

National Nursing & Nursing Education Taskforce (N3ET)



SCOPES OF PRACTICE Commentary Paper



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SCOPES OF PRACTICE

COMMENTARY PAPER

Message from the Chair

This commentary paper on **Scopes of Practice** is one step in long journey.

It will be a journey that challenges Australian nurses and midwives to examine aspects of professional life and practice, and the contribution that nurses and midwives make to health service delivery. It is an opportunity to explore how we can do things differently so that this contribution is strengthened and enhanced in the future.

This paper marks the start of the journey by presenting a perspective of the landscape and terrain that surround nurses and midwives and their practice at this time. It is hoped that by taking stock of the current influences and elements that shape the landscape of nursing and midwifery practice, the way forward will become clearer.

We value the views of the many stakeholders and encourage you to engage in this process.

Adjunct Professor Belinda Moyes
Chair of the National Nursing & Nursing Education Taskforce

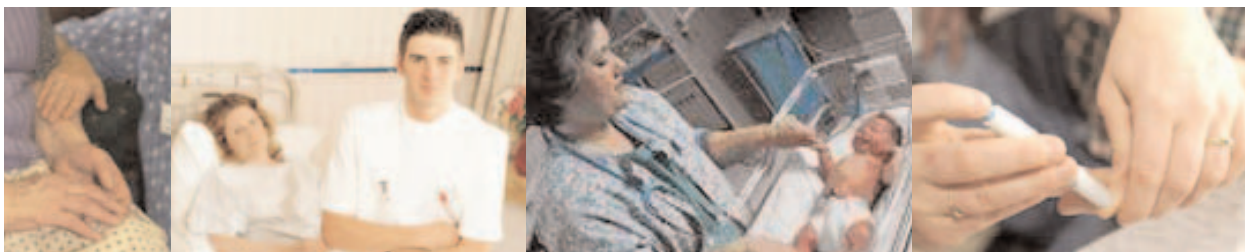
NATIONAL NURSING & NURSING EDUCATION TASKFORCE (N³ET)

The National Nursing & Nursing Education Taskforce (N³ET) was appointed in November 2003 to implement recommendations of the National Review of Nursing Education – Our Duty of Care report. The Taskforce brings together some of Australia's leading nursing and nursing education and training specialists who have been nominated for their leadership qualities and collective expertise. Members of the Taskforce are supported by a Secretariat located within, and supported by, the Department of Human Services, Victoria.

The Taskforce is “committed to an enhanced and sustainable healthcare system through the promotion of professional visibility and pride, quality education, regulation to nationally consistent standards, and capacity building in practice, education and research for nurses and midwives across Australia” (National Nursing and Nursing Education Taskforce 2003).

The Taskforce has the following terms of reference:

- To consider and develop proposals for implementation of the recommendations of the National Review of Nursing Education referred to the Taskforce by AHMC
- To report to AHMC, MCEETYA and ANTA MINCO on implementation of the National Review of Nursing Education recommendations referred to the Taskforce
- To consider and provide recommendations on any other nursing workforce or nursing education and training issues referred by AHMC such as reports of the Australian Health Workforce Advisory Committee
- To progress and report on implementation of recommendations on any other nursing workforce and nursing education and training issues approved by AHMC that are consistent with the Taskforce's priorities
- To progress implementation of the above recommendations, including the development and execution of individual projects, under a workplan approved by AHMAC
- To operate for two years with continuation being subject to review by Health and Education and Training Ministers.



N³ET Membership

Chair

Adjunct Professor Belinda Moyes

Nominee of the Australian Minister for Health and Ageing

Ms Rosemary Bryant	Executive Director Royal College of Nursing, Australia
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Nominee of the Australian Minister for Education & Training

Professor Jill White	Dean, Faculty of Nursing, Midwifery and Health University of Technology Sydney
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Nominee of the Ministerial Council for Education, Employment, Training and Youth Affairs

Professor Pauline Nugent	Head, School of Nursing Deakin University, Victoria
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Nominees of State & Territory Health Ministers

Professor Mary Chiarella (Nov 2003 – Jul 2004)	Chief Nursing Officer Department of Health, NSW
Adjunct Prof Kathy Baker (since Aug 2004)	Chief Nursing Officer Department of Health, NSW
Ms Fiona Stoker	Principal Nursing Adviser Department of Health & Human Services, TAS

Nominees of the Australian National Training Authority Ministerial Council

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Ms Di Lawson	Chief Executive Officer Community Services and Health Industry Skills Council

Nominee – Private Sector

Ms Sue Macri	Executive Director Australian Nursing Homes & Extended Care Association (NSW)
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Introduction

The Australian public makes a significant investment in the health workforce and in return expects effective, safe, quality care that improves the health and wellbeing of the Australian community (Australian Health Ministers' Conference 2004).

Nurses and midwives make a vital contribution to the health, aged care and community services system in Australia, working across a range of settings, and in diverse capacities and roles. (National Review of Nursing Education 2002, p.11)

The nature of health care is continually changing as the Australian population ages and as medical science and technology provides new and improved ways of managing health and illness. The health dollar is limited so it is important that we look to the future and develop the capacity of the health workforce to meet the challenges that lie ahead. The factors that are driving and shaping development of the health workforce are discussed further in [Section 3](#).

The recommendations of the National Review of Nursing Education - Our Duty of Care (2002)¹ (Our Duty of Care / the Review) are forward looking and aim to ensure effective capitalisation on the nursing and midwifery workforce investment.

The Review made 36 recommendations, encompassing issues that face nurses and midwives every day such as skill mix, work organisation, augmentation and retention of the current nursing and midwifery workforce, training of care assistants, funding of clinical education and national education standards for nurses and midwives. All but one recommendation, (Recommendation 2²) of the Review, have been accepted by the Australian Health Ministers.

Health workforce fact

Nurses and midwives comprise about 30% of all people working in health occupations, and about 54% of health professionals.

(Australian Institute of Health and Welfare 2002)

The National Nursing and Nursing Education Taskforce

A number of the recommendations impacting on nurses and midwives at a national level have been referred to the National Nursing and Nursing Education Taskforce (The Taskforce). The Taskforce is a lead vehicle for major nursing and midwifery education and workforce reforms in Australia.

The changes that will be effected through the work of the Taskforce and others implementing recommendations, will be far reaching and involve many stakeholders.

The Taskforce is committed to working in partnership with those who have an interest in the future of nursing and midwifery, and health service delivery to complete this work, as it is only through consultation, cooperation and collaboration that effective outcomes will be achieved.

Recommendation 4: Nationally consistent scope of practice

As work on implementing the recommendations proceeds it has become evident that Recommendation 4: A nationally consistent scope of practice, is central to the activities and recommendations.

1. The National Review of Nursing Education - Our Duty of Care (2002) is the final report of the National Review of Nursing Education. Established by the Commonwealth Government in 2001, the Review examined the future education needs of nurses in the health, community and aged care sectors and advised on appropriate education policy and funding frameworks.

2. The Health Ministers did not support Recommendation 2, which called for establishment of a National Nursing Council of Australia. It was agreed that it was preferable to undertake national action centred on the work of the National Nursing and Nursing Education Taskforce.



Recommendation 4 focuses on bringing a national perspective, and national consistency to dimensions of nurses' and midwives' practice, education and professional regulation. The recommendation is:

To promote a professional scope of practice for nurses and greater consistency across Australia:

- a) a nationally consistent framework should be developed that allows all nurses to work within a professional scope of practice, including the administration of medications by enrolled nurses
- b) to facilitate this development, all Commonwealth, State and Territory legislation and regulations that impact on nursing should be reviewed and reformed as required.

(National Review of Nursing Education, p.19).

How will Recommendation 4 be implemented?

This **Scopes of Practice Commentary Paper** is part of a suite of activities planned to progress the work on: *A nationally consistent scope of practice* (Recommendation 4). The paper seeks to promote a dialogue between nurses and midwives and it is hoped that the content of the paper will foster vigorous debate and discussion in the myriad of workplaces where nurses and midwives contend with such issues each day.

The follow up to this paper will be a **Scope of Practice Symposium** on 30th March 2005, at which attendees will be invited to debate the complexities and challenges involved with implementing a national framework for scopes of practice and how to address them.

It is anticipated that the Symposium will identify area of work that need to be progressed.

Details of the Scope of Practice activities can be found on the [National Nursing and Nursing Education Taskforce website](#).

Why have a Commentary Paper on Scopes of Practice?

Clearly, to be able to implement a framework for nationally consistent scopes of practice there first must be agreement on what a scope of practice is (or is not).

To many, this will seem “a given”. Don't all nurses and midwives understand their scope of practice and through their actions with each client/patient³ demonstrate that awareness? Doesn't that indicate that we all share a common view of how scopes of practice operate?

Whilst Recommendation 4 identifies the broad direction and principles that should underpin a nationally consistent approach to scopes of practice for nurses and midwives, it does not describe the steps needed to progress towards this goal.

To advance the work, there will need to be agreement by stakeholders on the purpose and nature of the framework before it can be put “into practice”.

In particular, this will require the key stakeholders to work together to overcome the barriers to national consistency and those very practices, views and positions that have contributed to diversity (or inconsistency) will need to be tackled.

This paper marks a beginning step in the process of working towards a national framework for **scopes of practice** for nurses and midwives by providing a commentary on aspects of **scopes of practice** that were introduced in the Review, and by beginning to explore the complexities and challenges around the work required to implement this recommendation.

3. It is acknowledged that there is considerable debate surrounding the labelling of recipients of nursing and midwifery services. In this paper, the patient /client refers to the full spectrum of consumers of health services.

SECTION 1

Who are the stakeholders?

Australian, State and Territory Governments, nurse and midwife regulatory authorities (NRAs), Australian Nursing and Midwifery Council (ANMC), education providers, peak nursing bodies, National Nursing Organisations (NNOs), unions, employers, specialist nursing interest groups, colleges, nurses, midwives, other health occupations and consumers of health care.

It is the nature of this paper that more questions are raised than answered.

It is hoped that through reading this **Commentary Paper**, nurses and midwives, and those with an interest in their practice, will be prompted to delve deeper into issues linked to scopes of practice, to peel back the layers of understanding, examine assumptions, biases and perspectives, and to think differently about the way scopes of practice for nurses and midwives are currently constructed. The Taskforce hopes that in engaging with this type of inquiry, the stakeholders will be open to contemplating new possibilities and potentials.

What is covered in this Commentary Paper?

To understand how this paper functions it is necessary to clarify what it is not doing. Firstly, it should be noted that this paper does not reinvestigate the ground that has been comprehensively explored by the National Review of Nursing Education, as the Our Duty of Care report (2002) was underpinned by extensive consultation, research, data, and literature.

Therefore, to achieve the outcomes intended by the National Review of Nursing Education, stakeholders will need to consider difficult and complex questions that this paper attempts to articulate and explore, such as:

- *What drives a scope of practice?*
- *What is a scope of practice?*

- *What might be the key elements of a definition and/or description of a nurse or midwife's scope of practice?*
- *How can we represent the relationship between nurses' and midwives' scopes of practice and that of other health occupations?*
- *Who (which organisation/body) is best positioned to determine the professional activities consistent with a scope of practice?*
- *Under which circumstances should a scope of practice be extended or expanded?*
- *What is the best way to enable and sustain scopes of practice so they can adapt to changing demand?*
- *To what extent should scopes of practice be regulated?*
- *How can this be done so that the public interest is protected while at the same time, flexibility and responsiveness is preserved?*
- *What might the key elements of a national framework look like?*
- *What needs to happen at the local, jurisdictional and national levels to implement an agreed, consistent approach to scopes of practice?*

More importantly this commentary paper **does not seek to:**

- Comprehensively analyse scopes of practice
- Propose definitions of scopes of practice
- Describe scopes of practice, or
- Prescribe definitive “solutions”/ a way forward.

It is the view of the Taskforce that it would be premature to undertake activities such as describing or analysing scopes of practice, before there was agreement on the way in which scopes of practice should be constructed.

In preparing this paper, the Taskforce is aware that considerable work has, and is being undertaken by stakeholders such as nurse/midwife regulatory

authorities (NRAs), in the States and Territories and at the national level. While this paper itself may not do justice to this work, the Taskforce acknowledges that it will be essential to reflect on the experiences and outcomes of these initiatives to arrive at a national consensus on a way forward.

Finally, this is just one way of looking at the issues around national consistency. It does not necessarily reflect the views of any or all of the Taskforce. Readers may not agree with the commentary. The point for readers though is to question why.

Who is this Commentary Paper for?

This **Commentary Paper** has been written to reach a wide audience, including nurses and midwives wherever they work and whatever work they are engaged in, employers, education and training providers, governments and policy makers, health workforce planners and regulators.

The issues it raises are fundamental to nurses and midwives, and will resonate equally with those that are currently preparing to enter practice as with those that are seen as leaders in any of the many practice domains of the profession.

Those that work with nurses and midwives or those receiving their services may also be interested in this work.

Nurses and midwives

In this paper “**nurses**” refers to Registered and Enrolled Nurses (Division 2 Registered Nurse in Victoria) and “**midwives**” refers to those registered, endorsed, licensed or authorised to practice midwifery. It is acknowledged that the debate about the scopes of practice of nurses and midwives must respect, value and accommodate the interplay that exists between all members of the team.

It is also acknowledged that there is considerable debate over the relationship between nurses and midwives and whether they are indeed separate and distinct discipline areas.

In Australia, midwives are registered and regulated under the same legislation that applies to nurses. However there is no uniformity around the way they are recognised. In some states midwives have a protected title, while in others they are registered in the same division as registered nurses. In some cases, midwifery qualifications are noted on the register, the nurse’s registration endorsed, or the nurse may be authorised to practice midwifery.

The debate has been coming to a head with the emergence of “direct entry” midwives; that is Bachelor of Midwifery graduates, who are seeking registration to practice as midwives, and not as nurses.

In deference to sensitivities around this debate, throughout this Commentary Paper, there has been a conscious attempt to ensure the text is inclusive of midwives. Hence, wherever practicable, the paper refers to “nurses” and “midwives”. In some places the discussion focuses on nurses, but readers should be open to considering whether these issues might just as readily apply to midwives.

For this same reason, and in recognition of the diversity of nurses’ and midwives’ practice there has been a conscious attempt to refer to multiple **scopes of practice**.

The complexities of diversity and plurality in practice will be further explored in the following sections of this paper.

Sections of this Commentary Paper

This Commentary Paper raises a number of complex issues that are interrelated and at times even circular. Whilst the paper is written to lead readers through the issues in an order that is hopefully logical, the sections are also intended to have sufficient integrity that they can be read separately.

An overview of the sections has been included (Figure 1) as a map to guide this journey and readers can move through the post introductory

SECTION 1

sections of the Commentary Paper in an order that makes the most sense to them.

In addition to the usual referencing system there are some notes on *Suggested Further Readings* at the end of each section that are related to the issues raised in that section. These are recommended to further inform the reading of this commentary.

To set the scene, Section 2 of this paper locates nurses' and midwives' scopes of practice within the current national health workforce context. Section 3 contains a review of the key factors that are impacting on the way we currently work in health. Section 4 explores what a scope of practice is and what drives changes in scopes of practice. The enablers of practice are explored in Section 5 and some of the ways of differentiating scopes of practice are examined in Section 6. The regulation of scopes of practice is the subject of section 7. Finally section 8 begins to explore what a national framework for scopes of practice for nurses and midwives might look like and highlights some of the challenges in striving for greater national consistency.

About words

Undoubtedly, words and text carry different meanings for various audiences, and different audiences have preferred ways of expressing similar ideas.

We may think we all mean the same thing when we say **scope of practice** but each of us will have a unique perspective of what it means. To highlight this point we have asked people to say what **scope of practice** means to them and used examples to illustrate a particular perspective or viewpoint throughout the paper. There is no right answer or definition. Many of the quotes exemplify that *“where you stand depends on where you sit”*.

This Commentary Paper does not take a particular stance on language or lexicon, but rather seeks to sensitise us to these many perspectives that need to be acknowledged and then reconciled if we are to achieve greater consistency.

It is also the case that different words may imply same or similar meanings, or may be intended to do so.

Indeed, this point becomes evident throughout the discussion and is a foundational premise on which this paper is based. For example, Chiarella (2001) found that there was a lack of consistency in approaches to regulating scopes of practice, and in part this was due to different definitions and understandings of what a scope of practice is. This was further compounded by confusion in the language used to describe scopes of practice, for example, use of terms *“enhanced”*, *“advanced”*, *“extended”* and *“specialist”*.

Throughout this paper, words have been used with the intention of implying “common sense”, rather than theoretical meanings. For ease of reading, where certain terms have a particular meaning, they have been explained in the text or footnotes. Undoubtedly, there will still be debate over meanings and it is hoped that this debate will inform the dialogue around achieving greater consistency.

An invitation to all stakeholders

Through this paper, the National Nursing and Nursing Education Taskforce is sharing the formative thinking that is shaping the direction that the work on nurses' and midwives' scopes of practice is taking.

The Taskforce invites you to join in exploring the complexities and challenges that are emerging as together we begin to navigate a course through this difficult and uncharted landscape.

Section 1

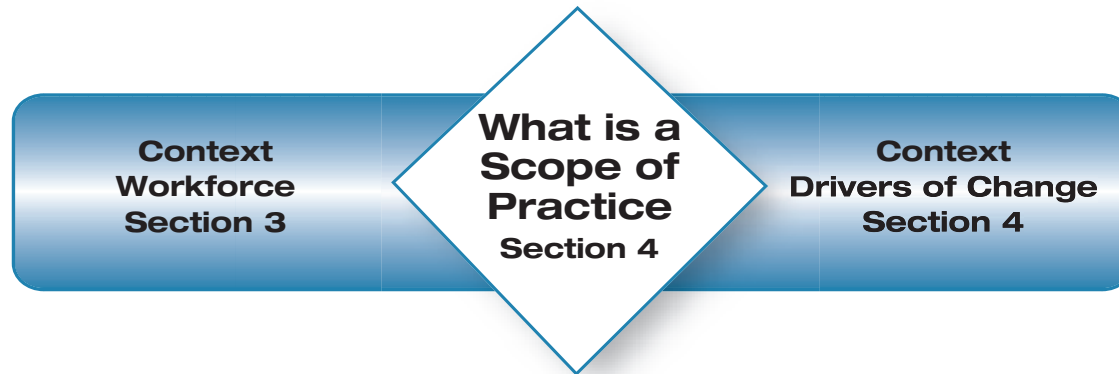
Suggested Further Reading

- Excerpts from Our Duty of Care, including 5.3 Regulation and legislation have been appended to this Commentary Paper. It is highly recommended that readers revisit the final report as well as the following sections of the National Review of Nursing Education: Nursing Regulation and Practice (2002):
 - 5.3.1 Factors influencing scope of practice
 - 5.3.2 Scope of Practice – enrolled nurses
 - 5.3.3 Future directions – guiding principles.
- More information on the Global Nursing Initiative can be found at the International Council of Nurses website at <http://www.icn.ch>

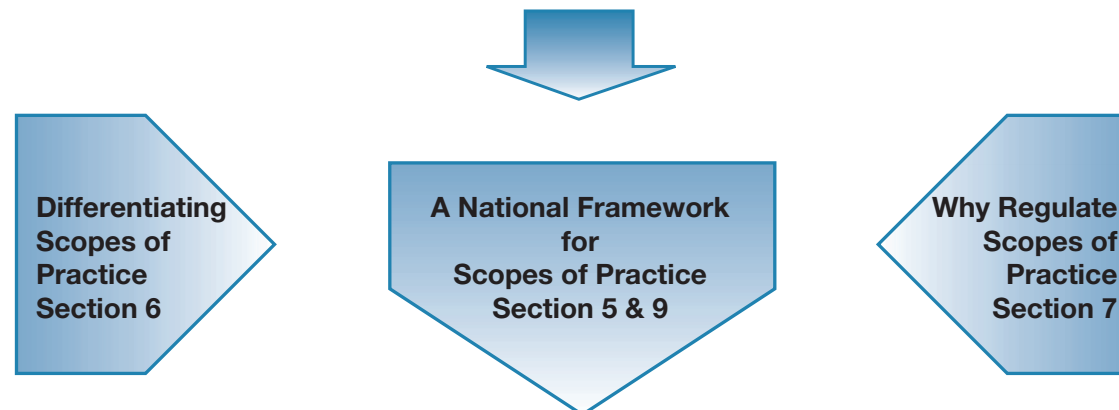
SCOPES OF PRACTICE

COMMENTARY PAPER

SECTION 1



Enablers of Practice - Section 5



An overview of the Recommendation

Our *Duty of Care (2002)* identified that there are a number of barriers to nursing development, many of which flow from the fragmentation arising from the different funding and policy responsibilities of the Australian, State and Territory Governments. It further argued that to realise the potential of nurses⁴, the removal of these barriers would need to occur in a coordinated, national manner. The new approach to nursing and scope of practice will recognise the diversity of nurses and nursing work, and be characterised by its:

- Responsiveness to change
- Flexibility of workforce structure and work organisation, and
- National approach to coverage (p.117).

