



Australian Nursing Council

REPORT TO AUSTRALIAN NURSING COUNCIL

Nurse Practitioner Standards Project

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All information in this report is current at 10 May 2004.

Glossary

advanced practice	<p>From RCNA position statement on Advanced Nursing Practice</p> <p>Advanced practice nursing defines a level of nursing practice that utilises extended and expanded skills, experience and knowledge in assessment, planning, implementation, diagnosis and evaluation of the care required. Nurses practising at this level are educationally prepared at postgraduate level and may work in a specialist or generalist capacity. However, the basis of advanced practice is the high degree of knowledge, skill and experience that is applied within the nurse-patient/client relationship to achieve optimal outcomes through critical analysis, problem solving and accurate decision making.</p> <p>Advanced practice nursing forms the basis for the role of nurse practitioner. The nurse practitioner role is an expanded form of advanced practice nursing which is specifically regulated by legislation and by professional regulation. Legislation may allow prescribing and referral, in addition to admitting privileges to health care facilities.</p>
authorisation	<p>The process through which the nursing regulatory authority sanctions the practice of nurse practitioners within their jurisdiction. The authorisation process invests legal authority and responsibilities on the person so authorised.</p> <p>Once an applicant is authorised, he or she will be registered, that is, have his or her details entered on a written record, and the nurse regulatory authority will endorse, that is, openly approve, of his or her practice as a nurse practitioner.</p>
autonomy	<p>Having a sense of one's own identity and an ability to act independently and to exert control over one's environment, including a sense of task mastery, internal locus of control, and self-efficacy.</p>
client	<p>A person or persons who engage(s) or is/are served by the professional advice or services of another. May refer to an individual, family or community. Use acknowledges that a significant part of nursing's services are delivered to people who are well and proactively engaging in health care, however in this study, 'client' and 'patient' are used synonymously to acknowledge that the same services may be used for both clients and patients.</p> <p>NB. We have used 'patient' and 'client' synonymously in the report to acknowledge that the same services may, at times, be delivered for both clients and patients.</p>
course	<p>A discrete unit of study that, when combined with other courses, comprises a program. In New Zealand the nomenclature for course is paper.</p>

extended practice Defines the level of nursing that draws upon advanced nursing practice knowledge and skill in conjunction with legislative provisions that enable the nurse to deliver a health service that encompasses a complete episode of care to clients/patients. This nursing care is autonomous and collaborative and determined by the health-service needs of clients in specific populations.

jurisdiction The limits within which a power or control can be exercised. Jurisdictions is used in this report to identify New Zealand and the five Australian states and territories in which nurse practitioners can be authorised, that is, the Australian Capital Territory (ACT), New South Wales, South Australia, Victoria and Western Australia. The Northern Territory, Queensland and Tasmania are collectively identified as the ‘non-authorising jurisdictions’.

NP Nurse practitioner.

nurse regulatory authority The legally constituted body in each jurisdiction charged with the regulation of nursing professional practice. The primary role of the nurse regulatory authorities is to protect the public through ensuring nurses demonstrate an acceptable standard of practice.

patient See ‘client’. Use acknowledges that nursing provides some of its services to people who are sick and, in the true Latin meaning, are ‘suffering’. We have used ‘patient’ and ‘client’ synonymously in the report to acknowledge that the same services may, at times, be delivered for both clients and patients.

program A collection of courses/papers/units of study that lead to an academic qualification.

paper See course.

Executive summary

The nature of the nurse practitioner role in New Zealand and Australia is embryonic; current nurse practitioners are practising in environments that are not entirely prepared for them and, in some sectors, politically resistant. Nurse practitioners working in Australia and New Zealand are pioneers, forging pathways towards improved services and expanding interpretations of the role and its potential. There is value in capturing this point in history as a basis for future development and evaluation of the role of the nurse practitioner and standards for nurse practitioner practice. This research project has embraced this challenge and provided an opportunity for both countries to learn from the long journey in North America, to avoid the ad hoc development of the United Kingdom, and to create a nurse practitioner role that meets health needs in Australia and New Zealand and builds constructively on research evidence.

This Nurse Practitioner Standards project has been sponsored by the Australian Nursing Council and the New Zealand Nursing Council. The aims of the project have been to conduct research that will inform:

- a description of the core role of the nurse practitioner
- core competency standards for the nurse practitioner in Australia and New Zealand
- standards for education and program accreditation for nurse practitioner preparation leading to registration/authorisation.

The study drew upon a range of data to address the research outcomes. The primary source of data was in-depth interviews, including a report of a nurse practitioner case study, with authorised nurse practitioners practising in Australia and New Zealand. Additional data were derived from nurse practitioner education programs from New Zealand and Australian universities and tertiary education providers, and interviews with academics from these programs. In addition, an extensive literature review relating to nurse practitioner authorisation, legislation and roles was collected and collated. Data were analysed according to the requirements of each data set and triangulated to produce findings that addressed the research aims.

One of the research aims was to describe the core role of the nurse practitioner. In summary the research findings are that the core role of the nurse practitioner is distinguished by autonomous extended practice. The practice is dynamic in that it requires the application of high-level clinical knowledge and skills in both stable and unpredictable as well as complex situations. The role is characterised by professional efficacy and has a therapeutic potential enhanced by autonomy and legislated privileges. Practice in this role is sustained by a commitment to lifelong learning and fidelity to the primacy of a nursing model of practice. The nurse practitioner is a clinical leader with a readiness and an obligation to advocate for their client base and their profession at the systems level of health care.

A further outcome of the research was the development of Nurse Practitioner Standards for practice and education. The findings determined that, in addition to a competency framework, Nurse Practitioner Standards needed to be informed by a method of practice that

incorporates attributes related to creativity, dealing with complexity and using competencies in novel and unpredictable environments. We have argued that a useful model to achieve this orientation is that related to the notion of capability (Stephenson and Weil 1992; Hase and Kenyon 2000).

The logical and critical link between competency and capability as benchmarks for nurse practitioner practice is the methodology used in education and evaluation of the nurse practitioner candidate. Capability therefore orients nurse practitioner competencies towards contextualised experiential learning and scenario-based evaluation. Hence this study produced both the competency standards for nurse practitioner practice and the educational requirements to meet the capability skill base for the nurse practitioner to practise in complex, changing and evidence-dependent practice environments. Accordingly, the findings will be a valuable resource for:

- nursing boards and councils to progress nurse practitioner authorisation processes
- health care providers to design and develop nurse practitioner models specific to local health service needs
- nurse clinicians for planning career pathways and postgraduate educational directions
- universities for design and implementation of nurse practitioner education programs that meet accreditation requirements
- specialty colleges and associations in developing specialist nurse practitioner competency standards.

Recommendations are made to support the coherent ongoing development of the role between New Zealand and Australia and an evaluation process is proposed to track the outcomes of continued nurse practitioner development and the impact of implementing the recommendations. Accordingly, we make the following recommendations for nurse practitioner practice across Australia and New Zealand. The recommendations are derived from the research findings and set out in compliance with the outcomes of the project.

RECOMMENDATIONS

1 Description of the core role of the nurse practitioner in Australia and New Zealand.

It is recommended that:

- 1.1 The following definition be adopted as the standard definition for Australia and New Zealand:

A nurse practitioner (NP) is a registered nurse educated to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications, and ordering diagnostic investigations. The nurse practitioner role is grounded in the nursing profession's values, knowledge, theories and practice and provides innovative and flexible health care delivery that complements other health care providers. The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practise.

- 1.2 The title 'nurse practitioner' be legally protected in all jurisdictions.
- 1.3 Best practice for nurse practitioners be established against the benchmark of existing National Multidisciplinary Clinical Guidelines relevant to their field of practice.
- 1.4 It is further recommended that the parameters of practice for the nurse practitioner be structured around the specialty field of practice and determined by local community needs and professional standards.

2 A set of core competency standards for the nurse practitioner in Australia and New Zealand.

It is recommended that:

- 2.1 The Nurse Practitioner Competency Framework developed from this research be accepted as the Competency Standards for nurse practitioner practice and education in all jurisdictions across Australia and New Zealand.
- 2.2 The Strategies for Evaluation of the Nurse Practitioner candidate developed from this research be adopted by educational institutions and nurse authorising bodies for evaluation and assessment of nurse practitioner candidates and applicants.

3 A set of education and course accreditation standards for the nurse practitioner in Australia and New Zealand.

It is recommended that:

- 3.1 The minimum award level for an accredited program for nurse practitioner education be a master's degree.

- 3.2 The Nurse Practitioner Education and Program Accreditation Standards presented in Table 3.1. be used by nurse authorising bodies to accredit master degree programs that lead to qualification and recognition of the nurse practitioner by the accrediting bodies.
- 3.3 The curriculum structure give primacy to the clinical field with mentored experiential processes being central to nurse practitioner education.
- 3.4 Accredited courses contain summative assessment sufficient to meet the regulation bodies' clinical and academic requirements through a comprehensive portfolio of learning and practice experiences.
- 3.5 Endorsement from specialist colleges and associations for specialty electives/ streams of the nurse practitioner curriculum be included in a program planning process.

4 A strategy and tools for evaluation and review of the role and standards.

It is recommended that:

- 4.1 There be a formal process for dissemination, feedback and monitoring of implementation of recommendations.
- 4.2 A trans-Tasman minimum data set for nurse practitioner practice be established.
- 4.3 The methodology for evaluation of the core role, education and authorisation recommendations accommodate the reality that implementation of this report may be gradual, with asymmetrical speed of uptake across jurisdictions.
- 4.4 Mixed methods be used for the evaluation research including:
 - prospective population-based epidemiological data collection using a minimum data set comprising information such as adverse events, costs and occasions of services
 - case study methods that include interview and focus group data collection to capture rich patient outcome data, interdisciplinary team work and nurse practitioner scope of practice
 - population surveys of all registered nurse practitioners, authorisation bodies and university nurse practitioner courses in two years from release of report.

section **1** Background

Throughout Australia and New Zealand, the professional practice of nurses is regulated in order to 'protect the public from unsafe, incompetent or unethical practice'. In Australia, responsibility for nurse regulation resides with the nursing regulatory authority in each state or territory. These authorities are invested with the legislative authority 'to exercise the powers, authorities, duties and functions' prescribed by the relevant state legislation in relation to nursing practice. Such activities commonly include maintaining a nurses' register, monitoring educational programs that prepare students for nursing registration or enrolment, monitoring nurses' professional conduct and undertaking disciplinary action as required, and advising the Minister on matters related to nursing practice. Across Australian states and territories there are over 30 separate Acts related to the regulation of nursing practice, for example, Nurses Acts, Controlled Substances Acts, Mental Health Acts and Public Health Acts. Until the establishment of the Australian Nursing Council (ANC) in 1992, there was no peak national organisation through which the Australian states and territories could formally negotiate consistent national standards for the regulation of nursing practice.

In New Zealand there is a single nursing regulatory authority, the Nursing Council of New Zealand, with responsibility for national regulation of nursing practice. As with the Australian nursing regulatory authorities, the primary purpose of the Council is public safety, which is protected through establishing and maintaining professional standards of practice. The powers and duties of the Nursing Council (NZ) are similar to those of the Australian state and territory nursing regulatory authorities, but at a national level. Functioning of the Nursing Council (NZ) and national nursing policy development in New Zealand is facilitated by a cohesive national approach to nursing regulation.

In Australia and New Zealand the nurse practitioner is a new and unique level of health care provider. Development of the nurse practitioner role has been driven in part by the health care reform agenda. As described by the ANC and Nursing Council (NZ), the shifting boundaries caused by health care reform have created impetus for development of new models of health care, but have also created some uncertainty regarding the boundaries, models of care and rights and responsibilities of nurse practitioners. The title, nurse practitioner, is now legislated in most Australian states and in New Zealand with its role benefiting from significant and progressive development over a relatively short period of time. However the role is evolving in both countries.

The *Trans Tasman Mutual Recognition Act 1977* requires that registration in New Zealand and Australia be mutually recognisable. In February 2002 the ANC and Nursing Council (NZ) formally committed to collaborative development of the nurse practitioner role under a Memorandum of Cooperation.

To facilitate this collaborative development, they tendered for research to provide:

- a comprehensive report on the development and progress of the role of nurse practitioners in Australia and New Zealand
- an agreed description of the core role of nurse practitioners in Australia and New Zealand

- an approved set of core competency standards for nurse practitioners to be applied in Australia and New Zealand
- approved national/trans-Tasman standards for education that can be applied in the accreditation of courses leading to a qualification for recognised nurse practitioners
- a strategy and tools for evaluation and review of the role and standards.

This research was commissioned jointly by the two organisations, with the call for expressions of interest released in September 2003. The successful research team was notified their tender had been accepted in November 2003. The team met with the project management committee, consisting of representatives from the ANC (See Appendix 1 for PMC membership, Appendix 2 for Expert Reference Group membership and Appendix 3 for Project Terms of Reference).

Tender requirements and deliverables were discussed and it was agreed that extensive consultation with consumers could not be achieved in the timeframe. In addition, many of the nurse practitioners had been authorised for relatively short periods of time and/or had not yet received the authority to practice in the full scope of the nurse practitioner role e.g. not prescribing, thus limiting the experience clients would have with nurse practitioner practice.

This research is only the beginning. Shared evidence-based authorisation and education criteria for Australian and New Zealand nurse practitioners will provide a strong and credible foundation for further development of the nurse practitioner role in both countries. Workforce flexibility will be facilitated by trans-Tasman recognition of common authorisation and education criteria. Employers, nurses and other health care professionals, and the public can be confident that nurse practitioners are providing a high-quality standard of care. Finally, this international research establishes a collaborative research model for professional regulatory authorities around the world.

Introduction

Implementation of the nurse practitioner role has required substantial amendment of health care Acts and regulations in both New Zealand and Australia. These Acts and regulations are set down by parliament and provide the broad legal framework within which the Nurse practitioner may practice. As noted in Section 1, health care responsibility in Australia is divided between Commonwealth and states or territories governments, thus health care professionals including nurse practitioners are subject to national legislation in both New Zealand and Australia, and further subject to state or territory legislation in Australia. National legislation most relevant to nurse practitioners includes the funding of health care (eg Medicare and the Pharmaceutical Benefits Scheme), and professional indemnity insurance.

This chapter is based on an extensive critique of published literature relating to nurse practitioner role and standards. A description of the electronic search processes is included in this introduction. The body of the chapter begins with a brief summary of the development of nurse practitioner roles worldwide and then considers the Australian and New Zealand literature more specifically. The concept of advanced practice nursing and its relationship to nurse practitioner practice is explored. The debate surrounding competency is briefly summarised. Finally, educational issues are summarised.

Many hundreds of papers have been published in health care journals on the topic of nurse practitioners and a key difficulty is developing some sense of order for the myriad references. Accessible summaries of the literature, addressing different perspectives, already exist but the research team considered it important to undertake a specific review of the very recent literature for the purposes of this project. We agreed upon search terms and strategy and an electronic search was undertaken. Table 1.1 provides the keywords used for the search. CINAHL, Medline, PubMed and HighRisk were the electronic data bases explored. No hand search was undertaken as nurse practitioner literature was distributed extremely widely in the nursing and related health literature. The reference lists of papers were scanned manually to find other literature not identified in the electronic search. The main search was limited to the past five years of publication (Jan 1999–Dec 2003 inclusive). Papers were categorised according to the type of literature using a set of categories adapted from the ENRiP study (see Table 1.2) (Read and Nolan 2002).

Table 1.1: Search strategy used to identify published literature

1	exp Nurse Practitioners
2	*Advanced Practice Nurses
3	1 or 2
4	exp SCOPE OF PRACTICE
5	*Nursing Role
6	4 or 5
7	3 and 6
8	limit 7 to English
9	limit 8 to yr=1999-2003

Table 1.2: Categorisation of published literature

Category	Descriptor of category
Original research	Material reporting research
Meta-analysis	Material reporting systematic reviews of literature
Experiential account	First hand experience of roles and roles/job descriptions
Polemic/anecdotal	Articles commenting on/giving opinions about the role and issues relating to it
Theoretical	Critical analysis and theoretical examination of roles

Most papers identified in the literature search comprised editorials, commentaries (that is, the polemic/anecdotal category) or were experiential descriptions. In the past five years, only 10 research papers published about Australian (nine) and New Zealand (one) nurse practitioners were identified. The apparent absence of published research in New Zealand was confirmed by the New Zealand member of the team. Several polemic and experiential papers included descriptions of or referred to findings from Australian trials but these papers did not include rigorous descriptions of trial methods or provide a critique of research data. Research and theoretical papers were searched to identify the nurse practitioner role as described in the literature and particularly where reference was made to standards or competencies. Where papers referred to specific nurse practitioner models, only the generic themes or broadly applicable findings were included.

Development and progress of the role

Overview of nurse practitioner development worldwide

Nurse practitioners have had a presence in health care delivery in some countries since the 1960s, more recently emerging in New Zealand and Australia. There is considerable international literature to support the introduction of a nurse practitioner level of service with studies demonstrating that the nurse practitioner delivers health care that is valued by the patient (Kinnersley, Anderson et al. 2000; Venning, Durie et al. 2000); and has a positive effect on patient outcomes (Brown and Grimes 1995; Sakr, Angus et al. 1999). A systematic review of nurse practitioner service in primary care demonstrated that nurse practitioners provide care equivalent to doctors at first point of contact with patients (Horrocks, Anderson et al. 2002). Furthermore, the review indicated that patients were more satisfied with care by a nurse practitioner and that the care was of a high quality. It also appeared that better use of nurse practitioners could improve primary health care access (Donald and McCurdy 2002).

As we shall see, despite these positive findings, the development of nurse practitioner services around the world has been dogged by inconsistency in terms of role definition, level of legislative control and funding issues. Pearson argues:

The role of the Nurse Practitioner is...ambiguous and the significant differences between how various countries define and operationalise the nurse practitioner has led to a great deal of confusion
(Pearson and Peels 2002, p55)

This review of the international literature is, for the most part, limited to the United States of America, Canada and the United Kingdom. Australian and New Zealand initiatives were influenced by developments in these countries. In addition, three Australian states conducted research to inform implementation of nurse practitioners in their jurisdictions. It must also be remembered that the title of nurse practitioner is not protected by legislation in the United Kingdom and the implications of this important difference will be discussed below.

International trends

The nurse practitioner role originated in the United States during the 1960s to assist in improving primary health care to under-served communities. It was preceded in the 1950s by the development of the physician's assistant role and there was, and still is, a perception that the two roles have some common characteristics (Fowkes, Gamel et al. 1994). The original impetus for these developments was the shortage of primary health care physicians (Dunn 1997). It soon became evident that nurse practitioners had the potential to provide safe, effective and accessible health care for communities with previously limited access to comprehensive health facilities (Brown and Grimes 1995).

The nurse practitioner role was quickly adopted throughout the United States, with university-based educational programs developing rapidly (Walsh 2001). Opportunities for nurse practitioners expanded and now, as well as the original primary health care delivery focus,

they include the vast majority of acute-care settings, such as inpatient specialty areas and emergency departments in major centres (Sherwood, Brown et al. 1997; Sakr, Angus et al. 1999). Arguably, these acute-care settings had previously been the domain of the clinical nurse specialist, a role not separately licensed. Nurse practitioners are licensed in each American state rather than nationally, resulting in considerable variation in educational requirements, role limitations, and levels of autonomy and authority (International Council of Nurses 2000; Pearson and Peels 2002). These disparities have led to debate about the nature of advanced practice roles and prompted consideration of a merger of clinical nurse specialist (CNS) and nurse practitioner roles in the United States. Mick and Ackerman (2002) argue that, although the two roles share similarities, these advanced practice pursuits are more different than alike, both philosophically and practically. As early as 1989 there was a call for merging the roles because research, consultation and education were incorporated into both roles. However, others argued that a fundamental difference between the two roles was that nurse practitioners were responsible for diagnosing and managing whereas the CNS provided care for patients with already identified health problems. At that time the proposal was not taken up but the debate continued with role delineation research providing conflicting results (Mick and Ackerman 2002). Nonetheless, it does appear that a consistent difference in the American context continued to be the finding that nurse practitioners provided more direct comprehensive patient care than the CNS (Dunn 1997). Indeed, Mick and Ackerman propose that much of the impetus for merger of the roles derives from economic not clinical reasons. This debate continues to swing back and forwards with the current trend towards differentiation again. Thus, it can be seen that, even in a country with a long tradition of nurse practitioner services integral to health care delivery, there is variation in educational preparation and the exact definition of nurse practitioner scope of practice. We will consider the advanced practice question more fully below.

In Canada, nursing and medical organisations were initially supportive of the nurse practitioner role in an era of physician shortage during the late 1960s (CNA 1993). Early evaluation studies were encouraging, again demonstrating that nurse practitioners were safe, provided cost-effective care, and achieved high levels of client satisfaction (Spitzer 1978). However, the lack of continued support by professional bodies and the existence of a physician surplus (contrary to earlier predictions) resulted in a failure to promote the policy and legislative changes required to fully implement the nurse practitioner role (CNA 1993; de Leon-Demare, Chalmers et al. 1999). During the late eighties, the nurse practitioner role re-emerged as an important contributor in the provision of health care services in Canada. This renewed growth was in response to a further perceived shortage of rural and remote area primary-care physicians, health care reforms (Bajnok and Wright 1993; de Leon-Demare, Chalmers et al. 1999), and increasing emphasis on preventative primary health care (CNA 1993) but there was still only very moderate implementation of the role. Most recently, there is another wave of interest in nurse practitioner level of service both in acute and rural areas (Moulton 2000; Cummings, Fraser et al. 2003; Donnelly 2003).

Similar factors to those evident in the United States and Canada paved the way for the implementation of nurse practitioners in the United Kingdom in the 1980s. These factors included a shortage of doctors and the need to reduce junior doctors' hours (Harris and Redshaw 1998), cost containment in health service provision, the development of a more skilled nursing workforce and the need to provide improved access to health care services

(Horrocks, Anderson et al. 2002). Following the nurse practitioners' success in delivering valuable, accessible health care in primary health care settings, the potential for nurse practitioners to work in acute-care settings was soon realised, and an increasing demand for their services followed.

However, several issues have hindered the development of nurse practitioners in the United Kingdom. As in the United States, there is the lack of consensus on the definition of the nurse practitioner role (Barton, Thome et al. 1999; Reveley 2001) again with a perceived overlap in nurse practitioner and CNS roles (Roberts-Davis and Read 2001). Some believe the two roles are conceptually and fundamentally different and thus should be recognised as two distinct entities (Reveley 2001). Further complicating the debate is the fact that the nurse practitioner title is not legally recognised or protected by the United Kingdom Nursing and Midwifery Council (Le Bon 2000). Also, there are no definitive educational requirements for nurse practitioners in the United Kingdom (Crumbie 2001; Mulholland 2001b), and there is a concern that nurse practitioners in the United Kingdom are moving towards a biomedical model, with their main focus being on the technical and medical aspects of patient care (Barton, Thome et al. 1999; Walsh 1999).

Internationally then, although the role of nurse practitioner is well established in countries with very different health care systems, there are similarities in the controversial issues surrounding nurse practitioner education and role definition. How does this compare to the situation in Australia and New Zealand?

Australia and New Zealand

The *Trans Tasman Mutual Recognition Act 1997* requires that registration in New Zealand and Australia be mutually recognisable. The health systems of the two countries are very different, with New Zealand having a predominantly centralised national health system and Australia having a mixed system with both public and private services closely entwined. The Australian health scheme is made much more complicated by a system of shared responsibilities between Commonwealth and state and territory.

In both Australia and New Zealand, there have been recognised advanced nursing practice roles for decades, prior to formal exploration of the potential for nurse practitioner role in either country. Table 1.4 (following this section on page 35) summarises the milestones in the two countries since 1992. It extends the original work conducted as part of the National Review of Nursing Education and provides an overview of the development and progress of the nurse practitioner role from 1996 to the present. It also incorporates the experience of New Zealand in developing and implementing the role of the nurse practitioner. However, this report would be incomplete without a brief critique of the events in these jurisdictions including the earlier contexts where appropriate. New Zealand developments will be considered first.

In 1998, a ministerial taskforce on nursing gave support to the development of the nurse practitioner role in New Zealand and recommended that the Minister for Health instruct the Nursing Council to formalise and validate specific competencies linked to the title of nurse practitioner (Ministerial Taskforce on Nursing 1998). A joint statement was released

by the Ministry of Health and the Nursing Council of New Zealand, announcing the new nursing qualification of nurse practitioner (Ministry of Health 2001). The framework for the nurse practitioner role is incorporated in a policy document that outlines the regulation of nurse practitioners, including competencies, educational requirements and processes for assessment by the council (Nursing Council of New Zealand 2001). The centralised nature of New Zealand health care service organisation has resulted in a uniform process for education and authorisation and, in December 2001, a neonatal nurse from Waikato Hospital became New Zealand's first nurse practitioner (Nursing Council of New Zealand Sept 2002). Currently, there are 10 authorised nurse practitioners in New Zealand with many more in developmental positions. There is a move to develop clear clinical pathways with the nurse practitioner as the recognised senior clinical position.

Despite this gradual development, there is no published research directly investigating nurse practitioner roles in New Zealand although there has been a survey of general practitioners' perceptions of nurse practitioner delivery of primary health care (Mackay 2003). The overall perception was favourable but there was concern over some role functions, not surprisingly the areas of concern being with those roles perceived to overlap with GP responsibilities. Then again, the findings of this exploratory study were not based on any experience of GPs with a nurse practitioner level of service because, at the time that the study was conducted, there was only one registered primary health nurse practitioner in New Zealand and this nurse was not practising in the area of the study.

In Australia, the concept of expanded roles for nurses as nurse practitioners has been debated for over a decade (Offredy 2000a). The debate has been informed by overseas experiences and also takes account of Australia's unique health care features. Such features include the geographical isolation and inequitable distribution of health services in rural and remote areas compared to cities, difficulties recruiting and retaining doctors in rural and remote areas (Hegney 1997), and Australia's much publicised poor record in the provision of health services to its Indigenous population, the Aboriginal and Torres Strait Islander communities (Hand 2001).

Nurses in many rural and remote areas of Australia have reportedly been practising within an expanded role similar to that of a nurse practitioner, but without legal sanction and formal recognition (Hegney 1997; Offredy 2000a). Presumably, this has occurred because they are often the sole health practitioner servicing these areas. The formalisation of the nurse practitioner role was therefore viewed as important for these nurses (Hegney 1997). Five states and territories have now undertaken formal projects to explore nurse practitioner practice with most work taking place in New South Wales.

New South Wales

In 1990, New South Wales established a project, initiated by the then Minister of Health, to investigate the nurse practitioner role. The project was conducted in three stages, with the first stage examining the role and function of the nurse practitioner in New South Wales (NSW Health Department 1992). In 1992, a multidisciplinary working party was formed by the New South Wales Health Department to review the stage one report and formulate some recommendations (stage two) (NSW Health Department 1993). Ten local pilot projects (stage

three) were subsequently established to explore the nurse practitioner role, specifically looking at the issues of cost, safety, feasibility, quality and effectiveness (NSW Health Department 1995). The working party recommended a range of practice contexts for the pilot projects, with the final selection including remote areas, general practice, and area and district health services. Upon completion of the pilot projects, the stage-three final report recommendations culminated in legislative changes to several Acts in 1998, including the *Poisons and Therapeutic Goods Act 1966*, the *New South Wales Nurses Act 1991*, and the *Pharmacy Act 1964* (Offredy 2000a). The nurse practitioner title was guaranteed protection following announcement of the *New South Wales Nurses Amendment (Nurse Practitioner) Act 1998*. This ensured that nurses required authorisation by the Nurses Registration Board of New South Wales (NRBNSW) before using the title of nurse practitioner. Re-authorisation is required every three years (Nurses Registration Board of New South Wales 2000; Reid 2001).

One of the provisions recommended by the stage three report was that a nurse practitioner position should be created only if a locally agreed need is first established by a local interdisciplinary group of stakeholders (Chiarella 1998). Currently, once this need has been established, a set of clinical guidelines is compiled and endorsed by the local multidisciplinary team. The guidelines determine the boundaries of practice for the nurse practitioner position including a limited prescription formulary, diagnostic investigations and medical referral procedures. The health department then reviews the proposal and gives approval (Reid 2001). Thus in New South Wales, the authorisation process is entirely separate from the approval of nurse practitioner positions.

The progress of nurse practitioner implementation in New South Wales has met with some resistance. Certain sectors of the medical profession initially had some concerns regarding the concept of nurse practitioners as independent roles (Chiarella 1998; Tattam 1998; Siegloff Clark 2000). These initial concerns were particularly related to nurses being given the power to diagnose and prescribe (Tattam 1998). While many in the medical profession have since accepted nurse practitioners, others continue to oppose their introduction, believing they threaten the quality of health services in rural areas (Moait 2000) and will subsequently reduce the availability of rural doctors in Australia (McDonald 2000).

