University of Plymouth

PEARL **https://pearl.plymouth.ac.uk**

Faculty of Health: Medicine, Dentistry and Human Sciences School of Nursing and Midwifery

2018-05-04

Scope of practice and workforce issues confronting Australian Enrolled Nurses: A qualitative analysis.

Endacott, R

http://hdl.handle.net/10026.1/11600

10.1016/j.colegn.2018.04.001
Collegian
Elsevier

All content in PEARL is protected by copyright law. Author manuscripts are made available in accordance with publisher policies. Please cite only the published version using the details provided on the item record or document. In the absence of an open licence (e.g. Creative Commons), permissions for further reuse of content should be sought from the publisher or author.

Scope of practice and workforce issues confronting Australian Enrolled Nurses: A qualitative analysis

Lisa McKenna [a, b,], Pamela Wood[c], Allison Williams[a], Margaret O'Connor [a, d,] Cheryle Moss [a], Debra Griffiths [a], Phillip Della [e], Ruth Endacott [a, f,] Wendy Cross [a]

a School of Nursing and Midwifery, Monash University, Australia

b School of Nursing and Midwifery, La Trobe University, Australia

c School of Nursing, Eastern Institute of Technology, New Zealand

d Faculty of Health, Arts and Design, Swinburne University, Australia

e School of Nursing and Midwifery, Curtin University, Australia

f School of Nursing and Midwifery, Plymouth University, UK

Final author version of manuscript accepted for publication in *Collegian*, accepted 02 April 2018

Abstract

Background: Enrolled Nurses constitute an important part of the Australian health care system. Recently, improvements to education and medication endorsement have initiated expansion to EN scope of practice.

Aim: This paper reports on a study conducted to inform development of revised Nursing and Midwifery Board (NMBA) of Australia Enrolled Nurse practice standards that explored with ENs their scope of practice.

Design: A qualitative design using focus groups and individual interviews with ENs across Australia. Data were analysed using thematic analysis.

Findings: ENs work in diverse practice contexts with differing scope of practice. Confusion existed regarding EN scope of practice as a result of many different types of ENs in practice. Care of unstable patients was seen to be outside the EN scope of practice. They were also often required to supervise the work of nursing assistants and new registered nurses. Lack of career pathway was seen as a limitation to ENs.

Conclusions: EN education and scope of practice has evolved significantly, particularly in many practice settings, since the existing standards were developed. Further work is needed to address issues related to EN supervision of new RNs and AINs (Assistants in Nursing), and clarity of EN supervision in specialist clinical areas.

1. Background

The scope, education and practice context of enrolled nursing has evolved significantly in Australia since the Competency Standards for Enrolled Nurses (ENs) were written in 2002 (Australian Nursing & Midwifery Council, 2002). Role growth has been driven by a number of factors, including Registered Nurse (RN) shortages, increasing patient acuity, and economic factors (Jacob, McKenna, & D'Amore, 2015). While not a new issue, this role expansion has contributed to role confusion between ENs and RNs (Jacob, Barnett, Sellick, & McKenna, 2013). In a study exploring activities undertaken by the two levels of nurse (RN and EN) in two Queensland hospitals, Chaboyer et al. (2008) found a degree of practice similarity between the two levels. However, ENs were found to focus on routine tasks, while RNs undertook less routine and more complex activities, including patient surveillance. A recent study by Jacob, McKenna, and D'Amore (2014a, 2014b) examined senior nurses' expectations of new graduate nurses. Jacob et al. found that there was large variation in perceptions and confusion about expectations of ENs and their scope of practice with relation to direct patient care. However, they established clear delineation with regard to complex care, high acuity skills and unstable patients being the domain of RNs. Furthermore, RNs assumed leadership and management functions, including supervision and delegation.

