge and adherence to the local policy about intravenous drug administration and job description document, vicarious liability, experience, discipline, acceptance of policies and willingness to learn. Question 39 gave the opportunity to respondents to

express themselves should they feel that the questionnaire had not exhausted all their feelings towards role expansion.

3.8 Pilot Study

A small-scale trial of the research method is essential as it serves to improve the research tool before the actual study is carried out. This could be a useful means for the researcher to use the appropriate words, ordering of question sequence and the reduction of non-response rate (Oppenheim, 1996).

Twelve nurses participated in the pilot study to pre-test the questionnaire. Each area under study was represented by 2 nurses conveniently chosen for their experience and knowledge in their field of practice. Moreover, 2 other questionnaires were given to nurses resembling the sample in the real study. Although no ambiguities were reported and all questions asked were clear, question 16 had to be reworded, scales in question 23 and 24 had to be changed and punctuation mistakes corrected. Also, changes in the layout were also suggested and executed. The pilot study also served to determine if nurses differentiate between the term expanded or extended role. All participants could not distinguish the difference between the terms. Therefore, for the purpose of the study these terms will be considered the same and referred to as expanded role.

3.9 Data Collection

A letter (Appendix 4) explaining the purpose of the study was distributed together with the questionnaire. The total amount of questionnaires distributed was 107. To ensure anonymity, questionnaires were given to a named person in each unit who agreed to distribute them. When filled, the named person returned them to the author sealed in the provided envelope. This method proved to be very effective for the response rate was 79.4%, that is 85 questionnaires. However, only 83 were valid for the purpose of the study for 2 participants who had less than 1-year post registration experience returned the questionnaires. The researcher's home and work telephone number were provided to make it easy for respondents just in case further clarification was necessary.

3.10 Validity and Reliability

"Validity refers to the degree to which an instrument measures what it is supposed to measure" (Polit & Hungler, 1995, p.353). The questionnaire used for this study appears to have face and content validity as the author tried to include all the appropriate questions that emerged from a comprehensive review of the literature on the expanded role of the nurse. Moreover, the research supervisors and participants in the pilot study expressed positively their views on the research instrument's face and content validity.

Reliability was defined by Cormack (1996, p. 181) as the "degree of consistency or accuracy with which the instrument measures an attribute". Therefore, if an

instrument is said to be reliable it has to produce consistent results even with a different sample. Moreover, no tool can be valid if it is not reliable.

For this reason a Cronbach's Alpha coefficient, which is the most widely used method to test reliability, was computed to test the research tool used in this study. This is the most accurate method as all possible split-half correlation for each section will be worked (Polit & Hungler, 1995). Results could range from 0 to 1 and the higher the results are, the higher the relationship and suitability. **The results of the Cronbach's Alpha coefficient test obtained for the nurses' attitude scale towards role expansion is 0.80.** This reflects an acceptable degree of reliability as defined by Polit and Hungler (1995).

3.11 Ethical Considerations

Permission to conduct this study was granted by the Board of Studies of the Health Services Management after a written proposal was submitted. Authorisation, regarding the distribution of questionnaires to the registered nurses in the sample chosen, was sought and obtained by the hospital authorities after the objectives were explained in a letter designed for the purpose (Appendix 5).

The respondents were asked not to include their names, so that information will not be related to a particular participant. Moreover, participants were assured that their responses would be strictly confidential and that the data collected will only be used for the purpose of the study. To safeguard the participants' anonymity, questionnaires

were handed in a sealed envelope to a named person working in the unit and later retrieved by the researcher.

Participation was voluntary and participants could withdraw at any stage of the study although completion of the questionnaire was extremely important to the study. A letter (Appendix 4) was enclosed with each questionnaire explaining its purpose. When the questionnaire was completed and returned, it was understood that consent was granted to participate in the study. The approximate length of time to complete the questionnaire, that is 10 to 15 minutes, was also indicated.

3.12 Data Analysis

The questionnaires were coded and the data collected from the closed ended questions were inputted in the computer to be analysed with the aid of a computer programme, the Statistical Package for Social Sciences (SPSS). Both descriptive and inferential statistics were used to analyse the data gathered from the questionnaires.

Descriptive statistics are procedures used to organise and summarise data so that important characteristics of the data can be described and communicated (Heiman, 2000). Inferential statistics permit inferences on whether relationships observed in a sample are typical to occur in a larger population (Polit & Hungler, 1995). The inferential statistics used included:

- The **independent sample t-test** which is the parametric procedure used for significance testing when two sample means are from independent samples (Heiman, 2000).

- **ANOVA test** which is a parametric procedure for determining whether significant differences exist in a study containing two or more sample means (Heiman, 2000).
- **Post hoc comparisons** which is a statistical procedure, in ANOVA, used to compare all possible pairs of sample means in a significant effect (like t-tests) to determine which means differ significantly from each other (Heiman, 2000).
- **Chi Squared** procedure which is the nonparametric inferential procedure for testing whether the frequencies in each category in sample data represent certain frequencies in the population (Heiman, 2000).

Content analysis was used to analyse data collected from open-ended questions. Groups were discussed with the research supervisor to identify and agree about the final topics. The results and analysis are produced in the next chapter.

Chapter 4

4 - Results and Analysis

4.1 Introduction

Results of the data from the returned questionnaires are being presented in this chapter. For clarity purposes, the write up is going to follow the sequence of the 5 sections of the questionnaire and for the purpose of simplification, percentage figures have been rounded to the nearest whole integer. Eighty-five out of 107 participants returned the questionnaire, however only 83 questionnaires were analysed, as 2 participants did not satisfy the inclusion criteria as they had less than 1 year post registration experience. This gives a response rate of 79%.

4.2 Section A – Demographic Data

The experience of the nurses under study varies as shown in Table 4.1. Fifty-two percent (n = 43) of the respondents have more than 6 years nursing experience while 48% (n = 40) fall under the 1 to 5 years nursing experience bracket.

Table 4.1: Number of respondents by gender & experience (n = 83)

Gender	**Nursing Experience**				**Total**
	1-5 years	**6-10 years**	**11-15 years**	**> 15 years**	
Male	**10** *(12)*	**7** *(8)*	**6** *(7)*	**9** *(12)*	**32** *(39)*
Female	**30** *(36)*	**10** *(12)*	**6** *(7)*	**5** *(6)*	**51** *(61)*
Total	**40** *(48)*	**17** *(20)*	**12** *(14)*	**14** *(18)*	**83** *(100)*

- *Numbers in parenthesis represent percentages*

Table 4.2 shows that the percentage of female degree nurses amount to three times as much as that of males while the percentage of nurses who are in possession of the traditional course certificate is very much higher than the graduate nurses.

Table 4.2: Number of respondents by gender & nursing course followed (n = 83)

Gender	Nursing Course Followed			Total
	Traditional	Diploma	Degree	
Male	19 *(23)*	8 *(10)*	5 *(6)*	32 *(39)*
Female	16 *(19)*	20 *(24)*	15 *(18)*	51 *(61)*
Total	35 *(42)*	28 *(34)*	20 *(24)*	83 *(100)*

- *Numbers in parenthesis represent percentages*

The number of staff nurses in the study consists of 32 (39%) males and 51 (61%) females (Table 4.3). The highest number of respondents, 26 (31%), work in Intensive Therapy Unit, while the lowest number of respondents, 8 (10%) work in the Coronary Care Unit.

Table 4.3: Number of respondents by gender & area of work (n = 83)

Gender	Area of Work					Total
	Surgical	Medical	ITU	CCU	A&E	
Male	4 *(5)*	9 *(11)*	12 *(14)*	4 *(5)*	3 *(4)*	32 *(39)*
Female	11 *(13)*	11 *(13)*	14 *(17)*	4 *(5)*	11 *(13)*	51 *(61)*
Total	15 *(18)*	20 *(24)*	26 *(31)*	8 *(10)*	14 *(17)*	83 *(100)*

- *Numbers in parenthesis represent percentages*

Table 4.4 shows that 14 (17%) degree nurses are in the 1 to 5 years experience bracket while 35 (42%) nurses who posses a traditional course certificate have more that 6 years nursing experience. It is important to note that the traditional course was phased out in 1992 and has been replaced by the diploma and degree courses.

Therefore no diploma or degree nurse has more than 10 years experience. Forty eight percent (n= 40) of the participants do not have more than 5 years nursing experience while 17% (n = 14) have more than 15 years nursing experience.

Table 4.4: Number of respondents by experience & nursing course followed (n = 83)

Experience	Nursing Courses Followed			Total
	Traditional	Diploma	Degree	
1-5 years	0	26 *(31)*	14 *(17)*	40 *(48)*
6-10 years	11 *(14)*	2 *(2)*	6 *(7)*	19 *(23)*
11-15 years	10 *(12)*	0	0	10 *(12)*
> 15 years	14 *(17)*	0	0	14 *(17)*
Total	35 *(42)*	28 *(34)*	20 *(24)*	83 *(100)*

- *Numbers in parenthesis represent percentages*

As shown in Table 4.5, the traditional nurses are identified as the most experienced. They are spread amongst the 5 areas under study, however the majority of them seem to work in ITU and the Medical section.

Table 4.5: Number of respondents by experience & area of work (n = 83)

Experience	Area of Work					Total
	Surgical	Medical	ITU	CCU	A&E	
1-5 years	9 *(12)*	6 *(7)*	16 *(20)*	3 *(4)*	6 *(7)*	40 *(50)*
6-10 years	3 (4)	7 (9)	3 (4)	1 (1)	5 (6)	19 (24)
11-15 years	2 *(2)*	2 *(2)*	2 *(2)*	2 *(2)*	2*(2)*	10 *(10)*
>15 years	1 *(1)*	5 *(6)*	5 *(6)*	2 *(2)*	1 *(1)*	14 *(16)*
Total	15 *(19)*	20 *(24)*	26 *(32)*	8*(9)*	14 *(16)*	83 *(100)*

- *Numbers in parenthesis represent percentages*

No diploma nurses work in CCU, while the highest percentages of diploma nurses are working in the ITU and the Surgical area (Table 4.6). Graduate nurses are more

concentrated in the speciality areas especially in the ITU where there are 9 out of 20 graduate nurses. The ITU nurses are almost equally divided amongst traditional, diploma and degree nurses.

Table 4.6: Number of respondents by nursing course followed & area of work (n = 83)

Nursing Course Followed	Area of Work					Total
	Surgical	Medical	ITU	CCU	A&E	
Traditional	**5** *(6)*	**12** *(14)*	**8** *(10)*	**4** *(5)*	**6** *(7)*	**35** *(42)*
Diploma	**8** *(10)*	**5** *(6)*	**9** *(11)*	**0** *(0)*	**6** *(7)*	**28** *(34)*
Degree	**2** *(2)*	**3** *(4)*	**9** *(11)*	**4** *(5)*	**2** *(2)*	**20** *(24)*
Total	**15** *(18)*	**20** *(24)*	**26** *(32)*	**8** *(10)*	**14** *(16)*	**83** *(100)*

- *Numbers in parenthesis represent percentages*

4.3 Section B – Expanded Role Activities

This section of the questionnaire sought to identify which activities the nurses in the study considered as an expansion of their role. Participants were also asked to indicate how often on a scale of 5 points the named procedures are performed.

Participants listed out more than 1 activity. Thirty-four activities were identified which ranked from non-nursing jobs, such as clerical duties, to regular nursing duties such as insertion of urinary catheters and naso-gastric tubes and to highly specialised activities namely dealing with ventilators and cardioversion. Identified procedures are listed in Table 4.7 together with the frequency these activities are performed. The most frequent activities performed appear to be administrating intravenous drugs, blood withdrawal and insertion of intravenous venflons. There are activities that are ranked very low in occurrence such as suturing and desloughing of wounds.

