



PROCEEDINGS – NURSE PRACTITIONER WORKSHOP

Introduction

The College of Nurses Aotearoa hosted the third in a series of workshops to foster debate and critical examination of the various issues associated with the ongoing development of the Nurse Practitioner role in New Zealand. The workshop was held at the Convention Centre, Palmerston North on 18/19 May 2007 and was facilitated by Joanna Harper of Harper Devine. Fifty-five people from various parts of New Zealand and from a wide range of practice and leadership settings attended the workshop. Chief Advisor Nursing, Mark Jones was present for most of the workshop and various other sector leaders presented at the event.

Previous workshops held in 1999 and 2003

A brief history of the focus and findings of those workshops is included as Appendix One.

Process

The College advised key stakeholders that it wished to host another two-day consensus workshop to debate current issues related to the ongoing implementation of the Nurse Practitioner role in New Zealand.

Early notification sent to stakeholders stated that

The two previous workshops, in 1999 and 2003, had been pivotal in progressing dialogue, understanding and decision-making. A number of issues now exist which warrant further attention by the profession.

The purpose of the proposed workshop will be to discuss:

- * The relationship of other advanced practice roles (often called CNS) to the NP role. Issues of career progression processes are not yet resolved.
- * Management of authorisation including of US and Australian NPs.



- * Issues often referred to as the generalist / specialist debate in relation to the NP role. Is it an either / or situation or can we accommodate all variations?
- * Future role and contribution of NPNZ as a division of CNA(NZ) Inc and of NPAC-NZ as an articulation of all major organisations.
- * Liaison with the Nurse Practitioner Facilitation (NPF) programme now led by DHBNZ following the completion of the Ministerial Working Party on Nurse Practitioner Employment and Development.
- * NP competencies.

Stakeholders were invited to affirm the direction of the workshop or suggest changes or additions to the proposed material for discussion.



Workshop Content

DAY ONE

*** Mark Jones (Chief Advisor Nursing: Ministry of Health)**

Mark Jones prefaced his presentation with the explanation that, whilst he had been listed as giving the view of the Ministry, he was in fact presenting the 'Personal Perusals of a Pondering Pom' – the title of his session.

Mark described his involvement in the development of the first NP programme in the UK, and subsequently in the establishment of the role in other European countries. Mark also worked with ICN to establish the International Nurse Practitioner and Advanced Practice Network.

A significant issue for Mark was the use of 'nurse practitioner' as both role title and scope of practice. He expressed a belief that using the title in this way could potentially undermine the 'essence' of NP practice. His view was that NPs practise from the basis of a broad 'population focus' which is subsequently narrowed by virtue of specific skill sets rather than pure speciality focus. He used two examples in an attempt to illustrate this: a recent proposal from a DHB to develop the role of 'nurse practitioner endoscopy', and that of a US women's health / colposcopy nurse practitioner.

The endoscopy proposal on the face of it had little to do with the essence of advanced nursing practice. It described a nurse who had been given additional instruction in endoscopy. The role would involve performing endoscopy day in and day out, with little contact with patients prior to or after the procedure. Hardly an advanced practice role, not really a nurse specialist role, perhaps in fact an 'endoscopy technician' role.

By way of contrast, the US NP had identified a population with whom she would work – women. She acquired the skill of colposcopy and ran a women's health clinic. As part of her work the NP, through detailed examination, history taking, and whatever, offered treatment options to women. These included colposcopy; a procedure which she was able to perform. In contrast to the endoscopy role, here was an advanced practice nurse working with a broad population having specific needs for an intervention in which she was an expert. She could duly claim credit to be an advanced practitioner.



Mark went on to suggest that having 'nurse practitioner' as the title of the most advanced level of practice acknowledged by the regulation authority in NZ ran the risk of the essence of NP practice described above being compromised. This is because other nurses who wish to legitimise a claim to advanced practice have nowhere to go other than to petition Nursing Council for recognition as a nurse practitioner.

