



Royal College
of Nursing

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A framework for developing practice in paediatric oncology nursing

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Executive summary

Today's paediatric oncology nurse faces a number of challenges, both from within the profession and from society, to provide clinical expertise in what is a complex and rapidly changing speciality. Advances in the medical treatment of childhood cancer means that expected survival rates have never been better. Consequently, nurses caring for children with cancer have had to keep pace with advances in treatment as well as with technological developments. The nature of care provided in inpatient, outpatient and community settings has changed over recent years and will continue to do so as a growing number of children in all three settings require highly specialised care throughout their disease trajectory.

Alongside these challenges, advances in medical science and technology have resulted in a reappraisal of traditional roles in both nursing and medicine, with the boundaries between the clinical work of doctors and nurses being redrawn. The team approach, in which doctors, nurses and other professions allied to medicine adapt and develop new skills, is being increasingly emphasised. For nurses, this has caused an increase in specialisation and some recent innovations clearly reflect an expansion of the nurse's role, often at the interface between nursing and medicine. This creates tremendous opportunities and challenges for nurses to develop their practice. Even so, as paediatric oncology nurses, we are concerned by the speed at which new roles in clinical practice are being developed and implemented, as well as by the philosophical debates surrounding them.

In response to these concerns, the steering committee of the RCN Paediatric Oncology Nurses Forum (RCN PONF) arranged a series of meetings to complement various conference presentations that had been commissioned to open up the debate about role development within the speciality. This also recognised the fact that, as a group, we had received a number of requests from members who were looking for guidance and clarification in relation to developing roles. Responding to their needs, we began to clarify our own thoughts – both in debate among the group and with the help of other expert nurses – and added that to a

synthesis of the growing volume of literature. This led us to share our thoughts at a recent paediatric oncology conference and start to develop a framework to facilitate future role developments.

This report presents the framework to you. The aim is for nurses in clinical, management and education roles to use it in collaboration with the multiprofessional team when considering role development in their own service.

The framework is made up of two parts. Following some background information, the first part outlines some of the defining characteristics of paediatric oncology nursing. The second part describes in detail a model to support developments in professional practice. When considering role development, it asks you to give attention to the following questions:

- ◆ Why is the change/initiative indicated?
- ◆ Does it fit in with national, regional and local strategies?
- ◆ What are the service considerations?
- ◆ What are the personal considerations?
- ◆ Have you clarified issues of accountability, authority and responsibility?
- ◆ What type of evaluation, audit and review is planned?
- ◆ How will your work be disseminated?

Although the framework has been developed by and for nurses working in paediatric oncology, we hope that other nurses caring for children and young people will adapt the information to their own area of clinical practice. In particular, consider the model referred to as a “safety net to support professional practice” (Royal College of Paediatrics and Child Health/Joint British Advisory Committee on Children's Nursing, 1996). It has the potential for being adapted and applied to role development in all areas of clinical speciality, hospital and community.

What follows is a framework within which we can discuss, develop and study nursing roles.

1

Introduction

Paediatric oncology nurses are faced with many professional challenges in the rapidly changing health care environment. Advances in treatment, technology and multiprofessional care have improved patient outcomes and, at the same time, drastically altered nursing practice. Although the core values of caring persist, roles and responsibilities have evolved and new opportunities for expanding the boundaries of nursing present themselves to individuals and organisations. As nurses seek to respond to change, they need clarity and direction so that they can progress with confidence in developing their roles or practice.

Developments in nursing are inextricably linked to continuing changes in government policy regarding the National Health Service (NHS). The ways in which nurses can work and develop their practice are constrained by the legislative framework of the NHS and by the regulatory framework set upon the profession by statute. Nevertheless, since the time of Florence Nightingale, the profession has always striven to influence government policy in health care provision.

Nowadays paediatric oncology nursing roles are diverse, offering opportunities to engage in direct clinical care as well as education, management and research. In addition, a number of other opportunities are afforded by the variety of clinical specialisms in paediatric oncology – for example, the clinical nurse specialist posts in bone marrow transplant, care of adolescents and intravenous therapy, to mention but a few. Nurses in all of these roles contribute to care in collaboration with other health care professionals. Role development has taken place in response to changes in health care and local circumstances; the more recent additions of case managers and advanced nurse practitioners represent continuing innovations in the organisation and delivery of care. However, it may be that such ad hoc and reactive role evolution would benefit from a proactive national framework that supports individual nurses who are considering practice expansion and provides safeguards for their patients.

To this end, the steering committee of the RCN Paediatric Oncology Nurses Forum (RCN PONF) have developed a framework for developing nursing roles.

2

Professional context

2.1

Relevant publications

The debate is gaining momentum around the issue of nurses developing new and different roles and expanding the care they provide. Some of the publications that have influenced the current situation are highlighted in Table 1.

2.2

Focus on paediatric oncology nursing

All of the publications highlighted in Table 1 have had an influence on the speciality of paediatric oncology nursing. This influence has often been implicit rather than explicit, however, as busy practitioners have tried to make sense of so much material and decide which ones relate directly to them. The result is that confusion abounds, with practising paediatric oncology nurses being unclear about the developments taking place in their speciality. In addition, nursing and service managers remain unclear about what roles are needed to develop the service while, in education, requests continue to be received for programmes to develop specialist practitioners. This must reflect the confusion that the UKCC is attempting to unravel (UKCC, 1999).

