Differences and similarities in scope of practice between registered nurses and nurse specialists in emergency care: an interview study

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Scand J Caring Sci; 2020; 34: 492–500

Differences and similarities in scope of practice between registered nurses and nurse specialists in emergency care: an interview study

Background: Wide variation exists between the nursing competence requirements seen in the emergency care context and the subsequent design of nursing education programmes. Clarifying nursing roles and scope of practice may shed light on inconsistencies and encourage nurses to work to their full potential.

Aim: Describe and clarify the overarching similarities and differences in registered nurses’ and nurse specialists’ scope of practice in emergency departments.

Methods: A qualitative study performed in Finland and Norway, based on 11 interviews analysed by means of qualitative content analysis.

Results: The results are presented in three main categories related to nurses’ scope of practice: The nurses share the same role, Competence varies and Same accountability and responsibility, with potential for development of the specialist role.

Discussion: Given the varying educational systems that currently exist, management teams face a more or less impossible task if attempting to standardise the scope of practice for different professional nurse groups. Still, nurse specialists possess competence that could be utilised to improve patient care and some specialisations seem more suitable for emergency care than others. Individual skills and qualifications should be recognised, which would enable nurses to work to their full potential.

Conclusion and implications: No differences were seen between registered nurses’ and nurse specialists’ role, and professional accountability and responsibilities in the context studied here, although the level of nursing competence differed. Before and even after consensus on uniform competence standards for the different professional nurse groups is reached, management teams should invest in reviewing nurses’ competence in relation to different expertise levels, and strategically recruit so that current health needs in the emergency departments can be met.

Keywords: competence, content analysis, emergency nursing, Finland, Norway, nurse, nurse specialist, interview study, role, scope of practice.

Submitted 8 August 2019, Accepted 12 August 2019

Introduction

Wide variation exists between the nursing competence requirements seen in the emergency care context, and in relation to the subsequent design of nursing education programmes (1). In Europe, it is ultimately the healthcare system stakeholders who determine the scope of practice for nurses working in emergency departments (EDs) (2). In the Nordic countries, hospitals and management teams typically employ registered nurses (RNs) alongside preregistration nursing students or postbasic nurse specialists (NSs). A diverse nursing skill mix can be beneficial, since some researchers maintain that a Bachelor’s level nursing education does not provide fully sufficient competence in emergency nursing (3,4). There is limited published research on the nursing competence required in the emergency care context, and the differences between RNs’ and NSs’ scope of practice remains under-researched (cf., (1)). A major barrier for fully utilising nursing
competence in emergency care is that nurses’ scope of practice in the setting is still undefined, because this also prevents nurses from fully implementing their knowledge and expertise in the setting (5). In the Nordic countries, interest in advanced practice nursing roles, for example nurse practitioners (NPs), is growing stronger (6,7). The current study is part of a larger research project entitled ‘Providing person-centered healthcare – Development of new models of advanced nursing practice in cooperation with patients, clinical field and higher education’, in which the education and implementation of the NP role in primary and emergency care in Norway are investigated. To facilitate the optimal use of different nursing competence levels and resources, one should investigate the currently existing nursing roles and associated scope of practice before implementing new roles (8). Nurses’ scope of practice is dynamic and should be responsive to changing health needs, knowledge development and technological advances, and periodic review is essential to its relevancy (9). Here, we describe and clarify the overarching similarities and differences between RNs’ and NSs’ scope of practice in the emergency care context.

Background

Standardised directives for nursing and midwifery education in the European Union (EU) were introduced in 2005 (10), in which the requirements for the training of nurses responsible for general care were delineated. Standardised EU directives for nurses whose training surpasses such entry-level education do not currently exist. Education requirements (e.g. programme length and academic level) and the work experience necessary for qualification differ considerably between EU countries, and various nursing titles are used (2,11). Three main professional nurse groups can, however, be discerned: RNs, NSs and advanced practice nurses (APNs).

Barton et al. (12) investigated the professional and occupational boundaries existing between different nursing roles and proposed a distinction between the concepts of ‘generalist’ and ‘specialist’ nurses (Figure 1). A generalist has ‘particular skills which are essentially transferable, allowing them to practice in a wide range of clinical settings’ (p. 58), while a specialist has studied beyond general training and focuses on a particular domain, thereby gaining quite distinctive skills in a particular area of practice (12). The International Council of Nurses (ICN) determined that NSs should possess skills beyond the generalist level and be authorised to practice as specialists with advanced expertise in a specific area of nursing practice (13). In the European Specialist Nurses Organisations’ (ESNO) common training framework, NSs should hold at least at Master’s level degree (14). Yet wide variation is still seen in the certification and regulation of NSs: in the length and level of educational programmes, professional working titles and scope of practice (2,11). In the emergency care context, practice standards for NSs in regard to education/diplomas or whether Master’s level studies are required do not currently exist (1). Therefore, RNs’ and NSs’ scope of practice in the emergency care context is of interest here.

