ADVANCED NURSING PRACTICE
IN NEW ZEALAND: 1998

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ABSTRACT

In the last decade, change in the health sector has often seemed to deny and thwart the professionalism and expertise of nurses. However, in the first half of 1998, a number of positive initiatives have come to fruition, which support the development of clinical and educational structures for advanced practice nursing in New Zealand. Within one month of each other the Nursing Council published its framework for post-registration nursing education, and the Nurse Executives of New Zealand published a proposal for the development of advanced practice roles: clinical nurse specialist and nurse practitioner. This article will explore these initiatives, and will examine the proposed clinical nurse specialist and nurse practitioner roles in light of experience in the United States in developing advanced or expanded nursing practice.

KEY WORDS: advanced nursing practice, clinical nurse specialist, nurse practitioner

INTRODUCTION

History is the archive, the drawing of what we are and what we are ceasing to be, whilst the current is the sketch of what we are becoming (Deleuze, in Nelson, 1997, p. 229).

The array of policy documents, proposals, Government decisions and undertakings released during 1998 suggests that currently there is a new wave of nursing professionalism and practice which is being sketched out in New Zealand. The development of advanced and extended nursing practice is gaining impetus.

Two key documents are Developing and Supporting Advanced Practice Roles: Clinical Nurse Specialist, Nurse Practitioner put out by the Nurse Executives of New Zealand (NENZ) in April, and the Nursing Council of New Zealand’s Framework, Guidelines and Competencies for Post-Registration Nursing Education published in May. While the development of both these documents has taken place over time, their issue occurred at a point when several other events were bringing the advancement of nursing practice into focus.

In February 1998, the Minister of Health, Bill English, established a Taskforce on Nursing, and then on May 12, International Nurses’ Day, announced that an amendment to the Medicines Act 1981 would be introduced to enable nurse-prescribing. At its meeting May, 1998, the Nursing Council agreed that, with allowance for existing diploma programmes to phase out, from 1998 entry to the register would be via a bachelor degree. Also within these first six months of 1998, it was announced that an additional $5 million would be earmarked by Government for Clinical Training Agency (CTA) funded post registration nursing programmes.

While New Zealand was the first country to enact a nurse registration act in 1901, it has been exceedingly slow to
develop the educational and practice-based conditions necessary for the development of advanced or expanded practice. After a decade of on-going health reform, re-engineering, down-sizing, and numerous policy documents which referred not to "doctors" and "nurses", but rather to "health care workers", it is ironic that there is now such momentum for the development of advanced nursing practice.

This article will explore these initiatives, and examine the proposed clinical nurse specialist and nurse practitioner roles in light of experience in the United States in developing advanced or expanded nursing practice.

Whether post-basic nursing education?

For some time, nurses have decried the lack of structure and mechanisms for national recognition for what used to be termed "post-basic" nursing education. A number of accounts describe the persistent and often frustrated efforts of nurses to establish enduring structures for post-basic education in the period 1920-1980 (Department of Health, 1988; Miller, 1984).

"Post-basic" was used to describe any formal programme of study following qualification as a registered nurse. More recently, the preferred term has changed to "post-registration" or "post-entry". The term "post-graduate" education refers to a formal programme of study, generally available to students who hold a first degree.

The enactment of the Education Act 1989, which established the New Zealand Qualifications Authority, with its power to approve and accredit non-university degree programmes, led to vastly increased access to bachelor degree studies in nursing. It was anticipated that as degree studies became more accessible, previously qualified nurses would complete a first degree, and there would be a concomitant increase in numbers of nurses taking up post-graduate study. To some extent, this appears to be occurring. However, availability of postgraduate programmes is still limited in terms of accessibility, and also with respect to the balance achieved between clinical components and an academic/research focus.

In 1994, as a result of an "unbundling" exercise, funding which was earmarked for post-registration education of health professionals was identified, and the CTA, now a division of the Health Funding Authority was established. Its function was to identify and fund post-registration clinical training and education, deemed of priority, for health professionals employed in the public sector. Currently, these programmes are contracted yearly, on a contestable basis. This severely limits longer-term strategic planning and development. There are also concerns regarding the small proportion of CTA funding committed to nursing.

Nevertheless, with some growth in the number of nurses undertaking postgraduate education, and with the CTA providing funding for those programmes substantially clinical in nature, a postgraduate structure to support the development of advanced nursing is beginning to appear. While this foundation and outline is beginning to take shape, what is urgently required is comprehensive set of designs.

