DEVELOPMENT OF ADVANCED PRACTICE IN THE DISTRICT NURSE ROLE

Sarah Scott’s literature review illustrates the relationship between power and traditional hierarchies in the NHS

Abstract

The aim of this literature review was to examine advanced practice in relation to the role of the district nurse. A significant finding was a paucity of evidence relating to advanced district nursing roles, which may influence future development of the service. A hypothesis drawn from the data is that district nurses are pro-actively advancing their practice but in doing so are changing their role rather than remaining in district nursing. The searched literature supports advanced nursing roles in terms of safe clinical practice, but questions remain over their cost effectiveness. In-depth analysis of the literature also revealed a correlation between the power of the medical profession and advanced nursing practice in primary care.

Keywords

Advanced practice, advanced nurse practitioner, community matron, district nurse, nurse prescribing, primary care

Increasing demand for primary healthcare services is driving fundamental changes in care delivery. Nurses are crucial to the delivery of health care in this setting (Department of Health (DH) 2008a, 2009, 2010a), with district nurses traditionally delivering nursing care to patients in their own home and practice nurses to patients in the surgery. Critics suggest that nationally district nurses have not embraced the opportunities to advance their role which, with the increasing emphasis on primary care nursing, one would expect to be happening (Toofany 2007, Queen’s Nursing Institute (QNI) 2009). Consequently new nursing roles have been developed to support primary healthcare services, such as the community matron role and advanced nursing roles in general practice.

The community matron role has been perceived by some district nurses as duplicating elements of the traditional district nursing role which, if given additional investment and training, the current district nursing service could provide (Lillyman et al 2009). The community matron role and the advanced practitioner role in general practice require evidence of advanced practice, advanced clinical assessment and advanced non-medical prescribing (independent (IP)/supplementary (SP) prescribing), qualifications not considered essential for the current district nursing role. So while district nurses have gained additional skills and knowledge in various areas of nursing and limited prescribing through the nurse prescribers’ formulary (NPF), they have not developed their role with regard to advanced clinical practice. The perception that district nurses were not advancing their clinical practice and were allowing other nurses to duplicate traditional areas of their role was the impetus for this critical literature review.

Research methodology

Primary sources of published literature and non-published literature in the public domain have been included and these were obtained via freedom of information (FOI) requests. The FOI requests were made to all primary care organisations in England and to the Nursing and Midwifery Council (NMC) to determine levels of IP/SP. IP and SP were used as determinants of advanced nursing practice as they fulfil the NMC (2010) advanced practice definition and are measurable, requiring NMC registration. Community matron and advanced nurse practitioners in general practice were used to allow comparison of role with district nursing.
The searched literature was categorised into district nurse, community matron, advanced nurse practitioner in general practice and advanced prescribing in primary care. Six emergent themes were identified.

**Emergent themes**

1. **Effectiveness of advanced nursing roles in primary care** Evidence across the categories consistently supports existing knowledge that advanced nursing roles in primary care are safe and effective. From a district nursing perspective no empirical evidence was found of the effectiveness of advanced practice roles. However, the combined conclusions of research examining the district nursing role suggest that there is a role for advanced practice within district nursing (Boyden and Edwards 2007, Baid et al 2009, QNI 2009, 2011, Aldridge-Bent 2011).

In general practice, research shows that advanced nurse practitioners have comparable clinical patient outcomes to GPs (Reveley 1998, Kinnersley et al 2000, Shum et al 2000, Venning et al 2000, Horrocks et al 2002, Laurant et al 2005, Seale et al 2006, Edwards et al 2009) and costs are comparable with those for GPs (Hollinghurst et al 2006). Inefficiency was seen in longer consultation times and the ordering of more tests. However, many of these studies are more than ten years old and may not reflect current standards of advanced nursing practice. Noticeably there have been relatively few recent empirical research studies examining the effectiveness of advanced nursing roles in general practice at a time where the increasing healthcare demands placed on general practice would suggest that there is a need for such research.

Analysis of the qualitative and quantitative research shows contradictory conclusions regarding the effectiveness of the community matron role: the qualitative studies conclude that this role is effective in meeting patients’ medical and social needs (Boaden et al 2006, Wright et al 2007a, Wright et al 2007b, Brown et al 2008, Bowler 2009, Williams et al 2011), while the quantitative research concludes that it is ineffective in its principal role of reducing unplanned hospital admissions (Boaden et al 2006, Gravelle et al 2007, Huws et al 2008). This dichotomy may come from the epistemological differences between research methodologies: qualitative research examining perceptions of the community matron role and quantitative research examining cost-effectiveness and efficacy.