Our Duty of Care (2002) maintains that the strength of the nursing profession in Australia lies in its flexibility, diversity and responsiveness to change, and the holistic approach to care that is unique to nursing philosophies. This is a strength that the Taskforce seeks to harness and capitalise on in the context of implementing a nationally consistent framework for scopes of practice.

In this section some of the issues raised by the Review related to a national approach to scopes of practice for nurses and midwives are outlined.

Why do we need a national framework for scopes of practice?

There are a range of ways to conceptualise scopes of practice and some of the approaches (including legislative approaches) to this that have been developed by the Australian States and Territories and some from overseas have been described in *Our Duty of Care (2002)*.

Highlighted throughout the Report is the lack of legislative uniformity currently governing nurses' and midwives' scopes of practice across Australia, including how they are defined, described, and regulated. Without a national approach, anomalous arrangements can develop that limit the flexibility of the nursing workforce.

The Report suggests that because of Mutual Recognition legislation⁵, the effects of differing approaches to scopes of practice impact most on enrolled nurses' practice, particularly in the area of medication administration and on the evolving practice domains of nurse practitioners.

Medication management has been a source of concern for nurses and employers particularly in the residential and aged care sector. The role of enrolled nurses with respect to medication administration in particular has been reportedly associated with decreased utilisation of this group of nurses and an increase in the use of other groups of workers (Aged Care Enrolled Nurse Working Party 2003).

Case Study #1 – Examples of disparities in ENs training & medication administration

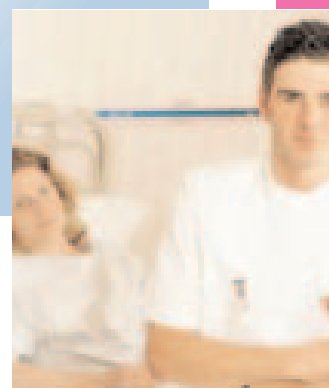
In Queensland, ENs who have completed accredited post-enrolment training or who have completed recent pre-enrolment training including medication management and are endorsed, may administer up to schedule 4 medications by all routes except IV, epidural/intrathecal, intraperitoneal and intraventricular routes.

In Victoria, Division 2 registered nurses (ENs) who have completed an accredited post-registration course and are endorsed may administer schedules 1 to 4, 8 and 9 medications via oral and topical routes, but not by injection.

In WA, pre-enrolment training includes medication management. ENs may administer up to

4. Our Duty of Care defined the nursing workforce in the broadest sense as encompassing registered nurses, (general and specialist), midwives and mental health nurses, enrolled nurses, nurse practitioners, nurse managers, nurse educators from both health and education sectors and trained care assistants (p.8).

5. Mutual Recognition legislation requires that practitioners from regulated professions are entitled to recognition of their registration by regulatory authorities across Australia and New Zealand provided that the dimensions of their practice are substantially equivalent for the registration category.



SECTION 2

Schedule 4 medications, as part of standard/normal practice. Endorsement of registration is not required.

Nurse practitioners (NP) is also an area where despite the lessons from other countries, the development of the role (and scope) to date has not occurred in a coordinated and strategic way nationally.

Enrolled nurses also reported to the Review that their scope of practice with respect to other aspects of care, differed not only between jurisdictions, but between employment settings and often between clinical areas within the one employment setting. An enrolled nurse might be permitted to undertake sets of tasks, skills or responsibilities in one workplace. The same practice by the Enrolled Nurse may be restricted in another.

As noted by the Review there have been quite different approaches to the development of nurse practitioner role across the States/Territories. Some jurisdictions have taken a liberal approach, leaving the regulation of practice to the NRA, while others have used statutory instruments such as legislation, schedules and regulations to draw the extent and limits of NP practice.

The effect has been a lack of clarity of the potential of the NP role both within the profession and by others (such as employers and consumers).

Case Study #2 – Nurse practitioners

The development of nurse practitioners (NP) in Australia already demonstrates considerable differences across those jurisdictions where the role has been implemented.

For example:

In South Australia, the applicant asking to be authorised by the NRA defines their scope of practice. This may be by defining a specific client group. The minimum level of preparation is Graduate Diploma. In SA, NPs determine their own formulary for prescribing and this is then authorised by the Nurses Board South Australia (after review by relevant Drug Advisory Committee).

In NSW, the NRA recognises NPs in six broad areas of practice, maternal and child health, high dependency, rehabilitation and habilitation, medical/surgical and community health nursing.

Educational preparation is Masters level. Medications that can be prescribed by NPs pertain to the individual NP position and as incorporated in the relevant clinical guidelines.

Consistency in scopes of practice therefore, offers substantial benefits for nurses and midwives, their employers, workforce planners and policy makers on a number of levels.

The development of a national framework for scopes of practice presents an opportunity to promote the strengths and enhance the potential capacity of the nursing and midwifery workforce to respond to future health care challenges in meaningful and beneficial ways for the Australian public.

National consistency is not always about “all being the same”

It is evident there are multiple dimensions to Recommendation 4, and this implies that a strategic and multifaceted approach will be required to achieve the outcomes intended by the Review.

It is the view of the Taskforce that this work should not be viewed as the impetus to describe in detail the minutiae of nursing activity. Rather, *Our Duty of Care* promotes a national framework to bring consistency in two main ways, that is:

- Consistency in **what is included in the scope of practice** of nurses and midwives of similar categories or groups across Australia (such as enrolled nurses or midwives), and
- National consistency in the approach to **managing** scopes of practice.

In this context, “managing” scopes of practice may include uniform approaches to defining or describing, regulating, and making decisions about extending scopes of practice.

Consistency is important but not sufficient argument in itself, to warrant attention and effort. However, if greater opportunities and benefit can be reached through increased uniformity, and the advantages that come from diversity can also be preserved, then the gains will outweigh the risks.

It is also important that a national framework or model for nursing and midwifery scopes of practice is located within the broader policy framework for health workforce planning in Australia. In particular, the Taskforce is committed to aligning this work with the vision, goals and principles of the National Health Workforce Strategic Framework, which defines the focus for Australian health workforce development.

Understanding and realigning health practitioners' scopes of practice is clearly part of a national agenda that has implications for the way nurses and midwives might practice in the future. Given the changing context of health, this work provides nurses and midwives with a timely opportunity to critically reflect on the customs and conventions that frame nursing and midwifery practice as well as health service culture.

It is a remarkable opportunity to actively examine and dismantle the barriers to effective utilisation of the nursing workforce and the impediments to the professional growth of the nursing and midwifery disciplines.

REFLECTIONS ON SECTION 2

To date nursing and midwifery scopes of practice have developed in a fragmented way. This has resulted in variation in what nurses and midwives can do and may have limited the potential of these disciplines.

Greater consistency (such as a national framework for scopes of practice) would offer benefits for nurses and midwives, and for the Australian public.

Consideration would need to be given to how greater consistency can be achieved and how that consistency can be maintained over time.

Section 2

Suggested Further Reading:

- The work by Chiarella (2002) and McMillan (2002) for the Review describes the approaches to scope of practice within legislation both within Australia and internationally. The research and Review papers for the Review can be found at <http://www.dest.gov.au/highered/programmes/nursing/reports.htm#papers>
- The Australian and State/Territory Health Ministers have developed the National Health Workforce Strategic Framework (Australian Health Ministers' Conference 2004) to give direction to the development of the national health workforce over the next 10 years. The framework and associated action plan can be found at:

http://www.health.nsw.gov.au/amwac/pdf/NHW_stratfwork_AHMC_2004.pdf

Taking stock - What factors are influencing the way we work in health?

The health system in Australia is complex and dynamic, with many types of providers of services and a range of funding and regulatory mechanisms. The factors influencing the demand for care are similarly complex and interrelated including:

- The average growth rate of the Australian population of just 1.2% means the population is ageing (Australian Bureau of Statistics 2004; Australian Health Ministers' Conference 2004).
- Scientific knowledge and technological advances are driving changes in models of care delivery (Armstrong and Armstrong 2002; National Review of Nursing Education 2002; Australian Health Workforce Officials Committee 2003):
- Health care consumers are becoming more informed and involved in how and where services will be delivered. At the same time they are demanding greater accountability and value from the services for which they pay (National Review of Nursing Education 2002; Australian Health Workforce Officials Committee 2003).

In this section some of the factors that are currently affecting the health workforce and in particular nursing and midwifery are explored.

The effectiveness of the health system in achieving its goals is ultimately a function of its performance as a system.

(Australian Institute of Health and Welfare 2004)

The structure and functioning of the health care workforce is critical to the functioning of the overall health system

(Duckett 2000)

The Australian health care system is also evolving in a global context, where health concerns are not confined or limited to national boundaries. The immediacy of international travel and information and communications technology brings global events to our doorstep and compels the Australian health community to respond to international

phenomena and events. The Australian health system, and its professionals, has to be prepared to deal with pandemics (such as avian flu and SARS), HIV/AIDS, terrorism and natural disasters.

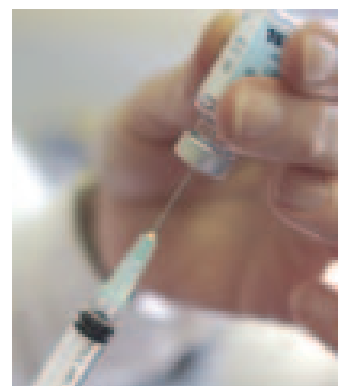
These represent some of the factors that are shaping demand for health care and informing the delivery of health services, setting a trend which is expected to continue over the next twenty to thirty years (Australian Health Ministers' Conference 2004).

Health workforce shortages

To meet the growing demand for care will require a skilled workforce in increasing numbers and while the national workforce currently grows at a rate of 170,000 per year this is predicted to be just 12,500 per year by 2020. (Australian Institute of Health and Welfare 2002; Australian Institute of Health and Welfare 2004).

For the health workforce this means that in the future there will be greater competition to recruit potential workers to the health industry and potentially fewer workers per capita to meet the demands of a burgeoning health service and aged care industry (Australian Health Ministers' Conference 2004).

More specifically this will mean that with fewer people working in health, there will also be fewer people to work in nursing and midwifery.



Health workforce facts

- According to the ABS Census, there were 450,792 people in Australia who were employed in health occupations in 2001.
- In 2002, there were approximately 209,000 registered nurses/midwives (80%), and 51,000 enrolled nurses (20%).
- Despite increased numbers of new graduates entering the workforce between 1995 and 2001 total registrations only grew by 0.4%
- Nurses and midwives are the fastest ageing group within the health workforce. The average age of the employed nurses increased from 39.3 years in 1995 to 42.2 years in 2001.

(Australian Institute of Health and Welfare 2003).

Nursing shortages

Nurses and midwives are already in short in supply, with shortages of nurses and midwives being experienced across Australia and internationally (Australian Health Workforce Advisory Committee 2004). As highlighted by Buchan (2002),

Nursing shortages are not just a problem for the nursing profession, they are “a health system problem that undermines health system effectiveness and requires health system solutions” (p.43).

In recent years there has been a number of national nursing/midwifery workforce studies, which indicate current and projected nurse shortfalls of significant proportions (Australian Health Workforce Advisory Committee 2002; Australian Health Workforce Advisory Committee 2002; Johnson and Preston 2002; Karmel and Li 2002; Shah and Burke 2002).

State and Territory Governments have also recognised the issue and conducted reviews of nursing recruitment and retention in an attempt to address workforce supply issues (Department of

Human Services Victoria 2001; New South Wales Health 2002).

In response, jurisdictions and employers are implementing a range of strategies to recruit and retain nurses and midwives including improved pay and career structures, safer working conditions and support for education in identified areas of shortage.

The Australian Government has also implemented measures to augment the nursing workforce including identifying nursing as a National Priority Area within education, and increasing the Government’s contribution to assist with the costs of providing clinical education and additional undergraduate nursing places. (Department of Education Science and Training 2004).

There is evidence that these strategies have been successful in improving recruitment and retention (Preston 2001).

Case Study #3 – Recruitment and retention

In response to the recommendations of the Victorian Nurse Recruitment and Retention Committee Report (Department of Human Services Victoria 2001), the Department of Human Services (Vic) put in place a comprehensive recruitment and retention strategy, which resulted in more than 4000 nurses returning to the workforce.

(Victorian Government Minister of Health 2003)

Yet, despite these efforts, nursing shortages abound in all states/territories and in a number of skills areas including aged care, community, critical/intensive care, and mental health.

So-called “general” nurses, midwives and enrolled nurses are also in short supply⁶. (Department of Employment and Workplace Relations 2003; Coulter 2004).

6. DEWR defines shortages: “when employers are unable to fill, or have considerable difficulty in filling, vacancies in an occupation, or specialised skill needs, within that occupation at current levels of remuneration and conditions of employment, and reasonably accessible location” (p.11). A national shortage is declared if there are shortages in the three largest states, or in a majority of states Department of Employment and Workplace Relations (2003). National and State Skill Shortage Lists Australia, Coulter, N., Department of Employment and Workplace Relations Canberra, (2004). Re: NSS List..

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Ongoing and worsening shortages of nurses and midwives are predicted to continue into the future with certain ramifications for delivery of health services.

Nurse workforce planning

There is a growing body of evidence that indicates that the proportion of suitably qualified and experienced nurses in the workforce positively affects patient outcomes (Aiken, Clarke et al. 2002; Needleman, Buerhaus et al. 2002; Aiken, Clarke et al. 2003; Needleman and Buerhaus 2003). At the same time, workforce projections are predicting that in the future there will be a diminishing pool of workers in the health industry including nursing and midwifery. This creates a dilemma for workforce planners as they consider the future development of the nursing and midwifery workforce.

Historically, nurse workforce planning has occurred at State and Territory level using different approaches and data. Recognising the need for consistency and coordination in nurse workforce planning, the Australian Health Workforce Advisory Committee (AHWAC) has recently published a guide to nurse workforce planning to assist State and Territories to meet local and national workforce demands (Australian Health Workforce Advisory Committee 2004).

The guide points out that while there is a range of approaches to workforce planning, there is a trend towards putting aside traditional assumptions about **scopes of practice** and clearly demarked occupational categories.

Government policy on workforce planning and development

Governments have a direct role and responsibility for planning and developing the health workforce to ensure its capability and capacity to meet current and future health care needs.

In this climate of rapid change and workforce shortage, the present and future capability of the health workforce has come in question. Given the predictions about future trends in the health workforce, there will need to be changes to models of services delivery along with changes to nature and composition of the workforce.

The Government's policy is that a strategic direction is required so that Australia's investment in the health workforce is directed towards ensuring "equitable, accessible, sustainable, timely and safe health care for the Australian public both now and in the future" (Australian Health Ministers' Conference 2004).

National Health Workforce Strategic Framework (NHWSF)

The Australian and State/Territory Health Ministers have developed the National Health Workforce Strategic Framework to give direction to the development of the national health workforce over the next 10 years.

The framework outlines a vision, guiding principles and strategies, and provides a blueprint for activity to develop the whole of the national health workforce. It is based on the understanding that the health system in Australia is in a constant state of evolution as it responds to the complex and ever changing health needs of the Australian population

(Australian Health Ministers' Conference 2004)

The principles outlined in the NHWSF represent a new, and somewhat pragmatic approach to health workforce planning, that is not reliant on fitting health care into the existing capacity of professional practice. It is more about ensuring that the "right practitioners are in the right place at the right time with the right skills (Australian Health Workforce Advisory Committee 2004).

The aim is to address changing requirements for health service or unsustainable workforce supply to maintain or achieve acceptable or enhanced levels of care or health outcomes (Australian Health Workforce Advisory Committee 2004).

Future directions – changing the workforce skill mix

Australia's health resources are limited, with health expenditure amounting to more than 9.3% of Gross Domestic Product (GDP) (based on 2001-02 figures: Australian Institute of Health and Welfare 2004), and continued growth in spending on health by Australians from their own pockets.

There is a strong argument that Australians cannot have everything they want from the health system (Menadue 2004). This means that the community must make choices about how the health dollar is best spent; and this involves choices about the composition, skills and distribution of work of the health workforce.

The NHWSF (Australian Health Ministers' Conference 2004) advises that to meet emerging health service needs:

“...complementary realignment of existing workforce roles or the creation of new roles may be necessary...”

(Principle 5: p.15).

Changes to workforce skill mix can be brought about through enhancing or extending the roles or scopes of practice of a particular health worker group; by substituting or expanding the breadth of some roles across professional boundaries; through delegation; and by creating new jobs and new workers.

While current pay structures, regulatory requirements and professional standards and codes may pose barriers to extending the scope of practice for some occupational groups, these forces are not immutable – they can be changed in order to better meet the community's needs.

The nature of the health workforce, nationally and internationally, is already changing with the evolution

in recent years of health worker roles such as Indigenous Health Workers, Aged Care Workers, Medical Assistants⁷, a range of technicians and assistants (including monitor technicians, renal dialysis technicians, specimen collection technicians) and generic health workers⁸. The review of the Health Industry Training package highlights that there is considerable employer and industry driven demand for development of a range of new technologist roles to meet existing and predicted service/skills gaps (Community Services and Health Industry Skills Council 2004; Pikulinski 2004).

At the same time, health work that was once considered “nursing” is now interpreted within a social paradigm as *personal care* or *life style support* and carried out by a range of community service workers such as personal care attendants and disability officers (Nurses Board South Australia 2003).

It is conceivable that in the future the range of new and expanded health worker occupations and roles will continue to develop and diversify. It also follows that new health occupations may evolve specialised and autonomous spheres of practice. While it might be argued that proliferation of health worker roles leads to risks of fragmentation of care, it should be acknowledged that these roles are evolving in response to industry service demands.

