



N³ET POSITION STATEMENT:

NURSE PRACTITIONERS AND CLINICAL PRACTICE GUIDELINES

The National Nursing and Nursing Taskforce (N³ET) supports evidenced based practice and acknowledges the growing body of knowledge on the relationship between safety and quality outcomes and the use of tools such as clinical protocols, pathways and practice guidelines (hereafter referred to as Clinical Practice Guidelines - CPGs). This position statement clarifies N³ET's view of how, and when, clinical practice guidelines should be employed to ensure they contribute to quality outcomes but do not unduly restrict how nurse practitioners (NP) practice.

Background

A key aspect of N³ET work is to identify opportunities to achieve greater national consistency in nursing and midwifery scopes of practice, including the Nurse Practitioner (NP) role. How NPs are regulated and authorised in each State and Territory has been documented (National Nursing & Nursing Education Taskforce 2005) and subsequently the requirements for NPs to employ CPGs has been identified by N³ET as worthy of further attention. In particular, concerns have been raised that local policies relating to CPGs are resulting in unwarranted regulation and even restriction of NP practice, further contributing to variation in NP practice across Australia.

In undertaking the NP mapping, N³ET identified examples of policies and procedures for NPs that were substantially different from those applied to other members of the health team. The exercise of these procedures raises questions such as:

- *If there are appropriate multidisciplinary CPGs already developed, why are NPs required to develop their own?*
- *Are other levels of nurses required to develop and practice within similar prescriptive statements of clinical practice?*
- *Are other health professionals required to develop practice guidelines?*
- *If so, are NPs asked to provide reciprocal review/endorsement of guidelines for other disciplines?*
- *What evidence is there that such regulation of practice is warranted?*

Undoubtedly, many policies are a legacy of the early NP implementation phase however, it is timely to review existing structures in the interest of national consistency and optimal deployment of the health workforce. Some processes stem from legislative provisions however, in a number of cases, the requirements are a matter of policy and regulation interpretation and as such, can be readily revised. Indeed, some jurisdictions are now promoting the use of pre-existing guidelines and providing resources to assist with the process.

It is the view of N³ET, that some of the policies currently in place may either overly protect or alternatively favour, one discipline over another and that ideally, health workforce policies should be transparent, fair and equitable to all members of the team. Such policies should be embedded in a risk management model for professional practice rather than driven by professional agendas.

The role of service planning and NP practice

In some jurisdictions, government processes for approving NP positions in health services are in place. Where this does occur, there is often a requirement for the health service to demonstrate the need for a NP service to be eligible for funding to support the additional or "new" position(s). N³ET's view is that comprehensive, inclusive service planning can be a powerful and effective way to engage the many stakeholders and to promote the development of rational and innovative service options that address consumers needs. There is however, evidence that novel processes have been developed to demonstrate how the NP services will be incorporated locally and that these processes are not always applied to other disciplines.

Further, the requirement to develop CPGs or a statement of scope of practice, to define and possibly limit NP practice, is often linked to the service planning processes for NP. Service planning methodology for NPs is often premised on "locally agreed need" for the NP service.

N³ET supports a service planning approach that provides a rational and consistent methodology for determining the services the community needs and the ways those services can be safely provided. It is however concerned that there may be some blurring between identifying a locally agreed *need* for a service and expectations that there is local agreement on how that need can be met and in particular how NP can, should or will practice to meet that need.

For example, the requirement to assemble a multidisciplinary team and consumers in service planning is commendable however where this is extended to that group approving the contribution/scope of practice of the NPs there is a need for some caution.

The N³ET concern in this matter is based on a fundamental aspect of professionalism, that is, that a nurse or midwife's practice does not need to be authorised by other disciplines. All nurses and midwives are accountable for their own practice and their scopes of practice are determined by a complex interplay of enablers including regulation, policy, education and the professional and workplace culture. (National Nursing and Nursing Education Taskforce 2005).

