

Advanced nursing practice: the case of nurse practitioners in three Australian states

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This paper provides insight into the work of nurse practitioners in three Australian states. Using a case study approach, the aim of the study is to give an account of some of the types of cases/patients who consult with the nurse practitioners in the states visited and to offer insight into one of the policy changes required to support the introduction of the nurse practitioner role. A snowball sampling technique was used to obtain the sample population of both 10 nurse practitioners and other health care personnel. Semi-structured interviews were conducted with the 39 respondents in both samples. The analysis of the 10 nurse practitioner interviews reported here shows that these nurses undertook a wide range of roles. The results of the semi-structured interviews with the nurse practitioners are described using four of the 10 interviews and reporting them as case studies. The results highlighted the need to address legislation issues and to prepare nurses adequately for their clinical setting and address the difficulties of continuing education of rural nurses.

Keywords: nurse practitioner, professional experience, advanced autonomous practice, education, Australia, health and nursing policy

INTRODUCTION

Over the last 15 years health care provision in countries such as the United Kingdom (UK), the United States of America (USA) and Australia has witnessed a shift in health care management styles. These have been driven by cost containment, advances in medical technology, reallocation of care functions from secondary to primary and community institutions, as well as increasing nursing and medical specialization. Together these have contributed to new models of care delivery and a restructuring of the health workforce, for example support workers are undertaking jobs previously done by nurses (Offredy 1995). The 1980s was a time of change in the British health care

system and it continues to be informed by reports which highlight these shifts in addition to advocating more flexibility in the delivery of care, taking into account patients' perspectives (Department of Health, DoH 1996). Alongside these shifts has been the development of the nurse practitioner role which was supported initially by a government-commissioned review of community nursing (Department of Health and Social Security, DHSS 1986). Thus a new role for the experienced nurse in general practice was envisaged.

BACKGROUND TO THE STUDY

The extensive debate about nurse practitioners has been a source of both inspiration and ignition to health commentators world-wide. Australia has been no exception. The Australian nurse practitioner debate began in New South Wales (NSW) at the 1990 NSW Nurses' Association

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Annual Conference where the then Minister for Health articulated support for independent nursing practice. In 1992 a working party (stage one) was established to pursue the issues associated with nurse practitioners.

The findings from the stage one working party concluded that nursing resources could be better utilized (New South Wales Health Department 1992). Nurses who were undertaking the role of nurse practitioners were constrained by legal barriers. The working party suggested that reforms in the areas of prescribing rights and initiation of diagnostic procedures would improve service provision by nurses. To this end they proposed that pilot projects should be established to ascertain client outcomes and the cost effectiveness of nurse practitioner services.

Following on from the stage one working party, a further working party (stage two) was established. A specific recommendation from the stage two working party was that a series of pilot projects described in the first report be established within 6 months and completed within an 18-month time frame (NSW Health Department 1993).

Stage three commenced in 1993. Ten research projects were chosen from 58 submissions. The projects were chosen from three practice contexts: remote areas, general practice and area / district health services. The dimensions of practice to be examined were: competencies, accountability, diagnostic imaging, diagnostic pathology, prescription of medications, referral procedures and professional indemnity insurance. Analysis of data from each of the pilot projects demonstrated that nurse practitioners are feasible, safe and effective in their roles and that they provide quality health services in the range of settings researched. Access by patients to health services was improved and patient expectations were satisfied. Some of these findings are similar to those found in UK studies addressing nurse practitioners (National Health Service (NHS) Executive South Thames 1994, NHS Executive 1996). However, it is important to note that Australia is characterized by great distances, sparsely distributed populations and considerable geographical and social diversity. Compared to metropolitan areas, some populations experience significant problems of inequity with respect to access to, and provision of, health care services. Consequently, strict comparisons of health care provision between Australia and the UK are to be avoided.

Other recommendations from the stage three committee addressed issues relating to the diagnostic imaging that may be initiated by nurse practitioners, their education, and the medication orders which may be written by them (NSW Health Department 1995).

These recommendations can be seen as establishing the important infrastructure required for nurse practitioner services so that, for example, significant gaps in their knowledge base can be filled and, of equal importance, these nurses are not practising beyond the bounds of the laws and regulations of their state and federal legislation.