Education programs for preparation of ENs have developed to accommodate recent practice expansion. The national introduction of an 18-month diploma, extending the previous 12-month certificate, has seen theoretical and practice expansion and greater emphasis on critical thinking and clinical decision making, and further blurred differences between the RN and EN (Jacob, McKenna, & D'Amore, 2014c,

2014d), while some ENs have undertaken additional education, such as medication endorsement. However, contexts for the delivery of education remain different. ENs are educated in registered training organisations (RTOs) while RN education is delivered in universities. While there are increasing similarities in content delivered, there remain differences in the depth to which material is taught, degree of critical thinking and self-direction required, and in the educational qualifications of those delivering the education (Jacob et al., 2014c, 2014d).

The addition of medication endorsement to facilitate medication administration and holistic patient care brought greater responsibility and accountability for ENs across Australia in the 2000s (Hoodless & Bourke, 2009; Kerr, Mill, & McKinlay, 2012). Until the introduction of national regulation in Australia, legislative frameworks for regulating EN practice varied across the states and territories (McEwan, 2008), hence it was implemented differently across jurisdictions. While adding medication endorsement to the EN's scope of practice was seen by some to increase opportunities, it was not necessarily adopted positively. Many ENs felt compelled to upskill to be able to administer medications (Nankervis, Kenny, & Bish, 2008), while others saw it as an added burden to their workloads (Kerr et al., 2012; Hoodless & Bourke, 2009). Concurrently, some RNs felt that EN knowledge limited their ability to safely administer medications (Kerr et al., 2012).

In recent years, advanced skills and roles for ENs have begun to emerge. Nankervis et al. (2008) found in their study in a rural Victorian town that many ENs held extended roles in areas such as infection control and wound management and were frustrated at lack of recognition for this. Heartfield and Gibson (2005) found ENs in rural areas and specialist settings were often working in roles with wider responsibilities than ENs in metropolitan areas. However, little is published about

extended EN roles. In one study that could be located, Tranter, Westgarth, and White (2011) describe EN roles in New South Wales haemodialysis units. They found that in more than half of the units, ENs undertook case management, while ENs performed native access cannulations in all units. However, according to Cusack et al. (2015), there remains insufficient research evidence about advanced roles for ENs and the types of supports needed for these nurses. Overall, there is insufficient evidence about EN scope of practice and how that is influenced in the work context. This paper describes findings from a qualitative descriptive study conducted as the second phase of the 2014 Australian Review of the Competency Standards for the Enrolled Nurse. This study sought to explore with ENs, understandings around their scope of practice.

2. Methods

All ENs across Australia were invited to participate in the study.

Invitations were distributed through the Australian Health Practitioner

Regulation Agency (AHPRA) web site. This was further facilitated by key stakeholders, including employers, regulatory authorities and professional organisations. Fourteen focus groups were conducted around Australia, involving a total of 95 ENs. In addition, individual interviews were conducted with seven ENs who were unable to attend a focus group. Interview questions (Appendix A) were designed to elicit information about ENs' scope of practice and the influences on their work. These were conducted across all states and territories and included ENs from metropolitan/regional (n=55, 57.9%) and rural (n=40, 42.1%) practice settings (Tables 1 and 2). Participants were recruited via communications facilitated through numerous professional, nursing and government organisations. Interviews

and focus groups lasted between 12 and 57min in duration, with a mean of 35min. Focus groups contained ENs from a variety of different health care settings. Due to demand, South Australia and Queensland were more highly represented than other states, however there was broad coverage across Australia.

Table 1 Demographic Characteristics

Variable		**N (%)**
Gender	Male Female	69 (92.3) 5 (6.8)
Role	EN ENAP	63(84.0) 12 (16.0)
Place of Birth	Australia UK NZ Other	56 (74.7) 14 (18.8) 2 (2.7) 3 (4.0)
Highest level of education	Certificate Diploma Advanced Diploma Degree	7 (9.3) 52 (69.3) 12 (16.0) 4 (5.3)
Work area	Medical Surgical Aged care Palliative care Emergency Department Other	22 (29.3) 13 (17.3) 5 (6.7) 5 (6.7) 11 (14.7) 19 (25.3)
Geographical location	Metropolitan/regional Rural	55 (57.9) 40 (42.1)
Only I identified as ATSI All gained their initial qualification in Australia n=20 of the 95 participants provided detail regarding geographical location only		