Jones felt that clinical nurse specialists with narrower scopes of practice than an NP, yet able to demonstrate advanced practice competencies, would begin to access the Nursing Council regulated 'NP scope'. The inherent risk here is to undermine the true nature of NP practice – broad population base, narrowed specialisation from that base, application of specialist skills as appropriate.

The proposal was to institute a scope of practice entitled 'advanced nursing'. NP would be an example of role which would fit within this scope, whereas other advanced practitioners – clinical nurse specialists with demonstrable advanced skills – could access the scope for the purpose of verification of their practice if they so desired. This would separate out the use of the term 'nurse practitioner' as a descriptor of role and level of practice.

Mark acknowledged that this could be a simplistic analysis, but offered the thesis to the group for consideration as part of their deliberations during the day.

* **DHBNZ - The NP Facilitation project - an update from Marilyn Rimmer**

Following termination of the Nurse Practitioner Employment and Development Working Party at the end of 2006, responsibility for creating an NP role development facilitation programme was passed to the DHBNZ with accompanying funding of \$300,000. The vision of the original working party was that two designated people would be appointed to work with DHBs (including PHOs) and NGOs for approximately one year to assist in the process of marrying areas of service need with the creation of NP positions.

Marilyn reported that DHBNZ had created a Nurse Practitioner Facilitation project steering group who have had one face-to-face meeting at this point. Members of that steering group are Dr Elaine Papps (Director of Nursing, Hawkes Bay DHB), Chair; Susanne Trim (NZNO, previously member of WP); Mary Smith (GM, Planning and Funding, Lakes DHB); Dr Susan Jacobs (NETS - previously member of WP); Eldred Gilbert (Director of Nursing, Primary



Care, C&C DHB); Mark Jones, Chief Nurse, (ex officio). It was also noted that NPAC-NZ is in the process of nominating an NP for the steering group.

DHBNZ have advertised one 0.4 co-ordinator position but at the time of the workshop had not been able to appoint. Marilyn also noted that it was DHBNZ's view that rather than have the two "champions" as previously envisaged by the Working Party, it would be better to concentrate on increasing the knowledge of relevant funders, planners and service leaders; and developing mechanisms which provide incentives for DHBs to establish NP positions. With the limited funding available for this project, it was felt more could be achieved this way, than through salaries for the full-time two champions.

* **NPAC-NZ - Presentation/update by the Chair, Deborah Harris**

The Nurse Practitioner Advisory Committee of New Zealand (NPAC-NZ) presented a brief overview outlining the purpose and terms of reference of the group. NPAC-NZ has recently reviewed the role of the committee with the four key professional nursing organisations, the Nursing Council of New Zealand, and other key stakeholders. NPAC-NZ presented the results of the review at the workshop. There was strong support for the continued development of NPAC-NZ. Priority areas for NPAC-NZ to focus on for the next three years were identified and discussed; these are listed here in order of identified importance:

- Influence DHBNZ into developing Nurse Practitioner (NP) roles and influencing the NP facilitation group
- Continue to advise the Nursing Council of New Zealand on matters related to the NP model
- Increase the profile of NPAC-NZ within Nursing
- Increase the profile of NPAC-NZ within Medicine and the public eye
- Influence and shape policy regarding the NP role
- Prescribing legislation and enactment
- Collective voice for NP issues
- Clarity surrounding the functions of the various NP groups
- Encourage broad scopes and define these

Finally the current employment status of NPs within New Zealand was presented (see attached map – Appendix Two)



* **Nurse Practitioners NZ: Presented by Jackie Robinson on behalf of Helen Snell, NPNZ Chairperson.**

Jackie reported that Nurse Practitioners NZ (NPNZ) is a division of the College of Nurses Aotearoa (NZ). NPNZ is open to all registered Nurse Practitioners in NZ and provides a forum to contribute to individual and national advancement of the NP role. In addition, NPNZ provides a professional formal network. The group meets twice a year and has regular contact via an email network where practice direction is debated and formulated on a national level. It is an opportunity to guide and integrate the strategic directions into the context of Nurse Practitioner clinical practice. Members act as a source of mentoring and support for all registered Nurse Practitioners in New Zealand and links with equivalent Nurse Practitioner forums internationally. NPNZ co-ordinates its efforts with the Nurse Practitioner Advisory Committee of New Zealand (NPAC-NZ) and provides a forum to contribute to the ongoing development of nursing as a discipline.

