



## Commentary

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### Advanced nursing practice: experience, education and something else

This paper provides some critical reflection on the development of the concept of 'advanced practice'. Whilst defining, credentialling and regulating advanced practice promises rich fruits for nursing, advancing nursing practice will be a consequence only if the right conditions are fostered for the development and provision of nursing expertise in practice.

A conscious and collective effort must be made to ensure that nursing expertise of all nurses is recognized and developed. One process which has shown promise in psychiatric and mental health nursing is 'clinical supervision'. Evolving nursing leadership roles and more education can only provide a partial solution to the problem of advancing practice.

In a hundred years time a nurse historian may well look back on the last five years of the twentieth century as a veritable semantic mine field and the current discourse on advanced practice as a rich source for analysis and deconstruction. Should time travel be invented, the future historian may decide to undertake a field study on the 'development of advanced practice' in the later part of the twentieth century. To the request 'take me to your leader' the historian may be directed to the 'team leader', 'nurse advisor', 'nurse specialist', 'charge nurse', 'unit manager', 'nurse executive', 'nurse practitioner', 'senior nurse' or be confronted by a statement such as 'we don't have a leader, we work as a multidisciplinary team'. Unable to find a leader the historian rephrases the request – 'point me in the direction of the nurse who has expertise . . . the advanced practitioner', to which the historian is directed behind a screen to where a registered nurse is holding a person's hand. The historian becomes confused, as in the future such mundane tasks as holding someone's hand have long since been

devolved to lesser skilled workers. 'Sorry . . . I think I have the wrong room I was looking for the room with the high tech equipment, the extended drug formulary, or the office with the care planning computer'. The historian suddenly has a flash of realization, it is knowing when to hold someone's hand, not the task itself that defines this nurse as expert.

What will be made of recent discussion on 'advanced nursing practice' in the future? Will the 'holy grail' have been attained, or will the state of nursing today be viewed as in some naïve developmental phase – clinging to the last vestiges of positivism and a compulsive need to define and categorize things? 'Advanced practice' is the current catch phrase and defining the scope of advanced practice appears to be a current preoccupation. Arguably this is a necessary thing given the present review of occupational regulation and the possibilities for extended and expanded roles for nurses. Nurses and managers may also select from a plethora of titles to ascribe to roles which can cause confusion. People need to know what role titles actually represent and regulation of titles may go some way to clarifying understanding. There is a not so hidden agenda in this debate, which goes beyond merely creating consistency and clarity in roles, that is the 'advancement of nursing'.

The advancement of nursing has become tied to the quest for recognition of nursing as a profession (Bucknall & Thomas 1997). The development of clearly defined roles for nurses may provide a platform from which to market nursing and further the agenda of professionalization. The term professional implies the fine virtues of competence, efficiency, altruism and integrity (Pilgrim & Rogers 1997). Professions also tend to be characterized by social status, the possession of specialist knowledge, self-regulation, autonomy over practice and power (Giddens 1993). As responses from the medical fraternity regarding extending nursing

practice to allow prescribing reveals, professions (of which medicine may be considered an archetype) also tend to jealously guard their patches and the monopolies over practice which they enjoy. Defining and regulating 'advanced practice' may go some way towards 'advancing nursing' through delineating nursing's professional turf. However, the down side may be the creation of a professional elite of 'advanced practitioners', the creation of yet another top-down hierarchy within nursing (Litchfield 1998), and inevitable turf battles. This may not amount to a real advancement for nursing, any more than the adoption of diagnostic taxonomies advanced the public standing of nursing in the 1980s. Whether or not nursing is truly advanced by this current preoccupation with 'advanced practice' will be determined by improved outcomes for those that are recipients of nursing care. If the promise of advanced practice is to be realised then consideration must be given to the conditions necessary for promoting expertise in practice.

### Expertise and advanced practice

Jacobs (1998, p. 4) observes that the 'development of advanced and extended nursing practice is gaining impetus'. The time is ripe for the development of new roles for nurses to assume and provision of supporting postgraduate courses and qualifications. For this to be an 'advancement' of nursing requires a commitment to becoming more adroit or expert at 'doing' nursing.

The debate about extending and expanding nursing practice challenges us all to reconsider the fundamental and often contentious question of what it means to be a nurse. Only with a sound understanding of what nursing is about can one begin to define what it means to be expert or to provide 'advanced' nursing.

The nurse who knew when to hold a person's hand showed a degree of expertise in nursing, although few may consider such an act as reflecting advanced practice. Certainly, there are no postgraduate courses in the making on advanced hand holding and nurses cannot claim handholding as it's exclusive turf. There lies the problem of defining nursing by observable tasks. When broken down into constituent parts – what nurses do, it seems that there are few things that are unique to nursing. Indeed, many tasks which have traditionally been associated with nursing, such as body care are being

usurped or delegated to aides, care associates and technicians. In the psychiatric field nurses are increasingly finding themselves in new and evolving roles such as case management, statutorily defined roles such as that of Duly Authorised Officer, and increasingly specialized roles such as crisis and early intervention. The development of these roles has been driven at least as much by political forces and the need to contain costs as by nurses themselves. These developments may well be good, in as much as they may meet particular health needs of individuals and groups, but they do challenge what it means to be a nurse, particularly when such roles may be assumed by any member of a multidisciplinary group.