The current debate in the United Kingdom (UK) regarding nurse practitioners has focused on moving towards recognizing those nurses who are working at a higher level of practice. The United Kingdom Central Council for Nurses, Midwives and Health Visitors (UKCC) acknowledged that concepts such as specialty and specialist practitioners are confusing and may be replaced by the term 'higher level practice' (UKCC 1998). Work is in progress (December 1999) to clarify what higher level practice entails. This article provides insight into some of the work undertaken by nurse practitioners in three Australian states. It also gives a brief mention to one of the policy changes in New South Wales. Not all states use the term nurse practitioner. However, it was generally recognized in the three states visited that nurse practitioners were a type of advanced practice nurses.

ISSUES ARISING FROM PREVIOUS LITERATURE REVIEW

It was not the intention of this study to include an appraisal of the literature relating to nurse practitioners as this has been explicated elsewhere (Hamric & Spross 1989, Safriet 1992, Solomon Cohen & Juszczak 1997, Offredy 1998). However, examination of the literature showed that definition of advanced practice and nurse practitioner roles and practices differ internationally as well as in the UK and Australia. This may imply that both national and international agreement on advanced roles and practices is still developing, and it may be that cross-cultural translation issues make consensus difficult. For the purpose of this paper the term nurse practitioner will be used as it was a title familiar to the Australian participants of the study. The conceptual definition of nurse practitioner used here is one borrowed from New South Wales which describes a nurse practitioner as one who is a:

... registered nurse working at an advanced practice level leading into practice as an expert nurse, the characteristics of which would be determined by the context in which they have been accredited to practice.

(NSW Health Department 1998).

AIM OF THE STUDY

This paper is part of a larger study in which the overall aim is to examine the decision making processes of nurse practitioner consultations. The aim of this paper is to give an account of some of the types of cases/patients who consult with nurse practitioners in Australia and to offer insight into one of the policy changes surrounding the nurse practitioner role.

Ethical approval was sought in Australia before embarking upon the research. Contact was made with key personnel at universities approximately 8 months prior to the commencement of the programme. Detailed

information on the proposed research programme was submitted to the universities as well as to potential study participants before approval was obtained.

METHOD

The research adopted a case study approach to explore the work of the nurse practitioners sampled. This approach allowed the researcher to focus on different characteristics of the practitioner whereby different ways of knowing gained from different experiences are brought together to understand and articulate practice and thereby create a new meaning. A disadvantage of the case study method is its lack of generalizability to other settings, although its conceptual development may result in the stimulation of comparable research elsewhere.

The setting

Three Australian states were visited as part of a research programme. Visits were made in each state to: university faculty staff and students, Nurses' Registration Boards, the Department of Health/Department of Human Services, Australian Nurses Federation, and the workplaces of nurse practitioners in rural and urban areas.

Subjects

Semi-structured interviews were conducted with a variety of non-nursing personnel and with a sample population of 10 nurse practitioners described in this paper. The rationale for the sample was to obtain a broad perspective on the development of nurse practitioners in the states visited.

A snowball sampling approach was used. This is an effective convenience sampling method whereby each respondent assists the researcher to find the next subject until there is a sufficient number for the research. It offered the researcher convenience but at the risk of sample bias. Several steps were taken to reduce the likelihood of sample bias: (a) subjects were sought from a variety of employment settings and with a good spread of respondent characteristics; (b) subjects included those with relevant post-registration qualifications as well as those without; and (c) both experienced and less experienced nurse practitioners were included in the study. A drawback of this approach is that the sample only represented a particular sector of the population under review and generalizations should not be drawn from these cases.

Procedure

Two sets of semi-structured interview schedules were devised, both of which had different foci. For the 10 practising nurse practitioners, the interview schedule was concerned with three broad areas, namely:

- demographic details such as, length of time in current post, length of nurse practitioner experience, age and qualifications;
- general issues which included issues relating to primary care and the employment of the nurse practitioner; and
- details of patient consultation, such as types of cases seen by the nurse practitioner, workload, referral patterns, research-based practice and decision making techniques.

The semi-structured interview schedule with non-nursing personnel addressed two main areas:

- respondents' perspectives on the evolving nurse practitioner movement; and
- some of the policy issues surrounding the nurse practitioner role.

