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Roles and functions of enrolled nurses in Australia: Perspectives of enrolled nurses and registered nurses

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Roles and functions of Enrolled Nurses in Australia: Perspectives of Enrolled Nurses and Registered Nurses

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ABSTRACT

Aims: To determine, from the perspectives of enrolled nurses and registered nurses, the current scope of enrolled nurse practice and to identify the activities that most enrolled nurses frequently performed in their workplace.

Background: Enrolled nurse scope of practice in Australia has evolved and expanded over the past decade. However, the unclear role, function and competency differentiation between EN and RN leads to role confusion and ongoing professional debate.

Design: Exploratory, descriptive study

Methods: A cross-sectional online survey of ENs and RNs across Australia was conducted examining their levels of agreement on statements related to the scope of practice and the clinical and nonclinical activities that ENs were required to perform in their workplace.

Results: Valid responses were received from 892 ENs and 1198 RNs. ENs mostly agreed that they understood their scope of practice; did not undertake roles for which they were unprepared; sometimes undertook activities other than direct patient care and believed that they operated equally to many registered nurses. The majority of ENs reported that they performed tasks mostly related to basic patient care in their workplace. There were a number of significant differences between perspectives of RNs and ENs

Conclusions: Clarifying the roles and scope of practice between the RN and the EN is important and explicit differences in responsibility and accountability between their roles must be clearly articulated in order to harmonise perceptions about role and capability.

Relevance to clinical practice: Health service providers, policy makers and education providers need to work collaboratively to ensure that facets of EN education and scope of practice in line with regulation are affirmed by all concerned.

What does this paper contribute to the wider global clinical community?

- ENs understood their scope of practice and mostly did not undertake tasks for which they were unprepared although different role perceptions between EN and RN were evident.
- The roles of EN and RN need to be clearly defined to reduce ambiguity, role conflict and role confusion. With revised standards for EN practice, role conflict and role confusion between RNs and ENs should be minimised.
- Health service providers, policy makers and education providers need to work collaboratively to ensure EN education and their scope of practice is affirmed by all concerned.

INTRODUCTION

In Australia, the nursing workforce comprises two levels of regulated qualified nurses (Registered Nurses (RNs) and Enrolled Nurses (ENs)) along with unregulated healthcare workers (Assistants in Nursing (AINs) or Personal Care Assistants (PCAs)) (Cubit & Leeson 2009). Each has a difference in the level of education (ENs undertake a Diploma and RNs a degree), scope of practice and subsequent responsibilities. According to the Nursing and Midwifery Board of Australia (NMBA), an EN is defined as an associate to the RN who demonstrates competence in the provision of patient-centred care as specified by the registering authority's licence to practise, educational preparation and context of care (ANMC 2002, p.2).

In 2015, there were 266,221 RNs, 60,378 registered ENs and 5,538 dual registered EN/RNs (Australian Health Practitioner Registration Agency 2015). The majority of the ENs worked in a clinical capacity (87.7%) and slightly more listed their main place of employment as public sector (23,338 FTE) than the private sector (20,421 FTE). One percent worked in education roles and only 0.2% in research.

BACKGROUND

In the past decade, the role of EN has expanded in many healthcare settings in Australia. Earlier studies examining the role and function of ENs found they were engaging in a diverse array of clinical nursing activities ranging from basic nursing care to more advanced activities (Gibson & Heartfield 2003, Kimberley *et al.* 2004, Milson-Hawke & Higgins 2004). Blay and Donoghue found ENs in acute surgical wards in Sydney, Australia were practising advanced clinical skills activities, including escorting post-operative patients and performing bladder ultrasounds; however the number of advanced skills performed was limited (Blay & Donoghue 2007). The Department of Health in Western Australia surveyed

ENs in 2007 and found the most significant change in *where* ENs practised was a move away from medical wards to more specialised areas such as ambulatory care, emergency departments and paediatrics (Robertson 2011).