* **The Relationship of the NP to other Advanced Practice Roles: Presented by Bernie Twomey, DHBNZ and Lyn Olsthoorn, NZNO**

The Relationship of the NP to other Advanced Practice Roles

The history behind scoping of senior nurse roles:

Prior to 2004 - 15 nursing collectives (5 MECAs) IEAs (Individual Employment Agreements) across 21 DHBs. Terms & conditions varied. Nurses who had similar roles and responsibilities were paid differently based solely on their place of residence and workplace. Titles were numerous - no agreed definitions for titles/roles.

In 2005 National MECA settled. Part of the terms and conditions of the MECA was the formation of the bipartite working party to align senior nursing positions and community based positions across the 21 DHBs.

The Job Evaluation Review Committee (JERC) was established with 16 members (eight DHBNZ & eight NZNO).

Compers was used as the tool for scoping as it had been used previously in several nursing DHB position evaluation reviews in the North Island and given this history it was considered a valid tool.

The committee discussed:

- 1) **Considerations in Job Sizing** Key features of this consideration included that:
 - only designated senior positions reviewed in the process



- the review is about the role not the person in the role
 - accurate job descriptions are vital
 - accurate organisational context of roles
 - nine Factors in Compers considered.
- 2) **Advanced Practice Roles** - Nurse Specialist and Nurse Practitioner discussed within the context of the JERC
- 3) **Progress made to date by the JERC committee includes:** Senior Nurses Titles Working Party, Senior Nurse Job Evaluation Review Committee, MECA currently being renegotiated.

WORKSHOP SESSIONS

Question - What is the relationship of the NP to other advanced practice roles? How do the notions of specialisation and generalism intersect with role definitions for advanced practice?

Three groups debated this topic and fed back to wider group. Common themes in the feedback included:

- NP roles are about health outcomes and the needs of the community and should be constructed and shaped accordingly.
- There is room for both broad and narrow roles. They are both equally valid and the NP must demonstrate Nursing Council competencies in whichever/both according to the needs of the population group for whom they intend to provide care.
- Lack of clarity about this issue is clearly acting as an employment barrier. We need a united way forward – to work together – resolve image issues (there is a lack of understanding of the role anyway).
- Nursing is holistic by definition and this is an important lens through which to view the nature of any advanced practice role.
- There is no clear differentiation between generalist and specialist anyway - how general is general and how specialist is specialist; potentially the terms just cause more confusion.
- What is the role of the CNS? Agreement that the common view is that it is a specialist role with more narrow scope. Do we need to value the role of CNS specifically?



- Credentialling process - we need one in NZ. CNS not NCNZ responsibility.
- Funding and industrial challenges for employers/DONs in employment of NPs.
- Do we need to articulate the difference between the CNS role and NP role? Does it actually matter?
- Was there ever a planned approach to the introduction of the NP roles – it is such an unknown? How many, what areas etc. How do we define the requirements?
- The issue of the lack of a clear career pathway for nurses to follow is probably one of the most challenging areas. The need to be very focused and plan education and career development means that the vagueness around advanced roles can create wastage of time and money for nurses.