Extending roles into prescribing and areas which have traditionally been the domain of other health professionals and calling these things 'advanced nursing practice' begs the question 'When does advanced nursing practice become basic doctoring or something other than nursing?' New roles must be integrated into nursing with a sound understanding of how such roles articulate with the philosophy and practice of nursing. Without starting from this position nursing may be transformed into some form of super generic health worker and the very things which lead nursing to be consistently rated by the public as the most trusted and respected of occupational groups may be lost. Expert nursing is advanced nursing, and advanced nursing is not merely some expanded or extended role.

Litchfield (1998, p. 20) defines expertise in relation to scope of practice

'Expertise is the capability of nurses to express the scope of practice within their particular workplaces'.

'Capability' implies an undeveloped or unused faculty (Sykes 1985) and to advance practice the application of expertise is required, rather than the mere possession of it. Expertise that is unused is not helpful to anybody. Consideration of how expertise develops and promoting the right conditions for the development and application of expertise is crucial to advancing practice.

Education is a necessary, but insufficient ingredient in advancing practice. There is a need for postregistration education in all spheres of nursing. Opportunities for postregistration education ought to be considered a right and a necessity to ensure the public good. With such rapid pace in technology, increasing speciality, and ever shifting organizational structures, the need has never been greater.

However, education may facilitate capability but it does not ensure application. Cottingham (1999) suggests that education is seen as a panacea to any problem facing nursing and advancing nursing is no exception. Nicol (1999, p. 25) for example, suggests that

‘Education is the key to safe, advanced health care delivery.’

Education may show someone how to hold someone’s hand but the expert will know when. The challenge is how to facilitate this knowing. Benner (1984) provided a framework to recognize expertise, but the concept has lost favour to some extent, as Sutton and Smith (1995) point out, because there is no formula for developing expertise. At least part of the drive towards defining and promoting ‘advanced practice’ according to roles is because it is easier than addressing the problem of developing expertise.

Schön (1983, pp. 16–17) notes that ‘situations of practice are characterised by unique events. . . . The unique case calls for an art of practice which might be taught, if it were constant and known, but it is not constant’.

Reflection in and on action may link the art of practice in uncertainty and uniqueness to the scientist’s art of research (Schön 1983, p. 69). The concepts of reflection on practice, praxis and critical thinking have been incorporated into many nursing curricula with a view to enhancing the artistry which is expert nursing. How reflection should be supported in practice is more contentious. One solution is clinical supervision which has been adopted from counselling training and is increasingly used as a tool for role development in psychiatric mental health nursing.

## Clinical Supervision

Clinical supervision is an emerging idea (Butterworth & Faugier 1992) which has been described as an essential process for skill acquisition and role development for student nurses (Gordan 1996, Bissell *et al.* 1984), orientating novices to the clinical area (Perez 1990), and furthering the expertise of experienced nurses (Minot & Adamski 1989). The functions of clinical supervision have been described as formative (educative/developmental), restorative (debriefing/recharging), normative (standard-setting/monitoring) (Bishop 1998). It involves a formal relationship between a nurse and an advanced practitioner who

has received training in providing clinical supervision. In the context of this relationship the work of the nurse is reflected upon and developed. As Consedine (1995) points out clinical supervision is different from the ‘line-management’ supervision, performance review, overseeing or auditing of clinical practice. Its purpose is to develop the ‘super vision’ of the nurse being supervised.

Clinical supervision is not a new idea and it is by no means new to nursing. Peplau viewed the nurse and client as having a mutual influence upon each other: ‘The kind of nurse each person becomes makes a substantial difference in what each person will learn as she/he is nursed throughout her/his experience with illness’ (Peplau 1952, p. 21). Thus the nurse becomes a participant observer rather than a spectator observer (Forchuk 1991), and the nurse’s reactions and responses to the person being nursed must be reflected upon if mutual growth is to occur.

Schön (1983, p. 49) challenges the professions to search for ‘. . . an epistemology of practice implicit in the artistic, intuitive processes which some practitioners do bring to situations of uncertainty, instability, uniqueness, and value conflict’.

Clinical supervision offers the promise of both reflection on and in action – bridging the gap between technical knowing and the artistry inherent in applying such knowledge in unique situations. Barker (1994, p. 66) argues that supervision in psychiatric nursing has two main aims

‘. . . to protect people in care from nurses and to protect nurses from themselves’.

This acknowledges that nursing can be taxing and sometimes damaging to practitioners and that supervision can have a protective function. Hawkins & Shohet (1989) points out that supervision is not a straightforward process and is even more complex than working with clients. Much like expert practice there is no concrete easily measured product at the end and it tends to take place in private. Supervision may be one tool that may serve to facilitate the integration of expertise and provide a formalized means of supporting nurses in the work that they do. This is becoming increasingly important as nurses at all levels of expertise are being expected to provide nursing in isolation from professional peers.