What does this mean for nurses and midwives?

Predictions about the future of health care and the vision outlined in the National Health Workforce Strategic Framework provide the context of nursing in the next decade.

As a result of their large number and capacity to practice across many different areas of health service, it is nurses that offers the greatest

7. VET competencies are currently being developed in QLD for GP assistants, who will assist doctors working in general practice.

8. A course is proposed for trial in Victoria, to prepare Generic Health Workers, who will work under the direction of a range of health disciplines. It is proposed that this course would articulate with higher study for practice in range of allied health disciplines.

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opportunity to achieve rapid and far reaching health reform (National Review of Nursing Education 2002).

It is evident that health service and workforce planners are interested in understanding not just nurses and midwives' scopes of practice but those of all health occupations and professions (their roles, activities, tasks, skills sets and functions), and how the various health occupations work together to provide services to the Australian community.

There are increasing calls on health professionals to articulate and define their domains of professional practice, so that the gaps and overlaps as well as the points of tension and flexibility can be openly explored.

A national framework for scopes of practice might assist nurses and midwives to engage with, and influence health workforce planning at a national level, by providing a:

- Unified and coherent way of expressing/representing nursing/midwifery work; and
- Systematic and coordinated approach to dismantling the barriers to expanding scopes of practice.

In this way, there can be effective allocation of resources to the development of the nursing and midwifery workforce, leading to optimisation of the contribution of nurses and midwives to the provision of health care in the future.

REFLECTIONS ON SECTION 3

To make a relevant and valuable contribution to health care in the future, nurses and midwives need to be open to the possibility of new roles and scopes of practice that extend into realms that are considered beyond, peripheral to, or not part of practice as it is understood today.

A nationally consistent framework for scopes of practice for nurses and midwives needs to be consistent with the vision, principles and strategies outlined in the National Health Workforce Strategic Framework. It is important that nurses and midwives are aligned with the national direction, and that they situate their present and future scopes of practice in relation to the broader health workforce.

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Suggested Further Reading:

- Nursing Workforce Planning in Australia (Australian Health Workforce Advisory Committee 2004) a general resource document on nursing workforce planning in Australia.
- The CSHISC discussion paper for the review of the Health Training Package (Community Services and Health Industry Skills Council 2004). This paper is available from the CSHISC website <http://www.cshisc.com.au/index.asp>
- The Nurses Board of South Australia's Summary of Issues Paper: Inquiry into the Role and Function of Unregulated Care Workers in South Australia (Nurses Board South Australia 2003). This paper describes the wide range of settings outside of the health sector in which these workers operate and is instructive in that it details the complexity of the issue and the need to consider the issue in a broader context than nursing.

What is a “Scope of Practice”?

Nursing and midwifery are practice disciplines, therefore talking about a scope of practice can be viewed as an attempt to define the margins of practice as well as the core of the discipline. In this section the factors contributing to how scopes of practice are formed are explored.

In the healthcare context, scopes of practice translate to what workers do in the course of employment. Healthcare work is made possible (or **enabled**), through a range of mechanisms including:

- authorisation at various levels (including legislation and statutory regulation)
- education and credentialing
- policy and funding structures
- standards regulating the workplace and industrial agreements and
- professional and workplace culture.

At present we do not have a universally accepted definition of **scope of practice**. The National Review of Nursing Education adopted a definition of nurses’ **scope of practice** drawn from the Queensland Nursing Council Scope of Practice Decision Making Framework:

“...that which nurses are educated, authorised and competent to perform.

The actual scope of practice is influenced by the context in which nursing takes place, the health needs of people, the level of competence of the nurse and the policy requirements of the service provider.”

(National Review of Nursing Education 2001; National Review of Nursing Education Australia 2002).

This definition is broad enough to apply to any health care setting, nursing activity or nursing role and it is a definition that has growing acceptance in

the nursing community both nationally and internationally (Australian Nursing and Midwifery Council. 2003; Royal College of Nursing UK 2003).

While it is an elegantly concise definition it approaches the issue somewhat obliquely, implying an unlimited potential and ill-defined boundaries.

In contrast, a more pragmatic approach to defining scope of practice is taken by health workforce planners. To facilitate integrated workforce planning⁹ at a national level, a more reductionist approach is required to be able to effectively plan. Knowing “*who can do what*” in terms of skills, tasks or healthcare interventions means that the number of workers with those abilities can be calculated.

From this perspective, **scopes of practice** refers to:

The nature, extent and limitations placed on a worker’s/practitioner’s work/practice.

(Kendall and Lissauer 2003; Australian Health Workforce Advisory Committee 2004).

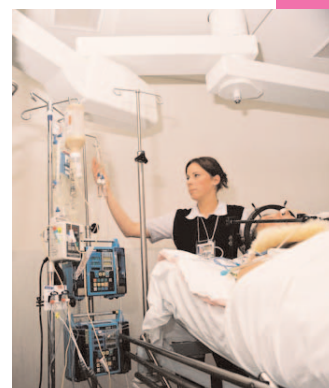
This approach also implies that all health workers have a scope of practice, even those workers that would not normally be classified as professionals or engaging in professional practice.

For nurses, as with other health professionals, this is a contentious view, as there is strong argument against reducing professional practice to lists of tasks, skills, roles or responsibilities.

What is meant by a “professional scope of practice”?

A tenet of professionalism is that disciplines (or professional groups) have a unique perspective they bring to bear on their work (Royal

9. The model proposed by Buchan, J. and N. Edwards (2000). “Nursing numbers in Britain: the argument for workforce planning.” *British Medical Journal* 320: 1067-1070., describes “integrated workforce planning” as having three dimensions, that are: integration of workforce planning with operational/service planning, integration of workforce planning for groups of workers (such as nurses, allied health) to reflect skill changes and the planning to achieve integration of multidisciplinary teams (including non-professional workers).



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College of Nursing UK 2003, Nurses Board South Australia, 2004; National Review of Nursing Education 2001; National Review of Nursing Education 2002.

Such uniqueness derives from the discipline's body of knowledge and research, perspective of the patient, health, illness and care; philosophy, professional governance and codes of conduct and practice.

There is however now a widening gap between the existing professional culture and community expectations of professional service. This view is challenging the "traditional 19th century" paradigm of professionalism that has permeated medical, health professional and health service culture. A new view of professionalism is crystallising in the wake of inquiries such as the Bristol Royal Infirmary, the Shipman case and the Inquiry into Obstetrics and Gynaecological Services at King Edward Memorial Hospital (Davies 1996; Australian Council For Safety And Quality In Health Care 2002; Davies 2004; Irvine 2004).

The new model of "patient centred professionalism" is characterised by consumers, governments and funding agencies demanding greater accountability and transparency in relation to regulation of health professionals including:

- Risk and disclosure
- Setting, monitoring and compliance with professional standards
- Defining what is acceptable practice
- Professional values that are consistent with the values important to the public
- Evidence based practice, and
- Robust approaches to revalidating the fitness of individuals to practice

Patient centred professionalism has implications for the ways health occupational groups construct and regulate their scopes of practice. It could be argued that as health professionals provide services to the community; the community therefore has a say in shaping their practice and the services they provide.

To be responsive, health professionals are obliged to develop their scopes of practice in line with community expectations and needs. This will undoubtedly need to include consideration of the broader national policy for the development of the whole of the health workforce, which is reflective of the community's objectives.

If professionals construct their services in such a way that they are not attractive to, or responsive to, the community's needs, the profession risks becoming redundant.

What lies within the scope of professional practice is therefore, subject to enhancement, negotiation and re-visioning for the benefit of the community.

Why have scopes of practice?

Scopes of practice for health practitioners, function in a number of ways to shape what practitioners do, the contribution they make to health service delivery and health outcomes, how they see themselves as practitioners and the image that they have in the eyes of the public.

For example, scopes of practice can:

- Provide guidance to practitioners and employers about what can or cannot be expected of a practitioner
- Form part the regulatory framework for health practitioners
- Be used to legally protect certain acts thereby limiting competition and protecting professional interests
- Inform the educational requirements and content of educational programs
- Inform the way groups of health workers work, and
- Assist policy makers and health workforce planners in relation to models of service delivery, workforce development and the allocation of health and education resources.

It is clear then that scopes of practice may serve more than one purpose at any given time, reflecting a range of stakeholder interest. A scope of practice can enable practice by providing authorisation, or indeed can limit practice by articulating boundaries. This is discussed further in **Section 5**.

Are Scopes of Practice static?

Over time, scopes of practice evolve as both the health care needs of the community and the demands of the healthcare sector mould what it is that nurses, midwives and other health professionals do.

Indeed, mostly changes occur without deliberate intent, strategic planning or intervention, and where this is the case, it is likely that practice change precedes practice regulation. Terms such as “role drift” and “role overlap” characterise this passive change in the work done by particular groups.

Some of the more potent and overt drivers of change impacting on scope of practice include government policy and funding directions, the industrial negotiation process, employer demand for skills and services, changes in health care needs/ models of service delivery and innovations in medical and communications technology (Australian Health Workforce Advisory Committee 2004).

As workers acquire new skill sets, expertise or dimensions of practice, they may let go of, or divest others. In turn, other groups of health workers may subsequently develop education and competence for the work that has been “left”. Similarly, where the scopes of practice of several groups of health workers overlap roles may be negotiated to improve access and service delivery. In this way the boundaries of scopes of practice are fluid, as over time the nature of what is, and is not part of normal or accepted practice changes.

Just as importantly the forces that shape scopes of practice are also in turn shaped by scopes of practice. A nurse or midwife’s scope of practice may be shaped by the content of an educational program undertaken to provide knowledge and

skills in preparation for practice in specific practice areas. At the same time, changes to scope of practice evolving within the clinical environment may drive the development of new educational programs/content. An example of this reciprocal relationship is the inclusion of modules on epidural management in pre-registration programs for registered nurses.

Our Duty of Care supports the view of nursing as an evolving discipline, but also contends that:

“nursing is defined by its practice which, in turn, is characterised by distinctive traditions, skills, knowledge, values and qualities” (p.45).

The predicted changes to Australia’s health system (such as the trend to increased specialisation and diversification) make it likely that nurses and midwives will develop knowledge, skills and expertise that enable them to practice competently, indeed expertly, with independent decision-making. These new roles and positions may be beyond, peripheral to, or extensions to the traditional core of nursing practice.

Conversely, as other health workers develop their roles, it is possible that their expertise in areas of practice might exceed that of nurses making nursing services in some areas redundant.

Case Study #4 – Nurse endoscopists (UK)

As part of a strategy to meet demand for gastroenterology services in the UK a major service improvement initiative is underway.

Government policy drivers for this change include the introduction of bowel cancer screening program to commence in 2006 across England, policies to deliver greater patient choice in investigation/treatment options and the NHS Cancer Plan and quality concerns (following a audit reported in medical journal).

£8.2 million over 3 years has been provided to support integrated endoscopy training that is being provided in 10 new training centres. Training includes Nurse Endoscopists who are then contributing

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additional capacity and flexibility to endoscopy services.

Further, a recent audit found that 75% of Endoscopy centres surveyed across the UK employed Nurse Endoscopists to provide diagnostic endoscopy services (and increasingly, interventional treatments).

(National Health Service 2004; National Confidential Enquiry into Patient Outcome and Death 2004)

The change process

Where change to a scope of practice is conscious and planned, the processes for managing the change need to be clear, transparent, coordinated and inclusive.

In Australia, NRAs play an integral role in determining and regulating scopes of practice for nurses and midwives either through direct legislated responsibility or through provisions that grant discretionary powers to formulate policies for the guidance of nurses and midwives practice.¹⁰

(2000; National Review of Nursing Education 2002; 2003; 2004).

While currently NRAs have responsibility for determining and regulating nurses' and midwives' scopes of practice, the processes for arriving at a scope of practice are not uniform across Australia, leaving questions about:

- The evidence underpinning changes and restrictions to practice boundaries
- Who should be involved and how appropriate consultation is undertaken
- Ways of validating scope of practice changes and reviewing the outcomes or impact of change

- Consideration given to the impact of scopes of practice changes on the whole of health workforce, and
- The supports that need to be in place to enable and sustain new or changed scopes of practice.

Negotiating stakeholder interests

Changing scopes of practice requires nurses and midwives to negotiate a range of interests including the profession, health consumers, policy makers, governments and other funding bodies, insurers, regulators, employers, education and training providers, professional organisations, unions and other care related workers. The emergent expectations about professional standards and transparency mean that broad and open consultation needs to underpin the change process.

Major changes to scopes of practice are more likely to succeed with the sponsorship and support of governments, regulatory authorities and key stakeholders and indeed governments and regulatory authorities often work in partnership to facilitate major change such as:

- where legislative reform is involved
- where the changes have broader implications for workforce and health service delivery, or
- if a practice is considered risky or intrusive.

Whilst each of the stakeholders brings a different perspective to the deliberations, it is unclear in this process whether certain agendas are privileged more than others. For example, does or should the Government's national workforce agenda have more influence over scope of practice decisions than a union agenda?

10. NRAs in Queensland, South Australia and Tasmania have a clear legislated responsibility to determine the scopes of practice for nurses and midwives. In other jurisdictions, the statutory instruments regulating nurses make provision for NRAs to formulate guidelines, standards or codes of practice and conduct for the guidance of nurses and midwives, giving the discretionary power to determine the scopes of practice of registered practitioners.

It is also unclear the extent to which the views of other health occupation groups are or should be solicited, even though they are at liberty to contribute to open consultations, and whether these views have any influence over the final product.

Major change to a scope of practice takes considerable time and is the product of intentional, strategic and coordinated activity to overcome the barriers to change, and to ensure the viability of new roles into the future.

For example, it is not unusual for the process of amending legislation to take more than 12 months as Governments follow the prescribed processes for evaluating the impact of proposed amendments, draft and schedule a bill for debate in the Parliament, and for Royal assent to be granted. Similarly, it takes time to develop and accredit appropriate education and training programs to support scopes of practice and for NRAs to develop professional standards, codes and guidelines.

While time and due process are clearly necessary to achieve effective outcomes, long delays in implementing changes to scopes of practice results in a lag between identifying a workforce need (an opportunity for nurses) and filling it.

It could be argued that this leaves a window for new roles for vocationally trained workers, perhaps with less regulatory restraints, to emerge in response to industry need.

There is a view that in a climate of deregulation, there is unwillingness by governments to regulate new practice and groups of health workers. This opens the debate about the type of mechanisms that should be instituted to ensure protection of the public interest. These issues are explored further in **Section 7**.

To ensure that nurses and midwives are able to respond to emerging needs by diversifying and take on new roles, there needs to be a systematic and considered approach to the planning and development of scopes of practice.

At the same time we need an approach that is not encumbered by unnecessary process or regulation, an approach that allows for timely change.

In the interests of achieving national consistency, a national framework for scopes of practice might provide a mechanism for strategic coordination of activity across jurisdictions, especially where multiple stakeholder groups are involved.

REFLECTIONS ON SECTION 4

The Australian public is challenging health professionals to respond to their needs in a different way and this requires health professionals to rethink how their services are positioned.

A national framework for scopes of practice needs to be based on stakeholder's agreement.

In the interests of achieving national consistency, a national framework for scopes of practice might provide a mechanism for strategic coordination of activity across jurisdictions, especially where multiple stakeholder groups are involved.

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Suggested Further Reading:

- The report into the Bristol Royal Infirmary (the Kennedy Report) is available from NHS Quality Improvement Scotland at <http://www.bristol-inquiry.org.uk/>
- Information about the Shipman Inquiry is located on <http://www.the-shipman-inquiry.org.uk/home.asp>
- Information about the Inquiry into Obstetrics and Gynaecological Services at King Edward Memorial Hospital Inquiry can be found at the <http://www.safetyandquality.org> (Australian Council For Safety And Quality In Health Care 2002)
- Irvine (2004) Time for hard decisions and patient centred professionalism.

Viability of practice - Enabling and sustaining scopes of practice

It is evident that scopes of practice evolve in response to a range of factors, however this is not always a straightforward process, especially where change is radical or imposed.

This paper adopts a broad and practical view of the dimensions of the health environment that make scopes of practice for nurses and midwives feasible and possible. This includes those forces and factors that provide the power, authority or sanction, the means, knowledge and opportunity as well as the operational capacity for nurses to practice. These we refer to as the **enablers** of scopes of practice.

In this section the following enablers of practice are discussed:

- Government policy and funding
- Statutory regulation
- Professional standards, codes and guidelines
- Education, training and competencies
- Professional indemnity and insurance
- Professional and workplace culture
- Workplace relations
- Technology.

In reading this section, it will become evident that the factors that can function as barriers to practice (or to expanding scopes of practice) are the same factors that are critical to the viability over time of how practitioners work.

Government policy and funding

The central role that Government plays in health workforce is reflected in the many government policies that are driving issues such as legislation reform, workforce development, and funding priorities for health, education and training. The interplay of the various government policies creates a complex and changing environment for health workforce development.

Government policy therefore, plays a key role in enabling scopes of practice for health practitioners, while also prescribing the principle direction of future development.

Case Study #5 – Government as a driver of Scope of Practice change

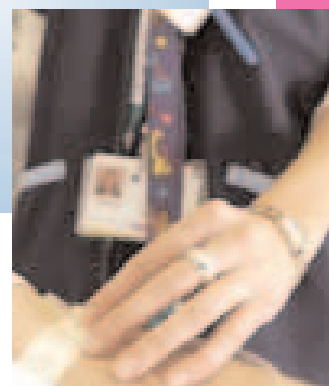
Recently one jurisdiction adopted, workforce strategy that included improving the utilisation of enrolled nurses in health and aged care settings.

Accordingly, the government dedicated resources to support the development of enrolled nurses' scope of practice in medication administration, and directed funding to develop training courses and to supplement the costs of training as an inducement to enrolled nurses for expanding and evolving their scopes.

To remain relevant in the changing context of health, nurses' and midwives' scopes of practice need to reflect these policy directions. At the same time, nurses and midwives need to develop and share a vision of their potential to practice, and to influence the shape of the political agenda and the direction of health policy.

Examples of National policy impacting directly & indirectly on nurses' and midwives' scopes of practice

- Mutual Recognition Legislation
- Trans-Tasman Mutual Recognition Agreement (TTMRA)
- National competition policy and principles (National Competition Act)
- National Health Priority Areas
- National Health Workforce Strategic Framework
- Our Universities: Backing Australia's Future
- Medicare



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Statutory regulation

The acts and statutory regulations that relate to nurses' and midwives' practice are part of a complex regulatory framework that provides for both the authorisation of practice and practitioners and restrictions to practice. Legislation may restrict areas of practice to certain appropriately qualified, credentialed or registered health professionals. While this may appear restrictive, legislation also enables those officially recognised or sanctioned to practice legally.

The regulation of scopes of practice is discussed in greater detail in **Section 7**.

Professional standards, codes, guidelines

As discussed in **Section 4**, nurse and midwife regulatory authorities (NRAs) have a legislated function to develop professional standards, codes of conduct and practice and guidelines to provide guidance for registered nurses and midwives about a range of professional matters, including what lies within their scope of practice.

Professional standards of this type are for protection of the public interest. They provide a mechanism for facilitating uniform high standards of practice by placing boundaries around the elements of a scope of practice that the NRA considers risky.