Studies have also shown that ENs fulfil care requirements similar to RNs. Chaboyer *et al*. compared activities undertaken by ENs and RNs on medical wards in Australia and reported that ENs performed direct care tasks similar to RNs (Chaboyer *et al.* 2008), including admission and assessment, hygiene and patient/family interaction, medication and IV administration and procedures. Similar indirect activities undertaken between the two groups were patient rounds and team meetings, verbal reports/handovers, care planning and clinical pathways. Over two decades ago, Bond found ENs with several years of experience working in less acute hospitals often assumed responsibilities on a par with those carried out by RNs working in high acuity settings (Bond 1996). Jacob and colleagues conducted a literature review to discover whether there were differences or similarities between ENs and RNs; they found more similarities than differences between the two roles particularly in patient care and skill requirements (Jacob *et al.* 2012). A literature review in 2013 found that the roles of ENs have expanded since their introduction into the Australian health care system, resulting in role confusion (Jacob *et al.* 2013). Although these studies demonstrate that the EN scope of practice has significantly evolved and expanded over the past decade, there is little distinction between undertaking care activities and assuming responsibility for patient management. Similarly, there is limited acknowledgment of the limitations of the EN role in care planning, with responsibility for ratifying the care planning resting with the RN.

The aims of the study were to determine from the perspectives of the ENs and RNs, the current scope of EN practice and the activities that most ENs frequently performed in their workplace. This study was part of a larger project to revise the Nursing and Midwifery Board

of Australia (NMBA) Standards for Practice for the Enrolled Nurse in accordance with contemporary practice.

METHODS

This was an exploratory descriptive study. All ENs and RNs across Australia were invited to participate in an online survey. A range of methods including newsletters, websites and emails were used to recruit the participants. Identified stakeholders (including regulatory authorities, professional and industry bodies) assisted with the recruitment by posting the study with the link to the survey on their websites; and employers of ENs assisted with sending out emails with the link to the survey. Completing the online survey implied consent to participate in the study. Ethical approval for the study was obtained from an Australian University Human Ethics Committee. Survey questionnaires were posted online using Qualtrics©(Qualtrics 2002), an online survey software from October 18 to November 28, 2012.

Survey questionnaire

The research team used a pragmatic approach to develop the questionnaire. Pragmatic approaches emphasise 'shared meanings' and 'joint action', when members of a research team reach a consensus about which questions are worth asking, which methods are most appropriate for answering them and the feasibility of different lines of action (Creswell 2003, Morgan 2007). According to Stange *et al*. a pragmatic questionnaire places emphasis on the context and focuses on appropriateness for the specific settings in which the questionnaire will be used (Stange *et al.* 2012). Three components of the survey questionnaire were developed: (i) scope of practice, (ii) contemporary activities and (iii) biographical information.

The Scope of Practice questionnaire consisted of 22 statements on which respondents assigned levels of agreement on a 6-point Likert scale ranging from strongly agree (6) to strongly disagree (1) (see Table 1). The Contemporary Activities Scale consisted of 89 activities that ENs could be required to perform in their workplace ranging from less complex activities such as fluid balance charting to advanced activities such as IV cannulation. Respondents rated these activities on a 3-point Likert scale ranging from regularly, sometimes and never (see Table 2 and a full list of activities at Table S1). The items for both questionnaires were derived from an extant review of the literature followed by the consensus process described above. The same questions were used for EN and RN questionnaires, in order to allow direct comparison of perspectives.

INSERT TABLES 1 AND 2

Data analysis

The data were entered into SPSS version 20 (SPSS, Chicago, IL) and analysed using descriptive statistics (count, percentage, mean and standard deviation). Responses to the Scope of Practice questionnaire by ENs and RNs were compared using T tests. Responses to the Contemporary Activities Scale were likely to be influenced by the work environment of the respondent, hence there was little merit in comparing EN and RN responses.

