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project

VICTORIAN NURSE PRACTITIONER

Final Report of the Task Force

Human Services

Peoplefirst

The Victorian Nurse Practitioner Project:

Final Report of the Taskforce

December 1999

The Victorian Nurse Practitioner Project: Final Report of the Taskforce

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Foreword

The development of the nurse practitioner role in Victoria is in keeping with international trends where advanced nursing roles have been developed and practised for some time with the goal of enhancing health care delivery. Nurse practitioner services are also currently being implemented in the public sector of rural and remote NSW.

Nurse practitioners in Victoria face a challenging future, one full of opportunities to make a positive difference to people's lives and to have satisfying and rewarding careers. The diversity of this advanced clinical nursing role demonstrates the numerous opportunities for nurses functioning at this level and the need for flexibility in fulfilling ever-changing health care demands.

The importance of collaborative practice in the provision of optimal care is well recognised. The development of the nurse practitioner role in Victoria has evolved from attempts to address concerns of individuals and communities including their demands for diverse options in health care, improved service access, and increased flexibility in models of health care delivery. The proposed changes are intended to improve the convenience of services for patients and carers as well as enhancing health care delivery and producing quality outcomes.

This Government is determined to ensure that Victorians have access to a world-class health care system underpinned by a well-trained and supported nursing workforce.

The release of this report represents the first phase of the process for nurse practitioner role implementation in Victoria. The taskforce has developed a framework for role implementation following extensive consultation with stakeholders. I believe it provides an excellent framework under which to progress and I thank the members of the taskforce for their work in producing this report.

Some members of the taskforce have expressed concern on the recommendations regarding the role of nurse practitioners in prescribing and diagnostics. Whilst I acknowledge those concerns, I support the implementation of the nurse practitioner model broadly as proposed by the taskforce. Those concerns and issues will be carefully addressed in the implementation process. I am confident that the personal professional commitment of all health professionals to the care of patients and the population generally, will assist in resolving these issues and will promote a comprehensive and efficient process.

I believe that the nurse practitioner role in Victoria is an exciting, innovative development and I look forward to its implementation.

JOHN THWAITES MP
MINISTER FOR HEALTH

Acknowledgments

The members of the Nurse Practitioner Taskforce are grateful to all those who were coopted for their expertise and to all those who provided time and energy in assisting in this project.

This report was prepared for the Victorian Minister for Health.

Nurse Practitioner Taskforce

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17 December 1999

The Hon John Thwaites
Minister for Health
555 Collins Street
Melbourne Victoria 3000

Dear Minister

It is with great pleasure that I present to you the completed report on the implementation of the nurse practitioner role in Victoria.

This report has been produced following an extensive period of examination of the international literature, consideration of key issues and consultation with stakeholders by the Ministerial Nurse Practitioner Taskforce.

I am pleased to be able to advise you that the majority of the recommendations of the Taskforce have been unanimously endorsed by its members. On some matters there has been dissent on the part of the Australian Medical Association (Victoria) and the Royal Australian College of General Practitioners (Victoria), from the majority views. These dissenting views are elaborated in the Appendix section of the report.

The focus of the report is on the strategies for change that will enable advanced clinical nurses to contribute to a more responsive, accessible and collaborative health care services for all Victorians. It is clear that the nurse practitioner role will lead to greater diversity in services and increased flexibility in the mode of health care delivery.

I commend the report of the Taskforce to you for consideration.

Yours sincerely

Dr T P Keating

Contents

Foreword

Acknowledgments

Executive Summary and Recommendations 1

Introduction 5

Background 7

The Victorian Nurse Practitioner Project 13

- Policy Development 13
- Community and Practitioner Consultation 14
- Nurse Practitioner Models of Practice 14

Role Definition and Title 17

Educational Preparation and Credentialling 23

Best Practice 31

Professional Indemnity and Legal Liability 37

Extended Nursing Practice 41

Legislative Changes 53

Financial Considerations 57

Appendix 1 — Legislative Changes Discussion Paper 61

Appendix 2 — Nurse Practitioner Taskforce: Terms of Reference 71

Appendix 3 — Subcommittee Membership and Terms of Reference 73

Appendix 4 — Community Consultation July 1999 75

Appendix 5 — Funded Nurse Practitioner Models of Practice 79

Appendix 6 — AMA (Victoria): Dissenting View 81

Appendix 7 — RACGP, Victorian Faculty: Dissenting View 87

List of Acronyms 91

Glossary 93

Bibliography 95

Executive Summary and Recommendations

Nurse practitioners have a potentially major role in rural, regional and metropolitan health care service provision in Victoria. The potential benefit of multidisciplinary approaches to health care suggest that the development of this role may lead to improved service access, greater diversity in services provided, and increased flexibility in mode of health care delivery.

In July 1998, the Nurse Practitioner Taskforce, consisting of representatives from nursing and medical professional and industrial organisations, the Victorian Department of Human Services and an independent chair, was appointed to establish a framework and process for the implementation of the nurse practitioner role in the Victorian health system. Community and practitioner consultation, development of policy, and implementation and evaluation of a number of Victorian nurse practitioner models of practice have occurred concurrently and interactively, and have informed the deliberations of the taskforce.

The taskforce examined the key issues relating to the implementation of the role identified in the proceedings of the Department of Human Services Nurse Practitioner Workshop (September 1997) and discussed further at Nurse Practitioner Forums (May 1999). These issues include role definition and title, educational preparation and credentialling, best practice, professional indemnity and legal liability, legislative requirements and financial considerations.

It was proposed that a number of nurse practitioner models of practice examine the nurse practitioner role in terms of feasibility, safety, effectiveness, quality and cost, consistent with the evaluation framework used in the recent New South Wales Nurse Practitioner Project. It is anticipated that these demonstration projects will provide valuable information about the nurse practitioner role in Victoria and comparable data which will be of national significance.

Funding was provided for eight nurse practitioner models of practice which were selected from 108 submissions by a nine-member selection panel of the taskforce. Another three existing models of practice agreed to participate in a concurrent Statewide evaluation. The Statewide evaluation will provide an overarching evaluation of the funded models of practice which may be quite disparate in nature.

Community and practitioner consultations have taken place in the form of focus group discussions and forums. Feedback from the focus group discussions and the forums has informed policy development and has generally supported the work of the taskforce and the direction it has taken.

This report is submitted to the Minister for Health by the Nurse Practitioner Taskforce chaired by Dr Tom Keating. It sets out a proposed framework and process necessary for the implementation of the nurse practitioner role into the Victorian health system where:

- Nurse practitioners are recognised as legitimate providers of health services in Victoria and the implementation of the role is not restricted by sector or geographic location.
- The title of ‘nurse practitioner’ is protected.
- The role extends current practice and is advanced, with a strong foundation in knowledge, skills and competencies, for both population and individual health.
- The position is remunerated at a rate commensurate with the skills and responsibilities required for the position.
- Interdisciplinary and collaborative planning and evaluation guide practice.

- The practice of prescribing medications, initiating diagnostic imaging and laboratory testing, approving absence from work certificates, referring to specialists, and admitting and discharging clients, corresponds to the context of practice.

The recommendations set out in detail below would apply across Victoria in both the private and public sectors. Legislative changes would be required to implement some of the key recommendations.

Recommendations

Recognition of the Role of Nurse Practitioners

1. That the nurse practitioner be recognised 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. (pp. 17–22)
2. That nurse practitioners be recognised as legitimate providers of health care services in Victoria and that the implementation of the role of nurse practitioners not be restricted by sector or geographic location. (pp. 17–22)
3. That the recommendations of this report be implemented without delay recognising that the Statewide evaluation of the demonstration projects will further inform the development of the nurse practitioner role. (pp. 17–22)
4. That core components of the nurse practitioner role include advanced clinical practice, education, counselling, research, quality improvement, administration and management. (pp. 17–22)
5. That the position of nurse practitioner be remunerated at a rate commensurate with the knowledge, skills, competencies and responsibilities required for the position. (pp. 17–22)

Regulation, Endorsement and Educational Preparation of Nurse Practitioners

6. That the Nurses Board of Victoria be the approved body to regulate the use of the title 'nurse practitioner'. (p. 23)
7. That the *Nurses Act 1993* (s. 62) be amended to prevent any persons who have not met the requirements of the Nurses Board of Victoria from using the title of nurse practitioner. (pp. 23, 53-54)
8. That the Nurses Board of Victoria use existing processes for the accreditation of courses for the nurse practitioner including the establishment of both guideline development and curriculum review panels and, further, that these processes involve nurse practitioners. (p. 24)
9. That the use of the title 'nurse practitioner' be restricted to that of a nurse registered in Divisions 1, 3 or 4 of the Register with the identified area of practice attached to the title. (pp. 24–26)
10. That guidelines for accreditation of nurse practitioner courses require maximum flexibility in course content, access, recognition of prior learning and clinical experience. These courses should include both core and context units. Extensions to nursing practice, such as prescribing, should be included as core components of the courses. (pp. 24–26)
11. That the Department of Human Services provide funding to a consortium of universities for the development of appropriate nurse practitioner courses. (pp. 24–26)

12. That the minimum educational requirement for recognition as a nurse practitioner be an accredited Masters level program with a strong clinical focus and a research project component. (pp. 24–26)

13. That the Nurses Board of Victoria, in establishing the process for nurse practitioner endorsement, provide a transition process of ten years for the attainment of the minimal educational requirement of a Masters for nurse practitioner recognition. Where a nurse practitioner does not meet minimum education requirements by 2010, the Nurses Board of Victoria may provide an exemption where appropriate, in particular, taking note of previous endorsement as a nurse practitioner or clinical experience. (pp. 26–27)

14. That the Department of Human Services make additional funds available for registered nurses wishing to undertake studies leading to recognition as a nurse practitioner. (pp. 26–27)

15. That the Department of Human Services fully fund a clinical chair to provide leadership in nurse practitioner practice, research, education, and policy development in Victoria. (pp. 26–27)

Standards/Competencies of Nurse Practitioners

16. That a framework be developed that enables core and / or specific standards / competencies to be developed that are nationally and internationally consistent in relation to nurse practitioners. (pp. 27–28)

17. That the Minister for Health request the Nurses Board of Victoria to facilitate the processes necessary for the development of a framework for standards / competencies for nurse practitioners that are nationally consistent and internationally compatible. (pp. 27–28)

18. That Commonwealth funding be sought for the development of a national framework for standards / competencies for nurse practitioners. (pp. 27–28)

Credentialling of Nurse Practitioners

19. Recognising that credentialling for advanced practice is the responsibility of the nursing profession, that the nursing profession monitor the outcome of the current national project funded by the Commonwealth examining the feasibility of credentialling, and that appropriate action ensuring both consistency of approach and maximum flexibility be taken. (pp. 28–29)

20. That the Nurses Board of Victoria, in establishing criteria for the assessment of continuing competence of nurse practitioners, give consideration to written statements of credentialled status from professional organisations as one component of those criteria. (pp. 28–29)

Best Practice

21. That the National Health and Medical Research Council (1999) *Guidelines for the Development, Implementation and Evaluation of Clinical Practice Guidelines* be used for the development of best practice clinical guidelines for nurse practitioner services. (pp. 31–36)

Professional Indemnity for Nurse Practitioners

22. That nurse practitioners demonstrate adequate professional indemnity insurance cover. (pp. 37–39)

23. That the Department of Human Services provide a professional indemnity insurance facility for nurse practitioners to ensure that the cost of professional indemnity insurance does not limit the implementation of the nurse practitioner role in any area of practice. (pp. 37-39)

Additional Legislative Requirements

24. That the *Drugs Poisons and Controlled Substances Act 1981* be amended to provide for limited prescribing authorisation for nurse practitioners.[1] (pp. 41–48)

25. That the nurse practitioner be authorised to prescribe from a formulary corresponding to the context of practice of the nurse practitioner.[1] (pp. 41–48)

26. That the Department of Human Services facilitate the process for the development of a prescribing formulary and guidelines, consistent with NH&MRC[2]guidelines, taking into account the variety of contexts of nurse practitioner practice.[1] (pp. 31–36, 41–48)

27. That the Department of Human Services facilitate the process for the development of guidelines, consistent with NH&MRC[2] guidelines, for specific diagnostic services which nurse practitioners may initiate in relation to the context of practice and for the systems necessary to manage the results.[1] (pp. 31–36, 48–49)

28. That referrals to a medical specialist from a nurse practitioner be coordinated by the client's nominated general medical practitioner (GP) in consultation with the nurse practitioner. Where a client does not nominate a GP, the nurse practitioner should be guided by locally agreed referral policies and protocols.[1] (pp. 49–50)

29. That the Department of Human Services facilitate the process for the development of guidelines for nurse practitioners requiring admitting rights and authority to approve absence from work certificates.[1] (pp. 50–52)

30. That all relevant legislation, including but not limited to the *Nurses Act 1993* and the *Drugs Poisons and Controlled Substances Act 1981*, be reviewed and amended according to the context of the nurse practitioner role. (pp. 53–56)

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[1] The AMA (Victoria) representative on the taskforce dissents from this recommendation. The rationale for this may be found on pp. 81-85.

[2] National Health and Medical Research Council. (1999) *A guide to the development, implementation and evaluation of clinical practice guidelines.* Endorsed 16 November 1998. Canberra, NH&MRC.

Introduction

The boundaries of nursing practice worldwide are being redrawn owing to the complex mixture of developments and pressures stemming from the changing patterns of health care and health care delivery. If nursing in Victoria is to contribute to a more responsive, accessible, innovative, effective, efficient and collaborative health care service, then structural, procedural and legislative changes are needed in the organisation of health care delivery.

The rapidly evolving role and ongoing debate internationally regarding an advanced clinical nursing role have important implications for the provision of health care services. As with any change or development, the notion of nurses taking on expanded, additional or different roles and responsibilities has been met with both support and criticism. Underlying the general recommendations made in this report, however, is the suggestion that in Victoria there is a unique opportunity for advanced practice nurses to establish key collaborative relationships with other health professionals in the delivery of effective and efficient health care. Furthermore, the collateral benefits of increased client choice and satisfaction are recognised.

The evolution of nursing as a profession has allowed the advanced practice nurse to emerge nationally and internationally. The demand for nurses to take on advanced clinical roles and the pressure for the development of programs to cater for these nurses continues to gather pace. Numerous questions will have to be addressed by the nursing profession as the role of the nurse practitioner is legitimised and further developed in Victoria. The role needs to be clear and pertinent to the needs of individuals and the population as well as health care providers. It needs to be academically and clinically robust, and flexible in nature. This report confronts some of the issues that may arise during this process by looking at experience gained nationally and internationally.

The variety of expanded and extended nursing roles and the numerous interchangeable terms to describe advanced practice nurses have proved problematic. To clarify the different advanced practice roles worldwide, a discussion on advanced nursing role nomenclature and its components is provided as a foundation for discussion on the numerous issues relating to the development and implementation of the role of nurse practitioner in Victoria. The issues examined in later sections of this report also include the educational preparation required for such a role; the determination of credentialling and advanced practice competencies; and factors relating to best practice, professional indemnity, legislative requirements and resource implications.

For the purpose of this report, the title ’nurse practitioner’ (unabbreviated) is used to refer to advanced practice nurses in Victoria and is defined as that of ‘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 practices’. The title is an inclusive one and includes midwives. When referring to other States or countries, the more generic title of ‘advanced nursing practice’ is generally used.

Background

Advanced nursing roles have been practised in the United States of America (USA) and Canada since the early 1960s. The United Kingdom (UK), New Zealand (NZ), Australia and various other countries have also addressed issues relating to an expanded and extended scope of nursing practice. The following is a brief summary of the developments in a number of these countries. Some of these developments are discussed further under the keys issues in the body of the report. The developments in Australia are briefly outlined at the end of this section and set the scene for the Victorian Nurse Practitioner Project.

USA

The evolution of advanced nursing practice in the USA in the 1960s is said to have been a response to the social demands for increased access to affordable, quality health care and, simultaneously, to the specialised nursing care requirements of increasingly complex patients. The advancement of practice was guided to a large extent by the social mandate of the nursing profession. (Dunn, 1997; Ford, 1997; DeAngelis, 1994)

A variety of expanded and extended nursing roles currently exist in the USA, all claiming to be forms of advanced practice. According to Patterson and Haddad (1992), these nursing roles may be seen along a continuum, depending on the extent to which their practice overlaps with functions traditionally regarded as belonging to the medical profession. At the extreme opposite ends are the clinical nurse specialist (CNS) and the physician's assistant (PA). The major focus for the PA is within the confines of medicine, while for the CNS, the focus is within the dimensions of nursing. (Bates, 1970) The role of the nurse practitioner (NP) in the USA may be seen somewhere along the continuum. This will depend on whether the employers are nursing services or physicians and if the NPs are to function independently, in rural community practice, or within the acute/hospital setting. (Dunn, 1997)

The PA, CNS and the NP are all considered to fall under the umbrella of advanced practice. Differences in role functions, however, exist both within and among the categories. While both the CNS and NP have a wide range of knowledge and skills and are educated to provide a holistic approach to care, the CNS has generally had a narrower focus, practised in acute or secondary and tertiary settings and centred on select populations characterised by particular health care problems. The NP, on the other hand, has practised principally in primary health care settings and has dealt with a wide range of health care needs. (Patterson and Haddad, 1992)

Some of the differences that have divided the CNS and NP roles in the past, however, have now become blurred. The differences in the range and depth of assessment skills and clinical judgement have minimised over time due to the movement of NPs into acute and day hospitals which has caused them to focus their skills and to increase their depth of knowledge in line with the needs of specific populations. In turn, CNSs, who in the past primarily practised in acute care, are now practising in primary health care settings. (Bates, 1970; Patterson and Haddad, 1992; Dunn, 1997)

The literature indicates that the boundaries between NPs and CNSs in the USA are now almost non-existent. (Patterson and Haddad, 1992; Fenton and Brykczynski, 1993; Dunn, 1997) Suffice to say at this point, that there were major differences in the historical development and implementation of the CNS and NP roles. Both, however, are considered to be advanced practice roles and much of the knowledge and many skills and competencies are shared, depending on the setting and the clinical situation.

Definitions of 'advanced practice' roles tend to present a clinical role that is multifaceted involving collaborative relationships with other disciplines. The American Nurses Association

(ANA) Congress of Nursing Practice put forward its definition of advanced nursing practice in 1991:

> *Nurses in advanced clinical nursing practice have a graduate degree in nursing. They conduct comprehensive health assessments and demonstrate a high level of autonomy and expert skill in the diagnosis and treatment of complex responses of individuals, families and communities to actual or potential health problems. They formulate clinical decisions to manage acute and chronic illness and promote wellness. Nurses in advanced clinical practice integrate education, research, management, leadership, and consultation into their clinical role. They function in collegial relationships with nursing peers, physicians, professionals, and others who influence the health environment. (McLoughlin, 1992)*

In the USA, there are currently approximately 140,000 advanced practice nurses. (ANA, 1997) In 1994, they represented approximately two per cent of the total population of nurses working in the USA. The majority functioned in specialities rather than as generalists, and most were employed in hospital settings working primarily with inpatients. (DeAngelis, 1994) While only CNSs were required to hold a Masters degree, the aim of the American Association of Colleges of Nursing (AACN) was to have all NP programs conform to their guidelines by 1997. (Woods, 1997) NPs are recognised in all States of the USA and they have legislated authority to prescribe in 49 of them. They have separate malpractice insurance, are recognised as independent providers by many insurance funds, and have been granted independent primary care funding rights by Medicare. (Pearson, 1999; AACN 1998; ANA 1997)

Canada

In Canada, the emergence of the nurse practitioner movement during the late 1960s stemmed from the perceived shortage of physicians and their reluctance to practise in underserviced areas, as well as the nursing profession's desire for increased autonomy and an expanded role. (Way and Jones, 1994; Hallman and Westlund, 1983) The earliest program to educate nurses in an expanded role began in 1967. Since that time, programs have been implemented according to need and funding. (Hallman and Westlund, 1983)

The 1972 Federal Boudreau Report (Report of the Committee on Nurse Practitioners, 1972) defined the NP as a nurse in an expanded role oriented toward the provision of primary care; participating as a member of a team of health professionals and relating to families on a long term basis. (Ottawa Department of National Health and Welfare, 1972, in Van der Horst 1992) An early but well designed study which offers evidence on the effectiveness and safety of NP practice is the Canadian Burlington Randomised Trial on health outcomes of patients. The study involved 1,598 families randomly assigned to a traditional family physician group (which included a conventional nurse) or to a NP group working in consultation with physicians. Each NP was assigned half as many patients as the physicians. The quality of care provided by each group was quantitatively measured by assessing the outcomes in ten indicator conditions and the prescription of 13 common drugs. The results demonstrated that NPs were able to safely and effectively manage 67 per cent of their patient visits without physician consultation. The remaining 33 per cent of the patients were appropriately referred to physicians for management. (Spitzer, Sackett, Sibley et al., 1974) According to Van der Horst (1992), this study confirmed many of the positive findings found in other studies indicating that NPs maintain high quality care and are accepted by patients.

Physicians' resistance, lack of government initiatives, and nurses' attitudes, however, have been identified as the three main problems hindering the development of the role of the NP in Canada. (Van der Horst, 1992; Hallman and Westlund, 1983) Legal difficulties have also existed due to the lack of: development of standardised educational programs; development of licensing criteria; provision for continuing and updating education; and provision of appropriate remuneration. (Hallman and Westlund, 1983) In 1983, there were only some isolated cases

where the potential of NPs was being used to the maximum—these cases involved NPs in community health centres, clinics operating under global budgets, private practices and northern outpost nursing centres. (Hallman and Westlund, 1983)

A renewed interest in an advanced role for nurses, particularly in the provision of primary health care, began in the late 1980s. (Way and Jones, 1994) In 1987, McMaster University, in association with Chedoke-McMaster Hospitals in Hamilton, Ontario, began to develop a Masters level program for nurses in the neonatal intensive care unit. Since then, other agencies have experimented with advanced practice nursing roles. Lobbying of government bodies has increased and the Nurse Practitioner Association in 1992 began to define the NP role and to develop standards of practice. (Van der Horst, 1992)

UK

The UK literature on nursing practice issues has been free flowing since 1990. It has focused on 'clinical nurse specialist' and 'nurse practitioner' roles as well as levels and scope of practice. While the CNS role has tended to describe a nurse with an in-depth knowledge of a client group or disease process, the NP role has been less clear, at times describing a doctor substitution role, at others describing an autonomous, comprehensive role. The CNS role has existed informally since the 1970s in such areas as infection control, tissue viability, stoma care and continence. The NP role, on the other hand, has developed from Barbara Stilwell's work in the 1980s in the field of primary care. (UKCC, 1998; Autar, 1996; O'Hanlon, 1996; Castledine, 1995; Brown, 1995) In the 1990s, posts with the titles of nurse practitioner, advanced practitioner and advanced nurse practitioner emerged with little consistency of use (UKCC, 1998).

The background to the development of the role of advanced nursing practice in the UK is manifold and includes the key strategic documents *A Vision for the Future* (Department of Health, 1993), the *Post Registration Education and Practice Project* (PREP) (UKCC, 1990), and *The Scope of Professional Practice* (UKCC, 1992). Political agenda issues including the reduction in junior doctor hours and the effective and efficient use of resources by health care providers have also been galvanising. (Woods, 1997) Health professionals working in specific contexts, furthermore, also hastened developments of advanced and extended nursing practice roles. (Last and Self, 1994; Barrett, 1995)

Following consultation with the nursing profession, the United Kingdom Central Council of Nursing, Midwifery, and Health Visiting (UKCC) identified two levels of practice following initial registration—specialist and advanced. The system for recording post-registration qualifications, however, remains voluntary and does not ensure clarity or protection for the public, users or employers. The titles are not protected and the UKCC does not define standards or specific training programs for either NPs or CNSs. (UKCC, 1998)

The UKCC has emphasised that the definition of advanced practice is not an additional layer of practice to be superimposed on specialist nursing practice. O'Hanlon (1996) suggests that the distinction between specialist and advanced practice seems to be whether the practitioner is educated to first degree or Masters level. A series of consultative workshops are currently being conducted by the UKCC with the purpose of clarifying the qualifications and titles of nurses operating at a higher level of practice. The arrangements, however, are not expected to come in until 2001. (Stephen, 1998; UKCC, 1998)

Nurse prescribing in the UK, however, has been on the agenda since 1986 and is discussed further under the 'Extended Nursing Practice' section of this report. Briefly, the Cumberlege Report (DHSS, 1986) recommended that community nurses should be able to prescribe from a limited list of items as part of their everyday nursing practice. In 1988, an advisory group established by the Department of Health to examine nurse prescribing recommended that in clearly defined circumstances, suitably qualified nurses working in the community should be

authorised to prescribe from a limited list of items and to adjust the timing and dosage of medicines within a set protocol. (Department of Health, 1989) The required legislative changes were passed in 1992 and 1994.