As it is a regulatory expectation that practitioners work within their scope of practice, and NRAs use scope of practice as indicators of professional conduct and practice boundaries, then NRAs have a responsibility to clarify practice boundaries for particular groups of practitioners.

The Competency Standards for Registered and Enrolled Nurses, the Code of Ethics for Nurses in Australia and the Code of Professional Conduct for Nurses in Australia (Australian Nursing and

Midwifery Council 2004) provide core guidance tools. In addition, NRAs in each jurisdiction also formulate additional tools to meet local needs (such as guidelines for the administration of medications by enrolled nurses).¹¹

With the exception of ANMC standards and codes, which are endorsed and adopted by all NRAs, there is a lack of national uniformity between State/Territory guidelines. This contributes to inconsistencies in scopes of practice.

Case Study #6 – Code of Practice for Nurse Practitioners

The Nurses Board of Western Australia has recently released a Code of Practice for Nurse Practitioners. (Nurses Board of Western Australia 2004)

The code provides guidance in the way NPs in that jurisdiction are expected to conduct themselves with respect to:

1. Respecting the knowledge and skills of other health professionals
2. Ensuring they have detailed knowledge of the science base for tests, investigations and medications, and
3. Awareness of laws pertaining to their practice

Arguably, these expectations are no different to that expected of any advanced practice nurse or indeed any nurse as these expectations are implicit in the ANMC Competencies and Code of Professional Conduct.

Credentialing

Employers and service providers have a responsibility to ensure safe and quality care. While professional registration provides a degree of assurance about an individual's competence to practice, employers may feel that additional benchmarks are warranted especially in relation to

11. For the most part where NRA codes, standards and guidelines are not statutory instruments and therefore not legally enforceable, they do inform the standards of practice expected of competent nurse, and may be used as a measure, or indicator, of a nurse or midwife's conduct and practice during an investigation of a complaint about professional misconduct, or during legal proceedings

high-risk practices. Credentialing or accreditation is one way of doing this.

Credentialing refers to a formal process used to verify the qualifications, experience professional standing and other relevant professional attributes of health practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality health care service within specific organisational environments (modified from (Australian Council for Safety and Quality in Health Care 2004). p.3.

There are two main approaches:

- Credentialing by employers
- Credentialing by professional organisations (or regulatory authorities).

Credentialing by employers

As part of clinical risk management employers are increasingly undertaking credentialing of aspects of practice for a range of health practitioners. This is seen especially in new or aspects of practice that are high-risk for certain employers.

For example there is widespread credentialing of nurses' practice in the application of acute pain management therapies such as patient controlled analgesia systems, epidural analgesia infusions and the management of fully implanted venous access devices.

Credentialing performed by employers is an important aspect of clinical risk management. However, as nurses and midwives expand their practice in new and different dimensions, the burden of credentialing increases and there is greater potential for disparity in the standards required for safe and quality practice, and greater diversity in scopes of practice.

Case Study #7 – ACSQHC credentialing work

Credentialing of medical practitioners by employers has a long tradition in Australia, and is considered a crucial aspect of quality and safety systems in health services.

The Australian Council for Safety and Quality in Health Care¹² (ACSQHC), has recently produced the "National Standard for Credentialing and Defining the Scope of Clinical Practice of Medical Practitioners

The purpose of the standard is to provide rigour, through a standardised approach, to credentialing and defining scopes of practice for medical practitioner by Australian health care organisations.

(Australian Council for Safety and Quality in Health Care 2004).

Credentialing by professional bodies

Credentialing of a professional's ongoing competence or expertise in a domain of practice is increasingly being undertaken by professional bodies. It is not a substitute for registration, though this relationship is complex as in practice. The requirements for registration and for demonstrating ongoing competence (a requirement by most NRAs for renewal of registration) and credentialing of practice may be the same, making it difficult to determine the benefits of the credential.

Systems of national credentialing of specialist practice offers greater consistency and assurances to employers, where there are inconsistencies in regulatory processes and recognition of nursing specialties.

There is a view that credentialing is part of a profession's responsibility to self-regulate its practice domain and its practitioners, with the objective of providing safe, quality care to the community.

12. This document is available from the ALSQHC website at <http://www.safetyandquality.org/>

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There is also a contrary view that credentialing may be anti-competitive if it places unwarranted restrictions on practice through exceptionally high standards that are difficult and costly to attain.

Case Study #8 – Credentialing in mental health

The ANZ College of Mental Health Nurses (ANZCMHN) criteria for credentialing criteria includes that "...first level practice in mental health nursing requires a Post-Graduate Diploma in Mental Health Nursing (or equivalent) or an undergraduate nursing degree with a minimum of one year specialist mental health nursing theory and 300 hours of mental health clinical experience..."

ANZCMHN Position Statement

http://www.anzcmhn.org/pdf/ANZCMHN_Education_Position_Statement.PDF

However NRAs recognise or register a range of qualifications at lower AQF levels as satisfying the criteria for registration as Mental health nurse. In some states, there is no requirement for additional education or training to work in mental health.

See also Case Study 9.1

A number of professional and specialist nursing groups have developed credentialing systems, (along with specialty competency standards), including Australian College Critical Care Nurses (ACCCN) who credentials practitioners in Advanced Life Support, ANZCMHN, Australian Association of Stomal Therapy Nurses and the Gastroenterology Nurses College of Australia.

The status of the credential, or its power to influence the way health professionals are perceived, is dependent on the recognition and support of the professional group, employers and policy makers.

Case Study #9 – Examples of credentialing and funding policy

Example 9.1

Under the Australian Government's Allied Health and Dental Care initiative (Nov 2004)¹³ benefits payable under Medicare have been expanded to include a range of mental health services provided by allied health professionals, including mental health nurses. Through this mechanism, credentialed mental health nurses are recognised within the policy and funding framework, and consequently have more opportunities to engage in private practice.

Example 9.2

The new MBS item (10998) extends payment for pap smears taken by Practice Nurse in regional, rural or remote areas. These nurses must be appropriately qualified and trained - which includes being credentialed in states where this is available. RCNA provides a national credentialing services for practice nurses

If employers, the professional group members and the industry, do not perceive there are net benefits from employing credentialed practitioners, then the status of these practitioners is less certain.

Credentialing of specialist practice raises some interesting questions about how the standards for credentialing are developed, whether they are robust and consistent with the standards applied to other health practitioner groups, whether they are anticompetitive.

At the same time, there are issues around the credibility and authority of representative groups, such as specialty associations/groups, to formulate scopes of practice instead of, or on behalf of regulatory authorities. To fulfil this role, national organisations would need to have a mandate to represent their members, appropriate governance arrangements, and would need to meet agreed criteria and standards to establish their credentials as an authoritative and sanctioned representative of a specified group of nurses/midwives.

13. More information about the Allied Health professional providing funded services is available on http://www.hic.gov.au/providers/resources/incentives_allowances/medicare_initiatives/pa8666_eligibility_fact_sheet.pdf

More information about the Credentialing of practice is available from <http://www.anzcmhn.org/cred/index.html>

ANZCMHN Standards of Practice For Mental Health Nursing in Australia (May 1995) at <http://www.anzcmhn.org/>

National Practice Standards for the Mental Health Workforce <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-mhinfo-ems-work.htm>

Education, training and competencies

Education prepares and equips nurses and midwives for practice by providing them with a certain level of competence. At the same time, in accordance with the ANMC professional code of ethics, a nurse or midwife:

...must be aware that undertaking activities that are not within their scope of practice may compromise the safety of an individual. Scope of practice is based on each nurse's education, knowledge, competency, extent of experience and lawful authority"

(Australian Nursing and Midwifery Council 2004, p. 3).

Hence there is an established, but complex and somewhat circular, relationship between education, competence, and the regulation of scopes of practice.

A professional should not engage in aspects of practice without being competent. Education (either formal or informal) is required along a process for ratifying competence before the practitioner includes the element within their individual scope of practice.

So, while pre-registration education and ANMC competencies shape the limits of a nurse's scope of practice on entry to practice, they do not circumscribe or limit the nurse's actual or potential scope of practice.

Indeed, there is an implicit expectation that practitioners expand their repertoire of knowledge, skills and competence as they become immersed in professional practice. They learn formally through structured programs such as Graduate Nurse Programs and post graduate studies and informally "on the job". As they become more experienced and exposed to a range of practice settings, there is an expectation that nurses become more capable, confident and competent in different areas of practice.

An issue to be faced by NRAs in meeting their statutory duties is to decide how, education and

competencies should be formalised, standardised and accredited to facilitate (what could be considered) normal professional growth and evolution of scopes of practice.

Case Study #10 – Competencies

While ANMC competencies form one of the benchmarks for registration, competency standards for areas of specialised practice have been or are being developed by a range of non-regulatory organisations such as:

- Australian College of Critical Care Nurses
- Australian & New Zealand College of Mental Health Nurses
- Australian College of Operating Room Nurses
- Australian Sexual Health Nurses

The regulatory status of these competencies is unclear; mostly they are used to assess performance in courses leading to specialist qualifications and to assess professional performance in employment.

While there is a legislated mandate for NRAs to form standards for courses/education/training programs leading to registration and endorsement, this is problematic at a national level as there are different categories of registration, differences in the recognition of specialist titles, and a lack of uniformity in requirements of education (both undergraduate and post graduate) across the States/Territories.

Professional indemnity and insurance

Managing the risks associated with the provision of health care is a challenge for service providers, practitioners, insurers and the public. We have increasingly informed health consumers who demand and expect quality and value for their health dollar. Not all risk can be eliminated, and there is an increasing trend towards making more transparent decisions about what is acceptable risk (Irvine 2004).

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Scopes of practice contribute towards managing risk by limiting practice and those who can practice, or by prescribing and making transparent standards of professional practice in areas considered risky.

Scopes of practice however are only one element in the risk management matrix, which also includes:

- a rigorous approach to the registration of suitably qualified practitioners
- professional standards, codes and guidelines industry standards (eg. ACHS standards and Standards Australia), and
- a structured and systematic approach to risk management by employers and service providers (based on Australian Standards¹⁴)

The law requires that professionals (defined as a person who gives expert advice and/or service to another person) "...exercise skill at an appropriate level expected of that professional" (OAMPS 2004).

A professional therefore may be held liable for a mistake even though there may be no negligence involved. Ordinarily, employers would be held vicariously liable for an employee's negligent acts, errors and omissions occurring in the course of their employment (Royal College of Nursing Australia 2002). However there are circumstances where this might not be the case.

To ensure that both the public and nurses are adequately protected, some States/Territories NRAs issue policies and guidelines about the minimum terms and conditions of professional indemnity insurance for practitioners. Indemnity insurance is a mandatory requirement for registration/recognition of nurse and midwife practitioners and other independently employed nurses, and evidence of minimum insurance cover may be required to qualify for registration.

Case Study #11 – Independent midwives

The experience of independent midwives illustrates how difficulties in obtaining liability insurance constrain the scope of professional practice. Without an insurer willing to provide affordable indemnity insurance, independent midwives have been unable to practice as independent practitioners since 2001¹⁵.

This has ramifications for the viability of midwifery service models and the effective utilisation of midwives and their skills set.

The Northern Territory (NT) Government has recently announced a commitment to provide indemnity through the Department of Health and Community Services to independent midwives while they are unable to obtain such indemnity for themselves. This is based on similar successful models implemented in Western Australia and South Australia (Northern Territory Government 2004). In Victoria, the Compulsory Professional Indemnity Insurance policy is required for independent midwives (as well as nurse practitioners and nurses practicing acupuncture).

As nurses and midwives develop different roles and expand their scopes of practice in the future, it is likely that they will also develop greater potential for practice as self-employed and sole practitioners (eg. nurse consultants, advanced practitioners, nurse specialists). However, the ability of these practitioners to engage in independent practice, or to fully explore their potential in service delivery will be limited without access to affordable insurance (Australian Nursing Council and Australian Midwifery College Incorporated June 2004, p.6).

As nurses and midwives take on a range of health/therapeutic practices associated with greater risks, indemnity and health service insurers will inevitably make decisions about whether they will accept, and underwrite the risks associated with their expanded practice.

14. AS/ANZ 4360:2004 Risk Management provides the Australian standards for risk management applicable to a range of settings including health.

15. To assist in making medical indemnity premiums more affordable, the Australian Government now provides subsidies for eligible medical practitioners through the Premium Support Scheme (which replaced the Medical Indemnity Support Scheme). This type of support is currently not extended to nurses and midwives practicing independently.

Without indemnification of practice, both professionals and health consumers are exposed. It is not inconceivable then that insurers will increasingly have a say in prescribing scope of practice, education, policy frameworks and industry supports required to support high risk roles and practices.

Professional and workplace culture (myths and conventions)

Nursing (and midwifery) culture operates with the broader context of health and health service culture to inform the ways nurses, midwives, and others, understand and construct their scopes of practice, how they engage with other health occupation groups, how they respond to the challenge of change.

This is a fertile environment, where the cultures of health disciplines and health occupational groups interplay, as they jostle to establish their professional and practice domains.

Cultures are manifest in the distinct patterns of values, attitudes, practices, beliefs that inform the way members of a cultural group or subgroup, conceptualise or understand the world and their place in it.

(Hall 1997)

Case Study #12 is an example of cultures competing to dominate a world-view of health care and to influence public, professional and political perceptions of the capability of nurse practitioners to work in areas of advanced practice.

Case Study #12 – AMA Position on Nurse Practitioners

The AMA position opposing the introduction of nurse and independent midwife practitioners demonstrates how professional culture can be a staunch obstacle; opposing new scopes of practice for nurses.

...“Medical practitioners provide services which cannot be replaced by those rendered by nurses or nurse practitioners. Primary health care is the role of general medical practitioners who provide comprehensive, safe, efficient and cost effective care.”

*(Australian Medical Association 1994)
and re-released 2002.*

At the same time, internal cultural forces play out within nursing and midwifery. For example, workplace bullying¹⁷ or “horizontal violence” is common within nursing organisations and is the subject of ongoing concern. The prevailing culture of nursing is evident in the disillusionment of new graduates nurses who having been prepared to practice in one way are then acculturated into a more restrictive way of practicing when they enter the workplace.

On one level, it could be argued that nursing culture makes nursing unique and is fundamental to the contribution that nurses and midwives make to health service.

An alternative view is that by harbouring a “victim mentality”, by fostering the mystique around nursing, by developing esoteric nursing taxonomies and lexicons with little reference to established medical and health languages and by drawing distinct and inflexible boundaries around practice, nurses and midwives can be marginalised from the broader health workforce and the national agenda for a unified and cohesive health workforce.

17. Workplace bullying is “repeated, unreasonable behaviour directed towards an employee, or group of employees that create a risk to health and safety”. Worksafe Victoria (2003). Prevention of bullying and violence at work. Guidance Note., Worksafe Victoria.

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Myths, perceptions, conventions

Myths and misconceptions about nursing and midwifery scopes of practice and education impact on the effective and optimal utilisation of the skills these practitioners bring to health care.

For example, there is a widely held belief that, as enrolled nurses practise under supervision or direction of a registered nurse, they are restricted to performing “simple” or “basic” nursing care, and cannot perform invasive procedures or provide care for patients with complex needs, such as those with intravenous infusions and tracheostomies. This is compounded by a belief that enrolled nurses’ scope of practice is limited to their pre-enrolment/registration preparation.

Similarly, the effective utilisation of registered nurses is hampered by persistent myths such as *“female nurses cannot perform male catheterisations”, “nurses cannot replace gastrostomy tubes”, “nurses do not make independent clinical judgements”, and “nurses practice under a physician’s direction”*.

Misconceptions such as these are reiterated and given authority through health service policies, procedures and protocols. These types of myths and assumptions about nurses’ practice reflect outdated attitudes and beliefs and an ignorance of contemporary approaches to education, professional development and the national vision and direction for development of the health workforce. Similarly others have views about nurses and midwives such as *“nursing resists change”, “nursing doesn’t have a unified voice/is fragmented, and doesn’t know what it wants”*.

In some cases, resistance to expanding or reviewing scope of practice reflects a fear of professional role erosion and role realignment over the needs of the community.

Case Study #13 – Australian College of Critical Care Nurses

The recently released draft position statement on the use of “non-registered nurses and unlicensed assistants (including enrolled nurses) in intensive care, illustrates how the professional subgroups (such as critical care nurses) create a discourse to protect their practice domain, and in so doing, restrict opportunities for other groups of nurses.

Despite acknowledging the contribution of enrolled nurses in many settings, the statement contends that “...The introduction of less skilled personnel into the critical care environment would greatly increase the supervisory workload of the current workforce”.

(Australian College of Critical Care Nurses 2004, p.5)

Case Study #13 (above) could impact on enrolled nurses by creating a culture, which restricts their opportunities to learn, develop and practice new and advanced skills, and to work in specialised areas of practice. This type of response to nurses by nurses reflects a reluctance to respect the contribution of all healthcare workers.

Entrenched beliefs about nurses and midwives, and their scopes of practice are difficult to erode, but critical to the contribution that nurses and midwives can make to health. These beliefs underpin organisational conventions and provide a basis (albeit ill-informed) on which organisation policies and practices are built and perpetuated.

Workplace relations

Workplace relations play an important part in placing parameters around what workers can and cannot do in the context of their employment.

Workplace relations in Australia are governed by both Federal and State legislation. Under the Australian Constitution, the Federal Government is able to make laws about workplace relations. Where there is inconsistency between Federal and State legislation, Federal legislation prevails.

With the exception of a small number of independent (self employed) practitioners, the majority of nurses and midwives currently work as

employees of health services, with the terms and conditions of their employment established through state and federal awards and enterprise agreements. While there is some degree of consistency, wages and conditions can vary depending on the relevant State/Territory and the specific area of nursing (Australian Nursing Federation 2004).

Awards and Agreements may influence scopes of practice by imposing conditions and limitations on tasks, duties, responsibilities (acting in charge) and workload (nurse-patient ratios) of different categories of nurses. The categories used to differentiate work and entitlement are usually based on the career structure.

While the system of workplace relations in Australia provides some certainty and security for both employers and employees, it also poses challenges and barriers to achieving greater consistency in scopes of practice for nurses and midwives across Australia.

Nurse & midwives' industrial environment

In Australia, nurses and midwives are employed under:

- 424 state and federal awards
- more than 1889 certified agreements
- The various agreements have been negotiated separately resulting in:
 - different parties (& thus agendas) as signatories
 - different definitions/classifications
 - different career paths
 - different award entitlements, wages and conditions
 - different expiry dates

that frame the work that groups of nurses can and cannot do, resulting in disparity between like-groups of nurses across Australia.

(Wagenet 2004)

Firstly, negotiating changes to scopes of practice is challenging, especially where new practices impact on patterns of work and service delivery and have implications for other nurses and health workers. It could be argued that rather than run the industrial gauntlet it may be easier to create new roles for new health workers.

Secondly, achieving consistency in scopes of practice involves negotiating a difficult terrain of industrial impediments and a range of stakeholder interests.

A national framework for making decisions about scopes of practice might provide a structured approach to planning and negotiating changes over the longer term, and may overcome some of the barriers posed by the fragmentation which stems from the decentralisation of the Australian system of work relations.