RESULTS

A total of 1104 ENs visited the online survey site; of these 947 (85.8%) ENs participated in all three sections of the survey, and 892 (94.2%) were able to be used for analysis. In relation to the total number of ENs employed in nursing at the time of the survey (n=52,654), there was a response rate of 1.8%. A small number of the ENs omitted to complete some of the demographic items; a summary of the demographic profiles is presented in Table 3. The majority (91.7%) were female with an average age of 48 years (SD 10.5). One third (33.9%)

worked in the acute care sector; and for those who reported 'other area of work' (29.2%), 6.8% worked in the community sector. Two hundred and eighty three (32%) were diploma qualified, and 8% held an advanced diploma. Approximately over 95% acquired their initial EN qualification in Australia. A substantial number (43.7%) of respondents had worked as ENs for over 20 years. The gender, employment fraction and age profile of our respondents was similar to the national picture of the EN workforce at the time of data collection.(AHPRA 2015) A total of 1356 RNs responded to the survey, with 1198 valid responses, a response rate of 0.005%. A summary of the demographic profiles of the RNs is provided as Table S2; again a small number of the RNs omitted to complete some or all of the demographic items. The majority of RN respondents were in the 40-59 years age bracket (71.7%), were female (87.4%) and worked in the public sector (80.1%).

INSERT TABLE 3

Survey results show that ENs report that they understand their scope of practice (see Table 1); however, 55% reported that they were prepared for roles they were not permitted to undertake and 67.3% stated their ability to practise to their full scope was often limited by hospital policies, guidelines and legal requirements, in particular enterprise bargaining agreements. Whilst 87.5% reported that they did not undertake *roles* for which they were unprepared, 36.4% reported that they were requested to undertake *activities* for which they were not prepared. Sixty-seven per cent reported that they undertook activities other than direct care (e.g. education, preceptoring, care coordination) and 75.3% believed that they operated equally to many RNs. Importantly, however, 66.8% of RNs disagreed with this. There were 50.7% of ENs who agreed that, in their organisation, they practise more like a RN than an EN, and 82% disagreed that they practise more like unregulated healthcare workers (PCAs, AINs). In addition, 63.8% disagreed that they required direct supervision from RNs.

Of the RNs who participated in the survey (n=1198), most agreed that ENs were highly skilled (87%) and did not require direct supervision for some tasks (97.1%). In contrast to the ENs, they agreed that ENs did undertake or commence tasks for which they were unprepared (62.2%) and 88.9% disagreed that ENs in their organisation operated more like unregulated healthcare workers. Further, 72.5% knew that ENs in their organisations performed very different roles to those in other organisations. A number of statements generated statistically significant differences in responses from ENs and RNs, highlighting different perceptions about role and capabilities. These are presented at Table 4.

INSERT TABLE 4

In order to explore variation in the EN survey data, Likert responses were grouped into 'agreed' (Strongly agreed, moderately agreed or agreed) or 'disagreed' (strongly disagreed, moderately disagreed, disagreed). Four statements were almost evenly split between agree and disagree (see table 5). These statements are reflective of ENs experience within their workplace and the standard deviations highlight wide variation in understanding from employers about the scope of practice of the EN role.

INSERT TABLE 5

The nursing activities regularly performed by most ENs were those of fundamental care as well as specialised nursing practices. The ten most and least regularly performed activities are provided at Table 3 (see Table S1 for the complete list with full Likert results). Both RNs and ENs noted that ENs performed tasks mostly related to fundamental nursing care (activities of daily living, documentation, communication, medication administration).

When viewed by State and Territory, there were no obvious patterns in the data, with no better or worse perceptions/experiences or activities reported by the RN and EN survey respondents.

DISCUSSION

Previous studies indicate that the scope of work performed by the EN is changing and that there may be a change in the activities and pattern of activities that ENs perform in relation to their roles. This change seems to have been driven by the ENs themselves, rather than a legislative change in scope. The introduction of the National (as distinct from the previous state-based) Registration and Accreditation Scheme implemented by AHPRA in 2010 was designed to enable health professionals to move around the country more easily, provide greater protections for consumers and promote a more flexible, responsive and sustainable health workforce (Australian Health Workforce 2010). These changes provide both consistency and greater opportunity for role variation; however, our survey results revealed homogeneity in relation to EN scope of practice across the country. The areas of homogeneity probably revealed strong pervasive aspects of contemporary workplace culture and practice. These included confidence in their role and care they undertook.