A total of 39 interviews were conducted and the subjects' verbalizations were recorded for subsequent verbatim transcription and analysis. The length of the interviews varied from 40 minutes to 1½ hours.

RESULTS

These results refer to the 10 semi-structured interviews conducted with the 10 practising nurse practitioners. The nurse practitioners in the three states visited (Victoria, South Australia and New South Wales) saw different types of patients and described themselves as either independent nurse practitioners, nurse consultants or a nurse practitioner specializing in a particular disease/client group. A selection of four case studies, from each state, is used to illustrate their clinical domain, educational preparation and decision making. Pseudonyms are used to protect the identity of the study participants.

Case study 1: an independent nurse practitioner

Peggy described herself as an 'independent nurse practitioner'. Her field of work was in women's health, but specifically in the provision of Pap smears (The terms Pap smear and Pap test are used in this paper to refer to the smear test developed by Dr George Papanicolaou for the detection of cervical dysplasia). What was striking about this practitioner was the narrow field of work in which she operated while at the same time referring to herself as a nurse practitioner. A synopsis of her work illustrates the point.

Peggy has been working as a Pap smear provider for the past 8 years. Her qualifications include: registered nurse; a family planning course; a university-based course in women's health, screening and therapies which is recognized as a nurse practitioner course to undertake Pap smears. This competency-based course consisted of

6 months theory ('lectures and assignments') and 6 months supervised clinical practice. During the latter period, course participants complete between 15 and 25 Pap smears with the emphasis being placed on the number of Pap smears that provided a 'learning experience of high quality' (Jarman 1997 p. 22). In addition, Peggy attended a 2-week cytology reading course, as well as other short courses relating to women's health.

Peggy reported that she had 'lots of experience in family health and family planning, before going out on my own'. Her caseload extended over a wide rural area. She was contracted to work from a variety of bodies and organizations, for example community health centres, neighbourhood houses, hospitals, and occasionally, GP (general practitioner) clinics. She provided her own equipment including a variety of speculae, a table, all the bedding requirements and two angled lamps. She was 'self sufficient except for water and power'. Patients were allotted 30-minute appointments during which time they received information about the role of the nurse practitioner, procedures for the smear test, and the equipment that was used. Breast awareness/examination formed part of the consultation process. A vaginal examination was undertaken if the nurse practitioner considered that this was necessary. The decision to undertake a vaginal examination was based on the patient's past and present history.

Peggy reported that many patients attended the clinic with complaints or problems unconnected with their Pap smear and for which her professional advice/opinion was sought. It was also stated that a significant proportion of the women attending for the Pap test did not, for a variety of reasons, attend their GP's surgeries, thus the nurse practitioner in this setting performed an extended primary care role, including welfare work and counselling but was only paid for Pap smears.

Completion of the relevant pathology forms was also undertaken by Peggy and these together with the slides on which a sample of cervical cells was placed were sent directly to the cytology service. Patients were informed of an approximate time frame in which they could expect their results. Decisions were made by the patients about whether or not their GPs should be informed of the result of the smear test, particularly if the invitation for smear testing did not originate from the GP. If required, Peggy would see the patient for a follow-up appointment.

Peggy decided, according to standardized procedures, the timing of the invitation for smear testing. The decision to refer patients to specialist services was made by the nurse practitioner on the basis of the result of the test, her knowledge and experience. When a patient failed to attend for an appointment a reminder was sent out by the nurse practitioner. When two appointments were unattended, a further reminder was sent from the cytology service. Thus data on patients' Pap smear results were

recorded by both the cytology service and the nurse practitioner.

Employment conditions

Payment to the nurse practitioner was by way of an invoice to whomsoever contracted her services. Similarly, she was charged by the hospital for using their sterilizing equipment for her specula. Peggy did not indicate who supervised her practice, although she was the clinical supervisor for other nurses undertaking Pap tests.

Quality control

Peggy's work was monitored by two institutions: a university credentialling system monitored and evaluated her role, and the cytology service provided reports on the levels of endocervical cells for each Pap test according to age group.

Case study 2: community health nurse practitioner

In contrast to the independent nurse practitioner described above, the nurses working in a rural area were forced to change their practice, without preparation, due to closure of the local community hospital. Practice shifted from a traditional hospital model to a primary health care, practitioner role. The situation was summed up by the nurse practitioner participant of the study: 'One day we're working as hospital nurses, and the next day we're supposed to be community health nurses without any training or qualifications'.