Technology

In the contemporary context of technically mediated care, nurses have developed particular expertise working at the patient-technology interface, blending and blurring the boundaries of humanistic caring with technical management.

A synergy of technological advances is currently driving rapid and major change and innovation in the ways health services are delivered, particularly in the areas of:

- Diagnostics (such as point of care testing and telemetry)
- Therapeutic management (such as minimally invasive techniques)
- Informatics and communications (such as Personal Digital Assistants or PDAs and wireless communication devices)
- Education and Training (such as simulated training settings).

The potential of technology in health will be increasingly realised as we progress from stand alone devices to complex (and powerful)

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integrated systems. In combination, these technological advances create a nexus of opportunity for nurses and midwives to develop new and expanded scopes of practice (Talamini and Hanly 2005). For example:

- Remote patient monitoring technologies together with the expert patient movement facilitate nurses to work in new disease management roles
- Portable equipment such as biofeedback and bladder scanners have enabled the development of continence nurses with a comprehensive range of management options
- Clinical decision making algorithms/software support the development of nurse-led call centres, and
- Advances in reproductive and genetic technologies require nurses to develop roles in counselling and ethics.

From these examples, it is evident that technology opens up new dimensions for nurse led services that add benefit for the community.

Case Study #14 – Computer-generated clinical guidance

A recent study in NSW tested hospital-based doctors, family practitioners and clinical nurse consultants on their knowledge of basic clinical practice, aided by a newly developed search engine.

- Faced with eight common scenarios, such as treatment for "glue ear" in young children or the best device to use for asthma medication, the entire group were 21 per cent better at answering questions when they used the search engine.
- The study, conducted in a computer laboratory, found there were no difference in the scores between the doctors and nurses. While the doctors did better on the questions unaided the difference in the performance between doctors and nurses disappeared when they were given access to the search engine.

- The search engine, designed to direct health workers to specialist databases, manuals, textbooks and guidelines endorsed by professional medical bodies, goes to the latest diagnostic/treatment information.

(Pollard 2005)

However, these new nursing roles will test the practicality and feasibility of our current pluralistic approach to the management of scopes of practice. The geographical distances in Australia are contributing to inequality in access to health services. Aided by technology, nurses will increasingly provide telehealth¹⁸ services in settings that are not bounded by jurisdictional borders, and increasingly, they will conduct elements of their practice in the virtual environment with clients who are potentially located across the world.

Consider for a moment, nurses located and registered across Australia employed to provide advice through a national nurse-led call centre to a national clientele. The ANMC guidelines on telenursing point out that the legal issues related to this aspect of technically mediated care, have yet to be tested and therefore:

...In the absence of a settled position, it is the ANC's (now ANMC's) view that nurses are required to be registered in the jurisdiction where they are located when providing the telenursing advice, and also in each jurisdiction where their telenursing advice may be received and acted upon...

(Australian Nursing Council 2003)

Without a national approach and consistency to scopes of practice, there is potential for disparity in the scope of practice of nurses employed to provide the same service. With potentially eight variations to their scope of practice, which one would guide their practice at any one time?

18. Telehealth is the use of information and communications technology to provide health services to individuals who are some distance from the health care provider. Department of Human Services Victoria (2003). Hospital admission risk program (HARP) Technology working party report. Melbourne. Telenursing and telemedicine can be viewed as subsets of Telehealth.

Which regulatory authority would they be answerable to?

Case Study #15 – Telehospice service (US)

To improve services to underserved rural and urban areas and to patients with limited care giver support, a telehealth project was launched in Michigan and Kansas in 2000. Two large hospices launched a bi-state hospice enabling nurses to connect with and assess patients from their offices through videophones located in the patients' homes. The service augmented onsite visits with emergent or supplementary "visits", and enabled the nurses to "be present" to help caregivers.

(Whitten, Doolittle et al. 2003)

Case Study #16 – Men's Sexual Health Service "Slipping through the NET"

As part of a research project an innovative Internet health education and research strategy (funded by Department of Human Services Victoria) has been established by the Alfred Health Education Service, Victorian HIV Service and the Infectious Diseases Unit, The Alfred (Melbourne).

The project was developed to reach men who have sex with men and who utilise Internet chat rooms to meet other men. It aimed to provide sexual health education, information and referral through public and private Internet chat rooms.

A registered nurse and an allied health professional both provided health education services. The nurse was qualified in sexual reproductive health through Family Planning Victoria and held a Masters degree in Sexual Health.

Evaluation of the service model revealed a range of positive outcomes that auger well for the transportability and broader application of this type of model.

(Cummings, Hillier et al. 2003)

In Australia, we have only begun to explore the potential for nurse-led services. However, technological advances offer enormous opportunities to support and ensure quality safe practice by nurses in range of new roles and across different settings and services. What needs to be addressed is how we understand nurses' scopes of practice in the virtual environment that technology makes possible.

REFLECTIONS ON SECTION 5

The enablers of practice for nurses and midwives are numerous, complex and inter-related.

A nationally consistent framework for scopes of practice would need to consider how to accommodate the numerous enablers that:

- *integrates the complexity without losing diversity*
- *builds responsiveness and flexibility, and*
- *acknowledges and harnesses the reciprocal nature of these elements.*

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Suggested Further Readings

More information about the Australian Government's policies related to health and ageing is located at:

<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/Legislation+%26+Policy-1>

Differentiating scopes of practice

Review of scope of practice statements and explanations of practice for a range of health and non-health professionals indicates that there is variation in how scopes of practice are described, with reference to one or some of the following:

- an area of science or disciplinary knowledge, including specialties
- skills sets, tasks, roles and activities commonly performed
- health conditions, illnesses or concerns diagnosed, treated or managed
- a client group or health service setting, and/or
- educational qualifications
- statutory provisions
- systems of legitimisation or authorisation such as credentialing, and
- professional responsibility to work to agreed standards and to maintain the competence and capability to perform activities.

These are the same types of criteria that nurses draw on to describe their scopes of practice. However, similar to other health professions, there is a lack of uniformity in the way these criteria are interpreted and the way they are applied.

There is also considerable uncertainty within the profession about how to accurately describe scopes of practice that may be different, and to map the relationships and articulations between them. This section explores some of the ways scopes of practice can be differentiated.

Typologies for classifying scopes of practice

Currently, in Australia we have an eclectic, fragmented and somewhat inconsistent approach to classifying nurses and midwives scopes of practice. There are six main typologies that nurses and midwives draw on to identify themselves and distinguish the nature and extent of their practice.

TYPOLGY	EXAMPLES
Registration Categories (protected titles)	registered nurse, enrolled nurse, midwife, mothercraft nurse, mental health nurse, nurse/midwife practitioner
Position title (role description)	case manager, call centre manager, pre-admissions nurse, discharge planning nurse, clinical consultant, liaison nurse
Industrial Award/ Career structure (pay point categories)	graduate nurse (new graduate), nurse unit manager, director of nursing (DON), clinical nurse specialist (CNS)
Area of expertise or specialisation (employment setting)	critical care, oncology; RDNS or community nurse, school nurse; mental health nurse, retrieval nurse
Level of proficiency	beginner, competent, advanced, expert
Qualifications (educational preparation)	BN, Grad Dip, MN, Ph D

Such variety reflects the federated system in which States and Territories legislate and regulate health and industrial relations matters, and develop their health workforces to meet local jurisdiction needs. The gradual evolution of nursing and midwifery practice, and with it the profession's response to areas of practice considered risky also played a role in the development of different approaches.

While there is considerable overlap between these typologies (for example *nurse practitioner* is a regulation category and protected title, a position title, and an industrial award category) there is also divergence as the typologies draw on different criteria to make distinctions between, or to classify different types of nursing and midwifery practice.



A nurse practitioner, for example, might also be considered an advanced practice nurse, however not all advanced practice nurses meet the criteria for classification/registration as a nurse practitioner.

It is not within the scope of this paper to explore all of the typologies that are used. In the interest of space, the application of registration categories, Area of expertise or specialisation and level of proficiency will be examined.

Registration categories

There is broad industry understanding that scopes of practice vary between categories or divisions of registration. Registered nurses, enrolled nurses and midwives have different scopes of practice. Different elements of their scopes are considered risky and require rigorous regulation. For example:

- Some NRAs publish scope of practice statements for enrolled nurses, which clarify their roles and responsibilities with respect to medication management and supervision of practice.
- NRAs (in line with statutory requirements) approve scopes of practice in the form of practice guidelines and medication schedules for nurse practitioners.
- ANMC is currently undertaking a project to develop a scope of practice and competencies for Australian midwives¹⁹

However, *Our Duty of Care* points out that there is a lack of uniformity in categories of registration between the States and Territories. For example, mental health (psychiatric) nursing is a registration category in some jurisdictions while in others it is considered an area of specialised practice. While NRAs might recognise qualifications in these areas and endorse registration accordingly, these areas may not be subject to protected title.

The myriad approaches to how nurses and midwives are registered are highlighted in the table below.

State/Territory	Registration Process
ACT	Single Register Single Roll Endorsements within Register <ul style="list-style-type: none"> • MH. NP or Midwife Endorsements within Roll <ul style="list-style-type: none"> • Medication Administration
NSW	Two Registers: <ul style="list-style-type: none"> • Registered nurse +/- Authorisation to practice as nurse practitioner – setting specified? • Midwives +/- Authorisation to practice midwife practitioner Single Roll of nurses with two lists <ul style="list-style-type: none"> • List A Enrolled nurses (NSW course) • List B Enrolled Nurse (mothercraft)
NT	Register for registered nurses with 3 divisions <ul style="list-style-type: none"> • 1 register for nurses • 1 roll for enrolled nurses • 1 register for DE midwives RNs can apply for an authorisation to work in a restricted practice areas <ul style="list-style-type: none"> • Midwifery (authorised) • Nurse practitioner (Authorised) – work underway to enable NPs

19. More about the ANMC Midwifery competencies research project is found on the ANMC website <http://www.anmc.org.au/>

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SA

Three Registers:

- general nurses register
- midwives register,
- mental health register
- Nurse Practitioners are “authorised”

One Roll for enrolled nurses

Endorsements within Register

- NP

Endorsements within Roll

- Medication Administration

Tas

Single Register for registered nurses & midwives
psychiatric/mental health nurses by
authorisation

One Roll for enrolled nurses

Vic

Single Register with 5 Divisions

- Division 1: BN graduates; additional qualifications of midwifery; maternal & child health; psychiatric and NP endorsement
- Division 2: graduates of VET sector courses
- Division 3: Psychiatric nursing (closed)
- Division 4: Mental Retardation (closed)
- Division 5: Mothercraft nursing (closed)

Endorsements within register

- Only nurses from Division 1, 3 or 4 endorsed as NP
- Medication administration endorsement for Division 2 nurses

Notation of Chinese medicine

WA

Single Register with 6 divisions

- Division 1: Nurses capable of practising independently as professional nurses.
- only under the supervision of a nurse registered in Division 1 or in a particular specialty.
- Division 3 Contains the names and particulars of Bodies Corporate.
- Division 4: Nurses granted Honorary Registration.
- Division 5: Nurses granted Provisional Registration.
- Division 6: Nurses granted Temporary Registration.

NPs registered as NP in Division 1

Note: In addition, there may be various other restrictions to practice, notations, etc.

If the objectives of a national framework include consistency in scopes of practice for nurses and midwives in Australia as well as a consistent approach to managing scopes of practice, then a key challenge for the stakeholders is to arrive at a shared understanding of:

- The groups of nurses/midwives practising with different scopes of practice,
- The features that might differentiate scopes of practice, and
- How these scopes of practice articulate or fit together within the expansive spectrum of nursing.

Specialist scopes of practice

In recent times, there has been a proliferation of nursing specialties and specialist training, reflecting similar trends towards greater specialisation in medicine and health care in general.

Currently in Australia, there is no agreed national definition of a “nursing specialty” or an agreed classification system for those areas that are, or should be considered specialty areas of nursing practice²⁰. The absence of such a national approach creates problems both for quality assurance and workforce planning (National Review of Nursing Education 2002).

There is no doubt that with increasing specialisation, nurses and midwives take on a range of new practices and decision-making responsibilities with greater risks attached.

Consequently, there is a view that scopes of specialist practice should be clearly defined and more closely regulated. As discussed in **Section 5**, specialty nursing groups have responded by developing practice guidelines and competency standards to guide the practice of qualified practitioners in these areas. While these tools have national application, their status and authority to influence scopes of practice is uncertain.

Currently the states and territories employ a range of legislative and regulatory approaches to specialist scopes of practice. There is a lack of uniformity in the nursing specialties that are regulated, and the mechanisms that are used to do this. As a result, scopes of practice for nurses in the same specialty vary between jurisdictions.

While it might be argued that specialties evolve to fill specific needs in local settings, inconsistencies in specialist scopes of practice lead to confusion and uncertainty for nurses, employers, education providers and workforce planners.

Therefore to adopt nursing specialties as a framework for categorising nurses’ scopes of practice, there would first need to be consideration and agreement on:

- What a nursing specialty is.
- A classification system for categorising nursing specialties into groups with like scopes of practice.²¹
- Whether specialties should be regulated by NRAs, or other professional nursing organisations.
- The types of risky specialty practices that might merit statutory or professional regulation.

Extended, advanced, enhanced and expert scopes of practice mean?

In nursing, terms such as:

- ‘expanded’
- ‘enhanced’
- ‘advanced’
- ‘expert’, and
- ‘extended’.

are often used to make distinctions between scopes of practice for nurses and midwives. However, there is little uniformity in the use of this language, leading to confusion about how these roles are different and how they sit in relation to each other.

Similarly, these terms are arbitrarily applied to practice in both general and specialised practice areas and to different categories of registration (such as “advanced practice nurses”, “advanced practice for enrolled nurses”).

20. The Nurse Labour Force Survey conducted in each State and territory has in excess of 70 specialty nursing areas listed.

21. Work on nursing specialisation has been referred by the Australian Health Ministers to the National Nursing and Nursing Education Taskforce.

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Extended scope of practice commonly refers to a change to include practice that is outside that which has, for whatever reason (including policy, funding, legislation, or cultural convention), been accepted as the normal scope of practice for that category of nurse. However, it is unclear what distinguishes advanced practice from extended practice, specialist practice and indeed normal practice, and how the scopes of practice for these different kinds of practitioners sit in relation to each other.

For example, nurse practitioners are considered *advanced* practitioners. Their practice includes prescribing medications, ordering diagnostic tests and referral and as such is considered an *extended* scope of practice. Their practice however can be developed in an area of specialisation, (for example, emergency care, women's health, and aged care). So nurse practitioners have *extended*, *advanced* and *specialised* scopes of practice.

Within Australia, there is a fragmented approach to extending scopes of practice for different categories of nurses. In part this is because we are starting from different places; different constructs of the norm. As a consequence, activities that might be considered extensions to practice in one jurisdiction or practice setting might be part of normal practice in another.

Case Study #17 – Enrolled nurses & medications (2)

In Victoria, medication management by enrolled nurses is classified as “extended scope of practice”. A complex suite of measures including government policy and funding support, amendment to drugs and poisons legislation, development of professional guidelines, additional post-enrolment/registration training and a shift in industry culture has been required to enable enrolled nurses to practice medication administration.

In contrast, in Tasmania and WA, enrolled nurses have for many years, practiced medication

administration. It is part of their normal scope of practice.

It is foreseeable that with the successful integration of EN competencies into the Health Industry Training Package²², that medication management will comprise part of the pre-registration curriculum for all enrolled nurses in the future. If this is the case, will medication management be an excepted or an extended scope of practice.

However, at present the nurses and midwives in Australia do not share a common understanding of issues such as:

- the markers of advanced practice or the features that makes it different
- appropriate qualification required to underpin advanced practice
- whether enrolled nurses can develop advanced practice roles.

Currently there is no coherent vision or strategic direction guiding the development of these roles so that advanced practitioners might best be used in the health system to benefit the Australian public.

Buchan (2004) points out, in a recent report to the Organisation for Economic Co-operation and Development (OECD), that, internationally definitions of these types of roles (and scopes of practice) are not clear cut and there is a “lack of parity in how these varying roles are regulated” (p.8). This impacts on the mutual recognition of nurses and midwives moving across national boundaries and potentially impacts on effective utilisation of the skills and potential of the global health workforce.

Given the inconsistencies in the way these terms are used, there is merit in clarifying:

- If there is a difference between extended practice and expanded practice

22. Recommendation 21 of the National Review of Nursing Education: Our Duty of Care calls for the ANMC competencies for enrolled nurses to be incorporated in the Health Training Package. More information about this project is available on the Community Services & Health Industry Skills Council Website at <http://www.cshita.com.au/index.asp>

- What constitutes advanced practice (when it is not the practice of nurse practitioners)
- Whether specialist practice is expanded, extended or advanced practice
- The point at which a new practice, or an extension of a nurse or midwife's role is sufficiently risky that it merits professional regulation, and
- When a new practice, or extension to a scope of practice, is integrated to the point that it is accepted as part of normal or expected practice.

Do nurses and midwives have one, some or many scopes of practice?

It is not possible within the scope of this paper to address all the complex and vexing issues inherent in differentiating scopes of practice. However, there are several that merit mention and ongoing consideration, as work progresses towards the development of a national framework.

Nurses/midwives in multiple roles

For example, it is possible for a nurse to be a registered nurse with the capacity to work competently in a range of practice areas. This nurse might also be a registered midwife and have additional qualifications and expertise in another specialist field such as critical care or community care. This nurse might also be a nurse/midwife practitioner in women's health, working in the community in this capacity several days a week.

Does this nurse have one, some or more scopes of practice? Where does one scope of practice begin and end? How is this type of complexity best represented or portrayed?

Nurses/midwives in “hybrid” roles

Representing scopes of practice for nurse and midwives employed in generic, blended and hybrid roles present similar challenging issues.

Increasingly registered nurses are filling “generic roles”; that is, health related roles that could be filled by a range of health occupations. If the role is not specified as a nursing role, to what extent does a nursing scope of practice apply? That is, if a person who is a registered nurse, is not employed as a nurse, to what extent are the person's activities limited by a nursing scope of practice? Can the nurse, employed in a generic capacity be trained to undertake complex clinical work that might be considered outside the normal scope of practice?

Same or similar questions might be applied to blended roles which require the incumbent to have both nursing registration and expertise, and qualifications in non-health fields, for example epidemiology, Chinese medicine, law, computer technology or business management. When roles are developed specifically to blend professional skills and practices, then it is unclear how to differentiate where each scope of practice begins and ends, and to which regulatory authority the person is answerable during hybrid practice.

From the preceding discussion, it is evident that there are a number of different typologies that can be used to make distinctions between nurses' and midwives' scopes of practice, and that these typologies, though commonly used, are problematic. What is clear is that there needs to be more consistency in terminology used to differentiate between scopes of practice and that there should be a consistent approach to categorising nurses according to their scopes of practice that resonates with the profession, regulatory authorities, employers and workforce planners.

Mapping scopes of practice against other health occupations

There is a view that health policy makers, health workforce planners and health service providers/employers are interested in practical descriptions of the skills sets and roles that fall within the nursing and midwifery scopes of practice.

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By mapping these against the scopes of practice (similarly described) of other health workers, role over-lap and gaps in skills and service provision are identified. This provides the impetus for either expanding the scope of practice of existing health occupation groups or developing scopes of practice for new health worker roles.