Table 4.7: Expanded role activities and number of occurrences (n = 83)

Number of Activities	Named Activities	Very Frequent	Frequent	Occasionally	Rarely	Very Rarely	Times Listed	Percent
1	*I.V. drug administration	46	9			2	**57**	**69**
2	Withdrawing blood	30	10	3	1	2	**46**	**55**
3	Insertion of I.V. venflons	10	12	3	2	2	**29**	**35**
4	Clerical duties	11	6	4			**21**	**25**
5	Chest physiotherapy	9	5	4			**18**	**22**
6	Using computers	8	4	5			**17**	**20**
7	Dealing with ventilator	11					**11**	**13**
8	Cardioversion		1	7	2		**10**	**12**
9	Triage	7					**7**	**8**
10	Management	2	3	1			**6**	**7**
11	Writing treatment on charts	4	2				**6**	**7**
12	Facing relatives	3	1	1			**5**	**6**
13	Counselling	2	3				**5**	**6**
14	Patients escort	1	3	1			**5**	**6**
15	Operating high-tech machines	4					**4**	**5**
16	Intubation		1	2		1	**4**	**5**
17	Insertion of urinary catheter	2	1	1			**4**	**5**
18	Checking blood results	4					**4**	**5**
19	Ordering pharmaceuticals	3	1				**4**	**5**
20	Admitting & discharging patients	2	2				**4**	**5**
21	Pre-hospital care	2	1	1			**4**	**5**
22	Extubation		1	2			**3**	**4**
23	Distribution of meals	1	2				**3**	**4**
24	Tracheostomy tube changing	1		1			**2**	**2**
25	Interpreting ECG			1	1		**2**	**2**
26	Applying plaster of Paris	2					**2**	**2**
27	**CAPD			2			**2**	**2**
28	Removal of central line			1			**1**	**1**
29	Removal of chest drains					1	**1**	**1**
30	Answer emergency calls	1					**1**	**1**
31	Helicopter flights			1			**1**	**1**
32	***NGT insertion		1				**1**	**1**
33	Desloughing of wounds			1			**1**	**1**
34	Suturing				1		**1**	**1**
	Total activities– 34							

**Intravenous,*

***Continuous ambulatory peritoneal dialysis,*

**** Naso-gastric tube*

4.4 Section C - Nurses' Attitudes Score

Section C sought to measure the nurses' attitudes towards the expanded role. The score is a mean result of 14 questions added together whose respective workings are shown in Appendix 6. The findings show an overall mean of 43 (62%). Slight differences could also be found between males and females. No statistical significance (when *p* is less than 0.05) was found when an Independent t-test was computed (t = -0.749; df = 82; p = 0.486, NS) between the male and female attitudes score towards the expanded role. Results are exhibited in Table 4.8.

Table 4.8: Attitudes towards the expanded role according to gender (n = 83)

Gender	Mean	Std. Deviation	% of overall mean
Male (*n = 32*)	44	9	63
Female (*n = 51)*	42	7	61
Total (n = 83)	**43**	**8**	**62**
Independent t-test: t = -0.749; df = 82; p = 0.486 NS* (p < 0.05) ****Not Significant***			

The nurses' attitude score was also computed according to level of experience. The over 15 years experience bracket scored the highest with a mean of 46 (66%). No statistical significance (when *p* is less than 0.05) was found when one-way ANOVA (Analysis of Variance) statistical test was computed (f = 1.144; df = 82; p = 0.332, NS) between the different levels of experience and attitudes score towards the expanded role. Results are displayed in Table 4.9.

Table 4.9: Attitudes towards the expanded role according to experience (n = 83)

Experience	Mean	Std. Deviation	% of overall mean
1-5 years (n = 40)	43	7	61
6-10 years (n = 17)	41	9	59
11-15 years (n = 12)	42	6	60
Over 15 years (n = 14)	46	10	66
Total (n = 83)	**43**	**8**	**62**
One-way ANOVA: f = 1.144; df = 82; p = 0.332 NS* (p < 0.05)			
****Not Significant***			

The degree nurses' attitude toward the expanded role gave the highest score with a mean of 46 (65%). No statistical significance (when *p* is less than 0.05) was found when one-way ANOVA statistical test was computed (f = 1.263; df = 82; p = 0.337, NS) between the respondents difference nursing education and the attitudes score towards the expanded role. Other results are shown in Table 4.10.

Table 4.10: Attitudes towards the expanded role according to nursing education (n = 83)

Nursing education	Mean	Std. Deviation	% of overall mean
Traditional (n = 35)	43	9	61
Diploma (n = 28)	41	7	59
Degree (n = 20)	45	7	65
Total (n = 83)	**43**	**8**	**62**
One-way ANOVA: f = 1.263; df = 82; p = 0.337 NS* (p < 0.05)			
****Not Significant***			

Nurses' attitudes towards the expanded role was computed and reveal that nurses in the surgical wards scored the lowest with 37 (53%) and nurses working in the Intensive Care Unit scored the highest with 46 (66%). Statistical significance (when

p is less than 0.05) was found when one-way ANOVA statistical test was computed ($f = 3.371$; $df = 82$; $p = 0.013$) between different areas of work and the attitudes score towards the expanded role. Post hoc comparison (Mean difference = 9.03; $p = 0.005$) determined that there is only a statistical significance between the ITU group and the Surgical group when p is less than 0.05. All results are exhibited in Table 4.11.

Table 4.11: Attitudes towards the expanded role according to area of work (n = 83)

Area of work	Mean	Std. Deviation	% of overall mean
Surgical (n = 15)	37	5	53
Medical (n = 20)	43	9	61
ITU (n = 26)	46	7	66
CCU (n = 8)	45	7	65
A&E (n = 14)	43	8	61
Total (n = 83)	**43**	7	**62**
One-way ANOVA: $f = 3.371$; $df = 82$; $p = 0.013$ ($p < 0.05$)			
Post hoc comparison: Mean difference = 9.03; $p = 0.005$			

4.5 Section D – Keeping abreast in nursing and competence

Section D, consisting of questions 20 to 29, explored how participants keep in touch with theoretical knowledge and practice and elicit the nurses' ideas of competence.

Question 20 and 21 asked participants to state whether or not they are currently involved in a post registration course or if they had completed any. Table 4.12 shows that 23 (28%) of the respondents are currently undertaking training while 51 (61%) have already completed a post registration course.

Table 4.12: Participants who are currently involved and completed post registration courses (n = 83)

	Currently involved in training		Courses completed	
	Frequency	**Percent**	**Frequency**	**Percent**
No	60	72	32	39
Yes	23	28	51	61
Total	**83**	**100**	**83**	**100**

A Chi-Squared test (χ^2) was computed between the below and above median scores (Median = 43) derived from the nurses' attitude score and those currently involved in training and those who are not. Results concluded no statistical significance when p is less than 0.05. Also, Chi-Squared test was computed to compare the below and above median score (Median = 43) from the nurses' attitude score and those who have completed or not a post registration course. Result revealed no statistical significance when p is less than 0.05. Results of these two summations are exhibited in Table 4.13.

Table 4.13: Chi-Squared between attitudinal low and high scores and nurses currently undertaking or completed a course and those who did not (n =83)

Courses	Statistical Test	Values		
Currently	Chi-Squared	$\chi^2 = 0.1331$	df: 82	p = 0.7152, **NS***
Completed	Chi-Squared	$\chi^2 = 0.0076$	df: 82	p = 0.9307, **NS***
Not Significant	***Results considered significant when p value < 0.05***			

Table 4.14 shows a list of the 9 courses being currently undertaken by respondents. Administration of intravenous drugs and First Line Management courses are the most commonly cited. Other participants are pursuing high level courses at the university.

Table 4.14 – Courses currently being undertaken by nurses (n = 83)

Course	Participants Involved	Percent
Administration of IV Drugs	6	7
First Line Management	6	7
Supervising and Assessing	4	4
Diploma in Management	2	2
Substance Misuse	1	1
Masters Degree in Health Service Management	1	1
Masters in Public Health	1	1
Masters in Nursing	1	1
Diploma in Advanced Clinical Nursing	1	1
Total	**23**	**25**

A high percentage of nurses pursued 19 different courses, which are listed in Table 4.15. Participants could have listed more that one course. Administration of intravenous drugs course is the most common course chosen by the participants.

Table 4.15: List of courses undertaken by participants (n = 83)

Courses	Completed by Participants	Percent
Administration of 1V Drugs	27	32
Infection Control	10	12
Critical Care	8	10
First Line Management	7	9
Clinical Medical Update	6	7
Basic Life Support	5	6
Assessing and Supervising Students	5	6
Cardiology	3	4
Research Awareness	2	2
Middle Line Management	2	2
Diploma in Health Service Management	2	2
Empowerment	2	2
Sports Management Therapy	1	1
Community Nursing	1	1
Rescue	1	1
Communication	1	1
Nature of Nursing	1	1
Creative Thinking	1	1
Advance Trauma	1	1

Courses, which cover a variety of skills, are mainly attended to at the Institute of Health Care (Table 4.16). Other venues for training, such as on the job or abroad are less frequently taken by the participants.

Table 4.16: Venue of training (n = 83)

The training was :	Frequency
On the job	9
At the Institute of Health Care	46
Abroad	13
Others	8

Question 23 and 24 were related to see whether nurses feel they are updated with theoretical nursing practice and research based practice. Participants had to choose from a 5 point scale ranging from 'not at all' to 'a great deal. No one answered 'not at all' as regards to theoretical practice. Results, which are exhibited in Tables 4.17 and 4.18, show that nurses feel that they keep more up to date in theoretical nursing practice than research based practice. Overall rating are higher for theoretical knowledge and on the lower side for research based practice.

Table 4.17: Updated to theoretical nursing knowledge (n = 83)

	Frequency	Percent
Little	17	20
Somewhat	34	41
Much	28	34
A great deal	4	5
Total	**83**	**100**

Table 4.18: Updated to research based practice (n = 83)

	Frequency	Percent
Not at all	6	7
Little	25	30
Somewhat	28	34
Much	19	23
A great deal	5	6
Total	**83**	**100**

One way ANOVA test was computed between the attitude score against the results achieved from how nurses updated themselves to theoretical practice. No statistical significance result was achieved when p was less than 0.05. Also no statistical significance (when p was less than 0.05) resulted after a one way ANOVA was computed between the attitude score against the scores achieved from how nurses updated themselves to research based practice. Results of these 2 computations are exhibited in Table 4.19.

Table 4.19: ANOVA test between attitudinal score and theoretical and research based practices (n = 83)

Updated to:	Statistical Test	Values		
Theoretical Practice	ANOVA	f = 0.710	df = 82	p= 0.836, **NS***
Research Based Practice	ANOVA	f = 1.173	df = 82	p = 0.298, **NS***
***Not Significant**	***Results considered significant when p < 0.05***			

The participants were asked in question 25 to indicate how they keep abreast about nursing. Nurses could list more than one option. Results are exhibited in Table 4.20. Reading nursing journals is the favourite method adopted by nurses to keep in touch with nursing. It is interesting to note that 10% (n = 9) browse the Internet to inform themselves with recent changes in nursing.

Table 4.20: Methods used to keep updated about nursing (n = 83)

Updated by:	Frequency	Percent
Reading nursing journals	62	75
Attending conferences	44	53
Attending lectures at IHC	27	32
The use of Internet	9	10
Other means	7	8

Question 26 inquired about the nurses' opinion regarding the need of further training to expand their role. On a 5 point scale respondents had to choose from measures ranging from 'strongly disagree' to 'strongly agree'. Results, which are displayed in Table 4.21, show with certainty that the respondents approve the notion of further training to expand their role.

