ROLE EXPANSION . . . from SPECULATION
to VERIFICATION

by

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The concept of role expansion is presently a major nursing issue. Over the past decade, one of the basic problems with incorporating this concept into nursing practice has been defining the term 'expanded role. Many contemporary nursing authors have written about this problem and expressed a need for the concept to be clearly defined. This study was an attempt to explore the concept 'expanded role' of the nurse by surveying nurses working in psychiatric settings. Two groups participated in the study; half from a community setting and half from a hospital setting.

A questionnaire was developed, by the author, to obtain data regarding specific variables that were thought to be inherent in, or strong indicators of, role expansion in nursing. The questionnaire consisted of 25 items and was distributed to a total sample of 64 nurses (32 working in community and 32 employed by a hospital).

It was found that 51 of the 64 nurses viewed their role to be expanded. In general, community employed nurses were older, more experienced and more highly educated than hospital nurses. A broad fundamental definition was verified by data analyses. Although the literature suggests that graduate level education is necessary to function in an expanded role, this was not the case in this study as only 10 nurses had masters degrees.
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Graphic Summary of Independent Treatment
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I would further like to acknowledge my appreciation to Dr. Elaine Cumming for her suggestions and assistance while developing my questionnaire and to Mr. Peter Tomlinson for his guidance during my computer analysis.

To those nurses who completed the questionnaire for the study, I thank you.
DEDICATION

I wish to dedicate this thesis to my mother and father. Their love, faith and constant encouragement over the past two years have been appreciated more than I can express. Thanks Mom and Dad.
CHAPTER I

Introduction

The concept of role expansion, as applied to the nursing profession, has, in the last decade become a major nursing issue. The development of such a concept resulted from scientific advances, population growth, the introduction of health insurance programs and the broadened focus of nursing education. These factors, as well as the trend toward a time of monetary restraint in Canada, have led to the realization that there are too few physicians to meet the ever growing demands of the lay public for high quality health care (Lamothe, 1972, 1). From this it became apparent that there would have to be a re-evaluation of how health manpower was being utilized. The nursing profession is one group who is addressing this question. It was during this re-evaluation of the roles and functions of nurses, that nursing experts realized the potential contribution of prepared nurses toward diminishing public demand for acute care. This potential became conceptualized in terms of "expanded roles" for nurses.

Many of today's professional nurses are assuming responsibilities and performing duties that not so very long ago were considered inappropriate for the nurse. It is through this gradual acquisition and acceptance of new dimensions to nursing care that the concept of role expansion has gained impetus. However, if role expansion is to be a process of change, it will require clear guidelines based on theoretical knowledge, skill in decision making and facilitation of
independent judgement that reflects the uniqueness of nursing as a growing profession (Lamothe, 1972, 9-19).

The changes in role perception and expectation have been occurring at a rapid rate. It would appear that it is the rate, rather than the change itself, that is causing confusion and frustration among physicians, the public, and nurses, regarding the nature of the new functions which nurses are acquiring. For many nurses the changes are stimulating in that they believe there is now opportunity to fashion a new role in which nurses with greater professional competence will be more active participants in coordinated efforts to provide better health care (Brown, 1970, 1). However, according to Lamothe "if we are not to put the cart before the horse, the new functions of nurses must first be defined, before they are implemented" (1972, 8). The multiplicity of functions adds to the confusion and creates controversy for those within and outside the roles. A clear set of guidelines would assist others to understand and utilize, more effectively, the expanded role nurse (Booney and Kikuchi, 1977, 102). The difficulty at the present time is the lack of clear guidelines resulting in the problem of clarifying what the expanded role entails. Until the concept "expanded role" can be operationally defined, there cannot be proper utilization of nursing manpower within an expanded role. Kathleen King (1974) sums it up nicely. She states,

"In recent years, articles and statements, regarding role expansion, abound until the jargon has become jaded and one wonders what is expanded about the work of either the nurse practitioner or a clinical nurse specialist." (54).
Even though it appears obvious that the nurses' role always changes in response to societies' needs, its functions have never been clearly defined (Lamothe, 1972, 4). This whole question of definition, then, assumes greater importance in light of confirming our unique contribution, as professional nurses, to the health care delivery system. In the words of Allen (1974),

"We cannot hope for backing, receive sufficient moral or financial support, nor have our beliefs about the expanded functions of nursing understood or taken seriously, until we can demonstrate within a research framework the nature of our services and their value to society." (4).

Statement of the Problem

In order to determine the dimensions of nursing services and their contribution toward meeting the needs of society, within a research framework, we must begin with an operational definition of the concept "expanded role". At the present time there is no definition that satisfactorily encompasses the many new working categories that are called "expanded roles", (i.e. clinical nurse specialist, nurse therapist, nurse practitioner, nurse consultant). This lack of a basic core definition is resulting in a large degree of interdisciplinary confusion. In other words, how do we define the expanded role of the nurse so that it reflects the fundamental similarities of function and purpose regardless of the working role which he/she assumes?
Purpose of the Study

The general purpose of the study was to develop and empirically test a fundamental definition of the expanded role of the nurse for nurses of all educational preparations in view of similarities in role function and clinical responsibilities as described in the literature. A secondary purpose was to utilize the information obtained to identify the educational gap (if one exists) between nurses functioning in expanded roles and general duty nurses with respect to staff nurse perceptions of expanded role nurse functions.

Specific Objectives of the Study

The specific objectives of this study were:

1. To determine what functions the nurse working in an expanded role is carrying out.
2. To determine the educational preparation of nurses in expanded roles.
3. To determine whether autonomy and independence are inherent in role expansion.
4. To determine role perception and expectation of expanded role nurses by nurses assuming this position.
5. To identify areas of confusion that could be dispelled through nursing education.

Definition of Terms

Nursing Population: those nurses presently registered in the
Province of British Columbia who are working in general duty and/or expanded roles in hospitals or community.

Expanded Role: A registered nurse, prepared at the masters level, who is functioning beyond the traditional nurse role, in an independent or semi-independent manner in the area of clinical therapist (performing psychiatric assessment and psychotherapy), nurse consultant, team member, liaison person or social change agent for the purposes of contributing high education and skill in the treatment of the sick and or distraught person or family, or the prevention of illness, aiding nurses to cope with ward and patient difficulties, and planning and preparation for persons upon their return to community. Her/his function could also be at the educational or research level, depending on her/his area of expertise.

Traditional Role: Those nurses prepared in basic hospital and/or university programs and who are presently working general duty in an established hospital (excluding supervisory and administrative personnel).

