Competency and context for the higher level nurse

Eileen Padmore

ARTICLE POINTS

1 The future of nursing cannot be decided unless the nursing role can be defined.

2 The main issue connected with higher level practice concerns the definition of competence.

3 Recent thinking suggests that nursing knowledge is both practical and theoretical.

4 The core impact of advanced practitioners should be on patients, clients and communities.

5 Social and political changes have created an opportunity for DSNs to influence nursing within their area of clinical expertise.

KEY WORDS
- **Higher level practice**
- **Role definition**
- **Clinical practice**
- **Multidisciplinary context**

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Introduction

Higher level practice in nursing is currently a hotly debated issue. This is a continuation of lengthy consideration of the rationales for specialist nursing roles and nurse practitioner or advanced nurse practitioner roles. While there seems to be no consensus on terminology, this article examines the concepts and practices behind the variety of labels applied to nursing in an attempt to analyse the notion of higher level practice. This should provide a platform from which to explore the competencies involved and the contexts in which they have developed. A follow-up article, in the next issue, will consider ways in which such a practitioner can impact on nursing at various levels.

Agreement concerning the nature of nursing itself has always been problematic, but Denner (1995) has argued that, unless there is a clear definition of the nursing role, no-one can say where nursing should go in the future. It follows that, if there are fundamental differences among nurses as to how they define nursing itself, then the same ambiguities will be present in any discussions on higher level practice.

The debate centres around whether nursing is what nurses do or what nurses know and, if it is the latter, what is the nature of that knowledge.

Reed and Ground (1997) see nursing as having moved away from a traditional task-oriented approach, where the only questions that were asked concerned the speed and efficiency of care delivery, to the use of philosophical models of care. This has created space for fundamental questions on the nature of nursing itself to be asked. Reed and Ground see this debate as healthy, given that nursing takes place in such a variety of contexts. With so many different people and a diversity of goals, uniformity is neither achievable nor desirable, and philosophy merely offers a mechanism for exploration of some of the issues.

Defining competence

The main issue connected with higher level practice arises over the definition of competence. Some of the strands of the debate are shown in *Table 1*. While there is no agreement on how such a multi-dimensional field of practice should be measured and rewarded, there is consensus about the need to do so. This is partly driven by the professional lobby seeking more renumeration with higher status and power, plus a career pathway for those in clinical practice. Another moving force is the case for clinical need, e.g. diabetes specialist nurses (DSNs) have developed a high level of clinical skills in many areas,

Table 1. Some of the opinions and questions surrounding the issue of competence in higher level practice

- Is competence merely the acquisition of the measurable skills and knowledge required to carry out the job satisfactorily?
- Do these skills include the less definable attributes such as attitudes, values and personal disposition as believed by Worth-Butler et al (1994)
- Some would argue that the ability to think critically and analytically underlies competency (Bauens and Gerharch, 1987; Harbison, 1991)
- Benner (1984) and Schon (1987) maintain that it is the 'artistry of practice' which differentiates the merely competent and the expert practitioners.

including that of stabilising patients on insulin, to the extent that the national diabetes service has become dependent on this expertise.

Thornley (1996) contrasts 'professional' and 'radical' nursing models as examples of handling the issues. The former is characterised by the search for professional closure through academic restrictions as an attempt to define nursing in terms of a profession that is clearly distinguishable from medicine and the ancillary fields. The latter is more complex and allows for a number of 'levels' of nurses, including the higher level nurse. This encourages the reduction of possible barriers, with greater mobility and flexibility.

Clinical aspects

Although nursing has shifted from a predominantly practice-based profession to one with a more theoretical base, recent thinking suggests that nursing knowledge is both practical and theoretical. Benner (1984) used the Dreyfus model to differentiate between skilled performance based on classroom principles and theory, and contextual skills acquired only in real-life situations. Similarly, Fulbrook (1997), in his research into the nature of advanced practice, found that the theme of expert or expertise was most commonly linked with 'knowledge from clinical experience rather than knowledge from formal education'. Unfortunately, such practice-based knowledge has not always been awarded high currency in the development of advanced nursing roles.

The early specialisms in the UK developed along functional rather than clinical lines; the main examples being administration, teaching, and planning (Kohnke, 1978). However, upwards nursing career movement in the UK was set along a management pathway for three decades by the implementation of the Salmon Report (DHSS, 1966).

Perhaps because of the lack of development of the clinical role which recognises the particular expertise of nursing knowledge and skills, nurses have been prey to other forces. These include developing specialist roles around body systems, as in medicine; or task-focused roles arising out of procedures that medical personnel no longer regard as high priority. Castledine (1994) has strong views on this subject:

> ***'To attempt to persuade professionally educated nurses that they should take on medical tasks and function at a lower level in the field of medicine represents an unbelievable human and intellectual waste.'***

Others would argue that it is not always helpful to try to differentiate between tasks that are specifically medical or nursing, on the grounds that nurses bring nursing skills to these procedures in the same way that doctors bring medical skills. However, it may be that by virtue of taking on certain medically oriented tasks there is less time to exercise skills that are specific to nursing. As a result, the patient will be denied an important aspect of care. The United Kingdom Central Council (UKCC, 1992) laid out six principles for the advancement of the scope of practice, the first being that the interests and needs of the patient must be paramount. By applying this principle, higher level nurses should be able to ensure that their roles are not driven by external conflicting interests or agendas.

Denner (1995) argued that nursing must be clearly defined before it could determine its future. Castledine (1998) put it another way by maintaining that nurses would continue to be confused about their specialist and advanced roles if they forgot where their core knowledge and competencies came from and became too preoccupied with copying medicine. The fact that career progression within nursing has been restricted to management or education for so long has also produced mind sets that devalue clinical practice. Obviously effectiveness in higher level practice will be inhibited by such influences and confusion, so how will nurses find a way out of this dilemma?