Amanda held a single qualification of registered nurse. The work of the five nurses at the centre could be defined as (semi) autonomous and together they provided the local population with direct access to a health care worker. Two of the nurses were midwives with active involvement in women's health and maternal and child health. The other health professionals visiting the centre consisted of: a pharmacist, a paediatrician, a physiotherapist, a diabetic educator and a speech pathologist. There were also two private alternative health therapists. Psychiatric nursing service was provided on a 24-hour call number. The centre also offered respite care for 1 day per week for local elderly or terminally ill patients.

When medication was required by the patient, the nurse telephoned the GP with her findings and suggestions. She then received a telephone order from the GP to dispense the drug, which was kept in a locked pharmacy cupboard at the centre. The GP wrote a prescription for the pharmacist to reimburse the nurse for that medication. In some cases the prescription for medication was written retrospectively. This meant that the clinical decision about medication and its dispensing was taken by the nurse practitioner prior to the telephone consultation with the GP.

Employment conditions

Amanda was employed by the health centre. She reported experiencing minimal professional support by her employers and little legislative protection for the extended scope of practice expected.

Quality control

An on-site co-ordinator provides some supervision, but Amanda reported that 'she's incredibly busy and it's not always easy to sit down with her and plan projects'.

Case study 3: nurse practitioner in epilepsy

This was a funded innovative position, the aim of which was to:

... reduce the incidence of hospital admissions by the introduction of a nurse practitioner service which will link support services between hospital and GPs and improve the self-management skills of clients with epilepsy. (Sarah, nurse practitioner in epilepsy)

Sarah described herself as a nurse practitioner. Her sole qualification was registered nurse, in addition to 6 years experience of working in the community with clients suffering from epilepsy. Sarah was based in the local hospital and had a dual role which included primary care. She described one aspect of her role thus:

... when someone comes in hospital for diagnosis my role is to educate them and support their needs and to a degree take diagnostic details; talk to all the family to get a feel for what's happened in the past as far as their management is concerned... I talk to them about what happens when they come in here, what we want from them, what we expect to get, how it would influence their ultimate treatment. I also make sure they come in with all the tests being done; they may need some imaging before they come in and some neuropsychology testing, so I make sure that's all co-ordinated. So really this part of the job is to participate in the co-ordination and all diagnostic work-up and history and management of the patients who come in for neurological surgery and supervise what's happening in the ward for the week; keep the neurologist informed if there are any problems. (Sarah, nurse practitioner)

The community aspect of the role had not developed due to the increase of in-patient care for this client group. However, telephone contact was made with patients after discharge from hospital and patients were informed that the nurse practitioner was their first line of contact. Telephone contact highlighted that patients did not necessarily have to go to their GPs as the nurse practitioner was able to provide a direct response to their problems. Treatment decisions were also provided over the telephone and these were seen to be documented in the patient's notes. A telephone call was also made to the patient's GP to inform her of the alteration in treatment and 'to make sure

that we are all singing from the same hymn sheet' (Sarah, nurse practitioner). She continued to explain that

... what the unit is trying to develop is a more responsive epilepsy service... research has shown that GPs don't know very much about epilepsy and when patients go along to their GPs, they [the GPs] are unsure of the drugs and unsure of epilepsy and its management. The patients themselves see this. So it's important that they [the patients] can access someone who understands what is happening to them. (Sarah, nurse practitioner)

Observation of Sarah's nurse practitioner-led clinic sessions revealed that detailed information was given to patients regarding, for example, side-effects of drugs, and the ramifications of non-compliance with therapy. New patients were allotted 1-hour appointments while follow-up patients were offered 30-minute appointments. Observation of education/management of a new patient (who was accompanied by his wife and son), showed that comprehensive education about epilepsy was offered to both the family and the patient which included how to respond to the epilepsy and basic safety. The discussion also included the varying lengths of time patients require medication, the side-effects of these and, importantly, the implications for drivers who are diagnosed as epileptic. During the consultation the nurse practitioner cited current research evidence to support her decisions about patient management. It is noteworthy that Sarah was one of two nurse practitioners to refer actively to research-based practice in their work (the other being the independent nurse practitioner).