As a concept, scope of practice can be considered a rather abstract construct, and it is poorly understood and inconsistently interpreted (15). According to the ICN (9), scope of practice communicates ‘the roles, competencies, professional accountabilities and responsibilities of the nurse’ (p. 16), while competency is ‘the effective application of a combination of knowledge, skill and judgement demonstrated by an individual in daily practice or job performance’ (p. 17). Competency relates to knowledge, understanding and judgement combined with a range of cognitive, technical or psychomotor and interpersonal skills, as well as a range of personal attributes and attitudes. According to the ICN (9), accountability refers to ‘the individual nurse being responsible and answerable for their own or others’ actions or inactions’ (p. 17) and relates to nurses’ legal liability and responsibility in daily practice, including that a nurse performs a role or function to an expected standard.

Aim

The aim of this study was to describe and clarify the overarching similarities and differences in registered nurses’ and nurse specialists’ scope of practice in emergency departments.

Methods

Design

This current study is a qualitative interview study including content analysis. Content analysis is recommended
when a condensed and broad description of a phenomenon is sought (16) and was therefore deemed appropriate here.

Settings
The study setting comprised of two EDs, one in Finland and one in Norway. The selected EDs provided twenty-four hour care for patients with medical, surgical or orthopaedic diseases or injuries (corresponding to level III trauma centres). The ED in Finland had approximately 53,000 annual patient visits and employed 53 nurses at the time of the study. The ED in Norway had approximately 28,200 annual patient visits and employed 55 nurses.

The nursing title ‘RN’ is protected in both Finland and Norway. RNs must hold a Bachelor’s level degree comprising 210 ECTS (European Credit Transfer System) in Finland (a 3.5-year programme) and 180 ECTS in Norway (a 3-year programme) (17). While there is a long history of NS practice and education in both Finland and Norway, training beyond entry level has never been nationally conceptualised, licensed or regulated in either country. No national definitions, guidelines or policies regarding the NS role exist (18,19) and access to specialist education in acute care varies. At the EDs that comprised this study’s setting, RNs worked alongside NSs with various specialisations, for example critical care, anaesthesia, psychiatry or public health. Only a few NSs were specialised in acute care.

Sample
Data collection commenced in January and was concluded in March 2017. The participants (n = 11) were selected through convenience sampling (20). Of the participants, four were RNs and four were NSs (two from Finland and Norway, respectively). To gain a broader understanding of the aim of the study and a leadership perspective, nurse leaders (NLs) were also included: two from Finland and one from Norway.

After the data collection dates were decided, the management teams for the participating EDs assisted with the recruitment of eligible RNs and NSs who would be working at the time of data collection. The participant inclusion criteria were a minimum of 2 years’ work experience in the current ED, varied work experience and proficiency in either the Norwegian or the Swedish languages. The research team directly contacted the eligible NLs. For an overview of participants, see Table 1.

Data collection
Semi-structured interviews were conducted with questions formulated to gain an understanding of the similarities and differences between RNs’ and NSs’ scope of practice. Scope of practice was exemplified to make the concept less abstract. The first question was about describing one’s/the nurses’ role at the unit, followed by questions about competence and rights and obligations, and similarities and differences between RNs and NSs scope of practice. The interviews were performed privately at the participants’ place of work and were recorded and transcribed. The interviews lasted between 10 and 47 minutes (mean length: 20 minutes).

Ethical consideration
Approval for this study was granted from the Ethics Committee. The research process was guided by the Declaration of Helsinki (21), and all participants gave their written informed consent.