Assumptions

The basic assumptions in this study were:

1. the concept of expanded role is important to the nursing profession;

2. the expanded role exists, despite the present confusion surrounding it, both clinically and conceptually; and

3. a fundamental definition can empirically be tested and should it be validated, could affect the health care of Canadians.
Limitations

1. Population -
   a) excludes non-registered nurses and those working in small and/or privately operated hospitals;
   b) excludes administrative and supervisory personnel;
   c) excludes those working in hospitals or communities outside the field of psychiatry. It appears that the greatest density of nurses working in expanded roles are within a psychiatric/mental health system. Hence, for this study, I am limiting the sample to this area.

2. The sample was one of convenience and generalizations to the larger nursing population cannot be made.

Overview

A selected literature review is presented in Chapter II. Chapter III contains a description of the methodology used in the study. Data analyses are presented in Chapter IV. Chapter V contains conclusions and implications of the findings.
Literature Review

In recent years the compiled nursing literature, describing the concept of role expansion, has become quite voluminous. There have been many attempts to define the term, explain its origin and future destination, and to account for the present needs of society and the nursing profession for such a concept. The somewhat broad scope which the literature covers deals with speculation and documentation of how nurses function within expanded roles (i.e. therapist, consultant, nurse specialist). However, such accounts seem to lack organized experimental design which would indicate, within a research framework, the unique nature of the role and functions of these nurses and their value to society and the profession.

One of the major issues, as described in the literature, is the problem of definition of the term "expanded role". Many authors have written about this problem, and expressed a need for the concept to be clearly defined. The whole issue has been looked at from many perspectives, but the basic concern remains the same; what is the expanded role of the nurse?

The literature review to follow is selective of the large amount of material dealing with the problem of definition. Although some of the views may appear to be somewhat militant in nature, they express the current position taken by many of the contemporary nursing authors. It is the intention of this investigator to determine the functions and clinical role of nurses working in an expanded role, in psychiatry,
in the hope that a core definition of the concept can be empirically verified.

Contemporary nursing literature cites many factors that are perpetrating the development of expanded roles for nurses. Several of the more important factors include a) a rapid growth of biomedical knowledge; b) broadening nursing education; c) increased public demand for health care; d) the women's movement; and e) the development of professional relationships among nurses and other health professionals (Secretary's Committee, 1972, 48). However, according to Lewis (1972),

"... if the nature of an enlarged nursing role is simply to extend the physician's therapeutic and illness-oriented services, then we haven't changed anything; we've simply distributed the same old work among more persons in the same old system. But, if the nurse is identified and used as a person with a different orientation than the physician -- one who provides a different kind of health care service -- then we have the potential for a new pattern of health manpower and some overdue restructuring of our health care delivery system." (21).

Nursing, if it is to remain an essential social service, must become more active in establishing the norms and functional guidelines that are to govern nursing practice (Driscoll, 1972, 26). As Schein, cited by Louise Murray (1972), states, "the essence of role innovation is a rejection of some of the norms which govern the practice of the profession combined with an interest in elucidating
the true or ideal role of the nurse professional in society" (60).

Role, as defined in Theodore Sarbin's Role Theory (1968) is "... an internally consistent series of conditioned responses by one member of a social situation which represents the stimulus pattern for a similarly internally consistent series of conditioned responses of the other(s) in that situation" (488-567). He further states that associated with role are role expectations and role perceptions. In terms of role expectations, there are two general kinds; rights and obligations. Rights are role expectations in which the actor of the role anticipates certain performances from the actor of a reciprocal role. Obligations are role expectations in which the actor of a role anticipates certain performances directed toward the actor of the reciprocal role. When Sarbin speaks of role perception, he sees this as an organized response of a person to a stimuli in a social context; a sequence of behaviours in which perceptual response and motoric response result in the actor performing actions appropriate to his location of the positions of self and other. Taken in the context of role theory, then, many of the difficulties and controversies concerning the expanded role for the nurse, can better be understood, for role change cannot occur if the clinician is the only one to view her role as having changed. The general public, other health professionals, and professional nurses themselves must develop and maintain similar perceptions and expectations of an advanced clinical nurse (Moore, 1974, 127). In light of society's current demand for improved health care, and the availability of nurses to help meet this demand, it becomes mandatory to formalize the expanded nurse's role (Walker, 1972, 29).
Nursing in Canada today is exciting, but frustrating and often confusing, as a result of rapid educational and role change. As the role of nursing expands, education expands, and the independent nature of the profession grows (Hatt, 1977, 1583). According to Bristow, et al (1974), "if we are not to lose sight of our raison d'être, we must address ourselves to our professional boundaries and norms in an effort to achieve legitimate power and authority" (31). In order to achieve this, we must know what we are preparing for in terms of role, function and purpose and have clear guidelines for practice available for the use of nurses and other health professionals. At the present time, instead of clear guidelines, we have confusion resulting from the interchange of terms like expanded and extended role; clinical specialist and nurse clinician, etc. An operational definition of "expanded role" would greatly aid in eliminating the shroud of confusion enveloping the concept at this time.

It becomes apparent that a critical issue in defining the expanded role of the nurse appears to be not so much the nurse's ability to function at a high level, but the attitudes of nurses and physicians toward allowing the nurse real independence and power in clinical decision making (Heiman and Kempsey, 1976, 587). According to de Tornyay (1971), "when we talk about changing roles, helping nurses to learn new skills is relatively easy. Changing attitudes is a different problem entirely" (976).

Slightly more than ten years ago, when nursing functions began expanding, few problems, particularly in the area of role change, were anticipated. There was a general feeling that these new functions incorporated into nursing were more appropriate for their educational
preparation. However, as time passed, it became more and more evident that general duty nurses did not see the expanded role nurse functioning any differently from themselves. Within that context, a true role change could not occur (Moore, 1974, 127). Even with better educational preparation, nurses had problems in taking on more responsibility. Part of the problem, as stated earlier, rests with the attitudes of physicians, the public and of nurses themselves regarding the new dimensions being incorporated into the nursing profession. But, perhaps even more important that the attitudes, is the somewhat haphazard attempt, by the profession, to delineate clear guidelines for defining the role, function, and clinical responsibilities of a nurse performing in an expanded role. According to Boone and Kikuchi (1977),

"Clearer guidelines would assist others to understand and to utilize this person more effectively. Because of the present ambiguity in the definitions, there is still controversy concerning the necessity, the expectations and the potential of the nurse performing within the context of expanded role." (102-103).