The ranking of the EN scope of practice (see table 1) has demonstrated that ENs in this survey understood their scope of practice and mostly did not undertake tasks for which they were unprepared. This is supported by the high ranking in the statement regarding their confidence in the nursing care that they provided. Different role perceptions between EN and RN were evident: the majority (62%) of RNs thought ENs did undertake tasks they were unprepared for. Respondents identified that ENs perform activities other than direct patient care; this echoes the findings of Chaboyer *et al.* that ENs undertake indirect patient activities including attending patient rounds and team meetings, verbal report/ handover and care planning and clinical pathways (Chaboyer *et al.* 2008).

EN survey respondents believed that they operated equally to many RNs and disagreed that they practised more like unregulated health workers. This is consistent with the findings from

earlier studies that ENs frequently undertake the same tasks as the RNs (Gibson & Heartfield 2005, Kenny & Duckett 2005) and was an important difference in perception between ENs and RNs in our data, with implications for patient safety and scope of practice. However, Kimberley *et al.* argued that despite activities undertaken by ENs being similar to RNs, there are knowledge gaps for ENs in the capacity for assessment and decision making (Kimberley *et al.* 2004). Changes to education preparation for ENs have been enhanced with the introduction of the National Health Training Package in 2007 to increase the depth of training across Australia (Australian Qualifications Framework Advisory Board 2007). Hence, from 2014 all ENs are taught at Diploma level (CS&H Industry Skills Council 2012) and different pedagogic approaches such as clinical reasoning and flipped classroom are being introduced (Dalton et al 2015), although these are yet to be evaluated. However, the distinction between EN and RN educational preparation remains; a recent interview study with RN and EN educators emphasised differences between high school education achievement of EN and RN student cohorts, requiring different approaches to education (Jacob et al 2014). A recent literature review also acknowledges the importance of clear differentiation between between ENs with advanced practice skills and RNs, reflecting the higher level of accountability resulting from the clinical decision making and critical thinking aspects of RN roles (Cusack et al 2015). By contrast, the perception that ENs and RNs perform similar roles despite different levels of educational preparation has prompted some countries, such as the United Kingdom, to phase out EN training and encourage ENs to convert to RN qualifications (Blay & Donoghue 2007, Brown 1994, Gibson & Heartfield 2003).

Eagar *et al.* explored the relationships in and between the scope of practice and communication amongst different groups of nurses in Sydney, Australia and found the scope of practice conflict between ENs and RNs was consistently discussed, and confusion about 'who does what and when' was constantly raised (Eagar *et al.* 2010). Our survey results

indicate that this persists and is evident across States and Territories. However, whilst our survey explored perceptions of EN roles, the results have implications for perceptions of other health care worker roles, for example Associate Nurse or Assistant Practitioner roles in the UK (Jackson *et al.* 2015, Traynor *et al.* 2015) and Licensed Practical Nurses in the United States (Shaffer *et al.* 2010). Occupational boundary disputes are often analysed between, rather than within, professions (Bach *et al.* 2012); our findings reveal some important differences in role perception within the nursing profession in Australia. This suggests that this is a fruitful area for further exploration; the NMBA Practice Standards for RNs and ENs (NMBA 2016) provide clear distinction between the roles but the application of the practice standards warrants investigation.

The NMBA clearly articulates that the EN, as an associate of the RN, must practise with the support and (direct or indirect) professional supervision of an RN but is responsible for his/her own actions and is accountable to the RN for all delegated activities (ANMC 2002, p.2). One of the five statements that ENs disagreed with in our survey was that they require direct supervision from the RN. Over a decade ago, Gibson and Heartfield identified that a key issue related to supervision was dependent on the EN's skills and attributes and the ability to act with relative autonomy in the context of nursing care within which they were practising (Gibson & Heartfield 2003). They commented that the argument for more flexible models of EN supervision does not necessarily imply an expanded scope of EN practice; rather it is to enable ENs to practise to their fullest capability within their regulated scope of practice, to ensure safe and effective standards of nursing care. The Practice Standards (NMBA 2016) now provide scope for indirect supervision of ENs so this should become a moot point in future.