Analysis
The interviews were analysed in two steps. In the first step, concept-driven coding of the transcribed material occurred. Concept-driven coding is a deductive strategy for building a coding frame using a preexisting source such as a theory, prior research or logic (22). Here, the ICN’s definition of scope of practice formed the basis for the concept-driven coding. The text was sorted into different domains, including the role, competence, and professional accountability and responsibilities. In the second step, the text under each domain was analysed separately using qualitative content analysis as described by Elo et al. (16). The analysis started with an open coding, where notes and headings (subcategories) were written in the interview text while it was repeatedly read. The subcategories were then organised and grouped under

Table 1 Participant descriptions

| Total | Registered nurses | Nurse specialists | Nurse leaders |
|-------|-------------------|-------------------|---------------|
| Professionals, n | 11 | 4 | 4 | 3 |
| Age of participants, mean (min-max) | 45.5 (29–61) | 35.0 (29–49) | 43.8 (37–52) | 57.7 (55–61) |
| Work experience at current ED in years, mean (min-max) | 10.2 (2.5–20) | 8.6 (2.5–17) | 8.5 (3.5–16) | 15.7 (10–20) |
higher order headings (generic categories) and later abstracted into main categories. For an overview of this process, see Table 2.

Rigour and trustworthiness

To achieve credibility, it is important to include participants who have experience of the phenomenon being studied (16,23). A minimum of 2 years' work experience at one's current unit was sought, and eight nurses (RNs and NSs) with varying work experience and education were selected. Variation and multiplicity are also stressed in content analysis (23), so the decision was made to include NLs as well. To enhance credibility, a brief description of the participants is included (Table 1). Together with the data collection, analysis and a description of the context, participant description also contributes to transferability (cf. (16)).

Dependability relates to interviews being co-created between the researcher and interviewee and which questions are asked (23). The interviews here were performed by two postdoctoral researchers (EB, RLM) with previous experience of research interviews. Both researchers piloted the interview questions by interviewing RNs, NSs and NLs in similar contexts. Some minor changes to the interview guide were made following this piloting, among others that scope of practice was exemplified.

Dependability can be strengthened by reporting how results are created (16,23) and including more than one researcher in the analysis process (23). The results here were described in the analysis and exemplified in the coding tree (Table 2). Several researchers were involved in the analysis, with EB holding primary responsibility and RL and the research project manager (LF) confirming the results; LF was included to contribute an outsider perspective. Participant quotations are included in the results to further enhance trustworthiness (cf. (16)). To protect confidentiality, the participants' profession (not country) and numbers were used to label the quotations.

Results

Three main categories related to nurses' scope of practice emerged from the analysis: The nurses share the same role, Competence varies, and Same accountability and responsibility, with potential for development of the specialist role. For an overview of the results, see Table 3.

The nurses share the same role

There are two generic categories included in this category, The nursing process determines the nursing role tasks and The nursing role stems from caring values.

The nursing process determines the nursing role tasks. The nursing process guided the RNs and NSs in their daily work. In regard to the nursing role, both RNs' and NSs' tasks included assessment, diagnostic reasoning, planning, implementation, evaluation and documentation. Based on patient histories and vital signs, the RNs and NSs admitted and assessed patients' conditions. They gathered information about the presenting problem, reflected on possible diagnoses from both medical and nursing perspectives, assessed urgency, drew up individual care plans, prioritised care allocation and sought to create conditions where treatment could be started and suffering eased as quickly as possible. This could include ordering tests (e.g. urine samples, electrocardiograms (ECG), standard blood samples) and/or assessing patients' treatment needs (e.g. fluids, pain treatment). Some treatment could also be initiated according to protocol.

During their assessment and/or treatment of patients, the RNs and NSs were also responsible for delivering care that was prescribed by physicians and/or physician assistants. They even continuously observed patients, repeatedly assessed and reported changes in patients' conditions, and documented the nursing process. One RN noted that:

My most important task here now is to... assess...ahh... patients' needs and assess how ill [the patient] is. How quickly does this patient need a physician? It is also important to see everything that is abnormal, is there something that I should... and to write down... belongs to important tasks. The whole patient is important as well and I should prioritise correctly and prioritise what is most important and do that first. (RN 3)

The nursing role stems from caring values. As seen above, the nursing role does not merely pertain to performing

| Table 2 Coding tree – example of how results were generated |
|------------------------------------------------------------|
| **Subcategories** | **Generic categories** | **Main category** |
| Assess patients' conditions | The nursing process determines the nursing role tasks | The nurses share the same role |
| Diagnostic reasoning | | |
| Plan care | | |
| Implementation of care | | |
| Evaluation | | |
| Make a confident first impression | The nursing role stems from caring values | |
| Listen to patients' stories | | |
| Dignity-conserving care | | |
| Advocacy | | |
| Follow laws, regulations and local protocols | | |
tasks but also includes seeing each patient as a ‘whole human being’ and safeguarding caring values. According to participants, the nursing role included making a confident first impression, which entailed spending time with patients and carefully listening to their stories. Following the nurse code, delivering dignified care and letting patients sense that they are being taken seriously was essential. Advocacy, for example taking into consideration whether it was safe to send a patient back home or seeking alternative solutions, was also necessary.