DAY TWO

* **Funding of Postgraduate Education – Prof. Jenny Carryer**

This presentation noted the significance of postgraduate education funding to the establishment of the NP role. Jenny Carryer noted that in January of this year, the College had provided the Tertiary Education Commission with an outline of significant concerns related to the funding of nursing education at postgraduate level. To date no definitive response has been received from the TEC although numerous discussions have been held. The TEC funding of Nursing EFTS is at considerable variance with all other clinical disciplines. Whereas medical EFT funding attracts over \$30,000 the amount for a nursing EFT is \$8,900. Other clinical disciplines range between these two extremes. The funding for nursing is now inadequate to support or guarantee:

- Programme quality
- Recruitment of high quality clinical and research staff against DHB salaries
- Maintenance of a vigorous and up to date teaching and learning environment
- Purchase of high quality clinical placements especially in innovative environments

Stresses created by inadequate EFT funding are compounded by the PBRF (performance based research funding) mechanism, which does not fully encompass the additional constraints of a clinical discipline. This is being explored currently by the TEC review of PBRF but we cannot afford to wait for or rely entirely on that outcome which will be at the end of 2008.



The volume of CTA money directed towards post entry clinical training for nursing through DHBs is completely inadequate. Lack of funding for the national entry to practice programme for nurses entering primary health care settings is just one of the serious outcomes.

Nurse Practitioner education and training is therefore funded on an ad hoc basis; this makes it very difficult for planned and co-ordinated activity by DHBs or NGOs to marry the development of positions in line with identified population need.

Professor Carryer noted that it remains the case that the funding of nursing education is seemingly not taken seriously despite the critical need for appropriate resourcing to support what is the largest, most diverse and flexible health workforce.

* **Nursing Council of New Zealand – Marion Clark**

During day one workshop participants had expressed considerable concern about the failure of Nursing Council to release results of the NP authorisation study done in 2006, the seeming absence of progress on new competencies and ongoing concerns about the time frame for the authorisation process. Participants also noted the huge amount of work that Nursing Council had done towards the establishment of the role, the many successful authorisations and Council's energetic work towards nurse prescribing. It was good to have Marion Clark present to address the issues.

Marion advised the workshop that the Council expected to publish the evaluation of the process within the next couple of months and that the draft competencies were to be circulated for feedback within the next couple of weeks. She also presented an analysis of the timeframes of the registration. Participants noted that Council had increased the resources for the registration of nurse practitioners and the time frame for dealing with applications had significantly reduced over the last six months. They also noted that overseas applicants were treated exactly the same as New Zealand applicants and any change to this would require a new Gazette Notice under Section 12 of the Health Practitioners Competence Assurance Act following due consultation. Marion presented an overview of the process and numbers of nurse practitioners and an update on the Medicines Bill and its impact on prescribing.



- * **The Generalist/Specialist debate. Panel discussion - Dr Michal Boyd, Sue Wood, Bernadette Forde**

Each panellist presented a personal perspective on the topic as summarised here.

Bernadette Forde, NP Mental Health (MH)

Specialist roles may be limiting and whilst Nurses (NPs) may have positions they are being supported into within their DHB or elsewhere, a specialist NP scope may be restricting to them (into the future if they wanted to move) as well as to their DHB in the future. General scopes will make for more transferable roles.

Bernadette discussed her own NP role in mental health and described how a portion of her role is determined at the start of the year based on the needs of the MH service and she explained how her NP skills are then used to meet that need. She provided examples to show how her first year was used to focus on the physical health needs of consumers of the service and getting better links and systems with GPs. The second year was developing a metabolic monitoring framework for the MH service. This was driven by a MoH directive and also consumer need. This year she is working with PHOs to strengthen the alignment between primary and provider-arm MH Services to build and strengthen the MH capacity and capability of the PHOs.

Bernadette focused on getting people to think beyond the narrow scopes that we have been seeing develop in the country and also talked about the need for international compatibility, for example, wound care specialist in the states would be seen as a CNS role.

Dr Michal Boyd, NP

Registration and Credentialing of Nursing Practitioners in the United States

Currently, there is no formal Clinical Nurse Specialist (CNS) recognition by New Zealand regulatory bodies such as the New Zealand Nursing Council. Some have suggested that the Nursing Council register CNSs in a process similar to that used for Nurse Practitioner registration. The question for New Zealand nursing is how can CNS's clinical expertise be formally recognised, without creating another cumbersome and costly registration process for the New Zealand Nursing Council.