The task of mapping scopes of practice for a range of health professions is confounded by the different approach to defining, describing and regulating scopes of practice of the various health occupations, and regulatory authorities across the jurisdictions.

It is perhaps in the recent development of nurse and midwife practitioner roles that we see the most rigorous attention to these criteria, with the elements being drawn into more comprehensive frameworks in support of practice.

There are however, risks for nurses and midwives from drawing tight boundaries around their practice. Their scopes of practice may be interpreted as the absolute limit to their capability rather than as the threshold of opportunity. Nurses and midwives may appear rigid and inflexible when in reality their scopes of practice are fluid and constantly shifting. For some nurses and midwives, this risk prompts them to resist attempts by others to develop more detailed descriptions of their work.

With so much variability, mapping of scopes of practice can only be conducted at a high level. An alternative is to map 'skill sets' of the various practitioner groups, to identify where the skills gaps are, the knowledge, skills and expertise required to fill the skills gap, and then identifying which health occupation group is best positioned to take on this new skill set. This is the approach that is being favoured in national and state level health workforce planning and development activities (see further readings in section 3).

To be meaningful in the context of health workforce planning, descriptions, or articulations of scopes of practice need to be based on a set of consistent descriptive criteria that has application to a range of health occupations.

It is tempting to grasp at simple solutions for some of these issues. There is comfort and reassurance when we find a "straightforward" solution for a knotty problem. Unfortunately it is generally true that "complex problems have simple, easy-to-understand wrong answers". Therefore we need to look for solutions that are sustainable and do justice to the future challenges surrounding scope of practice not just those that are fit for today's problem.

REFLECTIONS ON SECTION 6

A nationally consistent framework for scopes of practice should foster working relationships, embody the spirit of interdisciplinary partnerships and be respectful of the value and contribution of other health workers.

There is no consistency in categories of nurses. There may be benefit in grouping nurses into categories with like scopes of practice and to differentiate between scopes in meaningful ways.

A challenge in developing a national framework is to consider how to incorporate standards for 'determining' scopes of practice including:

- *Evidence to underpin changes/restrictions to practice boundaries*
- *Appropriate consultations*
- *Methods of validation*
- *Impact of scopes of practice changes on the whole of workforce, and*
- *Ways of enabling, supporting and sustaining new or changed scopes of practice*

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Suggested Further Readings

- The Community Services and Health Industry Skills Council has produced a number of documents that attest to the emergence and need for a range of health workers prepared in the VET Sector. The CSHISC HLT02 Review Discussion Paper points to a range of new health technician roles.
- The Industry Skills Report December 2004 points out that over the next 8 years strong growth in employment is forecast for a range of VET trained health workers including massage therapists, medical technical officers and Aboriginal Health Workers (Community Services and Health Industry Skills Council 2004)
- The prescribed scopes of practice and related qualifications for the 13 health professions under the NZ Health Practitioners Competence Assurance Act 2003 can be viewed in the New Zealand Gazette (Issue Thursday 9 September 2004) from the Gazette website at: [http://www.dia.govt.nz/Pubforms.nsf/URL/SupplementHealthPCA120Sep04.pdf/\\$file/SupplementHealthPCA120Sep04.pdf](http://www.dia.govt.nz/Pubforms.nsf/URL/SupplementHealthPCA120Sep04.pdf/$file/SupplementHealthPCA120Sep04.pdf)
- The “Defining Nursing” paper by the Royal College of Nursing (UK) is important reading. (Royal College of Nursing UK 2003)

The regulation of scopes of practice

The term “regulation” has several different connotations and for some “regulation” in terms of nurses/midwives’ practice means the relevant Nurses Act and the implications of that act for their practice. In reality though, health care and health professional practice is regulated through many interrelated mechanisms including legislation, professional regulation, and health industry regulation and standards. Health professionals practice in a regulated environment and the effects of regulation are instrumental in determining the scopes for practice of nurses and midwives.

The regulatory issues around scope of practice are worthy of some more detailed review. This section will explore some of the issues surrounding professional regulation, including the national policy context and the use of statutory and non statutory tools.

National policy context

Although a number of national policies impact on scopes of practice there are several key approaches that need to be considered in the context of regulation of practice at a national level, including National Competition policy and Trans Tasman arrangements.

National Competition Policy

In Australia, the statutory regulation of health professionals and their practice is guided by National Competition Policy (NCP)²³. Australia’s contemporary approach to statutory regulation is based on the premise that the purpose of professional regulation is for protection of the public interest, and not for protection of professions.

The corollary of this is that legislation and regulation should not restrict competition unless it can be demonstrated that:

- The benefits of the restriction to the community as a whole outweigh the costs, and

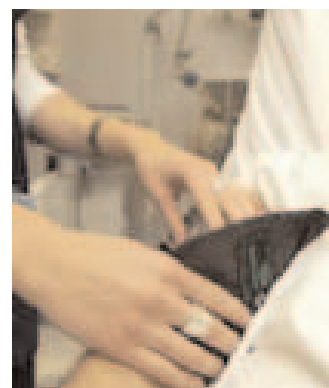
- The objectives of the legislation can only be achieved by restricting competition.

Over the past decade, NCP has driven a program of regulatory reform by all Australian States and Territories to balance the costs and public benefits of regulation (Buchan 1996; Queensland Treasury 1999). As a result, legislation regulating health practitioners has been reviewed and reformed in a number of jurisdictions.

Consistent with NCP, the Australian Health Ministers have agreed criteria for assessing the need for statutory regulation of health occupations. These are:

Criterion for assessing need for statutory regulation	
Criterion 1	Is it appropriate for health ministers to exercise responsibility for regulating the occupation in question, or does the occupation more appropriately fall within the domain of another ministry?
Criterion 2	Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?
Criterion 3	Do existing regulatory or other mechanisms fail to address health and safety issues?
Criterion 5	Is regulation possible to implement for the occupation in question?
Criterion 6	Is regulation practical to implement for the occupation in question?
Criterion 7	Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?

(Department of Human Services Victoria 2003, p.12)



23. Since implementation of NCP, Information about National Competition Policy is available from the National Competition Council website at <http://www.ncc.gov.au/index.asp> and includes an assessment of the Government’s progress in implementing National Competition Policy reforms to 2004, and submissions to the Productivity Commission on the review of the National Competition Policy reforms.

Where elements of an occupation's practice are considered risky or intrusive, there is a case for regulation of practice.

In keeping with NCP principles, decisions to amendment, or for new legislation regulating scopes of practice for health professionals must give consideration to whether regulation is warranted, feasible, practical, on balance beneficial, and whether the effects of regulation could be achieved through other mechanisms.

These principles also have application to the development of professional tools and instruments that form part of the professional regulatory framework (for example, codes of conduct, standards of practice, competencies, guidance notes, policies and position statements).

What is in the public interest?

Whilst it seems almost self evident that, regulation of health professional practice is for protection of the public interest, deciding what is in the public interest is a complex matter. The various stakeholder groups have a range of views about what is important and these views are not always aligned. Thus broad consultation is essential to evaluate the benefits and burdens of regulation for the public.

NRAs have responsibility for administration of Acts regulating nurses and midwives. Historically, they have interpreted their responsibilities in this respect, with a focus on protecting the public safety by ensuring the standards of practice of registered and enrolled nurses and midwives.

While the provision of safe quality care by nurses and midwives is a priority for the public, NRAs also need to give diligent consideration to issues such as equity, access and cost. For example, in circumstances where it is difficult to recruit registered nurses to remote areas, communities may consider that they would benefit more from

care provided by enrolled nurses than no services at all. Consider also the view that indigenous health workers are ideally positioned to provide support and care for indigenous women during pregnancy, birth and in the postnatal period.

Regulation needs to respond to changes in practice especially when this is driven by community needs. Changes such as those above require a shift in policy and of the regulation of professional practice.

Mutual recognition

Another key area of national policy affecting professional regulation is the area of mutual recognition²⁴. The Mutual recognition Agreement (MRA) and TTMRA are closely aligned with the National Competition Principles, which promote the removal of regulatory hurdles not required for public safety or benefit.

Under Australia's Mutual Recognition Agreement (MRA) the Governments of Australia agree to recognise each other's regulations, even where such regulations differ. The Trans Tasman Mutual Recognition Agreement (TTMRA) builds on and extends the principles of mutual recognition to the Government of New Zealand.

Mutual recognition principles enable nurses registered to practice in one jurisdiction to have their registration/enrolment recognised so they may practice elsewhere, provided their practice is substantially equivalent.

To meet their obligations under the MRA, NRAs recognise the registration of nurses and midwives with substantially equivalent scopes of practice. Under the agreement, equivalence can be achieved through the imposition of conditions on registration by the registering authority, for example restricting registration to certain activities or, on appeal, by the relevant Appeals Tribunal.

24. [Mutual Recognition Agreement \(MRA\)](#)

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However, determining the equivalence of scopes of practice is becoming more complex and contentious with increasing diversification and specialisation of nurses and midwives' practice, the different approaches to categorising nurses and their practice, differences in education and with the different limitations and boundaries that are placed around scopes of practice.

There is also a view that that MR and the TTMRA provide a potential gateway for applicants seeking registration to go "jurisdiction shopping" because of the differences across jurisdictions with respect to registration practices.

Some anomalies that need to be considered include that:

- Enrolled nurses from Western Australia (where medication management is part of scope of practice), must apply for endorsement of their registration in states such as Queensland and Victoria.
- In Victoria, to be entitled to endorsement, the enrolled nurse (with a medication endorsement from another state) must undertake additional bridging education to ensure their competence in the management of medications that are schedule 8 poisons. In addition, under the NBV guidelines, the enrolled nurse cannot administer medications by injection or parenteral route.
- The scope of practice of direct entry midwives with respect to their supervision and delegation relationship with enrolled nurses and unregulated workers has not been clarified.
- Problem with the recognition of New Zealand nurses under the TTMRA.
- In Western Australia and New South Wales a nurse can be simultaneously registered as an enrolled nurse, Mothercraft nurse and a registered nurse (on meeting the NRAs requirements). In Victoria and Queensland, a nurse cannot be simultaneously registered as an enrolled nurse and a registered nurse. In effect this is not mutual recognition of substantially equivalent occupations. It means that a person

cannot be employed in two different jobs in two different capacities.

Regulation of health professionals

Achieving national consistency in areas of health and professional regulation in a federated system is challenging, especially when the forces contributing to the irregularities and differences operate within a complex and multifaceted regulatory framework. There are few models of national consistency in like areas to follow although there is work currently being undertaken in the areas of national electronic health record (to bring a single health record) and national registration for medical practitioners.

Case Study #18 – National medical registration

In April 2004, following public consultation the Australian Health Ministers agreed to progress a nationally consistent approach to medical registration to facilitate the mobility of the Australian medical workforce, making it easier to doctors to work across state boundaries.

The approach includes a number of elements that will lead to consistency across all jurisdictions in relation to medical registration processes, categories of registration, public access to medical register information and processes for assessing maintenance of professional competence.

Key elements of the nationally consistent approach to medical registration include:

- Introduction of a multi-jurisdictional/national registration system under which a doctor registered in their jurisdiction of primary practice will generally also be eligible to practise in any other jurisdiction on the basis of that registration without having to lodge a separate registration application or pay a separate fee.
- The adoption of standard and consistent medical registration categories across all jurisdictions.
- The development of an online Australian Index of Medical Practitioners which will include all current registered practitioners in Australia.
- The adoption of a uniform set of medical practitioner information items that will be available to the public in all jurisdictions. Public access will be made available online through the Australian

Index of Medical Practitioners as well as through the medical boards in each state and territory

- A platform for a greater role for state and territory Medical Boards in assessing maintenance of professional competency.

There is currently a project underway to develop nationally consistent medical registration legislation in the priority areas identified by the Health Ministers, and an intergovernmental support mechanism to ensure consistency over time.

<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-workforce-new-discuss-paper.htm>

The successful implementation/progress of national consistency in these matters, especially where legislation is involved is dependent on the states agreeing to work together to progress an agreed program of work or agreed goals/outcomes, and this might need some form of intergovernmental agreement.

A national nursing policy

The Australian Nursing and Midwifery Council (ANMC), is funded by the state and territory NRAs and was established in 1992 to facilitate a national approach to nursing and midwifery regulation. The ANMC:

...works with state and territory nurse and midwife regulatory authorities in evolving standards for statutory nurse and midwife regulation...

(Australian Nursing and Midwifery Council).

Ten years after the establishment of the ANMC, the mapping of state and territory regulatory approaches undertaken for the National Review of Nursing Education (Chiarella 2002) highlighted considerable differences in:

- “construction” of registers for nurses and midwives (including registration categories,

endorsements, conditions placed on practice and recognition of specialist practice)

- approaches to mutual recognition
- standards sets, and
- approaches to defining and describing scopes of practice²⁵.

Despite identification of these differences, there has been little evidence of a focused Australia wide strategy to address the inconsistencies and anomalies in the regulation of nursing and midwifery practice although there is a renewed interest in this area of work.

The ANMC Strategic Plan for 2004-2007 includes development of standards for the scope of nursing and midwifery practice defined for Australia. (Australian Nursing and Midwifery Council 2004). To achieve this the Council is conducting a number of national projects including a number around competency standards. This is important national work. However, to achieve a national approach to statutory regulation will require a focus on a more coordinated and strategic approach to addressing the anomalies that exist. The tensions around the sovereignty of States/Territories may have contributed to some of the delays and impediments to this agenda in the past.

Approaches to legislation and statutory regulation of scopes of practice

Legislation regulating nurses and midwives in Australia is based largely on a reservation of title model. Queensland and WA are moving to a legislative model that incorporates provision for core restrictions.²⁶ Under this model, particular titles for nurses and midwives can only be used by those registered by the nurse and midwife regulatory authorities (Department of Human Services Victoria 2003, p20.)

25. Note, new legislation for the regulation of health professionals has since been introduced in ACT, NT and NZ.

26. Appendix (2) Models of regulation of Health Professions modified from DHS (Vic) Department of Human Services Victoria (2003). Regulation of the health professions in Victoria: a discussion paper. Melbourne, Policy and Strategic Projects Division, Victorian Government Department of Human Services.

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NRAs establish the qualifications and character requirements for entry to the profession, develops standards of practice, and investigate complaints of unprofessional conduct and apply sanctions.

This approach to regulation protects the public interest by ensuring that registered practitioners are qualified to provide nursing and midwifery services

The Australian Acts for nurses and midwives include very few core restrictions to practice²⁷. Mostly these provisions pertain to supervision of enrolled nurses and certain restrictions to nurse practitioner practice. For the most part any core restrictions to practice are not uniform though the legislation.

If there are risky and intrusive practices that should be regulated, this is generally accomplished through other forms of legislation. Some examples where legislation authorises, restricts or prescribes elements of practice include:

- Legislation for the regulation of drugs and poisons make provision for those who can prescribe, supply, and administer pharmaceutical substances (scheduled poisons)
- Legislation for the registration of births, deaths, marriages and changes of name prescribes that midwives are authorised to exercise certain responsibilities with respect to registering births (still births)
- Under legislation for the protection of children and young people, people with a duty of care to a child (this may include a nurse or midwife), commit an offence by failing to take action to protect a child at risk of harm.

It should be noted that legislation of this kind is generally enacted by the jurisdictions, leading to variation and inconsistencies, and contributing to variations in scopes of practice for nurses and midwives. For the most part, statutory limitations and prescription of practice are minimal.

Case Study #19 – The New Zealand Health Practitioners Assurance Act

The NZ Health Practitioners Competence Assurance Act (HPCAA) 2003 came into force on 18 September 2004. The Act provides a framework for the regulation of health practitioners in NZ. It covers a range of occupational groups, including nurses (and medical practitioners), and will repeal statutes covering 13 health professions.

The Act requires each of the regulatory authorities to describe the profession it regulates in terms of one or more scopes of practice and to prescribe the qualifications that a practitioner needs in order to be eligible to be registered in a scope of practice.

Under the Section 11 (2) of the Act, a scope of practice may be described in a number of ways including reference to:

- an area of science or learning
- tasks commonly performed:
- illnesses or conditions to be diagnosed, treated, or managed

In compliance with the Act, the Nursing Council of New Zealand has developed 4 Scopes of Practice for nurses: Registered Nurse, Nurse Practitioner, Nursing Assistants and enrolled nurses. The Act makes provision for the development of addition scopes of practice.

The NZ Act represents a different approach to scopes of practice to that in Australia. All health practitioners must be registered in a specific scope of practice and registered health practitioners are not permitted to practice outside their scopes of practice. Only registered health practitioners are authorised to use the scope of practice title

27. Chiarella, M. (2002) completed a selective review of nursing regulation and practice that demonstrates that there is a range of approaches to statutory regulation for nurse and midwives. More about the review can be found in the National Review of Nursing Education 2002. Regulation and Practice.

Restrictive and permissive approaches

The debate around scopes of practice was detailed by Chiarella (2002) for the NRNE through examination of the regulation of nursing. The analysis identified *“the full range of responses from jurisdictions that do not define scope of practice to defining it in detail”* (p.115).

The report suggests that two main approaches are evident:

- a client/patient focused approach, where client needs are identified as paramount
- an approach that defines and protects professional boundaries.

These two approaches are often reflected in whether the definition of scope of practice is permissive or restrictive (Chiarella 2001; National Review of Nursing Education 2002).

Restrictive approaches

Restrictive approaches focus on describing, prescribing or placing limitations on elements of practice. Detailed descriptions of scope of practice might include elements such as which nurses can undertake a certain practice, educational and training requirements, knowledge areas, recipients of care, practice setting, supervision requirements, other standards for a particular practice.

This has the effect of clearly authorising aspects of practice while at the same time drawing more detailed and definitive limits around the practice domain.

Case Study #20 – Alberta (Nursing Professions Act 1983)

As detailed in the Review, Alberta, Canada has Health Professions Act 1999, which requires health professions to identify restricted activities. In September 2000, there is a list of restricted activities were approved for registered nurses, including specific references such as:

“...to cut a body tissue, to administer anything by an invasive procedure on body tissue or to perform surgical or other invasive procedures below the dermis or the mucous membrane; to insert or remove instruments, devices, fingers or hands beyond the cartilaginous portion of the ear canal, the point in the nasal passages where they normally narrow, the pharynx, the opening of the urethra, the labia minora, and the anal verge, and into an artificial opening into the body...”

Restricted activities that were not approved by for registered nurses, subject to further clarification, include:

“...to cut a body tissue, to administer anything by an invasive procedure on body tissue or to perform surgical or other invasive procedures on body tissue below the surface of the cornea or in or below the surface of the teeth, including the scaling of teeth; to set or reset a fracture of a bone; to reduce a dislocation of a joint except for a partial dislocation of the joints of the fingers and toes; to use a deliberate brief, fast thrust to move the joints of the spine beyond the normal range but within the anatomical range of motion, which generally results in an audible click or pop; to prescribe or dispense parenteral nutrition; to prescribe diagnostic imaging agents; to prescribe radio-pharmaceuticals...”

(National Review of Nursing Education 2002)

Restrictive approaches arguably provide clarity and protection for nurses and midwives, employers and the public by describing the extent and limitations on scopes of practice. However, as discussed in Section 6, there are risks for nurses and midwives from drawing tight boundaries around their practice.

For this reason, there is a view that nurses and midwives should resist the thrust towards more detailed description of their work.