These concerns strongly resemble those raised in other countries. Many features of the New South Wales project have been incorporated in the other Australian state models.

Victoria

In Victoria, interest in the development of the nurse practitioner role followed the need for options that were more diverse, improved service access and increased flexibility in models of health care delivery (Victorian Government Department of Human Services (DHS) 2000). It was also claimed that many nurses in Victoria had been practising at an advanced level within an extended role for many years (NBV 2001).

In 1998, the Minister of Health initiated the Victorian Nurse Practitioner Taskforce following a two-day workshop held the previous year to explore the establishment of the nurse practitioner role. The aim of the taskforce was to provide a framework for implementation and recognition of the nurse practitioner role in the Victorian health system (Victorian Government Department of Human Services (DHS) 2000). The taskforce addressed issues

of educational preparation, best practice, credentialing, legal liability and professional indemnity, changes to existing legislation, and financial considerations related to the role (NBV 2001). The project included community and practitioner consultation, and extensive examination of 11 nurse practitioner models of practice (demonstration projects). In 1999, the taskforce reported on their recommendations, representing the first phase of the process of implementation of the nurse practitioner role in Victoria (Victorian Government Department of Human Services (DHS) 2000). The planned implementation of the nurse practitioner role in Victoria would not be restricted to the public sector or specific geographical areas (Victorian Government Department of Human Services (DHS) 2000).

The *Nurses (Amendment) Act 2000* protects the title ‘nurse practitioner’, specifies the requirements for endorsement on the register, and authorises the prescribing of a limited range of drugs and poisons by suitably qualified and experienced advanced clinical nurses (Trasancos 2002). In Victoria, nurses apply for nurse practitioner status on the strength of extensive clinical experience and recognition of prior learning, which form part of the endorsement process (Trasancos 2002). They must also have or be completing a master’s degree and have completed an approved pharmacology course.

South Australia

South Australia introduced a nurse practitioner project at the same time as Victorian nurse practitioner developments. In 1996, the South Australia Department of Human Services (SADHS) initiated a project to develop the role of the nurse practitioner (South Australia Department of Human Services 1999) and appointed a Nurse Practitioner Project Advisory Committee. Following a two-year period of detailed consultation with key stakeholders, and representation from five reference groups, the nurse practitioner project report was released in October 1999. The report contained 32 recommendations regarding the establishment of the nurse practitioner role. It addressed the main issues and changes in regulation, legislation, authorisation, education and policies that were required to enable nurses to legitimately practise at an advanced level (South Australia Department of Human Services 1999; Mahnken 2000).

The state government has approved a clinical and admitting privileges process for nurses, as set out in a report released in July 1999 (South Australia Department of Human Services 1999). South Australia has protected the title of nurse practitioner through endorsement, and has developed standards for nurse practitioner practice. The first nurse practitioners have been authorised.

Western Australia

In 1997, the government of Western Australia’s commitment to provide access to quality health care services for all Australians was the catalyst for the proposal by the Commissioner of Health to formally implement the role of the remote area nurse practitioner (Health Department of Western Australia 2000). In 1998, an operational framework for the proposed introduction of nurse practitioners was established. The committee recognised that many nurses in rural and remote areas were often the sole primary health care provider for the

community and were already functioning outside the legislative and traditional nursing boundaries of their scope of practice. The need to formalise and legitimise the extended and diverse range of roles within their practice was therefore acknowledged.

In April 2000, following an extensive review assisted by four project teams, the steering committee released a report for the first phase of the Remote Area Nurse Practitioner Project. This report made seven recommendations related to registration, employment conditions, education, accreditation, clinical protocols, legislative changes, and implementation for remote area nurse practitioners (Health Department of Western Australia 2000). The recommendations include the following: that the regulating legislation (*Western Australian Nurses Act 1992*) be amended to make the title ‘nurse practitioner’ protected under the Act, and that nurse practitioners be required to complete an appropriate postgraduate diploma accredited by the Nurses Board of Western Australia (Health Department of Western Australia 2000).

While the initial focus of phase one was on ‘designated remote area sites’ for nurse practitioners, the recommended operational framework for phase two has been expanded to include a wider range of settings in Western Australia other than solely remote areas. The WA Department of Health now sponsors up to 20 nurse practitioner students each year to complete a postgraduate qualification offered through Curtin University.

Australian Capital Territory (ACT)

In December 1999 the then ACT Department of Health, Housing and Community Care established a committee to explore the role of nurse practitioner in the ACT and this committee oversaw the conduct of a trial of four nurse practitioner models of service (ACT Government 2002; Gardner and Gardner 2004). The trial included an investigation of the educational needs of nurse practitioners and resulted in the first Australian evidence-based curriculum for a nurse practitioner master’s course, which was approved by the University of Canberra Higher Degrees Committee in 2003 (Gardner, Gardner et al. 2004). Legislation has now been passed in the ACT to protect the title and other legislative amendments made to enable the full scope of practice to be recognised.

Northern Territory, Queensland and Tasmania

In the Northern Territory many nurses are working in advanced practice roles, where they are responsible for supplying drugs and ordering diagnostic tests. Many of these nurses are practising solo in community posts in remote areas; they follow standard treatment protocols and occasionally work beyond these protocols according to their clinical judgment. The Northern Territory Department of Health and Community Services endorses the protocols and covers these nurses through vicarious liability arrangements. Currently, there is no position in the Northern Territory referred to as nurse practitioner, and the Nurses Board has not protected the title.

The Queensland Government investigated models of nurse practitioner appropriate for Queensland. There are already advanced practice roles that provide services including nurse-initiated supply of medications in designated areas, nurse-initiated X-rays and the provision of Pap smear services. Again, the title of nurse practitioner is not protected in Queensland.

In Tasmania, the Department of Health and Human Services announced in-principle approval for nurse practitioner roles in October 2003. The Nurse Practitioner Scoping Project commenced in January 2004. Again, the title of nurse practitioner is not protected in this state.

The nexus between advanced practice and nurse practitioner status

The notion of an advanced practice role for nursing has generated considerable debate over the past few decades (Jones and Davies 1999; Woods 1999; Pearson and Peels 2002; Richardson 2002; Turner and Keyzer 2002; Wickham 2003). The influences of the women's movement in the 1970s, the impact of tertiary education on nursing, technological advances and health service restructuring have all had a significant influence on the changing nature of the nurse's role and scope of practice (Percival and Hamilton 1996). As can be seen from international trends, nurses have embraced these changes and the opportunity they bring for 'extending the frontiers of practice' (Jones and Davies 1999, p 187). However, these positive developments have not been without some accompanying obstacles. There is a confusing array of titles used to describe the emerging nursing roles and levels of practice. Nomenclature such as advanced specialist, clinical nurse consultant, clinical nurse specialist, nurse expert and advanced nurse practitioner have all been considered as coming under the umbrella of advanced practice (Dunn 1997; Woods 1997; Hamric, Spross et al. 2000). As already discussed, the blurring of title boundaries internationally makes the issue even more contentious. The social and political forces operating within each country affect how these terms are used and what they actually represent (Mulholland 2001a). It is the nexus between the broader notion of advanced practice and the nurse practitioner title that is most relevant for this report. This aspect will be explored in greater depth.

Advanced practice refers to a level of practice most often identified with the novice to expert continuum proposed by Benner (1984). In this continuum an advanced practitioner is someone whose practice involves a high level of expertise, vision, professional leadership; a nurse who is contributing to new nursing knowledge, demonstrating social and political awareness, providing pragmatic and purposeful interventions that deliver positive patient outcomes, and facing the risks and the challenges associated with initiating change and advancing practice (Patterson and Haddad 1992; Sutton and Smith 1995; South Australia Department of Human Services 1999; Royal College of Nursing Australia 2000; Victorian Government Department of Human Services (DHS) 2000).

In the international literature, especially United States material, a nurse practitioner is regarded as one type of advanced practice nurse (American Academy of Nurse Practitioners 2002). Here the nurse practitioner demonstrates all the attributes of an advanced level of practice, but in an extended clinical practice. Extended practice utilises skills and knowledge beyond the usual scope of nursing practice provided in a specific setting and this is the case both in the northern hemisphere and here in Australia and New Zealand. Among the extended practice skills and knowledge often associated with the nurse practitioner role are advanced clinical assessment, interpretation of diagnostic tests including diagnostic imaging, implementing and monitoring therapeutic regimens, prescribing pharmacological

interventions, and initiating and receiving appropriate referrals (Hegney 1997; South Australia Department of Human Services 1999; Victorian Government Department of Human Services (DHS) 2000). An Australian interpretation, more recently, suggests that the nurse practitioner role goes beyond that of the advanced practice nurse rather than being simply one type of advanced practice nurse (ACT Government 2002; Gardner and Gardner 2004). As we will show, advanced practice standards and competencies may be used to inform the curricula and authorisation processes in both New Zealand and Australia but their use in this way is not unproblematic.

Anticipation about the promise of nurse practitioner practice has arisen in part from the sets of statements, sometimes called competency statements or competency standards, about advanced practice. These statements have been developed by professional organisations (New Zealand Nursing Council 2000; Royal College of Nursing Australia 2000) and are similar to some used overseas (American Nurses Association 2002; Carroll 2002). The competency standards developed by the Australian Nursing Federation (Australian Nursing Federation 1997) are undergoing revision at the time of writing of this report. From these standards master of advanced nursing programs have been developed. (see Chapter 2.4). Roles such as clinical nurse consultant and clinical nurse specialist have been created as new nursing career structures have been developed in each state and territory but the required qualifications, levels of remuneration and working roles vary enormously.

The historical tangle of state rather than national responsibility for employment and regulation of Australian nursing has resulted in disparate job descriptions and roles behind these titles. Furthermore, there has been a diminution of the potential influence that these new roles might have had on the Australian health system. The introduction of a new role with legal title protection, that of the nurse practitioner, presents potential for the nursing profession to make a novel and coherent contribution to health in Australia and New Zealand. But it is vitally important that we learn from the inconsistencies created by disparate definitions, education and regulation internationally and create a coherent role that is recognisable across the Tasman.

Level of service and definition of nurse practitioners

These inconsistencies beg the question of what empirical work has been undertaken to clarify the controversy. While there is a raft of polemical literature (for example, Jamieson and Williams 2002), to date there are few research publications that describe, critique or defend the way that the various existing nurse practitioner roles have been developed and defined, especially in terms of role expansion and limitation, although the United Kingdom experience is well described in the final report of the ENRiP project (Read 2001). Even in countries where the nurse practitioner role is well established, there is often difficulty in interpreting its scope of practice, due in part to the broad interpretation of the term 'advanced practice' and its associated range of often confusing nomenclature (Dunn 1997; Hamilton 1998; Offredy and Townsend 2000b). In the United States, for example, advanced practice and nurse practitioner roles are arguably moving closer together, while in the United Kingdom the role partly coincides with the role of nurse consultant (Manley 1997; Daly and Carnwell 2003). McGee (McGee 1998) argues that the statutory definition implies a certainty about advanced

practice that does not exist, while Castledine states that ‘there is no universal definition of a nurse practitioner’ (Castledine and Paula 1998, p 47).

To date, there is limited published research about Australian nurse practitioner role development. Sexual health is an area where Australian nurse practitioners have tested this level of service and reported favourable outcomes. Hooke and others explored sexual health service provision by nurse practitioners as part of the New South Wales nurse practitioner trial (Hooke, Bennett et al. 2001). This was an early model to be tested and some barriers to implementation were identified. The authors stated that development of competencies was a difficult task because these were still being developed at national level and had not yet been ratified by special interest groups. The team developing this model made an explicit decision to use standing orders rather than prescribing rights. Later, in the ACT, a sexual health nurse practitioner model provided effective clinical management, patient education and health promotion and referral services for patients with a variety of health issues. The nurse practitioner was able to intervene in an opportunistic fashion, providing accessible and acceptable service in multiple settings including to marginalised and at risk groups (O’Keefe and Gardner 2003/2004). This model developed a limited formulary of medications that were recommended for the role. The differing scope of practice of these two models (albeit in the same clinical field) specifically around use of limited formularies (and therefore prescribing rights) or use of standing orders arises in Australian and New Zealand literature as well as engaging some of the international assumptions about nurse practitioner level of service.

A more thorough examination of the role of prescribing is probably warranted at this juncture. New Zealand is in a period of evolution in terms of prescribing education and practice. All students in current masters’ degrees leading to nurse practitioner endorsement will take pharmacology and all applicants for nurse practitioner endorsement will have to have completed advanced pharmacology education.

There has however been debate within the profession in New Zealand about the suitability of prescribing, as a component of nursing practice. Most agree on the need for prescribing as a component of nurse practitioner practice and all agree with the need for pharmacology education even without prescriptive authority. However, some members of the profession believe prescribing itself should be optional. Reasons for this have to do with preferring to avoid adopting the medical model of practice into nursing. It is however agreed that if a nurse practitioner wishes to avoid prescribing they must be able to demonstrate that their particular patient or population group will not be disadvantaged by the nurse practitioner’s lack of prescriptive authority.

Consideration of the need for all nurse practitioners to be able to prescribe was also raised in the Australian context. A survey was conducted by McCann and Baker with some respondents arguing that individual nurse practitioners in mental health areas should not be coerced into undertaking this role (McCann and Baker 2002). This perspective considers the practitioner’s perspective but not that of the clients.

Conversely, in another of the ACT models, the wound care nurse practitioner role enabled provision of case management as well as wound care for an at-risk patient population with complex comorbidities (MacLellan 2002). The exploration of wound care as a domain of nurse practitioner practice demonstrated that, for this role, only very limited prescribing rights were needed because specialised wound care applications are freely available over the counter in

Australia. This model relied heavily on an ability to refer to specialist medical practitioners for management of comorbidities.

Mental health is another area where nurse practitioner services have been assessed and reported in the Australian research literature. Happell gave an account of a consultation liaison model where the nurse practitioner undertook a range of activities including education, liaison and interpretation of the Mental Health Act. (Sharrock and Happell 2001; Sharrock and Happell 2002). This is an interesting model because there is little direct patient contact. The study identified twice as much nursing assessment (3.5 per cent compared with 2.3 per cent) or monitoring of the health needs (9.1 per cent with 4.6 per cent) of patients via other staff rather than being undertaken directly by the nurse practitioner (Sharrock and Happell 2002). Some might argue that this role is more one of clinical nurse consultant than nurse practitioner (Manley 1997).

Finally, the only other Australian nurse practitioner model, reported in the research literature to date, is an evaluation of the nurse practitioner role in a major rural emergency department (ED) (Chang, Daly et al. 1999). Patients with non-urgent conditions presenting to ED were randomised to see either a doctor or nurse practitioner as part of the New South Wales nurse practitioner trial. There were no significant differences in client satisfaction between the two groups as measured using telephone interviews and there was strong support for the nurse practitioner role.

This summary of the level of service of nurse practitioners across New Zealand and Australia, serves to illustrate, once more, the current diversity that is reflected internationally. The inconsistencies internationally have resulted in variation in service delivery and misunderstanding within the community. These inconsistencies occur where there is state rather than national responsibility for nurse registration (Pearson and Peels 2002). They also occur where there is national nursing registration but no protection of the title of nurse practitioner, as in the United Kingdom. Indeed, Marsden claimed that until the United Kingdom had a clear national view on what exactly a nurse practitioner is, and how they should be 'titled', the health services would struggle to deploy them efficiently and safely (Marsden, Dolan et al. 2003). It is argued that this situation is developing in Australia at least (Dunn 2002; Jamieson and Williams 2002). It is germane to ask what the consequences of this diversity might be if it continues without examination. Development of consistent trans-Tasman competency standards will facilitate the development of efficient and safe nurse practitioner roles. However, competency development is not unproblematic.

Competencies

Competencies are widely used in vocational training course assessment. They became important in the vocational education sector in the early nineties in Australia through a drive to formulate measurable industry standards for work practices (Keating 1994) and the concept was adopted by nursing (Sutton and Arbon 1994) as well as other occupations. Competency benchmarks are used in Australia for undergraduate education and regulation through the ANC competencies (see Table 1.3 for definitions of terminology). In the same way,

New Zealand Nursing Council competencies are used for undergraduate nurse education and advanced competencies are used for postgraduate programs.

Table 1.3: Definitions of competency-related terms used by ANC and Nursing Council (NZ)

Australian Nursing Council (Australian Nursing Council Inc 2000)
<i>Core Competency Standards</i> Essential competency standards for registration or licensure.
<i>Competence</i> The combination of skills, knowledge, attitudes, values and abilities that underpin effective and/or superior performance in a profession/occupational area.
<i>Competent</i> The person has competence across all the domains of competencies applicable to the nurse, at a standard that is judged to be appropriate for the level of nurse being assessed.
<i>Competency Unit</i> Represents a major function/functional area in the total competencies of a Registered Nurse in a nursing context representing a stand-alone function which can be performed by the individual.
<i>Competency Element</i> Represents a sub-function of the competency unit.
<i>Competency Standards</i> Consists of competency units and competency elements.
Nursing Council of New Zealand (Nursing Council of New Zealand 2004)
<i>Competence</i> The combination of skills, knowledge, attitudes, values and abilities that underpin effective and/or superior performance in a profession/occupation area.
<i>Competent</i> The person has competence across all domains of competencies applicable to the nurse, at a standard that is judged to be appropriate for the level of nurse being assessed.
<i>Context</i> The setting/environment where competence can be demonstrated or applied.
<i>Competency Unit</i> Represents a major function/functional area in the total competencies of a nurse in a nursing context representing a stand-alone function which can be performed by the individual.
<i>Competency</i> Essential competency for registration.

While the use of competencies is widespread, the notion of clinical competence in nursing is controversial. Watson et al. (2002) claim that competence is a nebulous concept that is defined in different ways by different people. This is reflected in the competency literature which is diverse. There is support for and promotion of competency-based benchmarking including the suggestion that competency standards are a necessary balance against an over-intellectual approach to education and practice in nursing (Eraut 1998). In a systematic review of clinical competence assessment Watson and others concluded that there was almost universal acceptance of the need for assessment of clinical nursing competence but that reliability and validity of assessment methods remain vexed and could not be found in the published literature. Assessment of clinical competence was identified as a particular issue when trying to distinguish between different levels of competence (Giroit 2000).

Perhaps because of this, there is also a reported move away from a total reliance on competencies as a way of benchmarking practice standards (Storey 1998) in postgraduate

nursing. Competency assessment focuses on the technical and procedural elements of nursing practice and as such is argued to be a double-edged sword (Goldsmith 1999). Competency-based practice is regarded by some as reductionist in nature and providing only a limited view of professional practice leading to a stunting of professional development (McAllister 1998; Goldsmith 1999). It has been suggested that competence as a notion is unnecessarily restrictive and does not take into account the un-measurable aspects of nursing (McAllister 1998). Historically, competencies were associated with manual occupations and so have an inherent sense of opposition to academic or intellectual abilities: thus, there is an unavoidable tension in the idea of using competencies to measure the performance of a nurse who has completed a master's degree. Nonetheless, without a superior alternative, regulatory authorities must seek to demonstrate safe standards for nurse practitioner practice by use of competency standards. Thus, nurse practitioner standards are benchmarked using competencies with most Australian regulatory authorities using the ANF Advanced Practice competencies. Similarly in New Zealand, advanced practice competencies formed the basis for nurse practitioner education and regulation.

Summary

As argued throughout this review, the extant literature on nurse practitioner service illustrates the current diversity in nurse practitioner role and practice both internationally and locally in Australia and New Zealand. The inconsistencies produce variation in service delivery and misunderstanding within the community. For that reason, Australia and New Zealand should strive to learn from the international experience in order to prevent inconsistency in level of service within and across the two countries. Mutually agreed competency standards will ensure that there is a consistency in health care delivery at nurse practitioner level of service. Given the longstanding mutual recognition agreements between Australian states and territories and between Australia and New Zealand, we are in an exciting position with the potential to inform and lead an international movement in standardisation of the nurse practitioner role.

The development and progress of the role of the nurse practitioner in Australia and New Zealand

The following report of action (see table 1.4) towards implementation of nurse practitioner role extends the original work conducted as part of the Australian National Review of Nursing Education (2002) and provides an overview of the development and progress of the nurse practitioner role from 1992 to the current time. It also incorporates the experience of New Zealand in developing and implementing the role of the nurse practitioner.

The report is organised by area as follows:

- New South Wales
- South Australia
- Victoria
- ACT
- Western Australia
- Northern Territory
- Tasmania
- Queensland
- New Zealand

Table 1.4: Development and progress of the role of the nurse practitioner

Date	Action towards implementation of nurse practitioner role
New South Wales	
1992	Discussion paper <i>The role of nurse practitioner in New South Wales</i> released. Working party consisting of representatives and nominees from consumer associations, nursing and medical professional and industrial associations, NSW Department of Health appointed to develop issues raised in paper (Stage 2).
1993	Stage 3 Steering Committee established to manage series of pilot projects examining the nursing practitioner role in 'terms of feasibility, safety, effectiveness, quality and cost'. Ten pilot projects selected from 58 submissions.
1996	NSW Health released the <i>Nurse Practitioner Project Stage 3 Final Report</i> . Implementation of the nurse practitioner role in New South Wales was initially proposed for public health care settings in the state's rural and regional area health services.
1998	NSW Government announced that it was introducing a new advanced practice role for nurses.
October 1999	Amendments to the <i>Nurses Act 1991</i> provided for registered nurses to apply to the NSW Nurses Registration Board to be authorised to practise as nurse practitioners. The title 'nurse practitioner' was protected. Applicants were required to satisfy the Nurses Registration Board that they had 'sufficient qualifications and experience' to be authorised, and legislation limited authorisation to a maximum of three years. The legislation also provided for the Board to recognise areas of practice for a nurse practitioner.
November 1999	The Nurses Registration Board issued information to intending applicants, including assessment criteria. Applicants were able to submit documents and attend a clinical viva interview in order to demonstrate the assessment criteria. The Board also issued guidelines for education programs to be submitted for approval by the Board, specifying that programs would be at the level of master's degree and that graduates of approved programs are required to satisfy other requirements as well, including evidence of advanced practice.
January 2000	The Nurses Registration Board recognised six broad areas of practice: maternal and child health nursing, high dependency nursing, mental health nursing, rehabilitation and habilitation nursing, medical/surgical nursing, and community health nursing. These were the six clinical categories which had been identified in Russell, RL, Gething, L and Convery, P, <i>National Review of Specialist Nurse Education</i> , Department of Employment, Education, Training and Youth Affairs, March 1997.
November 2000	The first two master degree courses approved by the Nurses Registration Board: Master of Advanced Practice Nursing (High Dependency) offered by Avondale College and the Master of Advanced Nursing Practice – Rural and Remote, offered by the University of Southern Queensland.
December 2000	First two Australian nurse practitioners authorised. Also, approval granted for Master of Nursing (Nurse Practitioner) offered by University of Newcastle.
11 May 2001	The first nurse practitioner in New South Wales and Australia was appointed to an approved nurse practitioner position.
October 2001	NSW Health reported that nine nurse practitioners were authorised by the Board. Up to 40 positions (employee status) were to be considered for approval by the Director-General. Four actual nurse practitioner positions were approved at Wanaaring, Wilcannia, Ivanhoe and Tibooburra in the Far West Area Health Service, and 20 other positions were 'approved in principle'.
June 2002	Approval granted for fourth education program: Master of Mental Health (Nurse Practitioner) offered by the University of Western Sydney.
June 2003	Nurse Practitioner roles have been officially expanded to include metropolitan positions. Over 150 nurse practitioner positions have been identified and approved and over 50 nurses have been appointed into positions pending their successful authorisation. At this time, 17 nurse practitioners were authorised to practise in New South Wales.
March 2004	New South Wales had 35 authorised nurse practitioners in settings ranging from rural and remote to metropolitan emergency service, from community services to acute pain services.

Date	Action towards implementation of nurse practitioner role
South Australia	
1996	Nurse Practitioner Project and Ministerial Advisory Committee established to advise on the appropriate means for implementation of the role.
1999	The South Australian Nurse Practitioner Project Final Report (NuPrac Report) made a number of recommendations to progress implementation, including the development of processes of authorisation and credentialing of nurse practitioners, and legislative changes. <i>The Nurses Act 1999</i> allowed the Board to authorise areas of specialist nursing practice for inclusion on the register or roll and to determine and recognise special practice areas. The first special practice area recognised by the Board was nurse practitioner.
September 2001	The Nurses Board of South Australia endorsed the Professional Standards Statement for Nurse Practitioner Practice, the definition of 'nurse practitioner' and protection on the title. Master's not mandatory however Master of Specialist Nursing/Midwifery Practice (University of South Australia), Master of Nursing–Nurse Practitioner (Flinders University) and Pharmacology of Specialist Nurse/ Midwifery Practice (University of South Australia) offered.
March 2002	Department of Human Services released information kit providing information on the nurse practitioner role, regulation, implementing positions, preparation for practice, implementation of clinical guidelines, radiology tests, pathology tests and referral.
April 2002	Nurses Board endorsed regulatory framework and criteria for authorisation as a nurse practitioner. First nurse practitioner was authorised in December 2002.
June 2003	Three nurse practitioners were authorised: heart failure, neonatal intensive care and adult palliative care. The nurse practitioner (neonatal intensive care) also held registration as a nurse practitioner in New Zealand and was authorised through the Trans-Tasman agreement. This is the first nurse practitioner to be authorised in Australia or New Zealand through mutual recognition legislation.
January 2004	The first nurse practitioner completed 12 months of practice and, as agreed in the framework for authorisation of nurse practitioner roles in South Australia, submitted additional data for use in evaluating nurse practitioner roles in South Australia. The Nurses Board has committed to a five-year review of the nurse practitioner role, due in 2007.
March 2004	Controlled Substances Advisory Committee recommended changes to the Poisons Regulations to include nurse practitioners as an authorised prescriber. Framework for Nurse Practitioner Prescribing and Supply of Medications allows individual nurse practitioners to determine their own prescribing formulary and submit it to their health unit Drug Advisory Committee and, upon approval against an agreed standard, submit it to the Nurses Board for authorisation. This model recognised the diversity of areas of practice of nurse practitioners in the future and does not require a list of authorised medications in the Regulations. This model is unique to South Australia. The DHS is developing the proposal and will develop a prescription pad for all nurse practitioners authorised by the Nurses Board of South Australia to prescribe and/or supply medications.
March 2004	As of March 2004, five nurse practitioners have been authorised by the Nurses Board of South Australia and two applications are currently before the Board. The additional authorisation is in the area of emergency. The Board has had indication of pending applications in the areas of renal and neonatology.

Date	Action towards implementation of nurse practitioner role
Victoria	
1998	A Taskforce was established in Victoria by the Department of Human Services to establish a framework and process for the implementation of the nurse practitioner role in Victoria. Eleven nurse practitioner models of practice were funded in the first phase of the Nurse Practitioner Project.
July 2000	The Victorian Nurse Practitioner Project – Final Report of the Taskforce was released in July 2000. The Taskforce developed a framework for the implementation to progress the role in Victoria (Department of Human Services 2000).
February 2001	A Nurse Practitioner Implementation Advisory Committee was established. Eighteen models were funded as part of the second phase of the Nurse Practitioner Project.
November 2001	The Victorian Government implemented the <i>Nurses (Amendment) Act 2000</i> which granted the Victorian Nurses Board power to endorse eligible nurses for the nurse practitioner role and to accredit courses leading to endorsement, with ‘nurse practitioner’ as a protected title.
February 2002	Victorian nurses were able to apply to the Nurses Board of Victoria for endorsement as a nurse practitioner in the state.
March 2002	Within the second phase of the Nurse Practitioner project, the Department of Human Services called for submissions for sustainable models of practice in targeted areas including Aboriginal health care, aged care, disability care, mental health, occupational health and safety, and maternal and child health care.
February 2003	Five demonstration projects funded under Phrase Two – mental health (two), men’s health, maternal and child health and Aboriginal health (midwifery).
June 2003	The University of Melbourne commenced the Therapeutic Medication Management module in semester 1 for master degree students. La Trobe University in the process of developing a Master of Nursing Science (Nurse Practitioner) course to commence in 2004. To date, 16 scholarships have been provided to nurse practitioner candidates undertaking master-level studies. The Nurses Board of Victoria received 15 applications for endorsement.
January 2004	The first four nurse practitioner applicants were approved by the Nurses Board of Victoria and their names forwarded to the Minister for Health for review at the end of December. The Victorian Nurse Practitioner Project moved to Phase 3 with specialty areas of nursing targeted to develop the nurse practitioner role and strengthen the capacity of the health system. The first funding round in Phase 3 was targeted to emergency nursing. Demonstration projects continued to develop clinical practice guidelines for their context of practice, a requirement prior to endorsement with the Nurses Board of Victoria.
ACT	
December 1999	The ACT Department of Health, Housing and Community Care established the ACT Nurse Practitioner Project Steering Committee. The project consisted of a trial of four nurse practitioner service models in the ACT: Wound Care Nurse Practitioner (The Canberra Hospital), Sexual Health Nurse Practitioner (The Canberra Hospital), Mental Health Liaison Nurse Practitioner (Calvary Hospital) and Military Nurse Practitioner (Duntroon).
May 2002	The trials were completed and evaluated. Work began on the development of course curricula for a nurse practitioner component of a Master in Advanced Practice Nursing at the University of Canberra.
May 2003	The University of Canberra Higher Degrees Committee approved a nurse practitioner master’s course. The curriculum was developed out of the ACT trial findings.
Dec. 2003	The ACT Nurses Board endorsed the Registration Policy for Nurse Practitioners.
March 2004	The <i>Nurse Practitioners Legislation Amendment Act 2003</i> was passed into law, thus establishing the legislative framework for implementation of the nurse practitioners role in ACT.