New Zealand

In New Zealand, the title 'nurse practitioner' or 'independent nurse practitioner' has been used essentially by a group of nurses offering nursing services directly to the public. These nurses, however, are not prepared for advanced practice. The recent *Report of the Ministerial Taskforce on Nursing* (Ministry of Health 1998) identifies the barriers that prevent nursing from improving services to its patients and devises strategies to remove those barriers.

According to the New Zealand taskforce, the advanced nursing role offers a medium for the provision of highly skilled care, coordination of particular patient groups across hospital/community interface, and a high level of family health care service. (Ministry of Health, August 1998) It suggests further developing and supporting the clinical-nurse-specialist role to that of advanced nursing practice. In relation to expanding the scope of nursing, the taskforce identifies new roles that nursing could develop and new procedures that many nurses could undertake to the benefit of the patients and clients. It supports the setting up of mechanisms to support nurse prescribing, referrals, approval of sick leave and ordering of tests. It cautions, however, that the expansions identified must be underpinned by processes which assure New Zealanders that the nurses who undertake these procedures and roles are competent to do so. The New Zealand Nursing Council has recently developed policies relating to the expanded scope of nursing.

New Zealand's Minister of Health announced in May 1998 that prescribing rights would be extended to nurses and other health professionals and that designated health professionals would be able to select and administer specific prescription medicines for particular groups of patients in accordance with standing orders prepared by a medical practitioner, dentist or midwife. Policy work on the introduction of limited prescribing rights to nurses has commenced in the areas of aged care and child family health. (Ministry of Health, December 1998)

Australia

In Australia, discussions surrounding advanced level practice for registered nurses have been taking place for some time. New South Wales (NSW), however, has led the movement towards implementation of the role of the nurse practitioner. According to the NSW Health Department's Discussion Paper (1992, p.5), NPs have evolved in NSW due to 'consumer demand for diverse options in health care and a necessity for development of more cost-effective methods of service delivery'. A NP was initially defined by the working party as 'a registered nurse with appropriate accreditation[3] who practises within the professional role. S/he has autonomy in the work setting and has the freedom to make decisions consistent with his/her scope of practice, and the freedom to act on those decisions'.

The NSW Nurse Practitioner Project commenced in 1990 with a report of the final stage released in December 1995 (NSW Department of Health, 1996). A series of pilot sites were established to produce data from Australian studies which were designed and coordinated by local multidisciplinary committees. Nurse practitioner services are currently being implemented in the public sector of rural and remote NSW, and up to 40 positions (employee status) will be considered by the Director General. Due to the development of the accreditation processes, there will be a substantial lead time of at least 12–18 months before accredited nurse practitioners will be employed. (Meppem, 1998) To date 'approval in principle' has been given for seven positions. While the title 'nurse practitioner' is protected and nurses may be

[3] In NSW, the term 'accreditation' has been used to define what is understood in Victoria to signify 'credentialling'. Please see Glossary of terms for definitions.

authorised by the NSW Nurses Registration Board to practise as a NP, they will only be able to do so in the public sector where there is an approved position. There are no grandparent provisions for existing nurses. Any initiation of medication, furthermore, will apply to the individual position and will be incorporated in the relevant clinical protocol. (Meppem, 1999)

In the Northern Territory, a feasibility study of the role and function of the NP in rural and remote areas has recently been commenced. Similarly, in Western Australia, a steering committee has agreed that the nurse practitioner project in that State will focus on work in remote centres and other remote areas designated in its Rural, Remote and Metropolitan Area classification scheme. A definition of the scope of practice and the release of the remote area practice competencies has allowed an Education Working Party to commence the task of determining the appropriate knowledge and skills required by remote area nurses to provide safe, cost-effective care as nurse practitioners.

In South Australia, the Minister of Health recently launched the South Australian Nurse Practitioner Project Report. The 32 recommendations contained within the Report were endorsed by the Senior Executive of the Department of Human Services. The task of the Advisory Committee and reference groups formed to undertake the project was to provide the framework for overcoming any barriers to the implementation of the role of the NP. Stage 2 of the Project will constitute the implementation phase.

In Queensland, all nurses have recently been given extended authority relating to administration rights and supply of scheduled drugs and poisons in particular circumstances. Three practice settings have been identified: isolated practice, sexual health programs, and immunisation programs. The first isolated practice-endorsed nurses were due to complete their education in May 1999. Role statements have been established which include the role and accountability of the isolated practice endorsed registered nurse. (Queensland Health, 1997; Griffiths, 1998)

In the State of Victoria, the nursing profession and the Government have identified the need for broadening the scope of nursing practice and structuring its delivery to meet the health needs of the population. A two-day workshop was conducted in September 1997 under the auspices of the Department of Human Services to explore the establishment of the nurse practitioner role. (Department of Human Services, Victoria: Nurse Practitioner Workshop Proceedings, 1997) The specific goals of the workshop were to identify the issues in relation to the establishment of the role and to explore them in greater depth. The title and nature of the role, educational, legislative and regulation requirements, service models, and economic and consumer implications were considered. The workshop attempted to clarify these issues and to further discuss the nurse practitioner role in Victoria. Recommendations arising from the workshop relating to the coordination of the process of implementing the nurse practitioner role were made to the Minister for Health. Unlike most of the other States of Australia, the intention in Victoria is not to restrict the implementation of the nurse practitioner role to particular geographical areas or to the public sector.

The Victorian Nurse Practitioner Project

In July 1998, the then Minister for Health, the Hon Rob Knowles, MLC, appointed a taskforce chaired by Dr Tom Keating, Pro Vice Chancellor, La Trobe University, Wodonga, to develop a framework and process for the implementation of the nurse practitioner role in Victoria. The Nurse Practitioner Project is an action research initiative where the nurse practitioner role will be developed, refined and, in some cases, pioneered in Victoria. The process of developing a framework for role implementation has been an eclectic one where development of policy, community and practitioner consultation, and development, implementation and evaluation of a number of Victorian models of nurse practitioner practice have occurred concurrently and interactively.

This report outlines the framework and process for the implementation of the nurse practitioner role in Victoria, and sets out the recommendations of the taskforce and the rationale underpinning the recommendations. Undoubtedly, the implementation of these recommendations will be informed by the evaluation of a variety of Victorian nurse practitioner models of practice.

Policy Development

The Nurse Practitioner Project has the potential to both challenge and advance the nursing profession. It aims to enhance professional practice and adjust the boundaries for the development of future practice. The intent is to enhance health care delivery and produce quality outcomes in Victoria while establishing a framework for the implementation of the role. The main policy issues relating to the implementation of the nurse practitioner role have been considered under the following headings:

- Role definition and title
- Educational preparation and credentialling
- Best practice
- Professional indemnity and legal liability
- Legislative changes
- Financial considerations

The taskforce established some general principles to inform and guide its work. Issues of high priority included the need to safeguard the interests of clients (including choice, convenience and individual values); the need to ensure continuity of care; and the need to avoid fragmentation of health care. These principles assisted in formulating the recommendations. The taskforce met fortnightly between July 1998 and September 1999 and reviewed numerous issues in light of the national and international literature and their own professional knowledge and experiences. It also considered the broad spectrum of opinions put forward at various forums and discussion sessions. Due to the magnitude of the task involved in developing a framework for the implementation of the role of the nurse practitioner, the taskforce formed expert subcommittees to examine the above key dimensions and to work with the evaluators and with participants implementing a variety of nurse practitioner models of practice. Individuals with particular expertise were also coopted onto these subcommittees.

Each subcommittee met on a number of occasions between December 1998 and May 1999 and produced a report for discussion by the taskforce. The consensus reached (or not reached) and the rationale for this in relation to each of the above key dimensions is detailed in this report.

Community and Practitioner Consultation

Data gathered from community and practitioner consultation has informed, and will continue to inform, the policy direction in an iterative fashion. Two Nurse Practitioner Forums were held on 7 and 17 May 1999—one for the nursing profession and the other for the health industry. The objective of these forums was to elicit the views of health care professionals in the process of implementing the role of the nurse practitioner in Victoria.

The all-day forum for the nursing profession brought together more than 300 participants from a diverse range of fields including representatives from rural and metropolitan areas, health care facilities and other related organisations. The two-hour forum for the health industry brought together 40 representatives from similar areas with the addition of representatives from the medical profession including the General Practice Divisions-Victoria.

Community consultation took place in July 1999 in the form of a series of focus group discussions with consumer representatives. These focus group discussions assisted in discerning the key issues relating to the implementation of the nurse practitioner role which may impact on consumers and particular communities, and in identifying suitable processes for future consultation. Generally, the main points raised in the focus group discussions and the forums have supported the work of the taskforce and the direction taken.

Nurse Practitioner Models of Practice

As part of this action research initiative, the nursing profession was invited to submit sustainable nurse practitioner models of practice in late 1998 for consideration for funding and evaluation. The demonstration projects are to examine the nurse practitioner role in terms of feasibility, safety, effectiveness, quality and cost, consistent with the evaluation framework used in the recent NSW Nurse Practitioner Project. It is anticipated that these demonstration projects will provide valuable information about the nurse practitioner role in Victoria and comparable data which will be of national significance.

The overall **aims** of this part of the project are to:

- Demonstrate a variety of nurse practitioner models of practice.
- Identify any changes necessary in the Victorian health system to formally implement the role of the nurse practitioner.

The **objectives** of this part of the project are to:

- Enhance health care delivery.
- Develop a culture of collaboration and partnership with health care providers and the community.
- Identify appropriate practice settings.
- Develop models that demonstrate efficiency, and quality outcomes.
- Promote the nurse practitioner role within the health care system and the community.

Submissions were required to demonstrate a locally agreed need and collaboration with relevant interdisciplinary health care professionals. Evidence that the services of the proposed model were sustainable, client-focused, ensured continuity of care, and enhanced health care delivery, was also requested. Collaborative and interdisciplinary practice formed part of the inclusion criteria for funding.

Eight nurse practitioner models of practice were recommended by a nine-member selection panel. Another three models of practice agreed to participate in a Statewide evaluation. These

demonstration projects are located in a variety of health care settings including rural, remote and metropolitan locations (see Appendix 5). They are currently being funded for a period of up to 12 months and are subject to concurrent local evaluations and an external Statewide evaluation.

The University of Melbourne (Centre for Health Program Evaluation, and School of Postgraduate Nursing) has been commissioned to undertake a Statewide evaluation of the Victorian nurse practitioner models of practice. The aim of this evaluation is to explore the nurse practitioner role in order to improve health care practice. The Statewide evaluation will provide an overarching evaluation of the funded models of practice which are quite disparate in nature. It will also investigate the restrictions of current practice and the scope for improving and broadening current practice. The funded nurse practitioner models of practice and the Statewide evaluation were launched by the then Minister for Health on 30 March 1999 at the Royal Children's Hospital, Melbourne.

The following sections of the report outlines the discussions of the Victorian Nurse Practitioner Taskforce relating to the key issues identified in the process of developing a framework for implementing the nurse practitioner role in Victoria. These issues include:

- Role definition and title.
- Educational preparation and credentialling.
- Best practice.
- Professional indemnity and legal liability.
- Legislative requirements.
- Financial considerations.

Role Definition and Title

As mentioned in the 'Background' section of this report, definitions of 'advanced practice' embrace a multifaceted clinical role involving collaborative relationships with other disciplines. The definition put forward by the ANA Congress of Nursing Practice in 1991 is but one example. (McLoughlin, 1992) Similarly, the Australian Nursing Federation (ANF) (1997) emphasises the partnership role of advanced practice nurses 'with other health care professionals in progressing the health status of their patients and communities'. The organisation highlights the evidence demonstrating the value of partnerships and considers the nurse practitioner role to be at the apex of clinical nursing practice. Along the same lines, a position paper prepared by the Ministerial Advisory Committee on Nursing (MACON) (1997) in Victoria, Australia, defined the advanced practice nurse as a specialised registered nurse who is a member of an interdisciplinary health care team and deals with health maintenance and enhancement, disease prevention, risk appraisal, nursing diagnosis, management of nursing problems, client education and counselling. The advanced practice nurse should be educated through acquired, in depth knowledge and advanced skills in a defined practice area and through postgraduate programs that offer extensive clinical experience, intensive preceptorship and direct supervision.

Advanced practice roles are discussed at length in the nursing literature. Upon reviewing four advanced practice roles (NP, CNS, nurse consultant, and nurse clinician), Woods (1997) suggests that if these nurses are prepared to a Masters degree level and can demonstrate expert practice and skills in their area of practice, it could be argued that they qualify as advanced practice nurses. Sutton and Smith (1995) go further and suggest that the role of the advanced practice nurse is dependent on the personal attributes and disposition of the nurse in conjunction with clinical experience. The role is based on knowledge associated with caring and human communication rather than on the basis of a formal education or experience alone. They maintain that the difference between advanced nursing practice and other forms of nursing practice lies in the way that nurse practitioners think about, see and experience clinical practice. According to Sutton and Smith (1995), the advanced practice nurse is able to unify theory and practice and critically reflect on all aspects of client care. S/he is willing to 'bend the rules' and 'stretch' the boundaries of nursing practice for the benefit of patient care. The advanced practice nurse's actions are purposeful, directed towards excellence in client care and pragmatic. S/he focuses on the client and on situations which enhance positive outcomes for the client.

Although Sutton and Smith (1995) state that ideas from North American nursing do not truly capture the context of Australian nursing, their characterisation of the advanced practice nurse is very similar to Patterson and Haddad's (1992) description of advanced nurse practitioners. Regardless of title, role function or setting, Patterson and Haddad (1992, p. 20) describe these practitioners as:

> *nurses who push beyond the known boundaries of their profession; who have the vision and flexibility necessary to consider new possibilities for improvement and/or expansion; who have the urge to ask questions and seek out answers; who are willing to take the risks and face the challenges associated with breaking new ground; and who have the ability to articulate their thoughts clearly as they move ahead such that they contribute to the understanding and development of new knowledge and skills within nursing and thus lead their profession forward to meet the needs and demands of society.*

Patterson and Haddad (1992) also point to the integral part of research in the advanced nurse practitioner's quest for knowledge and clinical expertise. They suggest that the common thread linking advanced practice roles is found not only in the activities performed but also in the combination of specific attributes of the advanced practice nurse.

The Royal College of Nursing, Australia (RCNA, 1996) also contend that nursing practice encompasses much more than possession of a specialist knowledge base. The RCNA is in accord with a description of the advanced practitioner which includes that of a nurse who demonstrates a commitment to reflective practice and professional development; has broad social and political awareness; is capable of advocacy and collaboration; is focused on best patient outcomes; is an educational resource person; and is an expert, experienced nurse.

In Victoria, the taskforce agreed that the working definition of a 'nurse practitioner' would be based on the definition used in NSW with emphasis on the interdependent nature of the role:

> *A Nurse Practitioner is 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. (Victorian Nurse Practitioner Taskforce 1998)*

The taskforce also agreed that the framework for implementing the role of nurse practitioner in Victoria will not be based on substitution of medical care but on the development of an advanced nursing framework. Although claimed by some nurses in Victoria, the title 'nurse practitioner' has not been defined in any agreement or award in Victoria. (Iliffe, 1994) In NSW, the Working Party on the Nurse Practitioner Project 'agreed that because of the evolving and hence changing and ambiguous nature of the role and function of the Nurse Practitioner…..no single definition was appropriate'. There was agreement, however, that 'Nurse Practitioners are registered nurses educated for advanced practice, the characteristics of which would be determined by the context in which they practise'. (NSW Department of Health, 1993 p. 3/5) In South Australia, the NSW definition is also being used as a basis for the development of the role. The SA Advisory Committee on the Nurse Practitioner Project has postulated that the role is already in existence. (Department of Human Services, 1999)

There is evidence to suggest that some nurses already function in expanded and extended roles across Australia but do not benefit from the recognition, remuneration or legal protection required by such roles. (Cramer, 1992, 1995; Mahnken, Nesbitt and Keyzer, 1997; Williams 1998; RCNA 1997; Strange, 1994) In a recent national Australian study of rural nurses, Hegney et al (1997) found that the role of the rural nurse included independent prescription of drugs, taking diagnostic X-rays, attending labour, and transfusing blood. Kreger (1991) also found that rural and remote nurses in Australia frequently perform medical, pharmaceutical and allied health functions without legal authorisation, education, accreditation or monitoring.

Successful collaborative relationships between advanced practice nurses and medical practitioners in Australia are frequently reported. A recent report from a medical practitioner who has worked with nurse practitioners on palliative care teams, drug and alcohol units, sexual health clinics, correctional centres and Aboriginal health services, states that the full-time nurse practitioner currently working with him works in an autonomous but collaborative role performing basic examinations, immunisations, sexual health screens and Pap smears. She also counsels and supports clients both within and outside the clinic. (Gunn, 1998)

Although the role of the midwife is clearly different, commonalities with advanced nursing roles have been recognised. (Johnston, 1999) It is well recognised that midwives have provided leadership, nationally and internationally, in the development of professional autonomy. This leadership will undoubtedly inform the expansion and extension of the scope of nursing. In New Zealand, midwives were given equivalent legal status with medical practitioners in the provision of services for normal childbirth. *The Nurses Amendment Act 1990* ratified the right of midwives to prescribe, order laboratory tests and to gain access to hospital services. At the same time, midwifery and nursing were recognised as separate and distinct professions. (New Zealand College of Midwives, 1999; Fleming, 1998; Ministry of Health, 1997; Social Services Committee, 1990)

In Victoria, the taskforce has included midwives within the title 'nurse practitioner' as midwives are registered under the Victorian Nurses Act and are required to undertake an additional midwifery course. 'Midwife' is a protected title under this Act. As in New Zealand and some other countries, midwifery is recognised by the Australian College of Midwives as a separate discipline from nursing. The *Code of Practice for Midwives in Victoria* (Nurses Board of Victoria (NBV) 1996, revised 1999) uses the internationally accepted definition of midwife, which has been ratified by both the World Health Organisation (WHO) and the International Federation of Gynaecologists and Obstetricians.

In recent years, the nursing profession Australia-wide has been encouraged to map the role and scope of advanced nursing practice and to clarify the use of the variety of titles used. The AACN has only recently called for a 'standardised national advanced practice nursing certification process'. (AACN, 1999, p. 130) In Australia, the work of negotiating a national framework for the credentialling of advanced practice nurses and accrediting related education programs has begun. This will ensure credibility and consistency of practice.

From the numerous discourses that have taken place over the years (AACN, 1999; ANA 1997; Woods, 1997; ANF, 1997; Dunn, 1997; Calkin, 1984; Sutton and Smith, 1995; Patterson and Haddad, 1992), it is clear that a definition of advance practice nursing must incorporate its dynamic state. It must take into account both the expanded and extended role of the advanced nurse practitioner, and it must differentiate the advanced nurse practitioner from other nurses.

Nursing roles have expanded and extended to some extent by necessity to meet health care demands in underserviced areas. The terms 'expanded' and 'extended' in the literature in relation to nursing roles are generally used to signify the same thing. Occasionally, however, authors distinguish between the terms. An expanded role in nursing, according to Pearson (1993, p. 216), refers to 'a "deepening" and development of the role, drawing on those skills and areas of knowledge which are uniquely nursing'. An extended role, on the other hand, 'widens the nurse's role to include various tasks that were previously seen to be the domain of doctors'. It is generally recognised, however, that these roles are not mutually exclusive.

Bigbee (1984) suggests that nurse practitioners need to emphasise their 'expanded' nursing activities which include focusing on health promotion, education, and counselling. By doing so, Bigbee believes that the scope of nurse practitioner practice will progress in creative and constructive directions. The taskforce agrees with the need for such an emphasis in Victoria. As part of this approach, the taskforce believes that in the attempt to improve health service access, the complementary nature of the nurse practitioner role should be stressed. This is in keeping with Bigbee's (1984) suggestion that a collaborative approach to health care delivery would increase the available resources for creative, comprehensive health care and minimise the energy consumed in the maintenance, defence and acquisition of individual territory. In turn, so-called 'delegated' activities, such as prescriptive, diagnostic, and referral practices which are sometimes termed 'extended' practices, need to be viewed as mere tools necessary to competently practise in an expanded area of nursing expertise.

Health care demands have created several forms of advanced nursing roles. This diversity demonstrates the numerous opportunities for nurses functioning at this level and the need for flexibility in fulfilling ever-changing health care demands. The importance of implementing the role of the nurse practitioner in Victoria lies in its potential to respond to individual and population needs which are currently not met by existing services and to improve health care outcomes.

The emerging consensus appears to be that advanced nursing practice roles involve using advanced assessment skills, initiating diagnostic tests and undertaking treatment approaches, in partnership with clients and communities, whilst retaining a nursing perspective and working interdependently and collaboratively with a range of health care professionals as a matter of

course. Depending on the context of practice, the advanced nursing role may involve coordinating the care of clients or undertaking care management over an extended period of time across the community-inpatient-community care continuum in a comprehensive and integrated fashion. The role requires that nurses have considerable post-registration experience as well as postgraduate education to prepare them for safe and appropriate advanced practice. The role integrates advanced clinical practice, based on evidence and international best practice, with education, research, management, leadership and consultation, and requires nurses to utilise their considerable experience, knowledge and clinical judgement.

Role statements, together with codes of professional conduct and ethics, standards of practice and relevant legislation, set the standard and scope of performance that can be expected of all practitioners in the provision of health services. The taskforce believes that the advanced role of the nurse practitioner should combine knowledge, competence, experience, and intuitive judgment. In performing the role, nurse practitioners need to demonstrate sound integration of theory and practice and advanced problem solving and clinical decision making skills.

The NSW Nurse Practitioner Project concluded that the evidence from the pilot projects supports the proposition that nurse practitioners are feasible, safe and effective in their roles and that they provide quality health services in the range of settings researched. The NSW Project, however, operated under several provisos. The pilot projects were not to be set up to directly compare services provided by nurse practitioners and medical practitioners. It was also clearly stated that the nurse practitioner was to be an ‘essential member of an interdependent healthcare team’. (NSW, Department of Health, 1996, p. 2) These provisos, together with resource constraints, prevented many of the pilot projects from undertaking rigorous randomised controlled trials or conducting cost-effectiveness studies.

A report critical of the NSW Nurse Practitioner Project produced by Logan Consulting (1996) and sponsored by the AMA (NSW) clearly sees these limitations as severe weaknesses. It does not mention, however, the successful capture of a range of information from the triangulation of data from several complementary sources and methods. The use of qualitative methods, for example, is crucial in a study such as this because of the nature of the issues being explored. The focus is on the elucidation of experiences, practices, ideas, behaviours and values rather than on the production of data amenable to statistical analysis. Emphasis is placed on understanding the social context from the point of view of the participants; on gaining an understanding of how communities and individuals within them interpret health care; and on studying the interactions between the various relevant players. In exploratory projects such as this, flexibility is essential. Sensitive and controversial issues can be discussed and an in-depth understanding of the respondents’ experiences can be gained.

It is expected that the demonstration projects currently being conducted in Victoria will collect data from a variety of complementary sources and methods and provide valuable information about the role in Victoria. Furthermore, in order to conform with Competition Policy Agreements, the introduction of the nurse practitioner will not be defined by practice settings, but rather by the scope of nursing practice provided.

The purpose of the Australian competition laws and of the Australian Competition and Consumer Commission's (ACCC) enforcement of those laws in the health sector, is to ensure that competitive forces will be allowed to stimulate the development of products and services desired by consumers. The Commission is able to authorise anti-competitive conduct, where the conduct in question can be shown to result in a public benefit that outweighs its anti-competitive effect. (Fels, 1998) In accordance with the competition policy, the taskforce believes that consumers should be free to choose from a number of service providers based on informed decisions. A range of international studies suggest that suitably prepared advanced practice nurses, in collaboration with other health care professionals, can perform as well as, if not better than, doctors in the delivery of care in certain diverse areas. Included in this range are studies of

advanced practice nurses working in emergency departments, providing cervical screening, managing the care of clients with rheumatology, and prescribing certain medications. (Sakr et al., 1999; Vadher et al., 1997; Grahame and West, 1996; Thommasen et al, 1996)

Nurses working in an advanced capacity provide expert care in a range of midwifery and nursing general and specialist areas, complementary to that of other health care providers. In the provision of care, the advanced practice nurse promotes health and encourages client self-determination and involvement in their care. The role comprises several core components, which are constant across all advanced practices. However, the weighting given to each component will vary according to the context of practice and the needs of particular clients at any given consultation. In addition to the core components, there are context (specialty) specific components where knowledge and competence are required.