Further, the application of tools such as Decision Making Frameworks (DMF) can offer additional rigor and consistency to the way in which individuals make decisions about their scope of practice and how employers can negotiate changes to a nurse's

practice. To assist in this, N³ET supports the development and timely implementation of national principles for DMF.

N³ET supports the position that the services provided by NPs should be determined with reference to, and in collaboration with, other members of the team, other services providers and consumers. However, decisions about who can provide a service or therapeutic option therefore, must recognise and be respectful of the education, experience, authorisation and professional standards that apply to the professional rather than being influenced by professional interests.

Accordingly, the process of developing a statement of NP scope of practice and/or CPG with input from members of the team and consumers must be undertaken with explicit understanding and clear agreement on the role and extent of authority of the various members in the process.

The involvement of NPs in reviews such as service planning that directly or indirectly shape their practice indicates the collaborative and co-operative focus of nursing practice but does not imply that authority from other disciplines is required.

Further, N³ET would support NPs having similar reciprocal arrangements for all new or additional services in relation to all other health disciplines as a way of validating the assumptions underpinning the approach for the entire health team.

Clinical practice guidelines and NP practice

It has become common practice for CPGs to be a part of the various authorisation processes for individual NPs⁷ and in particular they were introduced in some jurisdictions as a way of managing the granting of prescribing authority for NPs.

Considerable effort and attention is often placed on the individual NPs CPG and the process for developing and implementing CPGs for use by NPs often includes a number of other service providers and professional groups. The rationale for this approach often has its genesis in the requirements or conditions other providers placed on the original introduction of NP model. Presumably, the approach is based on a belief that NP practice will be safe only if they are required to develop and practice within defined parameters. Further, some level of approval and oversight by other professions was and is, required.

A blanket approach is however burdensome, may create a false set of expectations about safe practice and is not embedded in established clinical risk management frameworks. The use of such frameworks in relation to NP practice would assist in developing an organisation- wide understanding of when CPG are warranted and provide a consistent stratified approach to the range of interventions and practices provided by the entire team (Australian Council for Safety and Quality in Health Care 2005;

⁷ Clinical practice guidelines are "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances" (Field 1990)

Department of Health Government of Western Australia No date).

The role of evidence based practice and how the use of tools such as clinical protocols, pathways and practice guidelines can contribute to the quality and safety agenda in health is important however, the ways in which such tools are developed, implemented, and revised can impact on their effectiveness. Evidence based practice can be defined as:

"...the integration of best research evidence, clinical expertise and patient values in making decisions about the care of individual patients. Clinical expertise is derived from the knowledge and experience developed over time from practice, including inductive reasoning".

(Committee on the Health Professionals Education Summit 2003)

N³ET supports this definition and notes in particular, the central principle that CPGs do not replace clinical judgement and are intended as a guide to making decisions not the sole way of managing a client/patient. The benefits of multidisciplinary guidelines include:

- Agreement on clinical aims and alignment of effort
- Synchronisation of care and the provision of more consistent information to clients,
- Less duplication, reduction in effort and cost associated with multiple separate, pathways/protocols,
- Promotion of innovation and flexible, responsive care options, and
- Greater sustainability of guidelines that improve care.

However, the use of CPGs by only one member or one discipline in the health team, such as NPs, can have contrary effects. The development of discipline specific CPGs rather than multidisciplinary tools can contribute to fragmentation of care, reinforce traditional roles for health workers and maintain conventional models of delivering services.

It is known that developing, implementing and managing CPGs is a complex process that requires considerable time², money³ and other resources. Considerable expertise is needed to lead the process, to reduce the bias inherent in the process and to manage the technical and change management aspects of the task. There is therefore, a need for considerable organisation commitment, attention and investment to support CPGs including transparent, equitable systems for resourcing their development, communication, dissemination and periodic review and evaluation (Hindle and Yazbeck 2005).