Date	Action towards implementation of nurse practitioner role
Western Australia	
April 2000	The Remote Area Nurse Practitioner Project (Western Australia— Project Report) April 2000 by the Health Department of Western Australia originally proposed that the role of nurse practitioner to be one for designated remote areas.
October 2001	In October 2001, under phase 2 of the Nurse Practitioner Project, the role was broadened to include a range of non-remote settings.
April 2002	Legislation required to enact the nurse practitioner role was being drafted, and a tender for the provision of appropriate courses had been called. Development of a comprehensive implementation pack was underway and pilot models were being considered.
April 2003	The <i>Nurses Amendment Act 2003</i> was assented to on the 9 April. Under the Act, nurse practitioners will be able to order routine diagnostic imaging tests, order routine pathology tests, and prescribe Schedule 4 medications.
2003	The approved Postgraduate Diploma in Clinical Specialisation (Nurse Practitioner) provided through Curtin University of Technology commenced in Semester 2. The Department of Health (WA) agreed to sponsor 20 full-time equivalent students per year for a total of three years.
March 2004	Thirteen nurse practitioners have been registered under the Nurse Practitioner Savings and Transition Clause.
Northern Territory	
1999	The Northern Territory Government established a Nurse Practitioner Project to determine the feasibility of implementing the role of the nurse practitioner, and the project reported in 2000.
2002	The Department of Health and Community Services, in collaboration with the Australian Nursing Federation in the Northern Territory, reviewed the career structure for nurses within the public sector. The review considered the role of nurse practitioners in the Northern Territory.
January 2004	The Northern Territory Enterprise Bargaining Agreement, including a clause stating that the Nurse Practitioner Project is to be developed within two years, was accepted by members.
Tasmania	
January 2002	The Tasmanian Nurse Workforce Planning Project – Final Report, advised that the Nursing Board of Tasmania, employers and nurses should all be involved in the development of the nurse practitioner role in Tasmania. The report recommended that the nursing profession review and report on nurse practitioner models for Tasmania, that the nurse practitioner role should be clearly defined, and that the Nurses Act should be amended to protect the title ‘nurse practitioner’ to ensure that it may be used only by those people who meet the requirements of the Board.
June 2003	A committee to scope the project for the implementation of nurse practitioners was established in June. Issues regarding prescribing, legislation, etc. were to be addressed as part of the role of the committee.
October 2003	The Health and Human Services Minister announced in-principle approval for a nurse practitioner role for Tasmanian nurses.
January 2004	The inaugural meeting of the Tasmanian Nurse Practitioner Scoping Project had been held. Project working parties were being finalised prior to the next meeting of the steering committee in February 2004. Nurse practitioner pilot projects in rural health, women’s and children’s health, mental health and diabetes are being considered.

Date	Action towards implementation of nurse practitioner role
Queensland	
May 2002	The Queensland Nursing Council was planning a project to determine the need for and regulatory framework suitable for nurse practitioners in Queensland. Legislative changes had been made to enable rural and isolated practice nurses to administer specific medications, and for all appropriately qualified registered nurses to order x-rays and take Pap smears. This project was delayed while the National Competition Policy review of the <i>Nursing Act 1992</i> occurred.
June 2003	The Queensland Health trial of the nurse practitioner role in four selected sites continued. Feedback from clients, community representatives, health care colleagues and nurses was very positive. Early evaluation from the two remote sites indicated very little difference between the endorsed role of the Queensland Isolated Practice Nurse and the Rural and Remote Nurse Practitioner role. The trial did not enable the registered nurses (nurse practitioners) to expand their scope of practice beyond what they are already authorised to do.
January 2004	The report on the Nurse Practitioner project went to the Office of the Director-General for forwarding to the Queensland Minister for Health but a state election intervened.
New Zealand	
1998	The report of the Ministerial Taskforce on Nursing (1998) focused on the untapped potential of the nursing workforce and provided the impetus for the development of the nurse practitioner role.
1999	The <i>Medicines Act 1981</i> was amended in 1999 to enable regulations allowing nurses and other registered health professionals to prescribe a specified list of medicines.
2001	Nursing Council developed its regulatory framework for nurse practitioners.
December 2001	First nurse practitioner endorsed.
July 2002	Minister of Health launched the document <i>Nurse Practitioners in New Zealand</i> , which provided information and guidance regarding the role of nurse practitioners.
2002	The Ministry of Health and the Nursing Council conducted a series of 21 presentations throughout the country to provide information to district health boards and other health providers about how the role could be implemented.
2003	Nurse practitioners working in areas of primary health, diabetes, gerontology, neonatal intensive care, mental health and child health.
January 2004	The Australian Nursing Council and Nursing Council of New Zealand launched their research project designed to develop competency standards for nurse practitioners in Australia and New Zealand. The project will take into account the various roles and functions nurse practitioners fulfil and legislative developments throughout Australia and New Zealand.

section **2** Reporting
the research

Introduction

Essentially, the aim of this project was to describe the core role of nurse practitioners in Australia and New Zealand and to develop national/trans-Tasman standards for the recognition and education of nurse practitioners. In order to direct the data collection and analysis for the study, this aim was formulated into the following research objectives:

- To draw on empirical evidence to illustrate the core role of nurse practitioners in Australia and New Zealand
- To investigate the current standards of education and program accreditation for nurse practitioners in Australia and New Zealand
- To describe the current authorisation requirements and processes for nurse practitioners in Australia and New Zealand.

The achievement of these research objectives provided the analytical basis to achieve the following outcome objective of the study:

To develop core standards for the nurse practitioner in Australia and New Zealand to inform a competency framework that can be applied to practice standards, education standards, program accreditation standards and processes for nurse practitioner authorisation.

Methods

The methodology to achieve these objectives needed to draw upon data relating to current practices, established processes across a range of jurisdictions, documentary evidence, unpublished literature and the experiential aspects of the nurse practitioner level of service in different geographical and clinical contexts of practice. A further consideration in designing the study was that the timeframe for the empirical component of the study was 15 weeks.

Accordingly, the research design incorporated a multi-methods approach that strategically focused on the most productive and most efficacious data sources. A range of data collection tools was developed and a variety of data sources was used. This incorporated research of policies and curricula, and survey and interviews with academics and clinicians. Data were collected from relevant sources in New Zealand and five states and territories in Australia.

Participant sample and recruitment processes

A population sample of authorised and practising nurse practitioners, and academic convenors of nurse practitioner programs, was used.

Nurse practitioners in New Zealand and each state in Australia where nurse practitioners were both legitimised and practising (New South Wales, South Australia and Western Australia) were invited to participate in the study. Through the nursing regulatory authority in each jurisdiction, authorised and practising nurse practitioners were sent a letter, an information sheet, consent form and contact details. They were invited to contact the investigator in their area if they were interested in participating in the interviews (see Appendix 4).

Academic convenors of all nurse practitioner education programs were identified through expert networks in Australia and New Zealand. These academics were contacted via email by one of the investigators. They were supplied with an information document and consent form (see Appendix 5) and invited to participate. Their participation involved submission of their nurse practitioner program curriculum document and participation in a follow-up structured telephone interview.

Additional data sources

Grey literature

This included collation of published nurse practitioner reports from New Zealand, New South Wales, Victoria, South Australia and the ACT. Nursing regulatory bodies from Australia and New Zealand were asked to contribute documentation on the regulatory processes governing nurse practitioner authorisation in their jurisdictions (see Appendix 6). Documentation was obtained from the ACT, New South Wales, South Australia, Victoria, Western Australia, and New Zealand. Additional documentation was accessed through the Internet and through follow-up contacts as required.

National nursing bodies

Specific nursing organisations in Australia and New Zealand were contacted and invited to submit comment relevant to all, or selected, outcomes of the project. Because of the large number of nursing organisations and specialty groups across the two countries, the selection criteria for this aspect of the study was national-level colleges, professional and industrial bodies. In Australia the (Australian Nursing Federation- and Royal College of Nursing-sponsored) National Nursing Organisation of Australia was included to represent specialty organisations and in New Zealand the Nurse Practitioner Advisory Committee of New Zealand (NPAC-NZ) was included, because of their critical role in nurse practitioner development in New Zealand (see Appendix 7 for example of letter and list of organisations contacted).

Data collection

Nurse practitioners

Interviews were conducted by all investigators with consenting nurse practitioners in New Zealand, New South Wales, South Australia and Western Australia. The interviews lasted for between one and two hours. The structure of the interviews included two distinct components. A semi-structured format was used to collect data relating to the nurse practitioners' employment, education, and authorisation experiences. In addition to collection of the above information, an in-depth interview was conducted to gain information on the experiential dimensions of nurse practitioner work. This latter part included a report of a de-identified case study that represented for that participant an exemplar of nurse practitioner service. These interviews were audio recorded and transcribed to produce text data.

Nurse practitioner education

The curricula documents on all nurse practitioner education programs in Australia and New Zealand were collected by one of the investigators who was not involved in nurse practitioner education. A data abstraction tool was developed and tested to standardise the information from these documents. In addition, semi-structured interviews were conducted by this investigator with academic program convenors. These interviews were structured by the fields in the data abstraction tool and enabled the academics to confirm, amend and elaborate on the curriculum information.

Data analysis

Analysis of the data was consistent with the standard for each data collection method. Management of the data was structured into two phases. Initially data were analysed within each data set. The second phase involved data analysis across the data sets to achieve triangulation of findings in relation to the project outcomes of nurse practitioner core role and standards for practice, education, accreditation and authorisation.

The approach to data analysis within each data set was as follows:

Nurse practitioner interviews

The nurse practitioner interviews produced 275 single-spaced pages of text data. These data were analysed using both deductive and inductive methods. First, data from the semi-structured component were collated across the content areas of the interview questions. These were related to minimum demographic data of sex and age and participants' background, perceptions and comments on:

- employment
- education levels
- education experience
- portfolio/authorisation process.

The interviews were first read through to gain a sense of the content and nature of the responses. The data were read and reviewed again and all answers to a single question were compiled. The data from the semi-structured component on the interviews were collated numerically.

Data from the in-depth interviews, including the selected case study, were analysed to gain insight into the core role of the nurse practitioner as perceived and reported by these clinicians. An inductive process was used to order the data according to recognised patterns within each interview then these data were collated across the data set according to identified storylines. The storylines were then collated according to several conceptual categories. A final read cross-checked all interviews for the identified storylines and highlighted textual samples which best captured the storylines in the analytical framework.

Nurse practitioner education

The data relating to nurse practitioner education required collation of information from all program curricula documents. These data were then analysed for patterns in relation to program characteristics, program management, conceptual curriculum, program content, its source and competency base, program accreditation and evaluation. Data from nurse academic interviews were matched to these fields to strengthen and deepen the curricula information.

Grey literature

In the first stages of data analysis, regulatory documentation from Australia and New Zealand was analysed using an iterative process. During initial data extraction, the main categories from each document were entered onto a table. The categories were compared and contrasted to provide a comprehensive view of the range of data provided in each document. Once common key categories were identified across the documents, additional data were sought from within and beyond the primary documentation to complete each category for all the jurisdictions. Following several analytic iterations, the final categories were developed.

Submissions from national nursing bodies

National nursing organisations of New Zealand and Australia were invited to provide up to two pages of comment relevant to all, or selected, outcomes of the project. These peak bodies provided the research team with their respective position statements and other background material. These responses helped to inform the analysis of the data gathered. Some organisations included advanced practice or nurse practitioner competencies in their submissions and these were interleaved with the competencies developed from our data to provide clarification for and validation of the project outcomes.

Data from all sources were then analysed to identify concepts and issues that were consistent across the submissions. In addition information relating to specialty competencies were analysed to inform development of specialty frameworks for education.

The process of data analysis using the above methods within each discrete data set produced results that were triangulated across the datasets to achieve findings in relation to the project outcomes of:

- nurse practitioner core role and core practice competencies
- standards for nurse practitioner education and program accreditation
- standards for nurse practitioner authorisation.

This process of triangulation is illustrated in Table 2.1.

Table 2.1: Illustration of data triangulation

Research outcomes	Data sets					Findings
	NP education programs	NP interviews	Nurse academic interviews	Grey literature	Submissions from nursing organisations	
Core competencies		✓		✓	✓	NP core role and standards
Standards for education	✓	✓	✓	✓	✓	NP education standards
Authorisation processes	✓	✓		✓	✓	NP authorisation

Measures to ensure validity of research findings

The participant recruitment and data collection processes are fully reported in order to establish a clear Audit trail. In addition, the reporting of the findings has included thick descriptions from the textual data material to enable the reader to assess the interpretations and follow the investigators' reasoning processes.

The findings from analysis of the nurse practitioner interviews were returned to the participants for member checking of fidelity of the findings with their own experience and knowledge of the core role of the nurse practitioner. The participants were invited to comment on these findings. All responses validated our findings according to their own experiences.

The collated data from each curriculum and related academic interview was returned to the academic participants to comment on accuracy and to enable them to include additional information.

All four investigators were involved in the collection and analysis of the data from nurse practitioner interviews. The data management for the education component of the study was conducted by one of the investigators who was not involved with nurse practitioner education. This ensured that commercial-in-confidence factors related to intellectual property were not compromised and avoided threats to the trustworthiness (Holloway and Wheeler 1996) of the findings.

Ethical issues

As far as possible, the identity of individuals who participated in the study, and universities, has been protected. Pseudonyms have been used throughout the report in relation to the narrative data. Aggregation of curricula data has been used to report trends and patterns. Nonetheless the number of nurse practitioners in Australia and New Zealand is small. For that reason we have not reported a breakdown of demographic information relating to nurse practitioners, their employing institutions or their educational institution. Hence, the method of reporting of results is such that no individual or an institution could be identifiable through data and any conclusions drawn about identity from this report will be speculative.

Ethical approval for the study was secured from the Queensland University of Technology, Human Research and Ethics Committees (see Appendix 9). Informed consent was obtained from all interviewee participants and university representatives who submitted their program curriculum document. Specific assurances were given to universities regarding commercial-in-confidence issues. Consent was given either verbally, audio recorded or written (posted/faxed consent forms or acknowledged in emails). Privacy and confidentiality will be maintained with no identifying information on individuals recorded in the report or other documents resulting from this project.

Limitations

As outlined in the literature review the role of nurse practitioner in New Zealand and Australia is evolving. Both countries have expended considerable effort thus far in developing and establishing the role but the length of time in practice for most of the small number of nurse practitioners is still very short. As researchers, we have explored the field very early in the evolutionary process and thus the recommendations must be viewed in that light and opportunities created for evaluation and re-evaluation.

Current nurse practitioners have come to their roles from considerable nursing experience and many have been delivering a high level of clinical service prior to endorsement in the role. The process of formalising the notion of advanced practice in New Zealand and Australia has been prolonged. This means that there are other nurses in other roles who are most certainly providing elements of practice comparable to or the same as those identified in the core role of the nurse practitioner. This may support assumptions that elements of the nurse practitioner role are in fact common to other levels of nursing practice. This needs careful examination.

We will demonstrate that the nurse practitioner role comprises a number of core elements, any of which may be and sometimes are, currently performed by other nurses in other categories. To some extent this will change and lessen as the boundary between nurse practitioner practice and other areas of nursing practice clarifies in the next five to 10 years. But we will show that what differentiates nurse practitioner practice now and in the future is the presence of all of the core elements including a particular attitude and approach to practice which will be explored in a later chapter.

In addition to the embryonic nature of the role in New Zealand and Australia, existing nurse practitioners are practising in an environment that is not entirely prepared for them and, in some sectors, is politically resistant. We have identified current nurse practitioners as pioneers, forging a pathway towards improved services and towards expanding interpretations of the role and its potential.

While in some ways this is indeed a limitation of the study in another sense there is tremendous value in having captured this point in history as a basis for future development and evaluation. Through this research project, both countries are offered an opportunity to learn from the long journey in North America, to avoid the ad hoc development of Britain and to create a nurse practitioner role, which is uniquely Australasian and builds constructively on available research evidence and the experience of other countries.

Introduction

The previous chapter explicated the study design and the strategies used in the collection and analysis of research data. The remaining chapters in Section 2 will report on the results of analysis of these data.

The analytical approach involved coding and aggregation of data within each data set. As illustrated in Table 2.1 these data sets were:

- nurse practitioner education programs
- nurse practitioner interviews
- nurse academic interviews
- grey literature
- submissions from nursing organisations.

The data were then triangulated and analysed against the three research objectives.

This part of Section 2 will describe the characteristics of the data in each data set. The following three chapters will then report on the findings according to the three areas of the research objectives.

Results

Nurse practitioner demographics

Fifteen nurse practitioners were interviewed. Their ages ranged between 29 and 56. There were 11 women and 4 men in the nurse practitioner sample. Interviews were conducted with nurse practitioners in all jurisdictions where nurse practitioners are authorised and the title is protected.

Nurse practitioner education programs

Fourteen program curricula comprising five programs from New Zealand and nine from Australian universities were included in the study. This represents 100 per cent of nurse practitioner programs offered throughout the two countries. Interviews were conducted with 12 academic convenors. While all universities sent their curricula documents for inclusion in the study, convenors from two of these universities did not consent or follow up requests to participate in interview. Demographic information relating to the program convenors was not

collected, as this information was not germane to the research outcomes. The distribution of programs across the Australia and New Zealand is:

New Zealand	5
New South Wales	3
South Australia	2
Queensland	1
ACT	1
Western Australia	1
Victoria	1

Nursing organisations

Nine nursing organisations from Australia and New Zealand were invited to send a submission relating to the research outcomes. All organisations accepted the invitation and submitted a document.

The following chapters will report on the results of analysis of the triangulated data according to the research objectives and research outcomes related to:

- the core role of the nurse practitioner in Australia and New Zealand
- current standards and requirements for nurse practitioner education and program accreditation
- current authorisation processes for nurse practitioners in Australia and New Zealand.

The core role of nurse practitioners in Australia and New Zealand

Introduction

Previous research has demonstrated that nurse practitioners have developed a new level of health service that builds upon extensive clinical experience (Offredy 1998), is characterised by specialisation (such as Walsh 2000), provides health service to populations that previously had poor access (MacLellan 2002; O’Keefe and Gardner 2003–2004), and that nurse practitioners work autonomously and in collaboration with other health care providers (Gardner and Gardner 2004). There is however no research to date that has identified the core role of the nurse practitioner and the numerous current standards and are not derived from research.

One of the aims of this research was to identify and describe the core role of the nurse practitioner. In researching the core role we examined the practice of fifteen clinicians to identify those elements that were common across a range of models. Interpretive methods were employed to investigate nurse practitioner practice and this chapter will report on the findings from analysis of data from interviews. This aspect of the research was guided by the following research objective:

To draw on empirical evidence to illustrate the core role of nurse practitioners in Australia and New Zealand.

The findings from this study showed that nurse practitioners in Australian and New Zealand work across a range of clinical settings, provide health service to specific population groups and are located in many specialty areas of health care. The nurse practitioner therefore can be the sole health care provider in a rural community with the closest nursing or medical colleague hundreds of kilometres distance, or a neonatal intensive care nurse practitioner located in the midst of a tertiary care environment surrounded by other specialist clinicians. Our research found that nurse practitioner clinicians in these varied models share skills and knowledge that are used in all fields of practice while also drawing upon knowledge and skills specific to their specialty field.

Findings

The analytical techniques we used were those recommended by Denzin (Denzin 2001), Sandelowski (Sandelowski 1995) and Seale (Seale 2000) and involved an inductive approach in the interpretive analysis of these data. An iterative reading of the texts identified patterns within and across the interview data. The data were then aggregated thematically according to these patterns, identified in this report as storylines (Sandelowski 1995). Inductive

analysis was used to order these storylines into conceptual categories. Through this process we have identified three major conceptual categories that account for the core roles of the nurse practitioner. In essence the conceptual category defines the broad practice role and the storylines explicate the practice features or elements of that category. A description of these categories follows.

Dynamic practice is structured through the storylines that identify those features of nurse practitioner practice that define the extended skills, knowledge and contexts of extended practice. Additionally this category provides insight into the ways that nurse practitioners manage autonomous practice and delivery of care in diverse and complex environments.

Professional efficacy is explicated through the storylines that report the characteristics of the practice of nurse practitioners, their personal identity as senior nurses and the commitment that these clinicians have to locating their practice within a nursing model. This category also reveals the varying ways that nurse practitioners identify the nursing role within their own extended practice model and how this influences accountability and autonomy.

Clinical leadership is developed as a defining feature of the core role of the nurse practitioner. The nurse practitioner leads in nursing through any of a number of roles such as researcher, clinical teacher, spokesperson and others and in this capacity takes responsibility for assisting the public, policy-makers and other health care professionals to understand the nurse practitioner role. In so doing they draw on their own personal development as senior clinicians and from the relevant evidence base to influence the quality and nature of services.

These conceptual categories have been developed from narrative accounts of nurse practitioner practice as perceived and described by the clinicians themselves. In the following pages we will fully develop these conceptual categories to gain new insights into the core role of the nurse practitioner. We will use thick descriptions (Denzin 2001) from the nurse practitioners' own accounts of practice that define each of the storylines. We will draw upon the literature to inform interpretation of these data and locate our findings in the established literature to develop new knowledge and achieve a re-definition of the core role of the nurse practitioner.

Dynamic practice

Dynamic practice relates to those aspects of the nurse practitioner role that describe clinical work (knowledge and skills) , the contexts of that work and the measures taken by the nurse practitioner to maintain their clinical expertise. What is consistent in the narratives across the range of models studied is the readiness to adapt extended knowledge and skills in a dynamic and unknown situation and to take responsibility for this initiative. Analysis of the storylines in this category indicated that at the core of the practice of nurse practitioners was in-depth and systematic clinical knowledge and skill. Further to this was the ability to apply the systematic processes of science in both conventional and unconventional ways according to the social and clinical context. The third aspect of this category was the imperative for these clinicians to maintain currency of clinical knowledge.

In-depth assessment, diagnosis and planning care

Kerry describes her growth in the knowledge of pathophysiology and the centrality of this knowledge in health assessment for her nurse practitioner role:

I've just astounded myself really how much I didn't know. You know, you have a bowel obstruction you do this, this and this but I actually really didn't understand right back to the pathophysiology behind that and what works and doesn't work and why you do this and not that. That's the thing that I found was the most useful thing that I learnt, really understanding about why we do certain things and what's actually happening in the body for that – for the calcium to rise and all those interwoven things that can happen too. I was really working very superficially before but I'm working a lot deeper now and I feel that I have a better understanding of what's going on.

Joanne describes how her knowledge of pathophysiology underpins the assessment process:

She had venous ulcers of long standing but now there is an arterial element as well, although I actually picked up a good Doppler signal from both the dorsalis pedis and the posterior tibial arteries. But I was unable to do a good brachial pressure index because of the way the ulcers were and the amount of pain. She had reasonable pain control but not as good as I would have liked. She had had persistent infections. She had a prominent allergic rash when I saw her due to being given antibiotics which she had actually told them she was allergic to and she was also passing frequent small amounts of urine and the antibiotics she had been given for the urinary tract infection had given her the rash.

Additionally there is an expectation that the nurse practitioner will respond to the findings of the assessment in a particular way. All nurses are expected to carry out assessments and respond to their findings within a nursing scope of practice. The nurse practitioner extends the scope and depth of that assessment and takes responsibility for responding directly to the results of their assessment or determining when collaboration and possible referral is needed. Fran demonstrates that level of decision making:

So, I decided he didn't need to go to hospital and I commenced emergency treatment for him, which was oxygen at 40 to 50 per cent, as British guidelines, and gave Salbutamol via nebuliser, which started to help him, and administered Prednisone, an all cortical steroid, and that would've been done intravenously if I'd needed to.

The extent and quality of patient assessment as described by participants is consistent with definitions of role development (Daly and Carnwell 2003). According to this definition, role development embraces both role extension and role expansion. Extension is the inclusion of practices not previously associated with the nurse's role and expansion involves greater responsibility, accountability and autonomy. Role development implies a new role that develops due to new demands and perceived shortcomings in the quality of patient care and health care resources. This study has clearly shown that nurse practitioners are delivering a new level of service in which they extend nursing by the incorporation of a range of tasks and procedures and they expand nursing by increasing the range of circumstances in which they

take responsibility for determining the response. Participants in this study provided a clear sense of responding to unmet individual and community need in providing a level of service commensurate with role development as identified by Daly and Carnwell (2003).

Management of presenting condition or events

The nature of a nurse practitioner position requires first-line response to a wide range of situations depending on the sphere of practice of the nurse and the context in which practice is located. Nurse practitioners need an extensive knowledge base from which to provide this service. Maree related a situation where application of scientific knowledge, rapid decision making and technical skill, in the emergency treatment of a patient resulted in positive outcomes:

This guy was in the pit in a mechanics place and he was burnt by fire. I was at home at lunch, his wife rang me and I was there within two minutes. I had said to them put him in the shower. So they had put him in the shower, I wrapped him in a sheet, put him in my car and took him to the clinic. I had him in the shower while I was getting all the bandages and everything ready and then his wife and I put SSD cream over every part of his burns and melanin bandaging and I was on to (the named emergency service) of course and I had him on Morphine.

Now I got a drip into a pretty shocked man which I think is quite a thing to do and I think that it takes an experienced nurse to be able to do those sort of things and he was in awful pain so he sort of shut down and I got that Morphine and loads of fluid into him, the bandages were all done and we had him in the plane 20 kilometres away within three hours and in hospital in four hours. Under good pain control, he didn't suffer any infection, he didn't even have to have skin grafting or go to (named) hospital and he was home within about five days.

Nurse practitioner decisions about patient/client treatments were derived from their assessments and made from a sound knowledge base. In the following narrative Jane describes how her in-depth knowledge of science and pharmacology informed her decisions about treatment options.

So then I went back with that information and had another look at his medication list. I was interested to know what his renal and liver functions were because some of the medications are contraindicated or 'use with caution' in the older adult and particularly those with any renal dysfunction or liver dysfunction. But he hadn't had any bloods taken that I could find, for at least a year and that concerned me particularly with regards to his diabetes medication. He was on Metformin and with congestive heart failure that really is contraindicated but also if he has any liver dysfunction or renal dysfunction with that it could be quite dangerous. So I organised for him to have some bloods taken and his HbA1c. I wanted to check that out as well and made some recommendations about changing his medications to discontinue the metformin and also the gliclazide because there was no need for him to be on gliclazide and insulin as well, and I couldn't increase the morning dose of his insulin because that would cause him to go even lower. So I made suggestions to decrease that I didn't actually, on the day I wrote all these

recommendations in his notes and then contacted the GP and said I visited this chap and these are my suggestions and I've documented them all in the notes.

The provision of technical procedures commensurate with the role and scope of practice is a core part of the nurse practitioner role. Role extension is significant here and accepted by nurse practitioners as integral to the care of their patients and clients. The provision of extended services is a convenience to patients but such tasks and procedures do not distract from or reduce the centrality of a nursing response to each patient or client. For example, one nurse practitioner concluded her description of highly technical practice including intubation, respiratory support, blood gas management, insertion of lines and titration of medications with the statement:

So it's kind of busy when you have a patient like that in the unit because there is a lot of emotional work to be done.

Here Dianne regards the technical skills in a matter of fact manner but regards the provision of emotional support and care as the principle focus and challenge in terms of planning care, supporting the family and other staff surrounding a critically ill patient. This aspect will be developed further when we focus on nurse practitioner practice as a core nursing role. It has additional relevance here because it captures the complexity of nurse practitioner practice beyond assessment and diagnosis.