One of the main issues is whether to recognise advanced practice scopes that are focused on a disease type, health problems or specific clinical interventions. This is what has evolved for Nurse Practitioner's scope of practice that include clinical specialties that range from acute neonatal care, rural primary health care, Maori health, diabetes care and wound care just to name a few. In contrast, another way to recognise advanced practice specialty is through very broad, population-based areas of practice encompassing common problems of that group of patients and likely co-morbidities, interventions and treatments. Examples include neonatal, child, women, adult, family, and mental health.

The United States has debated this issue for the last 30 years. Most states have chosen to use an advanced practice registry based on broad population scopes which include Nurse Practitioners, Clinical Nurse Specialists, Midwives and Nurse Anaesthetists. This registry does not recognise sub-specialties such as diabetes care, wound care, palliative care as the New Zealand NP registration process does. In the US, these sub-specialties are recognised through a separate credentialing process.

Therefore, there are two recognition processes for advanced nurses, one is registration through the State Board of Nursing and the second is credentialing through a recognised professional credentialing body. In the US, most Nurse Practitioners are required to have both APN registration and credentialing in a sub-specialty to fulfil the requirements of employment, for insurance and government payment and also to obtain malpractice insurance.

The American Nurses Association established the ANA Certification Program in 1973 to provide tangible recognition of professional achievement in a defined functional or clinical area of nursing. This organisation later became the American Nurses Credentialing Center. The purpose of this organisation is to certify healthcare providers in specified sub-specialties to provide tangible recognition of professional achievement in a defined functional or clinical area of nursing. There are over 25 different sub-specialty certifications available. This body also accredits educational providers, approvers, and programmes.

In New Zealand, there is currently no definitive mechanism to recognise advanced nursing practice sub-specialties except through Nurse Practitioner registration. This has resulted in very narrow NP sub-scopes based on disease or condition rather than population. Another option is to have a broad registration of NPs into population scopes, such as child, adult and



family, and to recognise specific clinical expertise of NPs and CNSs through separate credentialing process. Credentialing could be provided through professional bodies such as the NZNO and the College of Nurses Aotearoa. Credentialing would alleviate the need for a new and separate registration process through the New Zealand Nursing Council for Clinical Nurse Specialist.

Sue Wood (Director of Nursing: MidCentral Health)

Sue gave the following address summarised here.

The debate about generalist or specialist nursing is a spurious one. It survives in nursing discourse because of the lack of rigour in thinking around what it means to be a nurse, and the business of professional nursing.

Man began to specialise in the 17th and 18th centuries. The knowledge revolution from world travel and discoveries led the leaders of knowledge analysis and cataloguing to argue for specific disciplines of knowledge. There was a move away from the polymath – the well rounded man – to the specialist – a person steeped in knowledge in a discreet area in those times, such as scientists, botany and chemistry. I would contend the argument about specialist in nursing today is locked into the biomedical model of reductionism and Cartesian dualism.

In this biomedical model health equals the absence of disease. Medicine is rooted in the mechanistic world-view that is a given, taken for granted as fact, with bits and bytes, machines and aids. Specialists abound, within narrow fields so that a person requires up to 15 people to have their body systems attended to. Those people see only part of the whole; they do not integrate the part to the whole.

Specialisation requires reductionism; it requires the whole to be broken down into the parts. It's a widget model devoid of context and meaning. If nurses are specialists they too are then potentially focused on a body system. Should we then call them physician extenders? It is crucial that nurse practitioners resist at all costs such a practice. The focus for their value and difference lies in their focus on the whole person in context.

Disease is the manifestation of alteration at cellular, tissue, or organ level. Disease is treated as a thing in itself, something to be attacked. People can have a disease yet not



suffer, not experience an illness. Illness is the human experience of loss or dysfunction. Illness has a reality all of its own. The person lives the illness experience. Illness may or may not be related to disease. Yet the efficacy of the treatment of the illness will be hindered and suffering will be increased when treatment does not match the person's understanding of the illness.