Table 1 Publications exerting an external influence on nursing role development

United Kingdom Central Council	Royal College of Nursing	Department of Health	Research Papers
<p><i>The scope of professional practice</i> (1992)</p> <p>Gave more freedom for nurses to develop and expand their role, the onus being on individuals to define the limits of their own practice and sharpen their sense of personal accountability.</p>	<p><i>New horizons in clinical nursing</i> (1975)</p> <p>Described the case for an advanced clinical role and proposed the development of a clinical consultant.</p>	<p><i>A vision for the future</i> (1993a)</p> <p>Identified strategic aims for the nursing profession; focused on goals related to patient need, user participation, improvements in health and ensuring a high quality, cost-effective service. Of particular relevance to new nursing roles are the development of outcome indicators, clinical protocols and clinical audit, and the development of clinical practice.</p>	<p><i>Greenhalgh Report</i> (1994)</p> <p>Reported, following an activity analysis of junior doctors and nurses in six case study sites, that they should work together to share some tasks and develop partnerships to deliver clinical care.</p>
<p><i>PREP-standards for education and practice following registration</i> (1994)</p> <p>Attempted to clarify educational and professional preparation in terms of “specialist practice” and “advanced practice”.</p>	<p><i>The role of the nurse practitioner</i> (1997)</p> <p>Defined the role and scope of nurse practitioner practice, aiming to break down some of the confusion and ambiguity.</p>	<p><i>The Heathrow Debate</i> (1994)</p> <p>Considered the challenges facing nursing and midwifery in the 21st century; posed an agenda that has relevance to the development of nursing roles at the interface with medicine.</p>	<p><i>Touche Ross & Co</i> (1994)</p> <p>Reported, following an evaluation of diverse and innovative roles, that nurse practitioners provided a safe and valued service to selected patients.</p>
<p><i>A higher level of practice</i> (1999)</p> <p>Attempted to allay the confusion surrounding the notion of advanced practice by articulating this higher level of practice more clearly. Recognition of a higher level is to be founded on attaining clinical competence, with underpinning post-registration education, and accrediting practitioners working at this level.</p>		<p><i>Making a difference</i>(1999)</p> <p>The “Strategy for Nursing” outlines new ways of working and opportunities for new roles. A new career framework is presented and the role of the consultant nurse is clarified.</p>	<p><i>Developing new roles in practice</i> (1999)</p> <p>Presented the findings of the ENRiP Project. Provides an evidence-based framework detailing the direct and contextual issues, which impact on implementation when traditional patterns of work and role boundaries are challenged.</p>

3

Health service developments that have influenced nursing roles

Developments in nursing cannot be seen in isolation and changes within the medical profession, in particular, have always influenced nursing practice. Changes in junior doctors' hours, (DoH, 1990) and the so-called "New Deal" of 1991 (NHS Management Executive, 1991) led to increased interest from both government and the professions in what it is that nurses and doctors actually do. Much of this was task driven, looking at ways in which nurses might take on "doctor's jobs" and thereby alter the workload of service provision. For many nurses, however, this has proved a positive opportunity to develop their practice further.

Junior doctors' hours represented just one of many wide reaching changes in medical training recommended by the Calman Report (DoH, 1993b). These have had major implications for service provision, particularly in hospital care. Their impact is becoming very apparent in specialities such as paediatric oncology, where junior and middle-grade staff spend a relatively short time and do not have an opportunity to develop the knowledge and skills base required to care for such children and families. At the same time, nurses are continuing to push at the boundaries of their practice as they acquire greater skills and clinical expertise in the field. The demands of the service, therefore, make it inevitable that there will be changes at the interface between the work of doctors and nurses.

In 1996 a report entitled *Developing roles of nurses in clinical child health* was published by the Royal College of Paediatrics and Child Health/Joint British Advisory Committee on Children's Nursing. Membership of the working party that produced this document was wide and included representatives from nursing and medicine. The work was undertaken with RCN professional and financial support. The terms of reference for the working party were "to advise on expanding nursing roles in the care of children and their families, developing models of good practice and suggesting approaches to implementation" (p2). This included a flow diagram that offered the structure of a safety net when developing

nursing roles. The document drew conclusions from which the authors of the report could make a number of recommendations (appendix 1).

Government is beginning to recognise the ways in which nurses are extending the scope of their practice, as can be seen by its recent introduction of the concept of the consultant nurse¹. As part of its overall strategy for nursing, midwifery and health visiting, the Government is carrying on its consultation within and without the profession as to how nursing roles and practice should continue to develop.

In 1997, the Government began publishing a series of white papers and consultation documents in England, Scotland, Wales and Northern Ireland which put great emphasis on improved efficiency and high quality care in the NHS². There was a commitment to abolish the internal market in health care and much of the initial focus was on setting up primary care groups. Apart from the role of community nurses in setting up these new structures, the documents had little to say about nursing practice, other than a general expectation that trusts would strengthen the contribution that nurses could make. However, the commitment to a quality service impacts on all those who provide it and could give nurses more opportunities to develop their roles. The white paper in England was followed by another document – *A first class service* (DoH, 1998) – that further pursued the quality agenda for the benefits of patients³. Part of this document looks at setting up National Service Frameworks which are intended to lay down the standards of care that different groups of patients can expect. The document makes explicit reference to the work carried out for both cancer services – that is, the Expert Advisory Group on Cancer (Calman-Hine, 1995) and children's intensive care documents *A framework for the future* and *A bridge to the future* (National Health Service Executive, 1997a and b).