Table 4.21: Further training/courses to expand the nurses' role (n = 83)

	Frequency	Percent
Strongly Disagree	2	2
Disagree	2	2
Uncertain	1	1
Agree	46	56
Strongly Agree	32	39
Total	**83**	**100**

Inferential statistical tests for question 26 were computed against demographic data, gender, experience, nursing education and area of work, using the independent t-test and one-way ANOVA. Results that reveal no statistical significance (when p is less than 0.05) are displayed in Table 4.22.

Table 4.22: Statistical test comparing demographic data and approval for further training (n = 83)

Demographic Subject	Statistical Test	Values		
Gender	Independent t-test	t = 0.250	df = 82	p = 0.810 **NS***
Experience	ANOVA	f = 0.964	df = 82	p = 0.432 **NS***
Nursing Education	ANOVA	f = 2.099	df = 82	p = 0.089 **NS***
Area of work	ANOVA	f = 1.450	df = 82	p = 0.226 NS*
***Not Significant**	***Results considered significant when p < 0.05***			

The next question, number 27, was asked to see if participants feel competent when performing activities beyond their basic training. Results, which can be seen in Table 4.23, demonstrate that 32 (38%) of the respondents perform expanded role activities while they are not absolutely certain of their competency.

Table 4.23: Competent when performing expanded activities (n = 83)

	Frequency	Percent
Strongly Disagree	7	8
Disagree	7	8
Uncertain	18	22
Agree	45	54
Strongly Agree	6	7
Total	**83**	**100**

Inferential statistical tests for question 27 were computed against demographic data using the independent sample t-test and one-way ANOVA. Results, which reveal no statistical significance (when *p* is less than 0.05), are displayed in Table 4.24.

Table 4.24: Statistical test between demographic data and self-competence (n=83)

Demographic Subject	Statistical Test	Values		
Gender	Independent t-test	t = 0.560	df = 82	p = 0.120 **NS***
Experience	ANOVA	f = 2.374	df = 82	p = 0.059 **NS***
Nursing Education	ANOVA	f = 0.853	df = 82	p = 0.496 **NS***
Area of work	ANOVA	f = 1.844	df = 82	p = 0.129 **NS***
Not Significant	***Results considered significant when p < 0.05***			

Question 28 was open ended, asking nurses to state why they feel competent when performing expanded role activities. Fifty-one (51) participants answered this question giving more than 1 reason. Five groups emerged which are displayed in Table 4.25. Examples from each group are included in the Table. Nineteen nurses (23%) based their competency on experience, followed by 16 (19%) respondents who associated competence with on the job training. Eleven nurses (13%) showed confidence in their capabilities and the same amount of nurses associated competence with theory. Formal training with 5 (6%) respondents was ranked the least important to achieve competency.

Table 4.25: Groups regarding competency and examples (n = 83)

Groups	Examples
Experience **19 (23%) respondents**	• Many years of experience in different wards and departments (AA24). • I am doing such activities properly through experience (AA27). • Due to practice I feel competent to perform these activities (AA34). • I do not do anything if I am not certain of what I am doing. I have learnt from experience (AA36). • Because of the repeated times I have performed the activities (AA39). • Sometimes practice and experience are more important to make you competent (AA49).

Table 4.25. *(continued)*

Groups	Examples
On the job training **16 (19%) respondents**	• I had good mentors when I started working (AA3). • I make the best of myself to learn from experienced nurses (AA16). • Experienced nurses in this field taught me (AA22). • Initially, I was taught how to perform such activities and needed assistance while performing them (AA23) • I feel competent in performing these activities because I have learned to do them under proper supervision. (AA26). • Being mentored before I do anything when I am not certain of what I am doing (AA36).
Self Confidence **11 (13%) respondents**	• I feel competent when compared to other nursing staff (AA13). • I act safely and effectively (AA19). • Now I feel competent enough to do them on my own (AA23). • Because the outcome is not inferior to that of a medical officer (AA29). • By knowing what I am doing (AA63).
Theory based knowledge **11 (16%)** **respondents**	• Reading on my accord (AA1). • I backed up the information given by reading (AA3). • Keep myself up to date in nursing by reading (AA14). • I have learned through reading in relation to the expanded role (AA36). • Because I read about before performing expanded role Activities (AA58).
Formal training **5 (6%) respondents**	• I am well trained and certified (AA14). • I make it a point to acquire training regarding the subject (AA30). • I have been given specific training (AA32). • Attended various post registration courses (AA66). • I have attended post registration courses (AA71).

**The number in the brackets shows the code number of the questionnaire.*

Section D was concluded by question 29 that inquired about the nurses' opinion regarding the need for certification of training to perform activities not covered in pre-

registration training. Nurses strongly prefer to have a certificate of competence when being engaged in activities beyond their basic training as displayed in Table 4.26.

Table 4.26: Need to be certified to perform expanded activities (n = 83)

	Frequency	Percent
Strongly Disagree	4	5
Disagree	8	10
Uncertain	8	10
Agree	41	49
Strongly Agree	22	26
Total	**83**	**100**

Inferential statistical tests for question 29 were computed against demographic data using the independent sample t-test and one-way ANOVA. Results, which reveal no statistical significance (when p is less than 0.05), are displayed in Table 4.27.

Table 4.27: Statistical test between demographic data and need for certification (n = 83)

Demographic Subject	Statistical Test	Values		
Gender	Independent t-test	t = -0.333	df = 82	p = 0.736 **NS***
Experience	ANOVA	f = 0.923	df = 82	p = 0.455 **NS***
Nursing Education	ANOVA	f = 0.883	df = 82	p = 0.478 **NS***
Area of work	ANOVA	f = 0.832	df = 82	p = 0.509 **NS***
***Not Significant**	***Results considered significant when p < 0.05***			

4.6 Section E – Nurses knowledge about legal aspects

The questions of this Section were related to the knowledge of the legal aspects of the nurses' role when performing expanded activities.

Question 30 sought to find how many nurses read the local policy for administering intravenous medications. Fifty-nine (71%) nurses read such an important policy. Table 4.28 shows the results of this question.

Table 4.28:Read local policy of administration of IV drugs (n = 83)

	Frequency	Percent
No	24	29
Yes	59	71
Total	83	100

The participants level of agreement, on a continuum of 5-points scale, with the instructions held by this policy was sought from those who read the policy in question 31. Table 4.29 demonstrates that most of the nurses, who read the policy, are in accordance with policy directions.

Table 4.29: Level of agreement with the local policy for IV drug administration (n = 59)

	Frequency	Percent
Strongly Disagree	1	2
Disagree	5	8
Uncertain	8	14
Agree	29	49
Strongly Agree	16	27
Total	**59**	**100**

Inferential statistical tests for question 31 were computed against demographic data using the independent sample t-test and one-way ANOVA. Results as displayed in Table 4.30 reveal that there is no statistical significance (when p is less than 0.05) between the area of work and the respondents level of agreement with the local policy for the administration of intravenous drugs.

Table 4.30: Statistical test between demographic data and agreement with the local policy (n = 59)

Demographic Subject	Statistical Test	Values		
Gender	Independent t-test	t = -1.139	df = 58	p = 0.289 **NS***
Experience	ANOVA	f = 1.284	df = 58	p = 0.288 **NS***
Nursing Education	ANOVA	f = 1.938	df = 58	p = 0.117 **NS***
Area of work	ANOVA	f = 3.839	df = 58	p = 0.239 **NS***
****Not Significant***	***Results considered significant when p < 0.05***			

The next question (question 32), asked the nurses in the study if they had read their job description document. Information given is displayed in Table 4.31, which shows that 26 participants (30%) did not read the work contract document.

Table 4.31: Read the job description document (n = 83)

	Frequency	Percent
No	26	30
Yes	57	70
Total	**83**	**100**

In question 33, participants (n = 57) who read the job description document were asked to indicate their level of agreement, on a continuum of 5-points scale, with the statement that the job description leaves space to cover activities not covered under basic training. Twenty five percent (n=14), as shown in Table 4.32, disagree that the document leaves space to perform activities beyond basic training while 32% (n=24) show accordance and 33% (n=19) were uncertain.

Table 4.32: Job description covers the expanded role (n = 57)

	Frequency	Percent
Strongly Disagree	1	2
Disagree	13	23
Uncertain	19	33
Agree	16	28
Strongly Agree	8	14
Total	**57**	**100**

Inferential statistical tests for question 33 were computed against demographic data using the independent sample t-test and one-way ANOVA. Results, which reveal no statistical significance (when p is less than 0,05), are displayed in Table 4.33.

Table 4.33: Statistical test between demographic data and the job description containment (n = 57)

Demographic Subject	Statistical Test	Values		
Gender	Independent t-test	t = -0.707	df = 56	p = 0.478 **NS***
Experience	ANOVA	f = 0.927	df = 56	p = 0.456 **NS***
Nursing Education	ANOVA	f = 1.015	df = 56	p = 0.408 **NS***
Area of work	ANOVA	f = 0.309	df = 56	p = 0.871 **NS***
Not Significant	***Results considered significant when p < 0.05***			

The notion of vicarious liability was explored in question 34 where participants had to mark their level of agreement on a 5-point scale for a statement that nurses have the full backing and support of their superiors when performing expanded role activities. Results, that are exhibited in Table 4.34, show that there are inconsistent responses about the notion of vicarious liability.

Table 4.34: Support from superiors (n = 83)

	Frequency	Percent
Strongly Disagree	8	10
Disagree	16	19
Uncertain	22	26
Agree	23	28
Strongly Agree	14	17
Total	**83**	**100**

Inferential statistical tests for question 34 were computed against demographic data using the independent sample t-test and one-way ANOVA. Results as displayed in Table 4.35 reveal that there is statistical significance (when p is less than 0.05) between the area of work and the respondents level of agreement of their superiors support. Post hoc comparison determined that there is only a statistical significance between the ITU group and the Surgical group when p is less than 0.05.

Table 4.35: Statistical test between demographic data and support by superiors (n = 83)

Demographic Subject	Statistical Test	Values		
Gender	Independent t-test	T = -0.124	df = 82	P = 0.902 **NS***
Experience	ANOVA	f = 0.467	df = 82	P = 0.759 **NS***
Nursing Education	ANOVA	f = 1.286	df = 82	P = 0.283 **NS***
Area of work	ANOVA	f = 2.614	df = 82	**p = 0.001****
Post hoc comparison: Mean difference =1.54; p= 0.001				
****Not Significant***	***** Results considered significant when p < 0.05***			

Question 35 sought to learn what level of agreement respondents choose when asked that they will be considered as a nurse and not as a doctor or a member of another profession when engaged in expanded activities. Table 4.36 clearly demonstrates that the respondents appear to agree with the statement provided.

Table 4.36: Viewed as nurse not as a doctor when performing expanded role activities (n = 83)

	Frequency	Percent
Strongly Disagree	4	5
Disagree	3	4
Uncertain	5	6
Agree	51	61
Strongly Agree	20	24
Total	**83**	**100**

Inferential statistical tests for question 35 were computed against demographic data using the independent sample t-test and one-way ANOVA. Results, which reveal no statistical significance, (when p is less than 0.05) are displayed in Table 4.37.

Table 4.37: Viewed as nurse not as a doctor when performing expanded role activities (n = 83)

Demographic Subject	Statistical Test	Values		
Gender	Independent t-test	t = -0.753	df = 81	p = 0.421 **NS***
Experience	ANOVA	f = 0.927	df = 82	p = 0.436 **NS***
Nursing Education	ANOVA	f = 1.015	df = 82	p = 0.369 **NS***
Area of work	ANOVA	f = 0.309	df = 82	p = 0.141 **NS***
***Not Significant**	***Results considered significant when p < 0.05***			

The question of whether experience is taken in consideration when disciplined was put for the respondents to show their level of agreement on a 5-point scale (question 36). Again, answers to this question, displayed in Table 4.38, show that inconsistency dominates as small differences exist between the levels registered.