Since nursing began, in the late 1800's knowledge and expertise has greatly expanded. The clinical competence necessary for professional practice has been much greater than was anticipated (Lamothe, 1977, 7). According to Lamothe (1972),

"Since health care seems to fall naturally into a form in which the members of various disciplines work in teams, the role and functions of each participant
should be clearly laid down. This will encourage mutual cooperation and will help to avoid proliferation of roles." (17).

In 1972, a full scale effort was made to look at the expanding role of the nurse. This report, put out by the Department of National Health and Welfare in the form of the Boudreau Report states . . .

"The awareness of the unique contribution that other professions can make in the provision of health care is, however, becoming more and more widespread and is being gradually translated into corresponding increased responsibility and autonomy for these professions." (4).

The report goes on to stress the importance of developing those methods of health care already in existence as opposed to developing an entirely new category of health professional. In spite of these recommendations, we have seen impulsive development of nurse-practitioner programs, physician assistant programs, clinical nurse specialist and therapist programs, all of which have added to the confusion and complication of an expanded role for nurses. One has only to look at the literature to realize that the educational preparation for nurses for an expanded role widely varies. However, no matter what approach is used, success is dependent upon the mutual agreement of both the nurse and the employing agency as to the role the nurse will assume (Boone and Kikuchi, 1977, 108). It is difficult to achieve mutual agreement when the guidelines for practice are so
unclear. How does a "definition" such as that which appears in the Boudreau Report (1972) "... an extension of the present nursing role, with the nurse's unique skills in the provision of health care being developed and utilized more effectively, and the nurse's role in assisting the physician expanded through increased delegation of tasks by physicians to suitably prepared nurses ..." (6), help clarify anything about the new dimensions nurses are embarking on?

In June of 1972, Rachel Lamothe prepared a paper on the expanded role of the nurse in which she emphasized the need for changes in the role of nursing to meet the ever increasing demands of the lay public for health care (16). Lamothe stressed the need for clarifying and defining the new functions which nurses are undertaking, and also that if the needs of society are to be met effectively and efficiently, universities and departments of education must agree on the type of education required (19). More and more scholars in the nursing profession are leaning toward graduate preparation for assuming an expanded role. However, it should be noted that we are not merely dealing with educational programs; we are dealing with people whom we are trying to change and prepare for practice in new and different ways (White, 1975, 164). Inherent to the development of role expansion is increased autonomy, self-esteem and social support; the nurse must see herself as one who nurtures clients and families rather than maintaining a service to an agency or institution (Maekemes, 1974, 90). A crucial problem with achieving this, involves ambiguity and role confusion resulting from lack of clear guidelines for practice.

In 1976, Edith Wright did a survey study in which she attempted to determine what registered nurses thought about the expanded role
concept. She stated,

"Implicit in the decision to develop new roles for nurses is the assumption that a new role responds to a recognized need in the health care delivery and will make a difference in the care ultimately delivered." (112).

She further states that "... Before judgements can be made about the usefulness or feasibility of preparing nurses to function in extended roles, subgroups within the health care system will have specific queries and concerns that require attention." (Wright, 1976, 112). In order to satisfy and/or eliminate the queries and concerns, the nursing profession must be prepared with clear guidelines explaining both function and purpose, as well as the potential contribution the change has for better health care. If we do not deal constructively and collaboratively with the present problems, nurses will not be able to clinically meet the challenge of today's health care delivery head on (Moore, 1974, 127).

For many years nurses in rural areas of Western Canada and isolated areas of the Canadian North have functioned in expanded roles, without these being designated as such. However, emerging societal and governmental pressures related to reducing health care workers and the need of selected types of physician substitutes to provide medical care in remote areas, have together created a trend toward greater formalization of "expanded" roles for nurses (Hayes, et al., 1974, 34). From the literature, of which there is an abundance, it becomes apparent that the "formalization" continues to lack precision
and clarity with respect to commonalities among all expanded roles, and empirical evidence to determine what nurses in expanded roles are really doing. Clarity also takes on special importance here, for preparing a nurse to perform in a more autonomous role, does not mean that the system will allow her/him to function so. For a great many years now tradition has bound the relationship between nurses and physicians to extreme subordination-superordination (Bullough, 1976, 1478). Along with role change, there must be a change in professional self concept so that professionals are comfortable with their new functions and responsibilities, not confused or uncertain about the change, and directly responsible to and for the patient.

Expanding our role is important in light of health care demands, health care costs and economics. According to Lewis (1974),

"If we are to look forward to broad understanding and acceptance of the expanded role nurse, hasn't the time come for consideration of some broad, nationally determined standards and criteria? For years we have talked about the larger contribution that nurses could make within our health care structure given an opportunity to practice to their full potential. With the concept of role expansion, nursing has that opportunity." (89).

What we do today in nursing will be reflected in the future (Moore, 1974, 127). The problem, then, becomes one of verifying what we are preparing for; who are we when
we practice in an expanded role? It has been said, more often than not, that if nursing doesn't define the role, other health professionals will do it for us. In the words of Joan Gilchrist, as cited by Kathleen King (1974):

"We should not be content to follow along directions determined by others but should negotiate our position from a base which includes research, learning, administration and above all nursing practice knowledge." (55).

Martha Rogers (1972) has summed it up nicely.

"... it is nursing knowledge that nurses bring to the joint collaboration of a range of health professionals; it is nursing knowledge that adds new dimensions to human safety and human service; and it is nursing's body of scientific knowledge that guides nursing practice. Nursing is solely responsible for its own acts. Only out of mutual sharing and respect among health disciplines can there arise a nature and quality of health services that no single discipline can provide on its own." (44).

In conclusion then, if the concept of role expansion is to live a long, healthy life, a clear cut definition of the role and functions must be developed in the near future. The time has come, and nursing must meet the professional challenge of the day by actively participating in the preparation of guidelines to govern the practice of an expanded role nurse.
CHAPTER III

Methodology

This study was conducted through the use of a questionnaire which was completed by nurses working in a community or hospital setting, in the field of psychiatry. Aggregate data, obtained from responses to the questionnaire, were analyzed to determine what role perceptions, expectations and functions are inherent to a nurse working in an "expanded" role.