The Nursing Council Framework, Guidelines, and Competencies for Post-Registration Nursing Education

During this time when the walls that divide inpatient, outpatient, primary, tertiary and community care are coming down, society should expect that the
nursing profession will prepare and regulate advanced practice nursing for the good of the patient and society as a whole (Cronenwett, 1995, p.117).

By establishing a framework and guidelines for post-registration programmes, the Nursing Council clarifies the "national direction for the development and recognition of post-registration nursing education", and exercises its statutory authority to assess and endorse such programmes in fulfilling its role to protect the public. Furthermore, it "supports the portability of specialty and advanced practice nursing qualifications both nationally and internationally" (Nursing Council of New Zealand, 1998, p.3).

The Nursing Council Framework, Guidelines and Competencies for Post-Registration Nursing Education (May 1998) was developed out of a consultative process initiated by the Nursing Council in February 1996. It also drew on a Nurse Educators in the Tertiary Sector (NETS) position paper developed in the period 1995-96, later endorsed by both the Nurse Executives and the Nursing Council (NETS, 1997).

It is relevant to consider that this renewed impetus for the development of an advanced nursing education and practice structure was gathering momentum by the mid-1990s, and was being driven from the perspectives of both nursing education and nursing practice. When NETS had developed their position paper on post-registration education, they sought dialogue, consensus and endorsement from other key nursing groups. While the NENZ and the Nursing Council both endorsed the position paper, the absence of the New Zealand Nurses' Organisation (NZNO) is noteworthy, and might have presaged their withdrawal from the Ministerial Taskforce on Nursing which occurred in 1998.

The Nursing Council Framework, Guidelines, and Competencies for Post-Registration Nursing Education, delineates a "pathway from beginning nursing practice through to advanced nursing practice for those nurses who wish to pursue post-registration nursing education at other than the continuing education level" (Nursing Council, 1998, p.8). The framework discusses beginning nursing practice, returning to nursing practice, specialty and advanced practice.

In the early phases of Nursing Council's consultation on the proposed framework, it became clear that there were different understandings of the term "specialist" and "advanced" nursing practice, as used in the first draft document (Nursing Council, 1998). A subsequent draft, dated August 1997, saw a change in the terminology from "specialist" to "specialty".

The term "specialty", rather than "specialist" nursing practice used in the August 1997 draft emphasised a shift in thinking. This stance recognises that every area of nursing practice is a specialty area with its own unique characteristics. The Working Group was unable to identify any area of nursing practice, which could be called "general" nursing. Use of specialty nursing practice refers to the context of practice and overcomes the difficulty of defining specialist. It underlines the fact that merely working within an area of defined focus does not necessarily mean that the nurse is a specialist (Nursing Council, 1998, p.5).

The Nursing Council Framework states that the registered nurse may gain competencies for specialty practice through experience, or through completion of a specialty practice programme. The Nursing Council document goes on to say that a registered nurse who completes a
specialty practice programme could ultimately become recognised as a "specialist" practitioner. Nevertheless, in this attempt to provide clarification, the logic and language being used to delineate specialty practice remains equivocal. The relationship of specialist practice to advanced practice is not entirely clear in the Nursing Council framework.

Advanced nursing practice, as defined by the Nursing Council, "is the integration of research-based theory and expert nursing in a clinical practice area, and combines the roles of practitioner, teacher, consultant, and researcher" (Canadian Nurse Association, cited in Nursing Council May 1998, p. 10). The advanced nursing practitioner:

- Shows collaborative, expert practice across settings and within interdisciplinary environments;
- Shows effective nursing leadership and consultancy;
- Develops and influences health policies and nursing practice at a local and national level;

Advanced practice roles: Clinical Nurse Specialist and Nurse Practitioner

In April 1998, NENZ published a document, Developing and Supporting Advanced Practice Roles: Clinical Nurse Specialist, Nurse Practitioner. This paper proposes the formalisation of two independent, advanced practice roles, the clinical nurse specialist (CNS) and the nurse practitioner (NP), and recommends the educational preparation and credentialing process for these roles.

In proposing the formalisation of the roles of CNS and NP, NENZ draw on the development of these roles in the United States, where nurses in a range of advanced practice roles have been providing health care for more than 50 years (American Association of Colleges of Nursing (AACN), 1997). However, in spite of this rather long history of advanced nursing practice, "neither the educational preparation nor the certification process has been standardized" (AACN, 1997). Since 1992 the issue of regulating advanced practice nursing - the educational preparation, titling, and credentialing - has been an area of concern in the United States (AACN, 1997; Cronenwett, 1995; Hickey, Ouimet, & Venegoni, 1996; Rasch & Frauman, 1996).