Higher level practice

The UKCC is currently developing a system of benchmarking higher level practice through focusing on level rather than role. In the past, nursing has been bedevilled by the concept that tasks, skills and knowledge are related to specific roles and rewarded by the pay-grading system. This has been apparent when nurses refused to carry

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2. Practice-based knowledge has not always been awarded high currency in the development of advanced nursing roles.
3. It may be that by virtue of taking on certain medically oriented tasks there is less time to exercise skills that are specific to nursing.
4. The UKCC is now focusing on level rather than on role.

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1 The UKCC's pilot standard document emphasises that the main impact of nurses' work will be on patients, clients and communities.

2 Nurses moving into higher level practice will have to be adept at identifying and valuing their unique clinical skills.

3 Expert clinical nurses may be in a better position to challenge the boundaries of medicine than nurse managers and educationalists.

4 The care versus cure debate is central to the tensions between the disciplines.

out tasks for which they were competent because they were not at a high enough pay grade to do so.

The UKCC's pilot standard document (July 1999) gives characteristics of nurses working at a higher level of practice (Table 2). It emphasises that, although these advanced practitioners may be involved in research, management and education, the main impact of their work will be on patients, clients and communities. This represents a seismic shift in thinking for many nurses.

Nurses already working at or aiming for the higher level may have the additional task of achieving credibility and status with the bulk of the nursing workforce. There will also be 'territorialism' to tackle — nurses in education and management may well feel that their boundaries of practice are challenged by the new nursing elite. Nurses moving into higher level practice will need to be adept at identifying and valuing their unique clinical skills. They may also have to educate peers and professionals from other disciplines about these skills.

Impact on others

In the multidisciplinary context, medicine may be the profession most likely to feel threatened by the development of higher level practice. The recommendations of the Crown Report 2 (DoH, 1999), for nurses to become prescribers, have met with some medical opposition. This is despite the fact that nurses and other professionals had been hoping for more radical prescribing powers.

Table 2. Characteristics of nurses working at higher level practice

- Ability to contextualise health care within a broad and deep practical knowledge framework
- Enhanced skills in areas of empowerment, communication and consultation
- Significant knowledge in therapeutics, biological, sociological and epidemiological sciences (as recognised by patients, fellow professionals and those of other disciplines)
- Crossing professional and agency boundaries to effect change in order to improve client care.

United Kingdom Central Council (1999)

Expert clinical nurses may be in a stronger position to challenge the boundaries of medicine than nurse managers and educationalists because they will retain 'hands on' clinical care and thus be closer to the Government's advocated partner in care; namely the patient. There can be little doubt that some of the beliefs, values and practices in medicine need contesting. Jolley (1993) asserts that the social distance between medicine and nursing, as measured by class, status and power, is considerable, and that while medicine cannot solve society's health problems, it is still too closely followed as the model for development in health care throughout society.

The care versus cure debate is central to the tensions between the disciplines. Traditionally, nursing has been seen as the 'caring' profession and medicine as the 'curing' profession. This split has also followed gender and academic paradigms. Nursing has been seen as an art form, predominantly carried out by women, whereas medicine has been male-dominated and based on a positivist model of science. Barnum (1998) asserts that cure is no longer the private territory of medicine and that nurses can and should claim it as ' legitimate turf'.

Caution is needed when these two terms are defined. For instance, McGlone (1990) distinguishes between a disease that is cured and a person who is healed, which is a way of subordinating cure to care.

In the wider context

There are significant sociological and political changes afoot which challenge the traditional care versus cure debate and of which higher level nurses need to be aware. Sociologists describe us as being in a post modern society (Lyotard, 1984), characterised by:

- An increase in feminisation of the workforce
- An increase in consumerism
- A demise in deference to authority
- Death of the 'grand narratives' (e.g. the positivist scientific model of health care)
- An increase in the service sector with a reduction in manufacturing
- The globalisation of culture, with

the domination of cultural habits

- Rapid advances in technology and communication.

These changes have several implications for higher level nursing and its influence. The first of these concerns the traditional predominance of women in nursing and their subordinate role. Stein (1990) postulated that, in the USA, nurses were no longer playing the 'doctor–nurse' game of the dominant to the submissive because of the influence of the wider civil rights movement in society, of which the women's movement was part. It is important that expert nurses are aware of the force of their conditioning and are ready to challenge these influences in a professional and constructive way.

Second, the growth in consumerism and the demise in deference to authority is particularly evident in medicine. As recently as two decades ago, doctors were held in unassailably high regard. Nowadays, standards of care are being challenged in the courts and mass media, e.g. in consumer watchdog programmes. The headline of 'Bad doctors face sack under new NHS rules' in the *Daily Telegraph* (13 November 1999) is followed by an article that describes measures for independent annual appraisal of all NHS doctors; perhaps the first nail in the coffin of self-regulation for the medical profession.

This leads to the third point: the questioning of the bioscientific approach to health care in sociological terms. The result is that this model is coming to be regarded as less an unassailable truth than one valid fiction among many. This leaves the door open for nurses to prove the validity of their 'fictions'. Chief among these fictions for DSNs is the holistic model of care grounded in psychosocial theory.

For DSNs the opportunities to influence nursing within their area of clinical expertise have never been greater. In the next issue, consideration will be given to the ways in which DSNs might use this influence to the benefit of patients. ■

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PAGE POINTS

1. Social and political changes in society have implications for higher level nursing.
2. Expert nurses need to challenge the influence of conditioning in a professional and constructive way.
3. Independent annual appraisal of all NHS doctors may be the first nail in the coffin of self-regulation for the medical profession.
4. The opportunities for DSNs to influence nursing within their area of clinical expertise have never been greater.