Table 4.38: Experience is taken in consideration when disciplined (n = 83)

	Frequency	Percent
Strongly Disagree	16	19
Disagree	13	16
Uncertain	22	26
Agree	17	21
Strongly Agree	15	18
Total	**83**	**100**

Inferential statistic tests for question 36 were computed against demographic data using the independent sample t-test and one-way ANOVA. Results, which reveal no statistical significance (when *p* is less than 0.05), are displayed in Table 4.39.

Table 4.39: Statistical test between demographic data and consideration of experience (n = 83)

Demographic Subject	Statistical Test	Values		
Gender	Independent t-test	t = -0.037	df = 81	p = 0.971 **NS***
Experience	ANOVA	f = 0.927	df = 82	p = 0.560 **NS***
Nursing Education	ANOVA	f = 1.015	df = 82	p = 0.878 **NS***
Area of work	ANOVA	f = 0.309	df = 82	p = 0.661 **NS***
****Not Significant***	***Results considered significant when p < 0.05***			

The pre-ultimate question to be analysed, question 37, explored the level of agreement the participants hold about having guidelines (role boundary) regarding the expanded role. Results, which are exhibited in Table 4.40, show that this concept is highly acceptable amongst the respondents.

Table 4.40: Acceptance of guidelines (n = 83)

	Frequency	Percent
Disagree	2	2
Uncertain	4	5
Agree	33	40
Strongly Agree	44	53
Total	**83**	**100**

Inferential statistical tests for question 37 were computed against demographic data using the independent sample t-test and one-way ANOVA. Results, which reveal no statistical significance (when *p* is less than 0.05), are displayed in Table 4.41.

Table 4.41: Statistical test between demographic data and consideration of experience (n = 83)

Demographic Subject	Statistical Test	Values		
Gender	Independent t-test	t = -1.920	df = 81	p = 0.098 **NS***
Experience	ANOVA	f = 1.421	df = 82	p = 0.243 **NS***
Nursing Education	ANOVA	f = 0.427	df = 82	p = 0.734 **NS***
Area of work	ANOVA	f = 0.193	df = 82	p = 0.901 **NS***
Not Significant	***Results considered significant when p < 0.05***			

Table 4.42 shows the results obtained from question 38. Participants were asked to give their level of agreement, on a 5-point scale, about expanding their role. Eighty nine percent (n-74) agreed or strongly agreed about the role expansion.

Table 4.42: Willingness to expand (n – 83)

	Frequency	Percent
Disagree	1	1
Uncertain	8	10
Agree	38	46
Strongly Agree	36	43
Total	**83**	**100**

Inferential statistical tests for question 38 were computed against demographic data using the independent sample t-test and one-way ANOVA. Results as displayed in Table 4.43 reveal that there is no statistical significance (when *p* is less than 0.05) between the area of work and the respondents level of agreement to expand their role.

Table 4.43: Statistical test between demographic data and agreement role expansion (n = 83)

Demographic Subject	Statistical Test	Values		
Gender	Independent t-test	t = -0.978	df = 81	p = 0.599 **NS***
Experience	ANOVA	f = 0.628	df = 82	p = 0.243 **NS***
Nursing Education	ANOVA	f = 0.845	df = 82	p = 0.432 **NS***
Area of work	ANOVA	f = 3.150	df = 82	p = 0.055 **NS***
***Not Significant**	***Results considered significant when p < 0.05***			

Question 39, which was an open ended question, was answered by 25 respondents who made further comments about the nurses' expanded role. Eight groups emerged from their responses. Examples are displayed in Table 4.44. One respondent may have contributed to more than one group. The expanded role as an opportunity to increase knowledge was mentioned 12 times while considered stressful to nurses only once.

Table 4.44: Groups regarding the expanded role (n = 83)

Groups	Examples
Increase Knowledge **12 responses**	• I am always willing to learn new skill and expand my knowledge (AA14). • I try my best to add to my knowledge (AA30). • Expanded roles should not simply come about by experience but training and assessing should be made available (AA67). • Up to a certain point expanding our nursing duties means increasing our knowledge (AA73)
Hinder the nursing profession **5 responses**	• The nurse has her own responsibilities and duties to carry out with patients, so there is no need for doctors to delegate their responsibilities to the nurse (AA24). • Expanding one's role should be dealt with care not to hinder or compromise our 'Nursing Profession' (AA14).
Experience **4 responses**	• Lack of experience should never be an excuse for nurses when something goes wrong because if a nurse lacks experience or does not feel competent to perform any duty, s/he should ask for assistance/guidance from a senior person (AA83). • Expanded roles should not simply come about by experience but training and assessing should be made available (AA67).
Guidelines **3 responses**	• There is the need for more guidelines and protocols to do the expanded role and there should be somewhat protocols to support your expanded role (AA11). • Especially in our unit these expanded roles for part of our daily duty. It is always safe that protocols are developed and followed. What lacks is someone in charge capable of organizing lectures etc. about such procedures which can be then amalgamated with present nurse courses or even when these nurses graduate. Usually nurses head of shifts tend to inform and teach new comers about such protocols.
Teamwork **3 responses**	• Currently in my area of nursing, I consider intravenous cannulation and intravenous drug administration as part of my nursing duties and thus the medical and nursing profession work together on common grounds (AA38). • An expanded role does not mean that junior doctors are relieved of some of their workload. It should not mean so. Junior doctors should take up other work that they do not normally undertake.
Stress **1 response**	• Although expanding the nursing practice work may improve the public image towards the nurse, I think that due to the amount of workload already present on the adult wards, expanded roles contribute to increase the psychological and physical burden of the nurse (AA09).

4.7 Conclusion

Results appear to have answered the research questions, as the participants cited a list of activities presumed expanded and the frequency these activities are performed. The nurses' attitude score towards the expanded role was acquired and result analysed against demographic data. Participants also pointed out how they keep abreast in nursing as well as expressing the meaning of competence. Information that enlightens the researcher about the nurses' knowledge of the legal issues regarding the expanded role was also collected. Discussion of the findings will be dealt with in the next chapter.

Chapter 5

5 - Discussion of the Results

5.1 Introduction

The aim of the study is to identify if nurses are aware of the benefits and risks, and the legal issues relating to the expanded role. Staff nurses appear to be practicing expanded roles on a regular basis even though they may not have received formal training and been certified competent. It appears that some respondents did not have a clear understanding of the term expanded role. However, from the results, the following themes emerged namely: nursing attitudes towards the expanded role; ensuring competence and legal issues. These will be discussed in more detail in this chapter.

5.2 Nurses' Attitudes Towards the Expanded Role

The nurses in the study achieved a moderately positive attitude score towards the expanded role. This was obtained from a Likert scale of 14 statements to measure the nurses' attitudes towards the expanded role and resulted to a composite mean score of 43 (63%). This moderately positive score reveals that the nurses in the study hold a cautious attitude towards the expansion of their role. It appears that nurses are aware of the positive and negative aspects of the expanded role.

The positive aspects of the expanded role that motivate nurses to expand their role include the improvement in working relationships amongst professionals and an improvement in the delivery of multi-disciplinary care (Last et al. 1992; Leonard, 1999). The nurses themselves may benefit with increase job satisfaction as well as enlarging their knowledge, skills and promotion prospects (UKCC, 2000). The

nurses' expanded role also hold benefits for patients mainly through the delivery of safe, timely, holistic care (Leonard, 1999).

However, various arguments are brought against role expansion which decrease its attitude ratings. Nurses may be concerned with the increased workloads that may decline quality of care as the real nursing may have to be delegated to less qualified staff (Higgins, 1997; Leonard, 1999). The possibility that patients are being put at risk in the event that the nurse is not competent to perform a particular skill that could harm the patient is another reason detriment of role expansion. Results in this study show that 32 (38%) of the participants doubted their competency when engaged in expanded role activities. Also, the legal liabilities and disciplinary procedures may increase as nurses may be viewed to be performing activities that were not included in their job description (Dimond, 1995; Tingle, 1997). The move towards expansion of the nurses' role may also be viewed as exploitation as it may be argued that the authorities are using nurses instead of doctors to save money.

There seems to be valid arguments in favour and against the nurses' role expansion. Therefore, it appears that the nurses' rationale for adopting a moderately positive cautious attitude is that they view role expansion as both beneficial and risky to patients, the administration and themselves.

No statistical significant difference was found between the composite attitude mean score and the nurses' gender, experience, and education when independent t-test and one-way ANOVA statistical tests were computed. Statistical significance difference was achieved between the attitude composite mean score and the area of work when one-way ANOVA statistical test was computed. However, further probing of results

with a post hoc comparison test revealed that there is only a significant difference in attitudes toward the expanded role between the nurses working in Intensive Therapy Unit (ITU) and the nurses working in Surgical Wards. Magennis et al. (1999) also registered a statistical difference between the nurses in cardiology and nurses working in ITU and Medical Wards. Although it is difficult to explain this difference, a higher attitude score in the ITU may be due to the quality of work practised. ITU nurses have to deal with high-tech equipment and their patients need intensive care. The nurse-patient ratio in ITU is 1:1. Therefore nurses working in ITU may have more time to practice expanded role activities without fear of having to delegate nursing care to less qualified staff than Surgical nurses where the nurse patient ratio is much higher. Moreover, ITU nurses may rely on the support and easily accessibility of the expertise of a resident anaesthetist who is on duty 24 hours a day. However; the Surgical Wards have on call services to get through to a junior doctor and it may take some time until s/he attends the ward.

Apparently, nurses do not feel threatened by the expanded role as results reveal that 74 (89%) of the participants are willing to expand their role. This finding correspond to the studies undertaken by Last et al. (1992), Barrett (1995), Edwards (1995), Bowler and Mallik (1999) and Magennis et al. (1999). But, 9 (11%) participants showed that they are uneasy to commit themselves to role expansion. This number also correspond to the above mentioned studies. Further studies need to be undertaken to determine which activities need to be performed by nurses that were not covered in their basic training and the willing and opposing factors for nurses to perform expanded activities. With new knowledge the administration may be in a position to address the expanded role issue with a broader view and take well-informed decisions. Hence, measures may need to be targeted to ensure that nursing

care does not decline, safe practice will be delivered and the appropriate tasks delegated to nurses. Extra training may need to be provided to broaden the nurses' knowledge and skills of those identified procedures that need to be undertaken by nurses but were not covered in basic training. Also, the nurse patient ratio may need to be modified to accommodate the extra demands produced by the new activities and ascertain that basic nursing care will continue to be delivered by nurses. Thus patient care will not be compromised because nursing care continues to be delivered by reliable and qualified personnel who may induce quality care.

Fifty-seven (69%) participants stated that they are involved in at least one or more expanded role activities. The respondents named 34 activities, which they consider to be an expansion of their role. Activities range from clinical activities that need technical skills such as withdrawing of blood and venflon insertion, to others, such as performing triage, which need knowledge, experience and a lot of practice, while other activities were non-clinical such as the use of computers. Also nurses mentioned activities, such as the insertion of naso-gastric tubes and urinary catheters, which are traditionally considered as nursing duties (Pritchard and David, 1990). Some of the non-clinical activities mentioned, which were also found to be performed by the participants in Leonard's study (1999) were described in a local study by Bezzina (1996) as nursing duties that can be delegated to nursing aides and ward clerks.

These findings show that some of the nurses are not clear about the term expanded role. Leonard (1999) explained that expanded role activities are duties that are above and beyond those learnt in pre-registration training and for which additional education was required prior to the individual being deemed competent. Therefore, some of the

nurses may have answered the questionnaire without a clear insight of the term expanded role. Thus, since further probing of the participants was not possible one cannot exclude that the attitude of the respondents was to clerical activities or other activities that are not really expanded activities. Another point worth noting is that when nurses are demonstrating that they are not clear about their duties, an error or omission of certain aspects of care may rise for one practitioner relies on an other to perform particular tasks. Therefore, further studies are needed where the term expanded role of the nurse should be well defined and understood by the nurses and other health care professions so that everyone will be discussing the same subject. It will be more appreciated that when certain rules are suggested everyone will know to which activities they are targeted. This will prevent any confusion over responsibilities that may open up the potential for workplace dissatisfaction and conflicts amongst health carers (Leonard, 1999).