Data Gathering Instrument

The questionnaire (see Appendix B) utilized in this descriptive study was developed by this investigator, in consultation with experts in questionnaire development, as part of the research process. It was designed to elicit specific information regarding respondents' perception of their role, and level of clinical functioning as indicators of role expansion. The tool consisted of three parts; part one of demographic data used to determine whether variables such as age, education, years of experience, etc., effect role perception and level of functioning; part two consisted of hypothetical, situational items as indicators of how nurses can or would react in their respective work areas; part three was composed of open ended response items for purposes of eliciting the true perception of how nurses see themselves functioning in relation to education, experience and job description. The questionnaire contained a total of twenty-five (25) items. The privacy of subjects was ensured by anonymity of study participants.
Pretest

The questionnaire was pretested utilizing ten nurses working in psychiatry in community and hospital settings. The reasons for the pretest were:

1. to determine whether the questions were clear and unambiguous;
2. to determine whether the items were discriminating between 'expanded' role nurses and general staff nurses within psychiatry; and
3. to determine whether the questionnaire elicited the necessary information for determining role perception and role function for validating a definition of the concept 'expanded' role.

As a result of the pretest, format of the questionnaire was altered, two questions were eliminated and two questions were added.

Sample Selection

A convenience sample was obtained from those persons working within an 'expanded' role who attended the Quality Assurance Conference held at the Burnaby Mental Health Centre. They were contacted by this investigator, and 35 persons volunteered to participate in the study.

A second group of 35 persons was obtained from the nursing staff at Health Sciences Centre Hospital.
Implementation

Phase I:
Through a search of the literature, a definition reflecting the similar basic components of function was developed, for the expanded role of the nurse. From this definition, a questionnaire was developed to reflect the concept in question.

Phase II:
The questionnaire was mailed out to those persons who had been contacted through the Burnaby Mental Health Centre. Of the 35 mailed out the return was 91% or 32 questionnaires.

The same number, 32, of questionnaires was completed by the nursing staff at Health Sciences Centre resulting in a total sample of 64 subjects. All participants received the same questionnaire. Due to the nature of the sample selection and the fact the study was restricted to the field of psychiatry, generalizations cannot be made regarding the total nursing population.

Phase III:
Prior to data collection, criteria for converting the information into numerical values were established.

Part 2 dealt with situational items designed to elicit a behavioural response indicating the kind of judgement nurses utilize in a given situation. The following criteria were employed to convert this data into numerical scores.

1. If the response reflected synthesis of the presented data resulting in a clinically sound judgement; and
2. if the response was indicative of accepting responsibility for one's own actions, and
3. if the response indicated autonomous clinical function, the respondent was awarded a score of +1. If response to the item reflected 2 of the 3 criteria, the nurse was given +2; and if only one (or none) of the criteria was accounted for, the nurse was awarded a +3. After each item in Part 2 was scored in this manner, the numerical values were totalled which resulted in a cumulative judgement/decision score. These scores ranged from +6 which indicated high quality decision/judgement to +16 reflecting low quality decision/judgement activity. (For example, see Appendix C).

Part 3 of the data gathering instrument contained 3 questions utilized as indicators of independent functioning. These questions (1, 2 and 4) were also converted to numerical values. The procedure used to change the data to amenable form follows:

1. a response reflecting the most autonomous function was awarded +1;
2. a response indicating a team approach was assigned +2; and
3. a response reflecting dependent function was assigned +3 or +4 (dependent upon the number of available options).

Once the values were assigned to each item, they were totalled to achieve a cumulative independence score. These scores ranged from +3 indicating high independent functioning to +10 reflecting low independence. (For example, see Appendix D).

Phase IV: Method of Analyses

The data obtained from the questionnaire was analysed by utilizing the Statistical Package for the Social Sciences (Version 7)
computer program. Analyses consisted of two phases:

1) frequency distributions on all variables (job description, educational preparation, years experience, age, monthly salary, decision/judgement, independence, job perception, time spent, expanded role and location of practice) with the calculation of statistics in terms of mean, median, mode, standard deviation, variance and range; and

2) crosstabulations of all variables with subjects' perception of being in an expanded role, as the dependent variable, yielding chi squared values as an indicator of strength of relationships and the Pearson's Rank Order Correlation Coefficient (hereafter called Pearson's R) as an indicator of the direction of the relationship, should one exist. A significant relationship was held to exist with these two tests if at a 0.05 level of significance. Both phases of analyses were performed on the sample group as a whole (64 cases) and on each group (hospital - 32 cases and community 32 cases) separately.
CHAPTER IV

RESULTS

Introduction

This study was designed to determine whether specified demographic, functional, and education variables would differentiate between community nurses, who subjectively view themselves to be working in expanded roles, and general duty staff nurses employed in a hospital setting. All respondents are currently working in the field of psychiatry.

Demographic Data

The sample consisted of 64 registered nurses; 32 working in community settings and 32 employed by a hospital. Data analyses showed that community nurses had attained higher educational preparation than hospital nurses (see Table 4.1).

Table 4.1
Summary of Education Preparation
According to Work Location
in Raw Scores

<table>
<thead>
<tr>
<th>Location</th>
<th>Hospital</th>
<th>Community</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diploma</td>
<td>16</td>
<td>16</td>
<td>32</td>
</tr>
<tr>
<td>Degree</td>
<td>16</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td>Masters</td>
<td>0</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>32</td>
<td>64</td>
</tr>
</tbody>
</table>

n = 64
Frequency distribution demonstrated that of the group of 64, 31 (48%) worked as staff nurses, 10 (16%) as clinical nurse specialists, 16 (25%) as nurse therapists and 7 (11%) as head nurse/consultants. The mean age of the group was 33 years. More detailed analyses showed that community nurses were older than hospital employees (see Table 4.2).

In terms of experience, it was found that nurses working in the community had not only more general experience, but had worked in psychiatry longer than hospital nurses (see Table 4.3).