Sarah saw a wide variety of clients, ranging from children to the elderly. Patients' medications were altered without consultation with a doctor, but as defined in a doctor-nurse practitioner approved protocol. Alterations were seen to be recorded in the patients' medical records and their GPs were informed either by telephone or by letter written and signed by the nurse practitioner.

Employment conditions

Although Sarah was employed by the hospital, she was accountable both to the neurologist and the head of nursing. This dual accountability resulted in conflict and Sarah reported that 'the neurologist would like me to continue to provide an inpatient co-ordinated role... and the health commission and director of nursing are encouraging me to provide an outpatient community role'.

Quality control

This was provided mainly by the neurologist because of the close working relationship between the two clinicians.

Case study 4: community nurse practitioner

Susan's job entailed a variety of schemes such as undertaking youth health programmes (age 11-17) and

facilitating the following: young mothers' (under 25 years of age) support group; women's health programmes; gay and lesbian support group for young people; and co-ordinating tutoring classes for 11–17-year-olds. Susan was based in what could be described as an urban health centre, but with no medical practitioners permanently on site. The centre was a government-funded organization which was headed by a chief executive officer. Managers were appointed for different roles, such as finance, information technology, general service and health promotion. Team leaders reported to the appropriate managers. The teams included youth and family, aged care, counselling and paediatric. The participant in the study had a team leader as well as a line manager, who were different individuals. Susan was a registered nurse and a registered midwife with further qualifications in the same course in Pap smear provision outlined in case study 1 which entitled her to refer to herself as nurse practitioner.

Observation of a youth health clinic disclosed that some 17-year-olds attended the women's health sessions. The youth health clinic was a walk-in session where no initial appointments were necessary. Other health professions working in close co-operation with the nurse practitioner included a dietitian, a physiotherapist, a female GP and dental services. The young people arrived with an array of socio-economic and psychosocial problems. In some instances Susan acted as a conduit for directing clients to the appropriate service if their problem was outside her capabilities. The decision to refer clients was based on the nurse practitioner's knowledge of the patient's history, the presenting problem or condition, and knowledge of available services. Referrals were made to various agencies who, Susan said, were unaware of her status as a nurse practitioner. This was borne out by evidence of correspondence which was addressed to her as 'Dr Gibbs'. Her referral letters were written on the centre's headed paper and signed 'Susan Gibbs'. Susan's response to why she did not inform the consultants/specialists of her status was:

What matters is that my referrals are appropriate and that my clients are accepted and given the care they need. I know my referrals are appropriate because I have not had any refusal in two years. I can't beat the system, but I can get round it! (Susan, nurse practitioner)

Much of the work observed related to: advice on the contraceptive pill and self-care; pre-test counselling for HIV or sexually transmitted diseases; and to pre- and post-pregnancy termination counselling. On the day of the researcher's visit, the GP was in attendance and observation of the GP's work included general health assessments, treatment for sexually transmitted diseases and prescription for contraception.

Employment conditions

Susan is employed by the health centre and depending on the nature of the issue of concern, she will direct her query to either her team manager who had a health care background, or to the line manager, who is the budget holder and who did not have a health care background.

Quality control

In addition to the team manager who provides some clinical supervision, Susan's role has been subject to peer review. The local health department has also undertaken some evaluation about service provision and youth services at the centre. As in case study 1, a university credentialling system also monitors her role. There is also regular periodic assessment by clients.

NEW SOUTH WALES LEGISLATIVE INFRASTRUCTURE

The 25th August 1998 was an important day in the developmental process to recognize and implement the title and role of nurse practitioners in New South Wales (NSW). It is the first state in Australia to have the title of 'nurse practitioner' protected by legislation. Tacit agreement between states was secured to allow NSW to develop and pilot nurse practitioner programmes. Some states have already begun to emulate and adapt the NSW scheme to suit their local needs. However, a limitation of the introduction of nurse practitioners is that the scheme will commence initially with 40 nurse practitioners in rural and remote areas of NSW. This is due both to political and legislative imperatives.

The introduction of nurse practitioners in NSW necessitated changes to legislation as well as the introduction of clear guidelines/protocols on the implementation of nurse practitioner services. Legislative changes were introduced in the spring session (1998) of Parliament and included amendments to:

The Nurses Act (1991): there is protective legislation of the title 'nurse practitioner' which means that only registered nurses who have been accredited by the Nurses Registration Board of NSW will be able to use the title.