Another important point that emerged from the cited activities was that 18 (22%) participants mentioned chest physiotherapy as an expanded role. Nurses, who are the only health carers on duty and in direct contact with the patient 24 hours a day, may seem to be involved in the work of other health care professionals other than doctors if they believe it is for the patients' welfare. Therefore, nurses seem to be ready to tread on other professions' roles whenever the patients' condition demand their assistance, which may explain the reason why nurses may need to enlarge their role. This implies that nurses do not perform expanded activities just to achieve a higher status but to be able to deliver the best possible care to their patients.

Moreover, from the listed activities by the nurses as expanded roles, it appears that some of the activities correspond to the area of work such as dealing with ventilators in the ITU, cardioversion in the CCU and triage in the A&E Department. This shows that nurses perform certain activities only if they are working in particular areas. The participants in the study by Last et al. (1992), which was undertaken in intensive care units, did not only perform the necessary expanded activities but were of the opinion that such activities need to be considered as standard practice. This is the result of evolution of nursing to respond to new technological and scientific developments and it is imperative that training will be offered to nurses working in such units to meet its demands. Moreover, if expanded activities are necessary in particular areas it is essential that specialist training is available for nurses working in these specialities.

Meanwhile, other commonly cited activities were intravenous drug administration which was listed 57 (69%) times, withdrawing of blood which was mentioned 46 (55%) times and venflon insertion which was named 29 (35%) times. Nurses in the study seem to undertake these activities on a regular basis and it appears to be the daily routine of the nurses' work. This correlates with Last et al.'s (1992) and Leonard's (1999) findings and enforces Pace's (1999) results. Mackay (1993) also registered similar findings. Both nurses and doctors were not trained to perform these activities in their basic training (Mackay, 1993; Pace 1999). However, nurses and doctors could perform these activities if certain principles are followed, guided by knowledge of the anatomy and physiology to make them aware of the presence of certain structures (Boylan, 1984). According to Boylan (1984) there are no different principles or sets of principles involved in venflon insertion and withdrawing of blood

which have not already been learnt in basic training. Also, training should be provided where necessary to help practitioners to increase competence.

Such activities that are performed on routine basis may also be considered as nursing duties which could be shared with doctors especially if nursing care is not compromised. Leonard (1999) stated in her study that administration of drugs and withdrawing of blood were aspects of care commonly practiced in general wards. The reason why nurses administer intravenous drugs is that they perceive that in so doing they are preserving the welfare of patients. Drugs need to be administered to patients at regular intervals enabling the optimum level to be maintained in the blood stream (Mackay, 1993) and nurses are in position to attain this requirement (McKee & Lessof, 1992). Furthermore, Mackay (1993) stated that nurses view the administration of intravenous drugs as safer to patients when performed by them as nurses know better their patients and perform this activity more attentively.

This may indicate that nurses have the capabilities to perform such activities especially when practiced routinely. Experience and knowledge will develop nurses in competent and mature practitioners who may deliver care safely and to the desired levels. Thus, nursing will continue to evolve with new activities that are essential for the patients' welfare just as the measuring of blood pressure came over to be a shared activity between doctors and nurses. The debate is how competence will be ensured either through a certificate of competence for every expanded activity nurses perform or if nurses can determine their own competence when engaged in activities not covered in basic training. This concept will be discussed in the next section.

5.3 Ensuring Competence

The code of ethics for the Maltese nurses clearly indicates that nurses should acknowledge their limitations in their knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner (Department of Health, 1997). If nurses make a mistake because of lack of knowledge and skill or an overestimation of their own attainment and capability, the consequences could be harmful. Yet, results show that 30 (39%) of the participants engage in activities not covered in basic training when they rated themselves not competent.

This worrying result needs to be more deeply investigated with a research study to establish what is the actual reason nurses are getting engaged in activities they do not feel competent in. Leonard (1999) found that participants in her study had to endure verbal abuse, ridicule and questioning of both their professional judgment and their own professionalism in the event that they declined to undertake a specific expanded role. This is a form of bullying, which according to McMillan (1995) is a reality in health care settings that may be coercing nurses to perform activities that they actually are not confident to perform. Pressure may be placed on the nurses by means of assertions that the patient will, in some means suffer as a result of the nurses refusing to perform certain expanded procedures. Nurses may have the inability to deal with such a situation successfully, endangering the patients' health that could lead to legal liabilities for negligence. Nurses should resist such behaviour, which may come from peers, superiors and other health care professionals, and they should be encouraged to

be assertive when refusing to be engaged in activities in which they are indecisive about their competency.

Most of the nurses prefer to prove their competency by possessing a certificate that show that they have undergone training that make them legible to perform certain tasks. Results show that 63 (75%) of the participants in the study are in favour of certification before being engaged in expanded role activities. This finding was similar to other studies undertaken by Last et al. (1992), Barrett (1995), Edward (1995) and Magennis et al. (1999). It also appears that 45 (76%) of the participants, who answered the questionnaire, were in favour of the local intravenous drug administration policy, which is inline with the British DHSS (1989) document. These documents demand that nurses need a certificate of competence before being engaged in expanded role activities. It appears that nurses think that certification grant a shield that can protect them from legal litigation should the need arise because it is a tangible proof that demonstrate their competence.

However, certification does not guarantee that mistakes are not going to be made. Furthermore, certificates are not the only testimony of increased knowledge and competence. According to Bowler and Mallik (1998) certification for every task is not needed as professionals undergo a natural growth. In fact, the nurses in the study apart from attending courses (61 [51%]), read nursing journals (62 [75%]), attend conferences (44 [53%]) and browse the Internet (9 [10%]). Also, 32 (39%) of the participants stated that they keep abreast to theoretical practice while 24 (29%) feel updated in research based practice. Experience is also an important component to

attain competence for which no certificate is awarded. Therefore, nurses could be gaining their competence through different ways apart from formal courses.

Certification, according to Dimond (1995) will limit role expansion for only those activities for which nurses have attended a course. Yet the nurses (74 [89%] participants) in the study expressed their wish to expand their role. However, with the need for certification role expansion can only be achieved incrementally for tasks shed by other professions (Dimond, 1995).

Local nurses need a certificate to administer intravenous drugs although it appears from the study that this request is being ignored by 30 (36%) of the participants who are performing this activity without the needed certificate. This finding is similar to the results of a local study undertaken by Pace (1999). While most of the nurses prefer to be certified competent before performing expanded activities, when it comes to practice they still engage themselves without the needed certificate. Also, it is worth noting that intravenous drug administration is only one of several other expanded roles that are being performed without even a policy to guide those who undertake these activities. Therefore, identified tasks that are not covered under basic training need to have similar policies and the necessary training to ensure that nurses are competent. It is also important that those who have undertaken any form of training keep themselves up dated by attending renewal courses or reading, as the changes in health care make static knowledge dangerous. Also the necessary controls need to be in place to ensure adherence with the demands set by the policies.

However, this control is not being achieved for one policy as some nurses are still performing intravenous drug administration against the hospital's policy. It seems that certification ensued difficulties for nursing managers to ensure compliance, as they cannot be with everybody everywhere and they may have other responsibilities to attend to. Therefore, the central administration needs to educate nurses and instill in them the principles of responsibility and accountability as defined in the code of ethics and seek to initiate an open discussion to introduce a local general document that encompasses all the activities under the expanded role category. The discussion may have to include the nurses' representatives, unions and councils, and other health care professionals after documents adopted by foreign nursing councils and hospitals are well studied to have a broader knowledge of the situation in different countries. These discussions will challenge the present practice and instill the need for change. Resistance to change can be decreased by including the nurses or their representatives to make them own the document, thus propagate adherence. The British document *The Scope of Professional Practice* (UKCC, 1992) is a good model where primarily the practitioners will be directly accountable for their actions. This system is self-regulating where nurses will self determine their actual competence, irrespective how it was achieved, and assume accountability for their actions.

Moreover, the new document will emphasize the concept of accountability that may make nurses refrain from any activities beyond their competence that might compromise the interests of patients. However, it is imperative that the document will include the need for guidelines and training that according to Dimond (1995) are essential as legal safeguards to nurses. Therefore, the concept of competence and guidelines need to be more detailed if a new document is to be introduced.

It appears that nurses in the study agree about the need for guidelines, as they ensure a safer practice within established parameters giving clear direction of the path to follow. In fact, results in this study, which compare well with studies undertaken by Edwards (1995), Bowler and Mallik (1998) Leonard (1999) and Magennis et al. (1999), show that 77 (93%) of the participants agree or strongly agree about the need to work within the parameters of guidelines.

Therefore, the importance of role boundaries set by means of specific and clearly defined guidelines written in precise, simple and understandable language is to be emphasized (RCN, 22/01/2001). All stakeholders, that is patients, other health care professionals and personnel in managerial posts, need to participate in the formulating of such important documents (Parsley, & Corrigan, 1995). Such documents need to be made readily available and accessible to nurses and other health care professionals from ward files (Matthews, 1989). However, it is important that guidelines will be achievable adopted for the local hospital keeping in mind the local resource levels (RCN, 22/01/2001). Moreover, these guidelines need to reflect the latest valid and reliable evidence, consequently they should be regularly updated. Furthermore, the guidelines should include information on ways in which adherence may be monitored such as audit criteria and implementation information. If all these topics are included the guidelines may be said to be SMART that is, Specific, Measurable, Achievable, Reliable and Theory based (Parsley, & Corrigan, 1995). Clinical guidelines also help towards a uniformity of care irrespective of the person who is delivering (Woolfe, 1999) and act as parameters within which all health care professionals could work. However, guidelines should not limit clinical practice to rely on regulations but be flexible so that practice will remain dynamic in order to meet the changing care needs.

Once established nurses may only deviate from clinical guidelines after good clinical assessment of the circumstances and if a justifiable rationale can be identified and documented. Otherwise if harm occurs to patients when guidelines are not followed, it would be very difficult to prove one's behaviour and avoid legal liabilities (Tingle, 1997). Ward managers may need to be trained to encourage and demonstrate to their staff the importance of observing the established guidelines as well as the legal implications for deviating from such guidelines.

The ward manager's role of imparting information to staff needs to be stressed given that participants of the study claim that they did not read important documents such as the job description and the only local policy about intravenous drug administration. Likewise, British nurses (33% of 10,000) did not read *The Scope of Professional Practice* document, (UKCC, 2000) which regulates role expansion in Britain. The importance of adhering to the guidelines is emphasized because following them, may ensure improved standards of care preventing unnecessary legal or disciplinary procedures, as well as helping to protect nurses if something goes wrong and legal redress is sought by patients or their families. The legal issues of the expanded role will be discussed in the next section.

5.4 Legal Issues

Most of the participants in the study appear to have vague ideas about some of the legal issues that are associated with the expanded role. Documents with legal implications such as the job description document was not read by 25 (30%) participants while the administration of drug policy, the only local policy, was not

read by 24 (29%) participants. Those who read the job description document gave such inconsistent answers that it appears that they are unclear of what it entails. The job description is a work contract that indicates the employees' responsibilities (Tingle, 1997). When employees abide by the job description regulations they will be working within the agreed list of duties (Dimond, 1995). Therefore, it is important that nurses are well versed to ensure that the job description document allows for expanded role activities to be undertaken. In the case of mistakes the employer may not recognize work outside the job description parameters, thus the nurses themselves have to take full responsibility for their actions as they were acting outside their course of duty. However, if employers are aware that activities outside the job description are being performed and turn a blind eye to it then it could be said that they condone it and accept that employees' duties have been expanded to include the additional tasks (Dimond, 1995). In such situations, employers cannot imply that their employees are not working within the job description document and abdicate from their responsibilities. Therefore, personnel in managerial posts should know what their subordinates are being engaged in and immediately stop behaviour that may have grave consequences due to lack of knowledge, skill and competence.