Table 4.2
Summary of Age Distribution According to Work Location in Column Percent

<table>
<thead>
<tr>
<th>Age</th>
<th>Hospital</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 - 30</td>
<td>59.4</td>
<td>34.4</td>
</tr>
<tr>
<td>31 - 40</td>
<td>34.4</td>
<td>37.5</td>
</tr>
<tr>
<td>41 - 50</td>
<td>6.2</td>
<td>21.9</td>
</tr>
<tr>
<td>51 - 60</td>
<td>0.0</td>
<td>6.2</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

\[ \bar{x} = 30 \text{ years} \quad \bar{x} = 36 \text{ years} \]
Table 4.3
Summary of Years Experience as, an R.N.; Psychiatric Nurse, and in Present Job, by Location in Raw Scores

<table>
<thead>
<tr>
<th>Years Experience</th>
<th>Location</th>
<th>R.N.</th>
<th>Psych.</th>
<th>Pr. Job</th>
<th>R.N.</th>
<th>Psych.</th>
<th>Pr. Job</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 2</td>
<td>Hospital</td>
<td>7</td>
<td>15</td>
<td>26</td>
<td>1</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Community</td>
<td>8</td>
<td>9</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>3 - 5</td>
<td></td>
<td>10</td>
<td>6</td>
<td>6</td>
<td>10</td>
<td>15</td>
<td>7</td>
</tr>
<tr>
<td>6 - 10</td>
<td></td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>9</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>11 - 15</td>
<td></td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>16 +</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>32</td>
<td>32</td>
<td>32</td>
<td>32</td>
<td>32</td>
<td>32</td>
</tr>
</tbody>
</table>

n = 64

Participants in the study were found to have somewhat large salary differences in accordance with their location of employment. The average salary of the 64 nurses was $1442/month; for the community group it was $1563/month and for hospital employees $1321/month.

Of the total group of 64, 36 (56%) perceived themselves to be working clinically and 28 (44%) viewed their jobs as administrative (see Appendix E). In terms of role expansion, 51 (80%) saw themselves working in an expanded role and 13 (20%) did not.

In summary, the group consisted of 64 registered nurses ranging in age from 25 years to 60 years. They had varying years of experience and educational preparation. In general, community nurses were older and had more experience, with higher educational preparation than
hospital nurses. All respondents fell into either clinical or administrative areas of practice. The sample was composed of 32 hospital nurses and 32 community nurses.

**Demographic Data - Hospital Subgroup**

The hospital subgroup were all prepared at a non masters level and 19 (59.4%) nurses were under 30 years of age. Of this group 30 (93.8%) saw themselves working as staff nurses and 2 (6.2%) as nurse therapists. In terms of work experience, 81.3% of this group had been in their present jobs 2 years or less; 75% had 5 years or less psychiatric nursing experience and 65.6% had 9 years or less general experience as a registered nurse. Data showed that 81.3% or 26 nurses earned less than $1400/month.

**Demographic Data - Community Subgroup**

The group of community nurses was composed of 32 respondents, 10 of which were prepared at the masters level. Of the remaining 22, 6 held Baccalaureate degrees and 16 had diplomas in nursing. In terms of job description, 15 (46.9%) nurses viewed themselves as nurse therapists, 10 (31.3%) saw themselves as clinical nurse specialist, 1 (3.1%) as a staff nurse and 6 (18.7%) as a head nurse/consultant.

Community employees were older with 21 (63.3%) respondents being over 31 years of age. Work history of community nurses was longer as 16 (58.3%) had greater than 9 years experience as a registered nurse; 24 (75.0%) had more than 5 years psychiatric nursing experience; and 24 (75.0%) had been in their present jobs 3 or more years.
The salary for this group was higher with 25 (78.1%) nurses earning more than $1400/month. In terms of role expansion, 30 (93.8%) nurses viewed their roles as expanded and 2 (6.3%) did not.

Aggregate Crosstabulation Results

All variables discussed in the preceding sections were treated as independent variables and crosstabulated with data regarding expanded role. Of the 64 nurses, 51 (79.7%) perceived their jobs to be an expanded role.

Table 4.4

Summary of Aggregate Job Description
Crosstabulated with Perceived Expanded Role

<table>
<thead>
<tr>
<th>Job Description</th>
<th>Expanded Role</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Abs. Value</td>
<td>Col. PCT</td>
<td>Abs. Value</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>20</td>
<td>39.2</td>
<td>11</td>
</tr>
<tr>
<td>Specialist</td>
<td>9</td>
<td>17.6</td>
<td>1</td>
</tr>
<tr>
<td>Therapist</td>
<td>15</td>
<td>29.4</td>
<td>1</td>
</tr>
<tr>
<td>Consultant/Head Nurse</td>
<td>7</td>
<td>13.8</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>51</td>
<td>100.0</td>
<td>13</td>
</tr>
</tbody>
</table>

$x^2 = 8.80 \quad P < .06$

Table 4.4 showed the results of the crosstabulation of job description with perceived role expansion. The relationship was not statistically significant although it showed that staff nurses were much less likely to view their roles as expanded.
Table 4.5
Crosstabulation of Monthly Salary with Perceived Role Expansion

<table>
<thead>
<tr>
<th>Salary</th>
<th>Expanded Role</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Abs. Value</td>
<td>Col. PCT</td>
<td>Abs. Value</td>
</tr>
<tr>
<td>less $1399/month</td>
<td>22</td>
<td>43.1</td>
<td>11</td>
</tr>
<tr>
<td>$1400/month or more</td>
<td>29</td>
<td>56.9</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>51</td>
<td>100.0</td>
<td>13</td>
</tr>
</tbody>
</table>

\[ x^2 = 5.57 \quad P < .02 \]

Table 4.5 demonstrated the results of the crosstabulation of salary with perceived expanded role. The relationship appeared to have significance but since community employees make more money, much of the variability was taken up by the nature of the community group.

Table 4.6
Crosstabulation Results of Independent Function in Present Job with Perceived Expanded Role

<table>
<thead>
<tr>
<th>Independence</th>
<th>Expanded Role</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Abs. Value</td>
<td>Col. PCT</td>
<td>Abs. Value</td>
</tr>
<tr>
<td>Without Consulting</td>
<td>21</td>
<td>41.2</td>
<td>1</td>
</tr>
<tr>
<td>Team Approach</td>
<td>20</td>
<td>39.2</td>
<td>3</td>
</tr>
<tr>
<td>Routinely Consult</td>
<td>10</td>
<td>19.6</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>51</td>
<td>100.0</td>
<td>13</td>
</tr>
</tbody>
</table>

\[ x^2 = 12.77 \quad P < .002 \]
The strongest relationship which resulted from data analyses appeared in Table 4.6. This showed that nurses who view their roles as expanded exercise much greater independence in terms of working autonomously, without consulting a physician, than nurses who do not view their roles as expanded.

**Figure 4.1**

Graphic Summary of Independent Treatment Decision Crosstabulated with Expanded Role

Figure 4.1 graphically represented the percentage of time that nurses alone decide on the treatment for their patients/clients. The graph showed that, in general, nurses either decide 75-100% of the time or less than 25% of the time on patient treatment.
Data analyses showed that of those nurses who perceived themselves to be in expanded roles, 22 (45%) independently planned for their patients' clients' care. Of those nurses who did not perceive their role as expanded 10 (76%) decided on treatment less than 25% of the time.