In the United States, CNSs and NPs are two of the four categories of advanced practice nurses, which also include certified nurse midwives and certified nurse anesthetists. However, numbering approximately 70,000, CNSs and NPs together, account for 70-75% of all advanced practice nurses in the United States (Hickey et al, 1996).

Preparation for the role of CNS in the United States has required a master's degree in a nursing specialty. However, throughout the 1980s to 1990s graduates of these master's programmes "often came to clinical agencies with no discernable expansion of practice skills" (Cronenwett, 1995, p.113). Nevertheless, as they "had been socialised to be professional leaders and critical thinkers; motivated to learn and teach others, they contributed immensely to the improvement of basic nursing practice throughout the country" (Cronenwett, 1995, p.113). Their roles as CNSes were diverse, and included providing staff development and continuing education; leading practice initiatives, both within the discipline of nursing...
and interdisciplinary and developing and evaluating standards of care.

The CNS has traditionally practiced in an institutional setting, but the services provided have differed from institution to institution. Their practice has been characterised by collaboration with other nurses and with physicians, education, research, consultation and administration, and to a lesser extent, with direct practice (Cronenwett, 1995; Rasch & Frauman, 1996).

In the United States, the first NP programme was established in 1965 at the University of Colorado (McGrath, 1990). “The original impetus for the development of the NP role was a shortage of physicians, especially in underserved areas and in the care of poor people” (Rasch & Frauman, 1996, p. 142).

Debate arose over what traditional medical tasks could be assumed by NPs, including contention over which of those tasks required changes in nurse licensure. “This controversy resulted in rigid and rigorous educational requirements” (Rasch & Frauman, 1996, p. 142). A United States government study later demonstrated that 50 to 90 percent of physician responsibilities may be safely undertaken by NPs (US Office of Technology Assessment, in McGrath, 1990).

Additionally, in working through the arguments about "delegated medical practice" versus expanded or advanced nursing practice, NPs affirmed and delineated “the nursing practice inherent in their role” (Rasch & Frauman, 1996, p. 142). One result of these efforts has been “a standardised product”: the consumer, whether an employer or a patient, knows what a NP is able to do.

Until recently, the nurse practitioner has practiced mainly in primary care or ambulatory settings, while the CNS was seen primarily in hospitals. A study by Fenton and Bryczynski (1993) found that NP practice was more focused on health, while CNS practice was more associated with episodes of illness.

However, these distinctions have blurred (Cronenwett, 1995; Hickey et al, 1996; Rasch & Frauman, 1996). Increasingly, nurse practitioners are employed to deliver primary care to particular groups of patients in hospitals, while clinical nurse specialists are employed in group practices of physicians and surgeons. Market forces and re-engineering have led to reductions in physician house staff; CNS positions have been lost or redesignated as case managers; and opportunities for NPs in hospitals have expanded.

Furthermore, the body of evidence of NP effectiveness continues to grow as their practice includes both primary and tertiary care settings (Cronenwett, 1995; Grey & Walker, 1998; McGrath, 1990). While the concept of NPs developed in response to a physician shortage, the use of NPs has been found to increase accessibility, contain health care costs, improve preventative and wellness care, and improve quality of care (McGrath, 1990).

Nurse practitioner programmes are at the post-registration level, but not necessarily at masters level. Therefore some practitioners have lacked the “integration of theoretical, research and practice-based knowledge, accompanied by preparation and socialisation for leadership of the profession” (Cronenwett, 1995, p.113). The third report of the Pew Health Professions Commission (1995) noted that if nursing is to be able to respond to the critical challenges of health care, it must expand the numbers of masters level nurse practitioner programmes.
An advanced nursing practice structure for New Zealand

The clinical nurse specialist as proposed by the NENZ (1998), is described as:

working within a specialty to co-ordinate the care of patients for that episode of inpatient or community care (e.g. orthopaedics, respiratory, wound management); other nurse specialist roles work with particular patient groups and offer specialist advice e.g. infection control and diabetes management. These nurses use advanced assessment skills, undertake diagnostic tests and initiate treatment approaches, retaining a nursing perspective while coordinating care from a range of health team members (p.2).

In delineating the nurse practitioner role, the Nurse Executives state that this:

nurse provides care for a patient or group of patients over an extended period of time across the community-inpatient-community continuum or may involve engaging the client/families in the pursuit of health behaviour and healthful living. The nurse undertakes comprehensive assessment, diagnosis, care planning, care delivery, care coordination and monitoring of patient/client progress (p.4).