The Government uses these reports as examples of the need for equitable, high quality service provision in a particular speciality – a need which has been identified in paediatric oncology. Both of these reports refer to the need for specialist nurses, but do not define the ways in which nurses can develop their specialist practice to meet the needs of their patient population. Government policy, therefore, can and should provide the broad context within which the specific

1 See DoH, 1999 and National Assembly for Wales, 1999. As yet no strategy has been developed for Northern Ireland and Scotland.

2 These were, respectively, the white papers *The new NHS: modern and dependable* (DoH, 1997), *Designed to care* (Scottish Office, 1997) and *Putting patients first* (National Assembly for Wales, 1998) and the consultation document *Fit for the future* (DHSS, 1998).

3 In Scotland, see NHS MEL (1998) 75 and in Northern Ireland, HSS Executive (1997).

4

needs of children with cancer can be addressed.

Paediatric oncology services

4.1

Context of care

Childhood cancer is a rare disease with an incidence rate for children under the age of 15 of only 110-130 per million per year (Stiller, 1997). Although there still remains a proportion of children who will die from cancer, dramatic improvements have been made in reducing mortality rates over the last 30 years (Triche, 1992). Overall, 60-65 per cent of children with a malignancy are expected to reach adulthood (Pearson, 1996). Within the UK, nearly two-thirds of children who have a diagnosis of cancer can now expect to survive at least ten years (Stiller, 1994). There are now over 10,000 adult survivors of childhood cancer and that number is increasing by more than 500 each year.

There is a well-established mechanism for the centralisation and co-ordination of the treatment of childhood cancer in the UK. This model of service provision has operated for many years. Its main principle is that children and young people with cancer are referred to regional paediatric cancer centres to receive either all or part of their care. In some areas of the country, a management model has been established for sharing parts of care with the child or teenager's local paediatric department. This is what is known as "shared care" (Patel et al, 1997). In this model, children and families have access to primary, secondary and tertiary care. Care is integrated and co-ordinated between all three. However, to achieve "seamless" care, there needs to be a co-ordinated effort between the various key players. This principal and process is reinforced in the Expert Advisory Group on Cancer's report (1995).

Since the late 1960s, there has been a move towards co-ordinated treatment protocols and multi-centre therapeutic trials for all types of childhood cancer (Clinical Standards Advisory Group, 1993). This policy has formally stemmed from the establishment of the United Kingdom Children's Cancer Study Group

(UKCCSG) in 1977. UKCCSG runs co-operative clinical trials where the primary focus is on introducing innovative drug regimens and collecting scientific data and records of children's pathways of care (Stiller and Parkin, 1996). There are currently 22 UKCCSG centres for the treatment of childhood cancer in the UK and Eire. Three reasons have been identified for centralised treatment (Clinical Standards Advisory Group, 1993):

Technical Expertise

Doctors and nurses need sufficient exposure to the management of childhood cancer treatments to maintain an appropriate level of expertise.

Outcome

Survival rates have been improved in centres where patients benefit from the latest advances in treatment (Stiller, 1988).

Cost

Financial resources, both government and charity, are most effectively used when concentrated in designate areas.

Through centralisation of care, increased referrals provide the critical mass of work that drives the development of highly technical treatment advances in the specialist centres. This in turn will increase the need for specialised care (UKCCSG, 1997a). Audit and clinical effectiveness initiatives offer the means of ensuring that standards of service provision are set and maintained in each centre that offers specialist care. The published requirements for treatment centres allow for both local and national monitoring (UKCCSG 1997a, UKCCSG 1997b, Royal College of Pathologists, 1996).

During the past five years, several documents have been published that outline the standards required to offer a quality service to patients with cancer. First, the Expert Advisory Group on Cancer (Calman-Hine, 1995) recommends a network of expertise in cancer care that should be made available to all. Although the focus is on adult cancer services, the document calls for the maintenance of paediatric treatment centres, integration with cancer centres and the provision of specialist nursing in paediatric oncology.

Three documents that specifically focus on service provision in paediatric oncology refer to the need for appropriately qualified and experienced nursing staff (UKCCSG, 1997a and b; Royal College of Pathologists,

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The RCN Paediatric Oncology Nursing Forum framework for advancing nursing practice

1996). However, while the importance of specialist nurses is highlighted in all three documents, there is a distinct absence of detail regarding the role and training of paediatric oncology nurses.

The needs of children and their families are paramount. Children need to be cared for by skilled and knowledgeable professionals. Several documents have been produced that outline the requirements of a UKCCSG treatment centre. These all call for specialist paediatric oncology nurses. The expertise of nurses working in a specialist area are recognised as being able to offer comprehensive, quality care to patients (Royal College of Paediatrics and Child Health, 1996). UKCCSG (1997a) outlines the need for 24-hour access to expert medical and nursing advice for families, GPs, community staff and shared care hospitals. Children with cancer receive treatment in inpatient; outpatient and community settings. There is a need for specialist nursing in all these areas.