Table 4.7
Summary of Cumulative Independence Scores Crosstabulated with Perceived Role Expansion

<table>
<thead>
<tr>
<th>Independence</th>
<th>Expanded Role</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Abs. Value</td>
<td>Col. PCT</td>
<td>Abs. Value</td>
</tr>
<tr>
<td>High Ind.</td>
<td>31</td>
<td>60.8</td>
<td>2</td>
</tr>
<tr>
<td>Low Ind.</td>
<td>20</td>
<td>39.2</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>51</td>
<td>100.0</td>
<td>13</td>
</tr>
</tbody>
</table>

\[ x^2 = 6.82 \quad P < .009 \]

The data which appeared in Table 4.7 demonstrated that nearly 4 times as many nurses, who achieved high cumulative independence scores, viewed their roles as expanded and more than twice as many respondents, who achieved low independence scores, perceived their roles to be non expanded.

Finally, location of employment crosstabulated with perceived role expansion showed that 58.8% of those individuals who viewed their roles as expanded were employed in a community setting.
Chapter V

Discussion of Results

The preceding chapter demonstrated several statistically significant relationships that are important in terms of defining role expansion in nursing. However, when the data obtained from the two groups, separately, were examined, it was found that much of the occurring variability could be accounted for by the nature of the individual groups. For example, in terms of job description, institutional definition of staff nurse was different for hospital and community nurses and hence two totally different groups would emerge. As a result, staff nurses were much less likely to view their roles as expanded, than community employees. The trend, in the literature, was for nurses assuming expanded roles to be prepared at the masters level. The data indicated that only 10 persons held masters degrees and all others were prepared at a non masters level.

In terms of independent functioning, there was a statistically significant relationship with role expansion. By the very nature of working in community, nurses obtain greater independence and have less need to consult with the physician. This may account for the high variability which occurred.

On the whole, analyses of the data showed that community employed nurses were older, had more experience and were more highly educated than hospital nurses. This would account for the strong perception of role expansion which occurred in the community subgroup, as compared to the hospital group.
An interesting finding that appeared during data analyses was in the clinical vs. administrative orientation to practice. It was expected that those nurses who viewed their roles as administrative would spend most of their time performing administrative tasks. This was not consistently the case. Many of these persons spent as much time caring for patients as the clinically oriented group. This was particularly noticeable in the hospital nurses which probably indicates the difficulty in detaching oneself from patients by very nature of a hospital ward setting.

The data demonstrated by Figure 4.1 represented an unexpected relationship. Nurses were found to decide patient care at the two extremes; either 75-100% of the time or less than 25% of the time. One could speculate that since hospital settings are not conducive to high degrees of independent functioning, hospital nurses fall into the less than 25% category. Conversely, community agencies were on a more equality basis and therefore require more independence and freedom in decision making. This would also result in community employees achieving high total independence scores compared to hospital nurses. Community nurses had a more autonomous role which probably resulted in higher self-esteem and confidence in assuming greater responsibility for patient care.

Summary

The purpose of this study was to test specified variables that were thought to be inherent in, or strong indicators of, role expansion, in the hope that a fundamental definition could be verified. From data collected from 65 nurses, it was found that the statistically
significant relationships that occurred could be accounted for by
the nature of the two groups. Community nurses presented differently
than hospital nurses which could be the result of the institutional
hierarchy in which hospital employees work.

Conclusions

Since the sample was small (n = 64) and one of convenience,
generalizations were limited to community and hospital employees in
the field of psychiatry. In general, community nurses are older, more
experienced, better educated and function more autonomously.

At the beginning of this study five specific objectives were
constructed. These objectives were only partially fulfilled resulting
from inadequacies inherent in the questionnaire. It was difficult
to determine whether all the functions of expanded role nurses were
elicited. It was found that nurses in expanded roles do intake
assessments, therapy (individual, group and family), marriage coun-
selling, monitor medications and plan treatment for emotionally ill
patients.

Another objective dealt with educational preparation and the
expanded role nurse. Masters education was the exception rather than
the rule, but in general, community nurses were better educated and
hence felt more prepared for their assumed role.

A further area of interest was an attempt to determine
whether autonomy and independence were inherent to role expansion.
This would seem to be so, although by very nature of hospital vs.
community employment, conclusions here were made with caution.
It was the hope of the author that nurses' role expectation and role perception could be extrapolated from their definition of present jobs. This process was subjective and therefore not a realistic method of attaining this information. As a result, the investigation was not refined adequately and this objective was not met.

Lastly, it was hoped that areas of unclear expectation could be delineated so that changes in nursing education could be recommended. It was found that many nurses were unclear as to what the term 'expanded role' means, which was expected at the onset of the study. It was also found that role expansion was viewed in terms of location of employment, which need not be the case. One of the striking findings was that hospital nurses do not seem to know whether the jobs they are performing designate an expanded role or are simply traditional for the psychiatric setting. This was shown by the variation in response, by hospital staff, to whether they perceived their role to be expanded or not.

In terms of verifying the fundamental definition developed at the onset of the study, the investigation succeeded, with a minor change. Since 54 of the 64 nurses in the study were prepared at a non masters level, need for masters education was not validated. However, at the present time there are not enough nurses prepared at the graduate level to fill the positions requiring a masters degree. Hence these positions are being filled with individuals prepared at a non masters level.
Implications

An underlying premise in expanded roles for nurses is that these professionals are providing a better consumer and social service. In order to determine the impact that expanded role nurses are having with the consumer, there needs to be development of outcome scales designed to measure the effects of services rendered by expanded role nurses on behalf of the consumer.

Further, the study indicated that there was a cognitive dissonance among hospital employees in terms of role perception and role enactment. Research designed to elicit those variables that are effecting this would greatly aid in clarifying the position of a hospital nurse functioning in an expanded role.

The present trend is toward graduate preparation for nurses performing in expanded roles. Since only 10 nurses in this study held a masters degree, further research into standardized educational preparation is warranted. This would have to be in terms of comparing the level of clinical function (both theoretical and practical) of a nurse prepared at a masters level and a nurse prepared at a non masters level, both of whom are assuming expanded roles.

A replication of this study, utilizing more refined measurement techniques, complimented by daily work logs and personal interviews, would greatly aid in further clarifying the functions of expanded role nurses, both within and outside the field of psychiatry.