In defining the role of the nurse practitioner, the taskforce believes that it will be important to ensure that the role is achievable, consistent across similar practice areas, measurable, and communicated to relevant stakeholders, including clients. Since roles are rarely constant, a defined time for revision of the role statement should be set. Therefore, a role statement will be an important consideration in the development of nurse practitioner education and credentialling processes, as well as best practice standards and recommendations for legislative change.

Existing role statements of professional associations describe the roles of advanced practice nurses in specific contexts (for example, the Australian Diabetes Educators Association and the Oncology Nurses' Association). The final nurse practitioner role statement must be consistent with any existing role statements.

The purpose of developing a role statement for the nurse practitioner is to identify, and recognise, the customary functions that they perform in order to promote the role as a specific area of nursing practice, which extends the usual role of the nurse. Role statements also define the standard and scope of performance that can be expected.

The common core components of the role should demonstrate an advanced level of expertise in the integration of theory and experience into practice. Nurse practitioners, as advanced practice nurses, will have advanced knowledge and skills consistent with the context in which they practise. In carrying out the role, nurse practitioners will work interdependently but will be responsible and accountable to the patient and to their professional body for their actions and omissions, in accordance with professional codes and standards. It is expected that nurse practitioners will have as their primary focus, their clients and their families. The core components of the nurse practitioner role will include:

- **Clinical practice** which includes the ability to analyse clinical situations and address the non-clinical variables which affect health, including assessment, problem identification, problem solving, case management, appropriate collaboration and referral.
- **Education** which encompasses client education and continuing professional development in clinical practice and other areas such as pharmacology, diagnostic processes and procedures.
- **Counselling.**
- **Research and quality improvement** which includes undertaking research and quality improvement projects as well as monitoring care, evaluating outcomes, incorporating research findings into practice, and communicating research findings to colleagues.
- **Administration and management** including establishing collaborative practice networks, budgeting and service planning.

The components of the nurse practitioner role and of working relationships will vary according to location, context, and area of practice. All nurse practitioners, however, need to be educated to an advanced level and competent to practice. Furthermore, the classification of the nurse practitioner must be remunerated at a rate commensurate with the knowledge, skills, competencies and responsibilities required for the position and should have parity with management and academic salaries.

Having reviewed the literature and in light of their professional knowledge and experience, the taskforce unanimously recommends the following:

Recomendations

1. That the nurse practitioner be recognised 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.
2. That nurse practitioners be recognised as legitimate providers of health care services in Victoria and that the implementation of the role of nurse practitioner not be restricted by sector or geographic location.
3. That the recommendations of this report be implemented without delay recognising that the Statewide evaluation of the demonstration projects will further inform the development of the nurse practitioner role.
4. That core components of the nurse practitioner role include advanced clinical practice, education, counselling, research, quality improvement, administration and management.
5. That the position of nurse practitioner be remunerated at a rate commensurate with the knowledge, skills, competencies and responsibilities required for the position.

Educational Preparation and Credentialling

Underlying the rationale for the taskforce recommendations relating to the educational preparation and credentialling of nurse practitioners are the assumptions that the features which characterise **the practice of a nurse practitioner** are threefold, that it is:

- At an advanced level.
- An expansion and extension of practice beyond that normally undertaken by a registered nurse (in divisions 1, 3 and 4 of the register).
- Context specific.

Discussions by the taskforce focused on two major areas—the education required for a nurse practitioner, and the continuing education to ensure that competence is maintained and enhanced.

The taskforce agreed that considerable evidence exists to suggest that, within Victoria, there is currently a number of general and specialist nurses working in a variety of practice settings at an advanced level. Amongst these are midwives, sexual health nurses, psychiatric consultation liaison nurses and nurses working with the homeless. New roles for advanced practice nurses are also currently being explored and the taskforce expects that others will emerge as the health service scene continues to change.

The taskforce proposes that the education to be provided for the nurse practitioner must reflect not only the characteristics described above, but it must also be sensitive to the considerable level of experience already evident within the Victorian population of nurses, as well as have the capacity to prepare for new and emerging roles.

Educational Preparation

The taskforce considers that the title of nurse practitioner should be protected by legislation as are the titles 'registered nurse' and 'midwife'. In order to use the title 'nurse practitioner', a registered nurse must undertake a course of study (or its equivalent) satisfactory to the NBV. The processes associated with the accreditation and the level of such courses were considered by the taskforce and are detailed below.

Protection of Title

The title 'nurse practitioner' should be protected within the *Nurses Act 1993*. The title will be granted to those who have successfully completed an accredited course of study. As the NBV is charged with the responsibility for approving courses for registration purposes (*Nurses Act 1993 s.66(1)(c)),* the taskforce recommends that it is the most appropriate body to undertake the accreditation for nurse practitioners.

Recomendations

1. That the Nurses Board of Victoria be the approved body to regulate the use of the title 'nurse practitioner'.
2. That the Nurses Act 1993 (s.62) be amended to prevent any persons who have not met the requirements of the Nurses Board of Victoria from using the title of nurse practitioner.

Accreditation

Accreditation refers to the validation of the quality of an education course. The process usually involves assessment of the elements of a course against predetermined criteria, to determine whether the course meets the minimum standards set by a relevant body, for example, a university or registration board. (Gibson and Lawson, 1996)

The NBV already has in place processes for accreditation but will need to establish specific guidelines for the accreditation of nurse practitioner courses.

The current practice of the NBV is to establish an expert committee to develop the criteria for accreditation and publish them as **guidelines**. Such a panel consists of educationalists and clinicians, in particular, curriculum experts and expert clinicians in the field of interest. Once developed, the guidelines are distributed for comment to those who will be users in the area and other relevant stakeholders. This panel will also determine the arrangements necessary for recognition of nurse practitioners during the transition period.

For each course to be accredited, **a review panel** is appointed. The composition of the review panel is similar to that above. During the accreditation process, elements of the course are compared with the guidelines to ensure that minimum standards are attained. The NBV further monitors the facility offering the accredited course to ensure that standards are maintained.

The taskforce considers that the NBV is in an ideal position to use these existing processes for accreditation of courses for nurse practitioners.

Recommendation

3. That the Nurses Board of Victoria use existing processes for the accreditation of courses for the nurse practitioner including the establishment of both guideline development and curriculum review panels and, further, that these processes involve nurse practitioners.

Elements to be included in Guidelines for Accreditation

The taskforce suggests that the following aspects be taken into account by the NBV when developing guidelines for accreditation of nurse practitioner courses:

The Course

The course should consist of **core** elements reflecting the role that all nurse practitioners share. They will all be working at an advanced level of practice, therefore, the core area will include components related to advanced practice (for example, advanced assessment, relevant pathophysiology and pharmacology) as well as elements common to the role of all nurse practitioners. In addition, there should be a variety of subjects that capture the **context** within which nurse practitioners operate. Thus, there may be units, for example, relating to diabetes, women's health, remote and rural area nursing. To be recognised as a nurse practitioner, each nurse practitioner must demonstrate that s/he has successfully passed not only the core components, but also the units that relate specifically to their context of practice. Should a nurse practitioner change context, then s/he will need to re-apply for recognition. The context in which the nurse practitioner has sought recognition is to be placed in parenthesis, in order to ensure maximum protection of the public. An example of this would be as follows: Nurse Practitioner (Women's Health).

Extended Practice

It is in the area of **prescribing** and other extended practices, such as referral and diagnostics, that the nurse practitioner is differentiated from registered nurses (Divisions 1, 3 and 4). Therefore, units relating to these areas must be included as core content. Accreditation

guidelines will specify the broad range of content to be included in this unit and processes required to demonstrate collaboration with medical and other relevant health professionals in both the development and implementation of this unit.

Clinical Experience

Given the importance of the context of practice, the course must demonstrate how the student will acquire the clinical practice necessary for application of theory and gaining of experience in the clinical field. In Victorian universities, clinical postgraduate courses are well established in nursing and a strong pattern of collaboration exists between the universities and the clinical facilities. Close attention is paid to the clinical component. Students are expected to work in the clinical field while undertaking the course so that theory can be applied immediately to practice. It will be expected that clinical experience for nurse practitioners will be gained in the context area and that the university offering the course will demonstrate how it will approve and monitor the clinical facility to ensure that high standards are attained and maintained.

Recognition of Prior Learning

Given the number of nurse practitioners who are currently practising at an advanced level in Victoria, each accredited course must demonstrate clearly how it will incorporate recognition of prior learning (RPL) processes. Each course must include clear guidelines for how credit will be given for experience as well as units of study undertaken in a variety of educational settings. Other graduate courses, such as those in business, have policies and practices that ensure that relevant experience is given full recognition. This means that, in applying for an accredited course, a nurse practitioner furnishes evidence of already developed knowledge and skill in areas of the course that satisfy the unit requirements and ensure formal credit for such experience. As Iliffe (1994, p. 20) states:

> *Australian nurses want university credits for their educational efforts. They also want experience and prior learning acknowledged and formally recognised. Universities must enter into meaningful collaborative arrangements with clinical facilities in order to utilise the clinical skills and resources which health facilities can offer in the development of clinical electives.*

Flexibility of Course

Accredited courses must show flexibility not only in content, but also in access and mode of delivery. Because of the variety of contexts in which nurse practitioners practise, accredited courses will be expected to offer a wide variety of options in the context areas, or have collaborative arrangements with other universities or learning facilities as required to ensure adequate coverage of all context areas in Victoria. The taskforce believes that there is merit in such collaboration between universities to ensure maximum utilisation of limited resources.

The taskforce also considers it essential that all nurse practitioners, especially those in rural and remote areas of Victoria, have ease of access to education courses. Those developing the courses will need to make maximum provisions for quality learning in off-campus mode, ensuring that the isolated practitioners have not only easy access to the course, but also sufficient support for their formal learning and application of theory to practice. Clinical facilities will need to be assessed and monitored by the universities offering the course and evidence of the processes included in the document for accreditation. Again, there is merit in collaboration between universities, especially given the cost associated with development of off-campus study courses for relatively small numbers of students.

Level of Course

If the nurse practitioner is to operate at an advanced level, the educational preparation needs to reflect the role and practice at this level. This could be achieved by successful completion of a relevant postgraduate course, either a Graduate Diploma or a Masters Degree. The taskforce

considers that Masters level is appropriate for the following reasons. Firstly, graduates will have undertaken a substantive research study or project directly related to their area of practice. This enables the discipline of nursing to grow through evidence-based research into practice and the role of the nurse practitioner. It will also facilitate an inquiring mind and further develop the skills to communicate these findings both within and outside the nursing profession. Secondly, the Masters qualification will be recognised internationally. Other countries do not use the title of Graduate Diploma/Certificate.

The taskforce believes that Victoria is well placed to achieve the educational requirements of nurse practitioners through the clinical Master program processes already in existence. The taskforce considers it essential that the course has a strong clinical emphasis and that there be ease of access for all nurse practitioners, wherever they are located.

Recommendations

4. That the use of the title 'nurse practitioner' be restricted to that of a nurse registered in Divisions 1, 3 or 4 of the Register with the identified area of practice attached to the title.
5. That guidelines for accreditation of nurse practitioner courses require maximum flexibility in course content, and access, recognition of prior learning and clinical experience. These courses should include both core and context units. Extensions to nursing practice, such as prescribing, should be included as core components of the courses.
6. That the Department of Human Services provide funding to a consortium of universities for the development of appropriate nurse practitioner courses.
7. That the minimum educational requirement for recognition as a nurse practitioner be an accredited Masters level program with a strong clinical focus and a research project component.

Transition Phase

The taskforce recognises that assistance is required for those experienced nurses already working in an advanced and extended capacity, in their acquisition of the appropriate educational qualification. As mentioned, such assistance must be provided through RPL and maximum flexibility of courses. Financial assistance, however, is also required, as is the inclusion of a transitional phase to ensure that these practitioners are not disadvantaged in any way.

The taskforce asserts the importance of recognising the educational requirements of those nurses currently working in an expanded and extended capacity. It is expected that some of these nurses will already have sufficient qualifications for the nurse practitioner role. With the proposed flexibility of the courses, and RPL, others will be able to gain these in a relatively short time. To ensure that such valuable practitioners are not disadvantaged, the taskforce feels that it is necessary to provide them with protection by allowing a period of time for them to gain the necessary qualifications. It is expected that all such practitioners will have commenced to seek such qualifications within five years and have completed them in ten years. The NBV, through the expert education committee established (p. 24) will determine that necessary arrangements are established for endorsement of the nurse practitioner and that suitable guidelines are developed to ensure that the transition period proceeds without difficulty.

Financial Assistance and Leadership

The taskforce acknowledges that the cost of postgraduate courses is increasing, whether the course requires payment of fees or payment of the Commonwealth Government's Higher Education Contribution Scheme (HECS). It is expected that the number of registered nurses wishing to pursue advanced and extended nursing practice will be low. Therefore, for those nurses already working in this capacity, funding for scholarships to facilitate completion of

qualifications in the minimum time possible is desirable. In addition to this, such scholarships should be offered to those who wish to enter this field of practice for the next ten years, especially where a community need exists for such nurses. Clearly, such funding should be additional to the current allocation for nursing education.

To demonstrate the worth of the nurse practitioner role and to provide valuable leadership in the area, the taskforce proposes that funding should be made available for a nurse practitioner chair in Victoria. In the last three years, Victoria has seen the introduction of a number of professorial chair positions in clinical nursing. These have been established to offer professorial leadership in the investigation, evaluation, and delivery of nursing services in health service settings. They bring together the research expertise of universities and the professional expertise of health service agencies and apply advanced knowledge in order to improve health outcomes and achieve health gain.

The taskforce expects that a clinical nurse holding a professorial chair will act as a role model; provide a link with government and policy making; increase the links between practice, research and education; contribute to various committees across all levels from university/hospital through to international committees; increase the visibility and status of the nurse practitioner and provide leadership in relation to educational developments.

Recommendations

8. That the Nurses Board of Victoria, in establishing the process for nurse practitioner endorsement, provides a transition process of ten years for the attainment of the minimal educational requirement of a Masters for nurse practitioner recognition. Where a nurse practitioner does not meet minimum education requirements by 2010, the Nurses Board of Victoria may provide an exemption, where appropriate, in particular taking note of previous endorsement as a nurse practitioner or clinical experience.
9. That the Department of Human Services make additional funds available for registered nurses wishing to undertake studies leading to recognition as a nurse practitioner.
10. That the Department of Human Services fully fund a clinical chair to provide leadership in nurse practitioner practice, research, education, and policy development in Victoria.

Continuing Education

Conceding that knowledge and skills change with time, the taskforce considers it essential that the nurse practitioner, as for all other health professionals, maintains and enhances current competency. Competency is demonstrated during the course undertaken to allow recognition as a nurse practitioner, and it is important that the public is assured that such competency is maintained and enhanced. The issue of the demonstration of continuing competency is a difficult one and there are many ways this may be done. However, before any measures of such competency can be made, standards/competencies acceptable to the professional group, are to be developed.

Establishment of Standards/Competencies

The taskforce is aware that some professional nursing groups already have established standards and competencies and others are working towards them. The question is raised as to whether there should be a set of standards/competencies reflecting the role that all nurse practitioners share in common and/or whether there should be sets of standards/competencies reflecting the many contexts in which practice occurs. Given the work already underway in this area, it is essential that there is national consistency in developing such standards/competencies. Further, such standards/competencies must take into account international trends. To accommodate work already undertaken and to ensure that all groups within the nurse practitioner movement

have the opportunity for input into these standards/competencies, a group of experts should be formed to develop a national framework.

A process needs to be developed whereby this expert group can be established with clear guidelines for consultation and communication with the major stakeholders. The taskforce believes that for this to be successful, a nursing organisation or authority needs to facilitate the process. Having raised a number of options, the taskforce recommends that the NBV be requested by the Minister of Health to provide the leadership in establishing these processes and the infrastructure to enable an expert group to fulfil its mission. The NBV has the capacity to facilitate such a process and to coordinate a national approach.

Irrespective of the origins of the expert group, the taskforce believes that **funding** must be sought to enable the group to successfully complete its work of developing the national framework. As it is of national significance, a proposal for Commonwealth funding should be developed.

Recommendations

11. That a framework be developed that enables core and/or specific standards/competencies to be developed that are nationally and internationally consistent in relation to nurse practitioners.
12. That the Minister for Health request the Nurses Board of Victoria to facilitate the processes necessary for the development of a framework for standards/competencies for nurse practitioners that are nationally consistent and internationally compatible.
13. That Commonwealth funding be sought for the development of a national framework for standards/competencies for nurse practitioners.

Credentialling

The issue of credentialling for nurse practitioners was considered in detail by the taskforce. Credentialling is considered by some to be an important mechanism for demonstrating that competency is current. The focus of credentialling is on the performance of the individual against appropriate practice standards/competencies. The taskforce is of the opinion that the responsibility for participating in a credentialling process rests with the individual practitioner. However, there are a number of questions about credentialling that need addressing.

Who will be authorised to credential?

The taskforce is of the view that professional associations who accept this responsibility should be so authorised. Some groups have already begun to develop such a process (for example, Australian Diabetic Educators' Association), others are considering it and others have not yet seriously considered it.

How will performance be measured?

Many approaches are currently in operation. Examples of these include: different types of written submissions, including tests; performance assessment by self or peers; and keeping of a portfolio that would include evidence of effective continuing education. Whichever method is used, the issue of validity and reliability of measurement tools must be considered.

Who will bear the cost?

Depending on the method used and its frequency, credentialling can be an expensive process. If the professional organisation were to bear the total cost it would have to do so largely through annual subscription. If the cost were to be borne by the individual, then it would be fee for service. It is important that the cost does not outweigh the benefit.

How often is a credentialling process required for nurse practitioners?

Every three years has been proposed by NSW. There is no evidence for an appropriate length of time. An arbitrary decision would have to be made by each professional organisation and appropriate data collected on the corresponding outcomes.

The issue of what is credentialled, how and by whom, is, in the opinion of the taskforce, a matter for the professional organisation(s) whose membership includes nurse practitioners. It is desirable that there is a consistent national approach guided by an overall framework, but allowing sufficient flexibility for different groups.

A project has been funded by the Commonwealth Department of Health and Aged Care and managed by the RCNA which is examining the feasibility of establishing a national framework for the credentialling of advanced practice nursing. The progress of this study should be monitored and the outcomes evaluated to guide the development of credentialling of nurse practitioners in Victoria.

Continuing Competency

Credentialling on a regular basis is concerned with the demonstration of continuing competence. Although the NBV does not see credentialling as its role, it is mindful of the importance of nurses demonstrating continuing competence. Currently this is maintained through the codes of practice and ethics and through the 'recency of practice' requirement during annual registration. The latter requires self-declaration and there are obvious deficiencies in this process.

The Queensland and Tasmanian regulatory authorities have instituted a random audit to enable them to monitor the documentation that nurses keep demonstrating ongoing competence. The taskforce agrees that there is considerable merit in such a concept and it could require the nurse to keep a portfolio of matters relating to continuing education, performance assessment and peer review. It could also include a written statement of credentialled status issued by a professional organisation. The regulatory authorities are considering the issue of continuing competence in nursing. The onus for continuing education rests with the individual practitioner. This accountability extends to the issue of credentialling.

The issues surrounding credentialling are complex. The taskforce is aware that there has been some work done by individual nursing groups, but believes that such efforts need to be nationally coordinated. The issues of credentialling relate to all specialist groups in nursing and some of these groups have already undertaken work in the area. In addition, the ANF has developed standards for advanced practice. The suggestions put forward by the ANF will facilitate the coordination of efforts in relation to nurse practitioners. However, expert groups will need to be cognisant of the work of other groups such as the Australian College of Critical Care Nurses, the Australian College of Midwives Incorporated, National Nursing Organisations, Australian Diabetes Educators' Association, Australian and New Zealand College of Mental Health Nurses, and the RCNA.

Recommendations

14. Recognising that credentialling for advanced practice is the responsibility of the nursing profession, that the nursing profession monitor the outcome of the national project funded by the Commonwealth examining the feasibility of credentialling, and that appropriate action ensuring both consistency of approach and maximum flexibility be taken.
15. That the Nurses Board of Victoria, in establishing criteria for the assessment of continuing competence of nurse practitioners, give consideration to written statements of credentialled status from professional organisations as one component of those criteria.

Best Practice

Best practice is often interpreted as practice that is optimal and timely and based on the best available evidence. Terms such as 'best practice' are increasingly being adopted in the health literature, often without qualification or definition. The origins of the term are unclear but have been linked to the manufacturing sector where 'world best practice' has generally been used to describe technology that is regarded as leading to optimum efficiency. (Renhard, 1996; Commonwealth of Australia, Work in Progress Report, 1993) The purpose of adopting world best practice is to improve efficiency and international competitiveness.

The health sector has demonstrated an interest in improving efficiency and has adopted the commercially appropriate language (for example, National Health Strategy, 1990; Metropolitan Hospitals Planning Board, 1995; Health and Community Services Victoria, 1995). The notion of world best practice, however, requires that the practice be the same, regardless of context. In the health setting, it is often necessary to modify practices if optimum effectiveness is to be attained. As a result 'best practice' rather than 'world best practice' has become the term more commonly used to describe quality health care approaches. It is now well recognised that simply copying an approach is contrary to the notion of continuous quality improvement and that the best practice possible is contextually determined. (Renhard, 1996)

Best practice, as a concept, emphasises that practitioners should continually scrutinise the environment and compare their practice with similar activities and use this research to improve their own practice. This is commonly referred to as benchmarking in the commercial literature. (Macneil et al., 1994) The benefits of benchmarking are numerous and include:

- Encouraging innovation and the development of locally responsive and appropriate services through the processes of comparison and analysis.
- Minimisation or prevention of unnecessary research and development activities.
- Assuring rigour in the process used to select practice methods.

The 1998 Department of Human Services tender seeking submissions to demonstrate nurse practitioner models of practice in Victoria sought innovative, appropriate and locally responsive services. Both local and Statewide evaluation specifications also included a request to utilise best practice indicators.

Facilitating the move towards a best practice approach, including the push for the use of methodologically rigorous processes and the prevention of unnecessary research and development activities, has been the establishment of centres for evidence-based practice in all Australian capitals. These centres accommodate limited resources by centralising research information, providing ready access to a network of research activity, and by avoiding unnecessary duplication of research.

Evidence-based practice aims to eliminate ineffective health care practice. The taskforce cannot emphasise enough, however, that evidence needs to be supportive of local and responsive approaches to practice. It is not appropriate, for example, to expect rural health care practice to conform to standards of evidence formulated solely in metropolitan areas (McCarthy and Hegney, 1998) or to expect practice in a specific context to conform to evidence formulated in a different context, when such evidence may have limited relevance. As the working definition of nurse practitioner suggests, the characteristics of advanced practice will be determined by the context in which they practise. The efficacy of the practice of nurse practitioners would thus be specific to the particular context of practice.

Evidence-based practice builds on the skills many nurses already possess, it narrows the practice-theory gap and fosters collegiality amongst nurses by facilitating networking amongst clinicians and academics. As Alderman suggests, nursing can validate its practices and enhance its professional credibility through the achievement of effective outcomes-based on expressed client need. (Alderman,1996)

The taskforce also recognises that there are limits to evidence-based care. A lack of randomised trial evidence that a given practice or intervention is effective, for example, is not necessarily evidence that it is ineffective. Outcomes that are easy to measure are sometimes less important than those which are difficult or impossible to quantify. A simplistic approach towards evidence-based practice may harm rather than improve the health and wellbeing of consumers and population groups.

Renhard (1996) suggests a framework for developing and assessing best practice at the service delivery level which includes the following:

- Practitioners should be able to demonstrate that they have a working knowledge of generally accepted practices that are relevant to their practice.
- Where they have not adopted generally accepted practices, practitioners should be able to provide a clear rationale as to why they are not using these practices.
- If a practice is chosen that is not consistent with that which is accepted generally, its effectiveness should be demonstrable, using measures that include outcomes for individual consumers.
- Where a chosen practice is consistent with generally accepted practice, its efficiency should be determined and compared with established levels of performance.
- Where there is agreement that there is a generally accepted practice, practitioners should be able to describe a sound rationale and to demonstrate support for the chosen practice.
- The rationale should include an evaluation of outcome measures for the chosen practice and a review of similar practices and/or relevant research.

This framework represents a local, rigorous and responsive approach to practice which is in line with activities of the Nurse Practitioner Project. The taskforce, however, recognises the inherent complexity of health care and some of the difficulties associated with meeting public interests and working flexibly across boundaries. Best practice, nevertheless, is a dynamic attributable to the practice of all health care professionals and the development of the nurse practitioner role requires careful communication between all health care professionals if it is to be successfully implemented in the best interests of individuals and the population at large. It is expected that the collaborative effort between all health care professionals in the Department of Human Services funded Victorian demonstration projects will go some way in determining the benchmarks for best practice and developing models that demonstrate efficiency and quality outcomes.