It is also possible that the public interest might be undermined through unnecessary restrictions that limit nurses’ and midwives’ ability to provide a flexible range of services and to evolve to meet changing health care needs.

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Permissive approaches

On the other hand more permissive approaches provide a principled framework for reflective and responsible practitioners to ensure they have authorisation, adequate knowledge and the competence to underpin changes and extensions to their scopes of practice (National Review of Nursing Education 2002).

Permissive approaches are not overly prescriptive or descriptive, and do not draw definitive boundaries around scopes of practice. Instead, they are underpinned by foundational assumptions that:

- nurses and midwives, employers, regulators, health workforce planners and the public all share a common understanding of nursing and midwifery practice, and
- nurses and midwives as professionals abide by their professional obligations as laid out in profession codes of ethics and conduct.

Permissive approaches shift the burden of responsibility and accountability for determining the limits of professional practice from regulatory authorities to individuals and employers.

Accordingly, practitioners are individually accountable for their acts and accept responsibility for their practice, and for delegated aspects of practice (National Review of Nursing Education 2002).

Each nurse is also professionally accountable “for education and development of new knowledge and skills” (National Review of Nursing Education 2002, p. 52).

Under this model, nurse’s and midwives’ scopes of practice are highly individual and context specific. Permissive approaches accommodate the need for practice to be flexible, responsive, context specific and diverse. While there is less clarity of detail, there is greater certainty and guidance around the process for making sound decisions to extend the

scope of practice for individuals or groups of nurses.

The overall effectiveness of permissive approaches is dependent on both professional and employer integrity. Without both, permissive approaches can be exploited by the unscrupulous, and scopes of practice may develop without due consideration of the risks and benefits involved.

There is also a risk that without scrutiny and planning, that the ongoing development of scopes of practice will be largely unstructured and fragmented. While diversity may meet local needs, it provides challenges for employers who also have a responsibility to ensure a safe practice environment, for the strategic allocation of resources for workforce development, and for coordinating responses to national health priorities.

The Review acknowledged the significant work done by QNC on the principles that guide decision-making on scope of practice. Such a framework “provides the umbrella under which regulatory, sectoral and professional standards can sit” (p.118).

Case Study #21 – Queensland Nursing Council (QNC) – Scope of Practice Decision-Making Framework

The Scope of Practice Decision Making Framework (DMF) was first implemented in Queensland (QLD) 1998 as part of QNC’s statutory responsibility for regulation of nursing in QLD. One of the Council’s specific functions pursuant to the QNC Nursing Act (2000) is “to determine the scope of nursing practice, including activities that constitute, or are included in, nursing practice.

The DMF fulfils this function by providing “guidance for individual nurses, the nursing profession, other health care personnel, service providers and consumers in decision making about issues of nursing practice”

(Queensland Nursing Council 1998, p.2)²⁸

28. QNC is currently undertaking a review the Scope of the framework, and will revise the framework in light of the findings

Distinctive features of the DMF include that it is:

- based on sound methodology including research, extensive consultation with a range of key stakeholders and validation
- principle based
- based on a high level, conceptual definition of scope of practice for nurses, is permissive within defined limitations, and not prescriptive
- applies to nurses working in range of settings and roles and with a range of responsibilities and therefore respects the diversity of nursing practice
- acknowledges the responsibility of employers/health service providers to ensure the conditions for safe practice
- patient-focused and complies with National Competition Principles
- provides support for decisions that allow for development and growth in scope of practice, and
- has supportive materials and tools to assist in applying the framework.

Through this framework, individuals are empowered to make sound, supported decisions to extend their individual scope of practice or to facilitate the scope of practice of others, including those to whom they delegate aspects of their practice.

A national approach to decision making frameworks

The public interest might well be served by a complementary synthesis of both permissive and restrictive approaches, where there is a flexible and responsive decision making framework that enables scope of practice development and evolution, while still providing for more detailed description and regulation of risky practices.

As a principle based framework for making decisions about scopes of practice, the QNC DMF has received widespread recognition both nationally

and internationally, and the definition of scope of practice that is foundational to the model is quoted widely.

THE QNC DMF has been further supported by the final report of the Aged Care Enrolled Nurse Working Party (2003).

At a subsequent meeting of Chief Nurses and NRAs and the Australian Minister for Ageing to discuss action on the report's recommendations, stakeholders agreed that all jurisdictions needed a decision making framework. While the QNC model provided a sound basis for further development, it was agreed that jurisdictions should undertake to develop DMFs with reference to existing models within their own contexts.

Considerable work has been also undertaken by a number of NRAs to develop frameworks to assist decisions about scopes of practice, delegations of practice and how to work with other health occupation groups.

Although much of the work in this area by the jurisdictions draws on the QNC DMF, the pluralistic approach towards development of DMFs has resulted in a variety of frameworks to support scope of practice decisions. What has been lacking is agreement, or a process for reaching agreement, about the principles and key features that should be common to DMFs and an over-arching strategic coordination of these activities to promote greater consistency (and minimise duplication of effort).

It is clear that the permissive features of the DMF are attractive to nurses and employers as they allow for flexibility, diversity and responsiveness to local need. However, as the basis of national framework intended not just to bring consistency to scopes of practice, but to provide a mechanism for continuing consistency over time, this model does pose challenges and concerns such as:

- The QNC DMF has been evaluated by a number of states, and this has provided the foundation for variations on the model. In the interests of greater consistency, a national framework would need to reconcile or accommodate these differences.

SECTION 7

- Even though theoretically the DMF has application for all registered and enrolled nurses and midwives, its efficacy as a decision making tool for practitioners working in non-clinical domains, blended roles especially where the nurse has co-specialties and multiple professional registrations (eg. Chinese medicine or Law and Nursing) is as yet unclear.
- The framework relies on a shared understanding of what nursing practice is, and as demonstrated in section 5, there are many perceptions and myths perpetrated by nurses and others that lead to misconceptions about nurses actual and potential scopes of practice.
- DMFs provide for flexibility and diversity, but in so doing, promote endless proliferation and variation in scopes of practice . A national framework based on a DMF model would need to provide a way of conceptualising individualised scopes of practice, while still providing mechanisms for dealing with risky practices.
- The DMF accommodates scope of practice decisions for individuals, groups of nurses in particular settings, or for broader categories of nurses, but does not give direction as to the classification of nursing/midwifery groups or how these scopes of practice might map to one another.
- DMFs depend on nurses and employers making appropriate decisions about the type and nature of education and training to provide sound foundations, and the level of competence that is required for new practices. This leads to disparities and inconsistencies, which further fragment scopes of practice.
- The QNC DMF gives consideration to 3 principle factors: authorisation, education and competence, but does not prompt consideration of some of the broader drivers and enablers of practice (section 5), that are required to make practice viable and sustainable over time.

In conclusion, a national framework might provide a mechanism for strategically planning the development of scopes of practice for groups of nurses across Australia, in this way reducing the anomalies that result from pluralistic approaches, and making provision for uniform regulation where this is warranted.

REFLECTIONS ON SECTION 7

To date there has been little intentional national alignment and coordination of nursing and midwifery professional regulation with national policy directions in regulation more broadly.

A national framework may provide a mechanism for strategically planning the development of scopes of practice for groups of nurses across Australia, in this way reducing the anomalies that have resulted from pluralistic approaches and making provision for uniform regulation where this is warranted

Section 7

Suggested Further Readings

The final report of the project is available from the QNC website

<http://www.qnc.qld.gov.au/home/index.aspx> and is highly recommended reading

What might a national framework look like?

There are three principle challenges in conceptualising a national framework for scopes of practice. The first is to identify what we want the framework to do. The second is to identify what the key elements of the framework might be. The third is to map the steps to get there.

This section draws the threads of the discussion and reflections together to briefly introduce the main challenges in conceptualising a national framework for scopes of practice. Work of this nature is complex and requires the agreement and support of all the stakeholders. In particular there are some complexities associated with achieving inter-governmental agreement in matters such as this.

How we move forward on these matters will be considered at the Scopes of Practice Symposium in March 2005. The intent of this section is not to pre-empt that work but to consider some of the overarching concepts that may be important.

What do we want a framework to do?

Before deciding on how a framework may be constructed the purpose of the framework should be determined and agreed, as this will drive the nature of the features to be incorporated.

There are many possible options and it may be that a combination of outcomes may be the best “fit” given the range and breadth of stakeholders that have an interest. Clearly, a framework could incorporate one or all of the following:

- Show how scopes of practice for nurses, midwives and other health workers relate/interface (eg. the Map of scopes of practice and skills sets)
- Bring consistency to the scopes of practice of like groups of nurses and midwives across Australia (eg. consistency for enrolled nurses and nurse practitioners) and make provision for ongoing consistency as scopes of practice change over time

- Provide a nationally consistent approach to making decisions about scopes of practice at local and jurisdictional level (eg the DMF)
- Facilitate development of principles /processes to guide decisions about scopes of practice (eg. a national framework for enabling, sustaining and regulating scopes of practice)
- Guide how strategic decisions about future directions, formulating plans of action, and for coordinating activity are made, and
- Blend permissive and restrictive features to benefit the public interest.

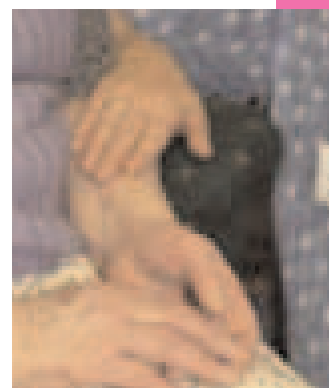
There will be other purposes that stakeholders may consider important. What is needed is consultation, debate and agreement about what we want a framework for scopes of practice to achieve.

What features should be incorporated into a national framework?

The purposes(s) will dictate to some extent the details of the features or elements of the framework, however at a simplistic level key features might include the following:

- The broader context and reason for the framework
- The principles that are the foundation of the framework
- The elements of a framework (such as any agreed terminology, understandings of scope of practice, nomenclature)

There is a strong argument for having features which are principle-based rather than prescriptive, and that guide actions, decisions and processes. This will build flexibility and accommodate a range of perspectives more readily than narrow and inflexible statements.



SECTION 8

The features should be based on agreement between the stakeholders, which could be formalised through mechanisms such as a memorandum of understanding.

There would also need to be accompanying work to ensure that consistent definitions and terminology (consistent with the national health workforce planning lexicon) are used as well as an agreed approach to distinguishing between groups or categories of nurses with like scopes of practice.

Finally, the approach to making decisions resulting in changes to scopes of practice would need to account for the drivers and enablers that shore up the feasibility, viability and sustainability of practice over time

What principles should underpin a national framework?

The direction of the National Review of Nursing Education 2002 Our Duty of Care Report was that a national framework should be underpinned by:

- responsiveness to change
- flexibility of workforce structure and work organisation, and
- national approach to coverage (p.117).

This is an excellent foundation for a national framework. In the development of this Commentary Paper it has also become evident that there are a number of other considerations that could have relevance in developing a comprehensive set of principles for a national framework for scopes of practice.

Over the following pages these have been drawn out from the relevant sections of the paper. The ones outlined in this paper may not be a definitive list and further debate and consideration may confirm or modify these, they are considered a starting point for consideration and debate.

Section 2

Why do we need a National Framework for Scopes of Practice?

Reflection on Section 2

To date nursing and midwifery scopes of practice have developed in a fragmented way. This has resulted in variation in what nurses and midwives can do and may have limited the potential of these disciplines.

Greater consistency (such as a national framework for scopes of practice) would offer benefits for nurses and midwives, and for the Australian public.

Consideration would need to be given to how greater consistency can be achieved and how that consistency can be maintained over time.

Implications for Scopes of Practice Framework

A framework for scopes of practice might:

Be based on an understanding that a national framework for scopes of practice will be beneficial for nurses and midwives, the profession, employers, policy makers, health workforce planners and the Australian community, and is achievable through cooperative and collaborative action.

Accept that national consistency in scopes of practice is feasible, possible and will benefit the public interest.

Include a vision that consistency will position nurses and midwives to make a valuable contribution to health care in the future.

Section 3

What factors are influencing the way we work in health?

Reflection on Section 3

To make a relevant and valuable contribution to health care in the future, nurses and midwives need to be open to the possibility of new roles and scopes of practice that extend into realms that are considered beyond, peripheral to, or not part of practice as it is understood today.

A nationally consistent framework for scopes of practice for nurses and midwives needs to be consistent with the vision, principles and strategies outlined in the National Health Workforce Strategic Framework. It is important that nurses and midwives are aligned with the national direction, and that they situate their present and future scopes of practice in relation to the broader health workforce.

Implications for Scopes of Practice Framework

A framework for scopes of practice might:

Adopt a view of the health workforce that is consistent with current government policy, outlined in the National Health Workforce Strategic Framework; including that nurses and midwives are part of an integrated health workforce and scopes of (professional) practice evolve to meet changing requirements of the Australian community.

Section 4

What is a Scope of Practice?

Reflection on Section 4

The Australian public are challenging health professionals to respond to their needs in a different way and this requires health professionals to rethink how their services are positioned.

A national framework for scopes of practice needs to be based on stakeholder's agreement.

In the interests of achieving national consistency, a national framework for scopes of practice might provide a mechanism for strategic coordination of activity across jurisdictions, especially where multiple stakeholder groups are involved.

Implications for Scopes of Practice Framework

A framework for scopes of practice might:

Include recognition that "new professionalism" insists on professional accountability, transparency and responsiveness to community expectations, needs and standards.

Adopt a broad view of "the public interest" that is consistent with the National Competition Principles; including that the public interest extends to consideration of a broad range of costs and benefit.

Section 5

Viability of practice – Enabling and sustaining scopes of practice?

Reflection on Section 5

The enablers of practice for nurses and midwives are numerous, complex and inter-related.

A nationally consistent framework for scopes of practice would need to consider how to accommodate the numerous enablers that:

- Integrates the complexity without losing the benefits arising from diversity
- Builds responsiveness and flexibility, and
- Acknowledges and harnesses the reciprocal nature of these elements.

Implications for Scopes of Practice Framework

A framework for scopes of practice might:

Promote a view that scopes of practice for nurses and midwives need to evolve and change over time to meet the changing health needs of Australians, and to contribute to addressing regional and global health issues.

Section 6

Differentiating scopes of practice?

Reflection on Section 6

A nationally consistent framework for scopes of practice should foster working relationships, embody the spirit of interdisciplinary partnerships and be respectful of the value and contribution of other health workers.

There is no consistency in categories of nurses. There may be benefit in grouping nurses into categories with like scopes of practice and to differentiate between scopes in meaningful ways.

A challenge in developing a national framework is to consider how to incorporate standards for 'determining' scopes of practice including:

- Evidence to underpin changes/restrictions to practice boundaries
- Appropriate consultation
- Methods of validation
- Impact of scopes of practice changes on the whole of workforce, and
- Ways of enabling, supporting and sustaining new or changed scopes of practice.

Implications for Scopes of Practice Framework

A framework for scopes of practice might:

Incorporate principles and mechanisms that promote consideration of all the factors that support and enable scopes of practice.

Section 7

The regulation of scopes of practice

Reflection on Section 7

To date there has been little intentional national alignment and coordination of nursing and midwifery professional regulation with national policy directions in regulation more broadly. There is now evidence of a willingness to move in this direction.

A national framework may provide a mechanism for strategically planning the development of scopes of practice for groups of nurses across Australia, in this way reducing the anomalies that have resulted from pluralistic approaches and making provision for uniform regulation where this is warranted.

Implications for Scopes of Practice Framework

A framework for scopes of practice might:

Incorporate the principles of National competition policy including that regulation of professional practice is to protect the public interest and not for the protection of professions, and that decisions to regulate practice should weigh the benefits and burdens of regulation.

What would be the benefits of such a framework?

The benefits of a framework that included some of the features outlined in the previous pages would be numerous and affect multiple stakeholders with a “win-win” outcome. Using principles, a national framework could be constructed to provide the following:

Potential Benefits for Key Stakeholders of Achieving National Consistency in Scopes of Practice					
	*Nurses/ Midwives	Consumers of health services	Jurisdictions /Government	NRAs	Employers
Shared understanding of scopes of practice in the context of employment	●				●
Enhanced legal protection for nurses/ midwives (eg: in defence of claims of professional misconduct)	●				●
Enhanced workforce planning (understanding where boundaries of practice overlap, where there are practice gaps)	●	●	●		●
Enhanced mobility of nursing/midwifery workforce within Australia/Trans Tasman (greater workforce responsiveness)	●		●		●
Enhanced interdisciplinary management of patients (understanding boundaries of practice & other health workers)	●	●			●
Improved decision making about scopes of practice (including methodologies for developing and validating scopes of practice)	●		●	●	●
Coordination of communication and consultation with stakeholders (eg: whether a dimension of practice merits regulation - statutory and/or professional mechanisms)	●	●	●	●	●
Alignment of nurses/midwives scopes of practice with national context (including Government policy, national health workforce policy, national health priorities, Trans-Tasman impact)			●	●	●
Facilitation of agreed program of legislation reform (eg: co-operative arrangements to share costs/workload related to changes to scopes of practice).			●	●	
Promotion of positive national images of nurses & midwives (eg: patient-centred, flexible & responsive to community's needs/values)	●	●			

* Nurses and Midwives includes professional and industrial organisations that represent them.

SECTION 8

Conclusion: finding a way forward

If you have got to this part of the paper you will have hopefully appreciated that there is a complex web of factors/forces contributing to fragmentation and inconsistencies across Australia. This paper has tried to unpick and expose some of this complexity.

At the same time the landscape is constantly changing. A number of jurisdictions are undertaking or planning to commence projects that will continue to shape and influence the scope of practice of nurses and midwives. Appendix 3 points to some of the exciting work being done across Australia around this issue. This is not an exhaustive list, and does not capture many of the exciting innovations and developments of the last few years. Indeed, it is likely that much more work is going on than is captured in this table but it gives some idea of the considerable interest, effort and concern that is current. It also highlights that the goals posts for consistency are continually shifting.

It is clear that to position nurses and midwives to make a valuable contribution in the future, a national framework should not just promote consistency at this point, but should make provision for ongoing consistency in scopes of practice for nurses and midwives across Australia and that strategically positions nurses as the nature of health work evolves and changes over time.

We have the opportunity to construct a framework that brings together key stakeholders, and provides a mechanism for sharing views, making decisions, forming strategic directions and coordinating activity.

Section 8 of this Commentary paper teases out what some of the key elements of a national framework might be. So, how do we move forward from this place?

The Commentary paper is part of a suite of activity to implement Recommendation 4 of the National Review of Nursing Education. It is expected that the Commentary paper will stimulate debate and dialogue that will inform the perspectives of the key stakeholder groups invited to attend a national symposium on scopes of practice for nurses and midwives.

This symposium will bring together a broad and encompassing range of stakeholders with an interest in the nursing and midwifery workforce to discuss and contribute to shaping the national framework.

The commentary in this paper is not intended to provide clear solutions. Through this paper, the complexity of the issues around consistency and scopes of practice are exposed and unpicked for consideration. It has not been within the scope of the commentary to comprehensively cover and deconstruct all the issues.

It is hoped that reading this Commentary Paper has been interesting and has challenged readers to think differently or to re-think, aspects or issues that have been presented.