The number of nurses performing in expanded roles with graduate preparation is very limited at this time. To help eliminate this problem, greater government funding for nurses desiring higher education would be needed. This would mean that nurses could return to university
free of financial worry. To further enhance this, development of programs for outlying districts would allow nurses to continue their education on a part-time basis.

Nursing education at the graduate level should be designed toward clinical specialization with emphasis placed on utilizing and understanding role theory and theories of change, as nurses performing in this capacity are to be the change agents for the profession. Also, expanded role nurses must be prepared to evaluate their contribution to patient care, as well as to the profession.

In terms of nursing practice, perhaps the most important consideration is quality care. At the present time, the most qualified nurses are situated in community settings, resulting in too few role models in hospitals. In order to help re-distribute available manpower, hospital nursing directors would have to actively involve themselves in organizational changes directed toward allowing greater flexibility and freedom for nurses assuming an expanded role within an institution. This could also be facilitated by co-operation between nursing associations and hospital administrators in clearly delineating the functions of an advanced clinical nurse working in a hospital. It is evident, that hospital administrations would have to be willing to provide strong support to a nurse working in an expanded role within an institution.

The survey indicated that nurses do have the potential to function in expanded roles given the flexibility and autonomy inherent in the community setting. If the present structure of institutions can be reorganized to allow the same flexibility and autonomy, then nurses employed by institutions, in expanded roles, could be utilized to their full potential.
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BOOKS and ESSAYS


APPENDICES
APPENDIX A

SUBJECT CONSENT FORM

As partial completion for a Masters Degree in Nursing, I am doing a research study concerned with comparing the perceived role, function and purpose of the nurse performing in an expanded role as described in the literature, and their actual practice. Should you participate in this study, it would require about 15 minutes of your time on one occasion only. All information is kept confidential and will be used for this study only. You have the right to withdraw from the study at any time. Please check one of the options below and place your signature in the supplied space.

1. I agree to participate

2. I do not want to participate

Subject Signature

Researcher: Sharon MacDonald MSN II
APPENDIX B

Instruction

Please Read Carefully:

On the pages to follow is a questionnaire concerning the expanded role of the nurse. Many of the items refer to particular situations and may not apply to your particular job. In answering these items please imagine yourself in the position described and respond the way you probably would act. Each item has been designed to elicit specific information. Because the items are short, you may feel you want to know more about the situation described; however, please respond the way you would act in relation to your present job.

There are no right or wrong answers! The questionnaire is designed to determine what is happening in your jobs, and not in an ideal situation. It is not necessary to put your name on the questionnaire; it has been coded prior to distribution in order to identify your place of work. Only aggregate data will be used in this study. I would like to thank you for your time and co-operation.

Sharon A. MacDonald
Part One:

1. What job description do you currently have? (If more than one applies, please indicate the per cent of time devoted to each.)
   1. staff nurse
   2. clinical specialist
   3. clinical therapist
   4. clinical consultant
   5. clinical instructor
   6. other/specify

2. (a) What is your highest educational preparation? (Please circle one)
   1. diploma
   2. degree
   3. masters
   4. other/specify

   (b) Have you attended any specialty training courses?
   1. Yes (please specify)
   2. No

3. How old are you? ________ years

4. How long have you worked as a nurse? ________ years ________ months
5. How long have you worked in psychiatry? _____ years _____ months

6. How long have you worked at your present job?
   _____ years _____ months

7. What is your current monthly salary?

8. Please rank order the following in accordance to how you see yourself working in your present job. (i.e. #1 would be most important, #2 next etc.)
   a. an educator
   b. a co-ordinator
   c. a consultant
   d. a clinical liaison
   e. an administrator
   f. a therapist
   g. other/specify

9. A new patient is admitted to hospital. After admission you find her tearful and sitting alone in her room. You are most likely to
   1. call her doctor
   2. spend some time talking to her
   3. give her a little more time to adjust to hospital and call back later
10. John, a 25 year old man, is being referred for psychiatric assessment. He is described as being hostile and physically abusive. You are most likely to
1. perform the assessment yourself.
2. perform the assessment but have someone else present.
3. have a more appropriate person assess John.

11. You are seeing a depressed woman who you feel is a high suicide risk although outward suicidal ideation is not present. You firmly believe that this woman should be hospitalized, but the psychiatrist on the team does not agree with you. You are most likely to
1. insist the woman be hospitalized.
2. abide by the psychiatrist's judgement.
3. other/specify

12. You have seen a patient at the request of the family doctor and have made recommendations for treatment. Later you discover that the family doctor has ignored your recommendations and asked a colleague of yours to see the patient. The colleague is a psychiatrist. You are most likely to
1. try to forget about the incident.
2. request a meeting with the family doctor and discuss the incident with him.
3. discuss the incident with the psychiatrist.
4. other/specify
13. You have assessed a teenager who is depressed as a result of pregnancy. Her parents have told her to get out of the home. You recommend outpatient treatment for her as well as counselling for the family. Several days later you are notified that this patient is admitted to hospital with a suicide attempt. You are most likely to
1. direct the case to your supervisor.
2. initiate a review of your previous assessment.
3. do nothing, as you probably couldn't have prevented the incident anyway.

14. A junior staff member is talking to a young man who is in hospital because of sexually deviant behaviour. As they are talking, you notice that the junior staff member is getting more and more distressed by the actions and conversation of this patient. You are most likely to
1. intervene and support the junior staff member.
2. discuss the feelings and reactions of the junior staff member at a later time.
3. ask the patient if you could join them, and then direct the conversation in a different direction.

15. Staff members on an inpatient unit are angry and upset by the behaviour of a disruptive attention-seeking patient. You are asked to help them cope with the situation. You are most likely to
1. assess the patient yourself and make specific recommendations.
2. meet with staff, explore their feelings about the patient and help them deal with them.
3. meet with staff and explore the circumstances surrounding the patient's behaviour.
4. suggest how staff could try to work the problem out themselves.
The following 9 questions deal with specific details of your everyday work. Please circle the most applicable response.