Use of these skills in complex and varied environments

As we have begun to demonstrate, the nurse practitioner assesses from a skill and knowledge base that is highly developed but does this while incorporating the individual and contextual contributions to each situation. There is a frequent assertion by nurse practitioner participants that there is value in delivering any care or service in a manner in which there is a human or therapeutic connection between the nurse and the patient or client. This underpins nursing assessment and it includes the ability to focus closely on the entire person rather than just the presenting or current problem for which care is being delivered. It could be argued that the connection is a component of caring and therefore a natural expression of nursing. This attribute goes further and includes a sense of creativity captured by nurse practitioners describing their actions aimed at addressing the total wellbeing of individuals or communities. In the following narrative Lucy describes what she considers a typical nurse practitioner approach to patient care.

An elderly man approached me in the street and asked if I would help him fill out forms so he could go into hospital and have a knee joint replacement. While we were filling in the forms I asked him a question about whether he had a problem with reading and writing, and the man started crying. I then told him about adult literacy services that were available and that after he was back on track, I'd be more than happy to take him.

He had the surgery was sent home from hospital on Panadeine Forte, and he had to walk about 50 yards down underneath the club house on two walking sticks to go to the toilet and have a shower. When I went out to see him on my first visit, he was very distressed because he was constipated and he kept wanting to go to the

toilet and had this long walk down. And I had to assess his safety too as well in this environment. I gave him a suppository or a small enema and, you know, then gave him a good talking to about, you know, bowel management on this kind of medication. I took his sutures out and monitored his progress and worked with the physiotherapist with him and eventually he was mobilising very well. It was at that point that I reminded him that I'd made him a promise about adult literacy and he was really keen. So, I negotiated that I'd meet him on the side of the road at half past eight one morning and I'd lined it up with the adult literacy people...

This Christmas I went out to see him and he asked me if I would post two Christmas cards for him which he had written. And I asked him if he had been doing some fishing lately and he told me that he hadn't had time to go fishing because he had five books to read.

Joanne's narrative echoes this complexity of care:

I often get patients with CORD and/or diabetes, they nearly always have pain so actually while I have been trying to separate out diabetes, and respiratory, because we can all manage in our own specialities, but to be looking at the complexity of a chronic disease person, because those are the ones that cause us huge problems at that end of the spectrum...when you get up to nurse practitioner the people who tend to get thrown at you are the complex ones who have got the major problems.

Joanne's area of practice is the care of people with wounds: in this narrative she nonetheless describes the interaction of her specialist knowledge with what she describes as general nursing knowledge. In some respects she dismisses the specialist knowledge as straightforward; we can all manage in our own specialities. This indicates that the real challenge for nurse practitioner practice is to move beyond the singular dimension of specialisations into the complexity of working with the many dimensions of a patient's complex health problems.

While the biophysical aspect of assessment was frequently described, many of the participants also reported assessment and treatment of the patient in terms of who they are and what circumstances impact on their health issue. The following narrative illustrates this in Mark's work with his client that demonstrates this multidimensional approach to assessment:

A 72-year-old woman, lives alone, pensioner, has one daughter but she lives in Sydney, doesn't drive, there's no public transport out here, and relies on friends for her fortnightly visit to the nearest major town for groceries and to do business. Her abode or her living conditions are poor. Meds, nil. This lady is an ex-nurse, actually, tough as nails. History, none significant, nil allergies. She sustained a degloving injury of her right heel from a horse's hoof. She was outside in bare feet, the horse came behind her and basically pared away the back of her heel. Now she had minimal blood loss and as I said, she was as tough as nails...

In reporting this assessment Mark does not differentiate the physical from the social aspects of assessment, but easily provides a holistic evaluation of this patient through building a picture that will inform his approach to management.

These findings are supported by Offredy (1998) in her study of nurse practitioner decision making. She found that nurse practitioners have an understanding of the patient in terms of their social circumstances as well as their presenting problem. Our research indicates that as well as a comprehensive understanding of the patient, nurse practitioners use this additional knowledge to inform decision making. In the above study, Offredy proposed that in approaches to decision making, nurse practitioners used a combination of pattern matching and intuition in arriving at decisions about patient care. This approach, according to her research, enables the nurse practitioner to engage in reasoning processes in non-problematic or stable as well as uncertain situations.

Maintaining currency of clinical knowledge

A recurrent theme in the interviews was the nurse practitioners' description of their ever-increasing appreciation of sound knowledge as the basis for good practice. Many described their growing recognition that knowledge is not a static entity and that research evidence, a strong foundation for practice, is continually evolving and must be continuously revisited. Nurse practitioners demonstrated commitment to currency of knowledge, to knowing how and where to access appropriate information and to needing dedicated time for that pursuit. As Joanne noted:

I was one of these people that up till 1990 , why do I need education I know it all, and then when I started I did two years diploma, two years degree, with two years post-grad certificate...And it's the old thing as soon as you start your education you actually realise that you don't know a lot and thinking the theory and with the practice makes you a much more rounded practitioner.

I think that we as nurses, we need to be made more aware of our professional accountability, that we need to be upgrading ourselves all the time with our knowledge base, and I think that should be, you know, become an entrenched activity of our everyday nursing, and I think that should come out in a Master's. I think that, just from my experience of going through the process, need to be really reiterating how medications work at cellular level.

And Sue noted her constant attitude of inquiry:

What are the research outcomes showing now...I felt that I had that going into the (nurse practitioner authorising) interviews, but I think I needed to understand as a nurse practitioner it was expected that I would know just a little bit more. I felt from my Master's program that I got that—and when I tell you that I've got an inquiring mind, I've been following through on things that are not just nursing ever since...

Participants in this study demonstrated their recognition that education and personal pursuit of knowledge are integral to maintaining good-quality and safe practice. They discussed their awareness that their knowledge needs are diverse and wide ranging because of the complexity of the role.

Summary: Dynamic practice

Dynamic practice has several core components as articulated by current nurse practitioners in New Zealand and Australia. At the heart are highly developed clinical practice skills focused on a particular population group or area of specialty practice. Key elements of dynamic practice are comprehensive assessment ability including advanced physical assessment and an analysis of the person in context. This is based on advanced knowledge of pathophysiology and the range of human sciences integral to nursing. Dynamic practice incorporates the ability to prescribe and to order investigative procedures according to assessment. These services are provided by a person who is also alert to community/public health assessment information in addressing need. Finally dynamic practice includes the need to address currency of practice as a continuous process.

Professional efficacy

Professional efficacy describes nursing at a level of practice that responds to high levels of clinical demand with significant clinical autonomy and accountability. While collaboration is important, the very nature of the nurse practitioner role allows that the nurse is responsible for the complete episode of care. This means accepting the need to act autonomously in decision making and the follow-through in patient care. The Ministry of Health document Nurse Practitioner in New Zealand (Ministry of Health 2002 p. 3), states ‘Nurse Practitioners, like registered nurses, are autonomous practitioners like other expert health professionals and do not require supervision of their practice by other disciplines’. This autonomy is based on a defined scope of practice certified by the Nursing Council of New Zealand. The document notes that nurse practitioners like RNs are fully liable for their own practice thus aiming to correct any misconceptions about nurses in general.

The nurse practitioner in responding to demand crafts a new and different health service relevant to population base and unmet access needs and firmly grounded in the discipline of nursing. Included also in this section is consideration of the degree to which professional efficacy supports the participation of the nurse practitioner as a senior member of the multidisciplinary team and in effective processes of collaboration.

Locating practice within a nursing model

Overwhelmingly the participants described their role as a nursing role, characterised by the combination of a range of technical skills delivered within a nursing framework. The nurse practitioner may be a specialist in a particular sphere but provides that service guided by a comprehensive nursing focus, which accommodates prevention and health promotion and also attends to the importance of assisting people to live satisfactorily with whatever condition they have. They are therefore able to provide high-level practice which includes independent decision making and the provision of specialist services for a wide range of patients and people while increasing the capacity of all nursing services. Nurse practitioners describe the incorporation of tasks which may have been previously performed by medicine

as a means of increasing access and improving services rather than as a change in the philosophical approach to practice.

The profession has for a long time expressed concerns that development of the nurse practitioner role extends nursing along a continuum towards medicine (Litchfield 2002). Certainly medicine itself has expressed considerable anxiety on this issue. Such a view somehow presupposes that the knowledge continuum is hierarchical with medical ability as a pinnacle of achievement and secured at the expense of nursing skill. Carryer, (Carryer 2002) argued that tasks do not define a discipline, rather it is the philosophical approach guiding practice which determines the nature of the discipline. Essentially this latter view is borne out by participants' responses to questions about the nature of their role vis a vis medicine.

The nurses who participated in this study are well experienced in working in teams in the health-service industry. This experience of working with other health professionals together with formal education has enabled them to consider the practice distinctions between medicine and what they do. As Hannah described it:

Well the main difference is that I'm a nurse and they are doctors and our philosophies are very different and nursing is more focused I think, towards the health and wellness model and looking at maximising a person's wellbeing, even if we can't fix their problem then we help them to be as well as they can and to cope with living with [their diagnosis].

I fall back on or take with me the things that are nursing all the time...the collaboration, the coordination of care, all those sorts of things that are inherently nursing. I believe I am a nurse and I believe in the nursing role, and the nursing role is to care, assess, take a history and to support. And a doctor's role is to diagnose and prescribe. However there is a small area of overlap between our professions, and it's in that area of overlap that I see me functioning as a nurse practitioner.

Another nurse practitioner, Dianne, articulated her role in bridging the disciplines and needing to work closely with both groups. She described it powerfully:

You need to speak the language of medicine and the language of nursing without having an accent for either. If you are with nurses you need to speak nursing speak and be very articulate and if you are not you will easily be pulled down and if you are with doctors, you need to be able to speak the language of medicine articulately but keep your nursing hat on.

Certainly all nurse practitioners were clear that their role had some overlap with what previously may have been considered the domain of medicine. Invariably they expressed comfort with that. One nurse practitioner having outlined the complex challenges of practice implied that the so-called medical aspects of practice were least likely to cause concern. According to Mark:

A lot of what I do isn't that medical thing. It's like I said, the medical stuff is quick. They [patients] come in, you do an assessment, make a diagnosis, may be order some investigations, commence treatment and the last of what I did [evaluation] 86 per cent of people got well, and 14 per cent were referred to a GP.

Other nurse practitioners made it clear that the addition of diagnostic ability, the ability to order pathology tests and X-rays and prescribing was essentially a convenience for patients borne out of remoteness or workforce shortages. But more importantly there was the sense that the ability to provide more comprehensive care (and add so-called medical tasks) actually assisted with reducing fragmentation and being able to deliver such additional services in circumstances where relationships are well established thus benefiting patient or client comfort with the service. The references to retaining a nursing model are strong and coherent and clearly very important to the participants. There is a sense of integration between the notion of holism and the desire to provide care across a continuum, which spans the bio-social, psychological and the ability to avoid referral away for relatively simple needs. There is recognition (referred to in many different ways) that medical encounters may be too focused on pathology, too brief and often occur between a practitioner and a client who have no real relationship in which to set their encounter:

It's just the way a conversation starts with the doctor compared to the way that I would have started it as a nurse practitioner. Where I suppose my first priority is to actually get to know the person first, to get a feel for who they actually are, what their background is, talk about the family, to make a connectness and then go on to say well what are the major issues physically for you at the moment and then start to work through them. I've just found that because the first line [from the doctor] was about What are your major symptoms? instead of saying who are you and where do you come from and what's your background—that was the whole visit was around that—all the physical things and then a few suggestions were made which we said we'd follow up with today—like we need to organise oxygen and all that sort of stuff and then we came back and we had this discussion about how this person didn't want to talk these others things but from my perspective no-one had even tried to talk about those things.

Even so all nurse practitioners expressed respect for medical skill and no reluctance to collaborate or refer as needed. In addition health promotion and maintenance, coordination and caring, and initial responses to a wide range of complaints or maintenance of care during many episodes is enhanced when it is performed by the same person. That person (the nurse practitioner) unhesitatingly refers on when medical skill is required. The debate hinges around what really comprises medical skill. Nurse practitioners are committed to a nursing model of care but accept additional responsibilities as needed to benefit clients. Such additional tasks move their practice into an overlap with things previously medical but they still give primacy to a nursing approach.

Baer (2003) notes that when nursing asserts its claim to take responsibility for the full episode of care, it invites comparisons with medicine as to the extent of nursing's authority to take that responsibility. Such comparisons and challenges probably only serve to obscure the focus clearly demonstrated by these participants which suggests that alterations in the service provided by different professionals should be guided only by a desire to provide the most accessible and best-quality service. Medicine exerts its hegemonic power in numerous ways and the long history of research comparing nurse practitioner outcomes with medical practitioner outcomes is testimony to the controlling effect of that power. In many ways these nurse practitioner participants are exhorting us to move on from such self-conscious

comparisons and to focus purely on the richness of nurse practitioner practice as a nursing service.

It seems fitting here to quote an American doctor writing for nurse practitioners in 1974.

By expanding your knowledge and skills into medicine, and thereby acquiring some of that control, you can in fact expand into nursing...Less medicine when mixed with more nursing, is probably better medicine (or to translate, better health care)...By expanding into medicine you will need—more than ever before—to increase your consciousness of what nursing is all about (Bates 1974, p.686).

Partnership and cultural awareness

Nurse practitioner participants frequently asserted the value of delivering any care or service in a manner which recognises there is a human or therapeutic connection between the nurse and the patient or client. This connection underpins nursing assessment; it includes the ability to focus closely on the entire person rather than just the presenting or current problem for which care is being delivered. It could be argued that this human connection is partnership and is a component of caring and therefore a natural expression of nursing. Some evidence suggests that nurse practitioners do extend the caring for into the broader dimension of caring about. This attribute goes further and includes a sense of creativity captured by nurse practitioners describing their actions aimed at addressing the total wellbeing of individuals or communities.

In the following narrative Rita describes the way that a patient/client responds to her as a nurse as being qualitatively different and uses the notion of connectedness:

I saw a young woman, a 35-year-old, yesterday with one of our doctors, that was our first visit to her and it was almost like we touched on things that she didn't really want to talk about and it was a bit of an uncomfortable visit. I went back today because there were a few things that I need to follow up on and we had a really connectedness—she just poured all this stuff out that didn't come out yesterday. Do you know what I mean and I just think it's a different way—people with nursing training just give off a different aura that people connect to. They don't see you as the busy doctor whose only got a limited amount of time and they haven't got time to talk about this and they have to go onto the next medical thing

There is a therapeutic link between patient and nurse in nurse practitioner practice and it is both a part of and a source for holistic practice. Through that therapeutic link the nurse practitioner incorporates the complex social context of each client and aims for lengthy and meaningful encounters. This process derives from a nursing approach whereby the nurse practitioner looks at the person in context as the core aspect of assessment. Explicit in participant descriptions was their highly developed personal autonomy and accountability but also the narratives consistently demonstrated the inclination of these clinicians to stay with a patient's problem until both they and the patient were satisfied with the outcome. In effect the 'being and staying with' is a feature of both the therapeutic relationship and the regard for 'who' the patient or client is in a cultural sense. One participant used the word 'connectedness' to describe this relationship.

Connectedness is expressed by the notion of emotional work seen as fundamental to the outcome of the therapeutic encounter and it is further expressed by concepts which are akin to partnership with patients or clients. The following narrative from Sophie demonstrates this aspect of practice. Providing a pharmaceutical solution for seriously raised blood pressure is a simple diagnostic and therapeutic response but the nurse practitioner takes into account that the person concerned is, for example, reluctant to use conventional medicine and has complex belief systems which need addressing before the nurse practitioner and patient can proceed together effectively. Sophie was describing her management of a patient who had presented with a very severely raised blood pressure level. She had previously referred the patient on to a medical colleague for treatment of severe hypertension and anxiety:

She rings me and she says I'm going to go off my Coversil, Sophie, I've got to tell you my urine's really smelly and my gums are bleeding and I am not going to put up with this, you know. And I said well, thanks for letting me know but, why don't you come down to the clinic. So, she came down and we took a specimen of urine and she had a urinary tract infection. And I looked at her gums and they were inflamed and she had infected teeth. So, I talked to her about that, that perhaps not the Coversil, it was the urinary tract infection, because she could actually see that, you know, on the stick and I said we can send a mid-stream specimen away, because like most of us, she likes to see and understand what's going on.

And then when I put the light in her gums I could see that, you know, they were infected. So, I gave her an antibiotic, Keflex, that I thought would have a secondary bacterial effect with her gums as well as her urinary tract infection. And I just talked about UTIs and she said well, I thought I might have had one but she said I wasn't itchy, I wasn't burning so bad this time. She said usually I burn and I said what do you do for it, and she has yoghurt douches, you see. So, this woman had been left untreated all these years. She has a chronic UTI and she had an acute episode and she blamed that on the Coversil and the bleeding gums, which were due to infected teeth, on the Coversil.

In this encounter Sophie provided care cognisant of the fact that her patient was averse to bio medical treatment modalities and much preferred alternative regimens. Sophie acted as a partner to the woman in negotiating care but also used her extensive clinical knowledge to underpin that process. This can be seen as respectful of the person's cultural mores and leads to addressing other issues of cultural competence integral to a nursing approach to care.

Ramsden (Ramsden 2002) notes that cultural safety 'lies in the establishment of the trust moment and in shared meaning about the vulnerability and power followed by the careful revelation and negotiation of the specifics and the legitimacy of difference' (p.133). The nurse practitioner recognises and respects the right of people to make their own journey through the health/illness encounter. It is a fundamental tenet of nursing that people receive care that has regard for their cultural differences including ethnicity, sexuality, gender preference and socioeconomic class. Such awareness underpinned nurse practitioner interview data on many levels and while cultural competence is a core competency for all nurses it must also be specifically recognised at this level particularly as nurse practitioners work in isolation, or lead services and clinics and manage referrals.

Referral

The context of nurse practitioner practice means that they must sometimes deliver the full episode of care, sometimes determine that appropriate referral is needed and sometimes accept referrals from other nursing or medical staff. These practices, in an evolving context of nurse practitioner practice, require that the nurse practitioner has a clear sense of the authority of their knowledge and skill and the ability to use that appropriately. In so doing they read the context carefully and draw on highly developed communication skills:

I had to be a bit bossy really and make it clear to them that their practices were unacceptable and that they needed to improve. They were really receptive but I don't think that they realised quite you know what the issues were so it was helping them to understand why I was so concerned about what was happening and what needed to be put in place to make sure that he was safe. I guess it was having the knowledge about that and then the confidence to address that and follow it through.

And:

I think you need to have a really good, very strong grounding and understanding in your own practice so you need to have that advanced knowledge of cardiac disease and have an understanding and knowledge of the treatment protocols and therapies that are used amongst this group of people. You need to have a very clear understanding of the diagnostics. So that's quite specific to your area of practice. But I also think you need to have a very strong understanding of general nursing skills...Your skills of observation, communication, of planning. I think being a good communicator is essential, so that you can relate to communicate effectively with all members of the team as well as to the GP and the family. I think you really need to have a good instinct and insight into the ways chronic disease affects people's lives.

I guess we are more autonomous now because we do not have to go through that consultation with the GP. I still do in cases that I'm particularly concerned about or have some reservations in, because there's nothing saying that you shouldn't and, in fact, I think it's best practice to do that, to speak with other colleagues in order to get the best outcome for your patient.

At the heart of good referral processes is effective collaboration and mutual respect for the ability and expertise of others. This applies to all disciplines who participate in the health care team. Participants have demonstrated that good collaboration and referral is increased when their own sense of authority is increased by confidence and competence.

Increased autonomy and accountability

This is an interesting area as all nurses are understood to be accountable for their actions (Carryer and Boyd 2003) and to have the authority to determine nursing responses to nursing assessments. Nevertheless nurse practitioner participants frequently referred to a sense of increased autonomy and accountability in their role. What perhaps focuses the

notion of autonomy more is the context of extended practice in that nurse practitioners are now legitimately approved to carry out functions, which they may have previously done in the grey area of standing orders, customary practice in some areas and relationships of trust between particular health professional individuals. As nurse practitioners they know they are legitimated to assess and follow through independently using referral as an outcome of their own clinical judgment:

[W]e were autonomous before but I actually, I am actually working more autonomously because I feel I have got the Nursing Council's approval to do it. So like whereas before maybe I would say I want to do this but I will actually check with your GP, consultant, whatever because I was always, you know you are always very conscious of practising within the scopes and limits, well not so much your limits but within your scope. Now, I feel that that's what I have been okayed to do so I am quite happy to carry on with, the decision is exactly the same, but whereas before I would just say to one of the medical staff is this ok. Now I will just do it and I will say to them this is what I have done (Joanne).

And having that degree of autonomy to order the specific pathology tests that are required to maintain these patients at home. So that if I respond to an emergency call for potential fluid overload, having the ability to go ahead and perhaps alter medication doses, order the biochemistry that's required, that to me is the difference (Miranda).

A nurse practitioner expresses a sense of legitimacy, of authority and of ownership of the additional roles. Nurse practitioners also recognised that the flipside of increased autonomy is of necessity increased accountability. It is not that they are more accountable as such a thing is not possible. Instead the role extension and role expansion simply extend the range of any nurse's autonomy and accountability:

I've been doing all these things for many years now, you know, honing it better and better, of course, but when I thought about authorisation I thought ooh, the buck stops with me on this one. (Robyn)

So, you start to think well, okay, well, I have a great deal of responsibility here, I need to know more about what I'm doing, you seek out information from more expert people who can teach you, you learn more, and the consequence of that being you can provide a thorough assessment or history taking of the patient which will lead to the planning of your management and expected outcomes. (Miranda)

I haven't got any extra permission to do anything more than I used to do, in other words I cannot write prescriptions, I cannot write referrals for fracture x-rays and I cannot write a request for pathology yet. I understood that was to happen, but it hasn't happened yet.

Despite the clear expressions of increased knowledge and expanded autonomy, the data reveal that new nurse practitioners are having a difficult time as pioneers out there in unprepared territory. This is compounding a sense of disempowerment in the very group we least want to feel disempowered and this issue will be raised again in the next section on clinical leadership.

Summary : Professional efficacy

In order to succeed in the nurse practitioner role the nurse must acquire both a level of knowledge and skill and an approach to using that knowledge in a manner we have defined as efficacy. This captures the sense of professional identity and authority which supports delivering extended skills based on patient/client need and delivering them from a sound base of nursing. The nurse practitioner self identifies as first and foremost a nurse and this identity determines the nature of practice. The nurse practitioner applies critical reasoning to negotiate evidence and adapt care to the lived realities of clients in vastly different contexts and achieves this by establishing a climate of mutual trust and partnership with patients and clients, and whole communities where relevant. The critical component of professional efficacy is the ability to respect the right of people to determine their own journey through a health/illness episode while ensuring that people have accurate and appropriately interpreted information on which to base their decisions.

Professional efficacy also means that the nurse practitioner participates as a senior member of any multidisciplinary team, recognising nursing autonomy and giving and accepting referrals as appropriate. To do this they implicitly understand their own accountability but also work collaboratively with other clinicians to secure the best care of each patient or client.

Clinical leadership

At the heart of nurse practitioner practice is their personal and professional recognition as leaders. The nurse practitioner role is derived from master's degree education, which develops extensive and extended clinical skills as well as a critical awareness of nursing's place in health-service delivery and its professional and political context.

The nurse practitioner role is first and foremost a nursing role, giving primacy to health but accepting responsibility for extended management of illness and injury. As such the nurse practitioner role is the most senior clinical role in nursing and of necessity a leader in clinical practice settings. The nurse practitioner draws from their knowledge base and their adherence to consistent evidence review to inform and guide health policy and to participate as a senior member of the discipline, especially in relation to their scope of practice.

The leadership ability of the nurse practitioner includes everything which relates to their personal sense of autonomy, power and accountability. There is evidence that this is shaped by educational preparation, the context of practice and probably by the political, legal and employment contexts of practice. Nurse practitioners expect to, and do, lead both in the immediate clinical environment and in the wider context of health-service delivery.

Dianne demonstrates clinical leadership as follows:

There's keeping the nurse safe, getting the family to the position where they can see that the hopes and dreams and everything that they had ever wanted for this little boy, this little boy has been growing inside mum for nine months and he has been a part of their family for ages and ages and they have been desperate for this child to be born and they have got a child whose profoundly unwell and

getting them to the point where they can see that this kiddie in fact has already died...Then once they have got to that position it's actually making sure that the nurses in the unit are ok about those kind of decisions.

Leadership here involves several components: leading and developing practice and leading in the sense of responsibility for others. Jane demonstrates how her leadership also involves responsibility for the practice of others:

Well, he, himself, wasn't a challenge at all, he was quite agreeable to everything but it was probably his situation where I was needing to work with a lot of different people and everything was happening to him really without having a lot of control. It was working with the nurse and making sure that all the other variables were taken care of, proper techniques of blood glucose monitoring and testing.

The area of clinical leadership is emerging as a central role. For many of the participants this aspect of their practice was still developing and this is reinforced by the lack of literature in this area. All of these nurse practitioners are pioneers forging a new role in territory that is in no way prepared for them. Their challenges range from confronting active hostility, explaining who they are to nursing, medical and allied health colleagues and a range of frustrations around minor legislative and infrastructure issues which have not been addressed in advance of their authorisation. In both countries they must contend with uncertain employment security.

In New Zealand the role is clearly and consistently defined but employment prospects are grim. Many who have become nurse practitioners were already delivering high-level clinical care and employers are reluctant to accept the new title and the increased remuneration when they can have (and have had) the service anyway. In Australia there appears to be a focus on filling positional vacancies and numerous uncertainties surround the infrastructure for those positions.

This early nurse practitioner workforce is somewhat battered by these challenges. Many have invested significant energy in getting to the point of applying for a position and are continuing to expend energy in dealing with an environment that is not quite ready for them. The leadership aspect of the role is tacitly recognised by all nurse practitioners, managed effectively by some and is embryonic in others. There is recognition from participants that they have to develop and achieve in this area.

Certainly, things, from an area point of view, like clinical supervision models [we]have to be involved in that. More involved in the quality stuff, making sure we meet the standards. (Mark)

that we are in positions that not only [as] nurse practitioners but as nurses we're in a position to implement the government policy of the day (Robyn)

We have grappled with the terminology here but essentially the data has supported the strong sense that the personhood of the nurse is critical to satisfactory expression of the role. Nurse practitioners practise in challenging environments and it is essential that they are able to negotiate challenges and inconsistent support mechanisms in a powerful way. Despite the challenges they need to retain clarity about their professional accountability, autonomy

and their responsibility to assist in interpreting the nurse practitioner role to the public, to colleagues and to other members of a team.

I look at nurse practitioner, the model of nurse practitioner that I'm trying to hold onto or develop, to show people that this can be, this can be a model for a nurse practitioner working in a community are.

Another aspect of leadership is the need for nurse practitioners to have in-depth knowledge of the legal and ethical dimensions of practice, policy directives and best practice guidelines which influence their own practice and that of the people they lead. Generally the policy aspect is recognised but not well developed as it is not yet a strong or established component of nursing education at any level:

The bit that I don't do a lot of is policy, influencing policy...and I feel like I need to do something about that and I've got an appraisal coming up on Tuesday and I'm going to say that, because we haven't had really good education surrounding policy development. (Deb)

Summary : Clinical leadership

The nurse practitioner is a leader in all dimensions of nursing practice. This is not only the most senior clinical role but a nurse practitioner also provides health service leadership from the perspective of senior clinician. Key elements of clinical leadership are the need to guide and influence care delivery systems through engagement in policy development either directly at local organisation and local government level or through active engagement in the policy work of their professional organisation. The nurse practitioner leads through any of a number of roles including researcher, clinical teacher, case coordinator, and spokesperson and in this capacity may take responsibility for assisting the public, policy-makers and other health care professionals to understand the nurse practitioner role. In so doing they draw from the relevant evidence base to influence the quality and nature of services provided.

Conclusion

This chapter has explicated the core role of the nurse practitioner in Australia and New Zealand based on a research process which for this section has involved interviewing 15 nurse practitioners. We have demonstrated that the core role is characterised by three areas of practice: dynamic practice, professional efficacy and clinical leadership. Practice is dynamic in that it involves the application of high-level clinical knowledge and skills in a wide range of contexts. The nurse practitioner in the role demonstrates professional efficacy enhanced by an extended range of autonomy, including legislated privileges. The nurse practitioner is a clinical leader with a readiness and an obligation to advocate for their client base and their profession at the systems level of health care.

Introduction

This chapter will report on the results of a comprehensive analysis of available education programs that lead to a nurse practitioner qualification. In this chapter we will also present an analysis of current nurse practitioner program accreditation processes in Australia and New Zealand.

The research objective guiding this analysis is:

To investigate the current standards of education and program accreditation for nurse practitioners in Australia and New Zealand.