Limitations

There were several limitations to the survey. The survey results are based on self-reported data that may or may not be an accurate representation of practice. Even though anonymity of the participants was protected, only 1.8% of practising ENs and 0.005% of practising RNs completed the online survey, which limits its representativeness of all ENs and RNs currently working. As part of the larger study we undertook non-participant observation of ENs in a range of settings across Australia; it was evident that access to IT portals for the purposes of recording care was severely limited. This lack of IT access may have influenced survey responses. Thus a further survey utilising different access modes, to determine the EN scope of practice in a bigger sample is warranted. Although it is not possible to cover all aspects of EN scope of practice and activities that may be frequently performed, the instruments were developed using a pragmatic approach arising from the literature review and from the expertise of the research team. Face validity was established via the project governance committee, which was comprised of both experienced RNs and EN. These bespoke instruments have shown utility with EN and RN survey respondents; however, formal steps to establish validity and reliability should be taken if the instruments are to have any longevity. Due to these limitations, the survey results have to be interpreted with caution.

CONCLUSION

Survey results revealed that ENs believed that they operated equally to many RNs, and higher than unregulated healthcare workers. However, due to differences in educational preparation between the RN and EN, the knowledge that underpins activities undertaken by ENs is different. A list of tasks and other activities does not adequately address knowledge base, decision-making and problem solving. Yet, often the scope of practice is reduced to a list of tasks or activities that the EN can undertake.

It is important to continue to define the roles between RN and EN and make explicit the differences in responsibility and accountability. Although these are articulated in the Practice

Standards, it is essential to monitor how they are applied in order to decrease ambiguity, role conflict and role confusion. The role and function of the EN should be optimised to meet the requirements of the current Australian healthcare system. Health service providers, policy makers and education providers need to work collaboratively to address EN educational preparation and their scope of practice.

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Table 1: Ranking of ENs levels of agreement on their scope of practice

Statement	Median (IQR)
I understand my scope of practice	6 (1)
I feel confident in all the care/work that I provide	6 (2)
I never undertake/commence a task for which I am unprepared	5 (2)
I know that ENs in other positions have very different roles to me	4 (2)
I believe that I operate equally to many RNs	4 (2)
PCAs, AINs and/or other health workers look to me for guidance	4 (2)
I undertake roles other than direct clinical care. For example, committee work, coordinating a work area, education, preceptorship etc.	3 (3)
My ability to practise is often limited by hospital policies, guidelines and legal requirements	4 (2)
The existing regulatory system limits my scope of practice	4 (2)
I am prepared for many roles and tasks that I am not permitted to undertake	4 (2)
RNs do not understand my scope of practice	4 (2)
In my organisation, I practise more like a Registered Nurse (RN) than an EN	4 (2)
I supervise PCAs and other health workers	4 (2)
I am often requested to do things for which I have not been prepared	3 (1)
RNs are cautious about delegating tasks and roles to me	3 (2)
As an EN, I require supervision from a RN	3 (2)
There are not enough RNs to supervise my practice adequately	3 (2)
It is difficult to say ‘no’ to a task I have been asked to undertake	3 (1)
I undertake roles for which I am not prepared because there is no-one else to do those roles	3 (2)
In my organisation, I practise more like a Patient Care Assistant (PCA) or Assistant in Nursing (AIN) than an EN	2 (2)
I undertake roles for which I am not prepared because I am afraid of losing my job	3 (2)

Table 2: Ten activities most and least frequently performed by ENs

Activities performed most regularly		Activities performed least regularly	
Activities	Regularly n (%)	Activities	Regularly n (%)
Blood glucose monitoring	694 (80.1)	Plaster cast application	31 (3.7)
Communication with health care team	690 (79.7)	Antenatal care	31 (3.6)
Assisting patient ambulation	677 (78.1)	Arterial blood gas collection	31 (3.6)
Activities of daily living	655 (75.5)	Postnatal care of the mother	27 (3.2)
Checking S8 and other drugs	616 (71.6)	JVP measurement	25 (3.0)
Handover delivery	616 (71.4)	Neonatal medication administration	24 (2.9)
Pulse oximetry	593 (70.2)	Chest X-ray interpretation	22 (2.6)
Aseptic dressing technique	591 (68.3)	Postnatal assessment	22 (2.6)
Fluid balance charting	584 (67.6)	Neonatal assessment	19 (2.2)
Patient education	559 (65.6)	Intra-osseos infusion	9 (1.1)