Table 2 EN participant demographic characteristics

Variable	Mean (SD)
Length of time as an EN	10.82 (10.77)
Age	46.10 (10.69)

Ethical approval was obtained from the Monash University Human Ethics Committee prior to undertaking this phase of the study. Prior to the commencement of interviews, a research team member provided participants with an overview of the study and participation, and participants provided written consent. Interviews ranged from 22 to 53min in length and were conducted in prearranged locations in each city. Interviews were audio-recorded and transcribed verbatim for analysis. A second research team member was present to take field notes for the purpose of clarifying comments within the focus group to aid later analysis. Transcripts were analysed by two research team members using thematic analysis informed by DeSantis and Ugarriza (2000), who note that a theme 'brings meaning and identity to a recurrent experience and its variant manifestations' (p.362). Each transcript was read multiple times to ascertain key ideas which were coded initially. Patterns of ideas and terminology emerging from the data were identified and key quotations grouped into categories, each representing a general set of ideas. Categories were refined and then further collated into themes. Trustworthiness of key themes was determined through both researchers meeting together to compare emergent themes, followed by team meetings where findings were reviewed and discussed by the whole research team.

3. Results

Whilst there was some overlap, results of the EN focus groups and individual interviews clustered into two broad themes, Diversity of EN scope and role and Workforce, with associated sub-themes. These themes and sub-themes recurred across the focus groups and individual interviews and none was more prevalent in a particular state/territory.

Few differences were reported between metropolitan and rural ENs, although some of the latter did report having more responsibility at times.

4. Diversity of EN scope and role

Within this theme, ENs talked about the diverse nature of their roles and scope of practice. They outlined challenges in working within scope, understandings of their roles, and issues related to individual skills and expertise.

4.1. Challenges working within scope of practice

There was extensive variation in EN scope and role across health and aged care sectors. In addition, nearly all ENs reported variations between practices in their own institution, across different clinical areas.

Some ENs admitted to challenges working within their scope of practice in some areas such as aged care and in small rural hospitals.

> *I worked in an aged care facility, and there were times where I felt I did work not within my scope of practice. Because there wasn't a registered nurse around, a lot of the times, I had to make the decisions. These were clinical decisions, [had to assess a patient, decide to call the doctor]* (F1.02).
>
> *We're in aged care. In the class we work at, we're expected*

to do a lot of things outside our scope, and not to ask questions. It's like no, I'm not comfortable with doing that, and then they go, fine, I'll find someone else, and it's the same. I can't. (F2.05)

I think the enrolled nurse is asked to step out of the scope of practice many a time, and the majority of that is because you're so short staffed. (F2.10)

ENs working in the acute care sector reported the most variation in practice across clinical areas. Many felt they did almost everything that RNs did, although this perceived similarity was mostly identified as relating to clinical tasks, such as IV medications and IV (intravenous) antibiotics.

I work in the acute medical unit and I do everything except for giving IV medications, IV antibiotics, almost everything the registered nurses do. (F2.03)

ENs acknowledged that RNs were largely responsible for patient management and care planning, and were seen to possess greater knowledge and better-developed physical assessment skills. In areas where there were greater numbers of RNs, ENs tended to perform more basic tasks. ENs working in specialised areas such as Emergency Departments (ED), Operating Theatres (OT) and renal dialysis units reported that they had a broad scope of practice and this included wound management, scrubbing for procedures in the OT, working as anaesthetic nurses and managing dialysis machinery.

I'm an enrolled nurse in an emergency surgical department…I give all of my own IV medications. I manage my own patient load…I do their care plans…I'm basically responsible for all the care of my patients. (F2.09)

…we work equally as an RN in recovery…we do everything… We have to be aware of everything, patients' care and any complications in their past histories…we do all our handovers as

well. There's nothing different. (F2.08)

In primary care and community settings, ENs were working in general practice, usually alongside RNs. ENs in general practice engaged in a number of additional activities.

> I'm in general practice in a rural country town, and I do wound care, immunisations, general treatment room duties. I'm a Pap smear provider, I do chronic disease management, diabetes management… suturing, spirometry, ECGs, venepuncture. (F1.01)

Some ENs reported having education roles within their area. They spoke of being required to preceptor undergraduate RN and EN students, as well as support new graduate RNs and other new members of staff.