1. In your present job you usually
   1. act independently without consulting a physician.
   2. routinely consult a physician.
   3. Both 1 & 2

2. In your clinical practice, who usually talks to patients first (other than the receptionist)?
   1. the psychiatrist.
   2. yourself and psychiatrist.
   3. you alone.
   4. other/specify

3. How many patients did you see last week?

4. Of the patients you saw last week, in how many of the cases did you alone decide what treatment should be?
   1. 75 - 100% of cases
   2. 50 - 74% of cases
   3. 25 - 49% of cases
   4. less than 25% of cases
5. Compared to other fulltime members of the health care team, your patient load is
1. about the same.
2. comparatively higher.
3. comparatively lower.
4. other/specify

6. Rank order the following (1, 2, 3, etc.) according to what, on the average, you spend your time doing during a normal day. (1 = most; 6 = least)
1. direct patient contact
2. charts and/or paperwork
3. administrative duties
4. teaching and/or supervision
5. consultant
6. other/specify
7. With specific reference to your daily practice, define your present job?

8. Do you consider yourself to be working in an "expanded role"?
   1. yes
   2. no
9. Do you feel that your academic and clinical training has prepared you to assume the role you are presently working in?

If so, how?                                    If not, why not?
10. Place any further comments here.
APPENDIX C

Calculation of Cumulative Judgement/Decision Scores

The data obtained from Part II of the questionnaire were converted to numerical values on the basis of the following criteria:

1. the response must have reflected synthesis of the available data resulting in a clinically sound judgement;
2. the response must have been indicative of accepting responsibility for one's own actions; and
3. the response must have reflected autonomous function.

A response that encompassed all three of the criteria was awarded +1; compliance with 2 of the 3 criteria resulted in +2; and one (or none) of the criteria resulted in awarding +3. When each item was scored, the total achieved on the 6 items was taken resulting in a cumulative judgement/decision score. The scores ranged from +6 indicating high quality judgement/decision through to +16 reflecting low quality judgement/decision activity. The example to follow demonstrates the procedure.

10. John, a 25 year old man, is being referred for psychiatric assessment. He is described as being hostile and physically abusive. You are most likely to

+1 1. perform the assessment but have someone else present.
2. perform the assessment yourself.
3. have a more appropriate person assess John.
11. You are seeing a depressed woman whom you feel is a high suicide risk although outward suicidal ideation is not present. You firmly believe that this woman should be hospitalized, but the psychiatrist on the team does not agree with you. You are most likely to
   1. insist the woman be hospitalized.
   +2 2. abide by the psychiatrist's judgement.
   3. other/specify ____________________________

12. You have seen a patient at the request of the family doctor and have made recommendations for treatment. Later you discover that the family doctor has ignored your recommendations and asked a colleague of yours to see the patient. The colleague is a psychiatrist. You are most likely to
   1. request a meeting with the family doctor and discuss the incident with him.
   2. discuss the incident with the psychiatrist.
   +4 3. try to forget about the incident.

13. You have assessed a teenager who is depressed as a result of pregnancy. Her parents have told her to get out of the home. You recommend outpatient treatment for her as well as counselling for the family. Several days later you are notified that this patient is admitted to hospital with a suicide attempt. You are most likely to
   1. initiate a review of your previous assessment.
   +2 2. direct the case to your supervisor.
   3. do nothing, as you probably couldn't have prevented the incident anyway.
14. A junior staff member is talking to a young man who is in hospital because of sexually deviant behaviour. As they are talking, you notice that the junior staff member is getting more and more distressed by the actions and conversation of this patient. You are most likely to
1. discuss the feelings and reactions of the junior staff member at a later time.
+2 2. ask the patient if you could join them, and then direct the conversation in a different direction.
3. intervene and support the junior staff member.

15. Staff members on an inpatient unit are angry and upset by the behaviour of a disruptive attention-seeking patient. You are asked to help them cope with the situation. You are most likely to
1. meet with staff, explore their feelings about the patient and help them deal with them.
+1 2. meet with staff and explore the circumstances surrounding the patient's behaviour.
2. assess the patient yourself and make specific recommendations.
3. suggest how staff could try to work the problem out themselves.

Total Judgement/Decision Score  = +12
Calculation of Cumulative Independence Scores

Data obtained from Part III (questions 1, 2 and 4) were converted to numerical values on the basis of the following criteria;

1. a response reflecting the most autonomous clinical function was assigned +1;
2. a response reflecting a team approach was awarded +2; and
3. a response indicating a dependent mode of functioning achieved a +3 (or +4 depending on the number of available options).

After each item was scored, a cumulative independence score was obtained by totalling the values assigned to the individual items. These scores ranged from +3 reflecting a high level of independent functioning through to +10 indicating a low level of independent functioning. The example that follows demonstrates the procedure with responses in ascending order beginning at the independent end of the continuum (response #1 is the most indicative of independent function).

1. In your present job you usually
   +1 1. act independently without consulting a physician.
   2. act independently but consult the physician at own discretion.
   3. routinely consult a physician.

2. In your clinical practice, who usually talks to patients first (other than the receptionist)?
   1. you alone.
   +2 2. yourself and psychiatrist.
   3. the psychiatrist.
4. Of the patients you saw last week, in how many of the cases did you alone decide what treatment should be?

1. 75 - 100% of cases
2. 50 - 74% of cases
3. 25 - 49% of cases
4. less than 25% of cases

Total Independence Score = +6
APPENDIX E

Development of Clinical/Administrative Categories

There were 3 items on the questionnaire designed to determine the practice orientation of the respondent. These were:

Part 1 Question 8
Part 3 Question 6
Part 3 Question 7

Part 1 Question 8
Please rank order the following in accordance to how you see yourself working in your present job.

a. educator
b. co-ordinator
c. consultant
d. clinical liaison
e. administrator
f. therapist

To obtain respondents orientation, these categories were collapsed in the following way:

1) a respondent with 2 of a, c, or f in their first 2 rank orders was classified as pure clinical;
2) all other combinations were classified as administrative.

Although there were some mixed respondents (i.e. a, e in first 2 ranks) these were not pure clinical and hence were classified as administrative orientation.
Part 3 Question 6

Rank order the following according to what, on the average, you spend your time doing during a normal day.
(1 = most; 6 = least)

1. direct patient contact
2. charts and paperwork
3. administrative duties
4. teaching and/or supervision
5. consultant
6. other/specify

To obtain respondents orientation on this item, he/she must have had 2 of responses 1, 2 or 4 in their top 2 rank orders for pure clinical. All other combinations were considered administrative.

Part 3 Question 7

With specific reference to your daily practice, define your present job?

This item was used as a reliability check for orientations obtained in Part 1, Question 8 and Part 3 Question 6.

i.e. If a respondent had a clinical orientation to question 8 and also on question 6, their definition of their job should comply with this. For the most part, this was so.