In the absence of research related to the effectiveness of IP/SP within district nursing, inclusion of NPF research has provided insight into the effectiveness of this lower level of prescribing, although the findings may not transfer directly to IP/SP. Collectively the NPF research showed positive outcomes: increased cost-effectiveness, autonomy and role satisfaction (Lewis-Evans and Jester 2004, Fisher 2005, Young et al 2009). However, it also shows that district nurses may not be fully exercising their prescribing powers, arguably reducing effectiveness (While and Biggs 2004, Bowden 2005, Fisher 2005, Hall et al 2006). While most of the research studies related to the effectiveness of IP/SP were not exclusive to primary care, they showed similarity with the NPF research that IP/SP is safe, effective and key to service development (Bradley et al 2005, Bradley and Nolan 2007, Carey et al 2007, Latter et al 2007, Cooper et al 2008, Courtenay and Carey 2008, Courtenay et al 2009, Latter et al 2011); but some independent prescribers were not fully exercising their prescribing authority (Latter et al 2011). It is noticeable that only a small number of authors have published research related to IP/SP. This is significant because it may lead to systematic bias, with the results not verified by other researchers.

2. **Patient perceptions of advanced nursing roles in primary care** Although there was no empirical evidence of patient perceptions of the advanced district nursing role, the predominantly qualitative research across other categories consistently showed high patient satisfaction levels. This was largely due to the longer time spent with patients, with high value given to the nurse-patient relationship (Berry et al 2006, Seale et al 2006, Williams and Jones 2006, Redsell et al 2007, Branson and Badger 2008, Carey et al 2010, Stenner et al 2010, Latter et al 2011). However, the evidence also suggests that patients have limited understanding of nursing roles within primary care (McKenna and Keeney 2004, Caldow et al 2007, Redsell et al 2007, Branson and Badger 2008). This is compounded by a variety of titles that are not used consistently (Nazarko 2004, Paniagua 2010) and this may influence future advanced nursing practice and its acceptance by patients.

3. **Intraprofessional barriers to the development of advanced nursing roles in primary care** Reluctance among nurses to develop advanced roles was identified in the NPF/IP/SP research where nurses were not fully using their prescribing authority (Stenner et al 2009, Latter et al 2011). The FOI data shows that nationally 3.8 per cent of all qualified nurses have developed their role in terms of IP/SP but this has not changed over the last five years despite a 4 per cent increase in the numbers of qualified nurses. Nationally there is a higher percentage...
of district nurses with an IP/SP qualification (15 per cent) compared with all nursing (3.8 per cent), and this number has risen by 2.5 times over the last five years, suggesting that nationally district nurses are proactively developing their role. However, it is uncertain how many of these district nurses, while retaining their NMC district nursing registration, are still working within district nursing.

It has been suggested that a significant number of community matrons were drawn from senior district nurses (Boaden et al 2006, Unsworth et al 2008). As the community matron role requires an IP qualification, this migration of district nurses to community matron roles may account for the rise in the numbers of district nurses with IP/SP over the last five years. It may therefore be hypothesised, and requires empirical research to test, that the impetus for this transfer of district nurses to the community matron role was the opportunity to develop a more advanced level of practice that the district nursing role does not currently require. This supports Pollard’s (2005) claim that some district nurses see the community matron role as career progression. Locally, the FOI data shows that 8.7 per cent of qualified district nurses have an IP/SP qualification, lower than the national average, and that most IP/SP nurses are specialist nurses. Both these observations need further exploration and may corroborate the local perception that district nurses are not developing their role while other nursing specialties are.

Concerns have been raised across empirical (Aranda and Jones 2008, Holt 2008, Aldridge-Bent 2011) and grey literature (Shields and Watson 2007, Milligan 2008, Pearcey 2010) that as nurses advance their practice into areas that were once the domain of doctors, the core values and identity of nursing, and its epistemological position, will be lost. Nurses who have developed their role argue that they have retained core nursing values, evidenced in the qualitative research by their consultations and patient communication differing in style from those of doctors (Ball 2006, Seale et al 2006, Stenner et al 2010b, Paniagua 2011). Hinchliff and Rogers (2008) identify the need for research that demonstrates the unique contribution that advanced nursing practice has to make, and argue that new outcome indicators should be developed that reflect ‘nursing’ rather than existing research that compares advanced nurse practitioners with doctors.

While there is limited research relating to the ‘identity of district nursing’, both Lillyman et al (2009) and Cook (2011) suggest that new nursing roles in primary care, particularly the community matron role, have contributed to a loss of identity of the traditional district nursing role. The symbolic power of the title ‘matron’ and the perceptions attached to it by laymen and professionals alike may imply a seniority that does not actually exist, but which may add to this loss of identity. Furthermore the FOI data revealed that the title ‘district nurse’ is obsolete in some primary care organisations, suggesting the role’s reduced status.