The Poisons and Therapeutic Goods Act(1966): amendments include granting and supplying rights to nurse practitioners for substances in particular sections of the Poisons Schedules. At present this excludes Schedule 8 drugs, that is, drugs of addiction. In exercising these privileges, the nurse practitioner must act within an approved formulary. 'Approved' means approved by the Director-General of NSW Health Service.

The Pharmacy Act (1964): amendments state that pharmacists can dispense medications prescribed by nurse practitioners. The Act has also been amended to allow

nurse practitioners to dispense medications with the same limitations as those imposed on medical practitioners.

It is recognized that in some practice arenas nurse practitioners may need access to Schedule 8 medications (drugs of addiction) and the issue is to be considered by a working group (Nurses Amendment Bill, 1998).

DISCUSSION

Nurse practitioners in the three Australian states visited undertook a wide variety of roles, particularly those in rural and remote areas. Evidence from this study showed that the rural nurse practitioners appeared to be key health care figures who provided information, made preliminary diagnoses on presenting problems and offered advice and treatment on a range of clinical and social problems (case study 1, Peggy). Kreger (1991) indicated that consumers of health care in rural areas expected rural nurses to function in an extended role, especially in the absence of a doctor.

This view is further supported by the Institute of Nursing Executives of NSW (1998 p.6) which asserted that:

Rural nurses have traditionally assumed the medical role by default, not design — the expectation of the community being that members will be treated in their own environment... This is a role with no formal medical recognition or legal sanction.

This is borne out by Susan's work in case study 4.

A critical issue identified by Amanda (case study 2) was the lack of educational preparation for the role as well as a lack of access to ongoing education and peer support. Although the nurse practitioner had many years experience in hospital care, a broader knowledge base was required in response to the community's needs. An evaluation of this new nursing practice model of health care delivery highlighted the issue of up-dating education. A formal programme focusing on community health was suggested by Amanda as beneficial as this included a social model of health, and community development. The broader knowledge base is crucial to these nurses if they are to develop the competencies required to deliver a nurse-led health service in the rural areas of Australia. Lack of education limits the service to the public and ultimately limits the decision making capacities of the nurse.

Evidence from the Nurse Practitioner Project Report (NSW Health Department 1993), as well as discussion with nurse practitioners interviewed during the research programme emphasized the need for advanced education programmes according to their practice specialty. Although one of the remaining six nurse practitioners interviewed had master's level education, she felt that she wished she 'had more knowledge about the systemic problems that might develop, and I would at least know about the different options available and I could take this

into account when making decisions and when educating patients' (Jenny, nurse practitioner).

Despite the legislative legitimization of the nurse practitioner movement in Australia, the NSW Branch of the Australian Medical Association (AMA) saw the decision as a 'black day for rural health' and claimed that the government had 'caved in to nurses' in a 'retrograde step used only in countries where primary healthcare is inadequate' (Editorial, *The Australian* 1998 p. 12). The medical profession's opposition to the concept of nurse practitioners is based on the 'fundamental premise that primary health care is the role of general medical practitioners who provide comprehensive, safe, efficient and cost-effective care' (Napier 1998 p. 8). The AMA believe that 'only medical practitioners have the requisite training, knowledge and skills to provide comprehensive patient care' (Napier 1998 p. 8). However, Humphries (1998 p. 3) writing in the *Sydney Morning Herald* quotes the Australian College of General Practitioners as saying that the decision to recognize nurse practitioners 'formalises a process already in place and established by need'. Sarah in case study 3 is reducing the need for patients in her specialist client group to see the GP and she is already able to alter drug regimes before gaining permission from the GP (as outlined in a doctor–nurse practitioner agreed protocol). Sarah cannot legally prescribe medication.

CONCLUSION

This Australian experience has some powerful implications for the current debates taking place in Britain in terms of the development and responsibilities associated with emerging advanced practice nursing roles. Not least of these implications is the need for the appropriate legal framework and policy infrastructure if the development is to succeed. This is particularly so in relation to changes in the interface between nursing and medicine and the threats and opportunities that this dynamic relationship evokes.

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