5.1 Defining the characteristics of paediatric oncology nursing

To date, despite the many references to the need for specialist paediatric oncology nurses, little has been published to support and outline ways in which expert practice can be developed in the speciality. In the context of the developments and debates outlined above, the working party considered what advanced nursing practice means in the field of paediatric oncology. They sought to bring some clarity to the current confusion surrounding nursing role development by looking at its constituent elements (see Gibson and Hooker, 1999, for more detail). They also considered what advanced nursing practice means within the speciality and addressed nursing role development as regards the notions of:

- ◆ **labels and titles:** description of role
- ◆ **dimensions of the role:** values and focus
- ◆ **area of speciality:** specialist role
- ◆ **level of expertise:** expert and advanced roles
- ◆ **medical and nursing models of care:** expanded roles.

5.1.1

Labels and titles: description of role

We recognise that a lot of the confusion stems from the increasing number of labels and titles being used to distinguish nursing roles. For example, for the role of a

clinical nurse specialist (CNS), there are a variety of levels of preparation and the criteria for these posts remain unclear, resulting in the title of CNS describing a diverse group of individuals (Humphris, 1994). We are in danger of adding to that confusion by introducing titles such as nurse practitioner (NP) and advanced nurse practitioner (ANP). It is imperative to have an agreed understanding of what these titles refer to. This should clarify the route of preparation, both clinical and educational, and the distinguishing features of these roles that relate to the title. We recommend using a title that:

- ◆ includes the word “nurse” or equivalent – for example, sister/charge nurse
- ◆ clearly defines what they do
- ◆ is familiar to colleagues, families and others
- ◆ defines their area of practice
- ◆ reflects agreed criteria for the post.

5.1.2

Dimensions of the role: values and focus

We recognise that role development evolves over time and responds to changes in society, both for an individual and the profession. We also recognise that the core of nursing is not defined by the tasks that we perform. Nursing practice is distinguished by our focus on holistic care, collaboration with families within a tradition of care and concern and an ever-growing body of nursing knowledge. As we expand our scope of practice, we will incorporate new knowledge and skills and thus advance our understanding of clinical nursing practice. We recognise that role development will be influenced by factors such as experience, level of expertise, personal and professional values, place of work, speciality and aspects of role transition. Thus role development will be dynamic, complex and context specific. We recommend that the role should:

- ◆ have a nursing focus (holistic care, family centred)
- ◆ be driven by the needs of children, young people and their families
- ◆ be appropriate to client group, needs and values of society
- ◆ be relevant in your place of work or in your team

- ◆ include reviews to ensure continued usefulness and potential for further change
- ◆ only encompass tasks upon which nursing can have an influence
- ◆ have clear responsibility and accountability for decision-making, implementation and outcome of all aspects of the role, within agreed practice boundaries.

5.1.3

Area of speciality: specialist role

The paediatric oncology nurse applies both paediatric nursing expertise and specialist oncology expertise (nursing and medical) to the care of the child and family. The speciality may have two dimensions:

- ◆ **area of practice** – that is, the patient group, such as adolescents or bone marrow transplant
- ◆ **location of the role** – for example, community, management, education.

It may be necessary to distinguish major and minor parts of roles. Could a nurse advance in all areas? Indeed, can “advancing practice” be a term that actually applies to nurses in education or research? We recommend that the role should:

- ◆ have a specific focus of specialist practice/client group
- ◆ have a role description that is explicit about clinical practice, as distinct from management, research and education responsibilities
- ◆ describe a job that needs doing, as opposed to a specific person’s attributes.

5.1.4

Level of expertise: expert and advanced roles

It is important to distinguish here between general and speciality knowledge. We have used Benner’s levels of skill acquisition (1984, appendix II) to clarify this part of the framework. At registration a nurse is deemed to be an *advanced beginner* in general paediatric nursing. However, the same nurse beginning to work in paediatric oncology would be considered a novice. This

nurse would develop expertise through a period of preceptorship, clinical supervision, education and training to progress on a continuum from novice to expert. It is this pathway, from novice to expert, that remains unclear in the speciality. While advancing specialist clinical practice, nurses concurrently advance their own knowledge and skills in paediatric nursing. This framework reaffirms the equal value of general and specialist knowledge and skills – those core abilities and qualities shared by all nurses and by all paediatric nurses.

We have clarified what we believe to be the defining characteristics of the *expert specialist*. We recognise that the majority of nurses have the potential to become experts in their field, involved in advancing their own practice. In contrast, we feel that only a few paediatric oncology nurses will practice at an advanced level. Thus the focus changes from the narrow concentration of the expert specialist to encompass additional features (appendix III). We recommend that:

- ◆ paediatric nursing practice become the core nursing focus.

5.1.5

Medical and nursing models of care: expanded roles

Although this would depend on the post and the individual, we emphasise that all health care is teamwork and each discipline has its primary focus. Medicine focuses on investigations, diagnosis and treatment of diseases. Nursing, on the other hand, focuses on the effects that the disease and its various treatments have on the individual and the family, observing side effects and managing symptoms. In paediatric oncology, nurses do undertake aspects of medical work, which is appropriate. However, we do it within the context of nursing. We develop further the therapeutic work of nursing.