The report will be structured around the main features of a program curriculum. Data were derived from curricula documents and supplemented by interviews with academic program convenors and nurse practitioners. Data have been aggregated and reporting will be in the form of trends and patterns. Programs will be identified by country when it is necessary to report and compare specific regulatory features as they influence the project outcomes.

Program characteristics

Level and duration of award

Thirteen of these programs leading to the award of a nurse practitioner qualification were masters' degrees. One was at graduate diploma level. Of the master's degree programs, six programs were four semesters in length and seven were three semesters. The graduate diploma was two semesters with an additional period required to complete a clinical internship.

In interviews with academic convenors all agreed that the master's degree was an appropriate standard for nurse practitioner education. The graduate diploma program was reportedly offered only at that level because of an historical factor determined by the regulatory authority. Planning is underway to move this program to a master's degree.

In interviews with nurse practitioners, all participants were asked their view on the level of education necessary for nurse practitioner training. All participants stated that nurse practitioner qualifications should be a master's degree, although some had qualified support for this position. Justification for the view related to the following perspectives:

- public perception of the level and stature of a master's degree as an important aspect of ensuring public confidence

- a belief that the master's degree offers scholarship that is comparable with the nature of the skills, knowledge and attributes required
- personal experience of the value of that level of education.

In some instances nurse practitioners provided support for this view based on their own experiences as pioneers while others offered a perspective influenced by having come to the nurse practitioner role through a different route. For example, as one master's graduate noted:

Not because it is a master's degree though, but because of what underpins a master's degree, it's the way that kind of education makes you think that is important, not the degree. So it's the critical appraisal and it's the critical analysis...

And another:

It made me more enquiring about what I do and how I do it in my everyday setting so that now—I read extensively and I just don't wonder why and ask someone...I go and seek it (the information) out myself.

For others, academic qualifications were initially viewed as secondary requirements:

We had two avenues of gaining authorisation and one was these masters' programs that were accredited, I felt a little bit peeved. I thought it was devaluing what I'd already done. But now...I feel that master's course was worth its weight in gold.

Nurse practitioners who did not have masters' degrees tended to take a more qualified stance and were overwhelmingly committed to the primacy of clinical experiences as preparation for the nurse practitioner role. The following three excerpts from interviews demonstrate the varied opinions of these clinicians:

I think for the purposes of perception and public confidence a master's (degree) is definitely the level, particularly when we're still debating with other health professional colleagues the worth or the need for nurse practitioners, or the safety. You know, that comes up a lot...I think it's very important to really set that standard, and that's been a worldwide standard, so I think that's certainly the place to be.

Well I'm aware that (the) University started a two-year course last year and...I really don't know what they are teaching, but I would like to see a lot of practical work. Well, I don't have a degree in anything, but I do have a lot of practical experience, and I'm very glad that the 'grandfather clause' was a deciding factor, because I think there are a lot of nurses who are very good nurses but because they can't do university degrees they fail to qualify. I don't always think that's right.

Title

Despite the common focus on nurse practitioner qualifications from these programs, the nomenclature in the titles was varied. Of the 14 programs seven had nurse practitioner in the title. Three were titled advanced practice and four were titled (Master of) Nursing.

Interview data helped to clarify this variation. Early programs in New South Wales had their titles influenced by the Nurses Registration Board. Many of the academics interviewed were supportive of not having nurse practitioner in the program title. This position was justified on the basis that the award did not qualify the graduate to be a nurse practitioner—this was the role of the nurses board authorisation process.

Entry requirements

Entry requirements across the 14 university programs were highly consistent, with the main variation being in requirements for experience in the specialty. Two programs required five years specialty experience, two required three years experience and three required two years experience. Another four had no requirements and the remaining three were non-specific. Nine of the programs required postgraduate training/qualifications in the specialty field and most of these were integrated into the master's degree. In terms of miscellaneous requirements, two required a completed portfolio for entry to the program and two required membership of professional/specialty association. Ten of the 14 programs had flexible entry and exit features.

Scope of the programs

Three of these programs were focused on one specific specialty, namely:

- rural and remote
- mental health
- high dependency.

Six university programs offered a range of structured specialty studies while five universities offered programs with a core group of courses and a framework or assessment mechanisms to obtain advanced/extended education in the candidates' own specialty. In interviews with academics this latter model was described as a necessary approach to nurse practitioner education to facilitate the development of skills and knowledge in new fields of extended nursing practice.

Program management

Accreditation profile

According to available data there are six jurisdictions where nurse practitioner programs of study can be accredited by the relevant nurses board/council to provide nurse practitioner education. Of the 14 nurse practitioner programs across New Zealand and Australia, 12 are accredited and two are awaiting accreditation.

In New Zealand, universities use the New Zealand Nurse Council Advanced Nursing Practice Competencies with or without prescribing. In Australia, the majority of authorising bodies

use the Advanced Practice competencies developed by the Australian Nursing Federation (Australian Nursing Federation 1997). Individual programs use the relevant competency standards in curriculum and some also draw upon developed competencies for the specialty (for example, the National Remote Area Nurse Competencies in Australia).

Curricula oversight

In the absence of formal inter-jurisdiction and trans-Tasman regulation of nurse practitioner training it became important to gain an understanding of the factors additional to the accreditation standards that influenced the content, teaching and learning process and oversight of nurse practitioner programs. The results indicate that eight of the 14 programs had specific curriculum management and curriculum advisory committees. The majority of these committees were multidisciplinary and comprised membership both internal and external to the university. The New Zealand programs all had oversight committees with membership designed to protect cultural integrity from a Maori perspective. Just one Australian program had consumer membership on oversight committees.

Conceptual basis for curricula

All curricula documents contained information relating to explicit assumptions about the content, teaching and learning processes and the profile of the graduate. There were a variety of descriptions relating to assumptions that determined the content of the programs. These have been analysed according to the themes set out in Table 2.2.

Table 2.2: Assumptions informing content

Extended scope of nursing practice	8
The nurse practitioner is distinct from other APN roles	6
Formal nurse practitioner definition	4
The nurse practitioner as research informed	8
Requiring advanced training in clinical practice (specialty)	9
Professional accountability/autonomy	2
Collaborative worker	2
Clinical mentor/leader	3

One program was designed on the assumption of education for an advanced level of health care during GP shortage. In interview, the academic from that program stated that this was an historical imperative and was currently under revision. Only two of the programs conceptually differentiated the nurse practitioner from the advanced practice nurse, the majority subsuming the nurse practitioner into the APN scope of practice.

There was a consistent approach across all curricula documents and interviews with academics that the learning program for nurse practitioners is informed by self-directed/ adult learning principles (see Table 2.3 below).

Table 2.3: Assumptions informing teaching and learning

Requirement for adult learning approach	3
Learning is collaborative	7
Use of the clinical field with clinical mentor/preceptor	13
Use of experiential/situated learning	4
Promoting self-directed/lifelong learning skills	8

Additionally all academics interviewed were committed to the clinical environment as a context for nurse practitioner education.

Data from the nurse practitioner interviews also strongly supported the centrality of clinical learning as preparation for the nurse practitioner role. For some, there was a dichotomy. Clinical experience was viewed as different from, and better than, the (perceived) alternative academic orientation of a master's degree. In responding to the question of level of education for the nurse practitioner one clinician stated:

...Seems we have put the cart before the horse in that we've got people becoming nurse practitioners and as a nursing profession we haven't really given a lot of thought to the content of a clinical master's, we are slinging things together as we go and it probably would have been better to have the clinical master's in place before the regulatory framework...

Others were wary of the quality of the clinical content in master degree programs. Participants who were very recent graduates of approved master degree programs in both countries expressed concern at the adequacy of the clinical content. They were especially concerned for students who would come to the degree without the level of clinical experience which had informed their own student experience. They were adamant that the clinical rigour of the master's degree must be maintained and developed while not losing the special qualities of master's degree education:

I think experience is really a key issue. I studied no higher than a Grad Dip, and I know that the master's are being developed and functioning at several universities. But I don't believe that academia is the main component that should determine a nurse practitioner.

Graduate profile

Data from the expected profile of the graduate was extensively related to generic nursing roles and scope of practice. That is, much of the language around the graduate profile related to outcomes of generic master degree programs and did not specifically focus on the unique aspect of the nurse practitioner scope of practice. Exceptions were programs that specifically

stated competencies and practice scope that was an extension to the scope of specialist and advanced nursing practice. These were:

- competence in advanced/extended practice
- ability to define the nurse practitioner scope of practice through portfolio
- ability to promote and negotiate the nurse practitioner role
- extended nursing knowledge and practice
- extended/advanced skills in assessment, diagnosis and use of therapy
- case manager
- independent practice
- lead collaborative expert practice across settings, within the interdisciplinary team
- pioneer in innovative nursing practice
- competence in prescription, administration and monitoring of medications in treatment.

These education outcomes were isolated from the collated profiles as relating specifically to the extended role of the nurse practitioner.

Curricula content

Findings from this study indicate that the current professional and regulatory environment in Australia, in which nurse practitioner programs of education are designed, is diverse, with scant attention to national priorities and cross-border collaboration. The situation in New Zealand is more cohesive due largely to the centralised nature of nursing regulation. The trans-Tasman context therefore is also diverse. Hence the content imperatives for nurse practitioner education have been determined locally and in response to the attitudes and opinions of each health service or clinical environment.

Accordingly, one of the questions in the interviews with academics related to the factors that influenced the program content. The responses were varied. In one program the content was designed from empirical curriculum research conducted during the nurse practitioner trial in their jurisdiction. For the remainder, content was determined through consultation with clinical specialists, specialty competencies when available, advisory committees, medical practitioners and the academics' own vision for the nurse practitioner role. Additionally many were influenced by publications from North America and United Kingdom.

In many of the programs the nurse practitioner stream was embedded in a general nursing master's degree program. Hence it was at times difficult to determine the content/courses that were specifically designed for nurse practitioner education.

Consistent with the assumptions influencing teaching and learning, the content of these programs all recognised the centrality of the clinical field to nurse practitioner education. Twelve of the programs required or preferred the candidates to be currently employed in their specialty field. In the remaining two the academics were unavailable for interview and there

was no clear indication in the relevant curriculum document. The same pattern applied to the requirement for clinical courses and internships where practice learning was supported by a clinical team, clinical preceptor or mentor. For many of these courses the clinical learning support was provided by medical practitioners and other health care professionals.

Specific nurse practitioner content was in some programs difficult to isolate, in some, the title of courses was conceptual rather than content descriptive. There was nonetheless a pattern across all courses relating to the content syllabus of these programs. These data have been categorised into three areas of content, namely universal content, frequent content and specialty content.

Universal content

Three study areas were contained in all 14 programs. These were:

- Pharmacology. In many programs the study of pharmacology was iterative in that this content was spread in several courses across the curriculum.
- Research with or without a focus on evidence-based practice. Research training, while present in all programs, varied in terms of scope. Some required candidates to conduct a small research project or practice audit while other programs contained research and/or evidence-based practice courses without empirical study requirements.
- Assessment and diagnosis, including imaging and laboratory diagnostics. This area of study was a major feature in all programs. While course titles varied there was a consistent commitment to content related to advanced and extended assessment and diagnostic skills.

Frequent content

Other study areas that were common across many of the programs included:

- clinical sciences (anatomy and physiology, pathophysiology)
- nursing professional and scope of practice studies
- clinical leadership
- society, law and ethics
- studies in cultural awareness and cultural aspects of nurse practitioner practice.

Content such as symptom management and therapeutics was listed in some programs. However these areas of study tended to be linked to specialty streams.

Specialty content

Specialty content was apparent in two forms: those programs that had designated specialty focus or streams (N=9) and those programs with a generalist core component and framework for specialty study (N=5). The pattern of specialty education varied. In some, content in the

specialty streams focused on specialist assessment and therapeutics and in others, content was guided by the competencies for that specialty, for example, the Australia and New Zealand College of Mental Health Nurses. Other programs located specialty education in the clinical practicum component. And others required the candidate to enter with a graduate diploma in a specialty field. Those programs with frameworks for specialty study worked from learning contracts and/or clinical practicum with dedicated preceptors/mentors or a clinical team for specialty learning.

Portfolios

Nine of the programs had a Portfolio requirement. This was most commonly in course assessment. In some programs this was a major and complex work, for others it was a minor assessment requirement. Considering the centrality of the Nurse Practitioner Portfolio in the authorisation/registration requirements in all jurisdictions, it is surprising that the Portfolio was not a stronger and consistent feature across all nurse practitioner education programs.

The nurse practitioner interviews focused questions related to content areas for nurse practitioner programs. Advanced assessment and pharmacology received top rating. This is consistent with the curricula data in that pharmacology and advanced assessment were featured in all 14 programs. Content related to patho-physiology, health systems, with policy and political issues also receiving frequent mention. Legal issues, and research skills and utilisation were noted as important. The importance of excellent communication skills was often mentioned by the nurse practitioners but not identified as a component of education programs.

Summary—Analysis of nurse practitioner narratives

The journey to acquire the role and title of nurse practitioner has, not surprisingly, been a varied one across both countries and across states. The sample, without exception, comprises very experienced nurses with a long history of specialist practice (in New Zealand), and in Australia, an extremely lengthy and diverse background of practice both in scope of practice and context.

The participants spoke strongly of what is described as lifelong learning, characterised by independence for learning and a growing thirst for knowledge ‘as you go along you learn what you need to know’. Several spoke of the difficulty in valuing one particular style of learning over another, describing all education as valuable and some noting that their appreciation for education expanded as their sense of the role developed. All participants in different ways, directly or indirectly, alluded to the necessary complexity of the ideal educational preparation. The reasons for this are made clearer later in this chapter when we address the nature of the role. Consistently the data spoke to the need for a nursing model as the core tenet in preparation for nurse practitioner practice, or as many of the participants described it, holism.

The results indicate that these authorised and experienced nurse practitioners see education as having a twofold purpose. The first is the obvious core clinical practice skills and

knowledge. The second is related to professional and scholarly development of the clinician. Reasons for this include underpinning their confidence through understanding, developing their ability to be articulate both in written work and orally and assisting them to deal constructively with the cultural challenges inherent in a pioneering role. Participants note, in varied comments, the need to have a clear understanding of the context of health service delivery, and the political, legislative and cultural impacts on practice. The vulnerability of these nurses in many settings validates their need for a range of skills to ensure their professional safety. This is not always directly recognised by the nurse practitioners themselves (although many do) but is inherent in the documented challenges they address.

Introduction

Implementation of the nurse practitioner role has required substantial amendment of health care Acts and regulations in both New Zealand and Australia. These Acts and regulations are set down by parliament and provide the broad legal framework within which the nurse practitioner may practise. As noted in Section 1, health care responsibility in Australia is divided between Commonwealth and state or territory governments; thus health care professionals including nurse practitioners are subject to national legislation in both New Zealand and Australia, and further subject to state or territory legislation in Australia. National legislation most relevant to nurse practitioners includes the funding of health care (e.g. Medicare and the Pharmaceutical Benefits Scheme), and professional indemnity insurance.

Nurse practitioner authorisation is the responsibility of the nursing regulatory authorities in each jurisdiction. The primary role of the nursing regulatory authorities is to protect the public through ensuring nurses demonstrate an acceptable standard of practice. With implementation of the role of the nurse practitioner, nursing regulatory authorities have set in train processes to evaluate nurse practitioner practice and authorise those that demonstrate they are able to meet the criteria set by the nursing regulatory authorities.

This chapter reports on a comprehensive analysis of the current legislation and authorisation processes regarding nurse practitioner practice. The research objective guiding this analysis was:

To evaluate legislation and competency standards and criteria that have been used for nurse practitioners in Australia and New Zealand

This chapter is divided into three parts. The first part describes the legislation framework as it relates to nurse practitioner practice in each jurisdiction. The second part describes the authorisation criteria in place across Australia and New Zealand. The third part analyses the data from nurse practitioner interviews that relate to the authorisation processes and criteria and how these processes articulate with the reality of nurse practitioner practice. From the perspective of individual nurse practitioners, all legal and other regulatory processes pertaining to their roles and scope of practice are brought together through the authorisation process.

Legislative framework for nurse practitioner practice

The title 'nurse practitioner' is protected in all jurisdictions where there is legislation to regulate nurse practitioner practice (Ministry of Health 2002; Nurses Board of the ACT 2004; Nurses Board of Victoria 2004; Nurses Board of South Australia March 2002; Nurses Board of Western Australia Sept 2003; Nurses Registration Board of New South Wales Sept 2003). The

title is protected by legislation in Australian jurisdictions and by trademark in New Zealand. In Queensland, the Northern Territory and Tasmania there is currently no legislation to regulate nurse practitioner practice and in these jurisdictions the title is not yet protected.

In both Australia and New Zealand, a wide range of legislation has required amendment to allow implementation of the nurse practitioner role. Such legislation includes not only the Nurses Act (however named in each jurisdiction), but may also include state or territory legislation related to regulation of:

Interpretation of legislation	<i>Legislation Act 2001</i> (ACT)
Health administration	<i>Health Act 1993</i> (ACT)
	<i>Public Health Act 1997</i> (ACT)
	<i>Nurse Practitioners Legislation Amendment Act 2003</i> (ACT)
	<i>Sexually Transmitted Diseases Act 1956</i> (ACT)
	<i>Tuberculosis Act 1950</i> (ACT)
	<i>Mental Health (Treatment and care) Act 1994</i> (ACT)
	<i>Nurses Amendment Act 1999</i> (NZ)
	<i>Health Practitioners Competence Assurance Act 2003</i> (NZ)
	<i>Health Acts (amendment) Act 1995</i> (Vic)
Other health professionals	<i>Medical Act 1894</i> (WA)
Controlled substances	<i>Poisons Act 1933</i> (ACT)
	<i>Pharmacy Act 1931</i> (ACT)
	<i>Drug Misuse and Trafficking Act 1985</i> (NSW)
	<i>Liquor Act 1982</i> (NSW)
	<i>Pharmacy Act 1964</i> (NSW)
	<i>Poisons and Therapeutic Goods Act 1966</i> (NSW)
	<i>Controlled Substances Act 1984</i> (SA)
	<i>Drugs, Poisons and Controlled Substances Act 1981</i> (Vic)
	<i>Misuse of Drugs Act 1981</i> (WA)
	<i>Pharmacy Act 1964</i> (WA)
<i>Poisons Act 1964</i> (WA)	
Environmental protection	<i>Radiation Protection and Control Act 1982</i> (SA)
	<i>Radiation Safety Act 1975</i> (WA)
Road safety	<i>Road Transport (Alcohol and Drugs) Act 1977</i> (ACT)
	<i>Road Traffic Act 1974</i> (WA)
Other	<i>Crimes Act 1900</i> (NSW)
	<i>Shops and Industries Act 1962</i> (NSW)

The terminology used to describe the regulatory processes allowing use of the title varies across jurisdictions. Nurse practitioner applicants are ‘registered’ in ACT and WA, ‘authorised’ in New South Wales and South Australia and ‘endorsed’ in New Zealand and Victoria. As described in the Glossary, the term ‘authorised’ will be used throughout this report to include authorisation, registration and endorsement of nurse practitioners.

Authorisation as a nurse practitioner in Australia and New Zealand

This part refers only to those jurisdictions where the title of nurse practitioner is protected and comprises three components: definitions, authorisation criteria and authorisation processes. First, there is a brief summary of the definitions used for the term ‘nurse practitioner’. The next part outlines the criteria, standards and/or competencies that the respective regulatory authorities require applicants to achieve in order to be authorised as a nurse practitioner. Finally, the nurse practitioners’ narratives describing their experiences of the authorisation processes are analysed.

Definitions

Legislation in each jurisdiction, and each nursing regulatory authority, uses a different definition for ‘nurse practitioner’ (see Table 2.4). The legislative definition is very broad, leaving the details of nurse practitioner practice to be defined by the nursing regulatory body. The primary purpose of the legislative definition is to provide title protection. Where this protection is established by other means, for example, trademark (NZ), the legislation may not contain a definition of ‘nurse practitioner’.

Table 2.4: Definitions of ‘nurse practitioner’ used in Australia and New Zealand

For each jurisdiction, legislative definitions are given first, followed by the nurse practitioner documentation.

Definition	Jurisdiction
ACT	
Nurse practitioner means a person who is registered as a nurse practitioner under the <i>Nurses Act 1988</i> .	<i>Legislation Act 2001</i>
A nurse practitioner is a registered nurse working within a multidisciplinary team whose role includes autonomous assessment and management of clients using nursing knowledge and skills gained through advanced education and clinical experience in a specific area of nursing practice. The role may include but is not limited to the direct referral of patients to other health care professionals, the prescribing of a designated and agreed list of medications, and the ordering of a designated and agreed list of diagnostic investigations. (The ACT Nurse Practitioner Project, Final report of the Steering Committee July 2002)	Nurses Board of the ACT 2003
New South Wales	
‘Nurse practitioner’ means a person authorised by the Board under this Act to practise as a nurse practitione	<i>Nurses Act 1991; Sect 3</i>
Nurse practitioners are registered nurses who practise at an advanced level and who are authorised to use the title. Advanced practice incorporates the ability to provide care to a range of clients at a level, which demands: <ul style="list-style-type: none"> • a repertoire of therapeutic responses • insightful sophisticated clinical judgments • clinical decision making justified by application of advanced knowledge. 	Nurses Registration Board of New South Wales Sept 2003

Definition	Jurisdiction
New Zealand	
Nurse practitioner not defined	<i>Nurses Act 1977</i> <i>Nurses Amendment Act 1999</i>
Nurse practitioners are registered nurses with masters' degrees and at least four years experience working in their chosen clinical area. They may have worked initially in a variety of clinical areas and then decided to specialise in one area of nursing practice. Nurse practitioners will have completed at least five years of academic study to gain their master's degree. Registered nurses must meet Nursing Council assessment criteria and competencies before the Council will recognise them as nurse practitioners.	<i>NCNZ 2002b</i>
South Australia	
Nurse practitioner not defined	<i>Nurses Act 1999 Sect 3</i>
A nurse practitioner is a registered nurse educated to function in an advanced clinical role. The scope of practice of the nurse practitioner will be determined by the context in which the nurse practitioner is authorised to practice.	Nurses Board of South Australia March 2002
The defining features of a nurse practitioner, as described in the South Australian Nurse Practitioner Project 1999, includes combined roles of educator, mentor, provider, manager and researcher within the context of need, setting, education and autonomy.	
Victoria	
'Nurse practitioner' means a nurse whose registration has been endorsed in accordance with section 8B ('Endorsement of registration for nurse practitioners').	<i>Nurses (Amendment) Act 2000</i>
The Victorian Nurse Practitioner Taskforce defined a nurse practitioner as '... a registered nurse educated for advanced practice who is an essential member of an interdependent health care team and whose role is determined by the context in which s/he practises' and stated that 'core components of the nurse practitioner role include advanced clinical practice, education, counselling, research, quality improvement, administration and management'.	Nurses Board of Victoria 2004
WA	
'Nurse practitioner' means a nurse who is registered under section 22A as a nurse practitioner	<i>Nurses Act 1992</i>
A nurse practitioner is a registered nurse educated to function in an advanced clinical role. The scope of practice of the nurse practitioner will be determined by the context in which the nurse practitioner is authorised to practice and will include legislative authority not currently within the scope of nursing practice (NNO 2000).	Nurses Board of Western Australia April 2003

As can be seen from the table, there are commonalities across the nursing regulatory authority definitions. All definitions describe the nurse practitioner as:

- a registered nurse
- practicing at an advanced level
- authorised to use the title
- educated to perform in an advanced role.

Most, although not all, regulatory authorities specifically identify an advanced clinical role for the nurse practitioner. The definitions in current use are, for the most part, based on consensus discussions from early 2000 (NNO 2000). They do not incorporate the role evolution and professional experience of nurse practitioners since that time and their diversity does not provide a clear foundation for consistent nurse practitioner regulation; thus revision is in order.

Authorisation criteria

The authorising criteria in New Zealand and each authorising state and territory in Australia is influenced by a variety of requirements. Each authorising body must comply with the legislative process as outlined in the various Acts and regulations. In addition, health departments may maintain authority for approving nurse practitioner guidelines or protocols and ratifying nurse practitioner positions. As will be discussed later in this chapter, these levels of control serve, to a greater or lesser extent, to direct or influence the scope of nurse practitioner practice in ways that may not reflect either client needs or professional practice. Finally, and most importantly, the regulatory authorities must protect the public by ensuring that authorised nurse practitioners practise at a standard that serves the public interest. In summary, each authorising body has developed criteria and processes to meet the expectations and requirements of legislation, health departments and the public.

As with much of the authorising documentation reviewed for this report, the terminology used across the regulatory authorities varies even if the concept they are describing is similar or identical. In order to achieve authorisation, nurse practitioner applicants are required to demonstrate they have met ‘criteria’ (New South Wales, New Zealand, Victoria), ‘standards’ (ACT, Western Australia), ‘evidence criteria against standards’ (South Australia) or ‘competencies’ (New Zealand). In this report, the term ‘authorisation criteria’ will be used to encompass all these terms.

Each of the regulatory authorities has developed nurse practitioner practice criteria related to educational preparation, clinical practice (direct client care), collaborative arrangements, professional development and leadership and evidence-based practice. In many cases these criteria are based on established advanced practice competencies.

Educational preparation

As described in chapter 2.2 all regulatory authorities except South Australia have developed criteria for approving courses suitable for nurse practitioner preparation and require nurse practitioner applicants to have undertaken an approved course or equivalent. Despite the variation in the level of courses approved by regulatory authorities, all except South Australia and WA require nurse practitioners to be educated with a master’s degree or equivalent, although in Victoria applicants need not necessarily have completed their course of study (Nurses Board of the ACT 2003; Nurses Board of Victoria 2004; Nursing Council of New Zealand Sept 2002; Nurses Board of Western Australia Sept 2003; Nurses Registration Board of New South Wales Sept 2003). Equivalency can be demonstrated through a combination of formal and informal education and experience.

Clinical practice

For all regulatory authorities, nurse practitioners are explicitly required to demonstrate both advanced and extended components in their clinical practice. The majority of authorisation criteria either explicitly or implicitly covers the areas of health assessment, diagnosis, therapeutic management and evaluation of client outcomes. Within each of these areas, the nursing regulatory authorities identify more specific requirements. In addition, all jurisdictions require nurse practitioners to demonstrate evidence-based practice across a range of therapeutic responses. Table 2.5 provides a summary of what can be loosely described as clinical practice criteria. These are collated from the documentation distributed by the nursing regulatory authorities (Nurses Board of the ACT 2004; Nurses Board of Victoria 2004; Nurses Board of Western Australia April 2003; Nurses Board of South Australia March 2002; Nursing Council of New Zealand Sept 2002; Nurses Registration Board of New South Wales Sept 2003).

Table 2.5: Clinical practice criteria

Criteria	Jurisdiction
The nurse practitioner will provide care to a specific client group demonstrating: <ul style="list-style-type: none"> • advanced and extended nursing knowledge and skills with complex clinical problem solving • a repertoire of therapeutic responses justified by application of advanced knowledge and evidence-based practice. 	All
Health assessment	
Conduct a comprehensive health assessment: anatomy, physiology, psychological, pathophysiology	All
Diagnosis	
Identify actual/potential health needs of the client group or individual	NZ, SA, Vic
Develop differential diagnosis including judicious ordering and interpreting diagnostic processes/pathology and radiology tests	All
Therapeutic management	
Anticipate, rapidly prioritise and respond to complex/dynamic/emergency situations	All
Provide prioritised therapeutic management options including applied pharmacology and drug administration	All
Provide ethically and culturally sound practice	All
Demonstrate judicious referral strategies/recognises limits to own practice	All
Facilitate client access to health services	NZ, SA, Vic
Provide relevant specialist counselling skills/therapeutic communication	NSW, SA
Communicate, collaborate and consult with client and appropriate health professionals	All
Hold admitting and/or clinical privileges as necessary	SA, Vic
Provide wellness and health promotion interventions	ACT, NSW, NZ, Vic, WA
Evaluation of client outcomes	
Evaluate clinical outcomes: monitor client responses, revise treatment plan, risk management, document	All
Document appropriate processes for client follow-up and review	SA

The ACT, New South Wales and South Australia have identified specialty areas of practice, or 'bands', (Nurses Board of the ACT 2003; Nurses Registration Board of New South Wales Sept 2003) (Nurses Board of South Australia March 2002). These bands include:

- mental health nursing
- rehabilitation and habilitation nursing
- community health/primary health care nursing
- women's and children's nursing/midwifery
- acute care/high dependency/medical-surgical nursing
- rural and remote nursing.

New Zealand (Ministry of Health 2002) had been using a more complex band system incorporating both specialty area of practice and target population, but that system is currently under review (personal communication).