> I precept the new grads…or the student registered nurses. I'll be precepting them at times, but I always precept them with a view to keeping my own scope of practice. (F2.04)
>
> …there are times, because of the skill mix, we're giving you the RN student, which in some ways is a bit silly, because we actually can't supervise them giving medications. That's beyond our scope. (F2.09)

Whether such supervision is within the EN scope of practice was unclear.

4.2. Understanding EN scope of practice

Most ENs demonstrated an understanding of their own scope of practice. In acute care, most reported being able to recognise when requests were being made for them to work outside their scope of practice and the need to relate this to RNs, doctors and other health professionals.

> *I feel that I'm out of scope of practice when patients become unstable.*
>
> (F2.06)

ENs believed that their scope of practice was not well defined in regulations or interpreted well in organisations, such as acute and primary care environments. Different areas within the one organisation or service could have different interpretations. Similarly, different states have different interpretations.

> … I find that quite difficult in the same hospital, having different practices in different areas, because where I work in theatre, my scope's pretty broad and I do lots of things, put in Jelcos and then I'll be asked to go help relieve on a medical ward…I find sometimes I'm getting myself in trouble, because there are things that I'm just not used to, like I can't put Jelcos in over there, and it's hard to know exactly what you're allowed to do in each area. Nurses are supposed to countersign my notes in that particular area, whereas we don't have any of that in our area (F2.10).

There was a perspective across focus groups and interviews that RNs often did not understand the individual EN's scope of practice. This was highlighted to be partially due to the fact that there was so much variation in the educational preparation of ENs that this, in turn, led to variation in what they were allowed or able to do.

> The confusion is we have too many levels of enrolled nurses…It is the frustration of some registered nurses, as well, because they have an enrolled nurse come in and she's either not medication endorsed, she's medication endorsed without IV, or she's got a diploma and there are constrictions around that. (F2.11)

> I don't think that registered nurses, as a collective, value the role the enrolled nurse plays in the health profession. I don't think they understand the enrolled nurse's role very well. (F2.10)

> Some RNs would be unsure about who is endorsed, who's

> not, especially with medication and the IV drugs. I think that would be very hard. (F1.04)

Many ENs felt that they were performing many skills in common with the RN and questioned whether there were differences in roles. However, what became evident through the interviews was that ENs were undertaking elements of some skills that only the RN could do in their entirety.

> A PCA [patient controlled analgesia] syringe, you cannot read so you can go and do the vital signs for those PCA obs…you cannot read the syringe because you are not a RN (F2.01)

> …you're allowed to check them [dangerous drugs] but you're not allowed to give them. (F2.02)

> You're not allowed to do complex wounds…we're not allowed to assess and we're not allowed to plan the care, but we've been doing that assessment – we do our observations on our patients, but yet, we're not allowed to do an assessment. (F2.01)

Many ENs reported that doctors often became frustrated when they asked an EN to undertake activities that the EN explained were beyond their scope of practice and they would need to find an RN who could undertake the tasks. The presence of advanced EN roles in some areas further contributed to confusion of doctors, due to their lack of understanding of the EN scope of practice and the extended scope that some ENs have achieved.

> …a lot of the doctors in ED, they're like, I thought you were a registered nurse…they go on the assumption that you are an RN and they'll give you things that are out of your scope of practice. You've just got to step back and go, I can't do that, but I'll get

someone who can. (F2.11)

They [doctors] get a little bit snotty when you say, I'm not supposed to do that. (F2.02)

4.3. Individual EN skills and expertise

Whilst most ENs understood their scope of practice, they felt they were not able to work to their full scope of practice. Their ability to do so depended on their specific context (clinical area), organisational policy, or the understandings and attitudes of RNs and others in the health care team in their areas. Overwhelmingly, participants reported significant variation in what they were permitted to do, not only between institutions, but within their own, that is, from one clinical area to the next.