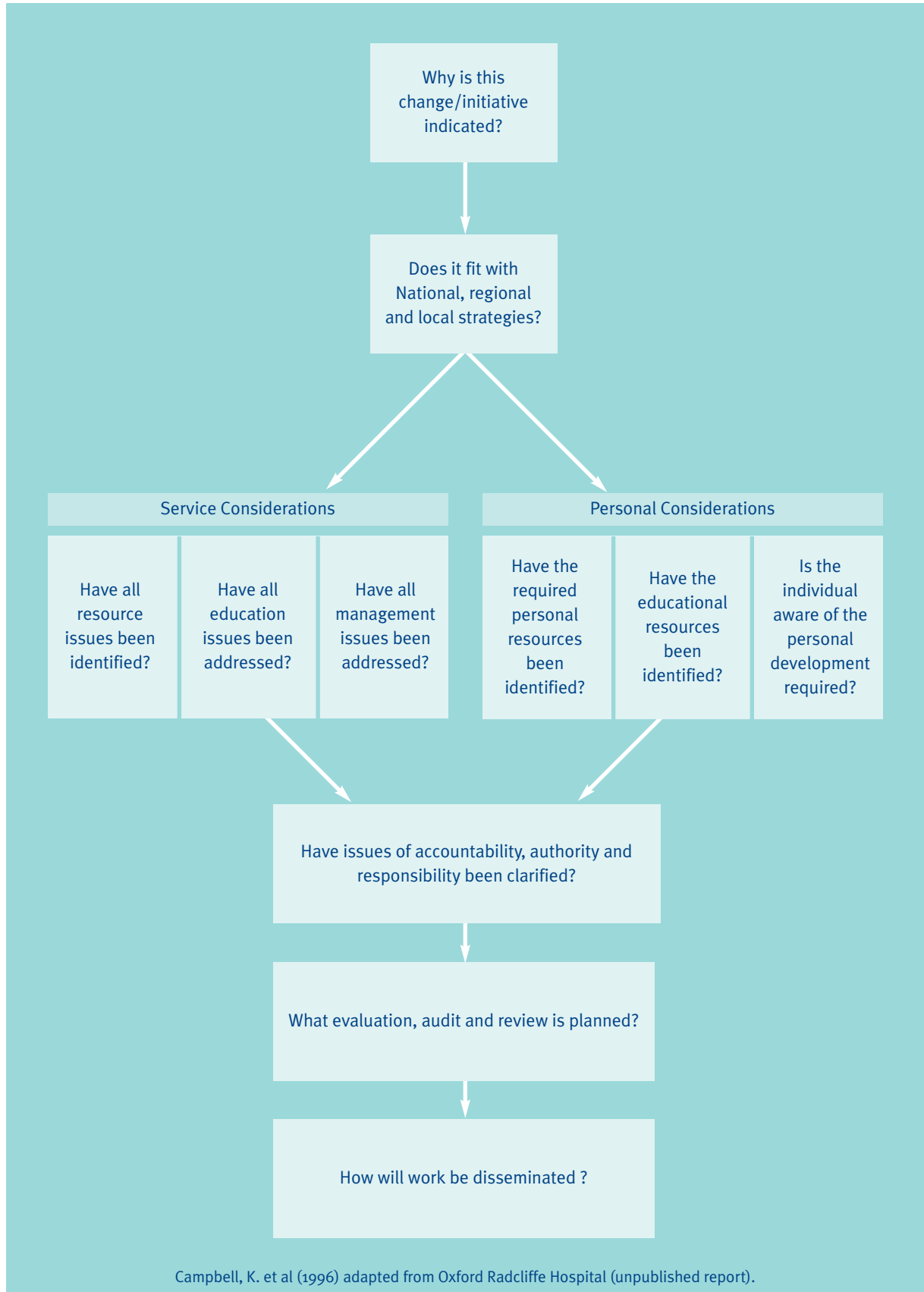
In relation to an expanded role, we have to decide what is appropriate and relevant for nurses to undertake, all the while ensuring that whatever role we expand into will make a difference to nursing and our patients. For example, we might consider that an expert nurse should be able to prescribe antiemetics since symptom management is clearly within the domain of nursing. In contrast, we might not consider it appropriate for an expert nurse to perform a lumbar puncture or bone

marrow aspirate. We have to ask ourselves whether nursing makes a difference in this situation. It clearly might in certain circumstances – say, when a child is having the procedure using distraction therapy – but would all experts undertake this role and is this advancing practice? We recommend that:

- ◆ the core values of nursing must be explicit in any role expansion, and
- ◆ improving patient care must be the purpose of any role expansion.

Having identified some of the characteristics of the development of nursing roles in the speciality, the working party then considered it essential to apply these to the reality of clinical practice. The “Safety Net” (Figure 1), developed by a team in Oxford and described in the document published by the Royal College of Paediatrics and Child Health/Joint British Advisory Committee on Children’s Nursing (1996), proved a useful model in doing so as it encompassed rationale, context, accountability and evaluation. This model has been adapted (with permission) to be used as guidance for nurses and the teams in which they work when they are looking to role development in their own service. The overall structure of the model remains the same; it is the additions that make the safety net very relevant to the speciality when considering role expansion.