Employers are vicariously liable to their employees' deeds. This is established by the Master/Servant principle (Dimond, 1995). In law the master will accept responsibility for the actions of servants where the servant is working in accordance with the policies agreed by both master and servant. This principle demonstrates that nurses have the necessary support for their actions when working in the course of their duty, hence the importance of their job description contents to be well known and adhered to. However, the nurses in the study gave mixed answers about their support from the

employer demonstrating obscure knowledge of the legalities that regulate employment.

Moreover, nurses showed vague knowledge about the legal aspects when performing activities beyond their basic training. Participants in the study cited inconsistent answers when asked about the value of experience and the difference of who delivers care. One will not be judged according to the level of experience or status when performing one's duty and if one performs an activity one has also to decide beforehand about one's capabilities. This is established in *Wilsher v Essex Area Authority* (1986) where practice does not change by experience or status. Moreover, according to the Bolam principle, (1957), when nurses are allegedly accused of negligence, their performance will be assessed by comparison to a reasonably competent member of the profession who performs that activity.

In view of the above mentioned points of vicariously liability and experience, delegation is an issue that needs to be reflected upon by personnel occupying managerial posts. The person who delegates always remains accountable and therefore must be conversant with the capabilities of each nursing member of the ward team (Matthews, 1989). Therefore, ward managers need to be very apt to delegate the correct task to the suitable person who has the abilities to deliver care appropriately. Inappropriate delegating may result in unnecessary harming of patients who can seek judicial redress resulting in financial losses to the organization.

Being informed and aware about the legal aspects of the expanded role may render the nurses more cautious when performing activities not covered in basic training. This

will also be to the advantage of the organization as there may be fewer errors resulting in costly legal litigation. The administration also has the responsibility to ensure that the necessary measures and controls are in place in order to achieve excellence of care avoiding unnecessary inconveniences. This includes the need for education to ensure that nurses are aware of the legal and professional responsibilities associated with expanded role activities.

Moreover, the hospital management should conduct an internal analysis (SWOT analysis) to identify those factors that help or hinder role expansion. Certain strengths are indicated by this study such as, nurses' willingness to expand (74 [89%] participants) and work within the parameters of guidelines (77 [93%] participants), nurses have the tendency to undertake courses (51 [61%] of the participants attended a post registration course), and a moderately positive attitude score towards role expansion. The weaknesses appear to be the unclear understanding of the term expanded role, the vague ideas about the legal aspects of role expansion and nurses undertaking activities when they were not sure about their competency. Opportunities can also be identified which include the detecting of those activities that are in the realm of nurses but not covered in basic training and need further training before they could be undertaken and to outline enforceable guidelines for expanded role activities. Also discussions need to be initiated to set up a document that regulate role expansion. Threats appear to be the lack of adherence and knowledge of already established regulations and policies as well as absence of role boundaries. Whilst these identified SWOT factors can be derived from this study, this exercise needs to be formally undertaken as the aim of the study was not to perform such an analysis and therefore these are not conclusive. After a SWOT analysis the organisation can

combine its strengths with the opportunities while reducing its weaknesses and prepare to counter threats. A well-reasoned SWOT analysis provides the basis for setting objectives and strategies (Johnson, & Scholes, 1988) to implement the right decisions regarding the expanded role that will be beneficial to patients, nurses and the organization.

5.5 Conclusion

The discussion gave an insight of nurses' attitudes towards the expanded roles which was found to be moderately positive. Most of the nurses are willing to expand their role and they are already involved in activities not covered in basic training. However, the term 'expanded role' need to be clarified as when nurses listed activities that they presumed to be expanded activities they included tasks that do not fit with the definition of expanded role. Also, nurses do not perform only expanded activities that pertain to doctors but also activities that pertain to other professions at par or below with nursing as long as it is for the welfare of their patients. Some of the activities cited correspond to particular areas of work while other activities are performed on regular basis. Therefore, certain activities might be considered as a shared activity with doctors or other health care professionals as long as they do not compromise basic nursing care and they are in the best interest of patients.

Respondents appear to favour certification to get involved in expanded role activities. However, certification is not the only method to gain competency as experience, reading journals, attending conferences and browsing the Internet contribute in gaining competency without being awarded by a certificate. Also, some local nurses ignore the demand for certification and still engage in administration of intravenous

drugs even without undergoing the required course. At present the only policy that exist is for the administration of intravenous drugs when it is known that nurses engage in other activities for which there are no regulations. Therefore, a nursing regulating body or the hospital administration needs to initiate a discussion with all concerned to set up a general document that regulates the role expansion based on self-determined competence and incorporating clinical guidelines and training. However, the necessary controls and assessment tools need to be in place to ensure adherence to the new regulations to avoid legal liabilities and disciplinary procedures. The legal aspects of the expanded role need to be more explained to the nurses so that they will have a clearer picture of legal aspects of role expansion. Thus, one presumes that nurses will be more cautious when performing activities not covered in their pre-registration training avoiding legal litigation and harm to patients. Further, the hospital administration should conduct an internal analysis to determine the positive and negative aspects that help or hinder role expansions. Action by the hospital authorities will be based on these findings although this study has already pointed out some areas to explore.

Conclusion, limitations and recommendations will be presented in the next chapter.

Chapter 6

6 - Conclusion and Recommendations

6.1 Introduction

The study was conducted with the aim to identify if nurses are aware of the benefits and risks, and the legal knowledge about their expanded role. These issues make the expanded role a managerial concern because it effects the quality of care. The research tool consisted of a 39-item questionnaire divided in 5 sections designed to answer the research questions to reach the aims and objectives of the study. The questionnaires were distributed to all the staff nurses (n=107) working in all Surgical and Medical Wards, Intensive Therapy Unit, Coronary Care Unit and the Accident and Emergency Department. Eighty-three (79% response rate) nurses returned the questionnaire that were valid for the study.

6.2 Limitations and Strengths

The areas of work were purposively chosen. However, the whole population of staff nurses working in the areas of work under study were chosen to constitute the population sample. Thus, generalization of findings is limited to staff nurses working in the chosen areas and not all nurses. However, the sample population make up one third of the whole population of staff nurses working in St. Luke's Hospital which may indicate some representativeness of this category of nurses.

The research tool was a self-report questionnaire that helped to reduce bias as the participants could not be influenced by the author's presence. However, bias may have been induced by the social desirability response especially when the researcher is known to the participants and holds a managerial post. Also, being a questionnaire,

clarifying and further probing of the answers, which could be achieved by an interview, was not possible thus limiting the possibility of an in-depth study. However, the high response rate shows that the risk of serious response bias was negligible (Polit & Hungler, 1995).

The questionnaire contained a Likert scale to measure attitudes which produced a high reliability score. Likert scales tend to perform well when it comes to a reliable rough ordering of people with regard to a particular attitude (Oppenheim, 1996). However, equal scores on a Likert scale do not permit to make assertions about the equality of underlying attitude differences and identical scores may have different meanings (Polit & Hungler, 1995).

6.3 Recommendations

Despite the limitations of the study, results and findings showed that the nurses' attitudes towards the expanded role are moderately positive, indicating a cautious approach. However, responses showed that interpretations of the term expanded role is not clearly comprehended. Activities that fall under the expanded role are being performed and some of them such as administration of intravenous drugs, blood withdrawal and insertion of venflons are widely practiced. The need for certification to be able to perform expanded role activities are discussed. Most of the nurses under study prefer to be certified competent before indulging in activities beyond their basic training though a number are performing intravenous drug therapy without the required course. However experience and knowledge, which are important factors of competence can be achieved without acquiring a certificate. Therefore self-determined competence based on ethical issues and accountability was also put

forward. Also, the importance of introducing guidelines, which will regulate performance, was highlighted. Managerial issues elicited from the themes were discussed and the need for managerial intervention was solicited. It is envisaged that the study findings would be given consideration by the concerned personnel and use it in their future decisions in regards to the nurses' expanded role.

A number of recommendations are proposed to the hospital management regarding the nurses' expanded role, namely:

- A study needs to be undertaken to clarify the exact meaning of role expansion in order to categorize activities that merit to be expanded roles.
- Training to ensure competence in expanded role activities.
- Specialization courses should be aimed to particular units as certain activities are only performed in these specific units.
- Enforceable clinical guidelines should be introduced because they provide patient care based on the best available evidence. They should also take into consideration the available resource, that is, equipment, material and human resources. However, clinical guidelines need to be regularly updated to reflect current research and knowledge.
- Measures need to be taken to institute effective control and audit on those who perform activities beyond their basic training to ensure that appropriate persons are delegated tasks within their capabilities.
- A discussion should be initiated in order to formulate a document to regulate the role expansion based on self-determined competence and accountability, and in accordance with the code of ethics.

- The job description document and other legal documents should be discussed between the employee and the managers so that employees will be informed about the course of their duty.
- Further research need to be conducted to investigate what are the positive and negative factors that contribute to the attitudes of nurses towards the expanded role. Once identified the necessary actions will be taken based on the findings.
- A research study need to be undertaken to determine what leads nurses to be engaged in activities that they do not feel confident to perform jeopardizing the patients' health and their career.

References

References

Ashworth, P. & Morrison, P. (1996). The notion of competence in nursing. In G. Hunt, P. Wainwright (ed.), *Expanding the role of the nurse: the scope of professional practice* (pp. 39-51). United Kingdom: Blackwell Science.

Barrett, G. (1995). To extend or not to extend: a postal survey of the opinions of nursing and medical staff regarding extended roles. *Journal of Neonatal Nursing, 1*(3), 9-13.

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice.* Menlo Park, California: Addison-Wesley.

Bezzina, E. (1996). *Efficient use of nursing resource as St. Luke's Hospital.* University of Malta: Unpublished master thesis.

Bolam vs. Friern Hospital Management Committee. *2 All England Reports 118.* Butterworths: London. (1957).

Bowler, S. & Mallik, M. (1998). Role extension or expansion: a qualitative investigation of the perception of senior medical and nursing staff in an adult intensive care unit. *Intensive and Critical Care Nursing, 14*(1), 11-20.

Boylan, A. (1984). The case against more training. *Nursing Times, September 19,* 37.

Bradshaw, A. (1998). Defining 'competency' in nursing (part 2): analytical review. *Journal of Clinical Nursing, 7*(2), 103-111.

Briffa, A. (1999). *Extended, expanded or go back to basics.* Suncrest Hotel, Qawra, Malta: Focus 2000: To raise the profile of nurses and nursing in the public eye.

Campell, T. & Lunn, D. (1997). Intravenous therapy: current practice and nursing concerns. *British Journal of Nursing, 6*(21), 1218-1228.

Castledine, G. (1996). Areas of practice. In G. Hunt, P. Wainwright (ed.), *Expanding the role of the nurse: the scope of professional practice* (pp. 101-112). United Kingdom: Blackwell Science.

Cormack, D. (1996). *The research process in nursing* (3rd ed.). London: Blackwell Science.

Darley, M. & Rumsey, M. (1996). The scope of professional practice: work to date. *Nursing Standard, 11*(4), 32-3.

Denner, S. (1995). Extending professional practice: benefits and pitfalls. *Nursing Times, 29*(14), 27.

Department of Health and Social Security (1989). *The extending role of the nurse.* London: DHSS.

Dimond, B (1995). *Legal aspects of nursing* (2nd edition). Hertfordshire: Prentice Hall.

Dimond, B. (1996). Legal aspects of role expansion. In G. Hunt, P. Wainwright (ed.), *Expanding the role of the nurse: the scope of professional practice* (pp. 54-73). United Kingdom: Blackwell Science.