Despite the success factors being well documented in the many "guides to developing guides" (National Health and Medical Research Council 1999; An Bord

² National Institute for Clinical Excellence (NICE) recommended process for a new guideline requires a cycle that takes up to two and half years to complete, from scoping to validation.

³ NHMRC estimated the cost to develop a single national CPG at \$160,000 in 1997, excluding dissemination or maintenance.

Altranais 2000; National Institute for Clinical Excellence 2004) and the literature on dissemination of practice change, N³ET is concerned that the burden of developing CPGs often rests at the level of the individual NP rather than at an organisation level - an approach that is likely to have limited success for both the individual or the organisation. Further, the return on investment will be maximised if CPGs are developed for use by all members of the team rather than investing in multiple CPGs for individual disciplines.

Adoption of interdisciplinary models of practice within healthcare is highly desirable and in interdisciplinary practice, decisions about services are based on principles of collaboration, co-operation and collegiality. N³ET supports the principle of equity in that the same or similar principles to guide decisions about scope of practice should apply for all members of the team unless there are compelling reasons (such as legislative restriction/protected practice) for developing different ones. The clear aim of such decisions is to improve access, safety and quality, not to restrict or protect practice. N³ET supports the development and application of multidisciplinary CPGs that focus on what care/treatments a given population requires rather than who provides the care. CPGs for the multidisciplinary team acknowledge and utilise the overlapping and complementary skill sets of the entire health team.

CPGs should be high level documents to assist decision making not detailed procedures or protocols. A risk management approach should be used to identify elements of a team's clinical practice that may warrant the use of a CPG.

If a decision is made that CPG are to be used, then N³ET recommends that:

- Nationally or internationally accepted guidelines should be adopted by the health team rather than by individuals.
- Except in clinically unique circumstances, existing guidelines should be used. There are a large number of guidelines and clearing houses for guidelines that have been developed both locally and overseas that can be used to identify potentially appropriate CPGs. A systematic approach to evaluating existing guidelines such as AGREE methodology (The AGREE Collaboration 2001) should then be used to identify suitable CPG rather than requiring NP to develop their own.
- If there is a need to develop a 'new' guideline, then nationally best practice methodology to develop multidisciplinary CPGs, such as that produced by NH&MRC (National Health and Medical Research Council 1999) should be used.

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REFERENCES:

An Bord Altranais (2000). Guidance to Nurses and Midwives on the Development of Policies, Guidelines and Protocols, An Bord Altranais,.

Australian Council for Safety and Quality in Health Care (2005). National Patient Safety Education Framework. Canberra, Australian Council for Safety and Quality in Health Care,.

Committee on the Health Professionals Education Summit (2003). Health Professionals Education: A Bridge to Quality, The National Academies Press.

Department of Health Government of Western Australia (No date). Pocket Guide to Clinical Risk Management., Department of Health Government of Western Australia.

Hindle, D. and A.-M. Yazbeck (2005). "Clinical Pathways in 17 European Union countries: a purposive survey." Australian Health Review 29((1)): 94-104.

National Health and Medical Research Council (1999). A guide to the development, implementation and evaluation of clinical practice guidelines. Canberra, National Health and Medical Research Council.

National Institute for Clinical Excellence (2004). The Guideline Development Process. An Overview for Stakeholders, the Public and the NHS. London.

National Nursing & Nursing Education Taskforce (2005). Nurse Practitioners In Australia: Mapping Of State/Territory Nurse Practitioner (NP) Models, Legislation and Authorisation Processes.

National Nursing and Nursing Education Taskforce (2005). Scope of Practice Commentary Paper.

The AGREE Collaboration (2001). Appraisal of Guidelines for Research & Evaluation (AGREE) Instrument. London, The AGREE Collaboration.

About N³ET

The National Nursing and Nursing Education Taskforce (N³ET) was appointed in November 2003 to implement recommendations of the National Review of Nursing Education (2002) *Our Duty of Care* report along with work from three recent Australian Health Workforce Advisory Committee (AHWAC) nursing workforce reports and additional work on nurse specialisation.

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