That's where I find it very, very wrong, what AHPRA [Australian Health Practitioners Regulation Agency] says we can do. Then as soon as you walk into the hospital, the hospital has another policy on top of that. Then you get on the wards and there's another policy on top of that. So when you're going between wards, it's very difficult to know what your policies are (F2.02).

Factors that influenced this included relationships with co-workers, individual ward/unit policies and procedures and whether ENs and their capabilities were known to the RNs within the clinical area. Relationships with registered nurse students and new graduates were reportedly particularly challenging.

We've had the odd student who's asked, where is their enrolled nurse to do their ADLs [activities of daily living]? (F2.09)
…sometimes the nurses that just come out of university come into the hospital setting. I've got years and years of experience, but I'm an enrolled

> nurse, so some of them don't want to listen to the enrolled nurse or to learn from the enrolled nurse. (F1.03)

5. Workload and workforce

Participants discussed a range of issues relating specifically to their workloads, in particular, the place of Assistants in Nursing (AINs) and impact of additional skills to their workloads, such as medication endorsement. They were also concerned about lack of career pathways and opportunities for career development.

5.1. ENs, RNs and unregulated health care workers

ENs reported being responsible for supervision of AINs or Personal Care Attendants (PCAs). In some instances, the EN worked in a team with these workers and allocated tasks. The EN was seen as the team leader in these cases. Polarised views about unregulated health care workers emerged. Some ENs saw them as yet another level of nurse that was not needed, and others felt there was still work that ENs were doing that could be performed by unregulated healthcare workers.

> An EN is not an AIN anymore, and the introduction of the AIN into the health facilities has definitely created that next rung on the ladder which was never needed. (F1.06)

> I'd really like to see PCAs having their own competency standards, too, nationally, because having PCAs giving out medications in nursing homes and stuff just worries me terribly, or AINs, if they haven't done a medication unit. Really, they've no idea what they're doing. (F2.04)

> I think there's still a lot of stuff that enrolled nurses do that perhaps somebody else could do. More like a ward ancillary or

> something like that. (F2.03)

The RN was identified as the person ENs would go to when they needed to refer concerns about patients. RNs were seen as a support and to have a greater knowledge base and to be the person making the key decisions.

> There probably is a little bit more division in my ward between ENs and the RNs…I've never had any kind of problem, but that division is noticeable. (F2.01)

> If there's anything I wouldn't know, I would say I'll check with the RN on the side I'm working on just to make sure. (F2.10)

> I'm glad they're [RNs] there for support. I'm glad I can go to them if I need their support, and if my knowledge base isn't quite up to what I need to know. I'm glad they're there to be able to bounce off…if I'm not sure about something. (F2.08)

> Some RNs micromanage, and they will look over your shoulder to the nth degree, and then others to the other side, they just let you go. (F2.10)

5.2. Expanding EN workload

Participants also discussed the impact of expanding their workloads to accommodate new skills. There was a view that some ENs would not be capable of taking on such development of their work.

> I don't want to be derogatory but some people aren't capable of doing extra stuff. They're still working within their limitations, they're still performing very well but they haven't done their drug accreditation. (F2.08)

Medication endorsement as an addition to EN scope of practice was generally seen as a positive factor. However, many ENs discussed that assuming responsibilities for this aspect of patient care added further pressure on their busy workloads.

> They [ENs] think now if they do an antibiotic, they're great, but

> they’re not thinking about still doing seven baths…our workload has actually increased on the wards plus we’re doing medications… We’re taking on the role of the RN really. (F2.01)

However, there was a perception by some that increasing ENs’ roles was a cost saving measure:

> …they’re letting you do cannulation and IVs, and they’re bringing in all these skills because we’re so much cheaper than the RN. (F2.02)

5.3. Career pathway for ENs

Career pathways were identified as an issue for ENs. Many expressed frustration that they could not easily access education, either in-house or external courses, related to specific aspects of their role, or for ‘upgrading’ to become a RN.