We nurses believe health is bigger than the sum of the parts. Nurses care for people in health, in the midst of pain, loss, fear, disfigurement, death, grieving, challenge, growth and transition. Nurses attend to the relationship between illness and disease. It is a privilege to be a nurse. Health in the modern age is a complex construct, it requires a holistic perspective as it is understood as wholeness integrated unity. Understandings of health are closely connected and are constituted by and help constitute understandings that are held about persons and their environment. Nurses claim to be about health; nurses attend to the lived experience and the meanings ascribed to these experiences.

We say we are holistic, yet we discourse and work within biomedical specialties which may lead you to think of nurses as specialists. To be holistic, nurses do have to address the body. Nurses do reduce the body to systems and organs to manage the therapy in the hope of improving the lived experience. But I would contend they do this with a lens that sees the parts and the whole, the lived experience demands they reconstitute to the whole, nurses work demands a broad set of competencies which address far more than the biomedical specialty they practice out of. Nurses need an access point for contact. This may be the area of practice but the specialty is not the practice territory. I contend that nurses are not specialists, they are holists.



Summary statement

Panellists and group discussions strongly supported an approach which affirms advanced practice roles as defined by a nursing approach. Loosely translated this perhaps means that whilst Nurse Practitioners may access their patients and clients by a particular population group (people with diabetes, people with mental illness, children, people with respiratory disease, elderly people), the care and service they provide will be holistic for that group. Simplicity of career development would see the CNS role, not as discrete role but, as a stepping stone to NPs and perhaps the period in role development when the skills and knowledge specific to the population group are honed.

Final Discussion

Following the panel presentations a whole group discussion was held at which it was acknowledged that a number of high level barriers were acting as a “log jam” to enabling both the full potential of nursing itself and, more specifically, the development of NP roles. Currently in relation specifically to NP role development there are a number of key issues that need urgent resolution at a strategic level.

1. Employment issues for NPs. Problems with lack of understanding of the role and the services provided by an NP.
2. Funding streams as a barrier to NP role development. Seeming inability for decision makers to manage funding streams to support role development.
3. Barriers to NP practice; legislative and custom and practice issues based on ignorance. Current debate about designated to authorised prescribers.
4. Education barriers through poorly supported funding of nursing postgraduate education.

Jenny Carryer suggested the need for a taskforce to examine these intersecting issues at a sufficiently high level. This was discussed by the workshop. The rationale for such a taskforce could be as follows:

Nursing is a diverse, flexible and broadly distributed workforce which holds huge potential for meeting current challenges if its development and deployment are not constrained by unnecessary impediments. Currently there are a number of issues jointly acting as a "log



jam" against ensuring the ongoing responsiveness of nursing to current needs for workforce development in the face of predicted service demand.

Over the last five years, the nursing leadership has provided a clear evidence-based rationale for the needed developments and has consistently articulated its willingness and enthusiasm to embrace change. Much expensive and time consuming work at the analysis and explanation level has been completed but almost no actual responses to that analysis have yet occurred at the policy level. Minor innovations and small-scale investment have tinkered at the edges only.

The root problem appears to stem from a bureaucratic lack of commitment to challenging the status quo and a lack of courage to challenge vested interests outside nursing. We need a relatively independent strategic consideration of the current barriers, an overview of the work already completed and high level championing at the policy level.



Appendix One

PREVIOUS WORKSHOPS

Workshop One 1999 (excerpted from proceedings)

By November 1998 it was evident that several tertiary institutions were beginning to plan advanced nursing practice programmes. Work towards the extension of prescriptive authority for nurses was also well underway. Throughout the health sector a proliferation of nursing titles and roles could be identified with no national consistency in scope of practice or educational preparation. All of this was occurring in a context in which:

1. There are different ideas about what percentage of the nursing workforce will ultimately practice at the advanced level - estimates range from 3% to 30%.
2. The available literature clearly supports Masters education as the only appropriate preparation for advanced practice, but there was some disagreement among New Zealand nurses, with some arguing that one year is sufficient and others suggesting that advanced practice is the result of experience alone.
3. Some were committed to the development of two very separate roles: clinical nurse specialist and advanced practice nurse. Others looked toward the North American experience where the development of two separate roles was considered to have been a mistake, and believed we should develop one role here.
4. Many believed that prescribing preparation should be an integral part of advanced practice preparation, whilst others argued that it can be separate.
5. Significant concern exists within the profession about the potential for advanced practice roles to mimic medicine and lose the unique character of nursing. Nursing is clear that this is not the goal of advanced practice roles.