4. Facilitators to the development of advanced nursing roles in primary care

The literature leads to the suggestion that the impetus for developing advanced nursing roles is often politically motivated to address the most pressing healthcare demands. An example is the introduction of community matrons to address the long-term conditions agenda where primary care organisations were instructed by the DH to implement the role (DH 2008b). Rashid (2010) suggests that the advanced nurse practitioner role in general practice was developed by GPs to manage their increased workload. Personal attributes may also be a factor in the development of advanced nursing practice. Latter et al (2011) suggest that IP has been driven by practitioners rather than by organisations seeking to increase the quality of the service. This is supported by the FOI data, which indicates that district nurses are pro-actively developing their practice. However, it also shows that the total number of qualified nurses with IP/SP appears to be self-limiting, with the total numbers not changing significantly over the last five years despite strategic policy that sees nurses as key deliverers of healthcare.

5. Relationship between the power of the medical profession and the development of advanced nursing roles in primary care

Analysis of the searched literature revealed a correlation between the power of medicine and the development of advanced nursing roles in primary care. This was predominantly illustrated in research related to nurse prescribing. Prescribing has traditionally been the exclusive domain of medicine but is increasingly being challenged through prescribing by nurses, posing a threat to medical power. The searched literature indicates how the medical profession has exerted its control over IP/SP.

One way to control and possibly limit nurse prescribing is to make the administrative process cumbersome. Qualitative data shows how GPs control the process of recording prescribing actions onto their computer systems (Bowden 2005, Hall et al 2006, Carey et al 2007), with nurses accused of ‘cluttering up’ the computer system with their prescribing documentation (Fisher 2005). The NPF research illustrates the consequences of this: district nurses...
were limiting their prescribing activity because it was easier to use the existing GP computer-generated prescriptions and they made local arrangements regarding what they would and would not record onto the GP computer system (Fisher 2005, Davis and Drennan 2007). This may contravene best practice, which recommends documentation of prescribing actions within 48 hours of issuing (NMC 2006).

The local FOI data shows a greater proportion of IP/SP in specialist nursing roles. This suggests that the relative ease of district nurses getting a GP computer-generated prescription compared with a hand-written IP/SP-generated prescription (which then has to be recorded on the patient’s GP notes), and the close working relationship that district nurses tend to have with the GP, may reduce their motivation to become prescribers.

Knowledge is another aspect of the power base of the medical profession. Doctors have questioned the knowledge base of nurse prescribers (Day 2005, Cressey 2006, Keighley 2006, Courtenay 2008, Hawkes 2009) and identified limits to their prescribing, even questioning the prescribing of paracetamol (Lewis-Evans and Jester 2004, While and Biggs 2004, Stenner et al 2009, Fisher 2010). This suggests that GPs’ acceptance of NPF prescribing may be due to its limited nature, which does not threaten their dominance of knowledge. Interestingly the term ‘non-medical prescribing’ is used for nurse prescribing. This suggests differentiation between medical and nurse prescribing when in reality doctors and independent/supplementary prescribers can prescribe across the entire British National Formulary, although IP/SP is limited to a nurse’s declared scope of competence.

While most prevalent in nurse prescribing, medical influence over the development of advanced nursing roles was seen in other areas of the literature. Baid et al (2009) cite anecdotal evidence of resistance by some GPs of advanced assessment by nurses as this is considered a medical role.

However, it is suggested that concern raised by the medical profession regarding advanced nursing roles is justified when currently there is no statutory regulation or scrutiny of advanced nursing roles by the NMC and no clarity regarding the pre-study competencies required for advanced prescribing. So while medical training in the UK is well established and regulated (General Medical Council 2012), and postgraduate GP training follows a common set of guidelines and regulation (Mehay 2012), this is lacking in advanced nursing roles. Until this is resolved by the NMC, these concerns will, justifiably, remain.

Socialisation of the doctor-patient relationship maintains and reinforces traditional hierarchies in the NHS. The searched literature indicates that patients reinforced traditional hierarchies by re-constructing the role of the advanced nurse practitioner to that of a doctor. Patients viewed the community matron as their family doctor from decades past (Sargent et al 2007, Brown et al 2008), saying the community matron was ‘like or even better than my GP’ (Leighton et al 2008). Patients also reinforced traditional medical hierarchy through their perceptions of superior academic ability among the medical profession (Caldow et al 2007, Redsell et al 2007, Rashid et al 2010).