Indicators of Best Practice

The development of indicators of best practice is occurring across the world and throughout Australia. Indicators do not necessarily differentiate between health professionals but rather the environment in which health care is delivered (for example, intensive care, and obstetrics).

Examples of common indicators of quality and best practice include:

- Professional competence
- Patient satisfaction
- Use of clinical practice guidelines.

The evaluation framework for the NSW Nurse Practitioner pilot projects, agreed for use in Victoria by the taskforce, includes indicators for access, best practice, appropriateness, cost and outcomes.

Clinical Practice Guidelines

Concerns about the effectiveness of practices in health care and the need to make the best use of available health resources have led to an interest in the development and implementation of clinical practice guidelines. These guidelines are 'systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances'. (Field and Lohr 1990 in NH&MRC, 1999) They are designed to improve the quality of health care, to reduce the use of unnecessary, ineffective or harmful interventions, and to maximise the chance of benefits for patients, at an acceptable cost. (NH&MRC, 1999) The taskforce is aware that clinical practice guidelines constitute just one component of good health care decision making. Consumers' preferences and values, as mentioned throughout this document, also need to be taken into account.

Guidelines have traditionally been based on the development of consensus among experts. It is now recognised, however, that guidelines should be based, where possible, on the systematic identification and synthesis of the best available scientific evidence. The NH&MRC (1995, 1999) has released a document setting out a method for developing clinical practice guidelines. The most recent document is a revised version of the earlier document and places greater emphasis on guideline implementation and evaluation.

Amongst the basic principles for developing guidelines as conceived by the NH&MRC (1999) is that the process be multidisciplinary and include consumers. It is suggested that if guidelines are to be relevant, those who are expected to use them or to benefit from their use should play a part in their conception and development. Involving a range of generalist and specialist clinicians, allied health professionals, experts in methodology, and consumers will improve the quality and continuity of care and will make it more likely that the guidelines will be adopted. The guidelines must also be flexible and capable of adapting to varying local conditions.

The primary purpose of clinical practice guidelines is to achieve better health outcomes by improving practice of health professionals and by providing consumers with better information about treatment options. Guidelines are viewed as an important link between best available evidence and good clinical practice. The procedures use to develop statements to assist practitioner and patient decisions are increasingly based on a thorough evaluation of evidence rather than on consensus of expert panels. (NH&MRC, 1999)

According to the NH&MRC (1999), guidelines will only be effective if they are perceived to be useful and if they are used in clinical decision making. They will be most effective when incorporated fully in the health care system and used alongside existing quality assurance activities. The NH&MRC (1999) concedes that the ongoing cycle of development, implementation, evaluation and revision in the light of new evidence and consumer feedback is crucial to the success of future clinical guidelines. (p.11)

Hicks and Hennessy (1999, 1998, 1997) support such a systematic approach to decision making in health care. They discuss the use of a 'psychometrically valid' instrument which they claim has the capacity to provide reliable research data about occupational boundaries of the nurse practitioner at a variety of levels. The use of such instruments together with clinical practice guidelines may well assist in clarifying some of the requirements related to the occupational scope of the nurse practitioner role.

The taskforce, however, recognises the 'medical' focus of the NH&MRC (1999) document. The document, for example, states that clinical practice guidelines are 'just one element of good

medical decision making' (pp. 1, 10) and the examples provided are exclusively about the practice of doctors and the 'interventions' or 'treatments' they use. The document does, however, state that the term 'clinical' encompasses all health care providers (p. 9) and it does indicate that 'different versions of the guidelines should be developed for different audiences - consumers, general practitioners, specialist nurses, and so on' (p. 3).

Recommendations relating to the development of best practice guidelines take into account the following issues:

- There are few accessible guides available for advanced practice nurses seeking to develop clinical practice guidelines.
- The NH&MRC emphasises that the guidelines 'not be unduly prescriptive' (p.7), that they be flexible, and of a multidisciplinary nature, which is consistent with the objectives of the Nurse Practitioner Project.

Recommendations

1. That the National Health and Medical Research Council (1999) *Guidelines for the Development, Implementation and Evaluation of Clinical Practice Guidelines* be utilised for the development of best practice clinical guidelines for nurse practitioner services.

There can be little guarantee of pursuing best practice, however, if practitioners are not allocated the time and resources to plan, collect and assess the essential information. Best practice at the organisational level offers the potential for ensuring best practice at the service delivery level. Organisational best practice has been associated with certain characteristics including collaborative practice and community participation.

Collaborative Practice

The concept of collaborative practice has guided the deliberations of the taskforce. It is well recognised that genuine collaboration with other health professionals promotes the best outcomes for clients. Behind the impetus for collaborative practice in health care has been:

- Consumer demands for high quality, responsive and efficient health care.
- Health professionals' concerns with fragmentation, disorganisation, impersonal and inaccessible health care.
- The push by governments for cost-effective services.

The Steering Committee of the NSW Nurse Practitioner Project recommended the investigation of options for an interdisciplinary forum of health professional organisations to further enhance collaborative practice and professional development. Proceedings of the 1997 Victorian Nurse Practitioner Workshop also recommended collaboration between health care professionals.

The taskforce believes that collaboration involves working together in a joint effort toward a commonality of goals with mutual respect for individual decisions and practice. Collaboration is defined as a flexible process of ongoing interaction, cooperation, and creativity between individuals from a number of disciplines involving interdependent decision making in relation to the direction of patient care and recognition of separate and combined spheres of activity and responsibility. (Lassen, Fosbinder, Minton and Robins, 1997; Norsen, Opladen and Quinn, 1995; Alpert, Goldman, Kilroy and Pike, 1992; Fagin 1992)

Individual goals of patient care are determined by patient need. Collaboration implies recognition of complementary roles since comprehensive health care today demands a broad spectrum of activities and expertise that no one practitioner can provide. (Lassen, Fosbinder,

Minton and Robins, 1997; Norsen, Opladen and Quinn, 1995; Alpert, Goldman, Kilroy and Pike, 1992; Fagin 1992) The taskforce agreed that collaborative practice should form the basis for care delivery in order to appropriately address the increasingly complex needs of clients and the health care system.

Collaborative practice involves acknowledging and respecting other opinions and viewpoints while maintaining the willingness to examine and change one's own. The interdependence of practitioners on the team is embraced by recognising individual talents of each member and acknowledging individual contributions to the overall plan of care. Hierarchical authority is replaced by equality and shared decision making. Decisions are made by compromise, according to the expertise of qualified individuals, and in the best interest of the client using the skills of all team members. (Norsen, Opladen and Quinn, 1995)

Collaborative practice involves honest and constructive discussion and exchange of ideas. Team members must be accessible to each other but team progress should not be hindered by unnecessary or superfluous communication. Norsen, Opladen and Quinn (1995) also emphasise the importance of autonomy and coordination in the collaborative effort. Autonomy authorises individual team members to carry out the plan of care. It exists within the boundaries of an individual's skill and competence and complements the work of the team. Coordination of all appropriate care components will reduce duplication of effort and will improve the convenience of services for patients.

The importance of collaborative practice in the provision of optimal care is well recognised. Following a review of the interdisciplinary health literature, Baggs and Schmitt (1988) identified six attributes of collaboration: cooperation, assertiveness, shared responsibility for planning, shared decision making, open communication and coordination. They define collaboration as 'cooperatively working together, sharing responsibility for problem solving and decision making to formulate and carry out plans'. The ANA Congress of Nursing Practice suggests that collaborative practice include a discussion of patient diagnosis and cooperation in the management and delivery of care. Each collaborator should be available to the other for consultation either in person or by communication device, but need not be physically present on the premises at the time health care activities are performed. Furthermore, it makes it clear that the patient nominated health care provider is responsible for the overall direction and management of patient care. (McLoughlin, 1992)

Successful collaboration, however, is dependent on a commitment to the care of clients and the population generally. This presupposes, amongst other things, clinical competence on the part of the practitioner. Issues relating to the maintenance of clinical competence continue to be explored and are discussed to some extent in the 'Educational Preparation and Credentialling' section of this report.. The International Council of Nurses (ICN) is exploring these issues at an international level. At a national level, the Australian Nursing Council Incorporated (ANCI) has developed competencies for the expected minimum standards of practice for registered nurses. Using these as a base, the ANF has defined generic competency standards for advanced nurses. More recently, a national credentialling feasibility project has been established with the aim of providing a nationally consistent measure of expertise for the advanced practice nurse.

Community Consultation

The importance of consumer input into health policy making processes is emphasised in the health literature. WHO's *Ottawa Charter* (1986) and the *Jakarta Declaration* (1997) make explicit the need for consumer involvement, as individuals and as population groups. More recent discussions relating to the role of social capital in creating healthy communities reiterate the benefits of participation and mutual trust.

The taskforce recognises the importance of involving individuals and communities in the Nurse Practitioner Project. The Department of Human Services tender for nurse practitioner models of practice included in its project deliverables the following consumer and community related outcomes:

- Enhancement of health care delivery, including identification of the benefits to the community arising from the proposed model of practice
- Development of a culture of collaboration and partnership with health care providers and the community.
- Promotion of the nurse practitioner role within the health care system and the community, including details of arrangements for education of consumers about the components of the role.

Evaluation indicators being used in the concurrent evaluations also provide the framework for community involvement in the project. Focus group discussions conducted in July 1999 and the release of the *Victorian Nurse Practitioner Bulletin* in August 1999 were also activities conducted to promote community consultation and aid participation in the project.

The extent to which participation actually occurs and whether it is tokenistic or substantial, are frequently raised questions. Lip service is often paid to participation and it is often more real in rhetoric than practice. Community participation initiatives, on the other hand, are often dismissed as being unrepresentative. This is a convenient response when a commitment to responding to the demands of individuals and community groups is lacking. Doubts about representation, however, need to be viewed in context.

In many projects, bureaucrats and health professionals invite individuals from the community to participate in an exercise defined by the bureaucrats and health professionals themselves. One of the focus group discussions relating to the Nurse Practitioner Project conducted in July 1999 suggested that consumer input was desirable prior to role implementation.

Indeed, the development of the nurse practitioner role in Victoria has evolved from attempts to address concerns of individuals and communities including their demands for diverse options in health care, improved service access, and increased flexibility in mode of health care delivery. This developmental, rather than instrumental, approach has aimed to encourage professionals to work alongside individuals and communities in a way that focuses on community and client priorities. The client and community focus of the Nurse Practitioner Project has been evident since the early stages when the call for submissions of nurse practitioner models of practice requested that a locally agreed need be demonstrated and that evidence be provided that the models were client-focused.

The form of participation needs to be made clear and its potential for power sharing recognised from the beginning. Undoubtedly, the skills of working in partnership with individuals and communities and respecting their priorities for health will require development.

Experience of participation in Australia and overseas suggests that in order to enhance the quality of health care delivery, service providers must be responsive to the needs of clients and communities. Service providers need to consult clients and communities about how they perceive quality care. Client and community criteria for quality may be quite different from the criteria put forward by providers. Clients and communities need to be involved in the planning, development, implementation and evaluation of standards, clinical guidelines and any services provided.

Professional Indemnity and Legal Liability

The taskforce has consulted with a number of insurance brokers and risk management consultants including AON and GIO, and has considered a number of professional indemnity issues in relation to the implementation of the role of nurse practitioner. These issues include:

- Voluntary / compulsory indemnity insurance
- Indemnity linked to registration
- Vicarious liability in Victoria
- Joint liability
- Existing Department of Human Services indemnity / malpractice arrangements.

Two recent reviews of professional indemnity insurance in Australia have examined the complex issues surrounding professional indemnity and make a number of recommendations. Department of Human Services policy on Public Liability and Malpractice, and current arrangements between the Department and health care providers have also been examined to inform potential arrangements for nurse practitioners.

The Final Report of the *Review of Professional Indemnity Arrangements for Health Care Professionals, Compensation and Professional Indemnity in Health Care* (1995) 'considers that there are strong public policy reasons to support government legislation requiring all health professionals to have adequate professional indemnity cover as a condition of practice', and that health services 'have adequate professional indemnity cover or be required to demonstrate sufficient financial reserves to be able to meet any probable maximum loss arising from negligence in service provision' (Recommendations 128 and 129).

The Final Report of the Victorian Parliamentary Law Reform Committee, *Legal Liability of Health Service Providers* (May, 1997) contains a number of key points that are relevant to the role of nurse practitioner. They may be summarised as:

- A government funded indemnity insurance policy already applies for publicly funded health services in Victoria.
- Existing arrangements for public health care providers are adequate and there is no need for compulsory professional indemnity insurance for public health care providers (para 2.125, p. 43).

It is of significance that support from both the Australian College of Midwives Incorporated and the RCNA for professional insurance for midwives and nurses has been reported. As documented, 'The Australian College of Midwives observed that affordable insurance is an essential requirement for midwives and that the College is investigating the possible provision of cover for all its members. The Royal College of Nursing recommended that insurance be made available through professional organisations or that nurses should be encouraged to fund their own personal professional indemnity scheme'. (Law Reform Committee, 1997, p. 42)

The report also made recommendation that all health service providers who are recognised by statute should be required to have insurance, and that professional indemnity needs to be linked with registration.

Of particular interest is that this recommendation has now been incorporated into the *Physiotherapists Registration Act 1998*. A grant of registration is subject to a condition that the physiotherapist must obtain or maintain insurance against civil liability in connection with the

practice of physiotherapy before commencing that practice and an application must be accompanied by evidence of such insurance.

A precedent has been set in the Physiotherapists Registration Act that it accepts that registered health professionals should have professional indemnity coverage. It may be argued that compulsory professional indemnity for nurse practitioners, apart from addressing key public policy concerns, will also address possible concerns related to the issue of joint and several liability when nurse practitioners and other health professionals develop collaborative working relationships.

In practical terms, if registration is dependent on having professional indemnity cover, then the NBV is the body to administer this requirement.

In summary, the salient points that require consideration, arising from this review of professional indemnity and subsequent taskforce discussions, include:

- That there are strong public policy grounds and government support for compulsory professional indemnity.
- Recent legislation in Victoria has tied professional indemnity to registration.
- Department of Human Services professional indemnity / malpractice policy covers the named health care agencies and their employees.
- Department of Human Services indemnity arrangements for procedural rural general practitioners (GPs) offers a discounted premium for specified procedural work. GPs must still hold insurance for non-procedural work for private patients.
- Joint and several liability is a significant issue for all health professionals.

Possible Professional Indemnity Arrangements for Nurse Practitioners

At present, Department of Human Services, via its insurance brokers, offers insurance for procedural GPs at a discounted rate compared with other available insurance products. The offer is available to GPs providing private procedural services at designated public hospitals, where GPs are providing a small number of services, with little or no specialist support available. GPs agreeing to the offer must continue to maintain private medical indemnity for all non-procedural work. GPs will continue to be indemnified for the treatment of public patients in public hospitals via the Department of Human Services / AON arrangements. This policy is based on claims made and capped.

This arrangement available to procedural GPs was developed by the Department of Human Services as a strategy to address the concern that the increasing cost of professional indemnity insurance could affect access to medical services in rural areas. A similar arrangement may be made to ensure that the cost of professional indemnity insurance does not limit the implementation of the nurse practitioner role in any areas of practice.

Nurse practitioners may have professional indemnity cover through a number of arrangements depending on their employment status. The distinction between employed and self-employed practitioners is central to any discussion of professional indemnity arrangements. Possible arrangements might include:

- All nurse practitioners employed by a health care agency, identified in the Department of Human Services Public Liability / Malpractice Policy, are deemed to be covered by the policy and have professional indemnity cover.
- Nurse practitioners contracted to work for a named health care agency, identified in the Department of Human Services Public Liability / Malpractice Policy, may be covered by the

policy but they must seek written confirmation from the agency to that effect. If the policy does not provide indemnification, then they should have personal indemnity insurance.

- Where a nurse practitioner is employed by an organisation not identified in the Department of Human Services Public Liability / Malpractice Policy, then vicarious liability would apply. However, the individual nurse practitioner remains at risk of personal suit and should have personal indemnity insurance.
- Nurse practitioners who contract their services to an organisation not identified in the Department of Human Services Public Liability / Malpractice Policy should have personal indemnity insurance.
- Nurse practitioners who are in private practice should have personal indemnity insurance.

As mentioned above, the Department of Human Services professional insurance facility was created to provide rural procedural GPs (particularly those involved in obstetric practice) with a cost effective insurance option as compared with their rising medical defence fund subscriptions. Without the option it was possible that a number of rural GPs would have withdrawn all or part of their services, particularly in obstetrics.

Nurse practitioners may be able to obtain suitable and cost effective professional indemnity insurance products from the insurance market which would satisfy the levels of cover considered adequate for nurse practitioner endorsement. If this is the case, Department of Human Services would not need to arrange a professional indemnity insurance facility for access by nurse practitioners.

Any Department of Human Services arranged professional insurance facility should only be considered if the private insurance market cannot provide a cost effective professional insurance product to satisfy professional endorsement purposes.

The insurance facility arranged by Department of Human Services for specialist rural GPs provides a choice for indemnity protection and is restricted to rural practice for public and private patients in designated hospital locations. Any similar insurance arrangement for nurse practitioners should contain eligibility provisions restricting the facility to nurse practitioners only.

Recommendations

22. That nurse practitioners demonstrate adequate professional indemnity insurance cover.
23. That the Department of Human Services provide a professional indemnity insurance facility for nurse practitioners to ensure that the cost of professional indemnity insurance does not limit the implementation of the nurse practitioner role in any area of practice.

Extended Nursing Practice

A major focus in the literature on advanced practice nursing concerns two clinical functions which have been viewed historically as belonging exclusively within the boundaries of the medical profession—ordering diagnostics, including radiographic examinations (X-rays), and prescribing certain types of medications. Other areas which have not dominated the literature but are equally as important in some settings include referral to specialists, admission and discharge of clients, and approval of absence from work certificates.

For advanced nursing to contribute to a more responsive and integrated health care service, numerous structural, legislative and procedural changes are required. Advanced practice nurses are currently constrained from providing comprehensive health services across the hospital/community interface by existing legislation, policies and practices. The taskforce is of the opinion that changes in the current arrangements in the areas of prescribing, diagnostics, and access to secondary and tertiary levels of care would improve the convenience of services for patients and carers as well as enhance health care delivery and produce quality outcomes.

The importance of working in collaboration with other health care professionals in developing advanced roles for nurses has been emphasised by the taskforce and is discussed in the 'Best Practice' section of this report. Of utmost importance to the taskforce is that collaborative practice form the basis for care delivery to address the increasingly complex needs of patients and the health care system. Careful communication focusing on the best interests of patients and clients is essential.

Prescribing Rights: Benefits in Extending to Advanced Practice Nurses

A number of benefits in extending prescribing rights to nurses are identified in the literature. This literature is largely from the USA, the UK and New Zealand and may not be directly applicable to the Australian situation. Apart from legitimising what some nurses already do, the benefits identified in the literature are:

- Improved client care
- Increased convenience for clients
- Improved nurse-client relationships
- Improved collaborative practice
- Potential reduction in costs.

Improved Client Care

- Improved access, particularly for older clients, people with a disability, the longstanding mentally ill, the terminally ill, the homeless, those living in isolated communities, families with a low income, patients newly discharged from hospital, and for those experiencing transport difficulties. (Ministry of Health, 1998; Luker et al., 1997; Poulton, 1994; Talley and Brooke, 1992; Smith, 1990)
- Prompt treatment and effective use of time of clients and health care professionals. Treatment is more likely to be started earlier, which could reduce secondary illnesses and costs. Nurse practitioner drug recommendations were well accepted by supervising physicians in a number of studies. (Ministry of Health, 1998; Mallett, Faithfull, Guerrero and Rhys-Evans, 1997; NSW Department of Health Nurse Practitioner Project Stage 3, 1996; Biester and Collins, 1991; Department of Health, 1989; LaPlante and O'Bannon, 1987)

- Appropriateness of the treatment. Nurses are identified by clients as knowing more about certain conditions such as wound care and continence and are regarded as prescribing more appropriately than GPs in certain situations. The most frequently prescribed drug categories in a number of studies include analgesics, antibiotics and antifungal agents (oral and topical), anti-inflammatory preparations (oral and topical), bronchodilators, decongestants, antihistamines, antitussives, birth control pills and other contraceptive devices, hormones, ophthalmic preparations, skin preparations, reagents for diabetes, antipyretics, and catheter care products. (Luker et al., 1998; 1997; NSW Department of Health, 1996; LaPlante and O'Bannon, 1987; Holland, Batey and Dawson, 1985; Batey and Holland, 1985)
- Improved client education. Nurses are perceived to be more likely to spend time explaining treatment and more likely to discuss the client's health care more fully than their medical counterparts; they are perceived to be easier to communicate with and have more time to listen to clients. (Luker et al., 1997; Brooks and Philips 1996; Paxton, 1996; Fawcett-Henessy, 1995; Baker and Napthine, 1994; Stilwell, 1991; Drury et al., 1988; Salisbury and Tettersel, 1988; Stilwell, 1988)

Increased Convenience for Clients

- Clients will be able to receive prescriptions more simply (for example during the time of a home visit) without the need to go to the surgery solely to obtain a prescription. (Crown et al., 1999; Ministry of Health, 1998; Luker et al., 1997; Mallett et al., 1997)
- Delays in discharge experienced by patients waiting for medicines to take home can be reduced. (Crown et al., 1999; Ministry of Health, 1998; Mallett et al., 1997)
- Repeatable prescriptions will allow patients on long term medication to renew their supplies of medicines more simply. (Crown et al., 1999; Luker et al., 1997; Smith, 1990)
- In particular circumstances, clients will be able to choose which health professional will be responsible for aspects of their care, including prescribing. (Crown et al., 1999; Luker et al., 1998; 1997)

Improved Nurse-Client Relationship

- Nurses have more regular contact with clients and are considered to be able to provide a comprehensive service to patients, improved continuity of care, convenience, and a stable relationship. (Luker et al., 1998, 1997; Talley and Brooke, 1992; Department of Health, 1989)
- Nurses are regarded as being more approachable and understanding; they tend to use technical language less; are regarded as more practical and more suitable for discussion of certain complaints. (Luker et al., 1998, 1997; Fawcett-Henesy, 1995; Cartright and Smith 1988; Stilwell et al., 1988)

Improved Collaborative Practice

- More effective teamwork with the improved use of the full range of skills and experience of all health care professionals. (Crown et al., 1999; Ministry of Health, 1998; Bigbee, 1984; Department of Health, 1989)
- Avoidance of duplication of effort; clients may have less need in some situations to consult two professionals; rather than act as substitutes for medical practitioners, the role and function of the nurse in such situations are regarded to be complementary to that of the role and function of the medical practitioner. (Luker et al., 1997; Poulton, 1994; Pickersgill and Clarke, 1990)
- Improved mutual recognition and acceptance of professional roles and facilitation of integrated health care practice. (Crown et al., 1999; Ministry of Health, 1997, 1998)

- Clarification of professional responsibilities leading to improved teamwork and a strengthening of professional partnerships (Crown et al., 1999; Ministry of Health, 1997; Department of Health, 1989; Bigbee, 1984).
- Nurse prescribing practices show that nurses are likely to consult other health care professionals when they encounter less frequently reported health problems. (Batey and Holland, 1985)

Potential Reduction in Costs

- Nurse prescribing practices suggest a cautious approach: nurses often do not choose drugs as a first line of treatment, are more likely to recommend non-pharmacological treatments, and use a holistic approach to patient management. (Iliffe, 1997; Hawkless 1989 in Iliffe, 1997; Sutliff, 1996; Mahoney, 1995; Batey and Holland, 1985; Holland, Batey and Dawson, 1985; Munroe, Pohl and Gardner, 1982)
- Time is saved by both nurses and clients waiting for prescriptions to be signed by doctors particularly when the doctor simply endorses the nurse's decision without question. (Jones and Gough 1997; Miller 1990 in Poulton 1994)
- Improved access to care, education and health promotion have the potential to improve the health of clients; compliance with treatments may be increased and this in turn may reduce the frequency of hospitalisation. (Department of Health, 1989; Campbell, 1997)
- Reduction in duplication of services since there is less need, in some cases as mentioned above, to see more than one health care professional. (Luker et al., 1997; Ministry of Health 1998; Talley and Brooke, 1992; Department of Health, 1989)

Prescribing Rights: Concerns and Potential Risks in Extending to Advanced Practice Nurses

The literature also identifies some concerns and potential risks of extending prescribing rights to nurses. These include the following:

- Where nurses lack of education in medical diagnosis, therapeutics, pharmacology and practical aspects of prescribing may lead to an increase in adverse effects and omissions in health care; there is a likelihood of inappropriate prescribing due to failure to recognise multi system illness. (Nilsson, 1994; Enkat Om Distriktsskoteskors Forshrinningsratt 1994 in Luker et al., 1998; Luker et al., 1998; Bradley, Taylor and Blenkinsopp, 1997; Gledhill, 1994; While and Rees, 1994, 1993; Hampson, 1986)
- The extension of prescribing to certain nurses may result in duplication or omissions in health care and the risk of polypharmacy and patient confusion. (NSW Department of Health, 1993)
- Having another health professional in the prescribing relationship has the potential of increasing costs; there will be also additional costs relating to the development of programs for educating, monitoring and reviewing nurse prescribers. (Jones and Gough, 1997; Poulton, 1994)
- Nurse prescribing will further expose nurses to the marketing prowess of the pharmaceutical industry. (Bradley, Taylor and Blenkinsopp, 1997)

Prescribing and Diagnostics: Legitimising and Developing the Role of the Advanced Clinical Nurse

National and international literature, and reports of clinical experience make it clear that ordering a limited range of tests and initiating the use of specified pharmacological substances by midwives is already common practice in many clinical settings with midwives generally working under informal agreements for the care of women during uncomplicated pregnancy, labour, birth and the postnatal period.