> I think the barrier is that there’s no formal career pathway. But there are barriers because you get so far and all of a sudden, a prerequisite will say that you can’t do it because you’re not an RN. (F1.01)
>
> …as for in-house, there are a lot of professional development opportunities for RNs…There’s nothing for ENs. (F2.11)

Many ENs saw that the only career pathway for them was to convert to an RN role. However, some stated that they did not want to do this because it would take them away from the bedside into more managerial roles, rather than direct consumer care.

> There’s an assumption that an EN will step into an RN role, like that's the natural pathway, but there should be a career pathway for an EN who wants to remain an EN. (F2.11)
>
> There are articulation pathways from diplomas, through to RN, but not everyone wants to be an RN. (F2.10)
>
> It's a competitive process to get into uni for an EN…I didn't

> get in on the first round, and I said, I hope it's not a reflection of my hospital-based training. (F2.05)
>
> I don't want to be registered because I see that more going into administration. (F2.09)

For those who had undertaken further education to expand their own scope of practice, there was little, if any, remuneration and ENs believed there should be a clear career structure that built in advanced practice roles.

> …enrolled nurses who go back to TAFE and do their advanced diploma…should be recognised for having gone and done that extra training and having your advanced diploma by having an allowance. (F2.01)

> Now we've done the advanced diploma, we're at the top…and there are no graduate diplomas…to add onto our ad vanced diploma…they expect that that's what you're going to be happy with. (F2.09)

> In addition, transition programs for newly graduated ENs were seen to be necessary, as many new ENs may have only had one clinical placement prior to graduation and required support when employed.
>
> There's no transitional program. You do your diploma, you get popped on the casual pool, and then you get flicked onto a ward…you get given the worst patients or the heaviest patient, and you're left alone. (F2.11).

6. Discussion

This study sought to examine scope of practice of Australian Enrolled Nurses from their own perspectives through focus groups and interviews with ENs to inform revision of the Competency Standards for Enrolled Nurses (Australian Nursing & Midwifery Council, 2002).

Findings identified a range of important contemporary issues relating to scope of practice and workforce factors influencing their practice. Findings provide new insights into EN practice, and reinforce that many issues previously reported remain unchanged for this group, despite recent changes to EN educational practice and introduction of medication endorsement.

Scope of practice issues emerged as particularly problematic for ENs across Australia. Many reported having to work outside of their scope of practice, especially in settings such as aged care, where there was no RN close by. Wider scope of practice was noted to be more common in specialist clinical areas. In addition, many verbalised the existence of confusion relating to scope of practice, to the extent that this could differ across clinical areas in the same health care organisation.

Such situations could prove detrimental for ENs who move around clinical areas and may lead to missed care or ENs being expected to perform activities they have not been appropriately prepared for. It suggests a need for health care organisations to be clearer about ENs' roles and responsibilities. However, most EN participants reported being unable to work to their full scope of practice. They did, however, recognise that managing patients who were unstable was within the RN's scope of practice and outside their own. This is reassuring and supports findings by Jacob et al. (2014a, 2014b) that senior nurses viewed RNs as needing to manage care of complex and unstable patients, a perception reinforced by final year registered and enrolled nurse students (Jacob, McKenna, & D'Amore, 2016). Hence, this is one area in which there is clear understanding about scope of practice. Overall, ENs in this study envisioned themselves as more task-oriented than the RN who assumed

leadership, delegation and decision- making roles and this reinforces findings of other studies (Jacob et al., 2014a, 2014b, 2016).

Similar to previous research, there remains confusion about EN scope of practice. ENs described understanding their own scope of practice but many RNs, doctors and other health professionals did not. Partly, that was due to different types of ENs in the workplace.

Medication endorsement was one aspect highlighted as causing such confusion. In their study, Kerr et al. (2012) indicated that around half of EN participants indicated they would not seek medication endorsement, assuming it would add extra challenge or burden to existing workloads. Even amongst those who were medication endorsed in our study, it was highlighted that some are endorsed to care for intravenous therapy and some are not, further adding confusion. In settings, such as general practice, there was also confusion about whether the general practitioner or RN was responsible for supervising the EN's practice. Clearly, this is one area that requires further exploration and clarification to ensure conformity with regulatory requirements.