Figure 1 Safety Net to Support Professional Practice in Paediatric Oncology Nursing



5.2

Using the safety net

This model is intended for use by nurses, in consultation with members of the multiprofessional team, when considering developments in the scope of nursing practice. This model can be used to facilitate role development for all nurses working with children and young people, although in this context it has been applied to the speciality of paediatric oncology nursing. Role development may encompass both minor and major changes, with the model being useful when considering changes to an existing role or developing a completely new one. The model provides a step-by-step overview of issues that should be addressed. Suggestions regarding specific questions are provided below.

The process must include the two key interrelated components of planning for role-development – that is, issues that relate to providing the clinical service and issues that pertain to the individual. The model provides a template for discussion, debate and consultation with colleagues, professional leaders and service managers. The personal development matters are offered as guidance for any nurse considering either role expansion or taking on a new position that involves expanded roles. This can be used for personal reflection or as a tool for discussion with a mentor or manager when planning future practice developments and education/training and support needs. Throughout this section, we pose a series of questions designed to make sure certain areas are being considered:

5.2.1

Why is this change/initiative indicated?

- ◆ Begin with an examination of the current team and the needs of the patient group.
- ◆ What has triggered the proposed change of practice? Consider, for example, treatment protocol, staffing review, financial pressures, junior doctors' hours, review of oncology service, clinical incident, changes in other staff roles/hours, societal and government changes.
- ◆ How are the changes expected to improve patient care? In what way might patients/families benefit?
- ◆ Are there benefits for the team?

5.2.2

Is it consistent with the relevant national and local strategies?

- ◆ Consider current Government strategies for nursing and health care.
- ◆ What regional and local guidelines have been produced in response to national strategic developments?
- ◆ Consider strategic guidance from the Royal Colleges.
- ◆ Consider cancer care strategies at national, regional and local level. For example, Calman-Hine working parties.
- ◆ Consider UKCCSG and RCN PONF recommendations.
- ◆ Consider issues that reflect the four countries.

5.2.3

What are the service considerations? Have all resource issues been identified?

Staffing

- ◆ Will this require or result in adjustments to nurse numbers?
- ◆ Will this alter the ratio of the skill mix to grade mix?
- ◆ Will there be a shift of medical input?
- ◆ Will there need to be an increase or adjustment to admin/clerical support?
- ◆ Will changes have an impact on any of the professions allied to medicine?

Equipment

- ◆ Where will the nursing interventions take place?
- ◆ Will there be implications that increase or decrease demand on beds or transfer activity to a different setting (for example, inpatient beds, day beds, clinic, patient's home)?
- ◆ Can the existing clinical facilities/space accommodate these changes?
- ◆ Is the required clinical equipment available?
- ◆ Is there adequate office space with IT support, telephone access/bleep/pager?
- ◆ Is new documentation required?

Finance

- ◆ Is funding available for the development project/training costs?
- ◆ Is funding available long-term for an ongoing commitment to the post?
- ◆ Is funding available to cover ongoing evaluation of the role and dissemination of the findings? Consider R&D support from the trust.
- ◆ Will the role development have an impact on commissioning or contracts?
- ◆ What will be the effects of any changes in activity on the service?

Time

- ◆ Have you allowed enough time to plan the project?
- ◆ Have you allowed for consultation with all members of the health care team?

Support structures

- ◆ Is there support from nursing management?
- ◆ Are nursing peers, medical colleagues and other members of the multiprofessional team involved?
- ◆ Do you have support from directorate and trust level management?
- ◆ Have you considered the work of other directorates/specialities? Have they already developed similar roles?

Knock-on effects

- ◆ What impact will there be on other nursing roles and on nursing colleagues in all care settings – hospital, shared care, community?
- ◆ What impact will there be on the provision of holistic care? Will the changes increase or decrease task-orientated care? What are the implications of this?
- ◆ What will be the impact on the work of medical colleagues and other members of the multiprofessional team?
- ◆ What will be the impact on continuity of care and communication patterns?
- ◆ Will existing tasks and responsibilities be delegated to others? If so, to whom and why? Is this appropriate and in the patient's best interests?

- ◆ If role development fails, where do you go from there?

Have all the educational issues been addressed?**Assessment strategy**

- ◆ Who will be responsible for assessing the nurse in this new role?
- ◆ What assessment approach will be taken?
- ◆ How will theoretical and practical knowledge be assessed?

Competencies

- ◆ Have competencies been written and agreed? If not, who will be involved in developing them?
- ◆ Do competencies encompass knowledge, skills and attitudes?
- ◆ Do they build on the current nursing role?
- ◆ Do they reflect national expectations as well as local?

Clinical supervision/ Individual Performance Review (IPR) framework

- ◆ Is clinical supervision in place?
- ◆ Who will be offering supervision?
- ◆ Will there be a need for a mentor or supervisor from another discipline? (for example, medicine, physiotherapy, psychology)
- ◆ Where does the new role fit in the nursing structure for IPR?

Educational support

- ◆ Is there an education programme available to develop this nursing role?
- ◆ Will there need to be discussion with education providers to develop a new course?
- ◆ Will study leave need to be built in before the role begins?
- ◆ Is in-house education/staff development support available?

Training programme

- ◆ What training does the post require, initially and on-going?

- ◆ Will training need input from medical/other colleagues and other nurses?
- ◆ What training must take place before the role begins?
- ◆ Who will be responsible for monitoring the training?
- ◆ Should the training be assessed and if so, by whom?