Minimum educational preparation for the CNS role is completion of "two advanced clinical practice papers as part of a postgraduate diploma programme, of six months duration", correlating with level 8 on the New Zealand Qualifications Authority framework (Nurse Executives of New Zealand, 1998, p. 7). For the CNS, the clinical practice papers should include study of:

- Advanced physical and psychological assessment skills through the lifespan;
- Major health problems and rationale for clinical treatment management plans and pharmacological management;
- Advanced communication, counseling and goal setting skills;
- Skills in care coordination, case management/other care delivery models and interdisciplinary practice strategies;
- Strategies to enhance interdisciplinary practice, collaboration, and credibility (p.7).

The educational preparation for the NP builds on to that required for the CNS, with the continuation of study at level 8 through completion of a master's degree. In addition to the areas of study above, preparation for the NP role would also include:

- Strategies for working with individual/families/communities to foster independence and participation in planning and evaluating their care;
- Focus on health promotion strategies including roles of other health specialist agencies;
- Health policy and health economics;
- Ethical and legal issues in health service provision, including issues relating to documentation, risk management, scope of practice;
- Research and evaluation methodologies including change management and project management of new services (p.7).
The proposal for both a CNS and a NP role by NENZ, builds on the United States experience, situates the roles within the New Zealand context, and aims to avoid a number of problematic aspects of the United States experience. The NENZ proposal suggests that the NP role may follow or evolve from the CNS role, following completion of a masterate. Preparation for both roles share some common curricular elements, but avoids the duplication of master’s preparation for two distinct types of nursing practice. Nevertheless, it does not seem appropriate to assume that a CNS is limited to those who hold less than a master’s degree.

While there is no reference to earlier drafts of the Nursing Council Framework Guidelines and Competencies for Post-Registration Nursing Education, the Nurse Executives’ proposal for CNS and NP roles does appear to sit within the framework for advanced nursing practice. One area of difference is that the Nursing Council framework appears to describe beginning specialist practice, while the NENZ proposal describes advanced specialist practice.

The NENZ proposal for the CNS and NP roles would benefit from statements of aims, expected outcomes, and delineation of proposed competencies for each role, and indeed, this is likely to happen as leaders in nursing practice and education work together. The outcome of the work preparing for nurse prescribing will clarify the educational preparation and competencies required for this aspect of advanced practice. Should there be concerted action on the recommendations arising out of the Report of the Ministerial Taskforce on Nursing (1998) this will further the development of advanced nursing practice.

However, tensions within the profession may stymie nursing’s opportunity to deliver its potential to the consumers of health care. NZNO’s withdrawal from the Taskforce appeared to revolve around concern about regulation of advanced practice. However, imbedded in the organisation’s explanations of its withdrawal was a vein of anti-intellectualism, and the view that experience equals expertise. Christman (1998), although writing about nursing in the United States, could have been discussing elements of New Zealand nursing when he commented, “...nurse leaders of the various organisations have shown a general reluctance to energise change in raising standards... Is this because they are uneasy about losing the votes of that vast two-thirds without degrees?” (p.58). NZNO’s stance underestimates the values and commitment of its members who are nurses.

The Minister of Health and nurse leaders within practice, education, governmental and statutory bodies have played critical roles in bringing forward the various initiatives which would release nursing’s potential to improve health care accessibility, quality, cost-effectiveness and consumer satisfaction. The range of initiatives may point to a shift in the health reform process. For the past decade, the focus has been overwhelmingly on the financing and organisation of health care. The end of the 1990s may see the recognition of the central role of nursing (and other health professions) in improving health care outcomes for the population. Will nursing be prepared? In this time of momentous development for nursing practice, it is critical for all nurses to work together to shape advanced practice nursing.

The introduction to the Nursing Council document acknowledges that
the framework and guidelines will be modified over time in response to the changing context of nursing practice and education. The Nursing Council was wise to plan a first review of the framework at the end of one year. Nevertheless, to some degree, this adds to both the uncertainty for nurses, and the urgency to develop strategies for tomorrow.

CONCLUSION

This article has attempted to draw out the context for the development of advanced nursing practice in New Zealand, and to generate discussion among nurses and the community they serve. It would be tempting, and somewhat understandable, if a large body of nurses said they were too weary, burned out, or just plain too weary to engage in shaping the future of the profession. That scenario would be unfortunate for the members of the profession, but more importantly, it would be a serious loss for the consumers of health care.

De Beauvoir (cited in McBride, 1994) concluded that there are two important life principles: immanence, maintenance of what is, and transcendence, progression to what can be; and that women have generally been charged with the former, to the exclusion of the latter. It’s time to redirect some of our energies to shaping the preferred future for nursing’s contribution to New Zealand health care.

References