All stakeholder views are valued. We suggest you use this paper to stimulate dialogue and debate and to explore the issues that resonate with you. We encourage you to consult further and to engage with the national groups that best represent your interests to inform their perspective and representation at the Scope of Practice Symposium (For a list of invitees please refer to the N³ET website).

Excerpt from National Review of Nursing Education 2002 – Our Duty of Care

5.3 Regulation and legislation

5.3 Regulation and legislation

While many nurses regard the current shortages as the main factor in the increase of unregulated care workers, this appears to be a simplistic view. In the aged care sector the growth of this group has displaced many enrolled nurses. Although, the inability to attract enrolled nurses because of reduction in training places may have influenced their availability, factors like financial constraints and the flexibility of the unregulated/unlicensed worker have resulted in the overlap of the scope of practice of these workers with that of enrolled nurses, particularly in aged care. In addition, supervision requirements and restrictions on the administration of medication make the enrolled nurse less flexible than the registered nurse.

There is a lack of consistency in legislative approaches in Australia in relation to scope of practice. Scope of nursing practice refers to that which nurses are educated, authorised and competent to perform. Chiarella (2001) examined the regulation of nursing and identified the full range of responses from jurisdictions that do not define scope of practice to defining it in detail. Two approaches are evident:

- a client/patient focused approach, where client needs are identified as paramount
- an approach that defines and protects professional boundaries

These two approaches are often reflected in whether the definition of the scope of practice is permissive or restrictive (Chiarella 2001).

The scope of practice of registered nurses and enrolled nurses is treated within a regulatory framework that requires nurses to meet particular competencies to be registered. There is no regulatory framework defining the scope of practice for trained care assistants.

Approaches adopted in different jurisdictions appear to reflect nursing practice within the culture of individual healthcare systems in Australia. Queensland has developed a decision making framework to support nurses' decisions on what fits

within their scope of practice and Western Australia is using this model for some developments in this area. Other jurisdictions such as NSW use the ANCI competencies as the set of minimum standards rather than defining scope of nursing practice.

As discussed in Chapter 4, the scope of practice of nursing has changed, demanding a shift in the professional role of nurses to one encompassing the functions of care-giver and the facilitative functions related to patient education, management, communication and research.

5.3.1 Factors influencing scope of practice

Scope of practice is influenced by many factors. The actual scope of practice of individuals is influenced by the settings in which they practise, the health needs of people, the level of competence of the nurse and the policy requirements of the service provider (QNC 2001).

McMillan and colleagues (2001) identify contextual factors such as increased diversity in practice contexts, increased patient acuity in all nursing contexts, financial constraints, the legal and political climate, and consumer expectations. They conclude that, over the last two decades, there has been a shift in the usual practice for all levels of nursing, particularly registered nurses and enrolled nurses, with the practice of both amplified so that what was previously considered expanded practice has become the norm. Cross- and intraprofessional boundaries have become blurred.

We recognise that this is a highly complex area, one that is predominantly the responsibility of the States and Territories, but it is an area of considerable frustration to those responsible for aged care in particular because it limits the best use of staff and reduces the status of enrolled nurses. While the impact of the range of legislative approaches in the different jurisdictions has largely been on enrolled nurses, the fragmented approach to developing the nurse practitioner role and the associated legislative/regulatory frameworks may have similar consequences for that role in the future.

APPENDIX 1

The Senior Nurse Advisory Group, North Western Mental Health, summarised the more general frustration for nurses this way:

There have been significant advances in nurse preparation, yet legal frameworks, regulatory bodies and government policies have not recognised nor capitalised on the increased skill base. This has led to significant economic costs to the Australian community and personal costs. Nurses feel their skills are not being utilised and leave the profession in search of fulfilment elsewhere.

(Response to the Discussion Paper).

5.3.2 Scope of practice – enrolled nurse

The Australian Nursing Council Incorporated (ANCI) report, *An examination of the role and function of the enrolled nurse and revision of competency standards* (2002a), provides an overview of State, Territory and New Zealand regulatory variation in relation to medication administration and related supervision of enrolled nurses. The consultants conclude that ‘the role and function of the enrolled nurses with regard to supervision and medication administration varies both within Australia and in comparison with New Zealand’ (p. 14).

This same report makes the case for the displacement of the enrolled nurse, evident in the statistical trends (see Chapter 5), in this way:

It is ironic for the enrolled nurse that the trends in their role erosion emanate from different and contrasting skill mix models. Where some employers have sought to change nursing skill mix by including greater proportions of registered nurses, others have sought to increase the numbers of ‘unregulated workers’ ... Though in some states studies are currently taking place, there is insufficient publicly available documented evidence to what unregulated carers are actually doing and how this articulates with the enrolled nurse role. Medication administration is however a particular feature in this context, as unregulated care workers are not restrained by legislation in the same way as enrolled and registered nurses.

(ANCI 2002a, p. 15)

A Review of the Current Role of Enrolled Nurses in the Aged Care Sector: Future Directions, prepared by the Working Group on Aged Care Worker Qualifications of the National Aged Care Forum highlighted many of the same issues put to us. *The Review of the Current Role of Enrolled Nurses in the Aged Care Sector: Future Directions* (Working Group on Aged Care Worker Qualifications 2001) shows that there is broad support for an enhanced scope of practice for enrolled nurses which would allow them to administer up to and including Schedule 4 (S4) medication provided there is appropriate education and supervision in a nationally consistent framework.

To achieve safe and effective medication management in aged care, the Working Group suggested a number of strategies such as:

- developing a nationally uniform extended scope of practice for enrolled nurses in medication administration
- approaching the Department of Education, Science and Training (DEST) to develop traineeships for a vocational Certificate IV in Community and Health Services
- approaching nurse regulatory authorities in the States and Territories to accredit modules in the enrolled nurse curriculum to allow enrolled nurses to administer up to and including S4 medications
- approaching the State and Territory governments to amend legislation and policy where appropriate to allow enrolled nurses with appropriate education and training to administer up to and including S4 medications
- seeking the support of the Commonwealth Government in promoting an expanded scope of practice for enrolled nurses and a nationally consistent framework for enrolled nurse practice.

5.3.3 Future directions – guiding principles

There were strong representations to the Review that a new approach is needed to define and regulate the scope of practice for different types of work settings and to require training of care workers. The important attributes of this new approach were:

- responsiveness to change
- flexibility of workforce structure and work organisation
- a national approach and coverage.

Nursing must recognise the range of scope of nursing practice professionally, industrially and educationally. Scope of practice must accommodate the breadth, range, extent, effect, influence and reach of nursing activities and needs to be applicable to different practice contexts. Ongoing review of the scope of nursing practice is essential because of the changing context of care, changing patients' and clients' needs, and changing models of care.

Alternative approaches are available. In Australia, the Queensland Nursing Council (QNC) has conducted much of the work on the scope of nursing practice. It commissioned research into the scope of nursing practice and has published a *Scope of nursing practice decision-making framework* that defines the scope of nursing practice as 'that which nurses are educated, authorised and competent to perform' (QNC 2001, p. 5).

The Review supports the QNC approach of using a framework that sets out principles to guide decision-making on scope of practice. A decision making framework provides the umbrella under which regulatory, sectoral and professional standards can sit. It enables linkage of all activities undertaken to ensure the competency of nurses. A similar approach is being followed in New Zealand where the Nursing Council of New Zealand is developing a competency assurance framework for nurses (2001). In contrast, the push towards the

development of competencies and standards for speciality areas by different professional bodies may lead to fragmentation, not to consolidation, and to confusion and unnecessary costs.

Development of the national framework for scope of nursing practice is a major priority given the foundation role it plays in nursing work organisation and planning. National leadership is required on these matters. We therefore recommend that one of the priorities for the new National Nursing Council of Australia is to gain agreement on a professional scope of practice model that allows for a flexible workforce structure and work organisation and is based on the principles set out in this report.

Recommendation 4 – Nationally consistent scope of practice

To promote a professional scope of practice for nurses and greater consistency across Australia:

- a) a nationally consistent framework should be developed that allows all nurses to work within a professional scope of practice, including the administration of medications by enrolled nurses
- b) to facilitate this development, all Commonwealth, State and Territory legislation and regulations that impact on nursing should be reviewed and reformed as required.

Proposed responsibility: Implementation taskforce with the NNCA

Models for regulation of the health professions

Adapted from Regulation of Health Professions in Victoria discussion paper 2003, Department of Human Services (Vic)

Model 1: Self-regulation.

Under this model, there are no occupational licensing or registration laws that require members of a particular profession to be registered with a statutory body. Consumers rely on a practitioner's voluntary membership of a professional association as an indication that the practitioner is suitably qualified, safe to practice and subject to a disciplinary scheme. Where the practitioner is an employee their employer also has responsibility for ensuring their safe and competent practice.

Model 2: Negative licensing.

Under this model, any person is able to practise in a self-regulated profession unless they are placed on a register of persons who are ineligible to practise. This is a more targeted and less restrictive form of regulation than Models 4–6 because it does not establish barriers to entry to the profession, but allows those with poor practice records to be excluded from practising without the need for a full registration system. However, it provides less protection to consumers than Models 3–6 and may be inappropriate when there is potential for serious harm.

Model 3: Co-regulation.

Under this approach, there is a range of models where regulatory responsibility is shared between government and the industry. For example, professional associations set membership requirements and administer a disciplinary scheme to ensure professional standards and the Government monitors and accredits these professional associations to ensure they act in a way that protects members of the public. Under such a system, practitioners who are not members of a co-regulated professional association are not legally prevented from practising or using the titles of the profession.

Model 4: Reservation of title only.

Under this model, particular titles of the profession can only legally be used by those who are registered by the relevant registration board. A statutory registration board establishes qualifications and character requirements for entry to the profession, develops standards of practice, and receives and investigates complaints of unprofessional conduct and applies sanctions, if necessary, including deregistration. It is difficult for a deregistered practitioner to practise because if they advertise their services to the public or use the reserved titles, they can be prosecuted through the courts for committing an offence. This form of regulation assures consumers that practitioners are qualified to provide services and their practice is subject to the scrutiny of a registration board. If there are risky and intrusive practices that should be restricted to certain registered health professionals, then these are generally contained in other forms of legislation, such as drugs and poisons Acts, radiation safety regulations and so on.

Model 5: Reservation of title and core practices.

Under this model certain risky and intrusive acts or procedures within the defined scope of practice of a profession are restricted via legislation only to members of the registered profession and other registered health professions identified in legislation. Unregistered and unauthorised (but registered) practitioners are not only prohibited from using reserved titles, but may be liable for prosecution for an offence if they carry out any of the reserved core practices for which they are not authorised. Exemptions are allowed for treatment provided in an emergency and where students perform core practices under the direction and supervision of an authorised member of the profession. This model has been implemented in Ontario, British Columbia and Alberta in Canada, and is currently being implemented in Queensland and Western Australia.

Model 6: Reservation of title and whole of practice.

This model is the most restrictive form of regulation and includes not only offences for unregistered persons to use reserved professional titles, but also a broad 'scope of practice' definition of the profession in legislation and an offence for unregistered persons to practise the profession. The main criticism of this form of regulation is that it allows monopolistic practices by the health professions and leads to demarcation disputes between the professions and increased fees and costs, with little if any added public benefits in terms of greater protection.

(Department of Human Services Victoria 2003, p.20)

Current Developments influencing Scopes of Practice (NRAs and Jurisdictions)

Current developments influencing Scopes of Practice (NRAs and Jurisdictions)

States/ Territories	Organisation	Current Developments/projects/changes	Further Information
ACT	Nurses Board of the ACT	<ul style="list-style-type: none"> Nurses Board of ACT is currently developing a Schedule and Standards Statements in accordance with the new ACT Health Professional Act 2004. Consultation at a Jurisdictional level is planned for April 2005 The new Act makes provision for maintenance of competence as a requirement of renewal of registration and the Board is developing its policy and requirements for this. ACT has registered its first nurse practitioner in the December 2004. 	www.nursesboard.act.gov.au
	Act Department of Health and Community Services	<ul style="list-style-type: none"> Complementary to the Nurses Board of ACT policy on medication administration by ENs, the Department is developing a policy on this matter to give consistent guidance on the practice of all ENs employed by ACT Health. 	http://health.act.gov.au
NSW	Nurses and Midwives Board of NSW	<ul style="list-style-type: none"> Recent amendments to legislation make provision for the Board to place conditions on registration on grounds of competence (although this does not apply to routine annual renewal). The Board recently authorised the first two Midwife Practitioners in NSW. Midwife Practitioner is a protected title. 	www.nmb.nsw.gov.au
NT	Northern Territory Department of Health	<p>Under the auspices of the Nursing Certified Agreement Taskforce, a number of reference groups have commenced working through issue arising from the current Agreement, including:</p> <ul style="list-style-type: none"> 5 reference groups implementing aspects of the Nurse Practitioner Project, focusing on legislation, regulation, employment; and implementation. A reference group for Advanced Scope of Practice for Enrolled Nurses <p>The Nursing Certified Agreement Taskforce is a joint collaborative between the Department and the ANF.</p>	www.nt.gov.au Paul Nieuwenhoven and Heather Traegar at Dept of Health and Community Services. Kirsty Hawkins – contact
	Nursing and Midwifery Board of the Northern Territory	<ul style="list-style-type: none"> In December 2004, the Board released a booklet to provide guidance to enrolled nurses, registered nurses, members of the health care team and clients/patients about the practice of enrolled nurses as it relates to the administration of medications in the Northern Territory. 	Available through the Health Professional Licensing Authority
QLD	Queensland Nursing Council (QNC)	<p>Current Projects include:</p> <ul style="list-style-type: none"> Review of Limitations on the Practice of Enrolled Nurses (Med) Review of the Scope of Nursing Practice Decision Making Framework Principles to Guide Decisions about the Nursing Practice Restriction Sections in the Nursing Act 1992 Review of Reliability and Validity of Self-assessment and Audit as Indicators of Continuing Competence for Practice 	www.qnc.qld.gov.au
SA	Nurses Board of South Australia (nbsa)	<ul style="list-style-type: none"> Standards for Delegation by a Registered Nurse or Midwife to an Unregulated Healthcare Worker in South Australia have been endorsed by the Board in February pending release in April. Scope of Practice framework for South Australia has been developed through a pilot trial and the draft is going out for consultation in March. The expectation is that the framework be endorsed by May 2005. 	www.nursesboard.sa.gov.au

Current developments influencing Scopes of Practice (NRAs and Jurisdictions)

		<ul style="list-style-type: none"> • About to commence work on an enrolled nurse framework to complement the Scope of Practice framework • Implementing the self assessment framework (standards and toolkit) for nurses and midwives to assess their ongoing competence – Consultation to validate the framework has commenced in Feb 2005 with a view to having it operational in June 2005 and will support declarations of competence for renewal in 2006/2007 • Prescribing framework for nurse practitioners and midwives in progress – changes to the regulations are holding over until the next Parliamentary session • Scope of Practice forum scheduled for April 29, 2005 	
	Department of Human Services	<ul style="list-style-type: none"> • SA Government has developed guidelines (2002) for The Assessment Of Admitting Privileges For Nurses & Midwives In South Australia. The document aims to describe a process whereby nurses or midwives can seek to pursue professional recognition and endorsement of their practice through the attainment of clinical and admitting privileges in South Australian health services. 	http://www.dh.sa.gov.au
TAS	Nursing Board of Tasmania (NBT)	<p>The Board is currently implementing the Recommendations of the EN Scope of Practice Project 2004. A number of working parties have been established, including:</p> <ul style="list-style-type: none"> • Working party for development of a Diploma in Health Nursing • Working party for development of an intravenous module (for ENs) • Working party for scopes of practice decision-making 	www.nursingboardtas.org.au
	Department of Health and Human Services Tasmania	<p>The Nurse Practitioner Scoping Project is a joint collaborative between DHS (Tas) and NBT to trailed nurse practitioners in Rural Health, Women's and Children's Health, Mental Health and Diabetes.</p> <p>The Policy and Legislation Committee for the project has released "The Discussion and Recommendations for the Framework and Regulation of Nurse Practitioners, December 2004". Consultation commenced on Monday, 10 January 2005 and is on-going.</p>	http://www.nursing.dhhs.tas.gov.au/nursepractitioner/index.html
Vic	Nurses Board of Victoria (NBV)	<p>A number of projects are underway or planned to commence as part of the Board's work plan, including:</p> <ul style="list-style-type: none"> • Decision Making Framework project • A review of recency of practice (commencement pending) <p>The Board endorsed the first nurse practitioners in Victoria in late 2004, and commenced endorsing Division 2 nurses who had completed approved medication administration courses at the same time. The Board is currently reviewing its Guidelines on medication administration by Enrolled Nurses and it's supervision and delegation guidelines.</p> <p>The first (Direct Entry) Bachelor of midwifery graduates registered as Division I Registered Nurses with restrictions to practice in midwifery in Victoria in Jan 2005.</p>	www.nbv.org.au
Vic	Department of Human Services	<ul style="list-style-type: none"> • Development and support for the Nurse Practitioner Project by DHS (Vic) is ongoing • The Department is currently leading work to explore extended scopes of practice for Division 2 nurses in a number of areas. 	www.nursing.vic.gov.au

WA Nurses Board of WA	<ul style="list-style-type: none"> • The Clinical Education for the Future Project is a joint initiative by the Nurses Board of Western Australia and the Office of the Chief Nursing Officer, Department of Health. The project is designed to identify and facilitate the evaluation, where necessary, of new models and methods of clinical education that are responsive to anticipated future trends in nursing and health care. A discussion paper that outlines the foundation of the Clinical Education for the Future Project and its progress to date is available from the website. A PowerPoint presentation that outlines the Clinical Education for the Future Project and invites feedback is also available. • Following from the Scope of Nursing Project, the Board has produced a Scope of Nursing Practice Decision Making Framework Learning Guide (December 2004) • Demonstrating Continued Professional Competence. The Board is developing a mechanism for assessing continued professional competence required for registration and professional practice. The participants for the 2005 demonstration audit of continuing Professional competence have been selected. 	www.nbwa.org.au
Department of Health, Govt of Western Australia	<p>The Clinical Education for the Future Project is a joint initiative by the Nurses Board of Western Australia and the Office of the Chief Nursing Officer, Department of Health (see above).</p> <ul style="list-style-type: none"> • A diploma course for EN pre-registration training has recently been introduced in WA • WA is investigating an enhanced role for midwives to order and interpret routine laboratory tests and initiate and administer certain pharmacological substances during uncomplicated pregnancy, labour, birth and the post-partum. The Enhanced Role Midwife Project is being developed and is near readiness for the implementation of the pilot phase, which will occur in March 2004. There are legislative components that are yet to be finalised by the project team prior to the implementation of the program proper, which will initially be piloted in three sites. 	http://www.nursing.health.wa.gov.au/
National		
ANMC	<p>The ANMC has developed a strategic plan to guide activities for 2005 – 2007. The Council's work plan includes a number of projects with relevance to scopes of practice:</p> <ul style="list-style-type: none"> • Accreditation of Nursing and Midwifery Courses • An Interim Review of the Competency Standards for the Registered Nurse • Role, Scope of Practice and Development of National Competency Standards for Midwives • The ANMC Nurse Practitioner Standards Project <p>The outcomes of these projects may impact on scopes of practice in all states and territories.</p>	http://www.anmc.org.au/

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