Limited prescribing rights for midwives have been discussed by various legislative and advisory bodies. (Midwives in Private Practice 1998) In November 1995, the NH&MRC endorsed the report *Options for Effective Care in Childbirth* (NH&MRC 1996) but excluded two recommendations put forward suggesting that measures be put in place to authorise midwives to order and interpret a limited range of tests, and to prescribe specified drugs as part of the care of healthy women during uncomplicated pregnancy and childbirth. The NH&MRC requested the National Health Advisory Committee to further consider these issues. In 1996 the Working Party to Review the Services Offered by Midwives in Australia was set up to advise on the two recommendations not endorsed and made numerous recommendations.

The working party concluded that ordering of a limited range of tests and initiating of a specified range of pharmacological substances under agreed protocols should be considered safe practice as they are integral aspects of comprehensive midwifery care. Tests and pharmacological substances considered appropriate for midwives to order or initiate are those which are considered to be supported by available evidence and which currently form part of routine midwifery services for care during uncomplicated pregnancy, labour, birth and the postnatal period. (NH&MRC, 1998)

Other advanced practice nurses also already instigate certain procedures, sometimes within established protocols, before a patient is seen by a medical practitioner. In a recent national study of rural nurses in Australia, Hegney, Pearson and McCarthy (1997) found that the role of the rural nurse encompasses dispensing and prescribing drugs without consulting with a medical officer. When more than 400 specialist nurses in NSW were surveyed about their prescribing habits, all responded that they were prescribing medication to some extent. The list of drugs included almost everything except narcotic and psychotropic (schedule 8) drugs. (Tattam, 1998) An examination of practices in the community of Mortlake, Victoria, indicates that advanced practice nurses are prescribing and undertaking diagnostics in their attempt to make more effective use of the available health workforce in that area. (Mahnken, Nesbitt and Keyzer, 1997) An examination of the Emergency Nurse Specialist Service operating at Monash Medical Centre since March 1998 reveals that organisational change with regard to initiation of pathology and medication administration by emergency nurse specialists has been secured. (Department of Human Services, Nurse Practitioner Proposals, 1999)

International Experience

Advanced practice nurses do not benefit from the recognition, remuneration, legal protection and educational preparation demanded by their roles. From the national and international literature, it is clear that these matters need to be addressed urgently in the best interests of patients and health care professionals alike. Some features of nurse prescribing practices in other countries follow.

Sweden

In Sweden, midwives are permitted to prescribe oral contraceptives. According to a survey published in *Primavardens Nyheter* (Primary Care News) in August 1994, midwives accounted for 62 per cent of all prescriptions for oral contraceptives issued in Sweden, gynaecologists for 30 per cent and GPs for only 3 per cent. Approximately 80 per cent of intrauterine contraceptive devices are inserted by midwives. Midwives' family planning clinics have been set up. (Nilsson, 1994)

A nurse prescribing scheme was introduced in 1994 in Sweden following a pilot scheme in 1988. This allows district nurses with a postgraduate qualification and additional training in pharmacology to prescribe 230 brands of products for 60 specific indications, including oral care, bowel care, nutrition, wound care, dermatology, infection, incontinence and breast care.

The list includes anti-allergy drugs, antimycotic agents, and less potent steroids for topical and systemic use. For some of the indications, the district nurse cannot issue the initial prescription. It is intended that the list will be revised annually. (Nilsson, 1994; David and Brown, 1995)

Those district nurses who are authorised to prescribe do not use protocols. They have a list of conditions for which they may prescribe from a list of products and the indemnity is held by the individual. (Crown et al., March 1999; Myles, 1998; Ministry of Health, 1997; Nilsson, 1994; David and Brown, 1995)

USA

In the USA, 49 States allow some form of nurse prescribing. Most States limit the setting for prescribing or limit the type of drugs that can be prescribed by nurse practitioners. In some States nurses may only prescribe within protocols laid down by a supervising physician. In most States nurse prescribers must undergo mandatory continuing education and audit. (Pearson, 1999; ANA, 1998, 1997)

There is no consistency or national consensus across States but studies indicate that the most influential factors in the effective prescribing of nurses are the scope of nurses' clinical experience and the nurses' educational background. (Pearson, 1999; Kass et al., 1998; Mahoney 1989 in Mahoney 1992)

UK

In 1989 in the UK the *Report of the Advisory Group on Nurse Prescribing* (Crown Report) recommended that certain nurses holding district nurse or health visitor qualifications should be allowed to prescribe from a limited formulary. (Department of Health, 1989) Although the items ultimately included in the nurse prescribers' formulary (NPF) may be purchased as over the counter products, the intention was for the formulary to be 'illustrative'. Regular revision of its contents as the role of the nurses developed was canvassed. (Luker et al., 1997)

The advisory group recommended that nurses with district nurse or health visitor qualifications who undertook additional training should be able to: prescribe from a nurses formulary; supply medicines within a group protocol for a particular clinical service; and adjust the timing and dosage of medicines within a patient-specific protocol. It recommended the patient specific protocol for timing and dosage of medicines be restricted to community psychiatric nurses, specialists nurses for terminally ill patients, and diabetic liaison nurses. It also recommended a group protocol for supply of medicines within a particular service be restricted to nurses with specialist training, such as stoma nurses, continence advisors, school nurses and paediatric CNSs.

A nurses' formulary was developed which contained a number of medicines, dressings, appliances and diagnostic agents. The UKCC was made responsible for designing and implementing appropriate courses of education in association with other professional bodies and educational institutions for nurse prescribing. It established training courses for district nurses and health visitors and developed a nurse prescribing module for incorporating into future courses.

Legislation amending the Medicines Act and enabling nurses to prescribe came into force in 1994. Pilot schemes were introduced and evaluated. (Luker et al., 1998) The majority of patients interviewed as part of the evaluation supported nurses being able to prescribe and in some areas, such as wound management, asthma and diabetes, nurses were viewed as having more expertise than GPs. In April 1998, the Secretary of State for Health announced plans to implement nationally the current nurse prescribing scheme in England. (Crown et al., March 1999)

In the final *Report of the Review of Prescribing, Supply and Administration of Medicines* (March 1999), the review team stated that the extension of prescribing to new professional groups, subject to safeguards, would result in benefits to patient care, improved patient convenience and better team work between professionals. It recommended that two types of prescriber be recognised: the **independent** prescriber and **dependent** prescriber.

The **independent** prescriber is responsible for the assessment of patients with undiagnosed conditions and for decisions about the clinical management required including prescribing. The **dependent** prescriber is responsible for the continuing care of patients who have been clinically assessed by an independent prescriber. This continuing care may include prescribing or continuing established treatments by issuing repeat prescriptions with the authority to adjust the dose or dosage form according to the patients' needs. Included in the examples of independent prescribers are family planning nurses and tissue viability nurses. Examples of dependent prescribers include specialist diabetes nurses, specialist asthma nurses and specialist palliative care nurses (pp. 50–51).

New Zealand

The issue of prescribing rights for advanced practice nurses in New Zealand has been under investigation for a number of years. The Minister for Health has indicated support for extending prescribing rights to nurses and other health professionals under certain conditions. Some work towards introducing limited prescribing rights to nurses working in two particular scopes of practice—child / family health and aged care—has begun. A consultation document seeking the health sector's comments on the proposed regulatory framework for introducing nurse prescribing in aged care and child family health was circulated in December 1998. The document also outlined the conclusions of the two working groups which were established by the Ministry of Health to define aged care and child family health scopes of practice and to identify generic classes of medicines which it may be appropriate for nurses to prescribe. (Ministry of Health, December 1998; Ministry of Health, August 1998; Ministry of Health, 1997)

In summary, the proposed framework is hierarchical and comprises:

- Enabling legislation—the Medicines Amendment Bill which is currently before the House of Representatives.
- Regulations enabling prescribing by designated nurses who have met specific competency requirements set by the Nursing Council of New Zealand.
- A schedule to the *Medicines Act 1981*, or an approved document, gazetted by the Minister of Health or the Director-General of Health, setting out the generic classes of medicines which registered nurse prescribers in defined scopes of practice are able to prescribe. (Ministry of Health, December 1998)

The Nursing Council is currently developing the competencies nurses will need to obtain nurse prescribing registration. Education programs will be clinically focused in nursing and involve teaching by pharmacists, medical practitioners and advanced nurse practitioners. They will cover advanced nursing practice skills, the process of prescribing, pharmacology, clinical assessment, differential diagnosis, therapeutics and physiology. (Ministry of Health, December 1998)

Working groups established for aged care and child health nurse prescribing have identified numerous benefits for consumers, the community and the health sector from the introduction of nurse prescribing. They also identified a number of potential risks. It was acknowledged that most of the potential risks, however, could be eliminated, minimised or managed by adequate client case management, by restricting prescribing to specified scopes of practice and medicines, and by ensuring that nurse prescribers have adequate education and training. The working

groups also noted that many of the potential risks identified are similar to present risks posed by medical practitioner prescribing. (Ministry of Health, December 1998)

Initiation of Medications

Generally, there are a four processes involved in the initiation of medications. In the context of the nurse practitioner role, one or more of these processes **may** be undertaken:

- **Diagnosis** of the patient's condition in order to determine a suitable treatment including the type of medication, its dosage and administration regime.
- **Prescribing** of medication which is defined by the NH&MRC (1998) as 'provision in writing by a medical professional or other designated professional, after clinical assessment of a patient, of instructions for the dispensing and administration of a drug or remedy'.
- **Supply** of the medication which is defined under the *Drugs, Poisons and Controlled Substances Act 1981* as 'supply, provide, give or deliver, whether or not for fee, reward or consideration or in expectation of fee, reward or consideration'. This can be done by a pharmacist according to the instructions in a legal prescription, or in some services where drugs are directly supplied to the patient by the service.
- **Administration** occurs when a person, other than the patient, gives an individual dosage of a drug to the patient to take and ensures that this occurs.

In Australia, no State drugs and poisons legislation allows diagnosis, prescribing, supply and administration of scheduled medications to patients by registered nurses. In some States in Australia, where registered nurses have an extended role in the initiation of medication, limitations have been placed on the role and practice in a variety of ways including:

- The setting in which the registered nurse is employed (public or private sector).
- The geographic area in which the restricted practice can occur (remote area nursing).
- The type of activities legally undertaken (no State legally allows the preparation of a legal prescription by a registered nurse for filling at a pharmacy external to the service).
- The development of a specific drug formulary.

The taskforce acknowledges that within the context of advanced practice for certain nurse practitioners, and in order to deliver an appropriate level of treatment for some patients as part of their continuity of care, the legal right and responsibility to initiate medications, however that is defined, will be necessary.

The general consensus was that a formulary for nurse prescribers should be developed corresponding to the context of practice. A formulary was understood by the taskforce as comprising a publication listing selected pharmaceutical products with their formulas. Formularies generally also contain information on prescription writing, adverse reactions, interactions, controlled drugs and dependence, and prescribing for children, the elderly, and during pregnancy, to facilitate the selection of suitable treatment.

The taskforce is of the opinion that the nurse prescribers' formulary should be flexible and be linked to clinical guidelines. The taskforce agreed that a group of experts, including nurse practitioners, doctors and pharmacists, should be convened to develop appropriate guidelines, and that these guidelines be consistent with NH&MRC (1999) guidelines and take into account the variety of contexts of nurse practitioner practice. Registered nurses who choose to become nurse prescribers will have defined and extensive clinical experience and skills and have completed appropriate educational programs that affirms their therapeutic knowledge in their context of practice.

Recommendations

24. That the *Drugs Poisons and Controlled Substances Act 1981* be amended to provide for limited prescribing authorisation for nurse practitioners.[4]

25. That the nurse practitioner be authorised to prescribe from a formulary corresponding to the context of practice of the nurse practitioner.[4]

26. That the Department of Human Services facilitate the process for the development of a prescribing formulary and guidelines, consistent with NH&MRC[5] guidelines, taking into account the variety of contexts of nurse practitioner practice.[4]

Diagnostic/Laboratory Testing

Along with prescribing rights, it may be argued that advanced practice nurses in particular areas of practice need to initiate diagnostic procedures and laboratory testing.

Nurses in both acute and community settings frequently encounter situations where diagnostic tests are required. For example:

- Advanced practice nurses in women's health areas routinely take vaginal and cervical swabs.
- In rural and remote areas, advanced practice nurses diagnose, often take blood samples and instigate appropriate treatment.
- In intensive care and emergency areas, nurses diagnose, take samples and instigate appropriate treatment, informing the medical practitioner who has ultimate responsibility of action taken.
- In community and acute settings, mid stream specimens of urine are regularly taken from clients who complain of burning and frequency of micturition; the pathology form is generally signed later by the client's GP or the resident medical officer.
- Routine blood sampling is done on admission to hospital with forms signed when the hospital medical officer arrives.

For quality assurance, legal liability, accountability and cost-effectiveness reasons, these current common practices need to be legitimised.

In Australia and New Zealand, nurses frequently have difficulty accessing diagnostic/laboratory testing (including radiological tests and ultrasonography), because of claim reimbursement issues. Advanced practice nurses often require a doctor to sign diagnostic and laboratory forms or they must arrange for a patient to have a separate appointment with the doctor to have tests ordered. In some hospitals, nurses will have to request that the registrar or medical officer on duty comes to the ward to sign the form, sometimes without seeing the patient. (Department of Human Services Victorian NPP proposals, 1999; Ministry of Health, August 1998)

Patients requiring diagnostic/laboratory testing often face long waiting times. Patients generally have two consultations with the doctor and three waiting times, one to see the doctor, another for the X-ray/laboratory test, and a third for the second consultation. (Parris et al., 1997; Kelly et al., 1995) These restrictive arrangements may result in an increased cost to the client, delayed or interrupted access to treatment, inconvenience to clients when a nurse-only consultation would have been sufficient; and lack of choice for clients who do not want to see a doctor.

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4 The AMA (Victoria) representative on the taskforce dissents from this recommendation. The rationale for this may be found on pp. 81-85.

5 National Health and Medical Research Council. (1999) *A guide to the development, implementation and evaluation of clinical practice guidelines*. Endorsed 16 November 1998. Canberra, NH&MRC.

Arrangements exist in some settings where doctors have 'pre-signed' forms and have agreed to allow nurses to order tests. In a few settings, some nurses have managed to obtain authorisation to order a range of laboratory tests. (Department of Human Services Victorian NPP proposals, 1999; Ministry of Health, Wellington, 1998; Mahnken, Nesbitt and Keyzer, 1997) The legal implications of these arrangements need to be addressed individually. All nurses, nevertheless, are responsible for practice within the limits of their own education and competency.

Removing the barriers to ordering diagnostic/laboratory tests for adequately prepared advanced practice nurses will assist with the development of appropriate, efficient and integrated health care services. Advanced practice nurses, for example, would be able to initiate treatment immediately for fractures by ordering X-rays as soon as a patient presents with a suspected injury; wound management nurses would be able to order wound swabs directly; and specialist continence nurses would be able to order ultrasound tests to monitor the bladder function of a person with a continence problem. (Dolan, Dale and Morley, 1997; Jones, 1996; Ministry of Health, Wellington, August 1998)

Initiation of Diagnostic Imaging and Pathology

In Australia, registered nurses can initiate a written request for diagnostic services, however no claim can be made against a Medicare Item in Category 5 'Diagnostic Imaging Services' of the Medicare Benefits Schedule Book and Medicare Item in Category 6 'Pathology Services'. Furthermore, it is an offence for nurses not to advise patients that there is no rebate. In accordance with the *Health Insurance Act 1973*, medical benefits are only payable for a diagnostic service following a written request of a medical practitioner. However certain circumstances allow dentists, prosthodontists, chiropractors, physiotherapists and podiatrists to request diagnostic services from a specified formulary.

Depending on the context of practice of the nurse practitioner, the taskforce considers that it may be necessary for prompt care and treatment of the patient that the nurse practitioner initiates a referral for diagnostic services from an agreed specified list. This list should have item numbers that apply to the nurse practitioner initiated diagnostic services.

Recommendation

27. That the Department of Human Services facilitate the process for the development of guidelines consistent with NH&MRC[6] for specific diagnostic services which nurse practitioners may initiate in relation to the context of practice and for the systems necessary to manage the results.[7]

Referral to Specialist Care

The taskforce acknowledges that in Victoria registered nurses can directly refer a client to a medical specialist but the client is unable to claim against Medicare for reimbursement of specialist fees. Medicare benefits are only payable if the referral is provided in writing by a medical practitioner or a dentist or optometrist referring in areas specific to their clinical practice. However, registered nurses can initiate referrals to hospital outpatient clinics and departments as long as no Medicare rebate applies to the attendance at such clinics.

There are several arguments to support the extension of referral privileges to nurse practitioners. Nurse practitioners must be able to appropriately respond to the needs of clients

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6 National Health and Medical Research Council. (1999) *A guide to the development, implementation and evaluation of clinical practice guidelines.* Endorsed 16 November 1998. Canberra, NH&MRC.

7 The AMA (Victoria) representative on the taskforce dissents from this recommendation. The rationale for this may be found on pp. 81-85.

according to the results of the diagnostic/laboratory tests. This includes referring on to specialist services when appropriate. The advanced practice nurse may have more specific information about the client's condition and have the overall knowledge and experience needed to make the referral. Sending clients to doctors for referral to a medical specialist will involve unnecessary double-handling, be inconvenient for the client, and lead to less timely and effective services. (Midwives in Private Practice, 1998; Mahnken, Nesbitt and Keyzer, 1997; Ministry of Health, 1997)

The practice of the nurse practitioner should be complementary to, and collaborative with, the GP. The Royal Australian College of General Practitioners (RACGP) is strongly in support of this. The RACGP definition of general practice is 'the provision of primary, continuing, comprehensive whole patient care to individuals, families and their community'. In Australia, GPs have been the traditional providers of referrals to medical specialists for patients/clients in the community, providing coordinated patient care in the community and allowing the GP to act as a 'gatekeeper' to more expensive medical specialist services. (General Practice Strategy Review Group, 1998)

There is an increasing emphasis on the community care of patients suffering serious acute and chronic illnesses. More community-based health professionals may be involved in the care of patients and families and it is better for these clinical practitioners to develop partnerships in clinical care and to coordinate services rather than fragment and duplicate care. This is supported at both the Victorian and Commonwealth Government level. The discussion paper on primary health and community support services (PHACS) states that 'providers will be required to establish working relationships with general medical practice, relevant dental practitioners and relevant acute and extended care providers' in order to qualify for primary care funding. (Department of Human Services, 1998) The Commonwealth Government, furthermore, has recently instituted new Medicare items to recompense GPs who are involved in the preparation of health care plans and the coordination of multidisciplinary patient care in the community.

In the first instance, nurse practitioner referral to medical specialist services should be coordinated through the client's GP. If the client has not nominated a GP, then the nurse practitioner may be guided by client preference and local policies or protocols developed in collaboration with Divisions of General Practice, hospital and community health services, patient/client groups and local medical specialists.

Recommendation

28. That referrals to a medical specialist from a nurse practitioner be coordinated by the client's nominated general medical practitioner (GP) in consultation with the nurse practitioner. Where a client does not nominate a GP, the nurse practitioner should be guided by locally agreed referral policies and protocols.[8]

Absence of Leave Certificates

Another barrier in the advanced practice nurse's ability to contribute to a more responsive and integrated health care service exists in the expectation that leave from work certificates must be signed by a medical (or paramedical) professional. Although midwives are able to sign maternity leave certificates, the expectation of most employers is that medical practitioners need to sign medical certificates. This may limit client access to leave and may affect client choice of health care provider. It is particularly inappropriate when the client has had contact only with an advanced practice nurse for care.

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8 The AMA (Victoria) representative on the taskforce dissents from this recommendation. The rationale for this may be found on pp. 81-85.

The expectations of employers that only medical practitioners should sign certificates needs to be addressed. For the benefit of clients, advanced practice nurses (as well as other health care professionals), need to be nominated in employment and other contracts.

Clinical and Admitting Rights

Policies and practices that specify which particular health professional is permitted to admit and discharge clients present another barrier in advanced practice nurses' ability to contribute to a more responsive and integrated health care service.

In Australia, clinical privileges are the clinical competencies which advanced practice nurses are deemed competent to perform as determined by a process of formal review by a group which includes professional peers. For example, clinical privileges are granted to a midwife by a process of formal peer review of the midwife's qualifications, education, competency, skills and experience.

Admitting privileges refer to the authorisation of procedures and specific care within a facility for those nurses and midwives who have been granted clinical privileges. Generally, the procedures performed with admitting privileges are determined by the clinical privileges granted, the approved service level of the hospital and availability of resources.

In February 1999, guidelines for the granting of clinical privileges and admitting privileges for nurses and midwives in public hospitals in South Australia were endorsed for distribution by the Senior Executive of the SA Department of Human Services. Compliance with the privileging process will be required in all future service agreements. A nurse practitioner/midwife in South Australia with admitting privileges may work in private practice or as an employee of a hospital and will have responsibility for the continuum of care which may include admission, discharge and follow-up of patients/clients.

The SA Department of Human Services is establishing a Nursing and Midwifery Clinical Privileges Advisory Committee, with membership that includes Department of Human Services representatives, the RCNA (SA Chapter), the Australian College of Midwives (SA Branch), the ANZ College of Mental Health Nurses, a consumer representative, and other members to be coopted as necessary. Each hospital board shall establish a formal process for considering the recommendations of the Nursing and Midwifery Clinical Privileges Advisory Committee and subsequently determining the admitting privileges to be granted. The hospital board's role is to interpret the clinical privileges recommended for the practitioner within the context of the hospital's defined service level and current needs; to formally authorise practitioners to admit patients and provide a specified range of services; and to implement monitoring systems in order to provide statistics required by the Nursing and Midwifery Clinical Advisory Committee for inclusion in a centralised database.

Guidelines for Clinical Privileges in SA were modelled on guidelines for medical practitioners and also incorporated information from protocols developed for the accreditation of midwives. (SA Department of Human Services, 1999)

In Victoria, practising midwives have a midwifery qualification endorsed on their current annual practising certificate and there is also a code of practice (*Code of Practice for Midwives in Victoria* (1999)) issued by the NBV which provides guidance to midwives in all settings of their professional practice. In 1996, a Department of Human Services letter was sent to public and private hospitals in Victoria providing maternity services, setting out criteria to be observed in affording clinical privileges to midwives in private practice and providing guidance to hospitals in relation to the Code. A statement on credentialling for midwife visiting rights in hospitals (October 1996) was circulated by the Victorian Branch of the Australian College of Midwives Inc. to provide guidelines for the accreditation process to be adopted by hospitals.

Policies and protocols established by hospitals should adhere to the Australian Council on Healthcare Standards regarding the affording of clinical privileges. Hospitals that provide maternity services electing to credential midwives for private practice should establish a credentialling/visiting privileges committee to make recommendations to the Network Boards and hospital boards in rural areas, regarding clinical privileges being sought by applicants for appointment as a midwife in private practice.

In affording clinical privileges to midwives in private practice, hospitals should address the following:

- Evidence of current annual registration.
- Evidence of maximum professional indemnity insurance.
- Evidence of membership with the Australian College of Midwives Inc.
- Professional referees.
- Evidence of participation in relevant ongoing education. (H&CS, 1996)

Very few hospitals in Victoria have developed processes for the awarding of visiting rights to midwives. Concerns about legal liability, professional indemnity insurance and payment to midwives have been identified as the major barriers. (Midwives in Private Practice, 1998)

Accountabilities and Collaboration

In the process of extending and expanding nursing practice, the taskforce believes that the interests of the client must always remain a priority. Any expansion or extension of nursing practice needs to be upheld by processes which assure individuals and the population at large that the nurses who undertake these roles are competent to do so. In accordance with codes of professional conduct and ethics, and standards of practice, nurse practitioners will be fully responsible for their own actions and will be legally accountable for their responsibilities in prescribing, diagnostic and laboratory testing, specialist referrals, and other extended practices—as nurses are now for their current responsibilities. Collaborative practice, professional indemnity insurance and ongoing maintenance of competencies form part of the process of developing and implementing the role of the nurse practitioner in Victoria. These are essential and are discussed throughout this report.