Support structures

- ◆ Has support from an education person been identified?
- ◆ Is there a need to link with another institution?
- ◆ Is support available from nurses undertaking similar roles outside of the team?

Have all the management issues been addressed?

Previous experience

- ◆ What experience is needed to undertake the role?
- ◆ What education level is needed to underpin the role?
- ◆ What is the length of time in paediatric oncology required to gain this experience?
- ◆ What evidence is needed to demonstrate that experience?

Mandatory and optional activities

- ◆ What aspects of the role development are essential?
- ◆ What are the priorities for service provision within this role?
- ◆ Are there elements that are subject to discussion and negotiation with the post-holder and stakeholders? For example, consider nurses clerking patients for routine chemotherapy, nurses initiating treatment of febrile neutropenia or nurses carrying out BMA or LP.

Timescale

- ◆ What are your priorities for this role?
- ◆ Can you formulate clear objectives and outcome measures for role development? For example, development of nurse-led management of mouth care or development of nurse-led clinic for leukaemia follow-up.

- ◆ Have you considered succession planning for this post/activity?

Job description/person specification/grade

- ◆ How would this role development fit into the existing team structure?
- ◆ What would the effect be on the existing grading structure within your unit? Are you looking at a completely new post or a further development of current roles and how will advanced nursing practice be recognised or rewarded?
- ◆ Have you agreed on the job title for this new role? Is it descriptive and unambiguous?
- ◆ What clinical grade has been discussed and agreed?
- ◆ What uniform will be worn?

Consultation with staff/personnel/professional organisations/unions

- ◆ Have members of the nursing team been included in discussion at an early stage?
- ◆ Do you have the support of the multiprofessional team? Are role expectations clear and realistic?
- ◆ Are your medical colleagues involved in discussions of roles and responsibilities? Their commitment is crucial.
- ◆ Do you have a shared focus on the needs of the child and family and the quality of care offered by the service?
- ◆ Is there agreement that development of nursing roles should remain in the hands of nurses?

Support structures

- ◆ Who will provide the support to nurses taking on role developments? How will you ensure they do not become isolated from the nursing team?
- ◆ Do you need to provide new structures or will current provision meet these needs?
- ◆ What support will nurses who are developing their role receive from (and give to) clinical colleagues?

5.2.4

What are the personal considerations?

Have the required personal resources been identified?

Support structures

- ◆ Who will act as your mentor? Is this the right person?
- ◆ Do you have clinical supervision in place? If not, who can help you arrange this?
- ◆ Is there a process for IPR established? How can you use this most effectively?
- ◆ Are expert practitioners available to offer you support?
- ◆ Will you have the support of your peers and colleagues?
- ◆ Do you have the support of the multiprofessional team?
- ◆ Is there a staff training and development unit available to you? How could they help?

Management support

- ◆ Does the role have nursing management support?
- ◆ Is there enough willingness, finance and time to invest in you as an individual?
- ◆ Do you have support through nursing leaders?

Have the educational resources been identified?

Structures to facilitate life long learning

- ◆ Do you have the support of an education facilitator?
- ◆ How can your peers, colleagues and other expert practitioners help you develop your knowledge and skills?
- ◆ Is there a sharing culture on your unit? How will you support and enhance this?
- ◆ Do you support and facilitate networking – internal and external – in your unit/organisation?
- ◆ Have you defined and agreed learning outcomes for the role?

Educational environment

- ◆ Do you have a ward-based education programme in place? Are there appropriate trust development programmes?
- ◆ Are you linked to an external institution? Are accredited courses, study days or diploma/degree/masters available?
- ◆ Who has the knowledge and skills (technical and nursing) to supervise your practice? Consider using staff from outside your unit or medical staff. Consider joint (shared) supervision.

What are the professional and personal development issues?

- ◆ What are your motives for wanting to undertake role development?
- ◆ What is your personal vision for nursing/paediatric oncology nursing?
- ◆ What is your philosophy of paediatric oncology nursing care?
- ◆ What are the benefits and risks – of success and failure?
- ◆ How do you describe your professional responsibility and accountability?
- ◆ How does this development fit in with your longer-term goals? What doors might it open (or close) for your future career?

5.2.5

Have issues of accountability, authority and responsibility been identified?

- ◆ How are the interests of the service users protected?
- ◆ Who holds ultimate clinical responsibility for patient care?
- ◆ Clarify the trust's position regarding risk management/vicarious liability and litigation procedures.
- ◆ Seek expert advice from nursing leaders, trade unions and professional bodies.
- ◆ Is there an operational policy that clearly documents the client group, professionals' responsibilities, activities, limitations to authority and so on?

6

Conclusion

5.2.6

What type of evaluation, audit and review is planned?

- ◆ Decide when, how and what to evaluate to give valid, unbiased and meaningful results that can guide future developments.
- ◆ What standards are you going to audit against?
- ◆ Consider what perspectives should be sought – viewpoints from the practitioners and service users, multiprofessional team impressions, service management issues, financial impact.
- ◆ Seek expert guidance.

5.2.7

How will work be disseminated?

- ◆ At ward/unit level – to colleagues, managers, multiprofessional team members?
- ◆ At directorate/trust level?
- ◆ To colleagues working with adults who have cancer?
- ◆ At national level – to RCN PONF and other bodies/organisations?
- ◆ Internationally?
- ◆ Consider reports, papers for publication, posters and oral presentations at conferences and meetings.