The purpose of the system varies between jurisdictions. In ACT and South Australia the nurse practitioner is authorised to practice only within a specific specialty area of practice and must reapply to the nursing regulatory authority to change bands (Nurses Board of the ACT 2003); Nurses Board of South Australia March 2002). In New South Wales expert panels from specialty areas of practice assess individual applications for authorisation. However authorisation to practise as a nurse practitioner is not restricted to a particular specialty area of practice (Nurses Board of Western Australia Sept 2003).

As described in the nurse practitioner interviews, these specialty areas of practice or bands can be problematic. It is not clear that Australia and New Zealand will ever develop to the point where there is nurse practitioner expertise in all specialty areas in all jurisdictions. Some nurse practitioners interviewed stated that the 'expert panels' reviewing their applications were not well versed in their area of practice and felt the panel would be hard pressed to evaluate their clinical practice. Consistently defined specialty areas of practice could facilitate cross-jurisdictional development of expert panels, thus increasing the potential pool of panel members and enhancing congruence in evaluation of nurse practitioners' application for authorisation.

Guidelines and collaboration arrangements

In New Zealand, South Australia and Victoria, the individual nurse practitioner is responsible for demonstrating role development including clinical guidelines and/or collaboration arrangements (Nurses Board of Victoria 2004; Nurses Board of South Australia March 2002; Nursing Council of New Zealand Sept 2002). In New South Wales and Western Australia, however, the health department controls the clinical guidelines and collaboration arrangements by providing approval independent of the authorising process, while the Victorian criteria describes the need for nurse practitioners to demonstrate 'verification of supervision' including 'elements of direction, guidance, oversight and coordination of activities' by a variety of personnel such as academics/educators, experienced clinicians, advanced clinical nurse specialists or medical practitioners (Nurses Board of Victoria 2004). The result in all of these jurisdictions is that role development is constrained in ways that may not be directly about professional practice or client needs (Harris and Redshaw 1998)

(see nurse practitioner comments under ‘Control of positions and employment’ below). Appropriate indemnity insurance is required by nurse practitioners in Victoria and South Australia. However this may be either individual insurance or under the auspices of the employer, e.g. public health care system (Nurses Board of Victoria 2004; Nurses Board of South Australia March 2002). These requirements appear to be influenced by perceptions of risk management.

Professional development and leadership

Aspects of professional leadership are explicitly included in the nurse practitioner criteria in New South Wales, New Zealand, South Australia and Victoria (Nurses Board of South Australia March 2002) (Nurses Board of Victoria 2004; Nurses Board of Western Australia Sept 2003) (Nursing Council of New Zealand Sept 2002). However only New Zealand, South Australia and Victoria explicitly address professional development in their nurse practitioner criteria. Participation and contribution to ongoing professional development opportunities such as professional support networks, workshops, seminars and conferences are required by South Australia and Victoria, as is documentation of a professional development history (Nurses Board of Victoria 2004; Nurses Board of South Australia March 2002). This professional development history may be equivalent to a professional portfolio; such a portfolio is required in all jurisdictions. In addition, New Zealand, South Australia and Victoria require the nurse practitioner to demonstrate application of reflective practice and to identify opportunities for expanding the nurse practitioner’s role and responsibilities (Nurses Board of Victoria 2004; Nurses Board of South Australia March 2002; Nursing Council of New Zealand Sept 2002). Finally, South Australia explicitly requires nurse practitioners to initiate processes for formal performance feedback (Nurses Board of South Australia March 2002).

Evidence-based practice

All jurisdictions require nurse practitioners to use evidence-based clinical practice. In addition, New South Wales, New Zealand, South Australia and Victoria require the use of research to enhance and evaluate relevancy, currency and efficacy of clinical practice while in New Zealand, South Australia and Victoria, nurse practitioners must develop, implement and critically evaluate evidence-based protocols (Nurses Board of South Australia March 2002; Nurses Board of Victoria 2004; Nurses Registration Board of New South Wales Sept 2003; Nursing Council of New Zealand Sept 2002). Quality assurance and/or risk management mechanisms are required to be developed, implemented, maintained and documented in most jurisdictions (Nurses Board of South Australia March 2002; Nurses Board of Victoria 2004; Nursing Council of New Zealand Sept 2002).

Evidence of achieving criteria

The application process itself opens the nurse practitioner applicant’s professional preparation, including formal and informal education and experience, to scrutiny by peers and experts in the relevant fields. All jurisdictions require nurse practitioners to present evidence of their level of achievement although the requirements for that evidence vary slightly between jurisdictions. Table 2.6 below presents the evidence required on initial application for authorisation as a nurse practitioner.

Table 2.6: Evidence required on initial application for authorisation as a nurse practitioner

Evidence	Jurisdiction
Initial registration	
Current registration as a nurse	All
Authorisation to practise midwifery/other scope as appropriate	NZ, NSW
Education	
Completion of a program approved by the NRB OR equivalent	ACT, NSW, NZ
Completion or undertaking a program approved by the NRB OR equivalent	Vic
Completion of a program approved by the NRB (transcript plus letter)	WA
Clinical experience	
5000 hours advanced practice appropriate for the relevant broad area of practice during the last six years	NSW
At least four years post-registration experience in nominated scope	NZ
Practice as a nurse practitioner or graduate from course within past five years	ACT
Portfolio	All
Interview	ACT, NSW, SA, NZ
Site visit	NZ
Indemnity insurance	SA, Vic

In addition, the ACT, New South Wales, New Zealand and South Australia require applicants to attend an interview before a panel of experts (Nurses Board of the ACT 2003; Nurses Registration Board of New South Wales Sept 2003; Nursing Council of New Zealand Sept 2002; Nurses Board of South Australia March 2002;). In New Zealand a panel member may undertake a site visit 'to observe the applicant's scope of practice in her/his usual practice setting' (Nursing Council of New Zealand Sept 2002, p 14).

Renewal

Renewal of nurse practitioner authorisation is required in all jurisdictions with the renewal period ranging from annual (Nurses Board of South Australia March 2002; Nurses Board of Western Australia Sept 2003) to every five years plus random audits (Nursing Council of New Zealand Sept 2002). In order to demonstrate continued clinical competence, qualifications and experience, nurse practitioners are variously required to provide a self-declaration and/or portfolio. Western Australia specifically states that nurse practitioner authorisation will not be renewed if the nurse practitioner has not practised as a nurse practitioner for a period

of three years or completed an approved qualification or refresher course (Nurses Board of Western Australia Sept 2003).

It should be noted that only New South Wales and South Australia have authorised nurse practitioners whose authorisation has come up for renewal, so the processes are very new and untried in most jurisdictions.

Summary of authorisation criteria

It can be seen that the potential nurse practitioner who wishes to be authorised must satisfy a very diverse range of authorisation criteria addressing educational preparation, clinical practice, collaboration arrangements, professional leadership and development and evidence-based practice. These diverse requirements may result in unintended consequences for the nurse practitioner's scope of practice as well as making the authorisation process very complicated for individual nurse practitioners. The next part of this chapter examines authorisation from the perspective of individual practitioners.

Nurse practitioner experience of the authorisation process

Nurse practitioners interviewed for this research were universally aware that assessment of clinical practice plays a key role in the authorisation process. Their comments reflected recognition that the early nurse practitioner roles are experiencing intense professional and political scrutiny. Further, nurse practitioners stated their clinical roles are challenging and they support rigorous processes to ensure nurse practitioners are able to provide the complex and demanding care required by their clients:

So that process was quite a reflective time and thinking about what the, what we have been calling scope of practice but now it's a speciality area of practice or something. What that would be and how it could be positioned and how it could be most effective to meet the needs of people with [clinical problem] in our community and then looking at the competencies and what evidence that I had to meet those...

From another nurse practitioner:

I am actually pleased that the whole process is as rigorous as it is because then you need to stand in front of your profession and if it wasn't like jumping through hoops of fire backwards you might have a hard time convincing yourself that you are worthy of the title. So it's very, very rigorous and it should be. It's the top of the clinical practice model for nursing and you need to be sure that people in those roles are appropriate.

The nurse practitioner interviews yielded rich narrative about the authorisation process. Analysis of these data will inform the development of more consistent authorisation criteria and processes and enhance mutual recognition processes across the Tasman. Data from the interviews is presented and analysed according to the components of the authorisation processes.

Portfolio

Development of a professional portfolio was seen by many nurse practitioners as a very positive exercise resulting in a clearer sense of their practice as nurse practitioners and in a sense of personal achievement:

Even though getting the portfolio ready was a long-winded process I think it was very helpful in sort of preparing me for the role and making sure every component of the role is ready before I actually implement the role. So I do believe the portfolio was extremely helpful... I think the portfolio allowed me to actually put everything within it and explain my role quite well.

...actually when you do it, it makes you realise how much you have achieved and have done and you don't always realise that... You know you think I really have done that and I have done that, you don't always get a lot of praise in the health system and it does you a lot of good to actually realise that there is positive stuff.

The majority of the nurse practitioners commented on the extensive time and effort required to develop their portfolios with most stating it took approximately six months to gather, organise and develop the required material. In addition to the time and effort, one nurse practitioner stated:

it's personally incredibly draining and so exposing as well'...

However then went on to say, in relation to the authorisation process:

I know it's hard, I know it's really, really hard but I'm pleased we are doing it this way and I would feel very, very sad if it changed....In order to be a nurse practitioner you need to be able to work right outside the box, be lateral, work outside your work time, push yourself harder, have a vision, lead the way ...with anything that you are at the top of your field, you need to be able to do that.

Thus, the data demonstrates that portfolio development presents nurse practitioners with an important tool for self-reflection and personal and professional growth.

Interview

Those nurse practitioners commenting on their authorisation interview process were generally supportive of the process, suggesting it provided an opportunity to expand and clarify aspects of their portfolio:

The interview is entirely around the competencies so your portfolio is there, each person has your portfolio and obviously they ask you the questions relevant to their area and you are given one patient scenario, which you are usually given over lunchtime and then you come back after lunch and discuss what you would do in that situation.

Not only that I could present it in a written form but then I could speak to it and elaborate further and extend what I had written in the portfolio, that I was who I was. That I was what I said I was in the portfolio. It also gave me the opportunity to

explore perhaps different areas, some areas in more depth, other areas they didn't ask me at all about.

It was apparent, however, that the interview processes varied considerably with some nurse practitioner candidates undergoing a review of all aspects of their role and others experiencing a panel quiz focusing on the support structures in place for their positions:

So then I had the interview, which was rather gruelling and rigorous, which it should be, I was absolutely exhausted...It's like one of those, maybe going through labour when you blank it, out but the interview took just over four hours.

They really didn't test my knowledge about [my clinical specialty] or about what I do. It wasn't specific in that regard—it was more about me understanding my boundaries and that I practise safely.

Most of the nurse practitioners' interviews were, however, clinically focused, often exploring the nurse practitioner's clinical knowledge in relation to a case study. Although this approach was supported by several nurse practitioners, there were some concerns that the authorisation process was re-evaluating knowledge and skills that had already been amply demonstrated in educational and employment venues and documented in the portfolio:

I think that's how the portfolio shines out, is that you have given the evidence of what you have done, you have given them the evidence of the communication chains that you've established, your networking, your team work, the way other health professionals perceive you in what you do, so I think that's all important evidence to say that you are clinically sound in what you are doing. You put your own quality assurance activities on that as well and that's the way you're judged clinically, not by the Nurses Board...I think having to go through any sort of viva at this level is certainly not on as far as I'm concerned. We have already done all that.

I think the danger of the portfolio is: are they going to judge me clinically or academically (which I don't think they should be doing as I think that's already been done) and that was what happened to me the first time. I think once you've written your context of practice, you've given them the evidence of your experience and your knowledge and education, that should be sufficient.

The data suggest that the purpose and format of the interviews was widely variable across the jurisdictions. In some cases, the interviews provided the nurse practitioner candidate with an important opportunity to clarify any areas of uncertainty in their portfolio, but in other cases the interview was simply a viva, examining the nurse practitioner's knowledge and skills. The nurse practitioners interviewed for this study were divided in their assessment of the interview as a clinical examination.

Some interviewees stated a clinical viva was an appropriate approach to ensuring nurse practitioners meet the highest standards of practice, but others stated that their clinical practice was more appropriately assessed in their education and employment setting with the portfolio providing evidence of their ability to perform in those settings. The variation in interview comments may be due to the diversity in educational backgrounds of these early nurse practitioners. For some interviewees, the rigorous demands of a clinically focused and assessed master's degree will have provided ample evidence of their ability to perform to the

high standard demanded by nurse practitioner practice. Other nurse practitioners have had no formal postgraduate education or assessment and no opportunity to undergo rigorous examination other than through the authorisation process.

Site visits

The New Zealand Nursing Council retains the option of a site visit as part of the authorising process. The nurse practitioner interviews indicated that the site visits are potentially valuable but there is some concern that the purpose and use of the visits be equitable and clear:

I know they can do a site visit after the interview and that has happened to a couple of the nurse practitioners over the year but I think they do that when they just want to verify certain aspects that maybe didn't come over in the interview. Maybe it's difficult to assess clinical practice on the exemplars. I think mental health was one area where that occurred and I think that option is there but I don't think it's essential because obviously if they have got the information from the exemplars and from feedback from colleagues.

One of the nurse practitioners suggested that the option of site visits might be helpful in cases where the nursing regulatory authority is unclear of the nurse practitioner's clinical role:

...maybe coming and seeing what I actually do may have just helped them to understand that I am actually working very clinically. I think if that's something that's really important to the authorisation process then coming to a clinic or something just to see that I actually am practising the way I say I am in my documentation.

Clinical guidelines vs. nurse practitioner protocols

Development and implementation of clinical guidelines was another area in which the nurse practitioner sample described wide diversity in their experiences. Understanding this diversity demanded interpretation in the context of the legislation and authorisation processes within each jurisdiction. For some nurse practitioners, clinical guidelines were a matter of those standards expected of all health care professionals when caring for a client group, and were multidisciplinary guidelines developed by a collaborative national or international professional body, e.g. Clinical practice guidelines for the psychosocial care of adults with cancer (NHMRC 2003), Assessment and management of cardiovascular risk (New Zealand Guidelines Group 2003).

For other nurse practitioners, however, development and implementation of so-called 'clinical guidelines' was an explicit effort to limit the nurse practitioner's practice, introducing artificial boundaries unrelated to the needs of clients or the demands of professional practice. These nurse practitioners were not describing 'clinical guidelines' as identified by the NHMRC (NHMRC 1999) or the NZGG (New Zealand Guidelines Group 2003), but rather 'nurse practitioner protocols'. These protocols created wearisome and excessively restrictive boundaries to clinical practice:

Well, you can't have a guideline for everything you do. It's impossible. I mean, a doctor doesn't have a guideline for everything he does, and...I think there was just such an outrage from the AMA and everybody else that it all became so prescriptive in these three areas I talked about earlier. You know, prescribing and ordering diagnostic radiology and pathology. I think it's just become too narrow.

And also it's impossible to get them signed off by anybody. There are nurse practitioners in [this jurisdiction] now who are still practising without guidelines and therefore can't use that authority they have to prescribe an order.

And I don't know where the problem is there. Even if you adopt a guideline in [this jurisdiction] that's gone through that rigorous process, and that was bigger than Ben Hur, it used to be, you know, about 50 people looked around the table and looked at them for about two years.

Even if you adopt one that's been signed off, you've still got to go through that process.

The international literature describes the risks of limiting practice through restrictive protocols. These risks include reducing ability of the nurse practitioner to respond to the wide variety of client needs seen in nurse practitioner practices, failure to appropriately employ nurse practitioners' extensive clinical and theoretical knowledge base in the clinical setting, misuse of restrictive protocols as evidence in malpractice suits, failure to fully develop professional practice including advanced and extended nursing practice, restrictions on evolution of innovative practice to meet changing health care system demands and inappropriate use of scarce resources to develop and maintain protocols (Nejedly, Broden et al. 1999; Likis 2003; Marsden, Dolan et al. 2003).

As with all health professionals, nurse practitioners are expected to be familiar with and adhere to the recommendations of multidisciplinary clinical guidelines such as those from the NZGG and the NHMRC. The real risk, however, is that so-called 'clinical guidelines' will be protocols, and such protocols will be seen as an invitation for inappropriate and potentially dangerous restrictions on the provision of innovative, responsive and evolving models of health care delivery. This is particularly true when non-nurses, for example, the powerful medical profession or health care administration, use protocols to exert control over professional nursing practice.

Control of positions and employment

In addition to clinical restrictions on professional nursing practice, financial restrictions are also used to restrict client services provided by a nurse practitioner. In New South Wales and WA, health districts wanting to employ nurse practitioners are required to develop nurse practitioner 'clinical guidelines' including prescribing guidelines and a business case. The departments of health are responsible for evaluating the proposals and approving 'designated areas' in which nurse practitioners can practise. Creation of designated areas as a separate and distinct process from authorisation of the nurse practitioner to practise in that area has created a cumbersome and unwieldy bureaucratic process unduly frustrating and limiting nurse practitioners:

Two years ago there's a big practice up here with a GP that was quite involved in the AMA stuff and we were having fights about nurse practitioners and where they could go, rural remote 40 positions, all that stuff. And I went to him and said, you know, this is—I took in my portfolio and I said this is what I've done, what I can do, I really want to work in general practice where I can use my skills, and he actually made a proposal to the area health service at a time when it was very, very political that he'd take me on as a pilot for the nurse practitioner job...

And the area health service turned him down. So, I think that's very interesting.

As with nurse practitioner protocols, the designated areas limit the scope of nurse practitioner practice and introduce what might be perceived as artificial boundaries into the nurse practitioner-client relationship. This disjointed process has been poorly understood by some nurse practitioners, potentially leading to inappropriate clinical practices:

I don't think that my boss should in any way have anything to do with policies and procedures for a Remote Area Nurse, I think maybe that Peer Review Panel should have had a lot to do with it, people like [names remote area nurse], people who have done it, people who have been—like the coordinators for Remote Area Nurses say in [remote health districts]. People who have a lot of experience with what a Remote Area Nurse does. Not this person who hasn't done any remote area nursing...

Funding or political issues may also block the development and implementation of nurse practitioner positions:

I tried to get some [nurse practitioner] positions signed off by the [title] to establish nurse practitioners in [district], and we had two signed off about two years ago to go to guidelines and then recruitment. And that hasn't moved anywhere, and that's to do with funding. And in the meantime I completed my Master's in Nurse Practitioner at [university], so I'm now authorised in the United Kingdom and Australia—well, [this jurisdiction]—and they're still struggling to create a position for me.

Again:

I think from a state point of view, I think we've got too embroiled in the politics...of guidelines and policies that take about three years to go through, and it's just been made very, very bureaucratic.

These limitations, and the difficulties they cause for potential nurse practitioners, clients and the employing health district, have been recognised and are being addressed in New South Wales. The challenge remains to develop a flexible and innovative nurse practitioner practice able to meet client needs while providing a framework for nurse practitioner education and authorisation.

Summary

Authorisation of nurse practitioners occurs in a complex legislative framework. This framework includes not only the Nurses Acts in each jurisdiction, but a wide range of legislation related to interpretation of legislation, health administration, regulation of other health professionals, regulation of controlled substances, environmental protection and road safety. Each of these Acts and their associated regulations impacts on nurse practitioner authorisation and implementation of the nurse practitioner role.

Nurse practitioner authorisation is the responsibility of the nursing regulatory authority in each jurisdiction. Although the nursing regulatory authority's central responsibility is to protect the public, the nurse practitioner authorisation processes must also meet the requirements of legislation and complement health department requirements. Given that the legislative and health department requirements vary between jurisdictions, and the evolution of the nurse practitioner roles in each jurisdiction has proceeded on different timelines and under different sociopolitical climates, it is not surprising to find wide variances in the authorisation processes and criteria. Some commonalities, however, do exist.

All nursing regulatory authorities require nurse practitioner candidates to demonstrate appropriate educational preparation, clinical practice, collaborative arrangements, professional leadership and development, and evidence-based practice. Educational preparation is usually required at master's degree or equivalent; clinical practice incorporates authorising criteria in the areas of health assessment, diagnosis, therapeutic management and evaluation of client outcomes; collaborative arrangements include appropriate referral mechanisms and guidelines; professional development requires self-reflection and ongoing education; and evidence-based practice demands utilisation of research and quality assurance activities.

Portfolios and interviews are most commonly used to assess candidates' ability to meet authorising criteria. In addition, New Zealand maintains an option for site visits. Nurse practitioners universally describe the authorisation process as difficult, challenging and demanding. They describe the high degree of reflection on practice and on the role of the nurse practitioner demanded by the authorisation processes. They describe the many benefits of this rigorous process: self-awareness, personal and professional growth, role clarity and professional credibility.

Nurse practitioners also described the limitations of their authorisation processes. Many of their concerns regarding undue limitations and restrictions on practice were due to the use of nurse practitioner protocols/guidelines and disjointed processes with authorisation of nurse practitioners separated from approval of clinical guidelines. This division has caused frustration and is perceived by some nurse practitioners to inappropriately limit their ability to meet the needs of their client group. Overseas literature clearly demonstrates the dangers of restrictive clinical and administrative practices, with failure to fully develop autonomous nurse practitioner practice leading to risks to client outcomes, health care service innovation, and development of professional nursing practice (Nejedly, Broden et al. 1999; Likis 2003; Marsden, Dolan et al. 2003).

As evidenced in this project, there is a clear willingness among nurse practitioners and nursing regulatory authorities to facilitate the development of the nurse practitioner role

in New Zealand and Australia. The consistency that exists between jurisdictions provides a vehicle for moving forward. In this project, New Zealand and Australia have the opportunity to demonstrate global leadership in development and implementation of international criteria for nurse practitioner education and authorisation.

section **3** **Synthesis**

The previous section reported on the outcome of data analysis relating to nurse practitioner core role, current approaches to education and program accreditation and nurse practitioner regulation. The collection and analysis of data informing Section 2 was directed by the three research objectives described on page 42 .

Section Three will draw upon these findings to develop knowledge related to the project outcomes. This section therefore will be guided by the overall Outcome Objective of the study. That is:

To develop core standards for the nurse practitioner in Australia and New Zealand to inform a competency framework that can be applied to practice standards, education standards, program accreditation standards and processes for nurse practitioner authorisation

This section therefore is structured in three parts, namely:

3.2 Nurse practitioner legislation and authority

This chapter presents the findings and recommendations in relation to nurse practitioner definition, title protection, clinical guidelines and bands

3.3 Nurse practitioner competency framework

This chapter will draw upon the findings related to the core role of the nurse practitioner to develop a nurse practitioner competency framework

3.4 Nurse practitioner education accreditation standards

The findings from Chapter 2.4 and the nurse practitioner competency framework will be combined with published literature to provide the basis for recommendations related to standards for nurse practitioner education and an accreditation framework.

Introduction

This chapter presents the findings and recommendations in relation to nurse practitioner definition, title protection, clinical guidelines and bands.

Definition

In order to provide a clear, meaningful and logical foundation for nurse practitioner regulation, a consistent definition of ‘nurse practitioner’ should be adopted across Australia and New Zealand. The definition of the nurse practitioner role used in regulatory documents serves as a logical foundation for nurse practitioner regulation. The definition should provide a meaningful statement of the key components of the role, offering an authoritative description of scope and boundaries. Ideally, a definition should provide clarity and ensure that stakeholders work from a common understanding of the term ‘nurse practitioner’. Current definitions do not provide that clarity as overwhelmingly evidenced by the national and international literature, political debate across Australia and New Zealand, and nurse practitioner interviews conducted for this study (Barton, Thome et al. 1999; Dunn 2000; International Council of Nurses 2000; Reveley 2001).

The proposed definition, developed from current regulatory documents and national and international literature, is:

A nurse practitioner is a registered nurse educated to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include, but is not limited to, the direct referral of patients to other health care professionals, prescribing medications, and ordering diagnostic investigations. The nurse practitioner role is grounded in the nursing profession’s values, knowledge, theories and practice and provides innovative and flexible health care delivery that complements other health care providers. The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practise.

Title protection

In order to protect the public and regulate the professional standards of nurse practitioner competence and conduct, the title 'nurse practitioner' should be protected in all jurisdictions, including non-authorising jurisdictions, in Australia and New Zealand.

The title 'nurse practitioner' is protected in each of the jurisdictions currently authorising the role. Internationally, the title is protected in the United States and Canada, but not in the United Kingdom, although the Royal College of Nursing has called for title protection (Le Bon 2000). Failure to provide title protection in the United Kingdom has resulted in widespread use of the title by persons with little or no advanced or extended educational preparation or skills. This, in turn, has led to inadequate ability to ensure high quality nursing care and diminution of the role in the health care system (Royal College of Nursing undated).

Nurse practitioner protocols

There is indication from this research that nurse practitioners in some jurisdictions are required to practise according to specific, detailed and prescriptive guidelines or protocols. The findings suggest that these guidelines are overly restrictive and place externally imposed limitations on the nurse practitioner and their capacity to respond to their clients' needs or to develop innovative service delivery. The risks of this approach have been well documented (Nejedly, Broden et al. 1999; Likis 2003; Marsden, Dolan et al. 2003).

There is a growing database of multidisciplinary clinical guidelines for best practice. As with any health care professional, nurse practitioners should identify the clinical guidelines that will serve to enhance the care they provide. Clinical guidelines, as described by the NHMRC (NHMRC 1999), and the New Zealand National Guidelines group (New Zealand Guidelines Group 2003) provide the evidence for improving the quality of health care in a clinical setting by reducing unwarranted variations in clinical interventions, and increasing the use of interventions with maximum benefit and minimum risk. It is apparent that, as with all health care professionals, the appropriate use of multidisciplinary clinical guidelines will assist the nurse practitioner to provide the best possible care to their clients.

Recommendations arising from this chapter

1 Description of the core role of the nurse practitioner in Australia and New Zealand.

It is recommended that:

- 1.2 The following definition be adopted as the standard definition for Australia and New Zealand:

A nurse practitioner (NP) is a registered nurse educated to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge

and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications, and ordering diagnostic investigations. The nurse practitioner role is grounded in the nursing profession's values, knowledge, theories and practice and provides innovative and flexible health care delivery that complements other health care providers. The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practise.

- 1.2 The title 'nurse practitioner' be legally protected in all jurisdictions.
- 1.3 Best practice for nurse practitioners be established against the benchmark of existing National Multidisciplinary Clinical Guidelines relevant to their field of practice.
- 1.4 It is further recommended that the parameters of practice for the nurse practitioner be structured around the specialty field of practice and determined by local community needs and professional standards.

From core role to generic standards for nurse practitioners

Introduction

In Chapter 2.3 we formulated the core role of the nurse practitioner in Australia and New Zealand. We demonstrated that the core role as described was derived from research, validated by nurse practitioner clinicians and affirmed by key stakeholders. We argued that the core role is characterised by three areas of practice as illustrated in the following table.

Table 3.1: Areas of practice in the nurse practitioner core role

Dynamic Practice		Components of Dynamic Practice
		Clinical knowledge and skills
		Practice in complex environments
		Currency of clinical knowledge
Professional Efficacy		Components of Professional Efficacy
		A nursing model of extended practice
		Partnerships and cultural awareness
		Autonomous and accountable practice
Clinical Leadership		Components of Clinical Leadership
		Critique and influence at systems level of health care
		Collaborative practice

Adoption of this as a standard description of the nurse practitioner core role will begin the process of standardisation of nurse practitioner issues across Australia and New Zealand.

The nurse practitioner role and national standards

The characteristics of the core role of the nurse practitioner as described in Table 3.1 provide a strong, research-based platform for development of national standards for nurse practitioner practice and education. This chapter will report on the development of Nurse Practitioner

Standards from the research findings. The following chapter will report on the standards for nurse practitioner education.

The research findings indicate that there are identifiable knowledge, skills and attitudes that can define the competencies of nurse practitioner practice. Our findings also identify that these competencies are embedded in a method of practice that draws upon attributes related to a different level of practice from the known and customary nursing roles and scope of practice. Hence the framework for nurse practitioner standards that follows will contain two layers:

- i) Competencies that describe the knowledge, skills and attitudes of nurse practitioner practice.
- ii) Indicators for recognising the attributes of the method of nurse practitioner practice.

These two layers will now be explicated to identify the extended practice characteristics of the nurse practitioner role.

Nurse Practitioner Standards

i) Competency framework

The above described characteristics of the core role of the nurse practitioner provide a strong starting point and organising structure for competency development. The practice areas, presented in Table 3.1 above, readily translate to Core Standards and the components of the three practice areas contribute to development of competencies for these standards. However the findings from the research into the core role are insufficiently precise to give detailed indicators for all nurse practitioner competencies; in some areas the data are less robust than in others. This may be related to the newness of the role of nurse practitioner and the relative lack of experience, particularly as it relates to clinical leadership, in the role of the research participants. Therefore in developing the competencies related to these three standards the investigators have combined the research findings with information from the literature (for example, NSW Health Department 1995; Read 2001; ACT Government 2002). The following Competency Framework defines the first layer for National Standards for Nurse Practitioner practice in Australia and New Zealand. The assumptions informing the development and use of this framework are as follows.