Dimond, B. (1998). Radiology nursing: legal issues surrounding the expanded role. *British Journal of Nursing, 7*(13), 793-796.

Dowling, S. (1997). Life can be tough for the inbetweenies. *Nursing Times, 93*(10), 27-28.

Dowling, S., Martin, R., Skidmore, P., Doyal, L., Cameron, A., & Lloyd, S. (1996). Nurses taking on junior doctors' work: a confusion of accountability. *British Medical Journal, 312*, 1211-1214.

Edwards, K. (1995). What are nurses' views on expanding practice? *Nursing Standard, 9*(41), 38-40.

Eraut, M. (1996). *Developing professional knowledge and competence.* London: The Falmer Press.

Farrugia, N., Abdilla , P., & Borg, M. (1995). *Policy for the giving of intravenous medications by qualified nurses.* G'Mangia: St. Luke's Hospital.

Feder, G., Eccles, M., Grol, R., Griffiths, C., & Grimshaw, J. (1999). Clinical guidelines: using clinical guidelines. *British Medical Journal, 318*, 728-730.

Furlong, N. & Glover, D. (1998). Legal accountability in changing practice. *Nursing Times, 94*(39), 61-62.

Green, C. (1999). Nurses and professional negligence. *Nursing Times, 95*(8), 57-59.

Health Division (1999). Health in Malta: Directorate Nursing Services. [On-line]. Available: http://www.magnet.mt/services/health/dnsannrep99.htm.

Heiman, G. W. (2000). *Basic statistics for the behavioural sciences* (3rd ed.). USA: Houghton Miffin Company.

Hellriegel, D. & Slocum, J. W. Jr. (1996). *Management* (7th. ed.). USA: South-Western College Publishing.

Hellriegel, D., Slocum, J. W. Jr., & Woodman, R. W. (1998). *Organizational Behaviour* (8th. ed.). USA: South Western College Publishing.

Hersey, P. & Blanchard, H. (1977). *Management of organizational behaviour* (3rd ed.). USA: Prentice Hill Inc.

Higgins, M. (1997). Developing and supporting expansion of the nurse's role. *Nursing Standard, 11*(24), 41-44.

Hind, M., Jackson, D., Andrews, C., Fulbrook, P., Galvin, K., & Frost, S. (1999). Exploring the expanded role of nurses in critical care. *Intensive and Critical Care Nursing, 15,* 147-153.

Hurwitz, B. (1999). Clinical guidelines, legal and political considerations of clinical practice. *British Medical Journal, 318*(7184), 661-664.

Johnson, G. & Scholes, K. (1988). *Exploring corporate strategy* (2nd Ed.). United Kingdom: Prentice Hall International Ltd.

Last, T., Self, N., Kassab, J., & Rajan, A. (1992). Extended role of the nurse in ICU. *British Journal of Nursing, 1*(13), 672-675.

Laws of Malta. (20/02/2001). Volume 1; Criminal Code, Chapter 9. Title VIII 'Of Crimes against the Person', Subtitle IV 'Of Involuntary Homicide or Bodily Harm', Section 225. [On-line]. Available: http://www.justice.magnet.mt

Leonard, S. (1999). The expanded role of the registered nurse: studying nurses' perceptions. *Nursing Times, 14*(43), 32-36.

Lunn, J. (1994). The scope of professional practice from a legal perspective. *British Journal of Nursing, 3*(15), 770-772.

Mackay, L. (1993). *Conflicts in care.* London: Chapman & Hall.

Magennis, C., Slevin, E., & Cunningham, J. (1999). Nurses' attitudes to the extension and expansion of their clinical roles. *Nursing Standard, 14*(43), 32-36.

Massachusetts' Board of Registration in (23/4/2000). Massachusetts regulations governing the practice of nursing in the expanded role. [On-line]. Available: http://www.state.ma.us.reg/boards/rn/cmr/24404.htm.

Matthews, A. (1989). *In charge of the ward* (2nd. ed.). London: Blackwell Scientific Publications.

McClarey, M. & Duff, L. (1997). Making sense of clinical guidelines. *Nursing Standard, 11*(51), 31-35.

McKee, M. & Lessof, L. (1992). Nurse and doctor: whose task is it anyway? In J. Robinson, A. Gray, R. Elkan (ed.), *Policy issue in nursing.* Philadelphia: Open University Press.

Mechanic, H. (1988). Redefining the expanded role. *Nursing Outlook, 36*(6), 280-284.

Nursing and Midwifery Board (1997). *Maltese Code of Ethics for Nurses and Midwives.* Malta: Department of Health.

Olade, R. A. (1989). Perception of nurses in expanded role. *The Journal of Nursing Student, 26*(1), 15-25.

Oppenheim, A. (1992). *Questionnaire design, interviewing and attitude measurement.* London: Pinter Publishers.

Pace, D. (1999). *Registered nurses' and junior doctors' perceptions of the nurses' extended role of intravenous drug administration.* University of Malta: Unpublished B.Sc. (Honours) thesis.

Parsley, K. & Corrigan, P. (1995). *Quality improvement in nursing and healthcare.* London: Chapman & Hall.

Polgar, S. & Thomas, S. A. (1991). *Essentials of nursing research methods, appraisal and utilization* (2nd ed.). London: Churchill Livingstone.

Polit, D. F. & Hungler, B. P. (1995). *Nursing research: principles and methods* (5th ed.). Philadelphia: J.B. Lippincott Company.

Pritchard, A. P. & David, J. A. (1990). *The Royal Marsden Hospital: manual of clinical nursing procedures* (2nd. ed.). London: Harper & Row, Publishers.

Quinn, T. & Thompson, D. (1995). The changing role of the nurse. *Care of the Critically Ill, 11*(2), 48-49.

Redfern, S. (1997). Reactions to nurses' expanding practice. *Nursing Times,* 93(32), 35-37.

Rieu, S. (1994). Trial and error: the extended role dilemma. *British Journal of Nursing, 10*(33), 17.

Royal College of Nursing (22/01/ 2001). What is a guideline? [On-line]. Available: http//www.rcn.org.uk/index.html.

Schembri, J. (1998). *The role of nursing aides at St. Luke's Hospital.* University of Malta: Unpublished post-graduate diploma thesis.

Scott, H. (1996). Unwanted medicine: the delegation of doctors' roles. *British Journal of Nursing, 5*(17), 1028.

Sheets, V. R. (1999). Supporting careers of competence: a regulatory challenge. American Board of Medical Specialties [On-line]. Available: http:www.abms.org/downloads/Sheets%20paper.doc.

Shekelle, P. G., Woolf, S. H., Eccles, M., & Grimshaw, J. (1999). Clinical guidelines: developing guidelines. *British Medical Journal, 318,* 593-596.

Shepherd, J. (1993). Nurses are changing not extending their roles. *British Journal of Nursing, 2*(9), 447.

Tingle, J. H. (1990). The extended role of the nurse: legal implications. *Care of the Critically Ill, 5*(5), 30-34.

Tingle, J. H. (1996). Clinical guidelines: risk management and legal issues. *British Journal of Nursing, 9*(1), 266-267.

Tingle, J. H. (1997). Clinical guidelines: legal and clinical risk management issues. *British Journal of Nursing, 6*(11), 639-641.

Treece, E. W. & Treece, J. W. (1986). *Elements of research in nursing* (4th ed.). USA: Mosby Co.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992). *The code of professional conduct.* London: UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992). *The scope of professional practice.* London: UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (2000). *Perceptions of the scope of professional practice.* London: UKCC.

Vaughan, B. (1990). Extended Roles. *Nursing Standard, 4*(41), 47.

Wainwright, P. (1996). Professionalism and the concept of role extension. In G. Hunt, P. Wainwright (ed.), *Expanding the role of the nurse: the scope of professional practice* (pp. 3-19). United Kingdom: Blackwell Science.

Wilsher vs. Essex Area Health Authority *3 All England Reports, 801.* Butterworths: London. (1986).

Woolf, S. H., Grol, R., Hutchinson, A., Eccles, M., & Grimshaw, J. (1999). Clinical guidelines: potential benefits, limitations, and harm of clinical guidelines. *British Medical Journal, 318*, 593-596.

Wright, S. G. (1995). The role of the nurse: extended or expanded. *Nursing Standard, 9*(33), 25-29.

Appendices

Appendix 1 – Local Policy for Intravenous Drug Administration

St. Luke's Hospital G'Mangia

Policy for the giving of Intravenous Medication by Qualified Nurses.

1. The Policy for the giving of Intravenous Medication should be made known in writing to all qualified nurses.
2. The clinical nursing role in relation to that of the doctor may be expanded in two ways, (a) by delegation by the doctor and (b) in response to emergency.
3. The doctor remains responsible for his patients and for the overall management of treatment.
4. The expanded role of the nurse should be exercised in the interest of patient care. The expanded role is not to be performed at the expense of basic nursing care. The nurse's primary obligation is to the performance of nursing activities that fall within her/his customary professional role.
5. Each individual nurse has a choice whether or not to expand her or his role. The nurse voluntarily chooses whether or not to administer each and every intravenous medication.
6. The nurse is to be specifically and adequately trained and assessed for the performance of the new task and she/he agrees to undertake it.
7. Such training is to be recognised as satisfactory by the employing authority who is also responsible to issue a certificate of competence on the successful completion of the mentioned training.
8. Such certificate will be withdrawn in circumstances of error during the performance of the said medication.
9. The new task is to be recognised by the nursing and medical professions and by the employing authority as a task which may be properly delegated to a nurse.
10. The delegating doctor is to be assured of the competence of the individual nurse concerned to carry out the medication.
11. The expanded role will cover only the giving of those intravenous medications on the approved, attached list.
12. Only certified nurses are authorised to administer intravenous medications on the prior written prescription of a doctor.
13. The insertion of the intravenous canula and the first dose are to be the responsibility of the doctor.
14. The responsibility for the preparation/dilution of the medication for IV therapy remains with the person administering the medication.
15. The nurse is responsible for carrying out delegated responsibilities competently. The primary liability is held by the individual nurse for her/his own action.
16. A periodic updating of theory and practice of the expanded role is to be undertaken.

Ms. N. Farrugia Mr. P. Abdilla Ms. M. Borg

30 May, 1995

Appendix 2 - Questionnaire

Section A

Please, tick ✔ where applicable.

1. Male

   Female

2. How long have you been practising nursing?

   a) Under 1 year

   b) 1 - 5 years

   c) 6 -10 years

   d) 11 - 15 years

   f) Over 15 years

3. Which course did you follow?

   a) Staff Nurse (Traditional)

   b) Diploma in Nursing

   c) Degree in Nursing

   d) Others

   Please specify ______________________________

____

4. Which area do you **currently** work in?

   a) Surgical

   b) Medical

   c) ITU

   d) CCU

   e) A & E Department

Section B

5. List below those activities that you perform in your ward / unit that you consider being an expanded role for nurses i.e. those activities not covered in basic training. In the space provided tick the frequency you perform these activities.

Activity	Very Frequently	Frequently	Occasionally	Rarely	Very Rarely

Section C

Please, tick ✓ where applicable

6. Expanding the scope of practice will enhance the quality of patient care by promoting a more holistic approach to patient care.

    1) Strongly Disagree
    2) Disagree
    3) Uncertain
    4) Agree
    5) Strongly Agree

7. Expanded role activities leave less time for core nursing duties which may compromise the quality of 'basic' nursing care

    1) Strongly Disagree
    2) Disagree
    3) Uncertain
    4) Agree
    5) Strongly Agree

8. Expanding the scope of practice will increase job satisfaction for nurses.

    1) Strongly Disagree
    2) Disagree
    3) Uncertain
    4) Agree
    5) Strongly Agree

9. If nurses continue to expand the scope of their practice, then nursing aids will be required to undertake 'basic' nursing duties, thus fragmenting patient care.