This is a time of change for nurses, other health care professionals and for the health service in which we all work. We must contend with this period of change by meeting the challenges that we face from within our speciality while also maintaining some degree of control and self-determination. Aspects of nursing roles need to be described and clarified so that we can move on to the important work of defining in detail the skills and competencies which will underpin career progression, educational programmes and the proper reward of clinical expertise.

There can be no doubt that nurses have a unique insight into patient/client care and the impact of models of care/service provision. We also understand how these needs are met through role development. We therefore need to involve junior as well as senior nurses, children/young people and their families in the debate about what is ideal, feasible, desirable and possible. This debate must also take place with other members of the multiprofessional team. They need to be consulted and to share in our vision. However, we must not allow ourselves to be distracted by only wanting to advance our profession. Meeting patient needs must be our guiding principle, with evidence-based policy lighting the way forward.

Our aim in RCN PONF has been to produce a framework that will enable nurses and organisations to act with confidence in devising and developing roles that are patient- and service-orientated. We believe that we have achieved this and that the framework described here provides practical guidance for developing practice in paediatric oncology nursing into the domain of medicine and potentially other disciplines.

7

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Appendix I

Recommendations and conclusions from the publication entitled *Developing roles of nurses in clinical child health*.

- 1 The prime consideration in developing professional roles in the child health services should be the quality of care offered to babies, children and adolescents and their families.
- 2 The need for detailed quantitative research into clinical performance should be given due recognition when allocating central and regional research and development funds.
- 3 As nurses take on new clinical responsibilities, it is important for them to receive professional recognition.
- 4 Multidisciplinary planning and collaboration are essential if new roles are to be efficiently integrated into clinical teams.
- 5 Where traditional nursing/medical boundaries are being crossed, there should be interdisciplinary discussions concerning lines of referral and accountability.
- 6 Clinical practice should be based upon clinical guidelines or protocols which have been agreed among the relevant professionals.
- 7 There is an urgent need to clarify the legal situation concerning prescribing and, if necessary, for new legislation.
- 8 Networking and dissemination of developments prevents needless waste of resources.
- 9 Education and training programmes must be developed to give due recognition to the clinical requirements of the service and the academic and professional requirements of students.
- 10 More opportunities should be available for nurses to expand their education to take first and higher degrees. This needs to be facilitated by developing part time or modular courses and to take into

account Accreditation of Prior Experiential Learning (APEL) and the Credit Accumulation and Transfer Scheme (CATS).

- 11 Managerial, professional and financial commitment is essential from the outset in role development.
- 12 Where appropriate, client groups should be included in professional role development.
- 13 In planning role development, quality outcome measures should be defined and, where possible, audit and evaluation of the relevant aspects of the service conducted before and after the introduction of service changes.

Royal College of Paediatrics and Child Health/Joint British Advisory Committee on Children's Nursing (1996)
Developing roles of nurses in clinical child health, London RCPCH.

Appendix II

Skill Acquisition (Benner 1984)

Novice

Any nurse enters a new clinical situation as a novice. Novice refers to beginners having had no experience in similar situations. The practitioner here uses rule-governed behaviour with heavy reliance upon theoretical principles and performing within limitations.

Advanced Beginner

One who demonstrates marginally acceptable performance and who has coped with enough real life situations to be able to transfer aspects such as global characteristics gained from previous experience.

Competent Practitioner

Typically, the nurse who has been on the same job in the same or similar situation for two or three years and develops when the individual begins to see...actions in terms of long range goals or plans for the competent nurse. A plan establishes a perspective and the plan is based on considerable conscious, abstract contemplation of the problem.

Proficient Practitioner

The practitioner perceives in wholes – that is, rather than needing to calculate consciously – and the plan will present itself within a specific context. The proficient nurse learns from experience what events to expect and how plans need to be modified.

Expert

The expert performer no longer relies on an analytic principle ... to connect ... understanding of the situation to an appropriate action. The expert has an intuitive grasp of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of unfruitful alternative diagnoses of situations.

Benner, P. (1984) *From novice to expert: excellence and power in clinical nursing practice*, Menlo Park, California: Addison-Wesley Publishing Company.

Appendix III

Characteristics that discriminate between expert and advanced levels of practice

Expert

- ◆ manages her/his own caseload
- ◆ carries out medical/technical procedures within the narrow band of the speciality (within a nursing context)
- ◆ uses expert decision making, applying skills and knowledge of the speciality and of paediatric nursing
- ◆ applies research, evaluates and develops own practice
- ◆ teaches/mentors less experienced staff in the clinical area
- ◆ is recognised as an expert in the multiprofessional team providing care
- ◆ recognises skills of “generalist expert” and refers to others as appropriate.

Advanced

Fulfils the above, and in addition:

- ◆ brings breadth to the depth/ thinks more globally, focusing on generalist and specialist, than the expert
- ◆ will be masters(clinical) prepared with extensive clinical experience
- ◆ identifies the need for and commissions research
- ◆ sees and takes opportunities related to practice development for client group
- ◆ is recognised in this role within the multidisciplinary team providing care across a broader field
- ◆ is a leader within the speciality.

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