Assumptions

- 1** The nurse practitioner is a registered nurse whose practice must first meet the following regulatory and professional requirements for Australia and New Zealand and then demonstrate the additional requirements of the nurse practitioner:
 - National Competency Standards for the Registered Nurse
 - Code of Ethics for Nurses
 - Code of Professional Conduct for Nurses.

These assumed requirements serve as the foundation for the nurse practitioner competency framework and are not repeated in the nurse practitioner framework.

- 2 The Nurse Practitioner Standards build upon the extant Advanced Nursing Practice Competency Standards used respectively in New Zealand and Australia. These founding standards are not repeated in the nurse practitioner framework.
- 3 The Nurse Practitioner Standards are based on findings from the Nurse Practitioner Standards Research Project. They are developed to ensure safe nurse practitioner practice that relates to a specific field of health care.
- 4 The Nurse Practitioner Standards are core standards that are common to all models of nurse practitioner practice. They can accommodate specialty competencies that are designed to meet the unique health care needs of specific client/patient populations.
- 5 The Nurse Practitioner Standards will be used by nurse practitioner education providers to develop the content and process requirements for a master's degree nurse practitioner education program.
- 6 The Nurse Practitioner Standards will be used by regulatory authorities to determine the eligibility of registered nurses seeking authorisation as nurse practitioner in Australia and New Zealand.

See following Table 3.2 for Nurse Practitioner Competency Framework

Table 3.2: Nurse Practitioner Competency Framework

Standard 1		Dynamic practice that incorporates application of high-level knowledge and skills in extended practice across stable, unpredictable and complex situations
Competency	Performance indicators	
1.1 Conducts advanced, comprehensive and holistic health assessment relevant to a specialist field of nursing practice	a	Demonstrates advanced knowledge of human sciences and extended skills in diagnostic reasoning
	b	Differentiates between normal, variation of normal and abnormal findings in clinical assessment
	c	Rapidly assesses a patient's unstable and complex health care problem through synthesis and prioritisation of historical and available data
	d	Makes decisions about use of investigative options that are judicious, patient-focused and informed by clinical findings
	e	Demonstrates confidence in own ability to synthesise and interpret assessment information including client/patient history, physical findings and diagnostic data to identify normal and abnormal states of health and differential diagnoses
	f	Makes informed and autonomous decisions about preventive, diagnostic and therapeutic responses and interventions that are based on clinical judgment, scientific evidence, and patient-determined outcomes

Standard 1 **Dynamic practice that incorporates application of high-level knowledge and skills in extended practice across stable, unpredictable and complex situations**

Competency	Performance indicators
1.2 Demonstrates a high level of confidence and clinical proficiency in carrying out a range of procedures, treatments and interventions that are evidence based and informed by specialist knowledge	<p>a Consistently demonstrates a thoughtful and innovative approach to effective clinical management planning in collaboration with the patient/client</p> <p>b Exhibits a comprehensive knowledge of pharmacology and pharmacokinetics related to a specific field of clinical practice</p> <p>c Selects/prescribes appropriate medication, including dosage, routes and frequency pattern, based upon accurate knowledge of patient characteristics and concurrent therapies</p> <p>d Is knowledgeable and creative in selection and integration of both pharmacological and non-pharmacological treatment interventions into the management plan in consultation with the patient/client</p> <p>e Rapidly and continuously evaluates the patient/client/'s condition and response to therapy and modifies the management plan when necessary to achieve desired patient/client outcomes</p> <p>f Is an expert clinician in the use of therapeutic interventions specific to, and based upon, their expert knowledge of specialty practice</p> <p>g Collaborates effectively with other health professionals and agencies and makes and accepts referrals as appropriate to specific model of practice</p> <p>h Evaluates treatment/intervention regimes on completion of the episode of care, in accordance with patient/client-determined outcomes</p>
1.3 Has the capacity to use the knowledge and skills of extended practice competencies in complex and unfamiliar environments	<p>a Actively engages community/public health assessment information to inform interventions, referrals and coordination of care</p> <p>b Demonstrates confidence and self-efficacy in accommodating uncertainty and managing risk in complex patient care situations</p> <p>c Demonstrates professional integrity, probity and ethical conduct in response to industry marketing strategies when prescribing drugs and other products.</p> <p>d Uses critical judgment to vary practice according to contextual and cultural influences</p> <p>e Confidently integrates scientific knowledge and expert judgment to assess and intervene to assist the person in complex and unpredictable situations</p>
1.4 Demonstrates skills in accessing established and evolving knowledge in clinical and social sciences, and the application of this knowledge to patient care and the education of others	<p>a Critically appraises and integrates relevant research findings in decision making about health care management and patient interventions</p> <p>b Demonstrates the capacity to conduct research/quality audits as deemed necessary in the practice environment</p> <p>c Demonstrates an open-minded and analytical approach to acquiring new knowledge</p> <p>d Demonstrates the skills and values of lifelong learning and relates this to the demands of extended clinical practice</p>

Standard 2**Professional efficacy whereby practice is structured in a nursing model and enhanced by autonomy and accountability**

Competency	Performance indicators
2.1 Applies extended practice competencies within a nursing model of practice	<p>a Readily identifies the values intrinsic to nursing that inform nurse practitioner practice and an holistic approach to patient/client/community care</p> <p>b Communicates a calm, confident and knowing approach to patient care that brings comfort and emotional support to the client and their family</p> <p>c Demonstrates the ability and confidence to apply extended practice competencies within a scope of practice that is autonomous and collaborative</p> <p>d Creates a climate that supports mutual engagement and establishes partnerships with patients/ carer/family</p> <p>e Readily articulates a coherent and clearly defined nurse practitioner scope of practice that is characterised by extensions and parameters</p>
2.2 Establishes therapeutic links with the patient/ client/ community that recognise and respect cultural identity and lifestyle choices	<p>a Demonstrates respect for the rights of people to determine their own journey through a health/ illness episode while ensuring access to accurate and appropriately interpreted information on which to base decisions</p> <p>b Demonstrates cultural competence by incorporating cultural beliefs and practices into all interactions and plans for direct and referred care</p> <p>c Demonstrates respect for differences in cultural and social responses to health and illness and incorporates health beliefs of the individual/community into treatment and management modalities</p>
2.3 Is proactive in conducting clinical service that is enhanced and extended by autonomous and accountable practice	<p>a Establishes effective, collegial relationships with other health professionals that reflect confidence in the contribution that nursing makes to client outcomes</p> <p>b Readily uses creative solutions and processes to meet patient/client /community defined health care outcomes within a frame of autonomous practice</p> <p>c Demonstrates accountability in considering access, clinical efficacy and quality when making patient-care decisions</p> <p>d Incorporates the impact of the nurse practitioner service within local and national jurisdictions into the scope of practice</p> <p>e Advocates for expansion to the nurse practitioner model of service that will improve access to quality, cost-effective health care for specific populations</p>

Standard 3**Clinical leadership that influences and progresses clinical care, policy and collaboration through all levels of health service**

Competency	Performance indicators
3.1 Engages in and leads clinical collaboration that optimise outcomes for patients/clients/communities	a Actively participates as a senior member and/or leader of relevant multidisciplinary teams
	b Establishes effective communication strategies that promote positive multidisciplinary clinical partnerships
	c Articulates and promotes the nurse practitioner role in clinical, political and professional contexts
	d Monitors their own practice as well as participating in intra- and inter-disciplinary peer supervision and review
3.2 Engages in and leads informed critique and influence at the systems level of health care	a. Critiques the implication of emerging health policy on the nurse practitioner role and the client population
	b Evaluates the impact of social factors (such as literacy, poverty, domestic violence and racial attitudes) on the health of individuals and communities and acts to moderate the influence of these factors on the specific population/individual
	c Maintains current knowledge of financing of the health care system as it affects delivery of care
	d Influences health care policy and practice through leadership and active participation in workplace and professional organisations and at state and national government levels
	e Actively contributes to and advocates for the development of specialist, local and national, health-service policy that enhances nurse practitioner practice and the health of the community

ii) Method of nurse practitioner practice

The above competency framework outlines the knowledge, skills and attitudes of nurse practitioner practice that is located at the extended level of nursing service. Taken in isolation some of these competencies and many of the performance indicators could be claimed by other levels of nursing, from the new graduate to the advanced practice specialist. And so they should be. Our research findings indicate that this claim will be an affirmation of the complexity and breadth of the nurse practitioner role. The nurse practitioner does not discard other levels and aspects of nursing practice; rather, our findings indicate that these are incorporated up to anchor extended practice firmly in a nursing model. A defining feature of the nurse practitioner level, then, is that the practice is characterised by the concurrent application of all these standards and competencies.

However the research findings indicate that there is an additional feature of nurse practitioner practice that is related to the method and contexts of practice. And these features must be captured and defined in any approach to evaluation, education and licensing of the nurse practitioner.

One of the most important outcomes from this research is the imperative to recognise that the practice of the nurse practitioner is qualitatively different from that of other roles and levels

of nursing. Nurse practitioner practice must accommodate a range of practice environments, deal with complexity and non-linear reasoning in health care and draw upon creative and non-standard solutions to achieve optimal outcomes for the client. The common aspect from the data is that nurse practitioners must be prepared to deal in conventional and innovative ways with complexity and novelty in the delivery of effective health care. The following quote from a published diary of a nurse practitioner further illustrates this and resonates with the above data from this study:

I feel I bring a unique perspective concerning collaborative practice in the SICU. I understand the philosophy and responsibilities of the surgical residents and at the same time am able to respond to and appreciate the nursing philosophy regarding patient care. At times there is conflict between physicians and nurses over such issues as, for example, whether all dressings should be changed with sterile technique or whether a certain patient should be made a 'no code.' As I gained acceptance of the surgeons as a primary care provider, I was able to discuss patient and nursing concerns objectively at rounds. I try to facilitate discussions that address the issues, which leads to decreased conflict and better communication between team members. On a personal note, the role development has required introspective work that at times has been uncomfortable and difficult. It has involved recognising the positive qualities in myself and also understanding those personal characteristics that I need to work on. (Jarvis 1999)

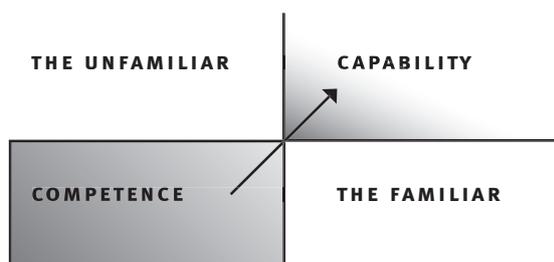
Our conclusion from this analysis is that in addition to a competency framework, Nurse Practitioner Standards also need to be informed by an approach to evaluation of the clinician that can accommodate these additional characteristics. A useful model to achieve this orientation is that related to the notion of capability (Stephenson and Weil 1992; Hase and Kenyon 2000). Capability has been described as a holistic attribute and, according to Hase (2000), capable people are more likely to be able to deal effectively with the turbulent environment in which they live (or work) by possessing an all-round capacity to deal with continual change. Cairns (1997) defines capability as 'having justified confidence in your ability to take appropriate and effective action to formulate and solve problems in both familiar and unfamiliar and changing settings'.

Hase and Davis (Hase and Davis 1999) describe capable people are those who:

- know how to learn
- are creative
- have a high degree of self-efficacy
- can apply competencies in novel and familiar situations
- work well with others.

These attributes are strongly represented in the description and characteristics of the core role of the nurse practitioner and are in partnership with the above competency framework. Capability does not preclude the expression of competence and nor is capability a higher level of competence; rather competence is viewed as an essential part of being capable. Capable people are able to use competencies in novel and complex situations. This is illustrated by Stephenson (Stephenson 1994) in Figure 1.

Figure 1: From competence to capability



Capability requires a different set of attributes from competency and it is the combination of these attributes that are central to the practice of the nurse practitioner. Within this approach to thinking about nurse practitioner standards we propose that, in the words of Phelps et al (Phelps, Hase et al. 2004), nurse practitioner competencies and capability are viewed as linking partners on a continuum. The logical and critical link between competency and capability as benchmarks for nurse practitioner practice is the methodology used in evaluation and education of the nurse practitioner candidate seeking qualifications and authorisation as a nurse practitioner. Capability orients nurse practitioner competencies towards contextualised experiential learning and scenario-based evaluation.

Informed by the Competency Framework and in line with the need to develop the Capable Practitioner for a nurse practitioner level of service we propose the strategies outlined in Table 3.3 to inform evaluation of the candidate seeking authorisation/academic qualifications as a nurse practitioner.

Table 3.3: Strategies for evaluation of the nurse practitioner candidate

Examples of Evaluation Methodology	
1	Presentation of complex case study from actual event in the candidate’s specialty area of practice
2	Use of a clinical viva, or viva voce
3	Action learning sets that candidates use to challenge individual and collaborative understanding in complex scenarios
4	Assessor observation of the candidate in the context of nurse practitioner practice. This may involve a ‘typical’ nurse practitioner episode of care
5	Use of a compiled portfolio that demonstrates competencies and capability in practice
Examples of Observable Characteristics (includes material from Phelps, Ellis et al. 2001)	
6	Creative
7	Confident in own skills and abilities
8	Persistent, determined and outcome focused
9	Willing to make individual judgment based on careful and critical review of contemporary evidence
10	Enthusiastic and motivated towards improving health care access and outcomes for specific populations
11	Demonstrates high level of knowledge and skills in Nurse Practitioner Competencies
12	Establishes and contributes to health care teams
13	Is self-efficacious in accommodating uncertainty and managing risk in complex patient-care situations

It should be noted that the above strategies and performance indicators are similar to those already used by several nurse practitioner authorising bodies in the jurisdictions considered by this study (see requirements for authorisation in New Zealand and New South Wales, Table 2.5). They are also consistent with the teaching and learning processes adopted by most of the nurse practitioner masters' degrees in both countries (see page 75). Nurse practitioners whose practice provided the essential data that informed these research findings are the product and outcome of these authorisation and education processes. This is therefore, a powerful and serendipitous triangulation of process, practice and research findings that gives a solid and robust affirmation to our proposed two-layered Nurse Practitioner Standards Framework.

The following chapter will explicate the requisite educational and assessment processes to meet the contextualised competency requirements and capability potential for the nurse practitioner.

Recommendations arising from this chapter

2 A set of core competency standards for the nurse practitioner in Australia and New Zealand.

It is recommended that:

- 2.1 The Nurse Practitioner Competency Framework developed from this research be accepted as the Competency Standards for nurse practitioner practice and education in all jurisdictions across Australia and New Zealand.
- 2.2 The Strategies for Evaluation of the Nurse Practitioner candidate developed from this research be adopted by educational institutions and nurse authorising bodies for evaluation and assessment of nurse practitioner candidates and applicants.

Introduction

The findings from Chapter 2.4 provide important research-informed knowledge about nurse practitioner education. This chapter will draw upon these findings together with the work in the previous chapter, and published literature, to report on the development of education and program accreditation standards and will present a framework for program accreditation for nurse practitioner training.

Preparation for practice

Analysis of the nurse practitioner interview data relating to preparation for the role gives strong support for master's degree preparation. This was justified on two levels. First the findings supported the need for strong educational preparation in order to meet the demands of the role. The second level was related to credibility with the community and other health disciplines as to the preparedness of these clinicians—it was proposed that this could best be achieved by the requirement for a master's degree as entry to practice. These findings are supported by the international literature where there is a strong trend to recommending master degree programs for advanced practice and, therefore, nurse practitioner education (Fowkes, Gamel et al. 1994; American Academy of Nurse Practitioners 1995; Davidson 1996; de Leon-Demare, Chalmers et al. 1999; Atkins and Ersser 2000; van Soeren, Andrusyszyn et al. 2000).

Specialisation is an important issue in nurse practitioner education and analysis of the curricula data identified two approaches used to deliver specialty studies in nurse practitioner education. These approaches included structured specialty streams as well as generic frameworks that could accommodate a student's chosen specialty field of study. While some of these streams were informed by specialty competencies (e.g. National Remote Area Nurse Competencies) others relied on generic advanced practice competencies. In response to an invitation for comments, the Australian and New Zealand College of Mental Health Nurses and the Council of Remote Area Nurses of Australia each commented on the importance of specialty competencies for nurse practitioner practice standards.

Further to this, the findings also support the need for a significant clinical learning component to the nurse practitioner education program. Nurse practitioner participants universally endorsed the centrality of the clinical environment to nurse practitioner education. There was also universal support from the academics interviewed for clinical learning to be a major component of the programs. A related issue on nurse practitioner education that was strongly supported by both clinicians and academics was the importance of student-directed

learning. These findings are supported by recent Australian research (Gardner and Gardner 2004) which reported the critical role played by the clinical environment in nurse practitioner training and the preference of nurse practitioner candidate participants for student-determined learning content and process.

These findings are consistent with the earlier discussion related to capability. The capability approach to learning incorporates the flexibility to respond to the specific, self-identified learning needs of students (Phelps, Ellis et al. 2001). Furthermore, the capability approach emphasises the role of complexity in influencing the learning context whereby dynamic systems provide the environment for non-linear and unpredictable events (Hase 2000; Phelps, Ellis et al. 2001). The clinical environment of health care therefore is a fitting milieu for the basis of nurse practitioner education, and student-identified needs as an appropriate learning process (Phelps, Ellis et al. 2001).

Lack of standardisation

Apart from these areas of agreement, the findings relating to nurse practitioner education indicate that a variety of standards, competency frameworks and interpretations of the role of the nurse practitioner have informed curricula development and accreditation approaches. There is also variability in educational levels for nurse practitioner education and a lack of consistency in the conceptual basis of these programs. Content varies across the programs with just three study areas of pharmacology, research, and advanced assessment, being common to all. One of the particularly inconsistent factors in the nurse practitioner education programs across the states and between the two countries is the lack of clarity in terms of specific nurse practitioner, as distinct from advanced practice, study requirements. This is consistent with the literature on nurse practitioner education (see Woods. 1997) where there is confusion and ambiguity related to nomenclature and educational requirements for the nurse practitioner (Gardner, Gardner et al. 2004).

This research has focused on those elements of education, authorisation and practice that are specific to the nurse practitioner. During nurse practitioner interviews participants were asked to focus their case study on those elements that were uniquely related to their nurse practitioner level of care. Findings from this study therefore relate to this extended scope of nursing practice, which builds beyond the specialist and advanced level of nursing.

Towards core education standards

The findings from this research present an opportunity for New Zealand and Australia to take a global leadership role in adopting a standardised, research-informed approach to nurse practitioner education and nomenclature. The advantages for the Australian interstate and trans-Tasman context are significant. Hence, this study provides important findings that can inform regulatory authorities about standard requirements for nurse practitioner education.

The previous chapter outlined the multidimensional approach that is necessary to structure knowledge about nurse practitioner standards. We drew upon the research findings and the literature that was theoretically aligned with our empirical findings and developed a two-layered structure for nurse practitioner standards. This included a competency framework that inherently describes the competency-based knowledge, attitudes and skills of extended practice matched with the concept of capability, which defines the features of performance of these competencies that are, in combination, uniquely related to the method of nurse practitioner practice.

Education standards

Nurse practitioner education programs that are structured to meet these Generic Standards will need to address not only the content requirements but most importantly the learning process and assessment requirements as determined by the imperatives of capability theory (Stephenson and Weil 1992) and illustrated in Table 3.3, and the contextual requirements for clinical learning. As Hase and Davis (Hase and Davis 1999) suggest, becoming capable requires different learning experiences from becoming competent. This thinking is also relevant for the specialty learning required in the extended practice context. In this aspect of nurse practitioner training the candidates, as advanced specialist nurses, are well placed to define and respond to their own specific learning needs. Structured pedagogical approaches to learning will be inadequate for the education of the nurse practitioner. Capability learning approaches offer an alternative in the form of flexible learning pathways that allow for increasing complexity and curriculum scaffolding through a rich variety of learning resources, and mentored self-directed learning (Phelps, Ellis et al. 2001).

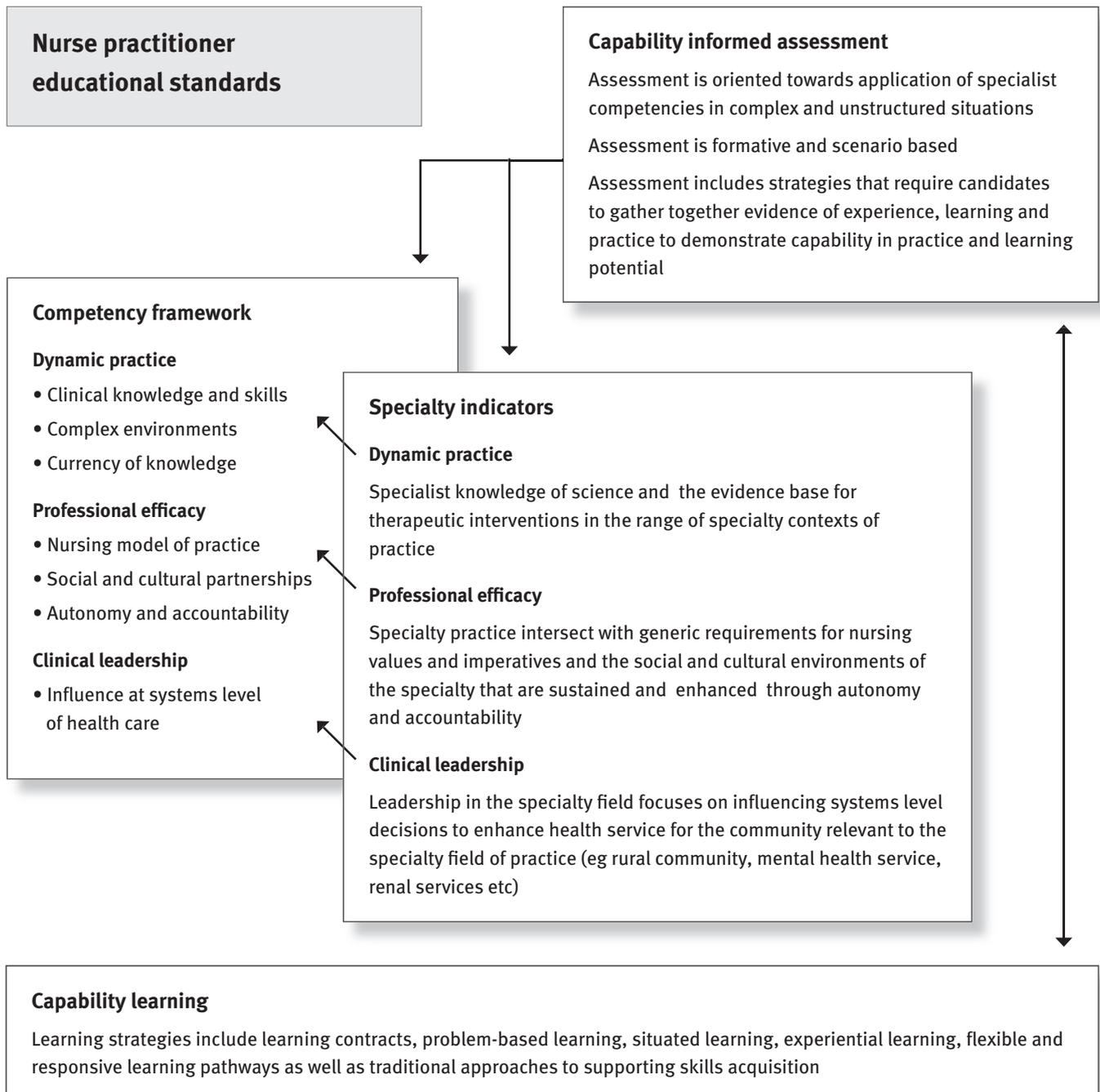
Accordingly, an accreditation framework for nurse practitioner education should include the following imperatives:

- A master's degree as the minimum education level.
- A planning process that includes consultation with specialist colleges and associations for specialty electives/streams of the curriculum.
- A curriculum design that includes:
 - content that meets the extended skill and knowledge competencies of the core role of the nurse practitioner
 - content that includes specialty skills and knowledge as indicators of performance in extended practice
 - learning and assessment processes that include capability approaches to learning
 - flexible learning pathways and support for student determined learning goals and strategies
 - structure that gives primacy to the clinical field and mentored experiential processes as central to nurse practitioner education.

In operationalising these imperatives we propose the model in Figure 2 to inform program and curricula developers and authorising and accrediting bodies. This model illustrates the configuration of all elements related to nurse practitioner education and the interface between the imperatives of competency learning and assessment, and, the influences of

capability theory on the learning environment for nurse practitioner education. The structure illustrates standards for education to support tertiary education providers in the development and delivery of nurse practitioner master’s degree programs. Additionally the model provides an evidence informed benchmark that can be applied in the accreditation of courses leading to authorisation as a nurse practitioner across all regulatory jurisdictions in Australia and New Zealand.

Figure 2: Model for nurse practitioner education program



Standards for accreditation of nurse practitioner programs

Traditionally, accreditation standards address two levels. These are i) accreditation of the program providers and ii) accreditation of the program. The objective and focus for this study has been to provide research-informed standards for program accreditation. Issues related to accreditation of program providers can be addressed by the relevant jurisdiction at the local level taking into account local influences.

The following standards for nurse practitioner education and program accreditation will be relevant across all jurisdictions. However, they will need to be applied in conjunction with accreditation requirements related to program providers already in place at nurse regulatory authorities.

Table 3.4: Nurse Practitioner Education and Program Accreditation Standards

Standard 1	Admission criteria for entry of students into the nurse practitioner program will ensure that candidates have sufficient and appropriate background
Required evidence	<ul style="list-style-type: none"> a Documents that specify requisite length and depth of experience in a specialty field of clinical practice b Documents that specify requisite education or equivalent in a specialty field as entry to the nurse practitioner program c Documentary evidence of required professional activity
Standard 2	The program curriculum will demonstrate content that addresses the Nurse Practitioner Competency Standards
Required evidence	<ul style="list-style-type: none"> a A detailed map of the curricula that indicates and locates the curriculum content related to each of the Competencies in the Nurse Practitioner Competency Framework in Table 3.2 of this document b Documentary evidence that relevant specialty organisations have been consulted in relation to the specialty/electives streams of the curriculum
Standard 3	The program curriculum will demonstrate teaching and learning processes that address the requirements for developing capability
Required evidence	<ul style="list-style-type: none"> a Evidence of curriculum structure that allows for flexible learning pathways and processes of support for student-determined learning goals and strategies b Evidence of a curriculum structure that incorporates extensive learning requirements in the specialist clinical field and mentored experiential processes as central to the educational experience c Documentary evidence that curriculum learning and assessment processes include capability approaches to learning
Standard 4	The program curriculum will demonstrate student assessment processes that address the requirements for developing capability
Required evidence:	<ul style="list-style-type: none"> a Assessment documents will demonstrate a commitment to contextualised, scenario-based assessment strategies as indicated in Table 3.3 of this document b Student assessment includes a comprehensive portfolio of learning and practice experiences that is examined both internally and externally to meet nurse practitioner authorisation requirements

These education standards provide a framework that can be applied by nursing regulatory authorities in accreditation of nurse practitioner master degree programs. These standards are based upon the Nurse Practitioner Standards that were developed from the research findings and presented in Chapter 3.3.

In relation to national/trans-Tasman standards for the nurse practitioner these can be applied in accreditation of qualifying nurse practitioner courses.

Recommendations arising from this chapter

3 A set of education and course accreditation standards for the nurse practitioner in Australia and New Zealand.

It is recommended that:

- 3.1 The minimum award level for an accredited program for nurse practitioner education be a master's degree.
- 3.2 The Nurse Practitioner Education and Program Accreditation Standards presented in Table 3.4. be used by nurse authorising bodies to accredit master degree programs that lead to qualification and recognition of the nurse practitioner by the accrediting bodies.
- 3.3 The curriculum structure give primacy to the clinical field with mentored experiential processes being central to nurse practitioner education.
- 3.4 Accredited courses contain summative assessment sufficient to meet the regulation bodies' clinical and academic requirements through a comprehensive portfolio of learning and practice experiences.
- 3.5 Endorsement from specialist colleges and associations for specialty electives/streams of the nurse practitioner curriculum be included in a program planning process.

section 4 Future directions

Introduction

The completion of this research project to develop generic standards for nurse practitioners in Australia and New Zealand is simply a beginning. The introduction of these competencies needs to be staged using an extensive dissemination and feedback strategy. The next phase is a comprehensive evaluation using a rigorous methodology incorporating wide-ranging consultation with stakeholders, including consumers, employers and the other members of the multidisciplinary health care team as well as the nurse practitioners themselves and those who educate and accredit them.