    1) Strongly Disagree
    2) Disagree
    3) Uncertain
    4) Agree
    5) Strongly Agree

10. Expanding the scope of practice means that the patient may benefit from the full range of the nurses' skills.

    1) Strongly Disagree
    2) Disagree
    3) Uncertain
    4) Agree
    5) Strongly Agree

11. In expanding the scope of their practice, nurses will find themselves more vulnerable to litigation.

    1) Strongly Disagree
    2) Disagree
    3) Uncertain
    4) Agree
    5) Strongly Agree

12. In the interest of professionalism, nurses should have more independence to decide and act in relation to expanding their practice.

    1) Strongly Disagree
    2) Disagree
    3) Uncertain
    4) Agree
    5) Strongly Agree

13. In striving to expand their roles, nurses risk devaluing the essential value of 'basic' nursing care.

    1) Strongly Disagree
    2) Disagree
    3) Uncertain
    4) Agree
    5) Strongly Agree

14. Expanding the role of the nurse to include medical tasks is simply a means of reducing the junior doctors' workloads.

    1) Strongly Disagree
    2) Disagree
    3) Uncertain
    4) Agree
    5) Strongly Agree

15. If nurses do not expand their role to include such tasks, then support workers will be recruited to do so, thus fragmenting patient care.

    1) Strongly Disagree
    2) Disagree
    3) Uncertain
    4) Agree
    5) Strongly Agree

16. Expanding the nurses' role to include such tasks allows doctors to offload more everyday tasks thus maintain the subservient image of the nurse.

    1) Strongly Disagree
    2) Disagree
    3) Uncertain
    4) Agree
    5) Strongly Agree

17. Expanding the nurses' role to include medical tasks increases the continuity of patient care.

    1) Strongly Disagree
    2) Disagree
    3) Uncertain
    4) Agree
    5) Strongly Agree

18. Nursing will be more stressful as a result of the increased workload generated by such expanded role activities.

    1) Strongly Disagree
    2) Disagree
    3) Uncertain
    4) Agree
    5) Strongly Agree

19. Expanding the nurses' role to include such activities will improve the quality of patient care.

    1) Strongly Disagree
    2) Disagree
    3) Uncertain
    4) Agree
    5) Strongly Agree

Section D.

Please, tick ✔ where applicable

20. Are you currently involved in post registration course/training?

Yes

No

If yes, please specify:____

____

21. Have you completed any course of study since your registration?

Yes

No *(go to question 23)*

If yes, please specify: ____

____

22. If you answered 'yes' to question 21, was the training:

a) On the job

b) At the Institute of Health Care

c) Abroad

c) Others

Please specify:____

23. Do you keep yourself updated with theoretical nursing knowledge?

1) Not at all

2) Little

3) Somewhat

4) Much

5) A great deal

24. Do you keep yourself updated with research based practice?

1) Not at all

2) Little

3) Somewhat

4) Much

5) A great deal

25. I keep updated about nursing by (*you can choose more than 1 answer*):

a) Reading nursing journals

b) Attending update lectures at the IHC.

c) Attending conferences, fora or symposia.

d) Others

Please specify. ________________________________

26. Qualified staff nurses should have further training/courses to expand their role.

1) Strongly Disagree
2) Disagree
3) Uncertain
4) Agree
5) Strongly Agree

27. I feel competent when performing activities that were not covered in the pre-registration training.

1) Strongly Disagree
2) Disagree
3) Uncertain
4) Agree
5) Strongly Agree

28. Why do you consider yourself competent?

____

____

____

29. Nurses need a certificate of training to perform an activity that was not included in the pre-registration training.

1) Strongly Disagree
2) Disagree
3) Uncertain
4) Agree
5) Strongly Agree

Section E
Please tick ✓ where applicable

30. Have you ever read the local policy for the giving of intravenous medication by qualified nurses?

Yes

No *(go to question 32)*

31. If you have answered 'Yes' to question 30, all other activities under the expanded role should have similar guidelines.

1) Strongly Disagree
2) Disagree
3) Uncertain
4) Agree
5) Strongly Agree

32. Have you read your job description document?

Yes

No *(go to question 34)*

33. If you answered 'Yes' to question 32, the job description leaves space to cover for the expanded role.

1) Strongly Disagree
2) Disagree
3) Uncertain
4) Agree
5) Strongly Agree

34. I have the full backing and support of my superiors when I perform duties that fall under the expanded role of the nurse.

1) Strongly Disagree
2) Disagree
3) Uncertain
4) Agree
5) Strongly Agree

35. When performing the expanded role I will be considered as a nurse not as a doctor or a member of another profession.

1) Strongly Disagree
2) Disagree
3) Uncertain
4) Agree
5) Strongly Agree

36. If nurses harm patients while performing expanded activities, their lack of experience will be taken in consideration when disciplined.

1) Strongly Disagree
2) Disagree
3) Uncertain
4) Agree
5) Strongly Agree

37. Guidelines (role boundary) are needed for activities that fall under the expanded role.

1) Strongly Disagree
2) Disagree
3) Uncertain
4) Agree
5) Strongly Agree

38. I am willing to learn new skills and expand my role.

1) Strongly Disagree
2) Disagree
3) Uncertain
4) Agree
5) Strongly Agree

39. Feel free to make further comments about the expanded role that were not covered by this questionnaire.

____

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Thank you for your participation.

If you have any difficulties or need more information do not hesitate to contact me.

Work Tel. 2595 1206

Home Tel. 232749

Appendix 3 - Permission to use Attitude Scale

----- Original Message -----
From: JAMES EDWARD SLEVIN <JE.Slevin@ulst.ac.uk>
To: lorry azzopardi <sandie@global.net.mt>
Sent: 12 ,Apr, 01 5:10 PM
Subject: Re: thesis - permission

Dear. Mr Lorry Azzopardi,

Regarding the permission to use the Likert scale adopted by Magennis et al. (1999) to measure the nurses' attitudes towards the expanded role.

Yes it is ok to use this questionnaire just reference and acknowledge it.

Good luck.

Best regards,

Dr. Eamonn Slevin

Appendix 4 - Introduction Letter to Questionnaire

Maltese Nurses' Perception of
Their Expanded Role

Dear Colleague,

I am currently reading for Masters Degree in Health Service Management at the Institute of Health Care. As part of my degree, I am conducting a research study on the nurses' perception of their expanded role.

If you are willing to participate in my study, please fill in the enclosed questionnaire, which should take 10 to 15 minutes to be completed. Most of the questions consist mainly of ticking next to the statement you mostly agree with, and there are a few other questions asked where you have to write your own opinion.

You are not obliged to participate but it would be very helpful for me if you could spare me a few minutes to complete this questionnaire. Once the questionnaire is returned, it will be taken that you have consented to participate at your free will. Information given will only be used for the purpose of the study and your identity will not be revealed at any time.

Please put your completed questionnaire in the envelope provided and seal it, then hand it to Mr. / Ms. ________________________________ from whom I shall pick it. Do not hesitate to contact me to clarify any queries you might have to fill this questionnaire. I may be reached at phone numbers 232749 (home) or 2595 1206 (work). Thank you in advance for your co-operation.

Yours sincerely,

____

Lawrence Azzopardi

Appendix 5 - Permission to Conduct the Research

101 Victory Street
Hamrun

30 September 1999

Medical Administrator
St' Luke's Hospital
G'Mangia.

Through Mr. P. Abdilla
Manager Nursing Services

Re. Permission to conduct a research

Dear Sir,

I am studying for a Masters Degree in Health Service Management at the University of Malta. With your permission I would like to conduct a research study at St. Luke's Hospital to identify the nurses' awareness of the risks or benefits and legal implications of the nurses' expanded role.

Data will be collected using a questionnaire distributed to staff nurses working in the Intensive Therapy Unit, the Coronary Care Unit, the Accident and Emergency Department, and Medical and Surgical Wards. From the results hospital authorities will have an idea of the risks and benefits the nurses' expanded role entails.

Thanking you in advance, I hope that my request will be granted.

Yours faithfully,

Lawrence Azzopardi
Nursing Officer

Appendix 6 - Individual Workings of the Likert Scale Questions

1. Enhancing quality of care by promoting a more holistic approach

	Frequency	Percent	Cumulative Percent
Strongly Disagree	3	4	4
Disagree	14	17	21
Uncertain	13	16	37
Agree	41	49	85
Strongly Agree	12	15	100
Total	83	100	

2. Compromise quality of care by leaving less time to basic nursing care

	Frequency	Percent	Cumulative Percent
Strongly Disagree	4	5	5
Disagree	21	25	30
Uncertain	10	12	42
Agree	41	49	91
Strongly Agree	7	9	100
Total	83	100	

3. Increase job satisfaction for nurse

	Frequency	Percent	Cumulative Percent
Strongly Disagree	1	1	1
Disagree	10	12	13
Uncertain	18	22	35
Agree	44	53	88
Strongly Agree	10	12	100
Total	83	100	

4. Fragmented care as more care assistants will undertake basic nursing care

	Frequency	Percent	Cumulative Percent
Strongly Disagree	7	8	8
Disagree	20	24	32
Uncertain	13	16	48
Agree	33	40	88
Strongly Agree	10	12	100
Total	83	100	

5. Benefit patients from a more full range of nurses' skills

	Frequency	Percent	Cumulative Percent
Strongly Disagree	4	5	5
Disagree	9	11	16
Uncertain	11	13	29
Agree	45	54	83
Strongly Agree	14	17	100
Total	83	100	

6. Render nurses more vulnerable to litigation

	Frequency	Percent	Cumulative Percent
Strongly Disagree	1	1	1
Disagree	16	19	20
Uncertain	15	18	38
Agree	33	40	78
Strongly Agree	18	22	100
Total	83	100	

7. Independence to decide

	Frequency	Percent	Cumulative Percent
Strongly Disagree	3	4	4
Disagree	3	4	8
Uncertain	6	7	15
Agree	49	59	74
Strongly Agree	22	26	100
Total	83	100	

8. Risk devaluing the essential value of basic nursing care

	Frequency	Percent	Cumulative Percent
Strongly Disagree	5	6	6
Disagree	24	29	35
Uncertain	10	12	47
Agree	33	40	87
Strongly Agree	11	13	100
Total	83	100	

9. Nurses being used as a means of reducing junior doctors workloads

	Frequency	Percent	Cumulative Percent
Strongly Disagree	7	8	8
Disagree	26	31	39
Uncertain	10	12	51
Agree	26	32	83
Strongly Agree	14	17	100
Total	83	100	

10. Fragment care by support workers being used if nurses do not expand roles

	Frequency	Percent	Cumulative Percent
Strongly Disagree	3	3	4
Disagree	30	36	40
Uncertain	24	29	69
Agree	18	21	90
Strongly Agree	8	10	100
Total	83	100	

11. Prolong the image of a hand maiden to doctors

	Frequency	Percent	Cumulative Percent
Strongly Disagree	6	7	7
Disagree	29	35	42
Uncertain	11	13	55
Agree	28	34	89
Strongly Agree	9	11	100
Total	83	100	

12. Increase Continuity of Care

	Frequency	Percent	Cumulative Percent
Strongly Disagree	7	8	8
Disagree	18	22	30
Uncertain	5	6	36
Agree	42	51	87
Strongly Agree	11	13	100
Total	83	100	

13. Increased Stress

	Frequency	Percent	Cumulative Percent
Strongly Disagree	2	2	2
Disagree	13	16	18
Uncertain	8	9	27
Agree	43	52	79
Strongly Agree	17	21	100
Total	83	100	

14. Improve quality of patient Care

	Frequency	Percent	Cumulative Percent
Strongly Disagree	9	11	11
Disagree	16	19	30
Uncertain	16	19	49
Agree	33	40	89
Strongly Agree	9	11	100
Total	83	100	