Patients informally set limits on advanced nursing roles depending on how serious they perceived their medical problem to be (Laurant et al 2005, Caldow et al 2007, Redsell et al 2007, Turner et al 2007). However, when patients trusted the advanced nurse practitioner, traditional hierarchical structures were broken (Barnes et al 2004, McKenna and Keeney 2004, Branson and Badger 2008, Stenner et al 2010, Latter et al 2011). Ultimately, Chapple et al (2000) conclude that the most important factor determining whether the advanced nurse practitioner role was accepted was whether it met the needs of the patient. Although this conclusion is over ten years old it is still relevant today and is supported by the DH position statement regarding advanced level nursing (DH 2010b).

The searched literature suggests that the nursing profession may unwittingly collude, reinforce and maintain traditional hierarchies in the NHS in its unwillingness to challenge traditional boundaries through the development of nursing roles. The NPF and IP/SP research substantiates this point: some nurses did not use fully their prescribing authority. As discussed, nurses take contradictory perspectives regarding the development of advanced nursing roles. They are seen by some as ‘mini-doctors’ and by others as advancing the role of nursing within a nursing philosophy. This may reinforce and maintain existing hierarchies of role and power in the NHS. The nursing profession, through its regulatory body, must find its unique place in the NHS, embracing advanced practice while retaining nursing’s philosophical values, and must consider what is best for the patient rather than being distracted by competing against the medical profession for status and hierarchy. However, medicine is not alone in protectionism of its professional power. Nursing, including district nursing, protects its own power, illustrated in the concerns raised by district nurses about the role of the community matron, which they perceived as threatening their traditional role and power status in primary care nursing.

6. Feminist critique of advanced nursing roles in primary care Although not explicit in the searched
literature, the development of advanced nursing roles in primary care can be critiqued using feminist theory to increase understanding (Turner 1995). Medicine remains the dominant profession in the NHS. It is a profession with more men (British Medical Association (BMA) 2010), although the proportion of female GPs is increasing (BMA 2010), while nursing is predominately a female profession (NMC 2007); 96 per cent of district nurses are women (QN 2009).

Feminists suggest that the construction of nursing roles has been influenced by the medical profession, retaining the subordination of nursing relative to medicine. Autonomous, advanced nursing roles challenge the dominance and status of medicine. The medical profession has responded to this threat by exerting control over the construction of advanced nursing roles in primary care, for example, in IP/SP. Feminist theory also suggests that the nurturing and mothering element, which forms the philosophical basis of nursing practice, maintains these hierarchical and patriarchal relationships.

The debate about whether advanced nurse practitioners are retaining the ‘nursing’ element to their role or whether, through the medicalisation of their role, they are becoming ‘mini doctors’, undertaking those tasks that GPs reject, illustrates this point. The NHS Confederation et al (2012) have developed this debate further, suggesting that in attempting to gain equality and similar status to the medical profession, the care and compassion of nursing has been lost. A feminist critique also suggests that females are socialised not to show the attributes and characteristics that are required to achieve power since these are perceived as unfeminine, whereas men are socialised and encouraged to display these characteristics. In primary care this is seen in the medical profession’s dominance of clinical commissioning groups and subsequently their control of primary healthcare services.

Conclusion
This review has substantiated well-established evidence and increased understanding by presenting new perspectives of advanced nursing roles. Collectively the research supports the development of advanced nursing roles in primary care. A key finding is the paucity of research regarding advanced practice in district nursing. This is significant for the future

References
of district nursing, which needs an evidence-base to support its place in the changing face of primary care nursing services and may have contributed to the development of other nursing roles in primary care at the expense of the existing district nursing service.

The national FOI data contradicted the author’s initial perception that district nurses were not developing their role, although that perception was understandable as the IP/SP numbers in the author’s locality were below the national average. The hypothesis is made that for district nurses to advance their practice they are changing their role and leaving district nursing. This hypothesis needs to be tested empirically.

This review has increased understanding and added to existing knowledge in two ways: first, by illustrating the relationship between power and traditional hierarchies in the NHS and the development of advanced nursing roles in primary care; and second by examining how feminism theory can be applied to the development of advanced nursing roles in primary care.

The implication for district nursing is that it needs to recognise and act on the issues raised in this critical literature review. District nurses need to demonstrate their unique contribution to primary care nursing services by developing an evidence base for both current and advanced district nursing roles and demonstrate how these support healthcare demands and policy. However, district nurses must also acknowledge the changing face of health care, changing workforce dynamics and changing boundaries in primary care. Ultimately, the requirement is that whoever visits the patient, whatever their title, they need to be equipped with the necessary clinical skills, of which advanced practice is a key requirement, to manage the more complex patients now nursed in primary care.

References


Queen’s Nursing Institute (2011) Nursing People at Home: The Issues, the Stories, the Actions. QNI, London.