Recommendation

29. That the Department of Human Services facilitate the process for the development of guidelines for nurse practitioners requiring admitting rights and authority to approve absence from work certificates.[9]

[9] The AMA (Victoria) representative on the taskforce dissents from this recommendation. The rationale for this may be found on pp. 81-85.

Legislative Changes

There is a number of Acts which may require amendment in the process of implementing the role of the nurse practitioner. The taskforce has examined the relevant legislation and considered the possible approaches for giving effect to the role. A more detailed discussion of approaches to the creation of prescribing rights for nurse practitioners is in Appendix 1.

Acts identified as possibly requiring amendment are outlined below. The types of amendments that may be required have also been noted.

Nurses Act 1993

The purpose of this Act is to protect the public by providing for the registration of nurses and the investigation into the professional conduct and fitness to practise of registered nurses. The Act establishes the NBV and empowers (s.66) it interalia to:

- regulate the standards of practice of nursing in the public interest;
- register persons who comply with the requirements of the Act as to registration so that they may practise nursing in Victoria;
- approve registered funded agencies or courses conducted by registered funded agencies which provide qualifications for registration purposes and qualifications in addition to those required for registration;
- set and conduct examinations and to establish standards for the conduct of examinations in registered funded agencies;
- accredit courses which provide qualifications for registration purposes and which provide qualifications in addition to those required for registration;
- investigate the professional conduct or fitness to practise of persons registered under the Act and impose sanctions where necessary;
- identify and distinguish between the principal functions that may be carried out by nurses registered in each division of the register.

If the use of the title of nurse practitioner is restricted to only those nurses with certain recognised qualifications and the NBV is the most suitable body to regulate these restrictions, then the following options need to be considered:

An endorsement process to identify those registered nurses who have met additional requirements of the NBV

This requires amendment to the legislation to create a definition of 'nurse practitioner' as a nurse registered in divisions 1, 3 or 4 of the register who has undergone further education as required by the NBV and is therefore entitled to call themselves a 'nurse practitioner'.

This would require a process to publicly identify those who are entitled to use the additional title and endorsement of the Register against the name of the nurse with a notation on the nurse's certificate of registration and/or their annual practising certificate. An amendment would also be required to Part 5 of the Act 'Offences' to make it an offence for any person using the restricted title who did not hold the additional qualifications and had not received endorsement from the NBV.

Create an offence to prevent claims as to additional qualifications

Section 62 of the Nurses Act 1993 titled 'Claims as to additional qualifications', prevents persons who have not completed a course in midwifery approved by the NBV from taking or using the

title ‘midwife’ or any other title calculated to induce belief that the person is a midwife, or claim to be a midwife or hold themselves out as being a midwife. There is no reference to ‘midwife’ in the definitions or registration sections of the Act.

In addition, if it is determined that nurse practitioners will be authorised under the Drugs, Poisons and Controlled Substances Act (DPCS Act) to undertake any of the functions ‘obtain, possess, use, sell or supply’ of scheduled medications, then an amendment to the Nurses Act 1993 may be required to establish a process for identifying those nurse practitioners who have that authorisation.

Mental Health Act 1986

The purpose of this Act is to protect people with psychiatric illness to ensure that services are delivered with their consent or with the consent of the authorised psychiatrist if they are unable to give consent. Amendments would be required if it was considered appropriate to give nurse practitioners the power to diagnose and recommend treatment.

Drugs Poison and Controlled Substances Act 1981

The purpose of this Act is to protect the public and regulate the law in relation to the use of drugs, poisons and controlled substances. If nurse practitioners are to be legally authorised to prescribe medications that are contained in the Schedules of the poisons List in section 12A(4) of the Act, then section 13(1) will require amendment to include nurse practitioners as authorised persons under the Act to obtain, possess, use, sell or supply scheduled medications.

Any restrictions, in additions to those already in the Act, on the role of the nurse practitioner to obtain, possess, use, sell or supply would require amendment to section 14 or the inclusion of a new provision to recognise the conditions, limitations or restrictions imposed on a nurse practitioner’s practice under the Nurses Act 1993 in respect of the prescription of any poison, controlled substance or drug of dependence.

Intellectually Disabled Persons’ Services Act 1986

The purpose of this Act is to prescribe rights and services to people with an intellectual disability. Section 66 of the Act enables registered medical practitioners to be appointed or employed by the Department as is necessary for the purposes of the Act. Specific functions to be carried out by medical practitioners are not identified. Most functions under the Act are carried out under delegations of the Secretary.

If the nurse practitioner role is to include these functions, then section 3 of the Act would require amendment and appropriate delegations made by the Secretary.

Alcoholics and Drug Dependent Persons Act 1968

The purpose of this Act is to permit the private sector to provide, under contract, services for the purposes of this Act and to provide any services that the Chief General Manager considers appropriate for the care, treatment or rehabilitation of persons who are, or are likely to become, alcoholics or drug dependent persons.

Registered medical practitioners are empowered under section 11(2) of the Act to order an alcoholic or drug dependent person to attend an assessment centre and under section 16 to issue a medical certificate supporting committal. If it is envisaged that the nurse practitioner role would include these functions, then sections 11(2) and 16 would require amendment.

Health Insurance Act 1973

The purpose of this Act is to provide for payments by way of medical benefits and payments for hospital services and for other purposes. Amendments may be necessary depending on the role of the nurse practitioner as defined.

National Health Act 1953

The purpose of this Act is to regulate the laws in relation to nursing homes and other facilities for the care of those with disabilities and the frail aged. Amendments may be required if nurse practitioners are to assume a role in prescribing medications included in the Pharmaceutical Benefits Schedule. Other amendments to sections depend on the role of the nurse practitioner and access to consequential health benefits schedules.

Pharmacists Act 1974

The purpose of this Act is to regulate the law in relation to pharmacists and pharmaceutical service, to protect the public by providing for the establishment of the Pharmacists Board for registration of pharmacists and investigation into their professional conduct. It is unlikely that amendments would be required to give effect to the role of nurse practitioner.

Children and Young Persons Act 1989

The purpose of this Act is to establish the Children's Court of Victoria, to provide for the protection of children and young persons and to make provision in relation to children and young persons who have been charged with or found guilty of offences.

Amendment to section 64(1C)(c) in relation to mandatory notification of child abuse by gazetted professionals is not considered necessary if nurse practitioners are registered under the Nurses Act 1993. Section 64(C)(c) refers to a 'person registered under the Nurses Act 1993'.

Health Act 1958

The purpose of the Act is to consolidate the law relating to the regulation of public health, radiation safety, sanitary provisions, nuisance management, control of infectious disease, immunisation, meat supervision, precaution against fire, and accommodation.

No amendments are required unless an expanded role of nurse practitioner includes functions carried out by medical officers of health who are registered medical practitioners appointed by councils under section 30 of the Act.

Health Services Act 1988

The purpose of this Act is to make provision for the development of health services in Victoria, for the carrying on of hospitals and other health care agencies and related matters. No amendments are expected to be required.

Human Tissue Act 1982

The purpose of this Act is to make provision for and in relation to the removal of human tissue for transplantation, for post-mortem examinations, for the definition of death and for registration of schools of Anatomy. Section 18(2)(a) may require amendment to add 'nurse practitioner' to the categories of persons who may receive revocation of consent under the Act. Section 9, which concerns the certification of consent, may also require amendment.

Road Safety Act 1986

One of the purposes of this Act is to provide for safe, efficient and equitable road use and in relation to this, section 55 may require amendment to empower nurse practitioners to take breath and blood samples.

Having reviewed the relevant Acts, the taskforce proposes that these be amended according to the context of practice of the nurse practitioner role.

Recommendation

1. That all relevant legislation, including but not limited to the *Nurses Act 1993* and the *Drugs Poisons and Controlled Substances Act 1981*, be reviewed and amended according to the context of the nurse practitioner role. (pp. 63–66)

Financial Considerations

The financial implications of the role to be undertaken by nurse practitioners can be considered similarly to other health service providers. Financial outcomes cannot be considered in isolation from quality outcomes. The taskforce agreed that the following should be taken into account:

- The remuneration of the nurse practitioner (agreed base salary).
- The cost to the employer (additional to salary and on costs).
- The cost to the patient (if any).
- Additional costs (if any) for the health system generated by decisions of the nurse practitioner.

The funding for the position and for services resulting from nurse practitioner activities come from a variety of sources:

- Government (publicly funded).
- Not-for-profit, non-government organisations (publicly funded).
- For profit, non-government organisations (private).
- Themselves (private).

Nurse practitioners may be either an employee, (salary or contract of service) or a contractor, (a contract for service). Because of their inability to gain access to Commonwealth funding sources, current funding options are limited to State public sector or private sector funding.

The issues canvassed by the taskforce include some funding options and financing of flow-on services—referrals and prescribing, in the context of various nurse practitioner models of practice and in view of possible amendments to legislation.

Scenario 1 — State Legislative Change

In this scenario it is assumed that there are amendments to State legislation only, establishing the nurse practitioner role, with prescribing, diagnostic and referral rights.

Status — Employee or Contractor, Employer—Government (State)

Nurse practitioner positions would be established and funded by the employer on the same basis that currently occurs with nursing positions.

Referrals

Referrals to other practitioners employed with the State-funded system would be funded either entirely by the State, or by the State with a patient co-payment. Patients referred to GPs would be able to access Medicare Benefits Schedule (MBS) rebates. Other referrals outside the State system would be funded by the patient or under certain circumstances non-Health Insurance Commission (HIC) insurers, such as private health funds.

Prescribing

Prescriptions filled within the State system would be funded entirely by the State, or by the State with a patient co-payment. Prescriptions filled in the community would be funded by the patient.

New Pharmaceutical Benefits Scheme (PBS) arrangements are being drafted to provide a continuum of care between the hospital and the community setting to ensure quality of care and promote safety. The reforms will allow PBS prescribing and dispensing in public hospitals for outpatients and admitted patients on discharge. A range of cytotoxic chemotherapy agents will be moved from the PBS to the Highly Specialised Drugs Program to ensure better access for public patients who will be eligible for subsidy for day-only admitted episodes. Hospitals, furthermore, will be required to implement continuum of care guidelines for pharmaceutical discharge planning.

Diagnostics

Diagnostic tests ordered within the State system would be funded entirely by the State, or by the State with a patient co-payment. Diagnostics ordered in the community could be funded by the patient, or the State.

Status — Employee or contractor, Employer—Not-for-Profit

Nurse practitioner positions would be established and funded by the employer on the same basis that currently occurs with nursing positions.

Referrals

Referrals to practitioners employed with the State-funded system would be funded either entirely by the State or by the State with a patient co-payment. Patients referred to GPs would be able to gain access to MBS rebates. Other referrals outside the State system would be funded by the patient or, under certain circumstances, non-Health Insurance Commission (HIC) insurers, such as private health funds.

Prescribing

Arrangements to fill prescriptions within the State public hospital system, funded entirely by the State, or by the State with a patient co-payment. Prescriptions filled in the community would be funded by the patient.

Diagnostics

All diagnostics ordered could be organised and funded within the State system.

Status — Employee or Contractor, Employer—For Profit Organisation

Nurse practitioner positions would be established and funded by the employer on the same basis that currently occurs.

Referrals

Patients referred to GPs would be able to gain access to MBS rebates. Other referrals outside the State system would be funded by the patient or under certain circumstances non-HIC insurers, such as private health funds.

Prescribing

Prescriptions filled in the community would be funded by the patient. Health insurance funds may choose to fund part of the prescription costs for private hospital inpatients.

Diagnostics

Diagnostics ordered funded by patient or in certain circumstances non-HIC insurers, such as private health funds.

Status — Contractor, Contract with Patient (Self-Employed)

Nurse practitioners would contract directly with the patient to provide them with services. The contract would usually be on a fee-for-service basis. The patient may be able to recoup nurse practitioner fees from private health insurance funds and other non-HIC insurers such as Department of Veterans Affairs, TAC, or WorkCover.

Referrals

Referrals to practitioners employed with the State-funded system would be funded either entirely by the State or by the State with a patient co-payment. Patients referred to GPs would be able to access MBS rebates. Other referrals outside the State system would be funded by the patient or under certain circumstances non-HIC insurers, such as private health funds.

Prescribing

Arrangements could be established to fill prescriptions within the State public hospital system, which would then be funded entirely by the State, or by the State with a patient co-payment. Prescriptions filled in the community would be funded by the patient.

Diagnostics

Arrangements could be established to fill diagnostics within the State public hospital system, which would then be funded entirely by the State, or by the State with a patient co-payment.

Scenario 2 — State and Commonwealth Legislative Change

This scenario assumes there are amendments to State legislation to allow the establishment of the nurse practitioner role, with prescribing and referral rights **and** amendments to the Commonwealth Health Insurance Act to permit patients of nurse practitioners to access MBS rebates and the Pharmaceutical Benefits Scheme (PBS) and to allow nurse practitioners to refer to specialist medical practitioners.

The effect of these additional changes would be to:

- Permit patients, who are referred from nurse practitioners to specialist medical practitioners, to gain access to MBS rebates.
- Permit patients of nurse practitioners to gain access to the PBS.
- Permit private patients of nurse practitioners to gain access to MBS rebates.

Alternatively, the Commonwealth may choose to limit the amendment to only permitting referral to a specialist medical practitioner, without providing patients access to the PBS or establishing items for nurse practitioner services in the MBS.

The Commonwealth, with the agreement of the States, is developing programs where there is pooling of funds from a number of sources. These programs offer the potential of extending the nurse practitioner role while ensuring its financial viability. The two notable programs currently in place are the Coordinated Care Trials and Multi Purpose Services (MPS).

Coordinated Care Trials have been operating in Australia for just over a year. The model for the trials has involved enrolment of people with complex or chronic conditions into formal care arrangements, with pooling of State and Commonwealth funds for their care. The funding pool has consisted principally of cashing out MBS, PBS and hospital inpatient funding. Other funds pooled have included the Royal District Nursing Service, HACC programs, mental health and community health services.

The MPS program is a joint Commonwealth/State program in rural communities, where agencies may pool their funding from a wide range of Commonwealth, State, and joint funded health, aged and community programs, to offer a more responsive range of services than is possible under traditional structures. The program allows a more integrated approach to service delivery and allows rural communities to expand the range of health prevention/promotion and community-based services, while providing appropriate bed-based residential and acute services.

In Victoria, there are MPS agencies at different stages of evolution. The model provides scope for the agencies to utilise flexible arrangements for employment of staff.

Appendix 1 — Legislative Changes Discussion Paper

Background

Internationally, there has been a trend to expand nurses' authority to prescribe scheduled drugs and poisons. In the USA, 49 of the 50 States have some form of prescriptive authority for advanced nursing practitioners. In the UK and New Zealand, the law is progressing in the same direction.

This paper provides a more detailed analysis of possible approaches to the creation of prescribing rights for nurse practitioners. It provides information on the following:

- The NSW approach to creation of prescribing rights for nurse practitioners.
- Victorian approaches to creation of prescribing and/or administration rights for other professions particularly optometrists, remote area nurses and ambulance officers.
- The Queensland approach to establishing possession and supply rights for nurses.
- Comparison of different approaches.
- Issues to consider in recommending implementation of prescribing rights for nurse practitioners.

NSW Model

In NSW, the prescribing and supply of restricted poisons is regulated under *the Poisons and Therapeutic Goods Act 1966*. The *Nurses Amendment (Nurse Practitioners) Act 1998* was passed by the NSW Parliament, received Royal Assent on 2 November 1998, and proclaimed on 29 October 1999. The object of the Act is to amend the *Nurses Act 1991:*

a) To allow the Nurses Registration Board to authorise certain registered nurses to practise as nurse practitioners.

b) To allow the Director General of the Department of Health to approve guidelines relating to the functions of nurse practitioners, and to allow such guidelines to make provision for the possession, use, supply and prescription of certain substances by nurse practitioners.

c) To prevent unauthorised person from using the title 'nurse practitioner' or otherwise holding himself or herself out to be a nurse practitioner.

The Act provides for amendments to the Nurses Act as follows:

- The Nurses Board to authorise registered nurses to practise as a nurse practitioner. Such authorisation is to be given only if the Board is satisfied that the person has sufficient qualifications and experience to practise as a nurse practitioner.
- Amendment to the definition of 'professional misconduct' and 'unsatisfactory professional conduct' to include contravention by an authorised and accredited nurse practitioner of the guidelines approved by the Director General relating to the functions of nurse practitioners.
- Amendments to the Nurses Register, the issuing of certificates and offence provisions or use of protected titles.
- Provision for time limited authorisation, for a maximum period of three years unless sooner cancelled or suspended by the Board.
- Provision for temporary registration as a nurse practitioner.

- Consequential amendments to the *Poisons and Therapeutic Goods Act 1966* to give effect to prescribing rights for nurse practitioners.

The Act provides for consequential amendments to the Poisons and Therapeutic Goods Act as follows:

- To allow the Director-General of the Department of Health to authorise a nurse practitioner, or class of nurse practitioners to possess, use, supply or prescribe any poison or restricted substance specified in Schedules 1, 2, 3, 5, 6 and 7 of the Poisons List (other than drugs of addiction) in accordance with the guidelines approved by the Director-General.
- Exemption for authorised nurse practitioners from the offence provisions of the Poisons and Therapeutic Goods Act relating to possession, supplying and hawking.
- Persons supplying poisons or restricted substances on the prescription of a nurse practitioner are exempted from the relevant offences under the Poisons and Therapeutic Goods Act.
- Holders of wholesalers licence or authority under the Poisons and Therapeutic Goods Act will be able to supply these poisons and restricted substances to an authorised nurse practitioner.
- Creation of offences for obtaining these substances from an authorised nurse practitioner via false or misleading representation, to forge or fraudulently alter a prescription of a nurse practitioner.

Other Acts amended to give effect to nurse practitioners authorised to supply and prescribe substances in the Poisons List include:

- *Correctional Centres Act 1952*
- *Crimes Act 1900*
- *Drug Misuse and Trafficking Act 1985*
- *Factories, Shops and Industries Act 1962*
- *Liquor Act 1982*
- *Pharmacy Act 1964*

Implementation

The NSW Nurses Registration Board has established a rigorous authorisation process for nurse practitioners. The NSW Department of Health has established a *Framework for the Implementation of Nurse Practitioner Services in NSW*. The framework addresses accreditation processes, legislative requirements, development of clinical protocols and the policy for assessing area of need. The framework does not include access to provider numbers or allow unlimited prescribing of medications. Any initiation of medication will pertain to the individual position and will be incorporated in the relevant clinical protocol. All nurse practitioner clinical protocols will require the approval of the Director-General. Nurse practitioner services are being implemented in the public sector of rural and remote NSW. Up to 40 positions (employee status) will be considered by the Director-General. While nurses may meet the accreditation criteria, they will only be able to practise as a nurse practitioner in the public sector where there is an approved position. There are to be no ‘grandparent’ provisions for existing nurses and any prospective nurse practitioners will be required to undergo accreditation by the Board.

Victorian Model—*Optometrists Registration Act 1996*

The Victorian *Optometrists Registration Act 1996* and associated amendments to the *Drugs, Poisons and Controlled Substances Act 1981* have created limited prescribing rights for suitably qualified registered optometrists. The amendments include:

- Creation of a power for the Victorian Minister for Health to approve a list of scheduled drugs that are appropriately prescribed by suitably trained optometrists. Creation of a power for the Optometrists Registration Board to endorse the registration certificates of those optometrists who have completed the required postgraduate qualifications so that they are trained to prescribe a restricted list of drugs approved for the purpose by the Minister.
- Consequential amendments to the Drugs, Poisons and Controlled Substances Act and regulations to authorise registered optometrists whose registration has been endorsed by the Board to possess, use, sell and supply the restricted list of scheduled substances as identified in the approval by the Minister.

The Drugs, Poisons and Controlled Substances Act amendments were:

- Addition in s.4(1) of a definition of a 'registered optometrist' as a person registered under the Optometrists Registration Act.
- Amendment to s.13 (1) to authorise those registered optometrists endorsed by the Optometrists Registration Board to obtain, possess, use, sell and supply Schedule poisons as specified in the endorsement.
- Amendment to s.13 (2) to restrict the above authorisation to prevent endorsed optometrists from sale or supply by retail in an open shop unless licensed under the Drugs, Poisons and Controlled Substances Act.
- Amendment to s.36B (1)(b) to create an offence for unauthorised possession of Schedule 4 poisons obtained from registered optometrists.
- Creation of powers for Governor in Council to make regulations with respect to the issue by optometrists of prescriptions for Schedule 4 poisons and offence provisions relating to breach of such regulations.

Implementation

The Optometrists Registration Act was passed in November 1996. However, the provisions relating to prescribing rights were not proclaimed until 1 July 1998. During this time, the Minister referred the matter for advice to the Poisons Advisory Committee (PAC). The PAC established a specialist subcommittee with representation from optometrists, ophthalmologists, pharmacologists, and pharmacists. The Optometrists Registration Board prepared a submission which:

- Identified the proposed list of drugs to be prescribed by optometrists.
- Proposed changes to undergraduate and postgraduate training of optometrists in order to provide the necessary theoretical and clinical knowledge and skills to safely prescribe the identified list of drugs.
- Addressed other matters considered necessary to implement the changes safely.

The Board submission was forwarded for consideration by the PAC subcommittee which made recommendations to the PAC on the list of drugs and required training. The PAC then considered and endorsed these recommendations before forwarding them to the Minister. The Minister approved under s.11 (5) the list of drugs in October 1998. The Optometrists Registration Board has recently formulated the procedure by which registered optometrists will seek and be

granted the endorsement to prescribe the listed drugs. This involves continuing negotiation with education providers to put in place adequate arrangements for clinical practice and supervision.

It should be noted that the legislative provisions creating limited prescribing rights for optometrists were first approved by Parliament in November 1996. The implementation process to give effect to Parliament's intention has then been slowly and carefully managed over a period of two to three years to ensure that the training is in place and the public protected.

Administration of Drugs by Remote Area Nurses

Victoria, Tasmania, and South Australia have developed flexible policies for the administration of drugs by registered nurses in remote areas. Section 19(3) of the Victorian Drugs, Poisons and Controlled Substances Act allows the Chief General Manager (Secretary of Department of Human Services) to issue a licence, permit or warrant subject to terms, conditions, limitations or restrictions determined by the Chief General Manager. Under s.20 (3), a permit issued under s.19 (3) authorises a person to purchase or otherwise obtain poisons or controlled substances for the provision of health services.

Bush nursing centres and community health centres have been issued with permits under these provisions to purchase poisons and controlled substances in the various schedules, including Schedules 2, 3, 4 and 8. A Health Services Permit in conjunction with the Act and Regulations generally sets out the storage, administration and record keeping requirements for these substances and allows the following:

> A nurse who administers a drug of addiction or restricted substance named on the permit does so only -
>
> - on the written authorisation of a medical practitioner; or
> - in an emergency:
>
> - Where contact with a medical practitioner is practical, on the oral instruction of the medical practitioner, in whose opinion an emergency exists; or
> - Where contact with a medical practitioner is not practical, if during the previous twelve months the nurse has demonstrated competence in physical assessment skills relevant to the condition for which the drug of addiction or restricted substance is administered.

A permit is granted to a specific centre subject to compliance with certain conditions on the permit. These permits have been issued to health services in remote areas.

Classification of Remote Areas

The classification of a remote area is based upon the availability of, and distance from, medical and pharmacy support. Remote centres reported being 25 kilometres or more, by the nearest practicable road, from the pharmacy they utilise and from their nearest medical practitioner. (Report of the Remote Area Nurse Practice Committee to the Chief General Manager Health Department Victoria, December 1987). There are 25 centres classed as remote. A remote area nurse is a registered nurse who has a significant role in relation to the primary health care of a particular rural community which is isolated from immediate medical support and/or other health care resources. They may work in bush nursing centres, small rural hospitals and community health centres.

Emergency Treatment

In 1992 in Victoria, following amendments to the *Drugs, Poisons and Controlled Substances Regulations 1985*, the legal framework was established to enable remote area nurses to

administer drugs on their own initiative, in accordance with *Emergency Guidelines for Remote Area Nurses*.

Remote area nurses are able to provide emergency care in the following circumstances:

- The nurse can demonstrate the satisfactory completion of training in emergency / critical care.
- Health and Community Services (now Department of Human Services (DHS)) treatment protocols are followed in an emergency situation.
- The nurse has been approved by Department of Human Services to perform that function.