I can make decisions about whether this patient cannot manage at home. Because this belongs to our [area of] responsibility, that when you send a patient home...yes, the physician sends a patient home but maybe he does not know that [the patient] cannot walk. So then we as specialist nurses must take responsibility for the patient that we can safely send the patient home. (NS 4)

The nursing role even included following laws, regulations and local protocols.

### Competence varies

There are two generic categories included in this category, Professional competence between the two groups varies and Individual competence within the groups varies.

#### Professional competence between the two groups varies

The RNs, NSs and NLs all maintained that professional competence between RNs and NSs varies. NSs have deepened theoretical knowledge and more developed judgement and practical skills.

The biggest difference that I can see is that those who [have] specialist education have another professional ‘weight’ than the regular nurses have and it is seen through that they create a professional sense of security in the unit, those who are a little inexperienced [seek] those who have more competence, and I see in the execution that they are...they can more, have a deeper understanding and act more quickly. (NL 1)

According to the participants, when NSs started working in an ED they could, generally speaking, more rapidly than RNs begin to perform more advanced tasks. NSs also typically had the competence to work more autonomously and did not consult with physicians to the same extent as RNs. The NSs even often took on a supervising role in their area of expertise.

#### Individual competence within the groups varies

The participants noted that formal education alone does not determine a nurse’s competence, clinical experience is just as important. Education is not per se a guarantor of competence, it is instead an individual’s ability to apply theory into practice that results in competence. Competence can be developed through work experience and/or in-house training:

I think I rely a lot on that I have a very very long [work] experience, have seen a lot...I do not have the expert competence that some intensive care nurses perhaps have in certain things. (RN 2)

The competence that the participating NSs had varied, because they had different specialisations. The RNs, NSs and NLs here noted that NSs specialised in critical care were a very useful resource because they could, for example interpret arterial blood gas samples and electrocardiograms, and had extensive knowledge of technical equipment, including surveillance monitors. NSs specialised in critical care were also normally confident in acute situations, because they knew what to do and had developed advanced teamwork and communication skills. NSs specialised in acute care were perceived as having advanced skills in differentiating between patients in need of and those in less need of acute care. One NS specialised in psychiatry mentioned that:

I talk more about other things with the patients...— It is not merely to...concentrate on this knee, but [instead] talk about everything, everything possible — and you may capture many other things than if you only concentrate on [the knee]. (NS 2)

Still, there were NSs who did not fully utilise their competence. For example, NSs specialised in perioperative care were hindered by the low number of surgical interventions seen in the emergency care context and as such their scope of practice was limited.

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Table 3 Overview of the results

| Role | Competence | Professional accountability and responsibilities |
|------|------------|-----------------------------------------------|
| Main categories | The nurses share the same role | Competence varies | Same accountability and responsibility, with potential for development of the specialist role |
| Generic categories | The nursing process determines the nursing role tasks | Professional competence between the two groups varies | Same accountability and responsibility for both groups |
| | The nursing role stems from caring values | Individual competence within the groups varies | Potential exists for development of the specialist role |

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Same accountability and responsibility, with potential for development of the specialist role

There are two generic categories included in this category. Same accountability and responsibility for both groups, and Potential exists for development of the specialist role.

Same accountability and responsibility for both groups. The RNs, NSs and NLs all maintained that differences between RNs and NSs in regard to accountability and responsibilities did not exist. One NL stated that, in general, RNs and NSs today have more authority and broader responsibilities than previously:

We have as you know taken on a lot of so-called physician’s work over the years. (NL 3)

The same NL noted that physicians could influence what RNs and NSs did or did not do:

You see, we work in a team with the physician and the physician perhaps does not want you to…that they do certain things, or else they want that [nurses] should do more than what [nurses] have the authority to do. (NL 3)

Another NL mentioned there were RNs and NSs with deepened competence who could take on a broader scope of practice, but simultaneously noted that there were regulations and laws that limited RNs’ and NSs’ authority and responsibilities. A third NL stated that nursing schedules were not planned emanating from specialist competence but were instead based on RNs’ and NSs’ work experience:

When we draw up a schedule or plan work duties then it is clear that I place the most experienced nurses where I know the most competence is needed. (NL 1)

Potential exists for development of the specialist role. The RNs maintained that they utilised their full competence in their daily work. Two NLs also noted that the RNs and NSs, in general, work according to their competence. However, according to one NL:

It is just that, that we do not know what competence [they have]. That is to say, it is a little different depending on where you come from. (NL 3)

The discussion continued, with the participants referring to the various different educational systems and previous work experience seen in the ED.