Table 3: Demographic profiles of ENs

Demographic feature	N	(%)
Age (year)		
20 and under	8	(0.9)
21-29	58	(6.8)
30 - 39	107	(12.6)
40 - 49	235	(27.6)
50 - 59	368	(43.2)
60 and over	75	(8.8)
Gender		
Male	73	(8.3)
Female	807	(91.7)
Working as EN (year)		
Less than 1 year	25	(2.9)
1-5	233	(27.3)
6-10	153	(17.9)
11-15	48	(5.6)
16-20	21	(2.5)
Over 20	373	(43.7)
Current area of work		
Acute care	301	(33.9)
Aged care	155	(17.5)
Mental health	52	(5.9)
General practice	96	(10.8)
Maternity services	14	(1.6)
Private practice	11	(1.2)
Other	259	(29.2)
Current work sector		
Public	646	(73.5)
Private	233	(26.5)
Employment type		
Full time	332	(37.9)
Part time	460	(52.5)
Casual	85	(9.7)
Highest level of EN education		
Hospital training	184	(20.8)
Certificate III	5	(0.6)
Certificate IV	35	(4.0)
Certificate IV with medication endorsement	233	(26.4)
Diploma	283	(32.0)
Advanced Diploma	71	(8.0)
Other	73	(8.3)
Initial EN qualification acquired in Australia		
Yes	839	(95.2)
No	42	(4.8)
Undertaken advanced training		
Yes	470	(54.3)
No	396	(45.7)
Place of birth		
Australia	698	(78.9)
Overseas	187	(21.1)
Aboriginal or Torres Strait Islander		
Yes	21	(2.4)
No	854	(97.6)

Table 4 Statements with significantly different rating between RNs and ENs[1]

EN	Sum of Ranks	RN/RM	Sum of Ranks	*P*[2]
I understand my scope of practice	1603.61	*I understand the ENs' scope of practice*	611.16	<.001
I am prepared for many roles and tasks that I am not permitted to undertake	1095.98	*ENs are prepared for many roles and tasks that they are not permitted to undertake*	982.87	<.001
RNs are cautious about delegating tasks and roles to me	864.40	*I am cautious about delegating task and roles to ENs*	1147.53	<.001
I supervise PCAs and other health workers	1099.99	*ENs supervise PCAs and other health workers*	950.40	<.001
Employer guidelines or policies restrict my scope of practice/ability to practise	1109.13	*Employer guidelines or policies restrict EN's scope of practice/ability to practise*	966.92	<.001
The existing regulatory system limits my scope of practice	1164.17	*The existing regulatory system limits ENs' scope of practice*	3921.27	<.001
PCAs, AINs and/or other health workers look to me for guidance	1352.05	*PCAs and other health workers look to ENs for guidance*	759.22	<.001
There are not enough RNs to supervise my practice adequately	926.85	*There are not enough RNs to supervise EN's practice adequately*	1102.86	<.001
I undertake roles for which I am not prepared because I am afraid of losing my job	617.89	*ENs undertake roles for which they are not prepared because they are afraid of losing their job*	1333.32	<.001
I undertake roles for which I am not prepared because there is no-one else to do those roles	768.31	*ENs undertake roles for which they are not prepared because there is no-one else to do those roles*	1216.97	<.001
I believe that I operate equally to many RNs	1192.61	*ENs think that they are same as RNs*	910.05	<.001
My ability to practise is often to limited by hospital policies, guidelines and legal requirements	1281.05	*ENs' ability to practise is often to limited by hospital policies, guidelines and legal requirements*	842.42	<.001
I never undertake/commence a task for which I am unprepared	1299.12	*ENs never undertake or commence a task for which they are unprepared*	829.92	<.001

1: based on a Likert scale 1-6
2: Mann Whitney U

Table 5 EN questionnaire statements evenly split between agree and disagree responses

Statement	% agree	Median	IQR
I am prepared for many roles and tasks that I am not permitted to undertake	55.0	4	2
RNs do not understand my scope of practice	52.6	4	2
Employer guidelines or policies restrict my scope of practice/ability to practise	50.7	4	2
In my organisation I practise more like a Registered Nurse (RN) than an EN	50.7	4	2