Designation and Training

Remote area nurses are designated by the Victorian Association of Health and Extended Care (VAHEC), in association with the Health Workforce Section of Department of Human Services. Designation status and approval to use the *Emergency Guidelines for Remote Area Nurses* is given to remote area nurses employed in Victoria who have completed an approved Department of Human Services program. The aims of the program are to develop and maintain knowledge and competence in advanced emergency nursing practice. Certain competencies must be maintained as part of the designation process.

Designation status may be sought by registered nurses working in remote areas positions classified by Department of Human Services.

Administration of Drugs by Ambulance Officers in Victoria

Within Ambulance Services Victoria, the Ambulance Services' Medical Advisory Committee authorises the protocols which provide for accredited ambulance officers to administer drugs of addiction (Schedule 8) and restricted substances (Schedule 4), including Schedule 2 and Schedule 3 drugs. Accredited ambulance officers can only administer approved drugs in accordance with respective protocols as authorised by this committee, and then only whilst on duty. Administration of drugs in any other circumstance is not approved and is unlawful.

The Ambulance Service Medical Officer is ultimately accountable for the effective monitoring of the use and administration of Schedule 8 and Schedule 4 poisons by accredited ambulance officers within the region and will advise the Chief Executive of effective protocols and suggestion for amendment to Ambulance clinical protocols.

The authority to purchase drugs by Ambulance Service Victoria regions and Ambulance Officers' Training Centre (AOTC) is subject to a Health Service permit issued by the Chief General Manager (Secretary of Department of Human Services) under S.19 (3) of the DPCS Act. Individual ambulance officers acting under the direction of persons nominated on the Health Service permit, can obtain drugs, poisons, and controlled substances for use in accordance with the regulations.

It is the responsibility of the senior officer of each region and AOTC to amend the Health Service permit when required. The senior officers may accordingly delegate the authority for this task to a nominated Responsible Officer. Each Region, Branch and Air Ambulance Service must keep an approved drugs of addiction Register which records all transactions. The administration must also be recorded on the patient care record.

The obtaining, storage, possession and administration and the maintenance of records of all transactions of the poisons or controlled substances must conform with *Ambulance Service Victoria Metropolitan Region - Policy on Drugs - March 1996* and as amended from time to time with the prior approval of the Department of Human Services.

Queensland Drug Therapy Protocols for Nurses

The Queensland Health Department in conjunction with the Queensland Nursing Council has recently completed a three-year review of the Poisons Regulations. A steering committee was established to look at the nursing aspects of the nurses regulations to ensure an effective set of regulations governing nurses possession, administration and supply of scheduled drugs and poisons. Broadly all nurses were given extended authorities including enrolled nurses, relating to administration rights and supply in particular circumstances.

Under the old regulations, nurses were authorised to administer medication on the written instruction of a medical practitioner. The Chief Health Officer had the power to authorise a person to administer and it was considered that this power better rested with the Nurse Regulatory Authority.

The new approach incorporates a drug therapy protocol model. Nurses in particular practice settings (public or private) who hold an endorsement from the nurse regulatory authority are authorised to possess, administer and supply medications identified in a drug therapy protocol. There are currently three practice settings:

- Isolated practice
- Sexual health programs
- Immunisation programs

There are drug therapy protocols for each of these practice settings. The isolated practice setting has about 100 plus different types of medication including antibiotics, contraceptive pill and Schedule 8 pain relief. Nurses who are seeking this endorsement have to successfully complete a course accredited by the Queensland Nursing Council. There are accredited courses in all three practice categories.

The first isolated practice endorsed nurses completed their education in May 1999. At this stage there is only one course provider - a rural health education unit which gives two unit credits to applicants with a post graduate diploma in rural and remote nursing. Role statements have been established which include the role of the isolated practice endorsed registered nurse, accountability and a profile of the person.

This approach does not entitle endorsed nurses to issue a prescription which can then be filled by a pharmacist. The endorsed nurse is trained and authorised under the protocols to assess a patient and administer and supply drugs for treatment. Prescription is the written authority to direct the pharmacist to supply, and this process is bypassed.

The protocols are developed by a drug therapy protocol steering committee made up of representatives of the three relevant professions of nursing, medicine and pharmacy, along with representatives from the Department of Health. The drug therapy protocols are approved by the Director General of Health. The *Health (Drugs and Poisons) Regulations 1996* provide the head of power for the approval of the protocols. The power of endorsement is under S.76 and 77 of the Queensland *Nursing Act 1992. S.76* provides for an annual license certificate to be suitably endorsed to show any authorisation to practise in an area of nursing. Such endorsement may be granted by the Council if the person holds a qualification recognised by the Council and if the application is made within a specified period after finishing the course. Suitably endorsed registered nurses are authorised to possess and supply drugs under the Regulations (attached to the Health Services Act).

The current approach is to be evaluated in two years and Queensland will be proceeding to examine the role of nurse practitioner over the next two years.

Comparison of Approaches to Creation of Limited Prescribing Rights

There are a number of differences in the approach to the creation of prescribing rights adopted by NSW and Victoria. There may be other approaches. In order to understand the differences in approach, a definition of what constitutes prescribing is required. When drugs are made available to a patient, there are generally at least four processes involved:

Diagnosis of patient's condition in order to determine a suitable treatment including the type of medication, its dosage and administration regime

Prescribing of the medication is defined by the NH&MRC (1998) as 'provision in writing by a medical professional or other designated professional, after clinical assessment of a patient, of instructions for the dispensing and administration of a drug or remedy'. In this context it means initiation and in some cases direct supply of drugs by practitioners acting entirely in their own right as professionals, that is, not acting under any protocols or orders. It may include preparation of a written prescription which can then be legally filled by a registered pharmacist, or in some cases, the medication may be supplied directly by the service employing the medical professional.

Supply of the medication. Supply is defined under *the Drugs Poisons and Controlled Substances Act 1981* as 'supply, provide, give or deliver, whether or not for fee, reward or consideration or in expectation of fee, reward or consideration'. This can be done by a pharmacist according to the instructions in a legal prescription, or in some services outlined below, the drugs are directly supplied to the patient by the service.

Administration is where a party other than the patient gives an individual dosage of the drug to the patient to swallow or otherwise take, and ensures that this occurs.

The debate about extending the scope of practitioners to include prescribing of scheduled medications is often confused because of confusion about the above roles. At present, no State drugs and poisons legislation allows diagnosis, prescribing, supply and administration of scheduled medications to patients by registered nurses. Limitations are placed on the role in a variety of ways, including:

- The setting in which the nurse is employed (for example public versus private sector)
- The geographic area in which the restricted activities can occur (for example remote area nursing)
- The type of activities legally undertaken (for example, it appears no State legally allows the preparation of legal prescription by a nurse for filling at a pharmacy external to the service).

Some of the differences in approach are outlined below.

Prescribing Versus Possession and Supply

In Queensland, the endorsed nurses are not empowered to issue a prescription which can be filled by a pharmacist. **The medication is directly supplied to the patient by the nurse.** In Victoria, processes are being established to ensure that pharmacists are able to determine the legality of prescriptions issued by endorsed optometrists, that is to determine whether a particular optometrist has the required endorsement, and whether their authorisation extends to the particular drug identified in the prescription.

Settings in Which Nurse Practitioners or those with Supply/Prescribing Rights Work

In NSW, the role of the nurse practitioner has been established only in the public sector. In Queensland, nurses with endorsed registration to possess and supply scheduled drugs may be working in any setting public or private.

Who Is Eligible for Approval To Prescribe?

In the NSW nurse practitioner model, the nurse practitioner role is tied to approved positions. In addition, the exact role of an individual nurse practitioner approved by the Director General of Health may or may not include prescribing rights depending on:

- The needs of the position.
- The education of the incumbent.

In addition, granting of the title is time limited, and must be renewed every three years. Presumably if approval of a nurse practitioner position is withdrawn by the Director General, then rights to use the title 'nurse practitioner' would also lapse. It is also expected that continued endorsement by the Nurses Board would rely on the nurse involved maintaining her/his training in areas such as prescribing up to date.

In Victoria, any optometrist can undertake the required training (given its availability) and seek endorsement from the Board to be able to prescribe. Prescribing rights are not tied to particular areas or positions. It is expected that once the required changes are implemented to the undergraduate training of optometrists, all new graduates will have the required skills and clinical experience and will be automatically endorsed by the Board. In Queensland, any nurse can apply for endorsement following completion of the required accredited education.

Process for Approval of the List of Drugs and Associated Protocols

In NSW, the approval of the list of drugs and protocols rests with the Director General of Health. In Victoria under the optometrists model, the final approval of the list of drugs rests with the Minister for Health. This approval was only provided following an extensive process to set parameters for the process by which the Optometrists Registration Board is to develop training requirements. Protocols for administration of the endorsement process and monitor implementation rests with the Optometrists Registration Board. In Queensland, the protocols have been established by a joint steering committee, with approval resting with the Director General of the Department of Health.

Conclusions

If the recommendation to implement prescribing rights for nurse practitioners is to go ahead, the following will need to be determined:

- Whether the role is to extend to all four components outlined above, that is diagnosis, prescribing, supply and administration.
- If the role is to include the preparation of legal prescriptions filled by a pharmacist external to the service, then the system for recognition of these prescriptions and those qualified to issue them will need to be determined in consultation with the Pharmacists Board and the Drugs and Poisons Unit of the Department.
- Whether the role is to extend to both public and private sector nurse practitioners.
- Whether there are to be any controls, as in NSW on the number of nurse practitioner positions available to be filled.

Below is an outline of an approach that might form the basis of a model for implementation of prescribing rights for nurse practitioners:

1. The *Victorian Nurses Act 1993* would require amendment to restrict use of the title of 'nurse practitioner' and create an offence provision within the Act for unapproved use.

2. The NBV would be a suitable body to have the role of accreditation of education courses undertaken by registered nurses in order to use the title 'Nurse Practitioner'.
3. Approval by the Board for a registered nurse to use the title 'nurse practitioner' could be conditional upon satisfactory completion of approved nurse practitioner education as well as meeting any other criteria established by the Board.
4. This approval to use the title 'nurse practitioner' could be tied to a specific area of practice and recorded against the nurse practitioner's name on the Register (a public document).
5. The *DPCS Act 1981* would require amendment to provide for authorisation to prescribe scheduled drugs and poisons by those endorsed nurse practitioners who have been granted prescribing rights as part of their accreditation.

   The nature of the authorisation would depend on the context of practice of the Nurse Practitioner. Not all nurse practitioners might be authorised to prescribe scheduled drugs if this is not required as part of their context of practice or included in their education.

Further work would be required to identify the areas of practice which might include prescribing of scheduled medications by nurse practitioners and the list of drugs that might be prescribed. For example, nurse practitioners trained in the area of practice of drug and alcohol might be authorised to prescribe Schedule 8 drugs.

Mechanisms would be required to ensure the continuing competence of nurse practitioners in prescribing of medication. These could include one or a number of the following approaches:

- Individual nurse practitioners to have responsibility for maintaining their professional competence including in the area of prescribing of scheduled drugs.
- A system of 'credentialling', perhaps operated by professional organisations, for assessment of continuing competence of nurse practitioners in their context of practice.
- The Nurses Board undertaking audits of continuing competence of nurse practitioners including those endorsed to prescribe in their approved area of practice.
- If an area of practice changes and this has implications for prescribing of scheduled drugs, then the endorsed nurse practitioners affected by this change may be required by the Board to undergo further education.

Restriction on Use of the Title 'Nurse Practitioner' — Some Approaches

There are a number of approaches to protection of title which may be considered if the use of the title 'nurse practitioner' is to be restricted only to those registered nurses who have undergone suitable additional training, and the NBV is put forward as the most suitable body to regulate the use of that title and determine the qualifications required:

Option 1: A Separate Division of the Register for Nurse Practitioners

This requires amendment to the legislation to create a separate division of the Nurses Register and a definition of nurse practitioner as a person registered within that division of the Register. An amendment would also be required to Part 5 of the Act 'Offences', to make it an offence for a person who was not a 'registered nurse practitioner' to use the title 'nurse practitioner'.

Option 2: An endorsement process to identify those registered nurses who have met additional Board requirements

This requires amendments to the legislation to create a definition of 'nurse practitioner' as a nurse registered in divisions 1, 3 or 4 of the Register who has undergone further education as required by the Board and is therefore entitled to call themselves a 'nurse practitioner'. This would require a process to publicly identify those who are entitled to use the additional title, and those who are not, for example, and endorsement of the Nursing Register against the name

of the nurse and a notation on the nurse's certificate of registration and/or their annual renewal form. An amendment would also be required to Part 5 of the Act 'Offences', to make it an offence for any person using the restricted title who did not hold the additional qualifications and not received the endorsement from the NBV.

Option 3: Create an offence to prevent claims as to additional qualifications

Section 62 of the *Nurses Act 1993* titled 'Claims as to additional qualifications' prevents persons who have not completed a course in midwifery approved by the NBV from taking or using the title 'midwife' or any other title calculated to induce a belief that the person is a midwife, or claim to be a midwife or hold themselves out as being a midwife. There is no reference to 'midwife' in the definitions or registration sections of the Act.

Appendix 2 — Nurse Practitioner Taskforce: Terms of Reference

1. Explore the issues and implement the associated recommendations identified in the proceedings of the Nurse Practitioner Workshop relating to:
   - Health economics
   - Role definition and title
   - Education of nurse practitioners for advanced nursing practice
   - Legislative change to relevant Acts
   - Best practice
   - Collaboration with other health professionals
   - Developing a culture of partnership, quality assurance, client satisfaction and community education.
2. Prepare and model a process for the evaluation of the implementation of the nurse practitioner role.
3. Develop a framework for submissions for funding of projects which will explore the role of the nurse practitioner in a variety of settings indicating that the role must be integrated, that is, form part of the service delivery; administer the processing of submissions; and make recommendations to the Minister about funding proposals.
4. Coordinate a forum to share with the nursing profession the outcomes of the nurse practitioner workshop.
5. Provide a final report after twelve months to the Minister for Health making recommendations for consideration of the Minister on the nurse practitioner role in Victoria.
6. The term of appointment for members of the taskforce is 14 months.
7. The taskforce may coopt individuals with specific expertise at any given time as the need arises.

At the conclusion of the project, the taskforce will have established a framework and process necessary for the implementation of the nurse practitioner role into the Victorian health system.

July 1998

Appendix 3 — Subcommittee Membership and Terms of Reference

Role Definition and Title

Trish Dunning, Joy Johnston, Anne-Marie Scully, Margaret Bennett, Claudia Trasancos

- To examine the literature and other relevant source material to inform the further development of the working definition and the draft role statement.
- Agree on a working role statement to guide deliberations.
- Coopt relevant practitioners to assist with deliberation.
- Use feedback from the project evaluations where appropriate.

Educational Preparation and Credentialling

Margaret Bennett, Tom Keating, Jocelyn Small, Pauline Nugent, Angela Bradley, Elizabeth Croke, Trish Dunning, Sue White, Lyndall Whitecross, Heather Jarman, Claudia Trasancos

- To reach consensus on the level of education program to be recommended for nurse practitioner preparation. This includes addressing the issues of flexibility of access to, and delivery of, the program, recognition of prior learning and a time frame for individuals to move towards the appropriate education program level.
- To identify issues relating to the funding of education programs for nurse practitioners (including access and equity issues).
- To identify processes required for the accreditation of nurse practitioner education programs and the credentialling of individual nurse practitioners.

Best Practice

Anne-Marie Scully, Jocelyn Small, Trish Dunning, Elizabeth Croke, Angela Bradley, Margaret DeCampo, Pauline Nugent, Lyndall Whitecross, Claudia Trasancos

- To agree on a working definition of best practice to guide deliberations.
- To coopt whomsoever is deemed appropriate.
- To report back to the taskforce on completion of deliberations.

Professional Indemnity and Legal Liability

Paul Woodhouse, Margaret DeCampo, Angela Bradley, Joy Johnston, Kathleen McLaughlin, Claudia Trasancos

- To consider all matters relevant to professional indemnity coverage for nurse practitioners, having cognisance of:
  - ◊ The need to protect the public.
  - ◊ Nature of employment/engagement of the nurse practitioner.
  - ◊ The interests of the nurse practitioner.
  - ◊ The interests of health care professionals with whom the nurse practitioner works.
  - ◊ Specific issues raised from the projects

- ◊ The practicalities of implementing any recommendations.
- ◊ Any other relevant issues that are identified.

- To advise the Nurse Practitioner Taskforce of the deliberations of the subcommittee.

Legislative Changes

Jill Linklater, Margaret Bennett, Pauline Nugent, Anne-Marie Scully, Paul Woodhouse, Rosemary Bryant, Claudia Trasancos, Steve Marty, Keith Moyle, Anne-Louise Carlton, Ruth Andrew, Vivienne Topp

- To examine existing legislation that may have consequence for the nurse practitioner role.
- To make recommendations to change relevant Acts to reflect nurse practitioner role.
- To coopt appropriate individuals onto the working party as required.

Financial Considerations

Margaret DeCampo, Tom Keating, Anne-Marie Scully, Paul Woodhouse, Jill Linklater, Claudia Trasancos

- To consider matters relevant to the financial sustainability of the nurse practitioner role, namely:
  - ◊ Remuneration options for individual nurse practitioners.
  - ◊ Funding options for individual nurse practitioners.
  - ◊ Funding of nurse practitioner associated activities.
  - ◊ Costs to consumers / patients.
- To consider these options across the spectrum of nurse practitioner employment settings, namely:
  - ◊ Employed, self-employed, contracted.
  - ◊ Public, non-government or private sectors.
  - ◊ Sessional or full-time.
- To advise the Nurse Practitioner Taskforce of the deliberations of the subcommittee.

Evaluation Reference Group

Tom Keating, Claudia Trasancos, Rosemary Bryant, Anne-Marie Scully, Trish Dunning, Margaret Bennett, Jill Linklater, Lyndall Whitecross, Elizabeth Croke

- To maintain ongoing contact with the evaluators
- To monitor the evaluation of the nurse practitioner models of practice.

Appendix 4 — Community Consultation July 1999

Community consultation took place in the form of a series of focus group discussions with consumer representatives. These focus group discussions have assisted in discerning the key issues relating to the implementation of the nurse practitioner role which may impact on consumers and particular communities and in identifying suitable process for future consultation.

Attempts to conduct two focus group discussions with consumer representatives in July 1999 were made. The following organisations were contacted:

Health Issues Centre

Koorie Unit, Department of Human Services

Victorian Aboriginal Community Controlled Health Organisation (VACCHO)

Country Women's Association

ORANA Family Services

Maternity Coalition

Carers' Association

Australian Greek Welfare

CO-AS-IT, Italian Welfare Organisation

Foundation for Spanish-speaking Older People Inc.

Inner South Community Health Services

Darebin Community Health Services

Moreland Community Health Services

Broadmeadows Community Health

Douta Galla Community Health

Victorian Mental Illness Awareness Group

Progress Association, Northcote and Broadmeadows

Australian Complementary Health Association

Carers' Links North

Association for Children with a Disability

Strong interest was demonstrated from most of the organisations listed above but unfortunately, scarce resources, tight time lines, and poor timing precluded many from participating in July 1999. VACCHO, for example, was due to have a full member meeting in September. The request for nominations of suitable consumer and health care representatives from Aboriginal communities were to be put forward and considered at this meeting. Some organisations requested at least three months' notice, while others emphasised the need for interpreters, aids and other facilities. Invitations for future ethnic-specific consumer group discussions were extended from particular organisations. Most of the organisations and individuals contacted

were very interested and requested that feedback be provided from the first series of focus group discussions conducted.

All organisations listed above were provided with some background reading on the Nurse Practitioner Project and were supplied with some examples of issues to consider for the focus group discussion.

1st Discussion: Aboriginal Health Service Representatives

The first discussion was held on 15 July 1999 with Aboriginal Health Service representatives. Numerous issues were raised by representatives from the Victorian State Division of Aboriginal and Torres Strait Islander Health and the Koorie Unit of the Department of Human Services. The implementation of the nurse practitioner role was seen as positive and as having the potential to provide beneficial outcomes for both Aboriginal communities and Aboriginal health care workers. The introduction of the role was seen as possibly serving as an incentive for GPs working with Aboriginal communities due to the presence of numerous gaps in the current provision of health care services. Potential benefits such as value-adding and flexibility in health care delivery were raised as possible gains.

The nurse practitioner was seen as having a 'huge' role in health promotion and illness prevention, working in conjunction with the existing Aboriginal Medical Services. Management of particular conditions such as diabetes, cardiovascular and respiratory illnesses were suggested as possible nurse practitioner activities. Improved access, particularly for individuals in isolated areas, more timely treatment, improved health education, and continuity of care leading to improved quality of care, were raised as potential benefits. It was suggested that in some cases, the nurse practitioner may have to take advantage of opportunities as they present themselves. An individual may attend a health care service with a painful toe, for example, and in the process of alleviating the pain and taking care of the toe, the nurse practitioner may find it an opportune time to work with the individual in health promotion and preventive activities, including diagnostic referral.

It was suggested that nurse practitioner services should not be promoted as second rate medical care. Core competencies and an appropriate range of skills need to be ensured. Ongoing monitoring and evaluation are also essential. Understanding and appreciation of Aboriginal history and the dynamics in Aboriginal health care delivery were considered to be critical. Cultural concerns and the social context of health care delivery were seen as imperative. It was put forward that the current work of Aboriginal Medical Services involved a move towards a socialist model of health care delivery which has its difficulties and involves the difficult process of changing attitudes.

In relation to the implementation of the nurse practitioner role, it was suggested that the question 'What is in it for Aboriginal health workers?' needs to be asked. It was stated that Aboriginal health workers were currently struggling to be recognised as part of the mainstream health care services and to have their competencies recognised.

A number of limiting factors in relation to the implementation of the nurse practitioner role were identified. It was stated that the Aboriginal community will have the overriding say as to the success of the implementation of the nurse practitioner role. The number of Aboriginal registered nurses was yet to be identified. It was felt that the implementation of the role involved a change in beliefs relating to what a health service involves and how health services may be delivered. If the nurse practitioner role is accepted, there is also the fear that doctors may feel that they are not needed or wanted. Since it is usually at crisis point when individuals tend to present themselves to a health care worker, compliance is often problematic. It was felt that a nurse practitioner who is able to fill in the gap, or in other words, case coordinate, would be invaluable.

For further discussion of the key issues relating to the implementation of the nurse practitioner role in Aboriginal communities, it was suggested that contact be made with the Australian Nursing Federation (ANF) Aboriginal and Torres Strait Islander interest group and to await for nominations from the Victorian Aboriginal Community Controlled Health Organisation.

2nd Discussion: Consumer Focus Group Discussion

The second focus group discussion was held on 22 July 1999 and involved five individuals representing a diverse cross section of the Victorian population:

Country Women's Association - Ensey

Rural consumer representative and community worker - Nandaly

Carers' Association - Melbourne

Foundation for Spanish-speaking Older People Inc. - Melbourne

Consumer Evaluation Consultant - Melbourne

Discussion began with an explanation of the difference between registered nurses and advanced practice nurses, and of the relationship between advanced practice nurses and other health care professionals. It was felt that the nurse practitioner would be a generalist rather than a specialist. The role was visualised as comprising a broad role with distinctive competencies.

Criticisms of the GP-patient relationship centred around dissatisfaction with the medical model and the attributes of the GP, the waiting time associated with seeing a GP, the lack of timely and appropriate treatment, the poor continuity of care, and the exclusion of family members in the care of clients. The tyranny of distance was also raised as a difficulty in relation to access to appropriate health care professionals in rural and remote areas. That some advanced practice nurses were extending their scope of practice was seen as a natural progression in the attempt to improve health care services. It was seen as providing the public with more choice and as having potential to produce a number of efficiency gains. It was strongly put forward that health care was about caring, not about churning out a unit of service.

The public health role of the nurse practitioner was felt to be critical and a social model of health care was considered to be the preferred mode of delivery. A case coordination and management role incorporating more caring and personalised services was strongly supported. The nurse practitioner was visualised as possibly being able to fill in the gaps associated with health care delivery. It was suggested that comprehensive needs analyses at the outset were essential. The numerous assessments that currently have to be conducted prior to receiving a service were described as ridiculous. The difficulties of attracting GPs to attend nursing homes and the lack of continuity of care were discussed.

Other benefits raised as possibly arising from implementation of the nurse practitioner role included more timely, responsive, appropriate and effective health services, improved continuity of care and case management between hospital and primary care settings, improved identification and management of medication problems particularly for clients on multiple medications, and improved patient and carer health knowledge. An integrated approach to health care delivery incorporating the use of complementary and alternative approaches to health care was considered to be important.