The NSs, however, indicated that their competence was not fully utilised. One NS with a specialisation in critical care noted that when working in a context that differs from the context one has trained for, it is unrealistic to expect to be able to fully use one’s competence. One NS with a specialisation in psychiatry stated that her competence was not fully utilised:

Not in comparison with working at a psychiatric institution. There I have full use of techniques…and methods such as cognitive methods that are used.

Here this means nothing. But what drew me to psychiatry was that I love working with people and I benefit from that here. (NS 2)

Nonetheless, some RNs and NSs maintained that NSs could shoulder more accountability and responsibilities than RNs:

You see, I think that we are several with specialist training in the emergency department. Possibly one could have…little more responsibility…in relation to…now I do not know how to say this…than the new, ‘fresh’ nurses. But I have never entirely thought about…what I could have done to make matters better. (NS 1)

One NS described cooperation with junior physicians as an area of development:

I work with junior physicians who come directly from school who have a lot…lots of good knowledge, but hardly seen a patient. (NS 1)

This NS continued, noting that her years of work experience and NS education have contributed to her development and implementation of intuition in practice, an ability that novices of any profession lack. This ability to comprehensively understand a patient’s condition was a valuable skill, for example, when assessing the acuteness of a patient’s condition or when reaching a diagnosis. Still, the RNs, NSs and NLs mentioned that they occasionally experienced disdain. One NS related that she had experienced the sentiment, ‘I am a physician, you are a nurse. I do this better than you’. This NS consequently experienced that she was not able to work to her full potential. The NLs all maintained that RNs and NSs already have the competence to engage in a broader scope of practice but that current laws and regulations hinder such.

The RNs and NSs even noted that a shortage of time hindered them from providing the level of care they wished to provide. The nurses perceived that they needed to be very task oriented and were often unsatisfied at the end of their shifts in regard to the creation (or lack thereof) of caring relationships. They also experienced that they had insufficient time to provide information to patients and patients’ families, among other things about the progression of the care process or optimal home care advice, and were therefore not always able to meet their responsibilities. The optimisation of resources in relation to patients’ needs was emphasised.

Discussion

In this study, we focused on RNs’ and NSs’ scope of practice in emergency care in two Nordic countries. We found that RNs and NSs share the same role and the same accountability and responsibilities. The same legislation and regulations apply to both RNs and NSs, and specialist education does not formally afford NSs greater
rights or accountabilities. However, in practice NSs work more autonomously, take on more advanced tasks and have deepened theoretical knowledge, and they are also perceived as taking on a supervisory role in their area of expertise. Therefore, based on the ICN’s definition of scope of practice (9), we conclude that RNs and NSs share the same formal role and professional accountability and responsibilities but that a discrepancy in competence and role realisation exists.

We found that both professional and individual competence varied, which complicated the attempt to clarify differences between RNs’ and NSs’ scope of practice. This was further complicated by the fact that clinical competence is an ongoing process, rather than a state (24). The results confirmed that competence does not merely stem from formal education but can also be attained through, for example in-house training or work experience (also in e.g. (25)). This is in line with Benner, who showed that situational experience, not just formal education, is needed to develop nursing competence and allow the movement from novice to expert practice (26). Furthermore, the experienced participants in this study, the NSs in particular, perceived that their competence was not fully utilised. This is problematic from several perspectives. In addition to the monetary cost to society associated with educating individuals whose competence is not effectively used, increased nurse turnover rates are directly related to the perception that one’s competence is unacknowledged (1,27).

In the Nordic countries, a formal description of and legislated support for NS practice is lacking. We therefore emphasise the further development of nursing skill management, that is, ‘an organization’s ability to optimize the use of its workforce’ (p. 2) (28). To evaluate and acknowledge existing nursing competence, development systems and/or career ladder programmes may be useful. Effective and vital for both individuals and organisations, development systems allow for the evaluation of and monetary compensation for nursing professionalism (29). Career ladder systems can further enhance involvement in leadership activities (30), a core element in (specialist) nursing practice (13) not mentioned by the participants here. Generic instruments are in place for measuring competence, for example the Nurse Competence Scale and the Nurse Professional Competence Scale (31,32). We would recommend use of the Professional Nurse Self-Assessment Scale, as it can help establish nurses’ clinical competence at different educational levels across specialties (33).