Confusion also existed within the EN cohort about differences between themselves and RNs. Many described common skills being performed by both groups. However, on further examination, it became evident that in many cases ENs were undertaking only parts of procedures that RNs could undertake fully, such as intravenous therapy. In their study, Chaboyer et al. (2008) recognised commonality in routine work activities between RNs and ENs such as assisting with activities of daily living. ENs commonly questioned performing non-routine activities. However, RNs spent significantly more time on patient progress rounds and

meetings with the multidisciplinary team. RNs were observed to spend more time with medication administration and intravenous therapy than ENs.

Broader workforce issues also arose in ENs' discussions. They described uncertainty about their level of responsibility for AINs, and whether that group were impinging on their own scope of practice. Poor delegation to nursing assistants in the USA was found to result in widespread episodes of missed care (Gravlin & Phoenix Bittner, 2010) which in itself is concerning for patient care. However, responsibility for the work of AINs and their delegation of tasks by ENs in the Australian context is unclear and requires development of appropriate processes. As well as working with AINs, many EN participants in our study questioned whether they should be preceptoring new graduate RNs. The appropriateness of this is questionable given their different scope of practice and supervision requirements. The overall implications for patient care and safe practice raise concerns about appropriateness and adherence with existing standards. Little is currently known about these areas and they warrant further investigation. There are acknowledged limitations to this study. Firstly, although focus groups and interviews were conducted with many ENs around Australia, those who participated may have been particularly motivated to take part and their numbers represented only a small proportion of ENs in Australia. Their views do not necessarily reflect the views of all ENs working around Australia. Secondly, the nature of the focus group interviews may have deterred some participants from voicing their opinions freely, although all focus groups were facilitated by skilled, experienced researchers. Demand to participate was particularly strong in some states, namely South Australia and Queensland, so issues from those states may

have influenced the overall findings. Despite these limitations however, the findings do add rich evidence to extend our understandings of EN work.

7. Conclusion

Enrolled Nurses constitute an integral part of the Australian health care system. Their education and scope of practice has evolved rapidly over recent years. This study examined issues surrounding EN scope of practice to inform development of revised practice standards. In doing so, it raised issues around diversity of EN practice and issues impacting on EN workforce. These included challenges around working within their scope of practice in some areas, fulfilling their scope of practice in others, and insufficient understanding of ENs' roles by some health professionals. Their roles were further complications with the presence of AINs and limited career pathways. Further work is needed to address issues related to EN supervision of new RNs and AINs, and clarity of EN supervision in specialist clinical areas.

Ethical approval

This study was approved by the Monash University Human Research Ethics Committee (MUHREC) on 14 November 2013. Approval number: CF13/2665 – 2013001423

Conflict of interest

The authors have no conflict of interest to declare.

Funding

This study was funded by the Australian Health Practitioner Regulation Agency as part of the National Review of Enrolled Nurse Standards for Practice.

Acknowledgements

The authors are grateful to the individuals who participated in the interviews and without whom this study would not have been possible.

Appendix A. Interview Schedule

• Describe the roles you currently perform.

• What do you understand by the term ‘scope of practice’?

• Are there times when you feel you are asked to work outside your scope of practice? (Include things you have not been prepared for).

• Are there times when you feel you do not work to your full scope of practice? (Include things you have been prepared for but are unable to perform).

• What employment situations/arrangements impact on your scope of practice? What makes it easy? What makes it more difficult?

• How do the roles of the Registered Nurse (RN) influence your roles?

• What interprofessional issues/dynamics impact on your scope of practice? What makes it easy? What makes it more difficult?

• There are advanced EN roles and skills. If you have been prepared for them, do you have the opportunity to use them? If you haven’t been prepared, are you intending to undertake them? Do you have organisational support to undertake them?

• What are the areas where you operate differently from other ENs in similar posts?

• What do you see as the barriers in your work to your potential as an EN?

• What supports and/or assists you in working to your scope of practice?

• In an ideal world, how would the work of the EN look?

• Has the role of enrolled nurses in your workplace expanded in the past five years?

• Has the level of responsibility of enrolled nurses in your workplace changed in the past five years?