An existing rural case scenario was described where a doctor was retiring and not to be replaced. On initial discussion, one rural participant felt it was not desirable for a nurse practitioner to replace the doctor since nurses generally are not perceived as being skilled to the same level as doctors, especially in the area of diagnostics. This was felt to be the general community perception as well as the historical understanding. Other participants suggested that

doctors do not have the necessary skills either and that skills are acquired over time. In areas and situations where a doctor has not been available, the rural community has managed but although this is possible it is not the preferred option.

It was stated that emergency respite care has been identified as an area of high need in a Melbourne study. It was considered, however, that the emphasis for the nurse practitioner, should be in primary health care and health promotion. Common sense was put forward as fundamental to the role.

Questions relating to who would be responsible for selecting nurse practitioners and nurse practitioner fees were discussed. The importance of affordability was raised. It was mentioned that 70% of Home and Community Care funding was taken up by the Royal District Nursing Service.

It was felt that the nurse practitioner role would vary in different contexts. The nurse practitioner would require appropriate education and upskilling in relation to other support services, pharmaceutical issues, diagnostic skills, and tele-medicine technology. The importance of interpersonal communication skills and of professional indemnity cover was raised.

Nurse practitioners were conceived as possibly prescribing medications up to a certain level. It was felt that nurse practitioners could work collaboratively with pharmacists. Although it was suggested that nurse practitioner prescribing not be limited to emergency areas, adverse health outcomes due to side-effects of medication was raised as a concern.

The use of nurse practitioners from a range of ethnic backgrounds in accommodating cultural diversity was considered to be important. It was acknowledged that women are the principal carers and providers of health care and it was suggested that work be done to build on this strength. It was also suggested that issues relating to the implementation of nurse practitioner should have first been put to consumers rather than to the professions.

Appendix 5 — Funded Nurse Practitioner Models of Practice

Central Wellington Health Service: Primary Health Care in a Remote Area

This model involves the provision of emergency services and health promotion activities and is being implemented in a geographically isolated and socioeconomically disadvantaged area where there are very limited medical services.

Barwon Health—The Geelong Hospital and Deakin University: Perioperative Nurse Practitioner

This model involves a pre-admission nurse assessment and triage process and nurse initiated decision making of pre-operative investigations based on an anaesthetic approved protocol.

Southern Health Care Network—Monash Medical Centre: Emergency Nurse Specialist

This model involves a more autonomous level of practice to improve the delivery of services to clients with minor injuries.

Southern Health Care Network—Community Health Services and Monash University: Well Women's Health Services

This model comprises screening, information and counselling services for women by women in three socially deprived communities in the south eastern metropolitan area and three in rural areas which are in the growth corridor and gateway to the Gippsland area.

Women's and Children's Health Care Network : Paediatric Eczema Nurse Practitioner

This models involves assessment, management and education of children with atopic eczema, and also includes outreach workshops for the education of GPs and nurses external to the hospital.

Women's and Children's Health Care Network: Neonatal Nurse Practitioner

This model encompasses mentoring, supervising and teaching as well as managing a caseload of neonatal patients in consultation, collaboration and supervision with a neonatal medical consultant.

Peter MacCallum Cancer Institute: Haematology Nurse Practitioner

This model focuses on the care of patients undergoing autologous bone marrow and progenitor cell transplantation, and involves practice spanning the entire care continuum.

Warrnambool and District Base Hospital: Wound Management Nurse Practitioner

This model comprises a nurse-led consultation wound management service and involves education, liaison, and an expansion of current activities including prescribing, diagnostics and referring.

Austin and Repatriation Medical Centre and the University of Melbourne: Consultation Liaison Psychiatric Nurse Practitioner

The Consultation Liaison Psychiatric Nurse provides liaison, educational and consultation services, and works on behalf of admitted clients who may exhibit symptoms of a psychiatric condition.

Women's and Children's Health Care Network: Well Women's Nurse Practitioner Role in a Tertiary Women's Health Setting

This model includes the provision of screening services to well women (such as pap testing, breast examination), specialised services (such as continence assessment), and health information, counselling and specialist referral.

Royal District Nursing Service: Homeless Person's Program

This model offers a primary health care response to homeless people within a holistic framework.

Appendix 6 — AMA (Victoria): Dissenting View

The Nurse Practitioner Taskforce makes 30 recommendations to the Minister for Health. AMA (Victoria) dissents from six of these recommendations on the basis of public safety and effectiveness of care. In addition, it is timely to briefly highlight two other related issues, the provision of health services in rural and remote areas and advanced practice nursing, which though not directly addressed by the taskforce require urgent attention in this context.

Rural Health Care

It is unarguable, that notwithstanding the tireless efforts of nurses and medical practitioners in rural and remote areas, access to health care in these locations is not adequate, especially when compared to the care available in metropolitan centres. A comprehensive approach by all tiers of Government is required to improve this situation. These general principles should underpin the Government's response:

1. Communities in rural Victoria should have access to quality health services on the basis of clinical need, delivered in a timely fashion and, as far as practicable, available close to where people live and work.
2. The introduction of new models of health care delivery in rural Victoria:
   a) requires the involvement and collaboration of local health professionals;
   b) must be adaptable to meet the specific requirements of each community;
   c) must build on the strengths of the existing system.
3. Health professionals, who work in rural Victoria:
   a) need access to relief from their practices on a routine basis;
   b) should be able to undertake professional development activities, including Continuing Education and research, where they practise;
   c) should have direct input into how health services are currently delivered and the planning of future services.

Advanced Practice Nursing

AMA (Victoria) acknowledges that nursing practice has changed in recent years. Increasingly nurses have developed expertise and education in specialist fields, which are often highly sophisticated or involves advanced technologies. It is reasonable that the effort and expense incurred by nurses in obtaining higher qualifications to practise in these fields is rewarded. AMA(Victoria) therefore supports the development of a viable and appropriately remunerated career structure for nurses to encourage them to undertake advanced training and to remain in the nursing field. The career structure must recognise those nurses who are currently working at an advanced level of practice in hospitals and the community, in both metropolitan areas and rural Victoria.

Safe and Effective Health Care

AMA(Victoria) believes that the most effective and safest health care is provided:

- when nurses and other health professionals work collaboratively with medical practitioners; and
- where agreed and complementary professional roles are recognised.

Therefore, AMA (Victoria) dissents from recommendations 24–29 made by the Ministerial Taskforce, as it believes they will undermine these fundamental principles for the provision of safe health care.

Recommendation 24 proposes that the *Drugs Poisons and Controlled Substances Act 1981* be amended to provide for limited prescribing authorisation for nurse practitioners. In the interests of public safety AMA (Victoria) opposes the introduction of a prescribing authority for nurses or nurse practitioners for the following reasons:

No identifiable need for nurse prescribing.

The taskforce's report draws upon USA and UK experience to justify the introduction of nurse prescribing. Articles published in nursing journals in those countries assert that nurse prescribing improves access to care and is convenient for patients. In the context of those two health systems that maybe so. The US health system has prohibitively high access costs for the poor and indigent. Consequently prescribing rights for nurse practitioners provided a mechanism to improve availability of care to the disadvantaged. In the UK there is a gross under supply of medical practitioners, with waiting times extending to weeks to see a general practitioner. In the US and UK nurse practitioners are effectively operating as doctor substitutes, without a medical education.

By contrast, in Australia we have a universal health care system, with 80% of general practitioner consultations bulk billed. There are also 30% more medical practitioners per capita in Australia compared with the UK. Neither cost nor access should be impediments to anyone finding medical care in a timely fashion in most of Victoria.

One hundred small rural towns, without a resident medical practitioner, are currently the focus of a recruitment drive by the Victorian Government to relocate suitably qualified medical practitioners to them. The success of this project will ensure every town in Victoria with a population large enough to sustain a medical practice will have a doctor and obviates the need for nurses working in these towns to have prescribing rights.

Currently there are a number of remote area nurses in Victoria, who are geographically isolated, but who have close professional relationships with medical practitioners in adjacent towns. This collaborative relationship enables the remote area nurses to discuss patient ailments and treatment options with the patient's usual general practitioner before commencing the treatment advised by the doctor. To facilitate this arrangement, the following legislation has been enacted:

> *Section 19(3) of the Victorian Drugs Poisons and Controlled Substances Act allows the Secretary to issue a licence, permit or warrant subject to terms, conditions, limitations or restrictions determined by the Secretary. Under Section 20(3) a permit issued under s 19(3) authorises a person to purchase or otherwise obtain poisons or controlled substances for the provision of health services.*
>
> *A Health Services Permit in conjunction with the Act and Regulations generally sets out the storage, administration and record keeping requirements for these substances and allows the following:*
>
> - *A nurse who administers a drug of addiction or restricted substance named on the permit does so only –*
> - ◊ *on the written authorisation of a medical practitioner; or*
> - ◊ *in an emergency –*
> - - *where contact with a medical practitioner is practical, on the oral instruction of the medical practitioner, in whose opinion an emergency exists; or*

- *where contact with a medical practitioner is not practical, if during the previous twelve months the nurse has demonstrated competence in physical assessment skills relevant to the condition for which the drug of addiction or restricted substance is administered.*

Permits are issued where the nurse is more than 25kms by road from a pharmacy or a medical practitioner.

The extended role proposed for nurse practitioners in remote areas may undermine their current cooperative relationship with GPs and place unreasonable expectations upon them by Government.

Dangers of prescribing

Prescribing medications is neither a simple process, nor risk free. Recent articles published in the *Medical Journal of Australia* (Dartnell et al., 1996 and Bhasale et al., 1998) have identified that about 6% of admissions to hospitals are due to adverse events related to drug therapy and that in general practice there are a significant number of adverse events related to prescribing of medications. While only a small percentage of adverse prescribing events were definitely avoidable, it highlights the risk to patients and the high cost to the community of them.

Bhasale et al's general practice study also identified:

- poor coordination of care;
- consultation by patients with other medical practitioners; and
- poor communication between health professionals;

as major reasons for adverse events occurring.

Extending the range and number of prescribers will increase these risks. A strength of primary care in Australia is that (ideally) one general practitioner knows intimately a patient's history, diagnoses, referrals and medications. This provides the basis for quality care and its effective coordination.

Educational preparation

Medical practitioners are unable to begin unsupervised practice until they have completed an undergraduate medical degree, an intern year and obtained a postgraduate medical fellowship. This takes about twelve years. From the outset, pharmacology and therapeutics are an integral part of the medical education process. The education of no other professional group is any way comparable to the intensity and depth of this process undertaken by medical practitioners.

Therefore, AMA (Victoria) is opposed to nurse practitioner prescribing because:

1. There is, in metropolitan and rural areas, no identifiable need.
2. There are considerable risks to the patient associated with prescribing.
3. It will cause fragmentation of care, which will confuse both patient and health care provider alike.
4. The educational preparation of nurse practitioners will be inadequate to ensure safe prescribing.

In remote areas, existing legislative provisions and the cooperative and collaborative relationship between remote area nurses and proximal GPs obviates the need for nurse prescribing.

Recommendations 25 and 26 propose that nurse practitioners be authorised to prescribe from a formulary and that such a formulary be developed. Consistent with AMA Victoria's opposition to nurse practitioner prescribing, AMA(Victoria) opposes prescribing from a nurse formulary.

However the distinction needs to be made between prescribing from a formulary and adjusting dosages of medications, which have already been prescribed by a medical practitioner. Adjusting medications by protocol, within well-defined parameters, is a legitimate and valued role of nurses with advanced knowledge and experience. This additional responsibility should be recognised.

There may be a role for Department of Human Services to assist in the development of local area protocols to guide medical practitioners and nurses, in circumstances where nurses are permitted to adjust dosages of medications prescribed by medical practitioners.

AMA (Victoria) opposes recommendations 27 and 28, which propose that nurse practitioners should be able to initiate referral for diagnostic and other specialist services.

GPs are the cornerstone upon which a high quality, cost effective health care system is founded. As the first point of contact and primary care provider, the general practitioner is responsible for coordinating the ongoing health care of the patient. The referral of patients from GPs to specialists is one of the strengths of the Australian health system. The referral serves as a formal link between the specialist and general practitioner, providing valuable communication towards optimal patient care.

Referral of patients to specialist medical practitioners from practitioners other than the patient's general practitioner may lead to unnecessary referrals, and fragmentation and loss of continuity of care, which may expose patients to unnecessary harm without producing any worthwhile benefits.

Evidence available about nurse referrals for diagnostic services (Thurston and Field, 1996) indicates that in the Emergency Department they order more investigations, which incur higher costs and delay discharge of patients, without necessarily improving patient outcomes. Nurse practitioners also took longer to assess patients and because of their narrow scope of practice were more expensive to employ than junior doctors. (Robinson and Inyang, 1999) Therefore claims about decreased cost and increased convenience must be treated with caution.

Where patients may not have a regular general practitioner, such as homeless people, local agreed models of care may be developed to facilitate access to specialist services.

AMA(Victoria) opposes recommendation 29, which proposes that nurse practitioners should have admitting rights to hospitals. Admitting rights to hospitals are a privilege granted, where the hospital has a demonstrated need, to the most senior members of the medical profession, based on evidence of qualifications and expertise. In larger public hospitals, the medical practitioner is usually appointed to a clinical unit, the members of which have similar professional interests and qualifications. Specialist trainees and other junior doctors are appointed to that clinical unit to provide 24-hour care to its patients, under the direction of the unit specialists. This unit structure establishes clear lines of responsibility and communication, which enhance the likelihood of patients receiving the right care at the right time. This outcome is further facilitated by locating unit patients on one ward or in close geographical proximity to each other so that nursing, paramedical and medical staff develop a shared understanding of the expected management of each patient. This clinical unit structure optimises the chances of safe and effective health care

It is unclear how nurse practitioners with admitting rights can be harmoniously integrated into this process. Further, it is unclear how nurse practitioners working outside the unit structure will be able to ensure patients have access to the safeguards inherent in the unit structure.

While granting admitting rights to nurse practitioners will at best have only marginal impact with respect to improving access to care, it is certain that it will prove to be very disruptive to the orderly running of hospitals and will lead to many other unintended consequences.

Conclusion

1. AMA(Victoria) believes that safe and effective health care is best achieved by nurses and other health professionals working collaboratively with medical practitioners. As nurse prescribing, initiation of specialist referrals and nurse admitting rights undermine collaborative practice, AMA (Victoria) dissents from these recommendations.
2. Improved access to health care in rural and remote areas requires a comprehensive response by all tiers of Government, professional organisations and the community.
3. Nurses who are currently employed in the health system at an advanced level of practice, must receive due recognition and be encouraged to continue to work to improve health care in Victoria.

Appendix 7 — RACGP, Victorian Faculty: Dissenting View

The Royal Australian College of General Practitioners (RACGP) – Victorian Faculty dissents from Recommendation 2 and supports the following wording for this recommendation:

> *Recommendation 2: That nurse practitioners be recognised as legitimate providers of health care services in Victoria in collaboration with medical practitioners and that the implementation of the role of nurse practitioners be in areas of locally agreed need and not restricted by sector or geographic location.*

The National Council of the RACGP issued the following position statement on nurse practitioners in Australia at the National Council meeting on 12 December 1999:

1. The RACGP reaffirms the role of the general practitioner as the key provider of primary medical care to the Australian community.
2. The RACGP has a continuing commitment to improve the health of the Australian community and supports the role of nurse practitioners within the context of the primary health care team, especially in rural and remote areas.
3. The RACGP opposes the use of nurse practitioners as substitutes for general practitioner services.
4. Where registered nurses are currently working at an advanced practice level in areas of medical service need, the RACGP supports the development of a nationally consistent collaborative model of practice for nurse practitioners. Such a model is based on a complementary relationship between the general practitioner (GP) and the nurse practitioner.
5. Key features of such a collaborative model are:
   - The establishment of a local committee of stakeholders, including local GPs, the local ambulance service / flying doctors, the local hospital and State / local government , other allied health professionals to:
     - ◊ assess the need for a nurse practitioner position;
     - ◊ draw up protocols and clinical guidelines for the position on the basis of local need;
     - ◊ draw up protocols for the limited ordering of diagnostic tests and imaging, and
     - ◊ establish protocols for the issue of prescription drugs from an agreed imprest.[10]
   - The nomination of a GP to provide support for the nurse practitioner and give advice on dosages, dressings, drugs and management in more difficult or complex cases;
   - Referral to the GP by the nurse practitioner for assessment when clinical guidelines and protocols are not readily implementable;
   - Referral to specialists through the GP;
   - Accreditation for all nurses applying for recognition and appointment to nurse practitioner positions;
   - Adequate insurance arrangements by the employers of nurse practitioners to protect patients in the event of mishap.
6. The RACGP opposes the concept of 'independent' nurse practitioners.

[10] An imprest being a stock of drugs akin to a ward stock, which has been duly authorised by a medical practitioner and properly dispensed with normal dosages written on the labels.

7. The RACGP opposes the provision of provider numbers to nurse practitioners, including provider numbers which confer rights to prescribe, refer or order diagnostic tests under the Medicare Benefits Scheme or the Pharmaceutical Benefits Scheme.
8. The RACGP will work with nursing professional organisations on the development of standards, guidelines and protocols to support collaborative nurse practitioner roles as well as other medical practice based and practice outreach nursing roles.
9. The RACGP will continue to support government initiatives to increase and to support the GP workforce in rural and remote areas, and other areas of medical service need.

Discussion

The RACGP policy on the establishment of nurse practitioner positions in Victoria rests on the concept of 'locally agreed need'. This concept was first established in the New South Wales Nurse Practitioner Project and obtained round table agreement from the multi-disciplinary steering committee. As explained above, 'locally agreed need' involves consultation with all local health service stakeholders about the need for the nurse practitioner position, the establishment of mechanisms to integrate the nurse practitioner services with the existing health services and, in collaboration with nurse practitioners, the development of local policies and protocols to support their work. Local GPs can be consulted through the RACGP and local Divisions of General Practice.

'Locally agreed need' provides the following benefits for nurse practitioner positions:

Benefits for Teamwork

The definition of a nurse practitioner incorporates the collaborative nature of the role: 'an essential member of an interdependent healthcare team'.[11] But collaboration requires the establishment of mutual goals and agreed roles[12] to guide the integration of the services of the health care professionals. Then all involved understand why and how they are to work towards health care objectives. Without this communication and understanding, healthcare professionals do not collaborate effectively and patients are left in a disconnected web of health care providers. A 'locally agreed committee' of managers, professionals and consumers will prevent this happening without giving any one person the right to veto the nurse practitioner position.

Benefits for Healthcare Systems in Victoria

There is no evidence that the nurse practitioner role can replace more cheaply any existing professionals in the Australian healthcare system. In fact they may be more expensive per item of service as shown in an Australian comparison between GPs and nurse practitioners in the provision of Pap Smears.[13] Yet, in collaboration with medical practitioners, nurse practitioners can extend the capacity of the existing health service by reaching geographically or socially isolated populations. Collaboration between practitioners underpins this practice because nurse practitioners are excellent at providing health screening and education and the treatment of minor injury and illness but must cooperate with medical practitioners for more complex and serious health problems. Locally agreed committees can ensure this support for the nurse practitioner exists.

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11 Recommendation 1, Nurse Practitioner Taskforce: Final Report. Department of Human Services, Victoria.

12 Collaboration definition, Nurse Practitioner Taskforce: Final Report. Department of Human Services, Victoria, p.5.

13 Dickinson J. Measuring the cost of nurse practitioners. *Australian Journal of Public Health* Vol 16 No 3, 1992: p. 214

Benefit for Patient Care

Nurse practitioners in collaboration with medical practitioners can provide improved quality of care for patients with chronic illness and disease. Nurse practitioners provide expert help in managing chronic illnesses such as asthma, diabetes, and heart disease in collaboration medical practitioners. They provide ongoing monitoring, education and support for lifestyle change and are adept at detecting abnormalities and deterioration in their patients' health. However nurse practitioners again require close collaboration with medical practitioners for the management of these changes.

The RACGP argues that nurse practitioners require adequate and workable systems of collaboration between health professionals to provide good patient care. Isolated nurse practitioners 'independent' from medical practitioners cannot provide the same range or depth of service to patients and will face health needs beyond their capacities. The RACGP believes that nurse practitioner positions in Victoria should be established in consultation with the community and existing health professionals including GPs according to 'locally agreed need.' Only this system will ensure effective collaboration between nurse practitioners and medical practitioners and this is why it is a necessary precondition for the RACGP support for nurse practitioner positions in Victoria.

List of Acronyms

AACN	American Association of Colleges of Nursing
ACCC	Australian Competition and Consumer Commission
ANA	American Nurses Association
ANCI	Australian Nursing Council Incorporated
AOTC	Ambulance Officers Training Centre
CNS	Clinical Nurse Specialist
DHSS	Department of Health and Social Security
GP	General Practitioner
HACC	Home and Community Care
HECS	Higher Education Contribution Scheme
HIC	Health Insurance Commission
INC	International Council of Nurses
MACON	Ministerial Advisory Committee on Nursing
MBS	Medicare Benefit Schedule
MPS	Multi Purpose Services
NBV	Nurses Board of Victoria
NH&MRC	National Health and Medical Research Council
NP	Nurse Practitioner
PA	Physician's Assistant
PAC	Poisons Advisory Committee
PBS	Pharmaceutical Benefits Scheme
PHACS	Primary Health and Community Support
PREP	Post Registration Education and Practice project
PTG Act	*Poisons and Therapeutic Goods Act 1966*
RCNA	Royal College of Nursing, Australia
RPL	Recognition of Prior Learning
UKCC	United Kingdom Central Council of Nursing, Midwifery, and Health Visiting
VAHEC	Victorian Association of Health and Extended Care
WHO	World Health Organisation

Glossary

Nurse Practitioner (Victoria)

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.[14]

Advanced Nursing Practice

Generally refers to an expanded and multifaceted clinical nursing role, encompassing collaboration with other disciplines. (Nurse Executives of New Zealand, 1998; Department of Human Services, Victoria, 1997; ANA, 1997; NSW Department of Health, 1996; Van der Horst, 1992; Patterson and Haddad, 1992)

Advanced Practice Nurse (USA)

'Advanced practice nurse', as used in the United States of America (USA), is an umbrella term given to a registered nurse who has met advanced clinical practice and educational requirements (ANA, 1997). These nurses demonstrate a high level of professional autonomy, conduct comprehensive health assessments, and have expert skills in the diagnosis and treatment of complex responses of individuals, families and communities to actual or potential health problems. Working in collaboration with other health care professionals, the advanced practice nurse formulates clinical decisions to manage acute and chronic illness and to promote health. The advanced practice nurse integrates advanced clinical practice with education, research, management, leadership, and consultation (ANA, 1991).

Collaboration

Collaboration involves working together in a joint effort toward a commonality of goals with mutual respect for individual decisions and practice. It is defined as a flexible process of ongoing interaction, cooperation and creativity between individuals from a number of disciplines involving interdependent decision making in relation to the direction of patient care and recognition of separate and combined spheres of activity and responsibility. (Lassen et al., 1997; Norsen, Opladen and Quinn, 1995; Alpert et al., 1992; Fagin 1992)

Accreditation

Refers to the validation of the quality of an education program. The process usually involves assessment of the elements of a program against predetermined criteria to determine whether the course meets the minimum standards set by a relevant body such as a university or a registration board. (Gibson and Lawson, 1996)

Credentialling

Credentialling is a mechanism for ensuring that competency is current within a specific area of practice. The focus of credentialling is on the performance of an individual against appropriate practice standards/competencies.

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[14] Adapted from the definition of a Nurse Practitioner developed by the Working Party in the NSW Nurse Practitioner Review (Stage 2 Vol 1 & 11, 1993, p. 3/5). This is a working definition that will be reviewed as part of the evaluation of the Victorian Nurse Practitioner models of practice.

Best Practice

Best practice is a comprehensive, integrated and cooperative approach to the continuous improvement of all areas of an organisation's operations. (Commonwealth Department of Health and Family Services, 1996) It is distinguished by the synthesis of evidence from different sources, a focus on consumers, the engagement of both management and service practitioners in the process of benchmarking, and the recognition that it is often necessary or desirable to modify service delivery practices according to local factors (such as culture or resources) if optimum effectiveness is to be attained. (Renhard, 1996; Legge et al., 1996; Commonwealth Department of Health and Family Services, 1996)

Prescribing

The provision by a medical or other designated professional, after clinical assessment of a patient, of written instructions for the dispensing and administration of a drug or remedy. (NH&MRC, 1998)

Protection of Title legislation

This refers to provisions within health professional registration Acts, such as the *Nurses Act 1993*, which restrict the use of certain titles, such as registered nurse, and make it an offence for any person who is not registered from using that title or holding themselves out to the public as being registered.

Protection of Practice legislation

This refers to provisions within a registered Act which define the practice of a particular profession and make it an offence for any person who is not registered from practising the profession.

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