Researchers have found that higher education is known to foster greater cognitive skills and is linked to improved patient outcomes (1,34,35). In well-renowned research on nursing education and skill mix (36,37), Aiken et al. found that higher proportions of RNs among nursing staff are associated with better patient outcomes. To the best of our knowledge, there is no similar research on RN–NS ratios in the emergency care context. This research is therefore justified, because a Bachelor’s level nursing education does not provide sufficient competence in emergency nursing (3,4). We also saw here that certain nurse specialties can be more well-suited to the emergency care setting (and thus beneficial) than others. Further and more in-depth investigation of which specialist competence areas and academic levels are most well-suited to the current and future needs in the emergency care context should be initiated in the Nordic countries.

We found that competence can be realised in different ways, which is in line with Benner, who found that situational experience, not just formal education, is needed to develop nursing competence and allow the movement from novice to expert practice (26). In an attempt to bring clarity to the differences between nursing roles from a theoretical perspective, when explaining the practice continuum, Barton added a novice–expert dimension alongside a generalist–specialist dimension (12) (Figure 1). Regarding RNs’ and NSs’ nursing role and competencies in relation to the novice–expert and generalist–specialist dimensions, RNs are considered to have generalist competence that varies along the novice–expert continuum. While NSs’ competence also varies along the novice–expert continuum, NSs are nonetheless considered to have specialist competence. Advanced practice nursing roles can be considered discriminatory, because APNs are considered to have advanced past novice on the novice–expert continuum (38). Therefore, one way to differentiate between RNs, NSs, and even NPs in the emergency care context could be the charting of competence on Barton’s novice–expert generalist–specialist continuum.

Study limitations

The RN and NS participants were selected by management team representatives, which can be seen as a limitation. It is possible that some were chosen because they had similar views to their management team, yet this cannot be confirmed as they appeared to speak freely and even critiqued their organizations’ leadership. Also, the limited number of RN, NS and NL participants, especially per country, can be seen as a limitation. Still, there is no set directive for sample size and data saturation during analysis was sensed (cf. (23)).

The appropriateness of using a qualitative design for a comparative study, in which the similarities and differences between RNs and NSs were investigated, can also be questioned. However, Morse (39) concluded that, ‘[A]ll description requires comparison’ (p. 1323). While quantitative designs might have strengthened our results, we sought to gather descriptions of RNs’ and NSs’ scope of practice in emergency care, and as such the design is considered appropriate.
Conclusion and policy implications

No differences were seen in the actual study between RNs’ and NSs’ formal role and professional accountability and responsibilities, although their level of nursing competence differed. RNs as well as NSs can achieve expert competence, but the path to such competence may differ. NSs’ education includes specialist competence in a specific area of practice and provides NSs with a foundation upon which to take on an expanded role that includes supervising colleagues and supporting professional development in their field of expertise, and which also provides NSs with a particular set of skills suitable for specific scenarios in the emergency care context. Nonetheless, NSs are not formally expected to take on a distinct expanded role. We emphasise that focus should be placed on skill management, that is, the adaptation of workers’ competence. This will be of benefit in the emergency care context, where a mix of nurses with different specialisations and different educational levels are seen. Management teams should invest in human resource management and more systematically review the competence inherent in the various professional nursing groups (RNs, NSs and NPs) in relation to the health needs of patients presenting in the emergency departments. If the clinical field is to be supported, uniform standards for nursing competence should be created for the different groups, including national recommendations for expanded scope of practice.

Conflict of interest

The authors declare that there is no conflict of interest.

Author contributions

The contribution by each author was: EB, RLM and LF designed the study, prepared the manuscript and contributed to intellectual content and revision. EB and RLM performed data collection. EB and LF performed data analysis.

Ethical approval

The study was approved by the Norwegian Centre for Research Data (Ref. no. 50160) (Norway) and Vaasa Central Hospital (Ref. no. 42/2016) (Finland). Data collection was also approved by the management teams in the emergency department in Norway and Finland, respectively.

Funding

Funding for the ‘Providing person-centered healthcare – Development of new models of advanced nursing practice in cooperation with patients, clinical field and education’ project has been provided by the Norwegian Research Council PraksisVel.

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