• Has the speciality areas in which enrolled nurses practice changed in the past five years?

References

Armitage, D., Milson-Hawke, S., Payne, T., Williams, A., 2015. Perceived difference of roles between the registered and enrolled nurse. *Australian Nursing and Midwifery Journal* 23 (2), 30.

Australian Nursing and Midwifery Council, 2002. National competency standards for the enrolled nurse. ANMC, Canberra.

Chaboyer, W., Wallis, M., Duffield, C., Courtney, M., Seaton, P., Holzhauser, K., et al., 2008. A comparison of activities undertaken by enrolled and registered nurses on medical wards in Australia: An observational study. International Journal of Nursing Studies 45, 1274–1284.

Cusack, L., Kennewell, L., Smith, M., Dennett, L., Cummins, B., Pratt, D., 2015. Advanced skills for enrolled nurses: A developing classification. Australian Journal of Advanced Nursing 32 (4), 40–46.

DeSantis, L., Ugarriza, D.N., 2000. The concept of theme as used in qualitative nursing research. Western Journal of Nursing Research 22 (3), 351–372.

Gravlin, G., Phoenix Bittner, N., 2010. Nurses' and nursing assistants' reports of missed care and delegation. Journal of Nursing Administration 40 (7/8), 329–335.

Heartfield, M., Gibson, T., 2005. Australian enrolled nurses have their say – Part 2: Scope of practice. Contemporary Nurse 19, 126–136.

Hoodless, M., Bourke, L., 2009. Expanding the scope of practice for enrolled nurses working in an Australian rural health service – Implications for job satisfaction. Nurse Education Today 29, 432–438.

Jacob, E., Sellick, K., McKenna, L., 2012. Australian registered and enrolled nurses: Is there a difference?. International Journal of Nursing Practice 18, 303–307.

Jacob, E., Barnett, A., Sellick, K., McKenna, L., 2013. Scope of practice for Australian enrolled nurses: Evolution and practice issues. Contemporary Nurse 45 (2), 155–163.

Jacob, E., McKenna, L., D'Amore, A., 2014. Senior nurse role expectations of graduate registered and enrolled nurses on commencement to practice. Australian Health Review 38, 432–439.

Jacob, E., McKenna, L., D'Amore, A., 2014. Senior nurse role expectations of graduate registered and enrolled nurses in Australia: Content analysis of open-ended questions. Contemporary Nurse 48 (2), 212–218.

Jacob, E., McKenna, L., D'Amore, A., 2014. Comparisons of the educational preparation of registered and enrolled nurses in Australia: The educators' perspectives. Nurse Education in Practice 14, 648–653.

Jacob, E., McKenna, L., D'Amore, A., 2014. Similarities and differences in educational preparation of registered and enrolled nurses in Australia: An examination of curricula content. Contemporary Nurse 48 (2), 199–211.

Jacob, E., McKenna, L., D'Amore, A., 2015. The changing skill mix in nursing: Considerations for and against different levels of nurse. Journal of Nursing Management 23, 421–426.

Jacob, E., McKenna, L., D'Amore, A., 2016. Role expectations of different levels of nurse on graduation: A mixed methods approach. Collegian https://doi.org/10. 1016/j.colegn.2016.01.006.

Kerr, D., Mill, D., McKinlay, L., 2012. Medication administration by enrolled nurses: Opinions of nurses in an Australian healthcare organization. Nursing Forum 47 (4), 203–209.

McEwan, B., 2008. Defining the scope of practice of enrolled nurses in medication administration in Australia: A review of the legislation. Collegian 15, 93–101.

Nankervis, K., Kenny, A., Bish, M., 2008. Enhancing scope of practice for the second level nurse: A change process to meet growing demand for rural health services. Contemporary Nurse 29 (2), 159–173.

Nursing and Midwifery Board of Australia, 2016. Standards for practice: Enrolled nurses. NMBA, Melbourne.

Tranter, S., Westgarth, F., White, G., 2011. The scope of practice of the haemodialysis Enrolled Nurse in New South Wales. Renal Society of Australasia Journal 7 (1), 24–29.