It has become a cliché to point out that people are presenting for tertiary care have more complex and acute health needs than ever before. Simulta-

neously, there are fewer structures for supporting nurses in the development of expertise, for example charge nurse positions are being replaced with managers and nurses are being expected to function semiautonomously rather than alongside expert practitioners. The opportunities to observe expert practice are being diminished and nursing expertise is further made invisible.

### Getting it right from the start

Supervision is but one possible solution to assist nurses in their role development. Another solution to the problem of promoting and valuing nursing expertise may be the formalization of advanced practice roles. One such role is the 'nurse specialist'. These are people who should possess expertise in nursing, specialist knowledge, and have a responsibility to develop expert practice. However, no one person or role can provide a solution to the problem of recognizing, developing and valuing expertise in nursing. The same conditions that are required to achieve these things for all nurses are required for nurse specialists to realise their potential. An investigation of how clinical nurse specialists (CNS) think and experience their role, Bousfield (1997) found that the majority of her sample felt unsupported, isolated and lacked role models and mentors. This may be the experience of many nurses at all levels of expertise. She suggests that the fulfilment of the CNS role depends on tangible and visible support from management and clinical teams and that a CNS must have the autonomy to utilise their expertise (Bousfield 1997). Whilst professional autonomy is a highly prized and talked about ideal, the attainment of professional autonomy remains elusive to most nurses. Bousfield (1997) suggests that nursing requires an 'attitude adjustment' away from hierarchical respect for and deference to authority, submissiveness and tradition. Whilst there may be some truth in the adage that nurses are their own worst enemies this should not detract from an analysis of the structural, attitudinal, political, industrial and institutional barriers to promoting expert practice. Rigidity in role descriptions, a constrained scope of practice and fashions such as 'clinical pathways' and the demand for 'evidenced based practice' may all constrain the expression of expertise through limiting the repertoire of responses which nurses may draw upon in a given situation. Just as health of communities will not be improved unless the broad social determi-

nants of ill-health are addressed, the consequences of not attending to the issues which enable and constrain the expression of nursing expertise may be lead to a body of highly educated, miserable and 'burnt out' nurses.

One seemingly positive development is that publicly funded postgraduate courses for nurses are likely to require a substantial component of clinical work, thus it is hoped, enabling the integration of acquired knowledge into clinical practice. However, postgraduate nursing education runs the very real risk of going down the same road of undergraduate nursing education, which is conspicuous by its lack of champions. What happens when the postgraduate course is over? Viewing nursing education as a production line in which raw material is placed in one end and a polished, finished product, be it an advanced or beginning practitioner is produced at the other end is flawed. Consideration must be given to supporting both beginning and would be advanced practitioners in continually developing their expertise.

### Getting back to basics

Extending the purview of nursing work into prescribing and other areas of medical practice may be a good thing. Clarification of what is required and the provision of educational and practice frameworks is necessary to ensure the safety of all concerned. However such extended roles should not be confused with expertise in nursing. Allen (1998) surveyed the opinions of 78 psychiatric nurses in England on their opinions of the content of advanced practice and found that most believed that an advanced practice nursing role should not just take on medical tasks, but should retain the expressive humanistic qualities of the nursing role. Nursing is challenged to ensure that what is fundamental to nursing is promoted and protected, not considered 'basic', but placed at centre stage.

The nurse in the opening paragraph was recognized as being an expert in knowing the right time to hold someone's hand. In many ways this simple and unsophisticated act reflected more of what it means to be a nurse than the selection of a drug from a formulary, no matter how expertly undertaken.

Nursing expertise tends to be hidden, invisible, highly contextualized, expressed and known in the context of relationships. Sutton & Smith (1995, p. 1042) challenge

'... the profession to consider carefully whether it wishes to re-establish a focus on the client or whether it wishes to maintain its current emphasis on the technical and procedural elements of practice'.

Perhaps the most important condition for promoting advanced practice is to return to basics and to recognize, value, cultivate, share and celebrate the expertise of nursing. Without proceeding from such a starting point we run the risk of mistaking the role (e.g. prescribing) as advanced nursing practice rather than yet another role which advanced practitioners may assume.

## Conclusions

The development of postgraduate educational opportunities and the development of advanced practice roles can only enrich nursing. However, putting all of one's eggs in one basket may make for a fine omelette, but a 'hit or miss' pavlova. Education, defining the scope and regulating advanced practice is necessary but insufficient to advance nursing practice. Equal weight must be given to supporting nurses in the development and expression of nursing expertise in practice. The concept of clinical supervision is one, which shows promise as a tool to support nurses in their development.

Organizations which express commitment to advancing expertise are likely to be rewarded in many ways. Value is added to education of nurses in that a safe environment is created so that people may develop their capacity into competency and expertise in practice. A supportive environment is necessary so that people who assume nurse specialists and other advanced practice roles are able to realise the potential of their roles. It will only be at this point that the adoption of such roles will become part of the solution to advancing nursing practice.

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