As part of the Nurse Practitioner Standards Project, the research team was asked to develop an evaluation strategy and this chapter describes this proposed strategy. The purpose of the evaluation is to examine:

- the appropriateness of the new competency standards and concept of capability as applied to nurse practitioners
- the services they deliver (that is, the role).

This appraisal is necessary because, as more nurse practitioner roles develop, it becomes possible to scrutinise more fully the context of practice and test client and community needs. The novelty of the roles in Australia and New Zealand to date made this level of exploration impossible within the current project.

A key outcome of this current report is the recommendation for consistency across Australian states and territories as well as trans-Tasman consistency. Indeed, a perceived need for consistency was a driving force behind the funding for the Nurse Practitioner Standards Project. The ANC is best placed to record the transition of all Australian state and territory jurisdictions. The process is already centralised in New Zealand.

To fully implement the findings from this report there will need to be processes for dissemination, feedback and monitoring of implementation of recommendations.

Consequently, this chapter includes recommendations for each of these processes as well as an evaluation of the widespread applicability of the competency, educational and regulation standards as recommended in this report. It should also be emphasised that development of the evaluation strategy has taken account of recommendations for evaluation of nurse practitioner roles and scope of practice made in the international and local literature as outcomes of earlier research projects.

Dissemination and feedback

Dissemination and feedback will be undertaken according to usual procedures followed by the Australian Nursing Council and the Nursing Council (NZ). In addition we recommend that plenary sessions at national nursing conferences, for example, Royal College of Nursing, Australia and New Zealand College of Nurses will provide an ideal additional professional forum for feedback. Sessions should be organised to include a facilitator and scribes, thus ensuring that discussion and feedback can be documented. It may be possible to organise these sessions at the 2004 conferences (July and September). This session format should also be encouraged at conferences of speciality nursing organisations in addition to a formal process of invitation for written comments from speciality organisations.

While the implementation process will be gradual, we propose that the evaluation project be established as soon as possible so that implementation, evaluation and amendment can be dovetailed. In this way, where a jurisdiction, educational facility or specialist organisation is more advanced, it can provide mentorship and support for other groups. The iterative nature of this process will also acknowledge and accommodate the imperatives of rapidly changing health care services.

Implementation of recommendations

Authorisation

All jurisdictions have subscribed to this project and the content of this chapter is based on the assumption that the recommendations from the report will be implemented.

The first challenge for Australian and New Zealand regulatory authorities is to identify areas where legislation needs to be changed. The move to consistency will necessitate alteration of registration processes in some jurisdictions. The process is already centralised in New Zealand. In addition, some Australian jurisdictions currently have no nurse practitioner registration process and will need to establish these processes (there are two Australian regulatory authorities explicitly awaiting outcome from this research before they finalise their registration processes).

The recommendation for consistency across Australian states and territories relies on legislative consistency in all Australian jurisdictions. While this is clearly outside the mandate of the regulatory authorities, it is incumbent on nursing organisations, whether statutory authorities (such as registration boards), professional organisations or industrial bodies, to lobby at both state and Commonwealth level for this legislative consistency.

Education

The new competency standards and capability requirements will direct not only the registration processes but also the preparatory education of nurse practitioners. We have recommended that education be standardised as a master's degree with consistency in

the educational requirements. Where there is a need for changes to postgraduate course curricula, these are likely to take some years. Practically speaking, it is anticipated that minor curriculum changes could be implemented in 2005 and major changes undertaken in 2006–2007 where needed. All new programs will have clear guidelines and standards for competencies to be achieved. The speciality component of courses should be delivered in partnership with clinical mentors and standards be developed through nursing speciality organisations where these exist.

Scope of practice/clinical/role of speciality organisations

In implementing the proposed standards and competencies, there is a need for work with speciality nursing bodies, as well as educational and authorising bodies. Several Australian nursing speciality colleges and interest groups are already in the process of developing competencies for nurse practitioners. Responses from these bodies during the data collection phase indicated that most organisations are keen to take up this role. These organisations are to be encouraged to develop competencies for their specialities and subspecialties using the framework provided in this report.

It should be acknowledged, however, that the speciality organisations and special interest groups vary widely in membership size and financial status. For some specialities these organisations are nascent or do not exist at all. This is a particular reality in New Zealand in part due to the relatively small size of the nursing workforce. Therefore, diverse support mechanisms will have to be developed to ensure that the full potential of speciality nurse practitioner roles is realised. Partnerships will need to be developed between these organisations and university departments to ensure that education and practice are in accord.

The evaluation process

Principles

We propose a comprehensive evaluation using mixed methods. The evaluation will need to incorporate assessment of:

- 1 comprehensive patient outcomes including adverse events
- 2 economic analysis of service provided
- 3 nurse practitioner service conditions and scope of practice including:
 - a funding source for position, continuing or fixed term, salary level
 - b reporting lines
 - c continuing education access including frequency and type of access, backfill arrangements
 - d full scope of practice facilitated (for example, ability to prescribe and order pathology tests)
 - e protocols/guidelines and formularies.

- 4 educational preparation processes including those for developing both competence and capability
- 5 regulation process including
 - a time period since registration as nurse practitioner
 - b re-registration process.

Methodology and methods

A comprehensive and rigorous evaluation strategy will require substantial commitment of resources. Data collection demands both statistical and qualitative methodologies, and utilisation of a wide range of data sources. The components of this methodology will be briefly outlined.

Minimum data set of nurse practitioner services

Consistent with the suggestion that nursing in Australia and New Zealand has the opportunity to make an international contribution to the understanding of nurse practitioner practice, reliable prospective practice data are needed. We recommend that a minimum data set of nurse practitioner service information be agreed upon and established to enable ongoing evaluation of the effects on the health services of introduction of a nurse practitioner level of service. There are recommendations in the international literature about components of a minimum data set and these should be explored (Clochesy 2002, Macintyre, 2001, p. 192). Establishment of such a database requires adequate funding, for example, through presentation of a business case to Australian Commonwealth Department of Health from ANC and to the Ministry of Health in New Zealand from Nursing Council (NZ).

Emergent evaluation

Given the current disparity between jurisdictions in the degree and mode of implementation of the nurse practitioner level of practice, any methodology designed to evaluate competency standards set out in this report needs to be able to take account of variation in speed of uptake of the recommendations. To address this need, we propose that the evaluation process should draw on the concept of 'emergent evaluation' as described by Arnkil (Arnkil, Spangar et al. 2002). Arnkil's process draws on the action research spiral and his methods include:

- identification of key voices
- dialogue and interaction
- simultaneous data collection and analysis
- hypothesis testing.

This methodology will allow for comparison between and within jurisdictions, juxtaposing those where the recommendations have been taken up rapidly and those where implementation is much slower. These comparisons will provide useful information for revision and refinement of the competency standards in Australia and New Zealand over the

next few years. As already indicated, this methodology accommodates the rapidly changing conditions in the health sector.

Emergent evaluation uses an approach known as ‘good futures dialogue’. The evaluator sets up a forum with stakeholders or ‘voices’ and facilitates the presentation of each sector’s perspective in turn. One evaluator acts as interviewer and another acts as a reflective partner. This gives each stakeholder group a chance to voice their perspective and have it discussed by other groups. The presentation and discussion is focused on ‘good future’ (where would you like the project to be in two years time), ‘support’ (maps out the key resource network) and ‘worries’ (present-day worries and anxieties). These dialogues would gather together consumers, nurse practitioners, their multidisciplinary team and representatives of the education and regulation bodies. Each forum should comprise representatives from jurisdictions representing both leaders and followers in implementation of the recommendations of this report.

Case study methods

The evaluation requires mixed methods and should include case study methodology to complement and expand upon the quantitative data obtained from the minimum data set. Case study methodology was used very successfully in one component of the comprehensive United Kingdom study of nurse practitioner practice (McDonnell, Jones et al. 2000; Read 2001). While the title of nurse practitioner in United Kingdom is not legally protected, many of the implementation issues are very similar to those experienced in both New Zealand and Australia, particularly in Australia, where there is great variation across state and territory jurisdictions. Case study methodology will enable a comprehensive evaluation of nurse practitioner roles once they are more established and will also provide the flexibility needed to explore roles in many different clinical settings and organisational frameworks (McDonnell, Jones et al. 2000). This methodology will allow ‘descriptive, exploratory and explanatory’ data collection and analysis (McDonnell, Jones et al. 2000). Risk levels can be assessed within case study methodology by facilitating reflection of the nurse practitioner on their roles and responsibilities, how they manage risk (e.g. of poor prescribing, misdiagnosis etc). Assessment of patient outcome can also be included (Carson-Smith and Klein 2003). In addition, case study methods are also appropriate for undertaking economic evaluation (Prescott 1994).

Survey methods and focus groups

Survey methods will be used to provide information on the practice of all registered nurse practitioners in Australia and New Zealand. Features to be investigated should include the funding source for the position (i.e. continuing or fixed term as this influences scope of practice and continuation of position) and salary level; reporting lines (to determine degree of autonomy, multidisciplinary team links, referral patterns); continuing education participation (access, uptake, content) including frequency, type and backfill arrangements as well as educational costs (overt and hidden) with an indication of who bears the burden; and the time period since registration as a nurse practitioner including re-registration intentions (to provide information for workforce planning). Such workforce planning could be conducted in partnership with jurisdiction departments of health where appropriate.

Survey methods and focus groups will be used to investigate the level of satisfaction with services as utilised by health service clients and other members of the multidisciplinary team. Survey methods, focus groups and interviews should be utilised to explore the level of satisfaction of nurse practitioner services from the perspective of health service managers.

Table 4.1 provides a timeframe for the evaluation process.

Table 4.1: Timeframe for evaluation

Dissemination and feedback	one year
Establishment of minimum data set framework	one year
Emergent evaluation forums	18 months (repeated at three years)
Commencement of case studies	two years
Surveys of nurse practitioners and educational changes	two years (repeated biennially)

The content of the proposed evaluation strategy can be summarised in the following recommendations arising from this chapter.

Recommendations arising from this chapter

4 A strategy and tools for evaluation and review of the role and standards.

It is recommended that:

- 4.1 There be a formal process for dissemination, feedback and monitoring of implementation of recommendations.
- 4.2 A trans-Tasman minimum data set for nurse practitioner practice be established.
- 4.3 The methodology for evaluation of the core role, education and authorisation recommendations accommodate the reality that implementation of this report may be gradual, with asymmetrical speed of uptake across jurisdictions.
- 4.4 Mixed methods be used for the evaluation research including:
 - prospective population-based epidemiological data collection using a minimum data set comprising information such as adverse events, costs and occasions of services
 - case study methods that include interview and focus group data collection to capture rich patient outcome data, interdisciplinary team work and nurse practitioner scope of practice
 - population surveys of all registered nurse practitioners, authorisation bodies and university nurse practitioner courses in two years from release of report.

Introduction

The research team, based on the data gathered and analysis conducted, have described the core role of the nurse practitioner in Australia and New Zealand and propose the following statement as a comprehensive description of the role:

The core role of the nurse practitioner is distinguished by autonomous extended practice. The practice is dynamic in that it involves the application of high-level clinical knowledge and skills in both stable and unpredictable, and complex situations. The role is characterised by professional efficacy and has a therapeutic potential enhanced by autonomy and legislated privileges. Practice in this role is sustained by a commitment to lifelong learning and fidelity to the primacy of a nursing model of practice. The nurse practitioner is a clinical leader with a readiness and an obligation to advocate for their client base and their profession at the systems level of health care.

From findings related to the core role of the nurse practitioner, we have developed competency standards to guide nurse practitioner practice and standards for accreditation of qualifying nurse practitioner programs. Accordingly, we make the following recommendations for nurse practitioner practice across Australia and New Zealand, set out in compliance with the outcomes of the project.

Recommendations

1 Description of the core role of the nurse practitioner in Australia and New Zealand.

It is recommended that:

1.1 The following definition be adopted as the standard definition for Australia and New Zealand:

A nurse practitioner (NP) is a registered nurse educated to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications, and ordering diagnostic investigations. The nurse practitioner role is grounded in the nursing profession's values, knowledge, theories and practice and provides innovative and flexible health care delivery that complements other health care providers. The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practise.

- 1.2 The title ‘nurse practitioner’ be legally protected in all jurisdictions.
- 1.3 Best practice for nurse practitioners be established against the benchmark of existing National Multidisciplinary Clinical Guidelines relevant to their field of practice.
- 1.4 It is further recommended that the parameters of practice for the nurse practitioner be structured around the specialty field of practice and determined by local community needs and professional standards.

2 A set of core competency standards for the nurse practitioner in Australia and New Zealand.

It is recommended that:

- 2.1 The Nurse Practitioner Competency Framework developed from this research be accepted as the Competency Standards for nurse practitioner practice and education in all jurisdictions across Australia and New Zealand.
- 2.2 The Strategies for Evaluation of the Nurse Practitioner candidate developed from this research be adopted by educational institutions and nurse authorising bodies for evaluation and assessment of nurse practitioner candidates and applicants.

3 A set of education and course accreditation standards for the nurse practitioner in Australia and New Zealand.

It is recommended that:

- 3.1 The minimum award level for an accredited program for nurse practitioner education be a master’s degree.
- 3.2 The Nurse Practitioner Education and Program Accreditation Standards presented in Table 3.1. be used by nurse authorising bodies to accredit master degree programs that lead to qualification and recognition of the nurse practitioner by the accrediting bodies.
- 3.3 The curriculum structure give primacy to the clinical field with mentored experiential processes being central to nurse practitioner education.
- 3.4 Accredited courses contain summative assessment sufficient to meet the regulation bodies’ clinical and academic requirements through a comprehensive portfolio of learning and practice experiences.
- 3.5 Endorsement from specialist colleges and associations for specialty electives/ streams of the nurse practitioner curriculum be included in a program planning process.

4 A strategy and tools for evaluation and review of the role and standards.

It is recommended that:

- 4.1 There be a formal process for dissemination, feedback and monitoring of implementation of recommendations.

- 4.2 A trans-Tasman minimum data set for nurse practitioner practice be established.
- 4.3 The methodology for evaluation of the core role, education and authorisation recommendations accommodate the reality that implementation of this report may be gradual, with asymmetrical speed of uptake across jurisdictions.
- 4.4 Mixed methods be used for the evaluation research including:
- prospective population-based epidemiological data collection using a minimum data set comprising information such as adverse events, costs and occasions of services
 - case study methods that include interview and focus group data collection to capture rich patient outcome data, interdisciplinary team work and nurse practitioner scope of practice
 - population surveys of all registered nurse practitioners, authorisation bodies and university nurse practitioner courses in two years from release of report.

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Appendices

Appendix 1	Composition of the Project Management Committee
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Composition of the Project Management Committee

Project Management Committee Members

Chairperson

Ms Jan Dent
Executive Director
Nurses Registration Board of NSW

Research & Policy Committee Members

Ms Moira Laverty
Chief Executive Officer
Nursing Board of Tasmania

Ms Margaret Watson
Chief Executive Officer
Nurses Board of Western Australia

Ms Marion Clark
Chief Executive Officer
Nursing Council of New Zealand

Committee Member with Expertise in Standards Research

Emeritus Professor Margaret Bennett

Nurse Practitioners

Ms Helen Gosby
Nurse Practitioner (Paediatrics)

Ms Julie Betts
New Zealand Nurse Practitioner Network (Wound Care)

ANC Chief Executive Officer

Ms Marilyn Gendek

Other

Ms Judi Brown
Chief Executive Officer
Nurses Board of South Australia

Expert Reference Group

Ms Taima Tukukino Campbell
Executive Director of Nursing & Midwifery
Auckland City Hospital
Auckland
New Zealand

Dr Frances Hughes
Chief Advisor Nursing
Ministry of Health
New Zealand

Ms Sue Lenthall
Head of Education
Centre for Remote Health
Flinders School of Medicine
Alice Springs
Australia

Ms Lorna McLellan
Principal Advisor—Nurse Practitioner Project
Nursing & Midwifery Office
New South Wales Health Department
Sydney
Australia

The research will provide:

- 1 A comprehensive report on the development and progress of the role of Nurse Practitioners in Australia and New Zealand;
- 2 An agreed description of the core role of Nurse Practitioners in Australia and New Zealand;
- 3 An approved set of core competency standards for Nurse Practitioners to be applied in Australia and New Zealand;
- 4 Approved national/Trans Tasman standards for education that can be applied in the accreditation of courses leading to a qualification for recognized Nurse Practitioners; and
- 5 A strategy and tools for evaluation and review of the role and standards.



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Faculty of Health, Victoria Park Road
Kelvin Grove Qld 4059 Australia
Phone 07 3864 5779 Fax 07 3864 5662
CRICOS No. 00213J ABN 83 791 724 622

9 December, 2003

Dear Colleague

I am writing to invite you to participate in a project to develop generic standards for nurse practitioner competencies and education in Australia and New Zealand.

This research project is being carried out on behalf of the Australian Nursing Council (ANC) which is made up of representatives of the Nursing Registration Boards from all Australian jurisdictions and the New Zealand Nursing Council. A team of consultants comprising myself, Professor Sandra Dunn in South Australia, Associate Professor Anne Gardner in ACT and Professor Jenny Carryer in New Zealand, has been retained by the ANC to undertake this research. The outcome will lead to development of national/Trans Tasman standards for the recognition and education of Nurse Practitioners.

A central part of this study is development of competency standards for the nurse practitioner. To this end we are inviting nurse practitioners to participate in a telephone survey. As a registered/authorised nurse practitioner your assistance and cooperation will be vital in ensuring that the research is well informed.

It is anticipated that the telephone interview will last between one hour and one and a half hours. The interview will be semi-structured and will include questions relating to your role as a nurse practitioner. In addition the interview will include questions relating to a specific case that you have managed. You will be requested to come to the interview ready to recall elements of this case. You will not be asked to disclose any identifying features of this case. After the interview, you will receive a written copy of the case study for you to review and confirm for accuracy.

The study has approval from the Queensland University of Technology Human Research Ethics Committee (**Reference No: 3317H**). Please see attached an information and consent form.

If you are willing to participate in this study, I invite you to contact one of the investigators as described below at your earliest convenience. A suitable time and date for the interview can then be arranged. I also welcome any questions you may have about the project. Contact details are:

Nurse practitioners in **New South Wales** please contact Glenn Gardner
Telephone: 07) 3636 5395. Email: glenn_gardner@health.qld.gov.au

Nurse practitioners in **South Australia & Western Australia** please contact Sandra Dunn:
Telephone: 08) 8204 4227. Email: sandra.dunn@flinders.edu.au

Nurse practitioners in **New Zealand** please contact Jenny Carryer
Telephone: 06) 350 5799 Ext 7719. Email: J.B.Carryer@massey.ac.nz; jenny.carryer@midcentral.co.nz

I do hope that you are able to take part in this important research and look forward to hearing from you in the near future.

Yours sincerely

Glenn Gardner
Professor of Clinical Nursing
Queensland University of Technology & Royal Brisbane and Women's Hospital



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16/12/03

Dear

I am writing on behalf of the investigating team conducting a study to develop generic standards for nurse practitioner competencies and education in Australia and New Zealand.

This research project is being carried out on behalf of the Australian Nursing Council (ANC) which is made up of representatives of the Nursing Registration Boards from all Australian jurisdictions and the New Zealand Nursing Council. A team of consultants comprising myself, Professor Sandra Dunn in South Australia, Associate Professor Anne Gardner in ACT and Professor Jenny Carryer in New Zealand, has been retained by the ANC to undertake this research. The outcome will lead to development of national/Trans Tasman standards for the recognition and education of Nurse Practitioners.

A central part of this study is development of standards for education of nurse practitioners and accreditation of nurse practitioner courses. To this end we are collecting data on all current courses in nurse practitioner education. As an academic with experience and knowledge in the area of nurse practitioner education, your assistance and cooperation will be vital in ensuring that the research is well informed. I am seeking/confirming your participation in the following areas:

- Providing a copy of your Nurse Practitioner Program curriculum
- Participate in a structured interview of approximately 30 minute duration.

The study has approval from the Queensland University Human Research Ethics Committee (**Reference No: 3317H**). Please see attached an information and consent form, I would like to also assure you that the curriculum document will be treated as commercial in confidence.

If you are willing to participate in this study, please contact me at your earliest convenience we can arrange a mutually suitable date and time for the interview. I also welcome any questions you may have about the project. My contact details are:

Telephone: 07) 3636 5395

Email: glenn_gardner@health.qld.gov.au

I do hope that you are able to take part in this important research and look forward to hearing from you in the near future.

Yours sincerely

Glenn Gardner
Professor of Clinical Nursing
Queensland University of Technology & Royal Brisbane and Women's Hospital

Invitation to regulatory authorities to provide input



Ref: 01.27.11

27 November 2003

Dear

Research Project to develop Generic Standards for Nurse Practitioners in Australia and New Zealand

I am pleased to advise that the above project has now commenced.

The project is a collaboration between the Australian Nursing Council and the Nursing Council of New Zealand.

A team consisting of Professor Glenn Gardener (QUT), Professor Jenny Carryer (Massey University), Professor Sandra Dunn (Flinders University) and Associate Professor Anne Gardner (ACT) have successfully tendered for the project under the auspices of Queensland University of Technology.

The Project is being conducted on a very tight timeframe. The consultants will be submitting their first report at the end of February. Therefore, on behalf of the Project Management Committee I am seeking your cooperation to respond quickly to any contact that the consultants will have with you or your staff.

The contribution of ...your organisation... will be extremely valuable in this project. Information materials about the project are currently being prepared and I will forward these as soon as possible.

I thank you for your cooperation.

Yours sincerely

Marilyn Gendek
Chief Executive Officer

Example of invitation to national nursing bodies to provide input



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CRICOS No. 00213J ABN 83 791 724 622

February 5, 2004

Dear

Re: Australian Nursing Council and Nursing Council of New Zealand sponsored project

Title: A research project to develop generic standards for Nurse Practitioners in Australia and New Zealand

I am writing to invite input from your organisation for the above project. As you may know the Australian Nursing Council and the New Zealand Nursing Council have jointly commissioned research to investigate nurse practitioner core standards and to develop generic competencies for education and practice for nurse practitioners in Australia and New Zealand. The timeline set for the project is very short and the research team is aware that it will not be possible to investigate all relevant issues exhaustively within this timeframe. To ensure that the report is as comprehensive as possible, we are inviting national nursing organisations of Australia and New Zealand to provide up to two pages of comment relevant to all, or selected, outcomes of the project.

The findings from this study will inform policy development for these two bodies. Further details can be obtained from the ANC website at: http://www.anc.org.au/o5news/_docs/Practitioner_bg.doc

The project team is being coordinated from Queensland University of Technology.

The team members are:

Professor Glenn Gardner, Lead Investigator, Chair in Clinical Nursing, Queensland University of Technology and Royal Brisbane & Women's Hospital, Qld

Professor Sandra V. Dunn, Chair in Clinical Nursing Practice, Flinders University/Flinders Medical Centre, SA

Ass Professor Anne Gardner, Research Centre for Nursing Practice, The Canberra Hospital and University of Canberra, ACT

Professor Jenny Carryer, Professor of Nursing, Massey University / MidCentral Health and Executive Director of the College of Nurses Aotearoa (NZ) Inc, NZ

Nurse practitioner service in Australia and New Zealand is a relatively new area of health service. Consequently, there is to date no standard approach to authorisation, education or competency definitions within the states of Australia and between Australia and New Zealand. This study will contribute to a standardised approach to nurse practitioner competency description, educational preparation and authorisation for practice. It will inform development of intra Australian and Trans Tasman mutual recognition policy, recommend standards for universities in development and review of nurse practitioner programs and address requirements for accreditation of these programs.

Specifically the research outcomes are:

- A comprehensive report on the development and progress of the role of Nurse Practitioners in Australia and New Zealand.
- Recommendations related to the core role of nurse practitioners in Australia and New Zealand
- Core competency standards for Nurse Practitioners to be applied in Australia and New Zealand
- National/Trans Tasman standards for education that can be applied in the accreditation of courses leading to a qualification for recognised nurse practitioners and
- A strategy and tools for evaluation and review of the role and standards

The findings from the project will be submitted to the Australian Nursing Council and the Nursing Council of New Zealand in March 2004.

The research team is conducting the investigation according to an agreed research protocol and must present our findings from that process. We do however acknowledge that this is a new, evolving and potentially sensitive area compounded by the challenge of our two countries working together to the benefit of both. Accordingly, we would value your organisation's contribution to the research. Your contribution within the required time frame will be well considered in the data analysis and recommendations. Your contribution should be sent to me, at the above E-mail or postal address no later than Friday 20 February. Please call Professor Jenny Carryer (027 4491 302) if you would like to discuss this invitation.

Thank you for your assistance in this very important Trans Tasman initiative. Please feel free to contact me or professor Carryer if you require further information.

Yours sincerely on behalf of the research team

Glenn Gardner
Professor of Clinical Nursing
Queensland University of Technology and Royal Brisbane and Women's Hospital

Nurse practitioner interview schedule

Semi-structured interview—try to cover following topics but follow leads as they arise

Ethics requirements

The purpose of this interview is to explore your experiences as a Nurse Practitioner, including the requirements of your role and the regulatory processes in your state.

Your participation in the study is entirely voluntary and you have the right to withdraw from the study at any time. If you decide not to participate in this study or if you withdraw from the study, you may do this freely. You are free to not answer any questions you may choose. I am noting your name and contact details so I can send you the case study information and make sure I have it correct, and follow up on any unclear areas when I am transcribing and analysing this data. Reports, papers etc, however, will be anonymous and no identifying information will be revealed to anyone outside the research team.

Are you willing to proceed with this interview? yes no

I would like to tape record this interview so I can concentrate on our conversation instead of taking copious notes. The interview will be transcribed verbatim to make sure all the data is accurate and complete.

Are you willing to have me tape record our conversation? yes no

Identifying data

1. Name _____
2. Contact number (ph) _____ (fax) _____
3. E-mail address _____

Demographic information

4. Sex male female
5. Age Less than 25 yrs 46 to 55 yrs 26 to 35 yrs
 56 to 65 yrs 36 to 45 yrs More than 65 yrs
6. State where authorised/endorsed NSW SA
 Vic WA
 NZ Other (eg overseas)
7. When authorised/endorsed _____/_____(month/year)
8. Band/setting of authorisation/endorsement _____

Education information

9. Participant's NP education Master's Graduate Diploma
 Graduate Certificate Other
-

10. When graduated _____/_____(month/year)

11. Course structure/content/assessment?

12. Most/least useful content for preparation as nurse practitioner? Why?

13. Level of education appropriate for nurse practitioner preparation? Why?

Employment history

14. Brief history

15. Present position

NP role

16. Differences and similarities to: prior role, nurse specialist, medical team, etc.

17. Knowledge, skills and attitudes critical to NP practice?

18. Benefits and challenges of being authorised/registered/endorsed?

19. Other comments

Registration/authorisation information

20. Describe registration/authorisation process eg portfolio, interview etc

21. Most and least useful parts of authorisation/registration process?

22. Suggestions for changes?

23. Other comments

Case Study

The NP will be requested to supply de-identified information relating to a case they have managed. Keep the case on NP activities eg specific information on what the NP (rather than other members of the team) did and thought. Consider pt presentation, knowledge and skills required for case management, relationship with other members of the team, relationship with pt/family, practices with this case identified as specific to the NP role, etc.

The research team would like to acknowledge your contribution to this project in reports and articles. Your name would be in the list of acknowledgements and not tied to any specific comments or data.

Are you happy to have your name acknowledged as a contributor to this project?

- yes no

Date: Thu, 11 Dec 2003 15:05:39 +1000
To: Glenn Elizabeth Gardner <ge.gardner@qut.edu.au>, glenn_gardner@health.qld.gov.au
From: Wendy Heffernan <w.heffernan@qut.edu.au>
Subject: Expedited Ethical Clearance - 3317H
Mime-Version: 1.0
Content-Type: multipart/alternative;

Dear Glenn

I write further to your application for expedited ethical clearance requested for your project, "A research project to develop generic standards for Nurse Practitioners in Australia and New Zealand." (QUT Ref No 3317H). This application was recently considered by the University Human Research Ethics Committee (UHREC) Expedited Ethical Review Panel.

On behalf of the Panel I wish to advise that your project has been granted ethical approval.

Consequently, you are authorised to immediately commence your project.

Please do not hesitate to contact me further if you have any queries regarding this matter.

Regards
Wendy Heffernan
University Human Research Ethics Committee