The following is a summary of the key points of agreement reached at the 1999 workshop:

Advanced Nursing Practice (APN)

- the role incorporates advanced knowledge, skills and practice wisdom manifested in clinical excellence which may involve specialisation
- Nurses in this role respond to complex situations in a diversity of contexts with holistic nursing care
- the scope of practice covers primary, secondary and tertiary practice settings
- there is a flexible partnership with Maori
- intersectoral and multidisciplinary collaboration ensures aims are shared
- the hallmarks of the APN are utilisation of research-based nursing knowledge
- APNs provide clinical leadership and direct care in a variety of capacities, managing client care case loads, with the right to prescribe, order tests, refer to specialist services, and to admit directly to health care facilities
- APNs (as for all other registered nurses) have full professional accountability but also work collaboratively
- APNs are politically active on behalf of improved service to patients and clients.

Education Preparation

- all post graduate nursing education must have a clinical focus and base
- the Nursing Council Framework, Guidelines, and Competencies for post-registration nursing education, and their continued refinement, is endorsed
- these competencies are to provide the benchmark for the Recognition of Prior Learning process
- full preparation for advanced nursing practice is to be a clinically focused Masters degree with options to exit at postgraduate certificate and postgraduate diploma level for experienced practitioners who have already acquired other sources of appropriate education. Education for prescribing must be positioned within advanced practice programmes as it has no meaning outside that context.
- advanced programmes to include a core component, specialty option, and a practice focus
- development of advanced nursing practice programmes requires consultation between practice and education
- professional advice should be provided to education providers to ensure consistency and adherence to national standards



Research

- research is integral to the role of the APN
- it is essential that the impact of APN on various stakeholders should be measurable in terms of both demonstrated health gains and quality nursing outputs

Credentialing

- Nursing Council to co-ordinate and manage the credentialing process with professional organisations
- In the same manner that the title nurse is protected, so must the title relating to advanced practice. Title protection is for public safety and this is especially important in the area of advanced practice
- current nursing expertise needs to be recognised through an RPL process (see Education)
- the role is underpinned by the Nurses Act and the Medicines Act.

Workshop Two (2003)

Leading up to this forum the College of Nurses Aotearoa worked with the nursing leadership throughout New Zealand to canvas opinions on issues that should be covered at the forum, and to determine the best processes and format for covering these issues. Initial input was welcomed from all nurses, and in particular assistance was sought from the New Zealand Nurses' Organisation, the Nursing Council of New Zealand, the Nurse Practitioner Advisory Committee, the Australian and New Zealand College of Mental Health Nurses, Nurse Executives of New Zealand, Nurse Educators in the Tertiary Sector, and the Council of Maori Nurses.

The first activity for the 80 participants was a SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis of the Nurse Practitioner role in New Zealand. This analysis was done in small discussion groups. The group as a whole then reconvened to share the findings of the SWOT discussion groups and to hear presentations from the three guest speakers. A major focus of the forum was participant generated analysis of six major topics which had been selected and advertised as part of the programme prior to the start of the Forum.



The six discussion topics are listed below:

1. Remuneration packages for Nurse Practitioners
2. Scopes of practice for Nurse Practitioners
3. Co-ordinating masters specialities nationally
4. Nationally consistent titles/a national clinical career structure for Registered Nurses
5. Bedding down implementation of the Nurse Practitioner role via the District Health Boards
6. Protecting the vision of the Nurse Practitioner as a senior clinician



Appendix2 NP

